Report on an unannounced inspection of

HMP Garth

by HM Chief Inspector of Prisons

7–18 November 2022

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Introduction

A part of the long-term high secure estate, HMP Garth is a category B training establishment located near Leyland in Lancashire. With a capacity for 845 adult men, at the time of our inspection some 790 were in residence, most of them assessed as presenting a high or very high risk of harm and serving lengthy sentences for serious offences. Although Garth is a comparatively modern establishment by HMPPS standards – opening in 1988 – it was already showing its age and seemed to us to be in need of some significant investment and refurbishment. However, nearly every prisoner had their own cell, and their appreciation of this was evidenced by the good condition in which most prisoners kept their accommodation.

This was our first return to Garth since 2019, when we reported on a much-improved prison that was achieving reasonably good outcomes in three of our healthy prison tests. Only in safety was improvement clearly required. At this inspection we found that the prison was still achieving some good rehabilitative outcomes and was also now much safer, but had deteriorated in respectful treatment, largely owing to the ageing infrastructure and weaknesses in relationships between staff and prisoners. We observed some very significant shortcomings in the delivery of purposeful activity, which on this inspection was judged poor.

Safety, not unreasonably, was the stated priority for leaders and the prison showed its capabilities most clearly in this area. Security was well managed and several indicators, such as reduced violence and less use of force, pointed to improvement. The prison was providing some very encouraging and preventative interventions targeted at more vulnerable prisoners, as well as some useful multidisciplinary support for those in segregation. Similarly, the prison was not complacent about its responsibilities for reducing suicide and self-harm, but despite a fall in self-harm rates, the scale of the challenge faced by the prison was to be seen in the three self-inflicted deaths and six other apparently non-natural deaths that had occurred since we last inspected.

The priority given to safety was not, however, in balance with the prison's broader purpose. Several policies, notably legacy practices from the time of the pandemic, were being retained and justified, it was claimed, for the purpose of promoting safety, but were in fact impeding the regime and limiting prisoner access to meaningful work, education, interventions, and even time out of cell. Safety will always be a priority, but a priority that must facilitate the institution's responsibility to operate in the broader public interest, ensuring meaningful training and progress through a sentence that allows prisoners to reduce their risk of reoffending. The approach at Garth lacked that balance, leading to significant frustration among both prisoners and those providing services to them.

Notwithstanding our criticisms, we had confidence in the leadership of the prison, who were capable, collaborative, and imaginative. Communication was good and leaders were open to new ideas. The prison's commitment to the promotion of keywork was also a strength, although delivery was still at an early stage. Going forward, the priorities for the prison should include: delivering a

more dynamic daily regime where all prisoners are active, without prejudicing safety; new investment in the built environment; and building the confidence and capability of the staff in managing and relating to prisoners.

Charlie Taylor
HM Chief Inspector of Prisons
December 2022

What needs to improve at HMP Garth

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

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

Priority concerns

1. **Many aspects of the prison were in very poor condition.** Lots of cells had insufficient furniture and some flooring was in decay, while most shower rooms were in a poor state and lacked privacy.

2. **The rate of non-attendance at health appointments was far too high.** This impaired the efficient use of health resources, including clinicians' time.

3. **Prisoners did not receive adequate time out of cell.** The regime did not give them enough access to purposeful activity, especially through unemployment, the cohorting arrangements, and staff shortage.

4. **There were too few education spaces, and not enough of the available spaces in education, skills, and work were allocated.** Attendance in education, skills and work activities was poor.

5. **Leaders did not provide a high-quality curriculum to meet the needs of the population, including support for those with additional learning needs.** There was no effective quality assurance of education, skills and work.

Key concerns

6. **Not enough was done to ensure prisoner safety following their arrival at the prison.** Private risk interviews were too often superficial, lacked sufficient attention to risks and vulnerabilities, and were not followed up systematically on the following day.

7. **The use of body-worn video cameras during incidents involving force was too low.** Important evidence showing the justification for force and attempts at de-escalation was not, therefore, routinely recorded.

8. **Drugs were too easily available.** The mandatory drug testing rate was high, and searching procedures were insufficient.

9. **Too many staff were passive or distant in their interactions with prisoners.** The lack of time out of cell and an effective key worker scheme had a detrimental effect on staff-prisoner relationships, while staff did not always challenge low-level poor behaviour.

10. **The application and complaint systems were not working well, with too many prisoners receiving answers late or not at all.** When they did receive an answer, it often did not adequately address the issue raised.

11. **Too little was being done to understand and meet the needs of prisoners from protected characteristic groups across the prison.** There was no needs analysis or strategic direction, which were necessary to support the promotion of equality. Consultation was infrequent and the analysis of data was too limited.

12. **Poor infection prevention standards in clinical areas could expose patients to harm.**

13. **Governance of medicines management was not robust, which was linked to the shortage of pharmacy staff.**

14. **Leaders did not make sure that all prisoners received information, advice and guidance towards finding appropriate education, training or employment on release.**

15. **Many prisoners felt stuck at Garth and could not progress in their sentence.** Some routine reviews of security category were late and many who had been recategorised were not moved to a prison offering the right opportunities for them.

Care Quality Commission regulatory recommendation

Care and treatment must be provided in a safe way for service users. This includes the proper and safe management of medicines.

About HMP Garth

Task of the prison/establishment
Category B adult male prison

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 790
Baseline certified normal capacity: 810
In-use certified normal capacity: 810
Operational capacity: 845

Population of the prison
- Most prisoners were assessed as high or very high risk of harm.
- 85% of prisoners were serving 10 or more years, of whom 38% were on indeterminate sentences.
- 19% were category C prisoners.
- Around one quarter of the population were of black or minority ethnic heritage.
- 38% identified as having a physical or mental disability.

Prison status (public or private) and key providers
Public

Physical health provider: Greater Manchester Mental Health NHS Foundation Trust (GMMH)
Mental health provider: GMMH
Substance misuse treatment providers: GMMH (clinical), Delphi Medical (recovery)
Prison education framework provider: Milton Keynes College
Escort contractor: GEOAmey

Prison group/Department
Long term high security estate

Brief history
HMP Garth opened in 1988. It is a category B male establishment, part of the long-term and high-security estate directorate, holding a complex population, predominantly convicted adults serving more than four years and those serving indeterminate sentences. In addition to the mainstream residential accommodation, the prison has several specialist units: Beacon Unit, offering the offender personality disorder pathway service; Building Hope Unit, a psychologically informed therapeutic environment; a drug recovery unit; and a residential support unit.

Short description of residential units
There are seven residential units A – G and a segregation unit.
B wing – Building Hope, Beacon and induction units
D wing – has an area for drug recovery
E wing – residential support unit
F & G wings – vulnerable prisoners.

Name of governor and date in post
Andy Lund, August 2022

Changes of governor since the last inspection
Steve Pearson, governor to August 2022

Prison Group Director
Gavin O' Malley

Independent Monitoring Board chair
Margaret Thorne

Date of last inspection
December 2018–January 2019

Section 1 Summary of key findings

1.1 We last inspected HMP Garth in 2019 and made 43 recommendations, four of which were about areas of key concern. The prison fully accepted 37 of the recommendations and partially (or subject to resources) accepted two. It rejected four of the recommendations.

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

Progress on key concerns and recommendations from the full inspection

1.3 Our last inspection of HMP Garth 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 report on progress in areas of key concern to help leaders to continue to drive improvement.

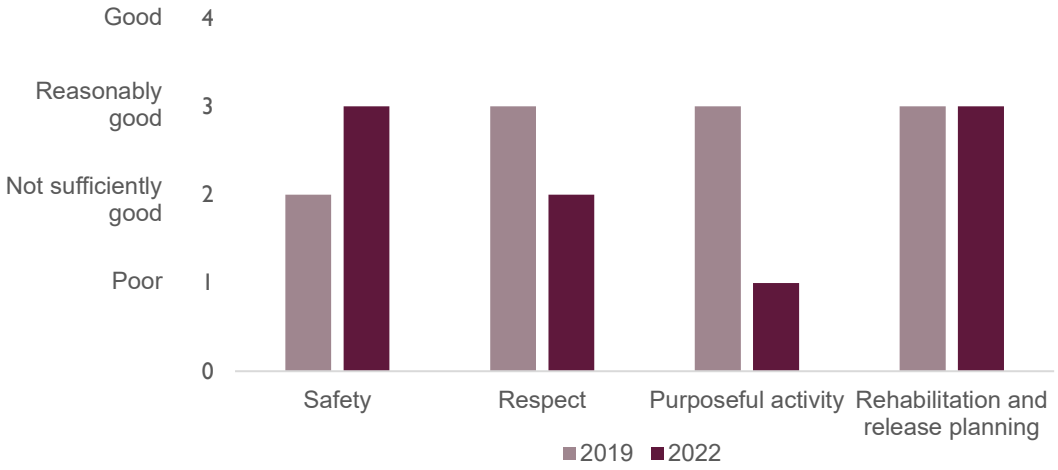
1.4 At our last full inspection, we made four recommendations about key concerns. At this inspection we found that two of these recommendations had been achieved and two had been partially achieved. Both recommendations on safety had been partially achieved, and those on respect and rehabilitation and release planning had both been achieved. For a full summary of the recommendations achieved, partially achieved and not achieved, please see Section 8.

Outcomes for prisoners

1.5 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).

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

Figure 1: HMP Garth healthy prison outcomes 2022 and 2019



Safety

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

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

1.7 The risks and vulnerabilities of new arrivals were not sufficiently assessed within their first 24 hours. The induction new prisoners received was insufficient and delivered inconsistently - most inductees spent most of their time locked in cell.

1.8 The incidence of violence had reduced, as had the severity of individual incidents, with few prisoners now reporting that they had experienced intimidation. The safer custody team collected data in support of further violence reduction but did not always make effective use of it. The quality of challenge, support and intervention plans (CSIPs, see Glossary) was variable, but had been improving.

1.9 The Residential Support Unit (RSU) and Building Hope Unit (BHU) provided targeted support for vulnerable prisoners and those re-entering mainstream conditions. They offered calm environments and valuable psychological input, but the daily regime on these units was often interrupted. Self-isolating prisoners received good support.

1.10 Disciplinary hearings were handled well, but over 200 adjudications were overdue because of staffing constraints, and too many prisoners faced long waits for adjudications to be settled.

1.11 The use of force was less than at the previous inspection and comparable prisons. Most use of force was proportionate, but staff used body-worn video cameras far too infrequently. Governance was, despite this, generally good.

1.12 The segregation unit, with fewer cells than before, was often full. Psychologically informed case management was well established. Staff

were knowledgeable and gave good support to prisoners, while leaders had improved the environment. The regime was often curtailed for lack of staff.

1.13 Physical security in the prison was generally proportionate, but the use of strip searching seemed to be excessive. Managers were aware of key threats to security and the flow of intelligence was good. Most target searches resulted in finds. There had been work to reduce drug supply. The mandatory drug testing rate had reduced, but still stood at 17.9%. There was interagency liaison to manage gangs and identified extremists, and very good work to tackle staff corruption.

1.14 There had been three self-inflicted deaths and six other apparently non-natural deaths since the last inspection. There was good progress towards implementing recommendations following investigation of the deaths. Self-harm had reduced. The safer custody department had worked hard to train staff in the relevant case management, but the quality of support was inconsistent. Prisoners with significant need and vulnerability were referred to the complex case meeting and were supported well. There had been some analysis of data, but not enough to identify and address the common causes and drivers of self-harm.

