Report on an independent review of progress at

HMP Rochester

by HM Chief Inspector of Prisons

2–4 June 2025

Contents

Section 1 Chief Inspector's summary

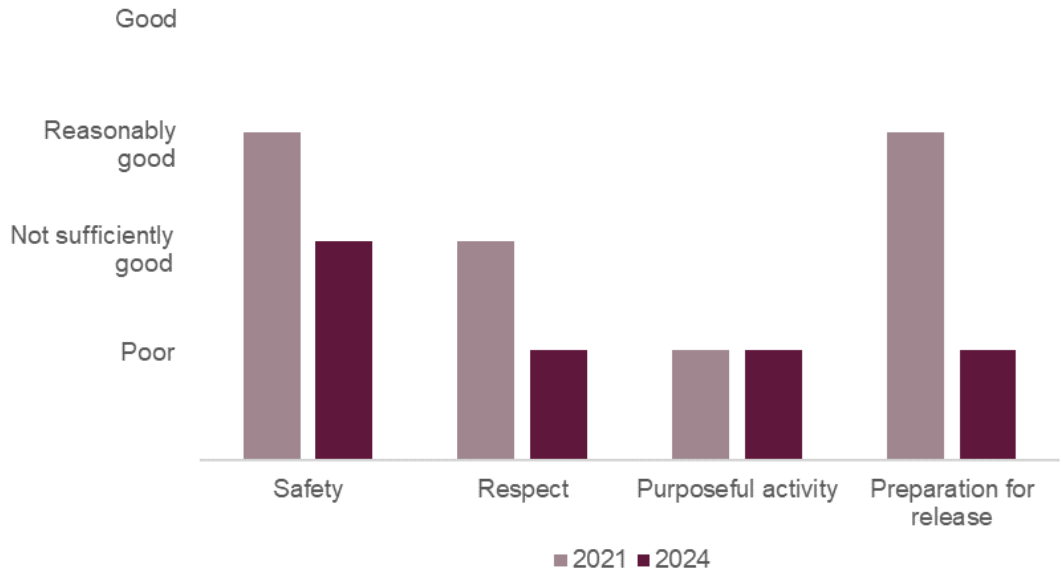
1.1 HMP Rochester is a category C training and resettlement prison. In 2024 HMP Cookham Wood reopened as an adult institution under the leadership of Rochester prison, adding up to an additional 180 spaces.

1.2 This review visit followed up on the concerns we raised at our last inspection of HMP Rochester in 2024.

What we found at our last inspection

1.3 At our previous inspection of HMP Rochester in 2024 we made the following judgements about outcomes for prisoners.

Figure 1: HMP Rochester healthy prison outcomes in 2024
Note: rehabilitation and release planning became 'preparation for release' in October 2023.



1.4 At the full inspection in 2024 the jail attracted our lowest healthy prison assessments in three of our four tests: respect, purposeful activity and preparation for release. These poor outcomes compelled me to write to the Secretary of State and invoke our Urgent Notification protocol.

1.5 Rochester was fundamentally failing in its rehabilitative purpose. We found less than a third of the population involved in purposeful activity. Prisoners were generally unlocked during the day, but most had nothing to do. We observed wings that were chaotic and poorly supervised.

1.6 Safety was also deteriorating. Reported incidents of violence against staff and prisoners had increased, use of force was high, and illicit drug use was endemic.

1.7 Accommodation across the prison was mixed, but most was dilapidated with some of the worst conditions we have seen in recent years. The

offender management unit was ineffective, and we identified some very poor outcomes in health care.

What we found during this review visit

1.8 At this independent review of progress, we found good or reasonable progress had been made in two-thirds of the concerns we raised and in half of the Ofsted themes.

1.9 The prison had been without a permanent appointment as governor from the time of the inspection in August 2024 until March this year. During that time there had been two interim governors for short periods, along with several other senior leadership changes, all of which had contributed to a sense of instability at the prison. However, since the permanent appointment of the governor there seemed to be more structure, and we found a leadership team that were beginning to work collectively to progress Rochester and improve outcomes for prisoners.

1.10 Staffing levels were lower than at the time of our inspection, often resulting in cross-deployment of specialist areas, and had resulted in the introduction of a temporary staffing profile to ensure a reliable regime was delivered.

1.11 In February 2025, the prison's population was reconfigured to hold prisoners convicted of sex offences (PCoSOs). This, along with the ongoing merger of HMP Cookham Wood (which transitioned to an adult site aligned with Rochester during the last inspection) created additional challenges.

