Report on an unannounced short follow-up inspection of

HMP Exeter

16–18 October 2007

by HM Chief Inspector of Prisons

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Introduction

Exeter is the local prison for the south west of England, holding male young offenders as well as adult men. It is experiencing many of the pressures of an overcrowded prison estate, and this inspection found that it had not improved in any area since the last inspection, and indeed had deteriorated in its resettlement work.

Exeter remained a largely safe prison. However, as in many local prisons, population pressure jeopardised attempts to support prisoners in the crucial early days of imprisonment. Not all new prisoners could be held on the first night centre, and staff elsewhere did not always know who they were. Suicide and self-harm prevention procedures were strong, though anti-bullying work, and support arrangements for vulnerable prisoners, had slipped.

Prisoners on D wing continued to have to slop out each morning: this is unacceptable in a 21st century prison. Relationships with staff remained in general good, though we deplored the unofficial breakfast break that the main staff group were taking during the core day, in a prison where prisoners in any event had far too little time out of their cells.

There were some very effective race relations procedures, and foreign national work had also developed. Legal services work was particularly effective, and had allowed nearly 59 prisoners to obtain bail over the previous nine months. Health services were also good and improving.

Exeter continued to provide too little purposeful activity for its prisoners: we estimated that around 40% of them were in their cells during the working day. Time out of cell was poor, with access to evening association only once a week for most prisoners. Though education and vocational training opportunities had increased slightly, there were insufficient activity spaces, those that existed were not filled, and allocation systems were poor.

The management of resettlement had stalled recently, and we did not believe that the proposed new management arrangements were viable in the long term. The new offender management unit operated reasonably well, but links with outside probation staff were weak. Short-term and remand prisoners' needs were assessed on arrival, but were not then tracked through a custody planning process. Nevertheless, provision across the resettlement pathways was reasonable, with particularly effective housing advice.

This is a disappointing report on a prison where the progress that we identified at the last inspection had stalled. Only one of our main recommendations had been achieved. This is to a considerable extent a reflection of the pressure that local prisons are under; but there are also measures that managers and staff can take to limit the damage and improve outcomes for their prisoners.

Anne Owers — January 2008
HM Chief Inspector of Prisons

Fact page

Task of the establishment:
A local prison serving the courts of Cornwall, Devon and south west Somerset, holding male adult and young adult prisoners, both unconvicted and convicted.

Area organisation
South West

Number held
477

Certified normal accommodation
316

Operational capacity
533

Last inspection
13-17 December 2004

Brief history
HMP Exeter was built in the 1850s as a local prison and continues as the local prison for the south west of England.

Description of residential units
The prison is a typical Victorian prison of radial design, with three galleried wings leading from a central hub, plus a separate, refurbished unit that currently houses vulnerable prisoners.

A and C wings	-	adult and young adult prisoners, both sentenced and remanded. Single cells, mainly for double occupancy, with in-cell sanitation.
B wing	-	first night/ detoxification centre, housing newly arrived and vulnerable prisoners.
D wing	-	vulnerable prisoners, mainly in single cells with no integral sanitation.

Section 1: Healthy prison assessment

Introduction

HP1 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2004 and examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress has been made and work remained to be done. All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

Safety	prisoners, even the most vulnerable, are held safely
Respect	prisoners are treated with respect for their human dignity
Purposeful activity	prisoners are able, and expected, to engage in activity that is likely to benefit them
Resettlement	prisoners are prepared for their release into the community and helped to reduce the likelihood of reoffending.

HP2 Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the National Offender Management Service.

...performing well against this healthy prison test.
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

...performing reasonably well against this healthy prison test.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns.

...not performing sufficiently well against this healthy prison test.
There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

...performing poorly against this healthy prison test.
There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

HP3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable

inspection of progress and, where necessary, to note additional areas of concern observed by inspectors. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected. From the evidence available they also concluded whether this progress confirmed or required amendment of the healthy prison assessment held by the Inspectorate on all establishments, but only published since early 2004.

Safety

HP4 In 2004, we assessed the prison as performing reasonably well against this healthy prison test and made 31 recommendations for further improvement. In this short follow-up inspection, we found that the prison had implemented 16 of our recommendations in full, three in part, and 12 had not been implemented.

HP5 The court escort service remained good. Late arrivals were rare. Information packs about Exeter were distributed to prisoners in advance of their arrival at the establishment. Use of video court links had increased, and was now almost at maximum capacity.

HP6 The reception building had not changed and was still a poor environment. Positively, prisoners spent a very short period in reception – typically, half an hour – before they were taken to the first night centre.

HP7 First night arrangements remained generally good for most new arrivals, although new pressures jeopardised safety. All new arrivals went to the first night centre on B wing, where they had interviews and assessments with staff to cover immediate needs and welfare issues. Although all new arrivals should have spent their first night in the centre, B wing was often full because it took the overspill of the increased numbers of vulnerable prisoners who could not be held on the vulnerable prisoner unit. Consequently, some new arrivals spent their first night on other wings, and night patrols on these wings did not necessarily know their locations. B wing also accommodated prisoners undergoing detoxification from drugs or alcohol, but night staff were not notified who these prisoners were.

HP8 Induction took place the day after arrival. This remained a good process and met prisoners' immediate needs.

HP9 Governance of anti-bullying and violence reduction in general had slipped, and was below the standard at the last inspection. However, there was little evidence that bullying was a significant problem, and prisoners said that they felt safe at Exeter. The violence reduction coordinator had no formal time for proactive work. The violence reduction committee was often cancelled and, when it did take place, attendance was poor. There had been no staff training in the anti-bullying strategy, and the previous impressive arrangements for victims and bullies were no longer in place.

HP10 Despite two recent deaths in custody, arrangements for suicide and self-harm prevention appeared good. The full-time coordinator had done considerable work to improve standards. The quality of self-harm monitoring documentation reviewed was good, with robust quality assurance evident. There were eight Listeners, who felt well supported, and more were due to be trained. Two care suites had been installed since the last inspection, but were in a poor condition.

HP11 The separation and care unit remained good, although it fulfilled the role of a basic segregation unit. The environment was the same as at the last inspection, although a separate adjudication room had been created. The staff group had good relationships with the prisoners. However, staffing levels were low, and prisoners sometimes did not get access to basic regime elements on busy days. The quality of monitoring entries on prisoners' wing history sheets had improved.

HP12 Adjudication procedures were sound. Investigations were thorough and procedures were fair overall. Punishment tariffs were in place and publicised to prisoners. However, full stoppage of earnings was used as a punishment, which can lead to bullying. The establishment accepted this immediately when we pointed it out.

HP13 Use of force had increased in 2006, but in 2007 had fallen back to the same level as at the last inspection. Current levels were not unduly high, given the size and nature of the establishment. However, no one could explain the variation. We were satisfied, from the paperwork, that staff use of force was legitimate and a last resort. Use of the special cell in the segregation unit had decreased significantly. However, prisoners spent too long in this accommodation, and the quality of recent record keeping was poor and did not provide assurances that governance arrangements were adequate.

HP14 Security arrangements were appropriate for the type of establishment, and did not unduly hinder the regime. Wing staff did not maintain running wing rolls, which was unusual for a category B prison. This was attributed to the lack of a movements officer, although we could see no reason why existing staff could not keep such a roll.

HP15 There was no 24-hour nursing cover on the detoxification unit, and we were not satisfied that arrangements were fully safe. Monitoring prisoners at night was difficult because of the design of the observation panels. Prisoners detoxifying from alcohol were located on B wing, rather than in healthcare. Day staff on the unit, however, provided good levels of care.

HP16 Arrangements for vulnerable prisoners had deteriorated, and their number had increased. Because of the overspill from D wing (see paragraph HP7), some vulnerable prisoners were on B wing, alongside prisoners detoxifying and those on first night and induction programmes.

HP17 Overall, although there had been some progress in this area, this was not sufficient to raise the previous assessment. The establishment was still performing reasonably well against this healthy prison test.

Respect

HP18 In 2004, we assessed the prison as not performing sufficiently well against this healthy prison test and made 43 recommendations for further improvement. In this short follow-up inspection, we found that the prison had implemented 19 of our recommendations in full, nine in part, and 15 had not been implemented.

HP19 The general environment in the main prison was reasonable, although external areas were badly littered. Conditions on D wing, however, were in as poor condition as at our last inspection, and prisoners continued to slop out on this unit. To facilitate 24-hour access to sanitation, privacy locks had been fitted on cell doors to enable prisoners to let themselves out of their cells at night to use the toilet. Extra gates had

also been installed at the end of landings to restrict prisoner movement, as well as CCTV cameras. These proposals had, however, been opposed by the Prison Officers' Association, and the matter was due to go to final arbitration. Access to showers was satisfactory. The availability of clean kit was not adequate.

HP20 Staff-prisoner relationships were generally good, although staff lacked a proactive approach. We were disappointed to see that prisoners remained locked in their cells during a scheduled morning domestic period, while the main staff group had an unofficial 15-minute breakfast break. This inappropriate and antiquated practice should not be allowed to continue.

HP21 The personal officer scheme was underdeveloped and had little impact on prisoners' lives. Personal officers were not proactive and not aware of how their role fitted in alongside the offender supervisors.

HP22 The incentives and earned privileges scheme functioned reasonably effectively. Basic regime was used relatively infrequently, and the treatment of prisoners on basic was not overly punitive. Extra incentives had been introduced to encourage prisoners to attain enhanced status.

HP23 The kitchen was now run by civilian staff, and catering provision had improved since the last inspection. Menu choices were more varied and took better account of cultural preferences. Some of the servery equipment remained poor.

HP24 Exeter had started to address diversity issues and had developed a policy document. The physical environment did not lend itself to prisoners with mobility problems. All new arrivals could self-declare any disabilities, care plans were drawn up, and there was good work with individual prisoners and good use of peer supporters. There was little in place for older prisoners, who were gradually increasing in number.

HP25 Race equality was governed effectively. A full-time social inclusion manager covered the role of race equality officer. There were excellent consultation arrangements with black and minority ethnic prisoners. The overall quality of investigations into racist incident complaints was very high, and standards had been improved by robust external quality assurance.

HP26 Foreign national prisoner provision had developed since the last inspection. There were 33 foreign prisoners, of whom eight were past their sentence expiry date. Consultation arrangements were part of the black and minority ethnic prisoner consultation. Good links had been established with the Border and Immigration Agency (BIA), which now held regular clinics. There was no peer support group for foreign national prisoners, and no links with independent immigration support groups.

HP27 The legal services team did a good job. All prisoners were seen and assessed during induction. Services were widely promoted, and prisoners could access the team readily. There had been 59 prisoners released on bail to date in 2007, which was an impressive achievement.

HP28 Prisoners' complaints were dealt with well. Systems had improved considerably since the last inspection and arrangements were good. Complaints were tracked until a final substantive reply had been made, and replies were courteous and subject to robust quality assurance by a senior manager.

HP29 Health services had maintained much of the progress previously reported. There was only a short waiting list for the dentist. Pharmacy arrangements were basically satisfactory, although there were still problems with arrangements for in-possession medications. Mental health work was good and developing. The inpatient regime remained poor, and secondary health screening for new arrivals was voluntary, which was inappropriate.

HP30 Although there had been some improvements in this area, the continuing poor conditions on D wing meant that we were unable to raise our previous assessment until there had been substantial improvements to the environment on this unit. The establishment, therefore, was still not performing sufficiently well against this healthy prison test.

Purposeful activity

HP31 In 2004, we assessed the prison as not performing sufficiently well against this healthy prison test and made 14 recommendations for further improvement. In this short follow-up inspection, we found that the prison had implemented four of our recommendations in full, two in part, and eight had not been implemented.

HP32 Time out of cell remained poor for most prisoners and had not improved since the last inspection. We were told that the regime would improve with planned new shift patterns, but these were unlikely to be implemented in the short-term. Most prisoners had evening association only once per week, although exercise in the fresh air was offered daily.

HP33 There were insufficient activity places to occupy all prisoners, particularly vulnerable prisoners, and a considerable number – some 40% of the population – remained locked in their cell during the core day. The work opportunities that were available were predominantly of low quality, doing little to prepare prisoners for employment on release. There was no specific regime provision for the 46 young adult prisoners who made up nearly 10% of the population. The establishment also failed to make the most of the available resources, as education and work places often went unfilled due to poor monitoring of attendance and restrictive supervisory arrangements.

