Report on an independent review of progress at

# HMP Exeter

by HM Chief Inspector of Prisons

**8–10 April 2019**

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**Glossary of terms**

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

# About this report

A1 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.

A2 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.

A3 Independent reviews of progress (IRPs) are a new type of visit designed to improve accountability to Ministers about the progress prisons make towards achieving HM Inspectorate of Prisons' recommendations between inspections. IRPs will take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny, and will focus on a limited number of the recommendations made at the inspection. IRPs will therefore not result in assessments against our healthy prison tests.[1]

A4 The aims of IRPs are to:

- assess progress against selected key recommendations
- 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 main concerns at the full inspection.

A5 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 May 2018, for further detail on the original findings.[2]

## IRP methodology

A6 IRPs will be announced at least three months in advance and will take place eight to 12 months after the full inspection. When we announce an IRP, we will identify recommendations from the original inspection report which are of most importance to the well-being of prisoners (usually no more than 15) and communicate these to the Governor/Director of the prison.

A7 During our three-day visit, we will collect a range of evidence about the progress in implementing each selected recommendation. Sources of evidence will include observation, discussions with prisoners, staff and relevant third parties, documentation and data.

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1 HM Inspectorate of Prisons' healthy prison tests are safety, respect, purposeful activity and rehabilitation and release planning. For more information see our website: https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/

2 Available at https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/10/Exeter-Web-2018.pdf

A8 We will make one of four possible judgements for each recommendation we follow-up:

- **No meaningful progress**
  Managers had not yet formulated, resourced or begun to implement a realistic improvement plan for this recommendation.

- **Insufficient progress**
  Managers had begun to implement a realistic improvement strategy for this recommendation but the actions taken had not yet resulted in any discernible evidence of progress (for example, better systems and processes) or improved outcomes for prisoners.

- **Reasonable progress**
  Managers were implementing a realistic improvement strategy for this recommendation and there was evidence of progress (for example, better systems and processes) and/or early evidence of some improving outcomes for prisoners.

- **Good progress**
  Managers had implemented a realistic improvement strategy for this recommendation and had delivered a clear improvement in outcomes for prisoners.

A9 Depending on the recommendations 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.

# Key findings

S1 At this IRP visit, we followed up 13 of the 47 recommendations made at our most recent inspection and made judgements about the degree of progress achieved to date.

S2 We judged that there was good progress in three recommendations, reasonable progress in three recommendations, insufficient progress in four recommendations and no meaningful progress in three recommendations. A summary of the judgements is as follows.