Respect

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

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

1.15 In our survey, fewer respondents than at the previous inspection said they were treated with respect by staff. Some staff interactions with prisoners were very good, but others were passive and distant. Low-level poor behaviour, such as vaping on the wings, commonly went unchallenged by staff. Most prisoners knew their key worker (see Glossary), but the quality of work was variable, and the frequency of key work sessions had dropped recently.

1.16 Most prisoners lived in single cells, but many aspects of the built environment were in very poor condition, including a lack of ventilation and inadequate cell furniture and fittings. A programme of shower room refurbishment had begun but most were in a poor state. Outside areas were well maintained and litter-free. Staff response to cell emergency call bells was often too slow, but leaders had started to address this.

1.17 The food was of reasonable quality, although the meals were served too early. The kitchen was clean and well managed, but supervision of serveries was often poor.

1.18 The prison council was well established and effective, with good support from leaders. The number of complaints had risen

considerably. Some quality assurance was in place and trends were identified, but there was little evidence of resulting management action.

1.19 Meetings to promote equality were well attended by senior leaders, but there was no forward strategy. The small equality team interrogated some local data but analysis was too limited. Engagement with the prison's black and minority ethnic population had improved and cultural awareness sessions were appreciated, but regular consultation with other protected groups, such as foreign nationals, was lacking. The needs of the many prisoners with disabilities were not always met.

1.20 The well-established chaplaincy provided weekly worship for all the main faith groups, and supported the less common faiths appropriately. Some activities had been slow to recommence in 2022, but there were plans to address this.

1.21 Despite significant challenges, access to most primary care health services was reasonable. Staffing was stretched, leading to frequent cross-deployment, which reduced the availability of clinics. Regime restrictions also often curtailed planned clinical appointments. Non-attendance rates at health appointments were excessive. Prisoners with long-term conditions received good support. Some health complaints had not been actioned and several complaint responses were of poor quality; this was addressed during the inspection. The waiting room in health care was unacceptable and several clinical rooms did not meet infection prevention standards. Prisoners with addiction problems generally received sound clinical support but treatment options were still too limited. Delphi worked closely with the clinical team and offered good psychosocial support to recovering prisoners.

1.22 Mental health services offered a range of interventions and support, but there were long waits for some psychological therapies. Social care assessments were completed promptly, but pharmacy services lacked sufficient trained and competent staff. Vulnerable prisoners on F and G wings had to wait up to 30 weeks to see the dentist.

Purposeful activity

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

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

1.23 Time out of cell was inadequate owing to the split regime (in which prisoners were cohorted into smaller groups and unlocked separately), staffing pressures and the high prisoner unemployment rate. Although prisoners in full-time employment were scheduled to have around six hours a day unlocked and the unemployed had around 2.5 hours, this was often substantially reduced because of wing lockdowns, both planned and unplanned.

1.24 Library and physical education facilities were good, but prisoner access to both was affected by the limited regime. The under-resourced PE team ensured at least twice weekly access but was not delivering any accredited courses.

1.25 There were enough places in skills and work to provide employment for those needing it, but only part-time. There were insufficient education places, and a fifth of these spaces were not filled. Learners in education took too many months to complete their programme and achieve a qualification. Vulnerable prisoners had no opportunity for vocational training.

1.26 The curriculum for education, skills and work lacked ambition, and there were no plans for those who could not attend activities. Most prisoners made little or no progress. Leaders and managers did not provide effective support for all prisoners with additional learning needs. However, the very few prisoners who attended vocational training built their knowledge, skills and behaviours incrementally.

1.27 The activities allocation board had stopped meeting, so that leaders no longer had oversight of how prisoners were allocated to education, skills and work.

1.28 Tutors and instructors created calm learning and working environments in education and workshops. In most cases, prisoners listened carefully to tutors and instructors. However, in workshops prisoners were not always well motivated, and a few instructors did not have high enough expectations of them. Attendance in education and at work was very low. If prisoners were able to attend, they were punctual.

1.29 Prisoners were frustrated by the recent changes to their pay policy, under which those who had not yet achieved certain qualifications could not be paid on the two highest pay bands.

1.30 There was a reading strategy, but it was not embedded across the prison. Managers assessed prisoners' reading ability through ad hoc and inconsistent methods. Quality assurance arrangements were weak, and leaders had not fully resolved any of the recommendations from the last inspection.

1.31 Not all prisoners received information, advice and guidance to support them towards their next steps.

Rehabilitation and release planning

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

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

1.32 Access to social visits was good for most prisoners, and family visits had resumed. In our survey, only 16% said visits started and finished on time. Visitors could book visits online, but the telephone booking system remained problematic. The visits hall was adequate, and there was good provision of food. A family link worker had been appointed, the charity POPS also supported families, and Storybook Dads (enabling prisoners to record a story for their children) had resumed. The visitors' centre remained in poor condition, while the video calling service was unreliable and underused.

1.33 The offender management unit was a cohesive and hardworking team, despite staff shortages, high caseloads and cross-deployment. The senior probation officer was well respected and effective. The team was working hard to address a backlog of OASys (offender assessment system) assessments, and completed new assessments and reviews on time, generally to a good standard. However, prisoners missed having regular contact with their prison offender manager.

1.34 Public protection was well managed. The interdepartmental risk management team oversaw risk management and discussed all high-risk prisoners due for release. Information sharing was mainly good. Multi-agency public protection arrangement (MAPPA) procedures were carried out well, and monitoring of communications was generally well managed.

1.35 The category C population had almost doubled, to 150; over half had not been able to progress to a suitable prison. There was good work to support progression for prisoners on indeterminate sentence for public protection.

1.36 A good range of programmes was provided, and a new in-depth needs analysis tool was helpful. Group programmes had restarted, but regime restrictions sometimes interrupted delivery. The Beacon Unit provided an important resource in the offender personality disorder pathway.

1.37 There was not enough support on finance, debt or life skills. During the last 12 months, 41 prisoners had been released, but very little pre-release support was available.

Notable positive practice

1.38 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.

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

1.40 The introduction of in-cell laptops improved prisoners' access to information on daily prison life and was greatly appreciated by them. (See paragraphs 2.2, 3.27, 4.18, 4.39, 4.52, 6.5, 6.12.)

1.41 The segregation unit provided psychologically informed care and progression planning for every segregated prisoner, involving individualised interventions to support a return to normal conditions and clinically informed support. (See paragraph 3.25.)

1.42 A new in-depth needs analysis tool had been implemented by the psychology clinical lead and was used effectively to identify prisoners requiring interventions. Departments including the offender management unit and education provided relevant information to support the individual's progress. (See paragraph 6.23.)

1.43 The psychology team was working effectively with prisoners serving an indeterminate sentence for public protection (IPP) to address blocks to their progression, including regular multiagency review meetings. (See paragraph 6.31.)

Section 2 Leadership

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

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

2.2 The governor and several senior managers gave clear and confident leadership, and there was good remote communication, including imaginative use of the new prisoner laptops; but many prisoners and some staff said that senior managers were still not sufficiently visible. The uneven quality of staff-prisoner relationships illustrated the need for managers to be modelling and inculcating positive professional behaviour around the prison.

2.3 Safety was given the highest priority by leaders, and this was appropriate given the prison's recent history and population profile. By various measures, the level of safety was better than in some comparable establishments.

2.4 Leaders had, more than in many other prisons, continued some of the approaches that had been necessary during the COVID pandemic, with smaller numbers of prisoners unlocked at a time on the main wings. Senior leaders thought this contributed significantly to safety, but many staff as well as prisoners expressed their wish for a more open regime.

2.5 Leaders were not providing an adequate or sufficiently predictable regime. This was due partly to problems with staff retention and absence, but was also in part deliberate in the belief that lower numbers unlocked improved safety. The cost was high: managers and staff in offender management and in health care, for example, were justifiably frustrated that their services could not be delivered properly because of the restrictions, but these departments were well led and leaders mitigated the negative impact as much as possible. In education, skills and work, by contrast, in spite of leaders' vision to provide a progressive curriculum, the level of delivery was very disappointing. Among prisoners, too, the great majority of whom had a long time to serve, many felt frustrated that they could not live a structured and purposeful life in prison or make progress because of the problems with the regime.

2.6 Increasingly, collaborative leadership was a strength, especially between the psychology team and operational managers. The contribution of forensic psychology had developed well in the establishment as a whole. The segregation unit was a notable example of shared leadership, but it was also developing in the discrete units that were a feature of the prison, and in the wider prison.

2.7 There had been insufficient investment in the prison's infrastructure. Especially on the older wings, the toleration of poor physical conditions affected the morale of those living or working there.

2.8 Leaders were responsive to the changing needs of the population, for example in support given to those serving indeterminate sentences for public protection (IPP) and in the range of offending behaviour work. They were not yet doing enough to meet the needs of those arriving at the prison, nor the small but increasing number being released from it.

2.9 Some key teams, such as those for safety and equality, were less well resourced than in many prisons; they prioritised their work appropriately, but could not cover all the tasks expected in those areas. Some data were being collected and analysed, but needed to be used much more systematically and confidently. Other departments, such as security and the programmes team, were making much better use of data.

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 Around 25 prisoners arrived at Garth each month. A body scanner was used on all of them, which was useful in detecting illicit items. It was not, however, clear why all prisoners, regardless of risk assessment, were also strip-searched. This included all prisoners who were being discharged to and returning from other prisons and external appointments. (See paragraph 3.30.)

3.2 The reception area was spacious but too bare and run down to provide much of a welcoming and informative environment. One of the two holding rooms, for example, did not have sanitation; the other had a toilet but it was dirty and was not sufficiently private.

Reception holding room

Toilet in reception

3.3 Reception staff were polite and offered new arrivals the opportunity to talk to a member of staff in private, although prisoners and staff told us that this had been introduced during our visit. A peer worker offered all new arrivals a hot drink in reception. Inappropriately, some personal information was obtained at an open desk in earshot of other prisoners and staff. In our survey, 75% of prisoners said they were treated well in reception, a decrease from 90% at the previous inspection.

3.4 Newly arrived prisoners did not wait long in reception before they were located on to the first night unit on B wing. First-night cells that we inspected were in poor condition: there were no curtains, desk or lockable cabinet. New arrivals were given a first night risk interview, in private, by a member of staff on the induction unit. The interview was brief and did not focus sufficiently on risks and vulnerabilities. Some but not all prisoners received a second interview on the day after arrival.

3.5 New arrivals we spoke to said they felt safe, and they were checked regularly during their first night. At the time of our visit, seven prisoners who had been at Garth for some time were located on the 16-cell induction unit. They were either awaiting transfer to other prisons or could not be located elsewhere in the prison on risk grounds; their presence alongside the new arrivals was not helpful.

3.6 Prisoners on the induction unit were locked in their cells for too long, some for 21 hours before they were unlocked for exercise.

3.7 In our survey, only 65% of prisoners said that they had received an induction, compared with 86% at the last inspection. The induction programme lacked structure. We were told that a prisoner would be visited by various departments, but the process was not clear or properly recorded. The induction booklet about life at Garth given to prisoners contained some out-of-date information. However, a peer worker, who was also a Listener (prisoner trained by the Samaritans to provide confidential emotional support to fellow prisoners) went through some important information with prisoners on the day after arrival, and this was appreciated.

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 The level of violence at Garth had reduced slightly since the last inspection and was in line with comparable prisons. There had been 166 violent incidents in the previous 12 months, including 67 assaults on staff. The proportion of violent incidents classed as serious was lower than at the last inspection. In our survey, 20% of prisoners told us that they felt unsafe in the establishment, compared with 32% in similar prisons, while the number who reported having been threatened or assaulted by other prisoners had fallen.

