Report on an unannounced inspection of

HMP Manchester

by HM Chief Inspector of Prisons

6–7 and 13–17 September 2021

Contents

Introduction

In 2020, HMP Manchester made the transition from a local to a category B training prison, retaining a small category A function and separate close supervision centre. At the time of our visit it held 624 men, of whom a third were serving indeterminate sentences.

The governor had taken on the challenge of transforming the culture of the prison and the mindset of the staff to focus on the rehabilitation of long-sentenced prisoners rather than the needs of a transient local prison population, but much of this work had been delayed or derailed by the COVID-19 pandemic.

Some material changes had certainly supported this process – all but a few prisoners were held in single cells, showers had been improved and new kitchens on wings would soon mean prisoners could cook their own food.

With COVID-19 restrictions still in place, many prisoners were still spending too long in their cells with few jobs available, very limited offending behaviour programmes and face-to-face education practically non-existent. Staff shortages restricted the number of prisoners who could get to the library, gym or workshops.

One of the themes of this inspection was the lack of trust that prisoners had in prison staff. For example, they did not believe that complaints would be dealt with robustly, they could not get hold of their stored property, the booking line for visits rang unanswered, there was often no response to applications and the vulnerable prisoners on K wing reported high levels of victimisation from staff.

The governor had taken some active steps to address this issue, moving his office and those of senior managers onto the wings to increase their visibility to prisoners and staff. He had put in a new system for managing complaints, brought in new quality assurance to respond to allegations of discrimination and he chaired the black prisoner consultation forum. He had also held a drug summit in which staff and prisoners were consulted on how to reduce the supply of drugs, from which leaders had developed a series of actions. At the last inspection we were very critical of the segregation unit and we were pleased to see improvements not only in the physical environment, but in the way men with often very complex needs were helped back into the main prison, with some impressive input from the psychology service in formulating support plans.

The governor had also prioritised improving the staff culture in the prison and the often good and caring interactions we saw with prisoners were evidence that progress was being made. Inspectors who had also been on the previous inspection noticed an improvement in the atmosphere. The prison had recently adopted a new incentive scheme that aimed to improve prisoners' behaviour, though it was too early to see the effects. Leaders had introduced targeted performance management for custodial managers to improve their confidence and competence in leading their teams; this was crucial to transforming the prison culture.

There was, however, much to be done – in some wings, inspectors were struck by the lack of engagement and poor attitudes of some officers. This along with a reluctance to turn on body-worn cameras, the unnecessary use of an aggressive, barking dog to accompany prisoners who were being relocated to the segregation unit, the unwillingness of some staff to challenge disruptive behaviour, the extraordinary strip-searching of prisoners who were being released and the often poor treatment of those at risk of suicide or self-harm, pointed to the scale of the challenge.

The board in the administrative block lists the 10 governors who have led the prison since the turn of the century, a turnover rate that explains why so many deep-set problems remain. If HMP Manchester is to make the transformation from a security-focused local prison to a category B training prison that rehabilitates the often challenging and complex men in its care, the prison service will need to make sure that this strong and effective governor has the time and money to complete the job.

Charlie Taylor
HM Chief Inspector of Prisons
October 2021

About HMP Manchester

Task of the prison/establishment
HMP Manchester is a category B training prison, holding a small number of category A prisoners, and a discrete close supervision centre.

Certified normal accommodation and operational capacity (see Appendix II Glossary of terms)
Prisoners held at the time of inspection: 624
Baseline certified normal capacity: 695
In-use certified normal capacity: 695
Operational capacity: 744

Population of the prison
- About 37 new prisoners had been received each month over the previous year.
- About 12 prisoners a month had been released into the community over the previous year.
- 55 foreign national prisoners were held during the inspection.
- 26.5% of prisoners were from black and minority ethnic backgrounds.

Prison status and key providers
Public

Physical and mental health provider: Greater Manchester Mental Health NHS Foundation Trust
Substance misuse treatment provider: Delphi
Prison education framework provider: Milton Keynes College
Escort contractor: GEOAmey and HM Prison and Probation Service

Prison group/Department
The long-term high security estate

Brief history
Manchester Prison opened in June 1868. Following a large-scale disturbance in 1990, the prison required major refurbishment. It was moved into the directorate of the high security estate in April 2003. In 2020, its function changed from a local to a category B training prison.

Short description of residential units
A wing: General population
B wing: General population
C wing: General population full-time workers
D wing: General population
E wing: Category A unit and category B and escape list prisoners
G wing: Drug and alcohol recovery unit and incentivised substance free living unit
H wing: Reverse cohort unit (see Appendix II Glossary of terms) and a small social care unit on H1
I wing: General population

K wing: Vulnerable prisoner unit
M wing: Health care inpatients unit.

Name of governor and date in post
Rob Knight, November 2019

Leadership changes since the last inspection
Governor Rob Young, August 2016 – November 2019

Prison Group Director
Gavin O'Malley

Independent Monitoring Board chair
Richard Christopherson

Date of last inspection
27, 28 June, 9–12 July 2018

Section 1 Summary of key findings

1.1 We last inspected HMP Manchester in 2018 and made 67 recommendations, five of which were about areas of key concern. The prison fully accepted 46 of the recommendations and partially (or subject to resources) accepted 12. It rejected nine of the recommendations.

1.2 Section 8 contains a full list of recommendations made at the last full inspection.

Progress on key concerns and recommendations from the full inspection

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

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

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

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

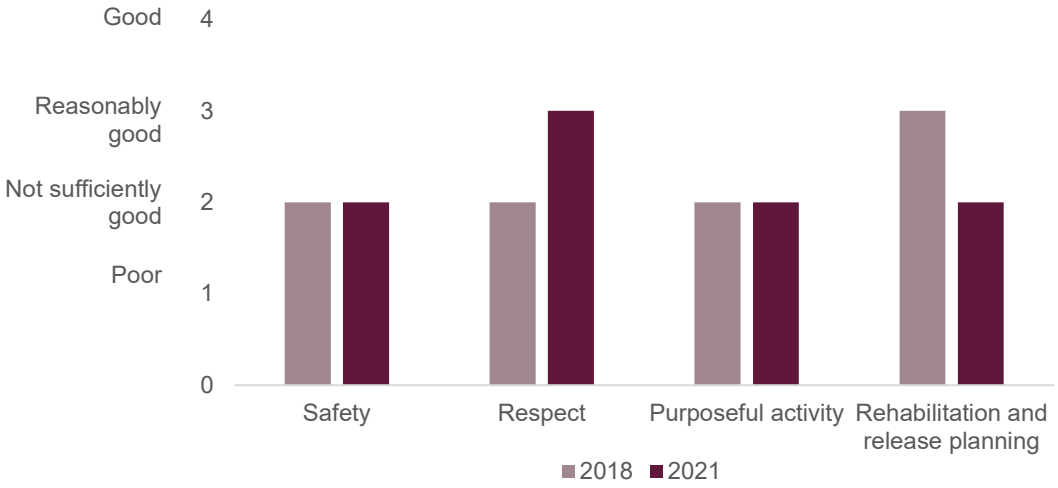
Outcomes for prisoners

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

1.8 At this inspection of HMP Manchester, we found that outcomes for prisoners had stayed the same in two healthy prison areas, improved in one and declined in one.

1.9 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account the prison's recovery from COVID-19 as well as the 'regime stage' at which the prison was operating, as outlined in the HM Prison and Probation (HMPPS) National Framework for prison regimes and services.

Figure 1: HMP Manchester healthy prison outcomes 2018 and 2021



Safety

At the last inspection of HMP Manchester in 2018 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

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

1.10 The reception area was clean, and prisoners were treated well overall, but strip-searching all new arrivals in addition to using the body scanner could not be justified. There was an appropriate focus on assessing the risks posed by new prisoners as well as their vulnerabilities. About two-thirds of prisoners in our survey said they felt safe on their first night. Cells were clean and well-equipped, and staff were friendly and helpful.

1.11 In our survey, 25% of prisoners said they felt unsafe at the time of our inspection and those with mental health problems or other disabilities were significantly more negative than other prisoners. Levels of violence were lower than at our previous inspection, however, the rate of serious assaults had increased. Management oversight of violence reduction work was limited. While initial investigations into violent incidents were reasonably good, management and support plans were largely ineffective in helping perpetrators change their behaviour. Safety and violence reduction strategies had been reviewed but did not fully explore the causes of violence at the prison.

1.12 Since 2018, there had been five self-inflicted deaths and five deaths that were not from natural causes, some of which were linked to drug use. The rate of self-harm incidents in the previous year was similar to the rate leading up to our inspection in 2018. Not all serious incidents of self-harm were investigated and the standard of enquiry in those cases that were investigated was poor. The prison's strategic approach to reducing the level of self-harm had been neglected. Monthly Safer Manchester meetings were poorly attended. There had been no

detailed analysis of data so that the causes of self-harming behaviour could be determined, or appropriate action planning taken to address them.

1.13 There was a death in custody action plan in response to Prisons and Probation Ombudsman recommendations, but there was little evidence showing that improvements were embedded in practice. Data analysis was too limited to inform a self-harm reduction strategy specific to Manchester.

1.14 Staff we spoke to knew who was on an assessment, care in custody and teamwork (ACCT) case management document for prisoners at risk of suicide or self-harm, but many told us they had not received enough training in how to use the new version and the quality of documentation was poor. Support offered to those in crisis or at risk of self-harm needed improvement. There were too few Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) and in our survey, only 50% of prisoners who had been on an ACCT said they felt cared for.

1.15 Too many adjudication cases, including those for serious incidents, such as violence and use of illicit drugs, were still waiting to be concluded. Force was used less often than at the previous inspection, but de-escalation attempts were inadequate in many of the incidents we reviewed, and oversight of the use of special accommodation was weak. The use of force committee was not effective and the application of data to make continuous improvements was limited. Management of the segregation unit was now good. Reintegration planning had improved, and staff had a good understanding of the risks and triggers for those in their care.

1.16 Security procedures were broadly proportionate and the prison appropriately prioritised action to reduce the supply of illicit items. Leaders had held a ‘drug summit’, a meeting where staff and prisoners identified concerns, and a subsequent action plan, which looked promising, was drawn up. The effectiveness of drug testing was undermined because action was not always taken following a positive test result.

Respect

At the last inspection of HMP Manchester in 2018 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

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

1.17 The inspection team saw many examples of positive staff-prisoner relationships. Most staff knew prisoners well and many offered good care, compassion and support, but we also observed some who appeared distant and disengaged. Problems with basic operational

systems undermined the level of trust prisoners had in staff. In our survey, only 54% of prisoners said staff had victimised or bullied them; for vulnerable prisoners on K wing the figure was higher at 81% COVID-19 restrictions had hindered the delivery of the key worker scheme (see Appendix II Glossary of terms), but prisoners with vulnerabilities, including those at risk of self-harm, were being prioritised for contact.

1.18 Almost all prisoners now lived in single cells and some important improvements had been made to living conditions. While prisoners had reasonable access to materials to keep their cells clean, some we inspected needed to be refurbished. For example, broken windows required fixing and a damp problem needed to be addressed. Communal areas and landings were reasonably clean and the installation of new showers on some wings was positive, but some outside exercise yards remained littered. Prisoners' access to their stored property was very poor.

1.19 There was a reasonable selection of food, but prisoners were negative about it and better supervision was required while meals were being served. The planned opening of kitchenettes on each wing would enable prisoners to cook for themselves.

1.20 The applications system was not always effective, and some prisoners did not receive responses to their questions, which added to prisoners' lack of trust. Despite timely responses, replies to complaints did not always address the issues, and prisoners had little confidence in the system. However, leaders were taking steps to make improvements.

1.21 The equality strategy was not specific to HMP Manchester and progress against the action plan was slow. However, the governor had taken responsibility for improving outcomes for black and minority ethnic prisoners. Consultation with prisoners from most of the protected characteristics had recently restarted and lead managers for each group had been identified to take the work forward. Data analysis to identify potential disproportionate treatment was improving.

1.22 There was a lack of trust in the discrimination incident reporting form (DIRF) system, but some steps had been taken to address this. Responses to DIRFs were poor and the quality assurance process did not identify many of the issues.

1.23 Despite having a large number of foreign national prisoners, little support was available for this group, for example, there was a lack of translated material.

1.24 Strong partnership working took place between the prison and health partners. Health and social care governance were inconsistent, and some wing medicine administration rooms were dirty and untidy. Systems for checking, cleaning and updating some equipment lacked oversight.

1.25 There was an appropriate range of primary care services, waiting times were short and urgent appointments were available every day. Inpatient services offered dedicated and compassionate care, supported by close partnership working between officers and nurses. The local authority provided suitable social care packages (see Appendix II Glossary of terms).

