Report on an independent review of progress at

HMP High Down

by HM Chief Inspector of Prisons

17–19 June 2019
This progress visit was carried out in partnership with the following bodies:

Ofsted
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**Glossary of terms**

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our ‘Guide for writing inspection reports’ on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/
About this report

A1 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.

A2 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.

A3 Independent reviews of progress (IRPs) are a new type of visit designed to improve accountability to ministers about the progress prisons make towards achieving HM Inspectorate of Prisons’ recommendations in between inspections. IRPs will take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny, and will focus on a limited number of the recommendations made at the inspection. IRPs will therefore not result in assessments against our healthy prison tests.1

A4 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.

A5 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 May 2018 for further detail on the original findings.2

IRP methodology

A6 IRPs will be announced at least three months in advance and will take place eight to 12 months after the full inspection. When we announce an IRP, we will 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.

A7 During our three-day visit, we will collect a range of evidence about the progress in implementing each selected recommendation. Sources of evidence will include observation, discussions with prisoners, staff and relevant third parties, documentation and data.

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1 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/

A8 Each recommendation followed up by HMI Prisons during an IRP will be 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 had not yet resulted in any discernible evidence of progress (for example, better systems and processes) or improved outcomes for prisoners.

- **Reasonable progress**
  Managers were implementing a realistic improvement strategy for this recommendation and there was evidence of progress (for example, better 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.

A9 When Ofsted attends an IRP its methodology will replicate the monitoring visits conducted in further education and skills provision. Each theme followed up by Ofsted will be 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.

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3 Ofsted’s approach to undertaking monitoring visits and the inspection methodology involved are set out in the Further education and skills inspection handbook at paragraphs 25 to 27, available at https://www.gov.uk/government/publications/further-education-and-skills-inspection-handbook
Key findings

S1 At this IRP visit, we followed up nine of the 60 recommendations made at our most recent inspection and made judgements about the degree of progress achieved to date. Ofsted followed up three themes.

S2 We judged that there was good progress in two recommendations, reasonable progress in four recommendations and insufficient progress in three recommendations. A summary of the judgements is as follows.

Figure 1: Progress on recommendations from 2018 inspection (n=9)\(^4\)

![Pie chart showing progress on recommendations]

S3 Ofsted judged that there was reasonable progress in one theme and insufficient progress in two themes.

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\(^4\) This pie chart excludes any recommendations that were followed up as part of a theme within Ofsted’s concurrent prison monitoring visit.
### Key findings

**Figure 2: Judgements against HMI Prisons recommendations from May 2018 inspection**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reception and first night processes should be efficient. Vulnerability risk assessments on new arrivals should be robust. Before being locked up for the night, prisoners should be welcomed, informed and supported by peers and staff. Cells should be clean, well prepared and fully equipped, and prisoners should be able to shower. (S52)</td>
<td>Good progress</td>
</tr>
<tr>
<td>Improved oversight and leadership of the segregation unit should ensure that prisoners have good living conditions and a consistently decent regime. All decisions should be appropriately authorised. There should be robust governance to monitor and maintain improvements. (S53)</td>
<td>Reasonable progress</td>
</tr>
<tr>
<td>Prisoners’ risk of harm to others should be routinely assessed on arrival, and appropriate mail and telephone monitoring applied as required. (S55)</td>
<td>Insufficient progress</td>
</tr>
<tr>
<td>Actions designed to reduce violence should be fully implemented and embedded (1.16)</td>
<td>Reasonable progress</td>
</tr>
<tr>
<td>The disproportionate use of force against black and minority ethnic (BME) prisoners should be explored and addressed. (1.27)</td>
<td>Insufficient progress</td>
</tr>
<tr>
<td>Drug- and alcohol-dependent prisoners should receive treatment on their first night without delay. (2.88)</td>
<td>Good progress</td>
</tr>
<tr>
<td>The strategic oversight of reducing reoffending should be informed by a detailed analysis of the needs of the current population and progress measured against a comprehensive action plan. (4.20)</td>
<td>Reasonable progress</td>
</tr>
<tr>
<td>The quality of offender management should be improved, to ensure that all prisoners receive adequate support, including timely completion of offender assessment system (OASys) assessments and regular, meaningful contact which is aimed at progression and risk reduction. (4.21)</td>
<td>Insufficient progress</td>
</tr>
<tr>
<td>Risk management planning in preparation for the release of high-risk prisoners should be given a greater priority. Offender managers should work closely with prison-based staff in the six months leading up to release, to put in place clear risk management plans, including confirmation of the multi-agency public protection arrangements (MAPPA) management level where relevant. (4.28)</td>
<td>Reasonable progress</td>
</tr>
</tbody>
</table>

