Report on an independent review of progress at

HMP Parc

by HM Chief Inspector of Prisons

5–7 January 2026

Contents

Section 1 Chief Inspector's summary

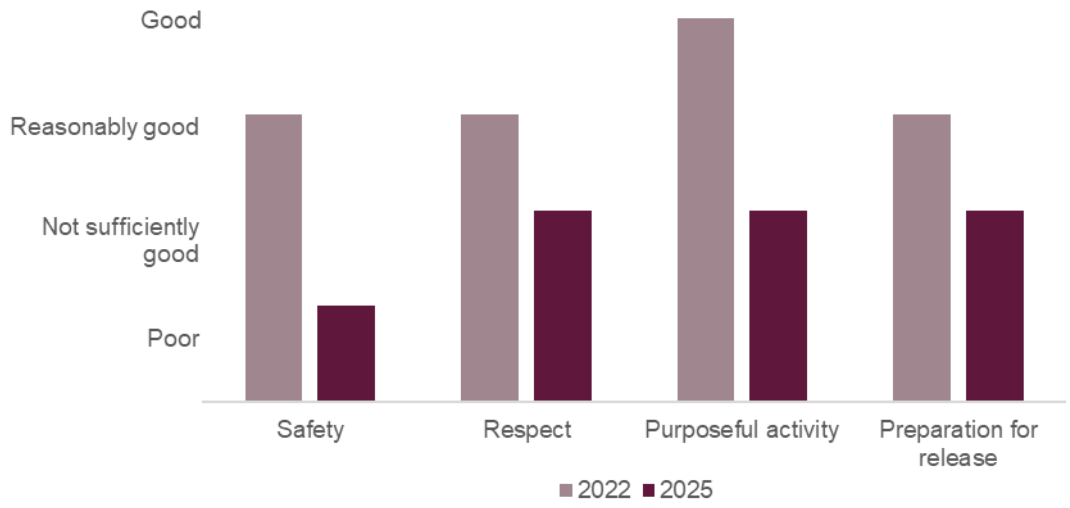
1.1 HMP Parc is a category C resettlement prison holding convicted adult men, young offenders, and convicted and remanded sex offenders. The prison also has a small unit for children, which we inspect separately.

1.2 This review visit followed up on the concerns we raised at our last inspection of HMP Parc in January 2025.

What we found at our last inspection

1.3 At our previous inspections of HMP Parc in 2022 and 2025, we made the following judgements about outcomes for prisoners.

Figure 1: HMP Parc healthy prison outcomes in 2022 and 2025
Note: rehabilitation and release planning became 'preparation for release' in October 2023.



1.4 At the last inspection, in January 2025, we found a serious deterioration in standards across all of our healthy prison tests. Once considered one of the most successful prisons in England and Wales, Parc had experienced significant challenges following leadership and contractual changes. Staff turnover had subsequently increased, and morale declined.

1.5 The prison was severely affected by drug ingress, with a particular risk posed by drones, which contributed to a cluster of deaths linked to synthetic opioids and several self-inflicted deaths in early 2024.

1.6 At the time of the inspection, levels of violence and self-harm were high. Prisoners reported frustration with inconsistent regimes and long periods of confinement, with too many men locked in their cells for up to 21 hours a day. There were delays in allocating prisoners to work, training or education, and they were frustrated with the lack of progression in their sentence.

What we found during this review visit

1.7 While we found insufficient progress in over half of the concerns we reviewed, we also saw committed leaders (see Glossary) and staff making genuine efforts to drive improvement, which was encouraging. However, as a result of persistent staffing constraints and regime limitations, improved outcomes in some areas had not yet been achieved.

1.8 Leaders had put considerable efforts into reducing the ingress of illicit drugs; secure window installation was progressing well, and leaders were making good use of technology and resources. As a result, there had been a decline in drug use.

1.9 Partnership working, both between providers and among departments, was working much more effectively to tackle the challenges that we had identified. Leaders had better oversight, and were now using data to drive improvements, particularly within the areas of safety and purposeful activity.

1.10 Progress in several areas was still hampered by significant restrictions to the daily regime. In the last six months, it had often been curtailed, resulting in long periods of lock-up and prisoners not getting to education or work. This was mainly because of staff shortages caused by poor retention, vetting delays and external hospital escort commitments.

