

Report on an independent review of progress at

HMP Manchester

by HM Chief Inspector of Prisons

3–5 June 2019

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Glossary of terms

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

About this report

- A1 Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.
- A2 All visits carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.
- A3 Independent reviews of progress (IRPs) are a new type of visit designed to improve accountability to ministers about the progress prisons make towards achieving HM Inspectorate of Prisons' recommendations in between inspections. IRPs will take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny, and will focus on a limited number of the recommendations made at the inspection. IRPs will therefore not result in assessments against our healthy prison tests.¹
- A4 The aims of IRPs are to:
- assess progress against selected key recommendations
 - support improvement
 - identify any emerging difficulties or lack of progress at an early stage
 - assess the sufficiency of the leadership and management response to our main concerns at the full inspection.
- A5 This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each recommendation we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in June and July 2018, for further detail on the original findings.²

IRP methodology

- A6 IRPs will be announced at least three months in advance and will take place eight to 12 months after the full inspection. When we announce an IRP, we will identify which recommendations we intend to follow up (usually no more than 15). Depending on the recommendations to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

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

² Available at: <https://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2018/11/Manchester-Web-2018.pdf>

- A7 During our three-day visit, we will collect a range of evidence about the progress in implementing each selected recommendation. Sources of evidence will include observation, discussions with prisoners, staff and relevant third parties, documentation and data.
- A8 Each recommendation followed up by HMI Prisons during an IRP will be given one of four progress judgements:
- **No meaningful progress**
Managers had not yet formulated, resourced or begun to implement a realistic improvement plan for this recommendation.
 - **Insufficient progress**
Managers had begun to implement a realistic improvement strategy for this recommendation but the actions taken had not yet resulted in any discernible evidence of progress (for example, better systems and processes) or improved outcomes for prisoners.
 - **Reasonable progress**
Managers were implementing a realistic improvement strategy for this recommendation and there was evidence of progress (for example, better systems and processes) and/or early evidence of some improving outcomes for prisoners.
 - **Good progress**
Managers had implemented a realistic improvement strategy for this recommendation and had delivered a clear improvement in outcomes for prisoners.
- A9 When Ofsted attends an IRP its methodology will replicate the monitoring visits³ conducted in further education and skills provision. Each theme followed up by Ofsted will be given one of three progress judgements.
- **Insufficient progress**
Progress has been either slow or insubstantial or both, and the demonstrable impact on learners has been negligible.
 - **Reasonable progress**
Action taken by the provider is already having a beneficial impact on learners and improvements are sustainable and are based on the provider's thorough quality assurance procedures.
 - **Significant progress**
Progress has been rapid and is already having considerable beneficial impact on learners.

3 Ofsted's approach to undertaking monitoring visits and the inspection methodology involved are set out in the *Further education and skills inspection handbook* at paragraphs 25 to 27. Available at: <https://www.gov.uk/government/publications/further-education-and-skills-inspection-handbook>

Key findings

- S1 At this IRP visit, we followed up 12 recommendations from our most recent inspection and Ofsted followed up three themes.
- S2 HMI Prisons judged that there was reasonable progress in four recommendations, insufficient progress in three recommendations and no meaningful progress in five recommendations. A summary of the judgements is as follows.

