Report on an unannounced inspection of

HMP Bullingdon

by HM Chief Inspector of Prisons

28 July – 7 August 2025

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Introduction

Despite the efforts of leaders and staff, HMP Bullingdon, a men's reception and resettlement prison in Oxfordshire, had not made sufficient progress since our last inspection in 2022. In several key areas, outcomes for prisoners had deteriorated, and many of the concerns we had previously raised remained unaddressed.

The widespread availability of illicit drugs was driving violence, debt and bullying across the prison. Drones were the primary route of ingress, but physical security measures had failed to keep pace with the evolving threat and the prison service had not done enough to help tackle the problem. The mandatory drug testing positive rate stood at 43.2%, one of the highest among reception prisons, and inspectors frequently smelt cannabis on the wings.

Violence had increased by 27% since the last inspection, and while the safety team had taken steps to understand the causes – ranging from gang activity to boredom – this had not translated into effective behaviour management. The use of force had risen sharply, with some incidents lacking evidence of de-escalation and proportionality. Although governance arrangements were in place, delays in reviewing body-worn camera footage and inconsistent adjudication practices undermined accountability. The segregation unit was in poor condition, and the regime offered little more than basic provision.

Relationships between staff and prisoners were not good enough. While some officers tried hard to support those in their care, there was too little key work and many interactions were transactional. This was not helped by the limited regime, which meant that over half the population was locked up during the working day. Leaders had introduced mentoring and extended training for new officers, but staffing shortfalls continued to affect all areas of the prison.

Ofsted graded the overall effectiveness of education, skills and work as inadequate. Attendance was low, and the curriculum did not meet the needs of the population, particularly the large number of unsentenced and short-stay prisoners. Too many were unemployed, and those who did work often failed to develop meaningful skills or gain qualifications. Support for reading was patchy, and not enough was being done to motivate prisoners or raise expectations about what they could achieve.

Many prisoners had little contact with their offender managers, and sentence planning was often delayed or superficial. Public protection arrangements were weak, with gaps in risk identification and monitoring. Too many prisoners were released homeless, and while some promising initiatives had been introduced – such as the resettlement accommodation advisory board and the departure lounge – these were not yet delivering consistent outcomes.

Bullingdon is a prison with potential but significant and persistent challenges have undermined its ability to deliver safe, respectful and rehabilitative outcomes for prisoners. It requires urgent and sustained attention from local and national leaders, particularly to tackle the threat of drones. We expect them

to develop a clear and measurable plan to address the concerns raised in this report.

Charlie Taylor
HM Chief Inspector of Prisons
September 2025

What needs to improve at HMP Bullingdon

During this inspection, we identified 14 key concerns, of which six should be treated as priorities. Priority concerns are those that are most important to improving outcomes for prisoners. They require immediate attention by leaders and managers.

Leaders should make sure that all concerns identified here are addressed and that progress is tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

Priority concerns

1. **Weaknesses in physical security allowed large quantities of illicit drugs to be delivered by drones.** The availability of drugs was driving an increase in violence. The mandatory drug testing positive rate was among the highest for this type of prison.

2. **Staff–prisoner relationships were not good enough and key work was too limited.**

3. **The health partnership had failed to address several longstanding issues which had an impact on patient safety and the delivery of some services.** For example, there was still no supervision at medication hatches, there were no meaningful development plans to drive improvement and local health care leaders did not have sufficient visibility or oversight to challenge poor standards.

4. **Time unlocked was too limited and too few prisoners had anything meaningful to occupy them.**

5. **The education and training curriculum did not meet the career goals of prisoners or the needs of the large proportion of unsentenced and short-stay prisoners.**

6. **There were significant weaknesses in the prison's understanding, management and oversight of public protection arrangements.**

Key concerns

7. **Use of force was not always a last resort, and some incidents lacked evidence of de-escalation.**

8. **Care provided on the inpatient unit was not good enough.** Some patients did not receive baseline health checks and assessments on admission; care plans varied in quality and there was inadequate monitoring of patients' nutrition and hydration**.** There were insufficient therapeutic interventions, and some areas of the unit did not meet infection prevention and control standards.

9. **Attendance at education, skills and work activities was too low.**

10. **The quality of teaching in education, particularly in functional skills and English for speakers of other languages, was not good enough.**

11. **Too many prisoners did not have an accurate assessment of their reading skills or receive appropriate support to develop these further.**

12. **Staff did not record the progress that prisoners made in developing their employability skills in order to support job search or further training.**

13. **Prisoners' resettlement needs were not reliably identified and addressed.**

14. **Too many prisoners were released homeless.**

About HMP Bullingdon

Task of the prison/establishment
HMP Bullingdon is a reception and resettlement prison for adult males.

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 1,102
Baseline certified normal capacity: 865
In-use certified normal capacity: 865
Operational capacity: 1,112

Population of the prison

- Over the last year, there had been an average of 436 new arrivals a month.
- Around 18% of the population were foreign nationals.
- Around 18% of the population were young adults.
- Around 30% of the population were from ethnic minority groups.
- Around 15% of the population were in receipt of opiate substitution treatment.
- Around 200 prisoners were referred to the mental health team each month.
- Around 200 prisoners were released each month.

Prison status and key providers
Public

Physical health provider: Practice Plus Group Health and Rehabilitation Services Limited (PPG)
Mental health provider: Oxford Health Oxford Health NHS Foundation Trust
Substance misuse treatment provider: clinical: PPG; psychosocial: Midlands Partnership NHS Foundation Trust
Dental health provider: Time for Teeth Limited
Prison education framework provider: Milton Keynes College
Escort contractor: Serco

Prison group/Department
South Central

Prison Group Director
Laura Sapwell (acting)

Brief history
HMP Bullingdon opened in April 1992 and has six house blocks, with the most recent added in 2008. A further residential unit is under construction.

Short description of residential units

- Arncott: general population, including the incentivised substance free living unit on A3
- Blackthorn: general population
- Charndon: general population
- Dorton: general population
- Edgcott: prisoners convicted of sexual offences

- Finmere: first night centre
- Segregation unit
- Health care inpatient unit

Name of governor and date in post
Amanda Thomson (acting), March 2025

Changes of governor since the last inspection
Laura Sapwell, until March 2025

Independent Monitoring Board chair
Jennifer Pilkington

Date of last inspection
24 October – 3 November 2022

Section 1 Summary of key findings

Outcomes for prisoners

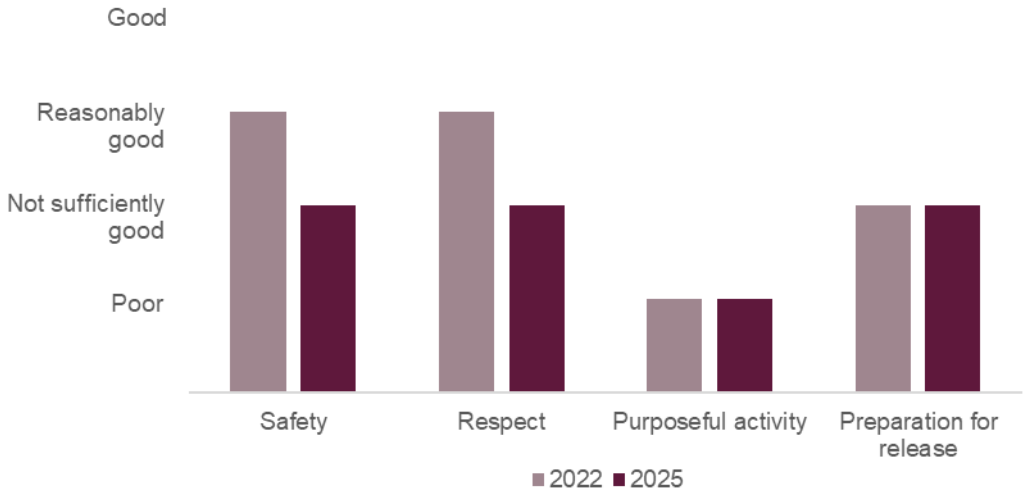
1.1 We assess outcomes for prisoners against four healthy prison tests: safety, respect, purposeful activity, and preparation for release (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.2 At this inspection of HMP Bullingdon, we found that outcomes for prisoners were:

- not sufficiently good for safety
- not sufficiently good for respect
- poor for purposeful activity
- not sufficiently good for preparation for release.

1.3 We last inspected Bullingdon in 2022. Figure 1 shows how outcomes for prisoners have changed since the last inspection.

Figure 1: HMP Bullingdon healthy prison outcomes 2022 and 2025



Progress on priority and key concerns from the last inspection

1.4 At our last inspection, in 2022, we raised 12 concerns, five of which were priority concerns.

1.5 At this inspection we found that one of our concerns been partially addressed and 11 had not been fully addressed. There had not been sufficient progress on our concerns, none were achieved in the areas of safety, purposeful activity or preparation for release. For a full list of progress against the concerns, please see Section 7.

Notable positive practice

1.6 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.

1.7 Inspectors found two examples of notable positive practice during this inspection, which other prisons may be able to learn from or replicate. Unless otherwise specified, these examples are not formally evaluated, are a snapshot in time and may not be suitable for other establishments. They show some of the ways our expectations might be met, but are by no means the only way.

Examples of notable positive practice		
a)	The safety team had undertaken work to improve their knowledge of those prisoners who were gang members and had delivered training to staff on gang awareness.	See paragraph 3.11
b)	The introduction of in-cell technology (Launchpad) had improved communication within the prison; for example, prisoners could now easily contact the safety team privately.	See paragraph 4.10

Section 2 Leadership

Leaders provide the direction, encouragement and resources to enable good outcomes for prisoners. (For definition of leaders, see Glossary.)

2.1 Good leadership helps to drive improvement and should result in better outcomes for prisoners. This narrative is based on our assessment of the quality of leadership with evidence drawn from sources including the self-assessment report, discussions with stakeholders, and observations made during the inspection. It does not result in a score.

2.2 Despite some recent changes of leadership, with a temporarily appointed governor and deputy, the senior team had worked hard to respond to the changing needs of a now more transient population. This had not been helped by some significant staffing shortfalls.

2.3 During the inspection, the acting governor demonstrated a good grasp of the prison's challenges and had plans to address a number of weaknesses that we identified, but the self-assessment report was limited and priorities were not well defined.