S4 Ofsted judged that there was reasonable progress in one theme and insufficient progress in two themes.

**Figure 3: Judgements against Ofsted themes\(^5\) from May 2018 inspection**

<table>
<thead>
<tr>
<th>Ofsted theme</th>
<th>Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>What progress have leaders and managers made with developing an effective education, skills and work strategy that meets the needs of prisoners, appropriately identifying weaknesses in the provision and raising the capacity to prioritise and effect improvement, in particular in areas such as activity space utilisation, attendance and punctuality?</td>
<td>Insufficient progress</td>
</tr>
<tr>
<td>What progress have leaders and managers made in improving the quality of teaching, learning and assessment through ensuring that prisoners access an effective induction that assesses their skills and provides them with information and guidance on how to develop their employability further, setting them sufficiently challenging targets to support the learning and improvement of job-related skills?</td>
<td>Reasonable progress</td>
</tr>
</tbody>
</table>

\(^5\) Ofsted’s themes incorporate the key concerns at the previous inspection in respect of education, skills and work.
What progress have leaders and managers made in improving the achievements attained by prisoners, with regards to qualifications and the development of employability and personal skills and behaviours ensuring that prisoners’ outcomes are of high quality? | Insufficient progress
Section 1. Chief Inspector’s summary

1.1 At our inspection of HMP High Down in 2018 we made the following judgements about outcomes for prisoners.

Figure 4: HMP High Down healthy prison outcomes 2015 and 2018

1.2 HMP High Down is a local category B prison in Banstead, Surrey, holding about 1,200 prisoners. At the inspection in May 2018, we found that outcomes had declined in two of our four healthy prison tests: safety and purposeful activity. In terms of safety, arrival and early days procedures were a significant concern. The prison was failing to support prisoners at the time when they were likely to be at their most vulnerable. The management of the segregation unit was poor and levels of violence in the prison had increased. There were significant weaknesses in public protection work. Purposeful activity was the area of greatest concern and had been judged as ‘poor’, our lowest possible rating.

1.3 At the time of the inspection in May 2018, High Down had been told that it would become a category C training prison in line with HM Prison and Probation Service plans for reconfiguring the prison estate. The uncertainty about its future role was hindering the prison’s ability to plan and progress. At the time of this independent review of progress (IRP) visit, the establishment had finally decided to focus on the local prison population it held and was no longer allowing itself to be distracted by the prospect of a change in function. However, the continuing delay after the inspection in making this decision had undermined the degree of progress it made, especially in purposeful activity. While there had been reasonable progress in activity induction processes, in two of the three areas assessed under Ofsted’s methodology, the prison was judged to have made insufficient progress. Attendance and punctuality were still poor, the number of activity places had not increased and nearly half the population was unemployed.

1.4 However, there was cause for more optimism in other areas. Of the nine key recommendations that we examined in the tests for safety, respect and rehabilitation and release planning, good progress had been made in two, reasonable progress in four and insufficient progress in three. We identified no recommendations for which there had been no meaningful progress.
1.5 In the test for safety, the reception process was now far better organised. We saw prisoners being screened thoroughly for vulnerabilities on arrival, and first night accommodation was generally well prepared. Violence had continued to rise in line with other establishments, but a well-considered violence reduction strategy had now been implemented and time would tell if it was fit for purpose. Attempts to understand and address the continuing disproportionate use of force against black and minority ethnic prisoners had been too slow, although a useful prisoner survey had recently been completed and was awaiting analysis. Our concerns about the arbitrary management of prisoners in the segregation unit had been addressed effectively, and new managers were implementing consistent and fair procedures, although the segregation environment had not yet been sufficiently improved.