Figure 1: Progress on HMI Prisons recommendations from 2018 inspection (n=12)⁴

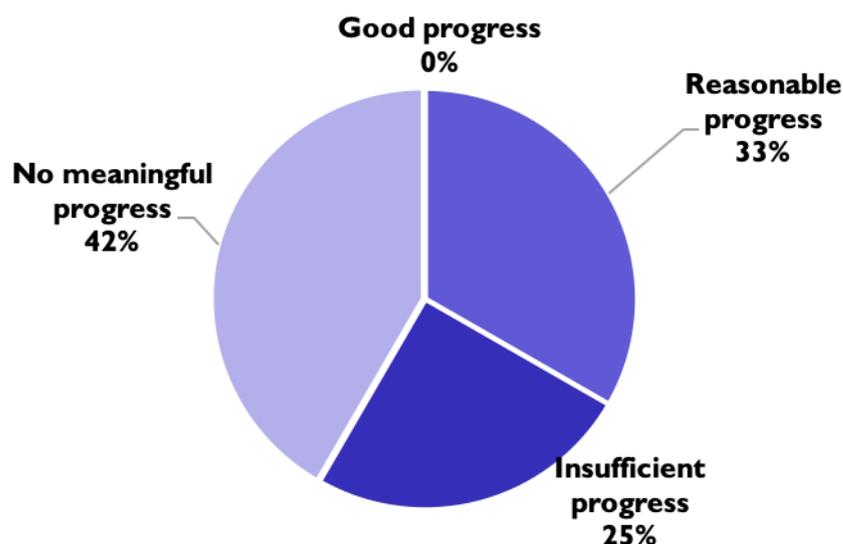


Figure 2: Judgements against HMI Prisons recommendations from 2018 inspection

Recommendation	Judgement
A clear strategy, based on a full assessment of violence at the prison, including causative factors such as poor living conditions, staff attitudes and illicit drug use, should be implemented to help reduce levels of violence and ensure that prisoners are kept safe. (S37)	Reasonable progress
The reintegration unit should provide a full regime each day for every prisoner or safeguards appropriate to a segregation unit should be introduced. (I.23)	Reasonable progress
Use of force data and trends analysis should be used to devise clear measurable actions to reduce the number of incidents of force. (I.30)	No meaningful progress
Use of force incidents, all forms of video recorded evidence and staff statements should be subject to regular quality assurance and rigorous scrutiny. (I.31)	No meaningful progress
The regime for segregated prisoners should be improved and include purposeful activities to prevent psychological deterioration. (I.37, repeated recommendation I.69)	Insufficient progress
A prison-wide drug strategy based on an analysis of the specific issues in the prison should be implemented and monitored by a multidisciplinary team at regular meetings to help reduce the availability and use of illicit	Reasonable progress

⁴ This pie chart excludes any recommendations that were followed up as part of a theme within Ofsted's concurrent prison monitoring visit.

drugs in the prison. (I.48)	
Action plans developed following death in custody investigations should be reviewed periodically to ensure that changes in practice and lessons learned are sustained over time. (I.55)	No meaningful progress
There should be a consistent case management approach to ACCTs to ensure seamless support and to improve the quality of ACCT procedures. (I.56)	Insufficient progress
All prisoners should have a single named member of staff assigned to them who supports and encourages them to achieve their objectives. Peer worker schemes should be adopted on wings to provide prisoners with an additional avenue of support. (S38)	Insufficient progress
A comprehensive approach should be taken to improving living conditions and to ensuring that all areas are kept clean, rubbish is collected promptly and cells are maintained. (S39)	Reasonable progress
Equality and diversity work should be given greater priority across the prison. There should be regular consultation with prisoners with protected characteristics to understand and meet their specific needs. The role and contribution of equality peer workers should be promoted and extended. All staff should be trained to ensure that they can identify and address inequality and discrimination. (S40)	No meaningful progress
All prisoners should be out of their cells for 10 hours and be occupied in purposeful activity during the core day, with the option of at least one hour in the open air. Retired prisoners and those unable or not required to work should not be locked up all day. (S41)	No meaningful progress

S3 Ofsted judged that there was reasonable progress in one theme and insufficient progress in two themes.

Figure 3: Judgements against Ofsted themes⁵ from 2018 inspection

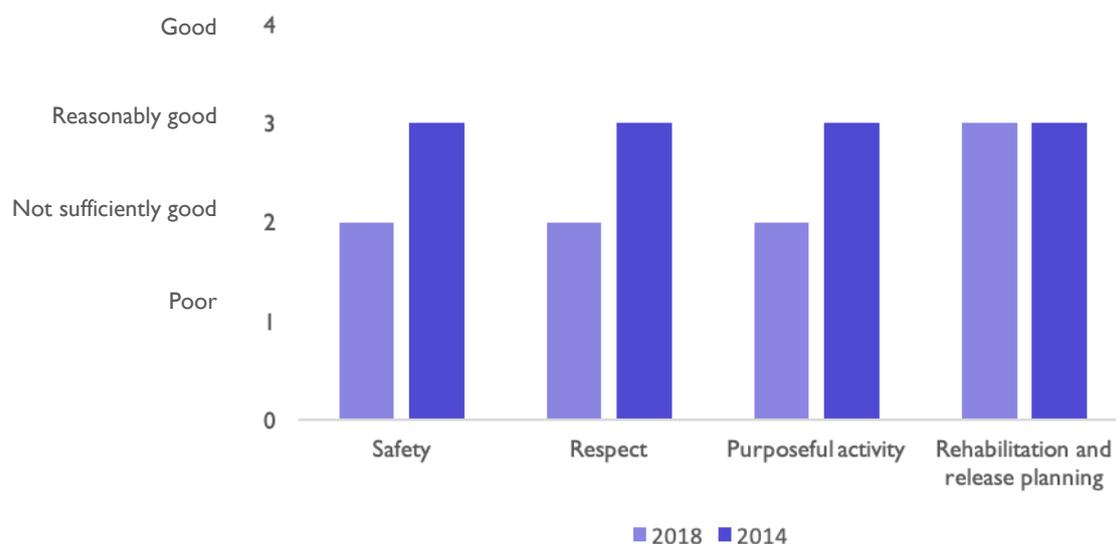
Ofsted theme	Judgement
What progress have leaders and managers made with their strategies to maximise the use of the available activity spaces, improving attendance and ensuring that the range of provision meets the needs of all groups of prisoners, and strengthening the links with employers that support prisoners' resettlement?	Insufficient progress
What progress have leaders and managers made in improving the quality of teaching, learning and assessment through monitoring and ensuring that tutors set up challenging targets for learners, provide high quality learning resources, and support prisoners to develop their English and mathematics skills?	Reasonable progress
What progress have leaders and managers made in ensuring that learners progress well in lessons, complete their courses successfully, and in improving the way instructors encourage prisoners to recognise and record the employment skills they develop so that they are well prepared for education, employment, or training on release?	Insufficient progress

⁵ Ofsted's themes incorporate the key concerns at the previous inspection in respect of education, skills and work.