HP34 The range of education and vocational training opportunities had improved slightly. Some prisoners could work towards accredited training in the kitchen, and there was also some basic industrial cleaning training. Classroom space developed in the main workshop had increased the range of activities, and links had been established with the resettlement function, but there was still little to offer. There were plans to convert the main workshop into classrooms and move the workshop, which would provide more flexible facilities for training. The arrangements for allocation to activities were weak and poorly coordinated. Prisoners could and did bypass the systems in place, with little challenge by staff.

HP35 The range of available work had not developed. The same two workshops provided only low-level packing.

HP36 Physical education provision had suffered from staff shortages. Much of the previous accredited PE programme had been dropped as a result, and staff had to provide a largely recreational programme to maximise use. Facilities remained much the same as at the last inspection.

HP37 Despite the limited increase in quantity and quality of some of the education and training, not enough progress had been made in this area to raise the previous assessment. The establishment was still not performing sufficiently well against this healthy prison test.

Resettlement

HP38 In 2004, we assessed the prison as performing well against this healthy prison test and made 10 recommendations for further improvement. In this short follow-up inspection, we found that the prison had implemented one of our recommendations in full, five in part, and four had not been implemented; one was no longer applicable.

HP39 The strategic management of resettlement had stalled recently following the departure of the previous head of resettlement. Other managers had since taken on responsibility for the reducing reoffending agenda for short periods of time, but had not made any headway. Consequently, there was no meaningful reducing reoffending action plan, no needs analysis of the population, and no strategic lead. The resettlement policy committee had ceased meeting, and only one inaugural meeting of the new reducing reoffending committee had been held in August 2007. The governor had recently decided to take on the role of head of reducing reoffending. While this gave out a positive message about commitment to this area, we doubted whether it would be sustainable.

HP40 We were joined by HM Inspectorate of Probation to look at the arrangements for offender management as part of their overall inspection of offender management in the probation areas of the South West. The establishment had set up an offender management unit, which operated reasonably effectively. Strategic links with the probation service were lacking. Community-based offender managers rarely attended the establishment to meet offenders and chair sentence planning meetings – this was usually left to the in-house offender supervisors. Although targets set for prisoners were appropriate, onward allocation was mostly driven by population pressures, rather than identified needs and the availability of interventions.

HP41 There were good systems for reviewing and assessing all prisoners' needs on arrival and referring them to the relevant departments or agencies. Sentence and custody planning arrangements for prisoners serving over 12 months but not in-scope for offender management were generally adequate, but there were no formal custody planning arrangements for those serving short sentences or on remand. For prisoners with public protection concerns, including those in-scope for offender management, the initial assessments were used to construct short-term sentence care plans, which were good quality, although involved some duplication of resources and were only relevant in Exeter.

HP42 Provision across the range of resettlement pathways was generally reasonable, and included good housing advice and pre-release discharge boards to review prisoners' needs before release. There was a reasonable range of interventions for a local prison.

HP43 Given the type of establishment, outcomes remained largely positive for prisoners. However, the recent lack of strategic direction and the lack of appropriate involvement by offender managers meant that our highest assessment was no longer justified.

Exeter was now, therefore, performing reasonably well against this healthy prison test.

Section 2: Progress since the last report

The paragraph reference number at the end of each recommendation below refers to its location in the previous inspection report.

Main recommendations (from the previous report)

2.1 The practice of slopping out on D wing should be ended as a priority. (HP51)

Not achieved. As at the last inspection, cells lacked integral sanitation and prisoners continued to slop out each morning, despite extra staffing at night to provide 24-hour access to toilets. Cells had been equipped with courtesy locks and we were told of plans to allow prisoners, within a gated area, to access the toilets at night. CCTV monitoring cameras had also been installed. However, these plans had not yet been implemented, and had been opposed, in their current format, by the Prison Officers' Association. The matter was due to go to final arbitration in 2008.
We repeat the recommendation.

2.2 The cleaning of their own cells by prisoners should not be counted as purposeful activity. (HP44)

Not achieved. The establishment's purposeful activity figure of around 19 hours per prisoner per week still included two hours for cleaning cells. Although considerably less than the previous figure of 10 hours per prisoner, these two hours were an estimation and not part of regime activity. We reject the idea that the time that prisoners spend emptying their bins is purposeful activity.
We repeat the recommendation.

2.3 Prisoners should not be placed in the special cell solely to protect them from self-harming. (HP45)

Achieved. The prison did not use special accommodation to prevent prisoners from self-harming. A governor's order stated that special cells were not to be used as a therapeutic intervention for vulnerable prisoners. Of the 13 incidents in 2006 that resulted in the use of the special cell in the segregation unit, none were to protect prisoners at risk of self-harm.

2.4 Night medication should be issued last thing in the evening. This is especially important for those undergoing detoxification. (HP46)

Partially achieved. Prescribed night sedation was administered at 7.30pm rather than at 5pm, as at the last inspection. However, 7.30pm was still too early.
We repeat the recommendation.

2.5 A specialist nurse should be located on the detoxification unit at night. (HP47)

Not achieved. Although nurse staffing levels at night had increased (see paragraph 2.121), we were concerned that no nurses were based on B wing, where prisoners underwent detoxification from drugs or alcohol, and no other staff were there all the time to observe prisoners who were detoxifying. This was compounded by the fact that there were no healthcare-style observation panels in the cell doors on the wing, which made observation of

prisoners difficult.
We repeat the recommendation.

2.6 More association should be provided to all prisoners, and more time out of cell should be available during the working day. (HP48)

Not achieved. The regime was essentially the same as at the last inspection, and we found considerable numbers of prisoners – amounting to about 40% of the population – locked in their cell during the core day. Most prisoners, except those on D wing and A4 landing, had only one period of weekday evening association. Time out of cell remained poor, and those not assigned to an activity place usually remained locked in their cells during the core day. We were told that the situation would improve when new staff profiles were introduced, but there was little prospect of this in the short term.
We repeat the recommendation.

2.7 The number of activity places should be increased so that work is available for all prisoners. Opportunities should be taken to accredit all skills acquired at work to reflect industrial practice and needs for employment. (HP49)

Not achieved. There had been some modest increases in the opportunities to accredit skills, and there was some basic British Institute of Cleaning Sciences (BICS) training when staff were available. Two officer instructors had recently achieved certificate of education qualifications. However, the overall number of activity places had not increased adequately.
We repeat the recommendation.

2.8 Residential staff should be trained in the monitoring and recording of prisoners subject to public protection arrangements as a matter of urgency. (HP50)

Not achieved. Although there had been child protection training for a few staff in 2005-06, this had not covered other elements of public protection, such as multi-agency public protection arrangements (MAPPA). Residential staff now received a weekly list of prisoners subject to MAPPA and public protection cases.
We repeat the recommendation.

Recommendations

Courts, escorts and transfers

2.9 Prisoners should be held in court cells for the minimum possible period. (1.7)

Achieved. Prisoners we spoke to told us that they had not spent too long in courts waiting to return to the prison.

2.10 The use of video link facilities should be further promoted to maximise their usage and reduce prisoner time spent in court cells. (1.6)

Achieved. The video link suite continued to be used to good effect. It had links with 10 courts, and provision for crown courts to use the facility for sentencing had recently been introduced. It could host up to 10 sessions on weekday mornings and 10 in the afternoons. The suite was well used, well organised and staffed by knowledgeable prison officers.

Additional information

2.11 The prison reported good working relationships with the escorting service. Late arrivals were rare, and these tended to be from out of area courts. Dialogue between reception staff and the contractor had improved since the last inspection. Prisoners received information booklets at court that described what they could expect on their arrival at the prison, including how to make complaints or access help.

First days in custody

2.12 Managers and staff should continue to seek improvement to the reception building, particularly to make the environment as welcoming as possible and to make it possible for prisoners to discuss personal information with staff in confidence. (1.21)

Not achieved. There had been no significant change in the physical condition of reception. The main area to process prisoners was still on the upper floor and only accessible from escorting vans through a narrow steep staircase. The area was poorly decorated and still unwelcoming. Holding rooms were small and poorly furnished. Apart from the medical room, there were no discrete areas where staff could interview prisoners in private.
We repeat the recommendation.

2.13 All prisoners should be allowed to shower before they are locked up on their first night. (1.22)

Achieved. All new arrivals could have a shower in reception on request. However, as they were processed quickly, they were offered a shower on their arrival at the first night centre (see below).

Additional information

2.14 Despite the poor environment in reception, new arrivals were processed quickly (within 30 minutes of arrival), were risk assessed and treated with respect by staff. Trained reception officers and prisoner orderlies focused on issues concerning prisoner safety, and had created a friendly atmosphere in spite of the stark physical conditions.

2.15 Following the basic initial processes, new arrivals were taken to the first night centre on B wing, where dedicated staff carried out detailed assessments of their initial safety needs. Conditions here were good. The area was comfortable, and prisoners could be seen in private for interviews.

2.16 Prisoners were normally accommodated on B wing for their first days in the prison. Although no specific cells were designated for first night use, handover procedures were good and all staff were aware of the location of new arrivals. The centre had eight cells with closed circuit television cameras that were used to observe prisoners considered at risk.

2.17 B wing also accommodated the drug detoxification unit (see paragraph 2.99) and vulnerable prisoners waiting for space on D wing (see paragraph 2.103). We were told that due to the number of vulnerable prisoners on the wing, new arrivals were occasionally located on other wings for their first night and induction programme. A log was kept of when this had happened, although it could not be located during the inspection.

2.18 All prisoners received a two-day induction programme, which covered in detail the information given to prisoners during the first night interview. Resettlement needs were assessed and prisoners were given practical help to deal with any immediate problems. Referrals were made to appropriate service providers, such as the counselling, assessment, referral, advice and throughcare service (CARATs), housing, employment and benefits advisers (see also paragraphs 2.231-236).

Further recommendation

2.19 All new arrivals should be located in the first night centre on B wing, unless they require specialist treatment.

Residential units

2.20 Cells and communal areas in D wing should be decorated. (2.13)

Partially achieved. A painting programme was in place, and most cells on D wing were clean and adequately decorated. However, some communal areas remained unchanged. Most corridors were grubby and needed redecoration. (See further recommendation 2.30.)

2.21 Lockable cupboards should be provided in all cells so that prisoners can secure their in-possession property. (2.14)

Not achieved. Lockable cupboards had been provided in many cells, but not all those on B and D wings.
We repeat the recommendation.

2.22 Staff should respond to cell call bells as soon as possible and, as an absolute minimum, all cell bells should be answered within five minutes. (2.15)

Not achieved. We tested six cell call bells, which were answered within three minutes. Records showed that staff generally answered bells within five minutes, but in some cases responses were considerably slower. Some had not been answered for 20 minutes.

Further recommendation

2.23 There should be effective management checks to ensure that staff consistently respond to cell bells within five minutes.

2.24 Cell inspections should be introduced to ensure that standards of cleanliness are being met. (2.16)

Achieved. Prisoners had good access to cell cleaning materials, and staff encouraged them to keep their cells clean. The general cleanliness of cells was good.

2.25 Showers should be screened. (2.17)

Not achieved. As at the last inspection, most showers on the residential units remained unscreened.
We repeat the recommendation.

Additional information

2.26 Given the age and use of the prison, the living conditions on most of the residential units were adequate. Most communal areas were properly maintained, and cells were generally clean and adequately ventilated. Although the conditions of most showers had not improved, access was good and prisoners could have a shower every day. Up-to-date information notices were displayed on boards on all residential wings, and prisoners were consulted through formal monthly meetings with staff.

2.27 Conditions on D wing remained particularly poor. Although there had been some improvement to its decoration, it was worn and communal areas were grubby. The narrow corridors made proper supervision of prisoners difficult, and areas for association were poor.

2.28 The grounds around the residential units were in a poor state. Despite regular checks, there were large amounts of litter beneath the cells, and prisoners had thrown food out of their windows. There were no effective systems to control this problem on a daily basis.

2.29 Only enhanced and remand prisoners could wear their own clothes. For the rest, access to clean prison clothing of the right size and quality was poor. Prisoners were restricted to two T-shirts and one pair of tracksuit bottoms per week. We were told there were often shortages of clothes during the weekly kit exchanges, and that prisoners did not get clean clothing that fitted properly.