1.26 The mental health team was responsive to demand, promptly assessing patients and prioritising support. Too many patients experienced delays in being transferred to hospital under the Mental Health Act.

1.27 The drug recovery unit was providing effective support, including outreach to patients on other wings. Clinical treatment arrangements were flexible and evidence-based, responding to needs. Pharmacy services had improved. Dental services were very good.

Purposeful activity

At the last inspection of HMP Manchester in 2018 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

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

1.28 Ofsted carried out a progress monitoring visit of the prison alongside our full inspection and the purposeful activity judgement incorporates their assessment of progress. Ofsted's full findings and the recommendations arising from their visit are set out in Section 5.

1.29 Most prisoners still had far too little time out of their cells and staff shortages at weekends exacerbated this. Approximately 43% of the population were unemployed and were locked in their cells for about 22.5 hours a day during the week.

1.30 Prisoners could now attend the library in person but only in very limited numbers. An order and delivery service continued to supplement the service. Literacy skills were promoted well. During the inspection, prisoners still only received one hour of gym time each week.

1.31 Leaders and managers did not provide enough education, skills or workplaces to meet the needs of all prisoners. They identified that, although they had the capacity to provide more face-to-face education places, they did not have enough prison staff to escort prisoners to the education wing.

1.32 Leaders and managers did not make sure that all the in-cell work packs were appropriately tailored to learners. Not all men received the support they needed to make progress. Too often, prisoners' access to education, training and work was determined by the regime, the wing they were on, or informal contact with prison staff, rather than their long-term plans. Leaders and managers had kept essential workshops

open during the pandemic, albeit at reduced numbers. Leaders had in place plans to expand their work provision and had continued to offer accredited courses throughout the pandemic.

Rehabilitation and release planning

At the last inspection of HMP Manchester in 2018 we found that outcomes for prisoners were reasonably good against this healthy prison test.

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

1.33 Most prisoners could only access one social visit a month for one hour and the length of time allowed on video calls was too short. Over the previous 18 months, a small number of prisoners and their families had taken part in a distance-learning relationships course. Support from family workers was good. The introduction of in-cell telephones helped prisoners stay in touch with their friends and family.

1.34 Meetings to oversee and drive forward reducing reoffending work had restarted after a long gap during the pandemic. There was no current strategy, but a needs analysis was being undertaken to inform one in the future.

1.35 Offender managers at the prison had become very task-focused in their work and their face-to-face contact with prisoners was limited. Prison offender managers' contact with too many prisoners was not sufficiently frequent and in most cases we reviewed, the focus on progression was not good enough. Only half of those in our survey knew they had a custody plan. Communication between offender managers in the prison and those in the community was effective and the quality of individual risk management plans was good.

1.36 Processes for identifying risks to the public posed by newly arrived prisoners were sound and measures to mitigate these risks were authorised and applied appropriately. However, there was a backlog of telephone calls waiting to be reviewed. The interdepartmental risk management team was not effective.

1.37 Categorisation reviews were timely, and decisions could be justified. Many prisoners who needed to be transferred to another prison so that they could progress remained at Manchester for too long.

1.38 The three types of accredited programmes on offer were appropriate for the population but the number of programme places planned for the following year would not meet the level of need.

Key concerns and recommendations

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

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

1.41 Key concern: Leaders had not yet made sure that the opportunities and services provided, such as offence-focused work, addressed the full range of needs among the new population of long-term category B prisoners. Staffing issues often affected prisoners' access to services because there were not enough officers to escort them from their wing.

Recommendation A: Leaders should make sure that services and progression opportunities, such as the range of offence-focused work, meet the needs of a long-term category B population – for example those convicted of violence against a partner. (To the governor)

Recommendation B: The staff profile and their allocation to tasks should be reviewed to ensure there are enough officers to escort prisoners to their appointments.
(To the governor)

1.42 Key concern: Governance and oversight of the use of force was weak. Data analysis was not sufficient and there was a lack of focus on learning lessons following incidents involving force, such as the use of batons. De-escalation techniques were not always used well enough and body-worn cameras were not routinely switched on during incidents. The use of special accommodation was not always justified.

Recommendation: Leaders should improve oversight of and accountability for the use of force, including special accommodation, to make sure it is only used when necessary and justified. Body-worn cameras should always be switched on at the beginning of an incident.
(To the governor)

1.43 Key concern: The level of self-harm remained high and there had been five self-inflicted deaths and five deaths through non-natural causes since the previous inspection. The new assessment, care in custody and teamwork (ACCT) case management documentation for prisoners at risk of suicide or self-harm was poorly completed in too many cases and prisoners did not always receive a good, proactive level of care.

Recommendation: The prison should take steps to reduce the level of self-harm. Prisoners should receive proactive, meaningful day-to-day care to reduce their risk of self-harm. Weaknesses in the standard of ACCT documentation should be addressed.
(To the governor)

1.44 Key concern: The use of key working to support prisoners and build trust in staff was poor, and some staff were not committed to promoting prisoners' progression or rehabilitation. Prisoners had negative perceptions of how some staff treated them. They did not have confidence in basic processes, such as the management of their personal property or the applications and complaints systems.

Recommendation: Leaders should implement ways of improving and measuring the levels of trust among prisoners to ensure that their perceptions about the prison are more positive. This should be supported by effective processes, such as the management of property and the applications and complaints systems. All prisoners should have a named member of staff who supports them to make positive changes in their lives.
(To the governor)

1.45 Key concern: We observed out-of-date stock items in primary care areas and gaps in mandatory training in moving and handling patients. Staff also had few opportunities to meet as a team and there was minimal evidence of lessons learned from incidents being widely shared.

Recommendation: Managers should strengthen oversight of primary care and social care services to make sure patient care is delivered safely.
(To the governor)

1.46 Key concern: Many prisoners were still locked in their cells for 22.5 hours a day during the working week and longer at weekends when the regime was regularly curtailed.

Recommendation: Prisoners should have regular and predictable time out of cell that is sufficient to promote rehabilitation and well-being.
(To the governor)

1.47 Key concern: Leaders and managers did not provide enough education, training or workplaces to meet the needs of all prisoners. For example, only 16 learners attended face-to-face classes in the education unit. Leaders did not make sure that prisoners were allocated to education or work activities that reflected their personal learning plans or goals. Too often, prisoners' access to education, training and work was determined by the regime, the wing they were on or informal contact with prison staff, rather than prisoners' long-term plans.

Recommendation: The number of education, training and workplaces must be increased significantly, and the allocation process should be well coordinated and equitable to make sure that prisoners undertake activities that meet their short-, medium- and long-term plans.
(To the governor)

1.48 Key concern: Sentenced prisoners had too few opportunities to receive visits from their family and friends and the sessions were too short. Visitors found it difficult to get through to the visits booking system by phone.

Recommendation: Leaders should make sure that prisoners are easily able to maintain links to their friends and family through regular, longer visits and an effective booking system.
(To the governor)

1.49 Key concern: Offender management in the prison was not proactive and contact with prisoners did not take place regularly and was not always meaningful, which meant individuals' progression was not fully supported.

Recommendation: Leaders should enable all eligible prisoners to receive structured, face-to-face offender management support that enables them to achieve their targets and progress through their sentence.
(To the governor)

Notable positive practice

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

1.51 Inspectors found five examples of notable positive practice during this inspection.

1.52 The governor and most of the senior leaders had moved out of the administration block and had relocated their offices on to the wings to improve visibility and communication. (See paragraph 2.2.)

1.53 Consultation with staff and prisoners through a 'drug summit' and survey to identify ways of addressing the use of illicit drugs had led to an effective action plan (See paragraph 3.31.)

1.54 Patients had access to the Greater Manchester Mental Health NHS Foundation Trust complaints department via their phone where they could register their complaints at trust level if they believed local staff would be biased in their handling of the issue. (See paragraph 4.35.)

1.55 Individual needs assessments carried out by pharmacy staff encouraged patients to take responsibility and be more confident in managing their own medicines. Reminder charts helped them keep track of when they had taken their medicines. (See paragraph 4.67.)

1.56 Library services promoted literacy among prisoners well. The Shannon Trust had continued to work with prisoners by providing in-cell work packs until face-to-face work could restart. The Writing on the Wall competition was well advertised and encouraged prisoners to write short stories. The Reading Ahead programme engaged over 250 prisoners, supplying free dictionaries and grammar books to those who took part. Participants prepared written reviews of six books or articles they had read through the programme. (See paragraphs 5.8 and 5.9.)

Section 2 Leadership

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

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

2.2 The governor had a clear understanding of the challenges facing the prison and had developed an appropriate set of priorities. His commitment to making improvements was clear, for example he had taken proactive steps to address the longstanding problem of illicit drugs entering the prison and had personally taken ownership of support for black and minority ethnic prisoners by chairing the forums. The decision to relocate leaders' offices to the wings instead of remaining in the administrative block helped improve leaders' visibility among staff and prisoners and promoted good communication (see paragraph 1.52).

2.3 There was a greater sense of order and calm in the prison than at our last inspection in 2018. Good leadership of some departments was in place, such as a renewed focus on the management of segregation and particularly strong partnership working between the prison and the health partners. A new incentives scheme had been introduced shortly before the inspection. This approach was based on good practice identified at other prisons and was being driven forward by a residential manager. However, management oversight of the offender management unit (OMU) was less robust. While core tasks were up to date, ongoing contact with prisoners by offender managers was not happening often enough and prison officer offender managers did not receive regular supervision of their casework.

2.4 In early 2020, HMP Manchester's role changed from a high-security local prison to a category B training prison with a small category A function. This led to the arrival of a new population with very different offending-related needs and expectations. However, due to the lack of places in other prisons and also the COVID-19 restrictions HM Prison and Probation Service and leaders in Manchester had not always been able to move prisoners onto other prisons to achieve their sentence plan targets. At the time of this inspection, there was still a large number of category C prisoners and a small number of prisoners convicted of sexual offences who should have been moved to other establishments to progress.

2.5 The change to a category B training prison in 2020 was followed shortly afterwards by the start of the COVID-19 pandemic. The need to

manage the pandemic and the absence of key partners on site hindered the development of a full range of rehabilitation opportunities for the new population. There were not enough opportunities for prisoners to undertake offence-focused work which meant that some were released having done little to reduce their likelihood of reoffending and risk of harm. (See key concern and recommendation 1.41.)

2.6 With the easing of COVID-19 restrictions, leaders were now able to speed up recovery steps, including the delivery of a better regime and a broader range of activities including more education classes.

2.7 Leaders had prioritised and overseen some important improvements in living conditions, such as the installation of a new heating system and the ongoing refurbishment of showers. Further funding from the Ministry of Justice had been earmarked for the replacement of the prison roof and cell windows.

2.8 The operational staff group was more experienced than at the previous inspection with far more having over two years in service. Several managers were newer in post and were not confident enough to hold others to account or provide support. Of the staff completing our survey, 29% said they had not had any opportunity to meet with a line manager to discuss their performance and 32% said they only did this once a year or less often. It was good that the Governor had recently introduced regular supervision for middle managers to develop their confidence and improve oversight of others. This is timely because we saw wing staff failing to challenge prisoners' poor behaviour, such as vaping on the wing landings.

2.9 Staff absences through sickness affected the delivery of the planned regime, for example, prisoners were often locked in their cells for much of the weekend. Redeployment to other operational duties limited the opportunity staff had to progress planned work or maintain a focus on the priorities. Leaders had not undertaken a staff reprofiling exercise to make sure that the right staff were in the right posts so that the regime could be delivered in full. An example of this was that there was the capacity to provide at least three times the number of education places, but the current allocation of staff meant not enough of them were available to escort more prisoners to the education wing.

2.10 We saw good and positive relationships between many staff and prisoners with some positive examples of care and compassion. However, leaders recognised that some staff were disengaged and had a limited belief in prisoner rehabilitation. Prisoners' trust in staff was being negatively affected by weaknesses in some basic processes, such as poor management of property and lack of replies to applications. Leaders had taken good steps to improve prisoners trust in the complaints system, but this needed more work.

2.11 Many wing staff we spoke to said they had experienced enormous personal pressure at work during the COVID-19 pandemic and that their morale had been affected over the previous 18 months. The governor recognised the importance of promoting staff well-being and

had maintained support systems throughout the pandemic, including the use of psychologists to run awareness raising and well-being sessions with staff, alongside more formal support systems, such as the care team.

2.12 Leaders were committed to providing training for staff, but this had been hindered during the pandemic and the current training plan was limited in scope. For example, training in trauma-informed ways of working with prisoners and mental health awareness events had not yet been rescheduled. Staff also told us that new assessment, care in custody and teamwork case management paperwork for prisoners at risk of suicide or self-harm had been introduced without formal training and some felt overwhelmed.