1.12 Despite these challenges, leaders had made commendable efforts in reducing recorded levels of self-harm and violence, as well as significantly improving living conditions. However, substantial concerns persisted regarding the availability of drugs in the prison, as well as outcomes in the provision of health services.

Charlie Taylor
HM Chief Inspector of Prisons
July 2025

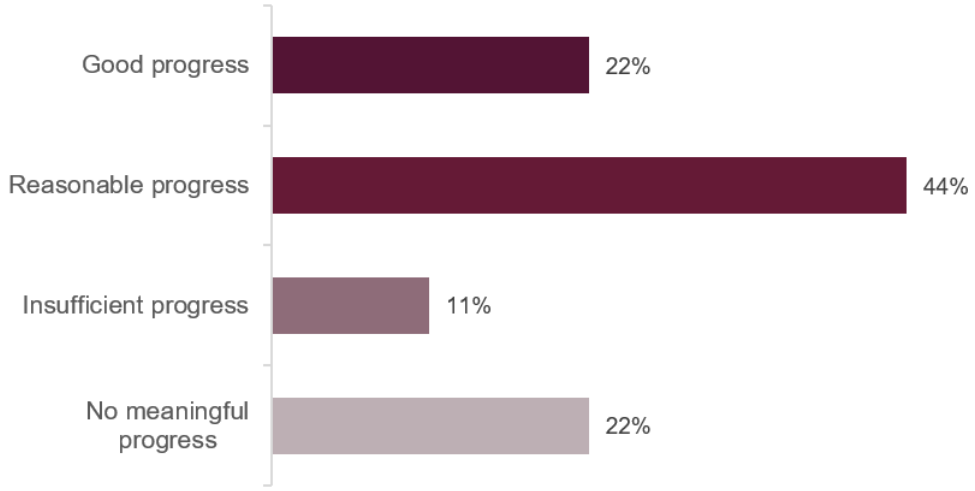
Section 2 Key findings

2.1 At this IRP visit, we followed up nine concerns from our most recent inspection in August 2024 and Ofsted followed up four themes based on their latest inspection.

2.2 HMI Prisons judged that there was good progress in two concerns, reasonable progress in four concerns, insufficient progress in one concern and no meaningful progress in two concerns.

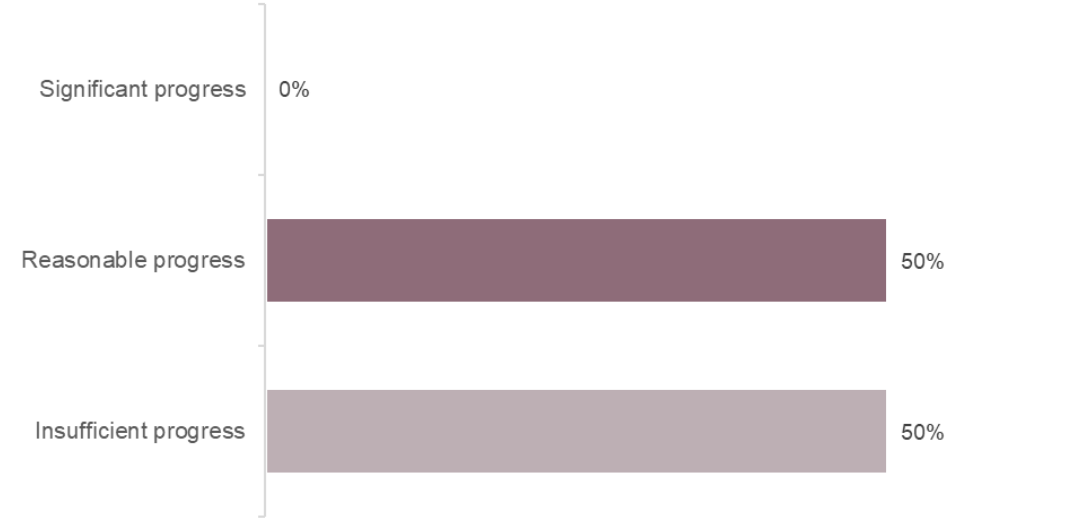
Figure 2: Progress on HMI Prisons concerns from August 2024 inspection (n=9)

This bar 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 significant progress in no themes, reasonable progress in two themes and insufficient progress in two themes.

Figure 3: Progress on Ofsted themes from August 2024 inspection (n=4).



