Report on an independent review of progress at

HMP Exeter

by HM Chief Inspector of Prisons

13–15 November 2023

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Section 1 Chief Inspector's summary

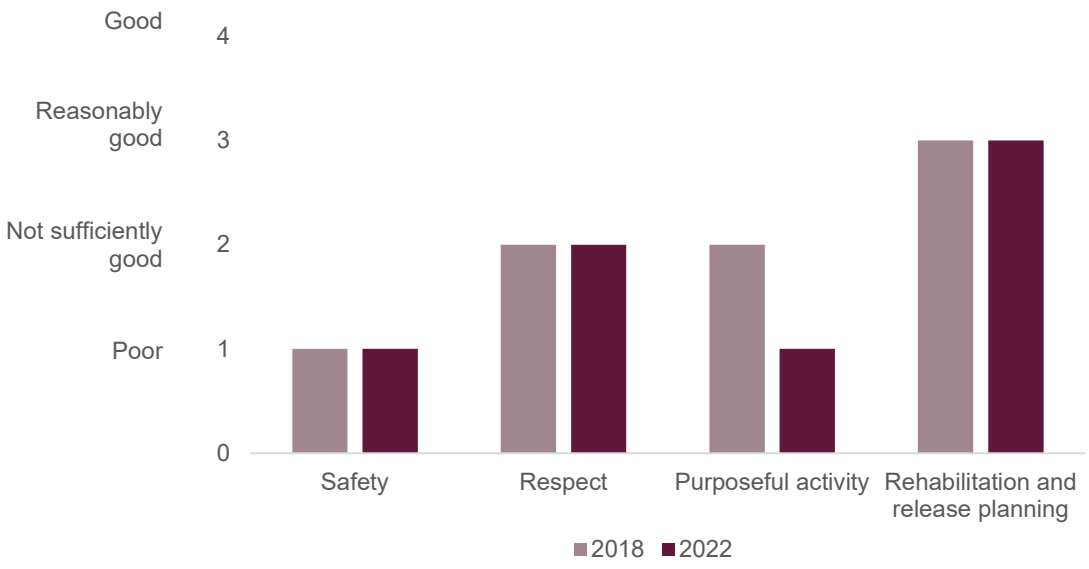
1.1 Built in 1853, HMP Exeter has a radial design, with three wings positioned around the centre. It is a men's reception prison with a small resettlement function, holding 306 prisoners at the time of our visit. There was a high turnover of prisoners with an average of 190 new receptions each month, and, during our visit, about 85% of men had been at Exeter for less than three months.

1.2 This review visit followed up on the concerns we raised at our last inspection of HMP Exeter in 2022.

What we found at our last inspection

1.3 At our previous inspections of HMP Exeter in 2018 and 2022, we made the following judgements about outcomes for prisoners.

Figure 1: HMP Exeter healthy prison outcomes in 2018 and 2022



1.4 At the last full inspection in November 2022, our concerns were so serious that I wrote to the Secretary of State to invoke the Urgent Notification process (see Glossary). This was the first time that we had repeated the protocol in consecutive inspections of an adult male prison. When the first Urgent Notification was issued in 2018, we reported that the prison was not safe and when we returned last year we found that things had, if anything, got worse.

1.5 At the last inspection, levels of self-harm were the highest of all adult men's prisons and there had been 10 self-inflicted deaths between the last two inspections. Arrangements for monitoring those most at risk, such as new arrivals, including those with substance misuse issues, were poor. We described the early days experience for prisoners as

chaotic – vulnerable prisoners too often spent their first few days at the prison in isolation and were subject to abuse from other men. Elsewhere, too many prisoners faced a poor regime, often spending most of the day locked in cells, many of which were in poor condition. Completion rates for those who did access purposeful activity were very low, as the learning and skills curriculum was not appropriate for the prison.

1.6 The instability of the senior leadership team meant it was difficult for the governor to address these significant concerns – there had been eight deputy governors and eight heads of safety in the four years between our inspections in 2018 and 2022. We raised concerns about safety during the 2018 and 2022 inspections. Equally, we were concerned that despite the Urgent Notification in 2018, Exeter did not receive the same support from HM Prison and Probation Service (HMPPS) that we have seen elsewhere. For example, CCTV that had not been working in 2018 had deteriorated further and staff were being sent to other prisons to cover shortfalls, suggesting HMPPS was not aware of the serious weaknesses at Exeter.

