

# **HM INSPECTORATE OF PRISONS**

## **HMP KILMARNOCK**

**INSPECTION: 8-9 NOVEMBER 2005**

**LAST FULL INSPECTION 25-29 OCTOBER 2004**



**SCOTTISH EXECUTIVE**



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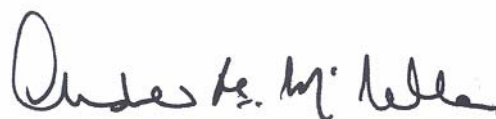
## 1. INTRODUCTION

1.1 The visit to HMP Kilmarnock was made as part of a programme to visit every prison in the year following a full inspection. In the course of such visits the purpose is to follow up points of note from the full inspection, to examine any significant changes, and to explore issues arising from the establishment's own assessment of itself. It should not be seen as an attempt to inspect the whole life of the establishment.

1.2 The Inspection Team comprised:

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December 2005

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## **2. PREAMBLE**

2.1 This follow-up report indicates that serious attention has been paid to the matters raised in the full inspection report of 2005, and that most have been dealt with satisfactorily. For example, the activity of the addiction staff is now more clearly focused and directed. Improvements have been made to the “rovering” system: this is the system by which prisoners are able to move to different parts of the jail under the escort of a Prison Custody Officer. When the system does not work properly prisoners have great difficulty in accessing facilities they need in the learning centre or the health centre. There is also evidence of more consistency in Induction and better integration of Sentence Management and Throughcare.

2.2 There is still not enough for remand prisoners to do. It is good that they spend significant periods of each day out of their cells; but it is not good that there are so few opportunities for useful activity for them. Some additional educational provision has been made: however, the day for a remand prisoner is still an empty, boring experience.

2.3 The Throughcare Centre is now well established. There was evidence from prisoners of its importance in making useful links with the community before release. The Criminal Justice Plan of the Scottish Executive says that support at the point when an offender leaves prison “is crucial in influencing future offending behaviour”. That is the work which is begun in Throughcare Centres (or Links Centres, as they are more usually called). The consolidation and extension of that work is important for public safety, as well as for the welfare of prisoners. However, the funding of the Throughcare Centre in Kilmarnock finishes in 2006. It is important that the operation of the Centre is maintained.

2.4 At around the time of the last full inspection of Kilmarnock, the BBC showed an ‘under cover’ documentary which expressed concern about the anti-suicide procedures in place in the prison. The full inspection did not provide evidence to support this concern; nevertheless this current inspection paid close attention to anti-suicide measures. In March 2005, a Fatal Accident Inquiry Report into the death of a prisoner in Kilmarnock in January 2002 was published. Following the documentary and the Fatal Accident Inquiry Report, Premier commissioned an independent audit of Kilmarnock’s Suicide Risk Management Strategy. This report found that the anti-suicide strategy at Kilmarnock was “comprehensive, well-managed and effective”. The current inspection report confirms that conclusion,

providing evidence of a strategy which is competent and thorough. Every prisoner group interviewed said that they felt safe in the prison.



### 3. PROGRESS ON RECOMMENDATIONS AND POINTS OF NOTE

Five Recommendations and forty four Points of Note were made in last year's full inspection report. Progress as follows:

#### *Recommendations*

Implemented	3
Partly Implemented	2

#### *Points of Note*

Implemented	26
Partly Implemented	7
Ongoing	2
Not Implemented	5
No longer relevant	4

### RECOMMENDATIONS

#### **11.1 There should be more activities available to prisoners when they are out of their cells in the evening and at weekends (paragraph 2.17).**

Partly implemented. There has been a slight increase in activities available, including night classes and extra PT. Prisoners had been surveyed but the level of response was disappointing. Some social events including a Burns Supper, A Sportsman's Dinner and a Pop Concert had been very popular.