3.9 Serious incidents of violence were investigated thoroughly, but staffing constraints meant that this did not always happen promptly. Investigations provided a clear account of what had happened but did not always identify lessons to drive improvement.

3.10 The enthusiastic and dedicated safer custody team was stretched. The team collected some data on safety and violence and was able to draw on this to inform its decision-making, but it did not have capacity to analyse data in depth. This meant that strategy and priorities concerning safety were not always rooted in robust data analysis or able to respond to emerging trends.

3.11 The weekly safety intervention meeting (SIM) was well attended and involved useful multidisciplinary discussion of challenging prisoners. It was positive that the SIM discussed all relocations within the prison and evaluated whether prisoner moves could potentially be disruptive. However, minutes from these meetings did not always clearly show that actions had been followed up.

3.12 Challenge, support and intervention plans (CSIPs, see Glossary) had been used to manage 182 prisoners in the previous year. The quality of plans was variable, and some did not illustrate individualised target setting that related to the root causes of behaviour. Leaders had introduced better controls over which prisoners were managed using CSIP and had implemented a more rigorous quality assurance process, which had led to a recent improvement in the quality of plans.

3.13 The establishment's incentives policy was not always used effectively to challenge poor behaviour, especially lower-level non-compliance on the wings. While prisoners on the basic level of the policy were generally reviewed promptly, some on enhanced status had not been reviewed even though records showed several instances of poor behaviour. There was little difference in what was offered between standard and enhanced levels, to provide motivation. An ongoing review was aiming to provide more consistency in how the policy was applied and to introduce new incentives.

3.14 The Residential Support Unit (RSU) and Building Hope Unit provided targeted support for vulnerable prisoners and those re-entering mainstream conditions respectively. The number of places on the RSU had increased since the previous inspection, so that more vulnerable prisoners could be accommodated. These units provided calmer environments and offered valuable input from psychology services to support prisoners. However, the daily regime and the frequent planned or unplanned cancellations of unlock limited the potential to provide structured activities that would support progression.

3.15 Self-isolators were managed and supported well, and residential staff now had more day-to-day input into their care.

Adjudications

3.16 There had been 2,612 adjudications in the previous year. In the sample we reviewed, the process was conducted fairly and tariffs were proportionate. Cellular confinement was only used as a punishment for the most serious of charges. Governance of adjudications remained good. Adjudicating governors met regularly to monitor data, and to review paperwork, tariffs and challenges to the process to ensure consistency.

3.17 At the time of the inspection, there was a backlog of over 200 overdue adjudications, most of which involved delays in hearing charges that had previously been adjourned. The main reason was lack of staff in the segregation unit to process adjudications. In consequence, many prisoners had waited for long periods for theirs to be resolved.

Use of force

3.18 Force had been used 124 times in the previous year, lower than at the previous inspection and comparable prisons. Batons had been drawn once in the same period but had not been used.

3.19 Paperwork documenting the use of force was adequate, although not always completed promptly. Footage of incidents that we reviewed showed that, in most cases, the use of force was proportionate and justified. However, in a small number of incidents a higher level of force than necessary was used, without adequate evidence of de-escalation. In some instances, officers had used bad language towards prisoners during the use of force.

3.20 Although body-worn video cameras were available to all operational staff, far too few incidents were captured using them. In the previous month, just a quarter of incidents had been recorded using body-worn cameras. Where they were used, they were often switched on after an incident had escalated and force had begun to be applied. In addition, CCTV footage of incidents was not routinely downloaded and stored. This meant that it was not always possible to assess the justification and appropriateness of the use of force, and that important evidence of efforts at de-escalation was often not collected.

3.21 Leaders reviewed trends in the use of force and discussed incidents at regular scrutiny meetings. While the oversight we saw was valuable, the feedback to staff involved in the use of force was poorly documented and it was not always clear what actions had been taken. Prisoners who had been involved in the use of force were not always debriefed after incidents.

3.22 Special accommodation had been used seven times in the previous year, a reduction on the previous inspection. Paperwork was properly completed, and each use appeared justified.

Segregation

3.23 In the last 12 months, 315 prisoners had been segregated, mostly to maintain good order in the prison. The number of cells in the segregation unit had decreased from 28 to 22 since the last inspection, and in consequence it was not uncommon for a few prisoners to be held in segregated conditions on residential units. Proper oversight procedures were used in these cases.

3.24 While most prisoners were held in segregation for between three and eight weeks, several highly complex prisoners had spent very long periods there - one had been segregated at Garth for 21 months, and another for almost a year. These long stays, which would normally be regarded as excessive, were justified to us by the prison because sustained and intensive work being done with these men which appeared to achieve real progression.

3.25 Support for prisoners in segregation was impressive. The unit was jointly run by a prison governor and a professional psychologist and offered embedded psychological case management. All segregated prisoners had clear and detailed progression plans and individualised interventions. We saw evidence of prisoners making good progress, including some who had successfully moved off the unit after long stays. The unit also provided good support for prisoners awaiting

transfers to secure hospital facilities. Prisoners on the unit said they felt supported and well cared for.

3.26 Reviews of segregation were multidisciplinary and timely, and focused appropriately on prisoners' welfare and their pathway to return to normal conditions. Reviews for prisoners who had been segregated for longer periods set realistic targets and included incremental plans to support their progression.

3.27 Living conditions on the unit were reasonably good, although some of the cells on the lower floor were worn out. Prisoners spent an initial period in basic cells. If their behaviour and engagement with the regime were good, they were moved to cells with access to laptops and televisions. Staff on the segregation unit were knowledgeable and supportive, and had good rapport with most of the prisoners.

3.28 Leaders had made some efforts to improve the regime on the unit, including the addition of a small fitness room, allocating on-wing work such as cleaning to some prisoners, and the planned opening of a small workshop. However, the day-to-day regime was often curtailed due to lack of staff, and prisoners were not always able to shower every day.

3.29 Risk assessments to determine the number of staff needed to unlock prisoners were now reviewed daily and adjusted when appropriate.

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.

3.30 Physical security arrangements were generally proportionate and aligned to risks. However, too many prisoners were strip-searched without an assessment of their individual risks (see paragraph 3.1).

3.31 Managers were aware of the key threats to security, and the monthly local tactical assessment provided an overview of key security concerns.

3.32 The flow of intelligence into the security department was good. In the previous 12 months, 8,241 intelligence reports had been submitted, with the highest number consistently related to illicit items and to order and control. Most intelligence reports were processed quickly but there were sometimes delays at weekends.

3.33 There was an effective dedicated search team (DST), but too often it was cross-deployed to other departments owing to staff shortages. During our inspection, and in our survey, prisoners told us that there were often delays in receiving their property. This was because the

DST was regularly unavailable to check property before its issue to the prisoner, which was a frustration for many. However, most requested targeted searches were carried out and they were effective. In the previous 12 months, 638 searches had resulted in finds of drugs on 72 occasions, mobile phones 59 times, weapons 107 times and 144 finds of alcohol.

3.34 There had been some work to reduce the supply of drugs, such as the use of an itemiser machine to detect drugs in mail and a body scanner. There had also been some effective work, led by police, to reduce the use of drones. However, despite enhanced gate security, which was meant to provide an airport-style level of searching on entry to the prison, Garth had not received an X-ray machine. Although the mandatory drug testing rate was lower than at the last inspection, it remained high at 17.9% in the previous 12 months. Suspicion drug testing had been carried out 69 times and resulted in 28 positive results.

3.35 Links with the police were good and police intelligence officers worked well with the security team. There was interagency work to manage gangs and identified extremists. Work to tackle staff corruption was very good. Prison managers worked effectively with the police when staff wrongdoing was suspected, and this had yielded some positive results.

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

3.36 Since our previous inspection, there had been three self-inflicted deaths and six other apparently non-natural deaths. Investigations into five of these had been completed and found they were linked to the use of illicit substances. Good progress was being made in achieving the recommendations in the death-in-custody action plan.

3.37 The rate of self-harm was lower than the last inspection, at 727 per 1,000 prisoners, compared with 1,056. In the previous 12 months, there had been 558 incidents of self-harm by 124 prisoners, of which 66 had been classified as serious. Not all of these had been investigated. At the time of our inspection, 11 investigations were outstanding, but those that had been carried out were of reasonable quality.

3.38 The safer custody department had worked hard to deliver training to staff in the new version of assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of self-harm, but in practice the quality of support delivered was inconsistent. Assessments

were usually good, but care plans, risks and triggers were often incomplete, and some daily interactions and supervisor checks were missing. Leaders were aware of this and work was under way to address the issues. Most prisoners we spoke to who were or had been on ACCT were positive about staff support.

3.39 Constant supervision had been used 57 times for 35 prisoners in the previous 12 months. One constant supervision cell was still located in the segregation unit, which was an inappropriate environment. Decisions to locate prisoners on an ACCT in the segregation unit were not well recorded nor always fully justified.

3.40 The safety intervention meeting discussed those involved in incidents of self-harm each week, but the focus was more on discussing the number of self-harm incidents and prisoners involved than on the incidents themselves and how they could be prevented. However, prisoners identified as having significant need and vulnerability were referred to the complex case meeting and were supported well.

3.41 Some analysis of data had taken place, but this required further development. The safer custody policy was mostly focused on process and lacked detailed analysis of the causes and drivers of self-harm.

3.42 At the time of our inspection, there were 11 Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners). In our survey, more respondents on F and G wings, holding vulnerable prisoners, than on other wings said that it was easy to speak to a Listener if they wanted to (58% against 27%). Prisoners told us that sometimes staff did not facilitate requests to see Listeners, but in-cell telephones enabled them to make free calls to the Samaritans.

Protection of adults at risk (see Glossary)

3.43 The prison's safeguarding adults policy was comprehensive and prison managers had links with the local safeguarding adults board. The oversight of prisoners who were providing support to vulnerable prisoners, such as collecting their meals or helping them with daily tasks, was weak (see paragraph 4.56). Many staff we spoke to during our inspection were largely unfamiliar with safeguarding and associated procedures, which increased the risk that needs could be missed.

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 About 30% of officers on the landings had not been in service before the COVID-19 restrictions. Support was given to new staff through a colleague mentoring scheme to help improve confidence and capability. We observed a varying quality of staff behaviour towards prisoners, from some very good engagement to some passive or distant interactions. Some low-level poor prisoner behaviour, such as openly vaping on the wings, went unchallenged by staff.

4.2 In our survey, 67% of prisoners said they were treated with respect by staff, fewer than the 80% at our previous inspection. Findings for prisoners who were 25 and under, for those from a racial minority and for Muslim prisoners were even lower. Only a quarter of respondents said that a member of staff had asked them in the last week how they were getting on, compared with 40% at the last inspection. Prisoners also attributed some of their negative perceptions to the extended time locked up and not having a consistent group of staff working on their wing.

4.3 The leadership team was committed to improving the standard of key work (see Glossary). In our survey, 92% of prisoners said they had a named key worker. Sessions rarely took place at the required frequency, having recently dropped in number. The quality of key work sessions varied, with some entries in prisoner case notes reflecting meaningful engagement while others were superficial. In general, entries labelled as 'key work' did not always refer to sentence planning targets or reducing the risk of reoffending, and we found some incorrect recording.