Notable positive practice

2.4 We define notable positive practice as:

> Evidence of our expectations being met to deliver particularly good outcomes for prisoners, and/or particularly original or creative approaches to problem-solving.

2.5 Inspectors found no examples of notable positive practice during this IRP visit.

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 2024.

Leadership

Concern: The high number of inexperienced officers did not always enforce standards of good behaviour among prisoners. Leaders were not sufficiently visible, and staff lacked support.

3.1 Most staff we spoke to report an increased visibility amongst leaders in recent months. Leaders had made changes to shift timings and adapted meetings which had improved their ability to be visible at key times, such as movements and at lock-up time. Most of our observations during the visit supported this. In addition, more senior leaders were completing weekly visibility rounds, visiting various areas of the prison and talking to staff.

3.2 There remained, however, real concerns. For example, staff still need to be more proactive and in control. We observed too much inappropriate behaviour, such as prisoners verbally abusing each other and vaping in communal areas against the rules, this often going either unnoticed or unchallenged.

3.3 Training and development for both new staff and leaders had improved. The induction arrangements for new officers had been enhanced by providing an additional week of shadowing with an experienced member of staff, as well as tasks set to help them develop relationships across different departments. Feedback from those staff having completed this programme had been positive. In addition, a range of initiatives was being developed for leaders aimed at improving capability and confidence. Only a small number of these sessions had been delivered so far, but more was scheduled.

3.4 Leaders had improved communication with all staff through weekly staff meetings at both Rochester and Cookham Wood to ensure staff were kept informed of key messages and information.

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

Safety

Concern: Levels of safety in the prison was deteriorating, and both violence and self-harm were increasing. The safety strategy was out of date, not well informed by data and lacked an action plan.

3.6 Reported self-harm incidents had reduced by 42% and overall recorded incidents of violence had reduced by 33% since our inspection. Prisoner on prisoner violence was now among the lowest in the category C estate.

3.7 This reduction had been driven by a good safety strategy which was reflective of the population and supported by a meaningful action plan which was focused on addressing many of the reasons behind violence and self-harm. Actions included help with debt management and improved peer support.

3.8 The national safety team had also been deployed to support the safety team at Rochester. Notably this had helped to improve their use of data, leading in turn to some better understanding of factors causing violence and self-harm.

3.9 The care given to those in crisis had improved, staff had been trained to have a better understanding of risks and triggers relating to self-harm, and the management of these prisoners through the assessment, care in custody and teamwork (ACCT; see glossary) process was significantly better than at the last inspection. Improvements included the introduction of a single case manager for each prisoner and ACCT documents we reviewed were of a much better standard. Leaders had put in place good quality assurance processes and, where needed, feedback was provided to case managers.

3.10 Safety peer representatives had been introduced; these prisoners supported those at risk of harm to themselves or others, and gathered information to help support improvements in safety. There were Listeners on both sites at Rochester, and there was more awareness of the scheme.

3.11 We considered that the prison had made good progress against this concern.

Use of force

Concern: Use of force was high, and oversight and accountability were lacking.

3.12 Use of force remained high, with 271 incidents in the last six months. The rate was similar to the last inspection, although most force used remained low level.

3.13 Incidents of PAVA (see Glossary) and baton usage had remained low, and all were appropriately reviewed following deployment. Some work had been done to improve the sharing of learning points.

3.14 Leaders had improved the weekly meeting to scrutinise use of force. All incidents were triaged and viewed by a multi-disciplinary team, which included external advisors that were subject matter experts. This gave greater assurance that each use of force was lawful. In the footage we reviewed at this visit, the force used was proportionate and necessary.

3.15 A training needs analysis had been conducted by the psychology team, in consultation with staff and leaders. There was now a credible plan in place to deliver training to upskill staff on de-escalation techniques, in an attempt to reduce the amount of force being used.

3.16 In addition, Leaders were now talking to prisoners after force had been used on them, and since the last inspection, post incident debriefs had followed in 70% of incidents, a significant improvement. At the time of our visit there was an analysis being conducted to draw themes to further develop ongoing staff training.

3.17 The safety team remained under resourced. One officer was identified to oversee use of force, but they were often redeployed, which impacted the work that could be done to reduce incidents of force.

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

Security

Concern: The availability and use of illicit drugs posed a major threat to safety and security. The positive drug testing rate was among the highest for this type of prison.

3.19 The availability and use of illicit drugs remained too high. Random mandatory drug testing (MDT; see Glossary) in the last six months showed a 48% positive rate, which was an increase when compared to the same period before the last inspection, and remained the second highest of category C prisons.

