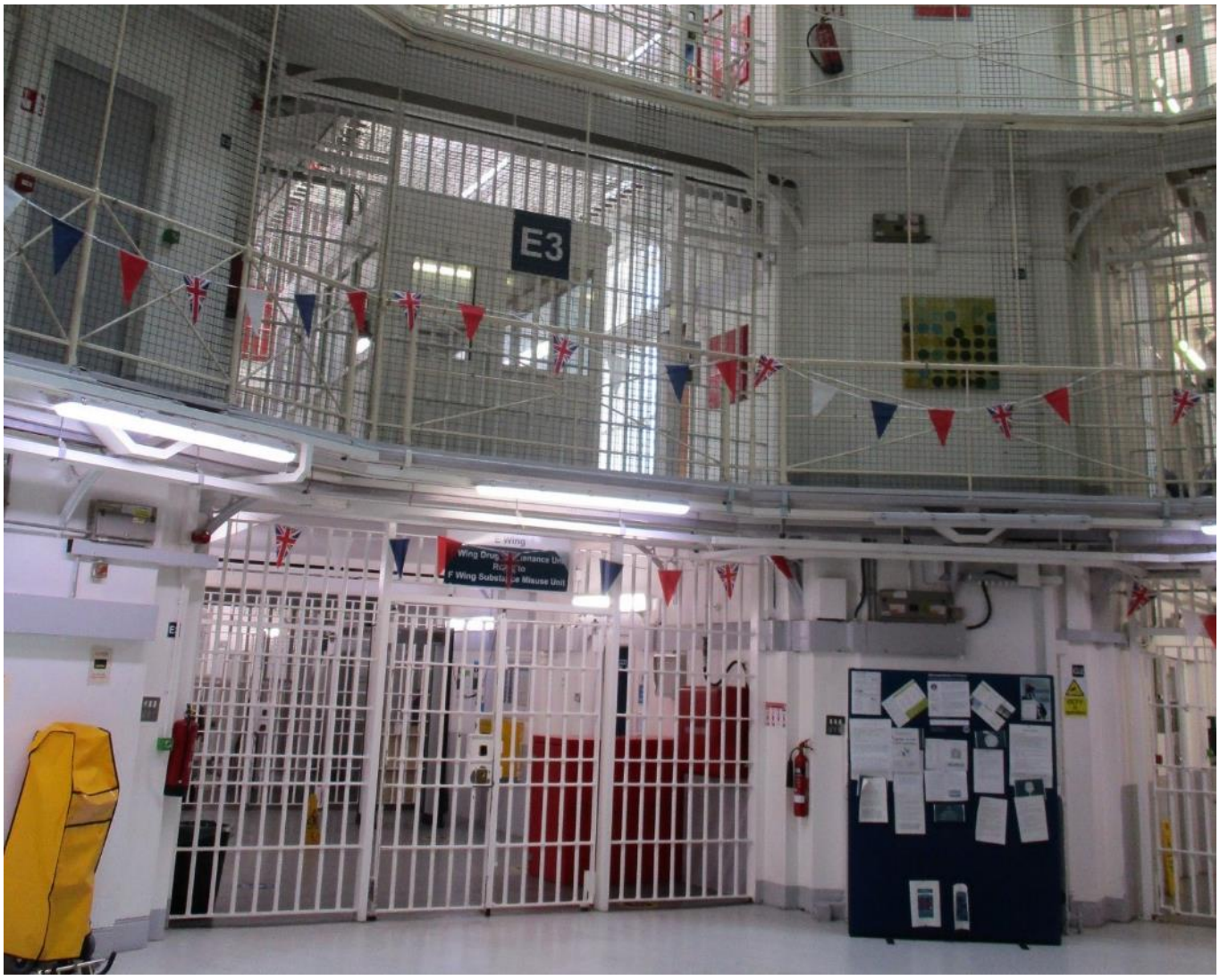
Report on an independent review of progress at

