Report on an unannounced short follow-up inspection of

HMP Garth

3–5 April 2012

by HM Chief Inspector of Prisons

Printed and published by:
Her Majesty's Inspectorate of Prisons
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Introduction

Garth is a category B training prison holding long-term life-sentenced prisoners, determinate sentenced prisoners serving four years and over and prisoners on indeterminate sentences for public protection who have committed serious and violent offences. This unannounced short follow-up inspection acknowledges the work done with some very challenging prisoners, but flags up the need for some improvements. There was sufficient progress across all of our healthy prison tests, except in resettlement.

Garth remained a fundamentally safe prison overall and consultation with prisoners about violence reduction had improved. D1 unit, however, held a difficult mix of prisoners, including some with mental health problems alongside those needing protection from debts or gang affiliation. It had moved away from its previous focus on rehabilitation and its current purpose was unclear. More needed to be done to ensure that prisoners were suitably and safely managed. Investigations into serious self-harm incidents were good and few prisoners were subject to suicide and self-harm monitoring (ACCT) procedures. Listeners (Samaritan-trained peer supporters) were well supported.

A range of suitable tactics were used to reduce the supply of drugs and illicit alcohol, but strip-searching automatically included squat-searches, the grounds for which were not always appropriate. Planned use of force needed to be better monitored for quality and training purposes.

The pre-entry regime applied to prisoners in segregation who refused to relocate after a time in segregation was punitive and provided an unacceptably restricted regime. This needed review to ensure a more proportionate and appropriate response that would more effectively help to reintegrate those involved.

Personal officers and offender supervisors knew what was expected of them and there was some good personal officer work.

Improvements were needed to the diversity policy, but it was good to see that positive efforts had been made to address the needs of older prisoners and those with disabilities. Consultation arrangements were developing with prisoners in most minority groups, but arrangements needed to be introduced for black and minority ethnic prisoners, and work with foreign national men needed attention. Health care provision was generally good.

Most workshops offered qualifications but learning progression was limited and some work was menial. Part-time education provided greater choice and prisoner participation rates had increased. Prisoners were positive about the gym but there was still no outdoor facility.

Offender management work was well embedded but prisoners' onward progression, although something outside the prison's control, continued to be delayed by the pressures of the general prison population and a lack of spaces across the wider estate. Public protection work remained good and there had been improvements to work on some of the resettlement pathways. Services in support of the children and families resettlement pathway, however, needed to improve.

Sufficient progress has been made in all healthy prison areas at Garth, with the exception of resettlement, which is let down by the lack of progress on any recommendations made under the children and families pathway. We are aware of plans to address some of the shortfalls but

it is disappointing that the prison has not acted more proactively to improve these services.

Nick Hardwick June 2012
HM Chief Inspector of Prisons

Fact page

Task of the establishment
Garth is a category B training prison, holding long-term life-sentenced prisoners, prisoners on indeterminate sentences for public protection and determinate sentenced prisoners serving four years and over.

Prison status
Public

Region
North West

Number held
Prison roll as at 2 April 2012: 841

Certified normal accommodation
811

Operational capacity
846

Date of last full inspection
30 March–3 April 2009

Brief history
Garth was opened in 1988. An additional wing (E Wing) holding 120 prisoners was built in 1997, housing a therapeutic community run in conjunction with Phoenix Futures. F and G wings, holding a further 180 prisoners, opened in August 2007, and the regime was expanded to provide both education and vocational training facilities.

Short description of residential units
A, B C and D wings are all built to the same design. Each has three landings. Landings 1 and 2 each have three spurs and landing 3 has two spurs. Each of these wings can accommodate up to 133 prisoners. These older wings have five single cells certified as suitable to accommodate two prisoners. D1 is the reintegration unit.

E wing provides accommodation on two landings with space for a total of 118 prisoners: 44 in the therapeutic community and 74 in the voluntary drug testing unit. F and G wings have a total of 180 places. F3 is used as the first night and induction unit; however this is in the process of relocating to A wing. Ten single cells on F wing and five on G wing have been certified as suitable for two prisoners.

Name of governor
Terry Williams

Escort contractor
GeoAmey

Health service commissioner and provider
Lancashire Care Foundation Trust

Learning and skills providers
The Manchester College

IMB chair
Bill Pickering

Section 1: Summary

Introduction

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

1.2 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.

1.3 The purpose of this inspection was to follow up the recommendations made in our last full inspection of HMP Garth in 2009 and assess the progress achieved. All full inspection reports include a summary of outcomes for prisoners against the model of a healthy prison. The four criteria of a healthy prison are:

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

1.4 Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected and giving an overall assessment against the following definitions:

Making insufficient progress
Overall progress against our recommendations has been slow or negligible and/or there is little evidence of improvements in outcomes for prisoners.

Making sufficient progress
Overall there is evidence that efforts have been made to respond to our recommendations in a way that is having a discernible positive impact on outcomes for prisoners.

Safety

1.5 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 41 recommendations in this area, of which 18 had been

achieved, 10 partially achieved and 12 had not been achieved. One recommendation was no longer applicable. We have made a further two recommendations.

1.6 Some prisoners continued to experience unnecessary stops at other establishments when they were being transferred to the prison. Although reception was closed at lunchtimes, there were arrangements to ensure that prisoners arriving unexpectedly at this time were not kept waiting in the van.

1.7 There was still no reception strategy, and the first night strategy did not cover the protection of vulnerable prisoners. Cell-sharing risk assessments were carried out in reception before prisoners were moved to the first night centre. Foreign national prisoners said that they did not receive any information in their own language when they arrived. The induction programme had been suitably reduced to one week and prisoners completed all stages of the programme.

1.8 Consultation with prisoners about the violence reduction strategy had improved. Investigations of unexplained injuries were regularly monitored by the safer Garth meeting. Staff frequently used procedures to report a wider range of antisocial behaviour but outcomes of investigations required improved monitoring. The CAB register recorded who had been subject to the violence reduction strategy and why, but reasons were too often vague and lacked effective analysis. The security department was not represented at safer Garth meetings and links between the department and the safer custody team were weak.

1.9 The allocation and evaluation unit on D1 held a difficult mix of prisoners, including some with mental health problems alongside others needing protection due to debts or gang affiliations. It had moved away from a focus on reintegration. Only 10 prisoners had moved on from the unit in the past 12 months, half of whom had transferred out. Many remained on the landing for long periods. The purpose of the unit was unclear to staff and some said that they would have welcomed additional training, for example in mental health awareness. The regime was limited. A robust review was required to introduce a suitable regime and to support and safeguard the prisoners living there effectively.

1.10 Investigations into serious self-harm incidents, which identified learning points and developed action plans, were good. Lessons from investigations were shared at area safer custody meetings, and there was suitable liaison with other prisons in some cases when prisoners at risk were transferred.

1.11 Relatively few assessment, care in custody and teamwork (ACCT) documents were opened, and these were now taken to activity areas and completed by staff. Listeners, who occasionally met with the safer custody team, received good support through the prison, in addition to receiving support from the Samaritans.

1.12 A designated manager carried out checks across all wings to ensure that the incentive and earned privileges scheme (IEP) operated consistently, but quality assurance needed improvement. Prisoners' IEP status was monitored by ethnicity, and prisoners could also raise concerns about the scheme at regular community action support team (CAST) meetings, attended by prisoner representatives. Many prisoners saw little advantage in being on the enhanced regime.

1.13 The security department used a range of tactics to reduce the supply of drugs and hooch in the establishment, but had no control over the deployment of drug detection dogs, which were a regional asset. Strip- and squat-searching was carried out in some cases without sufficient supporting intelligence.

