Report on an unannounced inspection of

HMP Forest Bank

by HM Chief Inspector of Prisons

9–20 December 2024

Contents

Introduction

Holding a population that increasingly consists of remanded or unsentenced prisoners, this category B reception prison in Salford has made progress under an experienced and capable director since our 2022 inspection. The north-west of England has been at the centre of the ongoing prison population crisis and Forest Bank has borne the brunt of much of this challenge, with the churn of prisoners meaning that in one month there were over 2,500 movements. Although some work had begun, there was more leaders needed to do to make provision for the remand and unsentenced population that made up 55% of the jail, many of whom spent long periods at the prison, languishing in small, overcrowded cells.

Men on the vulnerable prisoner wing were most likely to suffer because of these pressures, with a more limited work and education offer and greater likelihood of having activities, such as gym sessions, cancelled.

An increase from ‘poor’ to ‘not sufficiently good’ in our healthy prison test for purposeful activity reflects the work done in the jail to raise standards of education and improve the regime. Even prisoners in part-time work could get up to eight hours a day unlocked, while unemployed men were unlocked for around 4.5 hours daily, better than at most similar jails. Unfortunately, delays with induction created long delays in allocating prisoners to work, training or education, meaning that too many men remained unemployed. Prisoners in workshops were often involved in mundane activity but it was good to see that leaders had built good links with local employers to help more prisoners get work on release.

The ingress of drugs continued to be the biggest challenge facing the prison, and although there had been some good work to restrict the supply, too many illicit items were getting into the jail. The new incentivised substance-free living wing (ISFL) was not yet offering the sorts of transformative programmes and support that would help men recover from their addiction or reduce the demand for drugs.

Forest Bank had some of the highest levels of prisoner-on-prisoner assaults of any jail in the country, although those on staff were relatively low. Relationships between staff and prisoners were often very good, but we were disappointed to come across examples of officers being abusive to prisoners or failing to deal with reasonable requests. There was too much low-level rule-breaking going unchallenged while there were not enough incentives on offer to prisoners who behaved well. Greater visibility of leaders would help to build the capability of what is a more stable, but inexperienced staff group.

There had been a failure by the Ministry of Justice to retender the contract to run the jail during the expected timescale, meaning there was ongoing uncertainty for leaders and staff. While the director had worked hard to support his team during this time, there had been delays to recruitment and some much-needed investment in parts of the prison. Originally the winner of the bid was due to be announced in July 2024; at the time of inspection in December, there was still no news.

When this issue is finally resolved, particularly if a new provider takes on the jail, there will need to be a strong commitment from the prison service to make sure that the process is streamlined and efficient. Without this, progress at Forest Bank – a fragile prison with a risky and complex population, an inexperienced staff team and the ever-present threat of drugs – could easily be reversed.

Charlie Taylor
HM Chief Inspector of Prisons
March 2025

What needs to improve at HMP Forest Bank

During this inspection we identified 15 key concerns, of which five should be treated as priorities. Priority concerns are those that are most important to improving outcomes for prisoners. They require immediate attention by leaders and managers.

Leaders should make sure that all concerns identified here are addressed and that progress is tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

Priority concerns

1. **Prisoners often spent too long in the bleak and unwelcoming reception unit, then arrived late to the induction unit where most cells were poorly equipped.** Leaders had not done enough to understand and improve the prisoner experience in the early days of custody.

2. **Levels of violence were high, and too many prisoners felt unsafe.**

3. **The availability of illegal drugs posed a significant threat to the stability of the prison.** Positive drug tests remained very high and not enough had been done to reduce the demand for illegal substances.

4. **Patients were not able to access emergency care at outside hospitals within expected timeframes.** The lack of prison officers allocated to escort duties created unacceptable delays for some acute and potentially life-threatening health conditions.

5. **Leaders did not ensure that all prisoners had access to, and were engaged in, purposeful activities and that the personal development targets set were effective.**

Key concerns

6. **Levels of self-harm remained high**. Leaders did not use data well to identify and respond to emerging patterns of self-harm and had not identified clear, targeted actions to reduce it.

7. **Leaders were not sufficiently visible on residential units to support, mentor, and challenge staff, many of whom were inexperienced and struggled to manage the prisoners in their care.**

8. **Leaders had not been ambitious in their efforts to engage, motivate and meet the needs of the growing number of remanded prisoners, many of whom spent long periods at the prison.**

9. **Governance of the use of force was not sufficiently robust.** Too few incidents were captured on body-worn video camera, and too few incidents were scrutinised by leaders.

10. **Prisoners did not have confidence in the complaints process.** There was often a lack of investigation into the issues raised, including allegations about staff, and the quality of some responses was poor.

11. **Wing staff lacked awareness of the additional needs of prisoners in some protected groups.** As a result, prisoners with disabilities, neurodiversity or limited English often struggled to have their day-to-day needs met.

12. **Leaders had not ensured that vulnerable prisoners had access to an appropriate variety of education and skills sessions that would help prepare them for their next steps.** Nor did they make sure that prisoners who are neurodivergent or who need extra support received the help that they needed to remove barriers to education, skills or work.

13. **Leaders did not ensure that all workshop activities provided prisoners with a meaningful and productive learning experience.**

14. **Leaders did not ensure that prisoners were provided with teaching on radicalisation and extremism.**

15. **Prisoners did not have sufficient opportunity to meet face-to-face with their prison offender manager (POM) to discuss their progress.** Contact was not always regular or timely.

About HMP Forest Bank

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

Certified normal accommodation and operational capacity (see Glossary) as reported by the prison during the inspection
Prisoners held at the time of inspection: 1,463
Baseline certified normal capacity: 1,061
In-use certified normal capacity: 1,052
Operational capacity: 1,470

Population of the prison
- 512 new prisoners were received, on average, each month
- 190 prisoners were foreign nationals
- 32% of prisoners were from ethnic minority backgrounds
- 214 prisoners were released, on average, into the community each month
- 300 prisoners were receiving support for substance misuse

Prison status (public or private) and key providers
Private: Sodexo Justice Services

Physical health provider: Spectrum Community Health CIC
Mental health provider: Greater Manchester Mental Health NHS Foundation
Substance misuse treatment provider: Change Grow Live (CGL)
Dental health provider: Shark Dent
Prison education framework provider: Sodexo Justice Services
Escort contractor: GEOAmey

Prison group/Department
Prison Contracts Group within Directorate of Contracted Operational Delivery

Prison Group Director
Jamie Bennett

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 two more units added in 2009. Forest Bank holds remand and sentenced adult men and young adults.

Short description of residential units
A1 – Young adults
A2, B1, B2, C1, C2, F2 – Mainstream population
D1, D2 – Vulnerable prisoners (VP)
E1 – VP, VP induction
E2 – Induction unit – Mainstream population
F1 – Stop Think and Reset (ST&R) / Full-time workers
G1 – Incentivised substance-free living (ISFL)
G2 and H2 – Integrated substance misuse service (ISMS)

H1 ISMS induction

Name of director and date in post
Trevor Shortt 5 September 2022

Changes of director since the last inspection
Jonathan French January 2022 – 5 September 2022

Independent Monitoring Board chair
Chelsea Bindi

Date of last inspection
14–25 February 2022

Section 1 Summary of key findings

Outcomes for prisoners

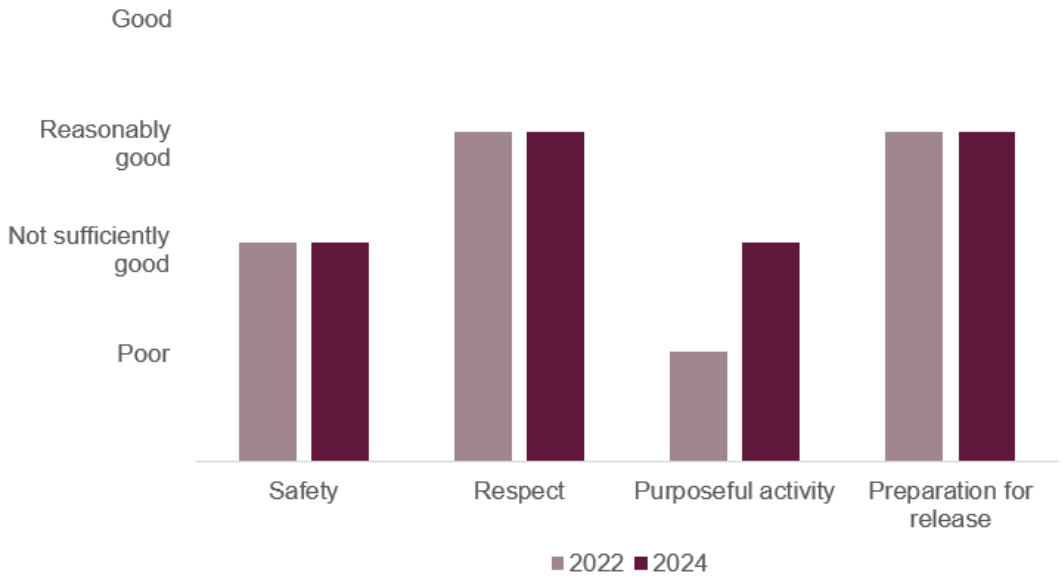
1.1 We assess outcomes for prisoners against four healthy prison tests: safety, respect, purposeful activity, and preparation for release (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.2 At this inspection of HMP Forest Bank, we found that outcomes for prisoners were:

- not sufficiently good for safety
- reasonably good for respect
- not sufficiently good for purposeful activity
- reasonably good for preparation for release.

1.3 We last inspected HMP Forest Bank in 2022. Figure 1 shows how outcomes for prisoners have changed since the last inspection.

Figure 1: HMP Forest Bank healthy prison outcomes 2022 and 2024



Progress on key concerns and recommendations

1.4 At our last inspection in 2022 we made 17 recommendations, 11 of which were about areas of key concern. The prison fully accepted 15 of the recommendations and partially (or subject to resources) accepted two.

1.5 At this inspection we found that five of our recommendations about areas of key concern had been achieved, one had been partially achieved, four had not been achieved and one was no longer relevant. Progress was most limited in Safety, where one recommendation had

been partially addressed and the other two had not been achieved. In Respect, one recommendation was no longer relevant and the other had not been achieved. The most progress had been made in Purposeful activity, where all four recommendations had been achieved. In Rehabilitation and release planning, one recommendation had been achieved and the other had not. For a full list of the progress against the recommendations, please see Section 7.

Notable positive practice

1.6 We define notable positive practice as:

> Evidence of our expectations being met to deliver particularly good outcomes for prisoners, and/or particularly original or creative approaches to problem solving.

1.7 Inspectors found four examples of notable positive practice during this inspection, which other prisons may be able to learn from or replicate. Unless otherwise specified, these examples are not formally evaluated, are a snapshot in time and may not be suitable for other establishments. They show some of the ways our expectations might be met, but are by no means the only way.

Examples of notable positive practice		
a)	Restorative Approach (RA) is mediation delivered by a manager and team of trained peer workers. We found several examples of mediation that had prevented further violence. The RA work had been accredited by the Restorative Justice Council, a registered charity promoting the use of restorative practices to resolve conflict.	See paragraph 3.19
b)	The Alert, Intervene, Monitor (AIM) electronic tool identified prisoners who appeared to be withdrawing from the prison regime and might be vulnerable. The prison then provided these men with additional support, including key work and welfare checks.	See paragraphs 3.22 and 3.61
c)	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 paragraph 6.24
d)	A new resettlement hub brought a range of services together in one unit. This allowed easier access for prisoners and made signposting more efficient for partner agencies.	See paragraph 6.31

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 Leaders were operating within the context of significant uncertainty caused by a delay in awarding a new contract to run the prison from January 2025. At the time of the inspection, Sodexo was entering a six-month extension to the existing contract but there had been no announcement about who would be running the prison after that. Clear messaging and assurance to staff from the director had achieved a 'business as usual' approach across most areas of the prison. This had limited the impact to some extent.

