HMIPS
HM INSPECTORATE OF
PRISONS FOR SCOTLAND

INSPECTING AND MONITORING

HMP Edinburgh

Full Inspection
6-10 November 2023

Contents

Introduction and Background

This report is part of the programme of inspections of prisons carried out by His Majesty's 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 21 bodies making up the NPM in the UK.

His Majesty's Chief Inspector of Prisons for Scotland (HMCIPS) assesses the treatment and care of prisoners across the Scottish Prison Service (SPS) estate against a pre-defined 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 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:

- Asking the Governor or Director in Charge for a self-evaluation – summary of their progress against previous recommendations, the challenges they face and the successes they have achieved.
- Obtaining information and documents from the 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.
- Reviewing policies, procedures and performance reports produced both locally and by SPS Headquarters (SPS HQ) specialists.
- Conducting a pre-inspection survey with prisoners prior to the inspection.
- Reviewing the Independent Prison Monitors (IPM) reports and a focus group with IPMs.

HMIPS is supported in our work by inspectors from Healthcare Improvement Scotland (HIS), Education Scotland, the 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 results of the pre-inspection survey will be published at the same time.

Key Facts

Location
HMP Edinburgh is located in the Saughton area on the west side of Edinburgh city, 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. The prison manages adult male prisoners on remand, short-term sentences (serving less than four years), long-term sentences (serving four years or more), life sentences and Order for Lifelong Restrictions (OLRs).

Brief history
The building of the prison started around 1914, with the first prisoner being received about 1920. It replaced Calton gaol, the current site of St Andrew's House on Regent Road, Edinburgh. The prison was completely rebuilt between 1998 and 2009. The oldest building within the grounds of the prison is Glenesk Hall, which opened in 1998; Ratho Hall, opened in 2009, represents the most modern accommodation.

Accommodation
There are four accommodation halls: Glenesk holds predominantly untried prisoners; Hermiston holds convicted and untried offence-protection prisoners; Ingliston holds both short-term and long-term convicted mainstream prisoners, including non-offence protection prisoners, as well as the First Night in Custody Centre; and Ratho is an enhanced unit holding low risk offence-protection prisoners. There is also a Separation and Reintegration Unit (SRU).

Design capacity
At the time of the inspection, the design capacity was 872. However, there was an additional 57 places providing an extended operating capacity of 929. The prison had an agreed Assessed Operational Limit of 973.

Date of last inspection:
28 October to 8 November 2019, published in 2020

Healthcare provider:
NHS Lothian

Learning provider:
Fife College

Overview by HMCIPS

The HMIPS 2019 inspection, published in 2020, reported that HMP Edinburgh was a well-run, effective but very busy prison with a solid performance by management and staff at all levels and managing one of the most complex mixes of prisoner population of any Scottish prison establishment.

In the intervening years HMP Edinburgh faced significant challenges not only with the impact of COVID-19 but also with high staff vacancies and staff absences. Despite this, HMIPS were disappointed not to find HMP Edinburgh in better shape, with explicit concerns about activity, time out of cell and the need for tighter assurance on use of force. However the prison did feel safe.

Overall, three standards were assessed as satisfactory and six as generally acceptable, indicating considerable room for improvement.

The main concern was the lack of a full regime for prisoners. In particular, the very limited evening regime with almost no activities taking place beyond a relatively small number of prisoners having access to visits and the gym. Prisoners were frustrated to be locked in their cells for most of the day with little opportunity for activities. The prison, in theory, could provide an excellent range of work and educational opportunities, including music and a radio station. However, too often staff from regime areas were pulled away to cover shortages in residential areas, and either work opportunities were cancelled or moving prisoners from residential areas to purposeful activity proved difficult, with no formal route movement. Greater effort needs to be made to improve the activity levels and we strongly suggest that a rapid reprofiling or workforce capacity modelling exercise is undertaken that addresses the issues.

The intention of the previous Senior Management Team was to bring in an improved range of evening activities post COVID-19. Different to the traditional evening recreation and providing opportunities for constructive case management interaction between personal officers and prisoners. Unfortunately, this worthy aspiration had not been realised, mainly as a result of staffing shortages. Instead, the prison appeared stuck in the unhappy position of not having enough staff available to run an adequate evening regime, and therefore trying to cram everything into the core day. This resulted in clashes between activities and entitlements, such as access to fresh air, leaving the majority of prisoners locked in their cells from 4.30pm onwards, exactly as they were during the COVID-19 pandemic. There was almost a defeatist attitude amongst staff about the prospects of ever being in a position to improve this situation.

The arrival of a new Governor-in-Charge (GIC) and Deputy Governor, however, provides an opportunity to shift that dynamic, address any issues with rostering and shift pattern that may be inhibiting progress, and re-energise and reinvigorate efforts to reintroduce a more productive regime.

There were a number of examples of good practice to report. These included an impressive peer mentor system for new admissions and a robust local induction process, although it was difficult for protection prisoners and foreign nationals who did not speak English to access this. It was encouraging to see that prisoners in the Separation and Reintegration Unit (SRU) received regular visits from a GP and a mental health nurse.

We saw good practice too in relation to the handling of property so that prisoners were able to receive their belongings quickly, and inspectors praised the support offered to veterans. We also commend the Physical Training Instructors (PTIs) on the relationships developed with partners in the community to arrange football themed events that brought families together and gave prisoners the opportunity to spend time with their children. The new staff mentoring scheme also looked promising.

Healthcare (HIS) inspectors identified 15 examples of good practice, including a system for fast tracking patients onto Opium Substitution Therapy, the weekly 'Person of Concern' meetings with SPS colleagues, the use of 'Change Grow Live' caseworkers to support people on liberation, and the weekly Attention Deficit Hyperactivity Disorder (ADHD) clinics delivered by a psychiatrist and a learning disability nurse. They also praised the training of SPS night staff in how to administer naloxone and the work alongside SPS colleagues to develop a trauma informed practice strategy.

Although the prison felt safe, a number of safety related issues worried the inspection team. As in the 2020 report, planned removals were still not always being properly recorded, and there was a shortfall in the number of staff whose Control and Restraint (C&R) training was up-to-date. Regular cell searching was not consistent with good practice and a lack of control was evident in relation to the movement of prisoners. Similarly, there was no evidence of an anti-bullying strategy being implemented, despite this being a recommendation from our 2020 inspection report.

Although we saw evidence of Talk to Me (TTM) case conferences being handled well, we have made a number of TTM related recommendations, including not resorting to Immediate Care Plan (ICP) protocols when staff were available to hold a case conference. Essential training in British Institute of Cleaning Science (BICSc), and Food Hygiene for those working as cleaners, in the serveries or kitchen were also well below where they should be.

