Report on an unannounced inspection of

HMP Exeter

by HM Chief Inspector of Prisons

31 October – 11 November 2022

Contents

Introduction

Exeter is a men's reception prison with a small resettlement function that held 388 prisoners at the time of our inspection. It has had a troubled recent history and in 2018 was subjected to an urgent notification because of its inability to keep the prisoners in its care safe. Four years on, I am disappointed to report that things have not improved at anything like the rate that we would have expected. Although this report points to some small improvements and some potentially promising work, the levels of care, particularly for the most vulnerable, were still nowhere near good enough. As a result, I was left with no alternative but to invoke the urgent notification again, the first time this has happened in consecutive inspections of an adult prison.

We were particularly concerned about the care given to prisoners in their first days and weeks in the jail. This is a critical and risky time in reception prisons during which prisoners feel frightened, overwhelmed, and are more likely to take their own lives. Support for new arrivals was particularly important at Exeter as more men than at similar prisons had mental health and substance misuse needs. The induction process at Exeter, however, was chaotic and lacked proper leadership oversight despite there having been 10 self-inflicted deaths since our last inspection. This was compounded by failures in the substance misuse service, which meant that some arrivals assessed as requiring supervision with medication and detoxification were not regularly visited by heath care staff. Most vulnerable prisoners spent their early days at Exeter on a wing with the general population, which put their wellbeing at risk. One prisoner, charged with a sexual offence, who had not been in prison before, described being locked up on C wing for days on end, with meals served at his door while prisoners outside shouted abuse at him. He had not received a proper induction outlining what would happen next, and he thought that this was how he was going to serve his entire sentence.

The levels of self-harm were the highest of all male reception prisons and although the jail had recently put some processes in place reduce this, it remained too high. Staff shortages in health care meant that the many prisoners who had mental health needs were not getting the support they needed.

Elsewhere, the quality of purposeful activity had declined and was now poor. Prisoners were locked up for long periods of time and very few attended work or education despite the availability of places. Long delays to education induction meant that many prisoners did not even have the chance to put themselves forward to join an activity. There seemed to be an assumption amongst staff that prisoners did not want to work, but inspectors talked to many who were bored and desperate to get off the wing and do something with their time. The learning and skills curriculum on offer was not appropriate for the jail, meaning that the completion rates for courses were astonishingly low.

The support from the prison service for Exeter did not appear to have matched that given to other prisons that have been subject to an urgent notification. Staff attrition in key management positions was high – the prison had a total of 8 deputy governors since the last inspection, one of whom left to take up a position with the Prison Group Director. Only recently had a decision been

made to upgrade the pay for the deputy's post. In addition, there have been 8 heads of safety in a prison that had previously been assessed as fundamentally unsafe by inspectors. In 2018 inspectors noted that CCTV was not working properly, four years later it had got worse. Astonishingly, during this inspection, four officers were on detached duty elsewhere in the estate, suggesting a lack of awareness by the prison service of the serious weaknesses at Exeter.

The governor was well liked by both staff and prisoners and was visible around the jail, but he did not have enough oversight or assurance needed to create a safer environment. This was, in part, due to the high turnover of staff in senior positions, and where there had been stability, for example in the offender management unit, we found an effective and well-motivated team.

Exeter will require a period of stability in the next year and a relentless focus on improving the safety of prisoners and making sure that they are able to spend more time in productive activity outside their cells. We will return to the prison in 2023 when we expect to see some meaningful progress – to achieve this, Exeter will need strong commitment from the staff team and significant support from the prison service.

Charlie Taylor
HM Chief Inspector of Prisons
November 2022

What needs to improve at HMP Exeter

During this inspection we identified 11 key concerns, of which four 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. **National leaders had failed to provide stability of leadership at the prison.** Exeter had had three governors, eight deputy governors and eight heads of safety since our previous inspection. This instability of leadership impeded progress at a high-risk site.

2. **The number of self-inflicted deaths and incidents of self-harm was very high.** Care for prisoners who were vulnerable on arrival or those who were in crisis while in custody was poor.

3. **The lack of clinical leadership and chronic staff shortages across the service had a detrimental impact on patient safety and the provision of care, particularly in the area of mental health.** This resulted in practice that did not meet national standards and unmet need for many patients.

4. **Many prisoners spent too long locked in their cells, purposeful activity was not prioritised, and few prisoners took advantage of what was offered, limiting their prospects of rehabilitation and reducing reoffending.**

Key concerns

5. **The level of violence at the prison was high and leaders were unaware of many of the causes.** Investigations into violent incidents were inadequate and did not inform an action plan to identify and reduce violence among prisoners.

6. **There was no key worker scheme, staff-prisoner relationships were mostly transactional and prisoners were frustrated by the inability of staff to meet legitimate requests.**

7. **The standard of the cells was poor.** Many had no glass in the windows, exposed electric wires, floors in need of repair and some contained mould.

8. **The education, skills and work curriculum was not fit for purpose. It did not provide meaningful or relevant learning or training opportunities which met prisoners' varied needs.**

9. **Leaders and managers had not dealt with the long-standing inadequacies of induction and allocations to education, skills and work.**

10. **The role of the quality improvement group and its impact were now slight and leaders and managers did not use available data well to monitor and manage the quality and impact of the provision.**

11. **Support to maintain family ties was not sufficiently focused on the outcomes experienced by prisoners.** There were no family days, nothing to mitigate delays in adding numbers to prisoners' pin phone accounts, basic interim visits provision and supervising staff who were not confident about visits times.

About HMP Exeter

Task of the prison/establishment
Reception prison serving courts in south-west England.

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 388
Baseline certified normal capacity: 319
In-use certified normal capacity: 241
Operational capacity: 412

Population of the prison
- 2,338 new prisoners received each year (about 195 per month).
- 39 foreign national prisoners.
- 10.15% of prisoners from black and minority ethnic backgrounds.
- Average of 89 prisoners released into the community each month.
- Number of prisoners referred for mental health assessment each month – on average 121 referrals per month, 110 triages per month, 107 triages per month within timescales.

Prison status (public or private) and key providers
Public

Physical health provider: Practice Plus
Mental health provider: Devon Partnership Trust
Substance misuse treatment provider: ISMS
Prison education framework provider: Weston College
Escort contractor: Serco

Prison group/Department
Devon and North Dorset

Brief history
Built in 1853, HMP Exeter is a Victorian prison of radial design, with three wings positioned around the centre. In the late 20th century, D wing was added and, more recently, education blocks were built. In recent years a refurbished reception, new visits hall and a social care unit (F wing) have been introduced.

Short description of residential units
A wing: 194 remand or sentenced and convicted adults and young prisoners. A4 landing vulnerable prisoners.
B wing: closed for refurbishment, when open holds 87 remand or sentenced and convicted adults and young prisoners.
C wing: 189 remand or sentenced and convicted adults and young prisoners. C4 landing: first night and induction unit.
D wing: enhanced living unit, holding 80 remand or sentenced and convicted adults and young prisoners.
F wing: closed for refurbishment. Previously social care unit holding 11 prisoners.

Name of governor/director and date in post
Richard Luscombe, November 2019 -

Changes of governor/director since the last inspection
Dave Atkinson, March – November 2019
Pete Elboum, 2015 – February 2019

Prison Group Director
Jeannine Hendrick

Independent Monitoring Board chair
Jenny Ellis

Date of last inspection
May 2018

Section 1 Summary of key findings

1.1 We last inspected HMP Exeter and made 47 recommendations, five of which were about areas of key concern. The prison fully accepted 35 of the recommendations and partially (or subject to resources) accepted six. It rejected six of the recommendations.

1.2 In March 2021 during the COVID-19 pandemic, we conducted a scrutiny visit at the prison. We made 11 recommendations about areas of key concern.

1.3 Section 8 contains a full list of recommendations made at the last full inspection and scrutiny visit and the progress against them.

Progress on key concerns and recommendations from the full inspection

1.4 Our last inspection of HMP Exeter took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for prisoners at the time. Although we recognise that the challenges of keeping prisoners safe during COVID-19 will have changed the focus for many prison leaders, we believe that it is important to report on progress in areas of key concern to help leaders to continue to drive improvement.

1.5 At our last full inspection, we made five recommendations about key concerns. At this inspection we found that two of those recommendations had been achieved and three had not been achieved. One recommendation made in the area of safety had been achieved and two had not been achieved. In the area of respect, one recommendation had been achieved and one had not been achieved. For a full summary of the recommendations achieved, partially achieved and not achieved, please see Section 8.

Progress on recommendations from the scrutiny visit

1.6 During the pandemic we made a scrutiny visit to HMP Exeter. Scrutiny visits (SVs) focused on individual establishments and how they were recovering from the challenges of the COVID-19 pandemic. They were shorter than full inspections and looked at key areas based on our existing human rights-based *Expectations*. For more information on SVs, visit https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/scrutiny-visits/.

1.7 At the SV we made some recommendations about areas of key concern. As part of this inspection, we have followed up those recommendations to help assess the continued necessity and proportionality of measures taken in response to COVID-19, how well the prison is returning to a constructive rehabilitative regime, and to provide transparency about the prison's recovery from COVID-19.

1.8 We made 11 recommendations about areas of key concern. At this inspection we found that one of the recommendations had been achieved, two had been partially achieved, five had not been achieved and three were no longer relevant.

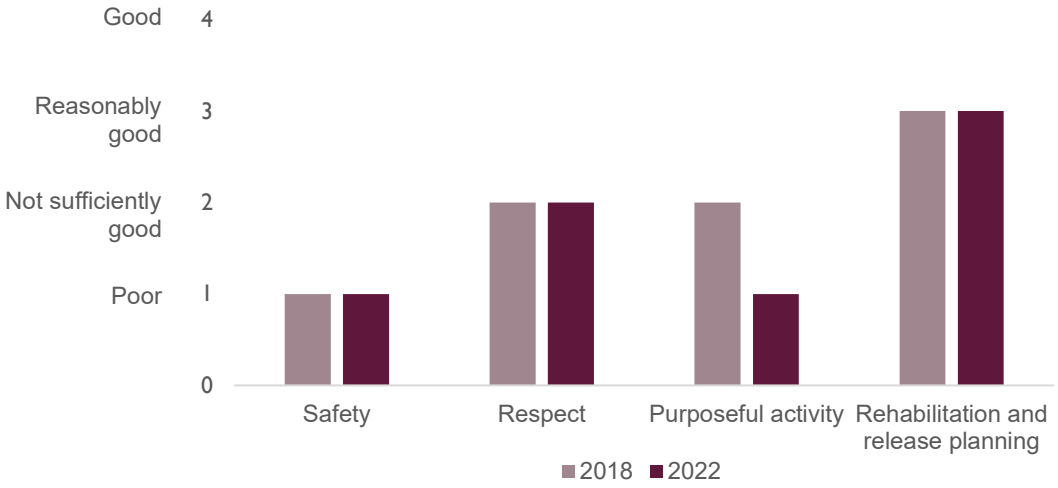
Outcomes for prisoners

1.9 We assess outcomes for prisoners against four healthy prison tests (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.10 At this inspection HMP Exeter, we found that outcomes for prisoners had stayed the same in three healthy prison areas and declined in one.

1.11 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account the prison's recovery from COVID-19 as well as the 'regime stage' at which the prison was operating, as outlined in the HM Prison and Probation (HMPPS) National Framework for prison regimes and services.

Figure 1: HMP Exeter healthy prison outcomes 2018 and 2022



Safety

At the last inspection of HMP Exeter in 2018, we found that outcomes for prisoners were poor against this healthy prison test.

At this inspection we found that outcomes for prisoners remained poor.

1.12 Reception procedures were reasonably good and all prisoners were interviewed privately by first night and health care staff to identify any risks. In our survey more prisoners than at other reception prisons reported arriving at Exeter with mental health or substance misuse needs. There were frequent delays for prisoners new to custody receiving medication and not enough observation of those detoxing which led to increased risk during their first days in prison. The induction process was not functioning, and as a result prisoners spent

too long locked in their cells on the induction unit, not understanding how to access services and support.