2.3 National population pressures and delays in court proceedings created significant logistical challenges for leaders, but they had not fully developed strategies to meet the needs of a growing number of remanded prisoners. There was a lack of ambition to engage this large cohort and too many prisoners were not purposefully occupied.

2.4 Leaders had made some improvements since the last inspection. Staffing levels and retention were better, and investment by Sodexo had improved some living and working conditions. However, the prison remained overcrowded. The use of drugs was widespread, despite work by leaders to disrupt the routes used to bring illicit items in (see paragraph 3.49). In addition, too many prisoners felt unsafe.

2.5 Time out of cell had improved. New leadership in education, skills and work had increased purposeful activity for some prisoners. Leaders had supported pockets of innovative work around the prison, but it was not always well promoted and too few prisoners were involved.

2.6 Leaders had not prioritised key work or contact with prisoner offender managers (POMs). This meant that very few prisoners were supported, encouraged, or challenged in a meaningful way, even though a high number of men stayed at the prison for some time.

2.7 Senior leaders understood the need to develop the role, skills and confidence of prison custody officers and first-line leaders to enable them to take better control of residential wings where low-level rule breaking was widespread. However, they were not sufficiently visible on the wings to support and mentor their junior colleagues, and to help them to understand the importance of rules and boundaries.

2.8 Leaders had fostered good relationships with partners and stakeholders. Leaders in health care and learning and skills were motivated to improve provision but were dependant on ongoing support from prison leaders to make the improvements required. Leaders had not ensured that all staff understood and valued the contribution of the Independent Monitoring Board.

2.9 An experienced and well-regarded director understood the strengths and weaknesses in the prison and had identified appropriate priorities. These were set out clearly in the self-assessment report and business plan for 2025. However, leaders had not developed the priorities into more detailed action plans to ensure they were delivered effectively. They gathered lots of valuable data but did not analyse and communicate it in a clear and comprehensive way, making it less useful as a means of driving improvement.

2.10 Leaders had been receptive to feedback from the inspection team, and we were confident that they would take steps to begin to make the improvements needed.

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 On average, over 540 prisoners arrived at Forest Bank each month. This included men sentenced at court, recalled to prison, and transferring from other establishments. This was a 59% increase on the year before the previous inspection.

3.2 Reception staff also had to manage remand prisoners going to and from court, and a high number of prisoners being released into the community. In November 2024 there were over 2,500 movements in and out of reception.

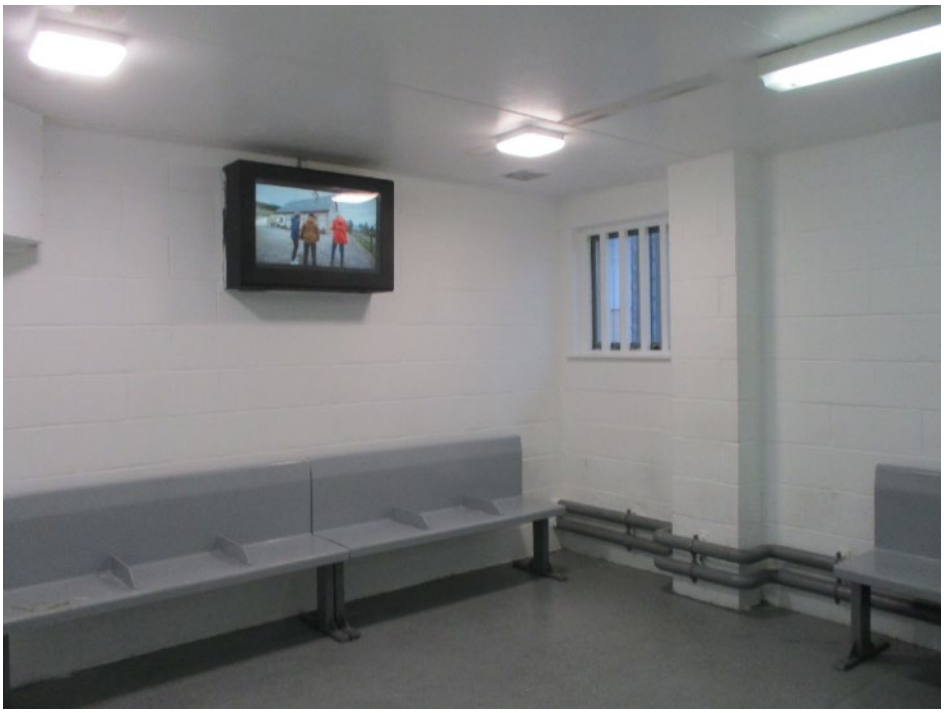
3.3 Prisoners coming from court often arrived late in the day, frequently after 7pm. Staff completed a private safety interview to identify potential vulnerabilities and indicators of self-harm. All new arrivals also had a health assessment while on the unit. Staff initiated assessment, care in custody and teamwork (ACCT) case management if they had concerns about new prisoners.

3.4 Prisoner peer supporters known as Listeners (prisoners trained by the Samaritans to provide confidential emotional support to their peers) could be requested by reception staff but were not based in reception to provide support for those who were struggling with custody (see paragraph 3.60). Two prisoners worked in reception to keep it clean and provide food and drinks for new arrivals, but they were not trained to provide information and advice about prison procedures to their peers. Trained peer supporters (known as Insiders) lived on the induction unit but were not based consistently in reception. They were often locked up in their own cells when prisoners arrived from court after 7pm.

3.5 Prisoners who did not have any public protection restrictions were entitled to a free phone call to let family or friends know where they were. However, some newly arrived prisoners told us they did not get this call and, in one of the cases we followed up, the reasons for refusing it were not justified.

3.6 Prisoners spent long periods in reception holding rooms that were clean but basic. Only two of the six rooms had a television. There was

also very little information provided about the prison to pass the time or relieve anxiety.



Reception holding room

3.7 We saw prisoners waiting several hours to move to the induction wing because there were no staff available to escort them. One prisoner spent almost 12 hours in reception. The prison did not systematically analyse the data on the length of time prisoners spent in reception or explore the reasons for excessive waits.

3.8 Despite having spent many hours in court cells, cramped escort vehicles and bare holding rooms, many prisoners who arrived on the induction unit in the evening could not access the shower. Significantly fewer respondents to our survey than at similar prisons said they were offered toiletries (51%), something to eat (73%) and support from another prisoner (23%) before being locked up on the first night.

3.9 New arrivals were located on one of three units on their first night: H1 for those who were withdrawing from drugs and alcohol; E1 for vulnerable prisoners; and E2 for the mainstream prisoners.

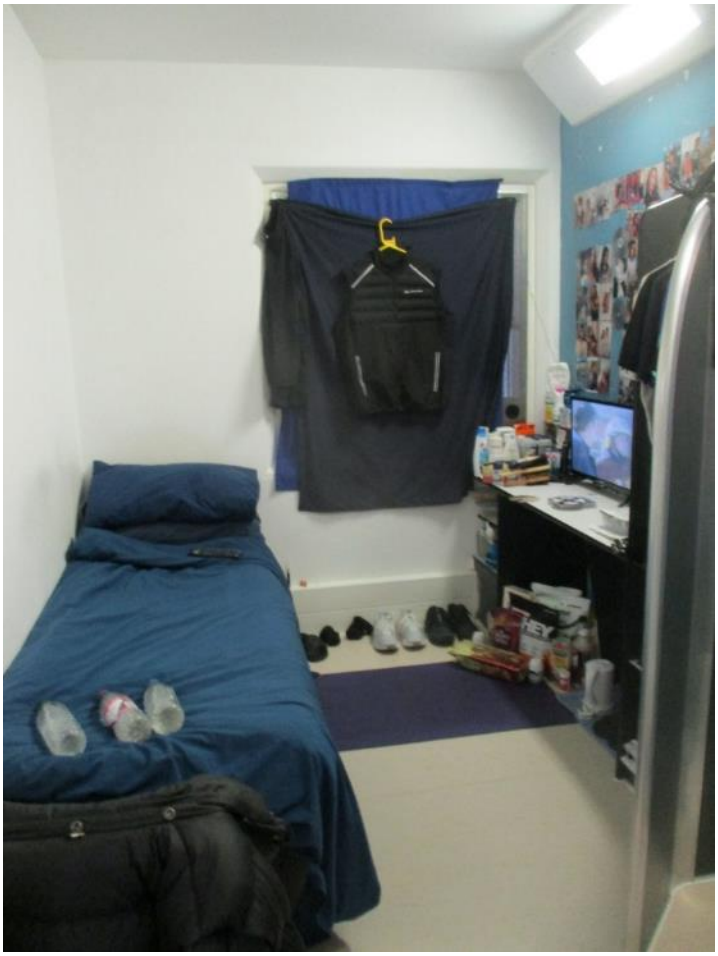
3.10 In addition to their routine checks, staff were scheduled to complete five checks on newly arrived prisoners throughout the night. However, there was only one member of staff assigned to look after 200 prisoners on both E1 and E2 wings. During our night visit this member of staff had 11 first-night arrivals and 11 prisoners who required at least hourly checks as part of their ACCT plan. This compromised their ability to carry out these checks effectively.

3.11 Too many new prisoners were placed in graffitied cells without a kettle, working television or telephone. For many men this meant they were

unable to contact their support network or the Samaritans. We raised this with managers during the inspection, but it was not addressed.

Left: double cell on E2: the cell had no kettle, phone, TV aerial, curtains or privacy screen for the toilet. Right: Graffiti above inside of cell doorway on FNC used to house a vulnerable trans prisoner during the inspection.

3.12 Cells on H1 wing, which housed prisoners who needed the integrated substance misuse service (ISMS), were generally better equipped.



Single cell H1

3.13 Staff and an Insider from the wing jointly delivered the induction programme. This included a gym induction session and an education induction to determine what activity prisoners could be allocated to. There were delays in completing the latter (see paragraph 5.23) and, as completion of the induction programme was not tracked and reviewed, leaders could not be assured that all parts were completed.

3.14 Following induction, most prisoners were moved swiftly onto other wings where they could settle into life at the prison. Men who were risk assessed as being unable to share a cell waited longer for a single cell to become available. Prisoners returning to Forest Bank after less than six months in the community could sign a waiver to bypass the full induction.

3.15 Leaders stated that exit surveys had been used to collate prisoner feedback, but they could not provide any evidence that this had been used to improve prisoners' experiences during their early days.

Promoting positive 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

3.16 In our survey, 30% of respondents said that they felt unsafe at the time of inspection. Overall rates of violence, including serious assaults, had increased since the last inspection and were now higher than most similar prisons. More positively, violence against staff had reduced and was now the lowest of all reception prisons.

3.17 Leaders had identified safety as a key priority, and there was cohesive work between staff in safety, security, and residential functions demonstrating an effort to address the high levels of violence. For example, there was a daily meeting to understand emerging safety and security risks. In addition, a daily movement of prisoners meeting managed the location of prisoners to minimise risk, including that posed by prisoners affiliated to urban street gangs in the community.

3.18 The safety team had developed basic but effective systems to improve the management of prisoners affiliated to gangs. Safety peer mentors met all new arrivals to highlight the risks of gang violence. Any immediate risks informed the daily movement of prisoners meeting and were shared with security and residential staff.

3.19 Measures taken by the safety team was complemented by good mediation work known as the Restorative Approach (RA). The RA lead was supported by a team of peer workers who had been trained to facilitate mediation between prisoners who were at risk of conflict. Since the implementation of RA at the prison in early 2023, there had

been over 400 referrals. Over half of these had led to mediation. Prisoners spoke positively about the work by the RA team, and we found examples of mediation that had prevented further violence. The RA work had been accredited by the Restorative Justice Council, a registered charity promoting the use of restorative practices to resolve conflict.

3.20 Challenge, support and intervention plans (CSIP) (see Glossary) were designed to manage the perpetrators of violence and were discussed at the weekly safety intervention meeting.