Section 1. Chief Inspector's summary

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

Figure 4: HMP Manchester healthy prison outcomes 2014 and 2018.



- 1.2** HMP Manchester is a core local prison serving courts in one of the country's major cities. With a capacity to hold up to 1072 adult men, 912 were held at the time of this review. In addition to its primary function, the prison held 33 category A or provisional category A prisoners, which was about 3% of the population. These prisoners, who required the highest levels of physical and procedural security, were concentrated in a small unit on one part of a residential wing.
- 1.3** We last conducted a full inspection of HMP Manchester in July 2018, when our assessments indicated deterioration in all of our healthy prison tests, except for rehabilitation and release planning. Outcomes were not sufficiently good in each healthy prison area, apart from rehabilitation and release planning where outcomes were reasonably good.
- 1.4** At that inspection we concluded that levels of violence had increased significantly since the previous inspection in 2014. The prison had failed to consider the influence that poor living conditions, the attitude of staff and illicit drug use had on the high levels of violence at the prison. There had been eight self-inflicted deaths between our 2014 and 2018 inspections, three of which had occurred in the six months preceding our inspection in July. Self-harm had also increased. Environmental standards around the prison were deficient, which encouraged a serious vermin problem. A small but influential number of wing staff were disengaged and there was little constructive engagement with prisoners. Little was done to promote equality. Too many prisoners, some 40%, were locked up during the working day, even though there was sufficient activity for all. Ofsted judged all aspects of the learning, skills and work provision as 'requires improvement'.

- 1.5** For these reasons, and due to my lack of confidence that managers were sufficiently focused on attending to the basics, I made the decision to return to Manchester just 11 months later to conduct this independent review of progress.
- 1.6** On this visit, we followed up 12 recommendations. We found reasonable progress had been made in four recommendations, insufficient progress made in three and no meaningful progress made in five. Working in partnership with us, Ofsted undertook a monitoring visit, following up three themes in education, skills and work provision. Ofsted found reasonable progress in one theme and insufficient progress in the remaining two.
- 1.7** The prison had recently revised the safety strategy and there was an appropriate structure in place to progress and deliver the related actions through a safety committee. Assaults on prisoners had reduced significantly since the full inspection, and we judged there to have been reasonable progress in this area. If the establishment is to reduce violence further, particularly against staff, the lengthy list of actions aimed at reducing violence should be prioritised and time bound.
- 1.8** The use of force remained high. Despite this, there had been no meaningful progress against this recommendation; governance had not improved, staff rarely used their body-worn cameras, with no adequate explanation for this, and too few recorded incidents were scrutinised to provide assurance and institutional learning.
- 1.9** The prison had decommissioned the reintegration unit and, to this extent, progress had been made. This might have contributed to the notable increase in the number of prisoners segregated. The introduction of dedicated psychology support on the segregation unit had led to some positive outcomes but the regime, although improved, remained very basic. We also questioned the strength of governance for prisoners who required multiple staff to unlock them, as these arrangements limited their access to the regime and opportunity to progress.
- 1.10** Reasonable progress had been made in efforts to reduce the supply of drugs, and mandatory testing results showed that drug use was relatively low compared with other local prisons. The drug strategy now identified the important links between relationships, environment, and drug use. Unfortunately, the meeting in place to drive the strategy did not explore these issues in sufficient depth or have all the key stakeholders in attendance.
- 1.11** Promising work to support prisoners in crisis had started so recently that progress at the time of the visit had to be judged as insufficient. This was very concerning given that there had been three further self-inflicted deaths since the full inspection in July 2018. It was bewildering to find that actions to prevent deaths in custody simply had not been reviewed until shortly before our visit. Similarly, the introduction of key work and wing peer support had been so slow that we could not yet see sufficient progress in this area.
- 1.12** The prison had made concerted efforts to tackle the ongoing vermin problem, and some improvements had been made to living conditions. However, there had been no meaningful progress in the important areas of equality and diversity or time out of cell.
- 1.13** There was evidence of reasonable progress in the quality of teaching, learning and assessment. However, Ofsted concluded that insufficient progress had been made in the other thematic areas they reviewed; attendance at work and education was not prioritised and too much activity was curtailed. Too few prisoners completed their courses and achievements were not sufficiently good.
- 1.14** HMP Manchester was relatively well resourced and had fewer inexperienced staff than we have found at similar prisons. It was therefore hard to understand why progress had been so slow in many critical areas. Such progress as there had been had only started in the

weeks and months immediately leading up to this review visit. The response to the 2018 inspection can only be described as too late and too weak. It is true that there were some encouraging outcomes, and most functional heads demonstrated enthusiasm and a commitment to improving their areas. However, at the time of this visit, we found there had been little or no meaningful progress against two-thirds of our recommendations. Without a fundamental shift in attitude towards the findings of HM Inspectorate of Prisons, we had no confidence that there could be significant improvements in the future. At the full inspection we had been told that reconfiguration to a category B training prison was imminent. On this visit, some 11 months later, we were told that the target date had been moved to October 2019. It is my considered view that unless the culture of the prison changes, and the need for improvement is taken seriously, it will not be ready for this change.