4.4 There was a wide range of effective peer work to provide additional support and guidance to prisoners.

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

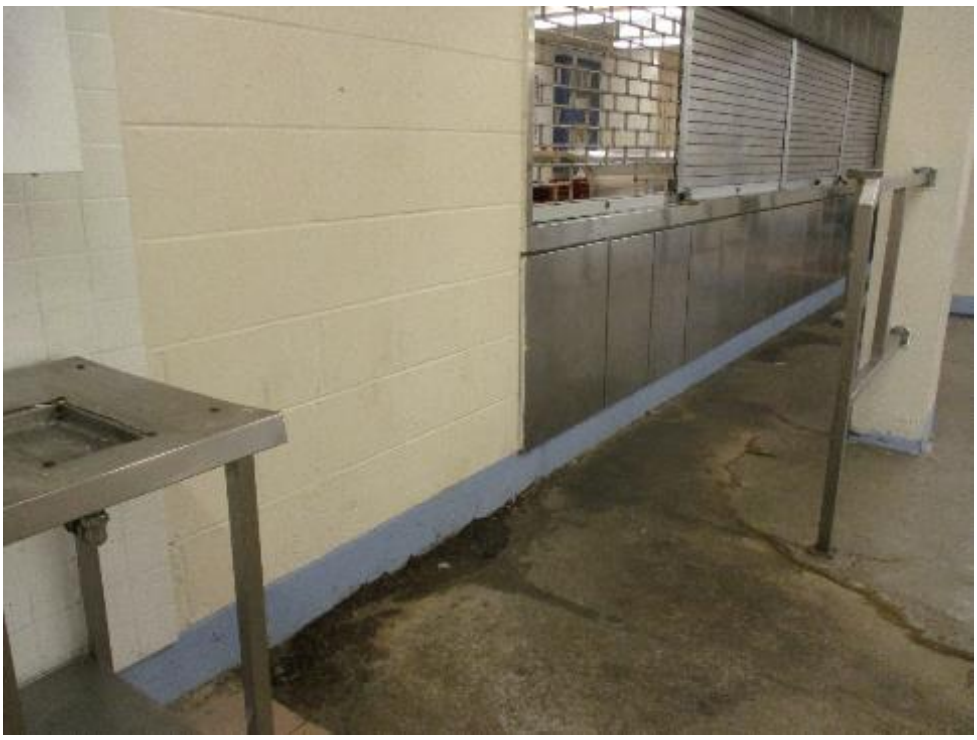
4.5 The prison remained an ageing establishment which, in parts, was in very poor condition. Leaders, however, focused appropriately on making the living conditions as decent as possible within tight budgetary constraints and complex contractual arrangements.

4.6 Few prisoners lived in overcrowded conditions and most had single cells, which they appreciated. Not all the relatively few double cells were big enough for two people.

4.7 Many cells in the older wings, A to D, were very small, but most prisoners accepted this and made the best of it. Those in the newer wings, E to G, were larger. Cells were generally free of graffiti and offensive displays, but many lacked ventilation, storage space, toilet seats, lids and screening, curtains, lockable cupboards and, in some cases, tables and chairs. Many prisoners personalised and made their cells more homely, but some were less well kept. In-cell telephones had been installed in all cells just before the pandemic period.

Cell on A wing

4.8 Outside areas were well maintained and free of litter. Communal areas on residential units were variable: some were grubby and some of the flooring was in poor condition, which was also the case in some cells.



Decayed flooring at servery on C wing

Poor flooring on A wing

4.9 Communal showers on most of the wings were very poor - they had variable water pressure, missing tiles and lacked privacy screens. A programme of refurbishment had begun on E wing. In our survey, only 71% of prisoners said they could shower every day, compared with 91% at our last inspection.

Showers on D wing

E wing showers

4.10 Most prisoners wore their own clothes, and many had their own bedding, which they could wash at least once a week in the wing laundries. Prisoners complained that there were not enough washing machines as a few were awaiting repair.

4.11 Only 21% of respondents to our survey said that their cell bells were normally answered within five minutes, but residents of F and G wings and the over 50s were more positive (at 36% and 47%). Electronic monitoring of response times was not possible owing to a system malfunction, but we observed that response to call bells was often too slow. Once we highlighted this to leaders, oversight was introduced pending repairs.

Residential services

4.12 The main meals that we saw were of reasonable quality. Prisoners selected lunch and dinner from a rolling monthly menu that offered a reasonable variety. Requirements such as halal, kosher and vegan diets were catered for, and the kitchen staff worked well with the health care department on meeting individuals' needs. The catering manager consulted prisoners about meals through the biweekly prison council meeting, prisoner surveys and comments books, but the books were rarely used.

4.13 Meals were served too early, at between 11.15 and 11.30am and from 4pm. Breakfast packs, which were small, were issued with lunch the day before, earlier than at the last inspection.

4.14 The main kitchen was clean and well organised. Food safety and handling training was given to all kitchen workers, but not to all servery workers, who should have completed this training before working with food.

4.15 Daily supervision of the meal service from wing serveries was ineffective. Servers were not always suitably dressed, and utensils were not always used correctly. We saw food transferred from hot trolleys into cold trays, and temperature checks not taken and recorded, which was unsafe.

4.16 Self-catering fridges, microwave ovens and toasters were available on all the wings, as were grills and air fryers on request. These facilities were not always clean or hygienic. There were only limited opportunities for prisoners to eat meals outside their cell with others.

Prisoner fridge on C wing

Dirty cooking equipment on F wing

4.17 Prisoners' perception of the shop had deteriorated. In our survey, only 54% of respondents said that the shop sold the things that they needed, compared with 70% at the last inspection. Prisoners told us that when deliveries were incorrect, they waited too long for a refund. A range of catalogues were available, but delivery of orders often took too long.

Prisoner consultation, applications and redress

4.18 Prisoners were very frustrated by the very poor working of the applications and complaints systems. The application system had recently changed, and prisoners now submitted them confidentially through their in-cell laptops. Data were not available, but managers believed the number had increased greatly. The prison now monitored the new system, but at the beginning of November 2022, just under 500 application responses were overdue. In our survey, only 39% of prisoners said that applications were dealt with fairly, compared with 55% last time.

4.19 In the previous six months, 2,093 complaints had been submitted, a 45% increase on the same period before our last inspection. Complaint forms were freely available on the wings. The night orderly officer collected completed forms and delivered them to the business hub, which lacked confidentiality: this was changed during our visit. Prisoners told us they often did not receive a response, or it was received late. In the sample we reviewed, we found delays and some responses that did not fully address the issues raised. Quality assurance was in place, and the Independent Monitoring Board now provided additional scrutiny of complaints.

4.20 There was good analysis of complaints each month, identifying trends and any issues that needed addressing, but little action followed, despite discussion at the senior management team and performance management meetings.

4.21 The prison council worked well. It was championed by senior leaders and had contributed to some meaningful changes.

4.22 Prisoners had good access to their legal representatives. Three private booths in the visits area could be booked on three days a week. Legal texts were readily available in the library.

Equality, diversity and faith

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

Strategic management

4.23 Strategic work to improve equality outcomes across the prison was not as good as at our last inspection, despite efforts by the small equality team. There was no dedicated equality role, and frequent redeployment left the team under-resourced. Equality work was not sufficiently embedded across the prison. Senior leaders were each allocated a responsibility for a key protected characteristic group, but these roles were not well developed and were too often perfunctory in practice. Some local data were scrutinised, but analysis was too limited and some potential disproportionality was missed. There was no prison-wide strategy to drive improvement in outcomes, and action plans did not specifically reflect the needs and experiences of the population at Garth.

4.24 The formal process for reporting discrimination (discrimination incident reporting forms, DIRFs) had been used 86 times in the last 12 months, and only a small number had been upheld. Although we were told that all DIRFs were quality assured, this was not supported by evidence, and an external scrutiny panel had met only once in the year to date. Prisoners told us that they had little faith in the process, and that delays in responses were common. Our sample confirmed this, with some responses taking several weeks. Some records were incomplete and some forms were missing. Investigations were not always thorough, and it was often not clear that the outcome had been relayed to the prisoner.

4.25 Consultation with prisoners sharing protected characteristics had not been regular, leaving the prison poorly placed to understand or act on their needs and experiences. Forums had restarted with some groups, and action points were fed into the equality action plan. However, these sessions were too infrequent, and actions often did not progress. For example, a request from prisoners from the Gypsy, Roma and Traveller community for a peer representative had been outstanding since March 2022. Prisoners told us of their frustration at the lack of progress.

4.26 Prisoner equality representatives were in place on some wings. They did not receive formal training or supervision, which was a gap, but they were in regular informal contact with the equality team and valued that support. Some representatives told us they felt undervalued and that staff did not always facilitate access to the wings. Leaders were aware of this and planned to enhance and develop the scheme. Regular subcommittee meetings were scheduled, but in practice only one had been held in the year to date, leaving the reps without an arena in which to feed back on equality issues.

Protected characteristics

4.27 About a quarter of the population were from a black or minority ethnic background, and engagement with these prisoners had improved. They greatly appreciated cultural awareness sessions delivered by an external specialist on a voluntary basis. Only about six prisoners at a time could attend, but there were plans to increase the number and to

involve prisoners in the training of new staff, which was positive. Despite this, prisoners described a lack of understanding of cultural diversity among staff. In our survey, only 47% of black and minority ethnic prisoners said that staff treated them with respect, compared with 74% of white prisoners, and only 47%, against 75%, said that there was a member of staff they could turn to if they had a problem (see also paragraph 4.2).

4.28 Too little had been done to understand the needs of foreign national prisoners. There was no allocated senior lead for this group and no forums had been held. Use of professional interpreting services was not adequately monitored across the prison, and younger prisoners described translating for older prisoners, as there was not enough translated information.

4.29 A large number of prisoners (303 according to prison data) identified as having a physical or mental disability, and their needs were not always met. Prisoners with mobility problems could not access basic elements of the regime - including health care - because of infrastructure problems, and some told us they had not been outside in weeks, which they said was greatly affecting their well-being. We saw prisoners in wheelchairs being carried up and down stairs. Staff awareness of the needs of neurodivergent prisoners was low. Only one meeting had been held with prisoners with disabilities in the previous year; prisoners highlighted issues with the provision of mobility and other aids. Some prisoners had carers to assist them with aspects of daily life, but the lack of formal training and supervision was a concern (see paragraphs 3.43 and 4.56).

4.30 Almost 20% of the population was aged over 50. In our survey, older prisoners responded more positively to questions about daily life and staff relationships in the prison. There was a dedicated landing for over 55s, and prisoners appreciated the quiet and calm environment, but felt otherwise overlooked, with very little tailored provision or activities targeted at their age group.

4.31 Only 15 prisoners had disclosed that they identified as gay, lesbian, bisexual or transgender. There had been only one forum with LGBT prisoners, largely focused on arrangements for events marking Pride month. However, too little was done to promote LGBT awareness more regularly.

4.32 There were five transgender prisoners at Garth. They described feeling supported by the equality team and had access to personal care items that they needed. However, they also told us they did not always feel safe on the wings. The prison had agreed appropriate compacts dealing with, for example, matters such as showering, but had had to issue reminders about appropriate searching practices.

Faith and religion

4.33 The chaplaincy provided a wide range of faiths with the opportunity to worship weekly, and could also support the less common faiths on a needs basis. In our survey, 80% of prisoners said they were able to attend religious services if they wanted to, which was better than at similar prisons.

4.34 The chaplaincy was well integrated into prison life, regularly delivering pastoral support on the wings and conducting welfare checks, including for prisoners at risk of self-harm or new arrivals. Some chaplaincy services had been too slow to recommence following the removal of COVID-19 restrictions. For example, the official prison visiting scheme and the Sycamore Tree (restorative justice) programme were not due to start until January 2023. Study groups had been similarly affected; before our inspection, just a Bible study group had recommenced, but the prison had plans to address this gap.

