Report on an unannounced inspection of

HMP Forest Bank

by HM Chief Inspector of Prisons

14 and 21–25 February 2022

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Introduction

Forest Bank is a privately managed prison, located in Manchester, that has been operated by Sodexo for well over 20 years. Currently designated a reception prison, it can hold up to 1,366 men. The prison has three primary purposes: to receive those recently remanded to custody and hold them until their court appearances are concluded; to hold those who are serving fairly short prison sentences; and to hold those requiring resettlement support as their release date approaches. Convicted men with time to serve would be expected to be allocated to training establishments elsewhere. As an approach, the model has some merit. The evidence, however, would seem to suggest the prison was struggling to make it work, primarily because there was simply not enough space to be sure all new prisoners (about 300 a month) could be accommodated. This inevitably meant that, on an almost daily basis, significant numbers of prisoners were being diverted to other prisons out of the area, impacting the individuals and undermining the prison's core mission.

This was our first visit to Forest Bank since 2019. In our healthy prison assessments, we evidenced similar outcomes in safety and respect, but deteriorations in both purposeful activity and rehabilitation and release planning (RRP). The impact of COVID-19 measures in the prison had made the lack of purposeful activity worse. We judged the prison's regime as 'poor', with prisoners experiencing very limited time unlocked. Leaders showed limited ambition to improve this situation. Our colleagues at Ofsted judged Forest Bank's overall learning and skills provision as 'inadequate', their lowest marking. It was clear to us that the prison needed to re-think both what constituted a useful and meaningful regime and how they approached supporting resettlement for a largely transient population.

This was not, however, the whole story. In late 2021, HM Prison and Probation Service (HMPPS) was forced to issue Sodexo with a formal rectification notice over their concerns about the safety of prisoners and the conditions in which they were being held. This was a concerning step, but there was clear evidence that the company had responded quickly and positively and had, for example, recruited a new Director and Deputy Director to lead the prison. Decisive action had seen noticeable recent improvement in living conditions and new priorities focused on improving safety had been identified. The plans to deliver these priorities, however, still needed more development to ensure their implementation was sufficiently robust.

More also needed to be done to make sure newly received prisoners were properly supported and inducted. Violence and associated measures, such as use of force, use of segregation, and the application of disciplinary procedures all remained high. Levels of recorded violence had paradoxically reduced, but violence among prisoners was still the fourth highest among comparable prisons. Combating the ingress of drugs and other illicit items – all of which likely fuelled some of the violence – also remained problematic; although again, there was some early evidence to suggest that measures to tackle this were having an impact.

In common with many prisons, a key strategic challenge for Forest Bank was staffing. We found a staff group who were committed to doing a decent job – and some 71% of prisoners told us they felt respected by them – although very limited unlock meant the building of meaningful and purposeful relationships was severely restricted. Nearly a quarter of all officers had less than a years' experience, and staff were often lacking in confidence or had a limited understanding of their role outside of the COVID-19 restricted regime. We saw repeated evidence of reticence among staff in enforcing the rules and confronting poor behaviour. Again, the prison was aware of the problem and were beginning to develop strategies to better support their staff.

Forest Bank is a prison in transition. We were told repeatedly that had we visited some months before, we would have found a prison in real difficulties. The prison was still dealing with some significant weaknesses; however, our findings were encouraging. HMPPS and the provider had taken decisive action and it was clear to us that the decline in living conditions had been arrested, sensible priorities identified and that there were some very hopeful signs of stability and improvement.

Charlie Taylor
HM Chief Inspector of Prisons
April 2022

About HMP Forest Bank

Task of the prison/establishment
A men's reception and resettlement prison

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 1354
Baseline certified normal capacity: 1061
In-use certified normal capacity: 996
Operational capacity: 1366

Population of the prison

- 3530 new prisoners received each year (about 294 per month)
- 171 foreign national prisoners
- 29% of prisoners from black and minority ethnic backgrounds
- 164 prisoners released into the community each month
- 96 prisoners on average referred for mental health assessment each month

Prison status and key providers
Private: Sodexo Justice Services

Physical health provider: Sodexo Justice Services
Mental health provider: Greater Manchester Mental Health NHS Foundation Trust
Substance misuse treatment provider: Sodexo Justice Services
Prison education framework provider: Sodexo Justice Services
Escort contractor: GEOAmey

Prison group
Custodial contracts group

Brief history
HMP Forest Bank opened in 2000 as a local prison serving the courts of Greater Manchester. Accommodation was initially provided over six residential units with a further two added in 2009. Single and double cellular accommodation was available, along with an inpatient facility in the health care centre. Forest Bank held remand and sentenced adult men and young adults.

Short description of residential units
A1, A2, B1, B2, C2, E2, F1 and F2 – convicted and un-convicted adults and under 21-year-olds
C1, D2 – convicted and un-convicted vulnerable adults and under 21-year-olds
D1 – reverse cohort unit (RCU)(see Glossary)/induction unit
E1 – closed
G1, G2 and H2 – recovery wings
H1 – RCU/induction unit for prisoners needing drug or alcohol treatment

Name of director and date in post
Jonathan French, January 2022
Ian Whiteside was the interim director from August 2021 to January 2022

Leadership changes since the last inspection
Matt Spencer, 2015–2021

Prison group director
Neil Richards

Independent Monitoring Board chair
Ross Hemsley

Date of last inspection
13, 14, 20–24 May 2019

Section 1 Summary of key findings

1.1 We last inspected HMP Forest Bank in 2019 and made 29 recommendations, eight of which were about areas of key concern. The prison fully accepted 20 of the recommendations, partially (or subject to resources) accepted eight and did not respond to one.

1.2 Section 8 contains a full list of recommendations made at the last full inspection and the progress against them.

Progress on key concerns and recommendations from the full inspection

1.3 Our last inspection of HMP Forest Bank took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for prisoners at the time. Although we recognise that the challenges of keeping prisoners safe during COVID-19 will have changed the focus for many prison leaders, we believe that it is important to follow up on recommendations about areas of key concern to help leaders to continue to drive improvement.

1.4 At our last full inspection, we made three recommendations about key concerns in the area of safety. At this inspection we found that one of those recommendations had been achieved and two had not been achieved.

1.5 We made three recommendations about key concerns in the area of respect. At this inspection we found that one had been partially achieved and two had not been achieved.

1.6 We made one recommendation about a key concern in the area of purposeful activity. At this inspection we found that this recommendation had not been achieved.

1.7 We made one recommendation about a key concern in the area of rehabilitation and release planning. At this inspection we found that this recommendation had not been achieved.

Outcomes for prisoners

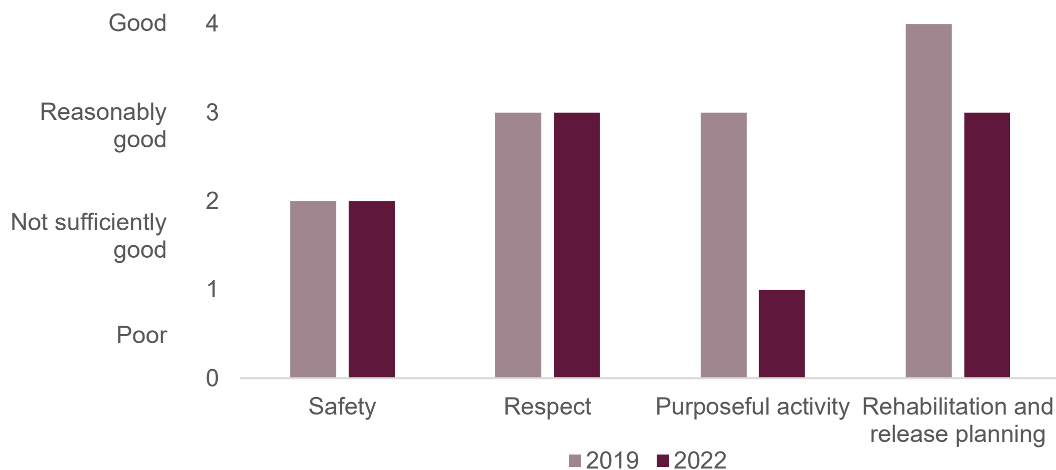
1.8 We assess outcomes for prisoners against four healthy prison tests (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.9 At this inspection of HMP Forest Bank, we found that outcomes for prisoners had stayed the same in two healthy prison areas and declined in two.

1.10 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account the prison's recovery from COVID-19 as well as the 'regime stage' at

which the prison was operating, as outlined in the HM Prison and Probation (HMPPS) National Framework for prison regimes and services.

Figure 1: HMP Forest Bank healthy prison outcomes 2019 and 2022



Safety

At the last inspection of Forest Bank in 2019 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

At this inspection we found that outcomes for prisoners remained not sufficiently good.

1.11 The reception area was clean, and processes were efficient, but we were not confident that an assessment of prisoners' risks was always explored thoroughly during initial safety meetings. Peer support provided in the first few days was good, but the induction programme was still not running in full, and too many new prisoners felt daunted and ill-prepared for prison life. Vulnerable prisoners felt significantly less safe on their first night compared with the rest of the population.

1.12 Violence between prisoners, although declining, remained very high and the fourth highest of all local prisons. Overall, 24% of men felt unsafe at the time of our inspection. Multidisciplinary meetings explored trends in violence data, but actions in response were not followed up effectively. The most serious perpetrators were managed through challenge support and intervention plans (CSIP) (see Glossary), but conflict resolution and other interventions were not yet embedded or having sufficient impact.

1.13 The number of incidents involving force was high. A range of data was reviewed and analysed but not used to make improvements. We found some concerning examples of potentially dangerous practice. Conditions in the segregation unit required improvement and the daily regime was very limited, but prisoners we spoke to were positive about their treatment.

1.14 Steps had been taken to stem the flow of drugs and other illicit items. These measures were helping to reduce availability, but not all requested cell searches were carried out, which was a missed opportunity. In our survey, 40% of prisoners said it was easy to obtain illicit drugs, which was higher than at similar prisons (26%), but lower than when we inspected Forest Bank in 2019 (61%).

1.15 The recorded level of self-harm had dropped by about 20% since our last inspection and levels were now similar to other local prisons. There had, however, been two self-inflicted deaths since the last inspection, and leaders had still to implement all of the Prisons and Probation Ombudsman's recommendations. Some staff on duty at night were not sure about how to respond to emergencies. The safety team was small and did not have a sufficient profile across the prison. Prisoners could not reliably access a Listener (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) and the scheme was not promoted well. The operation of the new assessment, care in custody and teamwork case management process for prisoners at risk of suicide or self-harm was not good enough. Care maps were weak and often out of date, and case files were not always easily accessible to staff.

Respect

At the last inspection of Forest Bank in 2019 we found that outcomes for prisoners were reasonably good against this healthy prison test.

At this inspection we found that outcomes for prisoners remained reasonably good.

1.16 Meaningful staff-prisoner relationships were being hampered by the extremely limited time out of cell, the lack of an effective key worker scheme (see Glossary) and the short stays at the prison that many prisoners experienced. Despite this, 71% of those responding to our survey said staff treated them with respect. In recent months, there had not always been enough officers in the units, and they did not always interact with prisoners or consistently challenge poor behaviour.

1.17 Half of the prisoners continued to live in overcrowded and cramped cells and many toilets lacked adequate privacy screening. In our survey, only 16% of prisoners said their cell bell was answered promptly, which was significantly lower than in similar prisons (26%).

1.18 All meals were taken to the cell door, which was disrespectful. As in 2019, just under half of the prisoners in our survey (43%) said the shop sold what they needed, which was lower than in similar prisons (57%).

1.19 There were some signs of recent improvements in prisoner consultation arrangements. Responses to applications were usually timely. Prisoners' access to complaints forms was inconsistent, some responses were delayed, and too many failed to address the complaint.

Prisoners had good access to legal advice, bail information and support.

1.20 Equality work was not underpinned by a comprehensive needs analysis. Focus groups had been temporarily replaced by questionnaires and in-cell calls during the pandemic, which made sure there was some ongoing consultation. Data collection and analysis was limited to a few key areas and did not always lead to changes in practice. Investigations into discrimination incident reporting form (DIRF) complaints were thorough, however responses were often delayed and not comprehensive enough.

1.21 There were few areas where prisoners reported disproportionate outcomes in our survey. However, prisoners with a disability or mental health problem were noticeably more negative about safety. There was little support available for younger or older men but provision for foreign national prisoners was good. The prison had not yet investigated black and minority ethnic prisoners' perceptions of being disadvantaged when it came to work allocations.

1.22 Health care governance and partnership arrangements were positive, and services were generally well-led, but the applications process was not efficient enough and triage arrangements were not consistent. A good range of primary health care services was available and waiting times for clinics were reasonable. Despite some improvements in the physical environment of the inpatient unit, it was not led by clinical staff and patients did not have enough access to daily activities. Mental health services were reasonable, but the range of interventions was too limited. Substance misuse services were good, as were pharmacy services, but medications were not always administered on time.

Purposeful activity

At the last inspection of Forest Bank in 2019 we found that outcomes for prisoners were reasonably good against this healthy prison test.

At this inspection we found that outcomes for prisoners were now poor.