#### **11.2 Prisoners should be escorted to where they need to be within the prison more efficiently (paragraph 2.18).**

Implemented. Changes to staffing arrangements and a decrease in staff absence levels have addressed this. However, there are occasions when a prisoner's attendance at his HRAT case conference is still dependent on whether or not an officer is available to escort him to the health centre.

**11.3 Induction should be carried out consistently and with all prisoners (paragraph 5.18).**

Implemented. Four Sentence Management Officers now carry out induction for convicted prisoners. The classroom element of induction is better scheduled, although this element has been reduced from two days to one. This means that prisoners can wait up to two weeks for induction. Induction for untried prisoners is carried out on the wing by residential officers using the information DVD. Some prisoners, usually first offenders, also go through a shortened induction document which is then attached to their wing narrative sheet.

Immediate information needs are met by a DVD and a booklet. Plans are well advanced to translate this booklet into eight of the most frequently used foreign languages.

**11.4 The overall Sentence Management System should be changed in order to integrate the elements more closely (paragraph 5.29).**

Implemented. Sentence Management documentation is now held in the secure office area within each houseblock. This means that Personal Officers no longer have to leave the wings to access the documents. The Sentence Management Officers manage the system and provide support and coaching in the wings. The process is now referred to as 'Sentence Management' rather than alternating with the term 'Sentence Planning'. A monthly audit system is in place to ensure compliance with target dates. A random sample of folders was examined and while most were satisfactory some were incomplete.

**11.5 All visiting staff who work alone, such as the optician, should hold their consultations in an area that can be observed by other staff (paragraph 6.29).**

Partly implemented. Most consultation rooms are easily observed by custody officers. The optician however still sees prisoners in the X-Ray room which has no observation windows. The door is left open to aid supervision but both the prisoner and the optician cannot easily be seen unless the custody officer is standing in the doorway of the room.

## **12. POINTS OF NOTE**

### *For Establishment*

#### **12.1 All missing or broken cell privacy keys should be replaced (paragraph 2.4).**

Implemented. Regular audits now take place and a supply of spare keys is kept.

#### **12.2 A drawer unit should be fitted in each cell (paragraph 2.5).**

Not implemented. Funding has not been made available. Prisoners are still disadvantaged.

#### **12.3 The process of allocating prisoners to shared cells should be formalised (paragraph 2.9).**

Implemented. Kilmarnock now use the SPS cell sharing risk assessment documentation.

#### **12.4 Management should continue to find ways to engage very vulnerable prisoners in more constructive activities (paragraph 2.11).**

Partly implemented. Very vulnerable prisoners still have quite an empty day. However, they can now access the peripatetic tutor for a personalised education programme, go to the library once a week and attend the gym every Friday. They are still offered exercise in the open air with the other prisoners, but almost always refuse. There are still few opportunities for useful activity for remand prisoners.

#### **12.5 Management should find ways of stopping prisoners removing wet clothing from machines in the laundry facilities in the wings and putting in their own (paragraph 2.15).**

Implemented. New laundry equipment and changes to procedures have addressed this. The laundry system now works well and is popular with prisoners.

**12.6 Management should put in place an appropriate system for washing plates and cutlery after meals (paragraph 2.16).**

Partly implemented. Washing up liquid is available in the wings but prisoners still have to wash their plates and cutlery in their cells.

**12.7 Quality assurance checks should be undertaken in the complaints procedure to ensure appropriate responses (paragraph 3.9).**

Implemented.

**12.8 Internal Complaints Committees should take place on time, and if necessary prisoners should be given an interim reply (paragraph 3.10).**

Implemented.

**12.9 The regime in the Segregation Unit should be reviewed (paragraph 3.19).**

Partly implemented. The prison awaits an overall review of Segregation Unit regimes by SPS. In the interim, prisoners in the Segregation Unit can attend the gym or be seen by the peripatetic learning advisor and be offered education.

**12.10 The practice of “double reporting” a prisoner for the same incident should stop (paragraph 3.21).**

Implemented. A daily check for “double reporting” is carried out by the Segregation Unit Manager who submits a weekly report to the Deputy Director.