3.20 In the last six months the prison had recorded 432 prisoners suspected as being under the influence of an illicit item, and prisoners we spoke to said drugs remained readily available.

3.21 Although there was some improvement in actions identified from intelligence since our last inspection, only around one-third of requested suspicion drug tests and 72% of intelligence ‘priority searches’ had been completed.

3.22 Albeit still in draft, the drug strategy had been reviewed and reflected the issues at Rochester, but the action plan to tackle the problems had not yet been finalised.

3.23 A comprehensive drone vulnerability and physical security self-assessment had been completed in January, and actions to improve physical security were ongoing. There was evidence of useful work to prevent staff corruption, and joint working with the police remained good. Disruption plans to support reducing supply of illicit drugs were discussed every two months.

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

Living conditions

Concern: Many cells and communal facilities were in a very poor state of repair, were vermin-infested and required substantial investment.

3.25 Improvements had been made to the living conditions at Rochester. Prior to receiving a change in the population, A, D and E wings had been refurbished and work was being completed on B wing during our visit. A key aim was to ensure cells were of a good standard.

A wing landing (left) and B wing undergoing refurbishment

3.26 A full cell audit across Rochester had been completed, to identify defects in the fabric of the cell and ensure adequate furniture was in place. The subsequent repairs were reasonably prompt.

3.27 A new regime provided designated time for wing cleaners, who we observed performing their duties to a reasonable standard. The use of prisoner work parties to help maintain cleanliness and make small repairs had been established, and wing decency checks were conducted by leaders. The results of these checks were shared with unit staff to support ongoing improvements.

Prisoner work party redecorating a cell

3.28 Communal areas and cells were notably in better condition, especially the older wings. They were cleaner, brighter, free from graffiti and cell toilets were screened. Frequent pest control measures and the improved levels of cleanliness had significantly reduced the vermin problem at Rochester.

3.29 However, many cells across all wings at Rochester still had broken window vents which caused prisoner frustration, as it reduced the flow of air into the cell. Leaders were putting together a business case to apply for funding to improve the windows and showers on the older wings.

3.30 We considered that the prison had made good progress against this concern.

Fair treatment and inclusion

Concern: Work to ensure fair treatment and inclusion was inadequate. Prison data had indicated disproportionate outcomes for prisoners in some protected groups, and Muslim prisoners reported more negative experiences.

3.31 Progress had been slow in efforts to improve the prison's approach to ensuring fair treatment and inclusion.

3.32 There was no strategy outlining the prison's vision and priorities based on the needs of the population, and equality meetings rarely happened.

3.33 Data analysis was not sufficiently robust in identifying potential disproportionalities for protected groups. The limited work that took place did not drive coordinated action planning to improve outcomes for prisoners.

3.34 A full-time equalities advisor had only been appointed shortly before our visit following a gap in provision.

3.35 Senior managers had recently been given responsibility for engagement with prisoners with protected characteristics. Some forums had recently been introduced; however, these meetings were not held consistently, sufficiently promoted, adequately structured or well-attended, which left the prison poorly placed to understand and act upon the needs and experiences of the population.

3.36 It was poor that there had been no targeted consultation with Muslim prisoners, and only a cursory attempt to engage with those from a Gypsy, Roma and Traveller heritage, to explore and address the negative perceptions that we identified at the last full inspection.

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

Health, well-being and social care

3.38 The Care Quality Commission issued an 'action plan request' notice following the inspection (see Appendix II) and took further enforcement action in the form of a Warning Notice, served to the provider on 25 June 2025 under Section 29A of the Health & Social Care Act 2008.

Concern: Clinical practice and poor oversight were allowing health care provision that was unsafe, ineffective and inefficient. For example, patients waited too long to be seen by a GP and both internal and external clinics were routinely cancelled.

3.39 The interim head of health care and operational health lead gave clear leadership to staff and, although a new partnership, had established a positive working relationship. NHS England had commissioned a new health needs assessment to address the patient needs following the recent changes in population.

3.40 Staffing remained a concern and recruitment was ongoing. Primary care staffing was supplemented by bank and agency staff. Too often, managers were working clinically, which distracted them from managerial responsibilities.

3.41 Clinical governance had improved but was still not sufficiently robust. We found gaps in audit results and a lack of action plans. GP waiting times were not accurately recorded or monitored. Appointments were routinely cancelled due to short staffing, and this was an ongoing risk to patient safety.

