URGENT NOTIFICATION – HMP BEDFORD

I am writing to inform you that on 12th September, HM Chief Inspector for Prisons, wrote to invoke an Urgent Notification for HMP Bedford. The Chief Inspector’s letter is being published on 13 September and I enclose a copy of the letter informing the Secretary of State of his decision. HM Inspectorate of Prisons (HMIP) is an independent inspectorate and therefore the decision as to whether to trigger an Urgent Notification is theirs. Key issues identified by HMIP are detailed in the enclosed letter. You will see that the Chief Inspector records a decline in standards over the past nine years, and that his concerns about the prison include violence, safety, drugs, living conditions, lack of control at the prison, and a lack of purposeful activity.

We created the Urgent Notification process as part of our commitment to transparency and accountability to improve performance and demonstrate what we are doing to turn prisons into safe places where offenders can change their lives. The Secretary of State will respond promptly in 28 days on the immediate action taken in respect of HMP Bedford. HMIP will publish their full inspection report within three months, as they do with all inspections. We will then produce a more in-depth action plan covering all recommendations made in this full report.

Over the next 28 days senior officials from HMPPS and the Ministry will prioritise action and provide senior backing and oversight. To drive forward progress in improving outcomes for prisoners and staff, a team of key people from across the organisation, including representatives from the prison has been formed, working very closely with national and local partners. This focus will continue to monitor and assure progress until the Secretary of State is satisfied that there is sustained improvement.

I hope this letter reassures you that we are doing all we can to support HMP Bedford throughout this process.
Dear Secretary of State

Urgent Notification: HM Prison Bedford

In accordance with the Protocol between HM Chief Inspector of Prisons and the Ministry of Justice, dated 30 November 2017, I am writing to you to invoke the Urgent Notification (UN) process in respect of HM Prison Bedford.

An unannounced inspection of HM Prison Bedford took place between 28 August and 6 September 2018. This inspection identified many significant concerns about the treatment and conditions of prisoners. Below, I have set out some of the evidence that underpins my decision to invoke the UN process, and the rationale for why I believe it is necessary. In addition, I attach a summary note which details all the main judgements that followed this inspection. The summary note is drawn from a similar document provided to the prison’s Governor and the Prison Group Director at the end of the inspection last week. The Governor and officials of the MoJ have been informed of my intention to invoke the UN process. I shall, as usual, publish a full inspection report in due course.

The requirements placed on HM Chief Inspector of Prisons under the Protocol

The UN process requires me to summarise the judgements that have led to significant concerns, and to identify those issues that require improvement. A decision to invoke the UN process is determined by my judgement, informed by relevant factors during the inspection that, as set out in the Protocol, may include:

- Poor healthy prison test assessments (HMI Prisons’ inspection methodology is outlined in the HMI Prisons Inspection Framework);
- The pattern of the healthy prison test judgements;

Date: 12 September 2018
• Repeated poor assessments;
• The type of prison and the risks presented;
• The vulnerability of those detained;
• The failure to achieve recommendations;
• The Inspectorate's confidence in the prison's capacity for change and improvement.

The Protocol sets out that my letter to the Secretary of State, with the accompanying note, will be placed in the public domain. It is my intention to publish the letter at 10am on Thursday 13 September 2018. The Protocol also sets out that the Secretary of State commits to respond publicly to the concerns raised within 28 calendar days. The response will explain how outcomes for prisoners in the institution will be improved in both the immediate and longer term.

**HMP Bedford – an unchecked decline in standards**

Before setting out the specific concerns arising from the inspection that have led to this letter, I think it important to note the continual and unchecked decline in standards at the prison over the past nine years. As you know, we inspect prisons against our healthy prison tests, which are based on independent standards in the areas of safety, respect, purposeful activity, and rehabilitation and release planning. In each category we award a grading ranging from the lowest, 'poor' (1), through 'not sufficiently good' (2), 'reasonably good' (3) to our highest, 'good' (4). The results of inspections at HMP Bedford since 2011 are as follows:

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<th>Year</th>
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Following the 2016 inspection the prison was made subject to a Performance Improvement Plan in September 2016, initially for a period of 12 months, later extended to 18 months. In November 2016 there was a major disturbance at the prison, after which a large number of prisoners were removed from the jail. In May 2018 it was decided that there had been insufficient progress against the Performance Improvement Plan and the prison was placed in 'special measures' by HMPPS. It should also be noted that in 2016 I referred to an 'abject failure' to address our recommendations from the previous inspection with only 12 out of 72 fully achieved. On this occasion we found that just 21 out of 68 had been fully achieved.