1.13 In our survey, 77% said they had a mental health condition and Exeter acted as an entry route into the prison system for several secure mental health units. While it had reduced over the previous year, the rate of self-harm remained higher than any other reception prison in England and Wales. There had been 10 self-inflicted deaths and one non-natural death since our last inspection. Prisoners at risk of self-harm told us that care varied considerably. Many prisoners we spoke to said that frustrations with daily life and difficulty getting problems resolved led to thoughts of self-harm.

1.14 The rate of assaults on prisoners had reduced but still remained higher than comparator prisons. Assaults on staff had increased, most of these were recorded as not serious and perpetrated by just a small number of prisoners. All violent incidents were investigated, but investigations varied in detail and were often late. As a result, leaders did not have a thorough understanding of the causes of violence. The challenge, support and intervention plan (CSIP) process was in place, but more oversight was needed to ensure that plans were meaningful and prisoners understood their targets.

1.15 The wings were better ordered than at the time of the previous inspection, but too much low-level behaviour went unchallenged. Incentives for prisoners who behaved well needed development. Adjudications had reduced and prisoners were placed on report for appropriate reasons.

1.16 The segregation unit had improved and was now well managed. Reintegration planning started as soon as a prisoner arrived and very few stayed segregated for long periods. We observed good interactions with prisoners by staff.

1.17 Use of force rates remained high. Monthly oversight meetings were now taking place and were well attended, and relevant data were discussed. Leaders planned to introduce a use of force action plan to reduce the high levels. Oversight was undermined by a very poor CCTV system and a lack of footage of incidents.

Respect

At the last inspection of HMP Exeter in 2018, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

At this inspection we found that outcomes for prisoners remained not sufficiently good.

1.18 In our survey, 63% of prisoners said that staff treated them with respect and, while we observed mostly respectful interactions, prisoners we spoke to were frustrated by the inability of staff to resolve issues like access to stored property, getting telephone numbers approved and

difficulty washing clothes. The key worker scheme was not operating which hindered the creation of meaningful relationships and was a missed opportunity to address the frustrations of many prisoners. Peer work had improved and was now reasonably good.

1.19 Several projects were under way to improve living conditions and other parts of the prison, but too many prisoners still lived in poor cells in overcrowded conditions. There had been improvements to the standards of cleanliness of communal areas. Most shower facilities had been refurbished, but some of these improvements had already been damaged. Access to property was poor. Laundry arrangements were inadequate and many prisoners were hand washing clothes in their cell. The implementation of electronic kiosks had improved the application process. Complaints were reasonably well managed. Most responses were polite and appropriate, but not always timely.

1.20 Oversight of equality was good and leaders actively sought to identify potentially disproportionate behaviour. There were good examples of support for transgender prisoners and the youth engagement lead provided group work and support for prisoners under 21. The regime for some prisoners with disabilities was poor. Faith provision was good, and all prisoners received fair access to corporate worship each week.

1.21 Long-standing issues with health care delivery had been exacerbated by the imminent transition of services to a new provider. Chronic staff shortages in all areas meant that delivery of care and support to patients was compromised, particularly in substance misuse and mental health services. Substance misuse services were not well integrated and patients receiving clinical treatment were not always observed in line with their care plan or with national guidelines, which was unsafe. Mental health services were focused on urgent and routine referrals. There was limited access to therapeutic programmes and some patients did not receive the mental health care they needed. Services for patients with a learning disability were limited and there was a considerable level of unmet need for those with autism and ADHD.

Purposeful activity

At the last inspection of HMP Exeter in 2018, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

At this inspection we found that outcomes for prisoners were now poor.

1.22 There was enough purposeful activity to provide at least part-time employment for all prisoners, but less than half the population were allocated and attendance was poor. Our time out of cell checks showed that only 29% of prisoners were in purposeful activity. Time out of cell was limited and the regime did not operate consistently.

1.23 There was an efficient system to ensure equality of access to the gym for prisoners. While the quality of delivery was good, there were no

outdoor activities and the provision was limited. Library provision was reasonable and prisoners reported good access.

1.24 Leaders in education, skills and work (ESW) had produced a detailed, honest and largely accurate self-assessment of the many weaknesses and comparatively few strengths of the provision. These leaders were resilient and determined to make improvements. However, they had not made sure that all staff understood the role they could play in correcting these weaknesses.

1.25 Not enough courses were available to meet prisoners' varied needs, not least the considerable number with learning difficulties and disabilities and those serving longer sentences or nearing release. Prisoners' attendance and punctuality at education and training sessions were routinely poor. The allocations process was chaotic with prisoners and tutors often not knowing who was going to be at what session or why. The proportion starting a course and achieving the qualification was also very low, particularly in English and mathematics.

1.26 There were not enough teaching staff to ensure that all classes in education could be scheduled routinely or cover provided for holidays and sickness. Too many education and workshop sessions were cancelled, often at the last minute, because there were no staff. This was demotivating for the attendees allocated to the sessions.

1.27 The relatively small number of prisoners who attended mainstream education or training sessions demonstrated good behaviour. The number and range of industry places were very limited and the work mundane. The places were mainly open to vulnerable prisoners who took pride in their work.

1.28 Leaders focused rightly on tackling day-to-day operational problems but had too little awareness of the data available to help them monitor and manage performance effectively. Improvement actions too often failed, often because there were not enough staff, a lack of funding or frequent destabilising changes in management.

1.29 Most wing staff did not understand the value of education, skills and work and did not prioritise getting prisoners off the wings to engage in purposeful activity. A large backlog of prisoners had not had an induction to ESW. Most prisoners' understanding and appreciation of the value of purposeful activities were poor.

Rehabilitation and release planning

At the last inspection of HMP Exeter in 2018, we found that outcomes for prisoners were reasonably good against this healthy prison test.

At this inspection we found that outcomes for prisoners remained reasonably good.

1.30 The visits facility was basic but enabled prisoners to have some contact with families and friends while the new visits hall was built. Family support services had recently been taken on by a new provider and were still bedding in. Arrangements for other types of contact were reasonable, although prisoners had faced delays in having their telephone numbers approved.

1.31 Strategic management of reducing reoffending work had not had sufficient focus. Although there was useful work was being carried out and some collaborative working between agencies, there was weakness in the coordination and monitoring of the various work strands.

1.32 The offender management unit had benefited from consistent leadership which had provided the foundation for a strong team ethos and well-embedded work practices. Support for remanded prisoners was better than we often see. This included an innovative project with local partners to put risk management processes in place for prisoners released from court after lengthy periods on remand. Nearly all eligible prisoners had an assessment of their risk and needs and a sentence plan. Levels of contact between prisoners and their prison offender manager (POM) had improved since the last inspection. POMs and their partner case administrators worked collaboratively, ensuring timely completion of categorisations and reviews with prisoner involvement. Home detention curfew procedures were started at the earliest opportunity.

1.33 Work to manage risk from prisoners convicted of more serious offences and within a few months of release was good. Arrangements for mail and phone monitoring were managed well.

1.34 The on-site pre-release team assessed the needs of all new arrivals and made referrals to support agencies. A vacancy in the team had prevented them from reviewing resettlement plans for low- and medium-risk prisoners nearing the end of their sentence. This gap was partially filled by reviews carried out by other agencies.

1.35 Provision for prisoners approaching release included support to gain employment, benefits advice, obtaining identification, bank accounts and help with accommodation. However, despite these efforts, too many prisoners had been released with no identified address to go to. The appointment of an employment lead demonstrated the focus on assisting prisoners to find jobs on release. The departure lounge

continued to offer valuable practical support and advice to prisoners as they were released.

Notable positive practice

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

1.37 Inspectors found one example of notable positive practice during this inspection.

1.38 Joint work with other criminal justice agencies made sure that risk management arrangements were considered in advance for remanded high risk of harm prisoners who could be granted bail or, following the time spent on remand, were likely to be released immediately from court after being sentenced with no oversight in place. (See paragraph 6.19)

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 At our last inspection in 2018 we issued an urgent notification (UN) because of the very poor safety outcomes. The response to the urgent notification by HMPPS national leaders differed from that at other prisons. We found less evidence of intervention and support at Exeter than at the other establishments subject to a UN and many serious shortcomings remained.

2.3 The governor was appointed in 2019 and had prioritised safety, but outcomes remained poor. He was committed to the establishment and was visible and very accessible to staff and prisoners. Exeter had struggled to recruit and retain staff in vital leadership roles and there had been eight deputy governors and eight heads of safety since our last inspection. This unstable leadership is the key reason for the failings in this report and reflects poorly on the involvement and support from HMPPS.

2.4 The governor and prison group director had taken recent action to improve the stability of the senior team by regrading the deputy governor and head of safety posts. The governor was also attempting to improve the recruitment process by introducing interviews and increasing the support for new officers to address the high rates of attrition among front-line staff.

2.5 The constant change of managers in areas including safety, residential units, health care and activity resulted in processes that were not robust enough to safeguard outcomes for prisoners. Leaders were unaware of key failings in the early days provision and had not ensured consistent care of those at risk of self-harm. This was a significant shortcoming given the previous urgent notification and continued high levels of suicide and self-harm at Exeter.

2.6 There was no oversight or control of key but basic processes including adding prisoners' numbers to pin phones, enabling prisoners to access their property and allocating them to activities. As a result, these systems did not function effectively. The exception to this was the offender management unit where consistent, strong leadership laid the foundation for good practice.

2.7 The transition of health care services to a new provider had distracted leaders from delivering safe care and effective oversight. Services that were already frail had become unsafe.

2.8 We identified some early signs of progress at the establishment: the levels of self-harm and violence remained too high but were starting to fall. The safety team had established valued peer support schemes for prisoners at risk of self-harm.

2.9 The many committed managers and staff at the establishment provided some basis for optimism. However, without further support from leaders in HMPPS to improve the stability of the leadership team, progress will be slow.

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 HMP Exeter was a busy reception prison which accepted prisoners from several courts across the south-west of England. Many prisoners were on remand and this was their first experience of prison.

3.2 Staff had developed good relationships with the local courts and the escort provider, which had helped them to manage arrival times. The number of late arrivals had reduced considerably since our last inspection.

3.3 With the exception of health care screenings, reception procedures were efficient. Both a Listener (trained by the Samaritans to provide emotional support to fellow prisoners) and an Insider (a peer mentor trained to give advice and guidance on prison life) were available to see new arrivals in a private, suitably equipped room. They initially saw each prisoner to help with immediate concerns and talked to them in more detail subsequently to explain what would happen next.

3.4 A safety screening was completed by a member of the first night team who passed on any concerns to officers on the prisoner's residential unit. However, there were regular delays, sometimes considerable, in health care staff attending to see new receptions and prisoners could spend long periods in the holding rooms waiting to be seen.

3.5 Prisoners were offered a hot drink and a meal but were rarely offered a shower despite facilities being available.

3.6 Prisoners who arrived without public protection concerns should have been given two pounds in phone credit on arrival so that they could make calls from their cells. We found several prisoners on the first night unit who had been unable to make a call because they had not received credit or the in-cell phone was not working. This was reflected in our survey findings where only 38% of prisoners said they had received phone credit during their first few days, compared with 61% at our previous inspection. We saw some prisoners who were understandably distressed because their family and friends did not know where they were, or they had been unable to make necessary domestic arrangements after they arrived at the prison.

3.7 The family support worker service was in transition and not regularly available to make calls to families for prisoners awaiting checks by prison staff. Prison staff tried to make these calls, but this was not always possible.

3.8 Several wings were being refurbished and a few areas were temporarily accommodating different cohorts of prisoners. C4 landing was now the first night and induction unit for mainstream prisoners. Prisoners convicted of an offence of a sexual nature or who felt under threat and needed to be located away from the main population should have been located on A4 on their first night. However, A4 was generally full so these prisoners were located on C4 instead, which was not appropriate.

3.9 This had a considerable impact on the induction and regime for these prisoners, who were locked up for extended periods. They should have been unlocked and escorted to A4 to meet an Insider, start the induction programme and have exercise just after lunch each day, but this did not always happen. Prisoners and Insiders told us they could be left in their cells all day, with contact limited to collecting medication and when staff brought their meals to the cell door. Three prisoners told us that they had missed at least one meal during their first few days, which staff had not delivered. Others reported that while on C4 they were regularly subject to prisoners shouting abuse through their cell door.