1.6 We had identified only one key recommendation in the area of respect – the need for drug- and alcohol-dependent prisoners to receive medication swiftly after arrival. We found good progress had been made against this recommendation in line with the generally improved reception experience.

1.7 In rehabilitation and release planning, we found more efficient and improving risk management planning before release, and better analysis of needs, although this work had also been affected by the uncertainty surrounding the role of the prison. Public protection monitoring had improved, but was still not sufficiently rigorous, and understanding of prisoners’ offending behaviour needs was still undermined by the large backlog of offender assessment system reports. The continuing shortfall in offender management resources similarly affected the quality of the work that was undertaken with prisoners. Efforts were being made to recruit more offender supervisors and probation officers and staffing was improving.

1.8 At this IRP, we found a focused and motivated management team, and staff who were keen to demonstrate that they were addressing the concerns raised at the inspection. Their efforts had resulted in reasonable or good scores in seven of the 12 recommendations and Ofsted themes, but there were considerable challenges ahead, not least in improving purposeful activity outcomes. Although the uncertainty about the prison’s future had yet to be fully resolved by HM Prison and Probation Service (HMPPS), we saw considerable local energy behind the challenge to turn progress into tangible outcomes. We look forward to seeing the results of those efforts when we return for a future inspection.

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

June 2019
Section 2. Progress against the key concerns and recommendations and Ofsted themes

The following provides a brief description of our findings in relation to each recommendation followed up from the full inspection in 2018. The reference numbers at the end of each recommendation refer to the paragraph location in the full inspection report.

Early days in custody

**Concern:** Reception and first night processes were poor. Prisoners who were new to custody often spent hours in dirty holding rooms, to be later located in ill-prepared and dirty cells, without being able to shower. Vulnerability risk assessments on these new arrivals were not robust, there were too few checks on their welfare and they were poorly supported during their early days in custody.

**Recommendation:** Reception and first night processes should be efficient. Vulnerability risk assessments on new arrivals should be robust. Before being locked up for the night, prisoners should be welcomed, informed and supported by peers and staff. Cells should be clean, well prepared and fully equipped, and prisoners should be able to shower. (S52)

2.1 The prison had consulted prisoners before designing a new and innovative approach to the reception process. Managers had mapped the key stages of reception and clearly signposted them. Prisoners visited each area in sequence, which ensured a steady flow of people through reception. We saw prisoners moving to residential wings reasonably quickly as a result. A few prisoners we spoke to said they had waited in reception for long periods, but the prison did not have a reliable tracking system to monitor timeliness.

2.2 The reception area was much cleaner and brighter, but holding rooms remained bare and unwelcoming. The prison had made bids for funding to improve seating and furnishings. Access to showers on arrival had improved and all new prisoners and those undergoing extended court appearances were offered a shower.

2.3 Initial vulnerability screenings had improved and those we observed were handled sensitively. Prisoners on the induction wing spoke positively about their experience. Peer supporters were used well to help prisoners settle in on arrival and undertook the initial stage of the induction process. However, vulnerable prisoners we spoke to described a much less positive and somewhat hostile experience.

2.4 Spaces were not always made available on the dedicated first night wings resulting in a haphazard approach to locating new arrivals. There was no central record of newly arrived prisoners to inform night staff of their location and no additional welfare checks were made during the first 24 hours of arrival.

2.5 Empty first night cells we inspected were reasonably equipped and had been checked by staff and prison orderlies, but some contained graffiti.

2.6 We considered that the prison had made good progress against this recommendation.
Managing behaviour

**Concern:** Although strategic oversight of violence was improving and clear processes had been outlined in a well-considered strategy document and supporting action plan, at the time of the inspection, processes were yet to be implemented fully, and too little was being done to make the prison safer.

**Recommendation:** Actions designed to reduce violence should be fully implemented and embedded. (1.16)

2.7 The key elements of the well-considered strategy we found at the last inspection had been implemented and were monitored through a dynamic action plan. Managers reviewed violence data every week to identify emerging trends and hotspots, and the monthly violence reduction taskforce meeting looked at all available data to help build an understanding of violence and inform strategic action.