The key findings of the latest inspection are set out in the attached summary note and I shall not repeat them in this letter. I shall instead set out some of our major areas of concern, and why it is necessary for me to invoke the UN process, even though I believe local management at the prison are working very hard in challenging circumstances, and at a time when 'special measures' imposed by HMPPS are already in place.
Violence
The rate of assaults had risen significantly since the last inspection, when measured over a 12-month period, and stood at a higher level than any other local prison, except HMP Birmingham. Assaults on staff had also risen dramatically and the rate was now the highest in the country. There had been 116 assaults on staff in the last six months, some of them serious. Many staff told us that they often felt unsafe. Meanwhile, the use of force had risen fourfold and was running at a rate nearly three times higher than at similar prisons we have inspected. Unsurprisingly, more than two-thirds of prisoners told us they had felt unsafe at some time, and over a third felt unsafe at the time of the inspection. These are very high figures.

A lack of control
Despite the best efforts of staff at all levels, there was a dangerous lack of control in many parts of the prison, leading us to fear that there could all too easily be a complete breakdown in order and discipline. Some 77% of available officers had less than one year's service. There was a corresponding lack of experience at all levels, and it was clear that this was having a significant impact on many areas of prison life.

We often saw prisoners refusing to comply with directions from staff, without sanction or effective challenge. The adjudication system was in disarray with only a third of cases being completed in the six months leading up to the inspection. As a result, prisoners knew that either because of delays or systemic failure, misbehaviour and defiant disobedience were very unlikely to lead to punishment. Rules were routinely broken and at times it felt as if prisoners were effectively in control, choosing when or if to comply with directions and consent to authority. On one occasion an inspector on the ground floor noticed food landing around him, coming from higher landings. He went up and found prisoners being disorderly, including throwing food. Prisoners' behaviour was very rowdy and unrestrained and the incident had the potential to escalate. Staff were unwilling to go upstairs to intervene, and prisoners told the inspector this was not unusual.

On another occasion the inspection team leader, herself a former senior prison governor, witnessed an outbreak of concerted indiscipline. A prisoner had been found in possession of an illicit mobile phone, and incited other prisoners, most of whom were unlocked, to cause a disturbance. Prisoners became very angry, noisy and challenging and refused to comply with staff when directed to lock up. Staff struggled to deal with the incident, and appeared not to know what to do. Supervisors were not in control. For a period of an hour and a half, prisoners made unreasonable demands and many of them were acceded to. What happened was not a controlled negotiation leading to a resolution, but a case of inexperienced staff capitulating to aggressive prisoners. Surprisingly, this serious incident, which took place on 3 September, did not appear on the HMPPS Daily Incident Report until 6 September when it was described as 'miscellaneous', as opposed to what it clearly was: an act of concerted indiscipline. Inspectors subsequently reviewed records held at the prison and found other incidents that should have been recorded as concerted indiscipline, but had not been submitted for inclusion on the national Daily Incident Report.
Drugs
In common with many other prisons HMP Bedford has suffered from high volumes of illicit drugs. One prisoner in five told us they had acquired a drug habit since arriving at HMP Bedford, and the smell of cannabis and other drugs being smoked pervaded some of the wings. The mandatory drugs testing positive rate stood at 27%. However, even this was not an accurate figure as a substantial proportion of those selected for testing refused the test – one can only assume that this was because they were expecting a positive result – but it wasn't recorded as such. It was clear that much of the violence was fueled by drugs. The prison had a drugs supply reduction strategy in place, but the ready availability of drugs showed that more needed to be done. It was clear that the prison lacked the necessary funding and modern technology to stem the flow.