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

June 2019

Section 2. Progress against the key concerns and recommendations and Ofsted themes

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

Managing behaviour

Concern: The violence reduction policy had not been reviewed and did not reflect the rise in violence at the prison. We were not confident that the prison focused enough on the impact that poor living conditions, staff attitudes and illicit drug use had on making violence more probable. There was little in place to reward positive behaviour.

Recommendation: A clear strategy, based on a full assessment of violence at the prison, including causative factors such as poor living conditions, staff attitudes and illicit drug use, should be implemented to help reduce levels of violence and ensure that prisoners are kept safe. (S37)

- 2.1 Since our full inspection in July 2018, there had been a notable reduction of almost 50% in prisoner-on-prisoner assaults. Assaults on staff, however, had increased marginally and around 28% were recorded as serious.
- 2.2 The prison had reviewed the safety strategy but only very recently, in March 2019. The updated strategy was based on the HMPPS prison safety framework incorporating five specific elements; people, population, physical environment, partnerships and procedural issues. This approach had enabled managers to identify causative factors of violence, such as living conditions and staff attitudes. The strategy included a lengthy list of strategic objectives with some detail on how improvements would be achieved. However, these were not sufficiently prioritised to target resources or time bound to enable managers to measure progress.
- 2.3 The safer custody team carried out investigations into violence reasonably promptly. The prison continued to use the 'challenge support and intervention plan' (CSIP)⁶ case management process to manage a small number of prisoners who presented the most serious risk of violence and to support some who had been the victims of violence. Nearly 400 CSIP referrals had been made during the previous six months but around a quarter of these had not been processed, and there was a need for more robust quality assurance.
- 2.4 The weekly safety intervention meeting continued to be a useful multidisciplinary forum to discuss a range of prisoners involved in acts of violence. This was now supported by a regular stability meeting that enabled the safer custody team to develop closer working relationships with residential managers. Attendance at the monthly safer custody meetings was poor, and there was little detailed analysis of data to help managers understand safety issues and identify short-term measurable actions to reduce violence.

⁶ CSIP is a national case management model for those who are violent or pose a raised risk of harming others through violence. Prisoners identified as the perpetrator of serious or repeated violence are managed and supported by a plan with individual targets and regular reviews.

2.5 The prison's incentives policy had been reviewed recently but there had been no change to the management and operation of the scheme. In May 2019, the month before the review visit, a group of prisoners were consulted on how the prison could incentivise good behaviour. However, because it was so recent none of the suggestions had been progressed further.

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

Concern: HI had been designated as a specialised reintegration unit for the most complex prisoners. We were concerned that the unit was another form of segregation without appropriate safeguards.

Recommendation: The reintegration unit should provide a full regime each day for every prisoner or safeguards appropriate to a segregation unit should be introduced (1.23)

2.7 The prison had decommissioned the reintegration unit, which had not been operating effectively at the time of our inspection, and to this extent progress had been made.

2.8 Following a survey of prisoners aged over 50 in late 2018, the prison had identified HI landing, the former reintegration unit, as a suitable area to accommodate a small cohort of older prisoners, some of who had identified social care needs. A specialist social care nurse continued to work with the safer custody team to identify prisoners who would benefit from being located on HI.

2.9 There was a positive unit ethos and prisoners spoke positively about the small group of staff who were allocated to work there. While prisoners could attend some activities outside the unit, including an over 50's gym session, regime curtailments meant that these vulnerable prisoners still spent prolonged periods locked in cell. More could be done to develop the role of the unit.

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

Use of force

Concern: Despite increases in the use of force, scrutiny had not kept pace with the increase and there was no regular quality assurance.

Recommendation: Use of force data and trends analysis should be used to devise clear measurable actions to reduce the number of incidents of force. (1.30)

2.11 There had been a small increase in the number of incidents of force since the last full inspection and yet the prison had no clear understanding of why use of force remained high.

2.12 Following the 2018 inspection, the monthly use of force meetings, chaired by the deputy governor, had lapsed. There had been only one meeting in October 2018 and then none until April 2019.

2.13 The safer custody team produced a limited range of data, which provided some useful indicators for the use of force committee. However, managers at the meeting did not use the data to analyse patterns or identify effective actions to reduce incidents of force.

2.14 The use of special accommodation had increased notably since our full inspection, with 37 recorded uses in the previous six months. This increase had not been identified at

committee meetings. Documentation that we reviewed was inconsistent and did not provide assurance that special accommodation was used proportionately. For example, the observation log for one prisoner held in special accommodation described him as acting passively and engaging with staff. Yet a manager had authorised continued use of special accommodation, citing continued violence by the prisoner as justification.

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

Concern: There was insufficient use of body-worn video cameras and use of force lacked effective governance.

