Report on an independent review of progress at

HMP Erlestoke

by HM Chief Inspector of Prisons

22–24 April 2025

Contents

Section 1 Chief Inspector's summary

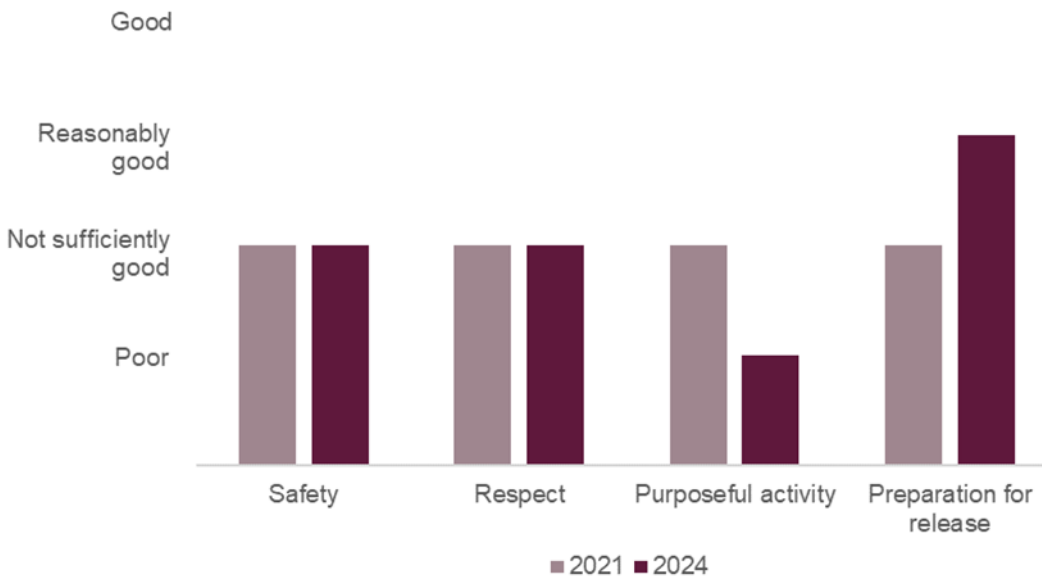
1.1 HMP Erlestoke, in rural Wiltshire, was built on the former grounds of Erlestoke manor house and became a young prisoners centre in 1970. Converted to a category C adult male prison in 1988, it is now a training and resettlement prison for around 500 men, mostly serving long or indeterminate sentences. The prison hosts a two-unit 'progression regime' designed to support prisoners to progress with their sentence.

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

What we found at our last inspection

1.3 At our previous inspections of HMP Erlestoke, in 2021 and 2024, we made the following judgements about outcomes for prisoners.

Figure 1: HMP Erlestoke healthy prison outcomes in 2021 and 2024
Note: rehabilitation and release planning became 'preparation for release' in October 2023.



1.4 At the 2024 inspection, it was disappointing to find many prisoners bored and frustrated, and that drug taking was rife. Violence was a serious concern, and oversight of the high levels of use of force was not good enough. Levels of self-harm at the prison were high and governance of health care services was weak. The key worker scheme (see Glossary) was ineffective and did not support sentence progression. We also found that not enough was being done to address negative perceptions of treatment among prisoners from ethnic minority groups.

1.5 At the time, I said that Erlestoke was a prison that has enormous potential, with prisoners who are keen to progress with their sentences,

and I was impressed with the energy that the new governor had brought. With the right support from the Prison Service, I felt that there was reason to be cautiously optimistic.

What we found during this review visit

1.6 During this review visit, we found some encouraging evidence of progress. Levels of violence were now lower than in similar prisons, and there had been some good work to address antisocial behaviour by young adults. The use of force and unfurnished accommodation had decreased and was now being properly scrutinised. Action had also been taken to strengthen governance of health care services, and oversight of medicines was more robust.

1.7 However, illicit drugs remained far too easily available, and the random drug testing positive rate was the same as at the time of the inspection (32%). While self-harm had reduced, there was still no action plan to address this properly and prevent future self-inflicted deaths. The quality of assessment, care in custody and teamwork (ACCT) case management support for prisoners at risk of suicide or self-harm was far from good enough. There had also been insufficient progress in improving the condition of first night cells and the regime on the induction unit.