3.21 Following an act of violence, the safety team oversaw detailed investigations which identified appropriate actions to reduce future risks. However, these actions were not transferred to the CSIP plan. This meant the system was ineffective in helping prisoners to address their violent behaviour.

3.22 Leaders had introduced a new tool called Alert, Intervene and Monitor (AIM) (see paragraph 3.61). The purpose of AIM was to identify prisoners who might be vulnerable and provide them with additional support, including key work and welfare checks. Early signs were promising and some limited key work referrals had been completed. However, leaders were not gathering evidence to show that it had led to improved outcomes for prisoners who were struggling. For example, there was no evidence that flagged concerns had led to regular welfare checks or a referral to CSIP.

3.23 During the inspection, we identified several complaints and concerns raised by prisoners about low-level bullying that had not been adequately investigated or reported. Staff on residential units did not always challenge poor behaviour and rule breaking, and this created an environment where bullying could prevail (see paragraph 4.3).

3.24 Prisoners identified as being vulnerable due to their offence were kept safe and lived on a separate unit. Although, as a result, they had poorer access to the full prison regime.

3.25 The prison culture was not motivating. Only 8% of respondents to our survey said that the culture of the prison encouraged them to behave well, compared to 17% at similar prisons. The local incentive policy also offered little to encourage good behaviour and rewards were not given consistently. Few prisoners we spoke to could say why it was worthwhile being on the enhanced level of the incentive scheme. Boundaries were also not always clear or enforced.

Adjudications

3.26 Leaders had tried to reduce a large backlog of outstanding adjudication hearings. At the time of the inspection there were still around 50 to be dealt with internally. A similar number, for more serious offences, had been referred to the police. This remained concerning but was a significant reduction on the number of outstanding hearings at our previous inspection.

3.27 Hearings were conducted in a relaxed manner, allowing prisoners to engage and present their case. Adjudicators used CCTV footage effectively, but some charges were undermined by insufficient evidence from body-worn video cameras.

3.28 In several cases, charges were dismissed due to a lack of body-worn video camera evidence to prove the charge. The staff involved in the incident were not appropriately debriefed to explain the reasons for the dismissal. This was a missed opportunity to help prison custody officers understand the value of using body-worn cameras.

3.29 Adjudications data was reviewed at the quarterly segregation, monitoring, and review group (see paragraph 3.43). Quality assurance of hearings was regularly conducted. However, recurring issues, such as incomplete written explanations or missing conduct reports, were still not addressed.

Use of force

3.30 Since the last inspection, the rate of the use of force had decreased by 15% and was now lower than in most similar prisons. This was at odds with the rise in violence. Many fights and assaults took place out of the view of staff and did not therefore result in a use of force, but improvements in governance and training are also likely to have improved de-escalation skills.

3.31 In the last year, staff had activated their body-worn video cameras in fewer than half of all use of force incidents. Even when cameras had been used, the prison had not retained sufficient footage to be assured that force was necessary, justified and proportionate. Most footage was deleted after one month. Leaders told us that funding had been approved for technology that would allow the security department to retain footage for longer.

3.32 The limited footage we were able to view showed staff managing serious incidents well and leveraging good rapport with prisoners to quickly de-escalate situations once force had been initiated.

3.33 Governance of use of force had improved but was still not sufficiently robust. Evidence from the weekly scrutiny meetings indicated that leaders had focused appropriately on increasing the use of body-worn video cameras. They had identified learning points which were addressed with individuals or integrated into new scenario-based training. However, far too few incidents were scrutinised in the meeting; usually only two or three incidents per month out of approximately 100 in total. In addition, the meetings were not always attended by prisoner advocates such as the chaplaincy, which meant there was no independent oversight.

3.34 Written records of monthly oversight meetings showed that leaders had used data to identify and act on emerging trends, such as the rise in non-compliance as a reason for force being used. They did not

routinely explore the reasons for disproportionate uses of force on prisoners from some protected groups (see paragraph 4.39).

3.35 In the past year, special accommodation had been used 13 times, including 12 times for one prisoner who had since transferred to a secure hospital. Written records we reviewed showed that these uses were for short periods, appropriately authorised, and proportionate to the sometimes extremely high risk posed.

Segregation

3.36 The use of segregation had reduced significantly since the last full inspection. Data from the previous 12 months showed that prisoners were segregated on just over 400 occasions, mostly awaiting adjudication. The average stay was 15 days, though this was skewed by a few long-term cases.

3.37 At the time of inspection, one prisoner had been segregated for over 120 days and was being supported by ACCT. This prolonged segregation had been approved by the HM Prison and Probation Service (HMPPS) contract controller. A transfer to another establishment had been agreed but was delayed due to unresolved transport issues. This was concerning given the impact on the prisoner's well-being.

3.38 There had been minor improvements to living conditions on the unit. Communal areas were clean, and most cells were spacious and graffiti-free, but toilets were heavily stained and lacked seats or covers. Exercise yards remained stark, with no equipment.

Room ready cell in the segregation unit

3.39 The unit's regime remained poor and offered little to support reintegration. Prisoners had limited access to exercise in the fresh air, showers, and electronic kiosks as they were locked up for over 23 hours a day. Prisoners were not permitted to collect their meals from a servery but were provided with food at their doors.

3.40 Relationships between segregated prisoners and staff seemed reasonable but staff had been applying unofficial punishments. Records from November 2024 indicated that staff had placed further restrictions on prisoners' already paltry regimes, including depriving access to a shower, without rigorous assessment and appropriate authorisation.

3.41 Prisoners were not routinely risk assessed to access off-unit activities, and there was little to motivate prisoners to progress while on the unit. At the last inspection we acknowledged some positive initiatives, such as regular contact with programmes staff, but these were no longer commonplace.

3.42 Review boards were held to discuss reintegration. Plans lacked sufficient detail to be effective, featuring generic targets that failed to identify and address the underlying reasons for segregation.

3.43 Governance of the unit was overseen by a quarterly segregation, monitoring and review group meeting. Leaders were not using available data to identify trends or drive improvement. The most recent meeting had not taken place. This undermined the importance of appropriate oversight.

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 misuse and effective drug supply reduction measures are in place.

3.44 Shortly before the inspection there had been a high-profile escape by a prisoner while out at hospital escorted by prison staff. Leaders had taken prompt action that included an external review by senior managers in HMPPS and Sodexo. During the inspection we were provided with evidence that the actions identified following the review were being addressed to minimise further risk.

3.45 Since the last inspection, there had been an increase in the number of intelligence reports which were triaged promptly by a small security team. The security team used this intelligence to inform a monthly assessment of emerging risks and devise security objectives which were then communicated to staff. The assessment tool was not used as effectively as it could have been to conduct comprehensive analysis of the risks faced, but the team had made some progress. For

example, the oversight and effectiveness of cell searches and suspicion drug testing had improved since the last inspection.

3.46 There were also effective strategies to ensure that key managers from security, residence and safety had oversight of emerging risks. This included a daily operational briefing and movement of prisoners meeting (see paragraph 3.18) to manage the risks presented by prisoners with gang or crime related affiliations.

3.47 The use of illicit items, including drugs and mobile phones, was a primary threat to the prison. In our survey just over half of respondents said that it was easy to obtain illicit drugs (51%) or medication (53%) that was not prescribed to them, both of which were significantly worse than similar prisons.

3.48 Illicit drug use was evident in mandatory drug test results. In the past 12 months, the positive test rate was 38%. This is among the highest of all reception prisons. Over the same period, nearly 400 suspicion drug tests had been carried out with a positive test rate of 74%, again reflecting extremely high levels of drug use.

3.49 Leaders had done extensive work to shut down many of the routes used to convey drugs into the prison, including tackling staff corruption, which had disrupted supply. There was evidence of excellent partnership work with the police and regional organised crime unit.

3.50 Technology, including body scanners, was used appropriately. Other aspects of physical security had also been strengthened to reduce throwovers and drones. Leaders monitored the quality of daily fabric checks of cells by staff to ensure prompt repair to damaged windows. This had also reduced the incursion of drones.

3.51 However, it was concerning that the prison did not have regular access to drug detection dogs. Managers told us that support from HMPPS regional dog teams had lapsed.

3.52 Despite some of the positive work to address the supply of drugs, there was insufficient focus on reducing the demand or incentivising those who did not take drugs. The drug strategy did not reflect the current risks and had not been updated for over 12 months. There was no effective action plan to monitor identified actions and evaluate progress.

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

3.53 Since the last inspection, there had been two self-inflicted deaths in the prison, and a third self-inflicted death which occurred shortly after the prisoner was released. Not long after this inspection there was a further self-inflicted death in the prison. Where appropriate, Prisons and Probation Ombudsman (PPO) recommendations had been implemented. An HMPPS early learning review of the death that had occurred one month before the inspection had made recommendations to minimise future risks. These recommendations had been added to the safety action plan alongside recommendations about the oversight of, and support for, prisoners in the segregation unit identified by the safety team.

3.54 Recorded levels of self-harm remained high. In the last 12 months there were 1,087 incidents involving 369 prisoners. Rates were about the same as at the last inspection and average compared to other reception prisons.

3.55 Investigations into 20 serious incidents of self-harm were thorough and identified appropriate areas for improvement. However, action was often focused on providing additional guidance to individuals, and there were missed opportunities to share learning more widely for greater impact.

3.56 Data was not used well to identify and respond to emerging patterns of self-harm. Leaders had identified the main triggers such as mental health issues, being new to custody, and not wanting to transfer to another establishment. Despite this, they had not clearly identified actions to explore these issues in more detail to find ways reduce self-harm. Instead, most planned actions to improve safety came from external sources, such as a 2023 audit, rather than from prison leaders' own knowledge and data. Actions were focused on compliance with the ACCT process rather than on reducing or preventing self-harm.

3.57 The prison environment was not always conducive to mental well-being. Leaders were aware of the importance of a respectful, decent and purposeful regime in reducing the boredom and frustration that can lead to self-harm. However, we found too few prisoners engaged in meaningful purposeful or recreational activity. Poorly equipped first-night cells also introduced needless risk at a key time for prisoners (see paragraph 3.11).

3.58 Prisoners with very complex needs, including some men with high self-harm rates, received a good level of support with multi-disciplinary input into their care plans.

3.59 However, day-to-day support for prisoners who had self-harmed was weak. Most of those supported by ACCT plans were not engaged in purposeful activity, and their care plans did not always reflect all their identified risks, triggers and sources of support. Wing staff were not always aware of the reasons a prisoner was being supported by the ACCT process or of their individual needs. In our survey, only 42% of the prisoners who had been on an ACCT said they felt cared for by staff.

3.60 There were only nine Listeners. This was insufficient for the population, although there were plans to train 30 more Listeners over the coming months. There were no Listener suites on units, so sessions were often held through or at cell doors. This was inappropriate and undermined the confidentiality of the scheme. At the time of the inspection, vulnerable prisoners did not have access to Listeners at all.

3.61 The AIM electronic tool was a promising new initiative that flagged up prisoners who appeared to be withdrawing from the regime and may therefore be vulnerable (see paragraph 3.22). This included prisoners who had not attended work or planned gym sessions, had not bought items from the canteen, or had stopped having contact with their families at visits or by phone. These prisoners were then provided with additional support. Early signs were promising but it was too soon to judge the effectiveness of this tool.

3.62 It was positive that prisoners' families and friends were able to contact the safety team easily to raise concerns and be kept informed, where appropriate. We also saw many examples of key workers encouraging prisoners who were struggling with their mental health to remain in contact with their loved ones.

3.63 In the past year, 21 prisoners had been under constant supervision for an average of over six days. Documentation we reviewed often did not make clear why a prisoner posed such a risk to themselves that they required constant monitoring, especially for long periods. Many prisoners under constant supervision did not have access to a purposeful regime, and we observed staff simply watching prisoners rather than engaging with them. Inadequate cells on I wing (formerly the health care department) were still often used for constant supervision, where prisoners did not have in-cell phones. One of these cells had, for unrelated reasons, only very recently been taken out of use.