3.42 Improved partnership working had positively impacted on the oversight and attendance at external hospital appointments.

3.43 Clinical record keeping had improved but there were still some gaps. Care plans were in place for patients with long-term conditions, but these were generic and lacked any evidence of patient involvement. Some patients, for example those with wounds, did not have care plans, which was poor.

3.44 Patient complaints were well-managed, with appropriate responses that addressed their concerns.

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

Concern: Medicine administration and supply arrangements were poorly managed and took too long. Supervision was limited and there was no patient privacy. Expected administration times were not being adhered to, and patients missed or faced delays in receiving important medicines.

3.46 The governance of medicines continued to be poorly managed.

3.47 Medicines administration started at 8am and took far too long, often up to lunchtime. Arrangements for patients to attend for medication continued to be poorly organised, and we observed prolonged periods when nothing was happening. The position of medication hatches had not been addressed and remained at waist height. Consequently, patients had no privacy during medicines administration, and staff and patients had to raise their voices to be heard, which was unacceptable.

3.48 Officer supervision of medicine queues and attendance at the hatch was poor. Patients were able to attend two or three at a time to the administration hatch and were not challenged to maintain an orderly queue. We observed many opportunities for diversion or secretion of medication and patients engaging officers in conversation, distracting them from their duties with no attempt by the officer to keep a vigilant view of the administration process.

3.49 Planning for a new dispensary had been approved and was to be located on a wing with high patient need, which was appropriate.

3.50 The administration of controlled drugs medication did not meet national or local policy requirements, which placed patients at potential risk of harm.

3.51 We found multiple occasions where patients did not receive medicines, including critical medicines. This again presented a significant risk to some patients and was poor.

3.52 Air conditioning units were in place, and there was regular room temperature monitoring. Fridge temperature monitoring was undertaken but we found two dates which showed temperatures in significant excess of the safe storage of refrigerated medicines. There was no evidence of escalation or what steps had been taken to provide assurance that the medication was safe to use.

3.53 Patients were understandably frustrated by delays in the timely supply of medication.

3.54 We considered that the prison had made no meaningful 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.

Theme 1: What progress have leaders and managers made to ensure all prisoners have access to appropriate enrichment activities?

3.55 The appointment of a permanent senior leadership team had led to stability and enabled leaders to reassess priorities and refocus efforts effectively. Leaders had taken thoughtful and sensitive steps to shift organisational culture, demonstrating their commitment to building a coherent and inclusive provision.

3.56 Leaders and managers had a thoughtful and inclusive approach to developing an enrichment curriculum, aligned to the diverse needs of all prisoners. They had analysed the prison population data to identify and plan an enrichment curriculum that supported prisoners' personal progression and health and well-being, enabling them to participate in different courses over time. This curriculum supported prisoners' rehabilitation.

3.57 Since the previous inspection, nine months ago, leaders had made progress in delivering their commitment to embed a positive cultural shift, which prioritised rehabilitation. For example, collaborative working with key partners such as the library and Shannon Trust (see Glossary)

had ensured prisoners benefited from initiatives such as DEAR (Drop Everything and Read) and the Penned Up literature festival 2025.

3.58 Leaders had purposefully designed enrichment projects and activities to broaden prisoners' understanding of values of tolerance and respect, equality, inclusion, and wider societal issues. They were aspirational that prisoners developed essential life skills such as managing finances, managing anger, and developing positive thinking that supported personal growth and preparation for life after release. Prisoners stated that while participating in these activities, they felt as if they were not in prison. This was beneficial to their mental health and well-being.

3.59 The implementation of improvement plans by leaders and managers was initially too slow, and a significant element of the enrichment curriculum only comes online this month. However, leaders' progress had recently gained pace. For example, they introduced a train-the-trainer course for prisoners to deliver a structured enrichment curriculum to other prisoners.

3.60 Leaders and managers had not yet secured equitable access for all groups. A small proportion of prisoners in full-time employment were unable to participate fully in these activities due to limited flexibility in scheduling. This restricted their opportunities for personal development and wider engagement.

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

Theme 2: Rochester was failing in its function as a training and resettlement prison. There were insufficient spaces in education, skills and work to meet the needs of the prison population, and too few prisoners were able to attend.

3.62 Leaders had increased the number of prisoner jobs, and these were sufficient to meet the population needs. However, too many were in roles such as wing workers, orderlies, and red bands. These prisoners did not receive appropriate instruction, supervision, and guidance while at work. As such, these workers were not developing the behaviours and attitudes required by employers on release.