3.10 Several prisoners who needed prescribed medication, some for serious conditions, had not received medication during their first few days and did not know when they would receive it. This caused high levels of anxiety and it was clear that some prisoners had started to feel unwell because of these delays. In addition, the large number of prisoners who started alcohol detoxification or opiate substitution therapy were not routinely observed and care plans were not consistently followed, which was not safe (see paragraph 4.85).

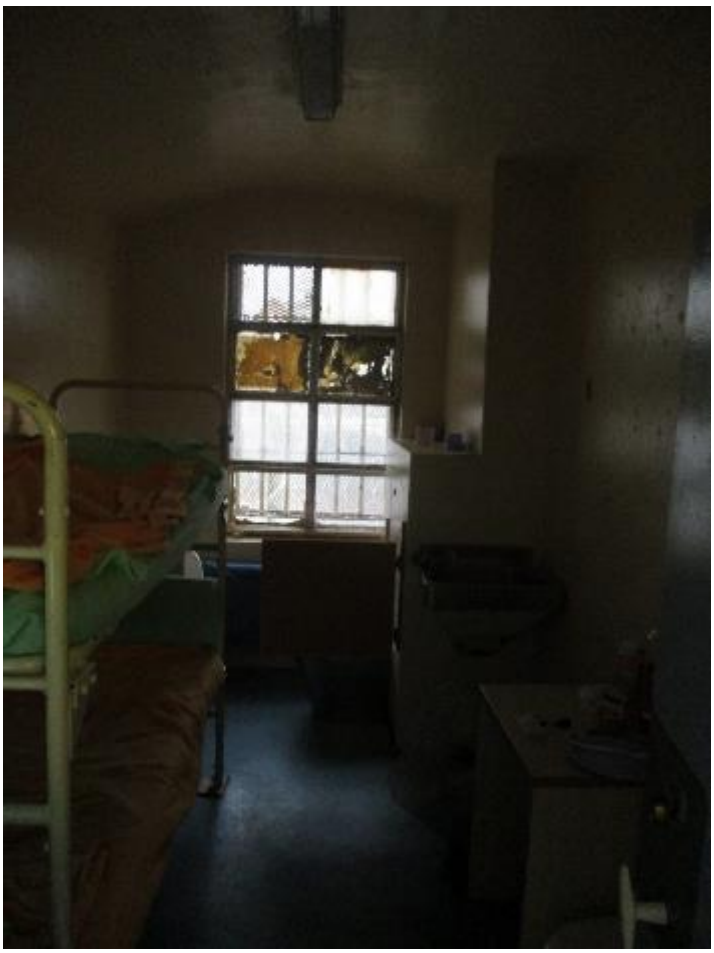
3.11 Induction was led by Insiders. On the first day prisoners were unlocked individually or in small groups during the morning and shown how to use the kiosk to make applications and bookings. In the afternoon, groups of about six prisoners went to an induction room where a member of staff and an Insider gave them information that they needed. The room was poorly equipped, contained inaccurate information and staff told us that the furniture was regularly stolen.

Induction room

3.12 Several key areas were missing from induction such as legal and appeal rights for newly convicted prisoners. Education and workshop assessments and induction and information, advice and guidance were rarely delivered on schedule, which meant prisoners spent far too long locked in their cells unable to get to education or work. In our survey just 27% of prisoners that induction covered everything they needed to know about the prison, and we met several new prisoners who were unaware how to resolve problems during their first few days which was concerning.

3.13 There was also little information for prisoners for whom English was not their first language. In our survey, only 73% of prisoners said that they had received an induction compared with 88% at our last inspection.

3.14 Many of the cells on the first night centre were poorly equipped. Several cells contained graffiti and broken furniture and some had telephones that did not work.



Induction cell

Managing 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

3.15 In our survey, 53% of prisoners said they had not felt safe at the prison and 21% said they felt unsafe at the time of our inspection. The level of assaults on prisoners had reduced since our last inspection but remained high and was more than 50% higher than comparator prisons. Assaults on staff had increased but records indicated that most assaults were not serious and perpetrated by a small number of prisoners.

3.16 During the previous 12 months, there had been 250 assaults, 126 on staff and 124 on prisoners. Challenge, support and intervention plans (CSIPs, see Glossary) were in place and all violent incidents were referred for investigation.

3.17 Investigations into violence were not always conducted promptly. At the time of our inspection, nine were awaiting completion that were up to 14 days late. The level of enquiry by staff to determine the causes of violent incidents varied. Some investigations that we reviewed were of very poor quality and did little to help managers understand the causes of violence. Plans derived from investigations lacked meaningful targets for prisoners to follow. We spoke to many prisoners subject to CSIP monitoring who were unclear about their targets and review dates. Most staff we spoke to were unclear about the purpose of CSIPs or how they could contribute.

3.18 Violence data were reviewed at the monthly safety meeting and leaders had a good understanding of where and when violence was taking place. However, the gap in understanding why it occurred was ill informed largely due to the poor quality of investigations.

3.19 Prisoners subject to CSIP monitoring were discussed at weekly safety intervention meetings (SIMs), but case managers did not always attend or provide updates.

3.20 Procedures to identify self-isolating prisoners were weak. We encountered two prisoners self-isolating of whom leaders were unaware, and both had a very poor regime.

3.21 The wings were less chaotic than at the last inspection but too much low-level behaviour continued to go unchallenged, for example vaping and breaches of dress code.

3.22 In our survey, 40% of prisoners said that the incentives and privileges policy motivated them to behave well and only 31% said they felt they had been treated fairly under the scheme. There were only slight differences between the three levels of the scheme which did little to motivate positive behaviour. There was limited oversight of the incentives scheme by managers. Electronic records were not always updated to reflect an upgrade from basic to standard level and these prisoners continued to experience restricted access to weekly canteen spends.

3.23 Enhanced prisoners could live on D wing where their cell doors were unlocked 24 hours a day. Prisoners appreciated this, but the unit was uninspiring and there was too little for them to do. While the exercise room on D wing was a good initiative, access to it was inconsistent. Many prisoners were unsure when they could use it and the published schedule was only adhered to intermittently. The possibility of self-cook facilities had not been explored and the absence of activities to relieve boredom such as board games and playing cards was a gap.

Exercise room, D wing

Adjudications

3.24 During the previous 12 months, there had been 2,513 adjudications, about half the number at the previous inspection. Adjudications were used for the most serious offences and the backlog was small. Adjudication standardisation meetings took place each quarter and the governor conducted very good quality assurance to ensure proportionality and consistency of adjudications.

Use of force

3.25 Unplanned use of force rates remained high and among the highest of similar prisons. There had been 387 incidents of use of force in the last 12 months and the level was increasing.

3.26 In our survey, 13% of prisoners said they had been restrained during the previous six months and only 40% of these said that someone had talked to them about it afterwards. There was a backlog of prisoner debriefs and records of those that did take place were poor, providing limited information about the reasons for each incident. Leaders committed to introducing quality assurance of interviews after the inspection.

3.27 Monthly use of force meetings were now taking place and were well attended. Relevant data were monitored but leaders were again unclear about the reasons for force being used.

3.28 Staff made good use of body-worn cameras, but the CCTV was no longer fit for purpose (see paragraph 3.37). Footage could not always be captured on CCTV and body-worn camera images were not

routinely saved. Use of force reviews were carried out on the following day by a custodial manager and sometimes by the independent monitoring board. The use of force meeting did not routinely review footage unless they were requested to, and there was no action plan to reduce the high levels of use of force.

3.29 The quality of use of force reports had improved since the introduction of an enthusiastic use of force coordinator who had addressed the backlog of incomplete reports and was also responsible for delivering training.

3.30 Special accommodation had been used 11 times during the previous 12 months. Prison records did not always show that special accommodation had been used as a last resort after other alternatives had been explored nor that prisoners were removed from special accommodation at the earliest opportunity.

3.31 Batons had been drawn but not used on three occasions in the last year and PAVA incapacitant spray was being distributed to staff at the time of our inspection.

Segregation

3.32 During the previous 12 months, 314 prisoners had been segregated. The average time spent in segregation was six days and no prisoners had been segregated for long periods (more than 42 days) since July 2022 which was positive.

3.33 The segregation unit on B1 had moved to C1 temporarily while B1 was refurbished. Monitoring, care and supervision of segregated prisoners had much improved and the unit was very well managed.

3.34 Reintegration planning started as soon as prisoners arrived on C1. The consistency of staff working on the unit had a positive effect on de-escalating prisoners and it was laudable that segregation staff routinely helped prisoners with their transition back to the wings.

3.35 The introduction of a one-page plan to help staff understand and support segregated prisoners was useful and staff we spoke to referred to it for guidance. Relationships between staff and prisoners on C1 were very good and we observed positive interactions with prisoners by professional and caring staff.

3.36 Quarterly separation monitoring meetings were taking place where relevant data were discussed. Disproportionality for prisoners from protected characteristics groups (see Glossary) was closely monitored.

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 use and effective drug supply reduction measures are in place.

3.37 At our previous inspection we highlighted the weaknesses of the CCTV – no action had been taken to improve the system in spite of the Urgent Notification. It had become almost impossible to capture, review and download images from CCTV. Leaders were very frustrated at the out-of-date technology that was no longer fit for purpose. A recent bid to upgrade the CCTV system had been rejected.

3.38 In our survey, 22% of prisoners said it was easy to get drugs and 16% alcohol compared with 60% and 38% respectively at the previous inspection. While this was positive, mandatory drug testing (MDT) rates were too high. Positive drug tests were principally for synthetic cannabinoids, cannabis or prescribed medicine. Limited intelligence-led drug testing was being carried out but not at weekends which undermined leaders' ability to determine the scale of illicit drug use. Leaders described plans to move away from random MDT to a more suspicion-based testing policy to improve understanding of the prevalence of drug use.

3.39 While there were regular drug strategy meetings, the action plan did not acknowledge or have actions to address the significant shortcomings in the substance misuse service (see paragraphs 3.10 and 4.85).

3.40 The flow of intelligence into the security department was managed well and 5,485 information reports had been processed in the last 12 months. These were reviewed quickly and there were no backlogs. Most intelligence-led searches had been conducted, with a positive find rate of 39%, principally drugs and weapons. The recent drug amnesty had had little impact.

3.41 The routine double-cuffing arrangements for category C prisoners on routine escorts was disproportionate.

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

3.42 There had been 10 self-inflicted deaths since our last inspection and one further non-natural death. Levels of self-harm had started to reduce recently but were still very high. There had been 626 incidents of self-harm during the previous 12 months compared with 532 before our last visit. This represented 1,636 incidents of self-harm per 1,000 prisoners which was the highest of all comparable prisons.

3.43 In our survey, 77% of prisoners said that they had a mental health problem against the comparator of 60%. The number of prisoners who said they had arrived at Exeter with drug or alcohol problems (36%) was similarly considerably worse. We found prisoners with high levels of need struggling to cope with long periods locked up in poor conditions compounded by a much-reduced regime and lack of access to basic items such as a towel and their permitted phone numbers. Prisoners told us that these frustrations and a perceived lack of care from some staff led to increasing thoughts of self-harm.

3.44 Staff identified such prisoners well and a large number of ACCTs (assessment, care in custody and teamwork case management of prisoners at risk of suicide or self-harm) were put in place. From the beginning of 2022, 475 ACCTs had been opened compared with 851 in the previous year. Governance and oversight of the ACCT process were improving and leaders had focused on staff training and had introduced a sound quality assurance procedure which was starting to drive improvement. The quality of ACCT documents and particularly care plans remained inconsistent, with some very good and very weak examples.

3.45 Investigations into serious incidents of self-harm and near misses took place after each incident and were of good quality.

3.46 Defensible decision logs were set up for prisoners who were segregated while on an ACCT and these were regularly reviewed by leaders. The quality of care plans and ACCT documents was generally better for prisoners in crisis located on the segregation unit.

3.47 There was good multi-agency attendance at the monthly safer custody meeting and a good range of data was used to identify trends in self-harm. A detailed consolidated action plan contained suitable actions to try to reduce self-harm levels and address the concerns of agencies such as our Inspectorate and the Prisons and Probation Ombudsman.

3.48 This monthly meeting linked with the safety intervention meeting which discussed every instance of self-harm over the previous week and checked that appropriate support arrangements had been put in place and amended where necessary.