**Figure 1: Progress on recommendations from 2018 inspection (n=13)**

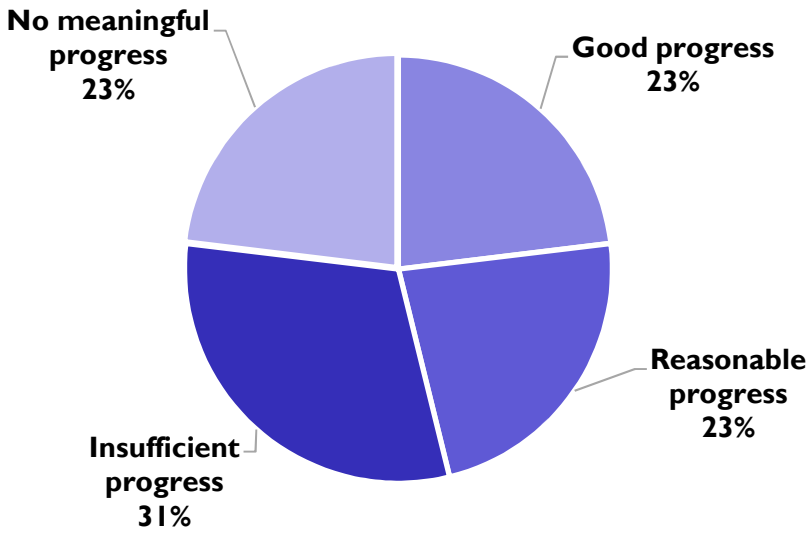



**Figure 2: Judgements against individual recommendations from May 2018 inspection**

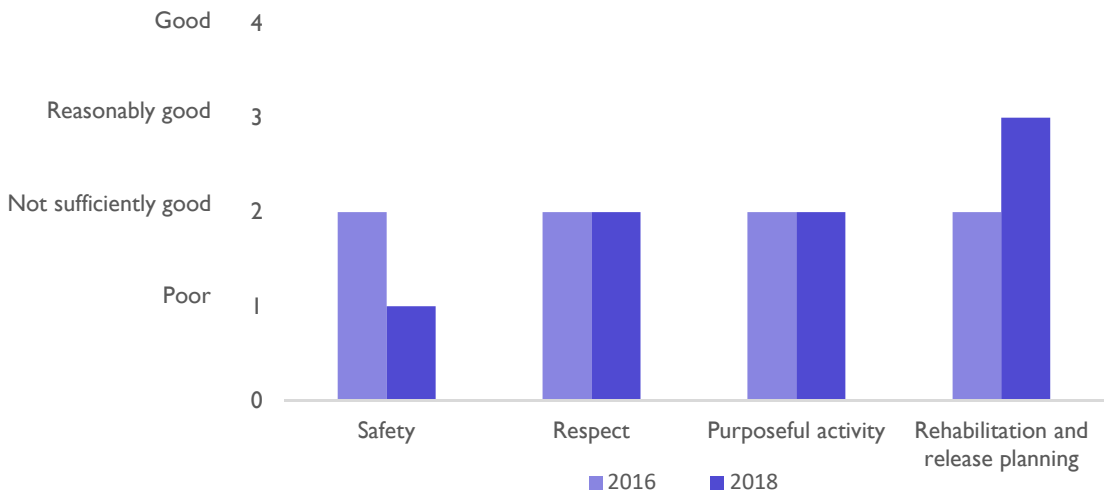
| Recommendation | Judgement |
|---|---|
| All aspects of the violence reduction strategy should be implemented. Supervision, by staff and by camera, should be effective in detecting and preventing bullying and violent behaviour. Engagement with prisoners to understand safety issues should be improved 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. (S36) | Reasonable progress |
| 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. (1.43) | No meaningful progress |
| 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. (S37) | Reasonable progress |

| | |
|---|---|
| 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 well-being. 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. (S38) | Good progress |
| 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. (S39) | Reasonable progress |
| 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. (S40) | No meaningful progress |
| All prisoners should have good quality weekly meetings with their keyworker, and these should be fully recorded in electronic case notes. (2.4) | Insufficient progress |
| The prison should ensure that applications are dealt with promptly and helpfully. (2.21) | Good progress |
| Quality assurance procedures should be developed to improve investigation of and responses to complaints. (2.22) | Good progress |
| All prisoners should be unlocked for sufficient time to access regime services, undertake domestic activities fully and have a daily period of association. (3.10) | Insufficient progress |
| All prison work should enable prisoners, including vulnerable prisoners, to develop useful vocational skills, improving their prospects of finding employment after release. (3.23) | No meaningful progress |
| 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. (3.38) | Insufficient progress |
| 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. (4.19) | Insufficient progress |

# Section 1. Chief Inspector's summary

**1.1** At our inspection of HMP Exeter in May 2018 we made the following judgements about outcomes for prisoners.

**Figure 3: HMP Exeter healthy prison outcomes 2018**




**1.2** HMP Exeter is a category B local and resettlement prison that holds prisoners sentenced by the courts of Devon, Cornwall, Dorset and Somerset. There are also prisoners from further afield on transfer from other prisons. The number of prisoners held at the time of this independent review visit was 476.

**1.3** The last full inspection was carried out in May 2018. Our judgements reflected a continued failure to deliver good or reasonably good outcomes for prisoners in three of our four healthy prison tests. Of most concern was the further decline in positive outcomes in the critical area of safety which attracted our lowest possible assessment of 'poor'. This was despite my comment in the 2016 report warning of inevitably poor outcomes in the future if the establishment failed to address the issues of violence, drugs and the lack of a sufficiently purposeful regime.

**1.4** There had been six self-inflicted deaths between the 2016 and 2018 inspections, and self-harm had risen by 40%. Despite the high levels of vulnerability, self-harm and suicide among prisoners at Exeter, cell call bells were routinely ignored by staff. The rate of assaults between prisoners was the highest we had seen in a local prison in recent years and had more than doubled since the inspection in 2016. Illicit drugs were still prevalent and living conditions for many in the prison were very poor. The lack of progress at the establishment, and in particular the sharp deterioration in safety outcomes, was so concerning that I decided to invoke the Urgent Notification Protocol.