1.8 More positively, however, the proportion of key work sessions taking place had increased significantly and there was a credible plan to improve their quality. There had also been steps to address negative perceptions of treatment among prisoners from ethnic minority backgrounds.

1.9 As I observed at the inspection, the lack of a purposeful regime was likely to be a key contributory cause for many of the prison's difficulties. Although Ofsted judged generally reasonable progress in the development of more purposeful activity during this visit, plans to offer a wider range of vocational training were still in the early stages. There was also not yet enough support for those who needed help with reading.

1.10 The challenge remains for staff and leaders (see Glossary) to build on these early signs of progress and counter the malaise that has blighted this prison for too long. Erlestoke is currently required by the Prison Service to fulfil a variety of functions; more clarity about the prison's purpose would be helpful. Leaders now need to focus on realising the rehabilitative potential of the establishment by motivating prisoners through a progressive regime and giving them a greater sense of purpose and direction during their time there.

Charlie Taylor
HM Chief Inspector of Prisons
June 2025

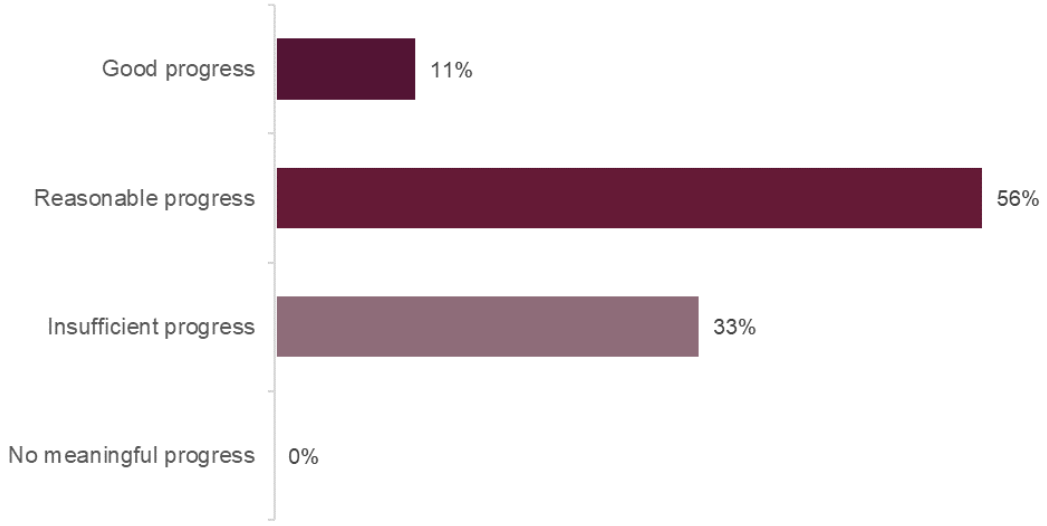
Section 2 Key findings

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

2.2 HMI Prisons judged that there was good progress in one concern, reasonable progress in five concerns, and insufficient progress in three concerns.

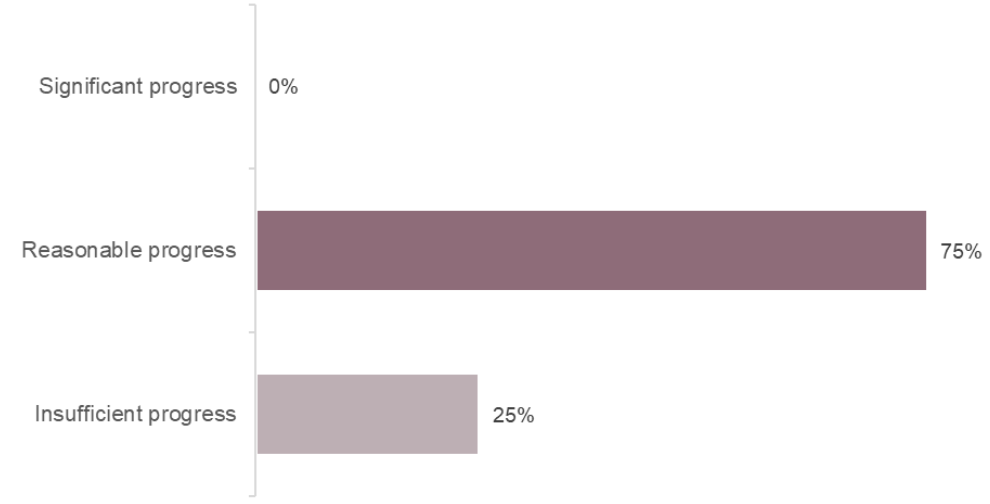
Figure 2: Progress on HMI Prisons concerns from 2024 inspection (n=9)