What we found during this review visit

1.7 At this IRP, we assessed that there had been reasonable progress in three areas and insufficient progress in four, two of which had been identified as priority concerns following the full inspection. Ofsted found that there had been insufficient progress in all three themes that they reviewed.

1.8 Since the last full inspection there had been further changes to the leadership team, including the appointment of a new governor. He was visible around the jail and led a daily briefing to all staff in which the vision and priorities of the prison were clearly communicated. An onsite prison performance lead staff member had implemented some effective improvements to governance and risk management processes. The prison had also benefited from additional middle managers who provided oversight of safety critical tasks. Nonetheless, most of these roles were funded on a temporary basis and, combined with ongoing population pressures, we found that progress in many areas was not sufficiently robust.

1.9 There had been a further self-inflicted death since the inspection, and managers had been slow to address issues identified by the Prisons and Probation Ombudsman (PPO). Rates of self-harm were similar to 2022, but care and support for individuals in crisis, including new arrivals, was improving. This was in part due to improved leadership within the health provider, better mental health services and additional HMPPS resources. For example, two staff assigned as ‘floorwalkers’ to oversee support for those in crisis had helped to drive up standards. However, these were temporary posts, and it was vital that such roles continued to make sure the work was fully embedded.

1.10 There had been good proactive work to determine and address the reasons for violence, and the oversight of incidents had improved.

Despite this, recorded rates of violence between prisoners remained the highest of all adult male prisons. Leaders understood the importance of the use of effective peer support schemes to support key areas of work, including safety. However, due to national population pressures, the governor was unable to retain prisoners trained in a variety of roles to continue this important work. It was disappointing that key areas of the prison's CCTV remained poor. This had an impact on aspects of safety, and HMPPS's promised funding to address such critical security infrastructure was too slow to materialise.

1.11 Action to improve living conditions had taken too long to implement and national population pressures meant that Exeter remained one of the most overcrowded prisons in England and Wales. While some aspects of formal key worker processes (see Glossary) had been not become embedded promptly enough, we did observe a positive staff group who were accessible to prisoners. It was encouraging that during the visit, we encountered very few complaints from prisoners about being unable to get simple tasks completed.

1.12 A new core day had been introduced in July to provide a more consistent regime. However, there continued to be long-term vacancies in both education and industries, which affected prisoners' access to purposeful activity. Too many prisoners believed they would not be at HMP Exeter long enough to benefit from any engagement with education, skills or work activities and many refused to attend or commit to activities they were allocated to.

1.13 There had been a full year between the last inspection and this review, and overall progress against our concerns was mixed. The new governor had focused the leadership team, providing staff with clear instructions on what was required to address the concerns identified following the Urgent Notification. In 2022, I noted that the prison needed a period of leadership stability, with adequate staffing – there were now signs of stability and while it is right to acknowledge that some progress has been made, much of it felt precarious. There were clear links between progress and staff resources. However, much of the additional resource was temporary and needed to be guaranteed for the longer term to make sure efforts being made led to improvements across all areas of the prison.