3.49 The head of safety had recently taken up post and was working to improve the quality of ACCT documentation, with a strong focus on staff training and awareness. Some of the improved processes and learning had yet to be fully embedded.

3.50 At the time of the inspection, there were eight Listeners, who were trained by The Samaritans to support fellow prisoners in crisis. The Listeners were helped by the local Samaritans who attended each week to offer support. However, Listeners told us that they sometimes struggled to get access to prisoners who needed them, with staff reluctant to unlock the prisoner or ignoring the request of the prisoner to see a Listener.

3.51 Peer mentoring was well developed. Six THREADS mentors were in place, a scheme run in the local area to help prisoners in crisis and at risk of self-harm. The mentors offered support to prisoners focusing on trust, hope, resilience, empathy, action, direction and strength. There were about 30 prisoners on the mentors' caseloads at the time of the inspection and a further 40 had received support through this innovative scheme.

3.52 A purpose-built constant supervision cell was located on A4. It contained safer furniture and a photochromatic door which allowed staff to observe the occupant while allowing privacy when required. The practice of using special accommodation in the segregation unit for constant supervision had ceased, which was good.

3.53 At the time of the inspection, a prisoner was on constant supervision. Staff were aware of his risk factors and observed him appropriately. It was good to see that the prisoner had been provided with a television to alleviate boredom.

Protection of adults at risk (see Glossary)

3.54 There was a good adult safeguarding policy that informed staff of their legal obligations and duty of care and appropriately signposted them to the local authority if they felt they needed to report a lack of care for any vulnerable adult.

3.55 The previous deputy governor remained part of the Devon adult safeguarding board but was due to be replaced by a prison representative.

3.56 Social care links with the local authority were good and staff were aware of how to make a referral if they felt a prisoner needed a social care assessment. The local authority responded quickly to referrals and we saw evidence of the positive impact of the support they provided with wheelchairs and other specialist equipment needed by prisoners.

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, only 63% of prisoners said that staff treated them with respect – these results were similar to those at the previous inspection and at other reception prisons. It was encouraging that 70% of prisoners in our survey said there was a member of staff they could turn to with a problem. Most prisoners we spoke to described staff as respectful, while a minority felt that some staff could be hostile. Relationships were undermined by weak systems and processes which meant that staff were often unable to resolve legitimate requests.

4.2 We observed mostly polite interactions, but they were generally transactional. Staff were not supervising prisoners effectively at key times including domestic periods and outside exercise. Some staff were cross deployed from other areas of the prison and were not familiar with the prisoners or the routines, which caused tension.

4.3 The key worker scheme was not operating, which hindered the establishment of meaningful relationships between staff and prisoners. This was a missed opportunity to address the frustrations of many prisoners and to support their progression while in custody.

4.4 Leaders had introduced and enhanced several peer worker roles, for example THREADS (see paragraphs 3.51 and 6.24), safer custody, prisoner information representatives and Shannon Trust mentors (providing peer-mentored reading plan resources and training to prisons). Prisoner representatives felt well supported in their roles and a dedicated member of staff provided oversight. Prisoner information representatives were not available on all wings and had limited access to the forms they needed to carry out their role.

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 Several substantial projects were in progress at the time of our inspection with further plans to refurbish A and C wings. This would include new cell windows, which were much needed. At the time of our inspection, 85% of prisoners were living in shared cells designated for one. The condition of the cells was poor: many had no glass in the windows, exposed electric wires and floors in need of repair and some cells had mould.

Cell with damaged window and floor

4.6 In recent months residential leaders had implemented a range of checks to try and improve standards on residential units. This was still being embedded at the time of the inspection and was yet to have a meaningful impact on living conditions.

4.7 In our survey, 60% of prisoners said that communal areas were normally clean compared with 44% at the previous inspection. Our observations confirmed the improvement.

4.8 Most of the shower facilities had been refurbished since our last inspection, with the refurbishment of A wing still in progress. The refurbishment was to a good standard, but it was disappointing that some showers on C wing were damaged and already in need of repair, with stall doors removed. Access to showers during prisoners' domestic period each day was reasonable, and 74% said in our survey that they had daily access to showers.

4.9 The lack of access to their stored property was a key frustration for prisoners. They could apply to wear their own clothes but had to use prison-issue clothing while they waited for a response and access to their property. Sufficient stock had been purchased to make sure there was an adequate supply, but in our survey only 43% of prisoners said they had enough clean, suitable clothes for the week against 59% at similar prisons. Prisoners faced difficulties getting their clothes from reception. Laundry arrangements were intermittent and A wing did not have any facilities at the time of the inspection. Some prisoners were hand washing clothes in their cell with equipment provided by staff, which was unacceptable.

4.10 Only a fifth of prisoners in our survey said that their cell bells were answered within five minutes. Cell bells were ringing continuously, particularly on C wing, and were symptomatic of prisoners being locked up for long periods with issues unresolved. Some oversight was provided by a monthly assurance check by leaders of 10% of cell bells within a timebound period and an investigation of those that had not been answered within five minutes.

Residential services

4.11 In our survey, 46% of prisoners said the food was good or very good, which was similar to the previous inspection and comparator prisons. Prisoners chose their meals from a varied menu on a four-week rolling cycle. The winter menu was in place at the time of the inspection which included a hot option at lunch. Prisoners were consulted about food through surveys, wing forums and separate consultations. These consultations had resulted in some changes to the menu, which was good.

4.12 The main kitchen was clean and well organised, with medical and religious diets catered for. Food coming from the kitchens was not labelled and servery workers had difficulty in identifying some of the meals. Wing serveries were poorly supervised; staff often stood outside the servery area where they could not see inside. The serveries were not always cleaned after use.

Wing servery with old food

4.13 All meals had to be eaten in cells, with no opportunity for prisoners to eat together. On D wing there was a toaster and microwave for prisoners to use, but on other wings these were only available to the servery workers.

4.14 The shop was accessible each week, although new arrivals could wait up to 10 days for their first order. Several catalogues were available for prisoners to buy items. In our survey, 55% of prisoners said the shop sold what they needed.

Prisoner consultation, applications and redress

4.15 The rate of complaints had remained similar to the previous inspection, with an average of 54 a month. Almost half of those submitted concerned property (see paragraph 4.9). Most responses were polite and appropriate. Leaders had put quality assurance in place and the independent monitoring board also provided independent scrutiny, which was good. Leaders had taken action to improve the timeliness of responses. As many as 37% of responses to complaints had been late each month, but this had improved recently and had reduced to 16% a month.

4.16 Consultation arrangements had been inconsistent. There had been very limited consultation until spring 2022, but this had recently improved with the reintroduction of wing forums at which attendance varied. A wing was well attended by several departments while the D wing forum was almost always attended by only one member of staff. Forums did lead to some change and, if prisoners' requests could not be supported, a rationale was given. There was no formal mechanism to share information from the meetings with the wider population.

4.17 The implementation of electronic kiosks had improved the application process. More than 5,000 applications were received in an average month. Leaders had some oversight and most responses to applications were timely. We reviewed a small number of responses which were appropriate.

4.18 In our survey, only 34% of prisoners said it was easy to communicate with their legal representative compared with 45% at similar prisons. This was particularly significant as just over half the population were unsentenced. Leaders needed to do more to understand these perceptions. Legal visit arrangements were adequate and a new video court facility was being built at the time of our inspection, which would enhance the service. The library held a range of legal texts and prison service rules and instructions. Prisoners had access to a bail information officer.

Equality, diversity and faith

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) and any other minority characteristics 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.

Strategic management

4.19 The strategic management of equality and diversity had improved. An up-to-date policy described the legal responsibilities of the governor and his team and how the policy would be achieved. There had been consultation with prisoners, but the policy was not informed by an up-to-date needs analysis of the population.

4.20 The equality lead was relatively new to the post and had made an impressive start. Monthly equality action team (EAT) meetings were well attended and a wide range of data were discussed which enabled leaders to investigate and address areas of potentially disproportionate treatment. Actions were tracked at each meeting and rated according to priority, and a high proportion of actions were completed. Each member of the senior management team led on consultation and activity for one of the protected characteristic groups (see Glossary). This was not yet fully embedded and some groups had not yet been consulted.

4.21 Discrimination incident report forms (DIRFs) were available on each wing and were collected three times a week by equality staff which helped to maintain the integrity of the process. During 2021 36 DIRFs had been submitted and 25 DIRFs had so far been submitted during 2022. The quality of DIRF responses was very good. Each of the sample of DIRFs that we viewed had been thoroughly investigated in a

timely manner with an appropriate response that answered the complaint. As an example, one DIRF was from a trans prisoner who complained that the range of goods on the canteen list did not meet the needs of trans prisoners. This was upheld and rapidly rectified.

4.22 Quality assurance of DIRFs was also good. The governor and the equality lead viewed all responses and provided feedback, and independent scrutiny was carried out by Be the Change, an independent charity, which viewed all DIRFs and provided a written report.

4.23 There were two equality representatives at the time of the inspection who routinely attended the EAT. These prisoners were available on the wings to support prisoners who identified with one or more of the protected characteristics.

4.24 Leaders had identified the need to improve staff knowledge of diversity issues and were delivering training. A good staff induction booklet was issued that gave details of each of the protected characteristics and was a helpful resource.

Protected characteristics

4.25 In our survey, the perceptions of black and minority ethnic prisoners about their treatment by staff differed from that of white prisoners in a few key areas. Only 32% of black and minority ethnic prisoners said that most staff treated them with respect compared to 69% of white prisoners. Only 26% said they had not experienced bullying or victimisation by members of staff compared with 61% of white prisoners. No black and minority ethnic prisoners said they had been encouraged to keep in touch with family and friends compared to 27% of white prisoners, a particularly poor statistic.

4.26 Black History Month had recently been celebrated with several cultural events taking place throughout the month which prisoners had helped to plan. The events included local guest speakers and varied cultural meals, and all were well attended and appreciated by prisoners.

4.27 At the time of our inspection, there was one transgender prisoner, although the prison regularly received prisoners at varying points in their transition. Prisoners were encouraged and supported to live in their acquired gender and leaders had a good understanding of their needs and rights.

4.28 Transgender case boards were held regularly and prisoners told us that they were supportive and a good forum in which to discuss any concerns that they had. This was reflected in the minutes of the meetings that we viewed.

4.29 Advice had been sought from a nearby female prison on items that may be needed by trans prisoners and where to source them. These items were made available to trans prisoners on request. We noted recent

correspondence from a trans prisoner who expressed thanks and feelings of inclusion while at Exeter, which was positive.

4.30 Prisoners with a physical disability usually lived on F wing which had good access to appropriate amenities, but this was temporarily closed for refurbishment. Prisoners with similarly poor mobility who needed to be separated from the main population were usually located on B2 landing but this was also being refurbished, and all prisoners with mobility difficulties were located on A2.

4.31 The wing facilities did not provide easy access to the exercise yard and it was difficult for these prisoners to experience a full regime. We witnessed these prisoners being almost carried down steps by their peers to have some time outside. Prisoners who should have been located on B2 landing had a worse experience and spent longer periods in their cells locked up with their meals delivered to their door for their own protection. One prisoner told us that he regularly missed exercise and collecting his medication. His in-cell phone was broken, he was not offered access to the library and his television reception was poor, leaving him with little to do while locked in his cell.

4.32 Social care was good and we saw suitable adaptations to cells and specialist equipment to help prisoners cope in their cells. In contrast, we observed prisoners with poor mobility sitting on hard plastic chairs in their cells.

4.33 There was one buddy, a prisoner peer mentor trained to support prisoners with a physical disability. He helped some prisoners, but demand was too great.

4.34 Personal evacuation plans were in place and staff knew where they were located on the wing. The plans were detailed enough for staff to know what had to be done for each prisoner in the event of an emergency.

4.35 There were 34 foreign national prisoners at the time of the inspection. Immigration enforcement staff were available on site and met prisoners to give them information on their case and deportation status.

4.36 Little information was displayed around the prison in languages other than English. The Big Word was used to interpret during initial reception but otherwise it was infrequently used. Most areas did not have access to a speaker phone to facilitate interpreting, although some were on order.

4.37 Foreign national prisoners who did not receive visits could claim five pounds additional phone credit each month to contact their families.