**12.11 The MDT officer should be able to attend addictions meetings (paragraph 4.4).**

Implemented.

**12.12 The prison should examine the balance of effort committed to the various elements of the addiction service (paragraphs 4.9 and 4.19).**

Implemented. The previous practice of running two twenty eight day programmes per month has been reduced to running one. The resources freed up have been used to introduce new or extended services including: follow-up evaluation of the programme one-to-one work; a 'drop in' clinic; harm reduction information; liaison with external agency workers; and a family information service. The addictions team has been increased to six by recruiting two addictions caseworkers and filling the vacant alcohol caseworker post.

**12.13 The addiction nurse should attend the case conference style meetings to look at care planning for individual prisoners (paragraph 4.10).**

Implemented.

**12.14 Clear guidelines should be given regarding the management of special risk prisoners entering the establishment (paragraph 5.2).**

Implemented. A Risk Alert Protocol has been put in place which ensures that potential risk is identified at the initial admission interview prior to prisoners being taken to the reception. A Risk Assessment Form is in use and a Risk Register is maintained.

**12.15 The provision of notices in reception for prisoners who do not speak English should be made a priority (paragraph 5.8).**

Implemented. Notices are in place which allow non-English speakers to identify their own language. Additionally, information notices in 12 of the most frequently used languages are on display. There is also access to the telephone translation service.

**12.16 Arrangements for the storing of prisoners clothing in reception should be improved (paragraph 5.9).**

No longer relevant. The storage area is still small and cramped. However, better housekeeping and the introduction of a disposal system for left property has improved the situation.

**12.17 The system for allocating responsibility for individual prisoners to Personal Officers should be reviewed (paragraph 5.21).**

No longer relevant. With the changes to the Sentence Management system identified at Recommendation 11.4, this is no longer an issue.

**12.18 The core screening tool for assessing needs in the SPS should be used in Kilmarnock (paragraph 5.31).**

Not implemented. A review identified resource implications which would require contractual change. After discussion between HMP Kilmarnock and SPS, no change has been made.

**12.19 Management should ensure that an integrated approach to Throughcare is in place (paragraph 5.36).**

Implemented. A management structure has been put in place to address the issue of a fragmented approach to service provision. This involves a Strategic Steering Group chaired by the Service Manager of APEX (who run the Throughcare Centre), and attended by the Assistant Director for Resettlement plus Managers from the service providers. An Operational Group is chaired by the Throughcare Manager and attended by the Resettlement Co-ordinator and representatives of the providers' line management. There is also an inter-agency group chaired by the Throughcare Manager and representing those who provide the services.

**12.20 Additional wall cupboards should be fitted in the health centre (paragraph 6.3).**

No longer relevant. Additional wall cupboards have not been provided but a tidy up of the area appears to have eliminated the need for this.

**12.21 "In patient" facilities in the health centre should be improved (paragraph 6.4).**

Implemented. Some re-decoration has taken place and portable screens are available to allow for added privacy at the bedside.

**12.22 Alternative arrangements to the holding rooms in the health centre should be found (paragraph 6.6).**

Implemented. Better scheduling of attendance at clinics such as methadone has reduced the numbers which are required to be present at one time. Water is available if requested.

**12.23 Links between the Registered Mental Nurses and addictions services should be improved (paragraph 6.15).**

Not implemented. There was only one RMN in post at the time of inspection with another expected to start in December. The new health centre manager is awaiting the outcome of a tendering process for pharmacy services which will free up nursing staff time and as a consequence will allow further strengthening of these links.

**12.24 The RMNs expertise would be better utilised if their time was dedicated to mental health issues rather than being used for general nursing duties (paragraph 6.15).**

Not Implemented. See 12.23 above.

**12.25 The staff alarm point in the dental surgery is too high on the wall and should be re-located (paragraph 6.23).**

No longer relevant. On reviewing this, the Inspectorate was satisfied with the current arrangement.