**1.5** At this independent review of progress we found that the prison's response had been good or reasonably good in almost half the recommendations we reviewed. However, there had been no meaningful progress against three of the 13 recommendations, two of which had been main recommendations in the last report. There had also been insufficient progress against four of the recommendations we were reviewing.

**1.6** Overall levels of violence had decreased since the 2018 inspection but incidents between prisoners, some of which were serious, remained higher than in similar prisons. A number of actions had been taken to reduce violence and the strategy to reduce violence further in the future was promising. The use of unregulated segregation had been eradicated, and governance of the use of force was improving. However, despite a rise in the already high use of illicit drugs in the establishment, there had been an inexplicable failure to develop a comprehensive drug strategy which, if properly implemented, would certainly contribute to a reduction in violence. A draft strategy was being put together and it is essential that this is now treated as a priority.

**1.7** Relationships between staff and prisoners were improving and improvement processes were in place to monitor cell bell responses. Although efforts had been made to improve living conditions, improvements had been slow and standards were still not sufficiently high. Despite Exeter being a pilot for the offender management in custody (OMIC) programme, progress had been too slow and the quality of interactions was variable. Progress had been good in the important areas of prisoner applications and complaints. However, in contrast and despite it being a main recommendation at our inspection, equality and diversity work had not been prioritised at all. We were also concerned that the establishment's future plans in this area relied too heavily on an enthusiastic middle manager and did not give appropriate responsibility to the most senior managers to drive this important work.

**1.8** There had not been sufficient progress against the recommendations relating to the regime and work. Attendance at education and work, some of which remained mundane, had not been prioritised. Purposeful activities and domestic periods were scheduled at the same time on certain days; this left some prisoners having to decide between a shower or work.

**1.9** The lack of progress in over half the 13 recommendations that we reviewed could be characterised by the statement 'too little too late'. The purpose of the Urgent Notification Protocol, which is only used where I have serious concerns about the treatment of and conditions for prisoners, is to initiate immediate remedial action. At Exeter, in too many critical areas, this simply had not happened. It was not clear whether this was as a result of a conscious decision not to prioritise our recommendations, bureaucratic inertia, or whether managers were simply overwhelmed or uncertain as to how to set about making the much-needed improvements. Whatever the reason, there had not been a sufficient sense of urgency in the prison's response to a number of key recommendations. The establishment was required to produce an action plan for the Secretary of State following the Urgent Notification, but a number of the deadlines in this plan had not been met on time.

**1.10** Nevertheless, there had been a proactive response to some recommendations in critical areas and there are now credible plans to make further improvements in the future. It is unfortunate that the prison had not devised and implemented some of these plans earlier as they would no doubt have led to a more positive assessment at this review of progress.

**Peter Clarke CVO OBE QPM** April 2019
HM Chief Inspector of Prisons

# Section 2. Progress against the main concerns and recommendations

The following provides a brief description of our findings in relation to each recommendation followed up from the full inspection in 2018. The reference numbers at the end of each recommendation refer to the paragraph location in the full inspection report.

## Encouraging positive behaviour

**Concern:** One in three prisoners felt unsafe. High levels of violence had increased significantly since the previous inspection and were higher than at other local prisons. Many incidents were serious. Important elements of the violence reduction strategy had not been implemented effectively, supervision was inconsistent, and the incentives and earned privileges scheme was not focused on motivating positive behaviour.

**Recommendation: 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.** (S36)

**2.1** In June 2018, the prison held a series of forums for staff and prisoners to discuss issues relating to violence. Discussions focused on key questions to identify the drivers of violence and the information gathered was subsequently analysed by senior managers. The findings from these meetings, and analysis of other local data, led to the relaunch of an evidence-based safety strategy in November 2018.

**2.2** The prison was trying to manage several competing and sometimes confusing action plans to reduce violence. Actions did not always identify a responsible lead and were not always appropriately time bound. This affected the establishment's ability to track progress and resulted in several key actions remaining incomplete at the time of our visit. However, this was recognised and managers aimed to rationalise and simplify the planning process.

**2.3** A weekly meeting had been introduced to interrogate and analyse various aspects of safety, including violent incidents and self-harm. Concerns and emerging trends in violence and self-harm were identified at an early stage, which prompted managers to intervene in an attempt to address the issues that had been highlighted.