Recommendation: Use of force incidents, all forms of video recorded evidence and staff statements should be subject to regular quality assurance and rigorous scrutiny. (1.31)

- 2.16** There was no evidence of an improvement in effective quality assurance since our full inspection. The prison provided data recording 282 incidents of force in the previous six months. However, only five were reviewed and discussed at the two use of force meetings held during that time. This level of scrutiny was insufficient to provide assurance that all uses of force were legitimate, necessary and proportionate.
- 2.17** The prison did not routinely review available video footage alongside staff statements as part of the assurance process. Where concerns were identified there was a failure to take appropriate action. For example, although the April 2019 meeting identified that an officer had been acting aggressively before a prisoner was restrained, there was no follow-up action to address this or to inform future learning.
- 2.18** Use of force documentation, including 80 staff statements, remained incomplete or missing and very few reports were completed within 72 hours of an incident, as required by HMPPS.
- 2.19** We observed more staff wearing body-worn video cameras than at the full inspection but there was still a reluctance to activate them during an incident. This reduced the opportunity to gather valuable evidence and to aid de-escalation. During our visit we observed a prisoner being restrained. The incident was not handled well by one officer in particular, and yet the supervisor did not remove the officer or instruct staff to activate their body-worn cameras.
- 2.20** We considered that the prison had made no meaningful progress against this recommendation.

Segregation

Concern: The regime for long-stay prisoners in the segregation unit was very poor. They were allowed 30 minutes for exercise every day but, only permitted showers and access to the telephone three times a week. Prisoners spent nearly all day locked in their cells with nothing meaningful to do and there was still little in place to mitigate the detrimental effects of prolonged segregation.

Recommendation: The regime for segregated prisoners should be improved and include purposeful activities to prevent psychological deterioration. (1.37, repeated recommendation 1.69)

- 2.21** Since our previous inspection, when we found that the use of segregation had increased, the use of segregation had increased once again, despite the decommissioning of the reintegration unit (see paragraph 2.7), and was now higher than at other local prisons.
- 2.22** There had been a modest improvement in the daily routine, and prisoners subject to standard unlock procedures were now offered access to exercise, a telephone call and a shower every day, except Wednesday. Apart from this, there remained little purposeful activity for prisoners, who remained locked in their cells for over 23 hours a day. We found no recent examples of prisoners attending an activity off the unit, such as the gym or an offending behaviour programme. The in-cell education provision was poor, with only two-and-a-half hours a week allocated for the whole segregation unit, E wing and the specialist intervention unit.
- 2.23** The introduction of dedicated psychology support for case management, including one-to-one interventions for some segregated prisoners, was positive. In some cases this had led to the successful reintegration of prisoners. The ‘know your prisoner’ plans produced by the psychology team identified triggers and provided useful information to help improve relationships and aid progression. However, the guides were not always used effectively, for example, when reviewing how many officers were required to unlock a prisoner.
- 2.24** Record keeping on staff unlock levels was poor, with no recorded justification for changing levels, and no evidence of actions to test whether it was safe to reduce them. Several prisoners remained on multiple officer unlock arrangements for many days, which affected their opportunity to engage in a regime and progress from the unit.
- 2.25** We considered that the prison had made insufficient progress against this recommendation.

Security

Concern: There was no whole-prison approach to link and address issues of supply, demand and treatment to limit the use of new psychoactive substances (NPS),⁷ and there was no evidence that the prison had made the link between living conditions and relationships, and drugs and violence. There were no multidisciplinary forums to coordinate measures to limit illicit drug use.

Recommendation: A prison-wide drug strategy based on an analysis of the specific issues in the prison should be implemented and monitored by a multidisciplinary team at regular meetings to help reduce the availability and use of illicit drugs in the prison.
(1.48)

- 2.26** The average mandatory drug testing (MDT) rate was around 15%, which was lower than the average at other local prisons.
- 2.27** The prison had appointed a senior manager with sole responsibility for the drug strategy. A drug and alcohol strategy had been produced and updated in May, the month before our review. Although not clearly structured around the approach outlined in the HMPPS prison drug strategy, the document was comprehensive and highlighted some major factors linked to the supply and demand of drugs. For example, the strategy acknowledged the need to offer a decent regime, including education and employment.
- 2.28** A monthly multidisciplinary drug and alcohol strategy meeting had been established in 2019. This included security and intelligence updates. However, attendance by managers from the

⁷ NPS are drugs that are developed or chosen to mimic the effects of illegal drugs such as cannabis, heroin or amphetamines and may have unpredictable and life-threatening effects.

residential or activities functions were poor, which limited the meeting's effectiveness to provide prison-wide solutions to the drug problem. Actions from the meeting focused on supply reduction and were not clearly aligned to the objectives set out in the strategy. As a result, the meeting did not explore or seek to address causative factors leading to drug taking, such as poor living conditions, time out of cell and the lack of opportunity to engage in purposeful activities.

- 2.29 Delphi Medical continued to deliver substance misuse services, and managed the recovery peer mentor scheme. These prisoners had been trained to offer support to peers with dependency issues. They were well directed and supervised.
- 2.30 A drug and alcohol awareness training package for staff had been developed, and was due to be delivered. There were plans for peer mentors to deliver awareness sessions to staff and attend the drug and alcohol strategy meeting.
- 2.31 We considered that the prison had made reasonable progress against this recommendation.