Suicide and self-harm
There had been five self-inflicted deaths since the last inspection, the most recent around a year ago. There was still more to do to implement recommendations from the Prisons and Probation Ombudsman, and the importance of addressing this promptly cannot be overstated as the rate of self-harm incidents had increased substantially since the last inspection. There had been 163 incidents of self-harm over the previous six months; this rate was higher than in similar prisons. Most prisoners in crisis said they did not feel well cared for. They faced living in grimy conditions with little time unlocked and hardly anything to do.

Respectful detention and living conditions
Living conditions were poor. The summary report attached to this letter sets out some of the deficiencies in the physical environment. There was a huge backlog of general repairs (over 600 repairs outstanding with over 400 going back to 2017) and maintenance tasks, with no prospect of them being completed or the backlog diminished. We found a prisoner located overnight in a cell that had supposedly been taken out of commission. It had a bed, but no other furniture, and a broken window. The toilet did not flush and there was builder's rubble on the floor from repairs that had not been completed.

At the time of the last inspection we reported on the difficulties prisoners were experiencing in gaining access to daily essentials such as clean clothing and bedding. On this occasion we found that towels and sheets were only being changed every four weeks, which is clearly unacceptable, and all too often it was still difficult to obtain certain items of clean clothing.

Prisoners with disabilities often struggled to get the help they needed and relied on the goodwill and friendship of other prisoners to get their basic needs met. Two prisoners who were amputees were unable to shower regularly as they didn't have the necessary adaptations. One said he had only had five showers this year and to wash himself he had to sit on the floor of his cell and try to splash water on himself from the sink.

Many areas of the prison needed cleaning and many shower rooms were dirty and decrepit. Despite efforts to deal with the problem the prison was still infested with rats and cockroaches. In one particularly gruesome example, a disturbed prisoner in the...
segregation unit lured several rats into his cell before killing them, all in a matter of hours.

**Purposeful activity**
The prison lacked a culture of work or learning. Even though there were sufficient activity places for every prisoner, at least on a part-time basis, few chose to attend and we could see little encouragement from staff to do so. In many classes and workshops only three or four prisoners attended. The prison has been operating on a restricted regime for some time, meaning that at best prisoners can access activities for half of the day. We found nearly 40% of prisoners locked up during the working day. Those that were unlocked tended to mill around in groups on the wings, doing nothing constructive. Our colleagues from Ofsted found that for those who did go to activities, the provision overall was assessed as inadequate.

**Conclusion**
In deciding whether to invoke the UN Protocol, a key consideration is whether I can have confidence in the prison's capacity for change and improvement. It is of great concern that for nine years the prison has been on a path of seemingly inexorable decline. Repeated inspection findings clearly show that this has been the case. For much of that time there was a marked inconsistency in the leadership of the prison, with frequent changes of governor. The present governor has now been in post for over a year, and that is welcome. The question for me is whether she and her team, clearly determined as they are to improve the prison, have the capability and capacity to do so.

As mentioned above, earlier this year HMPPS placed the prison in ‘special measures’, a move we understand was intended to help drive improvement and offer support. I have looked closely at the action plans that have been produced, studied the minutes of meetings that have been held to steer the implementation of those action plans, and discussed them with the Governor and the Prison Group Director. Some benefits will flow from those action plans. For instance, I am told that some experienced managers will soon be sent to HMP Bedford to help mentor the large number of new staff. There have also been welcome recent developments such as funding being made available for 24 new windows, for HMP Aylesbury to help with laundry problems, for a violence reduction manager to be appointed, and extra money for pest control. However, far too many important issues in the action plans have indeterminate or long timeframes for implementation. In terms of maintenance work, the plan notes that available resources ‘are not sufficient to address the backlog’. Finding suitable employment within the prison is helpfully acknowledged as a priority, but that this will happen ‘when a suitable solution becomes available’. The prison-level plan has 30 actions, and the Prison Group Director has quite correctly annotated 21 of them to demand clear timeframes, individual accountabilities and means of delivery.