3.63 Leaders had introduced a new regime. This offered opportunities for part-time activity in education and vocational training and workers in full-time roles could now access part-time education. However, too few full-time workers engaged in this.

3.64 Leaders and managers had introduced a new prisoner pay policy with prisoners in education, wing work, red bands, orderlies, and mentors gaining the highest rate of pay per session. However, since prisoners in part-time education and training attended fewer sessions, they received less pay.

3.65 Managers had improved the curriculum by introducing courses in traffic management and street works, to facilitate prisoners gaining jobs in the road management sector upon release. Plans to run courses in demolition and self-employment were advanced and teaching will begin soon. Arrangements to deliver rail track and a preparation for employment course were also in the preliminary stages of planning. These new courses effectively complement the construction skills certification scheme card and food hygiene course already delivered.

3.66 In this training and resettlement prison, almost a quarter of prisoners were unemployed, and absenteeism rates remained too high, with a third of prisoners failing to attend frequently enough. Only around a quarter of prisoners wanted to work on release and leaders were doing too little to promote the benefits of employment.

3.67 Ofsted considered that the prison had made insufficient progress against this theme.

Theme 3: Leaders had been too slow to implement a prison-wide reading strategy. Reading was not promoted sufficiently across the prison and too many prisoners did not receive appropriate support to develop their skills.

3.68 Leaders and managers had worked effectively with the prison education framework (PEF) provider to revise and implement a single, coherent reading strategy that ensured consistency in the promotion of reading. They had successfully engaged staff and prisoners, focusing on embedding a prison-wide culture that recognised reading as an essential skill that provided access to further learning, employment, and personal development.

3.69 Managers ensured prisoners had regular access to the library. For the small minority of prisoners who could not attend, such as those with a disability or those in the care and separation unit, the library took books to the prisoner. Prisoners with disabilities, such as sight loss, had accessed braille books from the RNIB and audio books.

3.70 Managers had communicated the reading strategy effectively, contributing to a greater awareness and visibility among prisoners and staff. Staff undertook briefings to increase their understanding of reading levels. For instance, staff were now aware that prisoners assessed as working below entry level 1 may struggle with reading short sentences, selecting numbers from a list, or telling the time. This clarity had helped staff better recognise the scale of need and respond more appropriately to individual prisoners' reading abilities. As such, leaders and staff were developing an emerging culture of increased consciousness and sensitivity to reading deficits among their prisoners.

3.71 Staff development had been well targeted to meet the needs of the population. Professional development in neurodiversity and how to best support prisoners had increased the confidence of staff in removing barriers to engagement. Staff now better recognised and responded to individual prisoner needs. For example, a prison officer arranged for a

prisoner with autism to visit the library during quieter times to engage more meaningfully with staff and reading resources. This personalised approach is beginning to have a positive impact on prisoners' access to, and enjoyment of, reading.

3.72 While these strategies are showing early signs of impact, implementation is still at an early stage and not all prisoners have access to, or are engaging with, this support.

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

Theme 4: The vast majority of prisoners did not benefit from access to high quality education, skills and work. The prison's quality improvement group, and its associated planning to address weaknesses, were ineffective at driving change.

3.74 Leaders and managers had completely overhauled the quality improvement group (QIG). Attendance had improved, and the meeting had a refreshed purpose and terms of reference. Different areas of the prison supported and contributed to the quality group. These have more focused remits, such as reading and the management of the PEF contract provider. However, reports from these important subgroups had too often been absent from the QIG meetings.

3.75 Leaders and managers had only recently introduced a new quality improvement plan, which clearly stated the planned actions and allowed for the regular monitoring of progress. There was also a new quality calendar, which laid out the tasks needed for quality assurance. This introduced new processes to industries, but it was too soon to measure its impact on prisoners' learning experience. So far, the quality calendar had not driven sharply focused actions that had led to improvements.

3.76 Leaders and managers had conducted regular needs analyses to inform the content and design of the curriculum offer and repeated this again to assess the specific needs of new prisoners convicted of sexual offences.

3.77 Leaders and managers had introduced new initiatives for recording prisoners' development in industries. These were in the initial stages of delivery but included the introduction of qualifications, CV builders, portfolios of work and progress in work booklets. The choice of option depended on the type and complexity of workshop and the length of stay of the prisoner. This was still in the early phases of roll-out and it was too early to assess its impact.