HMP Pentonville

by HM Chief Inspector of Prisons

11–13 April 2023



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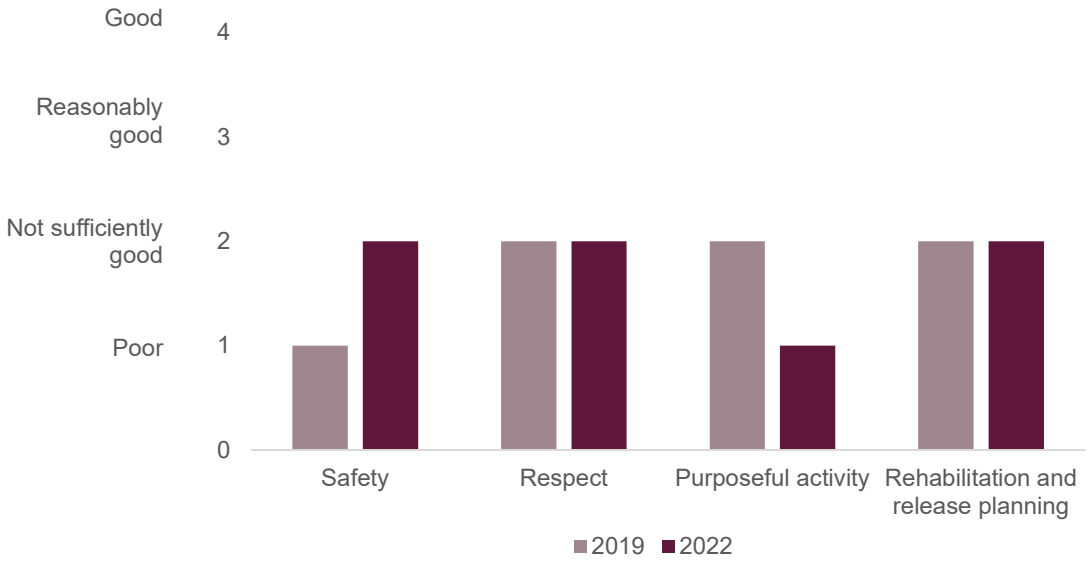
Section 1 Chief Inspector's summary

1.1 HMP Pentonville in North London is one of the oldest prisons in the country. It received its first prisoners in 1842 and was designed to hold 520 people in single cells. Today, it is a category B reception prison, holding over 1,100 remand and convicted male prisoners aged 18 and over.

1.2 At our previous inspections of HMP Pentonville in 2019 and 2022 we made the following judgements about outcomes for prisoners.

Figure 1: HMP Pentonville healthy prison outcomes in 2019 and 2022



1.3 Then we found that outcomes for prisoners were not sufficiently good in our healthy prison tests of safety, respect and rehabilitation and resettlement planning, while purposeful activity was assessed as poor. As we reported then, Pentonville has habitually been one of the more challenging and troubled prisons with a succession of poor inspections and, while the last full inspection identified some positives, many concerns remained. There had been some improvements to safety, but significantly there had been seven self-inflicted deaths since 2019 and the care for those at risk of self-harm was not good enough. Fundamental weaknesses in offender management and the provision of activities were identified and living conditions were poor.

1.4 These concerns were further exacerbated by the impact of limited time out of cell and more than 60% of the population living in overcrowded cells. As I said at the full inspection, if the prison was to make further progress, national leaders needed to accept the limitations of an establishment that has to work harder than most to battle through its entrenched problems.

1.5 At this independent review, we considered the progress leaders had made against nine of our concerns and two themes identified by Ofsted. While we did not identify sufficient evidence to report good progress in any of the areas reviewed, we did identify reasonable progress in five concerns, with insufficient progress identified against three. Ofsted found that there had been reasonable progress in both themes reviewed.

1.6 It was, however, extremely disappointing that in one of the most critical priority concerns – overcrowding – we found that there had been no meaningful progress. Paradoxically, rather than reducing the significant overcrowding, we found that the population was higher than at our full inspection, with plans to increase it further. Official National Statistics have predicted increases in the prison population for some time, and senior HMPPS leaders need to take responsibility for the failure to plan effectively to reduce overcrowding at Pentonville: overcrowding which inevitably has a detrimental impact on outcomes for prisoners across several areas.

1.7 Prison leaders had focused on making improvements for prisoners during their early days. There had been some tangible evidence of progress, but the approach taken by staff to providing prisoners with basic items for daily living was not consistent. The creation of G1 as a neurodiversity unit to support prisoners with specific needs was clear evidence of what leaders at Pentonville can achieve when population and staff resources are adequately managed.

1.8 Across the prison, the needs of prisoners with low-level mental health conditions were now being met and most of the shortfalls in primary care services had been addressed. However, time out of cell remained poor for most prisoners and progress against our concerns in rehabilitation and release planning was too slow.

1.9 This visit, eight months after the full inspection, identified several areas of reasonable improvement at Pentonville, for which the governor and his deputy should be commended. However, as I said at the full inspection, there have been more false dawns at this establishment than at most other prisons. The governor’s and his team's perseverance require significant support from senior HMPPS leaders, particularly to reduce overcrowding, to make sure that the fragile progress identified during this review can become fully embedded and improve outcomes over time for prisoners at Pentonville.