**12.26 The prison should introduce a computerised stock ordering system for the pharmacy (paragraph 6.27).**

Partly implemented. A SAGE computer programme is in operation. A pharmacy assistant has also been recruited. The health centre manager is currently reviewing the level of prescribing and is trying to reduce the stock level of drugs. This, aligned to the new pharmacy contract which it is anticipated will be awarded in January will improve the system of ordering and storing of drugs.

**12.27 The visiting pharmacist should be linked to the SPS pharmacy adviser (paragraph 6.27).**

Implemented. The health centre manager is a pharmacist and has established links with colleagues in healthcare at SPS HQ.

**12.28 The optician service could be improved through the introduction of a formal screening procedure for particular groups of prisoners (paragraph 6.28).**

Implemented. Prisoners attending the optician clinic are screened for diabetes. It is anticipated that planned changes to pharmacy provision will free up nursing time for nurse led clinics.

**12.29 In order to fulfil decontamination requirements for the podiatrist, the prison should purchase a hand-set and other tools that are sterilised and remain in the prison. Likewise any sharps should be disposed of in safe containers provided by the prison (paragraph 6.31).**

Partly implemented. A new podiatrist uses his own equipment and a sharps disposal facility is provided by the prison.

**12.30 All external visiting healthcare staff should be offered an induction programme (paragraph 6.32).**

Implemented. All staff including Agency Nurses receive induction prior to starting operational duties.

**12.31 Management should take urgent steps to address the weaknesses in breadth of provision of learning opportunities and re-establish access to appropriate programmes for remand prisoners and those in the segregation unit (paragraphs 7.1 and 7.16).**

Partly implemented. A tutor visits both areas two to three times per week and facilitates a range of one-to-one interventions. Remand prisoners can attend an evening class, but cannot access the learning centre during the day. However, last year's target for prisoner learning hours was 22,000 while 61,000 hours were delivered. From that performance there seems little contractual threat in allowing remand prisoners some access to the learning centre.



**12.32 The current failure to deliver basic skills of numeracy and literacy during the day should be addressed as a matter of urgency (paragraphs 7.4 and 7.16).**

Implemented. Vacancies within the learning centre have been filled and basic skills qualifications have risen from 90 last year to 182 in the year to date.

**12.33 Management should take steps to deal with the backlog of applications for distance learning programmes (paragraphs 7.6 and 7.16).**

Ongoing. There are currently 15 prisoners undertaking distance learning, this number fluctuates with transfers, liberations and new students.

**12.34 Management should consider how to overcome weaknesses in accommodation in vocational training (paragraphs 7.11 and 7.16).**

Implemented.

**12.35 Management should devise ways of providing certification in the welding and textiles workshops in recognition of the good practice there (paragraphs 7.12 and 7.16).**

Ongoing. SVQ units (mainly at Intermediate level 2) have been introduced in Health and Safety, Woodwork, Welding and Textiles. Kilmarnock and Ayr Colleges provide verification. While this is a welcome development, a concern remains that qualifications were identified to complement the employment which HMP Kilmarnock offers rather than identifying the qualifications which might best equip individuals for employment in the community.

**12.36 The well resourced library would be enhanced by the addition of subscriptions to appropriate periodicals (paragraphs 7.13 and 7.16).**

Implemented.

**12.37 The prison should ensure that the terms of the Contract are being met in respect of the delivery of mail to prisoners (paragraph 8.9).**

Implemented. Procedures were reviewed and mail now arrives in the wings on time. Complaints are investigated, and where necessary Royal Mail Investigations Branch is notified.

**12.38 Facilities for hand washing should be available in the safe cells in the health centre (paragraph 8.12).**

Implemented. This is achieved by the provision of hand wipes which are passed to the prisoner through the door hatch by a member of staff.

**12.39 The High Risk Assessment book should be held in the residential unit rather than in the control hub (paragraph 8.17).**

Not implemented. The books are still held in the hub but procedures are in place to ensure that staff check them during their shift and pass on information about anyone on High Risk Assessment (HRA) during the handover. During the night shift the documentation is taken from the control hub and attached to the prisoner's door. A check of the paperwork of the current cases in the health centre and an audit of some closed files showed that the custody staff are linking their care to the issues outlined in the care plan.