Charlie Taylor
HM Chief Inspector of Prisons
November 2023

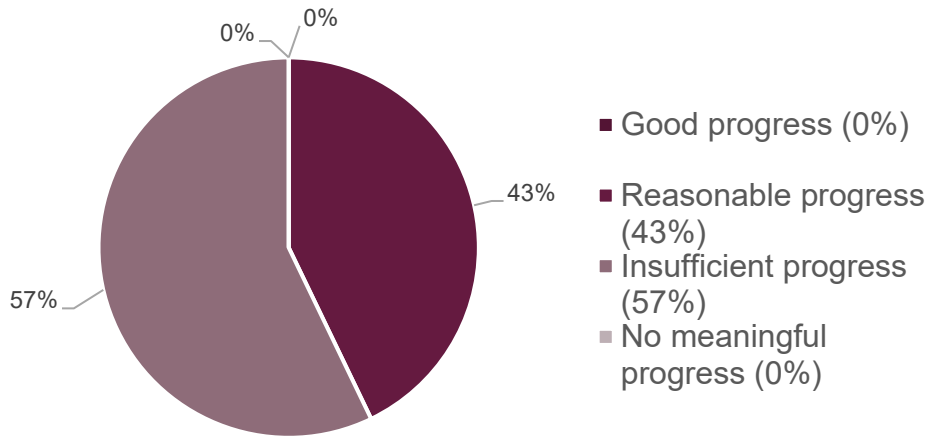
Section 2 Key findings

2.1 At this IRP visit, we followed up seven concerns from our most recent inspection in November 2022 and Ofsted followed up three themes based on their latest inspection.

2.2 HMI Prisons judged there was reasonable progress in three concerns and insufficient progress in four.

Figure 2: Progress on HMI Prisons concerns from November 2022 inspection (n=7)

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



2.3 Ofsted judged that there was insufficient progress in all three themes.

Figure 3: Progress on Ofsted themes from November 2022 inspection (n=3).

Notable positive practice

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

2.5 Inspectors found three examples of notable positive practice during this independent review of progress.

2.6 A well-organised and well-planned safety summit provided staff with comprehensive information to improve their knowledge and understanding of the different ways in which they could support the safety of prisoners. (See paragraph 3.9.)

2.7 A detailed, well-written and easy to follow A-Z guide on safety had been developed for staff to use as a reference guide. (See paragraph 3.10.)

2.8 The substance misuse service manager informed key stakeholders in the prison which prisoners were being stabilised, preventing unsafe transfers from being made. (See paragraph 3.18.)

Section 3 Progress against our concerns and Ofsted themes

The following provides a brief description of our findings in relation to each concern followed up from the full inspection in 2022.

Leadership

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

3.1 Since the full inspection there had been further changes to the senior leadership team, including the appointment of a new governor in May 2023, in addition to other functional lead staff members.

3.2 A complexity review by HM Prison and Probation Service (HMPPS) to assess the banding of key posts to promote more stable, better paid leadership had been unsuccessful. However, the prison group director had addressed this by providing payment uplifts for key roles. While this was positive, the additional funding was not guaranteed in the long term and there remained ongoing risks to the prison's leadership stability.

3.3 Similarly, the governor had created temporary positions at supervising officer and custodial manager level to support progress in the critical areas identified at the last full inspection. This included developing roles to support safety and improve decency across the prison. Funding for these posts was a combination of temporary provision from HMPPS and agreed overspends from the prison's budget. This meant the long-term future to make sure improvements were sustainable and fully embedded was not assured. This led to uncertainty for leaders and those fulfilling critical roles.

3.4 While the prison benefited from a full complement of prison officers at the time of our visit, staff were being sent to other prisons on detached duty. Leaders also spoke of pressure from HMPPS to reduce staff numbers because of ongoing refurbishment programmes. The number of staff unavailable for duty for various reasons was affecting leaders' ability to upskill new staff to meet the needs of prisoners at Exeter.

3.5 There had been more tangible evidence of other support from HMPPS, such as the appointment of a prison performance improvement lead staff member to help the leadership team improve strategic governance and risk management over an 18-month period.

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

Managing behaviour

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

3.7 Leaders' understanding of the drivers of violence had improved. A comprehensive range of data looking at trends and patterns was now collated and reviewed every month at the safety meeting. Leaders were well aware of the reasons for the high rates of violence, and, when there were spikes, responded appropriately with targeted prisoner forums to talk about the causes and exploratory discussions to learn lessons. Despite these efforts, however, this had not yet translated into improved outcomes.

3.8 Oversight of violent incidents was better, and all incidents were now investigated through the use of a challenge, support and intervention plan (CSIP) (see Glossary). Managers oversaw these inquiries and maintained oversight of any additional interventions that were identified to address the violent behaviour.

3.9 To improve staff's knowledge and awareness of safety issues, a well-planned and inclusive safety summit, spanning six weeks began in April 2023. It consisted of undertaking prisoner, staff and family surveys, as well as organising interactive events and analysing data and outcomes. The findings supported a revised safety strategy and action plan. (See paragraph 2.6.)