I fully understand that when the Urgent Notification Protocol is invoked, the necessary response can be time consuming and costly. I also recognise that human and financial resources are far from limitless, and that difficult decisions of prioritisation have to be made. That is a management responsibility in which, quite rightly, I am not and should not become involved. Nevertheless, as Chief Inspector I have a clear responsibility to
report what I find, and where I have significant concerns, to report them to you as Secretary of State.

My judgement is that placing the prison in 'special measures' does not, in itself, give assurance that the serious issues identified in this letter and attached summary report will be adequately addressed. The clear view of the Inspectorate is that immediate and decisive intervention is needed at HMP Bedford to avert further decline and an even more dangerous lack of control than is currently the case.

Yours sincerely

PETER CLARKE
Debriefing paper by HM Inspectorate of Prisons

Full inspection of:

HMP Bedford

28 August – 6 September 2018
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Healthy prison assessments

Outcomes for prisoners are good against this healthy prison test.
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

Outcomes for prisoners are reasonably good against this healthy prison test.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority there are no significant concerns. Procedures to safeguard outcomes are in place.

Outcomes for prisoners are not sufficiently good against this healthy prison test.
There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

Outcomes for prisoners are poor against this healthy prison test.
There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.
1. Safety

Reception processes were good but many prisoners were not supported well enough on their first night. Too many prisoners felt unsafe and violence, particularly against staff, was very high. Perpetrators of violence faced few challenges or sanctions. Victims of violence were poorly supported. Use of force was exceptionally high. Conditions in the segregation unit were appalling and managerial oversight was weak. There was a lack of order and control on some wings. Drugs were easily available. A good local supply reduction plan was in place but was undermined by a lack of investment nationally. Levels of self-harm were high and prisoners at risk of suicide and self-harm were not well supported. Outcomes for prisoners were poor.

Early days in custody
- Reception staff and prisoner orderlies were welcoming but holding rooms were bland and provided little to occupy prisoners.
- Initial safety interviews were now conducted in private and had a suitable focus on risk issues.
- Shortages of prisoner kit meant some new arrivals were not issued with sufficient clothing and bedding. Too often new prisoners did not go to the dedicated first night unit as it held prisoners who could not be located elsewhere. Instead they were located wherever there was a space, and these cells were not well prepared. Wing staff were often unaware of new arrivals and did not routinely check on their welfare.
- In our survey, less than half of prisoners said they felt safe on their first night.
- Induction was adequate, but many prisoners did not attend all elements. Peer worker involvement was positive but was not overseen by staff.

Managing behaviour
- In our survey two-thirds of prisoners said they had felt unsafe at some time and over one-third felt unsafe at the time of the inspection.
- Recorded levels of assaults, when measured over 12 months, had increased significantly since the last inspection and were much higher than all but one local prison. Assaults on staff had risen sharply and were higher than at any other local prison.
- Some detailed work had been undertaken to understand the causes of violence and a comprehensive safety strategy was in place, but there was no dynamic action plan to monitor actions to make the prison safer.
- The Governor chaired the safer custody meeting which was well structured, but minutes showed a lack of engagement from some key areas.
- The current prisoner violence reduction scheme was largely ineffective. There were few challenges or sanctions faced by perpetrators of violence beyond use of the incentives and earned privileges (IEP) and formal adjudications processes, which in themselves were not effective.
- There was still no specific violence reduction strategy for young adults who were over-represented in violent incidents.
- Support for victims of violence was inadequate.
- Vulnerable prisoners located on the dedicated vulnerable prisoner wing received a reasonable regime but others located elsewhere across the prison were often intimidated by other prisoners and had a poor regime.
The IEP scheme was ineffective. It did too little to incentivise good behaviour and was applied inconsistently. Too many IEP reviews did not take place on time. Target setting for prisoners on the basic level of the scheme was poor. Some prisoners were given generic targets, and others no targets at all.

The adjudication system was not used effectively to tackle more serious concerns and challenge poor prisoner behaviour. Over the last six months only around one-third of adjudications had been completed. The prison had begun to address the dysfunctional process for police referrals.

Use of force

Use of force was very high, at four times that at the last inspection and almost three times that of similar prisons we have inspected. Baton use was high. We found numerous occasions where special accommodation was used but not recorded.