Accommodation noticeably varied; while the newer accommodation in Ratho Hall was of a high standard, the remand hall of Glenesk was of much poorer quality. Many cells in Level 3 had missing toilet seats and ventilation was a problem in some cells due to blocked vents. Some small single cells in Glenesk were being used for two people, which did not meet internationally recognised standards on minimum space for multi-occupancy and in addition contained only one chair.

Cleanliness in some parts of the prison was noticeably poor, with for example litter collecting next to some external corridors. Control around the ordering and storage of towels and clothing needed improved.

As we have seen in many establishments, prisoners had no confidence in the complaints system. We make a number of recommendations in relation to this, the most significant is that SPS HQ should look to introduce an electronic system for registering a complaint and recording progress with responding to it, which would end prisoner concerns that complaints get lost, torn up or are not actioned.

Two further areas that could contribute to prisoner satisfaction would be making it easier for families travelling from afar to book double visits and ensuring equitable access to the prison library.

As with many of our inspection reports, we strongly urge timely access to programmes essential to rehabilitation, reinvigoration of the personal officer scheme and assurance that short-term prisoners who meet the criteria are considered for progression to HMP Castle Huntly.

In conclusion, the new Senior Management Team are faced with some difficult and long-standing challenges in allowing the prison to recover from its very restricted COVID-19 regime. We hope that this report provides clarity on the wide range of issues that need gripped and addressed. The management team, with the support of SPS headquarters, needs to provide a fuller regime whilst tackling some of the safety related issues identified by inspectors. Both issues will require serious management effort and support with ensuring the prison has the staffing complement necessary to deliver effectively.

In total we have made 112 recommendations, but we encourage the SPS and HMP Edinburgh to focus on the following key recommendations:

Recommendation 84: SPS and HMP Edinburgh should undertake a full reprofiling or workforce capacity modelling exercise that recognises the staffing and regime challenges facing HMP Edinburgh.

Recommendation 86: The HMP Edinburgh Senior Management Team should ensure that improvement priorities are effectively communicated and discussed with staff, particularly with regard to opening up the regime.

Recommendation 34: HMP Edinburgh should with immediate effect ensure that all planned use of force removals are recorded, all paperwork completed and subject to review as per SPS guidelines.

Recommendation 49: HMP Edinburgh should implement a controlled system for mass movement of prisoners.

Recommendation 48: HMP Edinburgh should ensure searching processes are in place for movement of prisoners around the establishment.

Recommendation 36: HMP Edinburgh should implement a violence reduction strategy.

Recommendation 31: HMP Edinburgh should ensure there is an anti-bullying strategy in place that meets the aims of the SPS anti-bullying policy (currently Think Twice 2018).

Recommendation 11: SPS HQ should withdraw the use of single cells as double cells for contingency plans in Glenesk, where they do not meet minimum space standards.

Recommendation 12: HMP Edinburgh should address the levels of graffiti and poor cosmetic state of many cells in Glenesk and ensure doors and handrails in the stairwell are painted.

Recommendation 16: HMP Edinburgh should ensure all cells have toilet seats.

Recommendation 64: SPS HQ should introduce a complaints system that will evidence when a complaint has been made and is able to track the progress electronically, with the prisoner receiving a written acknowledgment that his complaint has been logged and is offered progress reports when requested.

Recommendation 66: HMP Edinburgh should ensure all prisoners within each prison population have equitable access to participate in good quality employment opportunities.

Recommendation 67: HMP Edinburgh need to address the issues around escorting prisoners to the Learning Centre to improve attendance levels.

Recommendation 78: SPS HQ should ensure timely access to accredited programmes is available to enable evidence of change for progression.

Recommendation 74: HMP Edinburgh should reinvigorate the personal officer scheme and improve awareness of their role in the Integrated Case Management (ICM) processes to achieving the desired outcomes.

Recommendation 88: HMP Edinburgh should ensure that all core competency training increases to the required level as a priority.

Human Rights-Based Approach Overview

Panel Principles

Participation – Prisoners should be meaningfully involved in decisions that affect their lives.

During the admission process, prisoners were interviewed in a private setting and their views reflected in the Reception Risk Assessment (RRA) form. Reception staff made good use of translation services to ensure prisoners of all nationalities were able to participate in the admissions process. The First Night in Custody (FNIC) and SPS national induction booklets informed prisoners about the complaints process and the IPM service, but we would like to see the Prisoner Information Action Committee (PIAC) process added so that they are able to contribute to improving prison life. Frustratingly, this has been a recommendation in a number of our recent reports, and we have not seen any response to this from the SPS.

Although there were some examples of consultation on food and canteen through groups and PIACs, it was disappointing to note that there were no regular hall PIACs taking place across the prison, particularly as this was highlighted in the 2020 inspection report. Staff acknowledged that more should be done to engage with prisoners. Prisoners were participating in the reinvigorated Equality & Diversity (E&D) meeting as well as the protected characteristic themed groups, and these were recorded with clear actions. HMP Edinburgh had surveyed the population to help inform the regime plan for the post-COVID-19 arrangements and had consulted with Long-Term Prisoners (LTPs) when repurposing Ratho House.

During case conferences, prisoners were able to represent themselves in a person-centred way. Prisoners reported that they felt involved in their TTM case conferences, were clear about their management plan. The narratives in the case conference notes confirmed that each case was dealt with on the needs of the person, however prisoners reported that at times staff were less supportive than others. Inspectors observed a number of Rule 95 case conferences in the SRU, where they observed prisoners being given an opportunity to voice their issues and discuss their management plans. Disciplinary hearings were observed and found to be person-centred, ensuring each prisoner was given an opportunity to be heard.

Those participating in the ICM process were actively encouraged to get involved in their plans, to enable them to discuss their needs and allow them to establish links with relevant agencies prior to liberation. Those prisoners that were subject to statutory supervision arrangements were participating in Enhanced ICM processes and procedures. Prisoners' families were offered the opportunity to attend ICMs if they wished, but attendance was low. Short-term prisoners (STPs), who were not subject to statutory supervision arrangements on their release, had a very limited level of participation and interaction with the Standard ICM. Likewise, there was no formal mechanism in place to consider STPs for progression to open conditions.

Inspectors saw no evidence of formal participation with regards to bullying, harassment, and intimidating behaviour. HMP Edinburgh should ensure that prisoners are at the centre of any anti-bullying strategy. With little out-of-cell activity after mealtimes, staff had less time to interact with prisoners to allow prisoners to

share their needs and concerns. During the day, staff were often seen sitting around the desk and interacting with prisoners through closed grille gates, which is not conducive to building relationships.

Although there were processes in place to ensure prisoners were consulted about information to be shared with their family, prisoners reported they did not feel consulted, nor informed when this took place. Greater use should be made of the noticeboards and in-cell television system to inform prisoners of what activities are on offer, so they are able to participate.