4.38 Considerable efforts were being made to include prisoners and staff from the LGBT community. Links had been formed with Plymouth Pride and staff had a representative in the Pride in Prison and Probation consortium which offered support to staff identifying with this protected

characteristic. These links were improving staff knowledge about this group.

4.39 This work was not yet embedded, and no consultation had taken place with groups of LGBT prisoners to address their concerns or understand their perceptions of life at Exeter.

4.40 Good innovative support was given to prisoners with neurodiverse needs. A staff member with expertise in this area worked an additional day each week specifically to support this group. A neurodiversity support manager had recently been recruited to improve outcomes for this group in areas such as first night.

4.41 In our survey, 3% of respondents identified as coming from the Gypsy, Roma, Traveller community. Little additional support was available for this group and no consultation had taken place to address their needs.

4.42 Younger prisoners were well supported, particularly those under the age of 21. A youth engagement worker had been employed who regularly met and supported this group. Leaders felt that this had had a positive impact on the behaviour of this group and planned to expand the work to all under 25s.

4.43 The youth engagement worker also delivered the Kintsugi Hope programme, which was designed to help prisoners cope with mental health conditions and anger management and develop resilience. Eight prisoners were engaged in this programme at the time of the inspection.

Faith and religion

4.44 A dedicated team of chaplains provided good pastoral care to prisoners. Chaplains were also available to enable worship for the less common faiths.

4.45 All prisoners had equal access to corporate worship each week regardless of their location or status, and the number of prisoners taking part was increasing.

4.46 The chaplaincy saw each prisoner on the segregation unit every day and others highlighted to them by application or by staff. They attended each ACCT review and saw prisoners on ACCTs each week. They hoped to increase the frequency of these visits.

4.47 Bible study classes were held each week and the chaplaincy conducted bereavement counselling sessions for prisoners who had lost a family member or friend. The chaplaincy supported Changing Tunes (a charity which uses music and mentoring to help prisoners lead meaningful, crime-free lives) which allowed prisoners to express themselves using music as a medium to decrease frustration.

4.48 The chaplaincy oversaw a good prison visitors' scheme, a group of volunteers who visited prisoners who did not receive visits from family

or friends. Prisoners were very appreciative of this service and it was well used.

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.

4.49 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 utilised their powers under Section 64 of the Health and Social Care Act 2008 to gain evidence to assess the standard of the care being provided to the service users and to ensure the safety of care being delivered until the health provider's contract end. The provider deregistered for the regulated activities at the location shortly after the inspection and the service was transferred to a new provider.

Strategy, clinical governance and partnerships

4.50 Practice Plus Group (PPG) was the prime provider of health care services and some specialist services were subcontracted. Devon Partnership NHS Trust (DPT) delivered mental health services. The health care contract was due to transfer to Oxleas NHS Foundation Trust on 1 December 2022.

4.51 Partnership working between provider, the prison and key community stakeholders such as NHS England was focused on the transition of health care services to the new provider. Regular Local Quality Delivery Board meetings were held but had failed to identify and mitigate all risks to patient safety.

4.52 Long-standing issues with health care delivery had been exacerbated by the imminent transition of health care services to the new provider. Senior clinical leaders were not present on site and staff did not always feel supported by senior managers.

4.53 Chronic staff shortages in all areas had compromised the delivery of care and support to patients and services had to be prioritised each day to cover essential and urgent care. We observed a fragile staff team working under significant pressure and difficult circumstances, although health care practitioners clearly knew their patients well and treated them with dignity, kindness and respect.

4.54 Compliance with mandatory training by clinical staff was good, but there were gaps in the documentation of clinical supervision and irregular management supervision. This meant that potential risks to patient care or service delivery were not readily identified and addressed.

4.55 Leaders had oversight of incidents and a recently developed patient safety group meeting had started to identify themes from incident reports. There was a positive reporting culture and high numbers of incidents were reported. Learning from incidents was shared with clinical staff through daily handover meetings or during supervision.

4.56 Some clinical audits were taking place and appropriate actions taken when concerns were identified. We considered that managers did not have good knowledge of the Prisons and Probation Ombudsman's recommendations concerning deaths in custody and some actions remained outstanding, which was poor.

4.57 The provider operated a confidential health care complaints system with forms and boxes available on all wings. Concerns were resolved verbally within five working days in line with the provider's policy, which was good. The patient engagement lead saw all patients who raised a concern promptly to resolve their issues face to face and this had received positive feedback from patients.

4.58 Three formal complaints were outstanding at the time of inspection, all of which had exceeded the provider's response times. Managers were aware of these cases, all of which involved complex issues covering multiple sites which had affected the response times.

4.59 The patient engagement lead had started to develop communication with prisoners through a regular health care newsletter, face-to-face meetings and the use of patient surveys. This had proved extremely valuable in explaining the challenges of service delivery.

4.60 Clinical environments were generally clean and met infection prevention and control standards. There were continuing concerns about the fabric of the building which were outside the provider's control.

4.61 All staff used SystmOne to feed into a single electronic medical record for patients. Records that we reviewed were of a high standard with some good quality care planning for patients.

4.62 Appropriate emergency equipment was maintained and checked regularly. Clinical staff received the required training to respond to medical emergencies and prison staff told us that the health care team responded promptly.

Promoting health and well-being

4.63 There was no overarching local health promotion strategy, but health promotion material was visible across the prison. All the posters were in English, no information was available in other languages and a lack of 'easy read' material prevented some patients from accessing literature that met their needs.

4.64 A range of prevention programmes, including bowel cancer, aortic aneurism and retinal screenings, had restarted. NHS age-related health checks were offered inconsistently because of staff levels.

4.65 Screening for blood-borne virus had continued throughout the pandemic and patients who tested positive for Hepatitis C received prompt referral to local specialists.

4.66 A sexual health screening took place at reception and was followed up by a lead nurse who offered further investigation and treatment. There were established links with community specialist clinics if required, which was good.

4.67 The COVID-19 booster clinic had started and the flu vaccination programme had identified high-risk patients who were also offered the vaccine. There were 133 patients on the COVID-19 waiting list, which included some who had not started the course. Staff continued to encourage vaccination at every contact which was good.

Primary care and inpatient services

4.68 All new arrivals received an initial health screening from the primary care team. Secondary health assessments were not always timely which presented a missed opportunity to identify patient need. Patients who did not have English as their first language were not routinely offered the use of telephone interpreting and we were not confident that patient need was safely identified.

4.69 Staff were flexible in their approach and routinely delivered some community-based services on the wing. Applications were placed on the appropriate waiting list before being triaged by the relevant clinician. At the time of the inspection, 50 patients were on the waiting list for the nurse clinic with no effective triage structure and a maximum wait of 18 days, which was too long. This was raised with managers who took prompt steps to address the concern. Access to health care appointments varied because of the availability of prison staff.

4.70 In our survey, only 12% of respondents said that it was easy or very easy to see the GP. Patients requesting a routine GP appointment had to wait up to two weeks, although urgent appointments were facilitated much more quickly based on clinical need. Out-of-hours GP provision was in place and equitable with the community.

4.71 Patients who had long-term conditions and/or complex health needs did not always receive their review in a timely manner, which was poor. Staff endeavoured to complete individual annual reviews and, where that had happened, there were good quality care plans that demonstrated patient involvement.

4.72 The palliative care suite had been closed during the prison refurbishment and patients from Exeter and other local prisons had lost the opportunity to be cared for in an appropriate environment. Health care had maintained links with local specialist services in case of need.

4.73 The administrative oversight of external hospital appointments was good. Some appointments were cancelled because community hospitals were unable to facilitate the appointment or because of

operational issues in the prison. We were assured that the appointments were rearranged. Waiting times were in line with the community, which was appropriate.

4.74 Patients were seen before release and medication was supplied as required. Condoms were not automatically offered before release, which was a missed opportunity to minimise harm.

Social care

4.75 Social care arrangements were well established with Devon County Council. Need was identified on reception and monitored by safer custody, the health team and other professional groups. The referral pathway was clear and referrals received a prompt response.

4.76 Assessments occurred in a timely fashion and the local authority occupational therapist visited the site regularly. Staff providing personal care knew their clients well and were dedicated and caring. Detailed care plans were in place and patients valued the support provided.

Mental health care

4.77 The delivery of individual care to some patients was good, but overall access to mental health services was poor and some patients waited too long for a mental health response or did not receive the care they needed.

4.78 There were considerable and unsafe gaps in the allocation, skills and experience of staff. The stepped care model was not fully implemented. The provision of self-help materials for patients was good and appointments with the consultant psychiatrist were available in a timely manner. Psychological care at level four and above was inadequate because there were a number of vacancies in the psychology service. Patients with complex needs were not served well and waited longer for treatment or received no treatment before release.

4.79 Kind and caring nurses focused on managing urgent (within 48 hours) and routine (within five days) referrals and their involvement in ACCT reviews was good. Not all reception screenings included members of the mental health team and some patients' needs were not appropriately identified at the earliest opportunity. 'Early days in custody' practitioners responded well but only on request from the primary care team. Many referrals were generated through an open referral system after patients had arrived on the wings, creating even more delay.

4.80 Care plans were relevant and well documented, but the discharge pathway was poor and lacked a consistent approach. In some areas patients were unable to access the community mental health team (CMHT) on release if not registered with a GP. Reconnect, a community-based service, provided good support for newly released prisoners who did not meet the threshold for CMHT.

4.81 Patients with learning disability, autism and ADHD experienced a substantial level of unmet need. Care for people with neurodiverse needs and those with dangerous and severe personality disorder was underdeveloped and under-resourced. Staff tried their best to deliver basic therapeutic care in an environment that was wholly unsatisfactory and at times unsafe.

4.82 Joint working was observed between the mental health team, substance misuse and primary care team at the weekly multidisciplinary complex care meeting. However, despite several complex and high-risk individuals being under review, arrangements were not adequate to address the level of clinical risk fully. Senior clinicians had not yet resolved the high degree of clinical risk associated with one individual.

4.83 The service achieved the 28-day limit set out in NHS England's good practice guidance for transfer of patients to mental health hospitals.

Substance misuse treatment

4.84 Clinical and psychosocial services were both operating with staff vacancies. Clinical substance misuse staff were routinely required to facilitate medicines administration, limiting their time for clinical substance misuse assessments and reviews to only three hours a day. As a result, initial assessments and reviews of those receiving clinical treatment were frequently delayed, which was poor.

4.85 Patients disclosing previous or current substance or alcohol misuse were seen by a GP on their day of arrival. Following assessment of any withdrawal symptoms, GPs started alcohol detoxification or opiate substitution therapy where appropriate. Patients who started prescribing regimes were not routinely seen twice a day for clinical observations in line with national guidance on drug misuse and dependence (known as the Orange Book), and care plans instigated by the GP to review patients overnight were not always followed. This meant that patients were not appropriately monitored for signs of change or deterioration which posed a risk to their safe care and treatment.

4.86 Psychosocial support for patients was good. Despite operating with some vacancies, recovery workers saw all new arrivals to encourage engagement with the service and anyone was able to refer to the service subsequently if they did not wish to engage from reception. Group work had ceased during the COVID-19 pandemic and, despite attempts to reintroduce groups, there had been minimal attendance and engagement by patients. To mitigate the absence of group work, a comprehensive range of one-to-one interventions were delivered by the team.

4.87 Release planning work was started by recovery workers at the earliest opportunity and comprehensive work was undertaken to make sure that patients received continuity of care on release. Naloxone was offered to all patients before their release and all those on the

substance misuse caseload were offered training in the use of Naloxone, which was good.

4.88 Clinical treatment of opiate addictions was evidence based and approximately 70 prisoners were in receipt of opiate substitution therapy (OST) at the time of the inspection. A temporary arrangement was in place for a non-medical substance misuse prescriber (NMP) from a nearby prison to support the service two days a week. The NMP was available to prescribe remotely when not on site, but this was not enough to meet the demands of the remand population or the high level of need among patients.

4.89 The administration of OST was efficient, but the management of queues and observation by prison officers was inconsistent. We observed many opportunities for the trading of medication because of a lack of observation by officers.

Medicines optimisation and pharmacy services

4.90 Medicines were supplied by a nearby prison with a registered pharmacy and were administered from treatment rooms on the wings. Prescribing and administration were completed on SystmOne and prescriptions were clinically screened by pharmacists at the supplying prison to provide oversight and support.