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.

4.35 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).

Strategy, clinical governance and partnerships

4.36 Greater Manchester Mental Health NHS Foundation Trust (GMMH) was the lead provider of health and social care, with Delphi subcontracted to deliver psychosocial substance misuse services. Smart Dental was commissioned separately to provide dental services.

4.37 Regular local delivery board and clinical governance meetings informed service delivery. NHS commissioners held quarterly contract meetings with the provider and a new health needs analysis had been commissioned for early 2023. Partnership working between the health care providers, the prison and external partners was effective.

4.38 Non-attendance rates for all health appointments were too high and in the previous four weeks, over 200 appointments had not been attended, wasting valuable clinical time. We were advised that the main reason for this was the regime and frequent wing lockdowns. Non-attendance rates were now reported weekly to the prison's performance meeting, but this had not yet led to improvements. Many prisoners expressed frustration at not being able to attend health appointments.

4.39 The management of health complaints was ineffective, with no action on many complaints because leaders had difficulty accessing those submitted via prisoner laptops. Responses we sampled were poor and lacked senior oversight. This was addressed during the inspection.

4.40 Many clinical areas did not meet infection prevention standards, which was poor and created risks. A recent comprehensive infection control audit by GMMH had led to an action plan to address deficits, which required investment to ensure effective remedy.

4.41 Clinical staff's compliance with mandatory training and clinical supervision was good and the provider encouraged professional development. We observed skilled and conscientious clinical staff delivering care and treatment diligently and professionally. The primary care team faced recruitment challenges which were stretching resources, and relied on additional hours and regular agency staff to cover shortfalls.

4.42 Clinical incidents were reported and we were assured that managers reviewed all incidents and that any lessons learned were communicated to the local clinical teams and discussed at a regional level. Leaders had recently introduced a monthly learning lessons bulletin which all staff received.

4.43 SystmOne electronic clinical records were used for all patients and the standard of record-keeping was good. Patient engagement was reasonable and their feedback was collated regularly. We saw advanced plans to reintroduce monthly health care forums for patients, which was good.

4.44 Staff were trained in the use of immediate life support skills, and resuscitation equipment was fully appropriate, regularly checked and strategically placed throughout the prison.

Promoting health and well-being

4.45 There was no prison-wide approach to promoting health and well-being, but a strategy had been developed and a dedicated and enthusiastic senior public health nurse was coordinating health promotion activity across the prison. Health and well-being events had been facilitated in line with the national calendar, and a monthly newsletter was produced and delivered to every prisoner.

4.46 Immunisations and vaccinations were managed well and there were plans to administer influenza and Covid boosters imminently. National health screening programmes such as retinal screening and bowel cancer were in place, with data reported on and monitored.

4.47 Sexual health was managed well; health care had effective links with East Lancashire Hospitals NHS Trust and the Hepatitis Trust to make sure appropriate treatment was delivered. Condoms were provided by the health care department.

4.48 We saw advanced plans to introduce peer health care champions, which was good.

Primary care and inpatient services

4.49 Initial health screenings of new arrivals by a nurse enabled continuity of care and referrals to specialist care, if required, and we saw evidence of comprehensive secondary screening within seven days. Nurse staffing was stretched, and ongoing shortfalls caused regular cross-deployment to deliver core provision - such as medicine administration – which reduced available clinic times. Cancellation of clinical appointments because of regime curtailments contributed to prisoner frustrations, with only 27% of prisoners in our survey indicating that the quality of health care was good, compared with 42% in similar prisons.

4.50 Primary care services were available seven days a week but not overnight, and weekend input was more limited. Most care was delivered within the health care department. There was only one waiting room, and vulnerable prisoners on F and G wings were accommodated at separate clinic times which created access issues, though there was some outreach support to these areas. The waiting room itself was cramped with no access to toilets or drinking water.

4.51 Primary care delivered a planned and an unplanned care pathway, which generally enabled consistent and timely support to be delivered. Prisoners with long-term conditions were identified appropriately and received good support from a small team of nurses with appropriate skills. A palliative care pathway had been developed and used in line with the patient's wishes on at least one occasion.

4.52 Prisoners used their laptops or directly contacted health care staff to request a health appointment. Triage and allocation to a suitable clinic were undertaken well and appointment slips were delivered individually. Despite significant challenges, access to most primary care services was reasonable, with waiting times for a routine appointment with a GP at just over two weeks. Waiting times for other support, such as physiotherapy, podiatry and optician, were all reasonable. Access to external hospital appointments was generally prioritised by the prison, but demand was greater than the number of available escorts and, despite greater use of telephone consultations, several appointments for non-urgent consultant appointments had exceeded the 18-week threshold.

4.53 Most prisoners left Garth to go to other establishments and we saw examples of effective information sharing. Individuals released directly into the community were reviewed before leaving the establishment to determine what ongoing support was required, including medicine supply and referral to community agencies if required.

Social care

4.54 There was now a memorandum of understanding and information-sharing agreement with Lancashire County Council, which was responsible for the provision of social care. A county-wide prisons team at the council was undertaking prompt assessments of need following referral, and relationships between the council, prison leaders and the health care department were effective.

4.55 No prisoners were receiving a formal care package from the council, but systems to identify and respond to need were embedded and the practice manager maintained good oversight of referrals and assessments. Prisoners were able to self-refer.

4.56 Several prisoners received non-intimate support from prisoner buddies. They had received no training or supervision, which created unnecessary risks. (See paragraphs 3.43 and 4.29).

Mental health care

4.57 Prisoners' immediate mental health needs were assessed during their reception screening. Individuals with existing need were identified promptly and provided with ongoing support.

4.58 Care was provided by GMMH with additional input from the OUT Spoken Talking Therapy Service (part of the Survivors Manchester Group) who delivered trauma-based therapy services for 10 prisoners.

4.59 The GMMH team operated seven days a week, using a stepped-care model which ranged from directed self-help, low- to moderate-intensity therapeutic support through to support for individuals with significant complexity. Mental health nurses were regularly expected to undertake medicine administration, which took them away from their core duties. Nevertheless, an effective multidisciplinary team with a good skill mix that included regular psychiatry input, well-being practitioner support and a specialist learning disability nurse enabled a timely and proportionate range of interventions, though there were no group work or counselling services. The team also provided some bespoke input for prisoners on the Beacon Unit, including transitional support following discharge from the unit.

4.60 Prisoners could refer directly to the service. Other health professionals and prison officers could also make referrals, although, apart from the segregation unit, there was limited evidence of additional mental health training for officers.

4.61 A duty worker offered urgent support and undertook initial triage. Referrals were dealt with promptly using a validated format and prisoners appreciated the support offered. The team attended case reviews for all newly opened ACCTs and input was maintained if appropriate. New referrals were reviewed routinely at a single point of access meeting and allocated to a nominated practitioner once placed on the caseload, which stood at around 120 patients. The only

significant delays were for psychological services, where a small number of patients had waited over six months to see a psychologist. There were also long waits to access the well-being practitioner and the OUT Spoken service.

4.62 Practitioners received ongoing training and access to regular supervision, and most staff said they felt well supported. The clinical records we reviewed were generally thorough and appropriately captured assessment, risk and actual care provided. Thirty-two patients with severe and enduring mental illness were supported effectively using the care programme approach. Prisoners identified as requiring treatment in hospital were generally transferred promptly, except where a specialist forensic bed was required, when some short delays could be experienced. Pre-release arrangements ensured effective ongoing support into the community, including making use of the dedicated Reconnect service, and good communication was evidenced when patients moved to other institutions.

Substance misuse treatment

4.63 GMMH provided clinical substance misuse services working in collaboration with Delphi who delivered psychosocial support. Partnership working was good and both teams actively contributed to various forums including the drug strategy meetings, which had developed a coherent approach to tackling the prison's drugs problem.

4.64 Ongoing clinical need was identified at reception and prisoners already engaged in treatment were supported by the clinical treatment team. About 77 prisoners were in receipt of opiate substitute treatment, mostly for maintenance. Treatment options had improved, and prisoners could continue on buprenorphine if already prescribed, but they could not transition from methadone even if that were deemed to be clinically appropriate, though options to make sure more flexible prescribing in line with national guidance were being explored. The team was small and led by one registered nurse who was managing a large caseload. Nevertheless, regular treatment reviews, jointly undertaken with Delphi, took place promptly and thoroughly. There was no prescriber in the team and prescribing support was provided one day a fortnight. This was inadequate and led to delays in changing treatment, a problem that was magnified when the allocated practitioner was on leave.

4.65 Delphi worked very closely with the clinical team and offered a good range of psychosocial support. The service was well led with good governance that drove service development. Harm minimisation advice was routinely supplied, including for prisoners suspected of being 'under the influence'. Prisoners were advised of the services available on induction and 170 individuals were currently being supported across the prison through a range of programmes of different intensity, including a mix of self-directed workbooks, one-to-one interventions and group work. D1 wing functioned as a drug recovery wing and, although regime restrictions impacted on service provision too frequently, prisoners we spoke to valued Delphi's support. Officers

were selected to work on the wing, which was positive, but none we spoke to had received any additional training.

4.66 Several trained peer mentors delivered good support across the site. Mutual aid was not yet routinely available as there were too few volunteers available, so the option of virtual sessions was being explored.

4.67 Pre-release planning when required was good. Individuals needing support were identified early and linked into external support agencies. Where appropriate, prisoners were provided with training and a supply of naloxone (to counter the effects of opiate overdose) wherever indicated.

Medicines optimisation and pharmacy services

4.68 Medicines were supplied into the prison by HMP Wymott. The current delivery of medicines was not safe as there had been no risk assessments or manual handling assessments. These deliveries relied heavily on the goodwill of the wider health care team to carry large boxes upstairs to the pharmacy room. There were processes to reduce the number of duplicate supplies and waste medicines the prison was generating, but these were in early stages and needed further embedding. There was also a new process to enable prisoners to order their own as-required medicines. This aimed to enable ownership of medicine requests and also reduce waste; this also was in the early stages and required embedding.

4.69 The pharmacy team lacked sufficient capacity to provide an effective service - one whole-time-equivalent wing pharmacy technician worked compressed hours over four days with a second person who worked mainly at a nearby prison, if and when available. In the previous 20 working days, one member of staff was recorded on audit sheets on 12 working days. There was not enough capacity to cover all aspects of the required role effectively. There was no clinical pharmacy service and no pharmacy-led clinics, and no multidisciplinary team or complex case review meetings in this area.

4.70 Medicines not supplied in possession were administered twice daily at 8am and 3pm through four hatches serving the seven wings. Supervision of queues was inconsistent and on some wings poor.

4.71 Most prisoners (72%) received their medicines in possession. We reviewed 10 records from the 48 new prisoners admitted between 1 September 2022 and 15 November 2022 and all had their medicines reconciliation recorded, but none had an uploaded compact agreement and staff were unable to locate these. Prisoners were subject to cell checks, which were intelligence-led, as well as random and responsive to routine medicines reviews.

4.72 Emergency stock medicines were available and over-labelled medicines were available to be used out of hours. Not all staff had signed up to use the over-the-counter remedies policy, but these were

available to be used. Oxygen cylinders were not always stored securely, and signage was not always present, although staff took immediate action to rectify this when pointed out. The process for recording the receipt and administration of controlled drugs needed to comply with legislation and local policy. Automated equipment to measure liquid opiate substitute therapies was not available on F and G wings, and the process required a review to make sure it was risk-assessed and robust.