2.8 A well-attended weekly safety intervention meeting reviewed individual prisoners causing concerns because of violence, self-harm and their mental health, and agreed management and support plans with key workers, who were allocated to those causing the most concern.

2.9 Challenge, support and intervention plans (CSIPs)⁶ had been implemented across the prison for the most serious perpetrators of violence and most staff we spoke to had a good understanding of the process and other elements of the safety strategy, including their individual responsibility for making the prison safer. Prisoners subject to a CSIP were escorted around the prison, and a laminated information card was handed to receiving staff to ensure they were aware of the CSIP and continued to monitor the prisoners.

2.10 The safety team was better resourced and investigated all violent incidents. We were impressed with the quality of the investigations that we reviewed. Although all victims of violence were seen by the safety team, overall support for victims was underdeveloped, including for prisoners who were isolating themselves.

2.11 Despite management’s focus, levels of violence, including serious assaults, had increased since the last inspection, although they were not higher than the average for local prisons.

2.12 We considered that the prison had made reasonable progress against this recommendation.

**Concern:** We had found that 53% of all incidents of force were against prisoners from a black and minority ethnic background, despite this group representing only a third of the entire population. Managers had identified this repeatedly in the six months prior to the inspection, but there was no evidence of any action being taken to address these concerns.

**Recommendation:** The disproportionate use of force against black and minority ethnic prisoners should be explored and addressed. (1.27)

2.13 In the previous six months 47% of use of force incidents had involved black and minority ethnic prisoners, which remained disproportionately high as 35% of the prison population was from this background.

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⁶ CSIPs are used by some prisons to manage the most violent prisoners and support the most vulnerable prisoners in the system. Prisoners who are identified as the perpetrator of serious or repeated violence, or who are vulnerable due to being the victim of violence or bullying behaviour, are managed and supported on a plan with individualised targets and regular reviews.
2.14 The monthly use of force meeting continued to analyse data to determine emerging trends, and discussed the disproportionate number of black and minority ethnic prisoners being restrained, especially black prisoners aged between 21 and 29. However, subsequent action points had not been completed and little progress had been made.

2.15 Communication between the use of force committee and the equality team was good, and efforts had been made to consult with black and minority ethnic prisoners. A useful prisoner survey had been distributed but had yet to be analysed. All black prisoners between 21 and 29 years old were debriefed after an incident and information was being collated. However, this process had only started in recent weeks and had not yet contributed to an increased understanding of the problem or tangible outcomes.

2.16 The prison did not have a single coordinated plan for bringing together different strands of the work that were intended to explore and address the disproportionate use of force against this group of prisoners.

2.17 We considered that the prison had made insufficient progress against this recommendation.

**Concern:** Managerial oversight of segregation was weak. The living conditions and regime on the unit were poor. Staff made ad-hoc decisions to restrict prisoners' access to the regime further, without appropriate authority.

**Recommendation:** Improved oversight and leadership of the segregation unit should ensure that prisoners have good living conditions and a consistently decent regime. All decisions should be appropriately authorised. There should be robust governance to monitor and maintain improvements. (S53)

2.18 Although the use of segregation had increased in the previous six months, fewer prisoners were segregated than at comparator prisons.

2.19 Managerial oversight and leadership of the segregation unit had improved and was rigorous. Managers had undertaken defensible decision-making training and we found no evidence that decisions were made arbitrarily. All prisoners had access to a daily regime, but it was still not purposeful enough. Prisoners did not collect their own meals and had limited time out of cell. Prisoners could have access to TVs and radios subject to a risk assessment and they were now given flasks during the evening and night so that they could make hot drinks.

2.20 Managers completed daily cell assurance checks and were aware of all outstanding maintenance issues. A painting programme remained in place. Cell observation panels had been replaced with a new design and there had been no breakages. Although cells were reasonably clean, several had damaged floors, sinks and toilets, and some graffiti. Communal showers were in poor condition. Although they had recently been painted, they were inadequately ventilated. The exercise yards remained bleak and contained a lot of graffiti.

2.21 The deputy governor chaired the segregation management and review group and the meetings now took place regularly. Action was followed up and much of it had been implemented, although minutes did not properly record it.