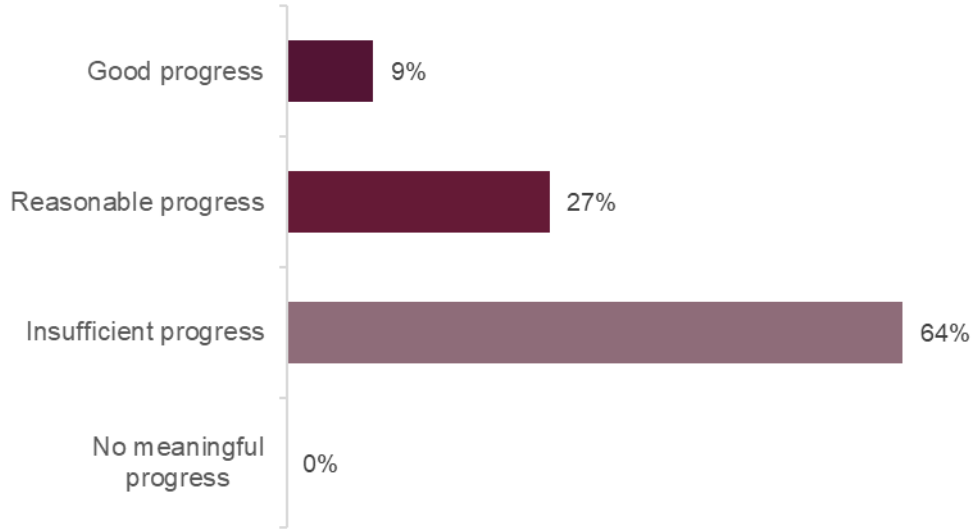
1.11 A lack of personnel also limited progress in other critical areas, including insufficient support for sentence progression and weaknesses in public protection. Without sufficient resources and an adequate regime, the prison will continue to struggle to achieve the necessary improvements in outcomes for prisoners.

Charlie Taylor
HM Chief Inspector of Prisons
January 2026

Section 2 Key findings

2.1 At this IRP visit, we followed up 11 concerns from our most recent inspection, in January 2025. We judged that there was good progress in one concern, reasonable progress in three concerns and insufficient progress in seven concerns.

Figure 2: Progress on concerns from 2025 inspection (n=11)



Notable positive practice

2.2 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.

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

Section 3 Progress against our concerns

The following provides a brief description of our findings in relation to each concern followed up from the full inspection in 2025.

Encouraging positive behaviour

Concern: The number of violent incidents was high. Leaders' understanding of the causes was limited and their response was yet to have an effect.

3.1 The overall rates of recorded violence in the last six months had risen by 25%, compared with the same period before the inspection, and remained higher than in similar prisons. Encouragingly, this had been on a steady downward trajectory in the last three months.

3.2 Although leaders had identified the main factors driving violence, their understanding of these issues remained limited. However, some action was being taken; for example, as debt was the main contributor to violence, a revised debt strategy was being developed to provide a renewed focus on this issue.

3.3 Data showed B block as a hotspot for violence. Leaders had therefore consulted prisoners and introduced a progression pathway, which had reduced the number of incidents. Additional checks had been added to the early days process to address the higher level of violence during this period.

3.4 Oversight within the safety function had improved. The safety team was now more established and had worked hard to embed basic processes and improve the collation of data. Leaders met weekly to review data, and at strategic meetings they reflected on trends over three-month cycles. The latter meetings were now better attended by staff from departments across the prison.

3.5 Leaders had addressed weaknesses in the adjudication system, but they were not doing enough to motivate prisoners to behave. Challenge, support and intervention plans (CSIPs; see Glossary) were used to manage prisoners who were perpetrators or victims of violence, as well as those isolating from their peers. However, despite improved quality assurance processes, weaknesses in the quality of support remained; targets and plans were generic, wing staff were not well sighted, and over half of those on an open CSIP were unemployed.

3.6 The introduction of bespoke peer support roles (STEP [smarter teamwork empowering prisoners] and Energise) was positive. These initiatives included training in supporting emotional regulation and conflict resolution. Peer supporters we spoke to were enthusiastic with

a strong sense of purpose. Although this was in its infancy and not yet fully embedded, it was a promising initiative (see also paragraph 3.19).