Charlie Taylor
HM Chief Inspector of Prisons
April 2023

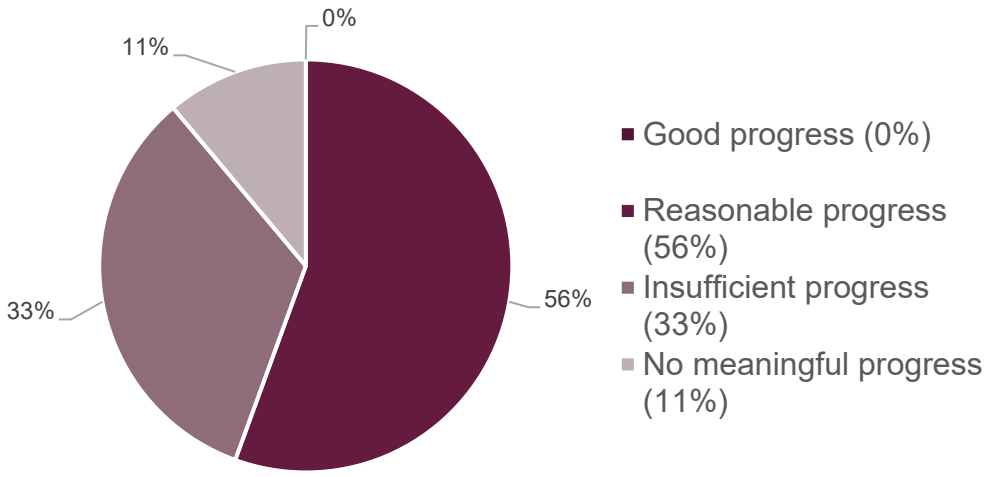
Section 2 Key findings

2.1 At this IRP visit, we followed up nine concerns from our most recent inspection in July 2022 and Ofsted followed up two themes based on their latest progress monitoring visit to the prison.

2.2 HMI Prisons judged that there was reasonable progress in five concerns, insufficient progress in three concerns and no meaningful progress in one concern.

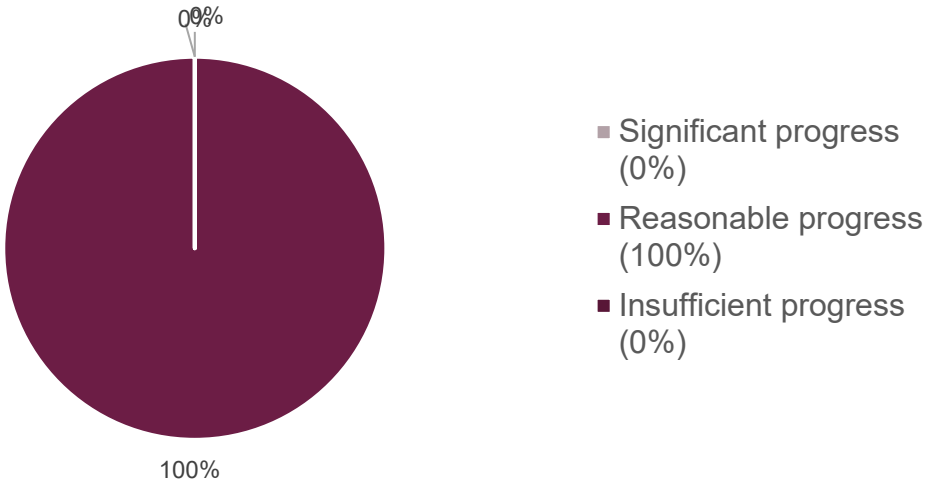
Figure 2: Progress on HMI Prisons concerns from July 2022 inspection (n=9)

This pie chart excludes any concerns that were followed up as part of a theme within Ofsted's concurrent prison monitoring visit.



2.3 Ofsted judged that there was reasonable progress in two themes.

Figure 3: Progress on Ofsted themes from July 2022 inspection (n=2).



Notable positive practice

2.4 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

2.5 Inspectors found one example of notable positive practice during this independent review of progress.

2.6 Listeners (prisoners trained by the Samaritans to provide emotional support to fellow prisoners) had access to a 'grab bag' including a kettle and drinks to help settle prisoners in crisis if called to support meetings. (See paragraph 3.27)

Section 3 Progress against our concerns and Ofsted themes

The following provides a brief description of our findings in relation to each concern followed up from the full inspection in 2022.

Early days in custody

Concern: Fewer than half of new arrivals said they felt safe on their first night in custody, and the management of risks was undermined by safety interviews that did not take place with sufficient privacy and the lack of first night checks for most prisoners.

3.1 Prison leaders had identified early days as a priority area and understood the importance of improving outcomes for prisoners during this critical time, as well as how this contributed to their perceptions of safety at the prison.

3.2 Many of the early days team had come into post since the inspection and often rotated between reception and the first night centre. Staff were enthusiastic and told us they had been involved in setting the direction of the work for the team at an away day in January 2023.

3.3 We saw staff working well with prisoner peer supporters in reception who greeted new arrivals positively and gave them information about the next stages of their custody.

3.4 The list of initial safety questions were only in English and we saw an example of staff using mime to ask if a prisoner had a problem with drugs, alcohol or self-harm. This was poor practice and confusing for prisoners.