Most prisoners understood the rationale of selection for paid work and were afforded their opinion during the Activity Allocation Board (AAB) in choosing the work they wished to attend. Library staff conducted a survey to further improve the services they offered, and used the responses to shape the services, making them more relevant to the prisoner population. However, access to the library was limited.

Prisoners' feedback was used by the PTIs to adjust the gymnasium programmes to better suit their needs.

Prisoners and staff acknowledged that maintaining contact with family and friends was a critical contribution to their personal wellbeing. Prisoners had access to in-cell telephones to use at their own convenience, and satisfactory access to face-to-face and virtual visits to help maintain close links with family and friends.

A number of prisoners benefited positively from engaging in activities within the Recovery Café and group work sessions, as well as undertaking religious observance. There were good examples of supporting more marginalised groups such as veterans.

Accountability – There should be monitoring of how prisoners' rights are being affected as well as remedies when things go wrong.

HMP Edinburgh had in place a number of processes that enabled the prison to monitor and take action when things went wrong, but the picture was inconsistent and required improvement. There were efficient processes in place for admission to and liberation from HMP Edinburgh, ensuring that convicted prisoners were offered induction and that on liberation travel arrangements and appointments in the community were facilitated.

Generally, the prison ensured that those in their care had access to basic entitlements such as clean bedding, toiletries, cleaning materials, and access to extra purchases through the prison canteen. However, there were several areas where the prison appeared to be struggling to meet the basic needs of prisoners, such as the supply of clothing and rain jackets, but there was evidence of the prison having plans in place to address several of these shortfalls. However, it was hard to understand why the prison would think it acceptable for prisoners to have to use toilets without toilet seats. Some prison staff were visibly upset at the inability to keep cells free from graffiti and meet basic needs. Prisoners in Ratho Hall appreciated the efforts made by staff to welcome and support them in their new enhanced wing, even though teething problems existed in delivering some of the things they had been promised.

Although prisoners reported being offered access to fresh air for an hour each day, action is needed to ensure those at work are afforded this opportunity without financial penalty.

There was a new TTM co-ordinator in place who inherited a good auditing process but had already identified areas for improvement. For example, reintroducing the quarterly TTM meetings that had not taken place during 2023. These meetings would enable the prison to analysis data, identify trends and any gaps in support. Having reviewed TTM files, there were examples of poor auditing by some First Line Managers (FLMs) signing off daily recording of case files and the weekly checks carried out by the duty managers.

The prison worked hard to ensure that enemies were kept separate through robust scrutiny, but there was no evidence of accountably within the Think Twice policy. There was no formal process, no monitoring, evaluation, or review taking place which was concerning.

Unit Managers were responsible for carrying out the orderly room process. They ensured all paperwork was completed covering all aspects of the process with a member of the Senior Management Team auditing the process. **Not all Special Security Measures (SSM) paperwork was up-to-date, and some paperwork was not signed off by prisoners, which needs to be addressed.**

Treat as Confidential (TOC) were handled efficiently. Processes to record outcomes of the Internal Complaints Committee (ICC) or recommendations to the prison from the Scottish Public Services Ombudsman (SPSO), were not adequately logged, meaning that learning outcomes were not always identified.

Regime managers effectively tracked the attendance of prisoners at work parties to evaluate when work parties ran, who attended them, and to record when work parties were cancelled.

Prisoner participation in work parties was influenced by the competing demands of other activities such as the gymnasium, education, prison programmes, the administration of medication and health services, and this needs to be addressed.

The prison was proactive in assessing and reviewing prisoners' risks and needs for programmes and support services, and in providing central oversight of ICM and Risk Management Team (RMT) processes and procedures. However, inspectors noted a fundamental disconnect between the role of the personal officer and the formal ICM arrangements under both Enhanced and Standard ICM processes, with little evidence of personal officer attendance at ICMs.

Inspectors also noted a decline in the number of monthly Order for Lifelong Restriction (OLR) behavioural monitoring forms submitted to OLR Case Managers.

HMP Edinburgh had a comprehensive range of management data and trackers in place, to ensure that processes such as the Health and Safety (H&S) management systems and cell certification were delivered and monitored by the Senior Management Team. However, there was less emphasis on following up

recommendations from HMIPS inspection reports timeously. Prisoner complaints were scrutinised to ensure the management team were aware of the issues involved and where improvement should be made. Inspectors considered that the handling of confidential complaints should be reviewed to ensure they are being responded to appropriately.

Non-discrimination and equality – 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.
During the inspection, there was no evidence of form of intended discrimination taking place. In most cases all prisoner categories were treated equally and fairly, although there was some inequality with regards to the treatment of prisoners depending on their status. Remands in particular had less access to activities than convicted prisoners.

Generally, prisoner and staff relationships were respectful which contributed to a safe environment. However, staff were frequently seen not wearing name badges, and could be unknown to prisoners, which was not conducive to building relationships. The reconfiguration of the different prisoner categories should ensure that particular groups, such as offence protection, are less likely to share areas with mainstream prisoners and therefore reduce the possibility of abuse.

The most vulnerable prisoners arriving at reception were treated well and all groups were treated equally. Staff were aware when markers for protected characteristics were raised and were alerted by reception when someone with additional needs was admitted.

Translation services were more widely used than we have seen in other recent inspections. Examples were seen on admission of documents being available in translated formats and also translation of legal documents. However, the translation of legal documents was not the responsibility of the prison and lies squarely with other organisations. Braille had been used where it enables individuals to fully participate in the ICM process. Additional support needs of prisoners were identified through the ICM and RMT process, to facilitate appropriate resources in the community.

The restricted regime where the prison was locked up for the most part after evening mealtime (4.45pm) affected time out-of-cell for those who were not working. Also, at times, it causes clashes in activities, for example attendance at work parties and access to fresh air.

Remand prisoners and those that did not speak English did not have access to national induction. Those that did not speak English were also denied access to the peer mentors due to the peer mentors not having access to translation services. HMP Edinburgh need to review this as soon as possible.

Prisoners with mobility issues occupying accessible cells were supported by passmen to keep their cells clean. However, accommodation for those with mobility needs was of mixed quality. It was found to be excellent in Ratho Hall but poorer in Glenesk. The number of accessible cells was inadequate for the prison population,

and it is expected that there will be more demand for these cells in the future. Prisoners had been trained in manual handling to allow them to push prisoners in wheelchairs, but an unintended consequence of the reconfiguration of the population meant that a number of the trained prisoners had moved to another hall. Due to resourcing issues, there was a lack of manual handling training opportunities, and therefore it was not clear how new prisoners would be trained to assist those that require it.