Protection of adults at risk (see Glossary)

3.64 The local safeguarding strategy was up to date and comprehensive. Most staff we spoke to said they were aware of how to recognise signs of vulnerability or harm in prisoners and could give hypothetical examples. However, we found some examples where vulnerability had

been missed or where staff were not aware of prisoners' individual needs (see paragraph 4.35).

3.65 A new electronic tool helped flag up indicators for vulnerability for new arrivals, while the AIM tool helped the safety team identify prisoners who were beginning to withdraw from the regime and isolate themselves (see paragraph 3.62). However, these tools were not yet fully embedded and were not being used effectively.

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 In our survey, only 66% of prisoners said that staff treated them with respect, and 41% said they had been victimised by staff. We reviewed a selection of complaints that prisoners had made alleging unfair treatment and poor behaviour by staff. Some of the responses did not provide assurance that the matter had been taken seriously, which undermined prisoners' confidence in staff and leaders (see paragraph 4.26).

4.2 The interactions we observed between staff and prisoners were mostly respectful. We met, and were told about, some good, committed officers. However, several prisoners also told us they were frustrated about a lack of help to get simple tasks done.

4.3 Officers failed to challenge behaviour including queue jumping, wearing inappropriate clothing and vaping in communal areas of the wings. Leaders were rarely visible on residential areas at key points of the day. They were not proactively setting standards or supporting some inexperienced staff who struggled to enforce rules and maintain boundaries.

4.4 Key work was not used effectively to support prisoners and help them to progress through their sentence. Four full-time officers were allocated to conduct key work sessions for prisoners assessed to have the greatest need. These included prisoners being managed through the ACCT or CSIP processes, and sentenced prisoners aged under 26 years old. The 1,100 prisoners not in the priority group did not receive regular key work.

4.5 The quality of key work was poor with few examples of meaningful conversations about behaviour or work to reduce reoffending (see paragraph 6.15).

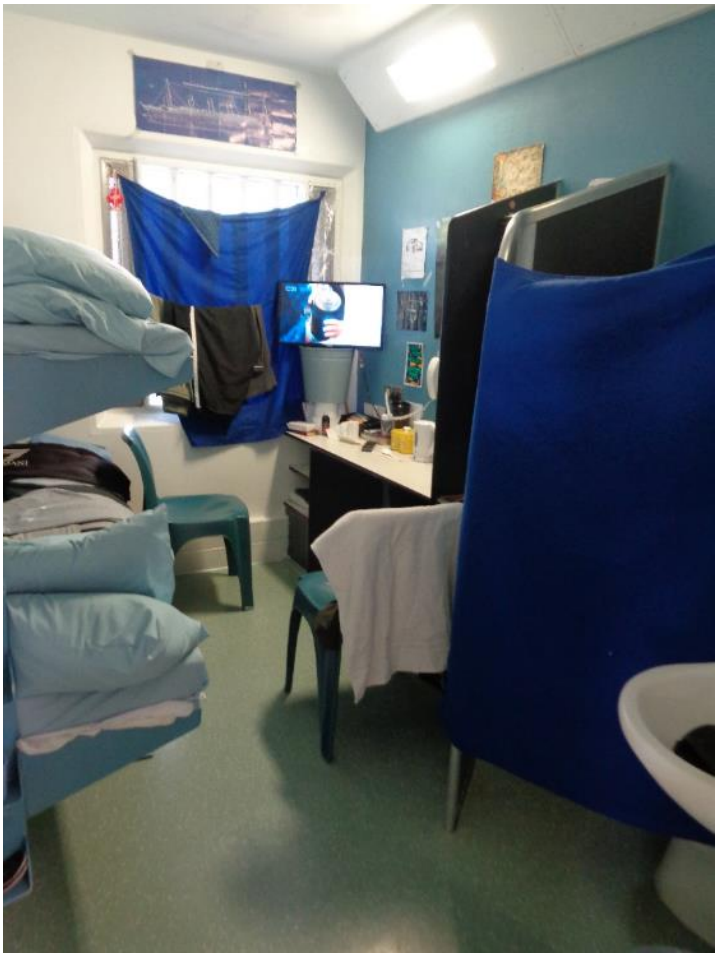
4.6 Several prisoners acted as peer workers to help other prisoners and support the work of staff across the prison. In some areas, peer workers were particularly effective, including as Insiders on the induction units, RA (Restorative Approach) mentors (see paragraph 3.19) and education mentors (see paragraph 5.31).

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

4.7 Too many prisoners (54%) had to share cramped cells that were designed to hold one person. Prisoners in these cells slept in bunks that were very close to the toilet, many of which had no privacy screens.



Double cell on H1

4.8 Most wings and cells were reasonably clean and well equipped. Some wing cleaners were proud of their efforts to maintain good and clean living conditions. However, procedures to get replacement mop and brush handles were unnecessarily complex and the security department had to approve requests. Improved vermin control procedures had significantly reduced the mice problem reported at the last inspection.

C2 landing

4.9 Since the last inspection, G and H wings had been refurbished but the cells on these units were noticeably colder than on other wings.

4.10 In our survey, 91% of respondents said they could shower every day. This is significantly higher than at similar prisons (70%). There had been some improvements to the communal showers on all wings with the introduction of individual screens to improve decency. The drainage in shower areas remained poor. Much of the flooring was also grubby and stained and this could not be removed with the equipment wing cleaners had access to. Leaders had plans to introduce a systematic deep-cleaning programme.

4.11 Each wing had industrial laundry facilities for prisoners to wash their own clothes. In our survey, far more respondents than at similar prisons said they could get weekly access to clean bedding (75% compared to 56%).

4.12 Some prisoners told us that emergency cell call bells were sometimes ignored. We did not observe this during the inspection, but the system was not monitored on A to F wings and leaders could not refute prisoners' claims. A newer system on G, H and I wings recorded response times, but leaders were not analysing the data.

Residential services

4.13 Prisoners could have a hot meal twice a day and healthy options were available on the menu. However, much of the food that prisoners selected was stodgy and processed, and the men were not always taking the salad or fruit offered to them. The kitchen, gym, and health

care teams did not work proactively together to encourage and promote healthy living (see paragraph 4.52).

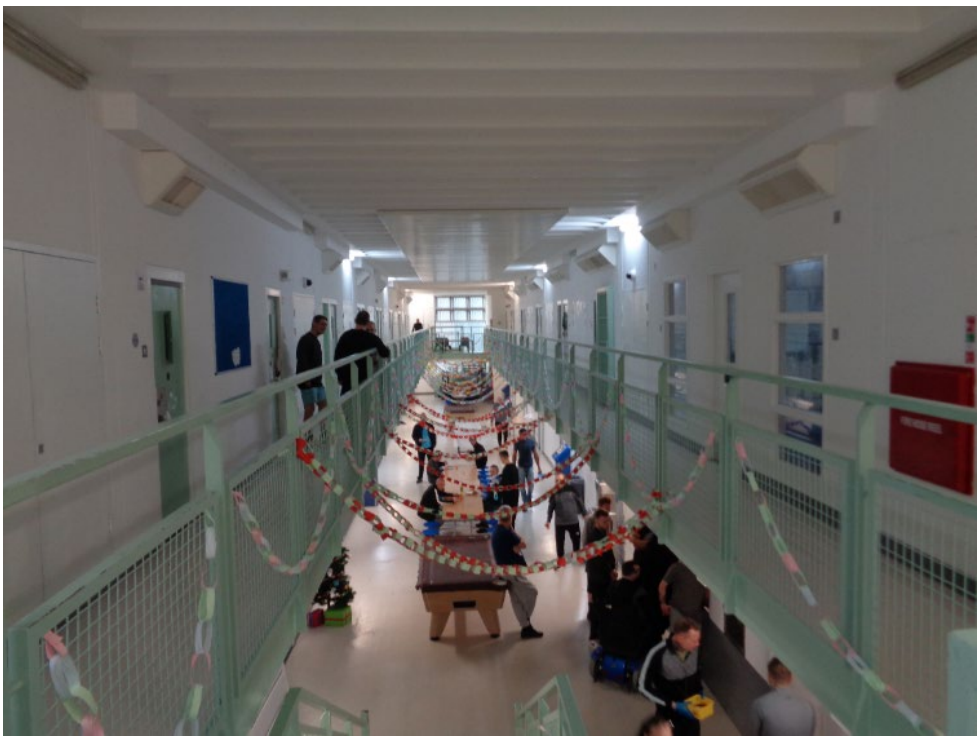
Salad being prepared in the kitchen

4.14 Many prisoners were critical about the food. At the time of inspection there had been 60 complaints about food in 2024. In our survey, far fewer respondents than in the previous inspection said the quality of the food was good (31% compared to 47%) or that they got enough to eat most of the time (23% compared to 38%).

4.15 Leaders carried out regular checks to make sure that hygiene standards on wing serveries were maintained, such as measuring the temperature of food before it was served. However, the prison was unable to produce records of such checks since August 2024. The management checks had also not ensured that servery workers wore appropriate PPE clothing to maintain standards of hygiene when serving food.

4.16 Staff also did not always supervise the meal service to make sure hygiene standards were followed and fair portion control was in place. We saw some prisoners queue jumping and it was not difficult to see how those forced to the back might get the wrong meal or less to eat.

4.17 It was positive that prisoners on most wings had the opportunity to eat together around tables in the communal areas, and that many chose to do so. This meant they were not forced to eat meals in cramped cells next to the toilet, as is often the case in other prisons.



Communal dining on G1

4.18 Since the previous inspection, prisoners were now issued with kettles to make a hot drink in their cells, and there was a cold-water dispenser in residential areas. There were no facilities on the wings for prisoners to make toast or heat food in a microwave, despite this being commonplace in some other prisons. Toasters had previously been available, but some prisoners had not been cleaning them after use. Managers had removed the toasters rather than making this a wing-cleaner's job or dealing with the behaviour.

4.19 Newly arrived prisoners were given a vape or snack pack which they paid back over time. Shop orders could be placed via wing kiosks twice a week. This reduced the waiting time for men to get their orders and the need to incur debt. Orders from the shop were packed on site, so any shortfalls were quickly remedied.

Prison shop

Prisoner consultation, applications and redress

4.20 Since our last inspection, prisoner consultation had improved, despite the rapid turnover in the population. In our survey, significantly more respondents than in the last inspection said that things sometimes change following consultation (43% compared to 21%).

4.21 Leaders had commissioned User Voice, a third-sector organisation that supports consultation in prisons, to lead on this work. The coordinator, who had experience of prison, had great credibility among prisoners. They met weekly with two prisoners who sat on the prison council. Both prisoners were also peer mentors and had been cleared by security to move around the prison more freely than most prisoners. This gave them good access to other members of the council on each wing to discuss and coordinate the main issues affecting prisoners.

4.22 Prison council leads met with managers on a regular basis to discuss and solve the issues prisoners raised. We found several examples where managers had acted on proposals from the prison council.

4.23 Each wing was equipped with electronic information kiosks. This allowed prisoners better control over some aspects of their daily life, such as selecting meals, booking visits, and submitting requests to different departments. We frequently saw queues to use the kiosks at key times of the day. Prisoners with poor literacy had to rely on fellow prisoners to help them navigate the system, which carried some risk.

Wing kiosk

4.24 In our survey, far more respondents than at similar prisons (49% compared to 35%) said that applications were usually dealt with within seven days. Prison data supported this. Some prisoners told us that responses often failed to deal with the request they had submitted, leading to frustration and delay. The prison did not have a quality assurance process for applications to make sure the system operated appropriately.

4.25 Over the previous 12 months, the rate of complaints had remained stable and was similar to that for other reception prisons. Prison data suggested that about 90% of the 2,650 complaints in this period were dealt with within seven days.

4.26 However, the quality of complaint responses we looked at were among the worst we had seen. Many did not fully investigate the issues raised including allegations about staff and being bullied by other prisoners (see paragraphs 3.23 and 4.1). Responses indicated that few prisoners were ever spoken to about their complaint or offered an apology, even when there appeared to have been a clear failing. In one example, a prisoner submitted a complaint stating that he had asked wing staff for clean clothes for three weeks to no avail. The response did not acknowledge the issue and suggested the prisoner ask wing staff for clothing.