2.4 Leaders were addressing concerns about the capability and confidence of newly recruited officers by extending initial training and offering mentoring and coaching. The 'shadowing' period in the prison for newly trained officers had been increased to five weeks for the completion of a 'Fundamentals of Prison' additional training programme. Although the previously high rate of attrition among prison officer recruits had improved, staff recruitment challenges persisted and were impacting most areas of the prison, including the gym, education, health care and operational support grades. About 30% of new officers were recruited from overseas, so the increase in the salary threshold and other changes to the visa sponsorship immigration rules were likely to create further difficulties for the prison in the future.

2.5 Some custodial managers and supervisory officers provided visible leadership, but more focus was needed on improving basic standards on the wings.

2.6 Leaders were making good use of new in-cell technology (Launchpad) to provide information and communicate with prisoners.

2.7 National leaders in HM Prison and Probation Service had not done enough to counter drones bringing drugs and other contraband into the prison (see paragraph 3.25).

2.8 Purposeful activity had not been prioritised by leaders. There were sufficient activity spaces to meet the needs of most of the population, but too many prisoners remained unemployed, and spaces were not used. Ofsted graded the overall effectiveness of education, skills and work as inadequate.

2.9 Greater support was needed to improve culture and practice in the offender management unit. Frequent changes in leadership had had a negative impact on the unit's stability and overall capability. However, collaborative work with community organisations to support prisoners' resettlement was positive.

2.10 Prison leaders had failed to prioritise their public protection responsibilities. However, some of the deficiencies had now been identified by leaders in the offender management unit and plans were being developed to address them, including improving the role of the public protection steering group.

2.11 The strategic health care partnership had failed to address several longstanding issues. There were no meaningful development plans for improvement.

2.12 Leaders were generally making good use of data to inform strategies and action plans, and mostly had good systems of assurance and oversight, which included useful support from the regional team. However, they had failed to address most of the concerns we raised at our last inspection.

Section 3 Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

Expected outcomes: Prisoners transferring to and from the prison are safe and treated decently. On arrival prisoners are safe and treated with respect. Risks are identified and addressed at reception. Prisoners are supported on their first night. Induction is comprehensive.

3.1 Too many prisoners arrived at the prison having spent several hours waiting for transport from nearby courts. It was also common for prisoners to be diverted from other areas, often arriving late in the evening, which meant some arrived on the first night centre in the early hours of the morning.

3.2 Staff in the reception department were welcoming and tried to put prisoners at ease during initial arrival procedures. However, fewer prisoners than at the time of the last inspection said that they had spent less than two hours in reception. We observed waiting times of up to four hours.

3.3 The reception area was clean but austere, with little useful information provided for prisoners while they waited. The practice of peer supporters providing early advice and support to new arrivals had ceased.

3.4 Initial safety interviews were conducted in private by first night staff. There was a good focus on risk factors, but those we observed were formulaic and did not explore potential personal issues sufficiently.

3.5 Most new arrivals were taken to the first night centre on Finmere unit. Cells were clean and reasonably well equipped for new arrivals, but many had graffiti that had clearly been there for some time. The regime on the unit was poor and new prisoners could expect just two hours out of their cell each day once they had completed induction.

3.6 Formal induction began on the day after arrival. Sessions were spread out over a nominal five-day period but often took longer to complete. Peer workers were effective in delivering some key elements of the process and a useful booklet was available in a range of languages. In our survey, most prisoners said that they had been inducted and that it told them what they needed to know.

Promoting positive behaviour

Expected outcomes: Prisoners live in a safe, well ordered and motivational environment where their positive behaviour is promoted and rewarded. Unacceptable conduct is dealt with in an objective, fair, proportionate and consistent manner.

Encouraging positive behaviour

3.7 Violence had increased by 27% since the previous inspection and the prison had recorded more assaults than most similar or comparable establishments. The rise in serious assaults, however, was more limited. Leaders had taken steps to improve their understanding of the underlying causes of violence, including holding a 'safety summit' and conducting a prisoner survey.

3.8 The availability of drugs was a key driver of violence in the prison (see also paragraph 3.24), but many prisoners told us that a lack of purposeful activity, boredom, bullying and debt were similarly all linked to violence.

3.9 The quality of investigations into violence were generally good, but this had not led to the development of meaningful or effective challenge, support and intervention plans (CSIP; see Glossary) to manage behaviour. To manage violence and antisocial behaviour, some prisoners were subject to a separate regime and could not have contact with others. In some cases, this isolation of individuals essentially operated as an unofficial punishment.

3.10 While leaders had recently introduced new incentives for enhanced prisoners, such as the opportunity to order a pizza once a week, many prisoners told us that these measures were not meaningful enough to encourage positive behaviour. Prisoners said that they saw little value in achieving enhanced status in the incentives scheme.

3.11 The safety team demonstrated good knowledge of current risks and emerging issues and had, for example, identified an increase in gang-related violence as a result of more prisoners arriving from out of area. They had begun some promising work to identify prisoners involved in gang activity and had delivered training to some staff.

Adjudications

3.12 The number of adjudications remained high, with over 5,000 in the last 12 months, which was too many for the prison to manage effectively. We found cases that could have been dealt with more appropriately at a lower level. There were also many that had been adjourned or referred to the police that remained outstanding.

3.13 The quality of reports and hearings was inconsistent. Leaders had recently introduced quality assurance of hearings, but this was yet to have an impact.

3.14 It was encouraging to see some use of rehabilitative adjudications. We saw examples of prisoners being given the chance to work with the substance misuse team on their addiction issues rather than face punitive measures.

Use of force

3.15 The number of use of force incidents had increased by 57% since the previous inspection, although approximately two-thirds involved low-level interventions.

3.16 Governance arrangements were robust, with all incidents triaged and then reviewed at weekly scrutiny meetings. However, the large number of incidents had led to delays of up to a month in reviewing body-worn camera footage.

3.17 PAVA spray (see Glossary) had been drawn 60 times in the past year and used 28 times, which was among the highest for reception prisons. Not all uses of PAVA had been fully justified, but leaders had identified and addressed these cases.

3.18 In the body-worn camera footage we reviewed, we saw some instances where the force used had been disproportionate and could have been de-escalated earlier. Positively, the safety team had already recognised many of these concerns, and there was a strong ethos of learning and improvement around use of force. Learning from the scrutiny meetings had shown that staff inexperience was a factor in the high levels of force used.

3.19 Special accommodation (see Glossary) had been used 26 times in the past year, although some of the cases involved prisoners having their water or electricity turned off rather than being held in the actual unfurnished cell in the segregation unit. Documentation justifying its use was not always sufficiently detailed or comprehensive.

Segregation

3.20 Conditions in the segregation unit were poor, with many cells showing signs of wear, including graffiti and damaged furniture. The exercise yards were bleak, with no physical activity equipment or anything to make the space welcoming. The cells and shower on the ground floor were in particularly poor condition.

Segregation cell (left) and segregation exercise yard

3.21 The regime remained restricted, with most prisoners receiving only their basic entitlement, such as a daily shower and up to one hour of exercise.

3.22 Reintegration planning had improved; peer workers supported segregated prisoners to gradually reintegrate by attending daily association periods on their new unit. Leaders had also introduced a workbook that provided an opportunity for prisoners to reduce their time in segregation if they demonstrated positive engagement.

3.23 The segregation team had developed plans to improve the unit, including some refurbishment. Officers had also begun key work (see Glossary). Prisoners we spoke to expressed respect for staff, and we observed positive interactions.

Security

Expected outcomes: Security and good order are maintained through an attention to physical and procedural matters, including effective security intelligence and positive staff-prisoner relationships. Prisoners are safe from exposure to substance misuse and effective drug supply reduction measures are in place.

3.24 The widespread availability of illicit drugs threatened the security of the prison and contributed to violence, bullying and debt (see also paragraph 3.8). The mandatory drug testing positive rate stood at 43.2%, the second highest among reception prisons. Prisoners told us that it was easy to get hold of drugs at the prison, and we often smelt cannabis on the wings during the inspection.

3.25 Drones were the primary route of drug ingress, and on one occasion multiple sightings of a group of drones had been observed in vicinity to the prison. The lack of closed-circuit television coverage and netting, along with the poorly designed or damaged windows, exacerbated the problem, and there had been little HM Prison and Probation Service investment to mitigate drone incursions. However, prison leaders were working jointly with the police to try to reduce the risk; there had been

good sharing of intelligence, resulting in arrests both in custody and the community.

Broken cell window

3.26 Inadequate supervision of the dispensing of medication also contributed to the availability of illicit substances (see also paragraph 4.87).

3.27 Leaders had introduced an incentivised substance-free living unit which was a positive step towards encouraging prisoners to remain drug free. Prisoners on the unit told us that, while this helped their drug recovery, there were not yet enough incentives.

3.28 Leaders had introduced additional meetings between the security, safety and drug strategy departments, to increase collaboration in response to the increase in drugs and associated violence and bullying. However, this had not yet resulted in a reduction in the use of illicit drugs and violence.

3.29 In other areas, security processes were generally proportionate to the risk posed by the large remand population. The security team reported good inter-agency working with key criminal justice agencies. Extremism and staff corruption were identified and managed appropriately.

Safeguarding

Expected outcomes: The prison provides a safe environment which reduces the risk of self-harm and suicide. Prisoners at risk of self-harm or suicide are identified and given appropriate care and support. All vulnerable adults are identified, protected from harm and neglect and receive effective care and support.

Suicide and self-harm prevention

3.30 There had been three self-inflicted deaths since the last inspection. Leaders had conducted their own investigations into these deaths, for which reports from the Prison and Probation Ombudsman (PPO) were still outstanding. Although several learning points from the fatal incidents, as well as from previous PPO reports, had been identified, these were not all being monitored routinely to make sure that changes were embedded. There had also been at least 29 incidents of serious self-harm in the previous 12 months, none of which had been investigated to identify learning opportunities.

3.31 The overall number of recorded incidents of self-harm had reduced by 11% since the last inspection and was now just below the average when compared with similar prisons. Although more individuals had self-harmed, levels had been on a clear downward trajectory in the previous year. Leaders attributed this reduction mainly to the razor ban and introduction of in-cell technology (see also paragraph 4.10).

