HMIPS
HM INSPECTORATE OF
PRISONS FOR SCOTLAND

INSPECTING AND MONITORING

FULL INSPECTION REPORT ON HMP EDINBURGH

FULL INSPECTION – 28 OCTOBER-8 NOVEMBER 2019

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INTRODUCTION AND BACKGROUND

This report is part of the programme of inspections of prisons carried out by HM Inspectorate of Prisons for Scotland (HMIPS). These inspections 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 detention. HMIPS is one of several bodies making up the NPM in the UK.

HM Chief Inspector of Prisons for Scotland (HMCIPS) assess the treatment and care of prisoners across the Scottish Prison Service estate against a predefined set of Standards. These Standards are set out in the document 'Standards for Inspecting and Monitoring Prisons in Scotland', published in May 2018 which can be found at **https://www.prisonsinspectoratescotland.gov.uk/standards**.

The Standards reflect the independence of the inspection of prisons in Scotland and are designed to provide information to prisoners, prison staff and the wider community on the main areas that are examined during the course of an inspection. They also provide assurance to Ministers and the public that inspections are conducted in line with a framework that is consistent and that assessments are made against appropriate criteria. While the basis for these Standards is rooted in International Human Rights treaties, conventions and in Prison Rules, they are the Standards of HMIPS. This report and the separate 'Evidence Report' are set out to reflect the performance against these standards and quality indicators.

HMIPS assimilates information resulting in evidence-based findings utilising a number of different techniques. These include:

- obtaining information and documents from the Scottish Prison Service (SPS) and the prison inspected;
- shadowing and observing SPS and other specialist staff as they perform their duties within the prison;
- interviewing prisoners and staff on a one-to-one basis;
- conducting focus groups with prisoners and staff;
- observing the range of services delivered within the prison at the point of delivery;
- inspecting a wide range of facilities impacting on both prisoners and staff;
- attending and observing relevant meetings impacting on both the management of the prison and the future of the prisoners such as Case Conferences; and
- reviewing policies, procedures and performance reports produced both locally and by SPS headquarters specialists.

HMIPS is supported in our work by inspectors from Healthcare Improvement Scotland (HIS), Education Scotland, Scottish Human Rights Commission, the Care Inspectorate, and guest inspectors from the SPS.

The information gathered facilitates the compilation of a complete analysis of the prison against the standards used. This ensures that assessments are fair, balanced and accurate. In relation to each standard and quality indicator, inspectors record their evaluation in two forms:

1. A colour coded assessment marker

Rating	Definition
✔ **Good performance**	Indicates **good performance** which may constitute good practice.
Satisfactory performance	Indicates overall **satisfactory performance**.
Generally acceptable performance	Indicates **generally acceptable performance** though some improvements are required.
Poor performance	Indicates **poor performance** and will be accompanied by a statement of what requires to be addressed.
Unacceptable performance	Indicates **unacceptable performance** that requires immediate attention.
Not applicable	Quality indicator is **not applicable**.

2. A written record of the evidence gathered is produced by the inspector allocated each individual standard. It is important to recognise that although standards are assigned to inspectors within the team, all inspectors have the opportunity to comment on findings at a deliberation session prior to final assessments being reached. This emphasises the fairness aspect of the process ensuring an unbiased decision is reached prior to completion of the final report.

This report provides a summary of the inspection findings and an overall rating against each of the nine standards. The full inspection findings and overall rating for each of the quality indicators can be found in the 'Evidence Report' that will sit alongside this report on our website.

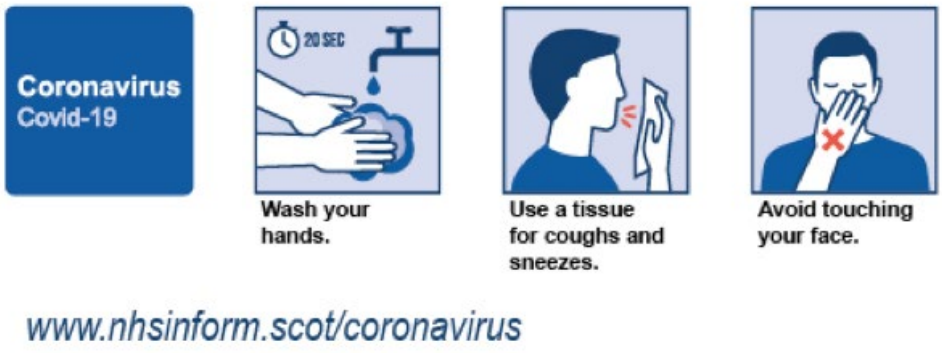
THE COVID-19 PANDEMIC

The findings and recommendations contained in this report relate to the circumstances HMIPS observed and encountered at the time of the inspection. We are acutely aware, however, that like many other organisations the SPS has been forced to adjust how it operates in response to the unprecedented challenges posed by COVID-19. The SPS has introduced a more restricted regime and shortened core day to follow Health Protection Scotland guidelines to restrict the spread of the virus and protect staff and prisoners safety.

HMIPS fully recognises that some of the issues identified in this report have therefore been overtaken, or in some cases exacerbated, by the action the SPS has been obliged to take in response to the COVID-19 crisis and that, as a result, the SPS and HMP Edinburgh will not be in a position to respond immediately to every recommendation we make. HMIPS nevertheless hope that the SPS and the prison management team will reflect on where action might be possible now in response to our recommendations and that, in the fullness of time, when the prison system is able to return to a more normal operating regime, all recommendations can be fully considered and addressed.

HMIPS recognise and commend the SPS and prison staff at every level of the organisation for their commitment and professionalism in keeping our prisons running in these most challenging of times.

Due to COVID-19, HMIPS has had to temporarily suspend its programme of full inspections and weekly visits by our team of Independent Prison Monitors. HMIPS has therefore introduced a remote monitoring framework and system of one day prison inspection liaison visits to provide assurance on the conditions and treatment of prisoners. Reports of our prison inspection liaison visits will be published on our website.



KEY FACTS

Location
HMP Edinburgh is located in the Saughton area of the city on the west side of Edinburgh, on the main A71.

Role
HMP Edinburgh is a large community facing prison receiving prisoners predominantly from courts in Edinburgh, the Lothians and the Borders, but also prisoners from the Fife area.

The prison manages adult male and female prisoners on remand, short-term sentences (serving less than four years), long-term sentences (serving four years or more), life sentences and Order of Life Long Restrictions.

Brief history
The building of the prison started around 1914, with the first prisoner being received about 1920 replacing Calton gaol, the current site of St Andrews House on Regent Road Edinburgh. The prison has been completely rebuilt in recent years and was the first prison to complete a refurbishment programme. The opening of Ratho Hall in January 2009 represented the completion of 10 years of redevelopment work. The oldest building within the grounds of the prison is Glenesk House which opened in 1998.

Accommodation
There are four accommodation halls: Glenesk holds predominantly untried prisoners; Hermiston holds male convicted and untried offence-protection prisoners; Ingliston holds male convicted mainstream prisoners, including non-offence protection prisoners; and Ratho holds all female prisoners. There is also a Separation and Reintegration Unit.

Design capacity
At the time of the inspection, the design capacity was 867. However, there was an additional 50 places providing an operating population of 917. The prison had an agreed Assessed Operational Limit of 964, which was the maximum capacity possible maintaining minimum legal requirements.

Date of last inspection:
6-17 March 2017

Healthcare provider:
NHS Lothian

Learning provider:
Fife College

OVERVIEW BY HM CHIEF INSPECTOR OF PRISONS FOR SCOTLAND (HMCIPS)

HMP Edinburgh was a well-run prison, which performed effectively in many aspects. Across our nine Standards, performance was evaluated as satisfactory against five Standards and generally acceptable against four Standards. This represents a solid performance by staff at all levels of the organisation in a very busy prison, with one of the most complex mixes of prisoner population of any Scottish prison establishment.

The inspection identified a number of positive findings. In particular staff/prisoner relationships, which are at the heart of any prison, and were almost universally described by prisoners and staff as positive and respectful. Inspectors found good evidence of effective, courteous and humane use of authority and action to promote respect and protect against mistreatment. The processes in relation to ensuring lawful detention and liberation were also sound, and the assessment by our Health Improvement Scotland (HIS) partner inspectors into Health and Wellbeing was very positive and encouraging. HIS inspectors particularly welcomed the collaborative approach adopted between the SPS and NHS staff, and the good use of multi-disciplinary working, the steps taken to tackle inequalities in health, the use of anticipatory care plans and action to support those requiring palliative care.

In a similar way, the structured action to promote Equality and Diversity in HMP Edinburgh stood out as positive and worthy of recognition, and there were many examples of effective interaction by the prison with a wide range of other partner organisations.

In total, 23 examples of good practice are highlighted in the report, where we commend the action taken in HMP Edinburgh to others.

In terms of the **PANEL** principles, there were clearly evidenced attempts to promote participation through PIACs and other mechanisms, and a structured approach to promoting non-discrimination and equality. However, the inspection team were concerned that women did not have access to as wide a range of programmes and opportunities as male prisoners. Similarly, offence and non-offence protection prisoners suffered from a more restrictive regime than other prisoners, with the risk of being locked up for unacceptably long periods. This was one of a few important areas that were troubling.

The main concern for inspectors, stemming from high staff absence, was the frequency with which work sheds had to be cancelled to pull staff back to provide cover in residential areas. To their credit, the senior management team were fully aware of the problem and looking at alternative solutions, but it was clear to the inspection team that regimes had been significantly disrupted for a considerable period – well over a year – and continued to be so on an almost daily basis. This impacted significantly on the levels of purposeful activity provided by the prison and led to an irregular regime for many prisoners.

Without question staff shortages were adding to the natural logistical challenges in getting prisoners to and from work sheds, education, the library etc. Finding ways to avoid having to close work sheds at short notice would have a dramatic impact on the ability of the prison to provide the sort of structured regime needed to support rehabilitative activity. HMIPS urge the prison to undertake workforce capacity modelling and make a full regime its top priority when responding to this inspection report.

However, action is also needed in a few other areas too. While admission arrangements were generally sound, we recommend the reintroduction of a First Night in Custody Unit and action to tighten induction and core screening arrangements. The condition of some parts of the prison, notably Glenesk Hall, needs addressed. We also make a couple of recommendations on clothing for prisoners and the need to tighten procedures in relation to implementation of Talk to Me the SPS Suicide Prevention Strategy and Think Twice the SPS Anti-Bullying Strategy. While the approach to case management and staff handovers in the Separation and Reintegration Unit was warmly welcomed by the inspection team, the lack of systematic video recording of planned removals was disappointing, and this will be subject to a recommendation to the SPS.

Action should also be taken to more deeply embed and support the Personal Officer scheme, and review whether the prison Social Work Team needs additional resources against the backdrop of increasing demands on statutory work. The backlog of general assessments needs to be reduced to improve access to programmes for all eligible prisoners, and a clear plan developed to address the gap in provision caused by the suspension of the SPS throughcare service.

However, despite these areas where improvements could be made, the key conclusion of the inspection was that the fundamentals for a good prison were in place, with a strong motivated senior leadership team recognising and committed to addressing the key challenges facing the prison. Our hope is that the compassionate responsible approach being adopted towards the issue of staff absence will succeed and address some of the challenges of staff shortages, allowing the prison to go from strength to strength and achieve its full potential in all areas.

Wendy Sinclair-Gieben
Chief Inspector of Prisons for Scotland

SUMMARY OF INSPECTION FINDINGS

Standard 1 Lawful and transparent custody
Satisfactory

Standard 2 Decency
Generally acceptable

Standard 3 Personal safety
Generally acceptable

Standard 4 Effective, courteous and humane exercise of authority
Satisfactory

Standard 5 Respect, autonomy and protection against mistreatment
Satisfactory

Standard 6 Purposeful activity
Generally acceptable

Standard 7 Transitions from custody to life in the community
Generally acceptable

Standard 8 Organisational effectiveness
Satisfactory

Standard 9 Health and wellbeing
Satisfactory

SUMMARY OF INSPECTION FINDINGS

STANDARDS, COMMENTARY AND QUALITY INDICATORS
HMIPS Standard 1
Lawful and Transparent Custody

The prison complies with administrative and procedural requirements of the law, ensuring that all prisoners are legally detained and provides each prisoner with information required to adapt to prison life.

The prison ensures that all prisoners are lawfully detained. Each prisoner's time in custody is accurately calculated, they are properly classified, allocated and accommodated appropriately. Information is provided to all prisoners regarding various aspects of the prison regime, their rights and their entitlements. The release process is carried out appropriately and positively to assist prisoners in their transition back into the community.

Inspection Findings
Overall Rating: Satisfactory Performance

In this Standard, one quality indicator was rated as good, five were rated as satisfactory and three were rated as generally acceptable, giving an overall rating of satisfactory performance. There were two examples of good practice identified and nine recommendations for improvement.

In terms of the **PANEL** principles for this Standard:

Participation: The involvement of peer supporters during the induction programme helpfully promoted the principle of prisoner participation and confidentiality was respected.

Accountability: In general the processes for admission and liberation etc. were robust, but more now needs to be done to iron out the few inconsistencies observed.

Non-discrimination and equality: Consistency in approach was an issue in a number of areas observed, which could affect perceptions of equality if not addressed.

Empowerment: The prison's comprehensive induction programme provided valuable information for prisoners.

Legality: Staff were knowledgeable about prison rules and processes and followed procedures in a lawful and professional manner.

Inspectors observed, at random, the implementation and execution of processes and practices pertaining to the nine quality indicators within this Standard. In general, staff were aware of, and often very knowledgeable of, the underpinning rules, regulations and laws that relate to all the quality indicators.

This Standard can be divided into three main constituent parts, which are addressed in turn below:

Admission: In general, the admission process which included, but was not exclusive to, admission, assessment, warrant verification, prisoner classification, initial information and critical date's verification were of satisfactory performance. However, there are recommendations within some of the QI write ups.

HMIPS Standard 1
Lawful and Transparent Custody - Continued

Induction: HMP Edinburgh had a comprehensive and inclusive induction process which was managed and delivered by a knowledgeable and committed officer, with the support of a team of trained and motivated peer supporters. However, it was apparent during the inspection that there were currently issues with the delivery of the induction programme. Furthermore, with HMP Edinburgh not having a designated First Night in Custody Area (FNIC), there were consistency issues with the initial accommodation of new admissions and transfers, which also presented consistency issues with the completion of Core Screens.

Release: The liberation process observed during the inspection was professionally managed, courteous and fully compliant with the establishments' Standard Operating Procedures (SOPs).

Emerging Concerns:

- All eligible prisoners should complete the full Reception Risk Assessment process, including the Healthcare Assessment, and no eligible prisoner should be afforded the opportunity to self-decline it.
- The uncovered posts in the reception should be filled as a priority, ensuring that all staff working in this critical area are fully trained and conversant in all processes.
- All reception staff should be within competency for Talk to Me Training.
- The First Night in Custody Units should be reintroduced for untried and convicted prisoners.
- The local peer mentor process for Reception should be adhered to.
- All holding rooms should be equipped with relevant local and national information. In addition, the prison should consider providing reading material and working televisions.
- All eligible prisoners should receive, or be offered, the National Induction Programme as soon possible after admission, despite any operational issues.
- All prisoners should receive a Core Screen within 72 hours of admission, as per ICM Practice Guidance Manual 2007.

Encouraging Observations:

- The process for verifying warrants and critical dates, and the subsequent Critical Dates Confirmation sheet issued to prisoners.
- The induction programme and associated peer supporters, when fully operational, should be recognised as good practice. In particular, the FNIC Booklet, Inductee Admission Checklist and co-delivery of session by staff and peer supporters.

HMIPS Standard 2
Decency

The prison supplies the basic requirements of decent life to the prisoners.

The prison provides to all prisoners the basic physical requirements for a decent life. All buildings, rooms, outdoor spaces and activity areas are of adequate size, well maintained, appropriately furnished, clean and hygienic. Each prisoner has a bed, bedding and suitable clothing, has good access to toilets and washing facilities, is provided with necessary toiletries and cleaning materials and is properly fed. These needs are met in ways that promote each prisoner's sense of personal and cultural identity and self respect.

Inspection Findings
Overall Rating: Generally Acceptable

In this Standard, two quality indicators were rated satisfactory, three were rated as generally acceptable and one was rated as poor, giving an overall rating of generally acceptable performance. There was one example of good practice identified and seven recommendations for improvement.

Inspectors found evidence supporting the achievement of this Standard to be mixed. There were some areas of the building that were in good repair, for example the Hub, Health Centre and Ratho Hall. Unfortunately findings elsewhere were not so positive and there are identified areas that require improvement.

With regard to the **PANEL** principles for this Standard:

Participation: This was found in some areas, for example there was evidence of discussions with prisoners across the establishment about food.

Accountability: This was partially evidenced. For example prisoners and staff were aware of the lack of sizes and poor quality clothing in some halls, and agreed on how it impacted on prisoners, but remedies had not yet been achieved.

Non-discrimination and equality: Inspectors did not witness any direct discrimination during the inspection, and observed staff working well with prisoners that appeared to have some complex needs. However, it could be argued that posters displayed in some cells did not sit well with the requirements of equality.

Empowerment: People had access to the basics required for a decent life, such as items to maintain personal hygiene and the ability to have clothes laundered. However, more could be done to improve the basic conditions in some halls, and some prisoners were not aware of how to order things like replacement mattresses.

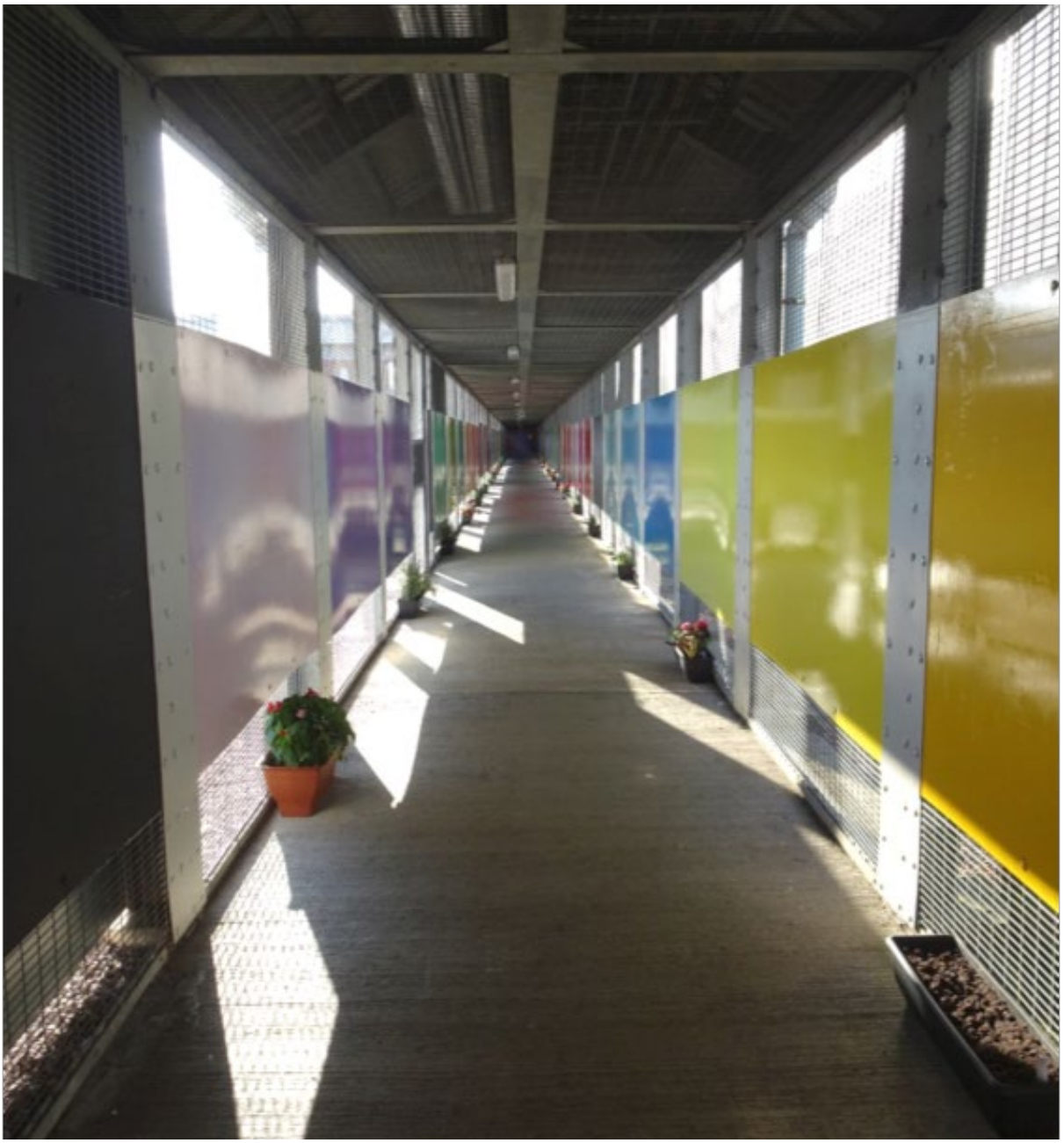
Legality: Inspectors did not find anything under this Standard that compromised any domestic or international laws.

Emerging Concerns:

- Action is required to improve the buildings conditions in some areas, particularly in Glenesk Hall.
- The clothing available to the male population should be reviewed to ensure there are a range of sizes available and that items are of a good quality.
- The contingency plans for the women's laundry should be reviewed to allow women to undertake their own laundry.

HMIPS Standard 2
Decency - Continued

Encouraging Observations:
Prisoners can complete an 'On Premises' Laundry qualification as part of British Institute of Cleaning Science which links to full-time employment in Professional Washing Services.



Corridor leading to women's residential hall

HMIPS Standard 3
Personal Safety

The prison takes all reasonable steps to ensure the safety of all prisoners.

All appropriate steps are taken to minimise the levels of harm to which prisoners are exposed. Appropriate steps are taken to protect prisoners from harm from others or themselves. Where violence or accidents do occur, the circumstances are thoroughly investigated and appropriate management action taken.

Inspection Findings
Overall Rating: Generally Acceptable Performance

In this Standard, one quality indicator was rated as satisfactory, three were rated as generally acceptable and three were rated as poor, giving an overall rating of generally acceptable performance. There were two examples of good practice identified and fourteen recommendations for improvement.

In terms of the **PANEL** principles for this Standard:

Participation: Prisoners felt able to participate in Talk To Me (TTM) case conferences.

Accountability: More was needed to fully implement the Think Twice and TTM strategies.

Non-discrimination and equality: There was support for those with disabilities, palliative care and transgender needs.

Empowerment: The prison provided extra support for prisoners who required it, but information on the Think Twice Strategy was not shared with all prisoners.

Legality: No issues identified.

HMP Edinburgh managed a complex range of individuals, including those at heightened risk due to their vulnerability, and could evidence that they were able to understand the needs of individuals reasonably well in regards to non-discrimination and empowerment. Positive support from both within the prison and external agencies was evidenced for those with disabilities, palliative care and transgender needs.

There was inconsistency with the peer mentoring process within Reception, where it was observed that staff were not clear on what service was available.

HMP Edinburgh had a range of alarms, Standard Operating Procedures (SOPs), contingency plans and processes in place aimed at ensuring the prison operated in a safe and secure manner. These were tested on a regular basis. Despite this there was a general feeling from both staff and prisoners that it was an unsafe environment due to staff shortages, violence and the increased use of Psychoactive Substances (PS).

The Head of Operations had worked well to introduce strategies to reduce violence. However, there was no evidence of the SPS Think Twice Strategy being implemented to protect and support the victims of bullying. Staff training figures in key roles such as Control and Restraint and Supervising Officer were below the amount required to effectively manage incidents confidently, safely and competently.

Whilst those subject to TTM were cared for appropriately, the application and assurance of the paperwork and process was not robust and requires attention.

HMIPS Standard 3
Personal Safety - Continued

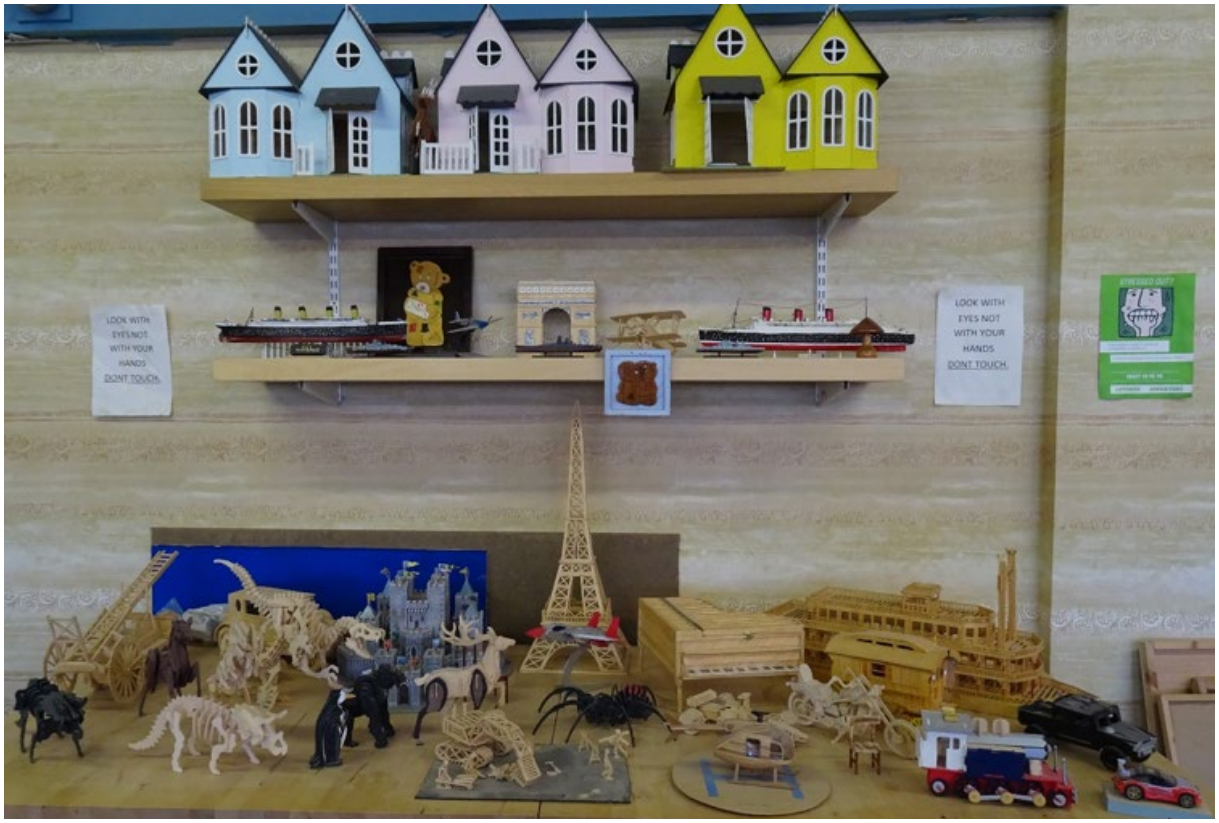
Health and Safety practice within the establishment was well-structured and although Risk Assessments and Safe Systems of Work (SSoW) were comprehensive and relevant, they were out of date and required review.

Emerging Concerns:

- No audit and assurance process for the TTM process.
- No toilet privacy screen in the safer cells in Hermiston.
- A tendency for Primary Care NHS Nurses attending TTM Case Conferences over the weekend to defer decisions could affect care plans.
- Although awareness sessions had been conducted for the SPS Anti-bullying Strategy, Think Twice, it has not been implemented fully within HMP Edinburgh.
- Staff were not challenging bullying behaviours nor supporting victims of bullying.
- The lack of competent accredited officers trained in Control and Restraint and Supervising Officer roles.

Encouraging Observations:

- Although still to be fully embedded, the introduction of TTM Champions in each hall was encouraging.
- Engagement with external agencies such as Marie Curie and Scottish Transgender Alliance to assist and involve those with specific care needs.
- Transgender training for staff.
- The compassion and care shown to those who may be vulnerable and required additional support by the FLM and staff within Hermiston Hall.



Prisoner art work

HMIPS Standard 4
Effective, Courteous and Humane Exercise of Authority

The prison performs the duties both to protect the public by detaining prisoners in custody and to respect the individual circumstances of each prisoner by maintaining order effectively, with courtesy and humanity.

The prison ensures that the thorough implementation of security and supervisory duties is balanced by courteous and humane treatment of prisoners and visitors to the prison. Procedures relating to perimeter, entry and exit security, and the personal safety, searching, supervision and escorting of prisoners are implemented effectively. The level of security and supervision is not excessive.

Inspection Findings
Overall Rating: Satisfactory Performance

In this standard, five quality indicators were rated as good, three were rated as satisfactory and two were rated as generally acceptable giving an overall rating of satisfactory performance. There were two examples of good practices identified and twelve recommendations for improvement.

With regard to the **PANEL** principles:

Participation: Inspectors observed Rule 95 case conferences being held in orderly rooms where prisoners were invited to participate both in writing and verbally.

Accountability: This was partially evidenced by the accurate record keeping of UoF forms. Whilst the Head of Ops reviewed all paperwork and the IMU FLM reviewed the majority of instances, at the time of the inspection there was no record of the Head of Operations reviewing CCTV of UoF. However a record of those checked is now in place.

Non-discrimination and equality: There was evidence of ICM case notes being updated on a daily basis within the SRU.

Empowerment: Inspectors observed that staff were empowered to carry out their duties and there was sufficient evidence in each area that processes and systems were in place and working effectively. Prisoners had an understanding of their rights and there were a number of documents available to assist in different languages.

Legality: Inspectors did not find anything to suggest the establishment was not acting legally.

HMP Edinburgh had several different population groups to manage, which could prove difficult while co-ordinating the complex movement of different populations around the prison during route movement and visits. HMP Edinburgh ensured that the security of the prison was maintained to a high standard and managed in an orderly and respectful manner.