Peer support workers

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

Security

Concern: The availability and use of illicit drugs were widespread. Nearly a third of all random drug test results were positive and, in our survey, over half of prisoners said that it was easy to get drugs in the prison.

3.8 Drugs continued to be far too easily available at Parc. However, efforts by G4S, supported by HM Prison and Probation Service (HMPPS), to reduce the supply into the prison were commendable. In the last six months, 24% of random tests had been positive in the last 6 months, compared to 31% before the last inspection.

3.9 Since the inspection, there had been a death in custody which was suspected to be linked to drugs. This was still under investigation by the Prisons and Probation Ombudsman and the coroner.

3.10 Investment in equipment and infrastructure to prevent drug ingress through drone incursions was impressive. Work to replace cell windows was well advanced and leaders had appropriately prioritised more vulnerable areas. In addition, leaders were deploying new technology.

Window installation

3.11 Leaders had recognised that tackling the use of drones had resulted in an increased use of other routes of ingress, such as through visits and property, and were using alternative measures effectively to restrict supply. Staff searching had increased substantially since the inspection, supported by the dynamic use of a mobile device to detect concealed items. This equipment was also being used on prisoners, to disrupt their movement of illicit items around the prison. In addition, there was a robust programme of suspicion testing, with the second highest number of tests carried out nationally, demonstrating effective challenge of prisoners suspected of taking illicit substances.

3.12 A dedicated manager had been appointed to strengthen the drug strategy and support recovery work. This role had improved links between the security team and the drug strategy, and the post holder had established positive relationships with prisoners.

3.13 The incentivised substance-free living unit (see Glossary) provided reasonable conditions for those wishing to remain substance free, and prisoners there spoke positively about the environment. However, the substance misuse recovery unit, which formed the first stage of the recovery pathway, needed further development to reflect a rehabilitation-focused ethos. Leaders were aware of this and had credible plans to provide further training for staff working on the unit.

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

Suicide and self-harm prevention

Concern: Levels of recorded self-harm remained high, and not enough was being done to address the causes of this.

3.15 There had been no self-inflicted deaths since the inspection. However, the rate of recorded self-harm remained broadly similar and was the second highest of category C prisons.

3.16 Positively, leaders now routinely investigated incidents of serious self-harm, although learning was not reviewed to make sure that changes had been embedded. Work to address this was underway.

3.17 Leaders had identified the main reasons for self-harm, but had not interrogated this further or developed a sufficient suite of interventions. For example, they had found that a leading cause of self-harming was to relieve stress, but had not considered how to respond.

3.18 Data showed regime curtailments were a big driver of self-harm, and although the prison had improved communication about upcoming restricted regimes, this had not affected the rate. More successfully, changes to the way that medication adjustments were communicated to prisoners had reduced the number of incidents.

3.19 The introduction of STEP and Energise peer initiatives (see paragraph 3.6) to support those struggling to cope was promising. The Energise programme identified prisoners through the weekly safety meeting and combined physical activity with personal development.

3.20 Leaders also had plans to set up a 'talk club' and implement the AIM (alert, intervene and monitor) system. This would highlight changes to prisoners' routines and flag potential risk factors, thus allowing leaders and staff to provide support to prisoners proactively.

3.21 Weaknesses in the assessment, care in custody and teamwork (ACCT) case management process for prisoners at risk of suicide or self-harm remained. In the ACCT documents we reviewed, planning was inadequate, reviews were not always multidisciplinary, and case management was inconsistent. Leaders had introduced a more robust quality assurance process since the inspection, but this had not yet delivered enough improvement. The introduction of enhanced case reviews to support more complex or prolific self-harmers was positive.

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

Health, well-being and social care

Concern: Actions by leaders to resolve and mitigate identified risks to health outcomes had been too slow. There was a shortage of suitable clinical space, particularly for dentistry, and insufficient prison staff to facilitate hospital escorts.

3.23 Senior health care and prison managers had reviewed the health and operational risks effectively following the inspection. There was now a single risk register, shared and reviewed comprehensively. Governance structures were now well established and key performance information was shared. Operational challenges were discussed at regular joint meetings, with improvement plans reviewed for progress against timelines. There had been some improved outcomes within the mental health and substance misuse services (see below). However, the long waits for dental appointments and large number of hospital appointment cancellations had not improved.