**12.40 When a Listener requires an emergency call to the Samaritan Co-ordinator for support, the requirement for confidentiality should be respected (paragraphs 8.20 and 8.22).**

Implemented. When Listeners require to make a confidential call to the Samaritans they are allowed to use a confidential line in the hall office.

**12.41 Consideration should be given to deploying a Listener in the reception area and in induction (paragraphs 8.21 and 8.22).**

Implemented. A Listener works in reception and sees prisoners there as required. A Listener is also deployed to the induction area when an induction programme is running.

**12.42 A review of the management of requests by prisoners to see a Listener should be carried out (paragraphs 8.21 and 8.22).**

Implemented. Requests to see a Listener are still recorded in a request book held in the control hub. A monitoring system is in place to ensure that a Listener makes a call within an agreed timescale.

**12.43 The Chaplaincy Team should attend the morning Management meetings (paragraph 8.41).**

Partly implemented. The full time chaplain attends a team meeting with his line manager who in turn attends the morning management meeting. This has not fully closed the communication loop as feedback is not always provided. Chaplains do not have access to the electronic desk top mailing system.

Chaplains are no longer allowed to meet with groups of prisoners without the supervision of a custody officer. This can lead to the last minute cancellation of the groups due to staff not being available. A number of the groups use visiting volunteers who have to be turned away when the groups are cancelled at the last minute.

**12.44 Prisoners serving food in the wings should be dressed properly for the task and be fully trained in food handling (paragraph 9.17).**

Implemented.

## 4. NEW DEVELOPMENTS

### 4.1 *Suicide Management Strategy*

An audit procedure has been introduced to ensure that custody staff are checking prisoners as reported in the 'observation logs'. The check involves matching the time recorded on the logs to the CCTV images and the watchman night patrol print outs. A check of the High Risk Assessment (HRA) minutes for this year demonstrates that meetings are held regularly, attendance at the meetings is good and appropriate attention is being paid to the safety of prisoners on HRA. The Listeners also reported positively on the support given by management to the HRA system although they sometimes have to see remand prisoners in the public area of the hall if the prisoner is in a double cell. The High Risk Assessment documentation now records when a prisoner is at court on a day when a case conference is scheduled. A prisoner's attendance at his case conference can still be dependent on whether or not an officer is available to escort him to the health centre.

### 4.2 *Prisoner Disciplinary System*

The number of disciplinary reports has fallen markedly since the last inspection.

### 4.3 *Human Resources*

There has been an increased emphasis on staff training in the past year. Facilities in the training area have been improved and the Investors in People award was achieved at the first attempt. There has also been a move to link training objectives to the strategic objectives of the prison.

There has been a focus on addressing staff absence, and this has now decreased significantly. This means that posts are more regularly and consistently covered.

### 4.4 *Accommodation*

Some prisoners had complained to staff and management that there was no guard fitted on top bunks. This had led to occasions when mattresses slipped and prisoners fell out of bed. The prison was in the process of fitting guards on all top bunks.

#### 4.5 *Safety and Security Developments*

An internal security audit resulted in some changes to procedures and to security refresher training for all staff. There has also been an increase in staff and visitor searches to help stop prohibited items entering the prison.

The prison indicated that more proactive security activity had led to reduced bullying and intimidation in the wings, and data indicates that there has been a reduction in threats made to staff, drug and drug paraphernalia finds and the need physically to restrain prisoners.

A Staff Alcohol and Drug Testing Policy has also been introduced, the first of its kind in a Scottish prison.

#### 4.6 *Throughcare Centre*

The Throughcare Centre at Kilmarnock is currently funded by a Lottery Fund grant. This funding is due to finish in April 2006. At present it is not clear how future provision of the Throughcare Centre will be met. It is important that this service is maintained.