Although there was some analysis of available data to identify hotspots and trends, managerial oversight was insufficient and the use of force committee did not review videos or incident paperwork. Almost all dossiers were incomplete and none included an injury to prisoner form.

Segregation

Use of segregation was similar to last time and to that of other local prisons.

It was evident that the unit managed some extremely challenging behaviour, but it was chaotic and managerial oversight of both the unit and segregated prisoners on normal location was lacking. Recording of individual behaviour was poor and the daily occurrence log was rarely used.

The environment and conditions in the segregation unit and overspill landing were appalling. General areas and cells were dirty and in constant need of repair, toilets did not flush properly and some cell call alarms were inoperative. The regime for those currently on the unit was poor.

There was some evidence of previous reintegration of prisoners back onto normal location, but too many prisoners were transferred out of the prison without their issues being addressed.

Security

The lack of order and control on some wings was a major concern. Staff struggled to contain an act of concerted indiscipline during our visit and we frequently observed periods where staff control was tenuous.

Dynamic security was poor and we witnessed little effective engagement from staff on some residential wings.

Intelligence was well managed and searching resulted in regular finds of drugs and other contraband, but too few searches and suspicion drug tests were completed.

The prison was focused on known and emerging threats, including organised gang activity, drug supply and associated debt. There was an appropriate focus on the risks posed by extremism.

Almost half of all prisoners surveyed said it was easy to get illicit drugs and a fifth said they had developed a drug problem at Bedford. Random drug testing rates were at 27%. We regularly smelt cannabis and other substances being burnt throughout the prison. A supply reduction strategy and action plan was in place, but it was hampered by a lack of funding and investment in available technology.
Safeguarding

Suicide and self-harm protection

• There had been five self-inflicted deaths since the previous inspection, the most recent a year ago. Progress against Prisons and Probation Ombudsman (PPO) recommendations was too slow and some actions had not been completed.
• The number of incidents of self-harm had increased substantially since the previous inspection and was higher than in similar establishments.
• ACCT processes (case management for prisoners at risk of suicide or self-harm) were weak. Initial assessments were mostly adequate but some care plans were missing or failed to address the issues of concern to prisoners. Many staff comments were observational rather than demonstrating quality interaction.
• In our survey only a third of prisoners who had been subject to ACCTs felt cared for, and any care provided was severely undermined by poor living conditions and a lack of purposeful activity.
• There were too few Listeners to meet the needs of the population and they were not available during the night.
2. Respect

Most staff were extremely inexperienced and struggled to exert their authority. Prisoners regularly and blatantly ignored rules and staff instructions – often without sanction or challenge. Living conditions were poor, often overcrowded, dirty and vermin-infested. Access to clean clothing and bedding was inadequate. Food and purchasing arrangements were reasonable overall. The number of complaints was high and too many were responded to too late or not at all. Equalities work was developing but too little was done to support most minority groups and outcomes for some disabled prisoners were particularly poor. Health care and substance misuse services were reasonable overall but mental health provision required improvement. Outcomes for prisoners were poor.

Staff-prisoner relationships

- Staff-prisoner relationships had deteriorated since the last inspection and were of considerable concern.
- The prison was managing a challenging, dynamic mix of prisoners, with a particularly inexperienced staff group. Seventy-seven per cent of available officers had less than one year’s experience and almost half of middle managers were temporarily promoted.
- Staff at all levels were committed to their work and trying to do their best, but as a group they were out of their depth. This lack of experience was having a significant adverse impact on many aspects of prison life.
- Some prisoners routinely and blatantly disregarded rules and appropriate standards of behaviour, without challenge. We frequently observed prisoners refusing to do as instructed by staff – and getting away with it. Poor supervision and control of prisoners created unacceptable risks.