2.13 Leaders' key priorities were set out in a 'vision' document. The priorities were appropriate, but there was a lack of information on the main issues facing the prison or outlining what success would look like. Some strategies were too generic to be effective, for example, the Safer Manchester strategy did not outline issues specific to the prison, such as the reasons behind violence and self-harm. However, leaders had used a 'summit' to explore the supply and demand for drugs, which had led to some useful action being planned (see paragraph 3.31).

2.14 Leaders had maintained strong partnership arrangements with stakeholders to deliver key services, but working with a wider range of external stakeholders, such as, specialist agencies involved in promoting equality and diversity, could have helped overcome resource constraints.

2.15 The northwest of England had been hard hit by COVID-19 and the prison mirrored this local trend. Four outbreaks in the prison had taken place over the previous 18 months. Leaders managed them well in partnership with Public Health England, but they had taken a toll on prisoners and staff, and there had been a number of deaths. During the inspection, none of the prisoners had the virus, but some staff remained absent form work due to COVID-19's long-term impact.

Section 3 Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

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

3.1 HMP Manchester received about 37 prisoners a month. All new arrivals were handcuffed when leaving the escort vehicle without a risk assessment having been undertaken to justify this. All were strip-searched, which was unnecessary, as a body scanner was used to detect secreted items.

3.2 The reception area was clean and functional, although holding rooms were sparse and did not provide prisoners with any information about the prison. Those we saw going through reception processes were dealt with promptly and efficiently. In our survey, 73% of respondents said they were treated very or quite well in reception. During our inspection, we observed prisoners getting a hot drink and staff taking time to interact with new arrivals.

3.3 The initial interview in reception to assess prisoners' risk of self-harm and other vulnerabilities was conducted at an open desk, which reduced the likelihood that important information would be disclosed. However, a nurse undertook a health screening and once they were in the first night centre, prisoners received two further risk interviews. Additional checks on new arrivals were carried out during their first night, providing additional reassurance about their safety.

3.4 68% of respondents to our survey, and those prisoners who arrived during our inspection, said they felt safe on their first night First night cells on the induction wing were clean and well equipped, prisoners we spoke to said they had access to all the basics they needed, although, they spent about 10 days on the induction wing, with very limited time out of cell (see paragraph 5.2).

3.5 Staff we observed on the induction wing were friendly and helpful towards prisoners. In our survey, only 11% of prisoners said they had had access to a Listener (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) and only 9% said they had been offered support from another prisoner before being locked in their cell for the first night (see paragraph 3.38).

3.6 In our survey, 73% of prisoners said they had received an induction but only 48% said it covered everything they needed to know about the

prison. However, prisoners we spoke to on the induction wing told us they got all the information they needed informally from staff.

3.7 Face-to-face induction sessions had restarted two weeks before our inspection and documentation was comprehensive, providing a wide range of information about the prison and regime. Peer workers were not involved in the induction, and documents were not available in languages other than English.

Managing behaviour

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

Encouraging positive behaviour

3.8 There was a greater sense of order and calm in the prison compared to our last inspection in 2018. Levels of violence had declined overall, but the rate of serious assaults had increased, and some incidents involved the use of bladed weapons. In our survey, 25% of prisoners reported feeling unsafe at the time of the inspection, but those with mental health problems and disabilities were significantly more negative. More of those living on K wing (75%), which held prisoners who were vulnerable because they had been convicted of sexual offences, said they felt victimised by threats and intimidation from staff and other prisoners than those in other areas of the prison (25%), this is in contrast to what we usually find.

3.9 Management oversight of violence reduction work was limited, and violence reduction officers were frequently redeployed to other duties, which limited the time they had to spend on carrying out safer custody work. However, we were confident that all reported violence was investigated, and that the quality of initial investigations was reasonably good.

3.10 Perpetrators of violence were meant to have been managed under challenge, support and intervention plans (CSIPs) (see Appendix II Glossary of terms) but following initial investigation, support from staff from key functions, predominantly residential staff, was poor. As in 2018, some staff lacked an understanding of how to apply the CSIP process. The prison had recently received support from HM Prison and Probation Service (HMPPS) to improve practice in this area, but more needed to be done to make sure staff knew what the CSIP process was for and were confident enough to implement it in full. For example, plans failed to demonstrate that sufficient support was offered, and reviews were not always completed. Some prisoners did not know they had been on a CSIP and were not included in the process. There was no formal support for victims, and basic tasks, such as scheduled welfare checks, did not always take place.

3.11 A weekly safety intervention meeting was well attended, and participants discussed prisoners of concern, but the formal strategic meeting, known as the Safer Manchester meeting, had only restarted in June 2021 and was not yet effective as attendance was limited.

3.12 Both the safety and violence reduction strategies had been reviewed recently, but they did not fully explore the causes of violence. They largely described national HMPPS guidance and were not supported by local data to identify weaknesses, drive improvements or support a reduction in violence. Action plans did not contain time-bound targets to improve outcomes or set specific measures of success.

3.13 A new incentives scheme had been introduced shortly before the inspection. This approach was based on good practice identified at other prisons and was being driven forward by a residential manager. The scheme also had a more systematic approach to ensure that reviews were carried out when they were due, and there was a greater emphasis on fairness and quality assurance. While the scheme showed promise, it was too early to tell if it would encourage prisoners to behave well.

Recommendation

3.14 **Perpetrators of violence should be managed robustly through individual plans, and proactive support should be given to victims.**

Adjudications

3.15 There had been 942 adjudications in the previous 12 months, a 50% reduction compared to the previous inspection. Some staff told us that they lacked confidence in the system and avoided using it as too many adjudication cases remained outstanding or did not proceed. During our inspection, there were 248 outstanding charges, some of which were over nine months old. Over a third of these charges related to serious incidents, such as violence or the use of illicit drugs, and over 130 that had been referred to the police were yet to progress. We also identified a significant number of charges relating to positive drug tests that were not processed due to staff shortages (see paragraph 3.29).

3.16 There were also daily operational issues that contributed towards delays in completing adjudications, such as staff failing to attend hearings or not providing the relevant documentation.

Recommendation

3.17 **The large number of outstanding adjudication cases not yet completed should be addressed to improve confidence in the system and challenge unacceptable behaviour, such as violence and the use of drugs.**

Use of force

3.18 There had been 384 incidents involving the use of force in the previous 12 months, which was lower than at the previous inspection.

3.19 Batons had been drawn on two occasions in the 12 months before the inspection and used once. Although all such incidents were reviewed, the investigations lacked sufficient managerial oversight and did not identify issues or lessons to be learned. For example, they did not address problems with staff swearing nor did they sufficiently explore alternatives to the use of the baton. (See key concern and recommendation 1.42.)

3.20 Some good work had taken place to improve the completion of paperwork relating to use of force incidents. During the inspection, very little was missing and most documentation demonstrated sufficient justification for the use of force. However, not all planned incidents were recorded, and body-worn cameras were not always switched on during incidents (see key concern and recommendation 1.42).

3.21 In our review of recorded incidents, de-escalation techniques were not always used well enough. For example, a continuously barking patrol dog accompanied all planned removals and relocations, heightening tension and there was little dialogue between staff and the prisoner. (See key concern and recommendation 1.42.)

3.22 Special accommodation had been used 23 times in the 12 months before our inspection, which was about the same as at the previous inspection. Paperwork we examined did not always provide enough justification for the use of special accommodation or demonstrate that it was for the shortest time possible. Although the use of special accommodation was reviewed by a manager, it was not clear what action had been taken to make sure lessons were learned as many issues with its use persisted.

3.23 The monthly use of force committee meeting analysed data but did not always take action to address issues raised. For example, in one set of minutes, it was identified that body-worn camera use was poor and that there was disproportionate use of force on black and minority ethnic prisoners, but no action was taken to address these concerns.

Segregation

3.24 The number of segregated prisoners had declined since 2018. The management of the unit had improved and was now good. It was positive that prisoners were no longer routinely strip-searched when entering the unit. Communal areas were clean, and all cells were adequately equipped and free of graffiti. A cell had been converted into an interview room for confidential meetings with prisoners to support and progression. The daily regime had improved slightly, and prisoners had daily access to fresh air while exercising and could also use the phones and showers every day. However, exercise yards remained

stark. Prisoners could also collect their own meals, which gave them the opportunity to interact with staff.

3.25 Reintegration planning was now good, and more prisoners moved back to the main wings. They benefited from the support of a psychologist and mental health specialist while in the unit, which had led to good quality assessments of their risks and needs and the development of a detailed plan for each prisoner. The plans assisted staff in understanding the risks and triggers of those in their care and were updated regularly to support reintegration.

Security

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

3.26 Security procedures were mostly proportionate, although some practices that we highlighted in 2018 remained. For example, all prisoners were routinely strip-searched on reception from other prisons, despite the availability and good use of a body scanner. Similarly, all prisoners being released into the community were also strip-searched, but the prison was not able to offer a valid reason for this practice.

3.27 The security team remained well-resourced and was appropriately focused on the supply of illicit items and associated violence, the prison's key risks. A monthly tactical assessment was used effectively to identify gaps in intelligence and provide other departments with an appropriate understanding of current security concerns.

3.28 The prison's links with Greater Manchester Police and the regional organised crime unit continued to help manage effectively the large number of prisoners from organised crime groups who were located at Manchester. In addition to the primary security team, a dedicated manager had a good understanding of the risks posed by staff corruption and threats caused by prisoners with extremist views.

3.29 Drug testing had restarted in April 2021 appropriately focused on suspicion testing. Data from results from April to July, indicated a positive test rate of 23.4%, just under half of which related to the use of psychoactive substances (see Appendix II Glossary of terms). However, testing staff were not scheduled enough time to follow up drug results, which meant that time limits for processing positive test results were sometimes exceeded meaning no action was taken against the prisoner. For example, in August, disciplinary charges were not brought in 60% of positive test results because the results had not been processed in time, which undermined the use of testing as a deterrent (see paragraph 3.15).

3.30 A dedicated senior leader oversaw the local drug strategy. There were close working relationships with the health and substance misuse service providers (see paragraph 4.60), but the monthly drug strategy meeting was poorly supported by staff from other key departments, such as the security and residential departments and the offender management unit.

3.31 The prison had held a consultation forum known as the 'drug summit' and undertook an associated survey, where the views of prisoners and staff were sought to help address the use of illicit drugs. The subsequent action plan had developed with pace. (See paragraph 1.53.)

Recommendation

3.32 **More staff should be available to make sure that laboratory test results demonstrating drug use are processed within the required timeframe so that disciplinary action can be taken against the prisoner.**

Safeguarding

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

Suicide and self-harm prevention

3.33 Since the previous inspection, there had been five self-inflicted deaths, two in the six months before our inspection. There had also been five deaths that had not been from natural causes, some of which were linked to drugs. The rate of self-harm remained similar to the level seen at the previous inspection which was a concern. (See key concern and recommendation 1.43.)

3.34 There was an action plan relating to findings from deaths in custody reports. However, many Prisons and Probation Ombudsman (PPO) recommendations appeared repeatedly and action to address them had not been fully embedded. For example, leaders had issued several notices to staff about the use of the correct emergency response code, yet this continued to be a recommendation in subsequent PPO reports. During our inspection, we received mixed responses when we asked staff about the correct procedure.

3.35 Leaders did not investigate all serious incidents of self-harm so lessons could be learned and those that were investigated lacked sufficient enquiry.

3.36 The prison's strategic approach to reducing the level of self-harm had been neglected. Monthly Safer Manchester meetings were poorly attended. There had been no detailed analysis of data so that the causes of self-harming behaviour could be determined and appropriate action planning taken to address them.

3.37 Staff we spoke to knew who was on an assessment, care in custody and teamwork (ACCT) case management document for prisoners at risk of suicide or self-harm, but many told us they had not received enough training in how to use the new version. As a result, the documents were poor. For example, care plans were missing or incomplete and they regularly failed to identify risks and triggers or sources of support. Records of staff's interaction with prisoners were often missing, case coordinators were frequently inconsistent, and supervisors did not always complete their daily checks. Some care provided to those in crisis was not as proactive as we would expect. In our survey, only 50% of prisoners who had been on ACCT case management said they felt cared for by staff, and prisoners we spoke to had mixed views about the standard of the support they received. (See key concern and recommendation 1.43.)

3.38 During the inspection, only five Listeners were in post, which was far too few. In our survey, 35% of prisoners said it was easy to speak to a Listener if they wanted to. Prisoners repeatedly told us they felt many staff did not support the scheme and did not always arrange for prisoners to have access to a Listener. The Listeners were positive about their role and the support they received from the Samaritans but felt that a lack of time of out cell hindered prisoners' access to their service. Although Listeners had recently started to attend the monthly Safer Manchester meeting, there were no other formal arrangements for them to meet regularly with the safer custody department to raise concerns.