Suicide and self-harm prevention

Concern: Recommendations relating to previous deaths in custody had not been regularly reviewed.

Recommendation: Action plans developed following death in custody investigations should be reviewed periodically to ensure that changes in practice and lessons learned are sustained over time. (1.55)

- 2.32 In the period between our two previous inspections (November 2012 and July 2018) there had been eight self-inflicted deaths. Since July 2018 there had been a further three self-inflicted deaths, and a fourth was awaiting classification. The investigations into these deaths indicated that recommendations from previous death in custody investigations had not been effectively implemented.
- 2.33 Although the prison had produced a spreadsheet contained all the recommendations made following death in custody investigations since 2017, and despite a standing agenda item for the safer custody meeting to review these, no systematic reviews had taken place. A review began a week before our visit and continued while we were in the prison.
- 2.34 We considered that the prison had made no meaningful progress against this recommendation.

Concern: The care offered to prisoners at risk of self-harm was not consistent and there were deficiencies in the management of ACCT (assessment, care in custody and teamwork)⁸ processes.

Recommendation: There should be a consistent case management approach to ACCTs to ensure seamless support and to improve the quality of ACCT procedures. (1.56)

- 2.35 In February 2019, safer custody managers concluded that previous efforts to improve the case management of prisoners on ACCTs through quality assurance of documents had been ineffective. An innovative approach, using two experienced senior officers to run all ACCT reviews in partnership with wing senior officers, began in late April 2019. This pilot aimed to improve care for prisoners and provide coaching for residential senior managers to improve

⁸ Case management for prisoners at risk of suicide or self-harm.

their skill and confidence in ACCT case management. These arrangements were promising but too recent to indicate reasonable progress.

- 2.36** The quality of current ACCT documents was reasonable, consistency of case management had improved and records of contact showed some good interactions. Safer custody staff made good entries on the prison's electronic case note system to ensure effective communication of the key events and decisions. However, some care map actions were progressed too slowly, which prolonged prisoners' distress, and we could not be confident that outcomes were improving. Prisoners' views about the care they received were mixed, but some were very positive.
- 2.37** The volume of self-harm over the previous six months remained broadly similar to our previous inspection and comparable to other local prisons. However, fewer than half of directly-employed staff had received the new HMPPS suicide and self-harm training.
- 2.38** We considered that the prison had made insufficient progress against this recommendation.

Staff-prisoner relationships

Concern: The lack of both a formal scheme to support prisoners and formal peer support schemes on the wings, and the presence of a small group of influential staff who were disengaged and showed little respect for prisoners, left many prisoners feeling unsupported and frustrated. Slow progress in establishing a rehabilitative culture further compounded the issue.

Recommendation: All prisoners should have a single named member of staff assigned to them who supports and encourages them to achieve their objectives. Peer worker schemes should be adopted on wings to provide prisoners with an additional avenue of support. (S38)

- 2.39** The keyworker scheme (in which prisoners are allocated an officer who should meet with them weekly) had been implemented slowly from October 2018. Most staff were now trained and most prisoners had an allocated keyworker. However, for many prisoners this allocation was recent and they had not yet had an initial meeting with their keyworker. Some staff were very dismissive of the keyworker scheme and told us that its main benefit was additional staff on the landing; others were more supportive.
- 2.40** In our review of keyworker records, we saw a few examples where keyworkers were helping prisoners achieve their goals and leading useful discussions. However, most records were short and did not yet evidence meaningful engagement. Data on the proportion of planned sessions delivered was incomplete and not yet reliable. Figures indicated that performance was improving but that targets were not yet met consistently.
- 2.41** We observed generally courteous, fairly formal interactions between prisoners and staff but there was very little relaxed engagement. Many prisoners complained to us about staff and were frustrated about the difficulties in resolving day-to-day problems. During association and movement periods, staff usually stood together in groups, observing passively rather than taking the opportunity to engage with prisoners. We also identified a punitive attitude across some aspects of prison life. For example, despite daily association periods, prisoners were only allowed to play pool at the weekends, and some prisoners' visitors (including partners) had received indefinite visiting bans.
- 2.42** Although peer workers were used well in other areas of the prison we found only two on residential units, who supported induction on A and I wings. Managers intended to use them to run prisoner information desks, but this had not yet begun.

- 2.43** Work to develop a ‘rehabilitative culture’⁹ had been reinvigorated. Each wing now had both prisoner and staff rehabilitative champions, but their impact to date was limited, and most prisoners struggled to define what was meant by a rehabilitative culture.
- 2.44** We considered that the prison had made insufficient progress against this recommendation.

Living conditions

Concern: Living conditions on the wings were far from adequate for many. Rubbish was left too long before collection and too much food was stored in window grilles and thrown out of windows, leading to a serious vermin problem.