2.22 We considered that the prison had made reasonable progress against this recommendation.
Health, well-being and social care

**Concern:** Long delays in the reception process had meant some prisoners did not reach their first night accommodation or receive their first dose of methadone until the early hours of the morning.

**Recommendation:** Drug- and alcohol-dependent prisoners should receive treatment on their first night without delay. (2.88)

2.23 Improvements to reception processes (see paragraph 2.1) had significantly reduced the time prisoners with substance-related problems had to wait to receive medication. A nurse was now routinely stationed in reception from 2pm until the last prisoner had been taken to the wings. This enabled them to be assessed reasonably quickly and, where necessary, referred to the substance use team on the drug support wing.

2.24 We reviewed records for the previous months and found no excessive waits. We tracked 15 prisoners across the previous month and found the average time from arrival at the front gate to the point of medication issue on the wing to be about four hours. Prisoners who were identified as having immediate support needs were prioritised and treated accordingly.

2.25 Plans were in place to relocate the substance use prescribing team to reception, which was likely to reduce waiting times further. The plans included the provision of a dedicated treatment room.

2.26 We considered that the prison had made good progress against this recommendation.

Education, skills and work

**Theme 1:** What progress have leaders and managers made with developing an effective education, skills and work strategy that meets the needs of prisoners, appropriately identifying weaknesses in the provision and raising the capacity to prioritise and effect improvement, in particular in areas such as activity space utilisation, attendance and punctuality?

**Insufficient progress**

2.27 Leaders and managers had identified accurately the main areas for development following the inspection. They had improved the quality of data that they used to monitor performance. However, they had been too slow to implement action to bring about effective improvements. Overall attendance remained too low, punctuality had not improved, and the number of activity places had not increased enough to reduce the large proportion of prisoners who were routinely unemployed. Leaders and managers’ efforts in planning and improving the education, skills and work provision had not been helped by delays in confirming High Down’s category B local prison status.

2.28 Overall attendance was as low as it was during the inspection in May 2018, although there had been a slight recent improvement in attendance at education classes. Leaders and managers collected and analysed data on attendance every day, but they did not use it to ensure that staff on the house blocks took swift action to get prisoners to attend activities. As a result, the momentum on setting high expectations for attendance was lost. Poor punctuality remained a weakness and too many prisoners arrived at activities up to 15 minutes late.

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7 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 last inspection report.
2.29 The number and range of purposeful activity places had not increased sufficiently since the inspection in May 2018. Leaders and managers had added a small number of extra places in the call centre, laundry and textiles workshop, and had introduced a new qualification in customer service. They had also reduced the number of unoccupied places in prison work. Nevertheless, nearly half of prisoners were still routinely unemployed and too many activity places were left unfilled.

Theme 2: What progress have leaders and managers made in improving the quality of teaching, learning and assessment through ensuring that prisoners access an effective induction that assesses their skills and provides them with information and guidance on how to develop their employability further, setting them sufficiently challenging targets to support the learning and improvement of job-related skills?

Reasonable progress

2.30 Leaders and managers had improved the induction process, which had been described as chaotic at the inspection. It now took place in the education department where it was quieter and more conducive to learning.

2.31 The content of the induction had been revised thoroughly and provided prisoners with a more effective introduction to the education and work available in the prison, including information on how they could apply to join different activities. All prisoners undertook basic skills assessments and received their results promptly. A one-to-one interview then focused well on prisoners’ prior work experience, qualifications and aspirations. Prisoners benefited from effective information and advice, which informed their short-term plans for education and work. As a result, prisoners had clear plans for progression.

2.32 Prisoners trained as classroom assistants provided good support to their peers throughout the induction, assisting in group activities and guiding learners who were undertaking initial assessments when teachers were conducting interviews. They acted as role models for new arrivals.

2.33 In a minority of instances, staff did not know enough about the needs of prisoners prior to their attendance at induction sessions. They lacked key information on prisoners’ language and health needs, which meant they could not develop sessions for them as they did not have the necessary support in place. As a result, some prisoners had to attend induction two or three times before they were allocated to work or education.