1.23 The regime had been severely restricted because of another recent outbreak of COVID-19. However, as this outbreak subsided, the prison had been slower to restore the regime than has been seen in many other establishments. About two thirds of prisoners were locked up during the core working day and those not involved in activities only had about two hours a day out of their cell.

1.24 Ofsted awarded its lowest grade for education, skills and work. Education, skills and work were not a priority and expectations of what prisoners could achieve were not high. Leaders and managers had not aligned their curricula to meet the changing needs of the prison population. Quality assurance and improvement arrangements were not effective.

1.25 There was no induction to assess prisoners' starting points, prior knowledge and skills, or future ambitions. Prisoners did not receive effective or impartial careers advice and guidance. Planning for the English and mathematics curricula focused on prisoners working towards achieving units of qualifications that might not have been recognised by other prison colleges or community colleges. Trainers did not routinely make sure that prisoners developed their English and mathematics in vocational training and prison work.

1.26 Leaders did not make sure that allocations to activities were fair, equitable and timely. Attendance at education, skills and work activities was low. Those who acted as mentors were not suitably trained and peer workers in the residential units did not have appropriate qualifications.

Rehabilitation and release planning

At the last inspection of Forest Bank in 2019 we found that outcomes for prisoners were good against this healthy prison test.

At this inspection we found that outcomes for prisoners were now reasonably good.

1.27 There were no family days and the number of social visits for each prisoner was not sufficient, especially for those on remand. Video calls were underused. The families team provided some good support but only to a very small number of men. Storybook Dads (in which prisoners record a story for their children to listen to at home) was available, and some parenting group work had just restarted, including a father-baby bonding session.

1.28 Forest Bank was a reception prison and the only one in the Greater Manchester area to accept prisoners on remand, but delivery of the model was hindered by significant population pressures and lack of spaces to accept new arrivals. For example, the prison could not meet the demand for places, meaning many remanded prisoners and others who should have stayed at Forest Bank in the lead up to release were routinely transferred to other prisons often miles away.

1.29 The number of sentenced prisoners requiring offender management was much lower than at the last inspection. Levels of recorded contact between these prisoners and prison offender managers was, however, poor.

1.30 Too many prisoners (40%) were released after their home detention curfew eligibility (HDC) date. This was due to their lack of time left to serve, insufficient available accommodation and disproportionate COVID-19 restrictions imposed by HMPPS.

1.31 Work to protect the public was robust and information sharing with community agencies such as children's services was effective.

Prisoners' mail and telephone calls were monitored well, and child contact restrictions were managed appropriately.

1.32 Initial categorisations were mostly timely, and reviews took into account a reasonable amount of useful information. Too many prisoners who should have moved onto other prisons to complete offending behaviour work remained at Forest Bank for too long.

1.33 There was not enough evidence to demonstrate the need for the Thinking Skills Programme and there were no structured interventions for men convicted of domestic violence or sexual offences. We found little evidence of prisoners taking part in individual offending behaviour work.

1.34 Release planning was reasonable for sentenced prisoners but not for remanded or unsentenced prisoners. Although they had a plan, they received too little support to address their problems. About 86% of sentenced prisoners left with settled accommodation, which was much better than we see elsewhere. However, remanded or unsentenced men did not receive help to find accommodation. Support for prisoners with finance, benefit and debt needs was far too limited.

Key concerns and recommendations

1.35 Key concerns and recommendations identify the issues of most importance to improving outcomes for prisoners and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of prisoners.

1.36 During this inspection we identified some areas of key concern and have made a small number of recommendations for the prison to address those concerns.

1.37 Key concern: Early days processes did not always keep prisoners supported or informed. Holding rooms in reception lacked useful information, prisoners' safety interviews were not held in private, and staff did not always make a full assessment of the risks posed by individuals based on information received and a detailed exploration of the concerns with the man. Vulnerable prisoners were held alongside the general population and felt significantly less safe on their first night. Prisoners could not have a shower on their first night. There was very little time out of cell for those in the induction unit and most prisoners did not get a full induction. As a result, prisoners too often felt unprepared for prison life.

Recommendation: All prisoners should feel safe on their first night. Support in the first few days should prepare new arrivals for prison life and they should receive sufficient time out of cell.
(To the director.)

1.38 Key concern: Levels of violence remained very high but interventions to manage perpetrators and support victims were too limited. The adjudication system was undermined by the large number of cases that

had not been concluded, which meant that some poor and antisocial behaviour went unpunished. The incentives scheme focused too much on punitive measures rather than promoting good behaviour.

Recommendation: Violence should be reduced using a range of effective interventions that challenge perpetrators and support victims. Good behaviour should be promoted and those who break the rules should be held to account.
(To the director.)

1.39 Key concern: Illicit items such as mobile phones and drugs had been easily available in the prison and had fuelled debt and associated violence. Steps had been taken to stem the flow but some of them, such as escorting prisoners to exercise yards away from their units were time consuming and possibly hard to sustain in the long term. Intelligence reports were processed swiftly, but not all requested cell searches were undertaken.

Recommendation: Leaders should take robust and sustainable action to reduce the availability of illicit items, including acting on all intelligence received.
(To the director.)

1.40 Key concern: The lack of an effective key worker scheme, little time out of cell and the very short stays of most prisoners had a detrimental effect on staff-prisoner relationships. A quarter of prison custody officers had less than a year in post and some lacked the confidence, knowledge and experience they needed to do their jobs effectively. Some staff were still too reticent to challenge poor behaviour consistently. We too often saw them in unit offices rather than interacting with and supervising prisoners.

Recommendation: Staff should receive enough training and ongoing supervision to give them the confidence, knowledge and skills to engage meaningfully with prisoners, support those who need their help and challenge poor behaviour consistently.
(To the director.)

1.41 Key concern: Despite raising significant concerns at our last two inspections, the inpatient unit remained poor. There was a lack of clinical leadership to coordinate health care input and no continuous nursing presence. Time out of cell was very limited and there was a lack of therapeutic activities. Patients could not routinely access the day room as it was constantly being used for other purposes.

Recommendation: The inpatient unit should deliver a clinically led, purposeful and therapeutic environment.
(To the director and the healthcare provider.)

1.42 Key concern: Leaders had been too slow to ease some COVID-19 restrictions. Very few prisoners had access to work or education, and we found about two thirds of the population locked up during the core working day. Unemployed prisoners had only two hours out of their cell

each day. Hardly any could visit the library and access to the gym was far too limited.

Recommendation: Prisoners should have more time out of cell to access purposeful activity including work, education, the gym and library.
(To the director.)

1.43 Key concern: Leaders and managers did not have effective oversight of the quality of the education, skills and work provision. They were unaware of the weaknesses in the standards of teaching, training and work.

Recommendation: Leaders should have effective oversight of education, skills and work provision, to make sure that the standard of teaching, training and learning is high enough to prepare prisoners effectively for their next steps, including employment.
(To the director.)

1.44 Key concern: There were too few purposeful activity places to meet the needs of the prison population and the allocations process was not fair, equitable or timely.

Recommendation: Leaders must increase the number of education, skills and work activity places to meet the needs of the prison population and make sure that allocations are fair, equitable and timely.
(To the director.)

1.45 Key concern: Education and training were not planned effectively enough to enable prisoners to increase their knowledge, remember what they had learned or achieve the most appropriate qualifications that would help them in the future. Support for those with additional needs or who struggled to complete their work was poor.

Recommendation: Leaders must make sure that all prisoners receive appropriate tuition and support that is planned effectively to enable prisoners to remember what they have learned and enable them to achieve relevant qualifications that are useful in the future.
(To the director.)

1.46 Key concern: There were too few social visits available for the population, especially for the large number of remanded and unsentenced prisoners. Other methods of communication, such as video-calling, were underused.

Recommendation: Prisoners, especially those on remand or unsentenced, should be able to have more visiting sessions, and video calling should be used more extensively.
(To the director.)

1.47 Key concern: Forest Bank was now a reception prison and the only one in the Greater Manchester area to accept prisoners on remand. The model was not working well and had badly affected outcomes for prisoners in a range of areas. Some remanded prisoners were sent from court to other prisons often miles away because the prison had no space, while others serving shorter sentences who should have stayed at Forest Bank in the lead up to their release were often transferred away from their resettlement area. Prisoners serving longer sentences needed to progress to training prisons but instead remained at Forest Bank.

Recommendation: The role of Forest Bank as a reception and resettlement prison should be reviewed to make sure it has the capacity to receive and retain the correct prisoners and thereby fulfil its designated function.
(To HMPPS.)

Notable positive practice

1.48 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.

1.49 Inspectors found four examples of notable positive practice during this inspection.

1.50 A dedicated worker delivered good support and made sure prisoners' social care needs were met. (See paragraph 4.56.)

1.51 The integrated substance misuse teams organised their caseloads based on geographical areas covering the Manchester region. This resulted in more effective and sustainable partnership working, which was delivering good through-the-gate support. (See paragraph 4.68 and 4.73.)

1.52 Work to protect the public was robust. A dedicated and skilled monitoring team listened to a high volume of calls every day with very few delays. Prison offender managers promptly shared concerns with other agencies. (See paragraphs 6.11 and 6.12.)

1.53 Accommodation outcomes on release were very good. The prison had a dedicated housing specialist and had received funding from the Greater Manchester temporary housing scheme. Data showed that 86% of sentenced prisoners had some form of housing on the day of their release. (See paragraph 6.22.)

Section 2 Leadership

Leaders provide the direction, encouragement and resources to enable good outcomes for prisoners. (For definition of leaders, see Glossary.)

2.1 Good leadership helps to drive improvement and should result in better outcomes for prisoners. This narrative is based on our assessment of the quality of leadership with evidence drawn from sources including the self-assessment report, discussions with stakeholders, and observations made during the inspection. It does not result in a score.

2.2 In August 2021, HM Prison and Probation Service issued a rectification notice to Sodexo because of significant concerns about conditions at Forest Bank. This included risks posed by the amount of contraband getting into the prison, high levels of violence, and very poor living conditions, all underpinned by the shortage of officers in post.

2.3 Since then, there had been several changes to the senior leadership team, including the appointment of a new director and deputy director. The main priorities set out by the director aligned with the concerns in the rectification notice, but action was not always supported by a clear enough measurement of when improvements had been achieved. The safety improvement plan, for example, indicated the achievement of actions, without evidence of better outcomes for prisoners.

2.4 Quick and effective leadership action had been taken by Sodexo and the prison leaders to improve living conditions and most residential units had been renovated and were now a decent standard. Steps taken to reduce the supply of contraband were showing early signs of success, but there were too many missed opportunities to further improve outcomes such as too few cell searches being completed and an underuse of the body scanner.

2.5 Leaders and managers did not have high enough expectations of what prisoners could achieve through education, skills and work. They had not aligned their curriculum to meet the changing needs or demographics of the prison population. Leaders and managers did not have sufficient oversight of the standard of education, skills and work. Quality assurance and improvement arrangements were not effective.

2.6 Being a designated reception and resettlement prison, the population of remanded men was now higher than at our last inspection. The large number of prisoners moving in and out of the prison posed significant challenges to effective leadership. Many prisoners who should have stayed at Forest Bank on remand or to serve their shorter sentence were moved on to free up spaces for the next days' new arrivals. Others were unable to move on to more suitable prisons to make progress towards their sentence plan objectives. HMPPS needed to make sure that the prison could hold the population it was intended for and that others are moved onto more appropriate prisons to progress.

2.7 Leaders worked well with partner organisations to achieve their priorities such as effective working with the police to reduce the amount of contraband being thrown over the walls into the prison. However, staff in different departments within the prison did not always work together well enough to take forward the priorities. For example, leaders across the prison needed to show better ownership and delivery of the work to promote Equality and Diversity and improve safety rather than leaving this work to individual teams.

Leaders had not addressed the shortages of officers which was continuing to have a detrimental impact on outcomes such as poor time out of cell and limited supervision of prisoners. Leaders had committed to providing three officers in each unit to improve supervision and control but in reality, this had been difficult to achieve. For example, in the last couple of months units were understaffed most days.

2.8 Officer retention rates were poor, with 25% of those in post at the time of the inspection having had less than one year's experience. Many officers we spoke to told us they were disillusioned and felt their well-being was being overlooked. Leaders had introduced a leadership course for senior prison custody officers (SPCOs), which most had completed. SPCOs and middle managers were located in the units to promote visibility. However, most officers said they did not have formal supervision or coaching meetings, and many we spoke to said managers and leaders failed to challenge poor staff behaviour.

2.9 Staff training had been very limited during the pandemic, which was reflected in our staff survey and when speaking to officers in the units. There was a lack of ongoing skills development opportunities and leaders had not yet put together a formal training and development plan for the coming year.

2.10 Governance arrangements in health care were robust and good multidisciplinary working made sure that lessons were learned, and practice improved. However, leaders had not provided enough resources to the safer custody team to take forward the key priorities they had or focus on continuous improvement.

2.11 While Forest Bank had experienced repeated outbreaks of COVID-19, we found that some of the COVID-19 restrictions in place at the time of this inspection too limiting. For example, prisoners had hardly any time out of cell. When we checked, we found 65% of men locked in their cells during the core working day, which was far higher than we have seen in other similar prisons recently.