Another unintended consequence of the reconfiguration of the population was that prisoners who had been attending the Learning Centre and had been moved to the remand hall, Glenesk, had to cease their studies. HMIPS were told that the Education Team were looking into this, and we hope that a remedy can be found to allow these prisoners to continue their studies.

Decisions made by senior management for those located within the SRU and at orderly rooms were non-discriminatory and they treated each case on an equal basis. The process for allocating work to sentenced prisoners was thorough and fair, although a few prisoners perceived rates of pay between jobs to be unfair. However, remand prisoners were not afforded the same access and were mostly given jobs within their residential areas.

All prisoners were eligible to access the gymnasium and sports hall and attendance was high across the prison population. Barriers to prisoner participation were identified by PTIs and alternative activities were offered. Library staff were aware of barriers that might exclude users, for example they had introduced a good range of books for prisoners with dyslexia.

Prisoners also participated regularly in awareness raising events such as Black History Month and LGBTQ+ awareness.

Access to the library was restricted to those attending education, which limited access to the rest of the prison population. Although there was a variety of satellite libraries and ordering services available in the residential halls, this did not address adequately the lack of access for most prisoners.

A range of canteen items were available to meet the needs of all groups and the E&D PIACs provided feedback on this.

Empowerment – Everyone should understand their rights and be fully supported to take part in developing policy and practices which affect their lives.
It is important that every prisoner understands their rights and have the opportunity to contribute to new policies and practices that affect them, and more could have been done in this respect. Prisoners had little voice in changes which affected them, and although there was some evidence of consultation though PIACs there was a sense that they had been reintroduced relatively recently because of the impending inspection rather than being embedded practices.

When admitted, prisoners were provided with information through the local and SPS national induction booklet, the latter in their own language. However, the version in stock was out-of-date and should be updated by SPS HQ as a priority.

Prisoners were provided with lots of helpful information by peer mentors about their entitlements, but there was a lack of knowledge amongst staff about entitlements for foreign national prisoners.

Disappointingly, there was little evidence of information and notifications in other languages on the prison notice boards.

Experienced staff were more aware of prisoners' entitlements than newer staff and were able to signpost prisoners to the appropriate support. The lack of knowledge was also apparent in the lack of a prison-wide approach to bullying, intimidation, and harassment. More experienced staff were able to anecdotally explain the actions they would take where bullying occurred, but this was ad hoc. Overall, prisoners were not being supported in the appropriate manner.

The Prison Rules were not readily available in all residential areas. They were in the library, along with an abundance of other legal documents, but access to the library was limited to those attending education. To mitigate this, the library offered photocopied pages from legal texts or online pages in response to prisoner requests. Prisoners had access to legal representatives in the agents visit area, but disappointingly there was no evidence of a process in place to ensure that foreign nationals were permitted a call to Diplomatic Services on arrival.

Each prisoner, whether attending their Rule 95 case conference or an adjudication, were provided with the appropriate support and information to understand the process. Each prisoner was informed of their right of appeal through the adjudication process.

While recent IPM reports evidenced that some prisoners were using the service, more could be done to raise their profile within the prison.

There was low confidence in the prisoner complaints system. Forms were not available in all halls and prisoners informed inspectors of instances where staff actively discouraged them from complaining.

Most prisoners in education were able to use self-directed study whilst working towards a wide range of qualifications, for example learning Spanish or History.

There was good evidence of individual prisoners being meaningfully involved in case management decisions through engagement with the ICM Team, ICM case conferences and the RMT Forum.

Plans for release were clearly explained to prisoners and their views were sought. They were able to self-refer to services in the Links Centre and advocacy services were also available through the Links Centre.

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

In the main, HMP Edinburgh staff followed lawful procedures and completed them in a professional manner. Entitlements such as access to fresh air for at least one hour per day was in place but on occasion it clashed with other activity. Prisoners should not have to choose their legal entitlement of fresh air over other activities, particularly when the prison withdraws wages if they choose fresh air over work.

In common with other SPS establishments, there was evidence that the prison was not always able to accommodate prisoner groups separately as set out in the Prison and Young Offenders Rules (Scotland) 2011. This was due to population in excess of capacity. However, the reconfiguration of the population will go some way to addressing this. The contingency cells, designed for one person, but being used as doubles in Glenesk Hall, did not meet internationally recognised minimum space standards.

Each case where Use of Force (UoF) was applied (Rule 91 of the Prison and Young Offenders Rules (Scotland) 2011) was documented and fully explained, identifying the appropriate UoF used. However, within the guidance, all planned removals must be recorded, a recommendation made in our 2020 inspection report, and this was not always evidenced. Removal from association was carried out via Rule 95 of the Prison and Young Offenders Rules (Scotland) 2011 as required.

Residential FLMs were not aware of, nor following, legislation regarding the complaints process and this requires to be addressed.

Prisoners were able to observe the requirements and engage in the practices of their religion or belief, and were also able to possess religious books, items and materials for their own personal use.

Collaboration between relevant agencies ensured that planning and preparation for release was aligned to relevant legislation, policy and guidance.

It was apparent, and fully acknowledged by the E&D Co-ordinator, that equalities impact assessments were not always considered when new practices, policies or strategies were introduced.

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
Generally Acceptable

Standard 6 Purposeful Activity
Satisfactory

Standard 7 Transitions from Custody to Life in the Community
Satisfactory

Standard 8 Organisational Effectiveness
Generally Acceptable

Standard 9 Health and Wellbeing
Generally Acceptable

Standards, Commentary and Quality Indicators

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

In this standard, five quality indicators were rated as satisfactory and four were rated as generally acceptable giving an overall rating of satisfactory. There was one example of good practice and ten recommendations for improvement.

According to the HMIPS pre-inspection survey, 53% of prisoners said that they were treated well in reception on arrival with a further 34% reporting being treated neither well nor badly. There was a Standard Operating Procedure (SOP) covering the admissions process and staff were knowledgeable about the processes. Prisoners were taken into a private room to assess their ability to understand and allow them an opportunity to engage in the admissions process, via the Reception Risk Assessment (RRA) form. Interviews were completed in a caring and supportive manner. Reception staff were making good use of translation services where needed.

HMP Edinburgh should consider prioritising the checking of warrants in reception, to prevent delays and allow GEOAmey staff to leave as quickly as possible. They should also place a phone in the interview room to allow translation interviews to take place in a private area.