3.39 Prisoners could access the Samaritans telephone line at any time during the day or night, using their in-cell phone, but a 30-minute limit on the length of the phone call was unnecessary. While leaders had tried to extend this time to three hours, issues with the telephone system meant they had not been successful.

Recommendations

3.40 **All serious incidents of self-harm should be investigated thoroughly so that lessons can be learned, and action taken to improve care for those in crisis.**

3.41 **The prison should make sure there are enough trained Listeners for the population and prisoners should always have access to the service.**

Protection of adults at risk (see Appendix II Glossary of terms)

3.42 The prison's safeguarding adults policy was too brief and out of date. The focus was on prisoners' social and physical care needs and did not explain what makes an adult vulnerable or contain guidance on how to protect them.

3.43 Links with the local adult safeguarding board had lapsed and prison staff had not been attending meetings, although there were plans to re-establish contact.

3.44 Most wing staff we spoke to were unfamiliar with safeguarding risks and were unaware of their responsibility to minimise them, increasing the possibility of issues being missed.

Recommendation

3.45 **Training should be provided to make sure that all staff are aware of their duties to safeguard vulnerable adults who are at risk of abuse or neglect.**

Section 4 Respect

Prisoners are treated with respect for their human dignity.

Staff-prisoner relationships

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

4.1 In our survey, 68% of prisoners reported that most staff treated them with respect and 71% stated that there was a member of staff they could turn to if they had a problem. The inspection team saw many examples of positive staff-prisoner relationships, in which staff knew prisoners well and provided a good level of care, as well as compassion and support. Support was particularly good on D wing and the induction unit.

4.2 We also observed staff who were distant and disengaged; they were unaware that their role in a category B training prison should be to rehabilitate prisoners. For example, some staff chose to avoid talking to prisoners when they had the chance. Some prisoners told us about staff speaking to them in a dismissive way or using inappropriate or foul language when addressing them. In our survey, only 46% of prisoners said they had not been bullied or victimised by staff while for vulnerable prisoners in K wing, the figure was 19%. (See key concern and recommendation 1.44.)

4.3 Some basic operational issues undermined the level of trust prisoners had in staff. For example, some prisoners had moved to a different cell and their property had been misplaced during the move, which caused frustration and mistrust. Additionally, in our survey, very few prisoners (24%) stated that, if they were being bullied or victimised by other prisoners, they would report it, further evidence of a lack of trust in staff. The prison information desk worker initiative was not well developed enough to offer an alternative way of seeking advice or guidance. (See key concern and recommendation 1.44.)

4.4 Over the previous decade, we have reported negatively about the delivery of personal officer and key work at Manchester and this weakness persisted. In August 2021, only 83 key worker sessions had been recorded and during the inspection we found that despite all prisoners being allocated a key worker, the majority were waiting for months to have their first session. However, during COVID-19 outbreaks, the prison had identified more vulnerable prisoners, such as those on an assessment, care in custody and teamwork (ACCT) case management document for prisoners at risk of suicide or self-harm, to make sure they received regular support from a key worker. (See key concern and recommendation 1.44.)

Daily life

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

Living conditions

4.5 Some important improvements had been made to prisoners' living conditions at HMP Manchester. A reduction in the prison population meant that at this inspection almost all prisoners (92%) now lived in single cells, whereas in 2018, approximately a third of prisoners lived in double cells and cramped conditions. All prisoners now also had a phone in their cell.

4.6 While prisoners had reasonable access to materials to keep their cells clean, some we inspected needed to be refurbished. For example, broken windows required fixing, a damp problem needed to be addressed, and toilet seats had to be replaced. While leaders had identified these issues, there were delays in getting them sorted out promptly – there were several outstanding maintenance tasks for the contract provider to deal with.

Broken windows in a cell

4.7 Communal areas on wings were mostly clean and, in our survey, 69% of prisoners said they were normally very or quite clean. Some prisoners continued to throw food and waste out of their cell windows, which meant outside exercise yards were littered. This continued to contribute to a rat infestation in some parts of the prison.

Outside exercise yard of B wing

4.8 It was positive that new showers were being installed, but in our survey only 56% of prisoners said they could have a shower every day.

New showers on one wing

4.9 Only 15% of survey respondents said they could access their stored property promptly if they needed it, and many more shared their frustrations about this during the inspection. Prisoners had to apply to reception to get hold of their stored property through the electronic system on the wings and if there were enough staff, they could collect some belongings for prisoners. However, reception staff were frequently redeployed, especially at weekends, which meant that prisoners experienced long delays. We found stored property cards in reception for 79 prisoners, whose property was ready for collection. (See key concern and recommendation 1.44.)

4.10 In our survey, 31% of prisoners reported that their cell call bell was answered within five minutes. Monitoring data showed that most cell call bells were answered within five minutes, and it was not routine for calls to be left unanswered for longer, which made it difficult to understand why prisoners had a negative perception.

Residential services

4.11 Although there was a reasonable choice of food, with options available for vegetarian and vegan diets, prisoners were negative about the quality. In our survey, 32% of prisoners said the food was very or quite good. Food comment books where prisoners could report issues were underused, but consultation on some wings had started to identify and address some of the problems.

4.12 During our visit, prisoners ate all meals in their cells. The prison planned to open kitchenettes with cookers and fridges on some wings

in the very near future. This would enable prisoners to cook meals for themselves.

4.13 The main kitchen was reasonably clean, as were some wing serveries. Better staff supervision was required when meals were being served to make sure portion sizes were controlled and to prevent food from running out.

4.14 Prisoners could order a sufficient range of goods from the shop and items from various catalogues could also be ordered, although a 50p fee was applied to each order, which was not appropriate. The facilities list, which sets out what property prisoners can have, was not yet suited to the longer-term population and required updating.

4.15 Support to help prisoners exercise their legal rights was adequate, but prisoners' phone calls to solicitors were cut off after 30 minutes, which was unnecessary.

Prisoner consultation, applications and redress

4.16 Prisoners made applications through the electronic system on the wings, but the response process was not working effectively. Some departments had not replied to applications in over two months, which caused additional frustration and led to prisoners' mistrust of staff. (See key concern and recommendation 1.44.)

4.17 The timeliness of responses to complaints was good, but prisoners had little confidence in the process. Leaders had noted this and were taking some steps to make improvements. However, we found that complaint forms were not always easily available on some wings, which meant prisoners had to ask a member of staff for one. Our survey showed that only 26% of prisoners who had made a complaint felt that it had been dealt with fairly, and some of the responses to complaints we looked at did not always address the issues raised and simply asked prisoners to submit a different form. A quality assurance check of 10% of responses did not always rectify these deficiencies. (See key concern and recommendation 1.44.)

4.18 During the pandemic, some limited consultation with prisoners had continued on the wings. This had recently been extended and the formal prisoner council meeting had started again, attended by most wing representatives.

Equality, diversity and faith

Expected outcomes: There is a clear approach to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relationships. The distinct needs of prisoners with particular protected characteristics (see Appendix II Glossary of terms) and any other minority characteristics are recognised and addressed. Prisoners are able to

practise their religion. The chaplaincy plays a full part in prison life and contributes to prisoners' overall care, support and rehabilitation.

Strategic management

4.19 A new overarching equality and diversity policy had been introduced, outlining the responsibilities of all staff in promoting equality in the prison. It was supported by an equality strategy, but it was not specific to Manchester and not informed by local consultation. The equality action plan contained relevant targets, but there was not enough evidence to show that they were being achieved. The equality action team (EAT) meeting had been suspended due to COVID-19 restrictions but had restarted in April 2021. It was chaired by the deputy governor or the governor, who demonstrated a strong commitment to equality work. Attendance by other key people was good and action to meet prisoners' needs was identified at the meeting but was not tracked, so it was difficult to tell if the changes had been made.

4.20 Two full-time equality officers had been appointed but not deployed to the equality team for some considerable time. The equality lead staff member and the safety custodial manager, whose remit covered safety and some residential units as well as equality, were struggling to complete the additional work created by the failure to deploy the equality officers.

4.21 A system of protected characteristic 'allies' – staff and prisoners who were responsible for supporting all prisoners with protected characteristics – had been in place, but it had not become embedded. Leaders had rightly reverted to a system where lead managers for each group had been identified to take the work forward.

4.22 Prisoner equality representatives attended the Equalities Action Team meeting and took an active part, however they did not have a specific job description or receive regular supervision for their role.

4.23 Some equality data was being generated, and the amount and quality was improving. Staff were also beginning to use the data to identify potential disproportionate treatment, but it was not always possible to see what action was taken as a result (see also paragraph 3.23).

4.24 Leaders had identified that they needed to collate initial equality data on prisoners more effectively and had introduced a screening tool for new receptions, but it was not yet fully embedded.

4.25 Consultation with most prisoners with protected characteristics was good and had taken place through the summer of 2020 and had then restarted in April 2021. Black and minority ethnic prisoners were consulted every month, while consultation with other groups took place quarterly.

4.26 Prisoners did not trust the discrimination incident reporting form (DIRF) system. Leaders had identified this and taken steps to address

weaknesses, which had led to an increase in the number of complaints submitted. Only 27 DIRFs had been submitted through the whole of 2020, while 43 had been submitted from April to September 2021. The quality and timeliness of responses to DIRFs were poor. In the sample we examined, two had not received a response after six months and several had answers that did not deal with the original complaint.

4.27 Quality assurance did not identify issues or challenge the quality of DIRF responses. West Yorkshire Fire Brigade undertook some external quality assurance, but their findings were not used to improve responses either.

Protected characteristics

4.28 In our survey, 22% of prisoners identified themselves as coming from a racial minority group. Prisoners from black and minority ethnic backgrounds were significantly more likely to report bullying or victimisation by prisoners (43% compared to 20%) or by staff (63% compared to 33%) than white prisoners. The governor had taken responsibility for improving outcomes for black and minority ethnic prisoners. Events relating to race equality, such as Black History Month, were well promoted, and information was provided to staff and prisoners.

4.29 Events, such as Gypsy, Roma, Traveller History Month, which had been well promoted in the previous year, had not been possible in 2021. Well-attended forums had taken place in 2020, but leaders had struggled to identify prisoners from this group recently and the previous forum had been cancelled due to a lack of attendance.

4.30 The prison held 55 foreign national prisoners during the inspection. There was not enough information available for these prisoners and we saw very little in languages other than English. A professional telephone interpretation service was available but not always used despite being needed.

4.31 Foreign national prisoners who did not receive visits received £5 a month in additional phone credit so they could contact their families. When the pandemic started all prisoners were also given £5 in phone credit, but this was not extended to foreign national prisoners, which was not acceptable.

4.32 No advocacy was available for foreign national prisoners, and the prison did not provide any information or support to help those being deported from the UK to access legal assistance.

4.33 Prisoners over the age of 50 accounted for 14% of the population and their needs were met. There were mixed outcomes for disabled prisoners. Those held on the H1 landing in the social care unit were well catered for – two full-time social care nurses were on hand and the facilities were suitable. Those in the normal prison location reported much poorer perceptions of their treatment. In our survey, 77% of disabled prisoners reported that they spent less than two hours out of

their cell on week days, compared to 54% of non-disabled prisoners, and 73% had felt unsafe at some point during their time at Manchester compared to 37% of non-disabled prisoners. Leaders did not know the reasons for this.

4.34 LGBT prisoners held regular well-attended forums. They could celebrate Pride month in June each year. Information on LGBT issues was available for staff and prisoners. A local transgender prisoner policy was in place to provide operational guidance for staff but it did not include some important areas such as the management of local case boards which should have ensured trans prisoners were encouraged and enabled to express their gender identity.

4.35 Leaders had set out a comprehensive plan to improve outcomes for young adults, who made up 18% of the population at Manchester. A detailed strategy was in place, as well as an action plan, which outlined the prison's objective of achieving accreditation in working with young adults. The plan included setting up a wing for younger prisoners to live on and implementing maturity screenings. It also included delivering the Choices and Change programme, a resource pack for key workers or prison offender managers to use in one-to-one sessions with young adults identified as having low psychosocial maturity.

Recommendation

4.36 **Information should be available in a range of relevant languages and professional telephone interpretation should always be used when necessary to support prisoners whose first language is not English.**

Faith and religion

4.37 A large team of chaplains was available for most religions. The chapel was used for both Muslim and Christian services, and there was a multi-faith room on A wing. Prisoners in the category A unit could participate in all forms of corporate worship in their visits room.

4.38 Chaplains had maintained their statutory duty throughout the pandemic and had seen all segregated prisoners every day. They maintained a log of prisoners that staff had identified as vulnerable and had supplemented this list with prisoners they had assessed as needing additional support. A member of the chaplaincy saw these prisoners every day. The team was active and attended most meetings, including some ACCT case management reviews for prisoners at risk of suicide or self-harm.