Section 3 Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

Expected outcomes: Prisoners transferring to and from the prison are safe and treated decently. On arrival prisoners are safe and treated with respect. Risks are identified and addressed at reception. Prisoners are supported on their first night. Induction is comprehensive.

3.1 Following the establishments designation as the reception prison for Manchester, all men remanded by courts in Manchester were now meant to be sent to Forest Bank (see paragraph 1.28 and 6.4). However, the prison was often full, which meant men were routinely diverted to other prisons. On the day we started the inspection, 12 remanded prisoners had to be redirected to HMP Liverpool and six went to HMP Leeds.

3.2 All prisoners who passed through reception were strip-searched. Although there was a body scanner to detect secreted items, it was not used enough and not all staff were trained to use it (see paragraph 3.28). The scanner was only being used for recalled prisoners or where intelligence indicated a potential risk.

3.3 The reception area was clean, but holding rooms were bare and unwelcoming, with metal seating and no useful information on display. Safety interviews were not held in private, which made it less likely that a prisoner would disclose personal information. Staff were friendly and had a good awareness of risk information contained in suicide and self-harm warning forms received from the court, but we were not assured that staff always fully explored this information with the prisoner to make a good assessment of his current risks and support needed (See key concern and recommendation 1.37.)

3.4 Reception processes were efficient. Prisoners received a hot meal and could make a two-minute phone call in reception, but they could not have a shower on their first night.

3.5 Prisoners had good access to Insiders (prisoners who introduce new arrivals to prison life), who welcomed them in reception and offered practical advice.

3.6 Due to COVID-19, leaders had stablished reverse cohort units RCUs (see Glossary) in which prisoners could isolate in small groups for their first 10 days. There was an RCU for prisoners from the general population and one for those with drug and alcohol treatment needs but none for vulnerable prisoners which left them located alongside others. It was not a surprise to find that in our survey far fewer vulnerable

prisoners said they felt safe on the first night (See key concern and recommendation 1.37.)

3.7 First night cells were bleak, as the induction units (D1 and H1) had not been refurbished. New prisoners received additional first night checks on their safety and well-being.

3.8 In our survey, 73% of prisoners said they had had an induction, fewer than at the last inspection (89%). The full induction process remained suspended for the general population. Instead, prisoners saw an induction officer at their cell door. Prisoners in the RCU for those requiring drug and alcohol treatment still received a formal induction in a group room with an officer and Insiders. However, too many new prisoners we spoke to felt daunted and ill-prepared for prison life. (See key concern and recommendation 1.37.)

3.9 Time out of cell (see Glossary) for new arrivals was very poor (see paragraph 5.2). Even though the induction officer asked prisoners for the phone numbers of friends and family on the morning after their arrival, it took about a week for prisoners to be able to start calling friends and family from their in-cell phones.

Managing behaviour

Expected outcomes: Prisoners live in a safe, well ordered and motivational environment where their positive behaviour is promoted and rewarded. Unacceptable conduct is dealt with in an objective, fair, proportionate and consistent manner.

Encouraging positive behaviour

3.10 The rate of violence had decreased by about 25% compared to our last inspection and in our survey fewer prisoners than previously reported experiencing bullying or victimisation (16% compared with 31%). However, violence between prisoners remained very high and was the fourth highest of all local prisons. Leaders attributed the high rate to the availability of illicit items, associated debt, staff inexperience and shortages. Approximately 40% of violent incidents in the previous 12 months were fights, often involving several prisoners. (See key concern and recommendation 1.38)

3.11 The survey findings about prisoners' perceptions of safety were broadly similar the 2019 findings with 24% feeling unsafe at the time of this inspection. Far more (64%) vulnerable prisoners said they had been subjected to verbal abuse compared with 28% of respondents amongst the rest of the population and half indicated they had had their property or canteen stolen compared with 21% of others in the prison. We observed prisoners from the main population spitting at and verbally abusing some vulnerable prisoners as they returned from work.

3.12 Violent incidents were investigated promptly, and the quality of investigations was reasonably good. The most serious perpetrators

were managed through challenge support and intervention plans (CSIPs) (see Glossary). The CSIP process was well embedded and prisoners were offered support from the accredited programme's team through one-to-one sessions or in-cell work, which was a positive initiative.

3.13 Other than the use of CSIP, there was little else in place to address violence or support victims. Conflict resolution was not available and there were no violence reduction peer workers or prisoner forums taking place. Incentives to promote good behaviour within the prison were also very limited. (See key concern and recommendation 1.38.)

3.14 The safer custody team was small which limited the amount of oversight it could provide to address violence in the prison (see paragraph 3.37). A weekly safety intervention meeting was well attended by staff from a range of departments and focused on the recent causes of and triggers for violence, but we could not see evidence of action being taken as a result. A strategic multidisciplinary meeting was held every month and explored data but we could not see evidence of lessons learned to identify longer-term action to reduce violence.

3.15 The prison's incentive policy was revised in November 2021, however there was few differences between the levels to motivate prisoners to behave well. The difference in rewards for standard level prisoners and enhanced was negligible and the ability to earn extra rewards such as an additional visit had been lost for most of the COVID-19 regime restrictions. (See key concern and recommendation 1.38 and paragraph 6.1.)

Adjudications

3.16 Data provided by the prison showed that there had been 5,700 adjudications last year which was much higher than the number reported in 2019. A significant proportion (20%) of charges were not proceeded with and there was a backlog of over 100 adjourned cases. Records showed that due to regular adjournments, prisoners often left the establishment before hearings were concluded. (See key concern and recommendation 1.38.)

3.17 Some adjudications were for relatively low-level rule breaking such as taking too long to return to a cell after a shower which could have been dealt with through an effective incentives scheme or more confident and consistent reinforcement of the rules by staff

3.18 Leaders acknowledged that sanctions were not always proportionate to the seriousness of the offence committed, for example, a prisoner who refused to go behind his cell door was more harshly punished than one who had flooded his cell.

3.19 Adjudications data was monitored at quarterly segregation monitoring and review group meetings, but this was not wholly effective in driving improvement. Gaps such as incomplete records and high number of

adjournments had been identified but no action taken to improve this. The same meeting had identified disproportionate outcomes for the young adult population which had been a persistent pattern, but again no actions had been taken to address this.

Use of force

3.20 Force was used on 1,342 occasions in the 12 months leading up to our visit, more frequently than at our last inspection, although half of all incidents involved more minor interventions, such as the application of guiding holds rather than the deployment of full control and restraint techniques. Most incidents (82%) were spontaneous and unplanned.

3.21 As at the last inspection, too few incidents involving staff using force on prisoners were recorded using body worn video cameras (BWVC) despite CCTV showing ample opportunity for staff to have turned their camera on. As a result, leaders often had to rely on poor quality CCTV recordings to review incidents. Leaders told us that all incidents were reviewed but we found some concerning examples of poor and potentially dangerous practice which had been missed.

3.22 Governance arrangements were in place but were not fully effective. A monthly use of force meeting analysed a range of data, including the reasons for force but this was not used to make the necessary changes. For example, it had been identified force was used more often at certain times of the day, but no actions had taken place to try and find out why or resolve this. Written statements reporting on incidents were not always completed on time and some dated back to September 2021. Some statements were not accurate as they did not reflect CCTV evidence, particularly in relation to the bad practice highlighted.

Recommendation

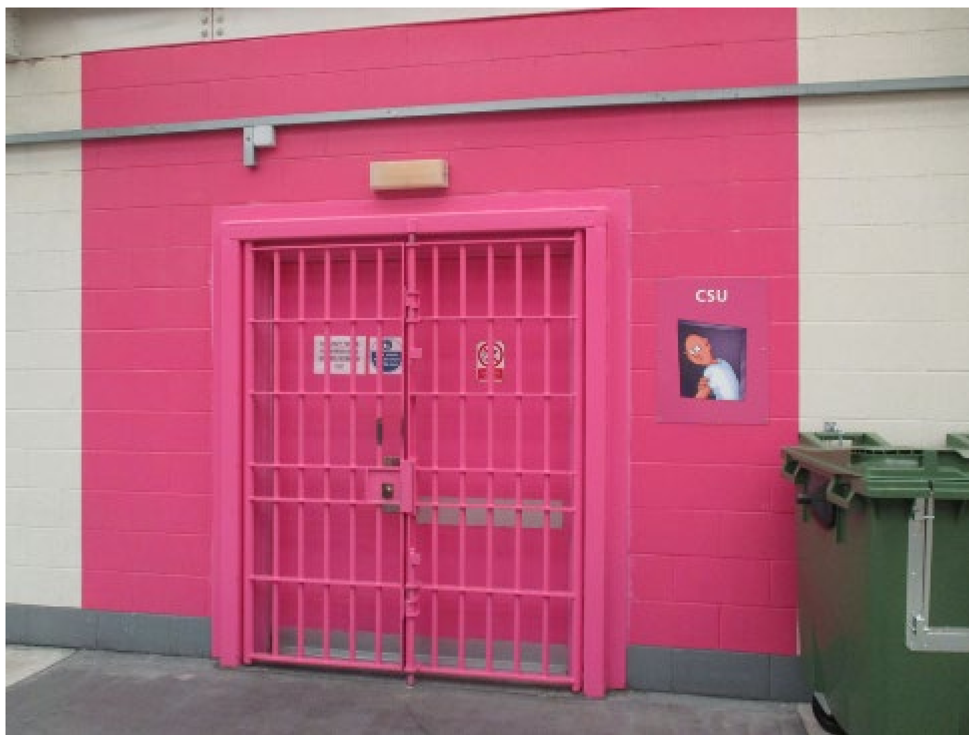
3.23 **Governance should make sure that the use of force is always necessary, proportionate and justified.**

Segregation

3.24 The use of segregation was slightly higher than at our last inspection, having risen from 362 uses in the six months leading up to our last inspection to 873 in the year before this inspection. Almost half of all those segregated in the last six months were waiting for an adjudication hearing and could have been held on the main wings without the need to relocate to the segregation unit.

3.25 Conditions in the unit required improvement. Some men held there had very complex needs and their well-being was not fully supported by the regime or living conditions. Communal areas were not always kept clean. Exercise yards were bare and had no exercise equipment. The daily regime was very limited, and prisoners received no more than 90 minutes out of their cells. Televisions were not permitted, and the only distractions were a radio, books on request and some basic activity

packs. Despite these limitations in conditions, 73% of prisoners responding to our survey said they had been treated well by staff. Staff had a good knowledge of those in their care and in our observations, we saw polite interactions.



Segregation unit entrance

3.26 Reintegration planning had improved since 2019 and the average length of stay in 2021 had been seven days. Segregation authorisation documentation was not always completed fully. Segregation review boards were held regularly but health care staff did not always attend them in person and targets set for prisoners were generic and not consistently reinforced.

3.27 Programmes staff visited the segregation unit three times a week. They attended segregation reviews, provided in-cell activity packs and spoke to prisoners to provide them with additional support and encouragement about their behaviour.

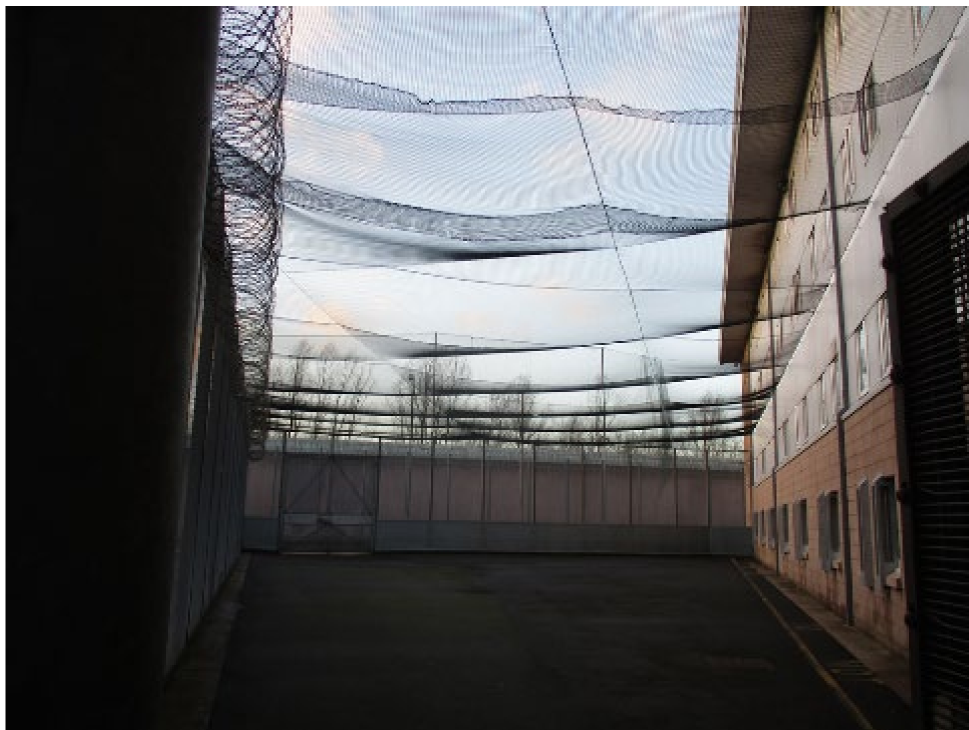
Security

Expected outcomes: Security and good order are maintained through an attention to physical and procedural matters, including effective security intelligence and positive staff-prisoner relationships. Prisoners are safe from exposure to substance use and effective drug supply reduction measures are in place.