4.91 There were a large number of vacancies in the team which limited the services that could be offered to patients. A pharmacist came to the prison twice a month which provided staff and patients with limited support. The pharmacist did not offer any clinics or face-to-face medication reviews.

4.92 Medicines were administered four times a day on the wings by pharmacy technicians and nurses. Separate hatches were used for the supply of opioid replacement medicines and all other medicines. Some queues were well managed and patients were given privacy at the hatch, but this was not consistent throughout the prison.

4.93 Medicines were stored appropriately in the pharmacy and on the wings. Controlled drugs were well managed and audited at regular intervals. Medicines were stored and transported through the prison securely. Cold-chain medicines were kept in suitable fridges which were continuously monitored.

4.94 An in-possession risk assessment was completed for the majority of prisoners on arrival which was reviewed after three months, if not before. This was good practice. However, there were occasions when the in-possession risk assessments were not followed and the reasons for this deviation were not always recorded, which was poor. Patients were supplied with seven days of medicines in possession which was a missed opportunity when a longer period would have enabled the patient to develop self-management of their medication.

4.95 Patients leaving the prison were given either a seven-day supply of their medicines or a prescription. There were arrangements to manage the discharge process and make sure that patients were linked with a prescriber on release, which was good.

4.96 The pharmacy recorded and reviewed any errors in order to learn from them. Members of the pharmacy team attended monthly medicines management meetings with colleagues from other areas of the health care team to support safe practice, which was good.

4.97 The prescribing of some abusable medicines and high-cost medicines was monitored, which was good.

Dental services and oral health

4.98 The dental health service was well organised with a clear model of service and good governance. At the time of the inspection, the service was dependent on agency nursing support while awaiting the professional re-registration of its permanent member of staff.

4.99 Dental access and waiting times were affected by the availability of prison staff to escort patients to their appointments. Patients provided good feedback with consistently high levels of satisfaction once they had attended the service.

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 activities which support their rehabilitation.

5.1 There were not enough activity spaces for all prisoners to be employed full time, but there was capacity for all prisoners to be engaged in purposeful activity at least on a part-time basis. Despite this, only 47% of the population were allocated to work, education or activity and the remainder were unemployed or retired. This was exacerbated by not all prisoners attending their allocated work. During roll checks that we undertook during work periods, we found only 28% of prisoners in purposeful activity including just 19% working off the wings, while the remainder were employed in domestic activity on the wings.

5.2 In these circumstances, prisoners spent long periods locked in their cells with limited opportunities to engage in purposeful activity. An unemployed prisoner received two and a half hours a day out of their cell which entailed an hour in the open air and a 90-minute domestic period for showers, time on the kiosk and association. If prisoners chose not to take time in the open air, then this time would be spent behind their cell door. Employed prisoners could be unlocked for between four to six and a half hours a day.

5.3 Leaders had implemented a daily regime that did not maximise prisoners' time out of cell to engage in activity, for example access to the gym and library was scheduled to take place during the domestic period.

5.4 In our survey, 83% of respondents said they knew the scheduled unlock and lock up times but only 44% said that these were adhered to. Our observations supported this. Unlock in the morning took place late and inaccurate roll counts delayed afternoon activity sessions. Wing cleaning and showers for servery workers were scheduled for the evenings, but staff shortages often prevented this from happening. Prisoners we spoke to were frustrated by the lack of consistency. Leaders did not record curtailments to the regime and the true extent of the problem was not known.

5.5 The hour that was scheduled for prisoners to spend in the open air each day was not always achieved because of the time spent unlocking prisoners and drift in the regime. We observed one period where prisoners were unlocked late and missed 15 minutes of their session.

Exercise yards

5.6 The gym facilities had reduced since the previous inspection with the loss of an outdoor sports area which was now used as an external area for C wing prisoners. The remainder of the gym facilities were in good condition and the showers had been refurbished.

5.7 The gym staff had developed a strategy to encourage prisoners' participation which had increased from 27% to 40% in three months. A survey had been completed to understand prisoners' perceptions and sessions were offered that appealed to a range of prisoners. The quality of delivery was good and prisoners were engaged in the sessions. There was an effective procedure for ensuring equality of access to the gym using the kiosk for applications and gym staff managed attendance robustly.

Gymnasium

5.8 Each prisoner was offered two sessions of gym a week which was sufficient for the existing population but would not be enough if demand increased. There had been no referrals for remedial gym from health care and the timetable offered no specialist sessions.

5.9 The library was centrally located in the prison and, in our survey, 72% of prisoners said that they could use the library at least once a week compared with 54% at the previous inspection and 25% in similar prisons. The library held a good range of books and had recently liaised with the public library in the community so that books could be ordered as required. The library was not spacious enough to deliver activities and there was limited seating.

5.10 Leaders had a reading strategy in place to encourage reading in the prison. The Shannon Trust mentoring scheme was available and there was a book club although access was affected by regime limitations.

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.

5.11 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

What does the prison do well and what does it need to do better?

5.12 The leadership and management team in education, skills and work (ESW) was mainly new in post but had identified correctly that the quality and impact of the great majority of the ESW provision were poor and worse than at the previous inspection. However, nearly all the team's initial improvement activities were a work in progress and so far lacked any impact. Leaders had not yet ensured that all staff understood the practical role they could play in identifying and eliminating weaknesses in the quality of provision.

5.13 While leaders were resilient and focused rightly on tackling day-to-day operational problems, they made little use of the data readily available to help them monitor and manage performance effectively. Their short-term improvement actions were well intentioned but too often failed. This was usually due to factors such as insufficient staff, a lack of funding or as a consequence of frequent destabilising changes in management. Managers' attendance at the monthly quality

improvement group (QIG) had declined during the previous six months. In that time, few of its proposed actions or priorities had been achieved. Timelines for completing tasks were regularly pushed back. The QIG's agenda largely duplicated those of other internal prison monitoring groups. Consequently, the QIG had progressively lost its previously distinctive role. There was now no effective forum for monitoring the quality of the ESW provision.

5.14 Despite the challenges they faced, ESW leaders were determined to effect improvement. An important first step was a comprehensive, honest and largely accurate evaluation of the ESW provision which confirmed the many weaknesses and comparatively few strengths in this area. Leaders were using this self-assessment well to prioritise change and improvement actions. This included plans to change the focus radically and extend the breadth of the curriculum so that prisoners would be better equipped to gain employment on release.

5.15 Notionally, there were sufficient activity spaces at the time of the inspection to provide at least part-time purposeful activity for each prisoner. However, most did not want to be involved in it at all and a large proportion were content to socialise companionably with peers on the wings during the working day without challenge by leaders.

5.16 Most wing staff did not understand the importance of education, skills and work. As a result, they did not prioritise getting prisoners off the wings and engaging with purposeful activity. Most prisoners' understanding and appreciation of the value of purposeful activities were poor. Despite the inducement of a generous rate of pay for attending education classes, very few prisoners chose to do so.

5.17 Leaders had not changed the curriculum offer for many years even though they recognised it was 'stale' and lacked appeal. The number and range of courses offered had reduced progressively over time and what was offered was not always available. For instance, courses in basic information technology and some mathematics and English lessons were not running during the inspection. There was just one vocational training area operating, which only provided a level 1 course in painting and decorating. Learners in this workshop were not supplied with any suitable protective equipment such as overalls and safety footwear. This practice did not meet industry standards.

5.18 Leaders had not ensured there was a sufficient range of education and training courses which met prisoners' varied needs, not least the substantial number of prisoners with learning difficulties and disabilities (LDD), those serving longer sentences or nearing release. For example, prisoners on longer sentences had scant opportunities, other than in mathematics and English, to progress to higher level learning and gain meaningful qualifications in education or skills. No prisoners were following an Open University or distance learning course.

5.19 The arrangements for identifying and assessing LDD learners during induction were ineffective. Managers did not carry out timely or effective LDD assessments so many prisoners who needed support did

not get it. Prisoners could complete a self-declaration of their LDD using a 'Rapid Screener' but this was too complex for most of them and few were able to complete the test accurately.

5.20 Teachers and trainers were rarely made aware of learners' assessed skills in English and mathematics when they started in education so could not plan learning accordingly. As a result, most teachers ran the initial and diagnostic assessment processes again. This duplicated effort unnecessarily but provided a more accurate profile of their skills. Nevertheless, it disrupted others' learning.

5.21 Leaders had recently appointed additional staff to eliminate a very large backlog of prisoner inductions to education. While the backlog was reducing, it was still substantial with a large number of prisoners having received no initial advice and guidance sessions several weeks after arriving at the prison.

5.22 The ESW induction sessions were ineffective. Prisoners' attendance and punctuality at the sessions were poor. The induction was brief and did not cover education, skills and work opportunities in sufficient depth. Prisoners were left unconvinced of the point of the provision. Managers did not use peer mentors to provide prisoners with first-hand endorsements of the value of purposeful activity.

5.23 During prisoners' assessment of their English and mathematics skills, managers invited them to self-select courses they might wish to do. This was before they had received independent careers advice. As a result, some prisoners had already enrolled on an unsuitable course providing no opportunity for career progression. Few prisoners received focused careers advice before release.

5.24 Staff took no account of prisoners' reading abilities during induction. Prisoners were asked to read, complete, sign and date several closely worded documents without reference to their ability to understand the content. Leaders did not have accurate data about prisoners' reading skills, particularly those with the least ability. Although leaders had devised a reading strategy, its full implementation was not planned until later in the year, which was too slow. Few staff knew much detail of the strategy, nor had there been any training in phonics or the use of reading diagnostic tools for use in initial assessment.

5.25 The allocations process to ESW was chaotic and poorly managed. On a daily basis, teachers often did not know which prisoners were going to be at what session, when or why. Too many prisoners were simply sent to a session without having requested to do so. Prisoners' attendance at sessions was routinely poor, being on average rarely more than half of those allocated.

5.26 Insufficient teaching staff were available to ensure that managers could schedule all classes in education routinely or provide cover for staff holidays or illness. Too many education and workshop sessions were cancelled due to a lack of staff, often at the last minute. This demotivated the allocated attendees.

5.27 The relatively small number of prisoners who did attend education or workshop sessions were generally attentive, ready to work and well behaved. The standard of their work was good, notably in art and English. Teachers provided prisoners with constructive feedback about how to improve their work further. The accredited Twinning project with Exeter City Football Club successfully increased learners' confidence and employability skills. The virtual campus (prisoner online access to community education, training and employment opportunities) was greatly underused.

5.28 Staff in the two industry workshops had created a calm and purposeful environment in which prisoners felt safe. Prisoners focused well on their mostly mundane tasks and took pride in their work. The ESW provision for vulnerable prisoners was the sole activity area in the prison where most prisoners allocated attended routinely and punctually. Teachers and workshop staff did not promote equality and diversity and British values and prisoners had only a limited understanding of these aspects.

5.29 The proportion of prisoners starting a course and achieving the intended qualification was very low. This was notably the case in English and mathematics. Far too many prisoners were being allocated to accredited courses they did not have the time to complete. However, most of the relatively small proportion who saw a course through to its planned end date achieved the target qualification.

5.30 Prison records showed seven prisoners enrolled in English classes who had left the prison. Allocations staff were unaware of this and new prisoners had not been allocated to fill these seven spaces. A large number of prisoners who had completed a personal and social development or construction course were still awaiting their certificates. Almost all of these had since left the prison and it was unclear when or if their certificates would reach them.

5.31 Leaders and managers from the education provider, Weston College, had not focused strongly enough on working with the prison to maintain or improve the provision. None of the recommendations at the previous inspection identified for the College's action had been achieved. Specifically, the education provider had made no progress in broadening the curriculum to meet the needs of a wider range of prisoners or improving prisoners' skills in using English, mathematics and ICT to enhance their resettlement prospects. Most teachers aimed to teach sessions effectively, but too few learners attended or benefited. Management of the education department had been through several disruptive changes since June 2022.

Section 6 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.

Children and families and contact with the outside world

Expected outcomes: The prison 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 Support for prisoners to maintain or rebuild family ties was in transition. The contract for family support work had been taken on by Prison Advice and Care Trust (PACT) not long before the inspection. A family engagement manager was available to prisoners and their families and managed the small visitors' centre. They had yet to start individual casework with prisoners and their families and family days had not yet been reintroduced which was later than at some other prisons. Planning was under way for both these elements of family support.