3.24 Senior leaders had created additional office and clinical space. The secondary mental health team had been moved into the safer custody area, which meant that additional clinical space was about to become available. This would offer an additional 20 sessions a week for a variety of clinics, and opportunities for external consultants to treat prisoners on site.

3.25 Actions agreed to try to reduce the number of cancelled hospital appointments were centred around bringing in specialist consultants. There were plans for a neurologist and a cardiologist to start clinics in 2026. This had the potential to provide early intervention and improve outcomes for some prisoners. However, there was no evidence of any action to increase the six daily escorts to hospital, which was inadequate to meet the needs of this large prison. Many appointments had to be rescheduled each month.

3.26 Externally facilitated information technology training for the clinical record system had been secured for April 2026.

3.27 The dental service improvement plan set out that the prison would explore the possibility of having a secondary mobile dental unit, but this had been abandoned. Some process mapping surveys had been undertaken to understand why there were so many missed dental appointments. This had not resulted in any improvements to date. In December 2025, there had been over 100 lost appointments due to non-attendance. Most were for urgent care, and waits varied from one day to several months, for prisoners who could not mix with others. Since the inspection, the overall number of people waiting for routine care had increased by about 100.

3.28 The efficiency of escorting officers for internal health care appointments was poor. Officers did not attempt to collect patients from work and clinics often ended early, and there was no senior staff oversight to prevent this. This meant that the non-attendance rate for many clinics was unacceptably high.

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

Concern: Mental health and substance misuse services were under-resourced and did not meet the needs of the population.

3.30 The Royal College of Psychiatry had undertaken a review of the mental health and clinical substance misuse services and made some clear recommendations. These were added to improvement plans. The psychiatry provision had increased from two sessions a week to 12, 60% of which were patient facing, which was excellent. This meant that there were fewer delays for urgent and new assessments, and the average wait for a non-urgent assessment had reduced by 15 weeks, and was now approximately six weeks.

3.31 Cwm Taf Morgannwg primary and secondary mental health care services had developed a new single referral pathway, supported by regular meetings, which had improved communication between the teams. Secondary mental health services were now recording patient contact on the clinical information system, but, because of a lack of formal training, were not yet using the system effectively to manage appointments, wait lists and caseloads.

3.32 There had been a small increase in the number of mental health nurses recruited into the primary care team, but delays in security clearance had extended the wait for interventions. The 28-day target for an initial assessment was being met and those in crisis were seen promptly.

3.33 Psychology interventions were still not available for those with more complex mental health needs, but a review of required staffing had been undertaken and recommendations were expected to be published soon after our visit. Psychological interventions were available for those cared for under the Dyfodol psychosocial drug service.

3.34 Secondary mental health services had little or no facilitated space in which to deliver confidential care, and psychiatry sessions were undertaken on the wings in ad hoc space, which was not equitable with the equivalent care in the community. It was commendable that staff continued to deliver treatment within these constraints.

3.35 The pharmacist independent prescriber for substance misuse remained in post. There was now one additional prescribing session, but pressures remained high. A business case had been submitted to HMPPS to increase the clinical resource, but this had stalled, with no decision made on increasing the provision further. Face-to-face consultations and 13-week reviews were still very limited.

3.36 Dyfodol was now fully staffed on site, which, along with the reduction in the number of prisoners being managed for being under the influence (see paragraph 3.8), had enabled a wider range, and more consistent delivery, of interventions.

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

Education, skills and work activities

Arolygiaeth Ei Fawrhydi dros Addysg a Hyfforddiant yng Nghymru
His Majesty's Inspectorate for Education and Training in Wales

This part of the report is written by Estyn inspectors.

Concern: Too few prisoners attended education, skills or work sessions, in part because of weaknesses in allocations and inconsistencies in the regime, and data on attendance were not used effectively across the prison to identify trends and address poor attendance.

3.38 Collaborative working between Novus Gower and G4S had strengthened through the development and embedding of new systems to oversee allocations and attendance at education, skills and work.