3.28 Security procedures were mostly proportionate, although some practices that we highlighted in 2019 remained. For example, prisoners were routinely strip-searched on reception from other prisons and when

released, despite the body scanner offering a more effective and less intrusive means of searching (see paragraph 3.2).

3.29 Leaders had focused their attention on the main security risks, including the supply of drugs and illicit items, organised crime and staff corruption. Illicit items, such as mobile phones and drugs, had been entering the prison in very large numbers, primarily in parcels thrown into exercise yards. In the six months ending December 2021, 1379 parcels had been thrown over, but only 26% of them had been recovered. The availability of so many illicit items had significantly undermined the safety and good order of the prison and were directly linked by leaders at the prison to debt and violence among prisoners. A few weeks before the inspection, steps had been taken to tackle the problem, such as security staff patrolling the yard during exercise periods, residential staff supervising them and new netting over some areas to catch parcels thrown over the prison wall. The measures had started to have an impact and according to the prisons data the number of parcels thrown over the prison walls and successfully received by prisoners had reduced significantly. Some exercise yards had been taken out of use as they faced the external wall and made it easy to throw over illicit items, so staff now escorted prisoners to other exercise yards, but this was resource intensive and took an officer away from supervising the house unit. We were not confident that this could be sustained in the long term. (See key concern and recommendation 1.39)



Netting covering the exercise yard

3.30 A monthly tactical assessment was used to identify gaps in intelligence and provide other departments with an appropriate understanding of security concerns. Not all intelligence was acted on, which was a significant missed opportunity considering the security threats the

prison faced. In the six months ending December 2021, only 44% of requested cell searches were completed. (See key concern and recommendation 1.39.)

3.31 In our survey, 40% of prisoners said it was easy to get hold of illicit drugs, which was higher than at similar prisons (26%), but significantly lower than last time we inspected (61%). The prison made effective use of a machine to detect drugs entering the prison through the mail, but the body scanner in reception was not used to its full extent. Drug testing had mainly focused on suspicion testing in the last six months of 2021, while random drug tests had mostly been put on hold due to COVID-19 restrictions. A total of 342 suspicion tests had been completed, yielding mostly positive results, suggesting that the intelligence received was good.

3.32 In 2021, 8532 intelligence reports had been submitted. They were processed swiftly and at the time of the inspection, there was no backlog.

3.33 Partnership working was strong. The security team and the integrated substance misuse services team met every month, and a substance misuse action plan supported their work. The prison's links with Greater Manchester Police were effective and joint working with the regional counter corruption specialist helped to manage the large number of prisoners from organised crime groups in Forest Bank. The security team had a good understanding of the risks posed by staff corruption and threats caused by prisoners with extremist views.

Safeguarding

> Expected outcomes: The prison provides a safe environment which reduces the risk of self-harm and suicide. Prisoners at risk of self-harm or suicide are identified and given appropriate care and support. All vulnerable adults are identified, protected from harm and neglect and receive effective care and support.

Suicide and self-harm prevention

3.34 The recorded level of self-harm had dropped by about 20% since our last inspection. In the previous 12 months, levels had been similar to those in other local prisons and had remained constant across the year. There had been 959 reported incidents involving 331 prisoners.

3.35 Two self-inflicted deaths had taken place since the last inspection. A draft Prisons and Probation Ombudsman investigation report about the first death had been handed to the prison in March 2020, but despite a significant amount of potential for learning lessons, none of the recommendations from the case had been added to the prison's action plan.

3.36 Emergency response arrangements were weak. In our survey, significantly fewer prisoners said their cell bell was answered promptly

compared with those in similar prisons (see paragraph 4.10). Managers had not made sure that staff on duty at night were confident or competent enough to respond to emergencies. We found inexperienced night staff who were not carrying their emergency response cell keys. There were no automated external defibrillators available in units for prison officers to use and health care staff had to provide one, potentially delaying an emergency response (see paragraph 4.39).

3.37 The safer custody team was small (see paragraph 3.14). The manager was acting up in post and had just two staff, so it was impossible for the team to be present in the units and to improve the standard of day-to-day work on safety. The team did not hold a high enough profile across the prison and other departments did not always support its work.

3.38 A safety improvement plan had been introduced, but it lacked focused outcome-based targets. Tasks were marked as having been completed without providing any evidence that outcomes had improved.

3.39 Analysis of data at monthly safety meetings was good, but there was little evidence that it had driven improved outcomes. The weekly safety intervention meeting concentrated on reviewing prisoners perpetrating violence and did not focus sufficiently on those at risk of suicide or self-harm.

3.40 Like many other prisoners, those at risk of self-harm continued to spend 22 hours a day in their cells with little additional support or purposeful activity to help them when they were in crisis (see paragraph 5.2). The new assessment, care in custody and teamwork case management process for prisoners at risk of suicide or self-harm was not well used. Staff did not have easy access to the folders as they were often kept in areas that were out of reach, such as in storage boxes, on the floor of unit offices or in storage cupboards. Care maps were weak, and some had not been updated after several case reviews. Issues raised in case reviews or assessment interviews were not always added to care plans. Daily summaries of interactions with prisoners were often left blank and many sections of the document were incomplete.

3.41 There were currently only seven Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners), not enough for the population. Listener training had continued during the pandemic and further training was planned for March 2022, but because of its reception function the prison struggled to retain Listeners for any length of time. Prisoners did not have reliable access to them, particularly at night, and there were no Listener suites in use. They often had to talk to prisoners through the cell door, which was inappropriate. The Listeners did not feel valued and newer staff were not always aware of the scheme.

3.42 Constant supervision facilities were inadequate. There was only one cell in the health care department, which did not have any electrical sockets so prisoners could not have a TV. When more than one

prisoner required constant supervision, it was carried out in a cell in the units, which was far from ideal.

Recommendations

3.43 **Staff in charge of units overnight should always carry an emergency cell key.**

3.44 **There should be enough Listeners for the population and prisoners should be able to access them 24 hours a day.**

Protection of adults at risk (see Glossary)

3.45 There were no systems in place to make sure that prisoners at risk of harm, abuse or neglect were routinely identified or supported. Although the prison had an adult safeguarding policy, managers found it hard to identify a responsible manager during the inspection. There was little awareness among unit staff of the process they should follow if they spotted a prisoner who was at risk of harm, abuse or neglect. There had been no specific training to improve unit staff's understanding of how to identify and support these prisoners.

3.46 Despite the large number of prisoners who passed through Forest Bank, the prison had no record of any adult safeguarding concerns that staff or prisoners had reported, nor of any action taken to support the prisoners. Staff had links with local safeguarding adults boards, but there was no evidence to show that expert advice had been sought.

Section 4 Respect

Prisoners are treated with respect for their human dignity.

Staff-prisoner relationships

> Expected outcomes: Prisoners are treated with respect by staff throughout their time in custody and are encouraged to take responsibility for their own actions and decisions.

4.1 It was difficult to build meaningful staff-prisoner relationships because of the extremely limited time out of cell (see paragraph 5.2) and short stays of many prisoners. Despite this, 71% of prisoners said staff treated them with respect. Most interactions we saw were friendly but functional and brief. (See key concern and recommendation 1.40.) A quarter of prison custody officers (PCOs) had been in post for less than a year and some lacked the confidence, knowledge and experience to do their jobs effectively which impacted on their relationships with prisoners.

4.2 In recent months, there had not always been enough officers in the units and, as at the last inspection, staff did not always interact with prisoners or consistently challenge poor behaviour, such as prisoners vaping on the landings or walking around without a shirt on. Staff frequently remained too passive and reticent. We often saw them sitting in unit offices rather than maintaining a presence on landings or speaking to prisoners. A lack of authority and skill in challenging low-level bad behaviour meant that staff too often resorted to the adjudications process (see paragraph 3.17). (See key concern and recommendation 1.40.)

4.3 In our survey, only 24% of prisoners, significantly fewer than at similar prisons (35%), told us that a member of staff had talked to them in the previous week about how they were getting on. The vast majority of prisoners did not have regular contact with a key worker (see Glossary). Delivery of the key work scheme had been weak, levels of key worker activity had mostly been declining throughout 2021 and there were few signs of improvement. A small group of priority prisoners were supposed to receive weekly key work sessions, while the rest of the population, over 1000 prisoners, were only entitled to a monthly session. However, just 16% of the monthly key work sessions had actually been delivered in January 2022. (See key concern and recommendation 1.40.)

Daily life

Expected outcomes: Prisoners live in a clean and decent environment and are aware of the rules and routines of the prison. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair.

Living conditions

4.4 The main residential part of the prison, units A to F, had recently undergone significant refurbishment to raise the standard of living conditions and prevent access to contraband. Most of this work had been completed with just a couple of units, including the reverse cohort units (RCUs) (see Glossary), still outstanding. The other residential units, G and H, had not required immediate attention and had not been part of the same refurbishment programme.

4.5 About half of the prisoners continued to live in overcrowded and cramped cells. Prisoners had to eat in their cells next to toilets (see paragraph 4.12), many of which were not adequately screened.

A typical cell shared by two prisoners

4.6 Cells were reasonably well equipped, and the prison had employed some prisoners as decency peer workers to maintain their upkeep. The prison had also introduced decency meetings to monitor any emerging issues relating to living conditions, but they had only started recently and were not always well attended. While communal areas were generally clean, most of the wings were unwelcoming and there was an ongoing problem with mice. Outdoor areas were bleak and exercise yards were small and bare.

A typical wing landing

4.7 Shower areas were grubby, and drainage was poor. They were not sufficiently private – shower rooms had a screen near the entrance but no cubicles. Leaders told us there were plans to refurbish them.

Communal showers

4.8 Prisoners had reasonably good access to cleaning materials. Laundry facilities were sufficient, and, in our survey, prisoners were significantly more positive about being able to access clean sheets every week compared with similar prisons (81% against 59%). However, prisoners could not always easily obtain prison-issue clothing.

4.9 In our survey, only 16% of prisoners said their cell bell was answered within five minutes, which was significantly lower than in similar prisons (26%) (see paragraph 3.36). The prison did not monitor responses well enough or consistently address slow response times. In units G and H, the cell bell system relied on an intercom feature and staff did not always know when they should attend a cell in person, rather than rely on the intercom.

4.10 Since the onset of the pandemic, prisoners had been unable to obtain their stored property and could not receive parcels from their family or friends after their first 28 days in the prison. This was particularly frustrating for prisoners who were serving long periods on remand. The prison had recently made efforts to give prisoners access to their stored property by assigning a member of staff to this role.

Residential services

4.11 All meals were served at the cell door, which was disrespectful and overly restrictive. In our survey, 47% of prisoners reported that the food was good. Prisoners appreciated the option of hot meals at lunch and in the evening. However, breakfast was unappetising and lacked variety. Many prisoners told us that food portions were too small, and we saw some prisoners being served very small amounts.

Consultations with prisoners about the food did not take place regularly.

4.12 The main kitchens were generally clean, although some equipment was not in full working order. The food trolleys were sometimes dirty, in poor condition and damaged, potentially leaving food at risk of contamination. There were no self-catering facilities. Prisoners had to rely on flasks of hot water in their cells, but the prison had begun the process of improving the electricity supply in units to allow for the introduction of kettles.

Dirty food trolley

4.13 Prisoners could order from the shop twice a week. In our survey, only 43% of prisoners said the shop catered for them, which was lower than at similar prisons (57%). Prisoners reported that many items were out of stock and the range was too limited, for example tinned items or fresh produce were not available. Prisoners also told us products were too expensive. Consultation in this area had been poor, but, at the time of the inspection, the prisoner council was beginning to look into these issues.

Prisoner consultation, applications and redress

4.14 Prisoner consultation had declined during the pandemic but was now improving. User Voice, a criminal justice charity, oversaw the prisoner council, however COVID-19 restrictions meant it was still unable to meet, so the User Voice lead staff member saw each council member individually. Prisoners were also invited to other meetings, such as the decency meeting where they could discuss residential issues. The planned introduction of in-cell kettles had begun as a result of this consultation (see paragraph 4.13). While they were positive steps,

consultation still did not take place regularly and sessions were not well-attended. Some prisoner representatives we spoke to questioned the value of their roles. In our survey, significantly fewer men than at similar prisons said that things changed as result of consultation (21% compared with 45%).

4.15 Applications could be made electronically via kiosks in the units. Responses to applications were reasonably timely and, in our survey, 49% of prisoners reported that applications were normally dealt with within seven days, significantly more than in similar prisons (36%). Limited quality assurance was in place. Some departments made prisoners wait three days before submitting another application, which was unhelpful especially for the large number of new arrivals and remanded prisoners.