4.39 Corporate worship had restarted, but numbers attending was restricted. Muslim prisoners could only attend Friday prayers once every three weeks because of their high numbers in the jail, while Christian prisoners could attend a service on four Sundays out of five. All Bible study classes, and additional faith work had been suspended due to COVID-19 restrictions.

Health, well-being and social care

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

4.40 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC issued 'requirement to improve' notices following the inspection (see Appendix III).

4.41 The change in the prison population was reflected in a health needs assessment completed in March 2021. Working relationships between the prison, commissioners and the provider Greater Manchester Mental Health NHS Foundation Trust (GMMH) were very strong, particularly during COVID-19 outbreaks at the prison. Public Health England had provided essential guidance in managing the outbreaks.

4.42 Clinical governance systems reflected NHS standards, measures had been put in place to address recommendations from deaths in custody reports, and lessons learned from other incidents had been implemented. For example, the assessment of new prisoners' mental health needs and risks had been improved. However, we found some inconsistencies in oversight, which introduced unnecessary risks in patient care.

4.43 More prisoners in our survey (59%) told us the overall quality of health care was good or very good. The prison council, used by health care staff to consult users on service developments, had been disrupted due to the restrictions. However, service user views on the quality of their experiences were being sought in a GMMH patient satisfaction survey, which had been reintroduced in August 2021.

4.44 An experienced manager had been brought in temporarily to manage the service, which had an appropriate mix of clinicians and support staff, with nurses and GPs providing 24-hour cover. There was less reliance on agency staff than in 2018, despite chronic problems in recruiting general nurses. We observed good-natured but professional interactions with patients.

4.45 Clinical supervision had been maintained as far as practicable throughout the COVID-19 restrictions. Staff had good access to mandatory training, but not all of them had participated in up-to-date moving and handling patients' courses. Other than staff handovers, we were not aware of any staff meetings where they could meet or share information, lessons learnt or concerns. There were plans to reintroduce a system to enable GMMH staff to learn lessons from adverse events across prisons in the north west, but it had not yet started. (See key concern and recommendation 1.45.)

4.46 Each patient had a confidential clinical record on SystmOne (the electronic clinical information system) which contained care plans for those with long-term conditions and consultation notes.

4.47 Health care staff, including those working in sub-contracted services, used GMMH policies, such as those for preventing and managing communicable diseases and safeguarding adults.

4.48 The health centre was a good facility, although some refurbishment work was needed to improve the environment. The two waiting areas had been refurbished to a reasonable standard. The wing clinical rooms did not meet infection control standards, were grubby and cluttered, and could not be used for sterile procedures.

4.49 Medical equipment was generally well-maintained and checked. However, we found several examples of out-of-date stock items such as syringes and vaccines, and blood-smeared content in one emergency bag, which was unacceptable. (See key concern and recommendation 1.45.)

4.50 Emergency equipment was strategically placed in the prison and checked regularly. Health staff were available to respond to emergencies using radio codes. However, not all custodial staff fully understood the code system or could find the nearest automated external defibrillator.

4.51 The health care complaints system had improved. It was now confidential, accessed easily by patients without them having to request forms, and complaints were no longer scanned into clinical records. Patients had access to a free confidential GMMH complaints line via their phones. (See paragraph 1.54.)

4.52 There were 35 to 40 complaints per month, although 40% of those we sampled were requests or comments. Responses were often informed by face-to-face meetings with complainants and were non-confrontational and timely, focusing on the issue raised. As in 2018, complaint responses were hand-written but might have been better if typed.

Promoting health and well-being

4.53 A new prison strategy for well-being had been drafted, but not yet implemented. The lead nurse was responsible for health promotion. GMMH promoted health at the health centre, such as through publicising the national calendar of health promotion events and making available condition-specific information leaflets, including those on diabetes, heart disease and hypertension.

4.54 Suitable local and national health screening took place for conditions such as chlamydia, COVID-19, diabetes-related eye problems and abdominal aortic aneurysm, and bowel screening was also available. Age-appropriate immunisations and vaccinations were being

administered, including those for blood-borne viruses and tuberculosis, and preparations for seasonal influenza were in hand.

4.55 Nurses provided sexual harm minimisation advice, and condoms were available to protect against infection transmission.

Primary care and inpatient services

4.56 New arrivals received a comprehensive screening and an assessment of their needs, which included an assessment of their physical and mental health. The reception screening process was thorough and covered baseline physical observations and testing for blood-borne viruses and COVID-19. Staff completed all primary and secondary health care screenings within the required timeframe.

4.57 An appropriate range of clinics was available, and access was timely. Same day appointments were available for urgent medical concerns. Clinics included GP appointments, nurse-led clinics, as well as optometry, physiotherapy and sexual health services. Waiting times were kept to a minimum – during the inspection, a GP appointment was available within 10 days of an application being received and nurse-led clinics were generally available within seven days. Prisoners submitted applications to the health care department through the electronic system, however applications were not always reviewed as a priority every day.

4.58 Attendance at nurse-led clinics had improved slightly but remained a concern. Between April and August 2021, 24% of appointments did not go ahead, 11.6% of which were as a result of non-attendance. Ongoing COVID-19 restrictions meant there was a reduced capacity in health care waiting rooms, and prison staff did not always escort patients to their appointments.

4.59 Oversight of long-term health conditions was good, each area having a lead nurse who worked well with the GP. Outside hospital appointments were well managed, leading to minimal cancellation.

4.60 The inpatient unit had 19 beds, 16 of which had become part of a north-west regional consortium of units, with an agreed policy for admissions, which meant inappropriate admissions were now uncommon.

4.61 Bed occupancy was high at 89% when we visited. Two or three beds were usually occupied by patients with physical health or palliative care needs. Their needs were often incompatible with those of most patients who had complex and severe mental disorders, awaiting hospital transfers.

4.62 A group of compassionate prison officers and nurses delivered personalised care, underpinned by good communication, shared risk assessments and detailed care planning. A registered nurse was on duty 24 hours a day. The staff group generally maintained a therapeutic

environment, despite some limitations related to the mix of patients and the use of inpatient facilities by category A patients.

4.63 It had not been possible to run therapy groups for some time, however, staff were imaginative in their attempts to deliver therapies, in some cases, through cell doors. The library also supplied books to order, and in-cell education packs and diversionary material were available.

4.64 Effective discharge arrangements were in place and all patients were seen about two weeks before they left the prison. Any arrangements for transferring ongoing care and treatment to a new provider were made during a discharge clinic. Patients were also given a supply of medicines to take with them, as necessary.

Social care

4.65 The prison had a memorandum of understanding, dated 2016, with Manchester City Council (MCC) for the provision of social care, although the prison could not produce its copy. MCC had appointed GMMH to provide social care.

4.66 Health care staff screened prisoners on arrival at the prison and referrals were made to the local authority for a further assessment of the prisoners' needs. Dedicated social care staff, trained in undertaking specialist assessments, responded in a timely manner to referrals.

4.67 During the inspection, 11 prisoners met the threshold for receiving social care. Social care support plans were in place and most care was delivered in the social care unit on H1 wing, where equipment and adaptations were available, including portable personal alarms for use in an emergency. A peer support worker, based in the unit, assisted with non-intimate care. Safer custody staff provided the worker with support and supervision. Relationships between social care staff, safer custody officers and prisoners in the social care unit were respectful.

Mental health care

4.68 GMMH provided specialist mental health services. Lower intensity psychological interventions and trauma-informed support were delivered by health and well-being practitioners and the Survivors Manchester group. A seven-day service was provided, and a specialist mental health nurse screened all prisoners on arrival, undertaking a full assessment within 24 hours if necessary. Support was appropriately prioritised.

4.69 There were about 100 patients on the caseload, and, despite current constraints, most patients were being appropriately supported on a face-to-face basis or through in-cell telephones as necessary. Support was provided promptly, although group work had been suspended, and psychological services interventions for patients with mild to moderate problems had only just been restarted. Plans to reintroduce a full range of interventions were realistic.

4.70 Staffing was adequate and mostly made up of mental health nurses with sessional psychiatric input. Clinical psychology was available one day a week, which was limited, given the prison's new population. The team met every day to make sure all referrals had been allocated, and regular multidisciplinary meetings reviewed caseloads. There was an open application process, and a formal diagnosis was not always essential to trigger support.

4.71 A duty worker responded to any acute concerns and the team provided regular input into initial ACCT meetings and ongoing reviews if required. Medical interventions included initiation of clozapine (an anti-psychotic) and we saw evidence of regular patient physical health checks.

4.72 Patients we spoke to were generally positive about the care and support provided. Care plans were basic but reviewed regularly. The care programme approach for patients with complex or severe and enduring mental health problems was not always used consistently or comprehensively and did not always involve a range of professionals. Prison staff, including those in the inpatient unit, had not received any recent mental health awareness training.

4.73 Few patients were released directly into the community, but the team worked closely with other agencies to make sure continuity of care was maintained. Patients requiring specialist care and treatment under the Mental Health Act faced significant delays in being transferred to hospital.

Recommendations

4.74 **Dedicated mental health awareness training should be available for custody staff.** (Repeated recommendation 2.85.)

4.75 **Patients requiring treatment in hospital under the Mental Health Act should be transferred without delay.**

Substance misuse treatment

4.76 A seven-day addiction support service was delivered through strong leadership, an established team and effective governance processes. We saw evidence of close working with partners. Staff from the provider Delphi regularly contributed to drug strategy meetings and were involved in promoting the incentivised substance free living unit on G wing. Substance misuse training packages were available, but few prison officers had made use of them.

4.77 Staff concentrated most of their efforts on the designated drug and alcohol recovery unit on G wing, which included facilitating some group work. One-to-one work took place across all residential areas and in-cell telephony allowed welfare support to continue, with 210 patients on the caseload.

4.78 Although the range of psychosocial provision had been reduced, services broadly met the needs of the population and patients we spoke to valued them. Substance misuse recovery plans envisaged reintroducing mutual aid through Alcoholics Anonymous and Narcotics Anonymous and promoting the role of peer mentors.

4.79 The quality of patient records was good, and they reflected regular contact and individual substance misuse recovery plans. A dual diagnosis pathway for patients with both mental health and substance misuse needs was being used effectively.

4.80 The prison's role change meant that very few new arrivals required additional clinical monitoring or detoxification support. Nevertheless, safe systems were in place, and reception screening flagged up any acute needs, which triggered a medical assessment on the following day if required. Harm reduction advice was provided to prisoners on arrival and delivered on an ongoing basis, while individual support was offered when required.

4.81 Forty-one patients were receiving opiate substitution treatment. Prescribing was flexible and tailored to individual needs. Plans were agreed with the patient, and there was clear evidence showing that regular reviews took place.

4.82 Discharge and transfer planning arrangements were in place, and as Delphi operated from several northwest prisons, consistent ongoing support could be maintained in many cases. Information and advice on avoiding an overdose after release were provided where necessary, along with a supply of naloxone (a drug to manage a substance misuse overdose). The ARC building located immediately outside the prison, was a good community facility, operating as a recovery hub that offered a range of advice and practical support.

Medicines optimisation and pharmacy services

4.83 Medicines were supplied by an on-site pharmacy. The pharmacy was well-led, well-staffed and had improved since 2018. It supported the prison in its drug strategy by ensuring strict prescribing of divertible medicines, such as analgesics, and by sharing the results of prescribing audits with the team to monitor progress. Individual needs assessments carried out by pharmacy staff encouraged patients to take responsibility and be more confident in managing their own medicines. Reminder charts helped them keep track of when they had taken their medicines and some patients, we spoke to, valued the support they received. (See paragraph 1.55.)

4.84 Staff pharmacists, including a non-medical prescriber, offered on site support to technicians and clinicians, medicine use reviews and twice-weekly pharmacy clinics. The roles of the six wing-based pharmacy technicians were developing. They made sure medicines on each wing were managed well and provided nicotine replacement therapy and individual advice to patients on how to manage their own medicines responsibly.

4.85 Medicines being delivered to the prison were stored in a building outside the prison before being received by the pharmacy, which meant they were unsupervised, which potentially meant the supply chain was not secure. In the prison, medicines were stored securely in the clinical rooms, where they were administered or supplied by pharmacy technicians and nurses.

4.86 Approximately 70% of medicines were held by patients in possession. We observed in-possession risk assessments being checked on SystmOne during medicines administration. Medicines were prescribed for 28 days where possible, although some patients received medicines for one or seven days in possession. Risk assessments were completed comprehensively for all patients every 12 months, or more frequently if required.

4.87 In-possession medicines were supplied as patient-named items – they had appropriate labelling and a dispensing audit trail. Patients on 28 days in-possession medication ordered their own medicines, and there was a system in place to help patients if they had not been ordered in time.