3.39 Newly established data recording and analysis arrangements had enabled leaders to monitor attendance more effectively across cohorts, wings and at an individual level. This had led to a clearer understanding of attendance and non-attendance patterns.

3.40 Leaders had taken steps to explore barriers to engagement in education, skills or work sessions by consulting small groups of non-attenders. In addition, strengthened quality assurance processes had enabled leaders to identify and increasingly challenge instances of unauthorised absence, supported by residential staff. Collectively, these actions had contributed to a gradual reduction in unauthorised absence over time.

3.41 Pathways within education and work had been clarified, and information about courses and progression routes was more accessible through induction processes and the introduction of in-cell technology.

3.42 The implementation of a data dashboard for education, skills and work staff had further strengthened allocation processes by improving the accuracy, accessibility and sharing of prisoner information between Novus Gower and G4S. This enabled daily monitoring of allocations, supported closer alignment of these with prisoners' needs and interests, and helped identify and reduce the number of prisoners without an identified employment pathway. As a result, allocation rates increased considerably from March 2025.

3.43 However, persistent regime curtailments, classroom closures and teacher shortages (partly due to vetting delays) disrupted learning and led to a substantial loss of learning time.

3.44 These disruptions led to courses extending beyond planned timescales and resulted in some prisoners experiencing delays in being allocated to and starting education provision.

3.45 Estyn considered that the prison had made insufficient progress against this concern.

Concern: Access to the library remained too limited, particularly for those not attending education classes.

3.46 The two libraries remained underused. The ability of all prisoners to access the library, both during education classes and at weekends, was hindered by regime curtailments.

3.47 Leaders had started to evaluate attendance at the library by prisoners in work, education and those who were unemployed.

3.48 Nearly all learners in education in the amenities building accessed the library once a week as part of their studies, which was an improvement since the time of the inspection.

3.49 Other prisoners were able to use the library on alternate Saturdays. Leaders had adapted timetables so that library visits did not clash with gym sessions, to improve engagement. However, there were limited places available for these visits and although staff prioritised these slots for those prisoners not in education, uptake remained low, particularly for unemployed prisoners.

3.50 Library access had improved for vulnerable prisoners. However, prison data in this area were collected in a way which did not allow a direct comparison with other groups across the prison.

3.51 Both of the libraries were pleasant spaces, which were well stocked and had a range of resources, including books for emergent readers, Welsh-medium books and audio books. The service was run by an enthusiastic team, who had introduced a small range of activities to incentivise reading, including visits from authors.

One of the libraries

3.52 Prisoners had benefited from the provision of in-cell tablet computers, which allowed them to access a range of reading material, although the choice of books was limited. In addition, a few prisoners used these tablets to order books, which were then delivered to their cell. A few wings had developed small reading areas for prisoners.

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

Concern: Some teaching was weak and did not challenge all learners or plan for their progression.

3.54 Overall, relationships between staff and learners were positive and supported a calm and purposeful learning environment. Teachers were generally supportive and encouraging, and used praise effectively to motivate learners.

3.55 In most lessons, staff demonstrated patience and appropriate humour, which helped sustain engagement and positive behaviour. Most teachers had a sound understanding of learners' abilities.

3.56 Peer mentors were a notable strength of the provision. Most gave clear and constructive verbal feedback, helping learners understand how to improve their work. This contributed significantly to learner engagement and confidence.

3.57 Where teaching was most effective, teachers applied their subject knowledge well and planned a range of engaging activities which were

well matched to the needs of learners, supporting them on an individual basis or in small groups.

3.58 However, the quality of teaching remained inconsistent. Where teaching was less effective, teachers' subject knowledge was weaker and, as a result, they relied too heavily on worksheets or schemes that were not consistently well matched to learners' needs.

3.59 Leaders had a secure understanding of the quality of teaching and learning. They had strengthened approaches to ensuring that all staff had a shared understanding of learners' starting points. They were successfully using development plans and professional learning to drive improvement, support middle leaders and hold staff to account. Recent improvements were beginning to have a positive impact on the success rates of specific groups of learners.

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

Concern: Self-evaluation of the education, skills and works provision was neither precise nor comprehensive, failing to prioritise the areas of most importance to securing progress.

3.61 Since the inspection, leaders had improved partnership working between Novus Gower and G4S. Some of the barriers to information sharing between the two organisations apparent at the time of the inspection had been addressed.