3.5 The reception area had been improved. The holding rooms had been painted with murals and information boards installed. Funding had not yet been secured to install televisions in each room. The interview booths that we criticised at the inspection had been redesigned and the layout appeared to afford greater privacy than previously.

Improved holding room

Interview booths

3.6 The first night centre had improved. Communal areas were clean; wing painters covered graffiti promptly, of which we found very little. New cabinets were delivered for all cells during our visit. Cell orderlies had been introduced since the inspection to prepare cells for new arrivals, including making beds; this enabled prisoners to settle more quickly.

First night centre cell

3.7 Despite these improvements, cells remained too small to hold two prisoners and despite some clear improvements since 2022, we identified a small number of new arrivals, who had not been given basic items such as pillows and a more consistent approach by all staff was needed.

TV hanging by torn sheet

3.8 Since the inspection, a requirement had been introduced for staff to make four checks on a prisoner during their first night. However, leaders and staff responsible for early days were not able to assure us that all checks had been completed.

3.9 Some prisoners subject to public protection measures waited too long for their phone account to be activated. This led to frustration and anxiety during their early days and was not acceptable.

3.10 We considered that the prison had made reasonable progress against this concern.

Managing behaviour

Concern: A high proportion of prisoners said they felt unsafe and, in our survey, over half said they had experienced some form of victimisation from staff.

3.11 The safety department had surveyed prisoners in February 2023 to gain a greater understanding of whether and why prisoners felt unsafe, and whether they felt they were treated respectfully by staff. It was disappointing that this survey had been carried out so long after the full inspection and the results had not yet been formally analysed at the time of our visit. Leaders responsible for safety had not produced any formal action plan to improve outcomes. Nevertheless, raw survey data that we reviewed demonstrated that fewer prisoners said they had felt unsafe or had been treated disrespectfully by staff than we found in our survey in 2022.

3.12 Despite the lack of formal analysis, leaders were able to highlight specific actions that had been taken that they envisaged would make the prison safer.

3.13 Leaders had identified that prisoners' early experiences at the prison were likely to affect how safe they felt and had focused their attention on making tangible improvements in this area (see paragraph 3.1).

3.14 The G1 neurodiversity unit had opened in August 2022. It accommodated up to 45 prisoners, many in single cells, who struggled to cope in the main prison environment. Most of them had histories of challenging behaviour and, without the support of G1, it was probable that they would have engaged in violence, self-harm or general disruption elsewhere in the prison. The additional support, therapeutic activities and good staff levels on the unit motivated good behaviour, and there were few incidents of violence and a reduction in assaults. This unit provided good evidence of what could be achieved at Pentonville when overcrowding and staff engagement are appropriately addressed.

3.15 Actions and interventions to reduce violence among young prisoners had increased since the inspection. Cohort arrangements were managed more sensibly which meant that the Time4Change programme was now available to more prisoners. A very small number of prisoners were undertaking the Duke of Edinburgh award.

3.16 Staffing levels had improved, although a combination of detached duty, sickness and temporary promotion continued to place pressure on the daily management of the regime.

3.17 Leaders had sought to improve relationships and communication between staff and prisoners by increasing staff retention rates, ensuring greater consistency of staff on the wings and delivering staff training sessions. However, this was yet to be evidenced in all aspects of staff-prisoner relationships; for example, very few key work sessions

were taking place, which hindered the building of stronger productive relationships.

3.18 Complaints about discrimination or the behaviour of staff were well managed and we saw evidence of staff who had been subject to performance management processes or investigations following complaints. Leaders also maintained an appropriate focus on staff corruption. Basic improvements to gate entry searches had yielded positive results including evidence of fewer illicit items entering the prison, which further contributed to a safer environment.

3.19 We considered that the prison had made reasonable progress against this concern.

Safeguarding

Concern: There had been seven self-inflicted deaths since the last full inspection and support for prisoners in crisis was not good enough.

3.20 The rate of self-harm at Pentonville continued to reduce and the recorded rate over the previous six months was the lowest among all reception prisons. There had been no self-inflicted deaths since the last full inspection.

3.21 Governance of work to prevent suicide and self-harm had improved and attendance at the monthly safer custody meeting was also better, including by staff and Listeners (prisoners trained by the Samaritans to provide emotional support to fellow prisoners). Data were used to inform action; for example, analysis of data on cell call bell responses had led to a review of staffing levels on one particular wing. The Prisons and Probation Ombudsman action plan was now reviewed at this meeting, including a sample of completed actions to ensure continuing compliance.

3.22 Staff on G1, the neurodiversity unit, had received additional training so that they could give more structured support to prisoners with a range of additional needs, including a number with a history of self-harm. Prison data indicated that incidents of self-harm reduced for prisoners after they moved to G1.