Dental services and oral health

4.73 Governance of dental services was sound. The dental surgery met all health and safety requirements, and there was maintenance of equipment. Medicines prescribed by the dentist were not always made available to patients promptly, which the pharmacy department needed to resolve promptly.

4.74 The dentistry team advised that appointment slips were not always delivered to patients, and attendance at clinics was an ongoing problem. The clinical support available had been diluted because of regime constraints and other factors; the service had been one of the last to be allowed to undertake aerosol generating procedures (AGPs, see Glossary).

4.75 Additional clinics had been provided and the dental team actively triaged patients on wings to make sure clinical priorities were determined. This had seen waiting times fall to around 12 weeks for a routine appointment. However, vulnerable prisoners on F and G wings could not access this additional provision; waits for these patients were inequitable and remained excessively long at up to 30 weeks. We were told that an additional dental suite would be brought into use creating easier access for these prisoners, on completion of some necessary capital expenditure. This should be explored to solve an obdurate problem.

Section 5 Purposeful activity

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

Time out of cell

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

5.1 Time out of cell was inadequate due to the split regime, in which prisoners were cohorted into smaller groups and unlocked separately. Leaders were maintaining the fragmented regime on the grounds that it improved safety, but there was a high cost in prisoners' access to services such as health care or education, and their ability to use their time constructively and so make progress in their sentence. On an average day, prisoners in employment received around six hours out of their cells, while unemployed prisoners were unlocked for just 2.5 hours, which was much less than at our previous inspection. At the time of our inspection, 140 prisoners were unemployed, increasing the number who spent long periods locked in their cells.

5.2 Frequent wing lockdowns caused by staff shortages reduced time out of cell. While some of these were planned, others occurred at short notice and prisoners were kept locked in their cells with little warning. Managers had ensured that lockdowns were spread evenly across the residential units and that prisoners could still attend work and gym sessions during these periods, but prisoners still spent far too much time in their cells, with little access to activities to occupy them.

5.3 In our survey, 35% of prisoners, compared with 13% at the previous inspection, said they usually spent less than two hours out of their cells on weekdays, and 46%, against 67%, reported having time to complete domestic tasks and associate with others at least five times a week. Just 54% of prisoners said they were able to exercise outdoors on at least five days a week, compared with 81% last time and 67% in comparable prisons.

5.4 The library was run by Lancashire County Council and provided a welcoming space, well laid out with a range of thematic displays to encourage readers. It was reasonably well stocked with audiobooks and easy reads, but the selection of books in foreign languages was limited. The library was complemented by an outreach service on the wings, which was appreciated by the prisoners we spoke to. The prison's monitoring data suggested that the library was underused, with regime restrictions affecting the numbers accessing it each week. Prisoners had too little access to reading experiences. Face-to-face reading groups had not yet resumed since the lifting of COVID

restrictions, and although the Shannon Trust reading programme attended the prison, only seven learners were registered, which was too low.

5.5 The prison's gym facilities, comprising two gyms, a sports hall and classrooms, were well managed. Prisoners also had access to cardiovascular equipment on the wings and some equipment in the exercise yard. The gyms were well equipped and in a generally good condition, although the showers in the older gym required refurbishment. The under-resourced PE team was making considerable effort to make sure prisoners could access gym activities at least twice a week, but this was affected by restrictions to the regime. Prison data showed that 40% of prisoners were accessing the gym, compared with 70% before the pandemic. Because of staff shortages, no accredited courses were delivered.

Education, skills and work activities

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

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

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

Overall effectiveness: inadequate

Quality of education: inadequate

Behaviour and attitudes: inadequate

Personal development: inadequate

Leadership and management: inadequate.

5.7 There were enough skills and work spaces to provide part-time sessions for prisoners, but insufficient education places to meet

demand. Even so, over a fifth of activity spaces were not filled at the time of the inspection. Too many prisoners in the segregation unit did not take part in any education, skills and work activity. Although vulnerable prisoners on F and G wings had the same opportunities to attend sessions in education as the general population, they could not take part in vocational training.

5.8 Leaders and managers did not have high enough expectations of all prisoners. Their vision to provide an ambitious and progressive education, skills and work curriculum had been significantly curtailed because of the prison regime and staff shortages. Most prisoners did not improve their work over time because they could not attend work, workshops and lessons regularly enough. The large majority of prisoners studying functional skills English made very slow progress, and tutors spent more time recapping previously learned theory than teaching new concepts.

5.9 Leaders and managers no longer had oversight of how prisoners were being allocated to activities. They did not make sure that prisoners' starting points or goals were considered when allocating activities. A significant minority of prisoners lacked motivation to attend, because they felt forced into job roles and activities that they were not interested in and had not chosen to do.

5.10 Prisoners were frustrated by the changes to the pay policy. Leaders had changed the policy to incentivise prisoners to achieve functional skills English and mathematics up to level 1. However, they had not provided enough education spaces for all those who applied. Prisoners who had not yet achieved level 1 functional skills in English and mathematics could not be paid on the two highest pay bands until they achieved those qualifications. About a quarter of prisoners were waiting for a place on these courses. Prisoners who were allocated to wing work were expected to achieve the same functional skills qualifications and complete an industrial cleaning qualification. Often, they did not meet these expectations because not enough education and vocational training spaces were available.

5.11 The curriculum lacked ambition, and leaders were not providing a curriculum for those who could not attend activities. Wing work was not well planned or organised across the prison. Prisoners did not develop the knowledge, skills and behaviours that they needed to help them prepare for their next steps and rehabilitation. Most prisoners made little or no progress in achieving their goals. Those undertaking wing work did not receive a clear induction, and managers did not check how well they completed their duties.

5.12 The very few prisoners who attended vocational training benefited from a purposeful curriculum where they developed their knowledge, skills and behaviours incrementally. There was a well-structured and constructed curriculum for the very few prisoners who studied catering and industrial cleaning. They achieved meaningful qualifications that were planned to help them gain employment once they were released from prison.

5.13 The prison education framework provider had not put its education curriculum in place successfully. It did not effectively review or adapt the curriculum it had planned to take into account the changes prison leaders had made to the regime. Although the curriculum was sequenced in a logical order, prisoners were only scheduled to attend two sessions a week. Tutors did not set them work to do in between sessions or provide additional training on the wings. Consequently, prisoners made extremely slow progress in developing new knowledge and skills.

5.14 Support for prisoners with learning difficulties and disabilities was ineffective. Although leaders had clear plans to support them, they did not consistently receive the planned support. When prisoners were unable to attend classes, staff frequently could not get on the wings to provide them with the support that they needed.

5.15 Staff were suitably qualified and experienced to train prisoners. They benefited from a range of effective vocational and industry training and development. For example, support staff completed training in cognitive behaviour therapy, and attended courses in mental health. Catering staff visited exhibitions to update their industry knowledge. However, leaders did not provide training to develop tutors' teaching skills. Tutors did not know what they specifically needed to do to further improve.

5.16 Tutors and instructors created calm learning and working environments in education and workshops. In most cases, prisoners listened carefully to tutors and instructors. Those who were able to attend were punctual. A small number of prisoners who were studying distance learning and Open University courses, including science, philosophy and counselling, appreciated being able to use the ‘virtual campus’ (giving them internet access to community education, training and employment opportunities) for their studies. They were motivated to learn. However, in workshops prisoners were not always well motivated. A few instructors did not have high enough expectations of what prisoners could achieve and prisoners became disengaged.

5.17 Leaders and managers planned for a diverse range of workshops, including textiles, electrical, engineering and woodwork, as part of the industries curriculum. Employers provided workshops that were designed to replicate external industrial standards and prepare prisoners for their release. However, at the time of the inspection a few workshops were closed, and most were functioning below capacity. Leaders and managers did not engage effectively with employers who offered workshops in prison. Employers did not feel well supported and they were unclear about how to raise any concerns they had. Managers and instructors did not monitor the development of prisoners' knowledge, skills or behaviours in workshops very carefully. They did not intervene when prisoners made slow progress. Managers had developed a 'progress in workbooks' process but this was not implemented well or used consistently by instructors or prisoners.

5.18 Quality assurance arrangements were weak. Leaders had not put in place effective actions or plans to prevent the decline of the quality of

education, skills and work since the previous inspection. They had not fully resolved any of the recommendations from the last inspection. For example, they did not make sure that prisoners improved their English and mathematical skills in prison work. Prison staff and most tutors did not provide prisoners with effective feedback. The very small numbers of prisoners in catering and industrial cleaning, however, received helpful feedback. Instructors told them what they had done well and what they needed to do better. They improved their work and made good progress in developing their knowledge and skills.

5.19 Leaders and managers failed to plan or provide a personal development curriculum. Most prisoners did not benefit from access to enrichment activities to broaden their skills and abilities. Leaders and managers did not use available funding to facilitate this, nor did they plan for prisoners to learn about democratic values. A large proportion of prisoners did not feel that the prison supported them to live healthy positive lives.

5.20 Leaders and managers had recently developed a reading strategy, but it was not embedded across the prison. Managers assessed prisoners' reading ability through an ad hoc range of methods which were not consistently used. They did not have oversight of the prisoners who could read and who could not. Reading was not promoted by staff. However, some prisoners who enjoyed reading were keen to read books and made use of the library; a few said that they had improved their vocabulary through reading since coming to the prison. A very few prisoners were trained as Shannon Trust mentors, supporting peers who had very low levels of literacy.

5.21 Leaders did not make sure that all prisoners received the information advice and guidance to support them to progress to positive destinations. Two-thirds of prisoners on the main wings had not received their first careers information, advice and guidance session. Prisoners did not have access to a high-quality careers service. Leaders did not make sure that the guidance prisoners received informed their sentence plans. A small minority of prisoners had clear long-term career plans to work towards.

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 Access to social visits was good for most prisoners. Visits were open for two hours an afternoon, five days a week, including weekends. Visit times continued to be an issue and in our survey, only 16% of prisoners, compared with 30% at similar prisons, said visits started and finished on time. Prisoners' families and friends were frustrated by this, with some having travelled long distances. Online booking was now available, but the telephone system remained problematic with out-of-date information on the automated system and long waiting times for calls to be answered.

6.2 The visitors' centre was still in a poor state, including leaking toilets. The visits hall was adequate, but the children's play area was small and only provided activities for young children. Family visit days had resumed, with high uptake and positive feedback. Leaders had recognised that training for staff working in these areas was inadequate and needed addressing. The food provision was sufficient and visitors were able to buy snacks for the prisoner to take back to their cell, unless they were on the lowest incentive level.

6.3 The voluntary organisation POPS (Partners of Prisoners) gave support to prisoners' families and worked with prison staff to hold family forums. For example, staff from health care had given an overview of their services, with an opportunity for family members to ask questions, which was positively received.

6.4 A family link worker had been appointed and was having a positive impact on supporting prisoners' engagement with families. There were good links with the New Bridge Foundation befriending project, offering support to prisoners who had no visits, and 16 prisoners were engaged with this service. Storybook Dads (enabling prisoners to record a story for their children) had resumed in 2022 and was valued by the prisoners who used it. A parenting programme was due to start, with several self-referrals already made.

6.5 Prisoners now had in-cell telephones, which helped them maintain family contact. They were positive about this and also appreciated the 'email a prisoner' service they could access through their in-cell laptops. The video-calling service was, however, unreliable and underused, and we saw intermittent internet connection affecting prisoners' visit with their families, which was frustrating. In our survey, only 8% of prisoners said they had used the video-calling service in the last month.

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.

6.6 During our inspection, 93% of prisoners held were assessed as high or very high risk of harm for serious violent or sexual offences. Only 15% of prisoners were sentenced to less than 10 years in prison. The prison held 297 indeterminate sentenced prisoners (38%), 49 of whom were serving an indeterminate sentence for public protection (IPP).