This bar chart excludes any concerns that were followed up as part of a theme within Ofsted's concurrent prison monitoring visit.



2.3 Ofsted judged that there was reasonable progress in three themes and insufficient progress in one theme.

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



Notable positive practice

2.4 We define notable positive practice as:

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

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

Section 3 Progress against our concerns and Ofsted themes

The following provides a brief description of our findings in relation to each concern followed up from the full inspection in 2024.

Early days in custody

Concern: First night cells were dirty and some were not fit for use. The regime on the induction unit was poor, and delays with the first shop order increased the risk of debt.

3.1 First night cells were in better condition than at the time of the inspection but were still not good enough. Cells had appropriate equipment and reasonable standards of cleanliness, although some contained graffiti and needed repainting.

First night cells

Graffiti in first night cells

3.2 Leaders had introduced checks to make sure that first night cells were in an acceptable condition before housing new arrivals, and a dedicated 'induction officer' was responsible for these. The unit manager had recently begun quality assuring these checks.

3.3 Despite this, checks were not yet being delivered consistently. Some recently arrived prisoners told us that their cells had lacked equipment, such as toilet brushes and furniture, or that they had been put in cells which had not been adequately cleaned.

3.4 The regime on the induction unit remained poor, with unemployed prisoners receiving only around two hours out of their cells each day. The induction timetable had been updated to provide some additional opportunities for new arrivals to be unlocked, with daily sessions held in the on-wing induction room with different departments or the induction orderly.

Induction room

3.5 New arrivals attending their induction sessions typically had around four to five hours unlocked each day, although they told us that this was not consistent, and some sessions could be as short as 25 minutes.

3.6 Some prisoners still waited for up to 10 days to receive their first shop order. The prison provided a range of 'reception packs' containing some basic goods which prisoners could pay for in arrears. They could request additional packs in advance of their first shop order.

3.7 We considered that the prison had made insufficient progress in this area.

Promoting positive behaviour

Concern: The prison was not doing enough to tackle violence. Not all such incidents had been investigated and there was no overarching plan to reduce violence.

3.8 Levels of violence had reduced by 25% since the inspection, including the number of serious assaults. Overall levels were now lower than in similar prisons, although the number of staff assaults remained slightly higher.

3.9 Staff resource in the safety team had increased, the safety strategy had recently been reviewed, and a violence reduction action plan had been created. However, actions identified at the monthly safety meeting were

rarely monitored or completed, and more work needed to be done to understand fully the drivers of violence.

3.10 Work with young adults, who were disproportionately involved in violence, had improved and there were early signs that this was contributing to the reduction in incidents. Fortnightly young adult strategy meetings had been held to discuss prisoners involved in antisocial behaviour, and appropriate action had been taken. Training had also been given to staff by an external organisation to work with this cohort.

3.11 Most violent incidents were referred to the challenge, support and intervention plan process (see Glossary), but weaknesses remained. There were delays in completing investigations and developing plans, and not all reviews were completed on time. We also found evidence of a prisoner being involved in a further act of violence before a plan had been put in place. However, when plans were developed, targets to support and challenge behaviour had improved. Quality assurance had recently been introduced.

3.12 Prisoners who chose to isolate in their cells received support from the psychology team, but there were still no reintegration plans.

3.13 Many prisoners told us that there was little to incentivise good behaviour, and the perception was that poor behaviour would often be rewarded by gaining a transfer out of the prison. In the last six months, 26 prisoners had been transferred from the segregation unit to another prison.