3.32 Although leaders used data reasonably well to inform the prison's safety strategy, there was insufficient analysis of the causes of self-harm. Not all reasons for self-harming were recorded, which limited opportunities to explore emerging trends and drive further improvements.

3.33 Prisoners at risk of self-harm or suicide were managed via the assessment, care in custody and teamwork (ACCT) case management process for prisoners at risk of suicide or self-harm. In the sample we reviewed, the quality of ACCT documentation was weak, but many of the prisoners we spoke to were generally positive about the care provided by staff. However, over four-fifths of these prisoners were not engaging in purposeful activity and they told us that the limited regime was affecting their well-being. Leaders had introduced a priority activity allocation system to support some of these more vulnerable prisoners to engage in education or work.

3.34 Key working was also prioritised for individuals struggling to cope, and prisoners were able to contact the safety team via their in-cell laptops if they had any concerns. The safety officers told us that they received many requests for help and, where possible, would go to see those prisoners to offer support.

3.35 In our survey, 48% of respondents said that it was very or quite easy to speak to a Listener (a prisoner trained by the Samaritans to provide

confidential emotional support to fellow prisoners) if they wanted to, which was better than at similar prisons (34%). A 'talk club' had also been introduced recently, which was a peer support initiative run by a registered charity with the aim of helping prisoners to talk more openly and look after their mental health.

3.36 During the inspection, we saw staff engaging well with a prisoner subject to constant supervision, and he told us that he had consistent access to the regime.

3.37 There was no oversight of the use of anti-ligature clothing (see Glossary) and there was evidence to suggest that it had been used inappropriately. There was no governance to authorise its use for those deemed to be at risk.

Protection of adults at risk (see Glossary)

3.38 A weekly multidisciplinary meeting was held, where safeguarding referrals were discussed and oversight of vulnerable prisoners was provided. However, leaders acknowledged that they needed to build prison officers' confidence in identifying those at risk. It was positive to see that prisoners who had been identified as victims of modern slavery were monitored at the weekly safety intervention meeting.

3.39 Leaders from the health care team attended the local safeguarding adults board.

Section 4 Respect

Prisoners are treated with respect for their human dignity.

Staff-prisoner relationships

Expected outcomes: Prisoners are treated with respect by staff throughout their time in custody and are encouraged to take responsibility for their own actions and decisions.

4.1 In our survey, 64% of respondents said that staff treated them with respect and 68% said that they had a member of staff they could turn to if they had a problem, both figures being comparable to those in similar prisons. However, the response to the latter question by those from an ethnic minority background was less positive (see paragraph 4.23).

4.2 While there were some positive staff interactions, prisoners told us that many officers were inconsistent and often unhelpful in response to basic requests. We observed that relationships, while polite, appeared to be transactional and distant. As a result of the limited regime, prisoners were mostly locked in their cells, which also hindered the development of meaningful relationships. Leaders had introduced extra support and training for the large proportion of inexperienced staff (see also paragraph 2.4).

4.3 Although leaders had been driving the delivery of key work (see Glossary), too few prisoners received this. Those considered to be struggling or most vulnerable were prioritised, and we saw some good examples of key work sessions to motivate and engage prisoners. However, overall, too few sessions were being delivered and the lack of continuity of key workers undermined the effectiveness.

4.4 Peer work was used well in some areas, such as in segregation and for the Shannon Trust (see Glossary, and paragraph 5.17). 'Here to Help' peer mentors provided support for prisoners across various aspects of the prison, including the induction. Other peer roles were not, however, as effective, for example, in reception and equality. Other positions, such as carers for those with social care needs and peer mentors in education, also lacked sufficient oversight.

Daily life

Expected outcomes: Prisoners live in a clean and decent environment and are aware of the rules and routines of the prison. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair.

Living conditions

4.5 The prison had opened as the first of its design in 1994 and was beginning to show its age. Much of the metalwork along walkways and around cell windows, for example, were not being maintained or even painted.

Window grilles

4.6 Some external areas were overgrown and littered with rubbish thrown out of cell windows. In our survey, fewer respondents than at similar prisons said that the exercise yards were normally kept very or quite clean.

Rubbish from cells

4.7 On most living units, communal areas were clean and well-kept near the entrance and wing office, but standards deteriorated on the cell landings. Floors, stairs and walls were grubby and areas around waste bins were splattered with food.

Landing waste bin

4.8 Although access to showers was very good, the shower areas were too often damp and mouldy. Although some had been refurbished to a

good standard, others were still poorly maintained. We found fungus on one shower ceiling, again indicating neglect.

4.9 Over a third of the population shared cells designed for one, with shared toilets screened by a thin curtain. These overcrowded cells had insufficient furniture. Toilets in most of the cells were kept reasonably clean but lacked seats or lids and were stained on the newer units.

Fungus on a shower ceiling (left) and crowded cell designed for one person

4.10 Most prisoners had a laptop and access to HM Prison and Probation Service in-cell technology (known as 'Launchpad'). This meant that they could access many services themselves, without resorting to paper-based applications, giving them some control over their daily lives. A wide range of information about services at the prison was available and departments used the in-cell technology well to advertise upcoming events.

4.11 Access to bedding, laundry, clothing and cleaning materials was reasonable. Although managers carried out decency checks, we found many cells to be dirty and contain graffiti that appeared to go unchallenged.

4.12 A 'decency team' of skilled prisoners was available for painting projects and small repairs but was too small to meet demand.

Residential services

4.13 In our survey, only 22% of respondents said that they had enough to eat at mealtimes. The portion sizes of some of the meals we saw were too small, and supervision at the point of service was not always adequate. We saw prisoners using the incorrect utensils, or gloved hands, to serve halal, non-halal and vegetarian food. Some units did not have sufficient equipment.

4.14 Meals were served too early and breakfast packs were given out on the day before they were due to be eaten. The prison had recently conducted a survey which found that prisoners were critical of the food. There were plans to explore some of these issues with the prisoner council.

4.15 Some wings had facilities for prisoners to dine communally, and leaders had ordered more tables for the rest of the prison. The regime allowed some time for prisoners to eat before being locked in their cells.

4.16 Only those on the incentivised substance-free living (ISFL) unit had access to some self-catering facilities. A kitchen had been fitted on this unit, but it had not been well-maintained. There was also no separate equipment for those with special dietary requirements.

4.17 In our survey, 65% of respondents said the prison shop sold the things they needed, which was better than in similar prisons (54%). In-cell technology enabled prisoners to browse catalogues more easily, although we were told that orders sometimes took too long to arrive.

4.18 There was no interim shop provision for prisoners in their early days at the prison, but there were plans to introduce a tuck shop.

Prisoner consultation, applications and redress

4.19 Most applications were now sent using the in-cell laptops (see paragraph 4.10). Although both staff and prisoners were still adapting to the new system, the prison's data showed an impressive 97% response rate to applications within the agreed timescale of one week. The new, easily accessible process had initially led to a huge increase in the number of applications, but this had now begun to stabilise. However, some paper-based applications were still in use, which had caused confusion and some delays.

4.20 Around 150 complaints were submitted each month, most often concerning non-receipt of property on arrival, the prison shop and residential issues. Oversight was good and regular quality assurance made sure that responses were prompt and appropriate. Where shortfalls were found, remedial action was taken and advice issued. Most complaints we viewed addressed the issues raised and were answered politely.

4.21 Consultation arrangements were sound. The monthly prisoner council was well attended by representatives from a wide range of departments and provided information as well as answering questions. Wing forums were used to identify issues from the wider population for council discussions.

4.22 There was good access to legal services. A suite of 'video courts' reduced the need to transport prisoners to hearings, and there was provision for virtual interviews with legal advisers. The library held a range of legal texts. Two bail information officers, who worked within the offender management unit, had provided support to meet bail conditions for around 150 prisoners in the year to date.

Fair treatment and inclusion

Expected outcomes: There is a clear approach to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relationships. The distinct needs of prisoners with particular protected characteristics (see Glossary), or those who may be at risk of discrimination or unequal treatment, are recognised and addressed. Prisoners are able to practise their religion. The chaplaincy plays a full part in prison life and contributes to prisoners' overall care, support and rehabilitation.

4.23 Work to promote fair treatment had weakened since the last inspection, and our survey showed that prisoners from some minority groups were more negative than their counterparts about various aspects of prison life. The lack of meaningful staff–prisoner relationships (see also paragraph 4.2) contributed to a culture where staff did not generally understand or respond to prisoners' individual needs and experiences. In our survey, only 50% of prisoners from ethnic minority groups said that they had a member of staff they could turn to, compared with 75% of others.

4.24 Positively, leaders had considered a wider range of data than we usually see and had identified areas of disproportionality. This included access to activities and searching, as well as use of force and violence. However, in too many instances, identification of the issues was not followed up with a meaningful response.

4.25 Recent efforts to consult minority groups offered some insight into their experiences, but many forums again lacked focus on action and provision remained limited.

4.26 Under-25s and prisoners from ethnic minority groups were over-represented in areas such as use of force and violence, and there was little targeted provision to encourage or incentivise them. We also found evidence of young adults (under 21) sharing cells with prisoners who were much older, which could be inappropriate. Encouragingly, leaders tried to prioritise young adults for allocation to education and work, along with neurodivergent prisoners and those with other vulnerabilities. However, there were still disparities; for example, no under-25s had been employed as a 'red band' (a trusted role which allows freer movement across the prison).

4.27 There was a weekly group for older prisoners and activities such as bowls on the vulnerable prisoner unit, but this provision was not yet in place for older prisoners elsewhere.

4.28 Our survey showed that prisoners with disabilities had more negative perceptions of their treatment than their counterparts; for example, more said that they had been bullied and victimised by other prisoners, and fewer that they had been allocated to education, training or work that would help them on release. Those using a wheelchair had limited access around the prison, and we saw some being unfairly restricted

from activities because lifts were broken. Evacuation plans for those who would have needed help in an emergency were not always sufficiently detailed or up to date.

4.29 Around 44% of prisoners had a self-declared neurodiversity need. A weekly Lego club ran for a small group of these prisoners and the neurodiversity support manager and psychology team created one-page support plans for some individuals. Monthly brief training sessions in neurodiversity had recently been introduced for some staff.