1.14 Planned use of force interventions were filmed but not monitored for quality and training purposes. The reasons for the use of handcuffs were now clearly explained in use of force paperwork. However, there were significant gaps in some use of force paperwork caused by the failure of staff involved in the incidents to submit a report.

1.15 A governor reviewed authorisation for the use of special cells every two hours, and there were no extended or overnight stays. However, the use of strip-searching and strip clothing in special accommodation was not supported by individual risk assessments.

1.16 Segregated prisoners had the opportunity to shower every day and staff working in the segregation unit were rotated regularly. Although some gym equipment had been introduced into the unit, it was only used by the segregation orderly, who although lived on the unit, was not segregated; prisoners subject to segregation did have access. Individual and meaningful behavioural targets were not being set or agreed with longer-term segregated prisoners. Records of the length of stay were not analysed to identify trends.

1.17 The published pre-entry regime segregation unit policy outlined a very limited regime for prisoners who had refused to return to their cell or to a wing following a period of segregation. This regime was inferior to the regime for prisoners on the basic level of the IEP scheme, which was wholly inappropriate.

1.18 The counselling, assessment, referral, advice and throughcare service now worked with primary alcohol users. Drug testing facilities on E wing had been refurbished and prisoners subject to voluntary drug testing were no longer strip-searched. Drug testing was generally carried out within identified timescales but there were some gaps in provision when staff were deployed elsewhere, particularly at weekends. There was now a mechanism to monitor target testing to ensure that prisoners were not being singled out for any reason other than reasonable suspicion.

1.19 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

Respect

1.20 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were good. We made 52 recommendations in this area, of which 25 had been achieved, eight partially achieved and 19 had not been achieved. Two recommendations were no longer applicable.

1.21 Some prisoners continued to share cells designed for one, which meant they were living in cramped conditions with insufficient furniture. Toilets in shared cells had been screened but those in single cells had not. Prisoners continued to complain about poor ventilation in cells and the opportunity for prisoners on the enhanced regime to purchase desktop fans had been withdrawn since the last inspection.

1.22 Facilities allowing prisoners to eat their meals out of their cells remained very limited. Prisoners continued to be prevented from accessing the internal garden, due, we were told, to security concerns and lack of sufficient staff supervision.

1.23 Prisoners in D1 continued to be excluded from prisoner consultation meetings. The personal officer strategy clearly explained the respective roles of personal officers and offender supervisors, and staff understood what was expected of them. With some exceptions personal

officer comments in the P-Nomis prison computer system demonstrated that officers were aware of and supported individual sentence management and resettlement activities.

1.24 The current diversity policy was inadequate; it provided only very superficial information and nothing specifically related to any of the individual protected characteristics. It was not based on a needs analysis and there was no action plan.

1.25 Good measures were in place to identify prisoners with disabilities. Prisoners identified as having disabilities and older prisoners were interviewed, and information recorded on their P-Nomis case notes. However, there was no ongoing monitoring or analysis outside the mandatory ethnic monitoring required by the National Offender Management Service (NOMS) to ensure that needs were addressed. Prisoner carers were appropriately vetted and supervised.

1.26 A scrutiny panel had been introduced to deal with racist incident report forms. The panel included prisoner representatives but no external representatives. External scrutiny took place separately every four months by a diversity manager from the local police force. Consultation focus groups were developing under most of the protected characteristics but there were none for black and minority ethnic prisoners. There were prisoner equality representatives on each wing whose roles were well promoted, and they had sufficient time to fulfil their responsibilities.

1.27 Interpreting and translation services were underused for non-English speaking prisoners. Wings only displayed very limited information of interest to foreign national prisoners and this was in English. The foreign national committee was not well attended.

1.28 The chaplaincy department's policy regarding prisoners in the segregation unit and D1 stated that prisoners should be allowed access to corporate worship. However, segregation staff did not allow prisoners to attend routine services.

1.29 Application forms were freely available on all wings and effectively managed and tracked via a computer-based system. Responses were timely. Complaint data was presented monthly to the senior management team, but there was little evidence of any discussion or action planning in minutes of meetings. There were no longer any active legal service officers and no system to help prisoners exercise their legal rights or assess the need for such a service.

1.30 The quality of all services, including GP services, was monitored to ensure that patients received an appropriate level of care, and action was being taken to address the high attendance failure rates. Waiting times had increased over the previous few months and efforts were being made to address the problem. Prisoners received clear information about their care and treatment and action was being taken to ensure consistency in the prescribing of medication. Robust monitoring of external appointments had resulted in fewer cancellations.

1.31 The health care department was being refurbished and infection procedures had significantly improved. All health care staff had received resuscitation training to intermediate life support level. Not all staff took up the offer of clinical supervision. Triage algorithms had been developed but were not always used by clinical staff, which could lead to inconsistency in decision making. There was now a lead nurse for older prisoners and the in-possession policy had been reviewed effectively. There was no longer an in-patient unit.

1.32 Prisoners were not able to buy items from the shop within 24 hours of arrival, and some had to wait 10 days to receive their first order. A wider range of non-branded goods was available and prisoners continued to be able to shop from catalogues, although a 50p handling fee per order was unacceptable.

1.33 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

Purposeful activity

1.34 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were good. We made nine recommendations in this area, of which four had been achieved, two partially achieved and three had not been achieved.

1.35 Adherence to the published core day was supervised every day by the duty governor who completed a written report for monitoring purposes. Delays to the regime were sometimes caused by morning medical treatments finishing late. Wing exercise areas were too austere and did not cater for the needs of mobility impaired prisoners.

1.36 Most workshops offered qualifications but few were above level 1; a few continued to occupy prisoners in repetitive menial tasks. Part-time education was well embedded and provided greater choice and increased prisoner participation rates. Attendance at education and training had increased to approximately 90%. The Offender Learning and Skills Service refresh programme was complete and all computers were in full working order.

1.37 Prisoners were able to access the library in a planned and timely manner but some prisoners reported that their visits to the library were too short. There was no monitoring of library use by ethnicity.

1.38 There continued to be no outdoor facility. Two gym periods a week had been incorporated into workshop activities enabling prisoners to choose between using the gym and staying in work, and attendance was monitored by ethnicity. A new timetable was soon due to be introduced to better meet the identified needs of prisoners with medical and age related issues. Prisoners in groups were very positive about the gym.

1.39 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

Resettlement

1.40 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 23 recommendations in this area, of which eight had been achieved, two partially achieved and 13 had not been achieved.

1.41 Although category C prisons no longer capped the number of indeterminate sentenced prisoners they would take, prisoners' progression continued to be delayed by population pressure and a lack of sufficient spaces across the estate.

1.42 Reasons for parole refusal were recorded and used to inform the needs analysis. Public protection resources had not been reduced and the offender management unit (OMU) continued to receive specialist administrative support.

1.43 OMU staff worked hard to ensure that offender managers attended boards for prisoners who were in scope (high or very high risk prisoners and those serving indeterminate sentences for public protection). All sentence planning boards for these prisoners were timely and chaired by offender managers. Offender supervisors continued to chair boards for prisoners who were out

of scope, and offender managers had attended 61% of these held over a recent 12 month period, compared with 33% in 2009.

1.44 Finance, benefit and debt services were not sufficiently well promoted and some prisoners and staff were unaware of the services available. However, prisoner peer advisors whose responsibilities would include service promotion, advice and signposting, were soon to be introduced.

1.45 The ethnicity, diversity and disability needs of the therapeutic community were not formally monitored to ensure equality of access and appropriateness of programme content.

1.46 Drug testing facilities on E wing had been refurbished and prisoners subject to compliance based drug testing were no longer routinely strip-searched.

1.47 Visits continued to be bookable only by telephone, and many visitors continued to complain about difficulties doing so. Not all visitors reached visits room for the 2pm start. The option of a closed visit or of leaving continued to be the only response to a drug dog indication.