3.14 We considered that the prison had made reasonable progress in this area.

Concern: The amount of force used by staff on prisoners and use of unfurnished cells was high. Scrutiny arrangements were not sufficiently robust, and we identified some examples of disproportionate use of force and an inappropriate use of PAVA.

3.15 The number of incidents of use of force had decreased by 13% since the inspection, and use of batons and PAVA (see Glossary) had also reduced.

3.16 Both the weekly and monthly use of force meetings were now held consistently, and all incidents were scrutinised by a multi-disciplinary panel. In these meetings, leaders had identified some inappropriate use of force and action had been taken.

3.17 Comprehensive quality assurance on all uses of PAVA and batons took place, and any identified learning points were followed up by a manager. Steps had been taken to share learning more widely among officers.

3.18 The use of body-worn cameras had increased, with an average of 74% of incidents being captured. Leaders were continuing to drive improvement, and staff were routinely encouraged to wear a camera.

3.19 The completion of debriefs after a use of force had recently improved, but attendance by health care staff at incidents remained poor.

3.20 Use of unfurnished accommodation had reduced and, from the documentation we reviewed, this was now more appropriate. Comprehensive quality assurance by the deputy governor provided detailed feedback to authorisers.

3.21 We considered that the prison had made good progress in this area.

Security

Concern: Illicit drugs were far too easily available. In our survey, 60% of respondents said that it was easy to get hold of drugs, and 32% of all random drug test results had been positive in the last year.

3.22 Illicit drugs remained far too easily available. The random mandatory drug testing positive rate for the last six months had stayed at 32%, and there had been 426 emergency medical calls for prisoners suspected of being under the influence of a prohibited substance.

3.23 Actions to address the drug problem were undermined by the frequent redeployment of staff responsible for suspicion drug testing. In the last six months, 81% of suspicion tests had not been completed.

3.24 The broken drug detection equipment we found at the inspection had been repaired and additional closed-circuit television (CCTV) cameras had been installed. However, some perimeter CCTV had still not been funded.

3.25 Excellent joint working with the police and regional dog search teams remained a strength, and staff corruption was managed robustly.

3.26 The pathway for prisoners to progress from the drug recovery wing to the incentivised substance-free living unit was now embedded. The unit held around 65% of prisoners with an addiction history, and they spoke positively of the support they received.

3.27 We considered that the prison had made insufficient progress in this area.

Safeguarding

Concern: The recorded levels of self-harm were very high and not enough was being done to reduce these.

3.28 Since the inspection, levels of self-harm had reduced by 37%, and of incidents needing external hospital care by 54%. There had been one self-inflicted death.

3.29 The safety strategy had recently been reviewed, although there was still no action plan to address the high levels of self-harm and to prevent future self-inflicted deaths.

3.30 Learning from investigations into serious self-harm and the recent self-inflicted death was not widely shared, which was a gap.

3.31 The data presented at the monthly safety meeting had improved, but more needed to be done to understand why prisoners were self-harming so that this could be addressed. Actions identified at the monthly safety meeting and weekly safety intervention meeting were still not monitored or completed consistently. Attendance at these meetings by key departments, such as residential officers, had not improved.

3.32 Additional resource had been allocated to the safety team, and they were now working together more effectively in a 'safety hub' and were starting to make improvements to existing systems.

3.33 Documentation to support ACCT case management remained of poor quality, with risk and triggers not being identified and care maps lacking meaningful actions. In our review, we found care maps without any targets or actions at all, and some reviews were very short and appeared cursory. Some prisoners we spoke to who were being supported by ACCT case management said that they felt as though staff did not care.

3.34 The constant supervision cell was still in the segregation unit and visibility by staff monitoring the prisoner within remained limited.

3.35 We considered that the prison had made insufficient progress in this area.

Staff–prisoner relationships

Concern: The key worker scheme was ineffective. Delivery was inconsistent and did not support sentence progression.

3.36 Prison leaders had overhauled the key work system, moving to a model where key workers were allocated from the prisoner's residential units. This had resulted in a substantial increase in the number of key work sessions taking place, and officers were generally positive about the change.