3.23 A survey had been carried out on prisoners' perceptions of safety and the findings had indicated ways in which those at risk of suicide and self-harm could be better supported. The findings had not been acted on nor had there been any communication with prisoners about the survey results (see paragraph 3.11).

3.24 During the previous 12 months, three investigations into near fatal incidents had been instigated, although we identified a further incident during this period that had not been suitably followed up. The three investigations that had been completed were sufficiently detailed and resulted in actions being identified, although there were no formal structures in place to make sure these had been completed.

3.25 Leaders had implemented a single case manager model to improve the quality and consistency of support for prisoners subject to the ACCT process (assessment, care in custody and teamwork case management of prisoners at risk of suicide and self-harm). Each manager was responsible for three or four cases to prevent overloading on the busier wings.

3.26 While this approach was sensible, the quality of documentation on the wings was still not good enough. Some ACCT documents remained open for extended periods with no evidence of action to support prisoners. One prisoner had identified his mother and sister as a source of support but had been waiting for 13 days for his phone PIN to be activated. He had been unable to contact them during this time and discussions about his risk had not been documented. Many prisoners on an ACCT confirmed that staff spoke to them regularly and they felt that this offered a degree of support.

3.27 Prisoners had good access to Listeners and there was a rota to identify cover through the night. There were Listener suites across the prison which had been decorated to soften the environment. Listeners had access to a 'grab bag', including a kettle and drinks, to help settle prisoners in crisis during a support meeting. This was positive practice.

Listener suite

3.28 We considered that the prison had made reasonable progress against this concern.

Daily life

Concern: The prison was severely overcrowded, and it could not decently or safely care for the number of prisoners it was currently required to hold.

3.29 The prison was more overcrowded than at the time of the full inspection.

3.30 Despite long-standing official National Statistics predictions for the increase in prison population, national leaders had failed to plan adequately for and support the reduction of the population at Pentonville. Instead, they intended to increase the population to 1,205 in the coming months, which would exacerbate the overcrowded and cramped conditions that many prisoners had to endure.

3.31 We considered that the prison had made no meaningful progress against this concern.

CQC Requirement Notice

CQC Regulation 12 requirement notice – Self care and treatment

3.32 The CQC regulatory notice was reviewed and found:

- Applications were collected daily from all wings and were being managed effectively.
- Complaints regarding access to appointments had reduced.
- Patients requiring access to secondary services were referred to the appropriate hospital within 24 hours, and during times of high pressure were being advocated for effectively to ensure timely access to treatment.

3.33 CQC found that the regulation was now being met.

Primary care and inpatient services

Concern: The primary care health service had a high nursing vacancy rate and not all agency staff had access to keys, which limited the duties they were able to carry out independently.

3.34 There were still nurse vacancies in primary health services, although this had improved. Fourteen staff had been recruited since our full inspection and only a few had left.

3.35 Relationships with partners had improved and the procedure for security clearance had become more efficient with agency staff cleared in advance of arrival. Weekly scheduling of security inductions had facilitated quicker access to keys for new staff.

3.36 All staff had keys which optimised their capacity to work independently and use clinical time effectively.

3.37 We considered that the prison had made reasonable progress against this concern.

Mental health care

Concern: The high number of prisoners with low-level mental health needs had long waits for appointments and few prisoners in our survey said they had been helped with their mental health problems.

3.38 At the time of our visit, the primary mental health provision was moving from Practice Plus Group to the subcontracted Barnet and Enfield NHS Foundation Trust, which already managed other mental health services at Pentonville. The handover was expected on 1 May 2023, two weeks after our review of progress. The entire health care provision was also moving to new models of care which divided all disciplines into early days in custody, planned care and unplanned care with primary care included in all three models.

3.39 Patients in crisis were assessed on the day that they were identified by the mental health duty worker in the unplanned care team. Data and clinical records were reviewed, response times reflected the expectation and records were comprehensive.

3.40 Many referrals were made to the daily health and well-being referral meetings, with more than 1,000 referrals received in some months. A multidisciplinary approach was taken to review the referrals and there was a comprehensive record of discussions at the meeting including access to care records and community mental health teams.

3.41 The waiting time for a priority health and well-being assessment was 10 days and for a routine assessment 14 days This had improved since our last inspection when patients were waiting for 10 weeks. The criteria for priority assessments included all arrivals who had never been in prison before. This was good practice which would be enhanced when the early days in custody model was fully implemented.

3.42 Access had improved for patients. Staff vacancies were still affecting the service but the use of agency staff to undertake initial health and well-being assessments had enabled the nurses to reduce the backlog of patients waiting for primary care interventions and the number of patients leaving without any interventions.

3.43 During our visit, about 80 patients were waiting up to five months for a one-to-one session and more progress was needed in this area. Some of these patients were receiving care from other mental health services which mitigated the risks, but we noted that a small number of these patients could slip though the net and deteriorate or leave without a welfare check. Managers picked this up and rectified it during our visit.