1.48 Visitors continued to be provided with conflicting published information. The play area remained unsupervised and poorly equipped. Partners of Prisoners and Families Support Group (POPS) had recently been awarded the contract to manage visitor services, and it was hoped that improvements would result. Family involvement in sentence planning was not invited or encouraged, and there were no opportunities for prisoners to receive calls from children or to deal with any arrangements for them. There was no family support worker.

1.49 Family visits continued to be available only to prisoners on the enhanced regime. There had been no evaluation of these visits and the sessions only lasted for two hours. Family days no longer took place.

1.50 On the basis of this short follow-up inspection, we considered that the establishment was making insufficient progress against our recommendations.

Section 2: Progress since the last report

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

Main recommendations (from the previous report)

2.1 Clear guidance and instructions should be issued to prisons and probation areas about the roles and responsibilities of offender managers and external probation officers in chairing sentence planning boards. This would ensure that boards and sentence plan reviews are not delayed to the detriment of prisoners. (HP42)

Achieved. Guidance and instructions about roles and responsibilities had been published to prison and probation staff and sentence planning boards for all in-scope prisoners were timely and chaired by offender managers. Boards for out-of-scope prisoners continued to be chaired by offender supervisors, although attendance by offender managers had improved (see recommendation 2.110).

2.2 Prisoners at Garth should be able to progress to category C prisons as soon as their risk allows and in accordance with their sentence plan targets. (HP43)

Partially achieved. The prison was holding 190 category C prisoners during the inspection week. Category C prisons no longer capped the number of indeterminate sentenced prisoners they would take, but prisoners' progression continued to be delayed by population pressure and a lack of sufficient spaces across the estate. Categorisation staff estimated that the waiting time for progressive moves had reduced from six to 12 months in 2009, to around six months (see recommendation 2.108).

2.3 Effective security measures including adequate locally controlled dog cover should be implemented to reduce the supply of drugs and hooch. (HP41)

Not achieved. The security department used a range of tactics to reduce the supply of drugs and hooch (illicit alcohol) but the deployment of drug detection dogs was controlled at a regional level.
We repeat the recommendation.

2.4 A diversity policy should be introduced to include all minority groups, meet the requirements of anti-discrimination legislation and outline how the needs of minority groups will be met. It should include an action plan to meet identified targets and be based on a needs analysis. (HP39)

Not achieved. The current policy was inadequate providing only very superficial information and nothing specifically related to any of the individual protected characteristics. No needs analysis had been carried out and there was no action plan.
We repeat the recommendation.

2.5 Prisoners should be fully consulted and involved in the further development of the violence reduction strategy to help decrease the number of violent incidents. (HP40)

Achieved. Consultation with prisoners about the violence reduction strategy had improved, and included the use of focus groups, the introduction of regular meetings with prisoner safer custody representatives and involvement of prisoners and Listeners at safer Garth meetings.

Recommendations – safety

Courts, escorts and transfers

2.6 Journeys to Garth should not include unnecessary overnight stops at other prisons. (1.6)

Not achieved. Prisoners still made unnecessary overnight stops when transferring to Garth. For example one prisoner transferring from a London establishment, spent one night at HMP Woodhill in Milton Keynes, followed by one night at HMP Bedford, before arriving at Garth. Another prisoner had travelled from London via HMP Forest Bank, an establishment only a short distance from Garth.
We repeat the recommendation.

2.7 All vans used to transport prisoners should be clean, free of graffiti and carry refreshments. (1.7)

Not inspected. No vans arrived during the inspection.

2.8 Reception should stay open at lunchtime if escort vans have arrived or are expected. (1.8)

Achieved. Reception staff reported that if they knew an escort van was due to arrive during lunchtime they would make arrangements to ensure staff were available when it arrived. Informal arrangements were also in place to admit unexpected prisoners; this involved the duty governor carrying out basic reception procedures to allow prisoners off the vehicle as soon as possible.

Early days in custody

2.9 Reception and first night strategies should include the protection of vulnerable prisoners. (1.21)

Not achieved. There was no published reception strategy and the first night strategy made insufficient reference to identifying and supporting vulnerable prisoners.
We repeat the recommendation.

2.10 Cell-sharing risk assessments should be completed before prisoners are located in the first night centre. (1.22)

Achieved. Cell-sharing risk assessments were completed in reception.

2.11 Non-smoker packs should be available in the first night centre. (1.23)

Achieved. Non-smoker packs were now available alongside smoker packs.

2.12 Induction should be reduced to a two-week programme. (1.24)

Achieved. Induction had been appropriately reduced to a one-week rolling programme.

2.13 Prisoners should complete all elements of the induction programme. (1.25)

Achieved. A record of attendance maintained by induction staff ensured that prisoners completed all elements of the programme.

2.14 Adequate arrangements and guidance should be available to staff about how to induct prisoners with little or no English. (1.26)

Not achieved. While measures such as telephone translation services and a database of bilingual prisoners were available, we were not assured that staff used them where necessary. Staff we spoke to were unaware of the database and most reported that they would not be confident using the telephone translation service.
We repeat the recommendation.

Bullying and violence reduction

2.15 The psychology department should have a more active role in developing safer custody policy and strategy and be represented at each safer Garth meeting. (3.19)

Partially achieved. Representatives from the psychology department attended safer Garth meetings only periodically – twice in the five month period from October 2011 to February 2012. They had been consulted about the development of the challenging antisocial behaviour strategy and about the survey analysis of prisoners' perceptions of safety.
We repeat the recommendation.

2.16 At least two prisoner representatives/Listeners should attend each safer Garth team meeting. (3.20)

Achieved. In the previous five months there had been at least two safer custody representatives or Listeners present at safer Garth meetings.

2.17 Unexplained injuries should be monitored by the safer Garth team. (3.21)

Achieved. There was regular investigation of unexplained injuries (31 in 2011 and 10 in 2012 to date) and these were monitored by the safer Garth meeting.

2.18 Staff should use the antisocial behaviour report forms to help provide better monitoring of the investigation of all violent incidents and their outcomes. (3.22)

Partially achieved. Antisocial behaviour report forms had been replaced by challenging antisocial behaviour (CAB) forms, which were used frequently by staff to report a wider range of antisocial behaviour. An average of 26 had been submitted each month over the previous six months; 21 prisoners had been placed on monitoring procedures and 31 had been offered support over the same period as part of the CAB strategy. The outcomes of these investigations, some of which included formal charges under prison discipline rules or sanctions through the incentive and earned privileges scheme, were insufficiently monitored. The security department was not represented at the safer Garth meetings, and links between the department and the safer custody team were weak.

2.19 A further survey of prisoners' perception and experiences of bullying and violence should be conducted and ways found to encourage prisoners to complete this. (3.23)

Partially achieved. A survey had been conducted in October 2011, but only 41 prisoners had responded. Although low – less than 5% of the population – it provided some positive perceptions of safety.

2.20 The type of bullying that leads to the opening of tackling antisocial behaviour documents should be analysed to help inform the development of the strategy. (3.24)

Not achieved. The CAB register recorded those who had been placed on the strategy and the reason for this to determine whether they needed to be monitored or to receive support. The descriptions of the behaviour that led to these documents being opened was often vague – they included: 'under threat', 'bullying' or 'feels vulnerable'. It was not clear, for example, whether these incidents were related to drugs, gang association or other factors.
We repeat the recommendation.

2.21 All staff involved with prisoners should be trained in the violence reduction strategy. (3.25)

Not achieved. Only 38% of staff had received training in CAB awareness.
We repeat the recommendation.