The Electronic Control Room (ECR) was effectively managed with competent staff who were knowledgeable and skilled in the operation of managing the controlled security doors for staff, visitors and prisoners throughout the prison. They were also highly vigilant of the perimeter fence and constantly monitored this, knowing which areas were particularly vulnerable and what to watch out for.

HMIPS Standard 4
Effective, Courteous and Humane Exercise of Authority - Continued

Male prisoners who were removed from association were located in the SRU. All of the prisoners held within the SRU were held lawfully. Staff were engaged with the Integrated Case Management (ICM) process and worked as a team to ensure that case notes and management plans were accurately recorded and completed on a daily basis.

Of the 260 incidents, 17 were planned removals as per the definition and should have been recorded. Only eight were actually recorded and footage of only two had been retained. CCTV was reviewed for a number of UoF and restraint incidences. The UoF forms were completed to a high standard, however, the forms require to be reviewed to capture the background information as to why UoF was necessary, and how this procedure would be carried out.

Since the inspection, inspectors have returned to HMP Edinburgh to review the use of video recording when there is UoF. A process has now been put in place by the IMU for the Head of Operations to review all UoF forms and identify if the incident was accurately video recorded. There remains a national lack of clarity as to when video recording is required. HMIPS will recommend that the SPS remove the ambiguity on this issue and determine more clearly when video recording is used. HMIPS would also recommend SPS consider implementing body worn cameras to improve the rate of video recording for unexpected violent incidents.

Emerging Concerns:

- The non-recording of planned removals.
- The time lost in purposeful activity due to the staff who worked in offender outcomes covering staff shortages in the halls.
- The use of psychoactive substances and staff concerns about exposure to them.
- The call system within the SRU which was very loud.
- The awareness of those prisoners who were placed on Special Security Measures should be heightened throughout the prison.
- Some staff were not checking every item prisoners were carrying on the route to check for illicit articles.
- The dip in mandatory drug testing of women due to staffing resources.

Encouraging Observations:

- The approach taken to individual case management within the SRU.
- The daily handover paperwork that was used in the SRU was helpful in providing a daily state of the regime, activities and general observations.
- Disciplinary hearings were consistently approached in a courteous manner with the Adjudicator engaged in the process of understanding why the situation arose.
- The Rapiscan machine had made significant progress in identifying mail that contained illicit substances and these items had been reported to Police Scotland.
- The vast majority of cell searches and area searches were carried out during the quarter inspected.
- Good quality searches were observed by inspectors throughout the prison, with good staff and prisoner relationships.
- The Mandatory Drug Testing staff were knowledgeable about the procedures relating to this process. Testing levels were maintained for male prisoners.

HMIPS Standard 5
Respect, Autonomy and Protection Against Mistreatment

A climate of mutual respect exists between staff and prisoners. Prisoners are encouraged to take responsibility for themselves and their future. Their rights to statutory protections and complaints processes are respected.

Throughout the prison, staff and prisoners have a mutual understanding and respect for each other and their responsibilities. They engage with each other positively and constructively. Prisoners are kept well informed about matters which affect them and are treated humanely and with understanding. If they have problems or feel threatened they are offered effective support. Prisoners are encouraged to participate in decision-making about their own lives. The prison co-operates positively with agencies which exercise statutory powers of complaints, investigation or supervision.

Inspection Findings
Overall rating: Satisfactory

In this Standard, six quality indicators were rated as satisfactory and two were rated as generally acceptable, giving an overall rating of satisfactory performance. There were eight recommendations for improvement.

There was evidence of some positive practice under this Standard, for example inspectors witnessed a lot of positive professional relationships between staff and prisoners. The main areas of concern relate to the inconsistency of the regime due to staffing pressures and the complexity of the prison population.

With regard to the **PANEL** principles:

Participation: Inspectors found evidence of good involvement of prisoners and their families. Family members were involved in processes relating to sentence progression and in putting support plans in place for prisoners with complex needs. Prisoners were consulted about daily life in the establishment, but this is an area that could be improved.

Accountability: There was evidence of prisoners using the complaints systems available to them and other agencies such as the Scottish Public Services Ombudsman and Independent Prisoner Monitors. Inspectors found that complaints were managed fairly and proportionally by the establishment.

Non-discrimination and equality: There was evidence of good support planning for some of the most vulnerable prisoners, and evidence gathered by other inspectors of a working strategy for equality and diversity.

Empowerment: Information was available in the main library to enable people to understand their rights. There was also evidence of the use of advocates for people that needed support to do so. Prisoner and family involvement was another area inspectors felt supported empowerment.

Legality: Inspectors did not find anything to suggest the establishment was not acting legally. However, the process for visits from legal representative and other agents could be improved.

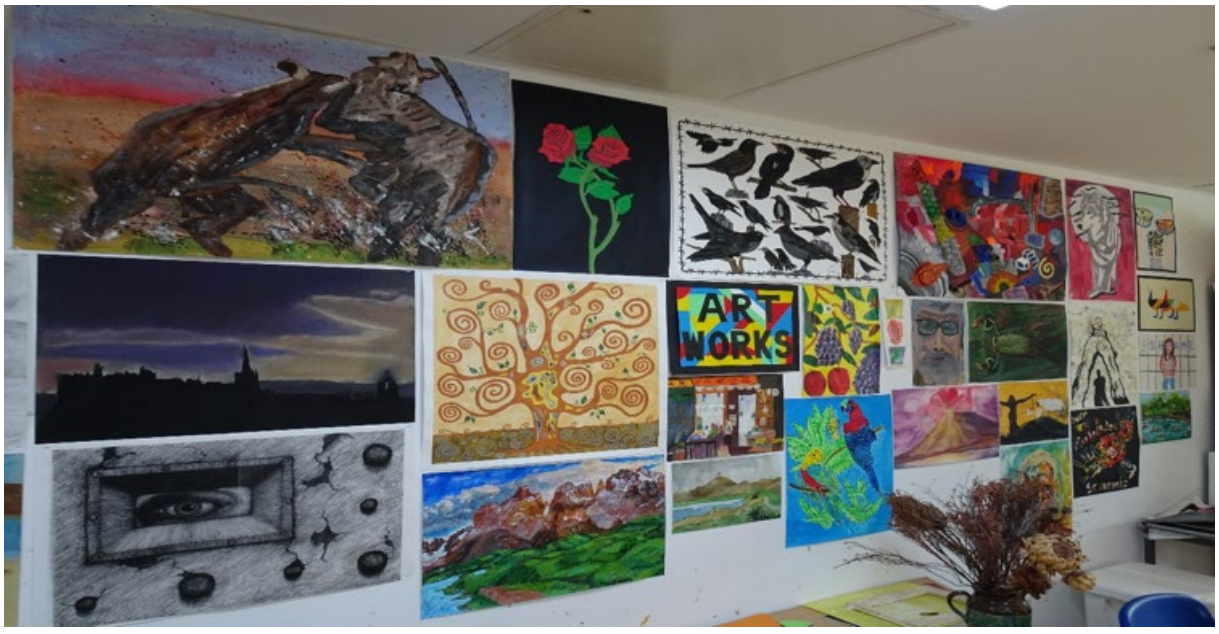
HMIPS Standard 5
Respect, Autonomy and Protection Against Mistreatment - Continued

Emerging concerns:

- The need to reduce the amount of time regimes are restricted, and ensure that any restrictions are not disproportionately applied to any population.
- HMP Edinburgh should try to reduce the mix of populations held on Glenesk 2 when numbers permit this to happen.
- SPS Headquarters should consider reducing the number of population cohorts in the establishment.
- SPS Headquarters should consider discontinuing the use of unnecessary strip searching in favour of known alternatives.
- The new canteen process should be reviewed after a period of around three months to ensure it is working well for everyone.
- There should be systems in place to ensure PIACs take place and are reviewed.
- HMP Edinburgh needs to review the systems in place for managing agents visits.
- HMP Edinburgh needs to look at improving the technological arrangements for virtual court appearances and the possibilities of expanding the service to more courts.

Encouraging observations:

- Good processes for communication of crucial information between prisoners and families around support for prisoners with complex needs and hospital admissions.
- Handling personal and sensitive information well.
- Respectful positive relationships between staff and prisoners.
- The new processes for managing the canteen list appeared to be working well, but needs to be kept under review.



Prisoner art

HMIPS Standard 6
Purposeful Activity

All prisoners are encouraged to use their time in prison constructively. Positive family and community relationships are maintained. Prisoners are consulted in planning the activities offered.

The prison assists prisoners to use their time purposefully and constructively and provides a broad range of activities, opportunities and services based on the profile of needs of the prisoner population. Prisoners are supported to maintain positive relationships with family and friends in the community. Prisoners have the opportunity to participate in recreational, sporting, religious and cultural activities. Prisoners' sentences are managed appropriately to prepare them for returning to their community.

Inspection Findings
Overall rating: Generally acceptable

In this Standard, three quality indicators were rated as good, four were rated as satisfactory, seven were rated as generally acceptable and one was rated as poor, giving an overall rating of generally acceptable performance. There were three examples of good practice and four recommendations for improvement.

In terms of the **PANEL** principles:

Participation: Opportunities to participate in purposeful activity were affected by long waiting lists for education and work shed closures. Communication between staff and prisoners could be improved by more fully embedding the Personal Officer scheme, as some prisoners were not aware of their critical dates.

Accountability: The prison was proactive in reviewing prisoners needs for programmes, but the frequent need to close sheds restricted purposeful activity to an unacceptable extent.

Non-Discrimination and Equality: The prison was proactive in recognising and promoting the needs of those with restricted characteristics.

Empowerment: In general prisoners were aware of their rights.

Legality: The frequent shutting of the work sheds and adverse impact on purposeful activity was not in line with the duty to facilitate rehabilitation under the Right to Liberty (Article 5 of the ECHR).

At the time of the inspection, there were insufficient employment opportunities for all prisoners, across all prison populations, and in particular for the female and untried prisoner populations. More than half of workshop activities were not available to prisoners due to staffing shortages. Overall, prisoners were consulted and encouraged to attend the work parties and the training opportunities available, with additional support being provided to prisoners who encountered barriers to participation. Scheduling of activities by the prison was proactive and considered the impact on prisoners, and prison populations, wherever possible. The training opportunity for prisoners offered in the hairdressing salon was good practice.

HMIPS Standard 6
Purposeful Activity - Continued

The system and rationale for allocating paid work to prisoners was fair and generally understood by staff and prisoners. Overall, the balance of prisoner and establishment needs for the scheduling of work allocation was appropriate. However, participation rates across the separate prison populations were variable and this led to frustration among some prisoner populations who wanted to participate in paid work activities.

Overall, there was an appropriate range of good quality educational opportunities available to prisoners. The subject range and levels were well considered, and there was an appropriate level of certification. There was good consultation underpinning the education offer. However, there were limited places available in the Education Unit, with space for only around 25% of the prison population. There were waiting lists for prisoners who wished to engage in education, typically of several months, for almost all education provision. Distance learning and individual learning in the residential halls was supported well by staff and three peer mentors.

All prison populations had scheduled opportunities to access sporting and fitness activities throughout the week, in the evening and at the weekend. There was a good range of physical and health activities available to prisoners and the variety and quality of activities provided were good. The majority of scheduled physical and health sessions were well-attended by prisoners. However, attendance at timetabled sessions by some prison populations was low, particularly by female prisoners.

The prison had a well-stocked and well-located library available to prisoners, co-located within the Hub alongside the Education Unit. All prisoner groups had some access to the library and the library provision was supported through the local authority. There was insufficient space in the library and visit slots are limited to 15 minutes, which made book and DVD selection a challenge for some prisoners. There were no thematic displays or promotions addressing issues such as mental health, which would typically be promoted through the library. There was very limited formal consultation with prisoners regarding the library or its stock, and feedback was drawn primarily from informal discussions with the library passmen.

The prison offered a very limited range of cultural, recreational and self-help activities. Prisoners were actively encouraged to reflect on their creativity and make entries for Koestler awards, and the prison had a large number of entries last year with a very successful 55 awards being achieved. There were very few cultural events recognised or celebrated across the prison and the prison was not proactive in raising awareness of broader religious, cultural or social events to the overall prison population.

HMIPS Standard 6
Purposeful Activity - Continued

Prisoners were provided with a broad range of activities, opportunities and services, but many of these opportunities were then restricted by closure of sheds. Considerable efforts were made to promote positive relationships with family and friends. Prisoners have the opportunity to participate in recreational, sporting, cultural and religious activities. A thorough and sensitive approach to case management was observed during the inspection. However, the main weakness was the operation of the Personal Officer system.

Emerging Concerns:

- All eligible prisoners and all prison populations should have an opportunity to attend an appropriate range of employment and training opportunities, particularly female and untried prisoners.
- More than half of workshop activities were not available to prisoners due to staffing shortages.
- Limited places available in the Education Unit, with space for only around 25% of the prison population.
- There was insufficient space in the library and visit slots were limited to 15 minutes, which made selection a challenge. There was very limited formal consultation with prisoners regarding the library or its stock and no thematic events.
- Inconsistent access to rain jackets and extra clothing for open air exercise.
- The profile of the Personal Officer scheme was variable. In some areas of the prison it was well established and functioned appropriately, but in others staff shortages and a lack of training and support meant it worked less well.

Encouraging observations:

- The training opportunity for prisoners offered in the hairdressing salon.
- An appropriate range of good quality educational opportunities available to prisoners.
- Distance learning and individual learning in the residential halls was supported well by staff and three peer mentors.
- A good range of physical and health activities was available to prisoners and the quality of these activities was good.
- A large number of entries for the Koestler Awards last year with a very successful 55 awards being achieved.
- The Visitor Centre (see photo below) and cooperation between Barnardos and SPS staff was excellent and represented good practice.
- The efforts made to promote child friendly visits were highly impressive.
- Some excellent examples of care and sensitivity in case management discussions, and appropriate participation of prisoners were observed.

HMIPS Standard 7
Transitions from Custody to Life in the Community

Prisoners are prepared for their successful return to the community.

The prison is active in supporting prisoners for returning successfully to their community at the conclusion of their sentence. The prison works with agencies in the community to ensure that resettlement plans are prepared, including specific plans for employment, training, education, healthcare, housing and financial management.

Inspection Findings
Overall rating: Generally acceptable performance

In this Standard, one quality indicator was rated as satisfactory and four were rated as generally acceptable, giving an overall rating of generally acceptable performance. There were five recommendations for improvement.

In terms of the **PANEL** principles for this Standard:

Participation: Long-term prisoners were able to participate in the preparation of their pre-release plan, but there were limited opportunities for short-term prisoners. There was no access to programmes for women or those on short sentences.

Accountability: The prison reviewed individual programme needs and included individuals in a suitable programme, but prisoners complained about waiting times to access programmes. Further action is needed to address the loss of throughcare services.

Non-discrimination and equality: Women were not given access to the same range of programmes as men.

Empowerment: As with other prisons, there was a disparity between the support and engagement provided to long-term prisoners and that provided for short-term prisoners and those on remand.

Legality: No issues were found.

Throughcare planning to support transitions from custody to life in the community was variable across the prison population. Individuals serving long-term, life and extended sentences, and therefore subject to statutory supervision on release, had the opportunity to contribute to a co-ordinated pre-release plan in order to address their community integration needs. The enhanced ICM process provided a robust structure through which to engage with individuals and support them to participate in assessments and pre-release planning. This was delivered well by experienced staff and managers. Meetings were well organised and attended appropriately by relevant prison and community-based agencies. Personal Officer attendance at ICM meetings was inconsistent, which meant that individuals were not always prepared well for meetings. Collaborative and detailed release plans were put in place for people subject to statutory release. The prison worked well with social work, forensic psychology services and other partner agencies based within the prison in order to ensure that risk and needs assessments were of high quality and decision-making forums, including risk management team meetings, were well informed. Given the statutory nature of the majority of the prison population, close attention was paid to ensuring that pre-release plans were collaborative, included all relevant partner agencies and prioritised community safety.

HMIPS Standard 7
Transitions from Custody to Life in the Community - Continued

However, many individuals on short-term prison sentences and not subject to statutory supervision on release had limited opportunity to engage in the preparation of formal release plans. The prison did not operate a standard ICM process and therefore formal arrangements, including the preparation of Community Integration Plans, were not consistent. In an effort to offset this, the prison had engaged with a wide range of external service providers to facilitate contact between individuals serving short-term sentences and agencies that could support their transition into the community. A well-equipped Link Centre had been established through which individuals preparing for release could engage with service providers. In addition, the prison had been successful in making arrangements with third sector organisations to provide direct support and practical help to individuals through contact with them in the prison halls. This process had previously been supported and enhanced by Throughcare Support Officers who provided support to people preparing for and following their release. However, following the national suspension of the service in September 2019, a significant gap had emerged in the level of pre-release planning undertaken and the provision of support for better community integration.

Statutory agencies including Prison-Based Social Work were working effectively with people subject to statutory supervision on release, though the increasing statutory population and associated work, had put pressure on the service to continue to deliver high-quality services within the existing resource. The prison provided an appropriate range of programmes for men serving long-term prison sentences. The Programmes Case Management Board was operating well in terms of reviewing individual programme needs and making arrangements to include individuals in a suitable programme. While a number of individuals had suitable access to programmes, greater success was hampered by waiting lists. There was no access to programmes for women in the prison or for people serving short-term sentences. This lack of provision limited people's prospects for progression and for successful community integration following release.

Encouraging Observations:

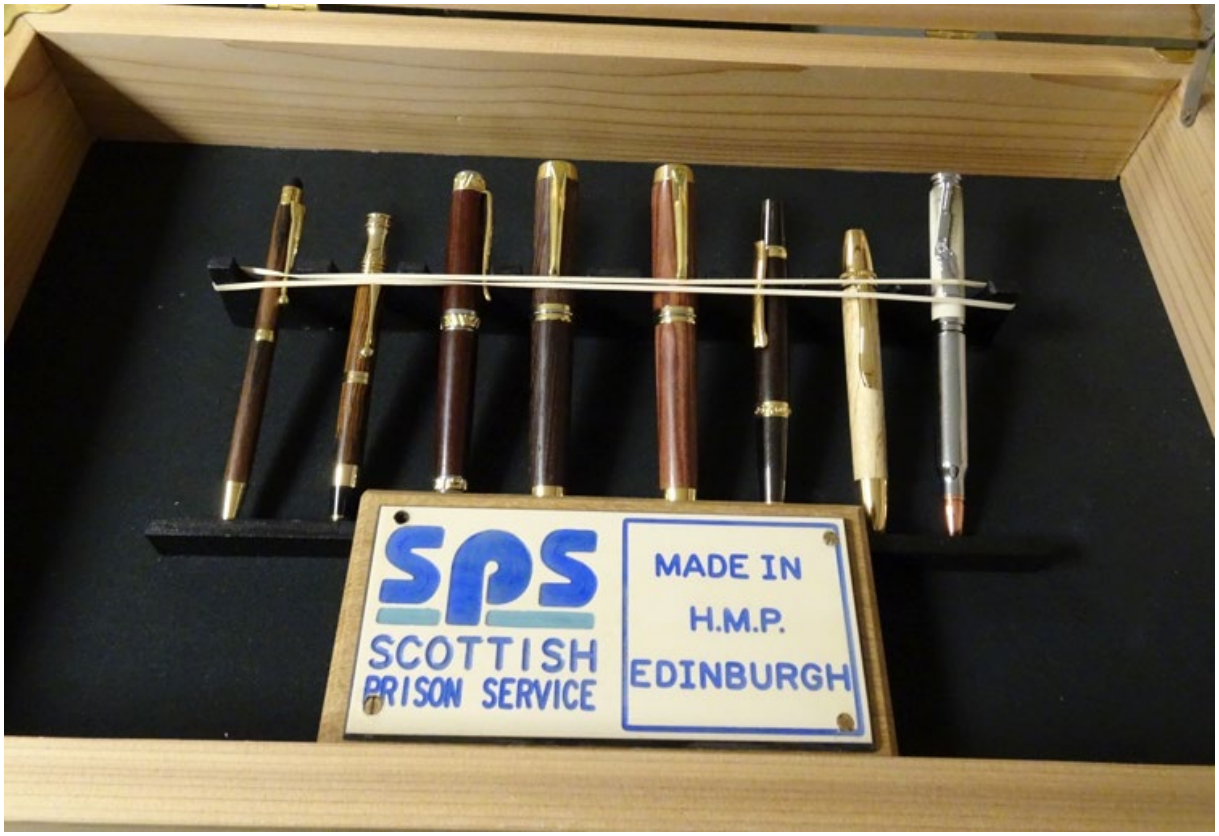
- Good communication was maintained with Community-Based Social Work services, Local Authorities and health and social care partnerships and relevant partner agencies.
- The enhanced ICM process was well embedded and operated to a high standard, led and co-ordinated by experienced and knowledgeable staff and managers.

Emerging Concerns:

- All prisoners should have an opportunity to participate in the preparation of a release plan and engage with appropriate services to support community integration on release.
- Steps should be taken to ensure that Personal Officers engage with and prepare individuals appropriately for ICM meetings.

HMIPS Standard 7
Transitions from Custody to Life in the Community - Continued

- There is a need to review the workload of the Prison-Based Social Work Team to ensure that adequate resources are in place to sustain the delivery of a high quality social work service against the backdrop of increasing demands on statutory work.
- The backlog of generic programme assessments needs to be reduced to improve access to programmes for all eligible prisoners.
- A clear plan is required to address the gap in provision of throughcare support following the suspension of the TSO service.



Pens made by prisoners for use in the SPS

HMIPS Standard 8
Organisational Effectiveness

The prison's priorities are consistent with the achievement of these Standards and are clearly communicated to all staff. There is a shared commitment by all people working in the prison to co-operate constructively to deliver these priorities.

Staff understand how their work contributes directly to the achievement of the prison's priorities. The prison management team shows leadership in deploying its resources effectively to achieve improved performance. It ensures that staff have the skills necessary to perform their roles well. All staff work well with others in the prison and with agencies which provide services to prisoners. The prison works collaboratively and professionally with other prisons and other criminal justice organisations.

Inspection Findings
Overall rating: Satisfactory Performance

In this Standard, two quality indicators were rated as good, four were rated as satisfactory and two were rated as generally acceptable, giving an overall rating of satisfactory. There were two examples of good practice with one recommendation for improvement.

In terms of the **PANEL** principles:

Participation: HMP Edinburgh sought to involve prisoners using a person-centred approach. Long-term prisoners were given the opportunity to participate meaningfully in their case management, and the prison actively engaged prisoners via PIACS. Clear action plans evidenced changes to food, canteen and E&D along with prisoners case management.

Accountability: Regime changes had delivered an improvement in access to fresh air and qualifications through the Physical Education Department. However, due to staffing constraints, core competencies were not at the expected level. Although there was evidence of external training being delivered, this was also hampered by staff shortages. Support for those most vulnerable was clear through talking to prisoners and minutes of meetings.

Non-discrimination and equality: This was generally strong, with detailed action plans on supporting those most vulnerable or marginalised. Language line was regularly used and external agencies such as Transgender Alliance attended numerous meetings. Inspectors reported that staff were understanding of the needs of those most vulnerable and sometimes complex issues, and dealt with them in a professional manner. However, women did not have access to the same range of programmes as men.

Empowerment: Inspectors found that staff and prisoners understood their entitlements. Evidence identified that a multitude of meetings sought to ensure prisoners had a voice and felt that changes could be made through dialogue. Action plans from meeting such as food and canteen forums showed changes to these areas, although at times it was over three months before actions were met.

Legality: HMP Edinburgh upheld the rights of prisoners through the prison rules and human rights. A particular strength was the engagement with transgender prisoners, where they had a great deal of experience and their processes and procedures in place to deal with these sometimes complex issues were sound.

HMIPS Standard 8
Organisational Effectiveness - Continued

Encouraging observations:

- The E&D sign posting manual that provides staff with comprehensive information on how to manage those with protected characteristics.
- The staff newsletter produced by the HR Dept.

HMIPS Standard 9
Health and Wellbeing

The prison takes all reasonable steps to ensure the health and wellbeing of all prisoners.

All prisoners receive care and treatment which takes account of all relevant NHS standards, guidelines and evidence-based treatments. Healthcare professionals play an effective role in preventing harm associated with prison life and in promoting the health and wellbeing of all prisoners.

Inspection Findings
Overall rating: Satisfactory performance

In this Standard, five quality indicators were rated as good, eight were rated as satisfactory, one was rated as generally acceptable and two were rated as poor, giving an overall rating of satisfactory. There were ten examples of good practice and 13 recommendations for improvement.

The healthcare team at HMP Edinburgh was committed to providing high quality care to their patients. All interactions observed between healthcare staff and patients were positive, professional and open. Staff spoken with had a good understanding of the health inequalities faced by their patients and all staff observed demonstrated a human rights and person-centred approach to care.

There were examples of positive partnership working between the healthcare staff and the SPS staff within the health centre, and collaborative working with third sectors agencies, community services and secondary care to improve health outcomes for patients. Inspectors also saw evidence that healthcare and social care staff worked together with patients requiring social care to develop their care plan. The health and social care plans were person-centred and reflected the individual needs of the patient.

The immediate health needs of all prisoners were assessed on arrival at HMP Edinburgh by a member of the healthcare team, using a standard health screening tool. Health screening was carried out in a room that maintained the prisoners' dignity and confidentiality throughout the consultation. Staff followed a formal process to determine whether a prisoner was fit to be in custody, and anyone identified as being at risk of self-harm or suicide was placed onto the TTM. Following their initial health screening on admission, patients were seen by an advanced nurse practitioner (ANP) at the first night in custody clinic. Patients with long-term conditions (LTCs) were identified at this clinic and patients had the opportunity to discuss any medical concerns, including the risk of self-harm and suicide.

The daily triage system enabled staff to respond to patient's immediate care needs as well as scheduled appointments arranged by an ANP or GP. SPS staff organised and supported patient's attendance at health centre clinics.

HMIPS Standard 9
Health and Wellbeing - Continued

There was a referral process to refer patients to secondary care services.

GEOAmey were responsible for escorting prisoners to secondary care appointments outwith the prison, however planned appointments in a secondary care setting could be cancelled at short notice as GEOAmey could not always provide an escort. There was no process in place to notify patients that they had missed an external appointment when this happened. Inspectors raised this with the health centre manager who took immediate action to implement a process to address and monitor this.

Inspectors were informed about some cases where NHS Lothian sent appointments directly from NHS Lothian to patients within the halls. Prisoners should not be notified in advance that they will be leaving the prison to attend an appointment, so inspectors escalated this for immediate action following the inspection as it was a risk to security. Inspectors will monitor the Board's progress with this.

Inspectors were concerned to see that not all prisoners who had returned from court convicted were not being reviewed by a member of the clinical team, as required under the TTM strategy. Primary care staff were not routinely contacted when prisoners returned under changed circumstances.

Health promotion material was displayed in the halls describing the services and support available to prisoners. Prisoners could self-refer to healthcare services and forms were available in the halls. Prisoners were encouraged to take up the wide range of health promotion activities including harm reduction, alcohol services and smoking cessation.

Blood Borne Virus treatment was available for any patient requiring hepatitis C treatment. There was an established process, in line with the Scotland hepatitis C elimination programme, for follow up of remand prisoners returning to the community to ensure continued access to treatment post release.

Primary care

At the time of our inspection, there were three primary care posts vacant, and as a result of this the band 7 was undertaking frontline duties. This meant that they were unable to provide line management support and had an impact on the ability of the primary care team to deliver the full range of clinics. An agreement had been made going forward to over-recruit to the healthcare team.

A clinical pharmacy service was provided and pharmacy advice and support was available to staff within the health centre. In line with the change in classification of gabapentinoids and NHS Lothian guidelines, there had been significant work carried out to review 100 kardexes of patients prescribed gabapentinoids. This had resulted in reduced numbers of patients receiving this medication and clearly identified systems and processes for those who did.

HMIPS Standard 9
Health and Wellbeing - Continued

There were concerns raised over the administration of medication timings, with examples of medicines prescribed for evening or night-time being given earlier. Inspectors discussed this with the health centre manager who raised this immediately with the SPS during the inspection, as lock up times were impacting on medication administration. The dispensing of morning medication was lengthy in some halls due to the number of medications being dispensed. To address this, plans were in place to create an additional space for staff to safely deliver medications within more reasonable time frames.

Long-term conditions, Palliative and end of life care

Specific long-term conditions (LTCs) clinics were not taking place at the time of the inspection due to staffing levels. There was no systematic approach to the management and review for all patients with LTCs to ensure they were followed up.

Inspectors were told that anticipatory care planning was at an early stage of implementation, initially for patients with palliative care needs, but there were plans to promote an anticipatory approach for patients with LTCs. Anticipatory care plans are used to describe the wishes of patients as their condition develops further and their health deteriorates. This was a positive development and current care plans were evident for patients with complex healthcare needs. These were regularly reviewed by nursing staff and demonstrated a collaborative approach with social care input.

There was evidence of consideration given to work safely and effectively within the parameter of the prison environment for the comfort and safety of the patients with palliative and end of life care needs. Alternatives were identified where treatments appropriate for community use could pose a risk to the patient in the prison environment. This was person-centred to meet individual needs.

Mental Health and substance misuse

The mental health and addiction nursing teams were jointly managed and worked collaboratively to deliver care across both teams. The mental health team was multi-disciplinary and the majority of mental health nursing staff were non-medical prescribers, which resulted in no delays in commencing necessary medications. Additional posts had recently been funded by Action 15, as part of the Scottish Government Mental Health Strategy 2017-2027. There was an investment in training in the nursing team, and development of staff supported the range of interventions in groups and for individual work. The delivery of low level psychological interventions by a mental health nurse was part of the service quality improvement programme for healthcare delivery.

National waiting times and guidance were being met for emergency, urgent and routine referrals, however patients were not informed of their appointment times by letters. There was evidence of the efforts by staff to manage caseloads to minimise any potential impact for patients, where the complex needs of some patients affected the ability to follow up on routine appointments.

HMIPS Standard 9
Health and Wellbeing - Continued

There was a monthly mental health multi-disciplinary team meeting where team members were able to work collaboratively to discuss patient's needs.