4.30 Around 18% of the population were foreign nationals, but leaders had not yet analysed data to identify any disproportionality affecting this group. A newly appointed foreign national officer specialist had begun to consider specific provision. Overall, support for maintaining family ties was insufficient; eligible prisoners were not receiving complimentary PIN telephone credit that we see elsewhere, and international secure video calls (see Glossary) were poorly promoted. While leaders had some oversight of those who were not proficient in English and the in-cell technology had good translation capabilities, professional telephone interpreting services were underused.

4.31 We found that 40% of complaints about discrimination were redirected to the complaints system without sufficient exploration. Of those that were investigated as discrimination incident reporting forms, the quality of investigations was generally reasonable, although there were examples where these could have been more in-depth. Leaders had recently engaged a local university to provide them with external quality assurance. Regional leaders also provided scrutiny and thorough oversight of work to promote fair treatment more generally.

Faith and religion

4.32 At the time of the inspection, despite some staffing issues, all prisoners were able to see a chaplain of their faith. A Rastafarian chaplain was also in place to deliver services, which we do not usually find.

4.33 However, there was a waiting list for new arrivals who wanted to join Muslim and Christian religious services due to the limited capacity of the chapel, which meant that they might have had to wait several weeks before being able to attend worship. Faith-based classes were also popular, with waiting lists for these too. A volunteer from the community provided bereavement counselling to prisoners.

Health, well-being and social care

Expected outcomes: Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.

4.34 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a

memorandum of understanding agreement between the agencies. The CQC found breaches of regulations and issued a request for an action plan following the inspection (see Appendix III).

Strategy, clinical governance and partnerships

4.35 NHS England (NHSE) commissioned Practice Plus Group Health and Rehabilitation Services Limited (PPG) as the prime provider of health services. PPG had subcontracted psychosocial substance misuse services to Midlands Partnership NHS Foundation Trust's Inclusion service and mental health services to Oxford Health NHS Foundation Trust (OHFT). Time for Teeth Limited delivered dental and oral health services. Oxford County Council (OCC) was the local authority.

4.36 We found the quality of health services in some areas to be adequate, but only 33%% of respondents to our survey said that the overall quality of health services was quite or very good. Health care staffing levels remained problematic. The high vacancy level of 30% across health teams resulted in a dependence on temporary staff to deliver essential clinical activity, and presented risks to patient safety. The high throughput of prisoners had substantially increased demand for some services in the previous year (referrals to substance misuse services had increased by 58%), but resources had not kept pace.

4.37 Regional partnership boards met quarterly, and NHSE held quarterly contract review meetings and conducted quality assurance visits to monitor the contract. A full health needs analysis had been completed in April 2024 and was refreshed in July 2025. However, the strategic health partnership had failed to progress some longstanding issues which were affecting patient safety and the delivery of some services. There were no meaningful development plans to drive improvement.

4.38 Local health care leaders had inadequate oversight and visibility to challenge the known poor standards and practices. Local governance structures were in place, including the two-monthly local quality delivery board, monthly medicines management meetings, the PPG-wide audit schedule and the regularly reviewed risk register. However, these did not support or steer the improvements needed.

4.39 Datix (an incident reporting system) was used to record clinical incidents. There was evidence of under-reporting in several areas and not all incidents were reviewed in a timely manner to identify learning, to minimise the risk of recurrence. When learning was identified, this was shared with the team at staff meetings and the daily handover.

4.40 A safeguarding policy and local safeguarding leads were in place, but some staff we spoke to did not know how to make a safeguarding referral. Attendance at the prison-led safeguarding meeting identified patients of concern. Safeguarding training compliance, as with other statutory and mandatory training, was reasonable.

4.41 A confidential complaints process was in place and was well managed by a member of the administration team. Responses were subject to

quality assurance and those we sampled were appropriate. Patient engagement was well supported (see below).

4.42 The infection prevention control audits had failed to address several breaches in expected standards. These included many clinical rooms that were poorly maintained, cluttered and not regularly cleaned, and overflowing clinical waste bins.

4.43 Clinical staff were clearly identifiable. Staff appraisal compliance and access to supervision were acceptable.

4.44 SystmOne (the electronic clinical record) was used across all services. The standard of documentation was generally good.

4.45 Medical equipment was subject to annual maintenance through a formal contract.

4.46 Almost three-quarters of health care practitioners were trained in immediate life support and had access to suitable equipment. However, the daily checks of this equipment were often not completed.

Promoting health and well-being

4.47 Overall, health promotion services were good and were meeting the needs of the population. Health promotion initiatives were delivered, with a range of materials that were designed to appeal to patients.

4.48 Sexual health and blood-borne virus screening was offered during the second reception screening. Prisoners could self-refer to local sexual health services and were referred to the local specialist service if needed. Relevant and appropriate sexual health advice was provided throughout their sentence and before release. Condoms were available from health care staff and in reception before release.

4.49 Information about national health promotion campaigns was available in a range of languages. Posters, flyers and leaflets were visible throughout the prison.

4.50 The patient liaison team (PLT) provided an effective link between patients, health services and the prison. All prisoners were seen within 72 hours of arrival and release planning started in the first appointment. The PLT worked collaboratively with the prison and followed the 'health promotion in justice' calendar, providing monthly themed health promotion topics, including immunisations, oral care and long-term health conditions. The PLT held daily wing clinics, which helped patients with their health queries, including those relating to appointments.

4.51 A dietitian worked collaboratively with health services, the gym and other prison departments to support patients to access information about nutrition. Patients could self-refer to the dietitian. Three clinics were held throughout the week and patients were given information about nutrition and food, as well as practical dietary advice. The dietitian also provided support to the kitchen.

Primary care and inpatient services

4.52 New arrivals were seen by a registered nurse, who conducted initial screenings to identify any immediate health care needs or long-term medical conditions that needed support. First and second reception screens, and the reconciliation of patients' medicines, were completed within the required timescales. A GP was available until 10 pm each weekday, to make sure that patients' clinical needs were met.

4.53 Staff dealt with high numbers of patient applications for health care appointments, which had increased considerably following the launch of in-cell technology (see paragraph 4.10). We found that the applications were not triaged effectively, to make sure that those with urgent health care needs were identified and prioritised.

4.54 Although 69% of respondents to our survey said that they found it difficult to see a GP, and 61% that they found it difficult to see a nurse, waiting times for most health care services were reasonable. A wide range of nurse-led clinics ran each day, and there were regular optician, physiotherapist, podiatrist and dietitian visits to support patients. The PLT visited the wings regularly to answer any prisoner health care queries and to chase up appointments if needed.

4.55 Health care records that we reviewed showed that patients received timely and appropriate health care interventions. Those needing more intensive treatment were discussed at weekly multidisciplinary meetings, to make sure that their complex needs were addressed.

4.56 The PLT worked hard to make sure that those leaving the prison had appropriate health care support to ensure a smooth transition. Before release, all received a health check, and a week's supply of medicine if needed.

4.57 There was a 21-bed inpatient unit (IPU), which accommodated patients with physical, social and mental health needs. However, those with no clinical need were sometimes housed on the unit because of a lack of accessible cells on the prison's main wings.

4.58 Not all key patient health checks and assessments were completed on admission to the inpatient unit, and the quality of care planning varied. There was inadequate monitoring of patients' nutrition and hydration.

4.59 Apart from fortnightly music therapy, there was a lack of structured activities on the unit to promote physical, mental and emotional well-being, and patients told us that there was little for them to do.

4.60 Some areas of the IPU were in a poor condition and did not meet infection prevention control standards.

Social care

4.61 A formal agreement between OCC and NHSE authorised NHSE to commission PPG to provide social care. A protocol was in place, but an information sharing agreement remained in draft form and unsigned.

4.62 Staff told us that patients could self-refer to social care services in the prison, but we saw no evidence of information about social care or patient referral forms around the prison. All referrals came via the health care department. There were no timeframes agreed with OCC and PPG from referral to assessment, and some patients had waited two months to be seen, which was too long.

4.63 When social care needs were identified, prisoners received prompt support from PPG. At the time of the inspection, there were six prisoners in receipt of a social care package (see Glossary), and all resided in the IPU, which we considered appropriate to meet their physical care needs. They all had PPG care plans, but these were not personalised. Despite this, patients we spoke to were satisfied with the care they received.

4.64 Equipment for prisoners to support day-to-day living was available, and portable call bells could be used for some prisoners to use in their cells in the IPU to summon emergency assistance.

4.65 Two prisoner carers were available (only on E wing) to help seven prisoners with routine tasks. The carers we spoke to told us that they did not provide any personal care, but helped with cleaning, bed making and pushing wheelchairs. The carers had not received training or supervision for their role, which posed a risk.

4.66 There were processes in place for continuity of care following release or transfer.

Mental health

4.67 The OHFT team was available from 8am until 5pm, seven days a week. It was a diverse team of highly skilled and motivated professionals which included managers, psychiatrists, psychologists, nurses and a social worker. Governance procedures were good.

4.68 The busy service received approximately 250 referrals each month, including self-referrals. Nurses triaged all referred patients, including those needing psychological services. However, because of staff shortages, they were unable to meet their expected targets for seeing routine triages. At the time of the inspection, urgent referrals were seen within 48 hours, but routine referrals were waiting 10 days. Following triage, cases were discussed and allocated at a multidisciplinary meeting.

4.69 Officers we spoke to knew how to refer those in need of mental health support and said that the team was responsive, visible and helpful. The team manager saw all new prison officers and offered information about the team and the referral process. Mental health awareness training was offered, but staff were often unavailable to attend.

4.70 The team supported 181 patients (approximately 16% of the population), through evidenced-based one-to-one sessions and self-directed support. There was only one group running at the time of the

inspection and this was subject to cancellation because of the lack of dedicated space. Sessions could be interrupted by officers needing to enter the shared rooms, which significantly disrupted the therapeutic process and had an impact on the effectiveness of the sessions.

4.71 Patients faced long waits for higher intensity and trauma-focused therapies. In our survey, 55% of respondents said that it was difficult or very difficult to see a mental health worker. Patients we spoke to who were receiving care and support from the team spoke of caring and helpful interactions.

4.72 Forty patients with severe and enduring mental disorder received effective close monitoring and support in line with the provisions of the Community Mental Health Framework. Clinical records were of good quality, but some care plans were not individualised.