2.22 All prisoners on D1 landing should have formal assessments as planned with an aim where possible to reintegrate into the general prison population. (3.26)

Not achieved. D1 had moved away from a focus on reintegration. We had concerns for the safety of some prisoners on D1, who were at risk both from themselves and from others. The purpose of the landing was unclear and few prisoners were reintegrated into the main population; around 10 prisoners had been moved from the unit in the past 12 months, five of whom had been transferred to other establishments. Some had been on the landing for long periods and there was a difficult mix of prisoners, some with mental health problems and others needing protection due to debts or gang affiliations. A recent serious assault with a racial aspect had been referred to the police for investigation. The purpose of the unit was unclear to staff, some of whom said that they would benefit from further training. The regime was limited and many prisoners we spoke to did not feel safe.

Further recommendation

2.23 The purpose, regime and population of D1 should be reviewed to ensure that prisoners are managed safely and appropriately.

Self-harm and suicide prevention

2.24 Investigations following serious incidents of self-harm should ensure that all aspects are covered. Lessons, including the need for better communication between prisons before a prisoner at risk is transferred, should be shared with area suicide prevention meetings with a view to improving practice. (3.41)

Achieved. There were good investigations following serious self-harm incidents, which identified learning points and from which action plans were developed. Lessons learned from the investigations, along with details of new initiatives, were shared at area safer custody meetings. There was regular contact with other prisons in cases where prisoners at risk were being transferred.

2.25 Assessment, care in custody and teamwork (ACCT) documents should accompany prisoners to their activities and instructors and teachers should make entries as required. (3.42)

Achieved. Relatively few ACCT documents were opened, around 12 per month, similar to when we last inspected. There were only three opened during this inspection. Workshop instructors said that ACCT documents were brought to activity areas and instructors made entries in them.

2.26 ACCT documentation should clearly identify that the possibility of involving families has been considered after an act of self-harm. (3.43)

Achieved. ACCT documents included consent forms for prisoners to fill in to allow staff to make contact with prisoners' next of kin following an incident of self-harm. These were completed in the majority of cases.

2.27 A protocol for the use of safer cells should be agreed. (3.44)

Achieved. There was a comprehensive protocol for the use of safer cells.

2.28 The safer custody manager should have regular meetings with Listeners. (3.45)

Partially achieved. Listeners had met occasionally with a member of the safer custody team. These meetings were not minuted, but we were told that any issues about the operation of the Listener scheme were discussed. Listeners also attended and raised issues at the safer Garth meetings and had fortnightly support meetings with the Samaritans.

2.29 The availability of the Samaritans' portable telephone should be more widely advertised. (3.46)

Partially achieved. The availability of the Samaritans' portable telephone was advertised on some but not all wings.

2.30 There should be sufficient first aid trained staff working at night. (3.47)

Achieved. In the month prior to this inspection a nurse and one first aid trained member of staff had been on duty and more night staff were due to be trained.

Security

2.31 Strip- and squat-searching should not be used unless there is intelligence indicating the need to do so. (6.7)

Not achieved. A security audit carried out in June 2010 stated that six out of seven strip-searches carried out by staff had inappropriately included a squat-search. Documents related to searches three months prior to the inspection demonstrated that the grounds for carrying out squat-searches were not always appropriate, for example in a search for hooch (fermenting liquid) or because it was a 'security search'.
We repeat the recommendation.

2.32 Comprehensive information about prison rules should be on display on all residential units. (6.8)

Achieved. A comprehensive range of information about prison rules was displayed on all wings.

Incentives and earned privileges

2.33 A designated manager should carry out checks across all residential wings to ensure that the incentives and earned privileges (IEP) scheme operates consistently across all areas. (6.38)

Partially achieved. A designated manager carried out checks of the IEP process across all residential wings, but quality assurance needed further development.

2.34 The number of black and minority ethnic and foreign national prisoners with enhanced status should be monitored and if necessary action taken to eliminate any inequalities. (6.39)

Achieved. The diversity and race equality action team monitored the ethnicity of enhanced prisoners and the IEP co-ordinating manager chaired the regular community action support team (CAST) meetings where prisoners could raise concerns about the IEP system.

The use of force

2.35 Planned use of force interventions should be filmed and monitored for quality and training purposes. (6.21)

Partially achieved. Use of force interventions were now filmed but were not monitored for quality and training purposes.

2.36 The reasons for the use of handcuffs should be clearly explained in use of force paperwork. (6.22)

Achieved. The reasons for the use of handcuffs were clearly explained in use of force paperwork and further recorded on a database for monitoring purposes.

2.37 Use of force paperwork should be certified by a manager not involved in the incident. (6.23)

Achieved. Use of force paperwork was now certified by the control and restraint (C&R) manager or the C&R coordinator who were not involved in the recorded incidents. There were significant gaps in use of force paperwork as staff involved in incidents had not always submitted a report as required.

Segregation

2.38 The authorisation for the use of special cells should be reviewed by a governor every two hours and reasons for extended or overnight stays, which should be exceptional, clearly stated. (6.24)

Partially achieved. Governors had recorded their visits to prisoners held in special cells but had not formally recorded their review in the appropriate section of the paperwork. Only two prisoners had been located in special cells for more than two hours in the six months prior to the inspection.

2.39 Strip-searching and strip clothing for prisoners in special accommodation should be used only if indicated by an individual risk assessment. (6.25)

Not achieved. There were no individual risk assessments to support strip-searching or the issuing of strip clothing to prisoners in special accommodation. Staff in the segregation unit said that the local security strategy stipulated that all prisoners should be strip-searched on entry to the segregation unit, which was not appropriate.
We repeat the recommendation.

2.40 Segregated prisoners should be able to shower daily. (6.26)

Achieved. Prisoners in the segregation unit were able to shower every day.

2.41 A policy for periodic rotation of segregation staff should be introduced. (6.27)

Achieved. The segregation policy outlined the staff rotation policy and was supported by an up to date list of staff authorised by the governor to work in the unit.

2.42 Increased opportunities for association and purposeful activity should be introduced in the segregation unit. (6.28)

Not achieved. A small amount of gym equipment had been installed in the segregation unit but only the segregation orderly, who was not segregated himself, was allowed to use it. A small room with seating and a TV had been provided and was mainly used for one to one work and interviews. Only one prisoner was allowed into an exercise yard at a time and education and chaplaincy contact was on a one to one basis.
We repeat the recommendation.

2.43 More meaningful and individual behavioural targets should be agreed with longer-term segregation unit residents. (6.29)

Not achieved. A standard pre-printed form stipulated three behavioural targets required of all segregated prisoners. One document for a prisoner located long term in the unit only had one further target stating that he should engage with the mental health team.
We repeat the recommendation.

2.44 Records of the average length of stay in segregation should be kept and monitored and analysed for trends by managers. (6.30)

Not achieved. Records of the length of stay of segregated prisoners were being compiled but there was no analysis of this information to determine the average length of stay in the unit or to identify trends.
We repeat the recommendation.

Additional information

2.45 The published pre-entry regime segregation unit policy revealed that a very limited regime was being applied to prisoners who refused to return to their cell on a residential wing or to a wing following a period of segregation. Prisoners were subject to weekly IEP reviews, could only make phone calls twice a week, did not have in-cell radios (they were already without in-cell televisions) and had restricted access to the library and canteen. This was inferior to the regime allowed to a prisoner on the basic level of the IEP scheme and was wholly inappropriate and unacceptable.

Further recommendation

2.46 Pre-entry procedures should be reviewed to ensure a proportionate and appropriate response to prisoners.

Substance misuse

2.47 The remit of the counselling, assessment, referral, advice and throughcare (CARAT) service should include work with prisoners who are primary alcohol users. (8.66)

Achieved. The CARAT service included work with prisoners whose primary addiction was alcohol. All drug services were being retendered by 2013 and it was anticipated that services would be fully integrated and include a range of alcohol and drug interventions.