Recommendation: A comprehensive approach should be taken to improving living conditions and to ensuring that all areas are kept clean, rubbish is collected promptly and cells are maintained. (S39)

- 2.45** Living conditions remained inadequate for most prisoners. Many cells lacked curtains and adequate furniture. Prisoners did not have privacy keys and there were no lockable cabinets in cells. The toilet in some shared cells was not sufficiently private, and some cells did not have telephones. Managers told us that 25 cells were out of action because of outstanding repairs. We found several occupied cells with broken window panes, including two (which we considered unfit for use) where five out of six window panes were missing. In the previous two months the prison had been using two officers as handymen to supplement the facilities management contract.
- 2.46** In other areas there had been improvements. A painting programme had enhanced the appearance of many cells and landings, although some prisoners reported recent problems getting paint. Communal areas on wings were cleaner than previously, but there was still room for improvement, particularly around staircases, bars and gates. Some showers had been refurbished and were now good but most were in very poor condition and were insufficiently private. Managers told us that the funding for shower refurbishment was not sufficient for the whole prison.
- 2.47** Managers had invested in pest control to tackle vermin, reduced litter in the grounds and ensured more regular waste collections from the wings. Better arrangements for the disposal of food waste had been designed, but these were not always observed; we found uncovered food waste left overnight on some wings. Although staff and prisoners told us that they regularly saw mice, we did not find evidence of infestation.
- 2.48** We considered that the prison had made reasonable progress against this recommendation.

Equality, diversity and faith

Concern: Attendance at the regular strategic equalities meeting was poor. Data was not analysed thoroughly enough to identify disadvantage or underrepresentation in significant prisoner groups. There was no regular consultation with prisoners with protected characteristics, and not enough was done to meet their specific needs. The role of equality representatives was not promoted sufficiently

⁹ In which all aspects of the prison setting support rehabilitation and contribute to it being safe, decent, hopeful and supportive of change, progression and help to the prisoner to desist from crime.

to ensure that prisoners knew about the support they could provide. There was no staff training in equality and diversity.

Recommendation: Equality and diversity work should be given greater priority across the prison. There should be regular consultation with prisoners with protected characteristics to understand and meet their specific needs. The role and contribution of equality peer workers should be promoted and extended. All staff should be trained to ensure that they can identify and address inequality and discrimination. (S40)

- 2.49** We did not find any evidence that the prison had acted to address this recommendation in 2018. In early 2019, responsibility for equality and diversity work was given to the senior manager also responsible for safety. A dedicated equality officer and foreign national coordinator were allocated to support this work.
- 2.50** The prison had not produced an equality strategy setting out what it needed to achieve to support equality and diversity work. An older person strategy had been produced in June 2019, the time of our review visit. There were no other plans setting out how the establishment would meet the needs of prisoners with protected characteristics.
- 2.51** The equality action team (EAT) had only met once in 2019, and included only rudimentary monitoring of ethnicity data, which did not lead to any action recorded in the minutes. The equality action plan was poor and lacked target dates or names of those responsible for completing actions. The minutes of the EAT in February indicated that it was not driving the action plan to make much needed improvements. An equality training package for staff had not yet been delivered.
- 2.52** Prisoner consultation forums had recently been reintroduced for a small number of protected characteristic groups but in some cases attendance was minimal (two prisoners attended the LGBT forum). There was no specific provision for black, Asian and minority ethnic prisoners. A planned under-25 forum had been cancelled. There had been few meaningful actions arising from the limited consultation that had taken place, and it was difficult to see how outcomes for prisoners with protected characteristics would be improved.
- 2.53** The prison had identified several equality peer workers, and posters on wings promoted them. However, they did not have a role description and had not received any additional support or training. There was no quality assurance of their work.
- 2.54** We considered that the prison had made no meaningful progress against this recommendation.

Time out of cell

Concern: Almost 40% of prisoners were locked in their cells during the core day. Retired prisoners and those unable to work were also locked up during the core day. Exercise periods in the open air were restricted to 30 minutes per day.

Recommendation: All prisoners should be out of their cells for 10 hours and be occupied in purposeful activity during the core day, with the option of at least one hour in the open air. Retired prisoners and those unable or not required to work should not be locked up all day. (S41)

- 2.55** The core day allowed up to nine hours a day out of cell for full-time workers, but far less for part-time workers and unemployed prisoners.

- 2.56** Despite the availability of sufficient full- and part-time activity, attendance was still poor. Work and education were not prioritised by management and sessions were regularly cancelled, leaving many prisoners locked up for long periods. A spot check on one wing during the inspection found 49% of prisoners locked in their cells during the morning. Prison data suggested that this was not unusual.
- 2.57** The core day allowed for up to 30 minutes of exercise in the open air each day, although the timings prohibited access for full-time workers, except for Friday and the weekend. On some wings, exercise was split to offer 15 minutes in the morning and 15 minutes in the afternoon. Few prisoners were recorded as having taken exercise every day, and many said that sessions were often cancelled or curtailed.
- 2.58** Time out of cell for retired prisoners on H1 (see paragraph 2.8) had recently improved but was inconsistent. Those located on other wings remained locked up for most of the day.
- 2.59** We considered that the prison had made no meaningful progress against this recommendation.