**2.4** In November 2018, some six months after the Urgent Notification Protocol was invoked, the prison introduced the HMPPS challenge, support, intervention plan (CSIP) process[3] to manage both perpetrators and victims of violence. There had been good early promotion of the CSIP process and we reviewed some good examples of intervention plans and support for prisoners. However, the quality of plans was inconsistent and important procedural aspects of the process, such as the need for consistent case reviews, were not fully embedded. CSIP, by design, focused on prisoners with the most challenging and complex concerns. Outside the CSIP process we were not confident that there was sufficient support or intervention for other prisoners involved in or subject to violence and bullying.

[3] CSIP is the national case management model for those who are violent or pose a raised risk of harming others through violence. Prisoners identified as the perpetrator of serious or repeated violence are managed and supported by a plan with individual targets and regular reviews.

**2.5** We observed reasonable supervision by staff on landings, but fabric checks and senior manager quality assurance checks had not addressed problems of damaged furniture and broken windows. There had been some improvement in the use of CCTV camera footage to review incidents and, while an upgraded camera system was more efficient, progress to repair damaged cameras was still too slow (see paragraph 2.16).

**2.6** The senior manager responsible for residential units was clearly visible and trying hard to raise standards. Support from the wider leadership team was also needed to ensure that staff understood their role in raising and maintaining standards, and making prisoners feel safe and motivated.

**2.7** Improvements had been made to the local incentives and earned privileges (IEP) policy to encourage positive behaviour, and governance in this area was better. Some improvements had been made to the enhanced wing and for enhanced prisoners living on C wing. However, revisions to the IEP policy had only been made in March 2019 and it was too early to assess its effectiveness.

**2.8** There had been an overall reduction in incidents of violence since the May 2018 inspection, but prisoner-on-prisoner violence remained higher than in most similar prisons. Although not originally the primary focus of our recommendation, in terms of prisoners' perception of their safety, it remained concerning that since the 2018 inspection, there had been two self-inflicted deaths and a further unexplained death shortly before this review visit. Over the previous six months, there had been an increase in the number of self-harm incidents, and levels remained among the highest in local prisons. Despite clear efforts to improve safety, the continued availability of illicit substances and poor living conditions remained contributing factors in incidents of violence and self-harm, and progress in these areas was slow (see paragraphs 2.13 and 2.28).

**2.9** We considered that the prison had made reasonable progress against this recommendation.

## Security

**Concern:** A drug strategy and supply reduction action plan were in place, but they were limited and did not address demand issues. There was too little evidence of integrated work across all departments to understand the link between wider prison issues and drug use.

**Recommendation: 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.** (1.43)

**2.10** The substance misuse team continued to deliver some good work and had useful links with the security team. However, despite the obvious link between the drug culture and violence, the prison had failed to adopt a whole prison approach to understanding the wider factors linked to substance misuse to help them reduce the supply and demand of illicit drugs.

**2.11** The drug strategy had only just been relaunched and, until March 2019, no drug strategy meeting had been held to explore the wide range of issues and risks. There was no meaningful action plan in place.

**2.12** The positive mandatory drug testing rate, including new psychoactive substances (NPS),[4] had increased sharply since the full inspection to 31.9%.

[4] Drugs that are developed or chosen to mimic the effects of illegal drugs such as cannabis, heroin or amphetamines and may have unpredictable and life-threatening effects.

**2.13** We considered that the prison had made no meaningful progress against this recommendation.

## Use of force

**Concern:** Governance of the use of force remained inadequate and could not assure managers or us that all force was appropriate or recorded.

**Recommendation: 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.** (S37)

**2.14** Managers had developed new systems for collating use of force reports which had delivered a significant improvement and almost all reports were now routinely submitted in good time. The quality of reports in our sample was mixed. Some were very good, but others lacked detail with insufficient justification of the necessity for force to have been used.

**2.15** The special cell was now used less frequently and the log was complete. Authorising paperwork for the most recent uses was reasonable.

**2.16** There had been some improvement in the use of body-worn cameras. Footage was downloaded each day and managers routinely reviewed it (54 reviews in March 2019) and fed back learning points to individual members of staff. Planned incidents were now video-recorded and the footage reviewed by the deputy governor. There had been some improvement in the use of CCTV camera footage to review incidents (see paragraph 2.5).

**2.17** Additional body-worn video cameras had been purchased and 44 were in use. A local policy indicated that a minimum of 39 cameras should be issued each morning, but we found only 31 had been drawn. We found staff working on the landings who had chosen not to draw a camera, suggesting that opportunities to de-escalate violent incidents could be missed. The independent monitoring board had also identified this concern. However, there was no regular monitoring of the number of cameras deployed.