2.48 All drug testing should be carried out appropriately, within identified timescales and without gaps in provision. (3.123)

Partially achieved. All drug testing was generally carried out appropriately and within indentified timescales. There were some gaps in provision as staff were redeployed to support operational areas of the prison, particularly at weekends.

2.49 A mechanism to monitor target testing, including by ethnicity, should be developed to ensure that prisoners are not targeted for any reason other than reasonable suspicion of drug use or possession. (3.124)

Achieved. Testing was monitored to ensure that prisoners were not being singled out for any other reason than reasonable suspicion of drug use or possession.

Recommendations – respect

Residential units

2.50 Two prisoners should not be required to share cells designed for one. (2.17)

Not achieved. A total of 38 cells designed for one prisoner had been certified under the Prison Act 1952 (section 14) as adequate for two prisoners to share. These cells were cramped and did not have the furniture normally provided for each prisoner.
We repeat the recommendation.

2.51 All in-cell toilets should provide privacy and be screened from the rest of the cell. (2.18)

Not achieved. In-cell toilets in single cells had not been screened, but those in shared cells had.
We repeat the recommendation.

2.52 Cells should be adequately ventilated and fans provided when necessary. (2.19)

Not achieved. Prisoners still complained that cells became too hot and were poorly ventilated. The opportunity for prisoners on the enhanced regime to purchase desktop fans to help improve the situation had been withdrawn. We were told that this was because the electrical

supply to cells was unable to cope with the demand when too many prisoners were using the fans in addition to other electrical items.
We repeat the recommendation.

2.53 Sufficient facilities should be provided for prisoners who wish to eat their meals out of their cells. (2.20)

Not achieved. Facilities for prisoners to eat their meals out of their cells were still very limited and most landings had no tables and chairs. Most prisoners returned to their cells to eat.
We repeat the recommendation.

2.54 There should be at least one telephone to every 20 prisoners on each wing and prisoners should be able to use these in private. (2.21)

Achieved. Three additional telephones had been provided on wings A to D, and F and G wings had six for 97 prisoners. Phones now had acoustic hoods or had been placed in booths, providing greater privacy.

2.55 Prisoners should have regular opportunities to use the internal garden. (2.22)

Not achieved. Prisoners still did not have access to a pleasant internal garden due, we were told, to security concerns and a lack of staff supervision.
We repeat the recommendation.

Staff-prisoner relationships

2.56 Regular consultation meetings should be held with prisoners on the allocation and evaluation unit. (2.31)

Not achieved. Prisoners in D1 were excluded from the regular prisoner consultation process. A prisoner representative from D1 occasionally met with the wing senior officer, but meetings were not always minuted or details systematically communicated to all prisoners on the wing.
We repeat the recommendation.

2.57 The distinct roles of personal officers and offender supervisors should be clarified in the personal officer scheme strategy document, which should be promoted more effectively to staff as a training guide for their role. (2.38)

Achieved. A good personal officer strategy clearly explained the respective roles of personal officers and offender supervisors, and staff in both roles understood what was expected of them. An offender supervisor workbook also explained the role in detail.

2.58 Monthly wing file history sheet entries and personal officer reports should provide an accurate chronological account of a prisoner's time at Garth and demonstrate that officers encourage men to maintain contact with their families and challenge and support them to comply with their sentence planning targets. (2.39)

Partially achieved. While there were some exceptions, particularly for prisoners who were failing to engage fully with the regime, there were many good quality personal officer entries in P-Nomis. It was clear that many prisoners had personal officers who were aware of and who supported individual sentence management and resettlement activities. There was evidence that regular management checks of entries were being monitored in bilateral meetings with line

managers. However, our inspection showed that a minority of line managers had signed off entries that did not show sufficient engagement with or knowledge of prisoners.

Equality and diversity

Strategic management

2.59 All prisoners with disabilities and older prisoners should be consulted about their individual needs and care and this should be recorded. (3.59)

Achieved. All prisoners with disabilities and older prisoners were formally interviewed following identification or self-referral, and information recorded on their P-Nomis case notes.

2.60 More effective screening for prisoners with disabilities should be introduced, including opportunities to identify disabilities after reception. (3.60)

Achieved. Good measures were in place for the effective screening for prisoners with disabilities. During the health care screening process on initial reception, a nurse completed a pro-forma for all prisoners, which was sent to the diversity manager, and self-referral forms were also freely available on all units.

2.61 The number of prisoners with disabilities and older prisoners should be monitored and regular analyses conducted to ensure their needs are addressed. (3.61)

Not achieved. While the total number of prisoners with disabilities and older prisoners was monitored there was no ongoing analysis to ensure needs were addressed.
We repeat the recommendation.

2.62 Monitoring should be introduced to ensure that prisoners from minority groups are not victimised or excluded from any activity. (3.62)

Not achieved. No monitoring took place outside the mandatory ethnic monitoring required by the National Offender Management Service.
We repeat the recommendation.

2.63 Prisoner carers should be suitably paid for the support they provide and their work should be effectively supervised. (3.63)

Achieved. A formal prisoner carer scheme was in place requiring applicants to be vetted, both by security and the diversity manager, and ensured payment, either for sessional or full-time responsibilities. Cleaning officers had been appointed as the primary point of contact for carers and they monitored day to day arrangements.

2.64 The prison should implement the planned scrutiny panel for racist incident report forms, which should include external representation and report findings to the race equality action team. (3.77)

Partially achieved. A scrutiny panel had been introduced which included prisoner representatives but no external representatives. External scrutiny did take place separately, with the diversity manager from the local police force scrutinising a sample of diversity incident report forms quarterly. Findings were reported to the race equality action team.

2.65 Managers responsible for race and diversity should hold a consultation group with prisoners from minority backgrounds to allow them to voice their concerns in a constructive environment. (3.78)

Partially achieved. Consultation arrangements were developing in the form of open invitation focus groups with prisoners under most protected characteristics, but there were no focus groups for black and minority ethnic prisoners.

2.66 Ethnic monitoring should be extended to take into account areas of concern to prisoners, such as access to offending behaviour courses and progression. (3.79)

Not achieved. Ethnic monitoring only included those areas that were a mandatory requirement of the NOMS and the lack of consultation with black and minority ethnic prisoners meant that such concerns could not be identified.
We repeat the recommendation.

2.67 Sufficient time should be given to race equality representatives to promote race equality throughout residential areas. (3.80)

Achieved. There was at least one prisoner equality representative on each wing. Their role was well promoted, and they had sufficient time to carry out their responsibilities.

2.68 Levels of spoken and written English of individual foreign national prisoners should be clearly recorded and interpreting and translation services used when necessary. (3.89)

Not achieved. A database had been initiated but was incomplete and most staff were unaware of its existence.
We repeat the recommendation.

2.69 Information on issues of interest to foreign national prisoners, such as telephone credit, legal advice and interpreting services, should be available on notice boards in residential areas and included in the foreign national policy. (3.90)

Not achieved. All wings had foreign national notice boards but they only displayed information relating to deportation arrangements in English.
We repeat the recommendation.

2.70 The foreign national meeting/committee should be given specific terms of reference. The committee should be multidisciplinary and include administrative staff who manage foreign national casework. (3.91)

Partially achieved. A foreign national committee met quarterly. Prisoner representatives and the administrative staff member responsible for foreign national casework attended the meeting. However, it was not a multidisciplinary meeting and other attendees only represented the diversity department. Terms of reference were in place.

Faith and religious activity

2.71 The policy relating to prisoners from segregation and D1 attending religious services should be made explicit to ensure their religious needs are met. (5.43)

Not achieved. The chaplaincy department's policy relating to prisoners' attendance arrangements from the segregation unit and D1 stated that prisoners should be allowed access to corporate worship. However, segregation unit staff reported that no prisoner was allowed to attend, and the D1 landing policy also contradicted this, stipulating that prisoners could not attend routine services. The chaplaincy department had made alternative arrangements in the unit itself.
We repeat the recommendation.