4.27 Despite the inadequacy of the investigations, the prison only upheld 14% of complaints. Those that were not upheld lacked adequate explanation and this undermined prisoners' trust and confidence in the process. In our survey only 26% of those who had made a complaint felt that they had been dealt with fairly.

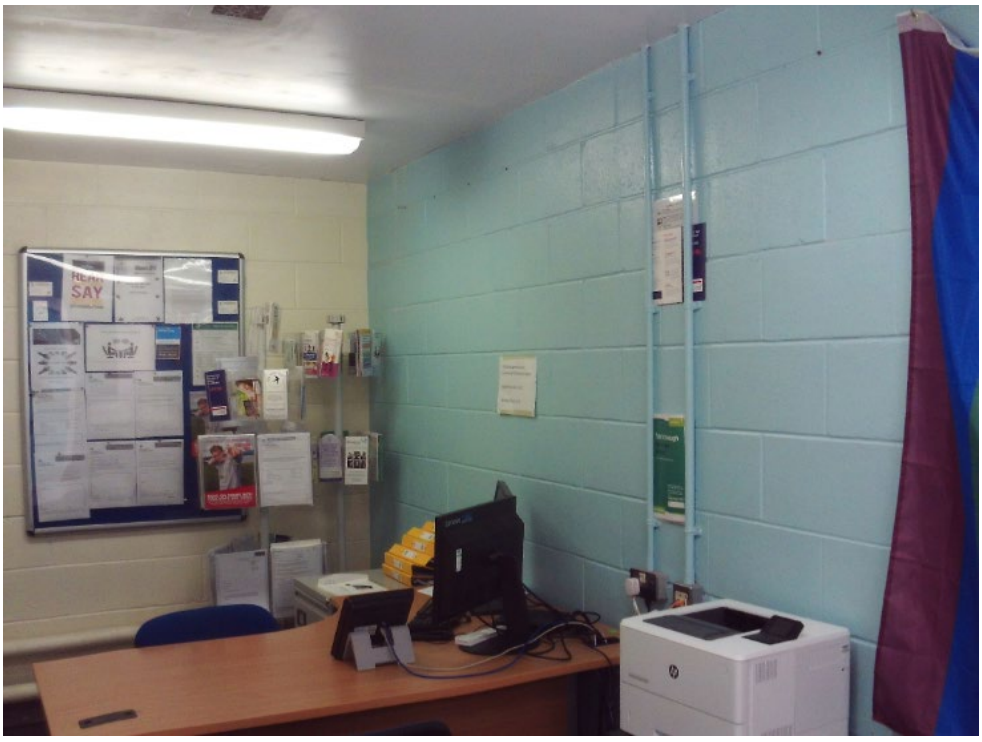
4.28 Prisoners had reasonable support to exercise their legal rights. All remand prisoners were visited by a bail support officer, who offered help to apply for bail. The legal visits provision was sufficient to meet demand. Some prisoners who needed to review large amounts of information from their legal team were given access to secure laptops.

Fair treatment and inclusion

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), or those who may be at risk of discrimination or unequal treatment, 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.

4.29 A dedicated equality team was doing some good work to enable fair treatment and inclusion. However, we still found evidence of unmet need across the prison. Wing staff also often lacked understanding of some prisoners' additional needs.

4.30 The equality team had a suite which could be used to meet prisoners privately. The equality officer used this for several surgeries each week which prisoners could request to attend. The equality team also monitored new receptions and was proactive in meeting any new prisoners who had been identified as having additional needs.



Equality suite

4.31 Around 13% of prisoners were foreign nationals. Home Office staff attended the prison regularly to give advice to foreign national prisoners who had been sentenced. The foreign national coordinator was active in working with several prisoners who had been identified as needing additional support. Despite this, across the establishment we found foreign national prisoners with limited English who were not adequately supported. Wing staff rarely made use of interpretation services and this had been a persistent issue for more than a year.

4.32 There were five adapted cells available for prisoners with mobility issues. While these men were appropriately located on lower levels, we found some individuals living in cells without adaptations such as grab rails (see paragraph 4.68). Some prisoners with disabilities told us that they did not receive adequate day-to-day support. Wing staff did not always demonstrate good awareness of these prisoners' needs or personal emergency evacuation plans.

Adapted shower (left) and adapted cell (right)

4.33 The prison lacked a formal 'buddy' system of peer support for prisoners with disabilities. Informal peer support arrangements were poorly supervised, which was a significant gap (see paragraph 4.69). Diversity representatives, who were asked to support their peers with disabilities, were not trained to do so and they were not located on all wings.

4.34 There was good support for a limited number of prisoners who are neurodivergent. The neurodiversity support manager conducted one-to-one casework with around 20 prisoners and ran a weekly well-being surgery. At the time of the inspection, the neurodevelopmental conditions team was providing support to 33 prisoners. Men were able to self-refer for this support through the kiosks, which was positive. However, staff on wings were often not knowledgeable about the needs of prisoners who are neurodivergent and were rarely aware of personalised support plans drawn up to help them engage with these prisoners.

4.35 At the time of the inspection, there were 55 prisoners over the age of 60. An older prisoners' morning was held every two months, but there was little else to occupy their time.

4.36 The prison held four transgender prisoners. Transgender case boards took place regularly, and those prisoners we spoke to were positive about the support they received from the equalities officer.

4.37 Around 20% of prisoners were young adults. The prison had established a dedicated wing which held around a quarter of this group. The wing provided enrichment activities including a weekly well-being session, additional gym sessions and accredited courses, though these were often limited to small numbers. Younger prisoners in other wings were often unable to access these arrangements, and they regularly highlighted to staff and inspectors they did not have enough to do.

Activity board on young prisoners' wing

4.38 The prison held regular forums for prisoners with protected characteristics and feedback was taken to diversity and inclusion action team (DIAT) meetings, which were held every two months and well attended. Prisoner representatives continued to attend DIAT meetings, which was positive.

4.39 While we saw some evidence of issues raised at the DIAT meeting being actioned and resolved, some long-standing concerns had not been adequately dealt with. This included a lack of black prisoners in orderly roles and disproportionate representation of black prisoners in use of force incidents (see paragraph 3.34). The equalities action plan was not effectively monitoring outcomes or progress.

4.40 In the previous 12 months, the prison had received 85 diversity incident reporting forms. While responses were courteous and generally timely, too often investigators did not speak to the complainant. This was a persistent issue highlighted at our last inspection. The Independent Monitoring Board continued to provide occasional quality assurance of responses, but this was not performed systematically.

Faith and religion

4.41 The chaplaincy was staffed by a managing chaplain and seven contracted chaplains, with visiting chaplains for most major faith groups. It offered a range of corporate worship opportunities, study groups and activities. This included Sycamore Tree, a six-week programme teaching prisoners about victim awareness and restorative justice, and weekly yoga sessions.

4.42 The chapel was a pleasant environment with a large multi-faith room, though it lacked washing facilities for prisoners or staff. The visits hall was used to accommodate additional prisoners for Friday prayers.

The chapel

4.43 The chaplaincy provided good pastoral care for prisoners, regularly visiting individuals on wings. A specialist bereavement counsellor also attended the prison weekly.

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.

4.44 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) 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

4.45 Commissioners held quarterly quality and performance meetings to monitor the contract and had recently undertaken a visit to test the quality of delivery. Regional partnership board meetings were in place where local issues could be escalated from regular quality assurance meetings and local delivery boards. All partners were sighted on risks associated with the service. However, there was a gap in reporting due to the lack of local medicines management meetings.

4.46 Datix (an incident reporting system) was used to record clinical incidents which were reviewed in a timely manner to identify lessons learned and mitigate against similar events reoccurring. Safeguarding reporting was in place, but more work was required to ensure that all incidents were reported.

4.47 A comprehensive clinical audit programme was in place, informing the service of areas for improvement. A recent audit had been undertaken of hospital escorts and in response a new Local Operating Procedure was being developed to support staff decision making on escorts for suspected fractures.

4.48 There was inadequate resource to facilitate external hospital escorts which created unnecessary risks (see paragraph 4.62). Although an audit had been undertaken on external escorts, more work needed to be done on the impact on outcomes for patients not taken out promptly and how to adequately resource this.

4.49 A confidential process for patients' complaints was in place. The queries option on the electronic kiosk allowed patients to resolve issues quickly and had reduced the number of complaints. The responses we sampled were mostly appropriate and within agreed timescales.

4.50 Staff we spoke to felt supported and we found supervision, appraisal, and mandatory training compliance to be reasonable. All services, except the dental team, used SystmOne (an electronic clinical record). Clinical notes we reviewed generally met professional standards.

4.51 Emergency resuscitation equipment was in good condition and daily equipment checks were completed. We were advised that an ambulance was promptly called in an emergency.

Promoting health and well-being

4.52 There was no prison-led health and well-being strategy to coordinate the activities of each department. Health promotion literature was limited and only available in English, which was a gap. Some material was available in the health care department but there was little or none on the wings.

4.53 Peer workers were available to support substance misuse services but there were no dedicated health champions. This was a missed opportunity to carry informed health promotion and information to other prisoners on the wings.

4.54 Health checks were routinely offered to patients and followed national programmes such as Abdominal Aortic Aneurism and bowel health screening. A weekly clinic offered immunisations and vaccinations including Hepatitis B and influenza. This was supported by drop-in clinics on the wings to improve uptake.

4.55 Sexual health screening was offered and there was a weekly clinic led by an enthusiastic nurse and health care assistant. Where appropriate, patients were referred to the hospital specialist sexual health clinic. Advertising of condoms and lubricants to patients at risk was very limited and condoms were not routinely offered when patients were being released, which was a missed opportunity.

4.56 There was an up-to-date and comprehensive disease outbreak control plan.

Primary care and inpatient services

4.57 The primary care team was skilled and highly motivated, offering a good range of services which included 24-hour response to urgent health problems. Health care applications were made via the kiosk and reviewed by nurses before being referred to the relevant clinic.

4.58 GP clinics were available Monday to Friday with a Saturday clinic for patients who had come through reception on Friday. However, GP capacity did not meet the need and the waiting time for a routine appointment was 20 days. Embargoed appointments were available in between for urgent reviews.

4.59 In the very busy reception, all new arrivals were seen for an initial health screen, offered blood borne virus testing and health needs, including long-term conditions, identified. Prompt referrals were made and, where appropriate, patients were seen and assessed by a GP based in reception. A second health screening was carried out, usually on the second day, and any who declined were followed up to encourage engagement and make sure health needs were identified.

4.60 Patients with long-term conditions were managed by the GP and received appropriate assessment and medication as there were no nurse led clinics. This model meant that patients did not receive ongoing health and well-being advice to assist their self-management.

4.61 A well-attended weekly multi-professional complex case meeting was in place where patients with more complex care needs could be managed. This improved consistency of care and provided integrated care.

4.62 The health administration team had effective oversight of external hospital appointments. There was insufficient escort capacity to meet the need. In any given month, up to a quarter of appointments had to be rearranged which meant that too many patients waited longer for their hospital appointments. We found evidence of unacceptable delays to unplanned hospital attendance at A&E which, in some cases, posed a significant risk to patient health.

4.63 A range of allied health professionals visited the prison, including a physiotherapist, optician, and podiatrist. Waiting times were reasonable.

4.64 The early release scheme had placed additional pressure on the team, with some patients being released with only 24 to 48 hours' notice. Patients were seen on the day of release, and provided with a GP summary, any hospital outpatient appointments and medication to take home. Ongoing health needs were discussed including the transfer of care to the community health team, if necessary.

Social care

4.65 The memorandum of understanding for the provision of social care between Sodexo, Salford City Council and Northern Care Alliance NHS Foundation Trust was in draft format. Spectrum Community Health (CIC) delivered care packages in cell for prisoners assessed as needing this level of support.