Prisoners with drug and/or alcohol dependence were identified during the admission process. Support from Change Grow Live (CGL) was available to patients who self-referred for addictions services. CGL ran group support and weekly SMART recovery groups, and provided individual support to develop person-centred personalised recovery plans.

For those patients not immediately identified as requiring Opiate Replacement Therapy (ORT), there was the ability to self-refer to the addictions service and assessment was undertaken by CGL. Following this, where ORT was indicated, a referral between CGL and the NHS, who delivered the addictions service, was required. Inspectors were told that for these patients there was a requirement to complete drug diaries and provide urine testing over a two week period before any ORT would be commenced, and this timescale at times extended to five weeks. Therefore, accessing ORT was inequitable to that of the community due to the current system. There was however a good working relationships between both agencies, and both NHS and CGL staff told inspectors that this was supported by regular meetings and communication.

Culture

All staff had attended induction training underpinning SPS security rules and professional boundaries. Staff were aware of the demands of delivering healthcare within the prison setting and the requirement for security. They were able to explain the boundaries between professional and ethical issues.

Primary care nurses distributed complaints to the appropriate services such as primary care, mental health, and addictions, ANP or GP. All complaints were recorded on the Datix system and not recorded in the patient's Vision record.

Formal complaints training was not currently embedded in statutory and mandatory training. Inspectors were told that the patient experience team had previously delivered training for staff but no time frames or evidence of this training was available at the time of the inspection.

HUMAN RIGHTS-BASED APPROACH SYNOPSIS

This synopsis follows the PANEL headings, illustrating how human rights principles apply to this inspection as a whole. This is not exhaustive of all human rights engaged, but is intended as a (brief) synopsis of the implementation of the Standards, taking a human rights-based approach in HMP Edinburgh.

HMIPS' approach is crucial for ensuring both that the human dignity of the prisoner is upheld and that prisons are places of productive, positive and useful education, work and interaction, leading to better outcomes in reducing recidivism and keeping our communities safer.

PANEL:

Participation

"Prisoners should be meaningfully involved in decisions that affect their lives"

Inspectors were provided with ample evidence of systematic prisoner participation within HMP Edinburgh. Inspectors found generally respectful and helpful staff/prisoner relationships and examples of good practice, which are highlighted below. An overarching theme that emerged was that HMP Edinburgh was facing a significant challenge from the logistics of housing several distinct prisoner populations. These populations shared staff and resources, while policy and treatment within them were found to diverge almost immediately. This was a background feature to most, if not all findings and reference will be made to the distinctions between the prison populations.

Levels of participation were highest within Ratho Hall compared to other halls, followed closely by Hermiston with Ingliston and Glenesk lagging significantly behind. There was a generally good level of awareness among prisoners of available processes where they could influence decision-making, including the complaints system. There was a considerable range of complaints and use of the complaints review system. There was a reasonable level of awareness of the Personal Officer scheme, though not everyone could name their Personal Officer and logistical issues reduced its effectiveness. Food Forums and PIACs were held on a regular, systematic basis, and there was planning around them to ensure that the prisoners attending them were equipped to represent the interests of other prisoners. The PIACs were well documented, with actions and logs that reflected an exchange of information and the decision-making processes within the prison. However the selection of PIAC attendees be audited to ensure that it remains democratic and representative.

The overcrowding in the halls had a clear impact on the effective participation of prisoners. This resulted in prisoners spending more time in their cell, as association and leisure periods were difficult to supervise due to inadequate staffing numbers. This impacted negatively upon morale amongst prisoners and staff alike. Both staff and prisoners described feeling that the prison regime was restricted and that there was no indication that things would improve. Adjustments were reported that may present risks, such as staff operating in lower numbers than procedurally required. Many staff interviewed expressed a view that they were under-resourced and felt bound to accept the status quo. Staff displayed a good degree of insight, in that they tried to adjust the regime, where possible, to allow prisoners to have more time outside their cells.

The prison had low numbers of ESOL prisoners and appropriate provision was made in terms of translation services. This issue is relevant from a human rights perspective as communication with frontline staff is critical in enabling prisoners to exercise their fundamental rights.

Prison staff received equality and diversity training on how to respect the rights and meet the specific needs of detainees in situations of vulnerability, and the skills necessary for working with them. Rule 75 of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) is clear that the prison administration has to ensure the continuous provision of in-service training courses with a view to maintaining and improving the knowledge and professional capacity of its personnel, after entering on duty and during their career.

There were some examples of good practice in the area of participation, particularly in relation to the care of prisoners in Hermiston, for example, the work of the chaplaincy and the content of educational programmes where standards, procedures and staff practices allowed prisoners to be meaningfully involved. There were also generally respectful and helpful staff/prisoner relationships. The family visits, and the visiting centre programme that ran alongside it, were a positive development in relation to participation and human rights. The prison could take a greater active role to facilitate communication of foreign nationals with their families abroad, for example via video-conference. This was lacking at the time of the visit.

The right to information is important for legal proceedings as well as when it comes to the rights, obligations and rules of life in detention. A wide range of practical information was provided in the induction booklet which was also supposed to be explained to prisoners in reception. This is an example of good practice which contributes strongly to the effective participation of prisoners in prison life. Induction of prisoners was, however, inconsistent in practice, with some prisoners receiving no information or receiving it too late. General Comment No. 2 (2008) of the Convention Against Torture on the implementation of Article 2 by States Parties makes clear that the right of detainees to be informed of their rights is a basic guarantee for all persons deprived of their liberty. The right to information must be especially guaranteed for certain categories of detainees who, for reasons of language, age, illness or intellectual disabilities do not have equal access to information. Translation services were available for use when needed. There was ample evidence of calls being made to language line for foreign nationals. Information was provided at the admission desk and via poster boards in various locations. Induction information was largely given out by Peer Mentors once located in a residential hall. There were concerns that incomplete information was being given and some instances of a lack of confidence in Peer Mentors. Regular auditing of Peer Mentors to ensure that they are carrying out their role satisfactorily is required.

Advocacy: Independent advocacy is an important communication tool used to enhance capacity and to aid useful communication. Advocard' Advocacy Service was included in the induction and First Night in Custody Booklet, but awareness of the service amongst prisoners was not particularly high. Particular groups of prisoners who engaged with external agencies accessed advocacy in that way e.g. Transgender Alliance advocated for Transgender Prisoners. There was no information available as to how prisoners could access advocacy. This is concerning as advocacy enables not only greater participation but safeguard prisoners' rights. There were a number of forums such as ICC hearings, parole board hearings, disciplinary hearings, where prisoners with identified support needs could be aided, by having an advocate to assist them to clearly express their views and wishes when decisions were being made about their lives. An orderly room was observed where the prisoner was identified as having low literacy skills at the beginning of the hearing. The prisoner had no advocacy services either in relation to the process, or the issues of concern to him which he raised in the process, which may have been beneficial to help improve his behaviour.

Accountability

"There should be monitoring of how prisoners' rights are being affected, as well as remedies when things go wrong"

A key aspect of accountability is addressing systematic concerns, in addition to individual ones.

There was a framework of administrative accountability in the prison. There were clear lines of management and staff seemed to engage with prisoners positively. The work of the Equality and Diversity Manager was commendable. There was evidence of a well-documented Equality and Diversity Policy and current Action Plan. The Action Plan was allocated resources and included distinct steps and measurability criteria. The Equality and Diversity Manager monitored systematic issues and significant events against Key Performance Indicators. There was evidence of data gathering and analysis of data to identify repeated issues, such as those relating to race and sexuality. There were regular Equality and Diversity Meetings chaired by the Governor.

Good practice: There were systems in place for auditing the provision of reasonable adjustments for prisoners with disabilities.

Complaints: Prisoner complaints are an important aspect of the framework for prison accountability. Prisoners were generally aware of the complaints system and it was utilised. Complaint forms were regularly available on most flats. There was evidence of investigation into complaints and ICC hearings were well-documented. Focus groups had reported that food was frequently the subject of complaints, however this was not reflected in the formal complaints system. Similarly, complaints about lack of access to the prison regime were fewer than expected. This suggests that prisoners are complaining informally and do not consider these issues to merit formal complaints. The prison management should avoid construing a lack of complaints in these important areas as an indication of satisfaction given that there is information to the contrary. Inspectors recommend that the prison continue to seek prisoner's feedback on these important issues through PIACs and food forums.

Staff reported a low level of confidence in the responsiveness of mental health support responding to referrals or requests for assistance. It was frequently observed that there was a high level of need for advice and assistance in dealing with challenges that could be attributable to a mental health condition or a personality disorder. Staff considered that there was insufficient provision of mental health support providing practical advice on dealing with mental health issues. This was a persistent and pervasive observation made by staff. They expressed their frustration that the situation had not improved and that it had profound impacts on prisoners and on operations. It is concerning that there was no apparent system for staff to discuss this issue with prison management. Prison management presented a programme of increasing capacity for mental healthcare and treatment provision, by increasing the number of psychologists.

Recommendation: The provision of nursing staff should be increased in order to improve response times and to provide care over the weekend, which is currently missing.

Inspectors were concerned about the regime for offence and non-offence protection prisoners in Glenesk Hall. These prisoners were not able to be accommodated with other prisoners in the same category due to space limitations. Which meant they could not take part in the same regime that the other Glenesk prisoners enjoyed. The logistics of population management, compounded by issues of overcrowding across the estate, prevented them from participating with other prisoners in their categories. The outcome of this was that these prisoners spent a disproportionate amount of time within their cells, including meal

times, which may amount to effective solitary confinement, as it is understood there may be instances where it could be up to 22 hours a day. This is particularly concerning, as Article 44 of the Mandela Rules defines solitary confinement as:

"... The confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days."

Separation of vulnerable detainees should be clearly distinct from solitary confinement and should never lead to restrictions on access to services (vocational training, exercise, work, etc.).

Inspectors suggest a review of the regime for these prisoners to ensure that it does not mimic conditions in the SRU, and is not a de-facto punishment which incentivises the prisoner to return to a situation of potential risk.

Non-discrimination

"All forms of discrimination must be prohibited, prevented and eliminated. The needs of prisoners who face the biggest barriers to realising their rights should be prioritised"

As iterated above, this prison faces a distinct logistical challenge due to the numbers of different populations that require to be segregated. This impacts the amenities available to all prisoners including work placements, library, education and healthcare.

In terms of ethnic diversity, at the time of the inspection, the proportion of the population that did not identify as White and Scottish was very small. A number of prisoners had identified as Jewish. However, there was a perception that this was not accurate as such a declaration gave prisoners access to a better quality of diet in the prison. There were few Muslim prisoners. No prisoners interviewed had considered that they were poorly treated on the basis of protected characteristics with the exception of one. This prisoner considered that she was socially isolated because of her religion. She complained that she had received sub-standard food for religious observation and also that she was not able to attend worship services with other members of her faith.

Both male and female populations had gay, lesbian and transgender prisoners among them. HMP Edinburgh had the highest proportion of transgender prisoners of all Scottish prisons. The prison seemed to be broadly compliant with the SPS Gender Identity and Gender Reassignment Policy. It was noted from the minutes of case conferences that NHS staff and social work staff rarely attended them, even on occasions where their input was required. Prison-based social work staff attributed this to inadequate staffing to plan and attend these meetings. A further issue highlighted by one transgender individual related to not finding out about clinical appointments and changes and cancellations of these, which could often cause significant delay to their transition progress because of the scarcity of these appointments. Evidence from case conference minutes for other individuals suggested that this is not an isolated case.

Among both female and male populations there were prisoners with learning disabilities and evidence of poor mental health. When interviewed, staff were unanimously of the opinion that mental health needs of prisoners were not taken as seriously as they should be, and staff were making decisions around the handling of the arising issues without adequate support.

Given that the prison has a role to educate and promote diversity, it is disappointing that the majority of prisoners are not involved in activities that do so. While it is understood that HMP Edinburgh is not particularly diverse in terms of ethnicity, there is still a role for the prison to

play in making prisoners aware of all diversity. For example, there is considerable diversity amongst the male population in terms of physical and mental disability; social background, and sexual orientation. Education about these areas promotes understanding and ensures that discrimination is prevented.

The participation of the male population in events that raise social awareness is also of concern. Anecdotally, it is considered that there are a higher number of gay and bisexual male prisoners than officially reported due to cultural stigma attached to male homosexuality in the prison environment. A Pride event, similar to the one that took place on Ratho Hall, would be an opportunity to address this and reduce discrimination against those groups. Similarly, an event such as the proposed International Men's Day is an opportunity to promote and celebrate the diversity of the male population, as well as to inform all in the prison of issues affecting the prisoners. Prison-based Social Work described the distinction in treatment between the offender groups as significant in a way that affects offender outcomes, both individually and more universally. For example, extending trauma-based care training to all staff may improve circumstances for male prisoners, many of whom have experienced trauma. This is not a circumstance unique to HMP Edinburgh, however the disparities in treatment are apparent due to the proximity of the populations.

The prison must ensure that reasonable adjustments are promptly provided for prisoners with disabilities. Inspectors noted that the treatment of prisoners with particularly high needs in the elderly population appeared to be person-centred and sensitive. External care staff provided services within the prison and this was widely appreciated.

Empowerment

"Everyone should understand their rights, and be fully supported to take part in developing policy and practices which affect their lives"

Prisoners should understand their rights, and be fully supported, so they are able to use their rights. Inspectors were concerned about the variability of information received by prisoners during induction, as explained above. Inspectors would expect prisoners to understand these processes and their entitlements, and that the information is available in a variety of formats to cater for those with different needs.

The information provided in the induction leaflet was comprehensive and largely accessible. Much crucial information necessary for prisoners to understand their rights and how to exercise them within the context of prison life was conveyed (e.g. how searches are carried out, how to maintain contact with family members). This information is crucial to empowering prisoners and achieving a shared understanding of their rights. In particular, information about education opportunities should take account of those with limited literacy for whom education may be most useful.

Inspectors also highlight the important role that can be played by independent advocacy, to support those with additional needs to access processes and protect their rights. An advocacy service was available to prisoners on request. However it should be better publicised amongst prisoners.

It is also important to empower staff in their duties. Awareness should be raised among staff of the mechanisms that are available to assist prisoners and the role they play in facilitating these, such as interpretation services and funds for phone calls outside the UK, so that they feel able to have ready access to them. Inspectors noted instances of staff self- managing issues without adequate support in dealing with the underlying issues. Instances included allowing prisoners with mobility issues to remain in the communal areas when other prisoners were locked in their cells; allowing a male prisoner to persistently remain shirtless

as a means of managing his poor mental health. Empowerment of staff also includes ensuring that there is adequate training and support for staff to deal with the challenges they face for example, responding to behaviours which are challenging or violent and recognising mental ill health and underlying conditions and responding appropriately.

Although staff and prisoners reported generally positive relationships, there were significant reports of stress amongst staff for a number of reasons:

1. The use of NPS causes significant concern to staff for their safety and that of other prisoners. Staff were aware of the risks of being exposed to these substances, however, felt extremely vulnerable to them because of the lack of information and intelligence around their use. The prison and the SPS should address this with staff and continue to develop strategies to reduce their use and to respond to injured staff.

2. Poor mental health amongst prisoners was frequently highlighted as a staff concern, as staff feel both ill-equipped to manage prisoners with poor mental health and to respond to adverse incidents brought about by acute behavioural difficulties and poor mental health. Staff did not perceive that there was adequate support from mental health staff. A joint response from the prison and the NHS is required that considers staff feedback and policies relating to what support can be provided to prisoners and staff, provides additional training to staff and allows time for this training to be undertaken safely.

3. The legacy of the Fatal Accident Inquiry (FAI) into the tragic death of a prisoner at HMP Edinburgh in 2015 had severely impacted morale amongst staff in the prison. Inspectors were aware that a significant amount of support was given to staff before, during and after the FAI. However, some staff still said they felt a significant degree of stress. This may be unavoidable given the adverse publicity surrounding the event at the time and the subsequent press coverage after the publication of the Sheriff's Determination.

Furthermore it is of critical importance that staff based in the SRU are systematically supported through training and ongoing learning related to the handling of incidents which require C&R techniques to be used, and the handling of behaviours which may be caused by underlying mental health needs or drug use.

The FAI into the death of Allan Marshall in 2015 found that "The system of training of prison officers in relation to the four medical conditions that may be triggered by or exacerbated by the use of force was defective." A review into control and restraints processes is now underway, which will consider all training requirements. Prison officers reported still feeling insufficient support or training for staff in the management of mental health conditions, despite this being a significant element of their job, particularly in SRU. This requires urgent attention and follow-up.

There was very limited refresher training given to staff around human rights or equality duties under the law. Updates to training were not scheduled, with no consideration given to the reduced staffing levels restricting staff time to carry out training. This undermines their ability to deliver on all aspects of a human rights-based approach.

Legality

"Approaches should be grounded in the legal rights that are set out in domestic and international laws"

A human rights-based approach requires the recognition of rights as legally enforceable entitlements and is linked to national and international human rights law. It is important that all categories of prisoners enjoy the full range of human rights and that staff are adequately supported. Inspectors identified areas where they believe further action is required, in particular to ensure that more marginalised prisoners do not fall through the gaps.

The realisation of human rights is facilitated in practice by both the provision of information and the need for proactive action to be taken to ensure prisoners are accessing their rights in practice. A human rights-based framework would be concerned with responding to prisoners' needs as they are raised, as well as anticipating areas of prison life where problems are likely to arise.

Healthcare and Diet: Some prisoners cited poor healthcare and a lack of availability of doctors. This was confirmed by staff reporting that the prison used Advanced Nurse Practitioners to prescribe medicines. Mental health treatment has been discussed above.

Staff would be assisted by training to understand their duties according to human rights standards, and prison management should engage constructively with a human rights-based system of governance.

ANNEX A

SUMMARY OF RECOMMENDATIONS

Key recommendations:

For ease of reference, HMIPS have grouped the recommendations listed below into seven key recommendations that summarise the key aspects that the inspectorate consider important for the Governor, the Scottish Government and the SPS to focus on:

Key Recommendation 1: Effective, Courteous and Humane Exercise of Authority: HMP Edinburgh should ensure that all planned removals are video recorded in line with SPS policy. HMP Edinburgh should ensure that incidences of UoF are reviewed by the senior management team, and make certain that the governance process is in place for reviewing incidents. In addition, the SPS should consider introducing body worn cameras for unexpected violent incidents. HMP Edinburgh should make training in Control and Restraints and Supervising Officer training a priority to ensure all staff are deemed competent to undertake their role to respond to incidents.

Key Recommendation 2: Risk Assessment: HMP Edinburgh should ensure that all eligible prisoners complete the full RRA, including the Healthcare Assessment. No eligible prisoners should be afforded the opportunity to self-decline the healthcare assessment. All admissions, transfers and returns from court with a change of circumstance should be seen by a NHS nurse during the reception risk assessment process. Moreover all RAs and SSoW should be reviewed immediately. HMP Edinburgh should endeavour to ensure that all prisoners' vaping preferences are met during the CSRA. Furthermore, on the occasions that vaping preferences are not met, there should be a process for monitoring and reviewing, with a view to meeting their preference as expediently as possible.

Key Recommendation 3: Personal Safety: HMP Edinburgh should ensure that all reception staff are within competency for Talk to Me Training. HMP Edinburgh should implement an audit and assurance process for TTM documentation. HMP Edinburgh should recruit and train more TTM trainers to meet the demand. NHS Lothian must ensure there is a process in place to provide health assessment to any patient on TTM returning from court with a change of circumstance. HMP Edinburgh should fully implement the Think Twice Strategy, including the referral process to support victims. This should also include awareness of the Strategy being provided to prisoners. Peer mentors should have training on the SPS Anti-bullying Strategy - Think Twice and the induction checklist should be updated to allow this information to be passed to new admissions.

Key Recommendation 4: Decency: HMP Edinburgh should review the posters on display in cells in male halls. HMP Edinburgh should ensure that the safer cells in Hermiston Hall are not used until a toilet privacy screen is fitted. The SPS should review Governors and Managers Advice Notice 28A/09 - SPS Posters, Pictures and Photographs in Cells Protocol and consider whether it needs updated. NHS Lothian must ensure that standard infection control precaution audits, including hand hygiene, are regularly undertaken by appropriately trained staff and actions are taken to address any non-compliances. All staff must be informed of the audit results and any actions required to improve practices.

Key Recommendation 5: Accommodation: SPS Headquarters should consider reducing the number of populations in the establishment. HMP Edinburgh should take action to improve the building conditions in Glenesk Hall. HMP Edinburgh should try to reduce the mix of populations held on Glenesk 2.

Key Recommendation 6: Prisoner Engagement: The systems in place for ensuring PIACs take place should be reviewed. HMP Edinburgh should ensure all eligible prisoners and all prison populations have an opportunity to attend an appropriate range of employment and training opportunities. HMP Edinburgh should work to reduce the amount of time regimes that are restricted, and ensure that any restrictions are not disproportionately applied to any population. HMP Edinburgh should take action to improve consistency in the operation of the Personal Officer system, so that all prisoners are aware of their Personal Officer, and staff are trained to confidently perform that role. HMP Edinburgh should take steps to ensure that personal officers engage with and prepare individuals appropriately for ICM meetings; submit reports in all instances and attend enhanced ICM meetings.

Key Recommendation 7: Good order and discipline: The SPS should implement robust strategies and equipment to minimise the risk of illicit articles, including PS, being introduced to establishments. The SPS and the Scottish Government should consider introducing a Rapiscan in every prison in Scotland to reduce the introduction of illicit substances in Scotland's prisons.

For the Governor:

1. QI 1.1 HMP Edinburgh should ensure that all eligible prisoners complete the full RRA, including the Healthcare Assessment. No eligible prisoners should be afforded the opportunity to self-decline the healthcare assessment.

2. QI 1.1 HMP Edinburgh should staff the uncovered posts in the reception as a priority, ensuring that all staff working in this critical area are fully trained and conversant in all processes.

3. QI 1.1 HMP Edinburgh should ensure that all reception staff are within competency for Talk to Me Training.

4. QI 1.2 HMP Edinburgh should consider reintroducing untried and convicted first night in custody units.

5. QI 1.2 HMP Edinburgh should ensure that the local peer mentor process for Reception is adhered to, with the peer mentor being available to interview all admission, transfers and any other prisoners on request.

6. QI 1.2 HMP Edinburgh should ensure that all holding rooms are equipped with relevant local and national information. In addition, they should consider providing reading material and working televisions.

7. QI 1.6 HMP Edinburgh should endeavour to ensure that all prisoners' vaping preferences are met during the CSRA. Furthermore, on the occasions that vaping preferences are not met, there should be a process for monitoring and reviewing, with a view to meeting their preference as expediently as possible.

8. QI 1.8 HMP Edinburgh should ensure that all eligible prisoners receive, or are offered, the National Induction Programme as soon possible after admission, despite any operational issues.

9. QI 1.8 HMP Edinburgh should ensure that all prisoners receive a Core Screens with 72 hours of admission, as per ICM Practice Guidance Manual 2007.

10. QI 2.1 HMP Edinburgh should take action to improve the building conditions in Glenesk Hall.

11. QI 2.1 HMP Edinburgh should review the posters on display in cells in male halls.

12. QI 2.3 HMP Edinburgh should review the availability and quality of duvets available and ensure prisoners are aware of the process to request a replacement mattress.

13. QI 2.5 HMP Edinburgh should review the clothing available to the male population to ensure there are a range of sizes available and that items are of a good quality.

14. QI 2.5 HMP Edinburgh should review female prisoners in Ratho Hall not being permitted to wear skirts or dresses in residential areas, to allow them to maintain a sense of personal identity.

15. QI 2.5 HMP Edinburgh should review the contingency plans for women's laundry.

16. QI 3.1 HMP Edinburgh should implement an audit and assurance process for TTM documentation.

17. QI 3.1 HMP Edinburgh should ensure that the safer cells in Hermiston Hall are not used until a toilet privacy screen is fitted.

18. QI 3.1 HMP Edinburgh should recruit and train more TTM trainers to meet the demand.

19. QI 3.3 HMP Edinburgh should raise awareness of the VRS, with FLMs being trained in their role and responsibilities for the completion of the VIR.

20. QI 3.4 HMP Edinburgh should fully implement the Think Twice Strategy, including the referral process to support victims. This should also include awareness of the Strategy being provided to prisoners.

21. QI 3.4 Peer mentors should have training on the SPS Anti-bullying Strategy - Think Twice and the induction checklist should be updated to allow this information to be passed to new admissions.

22. QI 3.5 The VRS should identify clear lines of responsibility to include the referral and recording of bullying incidents.

23. QI 3.5 A clear process should be established to collate and record the Think Twice Strategy paperwork and actions.

24. QI 3.6 HMP Edinburgh should ensure that the Response to Alarms SOP is adhered to, to ensure all areas of personal safety are maintained.

25. QI 3.6 HMP Edinburgh should make training in Control and Restraints and Supervising Officer training a priority to ensure all staff are deemed competent to undertake their role to respond to incidents.

26. QI 3.7 All RAs and SSoW should be reviewed immediately.

27. QI 3.7 Staff should be trained in Health and Safety and Fire Response to meet the required competency level for HMP Edinburgh.

28. QI 4.1 HMP Edinburgh should ensure that all planned removals are video recorded in line with SPS policy and SPS consider the use of body worn cameras for unexpected violent incidents.

29. QI 4.1 HMP Edinburgh should ensure that incidences of UoF are reviewed by the senior management team, and make certain that the governance process is in place for reviewing incidents.

30. QI 4.3 Hall Management should ensure that any mitigations received during the adjudication process are followed up by the Hall Manager.

31. QI 4.3 The Hall Manager should be satisfied that the prisoner is able to read and write and/or requires assistance prior to signing off the adjudication paperwork.

32. QI 4.4 HMP Edinburgh should ensure that there is a heightened awareness amongst senior management and staff of the SOP relating to SSMs

33. QI 4.5 HMP Edinburgh should ensure that all items carried on the route are searched for illicit articles.

34. QI 4.8 HMP Edinburgh should ensure that MDT testing for women takes place on a regular basis.

35. QI 4.9 HMP Edinburgh should ensure that all doors are locked in accordance with SPS locking policy.

36. QI 4.9 HMP Edinburgh should ensure that all items being carried by prisoners leaving accommodation areas are searched.

37. QI 4.10 HMP Edinburgh should carry out a review of external camera coverage.

38. QI 5.4 HMP Edinburgh should work to reduce the amount of time regimes that are restricted, and ensure that any restrictions are not disproportionately applied to any population.

39. QI 5.4 HMP Edinburgh should try to reduce the mix of populations held on Glenesk 2.

40. QI 5.5 In acknowledging there needs to be a robust process in place for managing the canteen in such a large and complex prison, the new process should be reviewed after a period of around three months to ensure it is working well for everyone.

41. QI 5.5 The systems in place for ensuring PIACs take place should be reviewed.

42. QI 5.6 HMP Edinburgh should review the systems in place for managing agents visits.

43. QI 5.6 HMP Edinburgh should look to improve the technological arrangements for virtual court appearances.

44. QI 6.1 HMP Edinburgh should ensure all eligible prisoners and all prison populations have an opportunity to attend an appropriate range of employment and training opportunities.

44. QI 6.7 The SPS should provide thicker, more waterproof jackets to facilitate access to open air during colder weather. In the interim, HMP Edinburgh should ensure consistent access to rain jackets and additional layers of clothes for all halls.

45. QI 6.13 HMP Edinburgh should take action to improve consistency in the operation of the Personal Officer system, so that all prisoners are aware of their Personal Officer, and staff are trained to confidently perform that role.

46. QI 6.15 The number of prison transfers made close to a prisoner's release date should be kept to a minimum to avoid unintentionally undermining the pre-release planning work undertaken with partner agencies.

47. QI 7.1 HMP Edinburgh should ensure that all prisoners have an opportunity to participate in the preparation of a release plan and engage with appropriate services to support community integration on release.

48. QI 7.2 HMP Edinburgh should take steps to ensure that personal officers engage with and prepare individuals appropriately for ICM meetings; submit reports in all instances and attend enhanced ICM meetings.

49. QI 7.2 HMP Edinburgh should review the workload of the prison-based social work team to ensure that adequate resources are in place to sustain the delivery of a high-quality social work service against the backdrop of increasing demands on statutory work.

50. QI 7.3 HMP Edinburgh should take steps to reduce the backlog of generic programme assessments and to improve access to programmes for all eligible prisoners.

51. QI 7.5 HMP Edinburgh should ensure that a clear plan is put in place to address the gap in provision of throughcare support following the suspension of the TSO service, so that all eligible prisoners have the opportunity to participate in effective pre-release planning.

52. QI 8.3 HMP Edinburgh ensure that staff area aware of the existence of the ADP and that they have an opportunity to read and understand it with regards to their role.

53. QI 9.2: SPS and GEOAmey must facilitate patients' attendance at appointments to secondary care. Appointments to secondary care should only be cancelled due to an unforeseen and extraordinary circumstance. Under the duty of candour, all patients who miss a secondary care must be informed of the reason why, and what actions will be taken to mitigate the risks to the patient as a result of this.

For the SPS:

54. QI 2.1 The SPS should review Governors and Managers Advice Notice 28A/09 - SPS Posters, Pictures and Photographs in Cells Protocol and consider whether it needs updated.

55. QI 3.3 The SPS should implement robust strategies and equipment to minimise the risk of illicit articles, including PS, being introduced to establishments.

56. QI 4.10 The SPS and the Scottish Government should consider introducing a Rapiscan in every prison in Scotland to reduce the introduction of illicit substances in Scotland's prisons.

57. QI 5.4: SPS Headquarters should consider reducing the number of populations in the establishment.

58. QI 5.4 SPS Headquarters should consider discontinuing the use of strip searching.

59. QI 6.7 The SPS should provide thicker, more waterproof jackets to facilitate access to open air during colder weather. In the interim, HMP Edinburgh should ensure consistent access to rain jackets and additional layers of clothes for all halls.