Further recommendations

2.30 D wing should be refurbished to provide prisoners with decent living conditions.

2.31 There should be a programme to ensure that the prison grounds, particularly around cells, are cleaned and properly maintained.

2.32 All prisoners should be allowed to wear their own clothes.

2.33 Prisoners should have access to enough clean clothing of the right size, quality and design to meet their needs.

Staff-prisoner relationships

2.34 Staff should take the opportunity to engage with prisoners during association. (2.24)

Achieved. We saw good levels of engagement between staff and prisoners during association. Staff were on landings when prisoners were unlocked, and the atmosphere was relaxed. Levels of supervision were generally good, and we saw many examples where staff and prisoners interacted positively.

Additional information

2.35 As at the last inspection, relationships between staff and prisoners were generally good. Staff were friendly in their day-to-day dealings with prisoners and treated them respectfully. They were generally interested in prisoners and keen to make their environment decent and purposeful. Most were smart, and their behaviour set a good example to prisoners.

2.36 Although staff were generally courteous towards prisoners, the use of prisoners' surnames was still the norm, and staff did not knock on cell doors before routinely entering cells. Staff entries in prisoners' files were also generally poor, with little insightful information (see below). We were surprised to see that, following the morning briefing at 8am, the main staff group had an unofficial 15-minute breakfast break while prisoners remained locked in their cells. This took place when, according to the establishment's own core day, prisoners were supposed to be unlocked for a domestic period. We were told that this practice had been taking place for years, but regardless of this, it was entirely inappropriate.

Further recommendations

2.37 The unofficial staff breakfast break should cease immediately.

2.38 Staff should refer to prisoners by their preferred name or title.

2.39 Staff should knock before entering cells on routine business, except in emergencies.

Personal officers

2.40 Staff on A wing should make regular entries in prisoners' wing history files in accordance with local policy. (2.30)

Partially achieved. Although there were regular entries in some files on all wings, their quality overall was poor and did not give assurance that personal officers provided advice on matters relating to their prisoners. Most centred on individual incidents involving negative behaviour or descriptions of routine events. There was no evidence that personal officers made entries according to a chronological schedule, and some files had no entries since the prisoner's arrival on the wing.

Further recommendation

2.41 Personal officers should make weekly entries in prisoners' history files, and these should reflect prisoners' personal circumstances and needs.

2.42 The monitoring system of wing history files should be consistently applied across all residential units. (2.31)

Not achieved. Although some senior officers monitored the quality of entries in prisoners' history files, this was still not consistent across all wings. There was nothing to indicate that the generally poor quality of entries was being addressed.
We repeat the recommendation.

Additional information

2.43 A comprehensive policy document clearly described the duties and responsibilities of personal officers. All prisoners had personal officers and knew who they were. However, personal officers did not consistently identify significant events that affected their prisoners nor were they aware of their needs. There was no evidence that personal officers had any input into sentence management processes, and they did not challenge their prisoners to complete

targets or direct them to resettlement services they required. Some staff seemed unaware of how the role of the personal officer sat alongside the new role of offender supervisor.

Further recommendations

2.44 Personal officers should be involved in resettlement and sentence management processes.

2.45 The personal officer scheme should clarify the respective roles of personal officers and offender supervisors.

Bullying and violence reduction

2.46 There should be more training in the anti-bullying strategy and this should include sessions on devising action plans and recording observations. (3.11)

Not achieved. Training in the anti-bullying strategy had not been scheduled. The anti-bullying coordinator had created a training package, but due to time constraints (see paragraph 2.51) and staff shortages had been unable to deliver it.
We repeat the recommendation.

2.47 There should be closer working between the anti-bullying coordinator and the self-harm and suicide coordinator. (3.12)

Partially achieved. Links between the anti-bullying and self-harm and suicide prevention coordinators had improved. However, these links were informal. The lack of time allocated to the anti-bullying coordinator (see below) had stalled the development of formal structures to link these areas. The monthly violence reduction meetings were often cancelled, and the quality of debate at meetings was inconsistent.

Further recommendation

2.48 There should be strong, formal links between the anti-bullying and the suicide prevention coordinators through a structured violence reduction committee that meets consistently.

Additional information

2.49 An anti-bullying policy document, published in 2005, outlined a three-stage intervention system with behaviour monitoring, warnings and an education course designed for bullies. Suspected bullies were put on to stage one of the strategy, where their behaviour was monitored and reviewed each week. Prisoners on the second stage had to attend a nine-week course on the effects of bullying, delivered by the physical education department. Prisoners who reached the third stage could face segregation.

2.50 The anti-bullying policy was outdated and needed revision. Some of the initiatives described, such as the anti-bullying course, victim support plans and staff training arrangements, were no longer in use. At the time of our inspection, there was no organised intervention for bullies, apart from monitoring and segregation in extreme cases, and nothing to support victims. We saw records for 43 prisoners under stage one of the policy between January and September 2007. We found no records for any prisoners subjected to stages two or three.

2.51 A residential senior officer had been appointed as the anti-bully/violence reduction coordinator, but had not been allocated formal time to carry out his duties. As a result, he was unable to monitor procedures or reporting systems, carry out quality checks of associated documentation or examine cases of unexplained injuries consistently.

2.52 Although wing staff identified bullies and instigated stage one procedures, not all were reported to the coordinator and formal reviews did not take place. Residential senior officers generally managed these cases in isolation from the coordinator.

2.53 The policy was nominally linked to an overarching violence reduction strategy that covered safe custody, anti-bullying, security and use of force. A violence reduction committee had been created to monitor progress against stated outcomes and to ensure that required action was taken. However, scheduled monthly meetings were generally poorly attended, with poor representation from the security department, healthcare and the drug strategy committee, and often cancelled. Minutes indicated that issues relating to violence were not given the priority they deserved, and there was no consistent analysis of violent incidents.

Further recommendations

2.54 The anti-bullying/violence reduction coordinator should be allocated enough formal time to carry out his duties.

2.55 The anti-bullying policy should be updated.

2.56 There should be interventions to tackle bullying and to support victims.

2.57 The prison should develop an effective overarching violence reduction strategy that is managed consistently by a committed multidisciplinary committee.

Self-harm and suicide

2.58 Night staff should receive refresher training in recording observations of prisoners. (3.20)

Achieved. All night staff had received training in assessment, care in custody and teamwork (ACCT) self-harm monitoring procedures. All training was in date at the time of our inspection.

2.59 Night staff should be instructed to assist self-harming prisoners immediately after raising the alarm, and not wait for assistance to arrive before opening the cell door unless there is specific intelligence to the contrary. (3.21)

Achieved. A protocol had been issued on the procedures to be used to unlock prisoners at night to help those in crisis. It set out the directions to staff on risk assessment arrangements. Staff we spoke to said that they would unlock prisoners at night to assist those in crisis following an individual assessment of the immediate risk.

Additional information

2.60 A comprehensive suicide prevention strategy document clearly set out the management arrangements, procedures and desired outcomes for keeping prisoners at risk and in crisis safe. It paid specific attention to vulnerable prisoners on D and B wings and those withdrawing

from drug addiction. There were copies of the document in all the residential wings and in communal points around the prison.

2.61 A full-time suicide prevention coordinator (senior officer) managed the protocols, and outcomes were monitored at the monthly safer custody committee meetings. Minutes of meetings showed that there were detailed discussions and strategic updates on identified trends or patterns of behaviour. There had been two recent deaths in custody, but inquests had not yet been held, and the report from the Prisons and Probation Ombudsman was awaited.

2.62 ACCT procedures had been in place since 2006, and over 90% of staff had been trained in their operation. At the time of our inspection, there were 21 open ACCT documents. The quality of written entries was particularly good. Most demonstrated an in-depth understanding of prisoners' individual circumstances and feelings. The coordinator made regular management checks of the quality of entries in documents. Reviews were held on time, and multidisciplinary meetings made high quality assessments. Detailed support plans were drawn up in consultation with the prisoner, and prisoners were encouraged to express their thoughts and feelings.

2.63 The prison had eight Listeners, including one based on the vulnerable prisoner unit and one in the first night centre. A further seven prisoners were in training at the time of inspection. Prisoners had 24-hour access to Listeners and a direct telephone line to the Samaritans. The Listener suites on D and C wings needed redecoration.

Further recommendation

2.64 The Listener suites on C and D wings should be redecorated.

Diversity

No recommendations were made under this heading at the last inspection.

Additional information

2.65 Diversity issues were discussed at a twice-yearly equal opportunities meeting for prisoners, chaired by the head of interventions. New arrivals were asked to declare any disabilities, and those who reported a disability were seen by healthcare staff to develop a support plan, if needed. They were also seen by the designated wing disabilities orderly.

2.66 There were no specific cells for prisoners with disabilities, but the prison responded to prisoners with specific needs when necessary. In one case, the establishment had made some adaptations to the bed and cell of a prisoner with poor mobility. One prisoner had recently lost his sight, and there had been arrangements for a worker from an external agency to help train him to use a white stick. A hearing loop had been installed in the visits area, and there were showers with seats in the healthcare centre and on D wing. There was also a stair lift on D wing. Large print and some audio books were available in the library.

2.67 There were eight prisoners in the establishment over retirement age, most of whom were on the vulnerable prisoner unit (D wing). Retired prisoners who were unemployed were locked in their cells during the core day. Retirement pay was £4 per week, out of which prisoners had to pay 50 pence per week towards their television. There were no age-specific activities for older prisoners. We were told that retired prisoners were encouraged to attend an art course held on

D wing, but staff on the wing were unaware that older prisoners should have been prioritised, and there were no retired prisoners on this course at the time of inspection. Retired prisoners told us that they had not been asked if they wished to attend this course, and there was nothing in their wing history files to suggest they had been.

Further recommendation

2.68 There should be greater regime provision for older prisoners. Retired prisoners who choose not to work should be able to access a range of age-appropriate activities, and should not be routinely locked in their cells during the core day.

Race equality

2.69 A race relations strategy should be written in consultation with prisoners from black and minority ethnic groups. This would allow prisoners, staff and visitors to see from a single source the direction of the prison in terms of race relations, the services available to prisoners and a description of the function and roles of the race relations liaison officer (RRLO) and members of the race relations management team (RRMT). (3.29)

Achieved. The establishment had introduced effective consultation with black and minority ethnic prisoners, and there had already been11 black and minority ethnic prisoner forums in 2007. The race equality strategy document had been revised in 2006 following the consultative process. The published document fully explained the services available and the role of the social inclusion manager, who was responsible for race and diversity issues, as well as other members of the race equality action team (REAT).

2.70 The number of prisoners used as race relations representatives should be increased to one per wing and a system that allows prisoner's access to them should be introduced. (3.30)

Partially achieved. Each wing had a race equality representative. However, we spoke to black and minority ethnic prisoners who did not know the name of their wing representative, and photographs of representatives were not displayed on B or D wings, which they should have been under the policy.

Further recommendation

2.71 Photographs of race equality representatives should be displayed on each wing.

2.72 The race relations liaison officer (RRLO) should be given sufficient facility time and appropriate office facilities to allow him to carry out his duties properly. (3.31)

Achieved. A full-time social inclusion manager at senior officer level covered the role of the race equality officer, as well as wider aspects of diversity and foreign nationals. He had his own office, with a telephone, computer and adequate storage. An administration support worker was being recruited to assist him, following a vacancy for this post. While it had been a busy period without administration support, the social inclusion manager confirmed that he had sufficient time allocated to his areas of responsibility and that cover arrangements were adequate.

Additional information

2.73 The black and minority ethnic population at Exeter was approximately 8%. The REAT met monthly and was chaired by the deputy governor. Attendance at these meetings was good and included representatives from external support agencies, as well as prisoner representatives.

2.74 The regular forums with black and minority ethnic prisoners, introduced by the social inclusion manager, were partly used to discuss race impact assessments. The establishment was up to date with its impact assessments and feedback had been good. Only two areas on the traffic light system had been assessed as amber; the rest were green.

2.75 Racist incident report forms (RIRFs) were freely available on all wings. There had been 20 RIRFs received to date in 2007 and a total of 46 in 2006. Racist incident complaints were investigated by a nominated member of staff from a team of six, which included the deputy governor and the social inclusion manager. The quality and thoroughness of investigations was impressive, and they were also subject to external review.