4.16 There were 3092 complaints made in the 12 months leading up to the inspection. Prisoners' access to complaints forms was inconsistent and in one instance we saw a complaints box left unlocked. Some complaints did not receive a response on time and in our survey, only 23% of prisoners said they were dealt with fairly. Responses we checked did not always address the complaint in sufficient detail. Quality assurance had not been effective in improving the quality of responses, but leaders were aware of this and were about to review it.

4.17 Prisoners had good access to legal advice. The large well-used video-conferencing centre was available for legal visits. A dedicated team in the centre brought prisoners to the facility every day for video meetings with their solicitors. In our survey, significantly more prisoners than at similar prisons said it was easy to attend legal visits (64% compared with 46%). There was a dedicated bail information officer who had worked with some prisoners to help them obtain bail.

Equality, diversity and faith

Expected outcomes: There is a clear approach to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relationships. The distinct needs of prisoners with particular protected characteristics (see Glossary) and any other minority characteristics are recognised and addressed. Prisoners are able to practise their religion. The chaplaincy plays a full part in prison life and contributes to prisoners' overall care, support and rehabilitation.

Strategic management

4.18 Priorities within diversity and equality work were not underpinned by a comprehensive needs analysis. The prison was scheduled to hold equality meetings every two months, which peer workers were invited to attend, but during the pandemic they had been held less frequently. The prison tracked progress from these meetings through a race and equality action plan.

4.19 The equality and diversity manager was supported by a diversity and inclusion lead staff member and a foreign national coordinator. The prison had also employed seven diversity peer workers to liaise between the prisoners in their units and the equality team and to raise issues at the equality meetings.

4.20 There was some good data collection, but it was limited to issues such as use of force and adjudications. While the prison analysed the data effectively and identified disproportionate outcomes for certain protected groups, action had not yet followed.

4.21 There had been limited support for and consultation with prisoners with protected characteristics during the pandemic. Focus groups had been suspended but prisoners had completed questionnaires, which at least provided the prison with some insight. The equality and diversity team also maintained contact with some prisoners from protected groups using in-cell phones.

4.22 Seventy discrimination incident reporting forms had been submitted in the year leading up to the inspection. Investigations were thorough but responses were not timely, did not describe the investigation that had taken place and were not comprehensive enough. In some cases, staff did not speak to the prisoner in person. The Independent Monitoring Board carried out some limited and infrequent quality assurance of responses.

Protected characteristics

4.23 In our survey, there were few areas where prisoners from protected groups reported disproportionate outcomes. However, more prisoners with a disability said that they felt unsafe at the time of the inspection (38% compared with 13%) or had felt unsafe at some point during their stay (66% compared with 41%). Prisoners with mental health issues provided similar responses. Little was being done to explore the differences in experience for these groups.

4.24 The support the prison did offer those with disabilities included the identification of those eligible for personal independence payments in the community and support to access additional benefits. There were some adapted cells for physically disabled prisoners, although one was missing grab rails around the toilet for a prisoner who was wheelchair bound.

4.25 Staff could not always identify prisoners who had personal emergency evacuation plans or find the documents. The plans were often not individual or detailed enough to be helpful during an emergency. Some prisoners acted as buddies for prisoners with physical disabilities to help with everyday tasks, but there was a lack of training and oversight for the buddy role.

4.26 The prison had identified that prisoners with mental health problems were more likely to have force used against them and had begun investigating this data.

4.27 The prison had identified through focus groups that black and minority ethnic prisoners felt disadvantaged when it came to work allocations and thought their views were not taken into account to the same extent as those of other prisoners. The prison had not investigated or addressed these negative perceptions. The number of prisoners who had declared they were from the Gypsy, Roma or Traveller community was very low. There was currently no additional support for older or younger prisoners, but because young adults were more likely to have force used against them or to be adjudicated, we were told the prison planned to introduce a strategy for this group as well as targeted staff training. (See paragraph 3.19.)

4.28 Support for transgender prisoners was sufficient. Those we spoke to told us they had good contact with the diversity and inclusion lead officer. They received a specific introductory pack and could buy other items to meet their needs, which the equality team ordered for them online. The prison catered for their clothing needs on an ad-hoc basis.

4.29 There were 177 foreign national prisons, 32 of whom were detainees and 33 who did not speak English. The prison had a dedicated foreign national coordinator who provided good support and ran a fortnightly surgery alongside immigration officers from the Home Office. Interpretation services were used well as were bilingual staff, for example, for key work sessions. However, some prisoners struggled with everyday tasks, such as making applications through the kiosk. Secure video calling facilities for foreign national prisoners were available, but uptake was low, even though the prison had made significant efforts to advertise the service in different languages.

Notices in a variety of languages

Faith and religion

4.30 In our survey, of those who reported they had a religion, 75% said they could speak to a chaplain of their faith in private if they wanted to, significantly better than comparator prisons (54%). Chaplains were visible around the establishment, offered some prisoners individual support and frequently visited prisoners who were held in the segregation unit.

4.31 Unlike some other prisons we have been to recently, Friday and Sunday religious services had not yet resumed, having not taken place since December 2021 and progress to restart them being slow. Significantly fewer prisoners (40%) reported that they were able to attend religious services if they wanted to, compared to the last inspection (90%).

4.32 Prisoners were able to watch funerals of close relatives online in the chaplaincy, but they were frustrated about being unable to attend family funerals in the community under escort.

4.33 Faith-based resettlement work was provided by The Message, a Christian charity, and prisoners of the faith, supported by the service, could access accommodation in the Manchester area. This was a very new initiative but looked promising. The resettlement chaplain also contacted all sentenced prisoners leaving Forest Bank to direct them to housing services and other agencies.

Health, well-being and social care

Expected outcomes: Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.

4.34 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) (see Glossary) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC found there were no breaches of the relevant regulations.

Strategy, clinical governance and partnerships

4.35 Each strand of health care was generally well-led and integrated governance and accountability arrangements were embedded. Partnership arrangements were mostly good and a health needs analysis informed service provision but there was scope for more collaborative conjoined working, particularly for patients with complex needs.

4.36 Staffing was tight particularly at night when health care professionals had to manage new arrivals and the inpatient unit, but arrangements were offset by a reliable team and flexible working. In our survey, only

12% of prisoners told us that it was easy or very easy to see a GP compared with 24% at other similar prisons, and we found triage arrangements were periodically curtailed due to staff shortages, which had led to frustration among patients.

4.37 Mandatory training was provided to all staff and there were opportunities for further development. Supervision was also in place. Clinical governance processes demonstrated effective clinical auditing and incident reporting systems, which had led to lesson being learned and improvements in the service.

4.38 The health care waiting room was drab, and patient toilets were directly visible from the seating area and lacked privacy. Clinic rooms were generally clean and compliant with infection prevention standards. However, facilities were not sufficient to meet the demand, although plans to improve them had been approved. Maintenance schedules for medical equipment were in place and health care practitioners told us they had access to appropriate medical devices and protective equipment.

4.39 Resuscitation equipment, including emergency medication, was held in key locations, but we had concerns about storage and access to the equipment because of the cluttered general storeroom at the main hub, which was addressed during the inspection. There was always a nurse with immediate life support skills on duty, but prison officers had no access to an automated external defibrillator, which could delay support particularly at night (see paragraph 3.36).

4.40 Responses to complaints did not always clearly answer the concern raised and quality assurance was insufficient. These deficits had already been identified by the head of health care and improvements were being introduced, including additional training for all senior staff and the introduction of face-to-face resolution particularly for more complex concerns.

Promoting health and well-being

4.41 Health promotion activities had been curtailed due to COVID-19 restrictions and information displayed across the prison was quite limited. Information leaflets, including those on diabetes, heart disease and hypertension, were distributed to patients during clinics and were available in languages other than English. The national calendar of health promotion events informed planned activities.

4.42 Screenings for health problems took place, for example, for blood borne viruses, sexual health, COVID-19, diabetes, abdominal aortic aneurysms and bowel cancer.

4.43 Prisoners had access to COVID-19 vaccinations in line with the community, and health staff actively promoted uptake, providing prisoners who were unsure about receiving it with face-to-face advice and education.

4.44 There were no health champion peer workers, but a sub-group of prisoners from the charity User Voice provided feedback about the service.

Primary care and inpatient services

4.45 A motivated primary care team provided a 24-hour service. Demand had increased since the last inspection and, although there were some vacancies, the team provided good support, which was continuously reviewed in response to COVID-19 restrictions.

4.46 All new arrivals had a health screening and a COVID-19 risk assessment. The GP and substance misuse team reviewed patients with more complex needs on their first night, which was positive. Onward referrals were made to the mental health teams as required and secondary health assessments took place within seven days of a prisoner's arrival.

4.47 Apart from two clinical areas in units D and E, all clinics took place in the four treatment rooms in the health care department. Space was limited, which restricted service delivery, but a proposal to enhance access had been provisionally accepted.

4.48 Prisoners could not use the electronic kiosk to make a health application – they had to make a paper or verbal request that usually triggered a nurse triage appointment. Verbal applications were made to prison officers, which meant patient confidentiality was not protected and the system was not wholly reliable. Information could be lost and there was no audit trail to identify the time taken to obtain an appointment. We found this inconsistent approach caused frustration among prisoners.

4.49 Despite these concerns, there was a wide range of nurse-led clinics, which included assessments to identify and manage patients with long-term conditions. Records demonstrated care planning and outlined case reviews and the interventions provided. The range of specialist clinics was good. They included physiotherapy, ophthalmic and podiatry clinics, and waiting times were reasonable. End-of-life and terminally ill patients were managed through joint working with a local hospice.

4.50 GP services were available seven days a week, and out-of-hours' cover was available but rarely used. Prisoners did not feel they could see a GP easily (see paragraph 4.36). However, we found patients had good access to urgent same-day GP appointments and non-urgent appointments within 10 days, which was good. No formal multidisciplinary discussions between the GP and psychiatrist took place to consider complex cases, which could have had a negative effect on patient care.

4.51 There was an effective system for managing external hospital appointments, including the clinical triaging of patients when appointments were cancelled or required rescheduling.

4.52 All patients were reviewed before their release and issued with take home medication, which was an improvement compared with our last inspection.

4.53 Despite some improvements in the physical environment of the inpatient facility and the development of admission criteria, there had been few other changes since the last inspection. The unit consisted of 19 beds in single and double cells, and one four-bed bay. Bed occupancy was at capacity and one cell was out of action. Staff working in the facility were kind and concerned about patient welfare, but other than social care health care assistants, no dedicated health care staff were attached to the unit. However, all inpatients had a care plan and were cared for by nurses on a peripatetic basis. Officers also monitored their well-being. (See key concern and recommendation 1.41.)

4.54 The head of health care worked with the mental health manager and practice manager to manage admissions and discharges from the unit. However, there was a lack of substantive clinical leadership, which meant required service improvements had not been prioritised or owned. Patients continued to have a poor amount of time out of their cells, and there was still a lack of therapeutic activities. Patients could not routinely use the day room as it was constantly used for other purposes, which did not support the well-being of those recovering from illness. (See key concern and recommendation 1.41.)

Recommendation

4.55 **The health care application system should be confidential and effective.**

Social care

4.56 Arrangements for identifying prisoners with social care needs were effective. Prisoners received an initial screening and were evaluated by a dedicated social care worker who provided impressive oversight, robust ongoing support and systematic reviews to make sure patients' needs were being met. A small team, backed up when necessary by nurses, provided support seven days a week, if required. Social care packages (see Glossary) were being provided for five prisoners who lived mostly in the inpatient unit. All the men we spoke to were highly complimentary about the care provided and we were able to review care plans, which were of a good standard. (See paragraph 1.50.)

4.57 Post-release and transfer support planning was triggered early through close partnership discussions, but pandemic constraints meant local authority staff had not been visiting the prison routinely. Oversight remained effective and more regular contact, including face-to-face systematic reviews of care, were being reintroduced incrementally.

Mental health care

4.58 In our survey, 66% of prisoners reported a mental health problem, which was similar to the last inspection. However, mental health caseloads had increased from 96 to 147.

4.59 Greater Manchester Mental Health NHS Foundation Trust provided specialist mental health input. The skills mix was quite narrow, and nurses were supported by psychiatry and psychological practitioners. Plans are underway to bring all mental health staff under a single leadership structure to improve governance, communication and partnership working.

4.60 Initial reception screening identified prisoners' immediate mental health needs and triggered referrals to specialist support. The primary mental health care team reviewed and triaged all referrals within 24 hours and about 96 were received every month. It took between 10 days to four weeks before prisoners received an initial assessment, which was excessive. Nevertheless, mental health provision overall was reasonable, but the range of interventions should have been enhanced in some significant areas.

4.61 Sodexo commissioned the Primary Mental Health service through Greater Manchester Mental Health as an integrated model alongside secondary care. Staff triaged and directed new referrals to appropriate services, attended initial assessment, care in custody and teamwork case management reviews for prisoners at risk of suicide or self-harm, and provided clinical oversight for inpatient care. A psychological well-being team provided good support for patients with mild to moderate problems. The mental health in-reach team helped those with more severe problems, including those subject to the care programme approach (mental health services for individuals diagnosed with a mental illness), on a Monday-to-Friday basis.