**2.18** The use of force committee now met monthly. It was chaired by the deputy governor and attendance was usually reasonable. We discovered some discrepancies in the use of force log, written reports and monthly reports which suggested that closer scrutiny of data and documentation was required. The committee reviewed 10% of incidents from the previous month, but with no access to associated video footage. The minutes did not always record the comments and no actions resulted from this activity. Given the scale of use of force at Exeter, we considered that quality assurance of reports required more attention.

**2.19** Use of force had started to reduce, which was good.

**2.20** We considered that the prison had made reasonable progress against this recommendation.

# Segregation

**Concern:** The conditions for segregated prisoners, both on the segregation unit and for those unofficially segregated or self-isolating, were very poor. They were locked up for almost 24 hours a day with little exploration of the root causes leading to segregation, minimum human contact, a poor regime, and no meaningful plans for their future management.

**Recommendation: 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 well-being. 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.** (S38)

**2.21** Prisoners were no longer held in unregulated segregation on C1 landing without proper authorisation or safeguards in place. The landing was now a designated area for prisoners on the enhanced level of the privileges scheme.

**2.22** There had been improvements to the regime in the segregation unit. An adequate but basic regime was now offered. Prisoners had access to a limited range of in-cell activities and a daily shower, phone call and period of exercise.

**2.23** Managerial oversight of the segregation unit had been increased and daily checks were conducted by the duty governor and custodial manager to ensure that prisoners were being encouraged to access the regime. Care plans were now discussed at the safety interventions meeting.

**2.24** Reintegration planning was effective and, in the cases we examined, explored the behaviours that led to the period of segregation. Very recent changes ensured that reintegration planning started at the 72-hour point of segregation, which was an improvement on the previous practice of starting after two weeks in segregation. Many prisoners relocated back to normal locations in Exeter rather than out of the establishment.

**2.25** We considered that the prison had made good progress against this recommendation.

# Living conditions

**Concern:** A huge backlog of maintenance work had left communal areas and cells in poor condition. Too many prisoners lived in overcrowded cells that did not meet basic health, hygiene and safety requirements. Staff and managers were inured to poor conditions and did not do enough to address this. Cell call bells in occupied cells were left unanswered for too long, even when staff were doing nothing else.

**Recommendation: 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.** (S39)

**2.26** There had been some improvements to living conditions, but progress was very slow.

**2.27** A six-month refurbishment programme had been scheduled in response to our inspection. However, this had only recently started, with just one wing completed. Despite a prolonged refurbishment programme in the segregation unit, there were still concerns about plumbing

leaks and temperature. There were still significant delays in the completion of repair work by the maintenance contractor.

**2.28** A cell standard policy had been implemented and any cells falling below the expected standard were not to be used to accommodate prisoners. Additionally, a tiered governance structure had been implemented for cell accommodation and fabric checks. There had been a reduction in the number of cells declared out of use since our inspection. Despite this quality assurance, we still found prisoners located in cells without windows, and a very recent example of a prisoner located in a cell in the segregation unit that was filthy and not fit for use.

**2.29** Improvements had been made to living conditions on D wing and some furniture had been replaced in other areas of the prison. Association equipment on some wings was still in a state of disrepair, and prisoners on F wing had little association equipment with which to occupy their time.

**2.30** Despite the introduction of weekly quality assurance checks by managers, standards of cleanliness were not set sufficiently high and parts of the prison were still very dirty.

**2.31** Prisoners still had concerns about regular access to clean clothing and bedding. This was due to broken washing machines and tumble dryers or the absence of accurate recording of items submitted to the contracted laundry service. The prison had recently introduced an in-house laundry team to address this longstanding problem.

**2.32** We observed many positive interactions between staff and prisoners.

**2.33** Some improvement had been made in monitoring the response time for cell call bells and more were being answered within five minutes. However, there was a risk of deterioration in this area due to a lack of continuous monitoring. A small number of prisoners still waited for exceptionally long periods before their bells were answered.

**2.34** We considered that the prison had made reasonable progress against this recommendation.

# Equality and diversity

**Concern:** Equality and diversity were not regarded as priorities, and there was insufficient attention to the distinct needs of different groups.