2.76 There was monthly ethnic monitoring. A frequent issue was over-representation by black and minority ethnic prisoners in PE. Use of force and adjudications involving black and minority ethnic prisoners had been identified as high in a recent monthly monitoring. Such issues were fully investigated at the subsequent REAT meeting, and this was evidenced in the published minutes.

2.77 Arrangements were underway at the time of our inspection for the celebration of black history month in October. The establishment had also held an event to mark the 200th anniversary of the abolition of slavery.

Foreign national prisoners

2.78 The foreign nationals liaison officer (FNLO) should be given sufficient facility time and appropriate office facilities to allow him to carry out his duties properly. (3.41)

Achieved. The social inclusion manger covered this role, and had sufficient time and facilities (see paragraph 2.72).

2.79 Reception, first night information and an induction pack should be available in languages other than English. (3.42)

Not achieved. None of the local information for new arrivals had been translated. The establishment had purchased a software package to translate this information in up to 12 languages, but this work had not yet started. The only translated information for new arrivals was nationally produced material.
We repeat the recommendation.

2.80 Contact should be established between the prison, immigration services and local immigration advice and support agencies. (3.43)

Partially achieved. The social inclusion manager had established good links with local immigration services in Plymouth and the Border and Immigration Agency (BIA) head office. BIA officers attended regularly for surgeries with foreign national prisoners, and also

responded to requests from the establishment to speak to individuals at their next planned visit. There were no similar links with local immigration support agencies.

Further recommendation

2.81 The prison should establish contact with local immigration advice and support agencies.

2.82 All foreign national prisoners should have access to a five-minute telephone call to their home country regardless of the cost. (3.44)

Achieved. Foreign national prisoners who had not received a visit in the preceding month were eligible for a free international telephone call. Eligible prisoners were given £2 telephone credit and a £5 international telephone card to enable a minimum call of at least five minutes.

Additional information

2.83 There were 33 foreign national prisoners, eight of whom were detained past their sentence expiry date. A foreign national policy document was in place. The foreign national committee met twice yearly and was chaired by the social inclusion manager.

2.84 The establishment used prisoners as interpreters for foreign nationals with no English, and there was also a list of staff who could speak other languages. A telephone translation service had been used twice in the past three months. Translation services were mainly used during induction. The establishment had also brought in an interpreter for a Chinese prisoner on an adjudication hearing.

2.85 Foreign national issues had been discussed at one of the black and minority ethnic forums (see paragraph 2.69), but there were no specific meetings for foreign national prisoners.

Further recommendation

2.86 There should be monthly support and information groups for foreign national prisoners.

Contact with the outside world

2.87 Closed visits should be authorised only where this is a significant risk justified by security intelligence and following consultation with the duty governor. (3.53)

Partially achieved. Closed visits were instigated following security information that indicated contraband material was likely to be passed on during a visit. They were appropriately authorised by a governor grade on a security information report. The choice of taking a closed visit or rebooking the visit was also offered when the passive drug dog made two positive indications on a visitor on the same occasion. There were six booths for closed visits in the main visits area, which were subject to CCTV monitoring. Twelve prisoners were currently subject to closed visits, and the governor responsible for security reviewed these cases on a monthly basis.

Further recommendation

2.88 Visitors should not be subject to a closed visit if no contraband material is found during a search.

Additional information

2.89 Visits were offered on five days a week. Visitors reported to a visits centre outside the prison gate and were called to the gate in small numbers. Processes were efficient and appropriate. Visitors told us that staff were friendly and respectful and that searching of adults and children was carried out sensitively, and they were positive about the refreshments offered. It was evident that staff knew many visitors and their circumstances. Searching by the drug dog took place in a separate room in privacy.

2.90 The visits room was large and could accommodate over 35 visits. It was well covered by CCTV. Prisoners and their visitors sat on fixed seating with a central table, some of which were dirty. The Prison Advice and Care Trust (PACT) ran the tea bar, which offered a range of refreshments, including healthy options and baby bottles and formula, and a well-equipped, child-friendly crèche.

2.91 Vulnerable prisoners received visits at the same time as other prisoners, and were clearly identifiable because of their location in a separate part of the visits area.

Applications and complaints

2.92 Replies to prisoners' complaints should address the complainant by name. (3.64)

Achieved. The complaints clerk attached written guidance to complaint forms when they were sent to the relevant department, which reminded staff that they should address prisoners by their names in their responses. In the completed complaint forms that we reviewed, replies were courteous, respectful and appropriately addressed to named individual prisoners.

Additional information

2.93 The establishment received approximately 22 complaints a week. Forms were freely available, and the complaints clerk emptied the complaint boxes each day. There was a year-to-date figure of 96.5% response to complaints within prescribed timescales. The guidance note for staff attached to complaints explained that only fully investigated complaints, not interim replies, were counted towards these figures. Any complaints not responded to that were due to reach the timescale were raised at a general management meeting held by the governor every morning, and an immediate response was required.

2.94 The complaints clerk completed an initial check of the quality of replies. Any that gave cause for concern were brought to the attention of the head of business management unit, who raised the issue directly with the member of staff. These arrangements worked well. Monitoring data was collated monthly and sent to senior managers, as well as publicised to staff.

Legal rights

2.95 Cover should be provided for the bail information officer when he is absent. (3.70)

Partially achieved. There was no cover for the bail information officer at the time of our inspection, but a new appointment had been made in the bail support unit and was due to take up post.

Additional information

2.96 Legal services were normally covered every day, including some cover at weekends. New arrivals were seen the day following their reception, and those who met the criteria for bail were targeted. Since the beginning of 2007, the bail information officer had secured 59 alternative addresses for prisoners who would otherwise have remained in custody at Exeter, which was impressive.

2.97 Information about legal services was included in the induction booklet. Prisoners could access legal services staff via application, and those on A or C wing could call in to the legal services office during the afternoon. Some legal service reference material was available in the library, including hard and electronic copies of Archbolds, as well as copies of Prison Service orders.

Substance use

2.98 Prescribing regimes for opiate users should be flexible and based on individual need, and comparable to treatment in the community. (8.64)

Partially achieved. Clinical staff had guidelines for substance misuse prescribing, but they did not allow for individual patient care. Patients were not able to receive psychosocial support as part of their detoxification regime.
We repeat the recommendation.

2.99 A supportive regime should be developed for prisoners undergoing detoxification, and officers on B wing trained in substance awareness. (8.65)

Not achieved. Prisoners undertaking detoxification on B wing had an impoverished regime, especially once they had completed their induction. They were unlocked, at best, for a maximum of 3.5 hours per 24 hours. This time included meals, one hour to clean their cell, shower and use the telephone, and one hour of outdoor exercise, weather permitting. Some officers had had some substance awareness training. There were no specialist staff on duty overnight on B wing and we were concerned that the handover arrangements did not provide the night staff with information on who was undergoing detoxification on B wing.
We repeat the recommendation.

Further recommendation

2.100 Night staff on B wing should be made aware of those prisoners who are undergoing detoxification.

2.101 Specialist medical and substance misuse nurse cover should be increased. (8.66)

Achieved. The nursing team had increased to three full-time nurses (one band six and two band five) and two part-time band five nurses. The team leader was a registered mental health nurse (RMN) and the other nurses were registered general nurses (RGNs). The team was responsible not only for prisoners receiving a detoxification, but also for all the primary care needs of prisoners on B wing. One of the GPs took responsibility for the substance misuse service, and also undertook two sessions a week at the local drug addiction services centre.

2.102 Data relating to the type and outcome of detoxification/maintenance regimes should be collated. (8.67)

Achieved. The substance misuse team gave the counselling, assessment, referral, advice and throughcare service (CARATs) team details of all prisoners on detoxification regimes on a weekly basis. This information showed the numbers receiving a detoxification regime for alcohol, subutex and methadone prescriptions and other detoxification regimes. CARATs staff used the information to check that they had received referrals for each of the patients and, if not, initiated an initial CARAT assessment.

Protection of vulnerable prisoners

No recommendations were made under this heading at the last inspection.

Additional information

2.103 There were 65 vulnerable prisoners in single cells on the designated vulnerable prisoner unit on D wing (the unit's full capacity). The population included prisoners with sex-related offences and those who felt at risk from other prisoners on mainstream wings. Despite poor living conditions (see paragraph 2.27), as at the last inspection, prisoners said that they felt safe on the wing and had good relationships with the staff. They said that they accepted their poor living conditions as a trade-off for feeling safe.

2.104 A published daily regime included exercise in the open air and evening association. However, there was insufficient purposeful activity to occupy most vulnerable prisoners on the wing. At the time of inspection, nine prisoners attended education classes each day in a small classroom on the unit, and 22 worked in the wing contract workshop, packing plumbing equipment for a local business. This meant that more than 50% of prisoners were locked in their cells with nothing meaningful to do during most of the core day.

2.105 The workshop was poorly equipped and could not accommodate work other than low-grade packing and assembly. No qualifications were offered, and the links with the education department to teach key work skills were not developed.

2.106 Because of lack of space on the vulnerable prisoner unit, there were also 29 prisoners segregated for their own protection who were temporarily accommodated on the upper landing in B wing. Most of these prisoners were not segregated due to the nature of their offence, but for other reasons, and we were unconvinced that they all needed to be located there. Conditions here were poor. There was no purposeful regime and association arrangements were inconsistent. Prisoners told us they were rarely given the opportunity to attend association, and their exercise was often cancelled. Other prisoners on the wing were aware of their circumstances. Although staff ensured that they remained separated, these vulnerable prisoners reported being intimidated and felt unsafe. The governor, at the time of the inspection, was trying to broker an arrangement with governors of some out of area prisons to

facilitate transfers of some of these prisoners from B wing to other establishments where they could go on to normal location.

Further recommendations

2.107 A full regime, including purposeful activity, exercise and daily association, should be offered to all vulnerable prisoners.

2.108 The prison workshop for vulnerable prisoners should be properly equipped to provide vocational training.

2.109 Genuinely vulnerable prisoners should not be located in isolated cells alongside mainstream prisoners.

Health services

2.110 An electronic primary care information system should be installed. (4.62)

Not achieved. The primary care trust (PCT) had purchased EMIS, an electronic medicine information system and staff had been trained in it, but it was not yet in use due to installation problems.
We repeat the recommendation.

2.111 Algorithm-based nurse triage should be introduced. (4.63)

Partially achieved. Staff had a triage pro forma for guidance and there were daily triage clinics, but prisoners could opt to see a GP without seeing a nurse first. The wait for the GP was within NHS limits.
We repeat the recommendation.

2.112 A more flexible appointments system should be introduced (4.64).

Not achieved. The administrative officer made up a daily list for wing offices that notified staff of prisoners expected to attend the primary care department in either the morning or the afternoon. Prisoners were also given an individual appointment slip stating the type of clinic. The senior management team had, in principle, accepted a proposal to introduce an appointments system based on this recommendation. However, this required a movements officer to be made available, which was linked to a staff reprofiling exercise that had yet to be implemented.
We repeat the recommendation.

2.113 A formal pharmacy service specification should be drawn up between HMP Exeter and the pharmacy at HMP Channings Wood. (4.65)

Achieved. A service specification agreement between the Devon prisons' pharmacy and the Devon Prison Partnership included specific additional services for Exeter (see below).

2.114 The temporary pharmacy technician post at HMP Exeter should be made permanent. (4.66)

Achieved. The temporary pharmacy technician post was identified in the service specification for pharmacy, and had been made permanent.

2.115 Standard prison drug prescription and administration charts should be used rather than locally produced charts. (4.67)

Achieved. Standard prison drug prescription and administration charts were used for most medications, but locally produced charts were used for detoxification medications.

2.116 The fax machine should be upgraded to cope with standard prescription charts and a dedicated telephone line should be made available. (4.68)

Achieved. There was a dedicated fax machine to fax prescriptions to the pharmacy at Channings Wood. Staff still photocopied the prescription charts, but these were kept for reconciliation by the pharmacy technician.

2.117 All pharmacy procedures and policies should be formally reviewed and adopted via the medicines and therapeutics committee and read and signed by all staff. (4.69)

Partially achieved. The medicines and therapeutics committee met quarterly. Although there were pharmacy policies and patient group directives (PGDs) in the wing-based treatment rooms, the paperwork was not signed by staff and it was not clear which staff were deemed to be competent to use the PGDs. Similarly, the policies were not signed by the relevant clinical staff and required updating.
We repeat the recommendation.