4.62 There was an absence of suitable therapy space and registered nurses were required to chaperone visiting psychiatrists during all patient contact while on site, which led to longer delays in in-reach team assessments. There were no resources for individuals who presented with neurodevelopmental needs, such as those with learning disabilities who required specialist assessment, nor any clinical psychology input for patients with more complex needs.

4.63 Care planning, risk assessment and general record keeping were of an acceptable standard. Some complex cases lacked detailed medical case summaries, and there was an over-reliance on nursing staff to complete detailed histories and referral documentation, which was very time consuming.

4.64 The mental health team had devised a bespoke three-hour training programme for new officers' induction, but a monthly drop-in session previously offered to all staff was no longer offered.

4.65 Most prisoners requiring a transfer to hospital under the Mental Health Act were still waiting too long for a transfer – nine out of the 12 transfers took between 21 and 159 days.

4.66 Discharge planning was effective and close liaison with other prisoner partners and community providers made sure patients received continuity of care post-release.

Recommendation

4.67 **The transfer of patients to hospital under the Mental Health Act should occur within Department of Health and Social Care guidance timescales.**

Substance misuse treatment

4.68 A longstanding leadership team led services well and supported a team of skilled and motivated staff. Close working was evident with other prison departments particularly in the delivery of the evolving drug strategy, which was used to inform practice.

4.69 Reception processes were robust and newly arrived drug- and alcohol-dependent prisoners were promptly assessed and provided with additional physical health monitoring and access to individual clinical treatment through the specialist nurse or duty doctor. Patients were initially supported in an RCU to make sure they were stabilised effectively, and ongoing prescribing reviews were flexible and responsive to individual needs.

4.70 Most support was delivered in the recovery unit. Plans to introduce a full recovery pathway, which included enhanced training for officers and the creation of a drug-free living unit, were well developed but had been on hold due to the pandemic.

4.71 Practitioners had maintained a level of integrated support, which addressed the needs of the population. The prison's significant change in function since the last inspection meant the focus of support had shifted. Staff concentrated on keeping safe those who might be detained for a short time through effective clinical treatment, emphasising harm minimisation, providing coping strategies and delivering low intensity support.

4.72 There were 188 prisoners receiving opiate substitution treatment and 287 in total on the psychosocial caseload when we inspected. Clinical records indicated patients had good support and individually tailored recovery plans, which showed evidence of integrated reviews being delivered at appropriate intervals. Group work and face-to-face input had been maintained and, although there had been an inevitable reduction in the number of peer mentors, prisoners still had access to a strong recovery network. Prisoners we spoke to were broadly appreciative of the support provided, which was reflected in our survey where 84% of prisoners in the recovery unit indicated they were receiving help with their drug problem.

4.73 Discharge planning started early with practitioners allocated to local areas in Manchester, enabling close partnerships and networks to be developed, which facilitated more effective continuity of care. (See paragraph 1.51.) Support arrangements included providing a controlled drug prescription if required and access to naloxone (a drug used to counter the effects of opiate overdose) and training in its use.

Medicines optimisation and pharmacy services

4.74 The move from a community pharmacy to one based on site during 2021 had improved medicines management provision, and the service was impressive. The pharmacy was staffed by two pharmacists (one of whom was a prescriber), five technicians and seven unit technicians. Medicines were administered twice a day from central hubs and nurses administered medicines at weekends.

4.75 Medicines were transported safely, and stock management and storage systems were appropriate. Policies and procedures were easy for staff to access, although they were not up to date.

4.76 About 36% of medicines were in possession, with 33% having a mixture of in-possession and non-in-possession medicines. A review was underway to increase the use of in-possession medicines. Since the last inspection, some in-cell lockable storage was available and there were plans to introduce it in all accommodation. Risk assessments were completed for all prisoners on reception, medicines were reviewed, and medicine reconciliation occurred within 72 hours to identify and resolve any discrepancies.

4.77 Medicines administration was appropriately recorded. Reasons for non-attendance were not always recorded, but prisoners who did not attend were consistently followed up.

4.78 Emergency medicines were available and prisoners with minor ailments could be treated with over-the-counter remedies. There was adequate out-of-hours medicine provision.

4.79 Medicines management in the units was mainly good. However, the medicine queue in the A to F hub was congested and officer supervision was inconsistent, which meant confidentiality was not maintained, increasing the likelihood of medicine diversion. In-possession medicines were issued separately from other medicines and some prisoners had to return to a hatch twice in a day. Supply was frequently curtailed because of regime demands, leading to short delays in prisoners’ access to treatment and inevitable patient frustration.

4.80 Prisoners leaving the prison received a seven-day supply of medicines and a copy of their discharge summary, which was an improvement since the last inspection.

4.81 There were well-attended monthly medicines and prescribing meetings, and a programme of audits was in place. The clinical governance and

medicines management committee met regularly and reviewed incidents. Plans were in place for pharmacy-led clinics run by the prescribing pharmacist, although a lack of clinical space meant they had not progressed.

Dental services and oral health

4.82 There was no hygienist or dental therapist, but all usual NHS dental treatments were available. COVID-19 escort requirements had caused some delays before patients could attend their appointments, but it took about 10 days for them to access routine sessions, which was good. The dental nurse reviewed all applications and updated waiting lists during every visit. Triage prioritised those with urgent needs and offered patients reassurance. Access was based on clinical risks and pain management requirements, and those requiring emergency care were seen on the same day.

4.83 An air purification unit to enhance ventilation was required to enable aerosol generating procedures to resume, and work to secure one was ongoing.

4.84 The dental suite was of a good standard – it had a large, separate decontamination room. Dental equipment was regularly maintained, infection prevention arrangements were robust and there were regular audits. Sterile supplies and waste management processes were sound. The dental surgery had up-to-date policies and procedures, as well as current supervision and training records.

Section 5 Purposeful activity

Prisoners are able and expected to engage in activity that is likely to benefit them.

Time out of cell

Expected outcomes: All prisoners have sufficient time out of cell (see Glossary) and are encouraged to engage in activities which support their rehabilitation.

5.1 The daily regime had been severely restricted due to another outbreak of COVID-19 in late 2021 and the national lock down in prisons once again. Leaders had been slower than in some other prisons to restore the regime and provide better access to support (See key concern and recommendation 1.42.)

5.2 Time out of cell for most prisoners was very poor. For many prisoners, what regime there was, was delivered early in the morning, which meant prisoners did not leave their cells for the remainder of the day. New arrivals were locked up for 23 hours a day and unemployed men only had two hours a day out of cell (See key concern and recommendation 1.42.). Full-time employed prisoners could spend up to eight hours out of their cells and part-timers six hours. During our roll checks, we found about two thirds of prisoners locked up during the working day and only about 20% of prisoners involved in purposeful activity. (See key concern and recommendation 1.42.) Meals were delivered to cell doors, further restricting time out of cell (see paragraph 4.12). (See key concern and recommendation 1.42.)

5.3 Many prisoners reported their frustrations with the limited regime and the increasingly stark difference between prison and community COVID-19 restrictions – all community restrictions had just been lifted when we inspected.

5.4 Access to the gym was very poor. Since July 2021, an average of 375 prisoners had attended the gym each week, about 30% of the population. COVID-19 restrictions meant that prisoners could visit the gym about once every 10 days. It had also been regularly shut for weekend sessions while physical education (PE) staff were redeployed to keep residential regimes running. There was no timetable with dedicated sessions for protected groups or for those referred by the health care department, but one was due to be implemented as soon as restrictions lifted. (See key concern and recommendation 1.42.)

5.5 The gym was well staffed, and eight out of the 10 staff were in post when we inspected. The large sports hall had been turned into a weights room and cross-fit area. There was also a room with

cardiovascular exercise machines, and an outdoor artificial grass pitch. There was no fixed exercise equipment in yards.

5.6 PE staff had not offered prisoners the chance to gain any vocational qualifications during the pandemic. The Street Soccer Academy was due to restart the week after we inspected. This project tackled youth homelessness and would involve prisoners through in-cell learning and activities on the artificial grass pitch. There were also advanced plans to reintroduce the Twinning Project, which provided prisoners with FA accredited qualifications, delivered by professional football coaches.

5.7 There was one full-time librarian and a library orderly, but the library had become peripheral to prison life. Ongoing COVID-19 restrictions meant that access was extremely limited, with only the small minority of prisoners who participated in education being able to visit. The library was also being used as a classroom because space in the education department was limited because of social distancing, which reduced the library's capacity further. (See key concern and recommendation 1.42.)

5.8 For nearly two years most prisoners had had to ask for books via the kiosk. They were then brought to them through a trolley service. The average number of loans was very low, with just 208 books requested using the kiosk and 41 books borrowed in person each month. The number of books that were not returned was high.

5.9 Reading schemes, such as those offered by the Shannon Trust and Turning Pages, were only just restarting. There had not been any analysis to determine who used the library services.

Education, skills and work activities

This part of the report is written by Ofsted inspectors using Ofsted's inspection framework, available at https://www.gov.uk/government/publications/education-inspection-framework.

Ofsted inspects the provision of education, skills and work in custodial establishments using the same inspection framework and methodology it applies to further education and skills provision in the wider community. This covers four areas: quality of education, behaviour and attitudes, personal development and leadership and management. The findings are presented in the order of the learner journey in the establishment. Together with the key concerns and recommendations, provided in the summary section of this report, this constitutes Ofsted's assessment of what the establishment does well and what it needs to do better.

5.10 Ofsted made the following assessments about the education, skills and work provision:

Overall effectiveness: Inadequate

Quality of education: Inadequate

Behaviour and attitudes: Inadequate

Personal development: Inadequate

Leadership and management: Inadequate

5.11 Education, skills and work activities were not a priority for senior prison leaders and managers. They did not have high enough expectations of prisoners. Consequently, leaders had not made sure that the education, skills and work curriculum was sufficiently ambitious. Learning programmes did not challenge prisoners or promote progression. Leaders had not aligned their curriculum to meet the changing needs and demographics of the prison population or to meet local skills needs. The content of the curriculum was far too narrow to provide prisoners with the breadth of knowledge, skills and behaviour that would be useful for their next steps.

5.12 Leaders and managers did not have sufficient oversight of the quality of education, skills and work activities and had not addressed the weaknesses identified at the previous inspection. Quality assurance and improvement arrangements were not effective in making sure that prisoners received high-quality learning, training and work experiences that prepared them successfully for future opportunities. Leaders and managers did not monitor the performance of staff regularly enough. Processes, such as lesson observations, did not help leaders to identify accurately the quality of teaching and training or staff development needs. Teachers, trainers and instructors did not receive regular professional development to help them keep up to date with their subject or industry knowledge or teaching and training practices. (See key concern and recommendation 1.43.)

5.13 The number of purposeful activity places did not meet needs of the prison population and there were not enough places. The availability of face-to-face lessons in education and vocational training was extremely limited. Leaders believed that they were allocating prisoners to all available face-to-face spaces. However, prisoners often did not know that they had been allocated to a course or they chose not to attend. The range of activities and qualifications for vulnerable prisoners, including sexual offenders, was not equitable with those provided for other prisoners. For example, vulnerable prisoners had no access to face-to-face learning. A few could attend one dedicated electrical assembly workshop. (See key concern and recommendation 1.44.)

5.14 Leaders did not make sure that allocations to education, skills and work activities were fair, equitable and timely. The process was cursory, poorly structured and did not sufficiently involve the relevant managers.

It did not take account of all education, skills and work activities, only prison jobs. Waiting lists for skills and work activities were too long. Prisoners applied for every place listed in the hope that they would be allocated to something. The allocations process did not take account of prisoners' individual prior achievements or experience. Those who had achieved entry level 3 or above in English and mathematics were added automatically to the prison work waiting list. The remaining prisoners were allocated mostly to in-cell learning activities. (See key concern and recommendation 1.44.)

5.15 Prisoners' attendance at face-to-face education and vocational training activities was low. Attendance for the few prisoners on English courses for speakers of other languages and in most prison work was high.

5.16 The pay policy was out of date and did not reflect current pay rates in the prison or the adjustments made to take account of the pandemic. Prisoners received lower rates of pay for attending education than most of their peers who attended work activities. This discouraged those prisoners who needed to improve their English and mathematical skills from attending education classes.

5.17 Teachers and trainers did not assess prisoners' starting points, prior knowledge and skills, or their future aspirations at the start of their activity programmes. Prisoners' individual learning plans were vague and targets were often too generic. Learning support for prisoners was extremely limited. Too many prisoners relied on their peers to help them with their work. Managers did not know which prisoners had additional needs, including learning difficulties and/or disabilities. (See key concern and recommendation 1.45.)

5.18 Prisoners who learned through completing in-cell learning packs received minimal tuition, support and feedback. Prisoners stated that they did not learn anything new. Most undertook in-cell learning to earn money and to relieve some of the boredom that arose from spending very lengthy times locked in their cells. Prisoners with additional learning needs were not supported effectively enough to complete the packs successfully. Too many prisoners found in-cell learning booklets uninteresting and repetitive.