4.88 Patients not receiving their medicines in possession or in multi-compartment compliance packs, were not routinely provided with patient information leaflets about their medicines. While they were available on request, staff said that patients rarely asked for them.

4.89 Medicines not received in possession were administered safely and effectively twice a day, but there was no provision for night-time medicines. This meant that the recommended dosage schedules for effective treatment were not adhered to. Paracetamol was prescribed twice a day (when the manufacturers recommend four times a day) and some sedating antidepressant medicines were also administered too early at 5pm.

4.90 Medicines were generally administered from patient-named packs, which were kept securely in the treatment rooms. But on some wings, a significant proportion of medicines was being supplied from stock, although the amount had been reduced since the previous inspection. Stock and named-patient medicines were separated in drug cupboards and trolleys.

4.91 Insulin that had been removed from a fridge for administration was not properly labelled to prevent it from being used after it expired.

4.92 Quantities of stock and over-the-counter remedies were reconciled by pharmacy technicians every week, but the checks were not recorded. The pharmacy was informed when items were administered to patients from stock or from over-the-counter remedy supplies, but there was no process in place for investigating items that were missing without an audit trail or explanation.

4.93 Equipment used for methadone dispensing was cleaned and calibrated every day. An adequate range of patient group directions (which

authorise appropriate health care professionals to supply and administer prescription-only medicine) and over-the-counter remedies was available.

4.94 Errors, near misses and drug alerts were dealt with appropriately. Fridge temperatures were monitored, and all were within range. A full range of standard operating procedures and policies was in place and there was a system for recording that pharmacy team members had read and understood them.

4.95 Adequate provision of prescribed medicines was made for court appearances or on release.

Recommendation

4.96 **All medicines, except methadone, should be administered from individually labelled patient packs at an appropriate time for maximum clinical effect.** (Repeated recommendation 2.104.)

Dental services and oral health

4.97 There were eight dental sessions per week, which was sufficient to meet the demand. Early in 2021, a locum dentist had not been able to enter the prison due to the application of category A rules on visitors, which had resulted in between 32 to 40 patients not receiving prescribed treatment.

4.98 The dental suite was of a high standard, with a large and specially designed decontamination room. The room was light and airy with good ventilation.

4.99 There was evidence that the certification for legionella and radiological testing, and equipment maintenance were up to date.

4.100 An efficient air purification unit had been introduced in 2020 and had been used effectively to reduce waiting times for aerosol-generating procedures (AGPs), which had built up as a result of COVID-19 restrictions. During the inspection, there were 30 patients waiting an average of three to four weeks for routine treatment, but no one was waiting for AGPs, which was impressive.

4.101 The dentist and nurse offered dental health promotion advice to patients during dental sessions. Both expressed frustration that the shop list did not contain items that would improve the dental health of the population.

Section 5 Purposeful activity

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

Time out of cell

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

5.1 Approximately 43% of the population were unemployed and were locked in their cells for 22.5 hours a day. Staffing shortages meant the regime had been curtailed for most weekends in the previous three months, and all prisoners spent nearly 23 hours a day in their cell on Saturdays and Sundays. Prisoners on the induction wing only had one hour out of their cells each day. (See key concern and recommendation 1.46.)

5.2 Only 10% of prisoners were in full-time employment, such as in the kitchens or workshops. These prisoners had the maximum of seven hours out of their cell each day. Prisoners living in the social care unit were now unlocked during the core day, which was an improvement since the previous inspection.

5.3 Most prisoners could go outside for approximately 30 minutes in the fresh air each day, although prisoners usually only received this opportunity once over the course of the weekend. Category A prisoners had to use the exercise yard for prisoners held in the segregation unit which was very small and bare.

5.4 Overall, peer work was underdeveloped for a category B training prison. Trained peer mentors had moved on from HMP Manchester when the prison had changed its role, and there were now very few left. A number of peer workers were working with the Shannon Trust (see paragraph 5.8) and in the induction unit, while others were acting as equality representatives, but prison information desk workers were only available on three wings and their role was restricted because their time out of cell was limited.

5.5 The main library had recently reopened, and prisoners were allowed to attend in person but in very limited numbers. An order and delivery service had been introduced during the COVID-19 restrictions and this system continued after the reopening. The delivery service, which was popular with prisoners, was organised by an officer who knew the library and its contents well.

5.6 Well stocked smaller libraries, as well as the delivery service, were available in the segregation unit and the social care landing on H wing.

However, those in the category A unit and in the inpatient unit could only use the delivery service, which meant the provision was limited for these prisoners.

5.7 The library was funded directly by the prison, allowing the librarians greater control of their stock and the flexibility to respond to requests from prisoners.

5.8 Several positive initiatives had taken place throughout the pandemic to promote literacy. The Shannon Trust, a charity that helps prisoners learn to read, had made in-cell packs available, and some face-to-face work had been reintroduced. There were 17 prisoners enrolled as learners at the time of the inspection and 16 mentors to support them as long as they were part of the same COVID-19 cohort. (See paragraph 1.56.)

5.9 Projects such as the Writing on the Wall short story competition had been advertised and 10 prisoners had submitted entries, with one entrant a runner up. Over 250 prisoners were taking part in the Reading Ahead programme, in which prisoners received a dictionary, spelling or grammar book, and had to write a review of six books or articles. (See paragraph 1.56.)

5.10 Manchester had gym facilities in three locations – there was a large and very well-appointed sports hall, weights room and fitness suite with an artificial football pitch available for most prisoners. Prisoners in the category A unit and those held on K wing had access to their own separate cardio and weights rooms, which were available in their units.

5.11 Prisoners had equal access to the gym but could only go once a week for one hour which was too short. Vocational classes in the gym had been suspended at the start of the pandemic and had not restarted.

Education, skills and work activities

This part of the report is written by Ofsted inspectors. From May 2021 Ofsted began carrying out progress monitoring visits to prisons to assess the progress that leaders and managers were making towards reinstating a full education, skills and work curriculum. The findings and recommendations arising from their visit are set out below.

5.12 Ofsted assessed that leaders were making insufficient progress towards making sure that staff taught a full curriculum and provided support to meet prisoners' needs, such as offering remote learning.

5.13 Leaders and managers did not provide enough education, training or workplaces to meet the needs of all prisoners. Only 16 learners attended face-to-face education in the education wing. Leaders identified that, although they had the capacity to provide more face-to-face education places, they did not have enough prison staff to escort learners to the education wing. The limited offer of workshops, training and education meant that prisoners could not be allocated to activities that met their longer-term needs. (See key concern and recommendation 1.47.)

5.14 Leaders did not plan a coherent in-cell learning curriculum that developed learners' knowledge over time. They did not routinely provide in-cell work packs that enabled learners to build on prior learning or catch up on lost learning or knowledge. Leaders and managers did not consider learners' starting points when issuing them with in-cell work packs. Learners simply selected the packs they wished to complete.

5.15 Leaders and managers did not make sure that all the in-cell work packs were set in an appropriate context or were at the right level of written language for the learner. For example, packs included activities that were not age appropriate – they used childish illustrations or referred to children in school. Some mathematics work packs were not planned logically or sequenced appropriately. Others did not provide learners with the opportunity to practise key elements of numeracy.

5.16 Not all prisoners received the support they needed to make progress in education, training, and work. A few men with identified learning needs became disengaged as a result. Some prisoners were unable to complete the pack on their own in their cell, and others displayed poor behaviour. Teachers' feedback did not identify what areas learners needed to work on or what their next steps should be. Learners' action plans did not identify the skills they needed to develop or consolidate. Although leaders had plans in place to roll out a mentoring curriculum across the prison, during the inspection, there were not enough trained mentors to provide additional support to learners on the wings.

5.17 Leaders did not make sure that prisoners were allocated to education or work activities that reflected their personal learning plans or goals. Too often, prisoners' access to education, training and work was determined by the regime, the wing they were on or informal contact with prison staff, rather than prisoners' long-term plans.

5.18 Managers had planned how they would like the information, advice and guidance, education induction and allocation processes to work in the future to ensure that prisoners undertake education, training, and work to meets their longer-term plans, but they were not yet in place.

5.19 Leaders had not developed detailed or ambitious plans for the future of education, training, and work provision. The prison's recovery from COVID-19 restrictions was slow. Increased prisoner participation in education, training and work remained low. The extra number of learners in face-to-face education depended on additional resources

being put in place to move prisoners from the wings to the education classrooms. Managers were unable to explain how the prison would tackle the backlog of prisoners who needed to catch up with English and mathematics and achieve the level 1 accreditation they needed to enrol in work.

5.20 Managers made sure that category A prisoners were involved in education and training. Leaders and managers had increased the number of opportunities for learners to participate in activities, including through face-to-face wing teaching, contact via in-cell phones, in-cell work packs and training, such as industrial cleaning on the wing.

5.21 Leaders and managers had kept open essential workshops during the pandemic, although the number of workplaces was reduced by over half. Workshops included the print workshops, bakery, kitchens, waste management and laundry, some of which continued to provide work opportunities for vulnerable prisoners. Leaders had in place plans to expand their work provision to include a digital print workshop, commercial pie manufacturing and an upcycling workshop.

5.22 Leaders and managers continued to offer accredited courses throughout the pandemic. Accredited training in vocational areas included catering and industrial cleaning, and more recently they had reintroduced accredited courses in English and mathematics. A small number of learners continued to study Open University courses.

Recommendation

5.23 **Leaders must develop and implement an ambitious and coherent education and training curriculum that meets the needs of the population, including those with identified learning needs.**

Section 6 Rehabilitation and release planning

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

Children and families and contact with the outside world

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

6.1 The introduction of in-cell phones helped prisoners maintain contact with their family and friends. Visits had been restarted in April 2021. Artwork, some created by prisoners, was on display in the visits room, which made the environment feel less austere. There were only 10 tables, due to social distancing. In our survey, only 4% of prisoners said they had been able to see their family in person in the previous month. (See key concern and recommendation 1.48.)

6.2 Visits for category A prisoners took place in a purpose-built room near their unit, and the number of visits allowed at any one time was similarly restricted. Staff had made efforts to make the visits area family friendly.

6.3 The number of visits allowed each month was small – convicted prisoners only had one one-hour visit, and remand prisoners in the category A unit only had two 30-minute visits per week. Video calls were also limited, and all prisoners were only allowed one 30-minute session a month. These limits did not promote contact between prisoners and their families effectively. (See key concern and recommendation 1.48.)

6.4 The booking system for visits was not working well and many visitors experienced delays in getting through. Visitors could take a COVID-19 rapid test before a visit and, if they were negative, could hug and hold hands. The crèche remained closed, but activity packs had been developed to help prisoners occupy children during visits.

6.5 The family support provider delivered a good service – a full-time family support worker regularly consulted prisoners and families. They also went to the prison to see prisoners who had made an application for help with specific concerns. A family helpline had been set up in the visitors' centre during the pandemic allowing messages to be shared between prisoners and families.

6.6 Fourteen prisoners and some of their families had completed a relationships course through a distance learning package, which promoted the prison's wider rehabilitation agenda.

Reducing risk, rehabilitation and progression

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

6.7 The establishment's reconfiguration to a training prison meant the population had changed from predominantly prisoners on remand to mainly prisoners serving longer sentences, including a life tariff. An analysis was underway to identify the offending behaviour needs of this group.

6.8 The prison had not yet produced a strategy outlining the objectives of reducing reoffending work. The strategic meeting designed to manage progress had only resumed in June 2021, having not taken place for over a year, and the action plan was out of date. Links with some resettlement partners had been weakened (see paragraph 6.30). The prison had a short list of strategic priorities that were broadly appropriate, although few managers we spoke to knew what they were.

6.9 As part of the reconfiguration, the prison no longer had a resettlement function and staff from the community rehabilitation company had left following changes to the national resettlement arrangements. We were told that over the following few months, Manchester would be accepting more prisoners serving shorter sentences, but there were no plans for how the resettlement needs of this group would be met.

6.10 Almost all prisoners at Manchester were serving four years or longer, and most were assessed as presenting a high risk of harm to others. Probation Officers in the prison had high caseloads and restrictions on contact with prisoners during the pandemic had led to their work becoming almost exclusively focused on the completion of tasks, such as parole reports, rather than working with prisoners on their offending behaviour. In addition, at the time of the inspection, probation officer offender managers were still only permitted into the prison for half of their time which was not good enough and meant they had fewer opportunities to meet prisoners face to face. Caseloads were lower for the five prison officer offender managers, who were still occasionally being redeployed to operational duties. We were concerned that the prison officer offender managers were not receiving regular case work supervision.