**Recommendation: 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.** (S40)

**2.35** Equality and diversity had not been prioritised, despite being the subject of a main recommendation. Nobody had been leading in this area until the equality adviser took up post in January 2019 and, until that point, there had been little meaningful work to understand and respond to the needs of prisoners with protected characteristics. The first equality action team meeting for a year took place in April 2019 but without prisoner representation.

**2.36** It was positive that support was in place for some protected characteristic groups, for example the allocation of a prison offender manager for all young adults. F wing continued to support prisoners with disabilities, many of whom were elderly. In addition, all prisoners were allocated a keyworker which should have met some individual need, although we did

not find any examples of key work that clearly recognised issues concerning a prisoner's protected characteristic.

**2.37** The appointment of the equality adviser had resurrected work in this area, but senior management support would be critical in prioritising equality and diversity work in the future.

**2.38** We considered that the prison had made no meaningful progress against this recommendation.

## Staff-prisoner relationships

**Concern:** At the 2018 inspection some entries recorded by keyworkers lacked depth. Contact between keyworker and prisoner was not frequent enough, and some prisoners had not been seen by a keyworker.

**Recommendation: All prisoners should have good quality weekly meetings with their keyworker, and these should be fully recorded in electronic case notes.** (2.4)

**2.39** Protected duty time had been assigned for staff to carry out 45 minutes' key work a week with each of the prisoners allocated to them. However, few prisoners experienced this level of contact and some said that they seldom saw their keyworker. The delivery of this work was not being driven by a senior manager and there was no evidence that key workers were held to account if they had not arranged or recorded sessions with prisoners.

**2.40** Some of the case notes we reviewed indicated good quality meetings focusing on the prisoner's progression in the establishment, for example how to achieve enhanced incentives and earned privileges (IEP) status or secure a wing move. We also saw examples of keyworkers attending ACCT[5] reviews and liaising with other departments, such as health care and psychology, to support the prisoner. However, there was little evidence of meaningful conversations with prisoners about their offending behaviour or how they could meet their sentence planning targets.

**2.41** We considered that the prison had made insufficient progress against this recommendation.

## Prisoners consultation, application and redress

**Concern:** Responses to applications were not tracked and we were not confident that they had been dealt with adequately.

**Recommendation: The prison should ensure that applications are dealt with promptly and helpfully.** (2.21)

**2.42** HMPPS had installed electronic kiosks on wing landings which enabled prisoners to access a range of services. An applications function had been installed in early March 2019, replacing the previous paper system. Prisoners could now easily track their applications and any responses. They appreciated having a permanent record of the responses they had received and generally spoke of prompt and polite replies.

**2.43** Implementation of the kiosks had been well managed, led by a national implementation team who were still on site and supported by peer supporters known as kiosk champions. Some

[5] Assessment, care in custody and teamwork case management of prisoners at risk of suicide or self-harm.

minor teething problems were still being overcome and a few kiosks were not working properly, but prisoners were universally enthusiastic about the new system.

**2.44** Managers were beginning to quality assure the kiosk system as a means of managing applications and were finalising a policy on future improvements.

**2.45** We considered that the prison had made good progress against this recommendation.

**Concern:** Some investigations into complaints were superficial and the quality of some responses to complaints was inadequate.

**Recommendation: Quality assurance procedures should be developed to improve investigation of and responses to complaints.** (2.22)

**2.46** Managers had produced a new complaints policy which explained the principles of procedural justice and gave examples of responses to complaints. Staff who answered complaints were familiar with this policy.

**2.47** Managers had also developed and refined a quality assurance process which was used to test 20 complaints a month against standards such as timeliness, sufficiency of investigation, respectfulness and clarity of response. This represented an average of 30% of complaints, which was good. Managers wrote to the originator of the response explaining whether it was adequate and praising or highlighting good practice as appropriate. Staff appreciated this recognition and support.

**2.48** Most replies were completed within the appropriate timescales. The majority of responses were at least reasonable, and some were good. However, some quality assurance was not sufficiently challenging and failed to identify whether prisoners should have been spoken to, or whether more investigation or a more detailed response was needed.

**2.49** We considered that the prison had made good progress against this recommendation.

# Time out of cell

**Concern:** There was often slippage to the regime and prisoners were locked up too early and unlocked late.

**Recommendation: All prisoners should be unlocked for sufficient time to access regime services, undertake domestic activities fully and have a daily period of association.** (3.10)

**2.50** HMPPS had only partially agreed to this recommendation and there was no embedded plan to address it.

**2.51** There had been no change to the published regime since the inspection, but prisoners spoke more positively about their access to domestic activities, for example, showers and electronic kiosks (see paragraph 2.42). Most said that they could now shower each day.