4.66 Governance and oversight of the service provision was not sufficiently robust across the partnership. However, partners were sighted on this, and a multi-agency meeting had been planned for early 2025.

4.67 Referrals to the local authority were prompt and there were no delays in providing care if the patients were within the thresholds. Health records outlined the daily care being delivered. Care plans in place did not adequately identify individual needs and how these were being met, and care plans were not sufficiently personalised.

4.68 There was limited availability of some equipment and aids with no equipment store on site. We found three prisoners were still awaiting the installation of grab rails from early November 2024. At the time of our inspection, one prisoner had been using urine bottles since October 2024, as the toilet raiser provided did not fit and no alternative had been sourced. Portable alarms for prisoners with restricted mobility or

impaired communication were not available for men to summon assistance in an emergency.

4.69 The prison is responsible for supporting prisoners with low-level care needs. However, some prisoners were receiving informal support from their peers. This meant that safeguards, such as appropriate selection, risk assessment, training or mechanism to provide support and supervision, were not in place.

Mental health

4.70 Greater Manchester Mental Health NHS Foundation (GMMH) provided an integrated primary and secondary mental health service, seven days a week. Governance arrangements within the team were well established. Patients received the appropriate level of care based on risk and clinical need. This approach was delivered by an extensive nursing and multi-disciplinary team, including nurses, psychology, psychiatrists, advanced practitioners, and a neurodevelopmental conditions team.

4.71 Any member of prison staff could submit a referral to the mental health team. Triage and assessments were completed within the required timeframe. All referrals were discussed at the well-attended weekly allocations meeting where patients were progressed via four pathway options: standard, neurodevelopmental, psychological, or enhanced care. Wait times for assessment and psychological interventions were not excessive.

4.72 GMMH also subcontracted additional services to extend their offer of group work sessions to improve well-being and promote recovery. This included a dedicated project with young people.

4.73 The team provided care to 167 prisoners and was ambitious to achieve positive outcomes for patients. Staff felt supported and spoke passionately about their roles. We observed effective joint working across health services and with partner agencies. Psychology worked closely with prison staff to support and manage some of the most complex men in the prison.

4.74 Care records were consistent and provided detailed narrative of care delivered. Care plans were generally clear, risk was identified, assessed and managed effectively. The mental health team aimed to attend all initial (ACCT) reviews and for patients on their caseload. A duty worker responded to acute concerns about prisoner welfare. Medical interventions, including anti-psychotic medicines, were available and we saw evidence of regular associated physical health checks for patients.

4.75 The service experienced delays for patients requiring specialist care and treatment under the Mental Health Act. At the time of the inspection, 14 prisoners were awaiting transfer to hospital. One prisoner had been waiting 121 days for a high-secure bed.

4.76 Discharge planning was effective. Staff contacted community mental health teams and GPs to support the transfer of care, although most patient stays were short due to a rapid turnover of prisoners coming into and leaving Forest Bank.

4.77 Prison staff received some basic training regarding mental health on induction and plans were in place to provide refresher training in the future.

Support and treatment for prisoners with addictions and those who misuse substances

4.78 A good substance misuse provision was provided via Spectrum for clinical care and CGL for psychosocial interventions. The service was described by leaders as integrated and joint working was evident, but this was not always the case. Both agencies had separate governance and management lines and each team had different ways to manage care and goal planning.

4.79 There was very high demand for opiate substitution and addictions with approximately 200 patients on the clinical caseload. Prescribing was initiated in reception following comprehensive assessments of history and withdrawal.

4.80 Prescribers ensured that prescriptions were safe. This meant that those arriving with unsafe combinations of medicines were placed on a reducing dose. This contributed to some dissatisfaction among prisoners. In our survey, 70% of respondents stated they experienced delays accessing all their medicines.

4.81 There were 13 drug workers who mostly focused on G and H wings (the integrated substance misuse wings). Almost all patients prescribed opiate substitution therapy were located on these wings which was good. In our survey, 51% of prisoners on these wings said it was easy to see a drug worker, 60% said the quality of the drug worker was good and 78% said they had received help to manage their addiction. However, 59% of respondents said it was easy to get hold of illicit substances on these wings and 71% said it was easy to get hold of medications not prescribed to them.

4.82 Referrals into the service were high with around 180 new assessments undertaken each month and a similar amount of release and discharge plans. These figures did not include the more complex assessments of interventions. Those found under the influence of illicit substances were all seen face-to-face by the drugs services, but most prisoners chose not to engage. G and H wings had suitable space for one-to-one and group work.

4.83 Six peer recovery workers were well embedded into the service. Two worked with inductions every week and the others were dispersed within other wings. Mutual aid was also available for those wishing to attend Alcoholics Anonymous on a Saturday morning.

4.84 Nasal naloxone (a drug used to reverse the effects of opiates and reduce the risk of death form overdose) was now mandated for prison staff and training had commenced in recent weeks.

4.85 An integrated substance-free living wing was available on H1 wing but had limited incentives. A relaunch of the wing was underway, but it was not a drug-free wing and there were no plans to change this. Voluntary urine testing was not in place and contradicted the purpose of the wing. Mandatory drug testing had been undertaken in the last month. This had produced a 50% positive rate for illicit drug use and suspicion testing had been higher.

Medicines optimisation and pharmacy services

4.86 An experienced team of pharmacists and pharmacy technicians provided a reduced pharmacy service. There were no pharmacist-led clinics, no local medicine management meetings and the team did not undertake any medicines reviews. The provision of a large number of prescriptions was impacting the team's capacity. Some input was given to local governance meetings but was not supported by any data or escalations by the medicines management meetings.

4.87 The pharmacy team worked well with the prison to resolve operational issues. For example, working with the gatehouse team to ensure medicine stock was delivered on time. Team members completed additional training to develop their knowledge and skills and received feedback on their performance.

4.88 Medicines reconciliation for new arrivals was prioritised and allocated on a rota. Patients who were receiving in-possession medicines had corresponding risk assessments. Most patients were responsible for ordering their in-possession prescriptions and requests were recorded. In-possession medicines were appropriately labelled but some were supplied in clear bags which could be seen by other patients.

4.89 The pharmacists liaised with health care colleagues to make sure patients prescribed complex medicines received the correct counselling and guidance. A translation service was available for non-English speakers to ensure patients understood their medicine prescriptions. Staff told us that officers were sometimes used to translate. This was not appropriate.

4.90 Team members managed the workload well and responded promptly to urgent requests for medication when patients were released or transferred.

4.91 Medicine administrations were mostly undertaken to a professional standard. This was led by the pharmacy technicians and recorded on clinical records. Medicines were administered twice a day for those requiring supervision and those prisoners collecting weekly and monthly were called at alternative times due to the sheer quantity of visits. However, due to the vast number of medicines being administered and the lack of hatches, staff administered side-by-side

within the main prison. This created risk and compromised confidentiality. Supervision of medicines queues was not particularly effective. Those prisoners that did not attend for critical medication were followed up appropriately. Over 200 controlled drugs were administered each day. This was done well but the numbers of prisoners and prescriptions, and the lack of hatches, were compromising the prison regime.

4.92 Emergency medicines were available, but records of the medicines used did not include patient details. Patient safety incidents were recorded and team members took action to reduce the risk of errors re-occurring.

4.93 Medicines were stored securely and patients had lockable facilities in their cells. Frequent checks were undertaken to ensure medicines were safe to supply. Patients' confidential waste and medicine waste were suitably managed.

Dental services and oral health

4.94 Dental services were available four days each week. The dentist and a dental nurse each provided two sessions. The electronic application system did not include an option to request a dental appointment and 78% of prisoners we surveyed told us it was difficult to see a dentist. However, for those patients who used the paper application system, the average wait for an appointment was four weeks. This was good.

4.95 The dental team worked flexibly with the prison to maximise the use of clinical time. Urgent need was prioritised and a full range of NHS-equivalent dental treatment was delivered. Health promotion was undertaken at the time of appointments and leaflets were available in health care.

4.96 Dental records remained paper-based but plans were in place to move to electronic records early in 2025. Records included patient treatment plans and provided a clear summary of the options discussed with each patient.

4.97 The dental suite and decontamination room was clean, and all equipment had been properly maintained and tested appropriately. Governance systems were good, with regular audits carried out. Staff received appropriate training and supervision.

4.98 Staff we spoke with were passionate about providing good quality patient care and improving the oral health of patients.

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 recreational and social activities which support their well-being and promote effective rehabilitation.

5.1 Time out of cell had improved since our last inspection. The daily routine now offered unemployed prisoners 4.5 hours out of their cells on weekdays for meals, association, domestic tasks and outdoor exercise. Prisoners on the 'basic' incentive level had their association curtailed and would only receive 3.5 hours unlocked.

5.2 In our survey, 33% of prisoners said that they spent less than two hours out of their cells Monday to Friday and 39% on Saturday and Sunday, which was significantly better than in similar prisons (56% and 63%).

5.3 Time out of cell was reasonably good for those involved in purposeful activity. Part-time workers typically received around eight hours out of their cells on weekdays. The small number of full-time workers on F1 wing received 10 hours including their evening association time.

5.4 Prisoners were offered an hour of daily exercise, which was positive, although exercise yards were bare.

Exercise yard

5.5 Too many prisoners were not engaged in purposeful activity. Around 44% of the population were not working or in education and there were few enrichment activities available to occupy their time. This affected groups such as retired prisoners, and some of the younger prisoners who couldn't go to work because they were at risk from other prisoners.

5.6 We found 44% of prisoners locked up during the working day, and only 30% involved in some form of purposeful activity.

5.7 Wings had some recreational equipment available during association periods, such as pool tables and table football, and a few wings had some exercise equipment. Prisoners could eat together at mealtimes, which was very positive (see paragraph 4.17).

Prisoners associating at mealtime on A1

5.8 The regime was reasonably reliable, although wings holding vulnerable prisoners had activities curtailed more frequently than others.

5.9 The library was a welcoming and organised space, managed by a single librarian supported by two prisoner orderlies. A varied selection of texts was available, including easy-read, self-help books, newspapers and a good legal reference library, but the number of books was limited given the large population. There were too few texts in foreign languages available to meet the needs of foreign nationals.

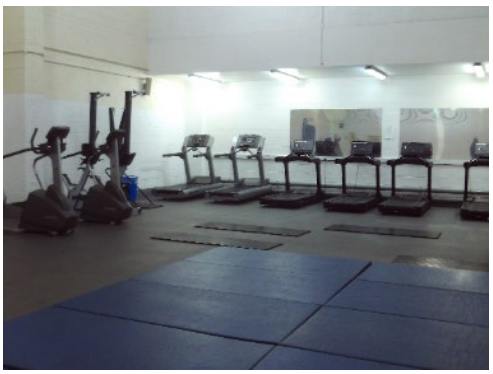
5.10 Since the last inspection, the library had reopened and now provided prisoners on each wing the opportunity to access it weekly. Those men in education had additional opportunities to attend and two evening sessions were also available to vulnerable prisoners. Capacity at wing sessions was limited to 15 prisoners.

The library

5.11 The library received around 1,200 visitors each month. However, the proportion of prisoners using the facility was not recorded or monitored to inform the development of the service. This was a gap.

5.12 The library offered few other activities, although there were books available on wings, in workshops and in the gym which were tailored to the interests of those attending. This was positive.

5.13 The gym was a large, well-equipped space with capacity for 75 prisoners at a time. There was a small AstroTurf pitch and a small gym in the workshop where courses could be completed. The pitch was used for courses run by Street Soccer Academy, a charity providing support for people with issues related to homelessness, offending behaviour, substance misuse, long-term unemployment and health issues. However, there was little other use of the pitch.

The gym

5.14 The gym offered a good weekly timetable that included evening and weekend sessions. Most prisoners could access two sessions a week, with additional sessions available for workers, health care referrals, physiotherapy and those completing programmes. It was also positive that quieter gym sessions were available for prisoners who are neurodivergent. Around 40% of prisoners were active users of the gym.