6.2 Physical arrangements for visits were also undergoing change. A new visits centre was being built and the temporary visits venue limited the number of visits that could take place at a time to 10 which was low for the population. The new building would be a much-improved facility but, pending its opening, the visits offer was basic, for example refreshments for visitors and prisoners were limited and there were no toilet facilities for prisoners. It did, however, enable prisoners to have some face-to-face contact with family and friends.

6.3 We saw staff who were uncertain about the start time of a visits session that we observed. This was reflected in our survey in which only 15% of prisoners said that visits usually started and finished on time.

6.4 There were reasonable arrangements for prisoners to have other types of contact including Storybook Dads (prisoners record a story to send to their children) and volunteer visitors organised by the chaplaincy. Post and email-a-prisoner processes were efficient and secure video calling (see Glossary) was in use through laptops on the wings. Prisoners appreciated in-cell phones but had experienced delays in adding numbers to their list of contacts when they arrived (see paragraph 3.7). Additional welfare calls were not offered to mitigate this. A backlog of more than 150 applications to have numbers added was addressed during the inspection.

Reducing risk, rehabilitation and progression

Expected outcomes: Planning for a prisoner's release starts on their arrival at the prison. Each prisoner has an allocated case manager and a custody plan designed to address their specific needs, manage risk of harm and reduce the risk of reoffending.

6.5 Strategic management of reducing reoffending work had not been sufficiently focused. The strategy and action plan were not based on a comprehensive analysis of the needs of the population. Minutes of two reducing reoffending meetings during 2022 indicated decent attendance but there were some gaps, for example accommodation had not been discussed at the meetings despite its importance to successful release.

6.6 Useful work was being developed and collaborative working between different agencies (see paragraph 6.19) aimed to deliver improved outcomes for prisoners. Overall, more oversight and coordination of the work strands and monitoring of outcomes were needed.

6.7 The offender management unit (OMU) had benefited from consistent leadership since the previous inspection which supported a strong team ethos and well-embedded work processes. The working atmosphere was positive and supportive and the team had few vacancies. Prison offender managers (POMs) and their case administrators, who were trained across all areas of OMU activity, worked collaboratively to ensure timely completion of time-bound processes.

6.8 POMs and case administrators described in very positive terms an open-door culture in which leaders were approachable and advice was readily available. We saw many examples of cases being discussed with colleagues to achieve the best outcome for the prisoners. Staff showed good knowledge of cases and spoke respectfully about prisoners.

6.9 Allocation of cases to POMs was timely and appropriate. Caseloads were reasonable at up to 30 cases per POM with the more complex and high risk being managed by one of the three probation POMs. Band four prison officer POMs were rarely cross deployed away from the OMU although they could be used at short notice for ACCT reviews or after an incident. In general, they were able to plan their work each day with confidence that they would be able to achieve the planned prisoner contact and complete other tasks.

6.10 All the POMs had regular consistent supervision from the senior probation officer (head of OMU delivery). They described how this supported practice development but also held them to account for contact with prisoners, report completion and other OMU tasks.

6.11 We reviewed, in depth the cases of 20 sentenced prisoners. All had had an assessment of their risks and needs completed within the last

12 months using the offender assessment system (OASys). Eighteen of these had a sentence plan, most of which were of reasonable quality. Progress against these plans was less good and we assessed that half had not made sufficient progress. Typically, targets focused on substance misuse and engagement with the prison regime were achieved more often than others.

6.12 Recorded contact between POMs and prisoners was in the upper range of those seen since we returned to full inspections. In all the cases that we looked at, there had been an introductory contact, typically within the first two weeks, followed by a series of good entries reflecting purposeful contact. Key work was not taking place (see paragraph 4.3) which was an omission.

6.13 More attention had been paid to remanded prisoners than we often see. Most of the 20 remand cases that we selected at random had a basic custody screening tool resettlement plan completed within a week of reception by the pre-release team (see paragraph 6.32) and immediate needs were identified and followed up. Some remand prisoners were further supported by oversight from a POM. These were more complex cases, for example younger prisoners, those with particular vulnerability, on remand for an offence likely to attract a long sentence and all MAPPA nominals (multi-agency public protection arrangements).

6.14 Eligible prisoners could access release on home detention curfew (HDC) and procedures were started promptly. Data provided by the prison showed that 11 prisoners over the previous 12 months had been released after their HDC eligibility dates. Most of these were caused by waiting for community checks to be completed or for a place in Bail Accommodation and Support Service accommodation.

Public protection

6.15 Thirty-eight per cent of the sentenced population were assessed as a high risk of serious harm to others and 32% of those due for release in the three months after our inspection were high risk. The management of risk from prisoners convicted of the more serious offences and within a few months of release was good.

6.16 A monthly interdepartmental risk management meeting provided necessary oversight of higher risk cases. Attendance at the meeting was good and well-informed discussions took place. In addition, a public protection steering group kept prison-wide public protection arrangements under regular review.

6.17 All appropriate prisoners in our case sample had a risk management plan, most of which were at least reasonably good. The weakest plans had been completed by community offender managers and did not pay enough attention to custodial risk.

6.18 Five of the cases involved prisoners who were six to eight months from release and were subject to MAPPA management. Each had sufficient

evidence of the level of MAPPA management being notified and appropriate risk management being discussed by the POM and the COM. The MAPPA information sharing reports (MAPPA Fs) prepared by POMs were timely and good irrespective of the background of the POM who had written them. POM attendance at community MAPPA meetings was consistent.

6.19 An innovative project had been developed after a potential gap in the risk management of remanded high risk of harm prisoners had been identified by OMU leaders. Collaborative working with other criminal justice agencies ensured that risk management arrangements were considered in advance for any such prisoner who could be granted bail or, due to the time spent on remand, was likely to be released immediately from court after being sentenced.

6.20 The processes for identifying prisoners who required contact restrictions or communications monitoring on arrival or subsequently were understood and applied by the OMU team. Staff carried out regular reviews of the need for monitoring using up-to-date lists and monitoring was removed when there was no evidence of continuing need. Leaders responded quickly to any risk of calls not being listened to promptly. The policy of limiting prisoners subject to monitoring to 20 minutes of phone calls each day made it easier to keep up to date with listening to calls but was punitive for the prisoners.

Categorisation and transfers

6.21 Initial categorisation and re-categorisation were timely. Prisoners could make representations and some had attended reviews to share their views. Transfers were prompt for most prisoners but moves to open prisons or a prison in a different area of England or Wales took longer. We were told that over the previous year some category D prisoners had been released before being transferred to an open prison.

6.22 At the time of the inspection, there were 10 indeterminate sentence prisoners including four who had been recalled to custody. All had been allocated a POM with a probation background and electronic case notes showed continuing interaction. Some were waiting for Parole Board input before they could move on from Exeter, others had court hearings or pending police investigations.

Interventions

Expected outcomes: Prisoners are able to access interventions designed to promote successful rehabilitation.

6.23 No accredited programmes were offered which was in keeping with the function of the prison. Work with prisoners was focused on helping them settle into custody or preparing for their release.

6.24 Initiatives such as the peer-led ‘THREADS’ which helped prisoners explore thought processes that could lead to negative actions, the

Twinning Project with Exeter Football Club and a newly introduced 'Link Up Club' (basic living skills) were appreciated by prisoners who took part in them. Leaders placed importance on individual progress and celebration events took place regularly.

6.25 Links between partners involved in supporting rehabilitation were aided by the co-location of most of these services in one area of the prison. They shared relevant information and referred prisoners between teams for the input that they needed. Most were seeing prisoners in person.

6.26 DWP workers attended the prison on most weekdays to see prisoners who requested support. They provided help with existing benefits claims and housing benefits and writing CVs and made sure that prisoners left with appointments at Job Centres.

6.27 A member of staff had recently been appointed to help prisoners get identification and open bank accounts. A prisoner orderly made sure that prisoners were aware of the service. There were no specialist debt advice services other than free advice line numbers on prisoners' pin phones.

6.28 The importance placed on helping prisoners to find employment for their release was demonstrated by the recent appointment of a prison employment lead who was part of the New Futures Network (an HMPPS initiative that brokers partnerships between prisons and employers). Work in progress included POMS sharing vacancies open to prisoners via the kiosks and developing links with potential employers in the area. Targeted job fairs were being planned.

6.29 'Check out' events arranged by the check-out and departure lounge coordinator afforded prisoners opportunities to talk to providers about training, apprenticeships and work options. The same worker also gave help with CV writing, ran the departure lounge (see paragraph 6.35) and regularly facilitated videolink interviews for prisoners with housing providers.

6.30 An average of more than 50 sentenced prisoners were released each month. HMPPS data showed that about 25% of prisoners had been released during the previous year with no accommodation identified when they left the prison despite efforts by staff from different agencies. There were no specialist housing workers on site to reassure prisoners about the work that was undertaken on their behalf and no measure of the sustainability of accommodation that prisoners went to.

6.31 There was no release on temporary licence (ROTL, see Glossary) to help prisoners gain employment, attend housing interviews or rebuild family ties. Leaders were starting to consider how it could be used.

Release planning

Expected outcomes: The specific reintegration needs of individual prisoners are met through an individual multi-agency plan to maximise the likelihood of successful reintegration into the community.

6.32 A small pre-release team assessed the resettlement needs of all new arrivals and referred them to support agencies. Immediate needs, such as claiming housing benefit to maintain housing or letting employers know about their circumstances, were followed up. Informative records of these assessments were shared with all those involved in the prisoner's management and described clearly actions that needed to be taken forward as part of the initial resettlement plan.

6.33 The team was understaffed by one caseworker and, as an interim measure, was not carrying out formal reviews of resettlement plans for low- and medium-risk prisoners 12 weeks before release, which was an omission. Work by other agencies had filled this gap to some extent. DWP workers carried out their own pre-release review, sending a questionnaire to prisoners via wing kiosks 12 weeks before their release. The responses were shared with other agencies. The prison employment lead also made contact 12 weeks before release and led a meeting with relevant services four weeks before release to review what had been put in place.

6.34 Procedures in reception for release included checks of licence requirements, return of stored property and provision of subsistence payments and travel fares. Prisoners said they could change into their own clothes in private and there was a small stock of discharge clothing for anyone who needed it. Prisoners were provided with duffle bags to carry their property.

6.35 The departure lounge coordinator saw prisoners before their release to offer practical support and charge their stored mobile phones ready for collection in reception. The departure lounge in the visitors' centre was open each weekday for prisoners and their families/friends to use. Hot drinks, phones and mobile phone charging facilities were available as well as advice on travel plans and encouragement to get to initial appointments on time.

Section 7 Summary of priority and key concerns

The following is a list of the priority and key concerns in this report.

Priority concerns

1. **National leaders had failed to provide stability of leadership at the prison.** Exeter had had three governors, eight deputy governors and eight heads of safety since our previous inspection. This instability of leadership impeded progress at a high-risk site.

2. **The number of self-inflicted deaths and incidents of self-harm was very high.** Care for prisoners who were vulnerable on arrival or those who were in crisis during custody was poor.

3. **The lack of clinical leadership and chronic staff shortages across the service had a detrimental impact on patient safety and the provision of care, particularly in the area of mental health.** This resulted in practice that did not meet national standards and unmet need for many patients.

4. **Many prisoners spent too long locked in their cells, purposeful activity was not prioritised, and few prisoners took advantage of what was offered, limiting their prospects of rehabilitation and reducing reoffending.**

Key concerns

5. **The level of violence at the prison was high and leaders were unaware of the causes.** Investigations into violent incidents were inadequate and did not inform an action plan to identify and reduce violence among prisoners.

6. **There was no key worker scheme, staff-prisoner relationships were mostly transactional and prisoners were frustrated by the inability of staff to meet legitimate requests.**

7. **The standard of the cells was poor.** Many cells had no glass in the windows, exposed electric wires, floors in need of repair and some cells had mould.