Further recommendation

2.118 All pharmacy procedures and patient group directives should be reviewed and updated.

2.119 Levels of medicines allowed in-possession should be increased following risk assessment and the provision of secure storage for prisoners in their cells. (4.70)

Not achieved. There was no documented risk assessment of prisoner suitability to have medications in possession, and prisoners had no secure storage for in-possession medications. Doctors made the decision for the small number of prisoners who had their medications in possession, but did not document their reasons.
We repeat the recommendation.

Further recommendation

2.120 There should be a documented risk assessment for in-possession medications.

2.121 Night-time nursing cover should be increased. (4.71)

Achieved. There were two nurses on night duty, although both nurses worked on the inpatient unit so there was no permanent nursing cover on B wing for prisoners undergoing detoxification (see recommendation 2.5).

2.122 Together with the primary care trust (PCT), continued efforts should be made to provide reliable and consistent dental care. (4.72)

Achieved. Dental services were provided by the local GP out-of-hours cooperative service. There were two sessions a week with extra sessions if the waiting list became too long. At the time of our inspection, the wait to see a dentist was no more than three weeks.

2.123 The deployment of medical staff should be reviewed to make better use of expertise and increase clinical input to the detoxification service. (4.73)

Achieved. The clinical managers had reviewed medical provision across the Devon Prison Partnership to improve efficiency and modernise the service, while maintaining a safe and high quality GP service. All the medical staff were GP-qualified. One GP, who took the lead in the detoxification service, undertook six sessions a week at Exeter, one at Dartmoor and two at the local addiction services, with whom the prison had good links. The other GPs also worked across all three prisons, as well as clinical sessions in the acute trust in areas such as cardiology and pain management.

2.124 A regular user forum should be established linked with the primary care trust (PCT) patient advice and liaison service (PALS). (4.74)

Partially achieved. Links with the local PALS had been achieved, but it had held only one patient forum at the prison.
We repeat the recommendation.

2.125 Primary mental healthcare should be developed with more out-reach work on the wings and greater integration with mental health in-reach team (MHIRT), detoxification services and counselling, assessment, referral, advice and throughcare (CARAT) staff. (4.75)

Partially achieved. A Devon PCT mental health review had recommended an integrated mental health service at Exeter. The Prison Partnership Board had accepted the recommendations in March 2007, but the commissioning proposals to implement them had not been agreed. At the time of the inspection, a local implementation group was being set up with representatives from the Devon Partnership Trust, which provided secondary mental health services, the PCT, the prison primary care team and CARATs to put the recommendations into action. There were registered mental health nurses (RMNs) in the nursing team at the prison, those working in primary care undertook primary mental healthcare clinics when their staffing numbers allowed, and the GPs were also involved in the care of those with primary mental health problems. Health services staff appeared to work well with wing staff to support prisoners with mental health problems.
We repeat the recommendation.

2.126 The regime in the inpatient unit should be further developed to include day care. (4.76)

Not achieved. The regime on the inpatient unit had not altered since our last inspection. Although staff from the education department visited two or three times a week, there was no formal therapeutic regime and no daycare facilities for those less able to cope with life on the main wings. We undertook a roll check one morning and found that six of the 12 patients on the unit were in the day room, but had nothing of any value to occupy their time. Patients were given a comprehensive induction booklet when they were admitted to the unit, and a letter that explained why they had been admitted and how their care would be planned and managed. All the inpatient beds were on the certified normal accommodation certificate of the prison, and

the unit sometimes held prisoners from the main prison when there was no other room to accommodate them. Although these prisoners were moved as soon as a space on one of the wings became available, the situation was not ideal.
We repeat the recommendation.

Further recommendation

2.127 The healthcare beds should not be part of the certified normal accommodation.

Additional information

2.128 Health services were commissioned by Devon Primary Care Trust as part of the Devon Prison Partnership, which also included HMPs Dartmoor and Channings Wood. Mental health services were provided by Devon NHS Partnership Trust. The PCT's intention to tender out all health services for the cluster had yet to be instigated, which had caused some concerns for staff.

2.129 Although all new arrivals at Exeter had an initial health screen, the more comprehensive secondary health screen was optional.

Further recommendations

2.130 The tendering of services should be expedited.

2.131 All prisoners should have a comprehensive secondary health screen within 72 hours of arrival.

Learning and skills and work activities

2.132 There should be a wider range of education courses to ensure that the needs of the more able prisoners and those wanting higher education are met. (5.11)

Partially achieved. There were some additional courses at a higher level, although the main emphasis of education provision was still on courses up to level two.
We repeat this recommendation

2.133 Information and communications technology (ICT) resources should be updated to reflect industrial and commercial standards. (5.12)

Achieved. New equipment had been installed, and one of the new classrooms in the main workshop area also had ICT equipment.

2.134 Procedures should be in place to ensure that all prisoners are able to benefit from initial assessment of literacy, numeracy and language resulting in appropriate individual learning plans. (5.13)

Achieved. Prisoners received initial assessments of their basic skills during induction. Although not all chose to attend education and therefore receive individual learning plans, all new arrivals had a protective factors assessment during induction, based around the reducing reoffending pathways, which generated a sentence care plan.

2.135 The education and training provision should be improved to allow increased participation for D wing. (5.14)

Partially achieved. Although the curriculum had not changed significantly since the last inspection, access had improved for some vulnerable prisoners with mobility problems on D wing, as a stair lift had been installed.

2.136 The management of the industrial contract workshops should be improved urgently to ensure safe working practices and better structures to the ways in which prisoners progress through the work activities. (5.24)

Not achieved. While the industrial contract workshop for vulnerable prisoners on D wing provided a work environment, albeit a low-skilled one, with opportunities to progress, the main workshop was less well structured (see paragraph 2.143). On the day we visited the workshop, less than half of the allocated prisoners attended and there had been no investigation into the whereabouts of those who were missing, although four staff were on duty (see recommendation 2.150). The workshop ran well under its potential occupancy rate, with around 10 workplaces unfilled. Prisoners in this workshop were less engaged with the work than those in the workshop on D wing, and there were fewer opportunities for progression. The current arrangements for monitoring attendance and supervising prisoners were not effective. There were plans to move this workshop (see paragraph 2.143).
We repeat the recommendation.

Further recommendation

2.137 Industrial workshops should run to their full occupancy rate.

2.138 A more effective process of passing initial assessment results to staff in the workshops should be implemented. (5.25)

Not achieved. The establishment had relied on the implementation of a new IT system (C-NOMIS) to achieve this. However, this project as planned had been dropped nationally, and so the situation had not changed at Exeter since the previous inspection.
We repeat the recommendation.

Library

2.139 The library should increase its opening hours for those on D wing. (5.15)

Not achieved. Prisoners on D wing were scheduled to get three library sessions per week. However, the full-time prison officer library officer was regularly cross-deployed to residential duties to cover staff absences, which meant that the main library on C wing and the library on D wing were frequently shut, as they were not allowed to open without a prison officer present. This seemed unnecessarily restrictive, particularly given the large numbers of officers on duty in the vicinity of both libraries.

Further recommendation

2.140 There should be alternative arrangements to enable the library to open as scheduled in the absence of a prison officer.

Additional information

2.141 Education provision remained good overall. Some additional resources had been provided, additional classrooms in the main workshop area had expanded the number of courses, and there were positive links with the resettlement department. Classroom efficiency was disappointing at around 70%, although this was likely to be a result of poor monitoring of attendance generally across the establishment.

2.142 The work available for prisoners remained inadequate. The additional classrooms in the main workshop had not yet led to an increase in activity places. As at the previous inspection, a maximum of 20 prisoners were allowed per instructor. With only two officer instructors on duty for most sessions, this limited prisoner numbers to 40 in this large area. However, the officer instructors only actively supervised the prisoners who worked in the workshop itself, and did not supervise the classes in the area, where individual staff ran each session. In addition, two managers were also based in the area. Current arrangements meant that if only one instructor were present and the classrooms had 20 prisoners, then the workshop could not open. This was clearly not a satisfactory system.

2.143 These arrangements hindered the running of the main workshop, as priority was given to filling the classrooms first and the number of prisoners who were able to work in the workshop depended on how many attended classes. The establishment also over-allocated prisoners to this workshop, and prisoners were sometimes sent back to their wings when too many turned up for work. The establishment planned to move the workshop and install more classrooms in the area, which would improve consistency in the running of the workshop and increase the number of activity places available. There were plans to accommodate up to 70 prisoners in this area once it was refitted with individual classrooms.

2.144 The industrial contract workshop for vulnerable prisoners was purposeful, with around 20 prisoners attending each session. The work was low-grade packing, though prisoners worked hard and experienced a work environment. They also had the opportunity to progress to number one roles in some tasks, which gave them additional responsibilities.

2.145 Systems for allocating prisoners to activities were weak. Although there was an allocations board, prisoners were able to bypass this. We spoke to a prisoner who had returned to the establishment only a few days previously who had managed to secure his old job as a wing cleaner without having to make an application through the normal route, although many prisoners seeking a job had been waiting much longer than him.

2.146 Monitoring arrangements for attendance at activities were also weak, except for the vulnerable prisoner workshop. Uniformed staff maintained a presence in the education department when it was open, but we saw little evidence that reasons for non-attendance were pursued with any rigour. In practice, prisoners could opt out of their allocated activity place if they wished and go to the gym (see paragraph 2.156) or remain in bed. Residential staff were not active in ensuring that prisoners attended their allocated activity.

2.147 The structure of the core day and the systems for prisoner movement also hindered attendance rates. If a prisoner had an appointment, for example in healthcare, he was not able to attend his allocated activity at all, even if the appointment lasted only five minutes. This was attributed to the lack of a movements officer to escort prisoners, but seemed extremely wasteful.

Further recommendations

2.148 All allocations to activities should be coordinated by an allocations board. Prisoners should not be able to bypass this system.

2.149 Staff supervision arrangements should not hinder the running of workshops.

2.150 There should be much greater emphasis on monitoring prisoner attendance at activities.

Physical education and health promotion

2.151 There should be a more appropriate outdoor facility. (5.31)

Not achieved. Facilities remained the same as at the last inspection. The exercise yard had been considered for possible conversion to an outdoor PE facility, but no funding had been made available for this.
We repeat the recommendation.

2.152 A wider range of courses should be offered. (5.32)

Not achieved. There had been a staffing shortfall over the previous 12 months and, as a result, much of the previous accredited work had stopped. Although some qualifications were still offered, and PE staff were committed to training, most of the PE programme was recreational.
We repeat the recommendation.

2.153 Access for vulnerable prisoners should be improved. (5.33)

Achieved. Access for vulnerable prisoners had improved to up to five times per week. However, this was being reviewed due to relatively low take-up of sessions.

2.154 There should be a suitable classroom for heart start, and manual handling courses. (5.34)

Achieved. PE staff had shared access to a classroom in the education department, which they could use for training.

Additional information

2.155 The PE programme had suffered from staff shortages over the previous 12 months. At the time of our inspection, there was the equivalent of only three full-time PE staff, which was low for an establishment of this size. Access for most prisoners was reasonable, and there had been efforts to link this to the incentives and earned privileges scheme, with greater access for prisoners on the enhanced level. There were no links with sentence planning.

2.156 As the main PE programme was not currently delivered, ad hoc gym sessions were run on most days. However, there were no effective controls for the allocation of prisoners to these sessions, and the gym staff went round the wings for volunteers to attend. In practice, prisoners could opt out of their allocated education or work to go to the gym.

2.157 Evening gym sessions were offered on weekday evenings, but only to the wing that had its turn for association. As access to association was so poor for most prisoners, this was a missed opportunity to enable access to evening gym.

Further recommendations

2.158 There should be more effective controls over the allocation of prisoners to gym sessions, and prisoners should not be able to avoid attendance at allocated activity in order to go to the gym.

2.159 Evening gym sessions should be offered to wings not scheduled for evening association that day.

Faith and religious activity

2.160 The services of an imam should be provided and his attendance should ensure that the religious needs of Muslim prisoners are being met. (5.42)

Not achieved. A full-time Muslim chaplain had been appointed, but had not yet taken up post. Friday prayers were held in a small but clean multi-faith room on C wing. The average attendance was about nine to 10 prisoners, who took it in turns to conduct prayers.
We repeat the recommendation.