4.73 Patients needing hospital treatment under the Mental Health Act were not always transferred in line with national timeframes; there were two such patients at the time of the inspection, and both had been waiting since June 2025, which was unacceptable.

4.74 Release planning was effective, with good links to community services to ensure continuity of treatment when needed.

Support and treatment for prisoners with addictions and those who misuse substances

4.75 In our survey, 40% of respondents said that they had a drug or alcohol problem and 41% said that it was easy or very easy to get illicit drugs in the prison.

4.76 The stretched substance misuse teams worked hard to deliver services to meet the growing demand. Inclusion staff attended all relevant prison and health care meetings and, while respectful, the partnership between organisations had not driven the development needed for resources and facilities to meet the demand.

4.77 At the time of the inspection, Inclusion was recruiting to two vacancies to complete its team. PPG's clinical service consisted of just 1.4 whole-time-equivalent registered nurses, which was not enough. Plans were in place for much needed additional clinical resource.

4.78 New patients were assessed on arrival and treatment was continued or initiated without delay, with onward referral for psychosocial interventions. Patients who needed closer observation were admitted to the IPU.

4.79 At the time of the inspection, 161 patients (14.6% of the population) were in receipt of opiate substitution treatment (OST), mainly comprising methadone. As a result of financial constraints, patients arriving on long-acting buprenorphine injections (an opiate substitution medication) had this treatment stopped and were converted to an alternative, which was poor. Non-medical prescribers, in addition to the

GPs, supported substance misuse prescribing. Reviews in accordance with guidelines were completed on time, but the clinical team did not have capacity to attend five-day reviews or work with the mental health team to support patients with a co-occurring diagnosis.

4.80 The Inclusion team was well led and motivated, triaging and prioritising all referrals promptly, with assessments completed within the five-day timescale. At the time of the inspection, 340 patients were under the care of Inclusion, with good care plans in place. A comprehensive range of one-to-one and group interventions was delivered, but space was limited to deliver these. Structured psychosocial group interventions had been tailored to meet the needs of short-stay patients. Recovery workers' caseloads were between 33 and 49. Capacity limited the time available to deliver interventions and support to those on caseloads. In addition to the significant increase in referrals in the last year (see above), the teams were also supporting large numbers of patients who had been reported as being under the influence of substances (70 patients in June and 50 in July 2025).

4.81 There were no peer mentors to support patients with substance misuse issues. Demand for mutual aid groups (Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous) was high, and this was available to patients living on the ISFL unit. There were plans to provide remote access to mutual aid, to increase availability to patients in the wider prison.

4.82 Inclusion delivered substance misuse training to new prison officers.

4.83 There were good links with community providers to support the large number of releases. In July 2025, 70 patients had been released on OST. Harm reduction advice and training in the use of naloxone (an opiate reversal agent) were delivered to patients on release.

Medicines optimisation and pharmacy services

4.84 Pharmacy services were delivered by a highly skilled and experienced pharmacy team, who followed written procedures. This was mostly a supply-led service and there were no pharmacist-led clinics. Team members usually attended health care team meetings and had opportunities to undertake additional training to develop their knowledge and skills.

4.85 More technicians were being recruited, to support the four who worked on the wings. The two dispensers were also enrolled onto a technician training course. The team worked well together and had effective systems to make sure that there were no dispensing backlogs. On one day during the inspection, prescriptions were ready to be sent to the wings for the following five days.

4.86 On some days, the pharmacy had closed as the regular pharmacists were on planned leave and no locum pharmacists had been available. The team told us that, to date, this had not had an impact on any patients as the prescriptions had been sent to the wings before the

closure. Additionally, FP10 prescriptions (paper prescription forms used in the NHS for prescribing medications) were available to send to a community pharmacy.

4.87 Medicines administration from the wings was mostly pharmacy technician led, with support from health care assistants and, occasionally, nurses. Poor supervision at medication hatches had not been addressed. There was no supervision by prison officers at any of these hatches and many patients gathered there, waiting for their medicines. This meant that there was no privacy for patients, and presented a risk of bullying and diversion of medicines. We saw health care staff failing to ask some patients for their identification or their date of birth, and who recorded the administration of a medicine before it was given to the patient.

4.88 We received reports of secondary dispensing (when medicines are removed from their original packaging) by some health care staff which the pharmacy team was investigating. We were told that staff had been reminded to stop this practice.

4.89 The pharmacy was usually given advance notice when patients were attending court, released or transferred; daily doses could then be arranged and electronic prescriptions generated.

4.90 Prescribing and administration of medicines were recorded on SystmOne.

4.91 Around 48% of patients had all or some of their medication as in-possession (IP), which was low. Risk assessments were completed, but many IP medicine supplies were still for seven days. The pharmacy technicians were reviewing all risk assessments to identify patients who could have 28-day supplies and to change the review period from 12 to six months. All medicines were appropriately labelled, but IP supplies were handed directly to patients, not concealed in a bag, so could potentially be seen by others. Random cell checks were completed by the pharmacy team, and non-compliance resulted in a review and change to the patient's IP status.

4.92 There was out-of-hours provision for medicines, and records were kept of the medicines used. Patients could receive over-the-counter medication such as paracetamol.

4.93 The pharmacy team responded suitably to errors involving patients' medicines. They kept records of these and identified opportunities to reduce the risk of mistakes.

4.94 Suitable arrangements were made for transporting medication around the prison. Refrigerator temperatures in the pharmacy were regularly checked and recorded. However, on the wings there were many days when refrigerator temperatures had not been recorded. Controlled drugs were managed appropriately and stored securely.

Dental services and oral health

4.95 Time for Teeth Limited offered seven sessions a week. In our survey, 68% of respondents said that it was difficult to see the dentist. At the time of the inspection, the waiting time for a routine appointment was 14 weeks, which was too long. There were over 300 patients waiting to be seen, but the list was carefully triaged by the dental nurse, to make sure that those in greatest need were prioritised.

4.96 Dental care records were detailed and showed that patients received appropriate assessment, treatment and oral health instruction.

4.97 Governance was strong and key areas of safety, such as radiography, infection control and the decontamination of dirty instruments, were managed well.

Section 5 Purposeful activity

Prisoners are able and expected to engage in activity that is likely to benefit them.

Time out of cell

Expected outcomes: All prisoners have sufficient time out of cell (see Glossary) and are encouraged to engage in recreational and social activities which support their well-being and promote effective rehabilitation.

5.1 In our roll checks, we found around 57% of the population locked in cells during the working day, but only 22% engaged in education, work or training off the wing. A further 10% were unlocked to work on the wing as cleaners and orderlies.

5.2 Unemployed prisoners had only around three hours a day unlocked. Time unlocked for those in full-time employment was much better, at around nine hours a day. Most prisoners could expect to be unlocked for approximately four hours a day at weekends.

5.3 There was little to do on the wings during association periods and most prisoners stood around on landings or sat in each other's cells. Some off-wing activities were occasionally available, with a small range of clubs and presentations from local organisations.

5.4 The library was well stocked and held a wide range of materials to meet the needs of the population, and DVDs were available to borrow. Capacity was limited to 23 per session and, although lists often showed that around 20 had applied, attendance was often much lower.

5.5 Storybook Dads, whereby prisoners record stories on video to be sent to their children, was popular, with around 150 recordings sent out to families each year. Great care had been taken to create an appropriate, child-friendly backdrop for the recordings.

Backdrop for Storybook Dads recordings

5.6 Despite PE staff shortages, access to the gym was reasonable. In our survey, most respondents said that they could visit the gym each week and more than at comparator prisons said that they could attend three or more times. However, few sessions that we observed ran at more than 50% capacity. Prisoners complained of curtailments, and there were days when staff shortages resulted in some areas of the gym being closed.

5.7 The gym was well equipped and catered for both individual training and team sports. Individual training plans were available on request and provision was made to support health care and substance misuse services.

Education, skills and work activities

This part of the report is written by Ofsted inspectors using Ofsted's inspection framework, available at https://www.gov.uk/government/publications/education-inspection-framework.

Ofsted inspects the provision of education, skills and work in custodial establishments using the same inspection framework and methodology it applies to further education and skills provision in the wider community. This covers four areas: quality of education, behaviour and attitudes, personal development and leadership and management. The findings are presented in the order of the learner journey in the establishment. Together with the areas of concern, provided in the summary section of this report, this constitutes Ofsted's assessment of what the establishment does well and what it needs to do better.

5.8 Ofsted made the following assessments about the education, skills and work provision:

Overall effectiveness: Inadequate

Quality of education: Inadequate

Behaviour and attitudes: Inadequate

Personal development: Inadequate

Leadership and management: Inadequate

5.9 Leaders and managers had provided sufficient education, skills and work (ESW) activity spaces, but they had not made sure that enough prisoners were engaged in ESW. Over a quarter of prisoners were unemployed. Very low attendance and long-term staff absences meant that too many activity spaces were not used. In education and vocational training, less than a half of the planned spaces had been used in the last contract year.

5.10 The curriculum that leaders and managers provided did not meet the needs of the high proportion of unsentenced and very short-stay prisoners. The subjects on offer did not match the outcomes of the thorough needs analysis which leaders had undertaken of prisoners' career aspirations and local and national employment opportunities. In our survey, only 27% of prisoners said that they had been allocated to activities that would help them when released. Prisoners were frequently transferred to other prisons or were released before they had completed their studies.

5.11 Leaders and managers had not resolved most of the key weaknesses identified at the previous inspection. The curriculum still did not offer enough subjects to meet the career aspirations of the prisoners. For example, by far the greatest employment goal of prisoners was to work in construction but managers had not provided courses to meet this aspiration. Too many activities lacked relevance and purpose. Many prisoners did not have enthusiasm for learning the subjects offered. As a result, they did not make enough progress in developing new skills and knowledge.

5.12 Leaders and managers had identified many of the weaknesses highlighted in the current inspection but had been too slow in making required improvements. Senior members of the quality improvement group did not attend meetings regularly, which limited its capacity to bring about change. The quality assurance arrangements implemented by the education provider had not succeeded in raising the quality of functional skills and English for speakers of other languages (ESOL) teaching. Managers had started to carry out structured quality assurance visits within industries, but it was too soon to judge if these had been successful in improving the quality of the prisoners' experience. No formal arrangements existed to quality assure or improve the skill development of the many prisoners who worked on the wings.