3.44 A new health patient engagement post had been filled to improve understanding of concerns about access to mental health services and to initiate improvements.

3.45 We considered that the prison had made reasonable progress against this concern.

Time out of cell

Concern: Time out of cell was poor for most prisoners. There were frequent regime curtailments, attendance and punctuality at activities were poor, most prisoners could not visit the library and they had inadequate access to the gym.

~~3.46~~ Time out of cell remained poor for most prisoners. Nearly 30 per cent of prisoners were unemployed and the published regime provided them with one hour and 40 minutes out of cell per day. However, during the visit, we observed slippage in the regime which reduced this time further.

3.47 Although the regime was now monitored more effectively, curtailments were still common but had reduced, and they were affecting fewer prisoners than at the time of the inspection.

3.48 Attendance at off-wing purposeful activity remained low at about 60%. Leaders had organised workshops to gain a better understanding and address the issues leading to poor attendance. This was yet to have a discernible impact.

3.49 There was a net increase of 48 activity spaces since our inspection (20 fewer full-time and 68 more part-time spaces). There were still not enough spaces for the number of prisoners held at Pentonville, although not all were filled. A range of new enrichment and well-being activities provided good opportunities for prisoners to spend additional time out of cell, but these were limited and infrequent.

3.50 Access to education had improved. Security managers had improved the full risk assessment and safe management of prisoners in cohorts and more prisoners from all wings were now able to access off-wing activity, including education. Gym and library access had been restored for almost all prisoners who could visit the library weekly and the gym at least twice a week.

3.51 We considered that the prison had made insufficient progress against this concern.

Education, skills and work

This part of the report is written by Ofsted inspectors. Ofsted's thematic approach reflects the monitoring visit methodology used for further education and skills providers. The themes set out the main areas for improvement in the prison's previous inspection report or progress monitoring visit letter.

Theme 1: What progress had leaders and managers made to ensure prisoners received sufficient or equitable access to a broad range of education, skills and work based on their needs?

3.52 Leaders and managers had, since the previous inspection, steadily increased the access prisoners had to education, skills and work. Now, regardless of which accommodation wing prisoners lived on, they had access to the full range of activities.

3.53 Leaders and managers had taken successful action to ensure there were sufficient activity places for prisoners. An increased number of places were part time. As a result, most prisoners who wanted to participate in education or work could do so.

3.54 Leaders were steadily increasing the number of education classes where prisoners could achieve qualifications. However, changes in staffing due to performance management had resulted in some delays.

3.55 Since the previous inspection, leaders had ensured that wing workers were appointed through the allocation process. This helped to ensure that only those suitable for wing work were allocated. However, prisoners who were on the painting and decorating course did not know how they could become wing painters.

3.56 Too many wing workers remained untrained. Leaders were aware of this and prisoners now received an information pack which contained helpful information about the role and the expectations. For example, where wing cleaners had not completed any formal qualifications, they were provided with useful information on the types of chemicals to use, the risks associated with them and the five steps of cleaning from preparation to quality assurance. Leaders were aware that this remained an area for improvement and had credible plans to provide accredited training for existing wing cleaners.

3.57 Prisoners' attendance at education, skills and work was too low. Too many prisoners did not attend activities because of competing priorities, such as legal or social visits or movements off the wings that were too slow.

3.58 Ofsted considered that the prison had made reasonable progress against this theme.

Theme 2: What progress had leaders and managers made to improve the quality of teaching across education, skills and work?

3.59 Leaders and managers frequently observed lessons and, in response, tailored professional development which then helped staff to improve.

3.60 Newly appointed staff were well-qualified and came with significant teaching experience. Leaders had focused their efforts to recruit the right staff and provide appropriate staff development. This had already started to have a positive impact on the quality of education, skills and work.

3.61 Prisoners developed good practical skills to a high standard. Through tutors' clear and detailed explanations prisoners in printing produced coasters, mugs and t-shirts for HMPPS. In textiles, prisoners worked carefully and produced bed sheets and pillowcases to a good standard for use within the Prison Service.

3.62 Tutors ensured that prisoners revised and remembered what they learned through individualised homework activities. Prisoners routinely completed their weekly homework and tutors ensured that this was marked quickly. As a result, prisoners developed the knowledge and skills they needed to achieve their qualifications successfully.

3.63 Prisoners' behaviour in class was good. Prisoners showed high levels of respect for each other and tutors in lessons. They were polite and respected the views of others in class. Prisoners responded to questions and were keen to increase their knowledge and skills. Tutors ensured that all prisoners were involved.

3.64 Managers had temporarily removed access to accredited training in textiles while new staff were trained to deliver the qualification. As a result, prisoners had no formal record of the skills they had learnt when they moved to another prison or on release.