3.37 The proportion of scheduled key work sessions had increased significantly, with 68% of planned sessions taking place in the previous six months, compared with 35% in the same period before the inspection. Most prisoners were receiving regular key work.

3.38 Leaders had begun to implement a good action plan to address shortcomings in key work. Fortnightly key work strategy meetings had been set up to provide oversight.

3.39 While this progress was positive, the quality of key work sessions remained inconsistent. We saw a few excellent examples of key work supporting prisoners' progression, but too often entries were formulaic or cursory.

3.40 Leaders had taken some steps to address the quality of key work. Officers were issued with key worker 'pocket guides', providing reminders on how to conduct an effective session.

Key worker 'pocket guide'

3.41 Quality assurance had been put in place to monitor the quality of key work. Unit managers conducted monthly quality assurance, alongside managers in the offender management unit (OMU), but this was not yet being delivered consistently across all residential units.

3.42 OMU managers had recently begun a monthly 'upskilling' session for key workers identified as performing poorly, which was positive.

3.43 We considered that the prison had made reasonable progress in this area.

Fair treatment and inclusion

Concern: There was limited action to address negative perceptions of treatment among prisoners from ethnic minority groups. These prisoners expressed frustration that their concerns were not being addressed.

3.44 Prison leaders had taken some positive steps to address negative perceptions of treatment among prisoners from ethnic minority backgrounds. Fewer prisoners than at the inspection spoke negatively about this, although some continued to express concern about their treatment.

3.45 Prison leaders were holding additional forums and meetings to look at issues being raised by prisoners from ethnic minority groups. We saw evidence that issues raised during these were addressed, such as setting up a meeting for prisoners to discuss their concerns with staff, adding additional items to the prison shop list and advertising opportunities for prisoners to create videos for staff about their cultural backgrounds and experiences.

3.46 Prison leaders had also taken forward suggestions aimed at improving relationships between staff and prisoners from ethnic minority backgrounds. Prisoner representatives had recently become involved in staff inductions, and had delivered two cultural awareness sessions during staff training days. These had been well received by staff and prisoners, although only a limited number of officers had been able to attend because of competing priorities.

3.47 A broader range of data was being monitored for disproportionate outcomes at monthly diversity and inclusion meetings. Positively, this was shared with prisoners through their laptop computers and discussed in forums. However, attendance at these meetings by senior managers remained inconsistent.

3.48 An external organisation continued to provide scrutiny of discrimination incident reporting forms (DIRFs) and had delivered training to some staff on how to conduct investigations. Prisoner scrutiny panels for DIRF responses was providing feedback to managers.

3.49 We considered that the prison had made reasonable progress in this area.

Health, well-being and social care

Concern: Clinical governance of health care services was weak. Clinical risks were not always identified, the management of clinical incidents was ineffectual and patients' complaints were poorly managed.

3.50 Following the inspection, the health care provider, Oxleas NHS Foundation Trust, had taken action to strengthen its clinical governance processes and use of data.

3.51 Local and strategic governance meetings had been reviewed to improve the scrutiny and oversight of the performance and delivery of the service. Work had been undertaken by the prison's health care team and supported by the wider organisation, health commissioners and prison leaders.

3.52 The local risk register now accurately captured risks, with more focused monthly risk register meetings and dynamic reviews. Senior staff had a better understanding of the importance of using the register.

3.53 The management of clinical incidents was now more robust, with better analysis and understanding of data and any emerging trends. Lessons learnt were shared with staff and informed service improvement. Clinical incidents were now reviewed twice a week, and investigations were more timely.

3.54 Management of complaints was now more coordinated, tracking had improved and responses were quality assured. Staff had received additional training to understand factors affecting complaints and how to formulate appropriate responses. The responses we reviewed were timely, polite and addressed the concerns raised. Specific health query and complaint forms, with an attached envelope, were now in place, but they were not readily accessible on all residential units. Many prisoners were still unaware of how to raise a health care complaint.

3.55 We considered that the prison had made reasonable progress in this area.

Concern: The governance and oversight of medicines were not robust, and inadequate support and reviews of opioid substitution therapy were putting prisoners at unnecessary risk of significant harm. There were gaps in patients' risk assessments and room and refrigerator temperature recording, missed doses of medicines were not always investigated and incidents were not reviewed in a timely manner.