Education, skills and work¹⁰

Theme 1: What progress have leaders and managers made with their strategies to maximise the use of the available activity spaces, improving attendance and ensuring that the range of provision meets the needs of all groups of prisoners, and strengthening the links with employers that support prisoners' resettlement?

Insufficient progress

- 2.60** At the full inspection the prison's leaders had failed to ensure that all available activity places were allocated and, where activities were allocated effectively, too many prisoners failed to attend their sessions regularly. The range of provision was too limited for some groups of prisoners, such as long termers. Links with employers were insufficient to enable prisoners to be better prepared and to consider their resettlement options on release.
- 2.61** At the monitoring visit we found that almost all prisoners had an allocated activity. However, leaders and managers had not ensured that prisoners had sufficient opportunity to attend their allocated education, vocational training or work (see paragraph 2.56).
- 2.62** Attendance at education and prison workshops, particularly in the English and mathematics provision, was too low. Many prisoners attended health care, had visits planned or remained locked in their cells when they should have been attending their classes or work areas.
- 2.63** Despite the completion of an educational and skills needs analysis, the provision for vulnerable prisoners, high security prisoners and those in the segregation unit had not improved since the previous inspection and remained too limited. The education outreach provision for prisoners was too restricted to meet their needs.
- 2.64** Leaders had proposed a learner employment strategy to work more closely with employers to provide education, training and employment opportunities for prisoners on their release. At the time of the monitoring visit the strategy had not been put into practice or evaluated to determine any impact. Prisoners did not receive sufficient pre-release support or

¹⁰ Ofsted's thematic approach reflects the monitoring visit methodology used for further education and skills providers. The themes set out the main areas for improvement in the last inspection report.

preparation. Too many prisoners were released from the prison without any assistance to help them gain employment or access further training.

Theme 2: What progress have leaders and managers made in improving the quality of teaching, learning and assessment through monitoring and ensuring that tutors set up challenging targets for learners, provide high quality learning resources, and support prisoners to develop their English and mathematics skills?

Reasonable progress

- 2.65** At the 2018 inspection, prison and education managers had not implemented effective mechanisms to evaluate effectively the quality of teaching, learning and assessment, and the skills and work provision at the prison. The resources to support learning were not at the expected standard or used effectively, particularly those to help prisoners improve their English and mathematics skills.
- 2.66** During the monitoring visit we found that the very recent appointment of a new education provider had had a positive impact in a short period in improving the quality of teaching, learning and assessment. Education managers had swiftly introduced quality processes and procedures, which tutors welcomed and embraced. Consequently, they were improving their skills in the setting of personal and academic targets for prisoners and providing more effective developmental feedback, which enabled prisoners to improve the standard of their work and make better progress.
- 2.67** Resources to promote learning were much improved since the previous inspection and used effectively to benefit prisoners to improve their English and mathematics skills. For example, prisoners could use their improved mathematics skills in art lessons to scale down 3D images, and in functional skills mathematics lessons prisoners used dictionaries effectively to determine the meaning of a polygon. However, managers had made no progress in ensuring prisoners improved their English and mathematics skills in vocational training or prison workshops, despite the introduction of a comprehensive strategy.
- 2.68** Prison and education managers had worked effectively together to form a realistic understanding of the quality of teaching, learning and assessment, identifying where improvements were required. Managers had accurately evaluated the quality of the provision. The introduction of a ‘teacher quality management plan’ had an effective focus on helping tutors improve their craft of teaching, but had yet to be fully embedded or implemented for all tutors.

Theme 3: What progress have leaders and managers made in ensuring that learners progress well in lessons, complete their courses successfully, and in improving the way instructors encourage prisoners to recognise and record the employment skills they develop so that they are well prepared for education, employment, or training on release?

Insufficient progress

- 2.69** At the full inspection education managers and tutors had not ensured that prisoners progressed and achieved well. Workshop instructors failed to encourage prisoners to recognise the skills they gained and accurately record them so they could be considered when seeking training or employment on release.
- 2.70** At the time of the monitoring visit, senior leaders and managers had not been successful in ensuring historical data and qualitative information from the previous education provider had been used to evaluate the proportion of prisoners completing their qualifications. They did not have an accurate understanding of how successful prisoners were at achieving their

qualifications. Anecdotal evidence suggested that a high proportion of prisoners achieved their education and vocational qualifications. Achievement rates in English and mathematics were also high. However, a small minority of prisoners did not complete their qualification outcomes and withdrew from their courses.

- 2.71** The tracking and recognition of the employability skills, including English and mathematics, developed by prisoners in the industrial workshops remained a weakness. Too often prisoners were unable to access their allocated work areas and, when they did so, instructors were reticent in ensuring the employability skills that many prisoners gained were recognised and recorded.
- 2.72** Managers had introduced several pilot schemes into the workshops but had not evaluated their effectiveness in enabling them to record the skills and behaviours gained. There was no provision to prepare prisoners for employment, training or education on their release.

Section 3. Appendix

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