3.65 Too many tutors did not routinely correct errors in prisoners' spelling and punctuation. As a result, prisoners frequently repeated their mistakes.

3.66 Ofsted considered that the prison had made reasonable progress against this theme.

Reducing risk, rehabilitation and progression

Concern: There were serious deficiencies in the performance of the offender management unit, including work on public protection. There had been some recent progress to address this concern, but it was fragile and depended on temporary staff remaining in post.

3.67 Leaders overseeing the offender management unit (OMU) were no longer on temporary contracts. Permanent appointments had been established for the head of OMU services and head of OMU delivery (formerly senior probation officers). This provided stability and oversight of the basic processes essential to the functioning of the unit and enabled leaders to gain a better understanding of the gaps in service provision. Nevertheless, OMU staff described morale as very low. They were frustrated by what they described as a lack of vision on how to progress and the time constraints caused by the high turnover of the population and the number of prisoners at the prison.

3.68 There was still no formal record of OMU meetings nor did the whole department meet together. The offender managers we spoke to said they did not feel the concerns they had raised were listened to.

3.69 A new daily information-sharing meeting with the OMU case administration staff helped to highlight key issues that required action or oversight.

3.70 Delays in responding to some key OMU functions such as general applications and complaints had improved, but these were still not efficiently processed. Other areas such as the backlog in the functional mailbox had progressed well and a considerable backlog had now been cleared.

3.71 Delays in allocating prisoners to offender managers had reduced but continued to affect the timeliness of key rehabilitation services and left risk unassessed for too long. This had a considerable impact with many prisoners waiting for long periods, sometimes several weeks, before any action, such as categorisation and OASys reviews, was taken.

3.72 A dedicated resource for public protection work had improved screening and monitoring procedures, but we were still not confident that the interdepartmental risk management team meeting facilitated appropriate sharing and consideration of risk information for prisoners before their release. The minutes of these meetings were not clear, there was minimal follow-up of actions from the previous meeting, and we identified some high-risk prisoners whose release arrangements were not reviewed before their release.

3.73 There had been a further three releases in error since our last inspection and more robust oversight was needed to prevent a recurrence.

3.74 There were continuing delays with the assessment of prisoners for home detention curfew and most eligible prisoners were either released late or transferred before their case could be assessed.

3.75 We considered that the prison had made insufficient progress against this concern.

Release planning

Concern: There was little funded resettlement support for almost one half of prisoners who were on remand, affecting their access to release accommodation and other resettlement services.

3.76 Demand for resettlement services remained high, with most prisoners only staying at Pentonville for a short time. The population of remanded prisoners had increased from 46% at our last inspection to 54% at this visit.

3.77 A recruitment strategy to address shortages in the pre-release team had been completed, but staff had yet to start their appointments. The team had been operating with a considerable shortfall and key procedures such as the initial assessment of prisoners' resettlement needs were not carried out. The pre-release team focused primarily on the sentenced population.

3.78 Good efforts had been made to include remand prisoners in the provision of some resettlement services. A voluntary sector coaching organisation (StandOut) had run employment preparation courses and a well-being peace education programme was open for all prisoners to attend. The Job Centre Plus advocate provided support for any remanded prisoners who requested it and the recent creation of an employment hub was an excellent initiative, led by committed staff running a promising employment support service. However, much of this support was based on the passion and dedication of staff rather than a formal, structured process and there remained a gap in funded resettlement support for the increasing remand population. There was still more to be done to achieve effective resettlement provision for this group.

3.79 The appointment of two bail information officers had provided valuable support to remand prisoners requiring this service.

3.80 Too many prisoners left Pentonville without sustainable accommodation on their first night.

3.81 Despite the limited space at Pentonville, a departure lounge had reopened which offered basic practical support for prisoners on the day of their release.

3.82 We considered that the prison had made insufficient progress against this concern.

Section 4 Summary of judgements

A list of the HMI Prisons concerns and Ofsted themes followed up at this visit and the judgements made.

HMI Prisons concerns

Fewer than half of new arrivals said they felt safe on their first night in custody, and the management of risks was undermined by safety interviews that did not take place with sufficient privacy and the lack of first night checks for most prisoners.
Reasonable progress

A high proportion of prisoners said they felt unsafe and, in our survey, over half said they had experienced some form of victimisation from staff.
Reasonable progress

There had been seven self-inflicted deaths since the last full inspection and support for prisoners in crisis was not good enough.
Reasonable progress

The prison was severely overcrowded, and it could not decently or safely care for the number of prisoners it was currently required to hold.
No meaningful progress

The primary care health service had a high nursing vacancy rate and not all agency staff had access to keys, which limited the duties they were able to carry out independently.
Reasonable progress

The high number of prisoners with low-level mental health needs had long waits for appointments and few prisoners in our survey said they had been helped with their mental health problems.
Reasonable progress