5.13 Managers had not planned an effective induction programme into ESW. Staff did not provide prisoners with the knowledge that they needed to inform applications for education or work. Information and discussions about the opportunities for learning at the prison were too brief. Attendance at the induction was very low. Careers information and guidance (CIAG) staff did not have quiet spaces or enough time to talk individually with prisoners in order to plan their individual learning programmes. As a result, prisoners did not contribute sufficiently to one-to-one discussions when considering available options. This led to them making applications for activities which did not always represent their longer-term employment goals. Managers were often slow to allocate prisoners to purposeful activities following induction. In many cases, prisoners were waiting around five weeks, which was too long for the large number of prisoners who stayed in the prison for only a few months. CIAG staff provided suitable support for the few prisoners with planned release dates, to help them plan their next steps. However, these prisoners did not benefit from access to the virtual campus (see Glossary), to enable them to be informed of typical job vacancies in the areas where they expected to live.

5.14 Milton Keynes College provided the education and vocational training. Most teachers and instructors were appropriately experienced and qualified. Teachers had planned the delivery of curriculums in a logical order, so that prisoners learned basic concepts and skills first before moving to more complex ideas and tasks. For example, in a mathematics lesson, prisoners learned about percentages and practised simple calculations before moving on to working out the impact of VAT when shopping, and the savings made during sales offering percentage reductions. In vocational training, staff supported

prisoners to develop new skills and knowledge, and prisoners enjoyed their learning. For example, in barista training, prisoners enjoyed being taught about the wide variety of coffee beans and learned how they were used in the different coffee drinks.

5.15 The quality of teaching in functional skills English and mathematics and ESOL was not consistently good. Teachers did not use questioning effectively to engage prisoners or to check learning. In too many lessons, a few prisoners dominated activities and others only rarely participated. This hindered the progress made by prisoners with lower existing skills and knowledge. Teachers did not ensure that mentors supported their peers effectively. Achievement in English, mathematics and vocational training was not good enough and, in most subjects, had declined in the previous year. Too few prisoners stayed to the end of their courses and achieved their qualifications. The proportion of prisoners progressing to higher levels of learning was very low.

5.16 Prisoners working on the wings and in most industrial workshops learned few new vocational skills. For example, work in the recycling workshops was very repetitive and mundane. In a minority of workshops (for example, in the prison kitchen, laundry and retail), prisoners did develop a range of valuable vocational skills. However, managers had not ensured that this learning led to opportunities to achieve external qualifications. Instructors only rarely recorded any progress that prisoners made in developing their wider employability skills, such as team working, using initiative or following health and safety guidance. As a consequence, when prisoners were released or transferred, they had no record of the progress they had made to support potential employment or further training.

5.17 Leaders and managers had not put in place effective arrangements to increase the reading skills of the great majority of the prison population. As a result of the very low attendance at induction, less than half of the prisoners who needed an assessment of their reading skills received one. These prisoners did not benefit from the extensive support available to help them to read better. Staff teaching entry-level functional skills English did not have sufficient phonics training to give the required help to early readers. Leaders had planned extensive training for prison officers to help prisoners with their reading, but this had not taken place. Consequently, the great majority of prisoners who did not attend education or training did not get the support and encouragement they needed to develop their reading. Prisoners who were assessed at induction as requiring help received good individual support from trained Shannon Trust (see Glossary) peer mentors. This support was well coordinated and monitored by Shannon Trust staff. These prisoners made good progress, including moving on to functional skills lessons. A specialist reading teacher used employment and benefit agency forms to deliver basic reading skills to a small group of prisoners. These prisoners made particularly good progress. Since the introduction of the reading strategy, neither library loans nor visits to the library had increased.

5.18 Teachers and inclusion practitioners gave effective support in education for prisoners with learning difficulties and disabilities (LLD). Teachers used helpful strategies to support prisoners with learning needs such as dyslexia. They wrote support plans that identified appropriate teaching and learning techniques, such as giving clear learning aims and using debate and discussion to consolidate points. However, the great majority of those prisoners with LLD engaged in industries or other work received little formal help. Leaders and managers had not yet delivered enough training for prison staff so that they could help and support all prisoners appropriately.

5.19 Overall, attendance at ESW activities was too low. Prisoners did not develop the important attributes of regular attendance and punctuality which employers require. Around a half of expected prisoners attended functional skills classes, despite management putting in place an equitable pay policy which incentivised their attendance. Attendance at industrial workshops was better but was still low. Leaders and managers received daily reports on attendance and routinely followed up absences, but this had not been effective in raising attendance to acceptable levels. However, attendance at a few activities (for example, cycle maintenance, barista skills and land-based industries) was good. Too many prisoners arrived late for lessons and industrial workshops.

5.20 Leaders and managers had not planned a personal development curriculum which supported prisoners to extend their interests beyond ESW. Too few opportunities existed for prisoners to widen their horizons and discover new interests and talents. Library staff provided a number of activities (for example, a chess club, plastic brick model making and origami) which benefited a few prisoners, but these activities took place during the working day. This prevented the attendance of most prisoners who were at work or in full-time education. Prisoners did not have the opportunity to learn about managing their own money, healthy eating or the skills of living independently. Prisoners were not well prepared for life on release.

5.21 Teachers carefully planned lessons to embed and contextualise prisoners' understanding of fundamental values, including democracy and equality of opportunity. For example, in an English lesson, prisoners talked with confidence about the respect and family-friendly environment within women's football, comparing it with the rowdy behaviour and divisiveness within the men's game. However, in workshops, instructors missed opportunities for prisoners to identify and develop these values. Prisoners demonstrated respectful behaviour to each other and to staff in learning and work activities. They worked collaboratively in groups, demonstrating a tolerance of individual differences. The atmosphere was calm and conducive to learning. Prisoners felt safe while attending education and work activities.

Section 6 Preparation for release

Preparation for release is understood as a core function of the prison. Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.

Children and families and contact with the outside world

Expected outcomes: The prison understands the importance of family ties to resettlement and reducing the risk of reoffending. The prison promotes and supports prisoners' contact with their families and friends. Programmes aimed at developing parenting and relationship skills are facilitated by the prison. Prisoners not receiving visits are supported in other ways to establish or maintain family support.

6.1 There was some good work taking place to support prisoners' contact with children, families and the outside world. Prison leaders had put in place a reasonable strategy to guide this work, and prisoners were generally positive about the opportunities they had to keep in touch with family and friends.

6.2 Social visits took place every day except Friday, and access to these was good, with more than 300 slots available each week. The visits hall provided a spacious, welcoming environment for visitors, with a well-equipped play area for children. A tea bar served a variety of food and drink, but no hot food was available.

Visits hall

6.3 While the visits hall was a pleasant environment, the two holding rooms in which prisoners waited for these sessions were austere, with graffiti and damaged flooring.

Visits holding room

6.4 Some prisoners, particularly those held on remand, told us of delays in the approval of telephone numbers and visitor names, to enable them to keep in touch with family and friends.

6.5 The visitors centre was staffed by the Prison Advice and Care Trust (PACT) and was a good facility for visitors, with a garden. PACT staff were active around the prison. Two case workers conducted one-to-one support with some prisoners, which included structured sessions on relationships and parenting.

Visitor centre and departure lounge (left), and visitor centre garden

6.6 Prison leaders held a wide range of events to maintain family ties, including family days (see Glossary) and 'celebration of achievement' events for prisoners completing courses in education and programmes, which family members could attend.

6.7 Prisoners not receiving visits were well supported. The chaplaincy provided some of these individuals with official prison visitors, and well-attended quarterly 'community days' offered an opportunity to socialise in the visits hall, with a range of outside support organisations attending.

6.8 The new in-cell technology (see paragraph 4.10) was used to access the 'e-mail a prisoner' service that allows prisoners and their family and friends to keep in touch via email.

6.9 Secure social video calling (see Glossary) was available through laptops on the residential units.

Reducing reoffending

Expected outcomes: Prisoners are helped to change behaviours that contribute to offending. Staff help prisoners to demonstrate their progress.

6.10 The turnover of arrivals and releases was high, and most prisoners did not stay very long at the prison. At the time of the inspection, about 80% of the population had been there for less than six months. This posed significant challenges, in terms of effective offender management, public protection and resettlement planning arrangements.

6.11 Since the last inspection, there had been some improvements in work aimed at reducing prisoners' likelihood of reoffending. Leaders generally understood the complexity of their population and the services they needed. A meaningful strategy set out the vision and priorities, and regular meetings coordinated actions reasonably well in efforts to improve outcomes for prisoners.

6.12 About 60% of the population were remanded. While some gaps in support for this group remained, there had been improvements. For example, prisoners could now get housing support and were able to apply for a nationally recognised form of personal identification (see also paragraph 6.32). The pre-release team prioritised assessment of remand prisoners' immediate resettlement needs, and two bail officers had been appointed to triage those who were potentially eligible to apply for bail and improve the risk information available for courts. However, some prisoners on remand told us that support was inconsistent, and several described delays in accessing the help they needed.

6.13 The effectiveness of the offender management unit (OMU) continued to be undermined by fluctuating staffing shortfalls. Operational prison offender managers (POMs) were regularly cross-deployed. Only 2.4 out of the profiled 5.4 whole-time-equivalent probation officers were in post, and one of these was due to leave imminently. Since the previous inspection, there had been at least six different senior probation officers. This frequent change in leadership had had a negative impact on the unit's stability and overall capability. In addition, the OMU staff were spread across various locations within the prison, hindering team cohesion and resulting in often fragmented and isolated working practices between POMs and case administrators. However, despite these challenges, all staff in the unit worked hard to keep pace with the high population turnover and the impact of numerous policy changes. Their resilience and commitment were commendable.

6.14 About 40% of the population needed a sentence plan and offender management. Delays in case allocation meant that some prisoners waited several weeks after sentence before any POM contact took place. Although a POM introductory letter was usually sent within a day or two of allocation, this did not compensate for the lack of early engagement. For short-stay prisoners, this resulted in minimal and transactional contact, often no more than a superficial check-in.