3.62 Self-evaluation processes had been enhanced, including through cross-provider observations and the involvement of useful expertise from Gower College Swansea and Novus.

3.63 The self-evaluation report was appropriately self-critical and clearly identified strengths and areas for improvement. The quality development plan was detailed and aligned well with the highlighted areas for improvement.

3.64 A cross-provider 'quality improvement group' had been formed and reviewed progress against the actions appropriately.

3.65 Useful professional learning activities, which linked well to priorities, had taken place and had been well received by staff.

3.66 Improved self-evaluation processes, improvement planning and professional learning were beginning to have an impact on the quality of teaching and outcomes for learners.

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

Reducing reoffending

Concern: Not enough was being done to support prisoners to reduce their risk or progress in their sentence. Contact with offender managers was infrequent, and key work delivery did not support offender management.

3.68 The establishment continued to hold a complex and diverse population, which posed challenges for offender management. These included remanded, unsentenced and sentenced prisoners, as well as licenced recalls, young adults, foreign nationals, prisoners convicted of sexual offences and those serving indeterminate sentences.

3.69 The offender management unit (OMU) remained constrained by persistent staffing challenges, including changes in leadership and shortages of probation-employed prison offender managers (POMs), caused by long-term sickness and unfilled vacancies.

3.70 While OMU leaders had recently introduced measures to monitor and drive improvements in the frequency of contact between POMs and prisoners, engagement remained inconsistent.

3.71 POM caseloads were still high, particularly given the risk and complexity of the cases they managed. Contact with prisoners was often infrequent, reactive to time-bound events and did not provide sufficient opportunities for meaningful sentence planning or progression. In the cases we reviewed, some prisoners had not had any contact with a POM for several months, and others had received none since arriving at the prison. This lack of engagement continued to be a source of frustration for many prisoners we spoke to.

3.72 The use of key work (see Glossary) had developed since the inspection. On all residential units, a small cohort of prisoners who had been identified as complex or vulnerable was each assigned a dedicated key worker. However, the quality of sessions varied considerably and they were not yet sufficiently supportive of offender management. Quality assurance measures to monitor the effectiveness of this work had recently been introduced.

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

Public protection

Concern: There were gaps in public protection arrangements. Checks of new arrivals were delayed, arrangements for offence-related monitoring were inadequate and oversight before the release of prisoners who presented the greatest risk was insufficient.

3.74 There had been some early signs of improvement in the prison's understanding and management of public protection arrangements, but some areas of concern remained.

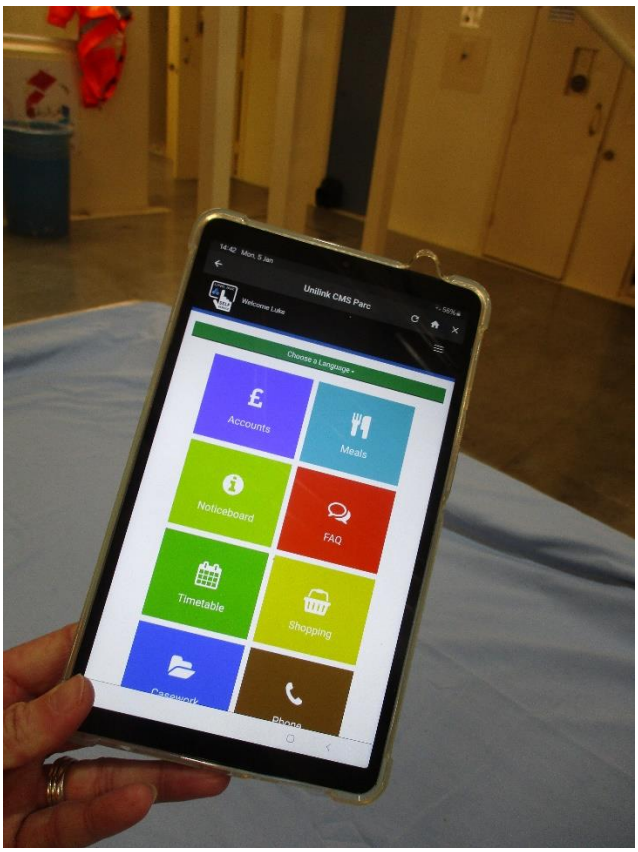
3.75 Oversight had been strengthened through the recent appointment of a public protection coordinator and the re-establishment of the public protection steering group, designed to provide senior management governance in this area.