Complaints

2.72 General application forms should be freely available. (3.101)

Achieved. Application forms were freely available.

2.73 All responses to applications should be returned within three days and recorded. (3.102)

Achieved. All applications except those requiring a response from the governor were effectively managed and tracked via a computer-based system. A high proportion of applications received responses within the new local target of five days, which was acceptable.

2.74 The analysis of complaints and any action taken by senior managers should be recorded. (3.103)

Not achieved. Complaint data was presented monthly to the senior management team, but although managers recalled discussion, there was little evidence of this or any associated action planning in minutes of meetings.
We repeat the recommendation.

2.75 Replies to complaints should be legible. (3.104)

Not achieved. Although most handwritten replies were legible, there remained a small proportion that was not easy to read.
We repeat the recommendation.

Legal rights

2.76 Legal service officers should receive refresher training. (3.113)

Not achieved. There were no longer any active legal service officers and there was no other well publicised system to help prisoners exercise their legal rights.
We repeat the recommendation.

Health services

Governance arrangements

2.77 The quality of GP services should be monitored to ensure that patients are receiving an appropriate level of care without undue waits for appointments. (4.44)

Partially achieved. The quality of all services, including GP services, was monitored to ensure that patients were receiving an appropriate level of care. Waiting times and attendance failure rates were advertised on each wing reflecting practice in the community, and action was being taken to address the high 'did not attend' (DNA) rates. Waiting times had increased over the past few months and many prisoners complained about waiting to see a GP and a dentist. To address this, regular locum staff were provided and a recent recruitment campaign had shortlisted additional GPs.

2.78 More structured activity for in-patients should be provided. (4.56)

No longer applicable. There was no longer an in-patient unit.

2.79 In-patients should be involved in planning their care. (4.57)

No longer applicable. There was no longer an in-patient unit.

2.80 Cancellation of external appointments should be closely monitored and reviewed at the clinical governance committee. (4.58)

Achieved. There was robust monitoring of external appointments resulting in a reduction of cancellations.

2.81 Health care application boxes should be emptied daily and applications processed the same day. (4.60)

Achieved. Health care application boxes were emptied each day and appointments swiftly triaged. The application process was effective. However, there were long waits to see the doctor and dentist and a high did not attend (DNA) rate. This could have been linked to the fact that prisoners often failed to receive appointment slips and action was being taken to address this.

Delivery of care (physical health)

2.82 Prisoners should be given clear information about their care and treatment, including prescribed medication. (4.45)

Achieved. Prisoners received clear information about their care and treatment and action was being taken to ensure consistency in the prescribing of medication.

2.83 A suitable waiting area should be provided for prisoners attending health care from the allocation and evaluation unit. (4.46)

Achieved. All vulnerable prisoners were escorted to the health care department.

2.84 Hand-washing facilities should be available in all rooms where health care is delivered. (4.47)

Achieved. The health care department was in the process of being refurbished and procedures to prevent infection had significantly improved.

2.85 All health care staff should have at least annual resuscitation and defibrillation training. (4.48)

Achieved. All health care staff had received resuscitation training to intermediate life support level.

2.86 All staff should have access to clinical supervision and records of this should be maintained. (4.49)

Partially achieved. Staff were allocated time for clinical supervision and although uptake by the mental health team was adequate, only limited use was made of this by primary care team staff. The head of health care was addressing this issue.

2.87 Triage algorithms should be developed to ensure consistency of advice and treatment to all prisoners. (4.50)

Partially achieved. Triage algorithms had been developed but were not always used by clinical staff, which meant there could be inconsistencies in decision making.

2.88 There should be an identified nurse responsible for the care of older prisoners. (4.51)

Achieved. There was a lead nurse for older prisoners.

Pharmacy

2.89 The in-possession policy should be reviewed to take into account the type of medication as well as the individual patient. (4.52)

Achieved. The in-possession policy had been effectively reviewed.

Dentistry

2.90 The storage room adjacent to the dental surgery should be converted as planned to a decontamination room with the installation of a washer/disinfector. (4.53)

Achieved. The health care department was in the process of being refurbished and the facilities in the dental suite had improved significantly.

2.91 The x-ray machine control panel and master switch in the dental surgery should be repositioned to facilitate access. (4.54)

Achieved. As a result of the refurbishment of the facilities in the dental suite, access to the x-ray equipment had improved significantly.

2.92 Cover for dentists' annual leave and sick leave should be provided. (4.55)

Achieved. Absence cover was provided for the dentist.

Delivery of care (mental health)

2.93 There should be regular scheduled meetings between the primary mental health and in-reach teams. (4.59)

Achieved. Lancashire Care NHS Foundation Trust employed an integrated team of mental health nurses who were co-located and met weekly.

Purchases

2.94 Prisoners should be able to buy items from the shop within 24 hours of arrival. (7.14)

Not achieved. Prisoners were not able to buy items from the shop within 24 hours of arrival, and some new arrivals had to wait 10 days to receive their first order. The range of goods available on induction to mitigate this difficulty was insufficient to meet the needs of prisoners.
We repeat the recommendation.

2.95 Prisoners unable to collect their orders on Friday afternoons should not have to wait until the following week to do so. (7.15)

Achieved. Wing staff signed for the orders of prisoners who were away from the wing when they were being distributed and delivered them later. Kitchen workers received their orders while at work.

2.96 A wider range of non-branded goods should be included on the canteen list. (7.16)

Achieved. There were opportunities to purchase non-branded goods in each section of the canteen list, which was reviewed quarterly at the CAST committee. All prisoners had an opportunity to submit suggestions for altering the list every six months.

2.97 Prisoners should continue to be able to shop from the existing range of catalogues. (7.17)

Achieved. Prisoners were able to shop from 14 different catalogues, but were charged a 50p handling fee for each order, which was unacceptable.

Further recommendation

2.98 Prisoners should not be charged a handling fee when placing orders.

Recommendations – purposeful activity

Time out of cell

2.99 The published core day should be followed. (5.48)

Achieved. The published core day was supervised every day by the duty governor who completed a written report for monitoring purposes. Delays to the regime were sometimes caused as a result of morning medical treatments finishing late.

2.100 Suitable exercise areas should be provided for prisoners with mobility difficulties. (5.49)

Not achieved. A lift enabled prisoners with limited mobility to access the exercise areas on F and G wings. The exercise areas were too austere and did not cater for the needs of mobility impaired prisoners.
We repeat the recommendation.

Learning and skills and work activities

2.101 All workshops should be fully utilised to allow all prisoners to benefit from the training opportunities available (5.19)

Partially achieved. Most workshops offered qualifications but few were above level 1; some workshops continued to occupy prisoners in repetitive menial tasks. Workshop time included two hours' access to the gym per week.

2.102 Attendance arrangements for education should be reviewed to allow greater flexibility and improve prisoners' participation. (5.20)

Achieved. Part-time education was well embedded and provided greater choice and higher prisoner participation rates. Attendance at education and training had increased to approximately 90% from 70%.

2.103 All workshop computers should be fully functional. (5.21)

Achieved. The Offender Learning and Skills Service (OLASS) refresh programme was complete and all computers were in full working order. The new signage workshop had commercial standard equipment.

Library

2.104 The library should be monitored by individual and ethnic origin to ensure fair and equitable access. (5.22)

Partially achieved. Processes were in place to ensure that prisoners were able to access the library and its facilities in a planned and timely manner. Book loans were monitored by ethnicity, but there was insufficient monitoring of the use of wider library facilities and resources.
We repeat the recommendation.