6.11 Recorded contact between prison offender managers and prisoners was not sufficient. Some prisoners, especially those who did not ask for help, were overlooked, and most of the 10 prisoners we interviewed were unable to name their prison offender manager. The almost

complete absence of key work in Manchester as a way of supporting offender management exacerbated this deficit in contact. (See key concern and recommendation 1.49.)

6.12 Some prison offender managers maintained separate paper contact logs, but they often contained information that should have been recorded on prison IT systems, where other staff, such as those working in safer custody, could have accessed it.

6.13 Prison-based offender managers were responsible for completing offender assessment system (OASys) reports for almost all prisoners at Manchester. Most had been completed, but in our survey only 50% of prisoners said they had a custody or sentence plan, of whom only 25% said staff were helping them to achieve their targets. Our interviews confirmed this view, with most prisoners being unable to describe their targets. While the quality of sentence plans was reasonably good, progress made against the targets was insufficient in more than half the cases we reviewed. This provided further evidence of prison offender managers' lack of contact with most prisoners. (See key concern and recommendation 1.49.)

6.14 The number of indeterminate sentence prisoners had increased since the previous inspection. We saw good support for some of these prisoners who were considered for parole, but there was no additional provision to help this group progress through their sentence.

6.15 Since the prison's new designation, few prisoners were released into the community directly from Manchester and, in most cases, the responsibility for managing any risks associated with a prisoner's release lay primarily with the community offender manager supported by the prison offender manager. We saw evidence of effective communication between the prison offender manger and the community offender manager, and the standard of release plans we reviewed was generally good.

Public protection

6.16 Processes for identifying potential risks to the public posed by newly arrived prisoners were sound. OMU staff screened all new arrivals and, where appropriate, managers were asked to authorise measures to mitigate the risk, for example through monitoring the prisoner's mail and phone calls. Decision making in such cases was appropriate and there were regular reviews. Information was shared with relevant departments, such as security.

6.17 During the inspection, 22 prisoners were subject to mail and phone monitoring, which was not excessive. The team responsible for monitoring calls said there had been a significant increase in call volume in the previous 18 months, and we found a backlog of calls that had yet to be monitored.

6.18 The monthly interdepartmental risk management team (IRMT) meeting was not well attended, and the scope of the meeting was too limited – it

did not consider the risks posed by all prisoners nearing release. The meeting focused on those who would be managed in the community under levels 2 (where the active involvement of one or more agency is required) and 3 (prisoners on the highest risk level) of the multi-agency public protection arrangements (MAPPA), but risks relating to this group of prisoners should already have been well documented. The IRMT did not routinely consider the potential risks posed by prisoners who were on MAPPA level 1 (prisoners on the lowest risk level) or those who did not have a confirmed MAPPA level. Not enough information about prisoners' risks was being gathered from departments outside the OMU. While the exchange of information relating to prisoners' risks between individual offender managers in the prison and those in the community was good, in the cases we reviewed, management oversight and information gathering were not effective enough.

Recommendations

6.19 **The phone calls of prisoners identified as posing a risk to the public should be monitored promptly.**

6.20 **Relevant information about MAPPA level 1 prisoners should be gathered from all departments and shared with the community offender manager to inform risk management planning and determine what multi-agency arrangements are required.**

Categorisation and transfers

6.21 The head of the OMU coordinated security categorisation reviews for category A prisoners. The reviews were timely and supported by comprehensive information.

6.22 Reviews for other prisoners were mostly completed on time and included recommendations from the prison offender manager. However, in some cases, the review was undertaken without direct contact with the prisoner, which was poor.

6.23 A lack of available spaces in the wider prison estate meant that many prisoners, who should have moved on, remained at Manchester for lengthy periods, where the opportunities for progression were far too limited.

Interventions

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

6.24 The prison offered three accredited programmes – the Thinking Skills Programme (designed to help prisoners develop cognitive skills to manage their risks), Resolve (to support those with convictions for violence to reduce the use of aggression) and the Healthy Identity Intervention (for those who have committed an extremist offence). Despite COVID-19 restrictions, the prison had been able to deliver these programmes to a small number of prisoners in the previous 12 months. A fourth programme, Kaizen (for higher risk prisoners convicted of a violent offence) would be available in 2022.

6.25 A recent needs analysis showed that the programmes were appropriate for the population. However, it also showed that there was a need for provision to address the offending-related needs of the large proportion of prisoners convicted of a violent offence against an intimate partner.

6.26 The programme places planned for 2022 would not cater for the number of prisoners who needed to undertake a programme. At the time of the inspection, about 90 prisoners were waiting for an assessment to see if they were suitable for a programme and we were concerned some prisoners might be released without their offending behaviour needs being met.

6.27 In a small number of instances where an offending behaviour need was identified that could not be met at Manchester, the prison had been able to arrange a transfer to another establishment within the long-term high security estate so they could complete a programme.

6.28 We found no evidence of prison-based offender managers undertaking work with prisoners to address their offending behaviour. However, the psychology team had developed tailored offending behaviour work, which was delivered on an individual basis for a few prisoners who were not suitable for programmes, or who could not access one, for example, because they had a learning difficulty. The prison also offered two non-accredited courses designed to motivate prisoners to participate in rehabilitation.

Recommendation

6.29 **Accredited programmes should meet prisoners' needs, and suitability assessments should be completed without delay.**

Release planning

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

6.30 Manchester no longer had a resettlement function. The number of prisoners released into the community had declined significantly, but almost all were assessed as presenting a high risk of harm to others. Resettlement plans should have been developed by the community offender manager, however, prisoners we spoke to were unaware of any preparations being made for their release, and prison-based offender managers were not being asked to support resettlement. However, most of those who were released went to a probation-approved premises, where they would have received ongoing help and support.

6.31 Practical release arrangements were reasonable, and reception held a stock of clothing and bags that could be issued to prisoners leaving the establishment. However, prisoners were routinely strip-searched on release, which was not appropriate.

Section 7 Recommendations in this report

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

Key concerns and recommendations

7.1 Key concern (1.41): Leaders had not yet made sure that the opportunities and services provided, such as offence-focused work, addressed the full range of needs among the new population of long-term category B prisoners. Staffing issues often affected prisoners' access to services because there were not enough officers to escort them from their wing.

Key recommendation A: Leaders should make sure that services and progression opportunities, such as the range of offence-focused work, meet the needs of a long-term category B population – for example those convicted of violence against a partner. (To the governor)

Key recommendation B: The staff profile and their allocation to tasks should be reviewed to ensure there are enough officers to escort prisoners to their appointments. (To the governor)

7.2 Key concern (1.42): Governance and oversight of the use of force was weak. Data analysis was not sufficient and there was a lack of focus on learning lessons following incidents involving force, such as the use of batons. De-escalation techniques were not always used well enough and body-worn cameras were not routinely switched on during incidents. The use of special accommodation was not always justified.

Key recommendation: Leaders should improve oversight of and accountability for the use of force, including special accommodation, to make sure it is only used when necessary and justified. Body-worn cameras should always be switched on at the beginning of an incident. (To the governor)

7.3 Key concern (1.43): The level of self-harm remained high and there had been five self-inflicted deaths and five deaths through non-natural causes since the previous inspection. The new assessment, care in custody and teamwork (ACCT) case management documentation for prisoners at risk of suicide or self-harm was poorly completed in too many cases and prisoners did not always receive a good, proactive level of care.

Key recommendation: The prison should take steps to reduce the level of self-harm. Prisoners should receive proactive, meaningful day-to-day care to reduce their risk of self-harm. Weaknesses in the standard of ACCT documentation should be addressed. (To the governor)

7.4 Key concern (1.44): The use of key working to support prisoners and build trust in staff was poor, and some staff were not committed to promoting prisoners' progression or rehabilitation. Prisoners had negative perceptions of how some staff treated them. They did not have confidence in basic processes, such as the management of their personal property or the applications and complaints systems.

Key recommendation: Leaders should implement ways of improving and measuring the levels of trust among prisoners to ensure that their perceptions about the prison are more positive. This should be supported by effective processes, such as the management of property and the applications and complaints systems. All prisoners should have a named member of staff who supports them to make positive changes in their lives. (To the governor)

7.5 Key concern (1.45): We observed out-of-date stock items in primary care areas and gaps in mandatory training in moving and handling patients. Staff also had few opportunities to meet as a team and there was minimal evidence of lessons learned from incidents being widely shared.

Key recommendation: Managers should strengthen oversight of primary care and social care services to make sure patient care is delivered safely. (To the governor)

7.6 Key concern (1.46): Many prisoners were still locked in their cells for 22.5 hours a day during the working week and longer at weekends when the regime was regularly curtailed.

Key recommendation: Prisoners should have regular and predictable time out of cell that is sufficient to promote rehabilitation and well-being. (To the governor)

7.7 Key concern (1.47): Leaders and managers did not provide enough education, training or workplaces to meet the needs of all prisoners. For example, only 16 learners attended face-to-face classes in the education unit. Leaders did not make sure that prisoners were allocated to education or work activities that reflected their personal learning plans or goals. Too often, prisoners' access to education, training and work was determined by the regime, the wing they were on or informal contact with prison staff, rather than prisoners' long-term plans.

Key recommendation: The number of education, training and workplaces must be increased significantly, and the allocation process should be well coordinated and equitable to make sure that prisoners undertake activities that meet their short-, medium- and long-term plans. (To the governor)

7.8 Key concern (1.48): Sentenced prisoners had too few opportunities to receive visits from their family and friends and the sessions were too short. Visitors found it difficult to get through to the visits booking system by phone.

Key recommendation: Leaders should make sure that prisoners are easily able to maintain links to their friends and family through regular, longer visits and an effective booking system. (To the governor)

7.9 Key concern (1.49): Offender management in the prison was not proactive, and contact with prisoners did not take place regularly and was not always meaningful, which meant individuals' progression was not fully supported.

Key recommendation: Leaders should enable all eligible prisoners to receive structured, face-to-face offender management support that enables them to achieve their targets and progress through their sentence. (To the governor)

Recommendations

7.10 Recommendation (3.14): Perpetrators of violence should be managed robustly through individual plans, and proactive support should be given to victims. (To the governor)

7.11 Recommendation (3.17): The large number of outstanding adjudication cases not yet completed should be addressed to improve confidence in the system and challenge unacceptable behaviour, such as violence and the use of drugs. (To the governor)

7.12 Recommendation (3.32): More staff should be available to make sure that laboratory test results demonstrating drug use are processed within the required timeframe so that disciplinary action can be taken against the prisoner. (To the governor)

7.13 Recommendation (3.40): All serious incidents of self-harm should be investigated thoroughly so that lessons can be learned, and action taken to improve care for those in crisis. (To the governor)

7.14 Recommendation (3.41): The prison should make sure there are enough trained Listeners for the population and prisoners should always have access to the service. (To the governor)

7.15 Recommendation (3.45): Training should be provided to make sure that all staff are aware of their duties to safeguard vulnerable adults who are at risk of abuse or neglect. (To the governor)

7.16 Recommendation (4.20): Information should be available in a range of relevant languages and professional telephone interpretation should always be used when necessary to support prisoners whose first language is not English. (To the governor)

7.17 Recommendation (4.58): Dedicated mental health awareness training should be available for custody staff. (Repeated recommendation 2.85.) (To the governor)

7.18 Recommendation (4.59): Patients requiring treatment in hospital under the Mental Health Act should be transferred without delay. (To the governor)

7.19 Recommendation (4.80): All medicines, except methadone, should be administered from individually labelled patient packs at an appropriate time for maximum clinical effect. (Repeated recommendation 2.104.) (To the governor)

7.20 Recommendation (5.23): Leaders must develop and implement an ambitious and coherent education and training curriculum that meets the needs of the population, including those with identified learning needs. (To the governor)

7.21 Recommendation (6.19): The phone calls of prisoners identified as posing a risk to the public should be monitored promptly. (To the governor)

7.22 Recommendation (6.20): Relevant information about MAPPA level 1 prisoners should be gathered from all departments and shared with the community offender manager to inform risk management planning and determine what multi-agency arrangements are required. (To the governor)

7.23 Recommendation (6.29): Accredited programmes should meet prisoners' needs, and suitability assessments should be completed without delay. (To the governor)

Section 8 Progress on recommendations from the last full inspection

Recommendations from the last full inspection

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

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2018, prisoners spent too long locked up in reception and there were gaps in first night care. Induction processes were reasonably good. Levels of violence had increased and were high and one in three prisoners felt unsafe. It was too soon to judge the effectiveness of promising work to reduce violence. The use of force was high and lacked sufficient scrutiny. The regime on the segregation unit was poor. Some aspects of security work were excellent. The drug strategy was inadequate. There had been three self-inflicted deaths in the last six months. Levels of self-harm had increased and the care provided to prisoners in crisis was too variable.

Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

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)
Not achieved

Recommendations

New arrivals should not be routinely handcuffed or strip-searched unless an individual risk assessment indicates the necessity for this. (1.11)
Not achieved (recommendation repeated)

Holding rooms should be welcoming and equipped with appropriate information for new arrivals. (1.12)
Not achieved

Interviews with new arrivals should be conducted in private and a thorough assessment of risk factors and personal concerns should be carried out. (1.13)
Not achieved

Prisoners should not be held in reception for excessive periods. (1.14)
Achieved

There should be enhanced checks of new arrivals during their first night in custody. (1.15)
Achieved

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)
No longer relevant

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)
Not achieved

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)
Not achieved

The regime for segregated prisoners should be improved and include purposeful activities to prevent psychological deterioration. (1.37)
Achieved

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)
Achieved

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)
Not achieved

There should be a consistent case management approach to ACCTs to ensure seamless support and to improve the quality of ACCT procedures. (1.56)
Not achieved

Safer custody meetings should be attended by all relevant departments and identified actions should be addressed promptly. (1.57)
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2018, relationships between staff and prisoners required improvement. Many parts of the prison were in disrepair. Areas in residential units were dirty and infested with vermin. Consultation and peer support were reasonable. There was a lack of confidence in application and complaints processes. Work on equality and diversity remained underdeveloped. There had been improvements in the provision of health, social care and substance misuse support services.

Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

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)
Not achieved

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

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)
Achieved

Recommendations

Higher standards of cleanliness should be maintained in and around residential areas and cleaners should be properly supervised. (2.10)
Achieved

Two prisoners should not share accommodation designed for one. (2.11)
Achieved

In-cell toilets should be adequately screened. (2.12)
Achieved

All showers should be refurbished and adequately screened. (2.13)
Partially achieved

Rules on property should be revised to allow prisoners to buy items or have property sent in more frequently. (2.14)
Not achieved

Wing serveries should be supervised to ensure that portion control and appropriate food hygiene measures are enforced. (2.18)
Not achieved

Lunch should not be served before noon and the evening meal not before 5pm. (2.19)
Not achieved

Breakfast should be issued on the day it is to be eaten. (2.20)
Not achieved

Responses to applications should be monitored to ensure timeliness and focus on the matters raised. (2.26)
Not achieved

Prisoners should be consulted to understand their lack of confidence in the formal complaint system and action taken to address this. (2.27)
Not achieved

Prisoner equality representatives should have specific duties to meet prisoners with protected characteristics and ensure that their needs are met. (2.35)
Not achieved

An independent group should be invited to scrutinise discrimination incident report forms to provide quality assurance. (2.36)
Achieved

Foreign national prisoners subject to immigration procedures should have access to independent immigration advice. (2.44)
Not achieved

There should be a strategy which supports gay, bisexual and transgender prisoners and creates an environment in which they can feel safe to disclose their sexuality. (2.45)
Not achieved

The equality strategy should address the needs of prisoners under the age of 25, with policies and procedures appropriate to their level of maturity. (2.46)
Not achieved

Prisoners who cannot work due to age, infirmity or disability should not be routinely locked up during the working day. (2.47)
Not achieved

There should be regular and recorded clinical supervision for all clinical staff. (2.63)
Achieved

All clinical areas should be fully compliant with current infection control standards. (2.64)
Not achieved

Patients should not routinely wait in health care for excessive periods before and after appointments. (2.65)
Not achieved

The Manchester Local Delivery Group should ensure that the health complaints system is tailored to the prison setting, is well publicised, understood and confidential, and that responses to complaints are legible. (2.66)
Partially achieved

The Manchester Local Delivery Board should establish regular monitoring of health care appointments and attendances to ensure that the systems are efficient and effective and meet contemporary NHS standards while being applied in a prison setting. (2.78)
Achieved

Dedicated mental health awareness training should be available for custody staff. (2.85)
Not achieved (recommendation repeated, 4.58)

Patients requiring mental health inpatient care should be transferred expeditiously. (2.86)
Not achieved

Drug and alcohol dependent prisoners should be consistently identified and assessed on arrival, and should receive additional monitoring during their early days by competent clinical staff. (2.93)
Achieved

Newly arrived prisoners should receive harm reduction information on illicit substance use in the prison and on substance misuse treatment services. (2.94)
Achieved

Supervision of medicines administration queues should be improved to maintain confidentiality and minimise potential bullying and diversion of supplies. (2.103)
Achieved

All medicines, except methadone, should be administered from individually labelled patient packs at an appropriate time for maximum clinical effect. (2.104)
Not achieved (recommendation repeated, 4.80)

Purposeful activity

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

At the last inspection, in 2018, too many prisoners were locked up during the core day instead of being engaged in purposeful activity and despite the availability of sufficient activity spaces for every prisoner. Prisoners in the general population could attend an appropriate range of activities but vulnerable prisoners and category A prisoners were disadvantaged. Prisoner allocation to activities was poor and not enough was done to improve attendance or punctuality. Prisoners who did attend activities behaved well. Too few prisoners completed their courses but achievements for those who did were good.

Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

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)
Not achieved

Recommendations

All prisoners should have one hour's exercise in the open air each day. (3.12)
Not achieved

Prisoners' access to the main gym facilities should be improved. (3.13)
Not achieved

Prison managers should ensure that vulnerable prisoners can access the same range of education courses as other prisoners. The number and range of activities for high-security prisoners should be increased significantly. (3.22)
Not assessed at this inspection

Novus managers should evaluate accurately the quality of the lessons. (3.23)
Not assessed at this inspection

Novus managers should ensure that classroom registers are accurate. (3.24)
Not assessed at this inspection

Managers should ensure that prisoners use computers for learning and developing the skills to find jobs on release. (3.25)
Not assessed at this inspection

Tutors and instructors should use information about prisoners' existing skills to set them appropriately demanding work and targets for their development. (3.33)
Not assessed at this inspection

Tutors should provide appropriate resources for prisoners in their lessons and high-standard hand-outs and worksheets. (3.34)
Not assessed at this inspection

Tutors and instructors should include tasks and activities in their teaching, training and assessment that improve prisoners' skills in English and mathematics. (3.35)
Not assessed at this inspection

Wing staff should encourage and persuade prisoners to attend their lessons and prison work activities regularly and punctually to increase their chances of gaining employment after release. (3.39)
Not assessed at this inspection

Prison and Novus managers should ensure that prisoners who start on courses can complete them. (3.44)
Not assessed at this inspection

Prison managers should ensure that instructors recognise and record accurately the skills that prisoners develop in prison work. (3.45)
Not assessed at this inspection

Resettlement / Rehabilitation and release planning

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

At the last inspection, in 2018, children and families work was reasonably good but the visits experience for some families was difficult. There were gaps in the reducing reoffending strategy which resulted in a shortfall in services for some prisoners. Some good casework demonstrated a proper focus on risk and sentence plans. Contact between offender supervisors and prisoners was good in many cases but was still inconsistent. MAPPA (multi-agency public protection arrangements) processes were managed well. More prisoners were being released on home detention curfew (HDC), although some were delayed beyond their earliest release date. Available interventions were appropriately targeted. All prisoners had a resettlement plan but too many prisoners were released without settled accommodation.

Outcomes for prisoners were reasonably good against this healthy prison test.

Recommendations

Prisoners should have access to training in relationships and parenting. (4.8)
Achieved

The concerns of prisoners about treatment of visitors should be investigated and addressed. (4.9)
Not achieved

A proportion of the non-contact tables should be removed and replaced with furniture appropriate for a predominantly local prison population. (4.10)
Not achieved

The offending-related needs of distinct groups of prisoners should be analysed and used to inform specific provision for them where needed. (4.24)
Partially achieved

Casework, professional supervision and personal development should be provided to all offender supervisors, whatever their professional background. (4.25)
Not achieved

All prisoners should receive adequate support from their offender supervisor, including regular meaningful contact which is aimed at progression and reduction of risk. (4.26)
Not achieved

All staff contact with prisoners should be recorded on one system to ensure that all parties are aware of and share relevant information. (4.27)
Not achieved

The number of Bail Accommodation and Support Services hostel places should be increased, to enable the timely release of prisoners on home detention curfew. (4.28)
No longer relevant

The proportion of prisoners provided with suitable and sustainable accommodation shortly after release from custody should be monitored, to establish the number who remain homeless or in transient accommodation. (4.35)
Not achieved

Release on temporary licence should be used in suitable cases to aid preparation for release. (4.36)
No longer relevant

Appendix I About our inspections and reports

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

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

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

Safety
Prisoners, particularly the most vulnerable, are held safely.

Respect
Prisoners are treated with respect for their human dignity.

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

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

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

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

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

concerns. Procedures to safeguard outcomes are in place.

Outcomes for prisoners are not sufficiently good.
There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

Outcomes for prisoners are poor.
There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

Our assessments might result in one of the following:

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

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

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

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

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

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

This report

This report provides a summary of our inspection findings against the four healthy prison tests. There then follow four sections each containing a detailed

account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 5, 2017) (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/). The reference numbers at the end of some recommendations indicate that they are repeated and provide the paragraph location of the previous recommendation in the last report. Section 7 lists all recommendations made in the report. Section 8 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

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

Inspection team

This inspection was carried out by:

Charlie Taylor	Chief inspector
Sandra Fieldhouse	Team leader
Ian Dickens	Inspector
David Foot	Inspector
Sumayyah Hassam	Inspector
Ali McGinley	Inspector
David Owens	Inspector
Rebecca Stanbury	Inspector
Rahul Jalil	Researcher
Amilcar Johnson	Researcher
Alec Martin	Researcher
Shannon Sahni	Researcher
Paul Tarbuck	Lead health and social care inspector
Steve Eley	Health and social care inspector
Chris Barnes	Pharmacist
Sue Melvin	Pharmacist
Matthew Tedstone	Care Quality Commission inspector
Joanne White	Care Quality Commission inspector
Alison Cameron-Brandwood	Ofsted inspector
Cath Jackson	Ofsted inspector
Martin Ward	Ofsted inspector
Martyn Griffiths	Offender management inspector
Sally Lester	Offender management inspector

Appendix II Glossary of terms

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

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

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

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

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

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

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

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

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

Psychoactive substances
Psychoactive substances generally refers to synthetic cannabinoids, a growing number of man-made mind-altering chemicals that are either sprayed on dried, shredded plant material or paper so they can be smoked or sold as liquids to be vaporized and inhaled in e-cigarettes and other devices.

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

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

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

Appendix III Care Quality Commission Requirement Notice

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

The inspection of health services at HMP Manchester was jointly undertaken by the CQC and HMI Prisons under a memorandum of understanding agreement between the agencies (see https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/working-with-partners/). The Care Quality Commission issued 'requirement to improve' notice/s following this inspection.

Requirement Notices

Provider

Greater Manchester Mental Health NHS

Location

HMP Manchester

Location ID

RXVX4

Regulated activities

Treatment of disease, disorder, or injury and Diagnostic and screening procedures.

Action we have told the provider to take

This notice shows the regulations that were not being met. The provider must send CQC a report that says what action it is going to take to meet these regulations.

Regulation 17 Good Governance

17. (1)(2)(a)(b)

Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

Without limiting paragraph (1), such systems or processes must enable the registered person, to:

Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

How the regulation was not being met

Systems or processes in place were not effective in assessing, monitoring and improving the quality and safety of the services being provided. In particular:

The primary care team did not meet regularly as a team. There were no healthcare service meetings which included staff from primary care, mental health, in-patients and social care.

Information relating to learning from incidents was minimal, structured feedback, including themes and trends was not provided to staff.

A range of equipment was out of date; including dressings, syringes, bio-hazard cleaning kits and defibrillator pads.

Paperwork within one emergency bag was blood stained.

Systems or processes in place were ineffective in assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users and others who may be at risk.

Staff did not always follow up on the outcome of medical testing. Test results from a procedure completed in August 2020 remained outstanding and at the time of this inspection in September 2021 they had not been followed up.

Staff had not recorded when an insulin pen had been opened, this meant staff would not know when to discontinue using the pen.

An out of date vaccination was stored in a clinical fridge.

Medicines were not delivered directly to the pharmacy, which meant they were unsupervised, potentially rendering the supply chain insecure.

Regulation 18 Staffing

18.(2)(a)

Persons employed by the service provider in the provision of a regulated activity must;

Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

How the regulation was not being met

The service provider had failed to ensure staff received appropriate training, as was necessary to enable them to carry out the duties they were employed to perform. In particular:

Sufficient staff had not completed required mandatory and essential training. This included moving and handling in-patients, basic life support, safeguarding adults and children, Mental Capacity Act, MHA Code of Practice and training in vulnerable adults and people with a learning disability.

Appendix IV Further resources

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

Prison population profile

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

Prisoner survey methodology and results

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

Prison staff survey

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

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

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/

Printed and published by:
Her Majesty's Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England