8. **The education, skills and work curriculum was not fit for purpose. It did not provide meaningful or relevant learning or training opportunities which met prisoners' varied needs.**

9. **Leaders and managers had not dealt with the long-standing inadequacies of induction and allocations to education, skills and work.**

10. **The role of the quality improvement group and its impact were now slight and leaders and managers did not use available data well to monitor and manage the quality and impact of the provision.**

11. **Support to maintain family ties was not sufficiently focused on the outcomes experienced by prisoners.** There were no family days, nothing to mitigate delays in adding numbers to prisoners' pin phone accounts, basic interim visits provision and supervising staff who were not confident about visits times.

Section 8 Progress on recommendations from the last full inspection and scrutiny visit reports

Recommendations from the last full inspection

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

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection in 2018, reception procedures worked reasonably well but some prisoners spent their first night in poor conditions. Almost one in three prisoners felt unsafe. The violence reduction strategy had not been effective in reducing high and rising levels of violence. However, the introduction of keyworkers using a casework approach looked promising. The adjudication system was managed fairly. The use of force was high and governance was inadequate. Conditions for the prisoner held in the segregation unit were poor, and there were few safeguards for the prisoners segregated on C1 landing. The drug strategy was not effective in reducing high levels of drugs available in the prison. There had been six self-inflicted deaths since the last inspection, and levels of self-harm were high. Outcomes for prisoners were poor against this healthy prison test.

Key recommendations

All aspects of the violence reduction strategy should be implemented. Supervision, by staff and by camera, should be effective in detecting and preventing bullying and violent behaviour. Engagement with prisoners to understand safety issues should be improved through consultation and targeted key work. There should be greater incentives for prisoners to behave well, and positive visible leadership should focus on creating a culture of optimism and encouragement.
Not achieved

All records of the use of force and authorising the use of the special cell should be completed accurately and in full. Immediate measures should be taken to ensure that all cameras, fixed and body-worn, are used effectively. Documentation and camera footage should be subject to vigorous management checks to identify issues and trends. This should inform actions to address the issues and reduce the number of restraint incidents.
Not achieved

Prisoners who are effectively in unregulated segregation should have adequate safeguards and managerial oversight. All prisoners segregated should have an adequate regime that safeguards their mental wellbeing. The underlying causes of poor or vulnerable behaviour that led to the segregation should be investigated and addressed. Reintegration plans should be thorough and not rely solely on a transfer out of the establishment.
Achieved

Recommendations

Prisoners should spend less than two hours in reception.
Not achieved

Prisoners should be able to shower on their first night in custody, and be located in clean, well-prepared cells.
Not achieved

Induction should start the day after arrival and be completed by all prisoners.
Not achieved

Prompt, adequate support should be provided for victims of intimidation and violence.
Not achieved

Targets for all prisoners on the basic level of the incentives and earned privileges (IEP) scheme should be individualised and should promote improvements in behaviour.
Not achieved

There should be a creative focus on providing enhancements that prisoners aspire to achieve through good behaviour.
Not achieved

There should be a prison-wide approach to exploring and understanding the wider factors linked to drug taking, such as living conditions, boredom and a lack of meaningful activity. The strategy should incorporate actions to address these wider issues.
Not achieved

Prisoners who require constant observation should not be located in special accommodation.
Achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection in 2018, staff-prisoner relationships were generally good. However, there was a lack of care for a significant minority of prisoners and widespread tolerance of poor conditions. The new keyworker scheme was promising. Too many areas of the prison were dirty and in disrepair. In-cell telephones were greatly valued. Cell bells frequently went unanswered for long periods. The quality and quantity of food were reasonable. Peer support was reasonably good. Leadership in equality work was weak, and there was little to identify and meet the needs of prisoners with protected characteristics. The chaplaincy provided an excellent service. Health services had improved and were mostly good. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

National and local managers should take concerted action to ensure that prisoners' living conditions are improved, and that cells falling below basic standards are not occupied. All prisoners should have supervised regular access to clean bedding and clothing. Staff should be proactive in their dealings with prisoners, including their response to cell call bells.
Not achieved

Equality and diversity should be given higher priority. Procedures and work practices covering all aspects of equality and diversity should be improved to ensure that the needs of prisoners from each of the protected characteristics are understood and dealt with fairly.
Achieved

Recommendations

All prisoners should have good quality weekly meetings with their keyworker, and these should be fully recorded in electronic case notes.
Not achieved

Prisoners should not have to wait two weeks to receive their first shop order.
Not achieved

Prisoners should be consulted regularly about the routines and facilities of the prison.
Not achieved

The prison should ensure that applications are dealt with promptly and helpfully.
Achieved

Quality assurance procedures should be developed to improve investigation of and responses to complaints.
Achieved

Adverse incidents should be promptly reported and investigated, and lessons learned shared with the full health team.
Achieved

Information about health services and national health campaigns should be easily available in all required formats and languages.
Not achieved

Prisoners should have easy and prompt access to the full range of smoking cessation support and barrier protection throughout their stay and on discharge, if required.
Achieved

Prisoners on all wings who have substance misuse problems should have access to all psychosocial interventions.
Achieved

Prisoners in shared cells should have secure storage for their medicines.
Not achieved

Medicines should be administered at clinically appropriate times, and officers should supervise medication queues effectively to ensure privacy and reduce opportunities for diversion and bullying.
Not achieved

Purposeful activity

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

At the last inspection in 2018, although time out of cell had improved since the previous inspection, too many prisoners were locked up during the core day. Library services were good. There had been improvements in the management of learning and skills in the previous few months, but it still required further development. Although there was sufficient purposeful activity for all prisoners, too few attended their allocated sessions. The prison did not offer sufficient provision in English and mathematics. The quality of learning and skills and work required improvement in several areas. Prisoners who attended activities were motivated, well behaved and achieved well. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Recommendations

All prisoners should be unlocked for sufficient time to access regime services, undertake domestic activities fully and have a daily period of association.
Not achieved

All prisoners should have access to at least one hour in the open air daily.
Not achieved

The gym showers should provide decent facilities for prisoners.
Achieved

College managers should develop the provision further so that prisoners can improve their skills in using English, mathematics and the use of information and communication technology to enhance the likelihood of successful resettlement.
Not achieved

Foreign national prisoners should have access to suitable provision to improve their spoken English.
Not achieved

Prison managers should improve the evaluation of the quality of training, learning and assessments in prison work, and ensure that the self-assessment report is accurate.
Partially achieved

All prison work should enable prisoners, including vulnerable prisoners, to develop useful vocational skills, improving their prospects of finding employment after release.
Partially achieved

Advice and guidance about courses should be improved to increase prisoners' chances of gaining employment after release, including a better use of the virtual campus for finding jobs.
Not achieved

Instructors should use information about prisoners' existing skills to set them appropriately demanding work and targets for their development.
Not achieved

Tutors and instructors should promote the values of fair treatment and respecting differences in their teaching and training sessions.
Not achieved

Tutors and instructors should include tasks and activities in their teaching, training, and assessment that improve prisoners' skills in English and mathematics.
Partially achieved

Wing staff should encourage and motivate prisoners to improve their attendance and punctuality to lessons and prison work activities so that they can increase their chances of gaining employment after release.
Not achieved

There should be effective measures to motivate prisoners to improve their English and mathematics skills.
Not achieved

Tutors and instructors should ensure that all prisoners always follow appropriate health and safety procedures.
Not achieved

Prisoners in prison work should be able to gain qualifications, and instructors should recognise and record accurately the skills that prisoners develop.
Not achieved

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 2018, children and families work was good. Strategic management of rehabilitation and resettlement was reasonably good. The community rehabilitation company (CRC), 6 Catch 22, was now well established, and integration between the key departments had improved. Contact with prisoners and the management of home detention curfew (HDC) had also improved. Category B sex offenders were now transferred promptly to an appropriate establishment. There was some good casework with high-risk prisoners, but there were weaknesses in the interdepartmental risk management team (IRMT) meeting. Release planning was reasonably good but too many prisoners were released without settled accommodation to go to. Outcomes for prisoners were reasonably good against this healthy prison test.

Recommendations

The prison should develop a needs analysis drawing on information about risk and prisoner need and use this to inform the reducing reoffending action plan.
Not achieved

Procedures to implement offender management in custody should ensure that their sentences and what will happen to newly sentenced prisoners are explained to them, that key worker contact is reliable and consistent, and that there is good liaison between offender supervisors and keyworkers based on agreed targets for progression and resettlement.
Not achieved

The interdepartmental risk management team should consider all high-risk prisoners and those subject to multi-agency public protection arrangements on their arrival and in sufficient time before their release, identifying risk factors and targets for risk management.
Achieved

Reviews of prisoner categorisation should include the opportunity for prisoners to make representations about their risk level, and they should be informed of the decision and what they need to do to progress.
Achieved

Transfer of prisoners should be based on an OASys assessment of their risk and should support their progression.
Not achieved

Prisoners with finance, benefit and debt problems should have ready access to competent specialist support.
Not achieved

Prisoners being released should not be required to change their clothes in view of staff.
Achieved

There should be adequate discharge clothing for prisoners who need it, and a bag for possessions provided if required.
Achieved

Recommendations from the scrutiny visit

The following is a list of the recommendations made in the scrutiny visit report from 2021.

Leaders and managers should set high standards, model the culture articulated by the governor and support frontline staff to improve relationships with prisoners. Oversight of practice should be improved to ensure the needs of prisoners, particularly the most vulnerable, are met.
Not achieved

Leaders should make sure that the reverse cohort unit operates effectively and that prisoners subject to cohorting arrangements have opportunities to leave their cell for a shower and time in the open air.
No longer relevant

A comprehensive induction programme should be developed to make sure that prisoners new to custody are given all the information they need in their early days at Exeter.
Not achieved

Prisoners in crisis should be supported by an ACCT procedure that is multidisciplinary, thorough, caring and leads to action which addresses the needs of the individual. Leaders should make sure that meaningful supervision and rigorous quality assurance processes embed and sustain progress.
Not achieved

The promotion of equality should be given sufficient priority and improved. Outcomes for prisoners from protected groups should see measurable improvements.
Achieved

The Partnership Board should review secondary health care screening procedures to make sure that the health care needs of all patients are identified and that assessments are completed.
Partially achieved

The Partnership Board should review the practice of administering medication at cell doors to make sure that it is undertaken in the safest possible way and meets professional and good practice standards.
Partially achieved

Leaders and managers should make sure that all prisoners have access to the essential resources they need to complete their in-cell education packs and that communication between prisoners and teachers is timely and supportive for all prisoners.
No longer relevant

Managers should swiftly implement plans to improve the skills of the newly recruited instructors to make sure that they are equipped to help prisoners develop their vocational skills.
No longer relevant

Leaders and managers should broaden the education, skills and work curriculum to meet the needs of a wider range of prisoners, providing them with the skills, knowledge and behaviour they need to progress to their next steps.
Not achieved

Leaders and managers should ensure rigorous oversight of all aspects of education, work and skills in order to monitor and sustain improvements in the quality of the provision.
Not achieved

Appendix I About our inspections and reports

Her Majesty's 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, police and 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.

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 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 Her Majesty's 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 recommendations 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 provides a summary of our inspection findings 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 5, 2017) (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/). Section 7 summarises the areas of concern

from the inspection. Section 8 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

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:

Charlie Taylor	Chief inspector
Angus Jones	Team leader
David Foot	Inspector
Angela Johnson	Inspector
Esra Sari	Inspector
Donna Ward	Inspector
Martyn Griffiths	Inspector
Emma King	Researcher
Helen Downham	Researcher
Alexander Scragg	Researcher
Helen Ranns	Researcher
Sarah Goodwin	Lead health and social care inspector
Karen Wilson	Health and social care inspector
Lyndsey Woodford	Pharmacist
Dayni Johnson	Care Quality Commission inspector
Nick Crombie	Ofsted inspector
Darryl Jones	Ofsted inspector
Russell Shobrook	Ofsted inspector
David Baber	Ofsted inspector

Appendix II Glossary

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

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

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

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.

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.

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 video calls
A system commissioned by HM Prison and Probation Service (HMPPS) that requires users to download an app to their phone or computer. Before a visit can be booked, users must upload valid ID.

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 purpose licence ROTL
Special purpose licence allows prisoners to respond to exceptional, personal circumstances, for example, for medical treatment and other criminal justice needs. Release is usually for a few hours.

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.

Appendix III 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: http://www.justiceinspectorates.gov.uk/hmiprisons/

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