5.19 Leaders had reduced the capacity of educational and vocational activities by using classroom and workshop spaces for general prison purposes. This prevented some practical training activities from taking place, such as cleaning. Prison work was mundane. Leaders admitted that the purpose of the work was to get prisoners out of their cells. Consequently, staff did not support prisoners in industry workshops sufficiently to identify or record the employability skills that they gained, for example in stock control.

5.20 The planning for the majority of teaching sessions did not have a logical structure to help prisoners build their knowledge, skills and behaviour sequentially over time. Activities in most lessons were not sufficiently varied. Teachers and trainers did not use questioning techniques effectively to check prisoners' understanding or to tackle

misconceptions before moving onto another topic. As a result, prisoners could not recall accurately what they had learned in previous lessons. Teachers and trainers did not routinely provide clear feedback on how prisoners, including those with learning difficulties and/or disabilities, could improve their knowledge and skills. (See key concern and recommendation 1.45)

5.21 Teachers were suitably qualified, but a few vocational trainers did not have relevant industry qualifications and/or appropriate up-to-date industry knowledge or experience for the subjects they were teaching. Staff vacancies across education and vocational training resulted in further gaps in the curriculum.

5.22 Managers had not checked that the qualifications that prisoners were working towards in English and mathematics would be recognised by other prisons or in the community. Trainers did not routinely make sure that prisoners developed their English and mathematical skills in vocational training and prison work.

5.23 Managers did not make sure that prisoners received effective, impartial careers advice and guidance when they arrived at the prison, during their stay or on release or transfer.

5.24 Staff offered men who were due for release limited help and support. Although a very small number of them received support to find work, managers did not routinely analyse the reasons why some did not gain employment. Leaders had plans to broaden the vocational curriculum to meet local skills needs by offering opportunities, such as forklift truck driving, barista skills and modular housing construction through subcontracting arrangements. They were due to start in April 2022. However, at the time of the inspection, negotiations with subcontractors had yet to be finalised.

5.25 Prisoners who acted as mentors for their peers, for example to support them with reading, were not suitably trained. Peer mentors in the residential units were not required to undertake appropriate peer mentor qualifications before being appointed.

5.26 The few prisoners who participated in education, skills and work activities developed confidence. The majority demonstrated positive attitudes to face-to-face learning activities. However, a few prisoners did not participate appropriately in lessons and were disrespectful to their teachers. In a few sessions, such as personal and social development, prisoners developed a good understanding of how to lead better lives and to avoid reoffending, for example through learning about the skills needed to gain sustainable employment.

Recommendation

5.27 **Prisoners should receive an appropriate induction to purposeful activities and timely careers advice and guidance throughout their time at the prison.**

Section 6 Rehabilitation and release planning

Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.

Children and families and contact with the outside world

Expected outcomes: The prison supports prisoners' contact with their families and friends. Programmes aimed at developing parenting and relationship skills are facilitated by the prison. Prisoners not receiving visits are supported in other ways to establish or maintain family support.

6.1 The help available to prisoners to re-establish or maintain relationships with their children or families had deteriorated since the last inspection. One of the main reasons for this was a reduction in the number of social visits under COVID-19 restrictions – only 12 prisoners could use the visits hall at any one time compared with 50 prisoners at the previous inspection. This meant that prisoners only received about two visits each per month, including remanded and unsentenced men, the majority of the population. Extended family days were also no longer available and there was no planned date to restart them. (See key concern and recommendation 1.46.)

6.2 Prisoners had access to phones in their cells from 7am till 11pm each day, but they were switched off overnight. Other methods of communication such as video-calling facilities, were underused, especially compared to some other prisons we have inspected recently. In our survey, just 7% of prisoners said they had had a video-call visit more than once in the previous month. However, 55% said that it was easy for family and friends to get to the prison, significantly more than at other local prisons (32%). The visits hall was large and provided visitors with a welcoming environment, although refreshments and snacks had not been available to buy for almost two years. (See key concern and recommendation 1.46.)

6.3 In our survey, only 24% of prisoners said that staff encouraged them to keep in touch with their family and friends. The families team was eager to restart the range of services that had been provided before the pandemic. So far only a small minority, around 30 prisoners, were receiving good, intensive individual support from the family support workers. The Storybook Dads scheme was available, allowing fathers to record stories for their children, and some parenting group work had just restarted, including a father-baby bonding session.

Reducing risk, rehabilitation and progression

Expected outcomes: Planning for a prisoner's release starts on their arrival at the prison. Each prisoner has an allocated case manager and a custody plan designed to address their specific needs, manage risk of harm and reduce the risk of reoffending.

6.4 Forest Bank was now a reception prison and was the only one in the Greater Manchester area to accept prisoners on remand. The proportion of men on remand or unsentenced had increased since our last inspection to around 45% from about 28%. This model was not yet working well. For example, demand for places from courts meant that some remanded prisoners were taken to other prisons often many miles away (see paragraph 3.1). Those serving sentences of under 18 months should have stayed at Forest Bank for the duration of their sentence, however, some of these also moved on. (See key concern and recommendation 1.47.)

6.5 Because of delays in the court system following the pandemic, prisoners often spent longer on remand, with over 90 having been at the prison for over a year and the longest for 30 months. The prison provided little to support to these prisoners and they received insufficient help to address their resettlement needs.

6.6 In our survey, significantly fewer prisoners (42%) said that their experiences at Forest Bank had made them less likely to offend in the future, compared to those in other local prisons (56%). Strategic oversight of work to reduce reoffending required improvement. There was no current needs analysis to inform what offender management and resettlement work the prison needed to provide for the mix of prisoners now held.

6.7 Because of the prison's change in function, the number of sentenced prisoners requiring offender management work was much lower than at the last inspection. This was reflected in our survey which found that significantly fewer prisoners (17%) reported that they had a custody plan compared to the last inspection (35%).

6.8 The change in function also meant that the prison was not responsible for completing assessments of the risks and needs of newly sentenced prisoners. However, because of delays in moving longer sentenced prisoners to more appropriate prisons, Forest Bank staff sometimes started these assessments only for the prisoner to be transferred, leaving the assessment incomplete.

6.9 There had been changes in the staffing profile in the offender management unit. At the time of our inspection, the group of prison offender managers (POMs) was made up of three probation staff and seven prison staff. They were rarely redeployed to other duties. However, prison service POMs had unmanageable caseloads of about

80 prisoners each and levels of recorded contact with prisoners were poor.

6.10 Although home detention curfew (HDC) processes were managed well, too many prisoners (40%) were released after their eligibility date, with the longest being eight weeks late. Some late releases were caused by a lack of suitable Bail Accommodation and Support Service housing. Sometimes there was simply no time left after sentencing to start HDC processes before a prisoner reached their eligibility date. Additionally, disproportionate COVID-19 restrictions imposed by HM Prison and Probation Service meant that prisoners placed in isolation because another prisoner in their unit had tested positive for COVID-19, were not allowed to be released until their isolation period had ended.

Public protection

6.11 Work to protect the public was robust and information sharing with community agencies such as children's services was effective. Restrictions on prisoners' contact with children was managed appropriately and reviews were up to date. (See paragraph 1.52.)

6.12 Mail and telephone monitoring was very good. There was a dedicated, knowledgeable and experienced monitoring team. At the time of our inspection, 74 prisoners were subject to a high level of monitoring, which meant their calls were listened to every day, with very few delays. A further 390 prisoners were subject to low-level monitoring, where staff routinely scrutinised their telephone calls to establish any potential areas of concern, such as repeat calls to the same number. They then used the information to listen to a random sample of five calls each month. Records of prisoners' telephone calls were good and were readily available to POMs who promptly shared any concerns about prisoners presenting risks with other agencies. This good quality work had led to the identification of some safeguarding concerns for victims and their families in the community. (See paragraph 1.52.)

6.13 Although the monthly interdepartmental risk management meeting was held remotely, attendance by staff from other departments in the prison, for example security, was poor. The meeting routinely discussed high-risk prisoners and those subject to multi-agency public protection arrangements (MAPPA), specifically level 2 and 3 prisoners due for release. However, the meeting did not focus sufficiently on risk management arrangements for MAPPA level 1 cases.

6.14 In the cases that we inspected, we found sufficient evidence of MAPPA levels being confirmed before a prisoner's release and of appropriate risk management discussions between the prison and community offender managers. The prison's information-sharing reports submitted to community MAPPA panels were reasonably good.

Categorisation and transfers

6.15 Initial categorisations were mostly timely. Re-categorisation reviews were usually based on a sufficient amount of information, although they

did not always seek input from the prisoner. Too many prisoners, serving long sentences who should have progressed to other prisons to complete offending behaviour work remained at Forest Bank for too long. At the time of our inspection, 203 prisoners were waiting to move to training prisons. (See key concern and recommendation 1.47.)

6.16 Some prisons were unwilling to accept certain types of prisoner, especially those convicted of sexual offences and young adults who had long sentences. This was inappropriate and further prevented sentence progression.

Interventions

Expected outcomes: Prisoners are able to access interventions designed to promote successful rehabilitation.

6.17 The Thinking Skills Programme was still being delivered at Forest Bank. However, with the change in the prison's function, it was hard to justify the need for it.

6.18 There were no structured interventions for men convicted of domestic abuse or sexual offences. Changing Thinking and Ending Violence was a local intervention for men involved in violence. Delivery of this intervention had started in the weeks before our inspection, but because of COVID-19 restrictions, only four prisoners were able take part in each session. There were 42 prisoners on the waiting list at the time of our inspection.

6.19 We found little evidence of prisoners taking part in any individual offending behaviour work with POMs, and there was little sign of in-cell workbooks being used to aid sentence progression.

Release planning

Expected outcomes: The specific reintegration needs of individual prisoners are met through an individual multi-agency plan to maximise the likelihood of successful reintegration into the community.

6.20 The need for resettlement help was high – about 170 sentenced prisoners were released each month. In our survey, 70% of those expecting to be released said they needed help with arranging benefits, 67% needed help to arrange physical/mental health support and 63% needed help finding accommodation.

6.21 Release planning was reasonable for sentenced prisoners. Those within three months of their release received telephone support from a resettlement worker and most had an appropriate plan in place. However, most prisoners were remanded or unsentenced. Although they received a plan following a telephone assessment, support was limited as it did not cover help with accommodation.

6.22 For sentenced prisoners, accommodation outcomes on release had improved since the last inspection. A dedicated housing specialist had been introduced and they had developed relationships with local authorities and housing providers in the community. There was also new funding from the Greater Manchester temporary housing scheme, and about 86% of prisoners now left with some form of accommodation on the day of their release, much better than we see elsewhere. The prison planned to develop this work further. (See paragraph 1.53.)

6.23 Support for prisoners with finance, benefit and debt needs was far too limited. Sentenced prisoners could open bank accounts, but no budgeting or money management courses were available.

Section 7 Recommendations in this report

The following is a list of repeated and new concerns and recommendations in this report.

Key concerns and recommendations

7.1 Key concern (1.37): Early days processes did not always keep prisoners supported or informed. Holding rooms in reception lacked useful information, prisoners' safety interviews were not held in private, and staff did not always fully explore risks during their early days. Vulnerable prisoners were held alongside the general population and felt significantly less safe on their first night. Prisoners could not have a shower on their first night. There was very little time out of cell for those in the induction unit and most prisoners did not get a full induction. As a result, prisoners too often felt unprepared for prison life.

Key recommendation: All prisoners should feel safe on their first night. Support in the first few days should prepare new arrivals for prison life and they should receive sufficient time out of cell.
(To the director.)

7.2 Key concern (1.38): Levels of violence remained very high but interventions to manage perpetrators and support victims were too limited. The adjudication system was undermined by the large number of cases that had not been concluded, which meant that some poor and antisocial behaviour went unpunished. The incentives scheme focused too much on punitive measures rather than promoting good behaviour.

Key recommendation: Violence should be reduced using a range of effective interventions that challenge perpetrators and support victims. Good behaviour should be promoted and those who break the rules should be held to account.
(To the director.)

7.3 Key concern (1.39): Illicit items such as mobile phones and drugs had been easily available in the prison and had fuelled debt and associated violence. Steps had been taken to stem the flow but some of them, such as escorting prisoners to exercise yards away from their units were time consuming and possibly hard to sustain in the long term. Intelligence reports were processed swiftly, but not all requested cell searches were undertaken.

Key recommendation: Leaders should take robust and sustainable action to reduce the availability of illicit items, including acting on all intelligence received.
(To the director.)

7.4 Key concern (1.40): The lack of an effective key worker scheme, little time out of cell and the very short stays of most prisoners had a

detrimental effect on staff-prisoner relationships. A quarter of prison custody officers had less than a year in post and some lacked the confidence, knowledge and experience they needed to do their jobs effectively. Some staff were still too reticent to challenge poor behaviour consistently. We too often saw them in unit offices rather than interacting with and supervising prisoners.

Key recommendation: Staff should receive enough training and ongoing supervision to give them the confidence, knowledge and experience to engage meaningfully with prisoners, support those who need their help and challenge poor behaviour consistently.
(To the director.)