3.10 Useful and beneficial guidance on many areas related to the safety and support of prisoners had been produced for all staff as resource and reference guides. An A-Z guide on safety, for example, was well-written, easy to follow and provided staff with clear direction (see paragraph 2.7). Other initiatives, such as the well-being centre, were also signs of welcome progress.

3.11 Despite this work, recorded rates of violence between prisoners remained the highest among all adult male prisons. The prison had not been helped by overcrowding and the closure of one wing meaning that prisoners could not be separated. In the six months before this visit, the rate for prisoner assaults had increased by 78%, compared to the same period up to the full inspection. Although violence against staff had declined, it too remained among the highest in the adult male prison group.

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

Safeguarding

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

3.13 There had been one self-inflicted death since our last visit. An action plan to address recommendations made by the Prisons and Probation Ombudsmen (PPO) was in place, and a manager had been assigned to oversee their implementation, but previous PPO reports had raised similar themes showing progress was slow.

3.14 The rate of self-harm was similar to our last inspection and remained very high and on an upward trajectory. Leaders attributed this to a select number of individuals with very complex needs who were repeatedly self-harming. We saw good examples of multidisciplinary working to support some of these troubled men, and very recent work by the psychologist provided targeted one-to-one support.

3.15 Comprehensive data were collated and analysed to identify trends. Regular oversight of repeat self-harmers took place at the weekly safety intervention meeting, but it was yet to support a reduction in the high rates of self-harm.

3.16 Assessment, care in custody and teamwork (ACCT) documents for prisoners at risk of suicide or self-harm had improved. Two staff had been temporarily assigned as ACCT 'floorwalkers'; they aimed to improve safety by providing regular robust quality assurance as well as training and guidance for staff. They had been a key driving force in raising standards.

3.17 Support provided to new arrivals was improving. A internal temporary 12-month post aimed to offer dedicated oversight of reception and induction procedures. Training on identifying appropriate risks and triggers had been delivered to many staff, and revised induction processes to provide better support for prisoners during their first 24 hours had been implemented. The changes were very promising but were yet to be fully embedded.

3.18 Processes were also now in place to make sure that prisoners arriving with drug or alcohol dependencies were effectively monitored. The substance misuse service manager informed key stakeholders which prisoners were being stabilised preventing them from being transferred unsafely. This was a significant improvement since the full inspection. (See paragraph 2.8.)

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

Staff-prisoner relationships

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

3.20 The prison had not resumed its key worker scheme (see Glossary) until several months after the full inspection and it had not been given sufficient priority since, so too few prisoners had benefited.

3.21 Every prisoner arriving at Exeter was assigned a key worker who had an average caseload of three prisoners, which was much lower than we usually see, suggesting a much better capacity to carry out planned sessions. However, key workers were frequently redeployed to other duties and prison data showed that in the previous six months only 14% of planned sessions had taken place.

3.22 Many of the sessions that had been recorded in that time had not been conducted by the prisoner's assigned key worker but as part of the induction process. Although discussions during some of these sessions were reasonable – for example they explored the prisoner's resettlement needs – there was no evidence of the officer following up any of the issues raised. The sessions did not enable prisoners and their assigned key worker to start building a positive relationship.

3.23 The prison had introduced a monthly quality assurance process in spring 2023, carried out by residential custodial managers. Some of those we spoke to had a very good understanding of what good key work looked like and had provided staff with appropriate feedback to improve standards. Notes from most of the key work sessions we reviewed were reasonably good and some were better than we usually see in similar prisons.

3.24 During the week staff were visible on the wings, interacting positively with prisoners, and inspectors received very few complaints about being unable to get simple tasks completed.

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

Daily life

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

3.26 Since the last full inspection, the roll had decreased by 22% to enable the large-scale refurbishment programme to take place, and during our visit, A wing was closed. However, despite the reduction in population, Exeter remained one of the most overcrowded prisons in the country, with 71% of prisoners sharing a cell designed for one.

3.27 Improvements from the refurbishment program were evident on B wing. Cells were in good repair and prisoners had an en-suite toilet, which improved decency.