6.7 The reducing reoffending strategy was not informed by an up-to-date needs analysis. There was an ongoing action plan in which key stakeholders were engaged, but the reducing reoffending meetings were not always well attended by different departments and the records of discussions were brief.

6.8 The offender management unit (OMU) was a cohesive and hardworking team, despite significant staff shortages and high workloads. During our inspection, some probation offender managers had caseloads of more than 85. Prison offender managers (POMs) were often cross-deployed because of staff shortages in the prison, affecting the work they were able to complete with individuals. The head of offender management delivery, a senior probation officer, was well respected by her team and across the prison, but her workload was too high. There was a vacancy for one of the two senior probation officer posts but no plan to fill it in the near future to relieve the pressures.

6.9 Due to the staff shortages, the team was working to a 'red' demand management tool designed to assist the senior probation officer to manage the workload. The team was prioritising public protection, assessments and pre-release risk management work rather than one-to-one sessions with prisoners and non-mandatory training.

6.10 The team was working hard to address a backlog of OASys (offender assessment system) assessments to make sure that all prisoners had an initial assessment. There were examples of prisoners transferred into Garth with no assessment completed in their previous prison. The assessments and reviews we sampled had generally been completed

within the timescales required by the Offender Management in Custody (OMiC, see Glossary) model (every two years for determinate sentence prisoners and every three years for those serving indeterminate sentences). However, not all had been updated following a significant change, such as a prison transfer, to make sure that the sentence plan and risk management plan were appropriate for the new location, or to inform recategorisation decisions.

6.11 Most of the assessments we reviewed were of an acceptable standard, and we saw some high-quality examples of well-reasoned and analytical assessments. For example, one assessment was linked to a comprehensive sentence plan in which the objectives were carefully sequenced to take account of the young prisoner's motivation and capacity to comply. The senior probation officer actively reviewed the quality of OASys.

6.12 In our survey, 56% of prisoners said they had a custody plan compared with 72% at the previous inspection, and only 39% said that staff were helping them to achieve their objectives. Some of the prisoners we interviewed valued the contact they had had with their POM, and some were making good use of their laptops to maintain contact by email. However, several prisoners felt let down by the lack of regular face-to-face contact. Most of the team were experienced probation officers who were frustrated that they were unable to undertake regular one-to-one work with the prisoners.

6.13 Key work (see Glossary) was of variable quality, but overall was insufficient to support the OMiC model. Some key workers understood the importance of linking their work with a prisoner's sentence plan, and liaised well with the OMU. Key workers had an important role in observing and recording evidence of behaviour, but the system to record this information was underused (see paragraph 4.3).

6.14 Risk management plans were generally comprehensive and drew on information from both the community and custody. We saw some good examples, which included an assessment of a prisoner's current attitudes and behaviour, an analysis of risks and warning signs of increasing risk.

Public protection

6.15 Most prisoners at Garth were assessed as high or very high risk and all were identified adequately on arrival. There was a detailed public protection policy, overseen by a steering group. Public protection functions were no longer managed by a separate team and were the responsibility of the head of offender management delivery. Public protection work was well integrated within offender management.

6.16 The interdepartmental risk management meeting (IRMM) oversaw risk management and discussed all high-risk prisoners due for release. We saw good examples of multiagency working and information sharing. Community offender managers (COMs) were invited to attend the meeting to discuss the cases they were overseeing, which provided

some invaluable discussions. The security department did not always contribute effectively to these meetings and provided limited information. The police intelligence function was not represented, even though they were part of the core membership.

6.17 Multi-agency public protection arrangement (MAPPA) levels were identified at the appropriate times and the prison made an effective contribution to pre-release MAPPA meetings. We saw some comprehensive and well-considered contribution forms, but as at the previous inspection, we saw entries that were copied and pasted from other documents without analysis of how the content should inform risk assessment or future management.

6.18 Monitoring of prisoner mail, emails and telephone contact was generally well managed. Staff who completed the monitoring had a thorough understanding of its importance and engaged well with security and prison offender managers when concerns arose. Individuals subject to monitoring were regularly reviewed and, where appropriate, discussed in the IRMM.

6.19 The OMU did not routinely access the violent and sexual offenders register (ViSOR). Some details were inputted by the case administrative team, but POMs did not use the system well enough to share information.

Categorisation and transfers

6.20 The category C population had almost doubled since the last inspection, to 150: 69 were on relevant transfer holds and 81 needed to be progressed. Despite the efforts of the prison, prison managers told us that, owing to a lack of category C places nationally, transfers could not be done promptly. In our survey and in conversation, prisoners expressed their frustration at the time it took to move to an appropriate prison to meet their needs, with some waiting over a year.

6.21 Two prisoners were category D and the prison was working to progress them, but they were experiencing similar delays to those who were category C. There had been an increase in prisoners being released from Garth, because of difficulties in transferring them to the appropriate resettlement prison within the last three months of their sentence (see paragraph 6.37).

6.22 The recategorisation assessments we reviewed were evidenced and defensible. Prisoners continued to be able to provide their own written contribution to support their case, which was good. The requirement to update OASys to assess for recategorisation had led to some assessments being overdue and a backlog of decisions for the prisoner.

Interventions

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

6.23 A range of programmes was provided. Prisoners were identified to take part in them by a new in-depth needs analysis tool implemented by the psychology clinical lead with other departments, including the OMU and education, providing relevant information to support the individual's progress. Accredited and non-accredited group programmes, delivered by treatment managers and psychologists, had restarted earlier in the year. Work continued to be done one to one.

6.24 In our survey, only 33% of prisoners said they had been on offender behaviour programmes compared with 57% at our last inspection. More programmes were planned to prioritise prisoners nearest to release, but some prisoners felt they were unlikely to progress for a long time because they were too far from their release date to complete interventions.

6.25 The number of places on the Thinking Skills Programme had increased from the last inspection. There had been 13 completions from April 2022 to date, with several groups taking place during our inspection. The Resolve programme, for medium-risk prisoners with a history of violent behaviour, had been decommissioned nationally, but prisoners with a high risk of violence were able to complete the Kaizen accredited offender behaviour programme for men assessed as high or very high risk. The Horizon programme for those convicted of sexual offences was delivered to those who met the criteria.

6.26 The Healthy Identity intervention, designed for those who had committed extremist offences, was delivered on a one-to-one basis, as was Identity Matters, for prisoners presenting risks associated with gang affiliation. Programmes to increase motivation and engagement continued to be delivered, which was appropriate. A new programme to Garth, New Me Strengths, was designed for prisoners with learning disabilities or challenges. The prison was working hard to understand this cohort to offer the support required, working with different departments.

6.27 The Sycamore Tree victim awareness programme, delivered by the chaplaincy, had not yet restarted after the Covid pandemic restrictions and only one prisoner was engaged with the restorative justice work now offered.

6.28 Prisoners were not always able to attend planned sessions because of the regime. Waiting lists were currently at a manageable level, but programmes could take longer to complete if prisoners were unable to attend sessions.

6.29 Category C prisoners did not routinely have access to programmes, but those assessed as high-risk before release or who were not able to

progress were prioritised. The interventions team was not resourced to assess prisoners for programmes not delivered at Garth, but the team had supported 34 prisoners in the last year to progress in other prisons.

6.30 The psychology team provided interventions on the discrete units and one to one where required across the rest of the prison. This was valued by the prisoners and we saw some excellent examples of positive outcomes for prisoners on units including the segregation, residential support and Building Hope units (see paragraph 3.25). The team was well integrated in the prison.

6.31 To address the lack of progression, there was some good work with prisoners serving indeterminate sentences for public protection (IPP). Monthly reviews with psychologists and POMs helped to identify where a prisoner was with their progression, and put plans in place to support them and address any blocks. There were some successes for this cohort. There was no other specialist support in the prison for those serving indeterminate sentences.

6.32 Provision for prisoners requiring support for finance, debt or life skills was inadequate. The education department provided some modules on finance and independent living, with limited uptake. The start date for contracted budget and money management training had been delayed.

Specialist units

Expected outcomes: Personality disorder units and therapeutic communities provide a safe, respectful and purposeful environment which allows prisoners to confront their offending behaviour.

Offender personality disorder units, including psychologically informed planned environments

6.33 The Beacon Unit offender personality disorder treatment service was delivered by Mersey Care NHS Foundation Trust and Garth. There were 48 places and it was used as a national resource. During our inspection, only 26 spaces were being used for the programme due to staff shortages in both the NHS and prison. Eleven beds were being used by prisoners not participating in the programme, and prisoners and staff were concerned about the negative impact this was having on those in treatment.

6.34 Prison officers were specially selected to work on the unit, but like the rest of the prison, they were often cross-deployed. Reflective debriefs involving clinicians and prison staff were facilitated twice weekly, and clinicians and officers told us supervision arrangements were good. The unit was also affected by the regime and programme sessions often had to be cancelled at short notice.

6.35 Psychology staff in the main prison continued to offer support to reintegrate prisoners who had completed the programme or had been deselected. We saw some positive examples of POMs engaged in joint

reviews with the prisoner and staff on the unit, and in one case during the inspection, the POM attended the family day with the prisoner.

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.

6.36 The number of prisoners released from Garth had increased since our last inspection to 41 in the last 12 months, even though it was not a resettlement prison. The majority were released to approved premises which, given their risk of harm to other people, was appropriate.

6.37 We found issues with the transfer of prisoners to the appropriate resettlement prison within the last three months of their sentence (see paragraph 6.21). Of those released directly from Garth, 29 were from a different resettlement area. There was no service provision for practical support on release or a through-the-gate worker, as there had been before the unification of probation services in 2021. Prisoners who we spoke to were anxious about their release, particularly when they were not in their local area, and some raised concerns about the lack of support they were receiving.

6.38 In most cases, there was a timely pre-release handover to the COM. Prisoners who were due for release were discussed in the monthly IRMM eight months before, with regular reviews (see paragraph 6.16). During our inspection, one prisoner told us he appreciated video calls with his COM and was able to understand his licence conditions and restrictions clearly because of this contact.

6.39 The head of offender management delivery supported prisoners to open bank accounts, and there were plans for a budget and money management course to support prisoners (see paragraph 6.32).

Section 7 Summary of priority and key concerns

The following is a list of the priority and key concerns in this report.

Priority concerns

1. **Many aspects of the built environment were in very poor condition.** Lots of cells had insufficient furniture and some flooring was in decay, while most shower rooms were in a poor state and lacked privacy.

2. **The rate of non-attendance at health appointments was far too high.** This impaired the efficient use of health resources, including clinicians' time.

3. **Prisoners did not receive adequate time out of cell.** The regime did not give them enough access to purposeful activity, especially through unemployment, the cohorting arrangements, and staff shortage.

4. **There were too few education spaces, and not enough of the available spaces in education, skills, and work were allocated.** Attendance in education, skills and work activities was poor.

5. **Leaders did not provide a high-quality curriculum to meet the needs of the population, including support for those with additional learning needs.** There was no effective quality assurance of education, skills and work.

Key concerns

6. **Not enough was done to ensure prisoner safety following their arrival at the prison.** Private risk interviews were too often superficial, lacked sufficient attention to risks and vulnerabilities, and were not followed up systematically on the following day.

7. **The use of body-worn video cameras during incidents involving force was too low.** Important evidence showing the justification for force and attempts at de-escalation was not, therefore, routinely recorded.

8. **Drugs were too easily available.** The mandatory drug testing rate was high, and searching procedures were insufficient.