Additional information

2.161 The chapel was large, centrally located and suitable for Christian worship. As at the last inspection, it was also used for secular activities. The chaplaincy team, led by a full-time Anglican chaplain, was enthusiastic, well regarded and fully integrated into the life of the establishment. Statutory duties were shared among a multi-denominational team of chaplains that represented the religious faiths of prisoners. The team offered a range of courses that fitted well into the resettlement pathways, including a relationship course, victim issues (Sycamore Tree) and the Christian-based Alpha course.

Security and rules

2.162 Members of the security committee should attend all meetings or send a representative in their absence. (6.11)

Achieved. The security committee met monthly and was chaired by the head of operations. Attendance at these meetings was good and included a representative from the escort contractor and the police liaison officer. Members of the committee from within the establishment were appropriately senior, and they sent representatives when they could not attend a scheduled meeting.

2.163 Authorised outcomes from security information reports (SIRs), such as target searches and reasonable suspicion mandatory drug tests (MDT), should be routinely completed. (6.12)

Not achieved. The establishment did not always complete target searches or reasonable suspicion MDT tests authorised through SIRs. We found two SIRs in which target searches had been authorised. One, on a prisoner, had not been completed. The other required an area

search, which had been completed but not until more than three weeks after the date of the SIR. The MDT co-coordinator confirmed that not all reasonable suspicion tests were carried out due to staff redeployment to other duties. Only six reasonable suspicion tests had been completed in more than nine months since the start of 2007, compared to a total of 46 for 2006.
We repeat the recommendation.

2.164 Quality checks of cell searches should be conducted by both security and residential managers. (6.13)

Achieved. Residential and security managers had targets for monitoring the quality of cell searches. After they observed a cell search, managers endorsed the searching return and provided feedback where necessary. This requirement had been included as a target in the annual appraisal form for appropriate managers.

Additional information

2.165 The establishment had recently had a full security audit and had achieved an overall rating of 87%. Around 35 SIRs were received per week, which were processed efficiently. A monthly summary of intelligence received was produced for the senior management team to analyse and agree security targets for the establishment. There was a 13-week target for completion of routine searches of cells and areas, which was routinely met. We were surprised that staff maintained no running total of wing numbers, which is unusual in a category B establishment. This was attributed to the lack of a movements officer, although this seemed unconvincing.

2.166 The main prisons that Exeter allocated to were Dartmoor and Channings Wood. Newly sentenced prisoners were interviewed and asked which prison they wished to be allocated to. Exeter had been affected by the high prison population, and had recently received overcrowding drafts from establishments as far away as Birmingham and Canterbury. Prisoners were notified of their allocation by a written slip, and were also seen by a discharge board before transfer. Prisoners' offending behaviour needs were not considered when deciding on a suitable allocation.

Further recommendations

2.167 The identified offending behaviour needs of prisoners should be considered in decisions on suitable allocations.

2.168 Running totals of wing numbers should be maintained.

Discipline

2.169 The adjudications room should be redesigned to ensure that any potential weapons are out of reach of prisoners. (6.33)

Achieved. At our last inspection, a single room in the care and separation unit doubled as a staff office and an adjudication room. Since then the office had been moved to another room, leaving the original room designated for adjudications. This room was small, but fit for purpose. The prisoner's table and chair were fixed to the ground and all potential weapons had been removed.

2.170 Charges should be fully investigated and this should be evidenced on the record of hearing (F256). (6.34)

Achieved. Adjudication records confirmed that hearings had been conducted appropriately. The record of hearing showed that the adjudicator asked all necessary questions to ensure that charges were fully investigated. Findings in the records we checked were fair and took full account of the evidence presented.

2.171 Pleas of mitigation should be taken into account by adjudicators before awards are made. (6.35)

Achieved. Prisoners could outline pleas of mitigation in written representations before an adjudication or verbally during the hearing. Such pleas were recorded on the record of hearing and referred to before the adjudicator decided on an award.

2.172 Adjudication standardisation meetings should take place regularly and these meetings should be minuted. (6.43)

Not achieved. Although adjudication standardisation meetings were scheduled to take place twice yearly as part of the monthly senior management meetings, none had been held for over 12 months.
We repeat the recommendation.

2.173 Award tariffs should differentiate between proposed awards for adults and young adults. These tariffs should be widely publicised to prisoners. (6.44)

Achieved. The establishment had produced separate adjudication tariffs for adult and young adult prisoners. Both sets of tariffs provided a scale of punishments and guidance on factors for adjudicators to consider before deciding on the severity of the award. Prisoners could access adjudication tariffs in the library.

2.174 The published tariff for charges of assault on staff and prisoners should be the same. Use of force documentation should be certified by an appropriate manager who was not involved in the original incident. (6.45)

Not achieved. In the published assault tariff for young adult prisoners, one of the points for consideration was whether the assault was on a member of staff. This suggested that assaults on staff still routinely attracted higher awards. Use of force documentation was now correctly certified.

Further recommendation

2.175 Tariffs for charges of assault on staff and prisoners should be the same.

2.176 Prisoners should not be held in the special cell any longer than is absolutely necessary. (6.36)

Not achieved. The special cell had been used 13 times in 2006 and once since the start of 2007. While the low use of special accommodation was commendable, some of the most recent uses involved long stays. For example, four of the last five cases involved stays of over 14 hours, and the single use in 2007 was the longest at over 25 hours. In this most recent case, most of the monitoring entries gave no indication that the prisoner was anything other

than compliant, yet he remained there for over 25 hours. We also found other examples where only the times of monitoring checks were recorded without any supporting comments. This failed to provide assurance that prisoners had been removed from special accommodation at the earliest opportunity.
We repeat the recommendation.

2.177 Authority for holding a prisoner in the special cell for longer than 24 hours must be obtained from a member of the Independent Monitoring Board (IMB). (6.37)

Achieved. In the one case in 2007 where single use of special accommodation had involved a stay of longer than 24 hours, authority for continued use had been granted by the IMB, which had endorsed the documentation accordingly. No incidents in 2006 involved use of special accommodation for more than 24 hours.

2.178 Prisoners in special accommodation should be monitored at least every 15 minutes and all monitoring checks should be recorded. (6.38)

Not achieved. New use of special cell documentation had been introduced since the last inspection. The Prison Service had also introduced new procedures, including monitoring checks of at least five times per hour for prisoners in special accommodation. The establishment had mostly failed to implement this level of monitoring, and had continued to monitor in line with the previous standard of every 15 minutes. There were, however, occasions when staff had slipped to monitoring prisoners at hourly intervals only. We also found occasions where monitoring checks were restricted to viewing the prisoners through the CCTV system. This was inappropriate, as it failed to enable staff and the prisoner to engage with each other.

Further recommendation

2.179 Prisoners in special accommodation should be monitored at a minimum of five times per hour, and this should happen through staff visits to the prisoner, rather than relying on CCTV.

2.180 All cells in the separation and care unit (SCU) should be fitted with effective privacy screening. (6.39)

Not achieved. Although in most of the cells in the unit the sanitation unit was positioned to ensure adequate levels of privacy, three had no privacy screening and toilets were visible from the observation port.
We repeat the recommendation.

2.181 Staffing levels in the separation and care unit (SCU) should be increased to guarantee daily access to exercise and showers. (6.40)

Not achieved. As at the last inspection, the unit was staffed by two prison officers during the main part of the day. On most days, prisoners in the unit had access to exercise and showers, and the three occupants we spoke to confirmed this. A review of the unit register, however, showed that, despite low numbers, on some days prisoners had not been offered access to exercise or a shower.
We repeat the recommendation.

2.182 Records of prisoner reviews in the separation and care unit (SCU) should reflect any active plans made to support a return to normal location. (6.41)

Not achieved. Reviews of segregated prisoners were chaired by a governor grade and routinely attended by wing, segregation and healthcare staff. The IMB also attended, but not on every occasion. Records of completed reviews provided little evidence of active plans to aid reintegration. Targets set were often meaningless and restricted to behaviour in the unit. We repeat the recommendation.

2.183 Entries in wing history files by separation and care unit (SCU) staff should be comprehensive enough to demonstrate that each individual's physical, emotional and mental wellbeing are being effectively monitored. (6.42)

Achieved. The quality of wing history file entries had improved. Unit staff regularly made monitoring entries that showed evidence of engagement with prisoners in their care. The good quality of entries by the duty governor, which we highlighted in the previous inspection, had been maintained.

Additional information

2.184 We noted that, on several occasions, adjudication punishments included 100% stoppage of earnings over seven days. This type of award was unhelpful, as it could tempt prisoners to borrow from others, resulting in debt and possible bullying.

2.185 At the time of inspection, 88% of staff had had control and restraint refresher training. There had been 132 use of force incidents in 2007 to date, which was a significant reduction on the 214 incidents in 2006. Nobody was able to explain this reduction however, and there was no formal trend analysis. The quality of use of force documentation was generally good, although not all planned incidents had been video recorded.

2.186 The quality of documentation for use of special accommodation had deteriorated since it had been revised earlier in 2007 (see paragraph 2.176). In some cases, just times of monitoring checks had been recorded with no supporting comments. In one case, there were no records of assessments completed by the designated manager. In the example of the stay in special accommodation that exceeded 24 hours (see paragraph 2.177), the required case review was not completed.

2.187 In the separation and care unit (SACU), communal areas were clean and cells were in a reasonable condition, although a few had graffiti. Relationships between staff and prisoners in this unit were positive. One concern was that all cells in the SACU were continuously monitored via CCTV with a monitor in the unit office. It was inappropriate that prisoners were continuously monitored without any risk assessment.

2.188 The regime in the SACU was basic. Prisoners could request in-cell education, but neither SACU nor education staff were proactive in encouraging prisoners to take this up. Subject to risk assessment, prisoners on the unit could also use an exercise bike. Risk assessments were also used to determine whether they could be issued with normal furniture. These arrangements worked well.

Further recommendations

2.189 Adjudicators should not give punishment awards of 100% stoppage of earnings.

2.190 All planned use of force incidents should be videoed.

2.191 A use of force committee should be created to monitor individual incidents and trends over time.

2.192 Designated managers should complete and record reviews on prisoners in special accommodation in accordance with published guidance.

2.193 Case reviews should be completed when prisoners are likely to remain in special accommodation for more than 24 hours.

2.194 Prisoners held in the separation and care unit (SACU) should only be monitored via CCTV when the need has been confirmed through risk assessment.

2.195 Education staff should visit the SACU regularly to encourage prisoners to participate in in-cell education.

Incentives and earned privileges

2.196 Work supervisors and education staff should make regular entries in wing history files so that they can be taken into account during incentives and earned privileges (IEP) scheme reviews. (6.58)

Achieved. Work and education staff provided formal reports on all prisoners applying for enhanced level.

2.197 Enhanced-level prisoners who are not located on designated enhanced landings should still benefit from the increased levels of time out of cell. (6.59)

Not achieved. As at the last inspection, prisoners on the enhanced level who lived on C2 landing did not benefit from additional time out of cell.
We repeat the recommendation.

2.198 The incentives provided to prisoners on the enhanced level of the incentives and earned privileges (IEP) scheme should be increased to the point that all prisoners are motivated to progress. (6.60)

Achieved. Incentives at enhanced level to encourage good behaviour had improved since the last inspection. As well as extra visits and a greater spending allowance, prisoners on enhanced level could also have their own DVD players, play station, two consoles and hand-held computer games.

Additional information

2.199 The incentives and earned privileges scheme was generally fair, open and consistently managed across the prison. A revised policy document and facilities list had been published since the last inspection, and was advertised on all residential units and in reception. Staff and prisoners were generally clear about the scheme's criteria for promotion and demotion.

2.200 New arrivals joined the scheme on the standard level unless they could show that they had been on enhanced at the prison they had transferred from.

2.201 Reviews for promotion were normally conducted following an application from the prisoner. Senior wing officers chaired review boards. Boards were conducted fairly in the presence of the prisoner. Demotion was based on behaviour over a period of time, and decisions to demote were ratified by a principal officer and the prisoner was informed in writing. Prisoners on basic regime were entitled to restricted association and visits, and prohibited from some work areas. Reviews of prisoners on basic were conducted every week, and most were put back on the standard level within seven days.

Catering

2.202 Hot food should be served at or above 63ºC. (7.9)

Achieved. Wing food registers showed that hot meals were served above 63ºC.