Daily life

Living conditions

- Living conditions were poor. Common areas in most wings were not kept clean. A wing, in particular, was filthy. Despite recent attempts to control vermin, rats, pigeons and cockroaches were everywhere.
- There were too few working showers in some wings. Many shower rooms were dirty and in poor physical condition. Some were decrepit.
- Many cells were overcrowded and cramped. Cleanliness was variable and many cells were grubby and poorly decorated. Some toilets were dirty and many were poorly screened. There was much graffiti, some of it offensive.
- Most cells had basic equipment such as kettles and TVs, although some had insufficient furniture. Some bunk beds were broken and a number had no ladders. Some cells had missing windows and many had broken, or blocked, observation panels.
- There was a huge backlog of general repairs and maintenance. Many cells were vandalised and assessed as not fit for habitation, but we nevertheless found a prisoner located in one.
- Laundry facilities were inadequate. Prisoners struggled to get access to essentials such as sufficient clean clothing. Towels and sheets were changed only every four weeks which was deplorable.
Residential services (catering and shop)
- The food was of reasonable quality, although breakfast packs were meagre. Having the main meal at lunchtime was not popular. The kitchen, despite a period of severe understaffing, was well organised and standards of hygiene and cleaning were high, but non-core work such as consultation and special event menus had suffered.
- The weekly small-item purchasing system worked well, but prisoners had to wait up to 10 days for their first full order which increased the likelihood of debt. The catalogue order system had improved, but many electrical items had been delayed for weeks awaiting testing.

Prisoner consultation, applications and redress
- Prisoner consultation arrangements were adequate.
- Until recently oversight of the applications process was poor. We were not assured applications were dealt with in a timely manner, or at all.
- The number of complaints submitted was high. Too many responses were late and 12% in a recent three-month period had not been responded to.
- Most complaint responses were adequate. However, some had not been properly investigated and apologies were not always offered when warranted.
- Some complaints about staff were not always investigated by an appropriately senior or independent person.
- Insufficient support was available to help prisoners with their legal needs.

Equality, diversity and faith
- There was now an established pattern of equality meetings and protected characteristic forums. Our survey showed relatively few major differences in perception between minorities and others, although staff-prisoner relationships stood out as the one area where black and minority ethnic and Muslim prisoners had more negative perceptions than others.
- There was good use of local data to look for evidence of inequity between different groups. However, there were, as yet, few real actions coming from the processes of consultation and analysis, except in a few cases such as the library.
- There were prisoner equality representatives, and equality officers had been identified but were not yet active. The handling of discrimination incident reports had improved, but the quality of investigation was inconsistent.
- Foreign nationals who spoke little English were disadvantaged by a lack of translated material and low use of telephone interpretation, and were at risk of being very isolated. Visiting immigration staff, whose visits were irregular, were the only source of information, though forums had been held.
- Prisoners with disabilities were identified to some extent, but for those on the wings there were no care plans and insufficient attention to meeting their basic needs. A few with significant disabilities were living in very poor conditions.
- A transgender prisoner was given reasonable care. No current prisoners had identified themselves as gay or bisexual. There was no positive affirmation of different sexual orientations to encourage openness.
- There was no distinct provision either for under-21s or for older prisoners, though the latter were largely content with their treatment.
Faith and religion
- The chaplaincy team was now much stronger; it was well led and core tasks were carried out efficiently. Additional services were provided, such as bereavement counselling, yoga and some through-the gate work through faith channels. There was insufficient focus in the establishment on enabling worship sessions to start on time with full attendance.

Health, well-being and social care
- Health care services had improved since our last inspection, but some concerns remained regarding mental health provision.
- A range of primary care services was available, but the team was struggling to engage podiatry services which had been absent for four months. Waiting lists were acceptable for most clinics.
- The confidential health complaints process was not routinely used by prisoners, and forms were not widely available. Prisoners had to ask wing staff and peer workers for health care application forms, which was inappropriate.
- Inpatients received a good level of care from all staff and had good access to a range of activities.
- One prisoner was receiving social care. Processes for referral and assessment were effective.
- Medication administration on the main wings was poorly supervised by prison staff and was not confidential.
- Dental facilities had improved since our last inspection, and the service was good.
- A well-integrated mental health team offered a limited range of primary support, but lacked capacity to provide sufficient levels of therapeutic interventions. Secondary care was reasonable. Urgent referrals were seen promptly but routine referrals took too long to be assessed.
- Overall provision for prisoners with substance misuse issues had improved, although only 55% of new arrivals requiring stabilisation were located on D wing, the designated drug treatment wing, which was unsatisfactory. Twenty-four-hour monitoring and observation was now taking place for most prisoners. Clinical care was good and we observed good joint working between clinical and psychosocial support services. Psychosocial support for prisoners with drug and alcohol problems had improved, and a third of all prisoners were engaged with the service. While one-to-one support was available to all, there was still limited access to group work for those not located on D wing.
3. Purposeful activity