2.34 Since the inspection, teachers had become more skilled at setting prisoners challenging academic and vocational targets. They had improved the way they recorded and monitored prisoners’ progress against these targets in their individual learning plans. However, teachers and instructors in workshops were still not consistently setting broader employment skills targets, such as developing effective communication and working in teams.

Theme 3: What progress have leaders and managers made in improving the achievements attained by prisoners with regards to qualifications and the development of employability and personal skills and behaviours ensuring that prisoners’ outcomes are of high quality?

Insufficient progress

2.35 An increase in the proportion of prisoners who achieved qualifications in business and IT subjects had been offset by a significant reduction in those achieving their basic skills English and mathematics qualifications. Education managers had not managed the transition between the awarding bodies for English and mathematics qualifications effectively, which meant too many prisoners were not being correctly entered for exams or re-sits. Managers had
implemented a plan to tackle this poor performance, but at the time of the review visit it was too early to see any results.

2.36 The number of prisoners leaving courses early remained too high. Overall withdrawal rates on education courses had improved slightly, but on English and mathematics courses the rate had doubled in the current year. Managers had implemented a new protocol to prevent prisoners from being moved unnecessarily from education classes to other activities. However, the protocol had only been in place for one month at the time of the visit so it was too soon to evaluate its impact.

2.37 Leaders and managers had reduced the number of cancelled sessions in education and work. As a result, prisoners were more confident about being able to complete courses and qualifications.

2.38 Those who attended education and work developed good technical and employment skills that prepared them well for work. However, teachers and instructors had not devised a way of recording skills in the many work areas where no qualifications were offered, such as in the laundry, textiles workshops and gardens. This meant prisoners on release could not show potential employers the range of employment skills they had developed.

Rehabilitation and release planning

Concern: Public protection restrictions were not used well enough to prevent prisoners presenting a high risk of harm from contacting their victims.

Recommendation: Prisoners’ risk of harm to others should be routinely assessed on arrival and appropriate mail and telephone monitoring applied as required. (S55)

2.39 Prisoners at risk of harm to others were now identified systematically on arrival, but public protection risk assessments to determine the need for monitoring high-risk prisoners’ mail and telephone calls were not being completed soon enough. The backlog of calls still waiting to be listened to was too high, in many cases up to two months, which meant the prison did not know what risk these prisoners posed, potentially putting the public in danger. Telephone monitoring log entries were inconsistent and, in some cases, poor quality.

2.40 Arrangements for monitoring incoming mail were now effective. The mail room had up-to-date lists of prisoners subject to monitoring and the public protection unit reviewed all correspondence and recorded log entries that were of a good standard.

2.41 Outgoing mail was not monitored consistently. Arrangements for sifting and reviewing mail for prisoners on house block 6, where a large number of high-risk prisoners were located, were managed by public protection staff and were effective. However, this was not the case for prisoners elsewhere across the establishment, who accounted for over half of prisoners subject to monitoring. Mail was not always sifted accurately and might therefore not have been reviewed, and prisoners might have been able to communicate with victims and vulnerable members of the community without being detected.

2.42 We considered that the prison had made insufficient progress against this recommendation.
Concern: A reducing reoffending strategy had been developed shortly before the inspection. However, because of the delay in confirming that High Down would remain a category B local prison, other strategic work had been postponed. There was no needs analysis of the population to inform the range of interventions and support required. Although a reasonably well-attended committee met each month, there was no action plan against which to monitor progress or set new priorities.

Recommendation: The strategic oversight of reducing reoffending should be informed by a detailed analysis of the needs of the current population and progress measured against a comprehensive action plan. (4.20)

2.43 At this review visit, we found the prison had done some work to ensure it understood the needs of its population and had recently undertaken a prisoner survey. A separate analysis focusing on prisoners’ offending behaviour programme needs had also been undertaken and as a result an accredited programme was due to be introduced later in the year.

2.44 The needs analysis did not include key elements, such as the needs of vulnerable prisoners, but plans were in place for an updated assessment incorporating prison-wide population demographics and information on pathways out of offending. The assessment would generate a full, detailed and comprehensive needs analysis to inform an updated, coordinated reducing reoffending strategy.