3.56 The management of patients on opiate substitution therapy had improved, with safe prescribing and good support offered from both the clinical and psychosocial substance misuse teams. Patients had access to an onsite prescriber and regular reviews were held to ensure coordinated, patient-centred care.

3.57 Concerted efforts had been made to improve the follow-up of patients not attending for their medication. There was now a written policy and staff received additional training on the importance of medication adherence. The in-possession medicines policy was in date, and all new arrivals continued to receive an in-possession medicines risk assessment. This was now reviewed at regular intervals and when circumstances changed, in line with expected practice.

3.58 Medicine reconciliations were completed within 72 hours. The out-of-hours cupboard and stock medicines were in good order and weekly audits were embedded. Quarterly audits for the management of controlled drugs took place, but some of the monthly medicines management audits had not been completed over the last six months.

3.59 Fortnightly pharmacy-led clinics were due to start soon. The management of medicine-related incidents had improved, and lessons learnt were shared with staff.

3.60 The temperatures of refrigerators and the rooms where medicines were stored were checked each day, but there were still a few gaps in the recording sheets we reviewed.

3.61 Weaknesses remained in the supervision of medication administration queues by officers, and overcrowding at the hatches continued to compromise confidentiality and increase the risk of bullying and diversion of medicines. Identity cards were checked when patients presented for their medicines.

3.62 We considered that the prison had made reasonable progress in this area.

Education, skills and work

This part of the report is written by Ofsted inspectors. Ofsted's thematic approach reflects the monitoring visit methodology used for further education and skills providers. The themes set out the main areas for improvement in the prison's previous inspection report or progress monitoring visit letter.

Theme 1: What progress had leaders and managers made to provide enough spaces in education, skills or work and to ensure that these spaces are fully used and allocated based on prisoners' needs and aspirations?

3.63 Leaders and managers had made significant recent changes to the process of allocating prisoners to purposeful activity. This new approach took much greater account of prisoners' needs and aspirations rather than relying on their individual preferences. Prisoners were, as a result, benefiting from a more targeted programme of purposeful activity that met their needs.

3.64 Managers held allocations meetings every week and ensured that staff from education, health care and security departments attended. This collaborative approach ensured that prisoners' suitability for specific activities was carefully scrutinised and assessed before they were allocated. As a result, most prisoners were now allocated to purposeful activities likely to benefit them during their time in custody and upon release.

3.65 The efficient allocations process, together with the introduction of a continuous 'roll-on, roll-off' mode of delivery in education and skills, resulted in better use of the available activity places. Prisoners could now join a vocational or training course whenever they were ready to do so, rather than having to be placed on a waiting list for a particular course to end.

3.66 At the time of the inspection, around 23% of prisoners were unemployed. During this review visit, we found significantly fewer unemployed prisoners. Most were awaiting allocation to activities following their induction, while others were retired, medically unfit, self-isolating or simply refusing to participate in the regime.

3.67 Although managers now provided enough activity spaces to meet the population's needs, attendance in education remained not good enough. The governor had appointed two officers to work alongside wing-based staff to ensure that they understood the importance of moving prisoners, including those reluctant to do so, promptly to scheduled activities. However, this initiative had yet to have an impact.

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

Theme 2: What progress had leaders and managers made to provide a sufficiently broad curriculum and to ensure that the quality of education, skills and work meets prisoners' needs and interests?

3.69 Prison managers had carried out a suitably detailed curriculum needs analysis. This identified construction, hospitality and building trades as key priority areas for the regions to which most prisoners were released. The analysis also identified self-employment as an area that many prisoners wanted to pursue at the end of their time in custody. Managers had taken effective action to ensure that the vocational curriculum reflected these priorities.

3.70 At the time of the inspection, too many industry workshops and education courses had not been running because of staff vacancies and long-term illness. At the time of this visit, the textiles workshop was open and courses in carpentry, cleaning and information technology were now running. However, although prisoners gained useful vocational skills in these subjects, very few workshops offered a recognised qualification which they could use upon their release. Courses in self-employment and multi-skills had been scheduled, but the tutors appointed to teach these subjects were still awaiting security clearances.