For the Scottish Government:

60. QI 4.10 The SPS and the Scottish Government should consider introducing a Rapiscan in every prison in Scotland to reduce the introduction of illicit substances in Scotland's prisons.

For the NHS:

62. QI 3.1 All admissions, transfers and returns from court with a change of circumstance should be seen by a NHS nurse during the reception risk assessment process.

63. QI 9.2 NHS Lothian must ensure that patients receive secondary care appointments through the health centre.

64. QI 9.3 NHS Lothian must ensure that all prisoners who require Naloxone training have access to this and an effective process is in place for the provision of Naloxone kits.

65. QI 9.5 NHS Lothian must ensure that patients are given the opportunity to have a copy of their care plan with agreed aims of treatment, and timing of reviews.

66. QI 9.5 NHS Lothian must ensure that the needs of patients with intellectual disabilities within HMP Edinburgh is being met through the external referral process.

67. QI 9.6 NHS Lothian must ensure that patients with long-term health conditions have individualised, person-centred care plans. The care plans must evidence that patients have had an explanation regarding their condition and have had involvement in the planning of their care needs.

68. QI 9.7 NHS Lothian must ensure access to ORT is available as soon as possible where this need has been identified, in line with national guidelines.

69. QI 9.8 NHS Lothian must ensure there is a robust process in place to support provision of medication to meet the needs of all patients on liberation.

70. QI 9.8 NHS Lothian must ensure that medication is administered as prescribed to minimise the risk of harm to patients. This includes ensuring that doses are not taken too close together or out with the time of day at which they are prescribed.

71. QI 9.12 NHS Lothian must ensure there is a process in place to provide health assessment to any patient on TTM returning from court with a change of circumstance.

72. QI 9.13 NHS Lothian must ensure that all staff managing complaints receive appropriate training to ensure that complaints are correctly managed.

73. QI 9.15 NHS Lothian must undertake a risk assessment to demonstrate the remedial actions taken to mitigate and monitor the risk of having no sink available in the treatment area.

74. QI 9.15 NHS Lothian much ensure that standard infection control precaution audits, including hand hygiene, are regularly undertaken by appropriately trained staff and actions are taken to address any non-compliances. All staff must be informed of the audit results and any actions required to improve practices.

75. Human Rights Overview: The provision of nursing staff should be increased in order to improve response times and to provide care over the weekend, which is currently missing.

ANNEX B

SUMMARY OF GOOD PRACTICE

1. QI 1.7 HMP Edinburgh's process for verifying warrants and critical dates, and the subsequent Critical Dates Confirmation sheet issued to prisoners.

2. QI 1.8 HMP Edinburgh's induction program and associated peer supporters, when fully operational, should be recognised as good practice. In particular, the FNIC Booklet, Inductee Admission Checklist and co-delivery of sessions by staff and peer supporters.

3. QI 2.5 The On Premises Laundry qualification prisoners can complete as part of British Institute of Cleaning Science, which links to full-time employment in Professional Washing Services.

4. QI 3.2 The introduction of the ACP, which was produced in partnership with Marie Curie, MacMillan, NHS, an SPS officer and a prisoner, is a good example of engagement and understanding the needs of individuals.

5. QI 3.2 The case conference approach and partnership with Scottish Transgender Alliance is a positive example of an individualised approach.

6. QI 4.2 On a daily basis, SRU staff met to discuss prisoners case management and ensured that accurate records were kept.

7. QI 4.2 A daily handover was in place which recorded the regime for each prisoner held within the SRU and compliance with paperwork was recorded.

8. QI 6.1 The training opportunity for prisoners offered in the hairdressing salon.

9. QI 6.9 The efforts made to promote opportunities for prisoners to interact with families and children, particularly with the Halloween themed night, were highly commendable.

10. QI 6.10 The Visitor Centre and relationships between the SPS and Barnardos staff were excellent and represents best practice.

11. QI 8.1 The E&D sign posting manual, accessible through SharePoint, that gave comprehensive information on how to manage those with protected characteristics.

12. QI 8.4 The staff newsletter produced by the HR Dept.

13. QI 9.2 Access to the provision of social care staff to assist patient's activities of daily living was provided on a 24-hour basis. Inspectors saw evidence that healthcare and social care staff worked together in collaboration with the patient to develop their care plan. Health and social care plans reviewed by inspectors were person-centred and reflected the individual needs of the patient.

14. QI 9.3 There was an established process, in line with the Scotland hepatitis C elimination programme, for follow up of remand prisoners returning to the community to ensure continued access to treatment post release.

15. QI 9.5 The impact of the nurse-led clinic for patients with ADHD.

16. QI 9.5 The monthly mental health multi-disciplinary team meeting in place where members demonstrated good multi-agency collaborative and partnership working.

17. QI 9.5 The majority of the mental health nursing staff were non-medical prescribers which meant no delays in commencing necessary medications.

18. QI 9.6 The anticipatory care plan process.

19. QI 9.11 The use of a recognised pathway combined with specialist input supported a person-centred approach to care planning for patients with palliative care needs.

20. QI 9.11 Patients identified with palliative care needs are reviewed every two weeks.

21. QI 9.11 Partnership working with the palliative care specialists was an area of strength.

22. QI 9.17 The governor, deputy governor and health centre manager met every six weeks to discuss any issues relating to matters between either staff groups. The agendas and minutes of these meetings demonstrated a collaborative approach towards decision-making and resolving issues.

23. Human Rights Overview: The systems in place for auditing the provision of reasonable adjustments for prisoners with disabilities.

ANNEX C

SUMMARY OF RATINGS

Standard/QI	Standard rating/QI rating
Standard 1 – Lawful and Transparent Custody	**Satisfactory**
QI 1.1	Generally acceptable
QI 1.2	Generally Acceptable
QI 1.3	Satisfactory
QI 1.4	Satisfactory
QI 1.5	Satisfactory
QI 1.6	Generally acceptable
QI 1.7	Satisfactory
QI 1.8	Good
QI 1.9	Satisfactory
Standard 2 - Decency	**Generally Acceptable**
QI 2.1	Poor
QI 2.2	Satisfactory
QI 2.3	Generally acceptable
QI 2.4	Satisfactory
QI 2.5	Generally acceptable
QI 2.6	Generally Acceptable
Standard 3 – Personal Safety	**Generally Acceptable**
QI 3.1	Poor
QI 3.2	Satisfactory
QI 3.3	Generally Acceptable
QI 3.4	Poor
QI 3.5	Poor
QI 3.6	Generally acceptable
QI 3.7	Generally acceptable
Standard 4 – Effective, Courteous and Humane Use of Authority	**Satisfactory**
QI 4.1	Generally acceptable
QI 4.2	Good
QI 4.3	Satisfactory
QI 4.4	Generally acceptable
QI 4.5	Good
QI 4.6	Good
QI 4.7	Good
QI 4.8	Satisfactory
QI 4.9	Satisfactory
QI 4.10	Good

Standard 5 – Respect, Autonomy and Protection Against Mistreatment	**Satisfactory**
QI 5.1	Satisfactory
QI 5.2	Satisfactory
QI 5.3	Satisfactory
QI 5.4	Generally acceptable
QI 5.5	Satisfactory
QI 5.6	Generally acceptable
QI 5.7	Satisfactory
QI 5.8	Satisfactory
Standard 6 – Purposeful Activity	**Generally acceptable**
QI 6.1	Poor
QI 6.2	Generally Acceptable
QI 6.3	Satisfactory
QI 6.4	Good
QI 6.5	Generally Acceptable
QI 6.6	Generally Acceptable
QI 6.7	Generally Acceptable
QI 6.8	Satisfactory
QI 6.9	Good
QI 6.10	Good
QI 6.11	Satisfactory
QI 6.12	Satisfactory
QI 6.13	Generally acceptable
QI 6.14	Generally acceptable
QI 6.15	Generally acceptable
Standard 7 – Transitions from Custody into the Community	**Generally acceptable**
QI 7.1	Generally acceptable
QI 7.2	Satisfactory
QI 7.3	Generally acceptable
QI 7.4	Generally acceptable
QI 7.5	Generally acceptable
Standard 8 – Organisational Effectiveness	**Satisfactory**
QI 8.1	Good
QI 8.2	Satisfactory
QI 8.3	Generally acceptable
QI 8.4	Generally acceptable
QI 8.5	Satisfactory
QI 8.6	Satisfactory
QI 8.7	Good
QI 8.8	Satisfactory

Standard 9 – Health and Wellbeing	Satisfactory
QI 9.1	Satisfactory
QI 9.2	Satisfactory
QI 9.3	Satisfactory
QI 9.4	Good
QI 9.5	Good
QI 9.6	Satisfactory
QI 9.7	Satisfactory
QI 9.8	Poor
QI 9.9	Good
QI 9.10	Not applicable
QI 9.11	Good
QI 9.12	Poor
QI 9.13	Satisfactory
QI 9.14	Good
QI 9.15	Satisfactory
QI 9.16	Generally acceptable
QI 9.17	Satisfactory

ANNEX D

HMP EDINBURGH – PRISON POPULATION PROFILE AS AT 27 SEPTEMBER 2019

Status	Number of prisoners	%
Untried Male Adults	169	18.4%
Untried Female Adults	25	2.7%
Untried Male Young Offenders	0	0%
Untried Female Young Offenders	0	0%
Sentenced Male Adults	601	65.5%
Sentenced Female Adults	80	8.7%
Sentenced Male Young Offenders	0	0%
Sentence Female Young Offenders	0	0%
Recalled Life Prisoners	11	1.2%
Convicted Prisoners Awaiting Sentencing	30	3.3%
Prisoners Awaiting Deportation	0	0%
Under 16s	0	0%
Civil Prisoners (Fines)	0	0%
Home Detention Curfew (HDC)	2	0.2%
Sentence	**Number of prisoners**	**%**
Untried/Remand	194	21.2%
Convicted Awaiting Sentencing	30	3.3%
0 – 1 month	7	76.3%
1 – 2 months	1	10.9%
2 – 3 months	1	0.1%
3 – 4 months	6	0.7%
4 – 5 months	10	1.1%
5 – 6 months	13	1.4%
6 months to less than 12 months	44	4.8%
1 - 2 years	96	10.5%
2 - 4 years	102	11.1%
4 years to less than 10 years	252	27.5%
10 years and over (not life)	52	0.1%
Life	109	11.9%
Order for Lifelong Restriction (OLR)	42	4.6%

Age	Number of prisoners	%
Minimum age:	21	
Under 21 years	0	0%
21 years to 29 years	184	20.2%
30 years to 39 years	327	36.0%
40 years to 49 years	199	21.9%
50 years to 59 years	111	12.2%
60 years to 69 years	54	5.9%
70 years plus	34	3.7%
Maximum age:	86	
Total number of prisoners	**915**	

ANNEX E

INSPECTION TEAM

Wendy Sinclair-Gieben, HMCIPS
Stephen Sandham, HMIPS
Paula Arnold, HMIPS
Calum McCarthy, HMIPS
Kerry Brooks, HMIPS
Kerry Love, HMIPS
Andrew Hunstone, SPS
Andrew Wilson, SPS
Ian Beach, Education Scotland
Dr John Laird, Education Scotland
Scott Anderson, Education Scotland
Ray Jones, Care Inspectorate
Helen Samborek, Healthcare Improvement Scotland
Lindsay Macphee, Healthcare Improvement Scotland
David Morrison, Healthcare Improvement Scotland
Dominic Tooley, Healthcare Improvement Scotland
Leon Wylie, Healthcare Improvement Scotland
Kirsten Horsburgh, Healthcare Improvement Scotland
Kenneth Crosbie, Healthcare Improvement Scotland
Tatora Mukushi, Scottish Human Rights Commission
Kavita Chetty, Scottish Human Rights Commission

ANNEX F

ACRONYMS USED IN THIS REPORT

ACP	Anticipatory Care Plan
ADHD	Attention Deficit Hyperactive Disorder
AMD	Archway Metal Detectors
ANP	Advance Nurse Practitioner
BBV	Blood Borne Virus
BI	Business Improvement
CCTV	Closed Circuit Television
CGL	Change, Grow, Live
CSRA	Cell Sharing Risk Assessment
DNA CPR	Do Not Attempt Cardiopulmonary Resuscitation
ECR	Electronic Control Room
E&D	Equality and Diversity
FLM	First Line Manager
FNIC	First Night in Custody
GMA	Governor's and Manager's Action
HRBP	Human Resources Business Partner
ICM	Integrated Case Management
IMU	Intelligence Management Unit
LODPP	Lost or Damage to Prisoner Property
LTC	Long-term condition
MDT	Mandatory Drug Testing
MoRS	Management of Risk from Substance
OPCAT	Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
ORT	Opiate Replacement Therapy
PCF	Prisoner Complaint Form
PER	Prisoner Escort Record
PIAC	Prisoner Information Action Committee
PRL	Prison Resource Library
PS	Psychoactive Substances
PTI	Personal Training Instructor
RMT	Risk Management Team
RRA	Reception Risk Assessment
SCQF	Scottish Credit and Qualifications Framework
SMT	Senior Management Team
SOCG	Serious Organised Crime Gangs

SOP	Standard Operating Procedure
SPSO	Scottish Public Services Ombudsman
SQA	Scottish Qualifications Authority
SRU	Separation and Reintegration Unit
SSM	Special Security Measures
SSoW	Safe Systems of Work
TSO	Throughcare Support Officer
TTM	Talk to Me – The SPS Suicide Prevention Strategy
UoF	Use of Force
VIR	Violent Incident Review
VRS	Violence Reduction Strategy

Evidence Report

HMIPS Standard 1

Lawful and transparent custody

Quality Indicators

1.1 Upon arrival all prisoners are assessed regarding their ability to understand and engage with the admission process.

Rating: Generally acceptable

HMP Edinburgh's prisoners' reception area was a relatively new purpose built building. It could be a very busy area, facilitating all prisoner movement to and from the establishment. The reception area consisted of a staff console area, prisoner toilets, holding rooms, a nurses' station and an interview room; it was noted that there were separate facilities for female prisoners. The facilities were adequate, if a little drab and in need of painting. There was some information, and or, notices on the walls of the communal areas, however, there was no information displayed in the prisoner holding rooms. In addition, there were televisions in two holding rooms, however, they were not in use during the inspection; information from staff confirmed that they are not utilised.

The reception was serviced by three First Line Managers (FLMs), 12 Officers and a Warrants Administrator; the early shift and back shift consisted of an FLM, a Warrants Administrator and three officers. A day shift officer also supporting a portion of each shift. However, it was highlighted that, at present, there were three uncovered posts within the group, which often resulted in staff from other areas providing cover or the reception running understaffed.

Staff and managers working in the reception, in addition to their core role training, which included Talk to Me (TTM), received warrants training. Information from the Training Manager confirmed that seven of the staff were currently warrant trained and all of the staff had completed TTM conversion training or TTM core training. However, it was noted that two member of staff's competency had recently expired and the training competency of a further two staff would lapse in the very near future.

Inspectors observed various movements across the inspection week, which included liberations, admissions, transfers and other non-core movements (hospital appointments etc). Staff were friendly, polite and professional. On arrival all prisoners were assessed for their ability to understand the process and there were language identification charts displayed at the point of admission. All prisoners were processed at the staff console one at a time and not in sight or sound of other prisoners. Once initially processed at the staff console, prisoners were searched before the staff completed the Reception Risk Assessment (RRA) in an interview room and, when appropriate, some were then seen by a nurse.

It was noted by inspectors that not all relevant prisoners received the healthcare component of the RRA. The RRA clearly states that all admissions, transfers and those convicted at court, or returned from court whose circumstances have changed, must complete the healthcare component of the RRA. However inspectors

observed, and were informed by the FLM and staff, that prisoners who had transferred, and or, returned convicted were routinely permitted to decline the healthcare assessment. Interrogation of the RRAs for 29.10.19, confirmed that all admissions completed the healthcare assessment. However, there were three return convicted prisoners who had not completed the healthcare assessment and four of the 11 transfers from other establishments also did not complete the healthcare assessment.

During the inspection there were no admissions of prisoners for whom English was not their first language. However, when challenged, all staff were aware of the available translation services. Furthermore, the establishment, when requested, produced a record of translation service costs since May 2019, which evidenced comprehensive use of translation services for admissions, induction, and case conferences, etc.

The admission process was, in general, efficient with the average prisoner being processed within approximately 30 minutes. Admissions were located into the assigned residential areas throughout the day without delay, with the exception of Glenesk Hall which did not receive prisoners between 16:15 and 17:15.

Recommendation: HMP Edinburgh should ensure that all eligible prisoners complete the full RRA, including the Healthcare Assessment. No eligible prisoners should be afforded the opportunity to self-decline the healthcare assessment.
Recommendation: HMP Edinburgh should staff the uncovered posts in the reception as a priority, ensuring that all staff working in this critical area are fully trained and conversant in all processes.
Recommendation: HMP Edinburgh should ensure that all reception staff are within competency for Talk to Me Training.

1.2 On admission, all prisoners are provided with information about the prison regime, routine, rules and entitlements in a form that enables the prisoner to understand.

Rating: Generally Acceptable Performance

Inspectors observed reception staff communicating courteously and professionally with prisoners. Prisoners were informed which residential area they would be located in, however, thereafter, they were afforded very little information pertaining to regime, routine and rules etc. This was compounded by the stark holding rooms which were devoid of any posters, notices, prison literature or reading materials; further compounded by the lack of televisions, and or, working televisions which could be utilised to provide prisoner information, and or, as a distraction.

Evidence pertaining to the HMP Edinburgh induction process provided that there was a nominated Reception Peer Supporter who would meet, greet and interview all admissions to provide peer support and information. During the inspection, there were no peer supporters available in the reception. When challenged, staff stated that the peer supporter was no longer willing to attend the reception. However this was contradicted by another officer who provided detailed information pertaining to

the induction process, which included the name of the Reception Peer Supporter. In addition, he stated that there appeared to be an issue between the reception staff and the peer supporter process, and that the staff did not request the Reception Peer Supporters attendance. He reiterated that the current identified Reception Peer Supporter was available to interview as per the local induction procedure.
There was a table and leaflet dispensers located near the door to the main establishment containing some induction information, which included the National Induction Programme Booklet (various languages) and the HMP Edinburgh First Night in Custody Booklet. Inspectors observed admissions and transfers being located in the holding rooms and then escorted to the main establishment without being offered any of the aforementioned information. When challenged, the staff explained that the information on the table was normally issued by the Peer Supporter and that they did not issue it.

It was noted by inspectors that HMP Edinburgh did not have a specific First Night in Custody facility. It was explained by staff that, until recently, all untried admissions were located in Glenesk Hall level 2. However, due to operational issues, remand admissions were now located throughout Glenesk Hall and convicted prisoners were located wherever there was space, taking cognisance of their classification.

Once located in the assigned residential area, all prisoners completed a Core Screen Assessment with staff, usually within 72 hours, and an Inductee Admission Checklist with the nominated Peer Supporter for that area normally with 24 hours of admission/transfer. However records showed some core screen assessments were not completed within 72 hours.

Recommendation: HMP Edinburgh should consider reintroducing untried and convicted First Night in Custody Units.
Recommendation: HMP Edinburgh should ensure that the local peer mentor process for Reception is adhered to, with the peer mentor being available to interview all admission, transfers and any other prisoners on request.
Recommendation: HMP Edinburgh should ensure that all holding rooms are equipped with relevant local and national information. In addition, they should consider providing reading material and working televisions.

1.3 Statutory procedures for identification and registration of prisoners are fully complied with.

Rating: Satisfactory Performance

HMP Edinburgh had a robust Standard Operating Procedure (SOP) for admitting prisoners, checking warrants and processing all information onto PR2; supported by a dedicated trained Warrants Administrator.

Only reception staff who were warrant trained processed prisoners, ensuring the validity of the warrant, and that all relevant information within the warrant was identified and communicated to the prisoner.

Inspectors observed numerous admission/transfers and noted that staff facilitated the seven point warrant check before systematically inputting the pertinent information onto PR2.

All warrants were passed to the Criminal Desk the following day to be confirmed, see QI 1.7.

1.4 All prisoners are classified and this is recorded on the prisoner's electronic record.

Rating: Satisfactory Performance

Inspectors observed the admission process/interviews of numerous prisoners, and were satisfied that all pertinent information relating to the classification of the individual prisoners was collected and annotated on PR2.

All prisoners were processed individually, out of sight and sound of other prisoners. It was noted that the interviews observed by inspectors were facilitated in an interview room. However, numerous staff stated that this was not common practice and that prisoner interviews usually took place at the staff console area. This was supported by the fact that that the interview room did not have a PR2 terminal.

The interviews observed were courteous, and staff encouraged prisoners to divulge as much information as possible to allow for informed and defensible decision making. Prisoners' property was listed, recorded and signed for. The prisoners' height was recorded and photograph taken; all information was annotated on PR2.

NHS interviews were facilitated in the nurses station (private office), with all relevant healthcare information being captured and recorded out of sight and sound of prisoners and staff.

1.5 All prisoners are allocated to a prison or to a location within a prison dependent on their classification, gender, vulnerability, security risk or personal medical condition.

Rating: Satisfactory Performance

HMP Edinburgh had a range of residential accommodation areas that were designated for specific prisoner groups, and there were other small bespoke populations contained within each area.

On admission, prisoners were asked a range of questions pertaining to classification, gender identification, vulnerability, medical conditions, etc. Additional information was gathered from the escorting staff, PERs, court paperwork etc. Cognisance of all the aforementioned was considered before allocating the prisoner to a residential area. However reception staff and residential staff indicated that there were sometimes issues, due to high numbers, locating prisoners in the correct residential areas. In particular they sometimes had to locate returned convicted offence and non-offence protection prisoners in Glenesk Hall until spaces were available in the appropriate areas.

The reception area had separate facilities and holding areas for females. In addition, there were separate holding areas for vulnerable prisoners who had requested, and or, been allocated protection status. Inspectors observed all prisoners being managed professionally and respectfully throughout the process.

Although not observed by inspectors, there was evidence that HMP Edinburgh, after working through the national policy, were locating transgender prisoners within the residential area that held the population they identified with. Furthermore, there was evidence that prisoners with mobility issues were being located in appropriate areas and cells.

1.6 A cell sharing risk assessment is carried out prior to a prisoner's allocation to cellular accommodation.

Rating: Generally Acceptable

HMP Edinburgh's SOP for Cell Sharing Risk Assessments (CSRA) was a robust and fit-for-purpose document which clearly identified the purpose of a CSRA and the role of the staff completing it. All staff spoken with directly about CSRA demonstrated good knowledge of the process and PR2 recording. It was also noted that the SOP contained step-by-step guidance for staff less familiar with the process.

Inspectors followed a number of admission prisoners through their admission journey, which included the handover from reception staff to residential staff. Inspectors observed the CSRAs being facilitated for two admissions in different locations. Both prisoners were present during the CSRA and subsequently located in double occupancy cells, which met the outcome of the CSRA.

A random sampling of 10 prisoners located within HMP Edinburgh, across all residential areas, provided that there were robust CSRAs completed for each appropriate double occupancy cell. It was noted, however, that there was evidence that not all prisoner's vaping preference had been met. On the occasions that it had not been met, it was annotated that they had been listed to be relocated to an appropriate cell which met their vaping preference.

Recommendation: HMP Edinburgh should endeavour to ensure that all prisoners' vaping preferences are met during the CSRA. Furthermore, on the occasions that vaping preferences are not met, there should be a process for monitoring and reviewing, with a view to meeting their preference as expediently as possible.

1.7 Release and conditional release eligibility dates are calculated correctly and communicated to the prisoner without delay.

Rating: Satisfactory Performance

All warrants were initially checked and processed, and a manual sentence calculation sheet was generated in the reception area by the Warrants Administrator or trained reception staff in the Administrators absence.

Inspectors observed numerous warrants being processed in the reception area and witnessed the prisoners being given the initial critical date information. In addition, inspectors observed the Court Desk staff procedure for the secondary assurance check (confirmation of warrant). The Court Desk staff received all reception movement details from the previous day along with all warrants. Each warrant was checked and confirmed as per warrant confirmation policy. The information was then stored in the prisoners warrant file and a separate Prisoner Critical Dates Form was generated and delivered to the prisoner.

Having observed three prisoners being admitted the previous day with new warrants, inspectors interviewed the prisoners and established that they all received their aforementioned Prisoner Critical Date Forms.

It was also confirmed by the Court Desk that there were no Critical Date Forms for untried prisoners. Untried prisoners wishing to establish their warrant or court dates had to request the information from the residential staff.

Good Practice: **HMP Edinburgh's process for verifying warrants and critical dates, and the subsequent Critical Dates Confirmation sheet issued to prisoners was identified as good practice.**

1.8 All prisoners attend an induction session as soon as practicable, but no later than one week after arrival, which provides a thorough explanation of how the prison operates and what the prisoners can expect, including their rights and obligations.

Rating: Good Performance

With HMP Edinburgh being a national facility which accommodates a diverse population, there were many discrete populations which required individual induction sessions. The induction process was managed by an enthusiastic, knowledgeable and passionate officer who had designed and co-delivered the induction process with the assistance of a team of motivated peer mentors, recruited and trained to deliver peer support and co-present elements of the induction presentations. All relevant prisoner information was available in eight languages and translation services were utilised for all prisoners for whom English was not their first language.

Core Screen: All prisoners completed a Core Screen document with staff as soon as practicably possible after admission, normally within 72 hours. They were completed with staff from their residential area and forwarded to the Core Screen Administrator who ensured that all identified referrals and interventions were annotated on PR2. Evidence from the Core Screen Administrator provided that, at the time of interview, there were 49 outstanding Core Screens dating from 09.08.19, however, there was a process for managing the outstanding Core Screens.

Inductee Admission Checklist: All prisoners completed an Inductee Admission checklist as soon a practicably possible after admission; usually within 24 hours. This was managed by the nominated peer supporter in each residential area, who were informed by the staff of all new admissions. The checklist was a robust and comprehensive document which covered all aspects of regime, routines and rules;

basically everything a prisoner needed to know on admission. The completed checklists were forwarded to the induction centre. All peer mentors retained a stock of the FNIC Information Booklets and ensured that all prisoners received a copy.

Induction: All male convicted prisoners admitted that met the criteria were invited to induction. The criteria included but was not exclusive to: prisoners serving over 31 days, not a recall, transfer convicted or had previously completed the induction within six months. Induction was not mandatory, therefore, prisoners were not compelled to attend. All prisoners refusing to attend signed a disclaimer which was returned to the Induction Unit.

The Induction Unit was a stand-alone purpose-built unit within the regimes area. The Induction consists of a number of wide-ranging sessions which were co-delivered by staff and peer supporters. The sessions were usually over four mornings (Mon-Thu), with bespoke sessions for protection prisoners and other prisoners unable to attend, with mainstream facilitated out-with these times.

Induction Statistics: Investigation of the data for September and October 2019, provided that there were 118 prisoners eligible for induction: admission convicted, return convicted or transferred in. Invariably, this number would have been reduced by the establishments' criteria for induction: 30+ days, previous induction within six months, concurrent sentences etc.

Information from the Induction Officer provided that there was no National Induction Programme offered to male prisoners during September and October 2019 due to an operational issue.

Offence and Non-Offence Protections: Bespoke sessions for protection prisoners and other prisoners unable to attend with mainstream prisoners were facilitated in the afternoons. The frequency of these sessions were dependent on the number of admissions, and/or, transfers within this population.

Remand: Remand prisoners received a Core Screen Assessment and the Inductee Admission Checklist facilitated by residential staff and peer supporters respectively. The untried induction programme was normally facilitated by staff from the Hub, however, information provided that due to staffing shortages this was not currently being facilitated.

Females: Female prisoners received a Core Screen Assessment and the Inductee Admission Checklist facilitated by residential staff and peer supporters respectively. The female induction programme was delivered by Ratho Hall staff (usually activity staff). Furthermore, the Induction Unit were currently developing a female specific FNIC Booklet.

Recommendation: HMP Edinburgh should ensure that all eligible prisoners receive, or are offered, the National Induction Programme as soon possible after admission, despite any operational issues.
Recommendation: HMP Edinburgh should ensure that all prisoners receive a Core Screens with 72 hours of admission, as per ICM Practice Guidance Manual 2007.

Good Practice: **HMP Edinburgh's induction program and associated peer supporters, when fully operational, should be recognised as good practice. In particular, the FNIC Booklet, Inductee Admission Checklist and co-delivery of session by staff and peer supporters**.

1.9 The procedures for the release of prisoners are implemented effectively with provision for assistance and basic practical arrangements in place.

Rating: Satisfactory Performance

The Court Desk facilitated a final check of the critical dates for prisoners approaching their liberation dates, and ensured there were no outstanding warrants. Once completed, a copy of the liberation scroll for the following day's liberations was generated and issued to the Reception Manager. Reception staff then confirmed the liberations with each residential area and prepared the prisoners property for liberation the next day.

Inspectors requested, and were provided with, a copy of the liberations for the week of the inspection. They identified two liberations on Friday 01.11.19, and arranged to observe the liberation process for both.

The two liberations, one male and one female, were brought separately to the reception, after those attending court had departed; approximately 09:15. Both liberations were processed quickly, courteously and professionally by the reception staff, which included jointly inspecting and signing for their personal property as per the SOP. Moreover, both liberations were provided with non-descript green duffel bags for their property and escorted out the establishments main entrance, via the Agents Visit Area. At the last secure door, final checks were completed by the Gate/Visits FLM, before both liberations exited the secure door and were directed to the cash office to collect their liberation grants.

Female liberation: It was observed that the female liberation was provided with a Naxalone kit and had received a clothing donation from the chaplaincy team, which was very gratefully received. In addition, investigation of PR2 records provided that she had completed a 12 month sentence and had 16 appointments, and/or interventions pertaining to resettlement and social care annotated on her Community Integration Plan. During a brief interview with inspectors, the female stated that she had received help and support prior to liberation and that she was being met at the gate by her Community-based Social Worker and Shine Mentor based in the Establishment.

Male liberation: It was observed that the male liberation had completed a five months sentence and had accessed two social care and no resettlement appointments, and or, interventions during his sentence. He declined to participate in an interview but did confirm he was a being met by a family member at the gate.