5.15 Eight physical education instructors staffed the gym. While they offered a reasonably reliable service, we saw evidence of occasional curtailments due to staff redeployments, particularly at weekends.

5.16 At the time of the inspection, gym staff were not providing prisoners with any qualifications, though plans were in place to introduce level 1 and 2 courses. Two accredited courses were being run by the Street Soccer Academy.

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 areas of concern, 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.

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

Overall effectiveness: Requires improvement

Quality of education: Requires improvement

Behaviour and attitudes: Good

Personal development: Requires improvement

Leadership and management: Requires improvement

5.18 Leaders had not ensured that all prisoners were engaged in purposeful activities. Since the previous inspection, leaders had increased the number of spaces in education, work and skills to encompass all convicted prisoners and more. The pay policy was fair and appropriate and did not disincentivise education. However, almost half of all prisoners remained unemployed, and there were not enough places to provide a purposeful activity for all prisoners. Our survey identified that 59% of prisoners were not encouraged to attend education, skills and work (ESW) activities by wing officers, and 61% stated that they did not think that education training or work would help them on release. Therefore, many prisoners lacked the motivation to leave their residential units.

5.19 Since the previous inspection, leaders had broadened their curriculums to strengthen their ability to help prisoners learn the necessary skills needed for employment on release. They had considered useful information about prisoners' intended geographical destinations. Through this activity, leaders had identified the need for basic construction skills in Greater Manchester and introduced a groundwork construction curriculum to help prisoners acquire the skills needed for employment.

5.20 Leaders had established successful links with employers to increase prisoners’ sustained employment opportunities. Employers visited construction workshops frequently to discuss employment opportunities for prisoners. Course instructors provided prisoners with beneficial support for up to six months after release. Because of these endeavours, around half of the prisoners who went into employment remained employed.

5.21 Since the last inspection, leaders had improved the process for prisoners approaching resettlement. They had ensured that most prisoners had been fully supported 12 weeks before their release. Prisoners had met with an effective resettlement board, an assurance board and attended events in the employment hub. The employment hub had assisted prisoners in producing their curriculum vitae, applying for jobs, setting up bank accounts, purchasing identification such as birth certificates or driving licences and practising interviews. Prisoners received practical support to help them reach their career goals and

become self-employed when released. A few had achieved this and were now self-employed and excited about their future.

5.22 Leaders did not ensure that vulnerable prisoners had access to an appropriate variety of education and skills sessions that would help prepare them for their next steps. Since the last inspection, leaders had improved the education and training provision for vulnerable prisoners. However, these curriculums were restricted to outreach English and mathematics and an evening school. The curriculums accessible were not equitable with those available to the main population, leaving vulnerable prisoners disadvantaged.

5.23 Leaders had not addressed the recommendation from the previous inspection to implement an effective induction process that met the needs and challenges of the prison population. Recently, the prison had been recategorised from resettlement to a reception prison. This change had increased the turnover of prisoners who resided within the establishment for a short time. Because of this, leaders had struggled to maintain an effective process that could keep up with the demands of a reception prison, leaving many prisoners without being inducted into ESW. This delay caused prisoners to lose their motivation to attend purposeful activities.

5.24 Leaders had improved the careers education and initial advice and guidance (CEIAG) for prisoners. Following the induction into ESW, prisoners attended a helpful CEIAG session. Tutors used this session to identify the starting points for English and mathematics and recognise the neurodiversity or special educational needs and disabilities of many prisoners. Tutors worked with prisoners successfully to identify their career aims. They used the Virtual Campus to store prisoners' personal development plans, providing all staff with an appropriate overview. However, the targets set by tutors were often too broad. Therefore, many prisoners discussed generic targets and did not understand the unique skills that they needed to develop to be successful.

5.25 Leaders had implemented an effective allocation process that had given prisoners swift access to ESW. The allocations team had used the information gathered during the CEIAG session well to allocate prisoners to the appropriate ESW activity.

5.26 Leaders had not ensured that prisoners working on residential units were engaged effectively in their jobs. Wing cleaners were appropriately trained and held accredited qualifications. However, many prisoners working on wings were disengaged from their work and spent their time relaxing and socialising with other prisoners. This approach did not help prisoners to prepare for work on release.

5.27 Sodexo provided the education and training within the prison. In education and most workshops, instructors had logically planned and ordered the curriculum. This enabled prisoners to develop the knowledge and skills needed to work successfully. Prisoners in horticulture had understood tasks such as dead hedge building,

flagging, and how to aerate and scarify lawns to promote growth. However, this did not consistently happen across all workshops. In the food hygiene workshop, activities lacked sufficient challenge. They were repetitive and did not support prisoners to develop the skills needed on release.

5.28 Most teachers in education used effective teaching practices to support learning. They used questioning techniques skilfully to check prisoners' understanding and effective ice-breaker activities at the start of each lesson to get prisoners in the right frame of mind for learning. They used various assessment techniques to determine prisoners' progress from their starting points. Teachers helped prisoners who had struggled with examinations with the opportunity to follow a themed workbook that resulted in accreditation. Prisoners across most subjects recalled their learning readily and retained it in their long-term memories.

5.29 Teachers had created interesting learning activities to prepare prisoners for examinations and support prisoners in their rehabilitation processes. In English, prisoners had spoken eloquently on unfamiliar topics, which led to respectful, relevant discussions and the sharing of differing views. In healthy living lessons, teachers had asked thought-provoking questions to encourage prisoners to think and reflect deeply. They had talked articulately about problems that could affect families such as crime, death and divorce.

5.30 Leaders had introduced appropriate accredited qualifications to support prisoners in achieving their next steps. Prisoners had achieved various qualifications in subjects such as English and mathematics, cleaning and biohazard cleaning, football coaching, construction multi-skills, and a construction skills certification scheme card, which provided beneficial education and skills for prisoners. Leaders monitored prisoners' progress closely and ensured that they took appropriate assessments as soon as possible to secure achievement before being transferred or released. All prisoners who finished their qualifications passed.

5.31 Most peer mentors in education and workshops supported prisoners effectively. Many peer mentors knew their peers very well and knew when and how to support them. However, a few peer mentors had not yet achieved an appropriate qualification and on a few occasions, they had needed to be directed by the teacher to realise that a prisoner needed help.

5.32 Leaders had implemented a successful reading strategy that supported prisoners across the prison to develop their reading skills. They ensured that prisoners had access to appropriate reading resources to promote the development of their reading skills. Many prisoners read for pleasure, especially non-fiction and historical novels. Staff were knowledgeable about how to support prisoners in developing their reading skills. They used the Shannon Trust programme to help prepare prisoners for classroom learning effectively. They developed prisoners' interest in reading through various initiatives such as reading clubs, one-to-one sessions, everybody reading in class, and club drop

and read aimed at unemployed prisoners. Prisoners could access books and newspapers from the library, including those for early readers, fiction and non-fiction and books for dyslexic readers. Teachers in education had incorporated the development of prisoners' reading skills successfully into their English and mathematics curriculums.

5.33 Leaders had provided several ways in which prisoners could access screening to identify those who are neurodivergent. The small neurodiversity team triaged support needs and implemented the most appropriate help when referrals were made. However, too many vulnerable prisoners had not undertaken the screening test to identify if they were neurodivergent or received the support they needed following the screening. This meant that they had struggled to engage fully in prison life or ESW activities.

5.34 Prisoners' attendance at ESW was high. Most teachers had created a calm learning environment where prisoners could engage honestly and enthusiastically in discussions. Prisoners shared some deeply personal experiences, which had been received respectfully and empathetically. They displayed positive attitudes and were enthusiastic about their learning. Prisoners in workshops had worked as a team to carry out tasks in a positive environment. Prisoners felt safe in ESW and had not reported any incidents of bullying or harassment.

5.35 Most prisoners in ESW had developed their understanding of fundamental British values through their learning and work activities. They had learned about various cultural topics, such as black history and cultural festivals and had participated in Indian and British cultural projects. Many prisoners knew how fundamental British values applied to general life and why they applied to them in prison. However, too few prisoners, including vulnerable prisoners, were able to recall any learning about extremism and radicalisation that would help them to keep safe from this kind of cohesion.

5.36 Since the last inspection, leaders had implemented a robust quality assurance calendar that had identified key activities that needed to be performed monthly. They implemented various quality assurance activities to ensure that prisoners' education had improved. Leaders used these activities to understand their strengths and areas of development and, when needed, put in place appropriate measures to meet almost all of the concerns from the last inspection.

Section 6 Preparation for release

Preparation for release is understood as a core function of the prison. 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 understands the importance of family ties to resettlement and reducing the risk of reoffending. The prison promotes and 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 visits provision had improved significantly since the last inspection. Social visits were available six days a week, including weekends and two weekday evenings. Prisoners on remand could receive up to three visits a week, while others could have one.

6.2 The visits hall was spacious and bright, and included pods for video calling and for quieter visits for families with additional needs. A tea bar sold snacks and drinks. Families could also buy a token to take a family photo in the photo booth, which was a positive initiative.

Visits hall and photo booth in visits hall

6.3 Visitors we spoke to said that they had been treated with respect. However, many noted that published guidance for visitors, such as about forms of identification they were required to bring and the dress code, was out of date and they had experienced difficulties on arrival.

6.4 The enthusiastic families team hosted four family days a year, as well as sessions aimed at very young children, baby bonding sessions and family sports days. They also ran group work sessions with prisoners, including parenting skills, positive thinking and providing guidance

about what to expect on release. Fifteen families were receiving intensive support from a dedicated family case worker.

Families room in visits

6.5 There was no separate visits session for vulnerable prisoners. Some vulnerable prisoners told us they did not feel comfortable or safe attending visits. Staff acknowledged that sometimes vulnerable prisoners were verbally abused by other prisoners while waiting in the holding room. Vulnerable prisoners were also excluded from family days and some other events, and there were no dedicated events for this group.

Reducing reoffending

Expected outcomes: Prisoners are helped to change behaviours that contribute to offending. Staff help prisoners to demonstrate their progress.

6.6 Forest Bank held a diverse and complex population of remand, unsentenced and sentenced prisoners, including prisoners recalled to custody and those serving life and indeterminate sentences. The prison managed a large turnover of prisoners with the proportion of prisoners on remand or unsentenced having increased from 45% to 56% since the last inspection, with a further 17% recalled back to custody.

6.7 The prison aimed to transfer prisoners promptly once they had been sentenced to a more suitable prison to begin the rehabilitation phase of their sentence. However, due to unprecedented population pressures and delays in the local courts, men remained on remand for lengthy periods of time. One prisoner had been on remand for 19 months, and many others for up to a year.

6.8 There had been improvements in the overall management of reducing reoffending work. Leaders had conducted a needs analysis, using a range of data and information across resettlement pathways relevant to preparation for release, and had a better understanding of the varied needs of their population. However, they were unable to demonstrate how this analysis was being used to shape and monitor the strategy for the different cohorts they managed.

6.9 Meetings to coordinate and drive reducing reoffending work were held on alternate months, with relatively good attendance from all partners. While not all pathways were covered at every meeting, the quality of discussion around outcomes for prisoners was good.

6.10 Protracted staffing shortages in the offender management unit, combined with a high turnover of prisoners in and out of Forest Bank, meant that caseloads for POMs were high, and the team had been under pressure.

6.11 However, at the time of the inspection, most vacancies had been filled. The recent appointment of senior probation officers had created some stability and leadership within the OMU team who now worked collaboratively and supported each other well. The new leaders were proactive in their efforts to address some of the challenges faced by the team during a difficult period but there was still some way to go.