2.203 All hot food should be served from suitable heated serveries. (7.10)

Not achieved. Some serveries still had insufficient space for all the hot meal choices, and so some hot food was served from containers placed on work surfaces rather than heated serveries. There were plans for the serveries to be updated.
We repeat the recommendation.

2.204 All broken servery equipment should be repaired. (7.11)

Achieved. We did not receive any complaints about broken equipment. A member of the catering department now attended the serveries at meal times and oversaw the servery process.

2.205 Prisoners should be able to work part-time in the kitchen, with reasonable access to other regime activities such as education and gym. The requirement to work a 6.5 day week should cease. (7.12)

Not achieved. Prisoners who worked in the kitchen were required to work a six-day week, although the establishment's action plan stated that prisoners worked only a five-day week. The number of prisoners who worked in the kitchen had increased to 18, with a normal daily roll of around 12. Those on the enhanced IEP level could access gym on some evenings.

Further recommendation

2.206 Prisoners working in the kitchen should have a maximum five-day week, and part-time work should also be available.

2.207 Robust safeguards should be in place to ensure that vulnerable prisoners' food is not contaminated. (7.13)

Not achieved. There had been no change in arrangements since the previous inspection. Although the establishment's action plan claimed that food trolleys were not identifiable, D (vulnerable prisoner) wing's trolley was clearly labelled. We were told that the escorting officer could switch meals between trolleys if they had any concerns, but this did not amount to a robust safeguard.
We repeat the recommendation.

Additional information

2.208 Catering provision had improved since the last inspection. The catering team was now fully civilianised. The menu cycle had moved from a two-week to a four-week cycle, and the range of choices and cultural options had increased. There was some positive promotion of diversity, although there was scope to increase this further. The meals that we sampled were satisfactory, and prisoners did not make any complaints about the food. Prisoners could now work towards national vocational qualifications in the kitchen, which were delivered by the education provider. Prisoner surveys were carried out, but the analysis of these was simplistic, and it was not clear what, if any, changes had resulted.

Further recommendation

2.209 There should be full analysis of any prisoner catering surveys, and the results, plus any proposed alterations to services, should be published to prisoners.

Prison shop

2.210 A reception pack to the value of at least £5 should be available for newly arrived prisoners. (7.23)

Achieved. A reception pack was now provided by Aramark, which ran the shop.

Strategic management of resettlement

2.211 The resettlement policy committee should monitor the implementation of the resettlement strategy and analyse available information to improve practice. (8.6)

Not achieved. There had been a number of management changes in the past 12 months. Following the departure of the previous head of resettlement, this post had not been filled and several managers had assumed oversight at various times. At the time of the inspection, the governor had recently confirmed that he was to take over the role of head of reducing reoffending. Although this set out a positive commitment to the reducing reoffending agenda, we considered that this model would be extremely difficult to make work. The resettlement policy committee had ceased meeting and had not yet been replaced by a meaningful reducing reoffending strategy group. The prison had no current resettlement strategy, up-to-date needs analysis, or reducing reoffending strategy. A reducing reoffending committee had met for the first time in August 2007 to review activity under the reducing reoffending pathways, but it was not yet clear who would prepare the strategy for this important area of work, and the dates for future meetings had not yet been agreed. Draft terms of reference for a reducing reoffending committee had been produced, but not yet approved.

Further recommendations

2.212 The prison should develop a reducing reoffending strategy and action plan that identifies responsibilities for the reducing reoffending pathways and develops work under the NOMS alliances.

2.213 A reducing reoffending committee should meet regularly to oversee developments across the pathways and develop work under the NOMS alliances.

Offender management and planning

2.214 Resettlement and sentence plans should be monitored and reviewed continually with identified staff responsible for ensuring that agreed targets are achieved. (8.13)

Partially achieved. Prisoners in scope for offender management and serving over 12 months took part in sentence planning meetings. These were usually only attended by the prisoner and offender supervisor and were chaired by a senior staff member from the offender management unit (OMU). Some departments were represented at sentence planning meetings regularly, but others, such as education and healthcare, were not invited to participate. Attendance from community-based offender managers was rare, and there was not enough capacity in the video conferencing facilities to facilitate remote participation. Prisoners serving under 12 months and those on remand were not subject to any formal sentence or custody planning. Although these prisoners were assessed on reception and their immediate needs recorded on a tracking system, it was not clear which staff were responsible for ensuring that their needs were addressed or services provided.

Further recommendations

2.215 The prison should encourage the attendance of community offender managers at sentence planning meetings and reviews.

2.216 There should be formal sentence or custody planning arrangements for short-term prisoners and those on remand.

2.217 Vulnerable prisoners approaching release should have access to the resettlement course or its equivalent. (8.29)

No longer relevant. The resettlement course no longer ran. It had been overtaken by the introduction of the offender management model, in which interventions were planned to meet the individual needs of prisoners during their sentence. Discharge boards had recently commenced and targeted prisoners three weeks before their release, with referral to appropriate agencies in the community. Vulnerable prisoners were included in these arrangements on a one-to-one basis.

2.218 Eligible and suitable prisoners should be considered for release on temporary licence as part of a planned preparation for release. (8.30)

Not achieved. Release on temporary licence (ROTL) was hardly used to support the effective community reintegration of prisoners following their release. Only one prisoner had been approved for ROTL in the last 12 months. ROTL processes were in place and known to staff, but there was some caution in promoting this facility.

Further recommendation

2.219 There should be greater use of release on temporary licence for eligible and suitable prisoners to support their reintegration into the community.

2.220 Sentence plans for prisoners listed as public protection cases should identify ways of reducing the risk posed. (8.40)

Achieved. All high-risk public protection cases, including those in scope for offender management, were allocated to a probation officer as their offender supervisor. Lower risk public protection cases were shared among the offender supervisor team. A sentence care plan was drawn up within 10 days of reception for these cases, and this identified the interventions at Exeter to reduce risk. Following the completion of offender assessment system (OASys) assessment at eight weeks, the two documents provided short- and medium-term plans for reducing the prisoner's risk of harm within Exeter and beyond. However, the sentence care plan duplicated material from OASys, was driven by offender supervisors rather than offender managers, and had currency only in Exeter. Prisoners were aware of their sentence plan and why they were completing specific interventions.

Additional information

2.221 Her Majesty's Inspectorate of Probation joined HM Inspectorate of Prisons to review the strategic management and functioning of offender management for those prisoners in scope.

2.222 The offender management unit (OMU) had been operational since November 2006. At the time of our inspection, approximately 80 prisoners were in scope for phase two of offender management. An OMU policy had not yet been developed.

2.223 Although the unit had no consistent strategic manager, staff were well motivated and enthusiastic. The unit was unable to predict the projected number of sentence planning boards required over the coming year. The notes of sentence planning boards that we saw were limited and did not reflect the depth of discussions that clearly took place.

2.224 Prisoners in scope for offender management did not have a minimum monthly contact with their offender supervisors. The expected level of contact between prisoners serving sentences of 12 months or more and offender supervisors was not clear.

2.225 Two offender supervisors completed OASys assessments and reviews. There was a small backlog, but staff were to be retrained in OASys to ensure there were sufficient numbers available to undertake reviews.

Further recommendation

2.226 Prisoners managed under the NOMS model should have regular monthly contact with offender supervisors.

Resettlement pathways

2.227 The range of vocational training programmes should be increased to meet the needs of the population and skill shortages. (5.22)

Partially achieved. The range of vocational training had increased slightly, and there was now some accredited British Institute of Cleaning Sciences (BICS) training and NVQ training in the kitchen. However, the overall range was still limited and not based on prisoner need. There was very little training for vulnerable prisoners.
We repeat the recommendation.

2.228 There should be more vocational employment-related training to meet resettlement needs. (5.23)

Partially achieved. See above.

2.229 Information systems should be developed that allow for the gathering of prevalence data and trends in drug-using to inform the drug strategy (8.63).

Partially achieved. Staff were in the process of updating the drug strategy document, and the results of the annual needs analysis were also under review. Although the 2006-07 drug and alcohol strategy was based on some data, reception testing data was not used to establish prevalence and drug trends.
We repeat the recommendation.

2.230 The frequency of voluntary drug testing (VDT) should be increased (8.68).

Not achieved. Although the prison met its target of 195 VDT compacts, all prisoners on enhanced status were expected to sign up for VDT, so in effect this figure included compliance testing. Prisoners were not tested frequently enough. In the previous month, the prison was 87 tests short of its target for testing.
We repeat the recommendation.

Additional information

2.231 The prison contracted St Petroc's Society (a Cornish-based accommodation service for the single homeless) to provide an accommodation service to prisoners. One full-time accommodation manager was based at the prison, with some additional part-time support. All prisoners had a housing needs initial assessment on induction. Those with an identified need were referred to the accommodation service for a more detailed assessment. The number of prisoners leaving without accommodation to go to was low. The accommodation officer had an extensive knowledge of provision in the region, and the prison could refer prisoners to the Prospects hostel, managed by the local probation area. Prisoners were assisted to maintain or close down tenancies where appropriate.

2.232 There were two Jobcentre Plus staff based at the prison, who were able to close down benefit claims as part of the induction process. They also made appointments for Freshstart interviews from discharge boards A budgeting course offered through the education department enabled eligible and suitable prisoners to open bank accounts. A debt counsellor visited the prison one day a week to deal with individual prisoner debt management.

2.233 Healthcare staff were in discussion with local GPs to improve the health side of discharge arrangements, with plans for lists of GPs in the South West with whom prisoners could register. Healthcare staff saw prisoners before they left and gave them a letter of introduction for their GP.

2.234 The prison ran the Family Man and Fathers Inside programmes under the children and families resettlement pathway. Family Man focused on improving communication within the family, while Fathers Inside aimed to improve parentcraft skills. Successful completion of specific units resulted in Open College Network (OCN) awards. Both courses ran over five weeks and consisted of 30 sessions each. Up to 20 prisoners could attend each course, but numbers of participants were usually lower. The chaplaincy also offered a regular two-day time for families course, which enabled prisoners and their partners to work on their relationship.

2.235 The Prison Advice and Care Trust (PACT) also ran a monthly family day in the visits hall, with a designated day for vulnerable prisoners once a quarter. The family day lasted for four hours and included refreshments and a buffet, as well as special activities for children, such as cake decorating or craft activities.

2.236 There were two accredited offending behaviour programmes – enhanced thinking skills and the short duration programme for substance misusers. The prison was slightly behind its targets for commencements and completions of these programmes. Some other non-accredited programmes were also available (see paragraph 2.234). The Sycamore Tree programme was also offered twice a year through the chaplaincy and delivered by Prison Fellowship volunteers.

Further recommendation

2.237 Prisoners should be given names and addresses of GPs in their area of discharge.

Section 3: Summary of recommendations

The following is a list of both repeated and further recommendations included in this report. The reference numbers in brackets refer to the paragraph location in the main report.