3.28 However, action to improve living conditions for prisoners on C and D wings had been too slow.

3.29 The cells on C wing, where most prisoners were housed, including those who had just arrived, remained poor. More than half the cells did not have curtains, and many, including those for new arrivals, had graffiti on the walls and doors. Residential managers told us that because of national population pressures, it was difficult to justify making a cell unavailable for a day if it required repainting.

Improved cell on B wing

Graffiti in C wing cell

3.30 Some of the cells and showers on D wing were affected by damp and mould which was not acceptable.

Damp on D wing

3.31 A new residential manager had been appointed in June 2023 and had developed a realistic improvement strategy. This included the appointment of a temporary Clean, Rehabilitative, Enabling and Decent (CRED) manager in October. The manager had introduced a systematic approach to identifying and addressing work required to improve the decency of each cell using a CRED team that included prisoners and staff from the works department. While the approach looked promising, the CRED team was not yet in place.

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

Health, well-being and social care

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

3.33 Oxleas NHS Trust was now the provider at HMP Exeter having taken over immediately following our last inspection. Historical staffing issues had worsened because of the instability created by contractual

changes. However, 12 months on, a new management team was in place, providing effective leadership, stability, and oversight of governance. The team was aware of risks and making progress on mitigation and service improvement plans. Commissioners' oversight was robust and there had been three quality visits since our last inspection, which confirmed that improvements had been made, aligning with our findings. Local quality assurance meetings were in place but lacked pharmacy and GP attendance, which the head of health care was addressing. Staff told us they had confidence in their senior team and felt supported. We saw some improvements in training and supervision.

3.34 Vacancies were high at 48%, but had incrementally improved following an initial dip, with only one resignation and several successful recruitments. The outlier for recruitment was the pharmacy team, which had eight vacancies and no substantive jobs being recruited to since our last inspection. This meant that primary care staff were required to administer medication, which had an impact on the delivery of primary care services. More recently, however, we saw regular bank pharmacy staff supporting the service, easing the pressure to some extent.

3.35 A range of primary care services, such as long-term condition reviews and wound care, were available with mostly reasonable waiting times. Staffing pressures meant that some activities were delayed, including second reception screenings and vaccinations. Managers were aware of these risks and had arranged additional clinics to catch up on the backlogs.

3.36 Patients could access a GP within 10 days and a GP was available in reception in the evening, although sometimes this was remote cover. All patients were seen on arrival at the prison and there was a discharge clinic for planned transfers and releases to ensure continuity of care.

3.37 Improvements had been made to the service since the last inspection, such as the addition of a long-term conditions clinic, led by a specialist nurse. A sexual health clinic was due to start imminently, once the member of staff had completed their training.

3.38 Patients received timely mental health support from a skilled team who cared for their patients. Referrals were triaged within the required timescales and patients were allocated to a clinician's caseload or offered self-help and distraction material.

3.39 Recruitment had continued with the recent addition of an assistant psychologist and psychotherapist. There was a focus on providing short-term, lower-level support to patients who were expected to move on quickly. However, longer-term patients also received person-centred support and had their care reviewed regularly.

3.40 The pharmacy team had been functioning on one member of staff since July. Pharmacy support was offered less frequently than at our previous inspection and members of the team were conspicuously

absent from local quality meetings. The extremely competent and motivated technician managed medicines effectively on site, making sure patients received their medications on time.

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

Time out of cell

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

3.42 Following the inspection, the prison had acted reasonably quickly to prioritise purposeful activity. A custodial manager had been appointed with full-time responsibility for improving the daily regime and prisoner attendance at activities.

3.43 The prison had also improved the approach to assigning prisoners to work and education. A regular sequencing board that took account of prisoners' skills and aspirations had been introduced, as well as a better system to monitor allocations and attendance.

3.44 In July, a new core day was introduced based on most prisoners being allocated a part-time activity for about two and a half hours each week day. The revised regime was designed to offer more consistent access to a domestic period, association and exercise, but many prisoners told us they were frustrated that if they chose not to go to the exercise yard they would be locked behind their door for that hour.

3.45 Prison data suggested that in August, 79% of prisoners were allocated to an activity, compared to 47% at the time of the inspection. However, long-term vacancies in education and industries meant that allocations had declined after this and was only at 64% at the time of our visit.