HMP Edinburgh had an impressive peer mentor/supporter programme in place that is worthy of sharing nationally. Almost every new admission and transferred-in prisoner met with a peer mentor and peer supporter as part of the admission process. The peer mentor had an allocated area within reception to meet with prisoners. They were given a First Night in Custody (FNIC) booklet that provided lots of helpful information. Once transferred to their final location within the prison, they were met by a peer supporter who took them through the regime for the hall and offered to go over the Induction Admission Checklist and any of the information provided to them by the peer mentor or within the FNIC booklet. This was a fantastic process for providing prisoners with the information they required before those eligible were offered the opportunity to attend national induction. SPS HQ need to update all versions of the 2012 SPS national induction booklet as soon as possible.

HMIPS Standard 1
Lawful and Transparent Custody – Continued

The FNIC booklet should be available in the languages spoken in the prison and HMP Edinburgh should ensure that staff are aware of foreign national prisoners' entitlements on arrival.

Inspectors were delighted to see the FNIC area up and running as this was a recommendation from the previous inspection however it had only opened the first day of the inspection, so it was early days. The immediate concern was that the area was shared with a cohort of non-offence protections and passmen, so space was limited. This was proven to be the case as the area had filled up by the end of the inspection week and therefore admissions were going to other areas that had space.

HMP Edinburgh should make every effort to have a safer cell and an accessible cell available within the FNIC area should it be needed.

Cell Sharing Risk Assessments (CSRAs) were being completed by hall staff when required and there was an appropriate assurance process in place. FLMs ensured compliance and secondary assurance was completed by residential Unit Managers. However, checks on some CSRAs revealed a lack of detail where a risk was identified and accepted and this needs improved. There were desk instructions available and the mentor for the establishment had been going over the process with staff. HMP Edinburgh should consider what else they can do to improve completion and prevent potential challenges should an incident occur.

Prisoners were notified of their critical dates via the internal mail within 24 hours of arrival.

In the HMIPS pre-inspection survey, 66% of respondents said that they were offered an induction on arrival at HMP Edinburgh, and this reflected the population that were being offered national induction.

There was a fantastic local induction process in place for all prisoners that spoke English, which is worthy of sharing nationally. National induction was being offered to all mainstream convicted prisoners at the induction workshop. Offence-protection prisoners were being offered induction once per-week in their hall, but uptake was poor because it clashed with the regime, and untried prisoners and those that did not speak English were not being offered it at all. HMP Edinburgh must review this as a priority to ensure that all categories of prisoners have equal access to the national induction programme.

The liberations process worked well, and staff followed the process in the SOP. Staff within the Court Desk and reception were able to clearly explain the liberation processes and there were SOPs available to guide them through it.

HMIPS Standard 1
Lawful and Transparent Custody – Continued

List of Good Practice

- The peer mentor/tutor process for prisoners that speak English.

List of Recommendations

- HMP Edinburgh should consider prioritising the checking of warrants in reception, to prevent delays and allow GEOAmey staff to leave as quickly as possible.
- HMP Edinburgh should place a phone in the interview room to allow translation interviews to take place in a private area.
- HMP Edinburgh and the NHS healthcare team should address the issues resulting in delays in nurses attending reception and operational staff escorting prisoners to residential areas.
- SPS HQ need to update all versions of the 2012 SPS national induction booklet as soon as possible.
- The FNIC booklet should be available in the languages spoken in the prison.
- HMP Edinburgh should ensure that staff are aware of foreign national prisoners' entitlements on arrival.
- HMP Edinburgh should closely monitor completion timescales for core screen paperwork.
- HMP Edinburgh should have a safer cell and an accessible cell freely available within the FNIC area should it be needed.
- HMP Edinburgh should take action to ensure CSRA entries on PR2 meet the required standard to prevent potential challenges should an incident occur.
- HMP Edinburgh should ensure that all eligible prisoners receive, or are offered, the National Induction Programme as soon as possible after admission.

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

Overview

In this standard, four quality indicators were rated as generally acceptable performance and two were rated as poor, giving an overall rating of generally acceptable. There was one example of good practice and 15 recommendations for improvement.

To cope with the rising prison population the prison was using some single cells in Glenesk as doubles, which breached internationally recognised minimum space standards of 6m² of personal space for one person in a single cell and a minimum cell size of 8m² for a double cell with two people. In Glenesk the décor was poor, and level of graffiti unacceptable and communal doors and stairwells were also in need of painting. Ventilation was a problem in some Glenesk cells and most cells in one landing had no toilet seats.

Although the standard of accessible cells was excellent in Ratho, one of the newer accommodation blocks, in Glenesk the accessible cells were of older design with significantly poorer décor. There was a structured maintenance programme, but some repairs had been outstanding for six months while awaiting parts and the Estates Team was operating with several vacancies.

Cleanliness was an issue in some residential areas and litter kept collecting against the external corridor connecting Ingliston with the main corridor, despite regular clearing-up operations.

There were issues with the ordering of clothing and control of towels and clothing sent to the laundry that resulted in some landings being short of certain sizes of clothing and towels. The prison was formulating plans to control this better and improve access to rain jackets. Arrangements for the disposal of old mattresses also needed improved, but there was evidence of a systematic mattress replacement programme.

HMIPS Standard 2
Decency – Continued

The laundry staff had a good system for checking with residential staff when bedding in particular cells appeared overdue for cleaning and there was a regular and effective laundry schedule. However, some prisoners complained about clothing coming back damp from the laundry, which the staff there attributed to prisoners putting too much stuff in their laundry bags rather than spreading the load over a number of days. To their credit the laundry staff agreed to put a reminder out to prisoners to help address this. Some prisoners did not wish their clothing to be dried using industrial tumble dryers, which they blamed for shrinking clothing, and were having their washing returned wet and then hanging it up in their cells to dry. This was unhygienic and carried other safety concerns. Therefore, the prison should provide opportunities for these prisoners to use smaller tumble dryers in residential areas.

A sizeable number of prisoners working as passmen in residential areas had not been BICSc trained, and less than 10% of prisoners working in the prison kitchen had achieved certification in Food Hygiene. Both of these essential training need to be addressed, along with reinforcement of basic training around the use of whites, food hygiene, and temperature checks in the pantries.

A high percentage of prisoners complained about the food, but both the quantity and quality of food looked reasonable during the week of our inspection. HMIPS sympathise with the challenge of trying to provide three meals a day on a budget of £3.19 per prisoner per day, while trying to cater for a range of special diets. It was commendable that the prison had won a Healthy Eating award in 2020. However, we support the plea made by prisoners for more variation in the menu and recommend that the prison looks to at least operate with a winter and summer menu to provide some visible variation.

List of Good Practice

- Laundry staff had a good process for reminding staff in residential areas when bedding from particular cells had not been washed for a long time so they could encourage the occupant to put it out for washing.