2.105 The information and communications technology (ICT) equipment in the library should be updated to enable learners to save their work and view distance learning course material. (5.23)

Achieved. The OLASS refresh programme had updated the prison's education and training ICT equipment including equipment in the library and on the virtual campus. Distance learners and students on Open University courses were able to access these facilities and save their work.

Physical education and health promotion

2.106 Outdoor sports facilities should be provided. (5.31)

Not achieved. There continued to be no outdoor sports facilities.
We repeat the recommendation.

2.107 Gym use should be effectively monitored to ensure equality of access. (5.32)

Partially achieved. A needs analysis showed that gym access at specific times did not work well for all prisoners and two gym periods a week had been incorporated into workshop activities when prisoners could choose between using the gym and staying in work. Gym attendance was monitored by ethnicity and a new timetable was soon due to be introduced to better meet the identified needs of prisoners with medical and age related issues.

Recommendations – resettlement

Offender management and planning

2.108 Assistance should be provided at a national level to ensure that category C prisoners are moved to suitable category C prisons quickly and that any vacancies that arise are filled expeditiously from the local and high security estate. (8.38)

Partially achieved. Progressive moves continued to be hampered by population pressure and a lack of space across the estate although waiting times had been reduced (see recommendation 2.2). There was no particular assistance to ensure that vacancies in Garth were filled expeditiously.

2.109 The prison should keep a record of why prisoners have been refused parole and use this information to inform its needs analysis of the population. (8.34)

Achieved. Reasons for parole refusal were recorded and used to inform the needs analysis.

2.110 Sentence planning boards should not be delayed more than two months because of the absence of offender managers or external probation officers. (8.37)

Achieved. Offender management unit (OMU) staff worked hard to ensure that offender managers attended boards for in-scope prisoners, and all sentence planning boards for these prisoners were timely and chaired by offender managers. Offender supervisors continued to chair boards for out of scope prisoners and offender managers had attended 61% of those held in a recent 12-month period, compared with 33% in 2009.

2.111 The ethnicity, diversity and disability needs of therapeutic community applicants and completers should be monitored and regularly evaluated to ensure equality of access and appropriateness of programme contents for all prisoners. (8.67)

Not achieved. The ethnicity, diversity and disability needs of the therapeutic community were monitored through key working and at monthly meetings. However, information about applicants and completers was not sent to the diversity, race, equality action team (DREAT) and we saw no evidence that strategic monitoring was being evaluated.
We repeat the recommendation.

Public protection

2.112 Any reductions to the offender management function should take into account the need to provide specialist input for public protection arrangements in order to safely manage the high-risk population. (8.35)

Achieved. Public protection resources had not been reduced.

Indeterminate-sentence prisoners

2.113 Proposed changes to offender management arrangements should ensure that specialist administrative support and expertise about the parole process for indeterminate-sentenced prisoners is retained. (8.36)

Achieved. The OMU continued to receive specialist administrative support.

Drugs and alcohol

2.114 The voluntary drug testing facilities on E wing should be refurbished or relocated to create an adequate testing environment. (8.68)

Achieved. The drug testing facilities on E wing had been refurbished.

2.115 Prisoners subject to voluntary drug testing should not be routinely strip-searched. (8.69)

Achieved. Prisoners subject to compliance based drug testing were no longer routinely strip-searched.

Finance, benefit and debt

2.116 The prison should ensure that all prisoners and not only those on induction are aware of the financial services available. (8.53)

Not achieved. Finance, benefit and debt services were not sufficiently well promoted and some prisoners and staff were unaware of the services available. However, there was encouraging evidence of an imminent re-emergence of prisoner peer advisors whose responsibilities would include service promotion, advice and signposting.
We repeat the recommendation.

Children, families and contact with the outside world

2.117 All visits should start at the advertised time. (8.86)

Not achieved. Visitors began moving from the visits centre into the visit search area within the prison 15-20 minutes before visits were due to start; consequently not all visitors were in the visits room for the 2pm start.
We repeat the recommendation.

2.118 Closed visits should be authorised only when there is a significant risk justified by security intelligence. (8.87)

Not achieved. Closed visits were not based on individual risk assessments or informed by additional security intelligence. The option of a closed visit or of leaving continued to be the only response to a drug dog indication.
We repeat the recommendation.

2.119 The correct time of visits and access to the booking line should be shown in all relevant publications. (8.88)

Not achieved. Conflicting published information continued to be provided.
We repeat the recommendation.

2.120 The visits play area should be suitably supervised and equipped. (8.89)

Not achieved. The play area remained unsupervised and poorly equipped; however we understood that a supervisor would be provided by Partners of Prisoners and Families Support Group (POPS), which had recently been awarded the contract to manage visitor services.
We repeat the recommendation.

2.121 Families should be invited and encouraged to participate in key aspects of sentence planning where appropriate. (8.90)

Not achieved. Family involvement in sentence planning was not invited or encouraged.
We repeat the recommendation.

2.122 There should be provision for prisoners to receive incoming telephone calls from children or to deal with arrangements for them. (8.91)

Not achieved. There were no opportunities for prisoners to receive calls from children or to deal with any arrangements for them.
We repeat the recommendation.

2.123 There should be a qualified family support worker to help prisoners maintain contact with family and friends. (8.92)

Not achieved. There was no family support worker; however we were told that the role would be filled by a suitable POPS worker.
We repeat the recommendation.

2.124 The annual needs analysis should include questions about prisoners' families in order to inform the pathway and improve service delivery. (8.93)

Not achieved. Although the draft needs analysis included some comments from a visitor survey, the methodology had not included any questions for prisoners about family contact to inform service delivery.
We repeat the recommendation.

2.125 The suitability of a 9.30am start for family visits and family days should be discussed and evaluated with prisoners, visitors and other groups involved in organising and managing these days. (8.94)

Not achieved. There had been no formal evaluation of these visits and all day visits had ceased due to funding cuts. Visitors could arrive at any time after the 9.30am start for family visits which included children and their carer, but the session ended at 11.30am. Visitors then left the prison but could return for an ordinary visit at 2pm.
We repeat the recommendation.

2.126 Family visits and family days should be open to all prisoners. (8.95)

Not achieved. Family visits were only open to prisoners on the enhanced regime.
We repeat the recommendation.

Section 3: Summary of recommendations

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

Main recommendation from the previous report — To the governor

3.1 Effective security measures including adequate locally controlled dog cover should be implemented to reduce the supply of drugs and hooch. (2.3)

3.2 A diversity policy should be introduced to include all minority groups, meet the requirements of anti-discrimination legislation and outline how the needs of minority groups will be met. It should include an action plan to meet identified targets and be based on a needs analysis. (2.4)

Recommendations — To the governor

Courts, escorts and transfers

3.3 Journeys to Garth should not include unnecessary overnight stops at other prisons. (2.6)

Early days in custody

3.4 Reception and first night strategies should include the protection of vulnerable prisoners. (2.9)

3.5 Adequate arrangements and guidance should be available to staff about how to induct prisoners with little or no English. (2.14)

Bullying and violence reduction

3.6 The psychology department should have a more active role in developing safer custody policy and strategy and be represented at each safer Garth meeting. (2.15)

3.7 The type of bullying that leads to the opening of tackling antisocial behaviour documents should be analysed to help inform the development of the strategy. (2.20)

3.8 All staff involved with prisoners should be trained in the violence reduction strategy. (2.21)

3.9 The purpose, regime and population of D1 should be reviewed to ensure that prisoners are managed safely and appropriately. (2.23)

Security

3.10 Strip- and squat-searching should not be used unless there is intelligence indicating the need to do so. (2.31)

Segregation

3.11 Strip-searching and strip clothing for prisoners in special accommodation should be used only if indicated by an individual risk assessment. (2.39)