Time unlocked was poor for most prisoners and when they were unlocked most had nothing purposeful to do. Library and PE services were adequate. The leadership and management of education, skills and work activity were inadequate. There were sufficient education, skills and work places for all prisoners to work at least part-time, but very few prisoners chose to attend. Far too many were unemployed. The range of provision was narrow and low level. The quality of provision, including teaching and learning, was inadequate and prisoners made too little progress. Too few prisoners completed their courses and gained a qualification. Outcomes for prisoners were poor.

Time out of cell

- Time out of cell was poor and few prisoners used it constructively, mostly spending it on the wings with nothing purposeful to do.
- A restricted regime had been in place for many months but there were often lengthy delays in locking and unlocking prisoners and moving them to activities.
- The few prisoners who engaged in work, education and training had up to five and a half hours out of cell most week days. Most others had about two and a half hours.
- Too many prisoners, around 39%, were locked in cells during the working day.

Library and PE

- Access to the library was reasonable and facilities were good. An adequate range of materials was available but activities to promote literacy were too limited.
- The gym was a well-equipped facility and the PE department offered a range of recreational PE activities, but nothing for older prisoners. We were not assured that access to PE was monitored for fairness.

Education, skills and work activities

Leadership and management of education, skills and work activities

- Leaders and managers had made very slow progress in tackling the weaknesses identified at the last inspection. All of the past weaknesses remained, most notably prisoners' low attendance and involvement in activities and induction, prisoners' poor punctuality, and the narrow and low-level range of provision.
- Further weaknesses at this inspection included some key aspects of teaching and learning which were still not good enough, a sharp fall in the number of prisoners attending initial skills assessments, and the low proportion of prisoners completing their courses and gaining qualifications.
- The prison's quality improvement arrangements were ineffective. Regular externally-led evaluations of purposeful activity provided thorough and accurate assessments about the quality of provision but ultimately charted a progressive decline in its effectiveness. Leaders' strategic planning did not lead to clear or systematic action planning. The prison did not promote a culture which recognised education, work and skills as a means of rehabilitation.
- There were enough activity places for all prisoners to attend work, training or education at least part time. But we found only around 20% of prisoners were engaged in any form of purposeful activity at any one time. Too many sentenced prisoners were not allocated to an activity and a third of prisoners were recorded as being unemployed.
- The community rehabilitation company (CRC) had begun to provide prisoners with pre-release support to enter employment, training or education, but this was mostly
recent and poorly attended. The education provider had begun to provide some useful information advice and careers guidance. Prison managers did not gather meaningful or accurate data to monitor prisoners' involvement in education, training or employment after release.

Quality of teaching learning and assessment
- Teachers were professional, committed and resilient but were not all providing consistently effective teaching and learning. Teachers' expectations of learners were not routinely high enough and there was a lack of challenge for prisoners generally.
- Planning for individual learning was too often ineffective, not least because most teachers did not know routinely who was going to attend a class. The few instances of prisoners' poor behaviour were not always managed well enough by teachers which led to low-level disruption of learning.
- Prisoners were not all making enough progress in sessions observed or over time.
- No specialist learning support was available to the substantial number of prisoners requiring it.

Personal development and behaviour
- Prisoners' behaviour in sessions observed had improved since the previous inspection but was still not consistently good. However, interactions observed between prisoners and with their teachers were generally positive and respectful.
- Very few of the prisoners we interviewed valued their learning or believed it would enhance their prospects on release.
- The accreditation of prisoners' skills developed through work was poor.
- Too few prisoners actually attended following enrolment on a course, and too many arrived at sessions determined to be sent back to the wings.