HMIPS Standard 2 Decency – Continued

List of Recommendations

- SPS HQ should withdraw the use of single cells as double cells for contingency plans in Glenesk where they do not meet minimum space standards.
- HMP Edinburgh should address the levels of graffiti and poor cosmetic state of many cells in Glenesk and ensure doors and handrails in the stairwell are also painted.
- HMP Edinburgh should address the problem of poor ventilation in cells in Glenesk from blocked ventilation slats.
- SPS HQ and HMP Edinburgh should work together to address the number of vacancies in the Estates Team and difficulties retaining skilled trades when market forces provide more attractive opportunities.
- HMP Edinburgh should address the problem of litter being thrown out of Ingliston cell windows and collecting in the external corridor leading to the main corridor.
- HMP Edinburgh should provide toilet seats for all cells that are missing them.
- HMP Edinburgh should ensure all prisoners working as passmen are BICSc trained and certificated.
- HMP Edinburgh should improve the process for disposing of used mattresses, so they do not have to be parked in storerooms holding clean bedding.
- HMP Edinburgh should consult prisoners at least on a six-monthly basis about any changes they wished made to the canteen list.
- HMP Edinburgh should follow through on its plan to introduce a more robust process for controlling access to towels and monitoring the number of towels sent and returned from the laundry.
- HMP Edinburgh should review the process for ordering new clothing to ensure it is working as effectively as possible.
- HMP Edinburgh should ensure that those prisoners not wishing to have their clothes dried in the industrial tumble dryers do not have to resort to hanging washing in their own cells to dry.
- The HMP Edinburgh Catering Manager should ensure that all prisoners working in the kitchen are Food Hygiene certificated.
- The HMP Edinburgh Catering Manager should consider the scope to introduce winter and summer menus to provide some variation in the main prison menu, involving prisoners in that through Food Focus Groups.
- HMP Edinburgh should reinforce training for pantrymen around basic food hygiene, the wearing of whites, and use of temperature checks.

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

Overview

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

In general Talk to Me (TTM) was managed reasonably well, which reflected the recent internal SPS audit where they had received reasonable assurance. The TTM Co-ordinator had recently taken up post and was acutely aware of a number of improvements that had to be made. The sampling of TTM files indicated that there was some work to be done to improve standards. Examples of improvement are to ensure that shift paperwork is completed properly, including First Line Manager (FLM) signatures and the person/role responsible, and improvement of narratives.

Some of the files highlighted mistakes that should have been picked up by the duty manager's audit. Inspectors attended TTM case conferences in Ingliston Hall and found the room was not fit-for-purpose and the timing of the case conference should not have been when prisoners were still out of their cells as the noise was a distraction. There was also a need to restart TTM quarterly meetings.

It was a complex picture with regards to keeping individuals and groups separate and the prison did well to manage this. The GIC and Senior Management Team were kept up-to-date on the challenges through formal and ad hoc meetings. FLMs were also informed on any actions to be taken to keep persons separate and any threats that may evolve.

The pre-inspection survey indicated that just over half (58%) reported feeling safe all or most of the time, with 20% feeling rarely or never safe. Throughout the week inspectors reported that the prison felt safe. Although more than half of prisoners (55%) reported witnessing staff members abusing, bullying, threatening, or assaulting another prisoner at HMP Edinburgh, and 40% reported that staff had abused, bullied, threatened, or assaulted them, inspectors did not witness any form of negative behaviour, and in fact witnessed a number of positive interactions throughout the week. However, it is rare for inspectors to witness poor treatment while on inspection and this is only a snapshot for one week.

HMIPS Standard 3
Personal Safety – Continued

Although this standard was satisfactory in most of the quality indicators (QIs), it was rated as generally acceptable due to QIs 3.4 and 3.5 being rated as poor.

There was no evidence of any anti-bullying strategy far less the national SPS policy, Think Twice 2018. With 31% of those surveyed reporting having been abused, bullied, threatened, or assaulted by other prisoners, it was disappointing there had been no improvement to the recommendation from the inspection report of 2020, that 'HMP Edinburgh should fully implement the Think Twice Strategy, including the referral process to support victims'.

The way that staff dealt with perpetrators or victims of bullying, harassment or intimidation could be described as ad hoc. Anecdotal evidence suggested that the more experienced staff dealt with bullying or intimidation when observed, but this could not be said for less experienced staff. Although most staff said they would report bullying via an intelligence report, which should be commended as it keeps the Information Management Unit (IMU) up-to-date with information, the prison must implement an anti-bullying strategy as a priority.

HMP Edinburgh were well placed with regards to dealing with incidents, with Incident Command Team (ICT) roles at full complement and mutual aid above complement. A good suite of Standard Operating Procedures (SOPs) supported operational readiness.

Health and Safety (H&S) in the prison was well organised, with the appropriate processes in place to dealing with accidents, near misses and fire evacuation. There was a long extensive list of those on the personal emergency evacuation plans (PEEPs), but it required an update. With only 41% of managers competent in H&S for Managers, there is a need to increase training to a more acceptable level.

List of Good Practice

- The support offered to veterans, allowing them a safe environment to support each other and share common experiences.

HMIPS Standard 3
Personal Safety – Continued

List of Recommendations

- HMP Edinburgh should ensure that they follow the TTM guidance and not utilise the ICP when the appropriate staff are available to hold a case conference.
- HMP Edinburgh should ensure that the timings and surroundings are conducive to a positive environment in which to hold a TTM case conference.
- HMP Edinburgh should ensure that TTM Co-ordinator meetings are held at regular intervals, and at least once per quarter.
- HMP Edinburgh should ensure that they have sufficient staff trained in manual handling so as to train prisoners to assist those in wheelchairs.
- HMP Edinburgh should encourage the opening of grille gates, if necessary one wing at a time, to encourage communication with prisoners and building relationships of trust.
- HMP Edinburgh should ensure there is an anti-bullying strategy in place that meets the aims of the SPS anti-bullying policy (currently Think Twice 2018).
- HMP Edinburgh should ensure the correct Fire Action Notices (FANs) are in place on every cell door.
- HMP Edinburgh must ensure that the PEEPs register is updated to reflect the current population.

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

In this standard, five were rated as satisfactory performance, two rated as generally acceptable and three rated as poor performance, giving an overall rating of satisfactory. There were three examples of good practice and 16 recommendations for improvement.

HMP Edinburgh attempted to provide a supportive environment for prisoners. This was evidenced during the Use of Force (UoF) witnessed and the compassion shown to the individual throughout the incident. Some planned removals had not been recorded, which was disappointing considering this was a recommendation made in our 2020 report. C&R training competencies were not at an appropriate level. The adjudication process took account of prisoner needs and looked to provide support where appropriate, not just a punishment. However, not all the rooms used for adjudications were fit-for-purpose.