2.45 The reducing reoffending meeting was reasonably well attended. An action plan was in place, but it was underdeveloped and did not reflect all the current challenges or up-to-date strategic priorities, and did not help drive forward action or monitor progress.

2.46 We considered that the prison had made reasonable progress against this recommendation.

Concern: There were far too few offender supervisors in post and not enough probation officers. Uniformed offender supervisors were often deployed elsewhere in the prison. Caseloads were far too high. The offender management unit (OMU) was solely reactive in its approach and could only respond to events in a prisoner’s sentence rather than providing meaningful engagement. Too many prisoners did not have an up-to-date offender assessment system report on their risks and needs.

Recommendation: The quality of offender management should be improved, to ensure that all prisoners receive adequate support, including timely completion of offender assessment system (OASys) assessments and regular, meaningful contact which is aimed at progression and risk reduction. (4.21)

2.47 Offender supervisor staffing levels had started to improve. The impact of redeployment had been reduced because there were now only two uniformed offender supervisors who carried caseloads, with other posts taken by civilian staff who were not subject to redeployment to other prison officer duties.

2.48 Full-time offender supervisors now held about 80 cases each, fewer than the exceptionally high caseloads at the 2018 inspection, but this was still far too many to provide effective offender supervision. There had been a 50% increase in the number of probation officers. As we would expect, they held the high-risk cases, but did not have sufficient time to manage such complex prisoners effectively.

2.49 The OMU had recruited six additional prison officer offender supervisors who were due to start work by September 2019. Three more full-time probation officers were needed to staff the team adequately, but their recruitment had not yet been confirmed.
2.50 Levels of offender supervisor contact with prisoners remained mostly reactive to sentence events such as home detention curfew applications or parole. There was no minimum expectation of contact.

2.51 The introduction of OMU surgeries across all six house blocks had partially helped to address the deficit in contact, but capacity was limited – a total of 36 contacts each week was offered among a sentenced population of about 800 prisoners. Nonetheless, these surgeries were a positive initiative that could have been further expanded.

2.52 Despite implementing a recovery plan, there was still a large backlog of OASys reports, most of which were owned by the prison. The OMU had completed an extra 96 assessments in the previous six months by offering probation staff overtime payment. However, this extra effort had not met the demand. There were 140 prisoners without an initial assessment, about 20% of all those who required one. Nearly 60% of prisoners who needed one, had not had an up-to-date assessment completed within the previous 12 months.

2.53 We considered that the prison had made insufficient progress against this recommendation.

**Concern:** We found too many cases of high-risk prisoners due for release who had not had their cases reviewed at the inter-departmental risk management team (IRMT) meeting. Risk management planning was far too variable. In some cases, the offender manager failed to engage with the offender supervisor, resulting in poor release planning.

**Recommendation:** Risk management planning in preparation for the release of high-risk prisoners should be given a greater priority. Offender managers should work closely with prison-based staff in the six months leading up to release, to put in place clear risk management plans, including confirmation of the multi-agency public protection arrangements (MAPPA) management level where relevant. (4.28)

2.54 High Down remained a busy local prison. The population was very transient and there were about 150 releases each month, approximately 20% of whom were high-risk prisoners.

2.55 The monthly IRMT meeting had very recently started to improve. High-risk prisoners had still been considered too near to release to allow for effective risk management planning, typically with less than three months to serve. About 40% of the population were eligible for MAPPA oversight in the community, but until recently management levels were too often confirmed too close to a prisoner’s release date to allow the prison to usefully contribute to multi-agency release planning.

2.56 However, OMU managers recognised these weaknesses and had adopted a more robust approach from June 2019. Release planning for high-risk prisoners now started six months before release, although the meeting did not yet effectively identify high-risk prisoners arriving at High Down with a very short time left before release.

2.57 The OMU had introduced a good process for formalising contact between prison offender supervisors and community offender managers at an earlier stage in high-risk cases. The new approach allowed deficits, such as those relating to the confirmation of MAPPA management levels, to be addressed in a timely fashion, and all relevant information was channelled into the new IRMT meeting. The approach showed promise but it was too early to judge the effectiveness of the changes.

2.58 We considered that the prison had made reasonable progress against this recommendation.
Section 3. Appendix

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