3.78 In the QIG, leaders and managers had not focused sufficiently on improving the experience of the prisoners in acquiring new knowledge, skills, behaviours, attitudes, and values. The QIG had not led to improvements in the day-to-day experience of prisoners.

3.79 Ofsted considered that the prison had made insufficient progress against this theme.

Reducing reoffending

Concern: The offender management unit (OMU) was critically under resourced and unable to deliver its core functions. There were weaknesses in public protection and risk management work, and insufficient contact between prison offender managers and prisoners, limiting support for sentence progression.

3.80 Staffing levels within the OMU had increased, but only recently. The appointment of two senior probation officers and five probation-employed offender managers, coupled with a nearly fully-staffed cohort of prison-employed prison offender managers (POMs), had helped to relieve much of the staffing pressures on the unit. As a result, POM caseloads had reduced and were now more manageable.

3.81 Contact between POMs and prisoners remained largely infrequent and often lacked sufficient focus and support to drive progression. We saw examples of prisoners who had not had contact with a POM for many months, and some who had not had any contact at all during their stay at Rochester.

3.82 While there were recent signs of improvement, this lack of regular and meaningful contact with an offender manager continued to be a source of frustration for some prisoners we spoke to.

3.83 The introduction of OMU wing-based drop-in sessions was positive. There were improvements in ensuring new arrivals were seen more swiftly by a POM.

3.84 Good work had taken place by staff within the OMU to improve risk management work and implement new public protection arrangements in line with national guidelines. This included training, supervision, and peer support to upskill the team in managing a new cohort of prisoners convicted of sexual offences.

3.85 Interdepartmental risk management meetings had recently been introduced. It was disappointing that prison-wide attendance at these meetings was poor, which undermined the OMUs efforts to drive improvement. While the scope of these meetings was still being developed, they lacked robust oversight of prisoners who posed the most risk.

3.86 Offence-related communications monitoring was not sufficiently resourced. There were delays in prisoners' calls being listened to, in some cases for several weeks. Some monitoring logs lacked enough detail. Arrangements to translate calls that were made in a foreign language were inadequate.

3.87 We considered that the prison had made reasonable 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

The high number of inexperienced officers did not always enforce standards of good behaviour among prisoners. Leaders were not sufficiently visible, and staff lacked support.
Reasonable progress

Levels of safety in the prison was deteriorating, and both violence and self-harm were increasing. The safety strategy was out of date, not well informed by data and lacked an action plan.
Good progress

Use of force was high, and oversight and accountability were lacking.
Reasonable progress

The availability and use of illicit drugs posed a major threat to safety and security. The positive drug testing rate was among the highest for this type of prison.
Insufficient progress

Many cells and communal facilities were in a very poor state of repair, were vermin-infested and required substantial investment.
Good progress

Work to ensure fair treatment and inclusion was inadequate. Prison data had indicated disproportionate outcomes for prisoners in some protected groups, and Muslim prisoners reported more negative experiences.
No meaningful progress

Clinical practice and poor oversight were allowing health care provision that was unsafe, ineffective and inefficient. For example, patients waited too long to be seen by a GP and both internal and external clinics were routinely cancelled.
Reasonable progress

Medicine administration and supply arrangements were poorly managed and took too long. Supervision was limited and there was no patient privacy. Expected administration times were not being adhered to, and patients missed or faced delays in receiving important medicines.
No meaningful progress

The offender management unit (OMU) was critically under resourced and unable to deliver its core functions. There were weaknesses in public protection and risk management work, and insufficient contact between prison offender managers and prisoners, limiting support for sentence progression.
Reasonable progress

Ofsted themes

What progress have leaders and managers made to ensure all prisoners have access to appropriate enrichment activities?
Reasonable progress

Rochester was failing in its function as a training and resettlement prison. There were insufficient spaces in education, skills and work to meet the needs of the prison population, and too few prisoners were able to attend.
Insufficient progress

Leaders had been too slow to implement a prison-wide reading strategy. Reading was not promoted sufficiently across the prison and too many prisoners did not receive appropriate support to develop their skills.
Reasonable progress

The vast majority of prisoners did not benefit from access to high quality education, skills and work. The prison's quality improvement group, and its associated planning to address weaknesses, were ineffective at driving change.
Insufficient progress

Appendix I About this report

HM 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, 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 in addressing HM Inspectorate of Prisons' concerns 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 concerns raised 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: Expectations – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)

The aims of IRPs are to:

- assess progress against selected priority and key concerns
- 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 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 concern we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in August 2024 for further detail on the original findings (available on our website at Our reports – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)).