The SRU was run well with a complement of three officers and a FLM. However, at times staff were used to escort prisoners out of the establishment, which restricted the SRU in carrying out their business. The management of Rule 95s was appropriate, with prisoners given the opportunity to have a voice and their residential area took the lead in this process, ensuring the prisoner maintained links with residential staff, creating an easier reintegration process. NHS did not regularly attend Rule 95 case conferences and at times information on the circumstances surrounding them being placed in the SRU was not given to the prisoner. Prisoners were not offered access to educational materials which is an option under Rule 95.

Not all cell searching took place within the PRL timescales, and on many occasions it was observed that prisoners were not rub down searched when moving from one area to another or the use of metal detectors or cell sense. There is a need to improve control with the movement of prisoners and implement a violence reduction strategy.

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

Prisoners had access to their property and personal cash. Reception processes were robust, and all property was recorded on the prisoner's property card. The establishment had a good reception request system which was used to record and action any property related issues. The pro forma system was clear and easy to use for staff, prisoners, and families. Access to cash was available to all prisoners through canteen and sundry purchases on a weekly basis.

HMP Edinburgh had a good process in place for mandatory drug testing, mainly used for progression cases, but also conducting risk assessments when required. Staff appeared knowledgeable and provided as much dignity as possible.

List of Good Practice

- HMP Edinburgh SRU prisoners receive regular visits from a GP and mental health nurse.
- Having an officer assigned to deal with property daily so prisoners are able to receive their belongings timeously.
- Good request system which was used for all reception requests keeping the process consistent.

List of Recommendations

- HMP Edinburgh should with immediate effect ensure that all planned use of force removals are recorded, all paperwork completed and subject to review as per SPS guidelines
- HMP Edinburgh should take immediate action to address the shortfall in C&R staff competence.
- HMP Edinburgh should implement a violence reduction strategy.
- HMP Edinburgh should ensure supervising officers are aware what a planned removal is and the requirement to video record the removal.
- HMP Edinburgh should encourage staff to use rigid cuffs during removals as a safer option.
- HMP Edinburgh should maintain staff complement in the SRU.
- HMP Edinburgh should ensure NHS staff receive invites to all case conferences.
- HMP Edinburgh should consider options to allow prisoners access to education materials whilst in the SRU.
- HMP Edinburgh should provide as much information as possible to prisoners during a Rule 95 case conference, and not make decisions on outcomes before they take place.
- HMP Edinburgh should ensure that in all adjudications that a formal record of previous adjudication outcomes are available for the adjudicator.
- HMP Edinburgh should ensure that the rooms used for adjudications are fit-for-purpose.

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

- HMP Edinburgh should ensure all review dates on SSM paperwork are carried out timeously adding a review date column in the SSM tracker document.
- HMP Edinburgh should ensure all SSMs are signed by prisoners and uploaded to PR2.
- HMP Edinburgh should ensure all cells are searched within the PRL timescales.
- HMP Edinburgh should ensure searching processes are in place for movement of prisoners around the establishment.
- HMP Edinburgh should implement a controlled system for mass movement of prisoners.

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: Generally Acceptable

Overview

In this standard, one quality indicator was rated as satisfactory, five were rated as generally acceptable and two were rated as poor performance, giving an overall rating of generally acceptable. There were no examples of good practice and 16 recommendations for improvement.

In relation to sharing critical information between prisoners and their families, there was a Standard Operating Procedure (SOP) informing staff of the processes and those spoken to were knowledgeable about the process which was found to be working well. The mail room and 'Email a Prisoner Scheme' both worked efficiently, with communication normally being passed to prisoners on the same day.

The HMIPS pre-inspection survey found that 55% of respondents said they were treated with respect by staff all or most of the time. Inspectors observed positive interactions between staff and prisoners, with some good examples of positive relationships. Nevertheless, some prisoners complained of staff swearing at them, and the Independent Prison Monitors (IPMs) had recently noted this too in their own reports. Due to staffing issues there were often changes to staff on residential halls, with staff attending from other areas, but name badges were frequently not worn. Grille gates were also kept closed by default which acted as a physical barrier to good relations.

Prisoners' rights to confidentiality and privacy were respected by staff. Staff and prisoners were aware of the process to follow in relation to information security breaches and subject access requests (SARs). Data Protection Privacy Statements should be displayed in all halls. There was sufficient space for confidential conversations, and confidential paperwork was generally kept secure. Cell safes were in a bad state of repair throughout the prison, and this should be remedied.

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

The environment of the prison appeared orderly and was reasonably predictable. Unfortunately, it was predictable that the regime would be limited, with work parties and other activities often cancelled. There was no routine route movement. The prison was in a state of transition following the movement of the female population, with a new visit and gymnasium timetable soon to be implemented. The new regime within Ratho Hall was yet to be embedded. Prisoners were frustrated to be locked in their cells for most of the day with little opportunity for other activities. There was little evidence of evening activities, despite many residential areas being fully staffed during the week of inspection. Inspectors were concerned that this had become the accepted norm. The prison in-cell television channel was a good facility operated by an enthusiastic officer. Unfortunately, this position was not prioritised and as a result this was an under-utilised resource for keeping prisoners informed.

In the pre-inspection survey, nearly two-thirds (61%) reported that prisoners were not asked for their opinions, while 28% said that prisoners were asked but things did not change as a result. Noticeboards were generally in a poor state, with limited information and notices often out-of-date. There was no evidence of regular Prisoner Information Action Committees (PIACs) taking place. This was highlighted during the last inspection and no progress had been made. Prisoners in Glenesk had limited access to activities and were unable to attend Education in particular.

Prisoners had access to most information necessary to safeguard themselves against mistreatment, including access to legal advice and the courts. Prison Rules were not available in all residential flats. A copy should be available in every hall and signs put up to inform prisoners how they can access them. The prison library had an impressive list of legal texts available, but only a limited number of prisoners were able to access this. The agents' visit area was adequate, well organised and operated efficiently. The process to ensure that foreign nationals can contact Diplomatic Services needs to be clarified.

The HMIPS pre-inspection survey informed us that only a minority (16%) of respondents felt that the complaints system worked well. The SOP for complaint handling referred to another prison establishment and was out-of-date. This needs to be remedied. First Line Managers (FLMs) were generally unaware of the complaint process and the timescales involved, and there is a need for training. There was evidence of Prisoner Complaint Forms (PCFs) being lost or never recorded. PCF2s were sifted by the Governor's Personal Assistant and this practice should cease. Complaint forms were not available on every hall and there was no opportunity to submit a complaint without involving an officer. This may act as a disincentive to some prisoners and should be remedied. There was a consensus among both staff and prisoners that the complaints process was not working well.