Recommendation — to the Director General

3.1 The practice of slopping out on D wing should be ended as a priority. (2.1)

Recommendations — to the governor

First days in custody

3.2 Managers and staff should continue to seek improvement to the reception building, particularly to make the environment as welcoming as possible and to make it possible for prisoners to discuss personal information with staff in confidence. (2.12)

3.3 All new arrivals should be located in the first night centre on B wing, unless they require specialist treatment. (2.19)

Residential units

3.4 Lockable cupboards should be provided in all cells so that prisoners can secure their in-possession property. (2.21)

3.5 There should be effective management checks to ensure that staff consistently respond to cell bells within five minutes. (2.23)

3.6 Showers should be screened. (2.25)

3.7 D wing should be refurbished to provide prisoners with decent living conditions. (2.30)

3.8 There should be a programme to ensure that the prison grounds, particularly around cells, are cleaned and properly maintained. (2.31)

3.9 All prisoners should be allowed to wear their own clothes. (2.32)

3.10 Prisoners should have access to enough clean clothing of the right size, quality and design to meet their needs. (2.33)

Staff-prisoner relationships

3.11 The unofficial staff breakfast break should cease immediately. (2.37)

3.12 Staff should refer to prisoners by their preferred name or title. (2.38)

3.13 Staff should knock before entering cells on routine business, except in emergencies. (2.39)

Personal officers

3.14 Personal officers should make weekly entries in prisoners' history files, and these should reflect prisoners' personal circumstances and needs. (2.41)

3.15 The monitoring system of wing history files should be consistently applied across all residential units. (2.42)

3.16 Personal officers should be involved in resettlement and sentence management processes. (2.44)

3.17 The personal officer scheme should clarify the respective roles of personal officers and offender supervisors. (2.45)

Bullying and violence reduction

3.18 There should be more training in the anti-bullying strategy and this should include sessions on devising action plans and recording observations. (2.46)

3.19 There should be strong, formal links between the anti-bullying and the suicide prevention coordinators through a structured violence reduction committee that meets consistently. (2.48)

3.20 The anti-bullying/violence reduction coordinator should be allocated enough formal time to carry out his duties. (2.54)

3.21 The anti-bullying policy should be updated. (2.55)

3.22 There should be interventions to tackle bullying and to support victims. (2.56)

3.23 The prison should develop an effective overarching violence reduction strategy that is managed consistently by a committed multidisciplinary committee. (2.57)

Self-harm and suicide

3.24 The Listener suites on C and D wings should be redecorated. (2.64)

Diversity

3.25 There should be greater regime provision for older prisoners. Retired prisoners who choose not to work should be able to access a range of age-appropriate activities, and should not be routinely locked in their cells during the core day. (2.68)

Race equality

3.26 Photographs of race equality representatives should be displayed on each wing. (2.71)

Foreign national prisoners

3.27 Reception, first night information and an induction pack should be available in languages other than English. (2.79)

3.28 The prison should establish contact with local immigration advice and support agencies. (2.81)

3.29 There should be monthly support and information groups for foreign national prisoners. (2.86)

Contact with the outside world

3.30 Visitors should not be subject to a closed visit if no contraband material is found during a search. (2.88)

Substance use

3.31 A specialist nurse should be located on the detoxification unit at night. (2.5)

3.32 Prescribing regimes for opiate users should be flexible and based on individual need, and comparable to treatment in the community. (2.98)

3.33 A supportive regime should be developed for prisoners undergoing detoxification, and officers on B wing trained in substance awareness. (2.99)

3.34 Night staff on B wing should be made aware of those prisoners who are undergoing detoxification. (2.100)

Protection of vulnerable prisoners

3.35 A full regime, including purposeful activity, exercise and daily association, should be offered to all vulnerable prisoners. (2.107)

3.36 The prison workshop for vulnerable prisoners should be properly equipped to provide vocational training. (2.108)

3.37 Genuinely vulnerable prisoners should not be located in isolated cells alongside mainstream prisoners. (2.109)

Health services

3.38 Night medication should be issued last thing in the evening. This is especially important for those undergoing detoxification (2.4)

3.39 An electronic primary care information system should be installed. (2.110)

3.40 Algorithm-based nurse triage should be introduced. (2.111)

3.41 A more flexible appointments system should be introduced. (2.112)

3.42 All pharmacy procedures and policies should be formally reviewed and adopted via the medicines and therapeutics committee, and read and signed by all staff. (2.117)

3.43 All pharmacy procedures and patient group directives should be reviewed and updated. (2.118)

3.44 Levels of medicines allowed in-possession should be increased following risk assessment and the provision of secure storage for prisoners in their cells. (2.119)

3.45 There should be a documented risk assessment for in-possession medications. (2.120)

3.46 A regular user forum should be established linked with the primary care trust (PCT) patient advice and liaison service (PALS). (2.124)

3.47 Primary mental healthcare should be developed with more out-reach work on the wings and greater integration with mental health in-reach team (MHIRT), detoxification services and counselling, assessment, referral, advice and throughcare (CARAT) staff. (2.125)

3.48 The regime in the inpatient unit should be further developed to include day care. (2.126)

3.49 The healthcare beds should not be part of the certified normal accommodation. (2.127)

3.50 The tendering of services should be expedited. (2.130)

3.51 All prisoners should have a comprehensive secondary health screen within 72 hours of arrival. (2.131)

Learning and skills and work activities

3.52 The number of activity places should be increased so that work is available for all prisoners. Opportunities should be taken to accredit all skills acquired at work to reflect industrial practice and needs for employment. (2.7)

3.53 There should be a wider range of education courses to ensure that the needs of the more able prisoners and those wanting higher education are met. (2.132)

3.54 The management of the industrial contract workshops should be improved urgently to ensure safe working practices and better structures to the ways in which prisoners progress through the work activities. (2.136)

3.55 Industrial workshops should run to their full occupancy rate. (2.137)

3.56 A more effective process of passing initial assessment results to staff in the workshops should be implemented. (2.138)

3.57 There should be alternative arrangements to enable the library to open as scheduled in the absence of a prison officer. (2.140)

3.58 All allocations to activities should be coordinated by an allocations board. Prisoners should not be able to bypass this system. (2.148)

3.59 Staff supervision arrangements should not hinder the running of workshops. (2.149)

3.60 There should be much greater emphasis on monitoring prisoner attendance at activities. (2.150)

Physical education and health promotion

3.61 There should be a more appropriate outdoor facility. (2.151)

3.62 A wider range of courses should be offered. (2.152)

3.63 There should be more effective controls over the allocation of prisoners to gym sessions, and prisoners should not be able to avoid attendance at allocated activity in order to go to the gym. (2.158)

3.64 Evening gym sessions should be offered to wings not scheduled for evening association that day. (2.159)

Faith and religious activity

3.65 The services of a Muslim chaplain should be provided and his attendance should ensure that the religious needs of Muslim prisoners are being met. (2.160)

Time out of cell

3.66 The cleaning of their own cells by prisoners should not be counted as purposeful activity. (2.2)

3.67 More association should be provided to all prisoners, and more time out of cell should be available during the working day. (2.6)

Security and rules

3.68 Authorised outcomes from security information reports (SIRs), such as target searches and reasonable suspicion mandatory drug tests (MDT), should be routinely completed. (2.163)

3.69 The identified offending behaviour needs of prisoners should be considered in decisions on suitable allocations. (2.167)

3.70 Running totals of wing numbers should be maintained. (2.168)

Discipline

3.71 Adjudication standardisation meetings should take place regularly and these meetings should be minuted. (2.172)

3.72 Tariffs for charges of assault on staff and prisoners should be the same. (2.175)

3.73 Prisoners should not be held in the special cell any longer than is absolutely necessary. (2.176)

3.74 Prisoners in special accommodation should be monitored at a minimum of five times per hour, and this should happen through staff visits to the prisoner, rather than relying on CCTV. (2.179)

3.75 All cells in the separation and care unit should be fitted with effective privacy screening. (2.180)

3.76 Staffing levels in the separation and care unit should be increased to guarantee daily access to exercise and showers. (2.181)

3.77 Records of prisoner reviews in the separation and care unit should reflect any active plans made to support a return to normal location. (2.182)

3.78 Adjudicators should not give punishment awards of 100% stoppage of earnings. (2.189)

3.79 All planned use of force incidents should be videoed. (2.190)

3.80 A use of force committee should be created to monitor individual incidents and trends over time. (2.191)

3.81 Designated managers should complete and record reviews on prisoners in special accommodation in accordance with published guidance. (2.192)

3.82 Case reviews should be completed when prisoners are likely to remain in special accommodation for more than 24 hours. (2.193)

3.83 Prisoners held in the separation and care unit (SACU) should only be monitored via CCTV when the need has been confirmed through risk assessment. (2.194)

3.84 Education staff should visit the SACU regularly to encourage prisoners to participate in in-cell education. (2.195)

Incentives and earned privileges

3.85 Enhanced-level prisoners who are not located on designated enhanced landings should still benefit from the increased levels of time out of cell. (2.197)

Catering

3.86 All hot food should be served from suitable heated serveries. (2.203)

3.87 Prisoners working in the kitchen should have a maximum five-day week, and part-time work should also be available. (2.206)

3.88 Robust safeguards should be in place to ensure that vulnerable prisoners' food is not contaminated. (2.207)

3.89 There should be full analysis of any prisoner catering surveys, and the results, plus any proposed alterations to services, should be published to prisoners. (2.209)

Strategic management of resettlement

3.90 The prison should develop a reducing reoffending strategy and action plan that identifies responsibilities for the reducing reoffending pathways and develops work under the NOMS alliances. (2.212)

3.91 A reducing reoffending committee should meet regularly to oversee developments across the pathways and develop work under the NOMS alliances. (2.213)

Offender management and planning

3.92 Residential staff should be trained in the monitoring and recording of prisoners subject to public protection arrangements as a matter of urgency. (2.8)

3.93 The prison should encourage the attendance of community offender managers at sentence planning meetings and reviews. (2.215)

3.94 There should be formal sentence or custody planning arrangements for short-term prisoners and those on remand. (2.216)

3.95 There should be greater use of release on temporary licence for eligible and suitable prisoners to support their reintegration into the community. (2.219)

3.96 Prisoners managed under the NOMS model should have regular monthly contact with offender supervisors. (2.226)

Resettlement pathways

3.97 The range of vocational training programmes should be increased to meet the needs of the population and skill shortages. (2.227)

3.98 Information systems should be developed that allow for the gathering of prevalence data and trends in drug-using to inform the drug strategy (2.229)

3.99 The frequency of voluntary drug testing (VDT) should be increased. (2.230)

3.100 Prisoners should be given names and addresses of GPs in their area of discharge. (2.237)

Appendix I: Inspection team

Jonathan French	Team leader
Steve Moffatt	Inspector
Marie Orrell	Inspector
Gordon Riach	Inspector
Elizabeth Tysoe	Healthcare inspector
Lisa Cox	Her Majesty's Inspectorate of Probation

Appendix II: Prison population profile

(i) Status	Number of prisoners	%
Sentenced	300	*62.9*
Convicted but unsentenced	58	*12.2*
Remand	112	*23.5*
Civil prisoners	1	*0.2*
Detainees (single power status)	2	*0.4*
Detainees (dual power status)	4	*0.8*
Total	477	100

(ii) Sentence	Number of sentenced prisoners			
	Adults	%	Young adults	%
Less than 6 months	82	*30.7*	16	*48.5*
6 months-less than 12 months	31	*11.6*	5	*15.1*
12 months-less than 2 years	28	*10.5*	5	*15.1*
2 years-less than 4 years	34	*12.7*	3	*9.1*
4 years-less than 10 years	40	*15.0*	2	*6.1*
10 years and over (not life)	6	*2.2*	0	
Life	46	*17. 2*	2	*6.1*
Total	267	99.9	33	100

(iii) Length of stay - *information not provided*

(iv) Main offence	Number of prisoners	%
Violence against the person	159	*39.75*
Sexual offences	61	*15.25*
Burglary	65	*16.25*
Robbery	36	*9.0*
Theft and handling	28	*7.0*
Fraud and forgery	4	*1.0*
Drugs offences	41	*10.25*
Other offences	4	*1.0*
Civil offences	2	*0.5*
Total	400	100

(v) Age	Number of prisoners	%
18 years to 20	46	*9.6*
21 years to 29 years	198	*41.5*
30 years to 39 years	123	*25.8*
40 years to 49 years	72	*15.1*
50 years to 59 years	25	*5.2*
60 years to 69 years	12	*2.5*
70 plus years	1	*0.2*
Total	477	99.9

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	183	*38.4*
Between 50 and 100 miles of the prison	122	*25.6*
Over 100 miles from the prison	87	*18.2*
NFA	85	*17.8*
Total	477	100

(vii) Nationality	Number of prisoners	%
British	449	*94*
Foreign nationals	28	*6*
Total	477	100

(viii) Ethnicity	Number of prisoners	%
White:		
British	428	*89.72*
Irish	2	*0.42*
Other White	13	*2.72*
Mixed:		
White and Black Caribbean	6	*1.26*
White and Black African	1	*0.21*
Other Mixed	1	*0.21*
Asian or Asian British:		
Indian	2	*0.42*
Pakistani	2	*0.42*
Bangladeshi	2	*0.42*
Black or Black British:		
Caribbean	8	*1.68*
African	4	*0.84*
Other Black	5	*1.05*
Chinese or other ethnic group:		
Chinese	2	*0.42*
Other ethnic group	1	*0.21*
Total	477	100

(ix) Religion	Number of prisoners	%
Baptist	2	*0.42*
Church of England	137	*28.72*
Roman Catholic	68	*14.25*
Other Christian denominations	42	*8.8*
Muslim	17	*3.56*
Sikh	2	*0.42*
Hindu	1	*0.21*
Buddhist	5	*1.05*
Jewish	1	*0.21*
Other	21	*4.4*
No religion	181	*37.94*
Total	477	99.98