6.12 Remand prisoners now made up 29% of the population and many of these men stayed at the prison for lengthy periods, often up to a year. Despite this, they remained a largely marginalized group, despite some small improvements since the last inspection. Remand prisoners now had access to some resettlement services (see paragraph 6.31), and they could participate in Changing Thinking and Ending Violence, which was a local intervention (see paragraph 6.28). However, extended remand time caused considerable anxiety and frustration among prisoners, many of whom were keen to progress or be released. Very few were being helped to navigate their time in custody; they had no access to a keyworker or POM, and they were not being encouraged by staff to engage in education and work; many languished in their cells with no purpose. The attitude of many staff and managers was that as remand prisoners cannot legally be required to work, they wouldn't try to force them. There had been no ambition on the part of leaders to challenge and address this to give these men a more purposeful experience while on remand.

6.13 Around a quarter of the population had been sentenced. The core function of assessing and planning for newly sentenced prisoners was achieved. OASys (offender assessment system) assessments were generally well-considered with adequate focus and analysis of risk which was underpinned by good quality assurance by managers. However, most were not completed in reasonable time or in line with HMPPS guidelines. In our sample of cases, some prisoners had still not been assessed after three months of being sentenced. In a small number of cases prisoners were waiting over six months. Ensuring

timely assessments was essential for addressing prisoners' concerns, promoting progress, and maintaining trust in the system.

6.14 The level of face-to-face contact between POMs and prisoners was not regular and did not always take place in a timely manner – a source of frustration for POMs themselves. Contact was led by urgent priority needs which meant contact to support progression was insufficient for many.

6.15 This was further compounded by a lack of good quality key work which failed to support offender management. Records confirmed that most prisoners had not received regular key work and some had not received any key work. For those who did, the interaction was focused more on well-being than behaviour or work to progress while in custody. In the small number of instances where targets had been set and practical support offered, there was a noticeable lack of follow-up.

6.16 Responsiveness to written applications by prisoners was good which mitigated to a small extent the lack of face-to-face contact and key work sessions.

6.17 The sentence plans that we reviewed demonstrated appropriate and realistic objectives, encompassing work around prisoner's criminal offences and other offending behaviour that had not led to a conviction. Personal development goals were set, such as enhancing employability skills. Objectives set by community offender managers (COMs) were often community-oriented and not relevant enough for the custodial part of the sentence.

6.18 Although most prisoners knew the targets in their plans, they were not always provided with a hard copy and were unaware that they could request it. This represented a missed opportunity to foster greater awareness and engagement with objectives, ultimately supporting prisoners' progress and rehabilitation.

6.19 The prison held 29 prisoners serving life or indeterminate sentences. Most of these prisoners had been recalled to prison following a breach of their licence conditions and were waiting for parole board input before they could move from Forest Bank. There was not enough support or one-to-one work to help these prisoners to understand and address the circumstances that had led to their return to custody. Lifer and indeterminate consultative forums no longer took place, although the new senior probation officers had started the process of maintaining some oversight of these prisoners.

6.20 The categorisation decisions we reviewed were appropriate, but prisoners were not involved in the process or routinely aware of when reviews were taking place. The reasons for decisions lacked clear analysis to justify the conclusions and therefore were not always clear to prisoners. Many prisoners waited too long to move to a more suitable establishment and there was no clear system to ensure prisoners were being transferred in priority order.

6.21 As a result, many sentenced prisoners expressed frustration about the lack of opportunity to progress in their sentence. They were unable to complete most offending behaviour programmes and were unable to demonstrate a reduction in risk. This included prisoners who were eligible for parole but had not completed the offending behaviour work required for approval to be released or recategorised.

6.22 There was good oversight of home detention curfew processes. Some prisoners were not released on time, although reasons for this were often outside of the prison's control, such as delays with community checks and a lack of supportive housing.

Public protection

Expected outcomes: Prisoners' risk of serious harm to others is managed effectively. Prisoners are helped to reduce high risk of harm behaviours.

6.23 Public protection arrangements were reasonably good. The call monitoring team, supported by the wider public protection function continued to provide a robust service.

6.24 The call monitoring team was made up of staff dedicated to this role who were skilled and experienced in identifying risky behaviour. They listened to a high volume of calls every day. At the time of the inspection, they monitored the daily communications of 29 prisoners. This number was lower than usual; the team usually monitored around double the number of prisoners/communications. Most was for prisoners posing a risk to children, but the team also conducted ad-hoc monitoring for prisoners who were subject to court orders such as non-molestation or restraining orders. Calls were listened to in a timely manner and there was little backlog. There were monthly reviews to determine whether continued monitoring was necessary. Appropriate action was taken when concerns were identified. Communications in foreign languages were translated, which is something we do not always see.

6.25 About 30% of the sentenced population were assessed as presenting a high or very high risk of serious harm to others and most were subject to MAPPA (multi-agency public protection arrangements, see Glossary) because of the nature of their offence.

6.26 The interdepartmental risk management meeting took place monthly and there was good discussion about most prisoners nearing their release date. While there was good attendance from POMs, there was insufficient attendance from other departments. The meeting did not routinely consider all high-risk prisoners approaching release. This hindered timely and collaborative oversight of these prisoners' risk and arrangements for release. However, we were assured that due to the good communication between POMs, COMs and agencies involved in MAPPA releases, risk was being managed sufficiently well.

6.27 Risk management plans completed in the prison demonstrated careful consideration of and a holistic approach to identifying and managing risks. Oversight of these high-quality plans was effective. Plans completed in the community were detailed, but focused solely on risks in the community, overlooking the custodial element of the sentence.

Interventions and support

Expected outcomes: Prisoners are able to access support and interventions designed to reduce reoffending and promote effective resettlement.

6.28 The programmes team continued to deliver two accredited programmes with good completion rates against their planned targets. Only sentenced prisoners were eligible for the Thinking Skills Programme. Changing Thinking and Ending Violence was a local intervention for men involved in violence and was now fully embedded. This course was available for both sentenced and remand prisoners.

6.29 Despite high numbers, there were no programmes to meet the treatment needs of prisoners convicted of sexual offences or those with a domestic violence offence.

6.30 Attempts to transfer prisoners to prisons offering a fuller range of programmes were often hindered by delays, including a lack of transportation and a reluctance on the part of other prisons to accept prisoners who vulnerable due to their offence.

6.31 A newly formed resettlement hub was an excellent initiative to better support prisoners before release. A wide range of services was available in the hub, making them easier for men to access. A pre-release team completed basic screening for all sentenced prisoners and gave remanded prisoners a self-assessment questionnaire. Any gaps identified led to referrals to partner agencies, all based within the hub, for advocacy, intervention or advice. Early indications are that the resettlement hub is having a positive effect on outcomes for prisoners, though it is currently too early to see full results.

Resettlement hub

6.32 Accommodation support was provided by Ingeus, a company commissioned to provide rehabilitative services in partnership with probation. Four dedicated advisors in the resettlement hub worked with all prisoners offering tenancy support, advice on rent arrears or council tax debt. They held workshops on entitlements from local authorities and made referrals for supported accommodation on prisoners' behalf.

6.33 There was a good provision to help prisoners with their finance, benefits and debt needs. Prisoners could apply to open bank accounts and were supported to obtain personal identification such as birth certificates.

6.34 Resettlement boards had restarted in recent months, but some work was required to make these more effective. Not all boards were held at least 12 weeks prior to release, which was often necessary to facilitate good planning.

Returning to the community

Expected outcomes: Prisoners' specific reintegration needs are met through good multi-agency working to maximise the likelihood of successful resettlement on release.

6.35 The average number of prisoners released each month had nearly doubled since the last inspection and the need for continued resettlement support remained high.

6.36 It was very concerning that in the last year around 500 prisoners had been released homeless. A further 412 men were released to accommodation that was not sustainable after three months.

6.37 Practical support for prisoners leaving the prison was reasonably good. Appropriate clothing was provided if needed from a well-stocked supply of donated items. Officers diligently reviewed licence conditions with prisoners, paying particular attention to the younger prisoners illustrating conditions with real-life examples. Respectful exchanges were maintained throughout the process.

6.38 It was commendable that officers arranged for taxis (funded by the prison) to transport individuals who were vulnerable due to mental health or mobility issues to probation appointments or release addresses.

Section 7 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.

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2022, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

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.
Partially achieved

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.
Not achieved

Leaders should take robust and sustainable action to reduce the availability of illicit items, including acting on all intelligence received.
Not achieved

Recommendations

Governance should make sure that the use of force is always necessary, proportionate and justified.
Not achieved

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

There should be enough Listeners for the population and prisoners should be able to access them 24 hours a day.
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2022, we found that outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

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.
Not achieved

The inpatient unit should deliver a clinically led, purposeful and therapeutic environment.
No longer relevant

Recommendations

The health care application system should be confidential and effective.
Achieved

The transfer of patients to hospital under the Mental Health Act should occur within Department of Health guidance timescales.
Not achieved

Purposeful activity

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

At the last inspection, in 2022, we found that outcomes for prisoners were poor against this healthy prison test.

Key recommendations

Prisoners should have more time out of cell to access purposeful activity including work, education, the gym and library.
Achieved

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.
Achieved

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.
Achieved

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.
Achieved

Recommendations

Prisoners should receive an appropriate induction to purposeful activities and timely careers advice and guidance throughout their time at the prison.
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 2022, we found that outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

Prisoners, especially those on remand or unsentenced, should be able to have more visiting sessions, and video calling should be used more extensively.
Achieved

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.
Not achieved

Appendix I About our inspections and reports

HM 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, 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 to benefit them.

Preparation for release
Preparation for release is understood as a core function of the prison. 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.

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 HM 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 identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for prisoners. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which should be attended to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list 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 outlines the priority and key concerns from the inspection and our judgements 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 6, 2023) (available on our website at Expectations – HM Inspectorate

of Prisons (justiceinspectorates.gov.uk)). Section 7 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 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:

Charlie Taylor	Chief inspector
Deborah Butler	Team leader
Ian Dickens	Inspector
Lindsay Jones	Inspector
David Owens	Inspector
Nadia Syed	Inspector
Dionne Walker	Inspector
Rick Wright	Inspector
Tareek Deacon	Researcher
Helen Downham	Researcher
Adeoluwa Okufuwa	Researcher
Sam Rasor	Researcher
Joe Simmonds	Researcher
Tania Osborne	Lead health and social care inspector
Sarah Goodwin	Health and social care inspector
Helen Jackson	Pharmacist
Joe White	Care Quality Commission inspector
Bev Ramsell	Lead Ofsted inspector
Kim Bleasdale	Ofsted inspector
Joanne Stork	Ofsted inspector
Suzanne Wainwright	Ofsted inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find.

ACCT
Assessment, care in custody and teamwork – case management for prisoners at risk of suicide or self-harm.

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.

Family days
Many prisons, in addition to normal visits, arrange ‘family days’ throughout the year. These are usually open to all prisoners who have small children, grandchildren, or other young relatives.

His Majesty’s Prison and Probation Service (HMPPS)
Carries out sentences given by the courts, in custody and the community, and rehabilitates people in its care through education and employment. HMPPS is an executive agency, sponsored by the Ministry of Justice.

Incentives scheme
Provides privileges as a tool for incentivising prisoners to abide by the rules and engage in the regime and rehabilitation. Privileges can be taken away from those who behave poorly or refuse to engage.

Incentivised substance-free living (ISFL)
Prison wings providing a dedicated, supportive environment for prisoners who want to live drug-free in prison.

Independent Monitoring Board (IMB)
Volunteers operating in every prison in England and Wales, and every immigration detention facility across the UK. They report on whether detainees are being treated fairly and humanely and given the support they need to turn their lives around.

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.

MAPPA
Multi-Agency Public Protection Arrangements: the set of arrangements through which the police, probation and prison services work together with other agencies to manage the risks posed by violent, sexual and terrorism offenders living in the community, to protect the public.

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

Prisons and Probation Ombudsman (PPO)
Independent organisation investigating deaths in custody, and complaints from people who are in custody or under community supervision.

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).

Secure video calls
A system commissioned by HM Prison and Probation Service (HMPPS) that requires users to download an app to their phone or computer. Before a call can be booked, users must upload valid ID.

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:

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.

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

This publication is available for download at: Our reports – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)

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