6.15 For prisoners serving longer-term sentences, the level of contact was generally better. While some interactions still consisted of routine check-ins, there were a few examples of more offending behaviour work and progressive, motivational conversations. Key work (see Glossary) was not well used to support offender management (see paragraph 4.3).

6.16 Most eligible prisoners had an offender assessment system (OASys) assessment. Our expectation is that these are reviewed annually, but we found that this was achieved in only just over half of all cases.

6.17 About one-fifth of the population had been recalled to custody following a breach of their licence conditions. Some of these prisoners had returned to Bullingdon multiple times while serving the same sentence. They told us that it was common to be in custody for three to four weeks without receiving their recall pack, if they received one at all. Records we reviewed also showed little or no contact with a community offender manager (COM) post-recall, to discuss the reasons for their return to custody or to identify additional measures needed for their eventual release.

6.18 There were delays in assigning prisoners' security categorisations. In the most extreme case, an initial categorisation took 38 working days to complete. Such delays had an impact on prisoners' ability to progress in their sentence and was a source of anxiety and frustration for many individuals we spoke to.

6.19 Recategorisation reviews were generally well considered, with logical and defensible decision making, but prisoners often did not know that their review had taken place and had not been asked to contribute. This lack of involvement not only limited transparency but also left prisoners feeling excluded from decisions directly affecting their progress.

6.20 While most transfers were prompt to open establishments, some category B and C prisoners waited too long to move to a more suitable prison. These included some prisoners convicted of sexual offences, as well as those from a different resettlement area who were supposed to be closer to home in preparation for their imminent release.

6.21 Prison-led oversight of home detention curfew (HDC) processes was reasonable. However, some prisoners were assessed or released late, for reasons outside of the OMU's control. For example, some serving long remand periods had already reached their HDC eligibility date by the time they were sentenced or had too little time left in their sentence to be released. Other reasons included delays in police checks, difficulty in verifying suitable addresses, late COM allocation and the lack of available or affordable housing.

Public protection

Expected outcomes: Prisoners' risk of serious harm to others is managed effectively. Prisoners are helped to reduce high risk of harm behaviours.

6.22 About half of the sentenced population had been assessed as posing a high or very high risk of serious harm to others, and a similar percentage (47%) were eligible for multi-agency public protection arrangements (MAPPA) on release because of the serious nature of their offences.

6.23 There were significant gaps in the prison's understanding, management and oversight of public protection arrangements. There were backlogs in the screening of new arrivals and weaknesses in the

identification of potential risks and implementation of restrictions. Concerningly, the prison was unable to confirm accurately how many prisoners posed a risk to children. Monitoring arrangements, including controls on contact through written correspondence and telephone communication, were poorly understood and not consistently applied when they needed to be.

6.24 The interdepartmental risk management team (IRMT) meeting did not have sufficient oversight of all high-risk prisoners due for release, including some of those eligible for MAPPA management or likely to be released immediately or quickly after sentencing. This was partly because the OMU failed to identify or include for consideration all cases, and partly because of the high volume of short-sentenced prisoners and recalls passing through the prison, often within a short space of time.

6.25 Risk management planning and the sharing of information between the prison and community probation teams lacked consistency and effectiveness. Not enough was done to escalate or reply to concerns or follow up on the lack of response from COMs.

6.26 Where MAPPA levels for those due for release had been confirmed, they were not always centrally recorded on prisoners' electronic case notes. Risk management plans were not always updated following a significant change in the prisoner's circumstances, and often failed to reflect their current situation, such as when they returned to custody.

6.27 The quality of reports produced by POMs to support MAPPA meetings were mostly adequate. Contributions completed by probation-employed POMs were generally more analytical than those completed by prison-employed POMs, which tended to be descriptive and limited the reader's ability to identify possible risk indicators or motivators.

6.28 Leaders in the OMU had already identified some of these deficiencies and were developing plans to address them, including improving the role of the IRMT meeting and the public protection steering group.

Interventions and support

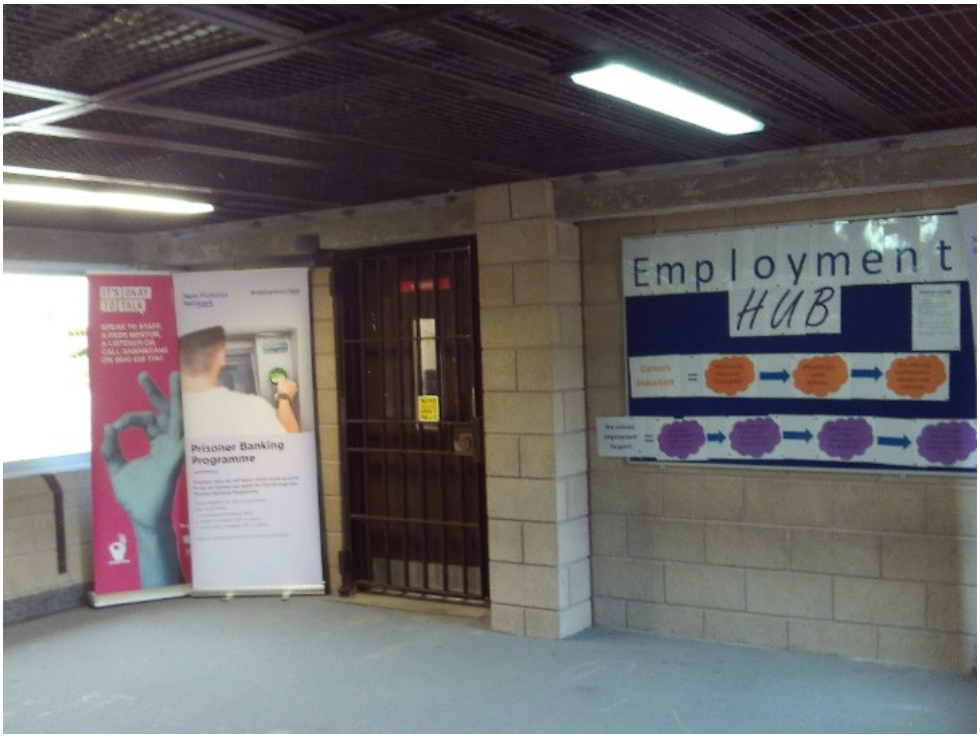
Expected outcomes: Prisoners are able to access support and interventions designed to reduce reoffending and promote effective resettlement.

6.29 A wide and appropriate range of programmes was available to address the offending behaviour of sentenced prisoners, and a reasonable number of individuals had completed an intervention in the previous year.

6.30 The programmes team was proactive and efficient in identifying individuals eligible for a programme. Sentenced prisoners arriving at the prison were assessed promptly, and programmes staff conducted an initial interview to assess their readiness. Few prisoners did not complete a programme once enrolled.

6.31 While this was positive, few interventions were available for prisoners held on remand, those who had been recalled to prison or those who were serving short sentences. Little structured one-to-one work took place for these individuals through their POMs or the regional psychology team.

6.32 Prisoners could access finance, benefit and debt advice through staff in the employment hub, and Department for Work and Pensions staff were on site to offer advice on benefits and arrange appointments for sentenced individuals approaching release. No courses on money management were run, although leaders had plans to introduce one with an external organisation. It was positive that prisoners on remand could now apply for personal identification (see also paragraph 6.12), but they were not able to have a bank account opened.



Employment hub

6.33 Prison leaders had conducted some positive work to establish links with employers, including regular events where prisoners could meet them in the prison. Some good work was undertaken to support 'job ready' prisoners to find work as they approached release, including some engagement post-release, but this was only available to a small minority of individuals who were assessed as being the most ready for work on release. Most prisoners, particularly those on remand, were not able to access this support.

6.34 Staff from an external charity were active in the prison, conducting mentoring and 'through-the-gate' support with some sentenced prisoners.

Returning to the community

Expected outcomes: Prisoners' specific reintegration needs are met through good multi-agency working to maximise the likelihood of successful resettlement on release.

6.35 The demand for resettlement services was high. In the previous year, on average, over 200 prisoners had been released each month, either from the prison or directly from court.

6.36 Timeframes to work with prisoners on fixed-term recalls, those serving very short sentences and immediate releases from court, were limited and posed significant challenges. In our survey, only about half of all respondents who expected to be released in the next three months said that someone was helping them to prepare for this.

6.37 Despite concerted efforts from resettlement staff and the pre-release team, longstanding staffing shortfalls and the high population turnover meant that not all prisoners' immediate resettlement needs were reliably or fully identified, centrally recorded or addressed.

6.38 Joint working and communication between POMs and COMs were not good enough to support release planning and prisoners were not always kept informed about what was being done to support them. In some cases, important information, such as license conditions or reporting requirements, were not discussed with prisoners until very late in the sentence, if at all.

6.39 A full-time worker from Ingeus (the commissioned rehabilitative services accommodation provider) was on site, to help prisoners on remand with their housing needs.

6.40 However, finding accommodation continued to be a challenge. The prison's data for the previous 12 months showed that about 30% of sentenced prisoners had no address to go to on their first night of release. The outcomes for many others, including those released directly from court, were largely unknown.

6.41 The introduction of the multi-agency 'resettlement accommodation advisory board', which considered sentenced prisoners at risk of being homeless in the South-Central area, and the 'immediate release pathfinder project', which aimed to support the release planning of those released directly from court, were promising initiatives in efforts to improve resettlement outcomes.

6.42 The 'departure lounge', located in the visitors centre, just outside the prison gate, offered valuable, practical help and resources for prisoners on the day of release. They could charge their mobile phone there, check travel arrangements and contact professionals such as community probation teams. A supply of basic mobile phones was available for those without one. There was also a small supply of clothing, footwear, towels and toiletries available for those who needed

them. However, disappointingly, the lounge was not always staffed or open when prisoners needed it.

Clothing available in the departure lounge

Section 7 Progress on concerns from the last inspection

Concerns raised at the last inspection

The following is a summary of the main findings from the last inspection report and a list of all the concerns raised, organised under the four tests of a healthy prison.

Leadership

Leaders provide the direction, encouragement and resources to enable good outcomes for prisoners. (For definition of leaders, see Glossary.)

Key concerns

Staff shortages were debilitating and had a major impact on outcomes for prisoners.
Not addressed

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2022, we found that outcomes for prisoners were reasonably good against this healthy prison test.