3.76 While the scope of the interdepartmental risk management team meeting was still being developed, it was now better attended and provided an improved oversight of release planning for some of the highest-risk prisoners. However, the process for selecting cases for review was not sufficiently clear or systematic.

3.77 Delays in completing transfer checks for new arrivals persisted. These were mainly due to shortages in staffing capacity, gaps in skills and experience within the case administration team, and the large number of prisoners arriving from other prisons without the necessary paperwork. As a result, key risk factors were not always identified, recorded, shared or acted on promptly, creating gaps in risk management and limiting the ability of staff to apply appropriate controls early in a prisoner's sentence. Leaders had recently developed a business case to secure additional resources in an effort to address these shortfalls.

3.78 Despite improved joint working between the security department and OMU, we were not confident that screening processes appropriately identified all those who should have been considered for offence-related monitoring. There were delays in communications being monitored, which meant that risks were not always identified and acted on swiftly, and authorisations and reviews were not always timely.

3.79 The introduction of in-cell tablet computers had been a positive initiative for prisoners. However, it compounded monitoring delays because the devices enabled incoming and outgoing text messaging, which significantly increased the volume of contacts that needed to be monitored.



In-cell tablet computer

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

Section 4 Summary of judgements

A list of the concerns followed up at this visit and the judgements made.

Recommendations

The number of violent incidents was high. Leaders' understanding of the causes was limited and their response was yet to have an effect.
Insufficient progress

The availability and use of illicit drugs were widespread. Nearly a third of all random drug test results were positive and, in our survey, over half of prisoners said that it was easy to get drugs in the prison.
Good progress

Levels of recorded self-harm remained high, and not enough was being done to address the causes of this.
Insufficient progress

Actions by leaders to resolve and mitigate identified risks to health outcomes had been too slow. There was a shortage of suitable clinical space, particularly for dentistry, and insufficient prison staff to facilitate hospital escorts.
Insufficient progress

Mental health and substance misuse services were under-resourced and did not meet the needs of the population.
Reasonable progress

Too few prisoners attended education, skills or work sessions, in part because of weaknesses in allocations and inconsistencies in the regime, and data on attendance were not used effectively across the prison to identify trends and address poor attendance.
Insufficient progress

Access to the library remained too limited, particularly for those not attending education classes.
Insufficient progress

Some teaching was weak and did not challenge all learners or plan for their progression.
Reasonable progress

Self-evaluation of the education, skills and work provision was neither precise nor comprehensive, failing to prioritise the areas of most importance to securing progress.
Reasonable progress

Not enough was being done to support prisoners to reduce their risk or progress in their sentence. Contact with offender managers was infrequent, and key work delivery did not support offender management.

Insufficient progress

There were gaps in public protection arrangements. Checks of new arrivals were delayed, arrangements for offence-related monitoring were inadequate and oversight before the release of prisoners who presented the greatest risk was insufficient.

Insufficient progress

Appendix I About this report

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

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

Independent reviews of progress (IRPs) are designed to improve accountability to ministers about the progress prisons make towards addressing HM Inspectorate of Prisons' concerns in between inspections. IRPs take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny and focus on a limited number of the concerns made 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 recommendation we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in [MONTH, YEAR] for further detail on the original findings (available on our website at Our reports – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)).

IRP methodology

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

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

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

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

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

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

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

Inspection team

This independent review of progress was carried out by:

Donna Ward	Team leader
Jade Richards	Inspector
Harriet Leaver	Inspector
Sumayyah Hassam	Inspector
Tania Osborne	Health and social care inspector
Rachel Hackling	Estyn inspector
Steve Bell	Estyn inspector
Richard Murray	Estyn 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.

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.

Incentivised substance-free living (ISFL) units
Dedicated prison units for prisoners who commit to living drug-free. Residents agree to a behavioural compact, undergo regular drug testing, and receive incentives such as extra time out of cell or access to activities. ISFL units provide a structured environment that promotes recovery, positive relationships, and healthier choices.

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.

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

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