3.46 The prison had taken steps to incentivise attendance, including increasing the wages for some education courses and offering a financial reward for successfully completing workbooks while engaged in one of the two remaining industries. Data suggested that there had been an improvement in attendance in the three months before the visit. However, it was too early to see positive, sustained impact from these strategies and too many prisoners were still refusing to attend or commit to the activities they were allocated to. (See paragraph 3.58.)

Too few prisoners allocated to activities

3.47 However, most prisoners only attended work or education part time, so they could not spend a full day unlocked. During our roll checks, 28% of prisoners were locked up during the core day, with 29% attending an activity away from the wing.

3.48 When prisoners were unlocked on the wing, there was very little to do - on C wing, there was a solitary table-tennis table. A small number of prisoners could join the book and Scrabble clubs available in the library, but for the majority there were no structured enrichment activities outside work and education.

3.49 Initiatives such as the introduction of a well-being centre, where activities such as yoga were being overseen by enthusiastic PE staff, were a good example of what could be achieved to improve activity and support a safe environment.

Well-being centre

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

Education, skills and work

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

Theme 1: What progress had leaders and managers made to ensure the education, skills and work curriculum met the needs and interests of prisoners, providing meaningful and relevant education and training opportunities which prepared them for their next steps?

3.51 The prison's leaders and managers were strongly committed to devising and implementing many well-considered improvement actions. However, the leadership team had not made timely progress in improving education, skills and work and the impact of their actions so far could not be demonstrated. Delays were largely due to a lack of senior-level staff in key posts for much of the year.

3.52 Leaders had changed how activities were scheduled. They now provided sufficient part-time activity spaces for all prisoners during either mornings or afternoons. However, there was not enough full-time activity for everyone. Around a third of prisoners were classified as unemployed.

3.53 Leaders had not broadened the curriculum content. It was still too narrow and in particular did not meet prisoners' vocational training needs. Leaders had responded to a large rise in the number of short stay prisoners by switching to mainly very short, unaccredited courses in English and mathematics. However, longer stay or more qualified prisoners could not now study full time accredited English or mathematics courses as they were not timetabled.

3.54 Prisoners' attendance at education and training sessions was poor. Frequently, only about half or fewer of those allocated to a session attended it. Prisoners too often arrived at an education session but then left to go to another activity, such as health care.

3.55 Instructors did not all use the new 'progress in work' booklets in workshops well. Prisoners working in the kitchens had no opportunities to accredit or record their development of skills or knowledge. The Clink programme had recently closed.

3.56 Weston College's staffing was still below full capacity despite the recent recruitment of additional teachers. Four instructors were out of commission in industries. Consequently, prisoners were unable to access the courses and training sessions that were part of their detailed job descriptions and learning pathways. Most prisoners could not enact these roles in full and achieve their learning goals.

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

Theme 2: What progress had leaders and managers made in tackling the long-standing inadequacies of prisoners' induction and allocations, including inaccurate assessments of their learning difficulties or disabilities to inform support plans that enabled prisoners to be successful in their education and training?

3.58 Shortly after their arrival, all prisoners should have attended an induction to education and a careers information, advice and guidance session but their attendance at both was poor. Too many prisoners believed they would not be at HMP Exeter long enough to benefit from any engagement with education, skills or work activities. Too many prisoners refused to attend or commit to activities they were allocated to.

3.59 Prisoners did not always know what course they had been assigned to as part of their learning pathway or job description. The number of prisoners waiting to be allocated to English and mathematics courses was too high. Managers' assessment of prisoners' learning difficulties

and disabilities had improved but was still not good enough. There was also a backlog of careers information, advice and guidance sessions as full-time advisor staffing was at 50% of capacity.

3.60 Leaders and managers had implemented initiatives to get more men to attend education, skills and work. These included prison officers recently appointed to prioritise prisoners' transfer from the wings to education. Financial rewards and sanctions were being more actively applied to incentivise prisoners' attendance. Education, skills and work staff had been regularly promoting the value of purposeful activity to staff at wing briefings. However, it was too early to see positive, sustained impacts from these strategies.