3.12 Increased opportunities for association and purposeful activity should be introduced in the segregation unit. (2.42)

3.13 More meaningful and individual behavioural targets should be agreed with longer-term segregation unit residents. (2.43)

3.14 Records of the average length of stay in segregation should be kept and monitored and analysed for trends by managers. (2.44)

3.15 Pre-entry procedures should be reviewed to ensure a proportionate and appropriate response to prisoners. (2.46)

Residential units

3.16 Two prisoners should not be required to share cells designed for one. (2.50)

3.17 All in-cell toilets should provide privacy and be screened from the rest of the cell. (2.51)

3.18 Cells should be adequately ventilated and fans provided when necessary. (2.52)

3.19 Sufficient facilities should be provided for prisoners who wish to eat their meals out of their cells. (2.53)

3.20 Prisoners should have regular opportunities to use the internal garden. (2.55)

Staff-prisoner relationships

3.21 Regular consultation meetings should be held with prisoners on the allocation and evaluation unit. (2.56)

Equality and diversity

Strategic management

3.22 The number of prisoners with disabilities and older prisoners should be monitored and regular analyses conducted to ensure their needs are addressed. (2.61)

3.23 Monitoring should be introduced to ensure that prisoners from minority groups are not victimised or excluded from any activity. (2.62)

3.24 Ethnic monitoring should be extended to take into account areas of concern to prisoners, such as access to offending behaviour courses and progression. (2.66)

3.25 Levels of spoken and written English of individual foreign national prisoners should be clearly recorded and interpreting and translation services used when necessary. (2.68)

3.26 Information on issues of interest to foreign national prisoners, such as telephone credit, legal advice and interpreting services, should be available on notice boards in residential areas and included in the foreign national policy. (2.69)

Faith and religious activity

3.27 The policy relating to prisoners from segregation and D1 attending religious services should be made explicit to ensure their religious needs are met. (2.71)

Complaints

3.28 The analysis of complaints and any action taken by senior managers should be recorded. (2.74)

3.29 Replies to complaints should be legible. (2.75)

Legal rights

3.30 Legal service officers should receive refresher training. (2.76)

Purchases

3.31 Prisoners should be able to buy items from the shop within 24 hours of arrival. (2.94)

3.32 Prisoners should not be charged a handling fee when placing orders. (2.98)

Time out of cell

3.33 Suitable exercise areas should be provided for prisoners with mobility difficulties. (2.100)

Library

3.34 The library should be monitored by individual and ethnic origin to ensure fair and equitable access. (2.104)

Physical education and health promotion

3.35 Outdoor sports facilities should be provided. (2.106)

Offender management and planning

3.36 The ethnicity, diversity and disability needs of therapeutic community applicants and completers should be monitored and regularly evaluated to ensure equality of access and appropriateness of programme contents for all prisoners. (2.111)

Finance, benefit and debt

3.37 The prison should ensure that all prisoners and not only those on induction are aware of the financial services available. (2.116)

Children, families and contact with the outside world

3.38 All visits should start at the advertised time. (2.117)

3.39 Closed visits should be authorised only when there is a significant risk justified by security intelligence. (2.118)

3.40 The correct time of visits and access to the booking line should be shown in all relevant publications. (2.119)

3.41 The visits play area should be suitably supervised and equipped. (2.120)

3.42 Families should be invited and encouraged to participate in key aspects of sentence planning where appropriate. (2.121)

3.43 There should be provision for prisoners to receive incoming telephone calls from children or to deal with arrangements for them. (2.122)

3.44 There should be a qualified family support worker to help prisoners maintain contact with family and friends. (2.123)

3.45 The annual needs analysis should include questions about prisoners' families in order to inform the pathway and improve service delivery. (2.124)

3.46 The suitability of a 9.30am start for family visits and family days should be discussed and evaluated with prisoners, visitors and other groups involved in organising and managing these days. (2.125)

3.47 Family visits and family days should be open to all prisoners. (2.126)

Appendix I: Inspection team

Joss Crosbie	Inspector (lead)
Rosemarie Bugdale	Inspector
Paul Fenning	Inspector
Jeanette Hall	Inspector
Martin Owens	Inspector

Specialist inspector

Jen Walters	Ofsted
Helen Carter	Health care inspector

Appendix II: Prison population profile

Please note: the following figures were supplied by the establishment and any errors are the establishment's own.

Population breakdown by:

Status	18–20 yr olds	21 and over	%
Sentenced	1	817	97.3
Recall		23	2.7
Convicted unsentenced			
Remand			
Civil prisoners			
Detainees			
Total	1	840	100

Sentence	18–20 yr olds	21 and over	%
Unsentenced			
Less than 6 months			
6 months to less than 12 months			
12 months to less than 2 years			
2 years to less than 4 years		8	0.95
4 years to less than 10 years		107	12.7
10 years and over (not life)		208	24.7
ISPP	1	211	25.2
Life		306	36.4
Total	1	840	100

Age	Number of prisoners	%
Please state minimum age	20	
Under 21 years	1	0.1
21 years to 29 years	302	35.9
30 years to 39 years	278	33.1
40 years to 49 years	169	20.1
50 years to 59 years	71	8.4
60 years to 69 years	17	2
70 plus years	3	0.4
Please state maximum age	78	
Total	840	100

Nationality	18–20 yr olds	21 and over	%
British	1	766	91.2
Foreign nationals		68	8.1
Not stated		6	0.7
Total	1	840	100

Security category	18–20 yr olds	21 and over	%
Uncategorised unsentenced			
Uncategorised sentenced			
Cat A			
Cat B	1	613	73.1
Cat C		214	25.4
Cat D		13	1.5

Other			
Total	1	840	100

Ethnicity	18–20 yr olds	21 and over	%
White			
British	1	644	76.7
Irish		6	0.7
Other white		21	2.5
Mixed			
White and black Caribbean		14	1.7
White and black African		1	0.1
White and Asian		1	0.1
Other mixed		3	0.4
Asian or Asian British			
Indian		12	1.4
Pakistani		31	3.7
Bangladeshi		4	0.5
Other Asian		15	1.8
Black or black British			
Caribbean		43	5.1
African		13	1.5
Other black		13	1.5
Chinese or other ethnic group			
Chinese			
Other ethnic group		4	0.5
Not stated		15	1.8
Total	1	840	100

Religion	18–20 yr olds	21 and over	%
Baptist			
Church of England		204	24.3
Roman Catholic		222	26.4
Other Christian denominations		48	5.7
Muslim		94	11.2
Sikh		4	0.5
Hindu		1	0.1
Buddhist		23	2.7
Jewish		5	0.6
Other		8	1.0
No religion	1	231	27.6
Total	1	840	100

Sentenced prisoners only

Length of stay	18–20 yr olds		21 and over	
	Number	%	Number	%
Less than 1 month			42	5
1 month to 3 months			64	7.6

3 months to 6 months	1	0.1	106	12.6
6 months to 1 year			156	18.5
1 year to 2 years			215	25.7
2 years to 4 years			162	19.3
4 years or more			95	11.3
Total	1	0.1	840	100

Unsentenced prisoners only

Length of stay	18–20 yr olds		21 and over	
	Number	%	Number	%
Less than 1 month				
1 month to 3 months				
3 months to 6 months				
6 months to 1 year				
1 year to 2 years				
2 years to 4 years				
4 years or more (no data)				
Total				

Main offence	18–20 yr olds	21 and over	%
Violence against the person	1	471	56
Sexual offences			
Burglary		32	3.7
Robbery		149	17.6
Theft and handling		2	0.2
Fraud and forgery			
Drugs offences		41	4.8
Other offences		52	6.7
Civil offences			
Offence not recorded/holding warrant		93	11
Total	1	840	100