HMIPS Standard 2

Decency

Quality Indicators

2.1 The prison buildings, accommodation and facilities are fit-for-purpose and maintained to an appropriate standard.

Rating: Poor

Although the overall rating for this quality indicator is poor, it should be acknowledged that inspectors saw some good examples in relation to the accommodation and facilities, for example the corridor approaching Ratho Hall and their safer cell. The Hub and Health Centre were also deemed to be of a high quality. However other areas of the establishment, in particular Glenesk Hall, were found to be poor.

In Glenesk Hall, inspectors observed people in cells with makeshift curtains, very few in-cell safes in working order and graffiti in both occupied and unoccupied cells. Decoration was poor and some empty cells, that could be required at any time, were not clean.

In Ingliston Hall, a person was occupying a cell that had not been fully repaired following it being damaged. Staff and prisoners spoken with reported that this situation had been ongoing for about five weeks. Inspectors also saw a single cell that was waiting to be repaired whilst other prisoners were sharing. Inspectors were informed that the cell had been out of commission for approximately three months.

The safer cells in Ingliston Hall were poor, they were bleak with graffiti on the walls and did not appear to inspectors to be particularly clean.

In some places there was evidence of an infestation of vermin. Inspectors saw action being taken to address it, but staff and prisoners advised this was an ongoing issue.

Double cells were of a reasonable size and there was no evidence of two people sharing a single cell. Inspectors observed inappropriate posters in the majority of cells seen in the male halls.

CSRAs were completed and fundamental reasons for keeping prisoners separate were always taken account of. However, inspectors were told of instances where one person that vaped and another did not may share a cell initially due to the high population.

Feedback about building maintenance was mixed. Inspectors witnessed fast and efficient responses to emergency situations, such as a burst pipe in Ingliston Hall and loss of hot water in Glenesk Hall, but also heard about what were described as long waits for other maintenance requirements.

Recommendation: HMP Edinburgh should take action to improve the building conditions in Glenesk Hall.
Recommendation: HMP Edinburgh should review posters on display in cells in male halls.
Recommendation: **The SPS should review Governors and Managers Advice Notice 28A/09 - SPS Posters, Pictures and Photographs in Cells Protocol and consider whether it needs updating.**

2.2 Good levels of cleanliness and hygiene are observed throughout the prison and procedures for the prevention and control of infection are followed. Cleaning materials and adequate time are available to all prisoners to maintain their personal living area to a clean and hygienic standard.

Rating: Satisfactory

Prisoners spoken to across the establishment said they were able to access materials to clean their cells when required.

Pass workers throughout the prison told inspectors they received training to do their jobs, which included infection control. Inspectors saw notices throughout the establishment informing people of which mops to use in each area, and there was a colour coding system in operation. One pass worker employed in a pantry area told inspectors they had not received training, but it had been established prior to them starting that they had relevant qualifications from previous employment.

All pantry areas observed were clean and those serving food wore blue gloves whilst doing so. Some of the hand sanitizers were empty in the pantry areas.

Shower areas were clean, but there did appear to be an issue with effective drainage in some halls.

Some halls were cleaner that others but all were of an acceptable standard.

2.3 All prisoners have a bed, mattress and pillow which are in good condition, as well as sufficient bedding issued by the prison or supplied by the prisoner. The bedding is also in good condition, clean and laundered frequently.

Rating: Generally Acceptable

Some prisoners told inspectors that the quality of the items was poor and inspectors saw a mixed picture in terms of quality, with some items being in better condition than others. Prisoners spoken to were unclear about how to request replacement mattresses.

There were reasonable opportunities for bedding to be laundered and changed throughout the establishment, but shortages of duvets and towels were reported to inspectors. Inspectors observed that there were low stocks of duvets on each hall and some were of a poor quality.

The laundry manager decided if bedding had become of an unacceptable quality to be returned to the halls, and recycled as much as possible. For example, duvet covers that were generally in good condition but damaged in places were converted to pillowcases by the housekeeping work party, and old towels were used as rags in the pantries. Inspectors deemed this to be a good innovation.

Recommendation: HMP Edinburgh should review the availability and quality of duvets available and ensure prisoners are aware of the process to request a replacement mattress.

2.4 A range of toiletries and personal hygiene materials are available to all prisoners to allow them to maintain their sense of personal identity and self-respect. All prisoners also have access to washing and toileting facilities that are either freely available to them or readily available on request.

Rating: Satisfactory

On all Halls inspectors observed that toiletries were readily available and prisoners had access to washing and toileting facilities. Female prisoners also had free access to sanitary products.

All prisoners without in-cell showers spoken to by inspectors reported that they had daily access to a shower.

2.5 All prisoners have supplied to them or are able to obtain for themselves a range of clothing suitable for the activities they undertake. The clothes available to them are in good condition and allow them to maintain a sense of personal identity and self-respect. Clothing can be regularly laundered.

Rating: Generally Acceptable

Clothing was available in all of the halls and there was a process in place to ensure it was regularly laundered.

The size range and condition of clothing available was an issue. Some of the clothing seen was in poor condition and on most male halls it was only larger sizes that were available. Several male prisoners told inspectors they often found it difficult to get clothes that fitted them properly, which made them feel uncomfortable at times, especially when going to visits. The exception was Ratho Hall, were inspectors saw a better range of sizes. Some women informed inspectors that they would like the option of wearing a skirt or a dress. When discussed with management they advised that this had never been raised with them. This is something that should be discussed to help women maintain a sense of personal identify. HMIPS are aware that skirts and dresses are not currently provided in any female accommodation in the SPS.

The laundry appeared to be well run, with good processes and thorough record keeping. Prisoners could have their clothing laundered on a daily basis. There was an effective tracking process within the laundry to prevent items going missing. Of

the 70,000 laundry bags that passed through last year only 31 complaints had been made with regard to missing items.

There was a standalone washing machine in the reception area to accommodate people with specific needs e.g. milder detergent due to skin conditions.

The staff and work party had chosen to work additional hours to meet the rising demand of the prison population. During the inspection, there was one washing machine out of commission and the laundry had been closed for two hours on two separate days to relocate the staff to residential areas to cover absences.

The main laundry was staffed by male protection prisoners who were, at the time of inspection, dealing with the majority of the women's laundry due to staff absence in the area where it would normally be done. Inspectors felt a better contingency should be in place.

An area of good practice in the laundry was the On Premises Laundry qualification prisoners could complete, as part of British Institute of Cleaning Science, which links to full-time employment in Professional Washing Services. Inspectors were pleased to hear that discussions were underway to try and offer this opportunity to women.

Recommendation: HMP Edinburgh should review the clothing available to the male population to ensure there are a range of sizes available and that items are of a good quality.
Recommendation: HMP Edinburgh should discuss with female prisoners in Ratho Hall the option of being able to wear skirts or dresses in residential areas, to allow them to maintain a sense of personal identity.
Recommendation: The contingency plans for the women's laundry should be reviewed to allow women to undertake their own laundry.

Good practice: The On Premises Laundry qualification prisoners can complete as part of British Institute of Cleaning Science which links to full-time employment in Professional Washing Services.

2.6 The meals served to prisoners are nutritionally sufficient, well balanced, varied, served at the appropriate temperature and well presented. Meals also conform to their dietary needs, cultural or religious norms.

Rating: Generally Acceptable

Food was an issue raised consistently with inspectors, during focus groups prior to the inspection and during the inspection, and across all populations.

The food that was provided to prisoners followed the Athena principles and the nutritional content was highlighted on the menus. The food budget was aligned to the number of prisoners and therefore had been increased to accommodate the rising population.

The menus were prepared on a three-weekly cycle and although there was a reasonable choice, prisoners said it could become very repetitive. Hall pass workers

held the menus and took orders the day before which were then submitted to the kitchen.

There was evidence to support the provision of a range of dietary requirements, including cultural and for medical purposes, but again there were reports of menus being repetitive and basic. Female prisoners reported that they found the food very carbohydrate heavy. There was evidence of regular food PIACs and inspectors were told changes to the menus were currently being considered. Independent Prison Monitors will follow up on this.

Food was transported from the kitchen to the halls using heated trolleys and prisoners reported it had often degraded by the time it reached them. Inspectors observed the food service on the halls. The food looked to be of a reasonable quality and did not sit in food trolleys for long periods of time. Inspectors saw there were systems in place to ensure prisoners received the food they had chosen and that different dietary requirements were catered for.

There was a mixed picture with regard to testing the temperature of food before serving. Some halls had clear and up to date records whilst others were without working temperature probes.

On some halls, meals were delivered to the cells of those who were less mobile and inspectors saw evidence of social dining. The exception to this was non-offence protection prisoners who were allowed out of their cells to collect their food but then locked up again to eat. Inspectors witnessed staff dealing well with prisoners at meal times who had what appeared to be mental health and behavioural issues.

HMIPS Standard 3

Personal Safety

Quality Indicators

3.1 The prison implements thorough and compassionate practices to identify and care for those at risk of suicide or self-harm.

Rating: Poor Performance

Staff and prisoners within HMP Edinburgh evidenced an understanding of the SPS TTM Strategy and inspectors checked the case files of those who were currently or recently subject to it. Whilst in most cases the paperwork was completed appropriately, there was no evidence of any audit or assurance process undertaken by an FLM or Unit Manager. A process was recently introduced which included a "Drop Box" in each area for TTM paperwork, and inspectors observed paperwork from seven days previous that had not been assured. Each area had TTM Champions who were responsible for the primary assurance process. Whilst a staff TTM Champion in each area is seen as a positive arrangement it needs more time to be fully embedded.

There was evidence that a Unit Manager attended the case conference of those located within a safer cell. There was little evidence of any items being permitted in use whilst located in this type of cell.

There were nine safer cells in various locations within HMP Edinburgh. Each location had a different style and standard and all were noted to be dull and of poor decorative quality. The safer cells in Ingliston Hall had electrical and TV sockets but inspectors were informed they were never used, and there was no evidence in historic records that these were considered in care plans. The safer cells in Hermiston Hall were of a better standard and cleanliness but neither had a toilet privacy screen, which should be addressed as a matter of urgency.

The admission process was observed and although individuals were being assessed for their risk of suicide or self-harm, as reported in Standard 1, inspectors observed that those returning from court with a change of circumstance or transfers from other establishments were not routinely assessed by a member of the health care profession. This was concerning as it did not allow a full assessment of risk upon return or admission to HMP Edinburgh.

Individuals who were recently subject to the TTM Strategy were spoken to. All indicated that they were aware of what had been discussed and communicated by SPS and NHS staff at each case conference, and felt that they had appropriate opportunity to be involved in the case conference and outcomes.

Inspectors were pleased to note that the Suicide Prevention Group had recently been re-established after an absence of around 16 months, and was chaired by the Deputy Governor. There was attendance externally by the Samaritans and there were currently nine Listeners trained to support those who required immediate

support. There was also plans in place to recruit and train further Listeners and ensure access to all areas, which has been identified as an issue and is to be addressed.

There were only two TTM trainers in the establishment and there had been a recent push on delivering TTM refresher training. During the inspection, those trained exceeded 260 staff, which was around 60% in competency with further training planned.

Recommendation: HMP Edinburgh should implement an audit and assurance process for TTM documentation.
Recommendation: HMP Edinburgh should ensure that the safer cells in Hermiston Hall are not used until a toilet privacy screen is fitted.
Recommendations: All admissions, transfers and returns from court with a change of circumstance should be seen by a NHS nurse during the reception risk assessment process.
Recommendation: HMP Edinburgh should recruit and train more TTM trainers to meet the demand.

3.2 The prison takes particular care of prisoners whose appearance, behaviour, background or circumstances leave them at a heightened risk of harm or abuse from others.

Rating: Satisfactory Performance

HMP Edinburgh had a diverse range of individuals in custody, including those who may be at risk and would require additional support. These included individuals with disabilities and significant health concerns, and within Hermiston Hall they also cared for two transgender individuals. Although not observed during the inspection, inspectors were satisfied during discussion that the reception staff were confident in their ability to take the appropriate action for those who presented with a protected characteristic upon admission.

Inspectors observed the Healthcare meeting, which was well-established and attended by a range of partners including NHS, Social Work, Chaplaincy and operational representatives from all areas within the prison, including an FLM and officer who worked within Hermiston. The establishment was also supported by Marie Curie and MacMillan Nurses who provided specific advice for those with palliative care needs. The meeting provided good evidence of collaborative working and supporting the needs of those with mental health, palliative and social care needs. The enthusiasm of the FLM and officer in attendance was pleasing, as they both displayed compassion and a willingness to care for those in need. Through partnership working with Marie Curie and MacMillan Nurses an Anticipatory Care Plan (ACP) was produced and allowed the individual to be supported to control and manage changes to their health and wellbeing.

There was evidence of a strong partnership with the Scottish Transgender Alliance, who attended individual case conferences for both the transgender prisoners in custody and those previously in custody. The minutes of the case conferences indicated clear support for individuals and staff involved in their care.

HMP Edinburgh contracts social care services into the establishment for a number of individuals mainly located in Hermiston Hall. Inspectors viewed cells and locations and noted that some cells had been satisfactorily adapted to meet the needs of the individual. Prisoners and staff spoken to also stated that they were content with the service provided by the social care services.

Good Practice: The introduction of the ACP which was produced in partnership with Marie Curie, MacMillan, NHS, an officer and a prisoner is a good example of engagement and understanding the needs of individuals.

Good Practice: The case conference approach and partnership with Scottish Transgender Alliance is a positive example of an individualised approach.

3.3 Potential risk factors are analysed, understood and acted upon to minimise situations that are known to increase the risk of subversive, aggressive or violent behaviour. Additionally, staff are proactive in lowering such risks through their behaviours, attitudes and actions.

Rating: Generally Acceptable Performance

HMP Edinburgh has a well-established Intelligence Management Unit (IMU), which evidenced that it was capable of collecting, collating and analysing intelligence received. They were supported by a Police Liaison Officer and had direct contact with Police Scotland Campus in Gartcosh. Inspectors heard how this partnership was crucial in the management of the various members of Serious Organised Crime Groups (SOCG). At the time of the inspection there were 527 Must Be Separate prisoners in custody and 103 Enemies, and the IMU provided information to Unit Managers and FLMs to manage within each of the areas of the four halls and Separation and Reintegration Unit (SRU) with reasonable effect and safely.

HMP Edinburgh implemented a Violence Reduction Strategy (VRS) in April 2019 and the Strategy was designed to reduce the level of violent instances within the establishment. Inspectors observed through analysis of data that since the introduction of the VRS, the average monthly violent incidents had reduced from 22 to 19. When comparing year on year data, there had been a significant reduction violence against staff and prisoner on prisoner. Whilst this was a positive step, it was noted by inspectors that only a few staff and FLMs could make reference to the VRS and its principles. Included in the VRS was the requirement of the FLM to conduct a Violent Incident Review (VIR) to identify good practice and lessons learned however, due to the impending introduction of a revised national Violent Incident Review Process this part of the policy was suspended.

The Head of Operations ensured the flow of information between the IMU and the Senior Management Team to identify risks and threats to prisoner and staff safety via a monthly Tactical Tasking and Co-ordination Group. Inspectors heard that due to the high numbers of SOCGs within HMP Edinburgh, Personal Communication Devices and drug introduction were assessed as the main threats to the establishment.

Of the staff and prisoners inspectors spoke to, there was a concern raised regarding the amount of violence and the use of Psychoactive Substances (PS) within the establishment. Staff reported that the use of PS was ‘out of control’ and there was a

view that they could do very little to tackle this issue. A spot check identified 29 prisoners held on Rule 95 conditions on one particular day, of which 17 were located in mainstream halls due to being involved in a violent incident or managed under the Management of Risk from Substance (MoRS) policy. During the inspection, a member of staff was observed to be escorted to hospital due to the potential effects of secondary PS inhalation.

Inspectors also attended a Risk Management Team (RMT) meeting and observed a well-structured meeting that assessed the risks of individuals with particular risks and implemented an appropriate action plan and support. An exceptional RMT was also held on a separate day for an individual who was identified from the Healthcare meeting as potentially being a risk to others. The speed in which this was identified and addressed was effective in reducing the risk of violence.

Recommendation: HMP Edinburgh should raise awareness of the VRS, with FLMs being trained in their role and responsibilities for the completion of the VIR.
Recommendation: The SPS should implement robust strategies and equipment to minimise the risk of illicit articles, including PS, being introduced to establishments.

3.4 Any allegation or incident of bullying, intimidation or harassment is taken seriously and investigated. Any person found to be responsible for an incident of bullying, intimidation or harassment is appropriately reprimanded and supported in changing their behaviour.

Rating: Poor Performance

All SPS establishments were required to have completed the SPS Anti-bullying Strategy - Think Twice training for all staff by 31 March 2019. However, inspectors noted that HMP Edinburgh had not achieved this and had only recently commenced training alongside the TTM training sessions. Inspectors had sight of the Think Twice presentation to staff and were satisfied it effectively provided the learning outcomes and raised awareness for the prevention of bullying and harassment and subsequent supportive actions. That said, during discussions with staff and the IMU, there was little awareness or evidence of any of the Think Twice paperwork being initiated despite recent bullying instances being recorded.

Recording of bullying and harassment was largely dependent on self-reporting by prisoners, and it was evident that staff preferred to report such instances through the intelligence reporting model. By using this, there was no support offered to the victims of bullying or harassment. Staff within the halls reported that they would usually move the perpetrator of bullying, however understood that this would place greater threat or identification to the victim.

Communicating the Think Twice Strategy to prisoners was the responsibility of the induction team however, due to staff shortages the induction had been infrequent and irregular and therefore not all prisoners were aware of the Strategy. The induction admission checklist used by the peer support mentors was very good but did not mention the Think Twice Strategy or what help was available. The peer

support mentors that were spoken to did not know about the Strategy or its principles.

Despite this there was adequate notices and posters in most accommodation areas raising awareness of anti-bullying and violence.

Recommendation: HMP Edinburgh should fully implement the Think Twice Strategy, including the referral process to support victims. This should also include awareness of the Strategy being provided to prisoners.
Recommendation: Peer mentors should have training on the SPS Anti-bullying Strategy - Think Twice and the Induction checklist should be updated to allow this information to be passed to new admissions.

3.5 The victims of bullying or harassment are offered support and assistance.

Rating: Poor Performance

As noted in QI 3.4, the Think Twice Strategy had only recently been rolled out to the staff within HMP Edinburgh, and as such there had not been any use of the national paperwork to identify support to victims of bullying and harassment or dealing with bullying behaviours. Current actions were taken internally, with FLMs and staff preferring to relocate the perpetrator of bullying as opposed to any strategic assessment or intervention.

Despite training being ongoing for a number of weeks, during the inspection there was no recorded evidence of the Think Twice Strategy approach or forms being used or completed. This negates the approach to support the victim and as such the principles of the Think Twice Strategy should be implemented more broadly and robustly than they are at present. (See Recommendation in QI 3.4).

The VRS document had a small section on bullying and referred to the Think Twice Strategy and how this would be embedded into the HMP Edinburgh VRS. However, it did not indicate how this would be done or recorded. Currently, the IMU assessed and recorded information received through intelligence reporting in relation to bullying or harassment, but this is mainly focussed on the perpetrator and not the victim. Neither the IMU nor any other function held a register of victims of bullying or perpetrators of bullying.

Recommendation: The VRS should identify clear lines of responsibility to include the referral and recording of bullying incidents.
Recommendation: A clear process should be established to collate and record the Think Twice Strategy paperwork and actions.

3.6 Systems are in place throughout the prison to ensure that a proportionate and rapid response can be made to any emergency threat to safety or life. This includes emergency means of communication and alarms, which are regularly tested, and a set of plans for managing emergencies and unpredictable events. Staff are adequately trained in the roles they must adopt according to these plans and protocols.

Rating: Generally Acceptable Performance

The Head of Operations was responsible for the management of the local policies and guidelines aimed at ensuring the prison operated safely. Contingency Plans were available both electronically and in hard copy and were located appropriately, and senior managers were aware of where to access them. The prison had both a radio and alarm pager system, and records indicated that these were tested regularly by the operations FLMs. Testing of the alarm system was also evident on a weekly basis.

There was an SOP for staff alarm response which was due for renewal in November 2019. This SOP was well written and clearly identified a phased response to alarms for weekdays, evenings and weekends. However, in discussion with staff and senior managers it was clear that this protocol was not adhered to and it was the norm that all available staff to respond to all alarms. Concerns were raised that in some incidences staff would respond without due regard to the supervision of their prisoners, without securing their areas and therefore increasing risk to themselves, other staff and prisoners.

Training records observed recorded that those in competency for Control and Restraint Phase 1 and the Supervising Officer was 91.2% which is lower than the required SPS standard of 95%.

Recommendation: HMP Edinburgh should ensure that the Response to Alarms SOP is adhered to, to ensure all areas of personal safety are maintained.
Recommendation: HMP Edinburgh should make training in Control and Restraints and Supervising Officer training a priority to ensure all staff are deemed competent to undertake their role to respond to incidents.

3.7 The requirements of Health and Safety legislation are observed throughout the prison.

Rating: Generally Acceptable Performance

At the time of the inspection, the establishment were in the process of recruiting a Health and Safety Co-ordinator, as the previous coordinator had resigned three months previously. In the interim period, support was being provided remotely and on a weekly basis by a Fire and Health and Safety officer from SPS Headquarters.

The establishment had a clear Health and Safety policy and structure and minutes of previous meetings were observed to be effective, with a clear action plan. The Governor chaired these meetings and attendance from all areas of the establishment

was evident. The Governor and senior managers also conducted regular inspections and reported to the coordinator.

All areas had either electronic or hard copies of Risk Assessments and Safe Systems of Work (SSoW) however, all were out of date by at least six months and up to 18 months. Despite this, they all appeared to be clearly written and were relevant to the area and function.

Training records indicated only a small percentage of staff were trained in all core to role Health and Safety and Fire related training for operational staff and senior managers.

Recommendation: All RAs and SSoW should be reviewed immediately.
Recommendation: Staff should be trained in Health and Safety and Fire Response to meet the required competency level for HMP Edinburgh.

HMIPS Standard 4

Effective, Courteous and Humane Exercise of Authority

Quality Indicators

4.1 Force or physical restraints are only used when necessary and strictly in accordance with the law.

Rating: Generally Acceptable Performance

The Use of Force (UoF) was observed during this inspection through the use of live Closed Circuit Television (CCTV) when an incident occurred within the exercise area. The incident observed was managed responsibly. An SOP was in place for responding to incidents which clearly detailed the immediate response areas for the primary response team. A number of UoF incidents were reviewed by inspectors which were recorded on CCTV. Two UoF incidents, that were planned removals, were also reviewed by the inspection team that had been video recorded.

A process was in place for recording all incidents of UoF forms, and this process was known within the prison. Forms were reviewed by the inspection team, with each section being completed accurately. This process was acknowledged by the Audit and Assurance Prison Resource Library (PRL) audit in February 2019, and was in place at the time of the inspection. Staff were able to explain the process and procedures for managing incidents that required UoF. The UoF paperwork was accurately completed and forwarded onto the IMU for review and retention purposes.

Of the 260 incidents of UoF since January 2019, 17 were planned removals as per the definition and should have been recorded. Only eight had been recorded and the footage of only two had been retained. There was an SOP in place for planned removals, which supported the Governors and Managers: Action 23/A, outlining guidance for the use of recording equipment during all planned removals. It was noted in the PRL audit in February 2019 that planned removals were not being video recorded. The Head of Operations assured inspectors that planned removals would be video recorded in future, with a governance and audit process put in place to review this. Since the inspection, reminders have been issued to managers requesting that the correct process, as per SPS policy, must be used for planned removals.

SPS Immediate Incident Reports had been completed for incidents within the prison, however, they were not all investigated within a 72 hour period, as per SPS policy.

The National Incident Report forms were in use. The local Reporting of Violent Incidents/Post Incident reports had been introduced locally and were then paused pending the introduction of new national Post Incident Violence Forms.

The levels of violence were monitored by the Head of Operations, and the incidents of violence had on average reduced in 2019. By comparison to this stage last year, all levels of violence had reduced within the prison, this is to be commended.

Recommendation: HMP Edinburgh should ensure that all planned removals are video recorded in line with SPS policy.
Recommendation: HMP Edinburgh should ensure that incidences of UoF are reviewed by the senior management team, and make certain that the governance process is in place for reviewing incidents.
Recommendation: the SPS should actively consider the introduction of body worn cameras for unexpected violent incidents

4.2 Powers to confine prisoners to their cell, to segregate them or limit their opportunities to associate with others are exercised appropriately, and their management is effected, with humanity and in accordance with the law. The focus is on reintegration as well as the continuing need for access to regime and social contact.

Rating: Good Performance

The SRU was a well-managed area of the prison, with supportive interaction by staff with prisoners. This engagement was accurately recorded within prisoners integrated case management notes on PR2. Management plans were available for each prisoner located within the SRU at the time of the inspection. On a daily basis staff met to discuss prisoners case management and ensured that accurate records were kept. This process was observed by inspectors as an area of good practice.

At the time of inspection, there were 14 prisoners located within the SRU. One prisoner was held under Rule 41 conditions. A copy of the hall regime was made available to the inspection team and there was evidence that a Duty Manager had visited each prisoner daily within the SRU and signed for this visit.

The staff, FLM and unit manager within the SRU were new to the area. However, they were all aware of their priorities and able to explain an agreed plan of action. Staff and management within the SRU were aware of policies and procedures for managing prisoners within the SRU and displayed competent knowledge of the rules. Relevant SOPs were made available to inspectors.

Rule 95 paperwork was reviewed by the inspection team and deemed to be correct. A rule 95(11) case conference was observed and was managed in a manner that was appropriate to the situation. The unit manager listened to the prisoners representations prior to making a decision. The case conference was held with the minimum of multi-disciplinary staff present and in accordance with policy.

All prisoners held under rule 95 conditions within the SRU were asked by the inspection team if they were aware of why they were on Rule 95 and located within the SRU. All of the prisoners, with the exception of one, understood this. A daily handover was in place, which recorded the regime for each prisoner held within the SRU and compliance with paperwork was recorded.

The cell call system was observed to be extremely loud within the SRU. Senior management within the prison acknowledged this and took immediate action to contact the contractor to have the system reviewed.

There were prisoner notices available in several languages within the SRU and translation was available upon request for any prisoner who required this, through the national contract. Staff were aware of this process.

Prisoners being managed under GMA 79A/14, Management of an Offender at Risk due to any Substance, were being managed in accordance with this policy. This was observed by inspectors within Ratho Hall, with the Rule 95 (1) paperwork being accurately completed.

Good practice: On a daily basis SRU staff met to discuss prisoners case management and ensured that accurate records were kept.
Good practice: A daily handover was in place which recorded the regime for each prisoner held within the SRU and compliance with paperwork was recorded.

4.3 The prison disciplinary system is used appropriately and in accordance with the law.

Rating: Satisfactory Performance

Inspectors witnessed a number of disciplinary hearings within the SRU and Ratho Hall. The hearings were held by different adjudicators and the delivery was consistent with the SPS guidance on disciplinary hearings. Within the SRU, the orderly room guidance and prison rules were available for use.

The disciplinary process within Ratho Hall had a care-centred approach, with consideration being given to understanding the situation and how the charge arose. It was observed that prisoners placed on MORs were managed in accordance with policy and were not seen in the orderly room until they were no longer being managed under this process.

Translation services for prisoners who required them when in the orderly room were available for prisoners within the SRU, and staff were aware of the national contract and how this could be utilised for this purpose.

Prisoners were asked by the adjudicator at the disciplinary hearings if they understood the orderly room process and explained why they were on report. The process was managed in accordance with SPS policy guidance. However a more basic understanding of the orderly room procedure should be explained to the prisoner by the hall staff or personal office prior to attending the adjudication process. The hall FLM from where the prisoner is placed on report should satisfy him or herself that the prisoner understands what they are signing for when they receive orderly room paperwork from staff. It should be determined by staff if the prisoner is able to read and write, requires translation services and/or requires assistance prior to the FLM signing the orderly room paperwork.

Where prisoners were found guilty in the orderly room they were offered the opportunity to appeal and the appeal process was explained. The hearing outcomes were fair and consistent. However, further information prior to the orderly room on the process should be explained to the prisoner to ensure that there is a full

understanding of the process. Mitigations provided by the prisoner at the disciplinary hearing should be followed up by the residential area to understand the reasons behind the charge.

Inspectors reviewed 10 incidences of disciplinary hearing paperwork and they were accurately recorded and in line with SPS policy.

Recommendation: Hall Management should ensure that any mitigations received during the adjudication process are followed up by the Hall Manager.
Recommendation: The Hall Manager should be satisfied that the prisoner is able to read and write and/or requires assistance prior to signing off the adjudication paperwork.

4.4 Powers to impose enhanced security measures on a prisoner are exercised appropriately and in accordance with the law.

Rating: Generally Acceptable Performance

A PR2 report was generated to ascertain how many prisoners were managed under Special Security Measures (SSMs) within the prison at the time of the inspection. There were six prisoners on SSMs, of which four were male and two were female prisoners.

A SOP for the management of SSMs was in place to provide guidance for a consistent approach. However, inspectors requested that this be reviewed to ensure that it is being followed in accordance with policy, and that there is a heightened awareness of which prisoners within the establishment are managed under SSMs. There was information available on SharePoint but some staff were unaware of who was on SSMs and what this meant in relation to the security measures in place for individuals.

SSM reviews were being undertaken for the majority prisoners who were being managed under SSMs. Some inaccuracies were observed by inspectors and rectified at the time of the inspection. Inspectors reviewed searching records for those prisoners managed under SSMs on PR2, and found that it was compliant with PRL searching standards for those prisoners on SSMs.

Inspectors observed that on one occasion during the inspection, paperwork did not accompany the prisoner to an activity out with the residential area, and staff within the visits area were not aware that a prisoner was placed on SSMs. Senior management should sign SSM paperwork when in an area where a prisoner is located on SSMs.