3.71 Managers had made suitable progress in ensuring that the quality of education, skills and work activities met the needs of most prisoners. College managers provided classroom and vocational training courses that were generally well attended and that helped prisoners develop a range of skills likely to help them during their time in custody. Quality improvement arrangements were well established and helped to ensure that prisoners benefited from provision that met their needs and interests.

3.72 There was good attendance at prison workshop sessions and prisoners were purposefully occupied there. The bicycle repair and farms and gardens work areas were particularly effective in providing purposeful activity. However, the newly refitted recycling workshop failed to

provide enough work to keep prisoners occupied. Many complained about the frustrations they felt when there was not enough work for them to do.

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

Theme 3: What progress had leaders and managers made to assess prisoners' reading needs effectively, so that they can provide suitable support for prisoners that require help with reading?

3.74 Leaders had implemented an appropriate procedure to assess prisoners' literacy and reading levels shortly after their arrival at the prison. Prisoners assessed as entry level 2 or below then received a more detailed reading screening to identify specific individual requirements. However, only a small number of prisoners who had completed the screening activity were subsequently offered support with their reading.

3.75 Managers relied to a considerable extent on the prison's library staff and on Shannon Trust (see Glossary) volunteers to support a small number of prisoners to enhance their reading confidence and ability. Shannon Trust volunteers ran 'read and relax' sessions for emergent readers to read books with their tutor and prisoner peer mentors. Library staff provided a reading group for prisoners who wanted to read independently and to discuss their reading in small groups. It was too soon to judge the contribution of these initiatives to improving prisoners' long-term engagement with reading for pleasure.

3.76 Prison leaders and managers had established a 'whole prison reading strategy' and gathered information on prisoners' reading abilities. College and library staff generally understood leaders' expectations regarding the importance of reading. However, initiatives such as training prison instructors in basic phonics to enable them to support prisoners in industries or workshops had not yet resulted in any meaningful impact.

3.77 Prison instructors did not routinely use the information available on prisoners to devise strategies or resources to support prisoners' reading needs. Leaders had made reading materials available in workshops, on the wings and in work areas across the establishment. However, prisoners did not use these 'book nooks' because the materials included were often too difficult for emerging readers and they could not take away books to read in their cells.

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

Theme 4: What progress had leaders and managers made to provide good-quality information, advice and guidance during induction to enable prisoners to make progress towards achieving their goals and help prepare them for release?

3.79 Leaders had effectively managed the recent contractual changes to the careers guidance provider. They ensured that this did not have an adverse impact on the quality of careers advice available to prisoners.

3.80 Managers had made improvements to the initial induction and interview process. This ensured that prisoners had a clear understanding of the range of activities and pathways available to them. Careers staff shared the information they gained on each new arrival's background and aspirations with the prison allocations team. As a result, prisoners were allocated to activities based on a suitable assessment of their aptitudes and abilities.

Education induction room

3.81 Prisoners recognised the improvements and support that the careers team gave them in focusing on their employment aspirations and opportunities. They were significantly more positive than at the time of the inspection about how they could use their time in custody productively to prepare for their next steps.

3.82 Leaders now offered a range of vocational pathways in hospitality, cleaning, carpentry and recycling. These also offered prisoners an opportunity to gain a qualification. However, managers did not offer prisoners working in the commercial workshops or in prison jobs the opportunity to study for a relevant qualification.

3.83 The quality of personal learning plans and their use across the prison required improvement. Too often, targets in prisoners' learning plans were overly generic, and insufficient effort had been made to personalise aims and long-term objectives clearly.

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

Section 4 Summary of judgements

A list of the HMI Prisons concerns and Ofsted themes followed up at this visit and the judgements made.