**2.52** The regime allowed prisoners to conduct domestic duties during the core day, but this was scheduled at the same time as work and education. Some prisoners routinely chose to remain on their wings to carry out domestic tasks instead of engaging in purposeful activity. Association was only offered on alternate evenings and the regime at weekends remained limited.

**2.53** The prison had only introduced very basic monitoring of the core day in March 2019 and there was no evidence that this was prioritised by managers.

**2.54** We considered that the prison had made insufficient progress against this recommendation.

## Management of education, skills and work

**Concern:** Too much prison work was mundane and prisoners did not develop a range of useful practical skills to help them on release. Vulnerable prisoners did not have access to a wide enough range of activities.

**Recommendation: All prison work should enable prisoners, including vulnerable prisoners, to develop useful vocational skills, improving their prospects of finding employment after release.** (3.23)

**2.55** HMPPS only partially agreed this recommendation on the grounds that it was not possible to ensure that all work in a local prison had a vocational training element.

**2.56** The plan to improve the quality of prison work was vague. It included an aspiration to improve the range of activity for all prisoners and to improve access to the learning zone for vulnerable prisoners. Much of the information presented as evidence of addressing this recommendation had not changed since our inspection.

**2.57** We visited the workshops and observed prisoners working on wings. The work remained mundane and the range of work opportunities had not changed since our inspection. Access to the learning zone remained limited to Friday mornings for vulnerable prisoners. Managers proposed to reserve the learning zone for vulnerable prisoners for two in every 12 weeks, but their plans were not developed. In the previous six weeks, art and painting and decorating classes had been added. These had been poorly attended.

**2.58** Since November 2018, a part-time teacher had offered work skills qualifications to prisoners working in the workshops. This intervention was based on a workbook with six modules, including health and safety and equality and diversity. Only eight of the 38 prisoners who had registered had completed the course, which was poor.

**2.59** Managers told us that a full review of work activities, the skills of the workplace supervisors and the accreditation opportunities available had been commissioned for the financial year 2019 to 2020.

**2.60** We considered that the prison had made no meaningful progress against this recommendation.

## Personal development and behaviour

**Concern:** Too many prisoners attended their activities irregularly and arrived late, impeding the development of employability skills to help them secure jobs after release.

**Recommendation: 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.** (3.38)

**2.61** Progress in this area had been slow. A process had been introduced very recently to identify why prisoners had not attended their activity, but it was too early to determine its

effectiveness. Efforts had recently been made to use IEP warnings more robustly following non-attendance at activities.

**2.62** Keyworkers were tasked with discussing attendance during key work sessions and custodial managers had been made accountable for attendance figures. Again, these measures had been taken very recently and we were unable to assess their effectiveness.

**2.63** Prison data indicated that there had been no improvement in attendance since our inspection.

**2.64** We considered that the prison had made insufficient progress against this recommendation.

## Reducing risk, rehabilitation and progression

**Concern:** At the 2018 inspection, links between keyworkers and offender managers were developing, but keyworkers and offender managers did not always coordinate work sufficiently, which risked undermining targets for progression and resettlement.

**Recommendation: 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.** (4.19)

**2.65** A prison offender manager met all newly sentenced prisoners. The prison had taken steps to encourage contact between the offender manager and keyworker assigned to each prisoner. We saw evidence of email contact and, in a few instances, case notes. However, key worker contact was inconsistent (see paragraph 2.40) and we found very few examples of keyworkers attending joint planning and review meetings with the offender manager.

**2.66** Keyworkers completed progression plans in printed copy, but we did not find details of the plans recorded in the prisoner's electronic case notes and the keyworkers we spoke to had not shared the progression plan with the relevant offender manager. Few keyworkers had access to OASys[6] so that they could review sentence plans before drawing up progression plans.

**2.67** The work and relationships between offender managers and key workers remained separate and very underdeveloped.

**2.68** We considered that the prison had made insufficient progress against this recommendation.

[6] Offender assessment system is used by prison and probation services to assess the risks and needs of an offender.

# Section 3. Appendix

## Review team

| | |
|---|---|
| Peter Clarke | Chief inspector |
| Deborah Butler | Team leader |
| Ian Dickens | Inspector |
| Jeanette Hall | Inspector |
| David Owens | Inspector |
| Nadia Syed | Inspector |