Prisoners spoken to understood the reason for them being placed on SSMs, and were able to explain the reasons why they were being managed under this process.

Recommendation: HMP Edinburgh should ensure that there is a heightened awareness amongst senior management and staff of the SOP relating to SSMs.

4.5 The law concerning the searching of prisoners and their property is implemented thoroughly.

Rating: Good Performance

Inspectors observed cell searching being carried out throughout the prison. With the exception of the property card being present, it was carried out as per SPS policy and guidance. It was carried out in a dignified manner, putting the prisoner at ease throughout. Inspectors viewed a cell search of a newly admitted female prisoner who had the searching process explained in detail to her. Inspectors observed the search being carried out in a trauma informed manner, where staff were situationally aware of the woman's anxiety at being searched.

A production was observed during this search and the process for managing this item was carried out within SPS guidance. Staff were able to explain to the prisoner what would happen next and what being placed on report meant. Staff explained the orderly room process and potential consequences. This approach by staff was performed in a very supportive, professional and caring manner, ensuring that the prisoner at all times was reassured that she would be listened to throughout the orderly room process and able to give a reason for the article being found in her room. A searching and production SOP was in place to provide staff with advice on searching and was adhered to. Staff could explain the process and were aware of procedures in line with Prison Rules.

Inspectors observed prisoners being searched while moving from the SRU to the prison reception. The search was carried out to a high standard with the boss chair being used upon exit to the main corridor. A SOP was in place for the use of the boss chair and staff were aware of the process and procedure for searching prior to a prisoner leaving the SRU.

Inspectors viewed searches being carried out at a number of locations throughout the prison and in particular, the visits area, reception and prior to leaving the halls to go to other areas. The searches were carried out in a dignified manner and in accordance with Prison Rules. Staff were knowledgeable about the searching standards and explained the process. Staff were able to explain the production process and understood the process if articles were found during a search.

When prisoners were being searched prior to route movement, the correct number of searches were carried out as per the PRL standard. Archway Metal Detectors (AMDs) were used as per the PLR guidance and searching ratios were adhered to. It was observed that some staff checked every item that was carried by prisoners prior to moving on the route, however, some staff did not search every item. A SOP was in place for route movement.

An inspection of quarterly cell search records was carried out by inspectors, and it was noted that that there were very few exceptions during the quarter that had not been searched in each residential area. Records were made available for all other areas of the prison and the quarter inspected displayed compliance with PLR standards. Inspectors were provided with records of targeted searches by the security team.

Searches of vehicles were observed by inspectors and were carried out in accordance with SPS standards.

Recommendation: HMP Edinburgh should ensure that all items carried on the route are searched to fulfil PRL 1.3.4.1 standard for illicit articles.

4.6 Prisoners' personal property and cash are recorded and, where appropriate, stored. The systems for regulating prisoners' access to their own money and property allow for the exercise of personal choice.

Rating: Good Performance

Inspectors observed prisoners cash being handed in at the cash office and the process of counting the cash in front of the visitor and issuing them with a receipt. This was also entered onto PR2 at the time of the money being accepted into the prison. There were triple checks in place for monies being received and the process was well-embedded. There was a clear audit process in place for ensuring that all cash was accounted for and checks were being undertaken.

The system for handing property out was clear and there were sound systems in place for this, for both remand and convicted prisoners. With permission being obtained from the Procurator Fiscal for any remand prisoners who wished to hand out property.

There were clothes available for those prisoners who did not own clothes to attending external escorts.

The Finance Manager chaired the Lost or Damage to Prisoner Property (LODPP) Board. The hall manager carried out the investigation prior to the Board, to provide them with sufficient information relating to the claim. GMA 29A/16 which provides advice in relation to the management of LODPP claims was being adhered to.

There were clear and concise processes in place for the management of prisoners' property within HMP Edinburgh. Both the reception manager and staff were able to state the processes involved for property entering and leaving reception, and how it was checked and accounted for. The process for prisoners requesting an item was observed by inspectors and it was managed in line with policy.

The storage facilities for prisoners' property within reception in HMP Edinburgh was extremely tight. With the exception of the valuable property store; there was no volumetric control system in place. This is something the prison said that they would wish to review in the absence of a national policy.

The process for storing valuable property was accurately recorded. All items that were received into reception were checked and recorded individually on a new record card, and the items were placed within a sealed bag with a number. The items were stored securely with limited access to anyone other than the staff with responsibility for this process. There was a SOP in place for the management of valuable property and a SOP for the management of lost or stolen property.

Prisoners can request to check their property at weekends within reception and there was a process in place for reception requests. There was information for prisoners to advise them on how to make sundry purchases.

There was at the time of the inspection, a significant amount of parcels received into the prison. There was a process in place for processing parcels, but it was noted by staff that this had recently increased significantly.

4.7 The risk assessment procedure for any prisoner leaving the prison under escort is thorough and implemented appropriately. Any restraint imposed upon the prisoner is the minimum required for the risk presented.

Rating: Good Performance

A number of prisoner escorts were observed by inspectors, which were facilitated by the contractor and one escort observed was facilitated by SPS staff. The reception staff and reception FLM had an in-depth knowledge of the reception process and were able to explain in detail the daily activities and paperwork that required to be completed accurately.

Inspectors observed that the route movement was routinely late each day, which had an effect on medication being issued by the NHS. This resulted in prisoners being delayed in attending reception as early as possible to begin the reception process for court. There was not a reasonable explanation of why the route was delayed each day and management were aware of this issue. Inspectors noted that the Governor was seen on the route on a daily basis.

The reception in HMP Edinburgh was managing a number of different population groups who required to be kept separate. The staff in the area were vigilant to this, and inspectors viewed the process being coordinated in an orderly manner and conducted professionally.

Risk assessments and PERs were observed during the inspection and were individualised to the person relating to the risk they posed.

Inspectors spoke to SPS staff who undertook a last minute escort and staff were able to state the process and procedures that required to be in place for a SPS escort.

The reception manager was aware of ensuring that risk assessments and PERs were individualised and was also aware of which prisoners within the establishment were on SSMs. There was a SOP in place for emergency escorts and an escort protocol was agreed with frequently used locations. There was separate guidance available to staff for high risk individuals who may require to go out on escort. This information was extremely relevant and contained information on a number of risk categories which staff required to know before the escort took place. An escort security brief was in place for staff to read which provided guidance on external escorts.

4.8 The law concerning the testing of prisoners for alcohol and controlled drugs is implemented thoroughly.

Rating: Satisfactory Performance

HMP Edinburgh carried out risk assessment and suspicion mandatory drug testing (MDTs) on men and women in separate areas within the prison. Staff who worked within both areas had a good knowledge of MDT procedures and could describe the process accurately.

There was a complement of four male staff to carry out the MDT process for men, with three staff on duty at any one time. The MDT staff also facilitated the health clinics which were being undertaken within the ground floor of the hub, within the vicinity of the MDT area.

A SOP was in place at the time of the inspection for MDT testing. There was also a guidance manual for staff in both the male and female testing areas. 601 tests had been carried out on male prisoners since January 2019.

The data provided by the MDT staff was available in paper format as well as on an electronic spreadsheet. Records were checked by inspectors randomly against PR2 records for a number of individuals and were accurately recorded. The MDT staff were knowledgeable about records management and knew when a data cleanse was due pertaining to their area.

Women were tested by the female staff within Ratho Hall in a separate area. Twenty-six women had been tested since January 2019. Unfortunately there had been no testing in this area since July 2019 due to shortages of staff.

The IMU FLM was provided with statistics by the MDT area as and when required for tactical tasking and analysis.

Because there was no recent community access, there were no records of testing for alcohol undertaken by HMP Edinburgh.

Recommendation: HMP Edinburgh should ensure that MDT testing for women takes place on a regular basis.

4.9 The systems and procedures for monitoring, supervising and tracking the movements and activities of prisoners inside the prison are implemented effectively and thoroughly.

Rating: Satisfactory Performance

Inspectors observed the route movement on a number of occasions during the inspection week, particularly the morning route. HMP Edinburgh had a number of populations to manage and coordinate. It was managed appropriately and in accordance with the SOP that was in place. However, the morning route did not appear to move on time from the residential areas as the numbers check was observed as being regularly late. This had a knock on effect for NHS staff issuing

medications and prisoners being in reception for the correct time to attending court. An FLM was in charge of the route once it was confirmed that numbers were correct.

Each residential hall had a written regime in place which detailed when the numbers check should take place and when the route should move. The hall regime detailed when prisoner movements took place throughout the day to work and visits, and there were clearly defined processes in place for key activities. There was a SOP in place for internal escorting of prisoners.

There were good arrangements within the Electronic Control Room (ECR) for monitoring route movement and prisoner activity throughout the prison. The ECR staff were knowledgeable about monitoring the movement of people throughout the establishment through controlled doors, and radios were used effectively to communicate when movement was taking place and to confirm that areas could move when it was appropriate to do so. There was a good range of cameras available to monitor internal movements, the picture quality was good, and staff were able to easily identify individuals.

Prisoners who were leaving accommodation areas through AMDs were observed walking through them. Not all folders and laundry bags belonging to prisoners were manually searched by staff. One observation by inspectors took place where a member of staff did search a laundry bag and uncovered a number of items that were not allowed on the route. For those accommodation halls that did not have AMDs, a hand held metal detector was used as per the PRL compliance ratio.

Inspectors observed that there were a number of doors unlocked and wedged open at various points during the day, which was not compliant with the SPS locking policy. This will trigger an alarm in the ECR.

There was an instance observed by inspectors when supervision of prisoners could have been heightened while prisoners were moving on route to the training area. The Head of Operations provided assurance that this would be rectified with increased vigilance in this area.

Prisoner exercise was observed by inspectors through the use of CCTV. The camera picture was clear and individuals could be identified in the event of an incident. The IMU manager had a good working knowledge of the camera coverage within the prison and was able to locate areas when required to review footage.

A new definition and reporting of incidents policy was being implemented within the SPS. This had been communicated through the Head of Operations to FLMs and will start to be embedded. The Head of Operations has provided assurance that incidents will be reviewed going forward as per the national policy.

Recommendation: HMP Edinburgh should ensure that all doors are locked in accordance with SPS locking policy.
Recommendation: HMP Edinburgh should ensure that all items being carried by prisoners leaving accommodation areas are searched.

4.10 The procedures for monitoring the prison perimeter, activity through the vehicle gate, and for searching of buildings and grounds are effective.

Rating: Good Performance

Inspectors observed the monitoring of the prison perimeter through the use of CCTV within the ECR, and reviewed the SOPs that were in place to support and provide guidance to staff. The ECR staff were able to explain in detail how many cameras monitored the external perimeter of the prison and how the Perimeter Intrusion Detection System (PIDS) were checked and monitored. The staff were aware of the contingency plans and what processes and procedures to carry out in an emergency situation. There were operating manuals in place for the equipment within the ECR and staff explained that they were regularly deployed to this post, which helped with the complexity of the monitoring of the physical security of the prison.

It was acknowledged that the night time camera coverage was poor however, Prison Watch was very active and neighbours to the prison were vigilant. There was sufficient Prison Watch signage around the perimeter of the prison.

The staff and managers within the Gate area were knowledgeable in relation to checking escorts and searching prior to escorts being departed from the prison.

The vehicle gate was staffed by a member of staff from the ECR. Inspectors observed the process of vehicles entering and exiting the prison. Staff were knowledgeable about the processes and procedures. Staff were observed by inspectors being courteous and polite to escorting contractors and prisoners who were in vehicles either entering or exiting the prison. Appropriate equipment and signage was in place within the vehicle lock area.

Inspectors observed staff being searched as they entered the prison. The searching was carried out in accordance with the SPS staff searching policy. Staff who worked in the vestibule area were knowledgeable about staff searching procedures. Inspectors viewed staff searching records which demonstrated that this process was being carried out.

The introduction of the Rapiscan equipment had assisted the prison in the detection of mail which could contain illicit substances. Inspectors viewed the mail that was ready for collection by Police Scotland. It was reported that seven out of 12 letters were suspected of containing illicit substances, all of which had been detected by the Rapiscan machine.

Inspectors were aware that Security Managers were having impromptu operations briefings with staff to update them on recent relevant security matters.

Recommendation: HMP Edinburgh should carry out a review of external camera coverage.
Recommendation: The SPS and the Scottish Government should consider introducing a Rapiscan in every prison in Scotland to reduce the introduction of illicit substances in Scotland's prisons.

HMIPS Standard 5

Respect, Autonomy and Protection Against Mistreatment

Quality Indicators

5.1 The prison reliably passes critical information between prisoners and their families.

Rating: Satisfactory performance

Inspectors found evidence that there were good processes in place for critical information to be passed between prisoners and their families. There was written evidence of contact being made with family members to seek their involvement in supporting prisoners with complex needs, and detail provided of families being kept up to date with developments, for example when someone was admitted to hospital.

Inspectors also saw evidence of multi-agency working across the establishment, for example with colleagues from NHS and Prison-based Social Work.

Detail gathered for other Standards supported the above by evidencing, for example, regular involvement of family members in ICM processes.

Inspectors asked, on the majority of halls visited, how staff passed sensitive information to prisoners, for example the death of a loved one. There were some differences in what inspectors were told, but the consistent message received was that this would be done in a confidential and respectful way, and contact made with people that could offer support if required, for example the Chaplaincy or Prison Listeners.

5.2 Relationships between staff and prisoners are respectful. Staff challenge prisoners' unacceptable behaviour or attitudes and disrespectful language or behaviour is not tolerated.

Rating: Satisfactory performance

Inspectors saw some good examples of interactions between staff and prisoners. Staff worked well with some prisoners that had complex needs. Some staff said that when prisoners were locked in their cells due to work sheds being closed for example, they tried to let people with mental health issues out if possible, as they appreciated how being locked up for longer periods could disproportionately impact on them.

Inspectors did not witness any disrespectful behaviour or hear any disrespectful language during the inspection from staff.

Inspectors spoke to one prisoner who informed them he was on hunger strike. On checking with staff, inspectors found they were aware of the situation and were able to evidence he was being managed appropriately.

Inspectors witnessed a lot of incidents of staff shouting prisoners names down the halls to let them know they were required for various reasons. This was less evident in Ratho Hall but it is a practice inspectors would like to see stopped, as it does not respect confidentiality or support a trauma informed approach.

5.3 Prisoners' rights to confidentiality and privacy are respected by staff in their interactions.

Rating: Satisfactory performance

Inspectors saw several interactions that constituted good performance in terms of prisoner's personal information being safeguarded. Examples included daily medication sheets being shredded and confidential information such as TTM paperwork being properly managed.

Inspectors witnessed calls being received from health and social work asking to see people and those requests being noted and professionally facilitated.

5.4 The environment in the prison is orderly and predictable with staff exercising authority in a legitimate manner.

Rating: Generally acceptable performance

On the whole, the environment was orderly but not predictable. There were six different populations being held in the establishment, which made managing the environment challenging. Staff told inspectors that increased incidences of the use of PS had led to the prison being less orderly and predictable.

During the period of the inspection, regimes were changed and restricted several times to accommodate staffing issues. One example was periods of recreation being changed in Ratho Hall, with one hall having recreation in the afternoon and the others in the evening. Although this ensured everyone had access to recreation it did mean some were locked up for long periods of time.

All halls reported periods when the regime had been restricted and inspectors saw evidence of several work parties being cancelled.

Prisoners said they were usually told when there was to be a change to the regime. Staff confirmed that if someone needed access to a phone when the regime had changed to afternoon recreation as opposed to evening, they would attempt to facilitate that as far as was possible.

Glenesk Hall was the area that presented most challenges in terms of an orderly environment. This was particularly apparent on Glenesk level 2 where there was a complicated mix of populations including non-offence protection, offence protection and mainstream prisoners. In addition, there were people subject to TTM and being held on a Rule 95. The regime for non-offence protection prisoners on this hall was very restricted.

In the SRU, the cell call system was used as the main means of prisoners contacting staff, which resulted in it being activated a lot with a very loud buzzer. Staff said that the amount of times the buzzer was pressed, with the level of volume, could increase their tension and stress levels.

Reception was busy and everyone was treated in a consistent manner. Some conversations were not as confidential as they might have been, with questions being asked of those new to the establishment at the area by the desk. Inspectors would question the process of strip searching as other methods such as body scanners and boss chairs would be of equivalent efficiency.

Recommendation: HMP Edinburgh should work to reduce the amount of time regimes that are restricted, and ensure that any restrictions are not disproportionately applied to any population.
Recommendation: HMP Edinburgh should try to reduce the mix of populations held on Glenesk 2.
Recommendation: SPS Headquarters should consider reducing the number of populations in the establishment.
Recommendation: SPS Headquarters should consider discontinuing the use of strip searching.

5.5 Prisoners are consulted and kept well informed about the range of recreational activities and the range of products in the prison canteen as well as the prison procedures, services they may access and events taking place. The systems for accessing such activities are equitable and allow for an element of personal choice.

Rating: Satisfactory performance

There was a robust process in place for ordering, fulfilling and delivering orders from the canteen list. There was an additional canteen sheet for women and a sundry purchase sheet for people to purchase items such as newspapers. A new system for managing the canteen on the halls had recently been introduced. Items were delivered in a clear, sealed plastic bags and if there were any incorrect or missing items the whole bag, still sealed, needed to be returned to allow it to be corrected. Some issues with the new system were raised with inspectors by staff and prisoners who said they would prefer it if not to all items had to be returned, due to the time taken to re-delivery.

Inspectors observed the canteen being delivered, and it was difficult to establish if all of the items one person had ordered were there. Prisoners preferred to take the risk of items being missing than return the order.

Information about events, activities and education seemed to be consistently available in all areas with sign-up sheets available to all.

There was evidence that meetings with prisoners were held, for example there was a strong performance in terms of food PIACs. However, there was no evidence to support PIACs happening regularly and consistently across the prison.

Recommendation: In acknowledging there needs to be a robust process in place for managing the canteen in such a large and complex prison, the new process should be reviewed after a period of around three months to ensure it is working well for everyone.
Recommendation: Systems in place for ensuring PIACs take place should be reviewed.

5.6 Prisoners have access to information necessary to safeguard themselves against mistreatment. This includes unimpeded access to statutory bodies, legal advice, the courts, state representatives and members of national or international parliaments.

Rating: Generally acceptable performance

Throughout the establishment there were SPS and NHS complaint forms available.. There was detail displayed about the Scottish Public Services Ombudsmen (SPSO), and the establishment provided details of decisions that had been made following prisoners contacting the SPSO.

There was information available in the main library about relevant procedures such as Parole, Prison Rules and the Children's Hearing System. However not all populations had good access to the main library. A satellite library had now been created in Glenesk 3, which is welcomed, but the establishment should ensure prisoners have access to the same range of information provided in the main library.

Inspectors observed how agents visits operated and how prisoners accessed virtual courts or visits. The system for accessing agents visits was not as robust as it might be. Inspectors could hear confidential conversations people were having with their solicitors and there were long waits for prisoners to be brought to see relevant agencies. Inspectors were also advised that enemy checks did not take place as part of the booking system and all populations were observed to be present at the same time. In speaking to staff some of the issues seemed to have been created by a change in how visit bookings were managed.

The sound quality for virtual courts was poor, and as far as inspectors could establish video links were mostly with Edinburgh Sheriff Court. Although enabling people to appear in any court in a way that best suits need was welcomed by inspectors, consideration should be given to trying to expand the service to other courts.

Inspectors spoke to a couple of agents who said they were able to book visits with relative ease.

Evidence was provided that there was a robust system in place for the management of privileged mail.

Recommendation: HMP Edinburgh should review the systems in place for managing agents visits.
Recommendation: HMP Edinburgh should look to improve the technological arrangements for virtual court appearances.

5.7 The prison complaints system works well.

Rating: Satisfactory performance

Inspectors looked at all PCF1, PCF2 and Internal Complaint Committee Meetings for a randomly selected two week period.

For the period selected Inspectors found that the majority were responded to within the agreed timescales.

Inspectors checked that agreed actions from complaints had taken place. For example money that was due to be refunded into someone's account had been refunded within acceptable timescales.

5.8 The system for allowing prisoners to see an Independent Prison Monitor works well.

Rating: Satisfactory performance

There were IPM request boxes, leaflets and posters in all of the halls. Some halls did not have IPM request forms, but staff seemed to know that it was their job to make them available.

Staff and prisoners were aware of the IPMs and staff reported seeing them on the halls from time to time. Given the number of requests IPMs received both via boxes and the Freephone, and the fact that different people contacted HMIPS, it seems fair to conclude there were no issues in terms of access to or knowledge about Independent Prison Monitoring.

HMIPS Standard 6

Purposeful Activity

Quality Indicators

6.1 There is an appropriate and sufficient range of good quality employment and training opportunities available to prisoners. Prisoners are consulted in the planning of activities offered and their engagement is encouraged.

Rating: **Poor Performance**

At the time of the inspection, there were insufficient employment opportunities for all prisoners, across all prison populations, and in particular for the female and untried prisoner populations. More than half of workshop activities were not available to prisoners due to staffing shortages.

Full and part-time employment opportunities were available for prisoners in work parties for pantry, catering, housekeeping, cleaning, laundry, gardens, recycling and waste management. The majority of these work parties were attended well by prisoners. The cleaning, laundry, catering and pantry work parties provided opportunities for prisoners to gain vocational qualifications. Almost all qualifications obtained by prisoners in these work parties over the past six months were from the British Institute of Cleaning Science. The quality of work parties provided by the prison was good.

Vocational training opportunities were available in arts and crafts, bike repair, domestic appliance repair, hand tool repair, painting and decorating, woodcraft and card making, hairdressing, joinery, recycling and radio station. The quality of these activities was good.

The prison was accredited to deliver vocational training qualifications up to SCQF level 5 in bike repair, domestic appliance repair, painting and decorating, joinery and hairdressing. Too few prisoners were provided with an opportunity to undertake these awards due to the closure of vocational training workshops. Although prisoners had an opportunity to gain a CSCS card, there was insufficient focus on employment at liberation as the construction trades workshops were substantially closed. The vocational training opportunities available to prisoners were short in duration and did not progress above SCQF level 5, limiting the progression opportunities for prisoners who were serving longer sentences.

The hairdressing salon provided good opportunities for male and female prisoners to gain skills and qualifications for employment on liberation. Many prisoners who attended the salon gained a qualification, and a few prisoners had achieved their assessor award. One prisoner had been awarded first prize in the British Barbers Association awards. The training opportunity for prisoners offered in the hairdressing salon was good practice.

Overall, prisoners were consulted and encouraged to attend the work parties and the training opportunities available, with additional support being provided to prisoners

who encountered barriers to participation. Scheduling of activities by the prison was proactive and considered the impact on prisoners, and prison populations, wherever possible.

Recommendation: HMP Edinburgh should ensure all eligible prisoners and all prison populations have an opportunity to attend an appropriate range of employment and training opportunities.

Good practice: The training opportunity for prisoners offered in the hairdressing salon.

6.2 Prisoners participate in the system by which paid work is applied for and allocated. The system reflects the individual needs of the prisoner and matches the systems used in the employment market, where possible.

Rating: **Generally Acceptable Performance**

The system and rationale for allocating paid work to prisoners was fair and generally understood by staff and prisoners. The work allocation of prisoners was monitored and reviewed regularly by the prison to ensure it continued to match the needs of individual prisoners, and the balance of prisoners across the overall prison population. The majority of eligible prisoners who wanted to participate in paid work were able to do so. The prison provided reasonable adjustments for prisoners who required extra assistance to participate in the work allocation system. When a prisoner wished to change a work placement, the reasons were discussed with the prisoner and appropriate action taken.

The opportunities for prisoners to participate meaningfully in discussions around the work available, and their skills and learning objectives, was limited. These opportunities were diminished further by the suspension of the induction process, where prisoners would normally find information on the work placements available and discuss their personal preferences.

Overall, the scheduling of work allocation worked well for the majority of eligible prisoners who wished to participate in work parties. However, participation rates across the separate prison populations were variable and this led to frustration among some prisoner populations who wanted to participate in paid work activities. For example, female prisoners were frustrated about some low number work parties in which they wanted to participate. They were unable to do so due to the establishment need to keep prison populations separate.

6.3 There is an appropriate and sufficient range of good quality educational activities available to the prisoners. Prisoners are consulted in the planning of activities offered and their engagement is encouraged.

Rating: **Satisfactory Performance**

Overall, there was an appropriate range of good quality educational opportunities available to prisoners. The subject range and levels were well considered and included support for a number of prisoners who were undertaking personalised

distance learning through Dumfries and Galloway College and the Open University. There was limited learning opportunities relating to life skills, which would help prepare prisoners better for release. The staff and prisoner relationships in classes and the quality of learning and teaching were purposeful, and prisoners recognised the value of the experience and the qualifications achieved.

Opportunities for prisoners to attend education classes was limited to around 25% of the prison population and there were waiting lists, typically of many months, for almost all classes. The education provision was well regarded by prisoners and those who engaged with education tended to stay in the same class for many months, or years. However, this limited access to education for a substantial number of other prisoners who would potentially benefit. Education opportunities were offered to all prison populations. However, the education offer to untried prisoners and female prisoners was limited. The Education Unit had made successful efforts in the last two years to engage more mainstream prisoners in education, encouraging participation by those who were often reluctant to attend purposeful activity.

There was a wide range of qualifications on offer in the EducationUunit, primarily through the Scottish Qualifications Authority (SQA), and prisoners were encouraged to undertake assessments and qualifications whenever possible. Prisoners gained a total of 406 SQA qualifications in the last academic year, and 1065 qualifications through other awarding bodies such as the Royal Society for the Prevention of Accidents for more focussed vocational training activities such as hygiene or safety. Staff were regularly encouraging prisoners to engage in performances, events and competitions which helped build their confidence and sense of achievement.

Education Unit staff provided individual learning for prisoners in the residential halls, supported by three peer mentors. This arrangement helped to support prisoners with specialist interests, basic education needs and those who found it challenging to work in groups. The work of the peer mentors was effective and delivered well, promoting education to prisoners whilst helping to meet individual needs.

Prisoners were consulted well on the opportunities offered in the Education Unit during regular meetings and monthly focus groups. Scheduling took good account of this feedback.

6.4 There is an appropriate and sufficient range of physical and health educational activities available to the prisoners and they are afforded access to participate in sporting or fitness activities relevant to a wide range of interests, needs and abilities. Prisoners are consulted in the planning of activities offered and their engagement is encouraged.

Rating: **Good Performance**

All prison populations had scheduled opportunities to access sporting and fitness activities throughout the week, in the evening and at the weekend. There was a good range of physical and health activities available to prisoners in a core programme which was based in the gym, games hall and on occasions, outdoors. The variety and quality of activities provided was good. The core programme was

supplemented by a well-considered variety of other physical activities such as volleyball, rounders, basketball and circuit training. Discrete sessions were scheduled for the over-45 prison population, and those with limited mobility, such as walking football and quiet weights. Prisoners also had the opportunity to access satellite gyms in their residential halls, and the equipment in them was of good quality.

All prisoners completed an induction session with a member of staff before accessing physical activity. Most prisoners who attended physical and health activities participated well and made good use of the facilities and equipment available.

The physical training instructors (PTIs) were proactive in encouraging prisoners to participate in physical and health education through the introduction of personal challenges, charity fun runs, a Street Soccer programme and motivational talks from guest speakers. The PTIs organised the movement of prisoners to and from the residential halls. This made best use of the time available for prisoners to attend scheduled physical and health activities. First aid training was provided by the PTIs, who also offered sessions on body statistics, health checks and lifestyle evaluations, mental health awareness and smoking cessation. These sessions were used effectively to motivate prisoners to improve their health and wellbeing.

The prison was proactive in consulting prisoners through focus groups and questionnaires, seeking their ideas for improvements and additions to the programme of physical and health activities offered. The views of prisoners were taken into account and implemented wherever possible. Examples of additional sessions suggested by prisoners included Boxercise, and for female prisoners Fit for Life and a walking group.

The majority of scheduled physical and health sessions were attended well by prisoners. However, attendance at timetabled sessions by some prison populations was low, particularly female prisoners.

The prison reviewed the scheduling of physical and health activities regularly and was proactive in providing each prison population with access to physical and health activities and education. Prisoners who encountered barriers to participation were supported appropriately to attend activities applicable to their individual needs wherever possible.

6.5 Prisoners are afforded access to a library which is well-stocked with materials that take account of the cultural and religious backgrounds of the prisoner population.

Rating: **Generally Acceptable Performance**

The prison had a well-stocked and well located library available to prisoners, co-located within the Hub alongside the Education Unit. The library provision was supported through the local authority. There was an adequate stock of materials including large print and other language books, texts on safeguarding and individual rights, and a substantial stock of DVDs. Inter-library loans were used well where

there was a demand for more specialised texts. There was insufficient space in the library, or time available, for prisoners to facilitate reading within the library, with library activities limited to book and DVD selection.

The main library was supplemented by satellite libraries established in Ratho and Glenesk Halls, which helped to make leisure reading more readily available to prisoners in these wings. Although the stock held in the residential halls was limited, it was rotated appropriately.

All prisoner groups had some access to the library, although visit slots were limited to 15 minutes, which made book and DVD selection a challenge for some prisoners. The main library activity was supported by three well informed passmen who engaged well with library users, and provide helpful support and guidance. They also led a monthly film club which facilitated film viewing and discussions on newly released films.

The library engaged in a few annual activities aimed at encouraging reading, such as book week and meet the author events. However, these were limited and there were missed opportunities for themed events, cultural events, or improved links with educational activity to promote the use of the library and wider reading. There were no thematic displays or promotions addressing issues such as mental health, which would typically be promoted through the library. There was very limited formal consultation with prisoners regarding the library or its stock, and feedback was drawn primarily from informal discussions with the passmen.

6.6 Prisoners have access to a variety of cultural, recreational, self-help or peer support activities that are relevant to a wide range of interests and abilities. Prisoners are consulted on the range of activities and their participation is encouraged.