HMI Prisons concerns

First night cells were dirty and some were not fit for use. The regime on the induction unit was poor, and delays with the first shop order increased the risk of debt.
Insufficient progress

The prison was not doing enough to tackle violence. Not all such incidents had been investigated and there was no overarching plan to reduce violence.
Reasonable progress

The amount of force used by staff on prisoners and use of unfurnished cells was high. Scrutiny arrangements were not sufficiently robust and we identified some examples of disproportionate use of force and an inappropriate use of PAVA.
Good progress

Illicit drugs were far too easily available. In our survey, 60% of respondents said that it was easy to get hold of drugs, and 32% of all random drug test results had been positive in the last year.
Insufficient progress

The recorded levels of self-harm were very high and not enough was being done to reduce these.
Insufficient progress

The key worker scheme was ineffective. Delivery was inconsistent and did not support sentence progression.
Reasonable progress

There was limited action to address negative perceptions of treatment among prisoners from ethnic minority groups. These prisoners expressed frustration that their concerns were not being addressed.
Reasonable progress

Clinical governance of health care services was weak. Clinical risks were not always identified, the management of clinical incidents was ineffectual and patients' complaints were poorly managed.
Reasonable progress

The governance and oversight of medicines were not robust, and inadequate support and reviews of opioid substitution therapy were putting prisoners at unnecessary risk of significant harm. There were gaps in patients' risk assessments and room and refrigerator temperature recording, missed doses of medicines were not always investigated and incidents were not reviewed in a timely manner.
Reasonable progress

Ofsted themes

What progress had leaders and managers made to provide enough spaces in education, skills or work and to ensure that these spaces are fully used and allocated based on prisoners' needs and aspirations?
Reasonable progress

What progress had leaders and managers made to provide a sufficiently broad curriculum and to ensure that the quality of education, skills and work meets prisoners' needs and interests?
Reasonable progress

What progress had leaders and managers made to assess prisoners' reading needs effectively, so that they can provide suitable support for prisoners that require help with reading?
Insufficient progress

What progress had leaders and managers made to provide good-quality information, advice and guidance during induction to enable prisoners to make progress towards achieving their goals and help prepare them for release?
Reasonable progress

Appendix I About this report

HM Inspectorate of Prisons (HMI Prisons) is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, court custody and military detention.

All visits carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

Independent reviews of progress (IRPs) are designed to improve accountability to ministers about the progress prisons make in addressing HM Inspectorate of Prisons' concerns between inspections. IRPs take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny and focus on a limited number of the concerns raised at the inspection. IRPs do not therefore result in assessments against our healthy prison tests. HM Inspectorate of Prisons' healthy prison tests are safety, respect, purposeful activity and rehabilitation and release planning. For more information see our website: Expectations – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)

The aims of IRPs are to:

- assess progress against selected priority and key concerns
- support improvement
- identify any emerging difficulties or lack of progress at an early stage
- assess the sufficiency of the leadership and management response to our concerns at the full inspection.

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each concern we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in June 2024 for further detail on the original findings (available on our website at Our reports – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)).

IRP methodology

IRPs are announced at least three months in advance and take place eight to 12 months after a full inspection. When we announce an IRP, we identify which concerns we intend to follow up (usually no more than 15). Depending on the concerns to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

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

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

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

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

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

Good progress
Leaders had already implemented a realistic improvement strategy to address this concern and had delivered a clear improvement in outcomes for prisoners.

When Ofsted attends an IRP its methodology replicates the monitoring visits conducted in further education and skills provision. Each theme followed up by Ofsted is given one of three progress judgements.

Insufficient progress
Progress has been either slow or insubstantial or both, and the demonstrable impact on learners has been negligible.

Reasonable progress
Action taken by the provider is already having a beneficial impact on learners and improvements are sustainable and are based on the provider's thorough quality assurance procedures.

Significant progress
Progress has been rapid and is already having considerable beneficial impact on learners.

Ofsted's approach to undertaking monitoring visits and the inspection methodology involved are set out in the *Further education and skills inspection handbook*, available at https://www.gov.uk/government/publications/education-inspection-framework.

Inspection team

This independent review of progress was carried out by:

Charlie Taylor	Chief Inspector
Sara Pennington	Team leader
Natalie Heeks	Inspector
Harriet Leaver	Inspector
Rick Wright	Inspector
Maureen Jamieson	Health and social care inspector
Sarah Campbell	Health and social care inspector
Mark Griffiths	Care Quality Commission inspector
Jai Sharda	Ofsted team leader
Chris Dearnley	Ofsted inspector

Appendix II Glossary

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

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

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.

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

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

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

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