9. **Too many staff were passive or distant in their interactions with prisoners.** The lack of time out of cell and an effective key worker scheme had a detrimental effect on staff-prisoner relationships, while staff did not always challenge low-level poor behaviour.

10. **The application and complaint systems were not working well, with too many prisoners receiving answers late or not at all.** When they did receive an answer, it often did not adequately address the issue raised.

11. **Too little was being done to understand and meet the needs of prisoners from protected characteristic groups across the prison.** There was no needs analysis or strategic direction, which were necessary to support the promotion of equality. Consultation was infrequent and the analysis of data was too limited.

12. **Poor infection prevention standards in clinical areas could expose patients to harm.**

13. **Governance of medicines management was not sufficiently robust due to the shortage of pharmacy staff.**

14. **Leaders did not make sure that all prisoners received information, advice and guidance towards finding appropriate education, training or employment on release.**

15. **Many prisoners felt stuck at Garth and could not progress in their sentence.** Some routine reviews of security category were late and many who had been recategorised were not moved to a prison offering the right opportunities for them.

Care Quality Commission regulatory recommendation

Care and treatment must be provided in a safe way for service users. This includes the proper and safe management of medicines.

Section 8 Progress on recommendations from the last full inspection report

Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy prison.

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2019, arrangements during prisoners' early days at the prison were reasonably good. Too many prisoners in our survey said they felt unsafe. Innovative work to combat violence was being delivered, but levels of violence remained high and some incidents were serious. Oversight of the use of force was good. Some prisoners spent a long time in the segregation unit. It was now monitored and managed well. Although conditions had improved, too many cells remained very dirty. Drugs were easy to get hold of and in our survey, about one in four said they had developed a drug problem while at Garth. The number of self-harm incidents was very high, but those at risk were mostly well cared for. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

The prison should be made safer through significant reductions in the number and seriousness of violent incidents. (S43)
Partially achieved

The availability of illicit drugs and associated debt, violence and victimisation should be reduced significantly. (S44)
Partially achieved

Recommendations

All newly arrived prisoners should be offered the chance to talk to a Listener before being locked up on their first night. (1.11)
Achieved

Disciplinary hearings should be dealt with promptly. (1.26)
Not achieved

The segregation regime for longer-stay prisoners should include some purposeful activity. (1.3)
Partially achieved

Assessments to determine the number of officers needed to unlock prisoners should be carried out every day. (1.38)
Achieved

The use of the constant observation cell in segregation should cease. (1.57, repeated recommendation 1.29)
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in in 2019, Most prisoners said staff treated them with respect. However, we continued to see rules being applied inconsistently. Living conditions remained variable, but some refurbishment was underway. Cell call bells were not always answered promptly. Food and the shop were reasonably good. The application system was not robust and some prisoners had negative perceptions of the complaints process. The prison now gave equality and diversity a higher priority, but more work to develop this area was required. Faith provision remained good. Health care provision had improved and was now reasonably good. However, there were still difficulties in ensuring prisoners could attend hospital appointments. Support for those seeking help with their drug problem was reasonably good. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendation

Prisoners should be able to access all hospital and primary care services within community-equivalent waiting times. (S45)
Achieved

Recommendations

All staff should consistently enforce the rules and prisoners who break them should be challenged and their behaviour addressed. (2.3)
Not achieved

More sophisticated consultation about the food provided should be undertaken at regular intervals and steps taken as a result to improve prisoners' perceptions. (2.15)
Achieved

The applications process should be improved – it should include the introduction of a system to track and quality assure responses. (2.21)
Partially achieved

All prisoners with protected characteristics should have a support forum and access to external specialist agencies. (2.38)
Not achieved

Interpretation services should be better used across the prison to ensure that all needs are met. (2.39)
Not achieved

All health and substance use service providers should contribute to a single patient record to ensure relevant information is shared effectively. (2.56)
Achieved

All prisoners should be able to wait in a suitable waiting room that provides a respectful and safe environment. (2.57)
Not achieved

Discipline staff should provide the health care department with adequate support so that a safe environment is maintained. (2.58)
Achieved

There should be a 'whole-prison' strategy to promoting health and well-being. (2.61)
Not achieved

An updated memorandum of understanding between all key stakeholders and regular meetings to monitor the provision should be in place to ensure that prisoners receive a good level of social care. (2.71)
Achieved

All discipline officers should receive mental health awareness training, to enable them to recognise and support prisoners with mental health problems. (2.79, repeated recommendation 2.81)
Not achieved

Transfers to hospital under the Mental Health Act should take place within the Department of Health's established guidelines. (2.80)
Not achieved

Appropriate options for clinical treatment should be available in line with national clinical guidance. (2.88)
Not achieved

The TC should have an operating policy and appropriately trained dedicated officers should support the ethos of the unit. (2.89)
No longer relevant

Medicine administration rounds should be supported in all areas by adequate officer supervision. (2.94)
Achieved

Robust governance arrangements should be embedded and involve key stakeholders to ensure oversight of medicine management and prescribing practice is effective. (2.95)
Partially achieved

Purposeful activity

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

At the last inspection, in 2019, time out of cell was reasonably good, particularly for those in full-time activities. However, we found too many prisoners locked in their cells during the working day. The gym provision was good, but access to the library had been poor over recent months. Ofsted rated the overall effectiveness of learning and skills as good. There were sufficient activity places, but attendance and punctuality needed to improve. Peer mentors were very effective. The standard of work in education and prison jobs was high, but there were too few accredited courses in some workshops. Some achievement rates, although improving, were not yet high enough. Outcomes for prisoners were reasonably good against this healthy prison test.

Recommendations

Prisoners should not be routinely locked behind their cell doors during the core working day. (3.9)
Not achieved

Library closures should be addressed to ensure all prisoners have access at least once a week. (3.10)
Achieved

Prison and education managers should ensure that prisoners attend education, training and work sessions regularly and on time. (3.21)
Not achieved

Wing workers should have sufficient work to keep them fully occupied. (3.22)
Partially achieved

Teachers should challenge the most able prisoners so they can make more rapid progress. (3.31)
Not achieved

Prisoners should receive effective developmental feedback to help them improve the quality of their work. (3.32)
Not achieved

Prisoners with additional support needs should receive effective support during lessons to ensure they progress. (3.33)
Not achieved

Instructors and work supervisors should ensure that prisoners improve their English and maths skills in prison work. (3.40)
Not achieved

The number of accredited qualifications available for prisoners in vocational training and work should be increased. (3.45)
Not achieved

Prison and education managers should ensure that more prisoners achieve full qualifications, particularly in English and maths. (3.46)
Not achieved

Rehabilitation and release planning

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

At the last inspection, in 2019, provision to help prisoners maintain contact with family was underdeveloped and there were some persistent problems with visits. Strategic management of reducing reoffending was reasonably good. Completed offender assessment system (OASys) reports and plans were reasonably good, but too many had not been reviewed or completed prior to prisoners' arrival. Much of the offender supervisors' contact with prisoners was not sufficiently proactive and did not take place regularly enough. Categorisation reviews were managed well. Contact restrictions were managed appropriately, but planning to manage risk of harm on release was weak. The range of accredited programmes was appropriate, but most of the sexual offenders were unsuitable for them. Some positive alternatives had been introduced. Despite considerable efforts, some men were not transferred to their local prison for release, which significantly hindered their access to basic resettlement help. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendation

A robust risk management plan for release should be developed in conjunction with the community-based offender manager. It should include a confirmation of the MAPPA management level. (S46)
Achieved

Recommendations

Visits should start on time. (4.9)
Not achieved

The visits booking system, including the telephone booking line, should be reviewed to ensure it is effective. (4.10)
Not achieved

Prisoners' access to visits should not be linked to their IEP level. (4.11)
Achieved

All prisoners should have an up-to-date offender assessment system (OASys) assessment and a high-quality sentence plan which are reviewed following a significant change in the prisoner's situation. (4.24, repeated recommendation 4.10)
Not achieved

The frequency and type of contact with offender supervisors should be based on the prisoner's level of risk and need. It should provide meaningful engagement and encouragement to progress, alongside appropriate offence-focused work. (4.25, repeated recommendation 4.11)
No longer relevant

Offender supervisors should be in regular contact with community-based offender managers to share information about ongoing risk of harm. In the months leading up to release they should confirm the risk management plan, including the most appropriate MAPPA management level. (4.35)
Achieved

Prisoners achieving re-categorisation should be transferred promptly. (4.39)
Not achieved

Prisoners should be transferred to the appropriate resettlement prison three months before their release. (4.54)
Not achieved

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

We also provide examples of **notable positive practice** in our reports. These list innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

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

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

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

This report

This report 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/). Section 7 summarises the areas of concern

from the inspection. 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 Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Martin Lomas	Deputy Chief inspector
Martin Kettle	Team leader
Sally Lester	Inspector
Rebecca Mavin	Inspector
Ali McGinley	Inspector
Tamara Pattinson	Inspector
Chelsey Pattison	Inspector
Fiona Shearlaw	Inspector
Helen Downham	Researcher
Grace Edwards	Researcher
Emma King	Researcher
Alexander Scragg	Researcher
Shaun Thomson	Lead health and social care inspector
Steve Eley	Health and social care inspector
Fiona Atkinson	Pharmacist
Kim Bleasdale	Ofsted inspector
Alison Cameron-Brandwood	Ofsted inspector
Andrew Holland	Ofsted inspector
Anita Pyrkotsch-Jones	Ofsted inspector
Helen Whelan	Ofsted inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. 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 in the women's estate for eligible women, 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.

Offender management in custody (OMiC)
The Offender Management in Custody (OMiC) model, which has now been rolled out in all adult prisons, entails prison officers undertaking key work sessions with prisoners (implemented during 2018–19) and case management, which established the role of the prison offender manager (POM) from 1

October 2019. On 31 March 2021, a specific OMiC model for male open prisons, which does not include key work, was rolled out.

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).

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 Garth 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.

Provider
Greater Manchester Mental Health NHS Foundation Trust

Location
HMP Garth

Location ID
RXVU7

Regulated activities
Treatment of disease, disorder, or injury.

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 12: Safe care and treatment 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Care and treatment must be provided in a safe way for service users. This includes the proper and safe management of medicines.

How the regulation was not being met
- Pharmacy services lacked sufficient trained and competent staff to deliver the safe and proper management of medicines across the site.
- Medicines compact agreements were not present in 10 out of 48 patient reception records reviewed between 1 September and 15 November 2022.

- Deliveries of medicines were unsafe and not risk assessed. Up to 18 boxes of medicines of different volume and weight could be delivered at any one time. These were not weighed, and staff had to carry them from the ground floor up the stairs to the second floor while also negotiating a number of locked doors.
- There was no Methasoft on F/G wing. Staff hand poured Methadone and administered it from a trolley located between two wings that had open doors during medicines rounds. There was no risk assessment in place for these arrangements.
- Controlled drugs books on E and F/G wings were not written chronologically in line with the provider's policy, with a risk that medicines could be missed due to this process. There were not always two signatures and we identified three missing entries even though the stock counts had decreased.
- We found oxygen cylinders in the downstairs storage room that were not securely stored. There was no signage present on wings or in health care to indicate there was oxygen stored in emergency bags.
- Not all health care staff had signed up to homely remedies policies yet these were available for use by all staff.
- Governance arrangements were not sufficiently robust to ensure safe and effective oversight of medicines management and prescribing practice. Medicines management meetings were cross-prison and were not quorate for the last three meetings.

To meet this regulation
Care and treatment must be provided in a safe way for service users. This includes the proper and safe management of medicines.

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/

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