7.5 Key concern (1.41): Despite raising significant concerns at our last two inspections, the inpatient unit remained poor. There was a lack of clinical leadership to coordinate health care input and no continuous nursing presence. Time out of cell was very limited and there was a lack of therapeutic activities. Patients could not routinely access the day room as it was constantly being used for other purposes.

Key recommendation: The inpatient unit should deliver a clinically led, purposeful and therapeutic environment.
(To the director and the healthcare provider.)

7.6 Key concern (1.42): Leaders had been too slow to ease some COVID-19 restrictions. Very few prisoners had access to work or education, and we found about two thirds of the population locked up during the core working day. Unemployed prisoners had only two hours out of their cell each day. Hardly any could visit the library and access to the gym was far too limited.

Key recommendation: Prisoners should have more time out of cell to access purposeful activity including work, education, the gym and library.
(To the director.)

7.7 Key concern (1.43): Leaders and managers did not have effective oversight of the quality of the education, skills and work provision. They were unaware of the weaknesses in the standards of teaching, training and work.

Key recommendation: Leaders should have effective oversight of education, skills and work provision, to make sure that the standard of teaching, training and learning is high enough to prepare prisoners effectively for their next steps, including employment.
(To the director.)

7.8 Key concern (1.44): There were too few purposeful activity places to meet the needs of the prison population and the allocations process was not fair, equitable or timely.

Key recommendation: Leaders must increase the number of education, skills and work activity places to meet the needs of the prison population and make sure that allocations are fair, equitable and timely.
(To the director.)

7.9 Key concern (1.45): Education and training were not planned effectively enough to enable prisoners to increase their knowledge, remember what they had learned or achieve the most appropriate qualifications that would help them in the future. Support for those with additional needs or who struggled to complete their work was poor.

Key recommendation: Leaders must make sure that all prisoners receive appropriate tuition and support that is planned effectively to enable prisoners to remember what they have learned and enable them to achieve relevant qualifications that are useful in the future.
(To the director.)

7.10 Key concern (1.46): There were too few social visits available for the population, especially for the large number of remanded and unsentenced prisoners. Other methods of communication, such as video-calling, were underused.

Key recommendation: Prisoners, especially those on remand or unsentenced, should be able to have more visiting sessions, and video calling should be used more extensively.
(To the director.)

7.11 Key concern (1.47): Forest Bank was now a reception prison and the only one in the Greater Manchester area to accept prisoners on remand. The model was not working well and had badly affected outcomes for prisoners in a range of areas. Some remanded prisoners were sent from court to other prisons often miles away because the prison had no space, while others serving shorter sentences who should have stayed at Forest Bank in the lead up to their release were often transferred away from their resettlement area. Prisoners serving longer sentences needed to progress to training prisons but instead remained at Forest Bank.

Key recommendation: The role of Forest Bank as a reception and resettlement prison should be reviewed to make sure it has the capacity to retain prisoners on remand and those serving under 18 months, while being able to transfer others to more suitable prisons.
(To HMPPS.)

Recommendations

7.12 Recommendation (3.23): Governance should make sure that the use of force is always necessary, proportionate and justified.
(To the director.)

7.13 Recommendation (3.43): Staff in charge of units overnight should always carry an emergency cell key.
(To the director.)

7.14 Recommendation (3.44): There should be enough Listeners for the population and prisoners should be able to access them 24 hours a day.
(To the director.)

7.15 Recommendation (4.55): The health care application system should be confidential and effective.
(To the director.)

7.16 Recommendation (4.67): The transfer of patients to hospital under the Mental Health Act should occur within Department of Health guidance timescales.
(To the director and the healthcare provider.)

7.17 Recommendation (5.27): Prisoners should receive an appropriate induction to purposeful activities and timely careers advice and guidance throughout their time at the prison.
(To the director.)

Section 8 Progress on recommendations from the last full inspection report

Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy prison. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in in 2019, work to support prisoners in their early days was adequate. Levels of violence had doubled since the last inspection and were high. Too many vulnerable prisoners did not feel safe. CSIP was used to manage the most serious perpetrators. The incentives scheme focused too much on punitive measures to deal with most antisocial behaviour. Too many adjudications were not concluded. Governance procedures did not provide adequate assurance that the use of force was always justified. There were weaknesses in the management of prisoners in segregation. Security arrangements were well managed. Supply reduction measures were broadly effective and MDT rates were lower than comparators. Self-harm incidents had increased significantly and were much higher than in comparable prisons. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

Self-harm should be reduced. Managers should devise a strategy and action plan to achieve that aim. (S38)
Achieved

Violence in the prison should be reduced. Strategies to achieve this requirement should include measures that incentive good behaviour whilst ensuring those who offend are held properly to account. (S39)
Not achieved

Vulnerable prisoners should be kept safe and protected from victimisation. Those seeking protection should be subject to effective risk assessment and risk management. (S40)
Not achieved

Recommendations

Prisoners should not be unnecessarily delayed in reception before moving to the first night centre. (1.11)
Achieved

Induction information should be available in a variety of languages. (1.12)
Achieved

First night cells should be clean, fit for purpose and should contain basic amenities. (1.13)
Achieved

Challenge, support and intervention plans (CSIPs) should be used effectively to address violent behaviour and support victims. (1.26)
Not achieved

Adjudications should be concluded swiftly to ensure that the system acts as a deterrent to violence and drug misuse. (1.30)
Not achieved

Records of the use of force and planned interventions should be scrutinised, including viewing CCTV and body-worn video camera footage, to ensure that the force used is necessary, justified and proportionate. (1.36)
Not achieved

The care and reintegration planning for prisoners segregated on an ACCT, or those with complex needs, should include clear evidence of measures to reintegrate them to the main population as soon as practically possible. (1.44)
Achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2019, relationships between staff and prisoners were respectful but too few prisoners had a keyworker. Prisoners were generally positive about daily life. Shared cells were ill equipped for two people. Food was reasonable and the prison shop arrangements were excellent. General consultation arrangements were not effective. Prisoners valued wing kiosks and were positive about the applications process. There were weaknesses in the management of complaints. Equality work was managed well and there was good support for prisoners with protected characteristics. Health services had improved since the last inspection and were good. The inpatient facility was not sufficiently therapeutic. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

Strategies should be put in place that provide staff with meaningful support and give them the confidence to exercise effective and impartial authority and control when supervising prisoners. (S41)
Not achieved

Cells should provide a decent environment which is in a good state of repair and fit for purpose. (S42)
Partially achieved

Consistent clinical leadership should ensure that the admission criteria, environment and regime for inpatients provide therapeutic value and encourage recovery. (S43)
Not achieved

Recommendations

Meals should be served at the correct temperature. (2.13)
Achieved

Answers to complaints should fully address all the issues raised. (2.21)
Not achieved

The personal emergency evacuation plan system should be applied consistently and provide assurance that the safety of all identified prisoners is assured in an emergency. (2.40)
Not achieved

Appointment slips for health appointments should be distributed in a way that preserves the patient's confidential medical status. (2.72)
Achieved

All prisoners should be released or transferred with their required medication, and this process should be recorded accurately and regularly monitored. (2.73)
Achieved

Patients requiring mental health inpatient care should be transferred within the national guidance timeframe. (2.87)
Not achieved

Purposeful activity

Prisoners are able, and expected, to engage in activity that is likely to benefit them.

At the last inspection, in 2019, time out of cell during the working day was worse than at the last inspection, although most prisoners had good access to evening association. Prisoners on the basic regime could be locked in their cells for 23 hours a day. Attendance at the library and gym was poor. Leadership and management of education, skills and work were effective. There was sufficient activity for most prisoners to work at least part time and the curriculum was appropriate for a local prison. Attendance at work was high and had improved in education. Punctuality was not consistently good. The quality of teaching, learning and assessment in education and training was good. Prisoner behaviour was exemplary. Outcomes and achievements were also good. Access to careers information and guidance was limited. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendation

Time out of cell for prisoners who do not work full time should be increased to enable them to take part in other purposeful activity such as gym, library or supervised association. (S44)
Not achieved

Recommendations

Managers should ensure that all allocations to work and training are fair and that all eligible prisoners have an opportunity to apply for all jobs. (3.19)
Not achieved

Managers should provide enough activity places to enable most prisoners to be occupied for the full working day. These should include more demanding and interesting work. (3.20)
Not achieved

Managers should provide prisoners with relevant careers guidance, particularly during induction, so that they can develop realistic and challenging plans for their future. (3.21)
Not achieved

Managers should ensure that all teachers and trainers support prisoners to improve their written English skills. (3.28)
Not achieved

Leaders and managers should ensure an even higher rate of attendance and punctuality at education classes to maximise prisoners' learning. (3.34)
Not achieved

Managers should provide prisoners with a comprehensive induction to help them make informed decisions about their career aims and interests. (3.35)
Not achieved

Managers should provide prisoners with formal recognition of the skills they develop. (3.38)
Not achieved

Rehabilitation and release planning

Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.

At the last inspection, in in 2019, work to help prisoners maintain contact with their families was good. Strategic management of resettlement was effective. Management of OASys and sentence planning was reasonably good, albeit with some weaknesses in assessment of risk. Good relationships had been forged with community partners. Public protection processes were robust. There was a good range of interventions except for prisoners convicted of a sexual offence. Progress for some prisoners was severely affected by a lack of spaces at category B training prisons. Joint efforts by departments including the 'integrated through the gate' team supported some effective through-the-gate work. Release on home detention curfew and rehabilitation generally were hampered by a lack of housing in the community. Outcomes for prisoners were good against this healthy prison test.

Key recommendation

Sentenced prisoners should be given progressive moves to another establishment or provided with appropriate interventions and opportunities for progression at Forest Bank. (S45)
Not achieved

Recommendation

Probation staff should be systematically involved in quality assurance, training and countersigning of individual prisoner assessments, to ensure that risk issues are understood and properly identified by all involved in offender management. (4.17)
No longer relevant

Appendix I About our inspections and reports

Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.

All inspections 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.

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this Inspectorate's thematic review Suicide is everyone's concern, published in 1999. For men's prisons the tests are:

Safety
Prisoners, particularly 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.

Rehabilitation and release planning
Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release into the community.

Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by Her Majesty's Prison and Probation Service (HMPPS).

Outcomes for prisoners are good.
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

Outcomes for prisoners are reasonably good.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

Outcomes for prisoners are not sufficiently good.
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.

Outcomes for prisoners are poor.
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.

Our assessments might result in one of the following:

Key concerns and recommendations: identify the issues of most importance to improving outcomes for prisoners and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of prisoners.

Recommendations: will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections.

Examples of notable positive practice: 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.

Five key sources of evidence are used by inspectors: observation; prisoner and staff surveys; discussions with prisoners; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of recommendations from the previous inspection.

All inspections of prisons are conducted jointly with Ofsted or Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council (GPhC). Some are also conducted with HM Inspectorate of Probation. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

This report

This report provides a summary of our inspection findings against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 5, 2017) (available on

our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/). The reference numbers at the end of some recommendations indicate that they are repeated and provide the paragraph location of the previous recommendation in the last report. Section 7 lists all recommendations made in the report. Section 8 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

Findings from the survey of prisoners and a detailed description of the survey methodology can be found on our website (see Appendix II: Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Martin Lomas	Deputy Chief Inspector
Sandra Fieldhouse	Team leader
Sumayyah Hassam	Inspector
Esra Sari	Inspector
Rebecca Stanbury	Inspector
Nadia Syed	Inspector
Jonathan Tickner	Inspector
Elenor Ben-Ari	Researcher
Rachel Duncan	Researcher
Amilcar Johnson	Researcher
Emma King	Researcher
Alec Martin	Researcher
Stephen Eley	Lead health and social care inspector
Tania Osborne	Health and social care inspector
Karen Wilson	Health and social care inspector
Anne Melrose	Pharmacist
Helen Lloyd	Care Quality Commission inspector
Alison Cameron-Brandwood	Ofsted inspector
Malcolm Fraser	Ofsted inspector
Alison Humphreys	Ofsted inspector
Suzanne Wainwright	Ofsted inspector
Liz Calderbank	Offender management inspector
Martyn Griffiths	Offender management 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

Certified normal accommodation (CNA) and operational capacity
Baseline CNA is the sum total of all certified accommodation in an establishment except cells in segregation units, health care cells or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged cells, cells affected by building works, and cells taken out of use due to staff shortages. Operational capacity is the total number of prisoners that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

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.

Protected characteristics
The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

Protection of adults at risk
Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

Reverse cohort unit (RCU)
Unit where newly arrived prisoners are held in quarantine for between seven and 10 days.

Social care package
A level of personal care to address needs identified following a social needs assessment undertaken by the local authority (i.e. assistance with washing, bathing, toileting, activities of daily living etc, but not medical care).

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.

Appendix III Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed reports distributed to the prison). For this report, these are [delete as required]:

Prison population profile

We request a population profile from each prison as part of the information we gather during our inspection. We have published this breakdown on our website.

Prisoner survey methodology and results

A representative survey of prisoners is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection. A document with information about the methodology and the survey, and comparator documents showing the results of the survey, are published alongside the report on our website.

Prison staff survey

Prison staff are invited to complete a staff survey. The results are published alongside the report on our website.

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