Rating: **Generally Acceptable Performance**

The prison offered a very limited range of cultural, recreational and self-help activities. The Education Unit provided a few thematic events relating specifically to classroom learning. However, prisoners were not aware of these beyond the classroom based activities. Prisoners were actively encouraged to reflect on their creativity and make entries for Koestler awards, and the prison had a large number of entries last year with a very successful 55 awards being achieved. The peer mentoring system was effective in encouraging self-help for individual prisoners.

There were very few cultural events recognised or celebrated across the prison. Observance of religious or cultural periods such as Chinese New Year, Diwali, Remembrance Day or Eid was supported for the prisoners who had that cultural link. However, there was no promotion or wider awareness raising to provide most prisoners with an understanding of other cultures and religions. A few events were offered for prisoners to celebrate Burns Day and Christmas. However, the prison was not proactive in raising awareness of other religions and cultures through religious, cultural or social events for the overall prison population.

There had been a successful Pride event organised recently within the residential hall for female prisoners. This provided a positive and upbeat message which was used to encourage greater understanding. However, this initiative was limited to the female population only. The gym staff had promoted a number of health initiatives and challenges, and added a range of new healthy activities for all prisoners who attended the gym sessions. The education unit also ran very positive celebration events when prisoners achieved awards or qualifications, encouraging a feeling of self-worth and family pride.

Overall, the number of themed and cultural activities promoted through education, the library and the wider prison community was limited. There were missed opportunities to promote a wider understanding of other religions, groups and cultures to all prison populations. The curtailed emphasis by the prison on equality and inclusion does not prepare prisoners well for liberation.

6.7 All prisoners have the opportunity to take exercise for at least one hour in the open air every day. All reasonable steps are taken to ensure provision is made during inclement weather.

Rating: **Generally acceptable**

All prisoners had the opportunity to take daily exercise for at least one hour in the open air.

Showerproof jackets were supplied for inclement weather, but they were thin and not particularly rainproof. There was a limited availability of these jackets in some halls and additional layers of normal clothing required to be worn to counter the cold.

Recommendation: The SPS should provide thicker, more waterproof jackets to facilitate access to open air during colder weather. In the interim, HMP Edinburgh should ensure consistent access to rain jackets and additional layers of clothes for all halls.

6.8 Prisoners are assisted in their religious observances.

Rating: **Satisfactory**

The Chaplaincy Team provided support for Christians and Muslims, with a range of services provided for different categories of prisoners at different times on Saturday and Sunday. Prisoners could contribute to the music and readings. Translations of the Bible were available in other languages such as Polish and Romanian, and the chaplaincy team had contributed to publication of an excellent book on prayer for prisoners. They had also contributed to a TV programme on Faith Behind Bars.

CDs with Muslim prayers were available and workshops were run on Wednesday and Thursday for Muslims. Efforts had been made to facilitate communal prayers for Muslims on Fridays, but low attendance levels precluded continuation. Although there was no Rabbi within the chaplaincy team, the prison would attempt to secure such services when requested and articles of faith were available to support those of Jewish and other faiths.

The Chaplaincy Team were proactive in visiting every prisoner in custody for the first time within 48 hours of admission, and provided support to all prisoners regardless of their faith or beliefs, for example at times of bereavement.

6.9 The prison maximises the opportunities for prisoners to meet and interact with their families and friends. Additionally, opportunities for prisoners to interact with family members in a variety of parental and other roles are provided. The prison facilitates a free flow of communication between prisoners and their families to sustain ties.

Rating: **Good**

There was a good system in place for visits, with opportunities to visit at different times and considerable efforts had been made to encourage and support family visits and engagement with children. The Halloween themed visits observed during the inspection were an example of best practice, with SPS staff and Barnardos staff going to considerable lengths to provide an enjoyable and memorable experience for prisoners and their families. Telephone access to families was readily available and communication about visits was facilitated clearly.

Good practice: The efforts made to promote opportunities for prisoners to interact with families and children, particularly with the Halloween themed night, were highly commendable.

6.10 Arrangements for admitting family members and friends into the prison are welcoming and offer appropriate support. The atmosphere in the Visit Room is friendly, and while effective measures are adopted to maintain security, supervision is unobtrusive.

Rating: **Good**

There was an excellent Visitor Centre next to the prison, which provided a warm and welcoming environment, with a good range of facilities for younger children. It was one of the very best Visitor Centres inspectors had seen.

The support provided to visitors by the staff there was excellent and interaction with children was particularly impressive. The relationship between Barnardos and SPS staff was clearly very positive, with both teams recognising and appreciating the contribution made by the other.

The Friends of HMP Edinburgh contributed positively through the running of a café inside the prison visit room, where friends and family could buy drinks and snacks for the visit.

Although the atmosphere in the visits room was friendly and supervision relatively unobtrusive, appropriate security was maintained. This was observed during the inspection when staff intervened to stop drugs being passed.

Good practice: The Visitor Centre and relationships between SPS and Barnardos staff were excellent and represents best practice.

6.11 Where it is not possible for families to use the normal arrangements for visits, the prison is proactive in taking alternative steps to assist prisoners in sustaining family relationships.

Rating: **Satisfactory**

Virtual visits were available, and a fund was available to assist with transport costs for some families where exceptional circumstances could be demonstrated.

Hearing loops and other facilities were available to support those with disabilities, and appropriate flexibility was shown in facilitating visits where special circumstances were agreed to exist.

Inter-prison visits were allowed in line with the national policy, and any representations made by prisoners against a transfer to another prison because of the impact on family relationships were carefully considered.

6.12 Any restrictions placed on the conditions under which prisoners may meet with their families or friends take account of the importance placed on the maintenance of good family and social relationships throughout their sentence.

Rating: **Satisfactory**

Visits were not withdrawn as a result of poor behaviour. Closed visits followed a robust system where the reason for imposing closed visits was clearly communicated and regularly reviewed, with appropriate warnings given when open visits were restored. Banning a visitor was seen as a last resort option and the reasons for this were shared with the prisoner, but restrictions were applied when necessary to preserve security.

6.13 There is an appropriate and sufficient range of therapeutic treatment and cognitive development opportunities as well as an appropriate and sufficient range of social and relational skills training activities available to prisoners.

Rating: **Generally acceptable**

The prison provided an appropriate range of therapeutic treatment and cognitive development opportunities and a good range of social and relational programmes.

Prisoners were aware of how to access programmes but were often frustrated by the length of the waiting list for many of them. Although it had started to reduce for some of the lower level intervention programmes.

The Personal Officer system was not operating consistently across the prison with several prisoners unaware who their Personal Officer was or complaining about frequent changes in Personal Officer.

Personal Officer attendance at Integrated Case Management meetings (ICM) was poor, with a disappointing performance in relation to timely completion of reports for ICMs. This was undoubtedly partly due to competing pressures on staff. However, staff did not always feel adequately trained to carry out the Personal Officer role, particularly in relation to ICMs. Further training for the Personal Officer role was being planned at the time of the inspection, but had not yet been rolled out.

Recommendation: HMP Edinburgh should take action to improve consistency in the operation of the Personal Officer system, so that all prisoners are aware of their Personal Officer, and staff are trained to confidently perform that role.

6.14 The prison operates an individualised approach to effective prisoner case management, which takes account of critical dates for progression and release on parole or licence. Prisoners participate in decision making and procedures provide for family involvement where appropriate.

Rating: **Generally acceptable**

There was a well-established system for identifying the needs of long-term prisoners and taking account of their critical dates for parole and progression, or release on licence. However, on some occasions during the inspection prisoners did not appear to fully understand their own critical dates or the process. The recommendation in QI 6.13 to strengthen training and mentoring for Personal Officers should assist with this issue.

Prisoners were involved in the decision making process. However, as with other prisons, HMP Edinburgh did not have the capacity to provide enhanced case management support for short-term prisoners, who received much more restricted support.

Inspectors observed a number of ICMs where the individual needs of prisoners were assessed with great care and sensitivity. HMP Edinburgh had conducted ICMs in the SRU or in the hall when that was necessary, to secure prisoner involvement.

Families were also involved where appropriate. Efforts were made during family visits to alert families to the scope to get involved in ICMs. Although concerns about lack of access for families to ICMs were raised with HMIPS during the inspection, inspectors observed cases where highly commendable efforts were deployed to keep families informed and take account of family concerns.

6.15 Systems and procedures used to identify prisoners for release or periods of leave are implemented fairly and effectively, observing the implementation of risk management measures such as Orders for Lifelong Restriction and Multi-Agency Public Protection Arrangements.

Rating: **Generally acceptable**

A good level of joint working between different agencies was observed during ICMs, with prisoners being involved in discussions about their future, such as their own plans on release. Risk management assessments were carefully considered by SPS

staff alongside prison and community-based social work services, prison psychologists and other partners, with appropriate sharing of relevant information. The casework involved in supporting Orders for Lifelong Restriction prisoners was undoubtedly onerous, but was given appropriate priority. However, concern was expressed by some staff about lack of time to fulfil the Personal Officer role and the need for additional training and support. The recommendation under QI 6.13 would also assist this QI.

Ongoing community support was encouraged and promoted. However, some third sector agencies expressed frustration that transfers to other prisons near to their release date risked undermining the pre-release planning done with partner agencies.

Recommendation: The number of prison transfers made close to a prisoner's release date should be kept to a minimum to avoid unintentionally undermining the pre-release planning work undertaken with partner agencies.

HMIPS Standard 7

Transitions from custody to life in the community

Quality Indicators

7.1 Government agencies, private and third sector services are facilitated to work together to prepare a jointly agreed release plan and ensure continuity of support to meet the community integration needs of each prisoner.

Rating: Generally acceptable performance

Senior managers demonstrated a sound understanding of the role and responsibilities of partner agencies with responsibility for supporting individuals, and making transition arrangements from custody to life in the community. Managers understood the challenges facing prison-based agencies, in delivering the wide range of tasks relevant to the large population of individuals subject to statutory supervision on release. Managers maintained effective communication with agencies providing services within the prison, and had good oversight of the external partner agencies providing services to individuals subject to statutory and non-statutory release.

Relevant statutory agencies and third sector partners were facilitated to work together to prepare jointly agreed release plans, through ICM meetings and arrangements. The enhanced ICM process focussed primarily on individuals serving long-term sentences and those subject to statutory social work supervision on release. The prison had experienced a steady increase in its statutory population since 2016 and as a result, the number of enhanced ICM case conferences had increased considerably. This resulted in additional pressure on an already relatively small resource, particularly as over five hundred enhanced ICM case conferences took place in the past year.

The standard ICM process was not being delivered for individuals subject to short-term prison sentences and those not subject to statutory release. This meant that there was a gap in the pre-release planning process for this group. The prison did not have a well-embedded case management system for people on short-term sentences and therefore community integration planning for non-statutory release was inconsistent. However, the prison had made a concerted effort to engage with a wide range of external service providers including statutory agencies, in order to facilitate contact between individuals and services that could support their successful transition into the community. The prison had a well-equipped link centre which was used to facilitate contact between individuals preparing for release and a wide range of service providers. The prison had been successful in maintaining the regular involvement of community-based services and agencies with a role in supporting people on short-term sentences on release. These agencies also had opportunities to collaborate on pre-release arrangements through informal contact within the link centre.

Recommendation: HMP Edinburgh should ensure that all prisoners have an opportunity to participate in the preparation of a release plan and engage with appropriate services to support community integration on release.

7.2 Where there is a statutory duty on any agency to supervise a prisoner after release, all reasonable steps are taken to ensure this happens in accordance with relevant legislation and guidance.

Rating: Satisfactory performance

The Prison-Based Social Work (PBSW) Team were fulfilling their responsibilities to plan effectively for prisoners' release on statutory social work supervision. The social work team met with individuals subject to statutory release to discuss release plans and to update an assessment of risks and needs. Good communication was maintained with community-based social work services, local authorities and health and social care partnerships and relevant partner agencies. Prison and Community-Based Social Workers attended enhanced ICM meetings regularly in order to collaborate with partner agencies on assessments and to develop pre-release plans. PBSW staff completed risk assessments to a high standard and shared information with partners on the level of support and monitoring that would be needed by prisoners following release. Given the statutory nature of the majority of the prison population, close attention was paid to ensuring that pre-release plans were collaborative, included all relevant partner agencies and prioritised community safety.

The enhanced ICM process was well embedded and operated to a high standard, led and coordinated by experienced and knowledgeable staff and managers. The steadily increasing number of statutory case conferences and associated tasks had placed additional pressure on a small case management team. Attendance by family members had exceeded local targets and the case management team had shown commitment to increase attendance wherever possible. Personal Officers do not routinely attend ICM meetings and there were times when Personal Officers had not provided individuals with information on Community Integration Plans in advance of meetings in order to assist them to prepare for their review.

The PBSW service was under increasing pressure due to an increase in statutory work. This included responding to the need for assessments, case conference attendance and completion of reports for a growing statutory population combined with the requirement to attend more frequent parole board hearings to provide oral reports.

Recommendation: HMP Edinburgh should take steps to ensure that personal officers engage with and prepare individuals appropriately for ICM meetings; submit reports in all instances and attend enhanced ICM meetings.
Recommendation: HMP Edinburgh should review the workload of the Prison-Based Social Work Team to ensure that adequate resources are in place to sustain the delivery of a high-quality social work service against the backdrop of increasing demands on statutory work.

7.3 Where prisoners have been engaged in development or treatment programmes during their sentence, the prison takes appropriate action to enable them to continue or reinforce the programme on their return to the community.

Rating: Generally acceptable performance

The prison provided an appropriate range of programmes for men serving long-term prison sentences. These included programmes aimed to address substance abuse and addiction issues, sexual offending and general offending through a cognitive and behavioural change programme. The Programmes Case Management Board was operating well in terms of reviewing individual programme needs and making arrangements to include individuals in a suitable programme. While a number of individuals had suitable access to programmes, greater success was hampered by waiting lists. This was particularly notable in respect of the Moving Forward: Making Changes programme to address sexual offending. Prison and Programme Managers recognised this issue and a proposal had been submitted for resources to run an additional strand of the programme. There was also a backlog in respect of generic programme assessments being undertaken and a considerable number of these were outstanding. This meant that the progression plans for some individuals were delayed until they had undertaken the relevant programme.

Individuals who had participated in programmes were provided with an opportunity to continue programme work following release where an outstanding treatment need had been identified. However, timely access was dependent on the availability of community resources for the delivery of the programme. Post-programme completion reports were in the main completed timeously and provided to other prison-based and community agencies to assist with sentence planning and post-release management.

No programmes were in place for women serving long-term prison sentences and therefore any identified needs were not being appropriately addressed. It requires a woman to transfer to HMPs Polmont or Cornton Vale. Access to programmes was also very limited for individuals serving sentences of between two and four years. While it is recognised that priority is rightly given to individuals with the greatest need and those who have a sentence long enough to accommodate the completion of programmes, a lack of provision for the aforementioned groups limits their prospects of progression and for successful community integration following release.

Recommendation: HMP Edinburgh should take steps to reduce the backlog of generic programme assessments and to improve access to programmes for all eligible prisoners.

7.4 All prisoners have the opportunity to contribute to a co-ordinated plan which prepares them for release and addresses their specific community integration needs and requirements.

Rating: Generally acceptable performance

Individuals serving long-term, life and extended sentences and therefore subject to statutory supervision on release had the opportunity to contribute to a co-ordinated pre-release plan in order to address their community integration needs. The ICM process provided a robust structure through which to engage with individuals and support them to participate in assessments and pre-release planning. Case management staff, working alongside prison and community based social work services and statutory and third sector partners, collaborated effectively to produce realistic release plans. The prison and statutory partners had a sound understanding of the risk and needs of the statutory population. They collaborated effectively in terms of assessment and case management planning and had formed strong working relationships with community agencies in order to put plans in place aimed to address individual needs and prioritise community safety.

Conversely, individuals serving short-term sentences and those not subject to statutory supervision on release experienced a less consistent pre-release planning process. The prison did not operate a standard ICM process. While case management systems had been introduced to increase the number of Community Integration Plans prepared for this group, the prison had not been able to routinely put these in place. This meant that a number of individuals did not have the opportunity to participate meaningfully in pre-release plans. However, the prison had established an effective link centre, in order to facilitate access to statutory and third sector agencies, to enhance arrangements for post-release support and community integration. The agencies within the prison link centre made a valuable contribution to assisting individuals to plan for release through making appointments with housing providers, Job Centre Plus and other relevant agencies.

The prison also made arrangements for external agencies and services to meet with individuals in the prison halls to provide support and assistance with planning for release. Third sector services including New Routes and Shine provided individuals with mentoring and practical support for moving back into the community. An important element of this was the post-release service that was provided to some individuals to support community integration and desistance from offending. The Willow project provided psychological therapy for women requiring mental health interventions. While there had been a pause in service delivery following a pilot of the service which concluded in 2016, the prison was working in partnership with Willow to re-establish and further embed the service to support improvement in the mental health of women in the prison. Third sector agencies highlighted that the transfer of individuals to other prisons close to their release date had a negative impact on pre-release planning and could disrupt the release arrangements that had been put in place.

7.5 Where the prison offers any services to prisoners after their release, those services are well planned and effectively supervised.

Rating: Generally acceptable performance

The throughcare support officer (TSO) service was introduced to provide support to individuals serving a short-term prison sentence in order to help them plan and prepare for release into the community. The TSO service was suspended nationally in September 2019. This has left a significant gap in the service provided to people before and after release, to support their successful transition from prison to the community. In the nine months prior to the suspension of the service, TSO staff had engaged with and provided support to almost one hundred people with a wide range of needs. This included listening to their needs, encouraging participation, contacting statutory agencies and third sector support services, and preparing release plans to enhance community integration and support desistance from offending.

The TSO service was valued by the individuals that had been involved with it. It provided them with reassurance that a release plan was in place and greater stability and support following release. The prison had made arrangements for a small group of designated staff to take over the responsibility for liaising with housing providers for individuals returning to a local authority out with Edinburgh and the Lothians. These officers also led on improving individual's employability prospects through the provision of training and support to obtain certificates including the CSCS card. This was a positive step forward and the staff were knowledgeable and committed. The prison had also continued to engage with a range of statutory and third sector agencies and facilitate prisoner engagement through the link centre. However, these arrangements did not replicate the provision of pre-release planning and throughcare support for the majority of eligible individuals.

Recommendation: HMP Edinburgh should ensure that a clear plan is put in place to address the gap in provision of throughcare support following the suspension of the TSO service, so that all eligible prisoners have the opportunity to participate in effective pre-release planning.

HMIPS Standard 8

Organisational Effectiveness

Quality Indicators

8.1 The prison's Equality and Diversity (E&D) Strategy meets the legal requirements of all groups of prisoners, including those with protected characteristics. Staff understand and play an active role in implementing the Strategy.

Rating: Good

HMP Edinburgh had a comprehensive E&D strategy and action plan for 2018-2020. It featured as a priority in the Annual Delivery Plan, which looked to ensure they were compliant with the Equality Act 2010. HMP Edinburgh's commitment had been recognised by the latest SPS audit, achieving substantial assurance. Also available to staff was a comprehensive E&D sign posting manual, accessible through SharePoint, that gave comprehensive information on how to manage those with protected characteristics and was an excellent document. The E&D SharePoint site also allowed access to the E&D minutes, the e-learning package on respecting individuals and information on national issues.

There was evidence that HMP Edinburgh demonstrated a good level of commitment to those that were most vulnerable within the prison. Minutes identified good levels of prisoner participation through E&D meetings which the Governor chairs, as well as a person-centred approach to dealing with particular protected characteristics. HMP Edinburgh have looked after a higher level of transgender prisoners than other establishments in Scotland, and appeared well-equipped to deal with the particular issues this group raises, which was confirmed by transgender PIAC meetings around staff professionalism. Comprehensive action plans were in evidence identifying individualised support plans, and although in some cases action points took over three months to complete e.g. suitable underwear for Trans prisoners, inspectors were content that overall actions had been dealt with expediently. Staff awareness of E&D issues was good and a number of training events took place titled 'Tool box talks', which included transgender training, dignity at work, homeless training, child protection, addictions and TTM, that enable staff to support those prisoners who were most vulnerable. It was encouraging to note that 89% of staff at HMP Edinburgh, who were available, had completed SPS E&D classroom training and 82.6% of staff had completed the E&D e-learning course.

During the inspection, it was clear that interpretation services were being used, identifying 118 incidents where translation was utilised by telephone, face to face and translation of documents for parole and immigration.

Good practice: The E&D sign posting manual accessible through SharePoint that gave comprehensive information on how to manage those with protected characteristics.

8.2 Appropriate action has been taken in response to recommendations of oversight and scrutiny authorities that have reported on the performance of the prison.

Rating: Satisfactory performance

An action tracker was in place to allow the Senior Management Team (SMT) to review any recommendations from scrutiny bodies on a monthly basis. The Business Improvement Manager was responsible for providing progress updates on areas for improvement which were reported at the monthly Business Improvement (BI) meeting for action. Any actions were communicated to Unit Managers for further dissemination.

PRLs were carried out by managers from other areas to allow a good level of independent scrutiny, and any actions were disseminated to the appropriate areas to be dealt with. An example of this was 89% compliance on subject access requests (PRL 2.3.3.5) a), where a number of staff were unaware what a subject access request was. This was forwarded to the manager responsible for that area with an action included in the tracker. Evidence was submitted showing that, where these actions had not been met, the BI manager followed it up with a reminder to the manager prior to the next BI meeting, creating an e-mail audit trail and a successful conclusion.

Focus groups with IPMs and discussions with the Prison Monitoring Co-ordinator for the Edinburgh confirmed that there was reasonable relationships between them and those that worked and lived in HMP Edinburgh. They generally felt that they were actively supported in their work and that the Governor responded constructively to their quarterly meetings and reports.

During HMP Edinburgh's last inspection 6 -17 March 2017, there were five poor ratings within the report. Since the last inspection, the structure of the HMIPS report has changed, with only nine standards rather than 10 and E&D is now intertwine within the whole report. The QIs have also been reduced from 156 to 85. Therefore there cannot be a direct comparison with previous ratings. A lot of work had been carried out to address the poor ratings.

8.3 The prison successfully implements plans to improve performance against these Standards, and the management team make regular and effective use of information to do so. Management give clear leadership and communicate the prison's priorities effectively.

Rating: Generally acceptable performance

HMP Edinburgh had developed an annual delivery plan, which included a business improvement plan, accessible on SharePoint and available to all staff. However staff are not notified of the ADP existence or any important updates or changes and the inspectors were not confident that staff would know how to access the ADP or its content. Within the tracker, actions on recommendations could be evidenced or where there were plans to do so. The tracker clearly set out action leads, timescales, status, progress, comments and proposed evidence. Where actions had

not been met, mitigation was highlighted and proposed actions identified. An example of this was is in response to recommendations from the CPT. Although the recommendation was not fully met at this time with regards to improvements to SRU and women prisoners, there was evidence of some progress being made.

While staff welcomed the visibility and leadership of the Governor and Deputy Governor, the majority of staff spoken with during the pre-inspection focus groups, and in discussions held during the inspection, felt that Unit Managers were less accessible and could be more visible within the prison. Staff thought that Unit Managers should communicate more readily and offer more support when staff have to deal with serious incidents. Staff also indicated that they would welcome more information on the strategic direction for the prison and plans for addressing important issues such as dealing with staff shortages i.e. replacing vacant lines.

A report written by the prison HR Business Partner in 2018 based on findings from the staff survey confirmed this. Only 33% of those that responded felt their manager helped them to understand how they contributed to the SPS objectives. Only 36% of staff felt involved in decisions that affected their work, and only 33% felt valued in relation the work they did, and only 21% felt confident in their senior managers decision making. All these results were down from the previous staff survey. However it should be noted that the response rate of 27% was very low, so some caution is needed in interpreting the results. An action plan had been submitted to the Governor from HR, highlighting a number of actions to deal with these concerns, including a communications strategy and engagement plan.

Recommendation: HMP Edinburgh ensure that staff area aware of the existence of the ADP and that they have an opportunity to read and understand it with regards to their role.

8.4 Staff are clear about the contribution they are expected to make to the priorities of the prison, and are trained to fulfil the requirements of their role. Succession and development training plans are in place.

Rating: Generally Acceptable performance

During the pre-inspection focus groups with staff and speaking with them throughout the inspection, inspectors reported that without exception, the main concern of staff related to staff shortages and the pressure they felt to work overtime to cover shifts.

Despite high levels of sick absence and staff reporting that morale was low, inspectors found motivated and committed staff who were providing a professional service under difficult circumstances. The 2018 staff survey results referred to in QI 8.3 indicated that staff were unclear as to their contribution to the SPS priorities. 75% of staff felt trusted to carry out their duties, however they did not feel encouraged to speak up if they identified a serious policy or delivery risk. During the inspection staff spoke highly of the support provided by colleagues, but felt that due to staff shortages they were firefighting most of the time.

Staff commented on a lack of personal development due to the staff shortages as it was difficult to be freed up to attend extra training. Although the staff survey report

confirmed this, the prison had put in place a number of actions to deal with learning and development, including a comprehensive staff training plan 2019/2020 that indicated a number of courses had been delivered out with core competencies e.g. in RMT and E&D.

Most staff training took place on Friday afternoons, and a good range of training statistics were provided. A dip test of e-learning was carried out that indicated a high number of attendees. The system also tracked staffs non-attendance where an email was sent to the FLM of the staff member to ascertain the reason for non-attendance and the staff member is then reassigned a training date. At the time of the inspection, core competency training stood below 90%. With regards to staff engagement there were regular staff meetings held across the different functions including a FLM meeting every Friday as well as a SMT meeting and MDMHT. Meetings are also held in residential areas covering both shifts, including subjects such as strengthening their regime. Offender Outcomes and operations also carry out regular team meetings which are normally weekly.

8.5 Staff at all levels and in each functional staff group understand and respect the value of work undertaken by others.

Rating: Satisfactory Performance

The pre-inspection focus groups with staff, and discussions held with staff during the inspection, indicated that there was respect amongst staff for the challenges faced by other groups of staff, and a good understanding of respective roles. Residential staff reported their appreciation for the support from other staff to fill posts, but appreciated that regimes staff would be better served training prisoners and getting them to work and education.

It was particularly pleasing that the working relationships between the NHS and SPS staff were assessed so positively under Standard 9, with clear evidence of good communication and mutual respect.

There was also a good working relationship between the management team and the Partnership Liaison Representatives (PLRs), which assisted in the development of new policies and procedures.

There was a comprehensive newsletter produced by the HR department that informed staff off recent developments in training and development, staffing changes, staff recognition, promotion campaigns and other staff news.

Good practice: The staff newsletter produced by the HR Dept.

8.6 Good performance at work is recognised by the prison in ways that are valued by staff. Effective steps are taken to remedy inappropriate behaviour or poor performance.

Rating: Satisfactory performance

Completion rates for annual appraisals were carefully monitored. It was reported that just under 50% of Personal Performance Management System reports had still to be submitted for year ending April 2019. Therefore it was difficult to assess the numbers of reports where poor performance was addressed.

HMP Edinburgh experience higher levels of absence with 17.6 work days lost per staff member per year, against the recognised work days lost variable of 7.1, which placed a lot of pressure on the prison. The HR and senior management teams had worked hard to reduce these figures over the last year, but it remained at a constant high figure. Sickness absence levels were closely monitored by senior management through an HR report at the BI meeting. Two training sessions were delivered by the HRPB and attended by 26 FLMs to support them in adhering to the return to work policy. The HRPB reported that standards of report writing and returns had improved as a result.

The prison ensured staff were visibly recognised at the entrance to the prison for their achievements. Over the past 12 months, one member of staff was given a Butler Trust award, six letters of recognition were issued by the Governor, six Chief Executive and 21 governor awards were also presented to individual staff or groups within the prison.

The Governor sends out letters of recognition for those who have been absence free for a year, has informal chats with staff who have worked at the prison for more than five years, and speaks to all staff leaving the prison, whether on retirement, moving on to other employment or due to ill health. Since the first of January 2019 16 staff have left under capability procedures.

As part of the prison's centenary celebrations, an officer was recently recognised for providing 44 years of service to the SPS, all of it at HMP Edinburgh.

8.7 The prison is effective in fostering supportive working relationships with other parts of the prison service and the wider justice system, including organisations working in partnership to support prisoners and provide services during custody or on release.

Rating: Good Performance

There were numerous examples of HMP Edinburgh working well with other organisations responsible for providing services for prisoners. Both during their sentence and on liberation, and these links were a strength within the establishment.

HMP Edinburgh listed 34 third sector agencies working within the prison.
There were many examples of collaboration between the prison and outside agencies, including promoting health and wellbeing and working with universities in

providing distance learning. One particularly good example was the 'bus project' - a multi-agency partnership involving Heavy Sound who support vulnerable and disadvantaged young people in the music and creative arts sphere. Prisoners contributed to refurbishing the bus and, when finished, the bus will provide support to those with drug and alcohol issues, along with advice on healthy living, IT support, refreshments and an area to provide haircuts. HMP Edinburgh celebrated International Women's Day with poster campaigns, guest speakers and a range of activities promoting women's rights, and street soccer who worked with prisoners through soccer to improve communication skills, self-esteem and to form links for support on liberation.

Unfortunately, the national suspension of Throughcare Support Officers (TSOs) in September 2019 has led to a reduction in engagement with outside agencies in supporting those leaving the prison. By the time the scheme was suspended, Edinburgh TSOs had engaged with 93 male and female prisoners from 14 different local authorities, supporting them in housing employment and addictions. New routes and components of addictions through care (CGL) have filled some of the gaps but it remains to be seen if this will compare to the services provided by TSOs.

8.8 The prison is effective in communicating its work to the public and in maintaining constructive relationships with local and national media.

Rating: Satisfactory Performance

Although SPS HQ deal with all requests for media and the prison cooperated where practical with any media requests, HMP Edinburgh had engaged with national and local issues such as smoke free prisons and job based initiatives as examples, with subjects like the recent centenary celebrations, the bus project and staff awards appearing in the SPS twitter page.

HMIPS Standard 9

Health and Wellbeing

Quality Indicators

9.1 An assessment of the individual's immediate health and wellbeing is undertaken as part of the admission process to inform care planning.