Key concerns

The use of force was not always proportionate, and some staff did not do enough to de-escalate incidents before using force.
Not addressed

ACCT case management for prisoners at risk of harm did not always evidence targets and interventions that were tailored to their individual circumstances.
Not addressed

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2022, we found that outcomes for prisoners were reasonably good against this healthy prison test.

Key concerns

Living conditions on the main A–D accommodation were poor.
Partially addressed

Purposeful activity

Prisoners are able, and expected, to engage in activity that is likely to benefit them.

At the last inspection, in 2022, we found that outcomes for prisoners were poor against this healthy prison test.

Priority concerns

Prisoners spent too much time locked in their cells with little to do.
Not addressed

Leaders and managers had not designed an appropriate education curriculum that met the needs of the prison population, especially vulnerable and non-sentenced prisoners.
Not addressed

Leaders and managers did not identify the education, vocational training and commercial work starting points of individual prisoners. Prisoners did not engage in meaningful education and workplace activities, which had a detrimental impact on their attitudes to learning and attendance at their lessons and therefore their ability to progress.
Not addressed

Leaders and managers had not ensured that all prison and education staff knew how they could support prisoners to become more interested in reading and develop their reading skills.
Not addressed

Key concerns

Leaders and staff had low expectations about what prisoners could be trusted to do or achieve, and didn't do enough to motivate prisoner engagement in purposeful activity.
Not addressed

Rehabilitation and release planning

Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.

At the last inspection, in 2022, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

Key concerns

Prisoners had too little contact with their prison offender managers (POMs) and there were too few opportunities for prisoners to progress during their sentence.
Not addressed

Public protection arrangements were not robust enough to assure leaders that risk was managed properly.
Not addressed

Outcomes for remand prisoners were worse than convicted prisoners in key areas, including education, careers guidance and support for resettlement.
Not addressed

Appendix I About our inspections and reports

HM Inspectorate of 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 inspections 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.

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this Inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. For men's prisons the tests are:

Safety
Prisoners, particularly the most vulnerable, are held safely.

Respect
Prisoners are treated with respect for their human dignity.

Purposeful activity
Prisoners are able, and expected, to engage in activity that is likely to to benefit them.

Preparation for release
Preparation for release is understood as a core function of the prison. Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.

Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by HM Prison and Probation Service (HMPPS).

Outcomes for prisoners are good.
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

Outcomes for prisoners are reasonably good.
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.
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.
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.

Our assessments might result in identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for prisoners. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which should be attended to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Five key sources of evidence are used by inspectors: observation; prisoner and staff surveys; discussions with prisoners; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of concerns from the previous inspection.

All inspections of prisons are conducted jointly with Ofsted or Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council (GPhC). Some are also conducted with HM Inspectorate of Probation. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

This report

This report outlines the priority and key concerns from the inspection and our judgements against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 6, 2023) (available on our website at Expectations – HM Inspectorate

of Prisons (justiceinspectorates.gov.uk)). Section 7 lists the concerns raised at the previous inspection and our assessment of whether they have been addressed.

Findings from the survey of prisoners and a detailed description of the survey methodology can be found on our website (see Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Martin Lomas	Deputy Chief Inspector
Sara Pennington	Team leader
Jade Richards	Inspector
Rick Wright	Inspector
Sumayyah Hassan	Inspector
Harriet Leaver	Inspector
Paul Rowlands	Inspector
Dionne Walker	Inspector
Sam Rasor	Researcher
Sam Moses	Researcher
Phoebe Dobson	Researcher
Adeoluwa Okufuwa	Researcher
Simon Newman	Lead health and social care inspector
Gift Kapswara	Health and social care inspector
Lynn Glassup	Health and social care inspector
Helen Jackson	General Pharmaceutical Council inspector
Janie Buchanan	Care Quality Commission inspector
Allan Shaw	Ofsted inspector
Viki Faulkner	Ofsted inspector
Darryl Jones	Ofsted inspector
Joanne Stork	Ofsted inspector
Rachel Clark	Ofsted inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find.

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

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

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.

Family days
Many prisons, in addition to social visits, arrange ‘family days’ throughout the year. These are usually open to all prisoners who have small children, grandchildren, or other young relatives.

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

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

MAPPA
Multi-Agency Public Protection Arrangements: the set of arrangements through which the police, probation and prison services work together with other agencies to manage the risks posed by violent, sexual and terrorism offenders living in the community, to protect the public.

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.

PAVA
PAVA (pelargonic acid vanillylamide) spray is 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).

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

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

Secure social video calling
A system commissioned by HM Prison and Probation Service (HMPPS) to enable calls with friends and family. The system requires users to download an app to their phone or computer. Before a call can be booked, users must upload valid ID.

Shannon Trust
A national charity which provides peer-mentored reading plan resources and training to prisons.

Social care package
A level of personal care to address needs identified following a social needs assessment undertaken by the local authority (i.e. assistance with washing, bathing, toileting, activities of daily living etc, but not medical care).

Special accommodation
Unfurnished accommodation – used to manage prisoners who cannot be located safely in normal accommodation.

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

Virtual campus

Internet access for prisoners to community education, training and employment opportunities.

Appendix III 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 inspection of health services at HMP Bullingdon 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 a request for an action plan following this inspection.

Action Plan Request

Provider

Practice Plus Group Health and Rehabilitation Services Limited

Location

HMP Bullingdon

Location ID

1-4075822352

Regulated activities

Treatment of disease, disorder, or injury and Diagnostic and screening procedures.

Action we have told the provider to take.

This notice shows the regulations that were not being met. The provider must send CQC a report that states what action it is going to take to meet these regulations.

Regulation 12 Safe Care and Treatment- Ensure care and treatment is provided in a safe way to patients.

(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—

(a) assessing the risks to the health and safety of service users of receiving the care or treatment.
(b) doing all that is reasonably practicable to mitigate any such risks.

How the regulation was not being met:

- Staff were using the Exceptional Safety Assessment at busy times on reception but did not always follow up with a comprehensive first reception health screen to fully identify patients' needs.

- There was inadequate oversight of prisoners' healthcare applications for appointments. On the Monday of the inspection, we found there were 289 applications awaiting triage, 25 of which had been on the list for over 5 days. On the Tuesday, there were 210 applications, 28 of which had been on the list for over 5 days. There was no daily clinical triaging of the applications to identify risk and prioritise patient need.

- PPG's standing operating policy for the inpatient unit stated that all patients admitted to the service, regardless of the clinical reason for admission, must have a falls risk assessment, a MUST score calculated, a pressure ulcer risk assessment and a Rockwood frailty score completed. We did not find evidence these had been completed for all patients in the care notes we reviewed.

- One patient on the inpatient unit had experienced a fall in May 2025. No assessment had been completed before or following this incident to determine the factors contributing to the falls' risk.

- There was inadequate monitoring of patients' nutrition and hydration. We viewed the food and fluid charts for 2 patients on the inpatient unit. The charts did not always contain details of the actual quantity eaten, what was eaten, or how many millilitres of fluid the patient had drunk. The total daily amount of fluid intake was not measured to ensure an adequate amount had been received. There was a period of 8 days in July 2025 where the charts had not been completed at all.

- We reviewed 5 sets of care records on the in-patient unit. There was no evidence in the records that patients had been actively involved in planning their care. Staff told us that patients were not routinely offered a copy of their care plan, and patients we spoke with were not aware of their plans.

- PPG's standing operating policy for the inpatient unit states that all patient care plans should be reviewed every week. Not all plans we checked had been reviewed weekly to ensure they remained accurate, effective and relevant as patient need changed.

- Apart from fortnightly music therapy, there was a lack of structured therapeutic activities on the inpatient unit to promote patients' physical, mental, and emotional well-being. Patients told us there was little for them to do. This issue was raised at the previous inspection in 2022, with little evidence of improvement.

- We observed some health staff who did not ask patients for their ID or their date of birth when they attended the medicines' administration points, and staff who recorded the administration of a medicine before it was given to the patient.

- We found numerous gaps in the records to show that medical emergency response bags had been checked each day. One emergency bag did not contain a saturation probe, tuff cut scissors or the correct amount of adrenalin ampoules. The glucagon had been kept out of the fridge and its expiry date had not been reduced to ensure its effectiveness. These shortfalls had not been identified in the fortnightly contents check of the bag.

Regulation 17 Good governance.

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

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

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).

assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

How the regulation was not being met:

There was lack of oversight of risk and a failure of partnership working to address long-standing issues which impacted on patient safety and the delivery of some health services. For example,

- On 14/12/2016, a risk was added to the register which stated: If the medication queues are not adequately supervised/supported by the prison, there will be additional pressures placed on patients collecting their medication and healthcare staff administering medication. During this inspection, some 9 years later, we found that medicines' queues were still poorly supervised and chaotic, and we witnessed the diversion of medicines.

- On 03/11/2022 a risk was added to the register which stated: If the transport company utilised by HMPPS for external escorts is not able to meet their contractual requirements, patients will be impacted. During this inspection, some 3 years later, administrative staff told us that there were still huge problems with the contracted taxi company which impacted negatively on patients attending their medical appointments and took large amounts of their time to sort.

- On 03/03/2023- a risk was added to the register which stated: If infection control, fixtures, fittings and cleaning standards do not meet national requirements there is a risk to patients, staff and the organisation. During

this inspection, some two years later, we found areas of the inpatient unit which were in a poor and unhygienic state. The provider's own infection prevention and control audit in February 2025 had identified numerous concerns resulting in an overall score of 77%, the reaudit in May2025 showed a deterioration in standards, with a score of 70%.

- We came across several incidents that had not been reported using the clinical reporting system. These included incidents involving medicines' errors, short staffing and use of the exceptional safety assessment. Staff told us they did not have enough time to complete incident reports.

Appendix IV Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed reports distributed to the prison). For this report, these are:

Prison population profile

We request a population profile from each prison as part of the information we gather during our inspection. We have published this breakdown on our website.

Prisoner survey methodology and results

A representative survey of prisoners is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection. A document with information about the methodology and the survey, and comparator documents showing the results of the survey, are published alongside the report on our website.

Prison staff survey

Prison staff are invited to complete a staff survey. The results are published alongside the report on our website.

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)

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