Time out of cell was poor for most prisoners. There were frequent regime curtailments, attendance and punctuality at activities were poor, most prisoners could not visit the library and they had inadequate access to the gym.
Insufficient progress

There were serious deficiencies in the performance of the offender management unit, including work on public protection. There had been some recent progress to address this concern, but it was fragile and depended on temporary staff remaining in post.
Insufficient progress

There was little funded resettlement support for almost one half of prisoners who were on remand, affecting their access to release accommodation and other resettlement services.
Insufficient progress

Ofsted themes

Prisoners did not receive sufficient or equitable access to a broad range of education, skills and work based on their needs.
Reasonable progress

There was too much variation in the quality of teaching across education, skills and work.
Reasonable progress

Appendix I About this report

Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.

All visits carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

Independent reviews of progress (IRPs) are designed to improve accountability to ministers about the progress prisons make towards achieving HM Inspectorate of Prisons' recommendations in between inspections. IRPs take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny and focus on a limited number of the recommendations made at the inspection. IRPs do not therefore result in assessments against our healthy prison tests. HM Inspectorate of Prisons' healthy prison tests are safety, respect, purposeful activity and rehabilitation and release planning. For more information see our website: https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/

The aims of IRPs are to:

- assess progress against selected key recommendations
- support improvement
- identify any emerging difficulties or lack of progress at an early stage
- assess the sufficiency of the leadership and management response to our main concerns at the full inspection.

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each recommendation we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in [MONTH, YEAR] for further detail on the original findings (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/).

IRP methodology

IRPs are announced at least three months in advance and take place eight to 12 months after a full inspection. When we announce an IRP, we identify which recommendations we intend to follow up (usually no more than 15). Depending on the recommendations to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

During our three-day visit, we collect a range of evidence about the progress in implementing each selected recommendation. Sources of evidence include observation, discussions with prisoners, staff and relevant third parties, documentation and data.

Each recommendation followed up by HMI Prisons during an IRP is given one of four progress judgements:

No meaningful progress
Managers had not yet formulated, resourced or begun to implement a realistic improvement plan for this recommendation.

Insufficient progress
Managers had begun to implement a realistic improvement strategy for this recommendation but the actions taken since our inspection had had not yet resulted in sufficient evidence of progress (for example, better and embedded systems and processes).

Reasonable progress
Managers were implementing a realistic improvement strategy for this recommendation and there was evidence of progress (for example, better and embedded systems and processes) and/or early evidence of some improving outcomes for prisoners.

Good progress
Managers had implemented a realistic improvement strategy for this recommendation and had delivered a clear improvement in outcomes for prisoners.

When Ofsted attends an IRP its methodology replicates the monitoring visits conducted in further education and skills provision. Each theme followed up by Ofsted is given one of three progress judgements.

Insufficient progress
Progress has been either slow or insubstantial or both, and the demonstrable impact on learners has been negligible.

Reasonable progress
Action taken by the provider is already having a beneficial impact on learners and improvements are sustainable and are based on the provider's thorough quality assurance procedures.

Significant progress
Progress has been rapid and is already having considerable beneficial impact on learners.

Ofsted’s approach to undertaking monitoring visits and the inspection methodology involved are set out in the *Further education and skills inspection handbook*, available at https://www.gov.uk/government/publications/education-inspection-framework.

Inspection team

This independent review of progress was carried out by:

Angus Jones	Peer reviewer
Ian Dickens	Team leader
Lindsay Jones	Inspector
David Owens	Inspector
Nadia Syed	Inspector
Emily Cretch	Policy officer, observer
Tania Osborne	Health and social care inspector
Dayni Johnson	Care Quality Commission inspector
Steve Lambert	Ofsted lead inspector
Shane Longthorne	Ofsted inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Care Quality Commission (CQC)
CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: http://www.cqc.org.uk

Certified normal accommodation (CNA) and operational capacity
Baseline CNA is the sum total of all certified accommodation in an establishment except cells in segregation units, health care cells or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged cells, cells affected by building works, and cells taken out of use due to staff shortages. Operational capacity is the total number of prisoners that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

Key worker scheme
The key worker scheme operates across the closed male estate and is one element of the Offender Management in Custody (OMiC) model. All prison officers have a caseload of around six prisoners. The aim is to enable staff to develop constructive, motivational relationships with prisoners, which can support and encourage them to work towards positive rehabilitative goals.

Leader
In this report the term ‘leader’ refers to anyone with leadership or management responsibility in the prison system. We will direct our narrative at the level of leadership which has the most capacity to influence a particular outcome.

Protection of adults at risk
Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

Time out of cell
Time out of cell, in addition to formal 'purposeful activity', includes any time prisoners are out of their cells to associate or use communal facilities to take showers or make telephone calls.

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

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