Rating: Satisfactory performance

On arrival at HMP Edinburgh the immediate health and wellbeing needs of patients were assessed by a member of the healthcare team using a standard health screening tool. Staff followed a formal process to determine whether a prisoner was fit to be in custody and anyone identified as being at risk of self-harm or suicide was placed onto TTM.

Health screening was carried out in a room that maintained the prisoners' dignity and confidentiality throughout the consultation. Staff explained the health screening process to prisoners and encouraged them to be involved in the process. Routine drug screens were carried out if patients opted in and a referral for blood borne virus (BBV) screening was offered. The health screening process informed the patient's care planning and referrals were made to the relevant services with the patient's consent. Staff explained that all health screening information was clearly recorded onto the Vision patient electronic record system. During the inspection, the Vision system was not accessible but healthcare staff had access to a paper version to be recorded electronically on return to the health centre.

9.2 The individual's healthcare needs are assessed and addressed throughout the individual's stay in prison.

Rating: Satisfactory performance

Following their initial health screening on admission, patients were seen by an advanced nurse practitioner (ANP) the following day at the first night in custody clinic. Patients with LTCs were identified at this clinic and had the opportunity to discuss any medical concerns, including the risk of self-harm and suicide. There was a system for checking and verifying prescriptions with the community pharmacy service, which supported continuation of existing treatments. All information was directly entered into the patient record on Vision.

Inspectors observed first night in custody clinics and found that staff listened to any concerns raised by patients, offered reassurance and support, discussed referral to other services and described the range of health services available and how to access these.

A wide range of health promotion material was displayed in the halls describing the services and support available to prisoners. These included helpline numbers and leaflets for peer support through the Listener scheme, independent advocacy, alcoholics anonymous and how to access condoms. Inspectors also saw posters

publicising a health promotion event for prisoners and families to attend planned for November 2019.

Prisoners could self-refer to healthcare services and forms were available in the halls. Prisoners could place referral forms in locked boxes which were only accessible to nursing staff, which ensured confidentiality. There was a clear indication of the current expected waiting period for non-urgent referrals to primary care displayed within the halls. Different versions of referral forms were available and although the forms used simple language and some had pictures, they were not available in different languages or suitable for patients with literacy issues. Inspectors were told that the forms were currently under review to improve access to all.

The daily triage system enabled staff to respond to patient's immediate care needs as well as scheduled appointments arranged by an ANP or GP. Inspectors observed that attendance at health centre clinics was organised and supported by SPS staff.

There was a process to refer patients to secondary care services, and GEOAmey were responsible for escorting prisoners to secondary care appointments out with the prison. Inspectors were told that escorts to planned appointments in a secondary care setting could not always be provided by GEOAmey and could be cancelled at short notice. Following this, there was no process in place to notify patients that they had missed an external appointment. Inspectors raised this with the health centre manager who took immediate action to implement a process to address and monitor this.

Inspectors were told about some cases where appointments were sent directly from NHS Lothian to patients within the halls. This was a security risk as prisoners should not be notified in advance that they will be leaving the prison to attend an appointment. Inspectors escalated this to NHS Lothian following the inspection for immediate action, and inspectors will monitor the Board's progress with this.

A response nurse was identified at each shift handover meeting to attend any patients who had been identified through a code blue and red. There was appropriate emergency equipment available and a robust system in place for necessary checks of this. There was an arrangement in place for access to out of hour's service for emergencies.

Inspectors were told that where there was the need for a patient to be seen by secondary care, as a result of a healthcare emergency, SPS and healthcare staff made the necessary transfer arrangements. This was supported by a clear process within an SOP for the 'Acutely unwell patient'.

Access to the provision of social care staff to assist patient's activities of daily living was provided on a 24-hour basis. Inspectors saw evidence that healthcare and social care staff worked together in collaboration with the patient to develop their care plan. Health and social care plans reviewed by inspectors were person-centred and reflected the individual needs of the patient.

Recommendation: SPS and GEOAmey must facilitate patients' attendance at appointments to secondary care. Appointments to secondary care should only be cancelled due to an unforeseen and extraordinary circumstance. Under the duty of candour, all patients who miss a secondary care must be informed of the reason why, and what actions will be taken to mitigate the risks to the patient as a result of this.
Recommendation: NHS Lothian must ensure that patients receive secondary care appointments through the health centre.

Good practice: Access to the provision of social care staff to assist patient's activities of daily living was provided on a 24-hour basis. Inspectors saw evidence that healthcare and social care staff worked together in collaboration with the patient to develop their care plan. Health and social care plans reviewed by inspectors were person-centred and reflected the individual needs of the patient.

9.3 Health improvement, health prevention and health promotion information and activities are available for everyone.

Rating: Satisfactory performance

BBV treatment was commenced for all patients requiring hepatitis C treatment. This included both remand and sentenced prisoners. There was an established process, in line with the Scotland hepatitis C elimination programme, for follow up of remand prisoners returning to the community to ensure continued access to treatment post release.

Prisoners were encouraged and supported to take up the wide range of health promotion activities and opportunities available to them including; harm reduction, smoking cessation, sexual health, alcohol services and smart recovery groups.

There was a comprehensive selection of self-help and health promotion materials within the halls. This included information on how to access services and helplines. Inspectors were told that health staff did not currently attend induction sessions, however inspectors saw a healthcare presentation which was included at induction for those new to the prison.

In addition to BBV screening there were a range of national screening and immunisation programmes available to patients. Inspectors saw that national screening information for individuals was received at the health centre and recorded in patient notes.

Change Grow Live (CGL), a national health and social care charity, provided pre-liberation harm reduction groups. However, inspectors found that the process to ensure that patients identified within the group received naloxone on liberation was not followed. This lack of clarity of the pathway to ensure all patients at risk had access to Naloxone on liberation was a concern which was raised with staff for immediate action.

Delivery of training and provision of Naloxone kits for patients with a planned liberation date was effectively delivered, where these patients were identified. However, there was no system to ensure that all remand prisoners had the same access to Naloxone training as planned liberations, therefore this was not equitable. Inspectors were told that the manager for the addiction team was working with the SPS to rectify this. Overall, the provision of Naloxone training for patients and availability of information across the prison was limited.

Recommendation: NHS Lothian must ensure that all prisoners who require Naloxone training have access to this and an effective process is in place for the provision of Naloxone kits.

Good practice: There was an established process, in line with the Scotland hepatitis C elimination programme, for follow up of remand prisoners returning to the community to ensure continued access to treatment post release.

9.4 All stakeholders demonstrate commitment to addressing the health inequalities of prisoners.

Rating: Good performance

Equality, diversity and human rights training was integral to the mandatory training for all staff working within the health centre.

During the inspection, staff spoken with possessed a good understanding of the health inequalities faced by their patients. Staff were also able to describe how they promoted and carried out inequalities-sensitive practice.

Staff behaved in a professional manner, were polite, positive, and treated patients with dignity and respect throughout the range of healthcare interactions observed by inspectors. All the staff observed demonstrated a human rights approach to care. One example was identifying when interpreters were required for patients using both 'language line' and requesting attendance of interpreters for patients who did not have English as their first language. There were some examples of health promotion and advice in languages other than English and healthcare staff were also observed advocating on behalf of patients with intellectual disabilities and cognitive impairment including dementia.

9.5 Everyone with a mental health condition has access to treatment equitable to that available in the community, and is supported with their wellbeing throughout their stay in prison, on transfer and on release.

Rating: Good performance

The mental health team was multi-disciplinary with mental health nurses and psychology and psychiatry input. The team had recently expanded with additional posts funded by Action 15, which is part of the Scottish Government Mental Health Strategy 2017-2027. Two psychological therapists had been recruited to work across the two estates along with administration posts and a mental health

occupational therapist. Potential developments of the service included the provision of trauma informed group work within the halls and additional one-to-one sessions initially for sentenced patients, with plans to extend the assessment to remand patients. This additional resource was a positive addition to increase the scope of delivery of mental health service across the prison.
The mental health team worked Monday to Friday and were not routinely required to dispense patient medication, however they did at times undertake this duty if required. This allowed the mental health nurses to deliver a wide range of mental health interventions. This included triaging referrals, carrying out assessments and reviews, providing depot clinics, over-seeing high dose anti–psychotic monitoring and responding to urgent and emergency requests to see patients. Inspectors spoke with patients and staff who were positive about the impact of the nurse-led clinic for patients with attention deficit hyperactive disorder (ADHD). Patients were offered assessment for ADHD and could re-establish or commence treatment if appropriate.

Inspectors were told that there was a monthly mental health multi-disciplinary team meeting in place where members demonstrated good multi-agency collaborative and partnership working. The team consisted of clinical psychology, mental health nurses, social work, SPS, forensic and clinical psychology, offender outcomes, residential and adhoc specialist input and they discussed prisoners with complex care needs.

Formal pathways were in place to identify if an individual required treatment and transfer to hospital, under the Mental Health (Scotland) Act. If specialist support was not available within the prison, a referral was made from the mental health team, for example, to the NHS Lothian forensic learning disability team. Inspectors saw examples of patients where a referral had been made to this service and a response was awaited to confirm the waiting times for an appointment. However there was no agreed timeframe within which a response should be received.

There was a process of referral to community mental health services when patients were liberated. Inspectors saw that referrals were monitored and identification of community contacts followed up and documented in Vision.

National waiting times and guidance were being met for emergency, urgent and routine referrals, however patients were not informed of their appointment times by letter. Staff told inspectors that the complex needs of some patients did at times impact on their ability to follow up on routine appointments. However there was evidence of clear efforts to manage caseloads to minimise any potential impact and see patients within planned review timescales.

Within the records reviewed there was evidence of assessment and planning of care which demonstrated the patient's involvement and agreement. Some patients spoken with did not have access to a copy of their care plan and were unclear about the frequency of appointments, reviews or aims of treatment. Inspectors were told by some patients that receiving appointment letters would be welcomed.

Within the nursing team, an investment in training and development of staff supported the delivery of a range of interventions in groups and for individual work. Delivery of low level psychological interventions by a mental health nurse was

incorporated into a service quality improvement programme for health care delivery. Success measures to demonstrate the impact were being considered as part of this work.

The mental health and addiction nursing teams were jointly managed and the benefit of this was evident in the collaborative approach to delivering care across both teams. The majority of the mental health nursing staff were non-medical prescribers which meant no delays in commencing necessary medications.

Where there was a need identified for a cognitive assessment the mental health nurses would make the initial assessment. If necessary a follow-up assessment would be arranged with the psychiatrist.

Patients with a diagnosis of dementia were supported to carry out their daily living activities with social care input as described in QI 9.2. Inspectors were told that alternative care within other prisons, hospital or within a care home setting had been considered to meet the needs of the patient. Inspectors heard that it was difficult to identify alternative environments for long-term care and this was a challenge to planning care to meet the needs of patients with a diagnosis of dementia.

Recommendation: NHS Lothian must ensure that patients are given the opportunity to have a copy of their care plan with agreed aims of treatment, and timing of reviews.
Recommendation: NHS Lothian must ensure that the needs of patients with intellectual disabilities within HMP Edinburgh is being met through the external referral process.

Good practice: The impact of the nurse-led clinic for patients with ADHD.
Good practice: The monthly mental health multi-disciplinary team meeting in place where members demonstrated good multi-agency collaborative and partnership working.
Good practice: The majority of the mental health nursing staff were non-medical prescribers which meant no delays in commencing necessary medications.

9.6 Everyone with a long-term health condition has access to treatment equitable to that available in the community, and is supported with their wellbeing throughout their stay in prison, on transfer and on release.

Rating: Satisfactory performance

Patients with a long-term health condition were identified by the primary care team at admission and followed up the next day at first night in custody clinics run by ANPs. There was an effective triage system which provided an opportunity to identify patients who had potentially deteriorating health conditions. This resulted in a referral to the ANP or GP, or treatments carried out by nurses in the halls.

Due to staffing levels, specific LTC clinics were not taking place at the time of the inspection. There was an absence of a systematic approach to management and review for all other patients with LTCs to ensure they are followed up. Routine

appointments were used within the health centre for patients with LTCs. The patient records that inspectors reviewed indicated that appointments for screening and reviews, including medications reviews, were being scheduled and were taking place appropriately to support the management of patients. These demonstrated condition specific information but did not show evidence of patient's involvement in the planning process.

Anticipatory care plans are used in primary and secondary care to describe the wishes of patients as their condition develops further and their health deteriorates. Inspectors were told that anticipatory care planning was at an early stage of implementation and although initially being utilised for patients with palliative care needs, there were plans to promote an anticipatory approach for patients with LTCs. This was a positive development and current care plans were evident for patients with complex health care needs. These were regularly reviewed by nursing staff and demonstrated a collaborative approach with social care input.

Equipment was available for patients with physical disabilities and reduced mobility. Inspectors saw designated 'accessible' cells which were appropriate for wheelchair access and the provision of a hospital bed. Personal evacuation plans were in place for patients inspectors observed.

Recommendation: NHS Lothian must ensure that patients with long-term health conditions have individualised, person-centred care plans. The care plans must evidence that patients have had an explanation regarding their condition and have had involvement in the planning of their care needs.

Good practice: The anticipatory care plan process.

9.7 Everyone who is dependent on drugs and/or alcohol receives treatment equitable to that available in the community, and is supported with their wellbeing throughout their stay in prison, on transfer and on release.

Rating: Satisfactory performance

Prisoners with drug and/or alcohol dependence were identified during the admission process. A patient group direction was in place to ensure any immediate detoxification was initiated and continuation of existing opiate replacement therapy (ORT) was discussed and arranged. Where initial detoxification was commenced on admission, patients were followed up the next day at the first night in custody clinic and assessed by an addictions nurse. Access to ORT commencement through the NHS adhered to the NHS Lothian protocols, was satisfactory and appeared to work well.

Support from CGL was available to patients who self-referred for addictions services. CGL ran group support and weekly SMART recovery groups and provided individual support to develop person-centred personalised recovery plans.

For those patients not immediately identified as requiring ORT there was the ability to self-refer to the addictions service and assessment was undertaken by CGL. Following this, where ORT was indicated, a referral between CGL and NHS, who delivered the addictions service, was required. Inspectors were told that for these

patients there was a requirement to complete drug diaries and provide urine testing over a two week period before any ORT would be commenced, and this timescale at times extended to five weeks. Therefore, accessing ORT was inequitable with the current system. There was however a good working relationships between both agencies and both NHS and CGL staff told inspectors that this was supported by regular meetings and communication.

Patients had personalised care plans in place with clear goal settings and there was evidence of involvement and agreement of plans by the patients.

Inspectors observed the mental health team and the addictions team working together and delivering a person-centred approach to care. The addictions team was multi-disciplinary and included a GP clinical lead for addictions and consultant psychiatrist input every four weeks. There was no waiting list for addiction services. The nurses in the addictions team were registered mental health nurses. Where patients on the addiction nurse caseload also had mental health needs, they were assessed by the addiction nurse and a care plan was implemented, meeting the dual needs of the patients.

Staff in the addiction team had recent training in low intensity psychological interventions. There were plans to develop the service with increased clinical psychology provision and occupational therapy in the future.

Where community services were available, links were made for discharge planning. Inspectors heard this process was more complex for patients living out with the immediate geographical area and this had been impacted by the loss of SPS throughcare officers who would be involved in supporting patients with the liberation process.

Recommendation: NHS Lothian must ensure access to ORT is available as soon as possible where this need has been identified, in line with national guidelines.

9.8 There is a comprehensive medical and pharmacy service delivered by the service.

Rating: Poor performance

A clinical pharmacy service was provided and pharmacy advice and support was available to staff within the health centre. A clinical pharmacist post had been introduced in the previous six months and there was ongoing development of this role to maximise the best use of this resource. Two full-time pharmacy technicians were responsible for ordering all stock and in-possession medications. Inspectors were made aware that the pharmacy technicians had been asked to support medicines administration, however, this had the potential to reduce the availability of pharmacy staff to deliver a full service and access development opportunities. Medicines reconciliation was carried out by the ANP the day after the patient had been admitted to the prison using the emergency care summary and community pharmacy.

Of the cells that inspectors looked at, patients had access to a lockable storage box to safely store any in-possession medication.

A Home Office Controlled Drugs license was in place and an SOP had been formally signed off by the NHS Lothian Area Drug and Therapeutics Committee. These were all up to date. The SOPs were kept in the pharmacy department and could be easily accessed by staff. A review of the "stock" medications showed that these were well maintained and covered all emergency drugs.

Inspectors were told that the multi-disciplinary prescribing assessment group met on a weekly basis to discuss patients with complex medication regimes. The group comprised of ANPs, GP, pharmacist, health centre manager, nursing staff and a Lloyd's pharmacist. Inspectors were also informed that the clinical pharmacist sat on the clinical management team group at which policies were discussed.

Inspectors acknowledged that there had been significant work carried out in HMP Edinburgh to review 100 kardexes of patients prescribed gabapentoids. This was in line with the change in classification of gabapentoids and NHS Lothian guidelines. The work was overseen by a group which included the lead pharmacist, GP and health centre manager, and had resulted in reduced numbers of patients receiving this medication and clearly identified systems and processes for those who do.

During our inspection, in some halls the dispensing of morning medication was lengthy due to the number of medications being dispensed in those halls. Plans were in place to create an additional space for staff to safely deliver medications within more reasonable time frames. There was no date identified for this change to be implemented.

Concerns were also raised over the administration of medication timings. There were examples of medicines prescribed for evening or night-time being given earlier, and in other cases medicines being given to patients at too close an interval. Inspectors reviewed a sample of prescription charts and recording sheets which confirmed this concern. This was discussed with the health centre manager who raised this immediately with the SPS during the inspection, as lock up times were impacting on medication administration.

Staff told us that when patients went to court those with in-possession medicine took these with them, however those due supervised medicines at lunch time would not have these available. Where medicines were supplied for liberation, this was for a five day period. Discussions to move to a system using GP 10 prescriptions had taken place, but this change had not been implemented at the time of our inspection. There was a gap in provision for patients on remand who were prescribed controlled drugs. These were not being supplied for liberation.

Recommendation: NHS Lothian must ensure there is a robust process in place to support provision of medication to meet the needs of all patients on liberation.
Recommendation: NHS Lothian must ensure that medication is administered as prescribed to minimise the risk of harm to patients. This includes ensuring that doses are not taken too close together or out with the time of day at which they are prescribed.

9.9 Support and advice is provided to maintain and maximise individuals' oral health.

Rating: Good performance

Systems and processes were in place for both emergency and routine appointments. These were monitored regularly to make best use of available resources. If a patient was unable or refused to attend an appointment, there was a process in place to see a patient from the waiting list.

The waiting time for a routine appointment for both male and female patients was within the Scottish Government's recommended time of 10 weeks for access to routine dental treatment. Clinics were well organised and where there was opportunity to re-allocate appointments that were not kept, this was robustly managed.

The majority of dental emergencies were treated by the prison dental service. However if this was not available or not appropriate, treatment could be accessed from the community dental services.

The dental room was fit for purpose. There were safe systems in place to ensure that dental instruments were removed from and delivered to the dental rooms. All dental instruments were decontaminated in line with national guidance.

Patients had access to oral health supplies within the halls and there was some evidence of information available in languages other than English.

Inspectors were told that oral health promotion staff attend the prisoner induction programme on a weekly basis and also contributed to health rotation days within the visitors centre.

9.10 All pregnant women, and those caring for babies and young children, receive care and support equitable to that available in the community, and are supported with their wellbeing throughout their stay in prison, on transfer and on release.

Rating: Not applicable

There were no pregnant women living in HMP Edinburgh at the time of the inspection.

9.11 Everyone with palliative care or end of life care needs can access treatment and support equitable to that in the community, and is supported throughout their stay in prison, on transfer and on release.

Rating: Good performance

At the time of the inspection, there were several patients residing in HMP Edinburgh with palliative care and end of life care needs, the needs of those patients had been assessed using standardised assessment tools.

Details about prisoners' palliative or end of life care needs were recorded on the HMP Edinburgh electronic palliative care register. The register included a traffic-light system to indicate the level of care required by each patient: 'green' indicates that a patient is fully self-caring through to 'red' when the person requires full care and input from secondary care or third sector may be required.

Formal guidance was in place to support staff when it came to contacting the palliative care service, and evidence of a review by a palliative care specialist was detailed on care plans and discussed at a fortnightly review meeting.

Inspectors reviewed several patient records and found that patients were involved in the planning of their care. Consent was sought for information sharing where appropriate and this was documented. Information shared included end of life care wishes and preferred place of death, with evidence of discussion with the patient on their choices.

For patients with palliative care needs, use of a recognised pathway combined with specialist input supported a person-centred approach to care planning.

As reported in QI 9.6, at the time of the inspection anticipatory care planning was being trialled for patients with palliative and end of life care needs.

SPS staff had received do not attempt cardiopulmonary resuscitation (DNA CPR) training. They were able to competently describe the process that would be followed and the support available for those patients with a DNA CPR certificate in place.

Within palliative care planning there was evidence of consideration given to work safely and effectively within the parameter of the prison environment for the comfort and safety of the patients. Alternatives were identified where treatments appropriate for community use could pose a risk to the patient in the prison environment. This was person-centred to meet individual needs.

Good practice: The use of a recognised pathway combined with specialist input supported a person-centred approach to care planning for patients with palliative care needs.
Good practice: Patients identified with palliative care needs are reviewed every two weeks.
Good practice: Partnership working with the palliative care specialists was an area of strength.

9.12 Everyone at risk of self-harm or suicide receives safe, effective and person-centred treatment, and support with their wellbeing throughout their stay in prison, on transfer and on release.

Rating: Poor performance

Any patients identified as being at risk of self-harm or suicide during their admission to prison or during their stay in prison were immediately commenced onto TTM.

TTM case conferences were held Monday to Friday and were attended by the mental health nurses. Those scheduled over the weekend were attended by members of the primary healthcare team who were trained in TTM. Any relevant information was shared at the nursing handover.

Inspectors reviewed several completed care plans and found them to be comprehensive and demonstrated patient involvement. This was reflected during a case conference that inspectors attended.

Inspectors were concerned to see that prisoners who had returned from court convicted were not being reviewed by a member of the clinical team, as per TTM.

Recommendation: NHS Lothian must ensure there is a process in place to provide health assessment to any patient on TTM returning from court with a change of circumstance.

9.13 All feedback, comments and complaints are managed in line with the respective local NHS Board policy. All complaints are recorded and responded to in a timely manner.

Rating: Satisfactory performance

Inspectors saw the confidential system in place in the halls for patients to make complaints about healthcare. Patients submitted complaints forms into a locked triage box which was only accessible by nursing staff, who emptied it on a daily basis. The complaints procedure was clearly explained within the complaints form and included the time frame that patients should expect to wait for a response. In addition, there were forms sign posting patients to independent advocacy and the SPSO.

Complaints were managed in line with the local NHS policy. Primary care nurses distributed complaints to the appropriate services such as primary care, mental health, and addictions, ANP or GP. All complaints were recorded on the Datix system and not recorded in the patient's vision record. Responses to patients were sent in sealed envelopes and a copy was stored in the information assets register, which was managed by the health centre administrator.

Staff spoken with indicated that they would assure patients that complaints were managed confidentially and would have no negative impact on current or future care and support. Inspectors observed this taking place during a visit to a hall.

There was no evidence that staff had completed formal complaints training. This was not currently embedded in statutory and mandatory training. Inspectors were told that the patient experience team had previously delivered training for staff, but no time frames or evidence of this training was available at the time of the inspection. Inspectors saw evidence of the planned clinical passport for staff in which complaints and feedback was a training component, however no dates for the roll out of this training were confirmed at the time of the inspection. Inspectors were told that staff received support from senior colleagues in managing complaints and that they were discussed at team meetings.

Recommendation: NHS Lothian must ensure that all staff managing complaints receive appropriate training to ensure that complaints are correctly managed.

9.14 All NHS staff demonstrate an understanding of the ethical, safety and procedural responsibilities involved in delivering healthcare in a prison setting.

Rating: Good performance

All staff working in the prison estate had attended induction training underpinning the SPS security rules and professional boundaries. Staff were able to explain the boundaries between professional and ethical issues. They were aware of the demands of delivering healthcare within the prison setting and the requirement for security, including the process to safely store healthcare information. Staff were also clear about their duty to pass on any intelligence that may compromise the health and wellbeing of a prisoner or the safe running of the prison. SPS staff had systems and processes in place for raising concerns about patient's welfare.

Both healthcare and SPS staff were able to describe how to raise concerns. Primary health care staff attended any patients where restraint had been required by SPS staff.

9.15 The prison implements national standards and guidance, and local NHS Board policies for infection prevention and control.

Rating: Satisfactory performance

Inspectors found that all staff spoken with were aware of, and had an understanding of the principles of infection prevention. Staff told inspectors that they could access national guidance and infection control manuals for reference. The majority of staff were observed to practice standard infection control precautions, including hand hygiene, when carrying out their duties. Primary care staff could describe the precautions they would take in the event of a body fluid or blood spill. There was no product available in the treatment rooms within the halls due to the lack of secure lockable storage, however staff told us where they could access this. Clinical areas within the halls were cleaned by nursing staff while pass men were trained in bio hazard cleaning and undertook this within the halls. There was an SOP in place for outbreaks and a link established with public health for advice and support in NHS

Lothian. Minutes from NHS Lothian's infection control committee were shared and available for staff.

The fabric of the health centre building was in good state of repair. However, some of the walls and work surfaces within the medical rooms in the halls were damaged, and none of the clinical hand wash sinks in the halls were compliant with SHTM 64 guidance. In one hall there was no sink available within the treatment area. Inspectors requested a risk assessment to demonstrate the remedial actions to mitigate risk. This was not available at the time of inspection, but inspectors will monitor progress against this. Any estates issues were reported through the SPS estates system. Staff indicated that any estates issues were dealt with in a timely fashion and there were no jobs outstanding.

Compliance with standard infection control audits was variable due to poor staffing levels. The health centre manager had access to the electronic system staff should be inputting audit data into. Any non-compliances with standard infection prevention and control precautions were raised at the daily safety brief and staff handover. The health centre manager indicated that once staffing levels improved, audits would be re-instated.

Recommendation: NHS Lothian must undertake a risk assessment to demonstrate the remedial actions taken to mitigate and monitor the risk of having no sink available in the treatment area.
Recommendation: NHS Lothian must ensure that standard infection control precaution audits, including hand hygiene, are regularly undertaken by appropriately trained staff and actions are taken to address any non-compliances. All staff must be informed of the audit results and any actions required to improve practices.

9.16 The prison healthcare leadership team is proactive in workforce planning and management. Staff feel supported to deliver safe, effective, and person-centred care.

Rating: Generally acceptable

The mental health and addictions team were appropriately staffed and rostered to provide a service during core hours, which was an effective use of resources. There were three posts vacant in the primary care team at the time of the inspection. As a result of the vacancies, the band 7 was undertaking frontline duties and were therefore unable to provide line management support. Staffing was regularly discussed at senior manager meetings and had been escalated through the NHS Lothian governance structure. As a result, an agreement has been made to over-recruit to the healthcare team going forward. Currently four posts for primary care have been secured. The current staffing issues were documented as a risk on the NHS Lothian risk register. Senior managers told inspectors the recruitment process was lengthy due to a new NHS wide system of recruitment. This is a recognised national issue.

Although the senior charge nurse received regular one-to-one supervision, line management and appraisal meetings, the remainder of primary care staff were not receiving line management or clinical supervision.

Staff were supported by line managers to complete appraisal, mandatory training and develop skills to enhance practice. This was evidenced for mental health and addictions staff.

There were currently no team meetings for primary care staff, or one-to-one meetings for primary care staff other than the senior charge nurse. Inspectors did observe a comprehensive handover of all patients and tasks to be undertaken at a daily multi-disciplinary meeting, attended by all clinical staff. This was a robust process.

Staff in the primary care team described a good team relationship and inspectors were told that staff can approach senior staff for support at any time. However, there was a reduction in time available to the senior charge nurse for primary care to undertake a full range of necessary leadership and management duties.

Staff had received their induction training, including training provided by the SPS and statutory and mandatory training. However, other training and development opportunities had not been available to staff due to the current staffing constraints. The senior charge nurse was able to generate reports to demonstrate compliance with statutory and mandatory training. This was regularly discussed at healthcare leadership meetings.

9.17 There is a commitment from the NHS Board to the delivery of safe, effective and person-centred care which ensures a culture of continuous improvement.

Rating: Satisfactory performance

The NHS Lothian vision for health care was on display in both patient and staff areas within the health centre and when asked, all staff confirmed they were aware of it.

Although all staff were able to describe their immediate line management structure not all were familiar with the NHS board management structure.

The governor, deputy governor, health centre manager and senior NHS Managers met every six weeks to discuss any issues relating to matters between either staff groups. The agendas and minutes of these meetings also demonstrated a collaborative approach towards decision making and resolving issues.

All senior primary care staff across HMP Addiewell and HMP Edinburgh met on a weekly basis to discuss the NHS Lothian quality improvement plan for prison healthcare. Inspectors were told that to date, patients feedback was not routinely used to inform the improvement planning process. However, recently, the service had begun to strengthen its engagement with patients to ensure that their views and experiences informed future quality improvement initiatives. The minutes reviewed by inspectors confirmed this.

All incidents were recorded into Datix, in line with the NHS Lothian incident report process, and reviewed by the health centre manager. Staff reported that they felt comfortable to report any issues or concerns. Peer support was also in place to support staff following any incidents as well as formal debriefing sessions. Senior staff also described the internal governance structures for escalating issues and concerns. Inspectors saw examples of good working relationships between SPS and healthcare staff to facilitate patient's attendance at appointments. Inspectors also observed examples of collaborative working with third sectors agencies, community services and secondary care to improve health outcomes for patients.

Good practice: The governor, deputy governor, health centre manager and senior NHS Managers met every six weeks to discuss any issues relating to matters between either staff groups. The agendas and minutes of these meetings demonstrated a collaborative approach towards decision making and resolving issues.

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