Achievements and outcomes for prisoners
- Too many prisoners started but did not complete an accredited course or gain the qualification. This was particularly the case in full functional skills courses in English and mathematics, ESOL and employability. The relatively few prisoners who did complete an accredited course usually achieved their qualification.
- Too many prisoners left the prison no more qualified or skilled for work than on entry to the prison.
4. Rehabilitation and release planning

Work with children and families was adequate. A majority of sentenced prisoners, including all high-risk prisoners, received regular and meaningful offender supervisor contact. However, the offender management of low- and medium-risk prisoners – about 40% – had effectively ceased because of staff shortages. Many prisoners did not have an up-to-date OASys. Home detention curfew (HDC) processes were not effectively managed. Prisoners struggled to progress and move on to other suitable prisons. Public protection arrangements were reasonably good. The need for housing and debt support was high but provision was too limited and too many prisoners were released homeless. Demand for release planning was high and resettlement needs were identified promptly on arrival, but there was no assurance they were met. Outcomes for prisoners were not sufficiently good.

Children, families and contact with the outside world
- There was a good new strategy document on children and family ties, but the level of delivery had reduced, with no parenting courses or family 'craft box' sessions. Children's visits were held regularly, a cycle of quarterly family days had begun, and a community worker provided a valuable service for families of prisoners who lived locally.
- The visits hall, although of limited size, was well run, with good assistance from Ormiston Trust staff and volunteers. The environment was tired with fixed rigid furniture but with a good cafe and play facilities. Visits booking was now working reasonably well.

Reducing risk, rehabilitation and progression
- Strategic management of reducing reoffending remained weak. The reducing reoffending strategy was thoughtful but aspirational and based on a limited needs analysis. The reducing reoffending committee rarely met and did not drive improvement. There was no action plan to monitor progress.
- A lack of staff and experience undermined the work of the offender management unit (OMU). The CRC remained under-resourced and the two were not well integrated.
- Those prisoners supervised by on-site probation officers (amounting to about 60% of sentenced prisoners), including all high-risk men, were well managed, and had regular, meaningful contact.
- Uniformed offender supervisors were constantly cross-deployed which meant that about 40% of the OMU's caseload, of low- and medium-risk prisoners, had little or no ongoing contact.
- About 40% of all eligible prisoners did not have an up to date OASys assessment and many others had already transferred without an assessment to inform their move.
- Basic, but critical, administrative tasks such as sentence calculation were not promptly completed, which frustrated prisoners and affected outcomes in areas like release planning.
- HDC processes were not effectively managed. Some prisoners who should have been considered for HDC were not.
- There was insufficient oversight to ensure the appropriate and prompt transfer and progression of sentenced prisoners.
Public protection
- There was a regular interdepartmental risk management team (IRMT) meeting with an appropriate scope, but attendance from other departments was weak and high-risk prisoners were considered too close to release to allow time for remedial action.
- There was good information exchange between community offender managers and on-site probation officers in most high-risk cases we looked at.
- Mail and telephone monitoring arrangements were generally well managed and reviewed in a timely manner.

Interventions
- The introduction of the Reactiv8 programme (a sports-based approach to improve thinking skills) was very positive and suitably focused on a young and short-term population.
- In our survey, significantly more prisoners than at other local prisons reported they needed help around finance, benefit and debt. Support from the CRC overall was too limited, but prisoners could now open bank accounts, which was an improvement.
- There was high demand for help with accommodation. Despite the best efforts of the CRC, a third of prisoners with an identified accommodation need were released homeless. Remand prisoners who made up half of the population were not helped to find accommodation at all.

Release planning
- Demand for resettlement services was very high, with about 90 prisoners released each month. Many prisoners stayed for a very short time — about 60% of the population had been at Bedford for three months or less.
- CRC provision remained too limited. While initial resettlement plans were completed on time and appropriately identified need, too many prisoners did not have their plan reviewed prior to release to ensure that referrals and actions were completed.
- The pre-release board, which was potentially extremely useful, was poorly attended and was not given sufficient priority by the prison.