3.61 Only a small minority of staff across the prison had received formal training to raise their awareness of how best to support prisoners with learning difficulties and or disabilities. Neurodivergent prisoners were not being routinely given all the support, advice and guidance needed to enable them to better manage their time within the prison.

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

Theme 3: What progress had leaders and managers made to develop the role and impact of the quality improvement group, including its effective use of data to monitor and continuously improve the quality of education, skills and work?

3.63 The prison's quality improvement group (QIG) now played a central role in identifying and coordinating improvement actions in education, skills and work. It followed relevant terms of reference and adopted a thorough, in-depth approach to its task. Minutes of QIG meetings were comprehensive and reflected its broad brief. Senior staff were mandated to attend the monthly QIG meetings, and most did. Nonetheless, most of the concerns the QIG dealt with were long-standing systemic weaknesses which had yet to be resolved and were work in progress.

3.64 While the QIG had implemented numerous improvement actions it was not yet using impact measures well enough to monitor and manage the performance of the improvement actions effectively. QIG members' view on the progress being made against the Urgent Notification action plan were over-optimistic. Leaders were too quick to believe that having new processes in place would fix specific problems over time rather than focusing on continuously reviewing the effectiveness and impact of actions, amending strategies where necessary.

3.65 The QIG, and senior leaders running the now weekly performance review meetings, had a wider range of data with which to identify trends and base decisions, but the data available was not yet comprehensive. For example, there were no agreed metrics in place to measure the impact of, or prisoners' achievement on, the short unaccredited English and mathematics courses which now comprised the bulk of the

education offer. Qualitative and quantitative datasets, for example to measure the extent and impact of staff training or prisoners' development of personal and employability skills, were not yet in place.

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

Section 4 Summary of judgements

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

HMI Prisons concerns

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

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

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

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

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

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

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

Ofsted themes

What progress had leaders and managers made to ensure the education, skills and work curriculum met the needs and interests of prisoners, providing meaningful and relevant education and training opportunities which prepared them for their next steps?
Insufficient progress

What progress had leaders and managers made in tackling the long-standing inadequacies of prisoners' induction and allocations, including inaccurate assessments of their learning difficulties or disabilities to inform support plans that enabled prisoners to be successful in their education and training?
Insufficient progress

What progress had leaders and managers made to develop the role and impact of the quality improvement group, including its effective use of data to monitor and continuously improve the quality of education, skills and work?
Insufficient progress

Appendix I About this report

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

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

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

The aims of IRPs are to:

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

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each concern we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in November 2022 for further detail on the original findings (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/).

IRP methodology

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

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

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

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

Insufficient progress
Managers had begun to implement a realistic improvement strategy to address this concern but the actions taken since our inspection had had not yet resulted in sufficient evidence of progress (for example, better and embedded systems and processes).

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

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

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

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

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

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

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

Inspection team

This independent review of progress was carried out by:

Ian Dickens	Team leader
David Owens	Inspector
Nadia Syed	Inspector
Tania Osborne	Health and social care inspector
Matthew Tedstone	Care Quality Commission inspector
Nick Crombie	Lead Ofsted inspector
Alan Maddox	Ofsted inspector

Appendix II Glossary

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

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

Challenge, support and intervention plan (CSIP)
Used by all adult prisons to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Not everyone who is violent is case managed on CSIP. Some prisons also use the CSIP framework to support victims of violence.

Key worker scheme
The key worker scheme operates across the closed male estate and is one element of the Offender Management in Custody (OMiC) model. All prison officers have a caseload of around six prisoners. The aim is to enable staff to develop constructive, motivational relationships with prisoners, which can support and encourage them to work towards positive rehabilitative goals.

Leader
In this report the term ‘leader’ refers to anyone with leadership or management responsibility in the prison system. We will direct our narrative at the level of leadership which has the most capacity to influence a particular outcome.

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

Time out of cell
Time out of cell, in addition to formal 'purposeful activity', includes any time prisoners are out of their cells to associate or use communal facilities to take showers or make telephone calls.

Urgent Notification
The Urgent Notification process was introduced in 2017 and is a means of raising immediate, urgent concerns following an inspection which requires a response and action plan from the Secretary of State within 28 days. Find out

more: https://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/urgent-notifications/

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

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