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 concerns we intend to follow up (usually no more than 15). Depending on the concerns 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 concern. Sources of evidence include observation, discussions with prisoners, staff and relevant third parties, documentation and data.

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

No meaningful progress
Leaders had not formulated, resourced or begun to implement a realistic improvement strategy to address this concern.

Insufficient progress
Leaders had begun to implement a realistic improvement strategy (for example, with better and embedded systems and processes), but prisoner outcomes were improving too slowly or had not improved at all.

Reasonable progress
Leaders were implementing a realistic improvement strategy, with evidence of sustainable progress and some early improvement in outcomes for prisoners.

Good progress
Leaders had already implemented a realistic improvement strategy to address this concern 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:

Martin Lomas	Deputy chief inspector
Donna Ward	Team leader
Natalie Heeks	Inspector
Harriet Leaver	Inspector
Jade Richards	Inspector
Sarah Goodwin	Health and social care inspector
Bev Gray	Care Quality Commission inspector
Emily Hempstead	Care Quality Commission inspector
Anne Melrose	Pharmacist
Dave Everett	Ofsted inspector
Carolyn Brownsea	Ofsted inspector

Appendix II Care Quality Commission action plan request

Care Quality Commission (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

The review of health services at HMP Rochester was jointly undertaken by the CQC and HMI Prisons under a memorandum of understanding agreement between the agencies (see Working with partners – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)). The Care Quality Commission issued requests for action plans following this inspection.

Breach of regulation

Provider: Oxleas NHS Foundation Trust
Location: HMP YOI Rochester
Location ID: B1E0L
Regulated activities: Diagnostic and Screening Procedures
Treatment of disorder, disease or injury

Regulation 17 (1) and (2 a) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to

a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

How the regulation was not being met:

Systems and processes were not always effective for assessing, monitoring and improving the quality and safety of the services provided.

- Incidents were not consistently reported. We were told about unreported incidents such as medicines errors and low staffing levels. This means themes and trends may not be identified or learned from.

- The risk register was not managed effectively. Identified risks to patient safety were documented, however there was ineffective monitoring and oversight.
- Completed audits were not reported on accurately at management meetings. Action plans had not been completed to ensure identified weaknesses were improved on.
- Patients frequently had long delays in accessing primary care and the waiting list was not reflective of the time patients waited to see a healthcare professional.

Regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part

How the regulation was not being met:

The provider did not always have sufficient numbers of suitably qualified, competent, skilled, and experienced staff deployed to meet the needs of service users.

- The provider had not fully recruited to the staffing establishment and cover arrangements for vacant positions were not sufficient.
- The provider's optimum and minimum staffing levels did not reflect the needs and demands of the service. The provider defined their optimum staffing level for every whole shift as 9 qualified nurses and 2 healthcare assistants per shift. It had been agreed following the last inspection to include a temporary increase of one full-time qualified nurse until a new business case had been agreed, but this was not in place. Shifts did not always have the full complement of 11 staff and frequently worked with 10 or less healthcare staff. Management regularly worked clinically to support staff with workloads

Appendix III 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.

ACCT
Assessment, care in custody and teamwork – case management for prisoners at risk of suicide or self-harm.

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Challenge, support and intervention plan (CSIP)
Used by all adult prisons to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Not everyone who is violent is case managed on CSIP. Some prisons also use the CSIP framework to support victims of violence.

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.

Listener
Prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners.

Mandatory drug testing (MDT)
Enables prison officers to require a prisoner to supply a urine sample to determine if they have used drugs.

Offender management in custody (OMiC)
The Offender Management in Custody (OMiC) model, which has been rolled out in all adult prisons, entails prison officers undertaking key work sessions with prisoners (implemented during 2018–19) and case management, which established the role of the prison offender manager (POM) from 1 October 2019. On 31 March 2021, a specific OMiC model for male open prisons, which does not include key work, was rolled out.

Offender management unit (OMU)
The aim of offender management units in prisons is to try to rehabilitate people so they are less likely to offend in the future.

PAVA
Pelargonic acid vanillylamide – incapacitant spray classified as a prohibited weapon by section 5(1) (b) of the Firearms Act 1988.

Protected characteristics
The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

Shannon Trust
Charity that supports people in prison to learn to read.

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

This publication is available for download at: Our reports – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)

Printed and published by:
HM Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
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