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

IPM posters were displayed in many, but not all, residential halls. Over half (55%) of respondents to the survey reported they did not know the role of the IPM, and more reported that they did not know how to make contact (61%). The IPM number, however, is on all prisoners' phones. Staff stated that they were not aware of regularly seeing IPMs around the prison. The local IPM team should develop a strategy to raise their profile within HMP Edinburgh.

Summary of Recommendations

- HMP Edinburgh should ensure that all staff wear their name badge.
- HMP Edinburgh should ensure that Data Protection privacy statements are displayed in all halls.
- HMP Edinburgh should provide working lockable cell safes for each prisoner in every cell.
- HMP Edinburgh should work to reduce the number of times that regimes are restricted.
- HMP Edinburgh should seek to improve the evening regime, where staffing levels permit, if necessary on a rotating basis one area each evening.
- HMP Edinburgh should make more use of the in-cell TV channel to inform prisoners of daily regime changes, and to communicate plans in progress.
- HMP Edinburgh should review and update the noticeboards throughout the residential halls, to ensure that information is relevant and up-to-date.
- HMP Edinburgh should hold regular PIAC meetings in all areas to allow prisoners a voice.
- HMP Edinburgh should ensure copies of the prisoner rules are available on each residential flat and that prisoners are informed of how to access them.
- HMP Edinburgh should develop a complaints SOP that is fit-for-purpose and specific to the prison.
- HMP Edinburgh should ensure PCF forms are freely available within flats and install complaints boxes so that prisoners do not need to ask for them or hand them to an officer.
- HMP Edinburgh should ensure that all FLMs are trained in the complaints process as soon as possible and that FLMs also record all PCF forms before seeking to resolve the complaint.
- HMP Edinburgh should cease the process of the Governors PA assessing the validity of PCF2 forms.
- HMP Edinburgh should ensure the ICC findings are incorporated within the PCF paperwork, rather than on a separate form and the chair of ICCs should be more involved in investigating complaints coming before the committee.
- SPS HQ should introduce a complaints system that will evidence when a complaint has been made and is able to track the progress electronically with the prisoner receiving a written acknowledgment that his complaint has been logged and offered progress reports when requested.
- The local IPM team should develop a strategy to raise the profile of their work with prisoners and staff.

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: Satisfactory

Overview

In this standard, one quality indicator was rated as good, six quality indicators were rated as satisfactory performance, six quality indicators were rated as generally acceptable and two were rated as poor. Giving an overall rating of satisfactory performance. There was one area of good practice and 12 recommendations for improvement.

The prison had an appropriate range of planned employment opportunities for prisoners; however, a significant number of work parties were often cancelled at short notice due to staff shortages in residential areas. Those that were able to attend work parties participated in a comprehensive induction session before engaging in any work activities.

The Learning Centre was a positive environment for prisoners to engage in learning activities. It was well equipped with a range of good learning resources. Prisoners engaged well with staff and relationships were positive. Access to education could be improved if the traditional route was restored as there were a number of issues with prisoners attending the Learning Centre due to staffing problems. Attendance at classes compared to places available was less than half.

Attendance at the gym was high with around 800 spaces timetabled for prisoners each week. A good range of health and fitness activities were on offer with all those attending the gym completing an induction before accessing the facilities and equipment. There appeared to be a good relationship between Physical Training Instructors (PTIs) and gymnasium users, where they would offer advice and guidance when requested. The prison library offered a good range of quality materials with an appropriate selection of fiction, non-fiction, large print, graphic novels and books in 30 different languages. Library staff engaged well with prisoners, supporting them to access library materials of interest to them. There were good links with external library services opening up a large range of books and DVD/CDs.

HMIPS Standard 6
Purposeful Activity – Continued

Education Centre staff promoted their services through a range of activities to allow prisoners to see what services were on offer. This was complemented by prison staff who used induction, prison radio, and a comprehensive booklet to raise awareness of the cultural, recreational, and self-help activities available to all prisoners.

Prisoners benefited from the national induction process which included information regarding educational opportunities. This induction also included a screening process for literacy and numeracy and the use of a Learning Disabilities Tool that identifies those with additional support needs (ASN). Peer Tutors were on hand to work with incoming prisoners, helping them to settle into education more easily. A few prisoners reported that it was difficult to access education. However, once they did attend, they found the experience positive.

The prison offered a wide range of Scottish Qualifications Authority (SQA) qualifications at Scottish Credit and Qualifications Framework (SCQF) levels two to six. These qualifications were selected to help prisoners gain employment upon release, in particular certification for the British Institute of Cleaning Science (BICSc), food preparation qualifications, and Construction Skills Certification Scheme (CSCS) cards.

Some prisoners participating in education were successful in gaining awards such as the 2023 Adam Smith Scholarship. Prisoners in art classes produced 101 entries for the 2023 Koestler Awards, and prisoners were supported to participate in the Open University programme studying degree level subjects.

Arrangements were in place for prisoner access to fresh air daily, with one hour provision for each area being built into the regime. Unfortunately, not all prisoners had access to waterproof jackets at the time of inspection.

HMP Edinburgh visiting facilities and the Visitors Centre provided a warm, welcoming and relaxed backdrop to a positive experience for most prisoners and visitors. Inspectors were encouraged to find that the local Children and Family Strategy Group continued to work towards improvements within this area, to provide a framework for children and family related services within HMP Edinburgh, and to identify gaps in service and areas of improvement.

Four full-time prison officers undertook the role of Family Contact Officer (FCO) and several events had recently been organised. In addition, a full-time parenting officer was in place to support family connection during Play Learn Connect (PLC) visits and to support Early Years Scotland (EYS) in their work. All were enthusiastic and committed to their role to ensure that prisoner/family relationships were supported.

HMIPS Standard 6
Purposeful Activity – Continued

Inspectors saw that the Chaplaincy Team were actively engaged and integrated into day-to-day operations within HMP Edinburgh, with a range of activities for both staff and prisoners available.

Enhanced Integrated Case Management (ICM) was the endorsed process designed for all long-term prisoners (LTPs) and short-term prisoners (STPs) who were subject to post-release statutory supervision. This process utilised full risk and needs assessment and a case conference model for action planning. This approach brought together the prisoner, key internal and external staff, and where appropriate the family, to examine an individual's progress through custody. Inspectors were provided with reasonably good evidence of enhanced ICM being integrated into day-to-day operations through a motivated and competent ICM team. However, the prison was overly reliant on this team to drive ICM rather than building the infrastructure around the personal officer and prisoner relationship.

Standard ICM was the endorsed process designed for all prisoners not subject to post-release supervision. The process was intended to be delivered primarily by specialist providers who assessed, and action planned within their area of expertise, by consistently updating the Community Integration Plan (CIP). Unfortunately, inspectors found little evidence of Standard ICM being integrated into day-to-day operations in HMP Edinburgh, with the onus falling on Hub staff having oversight of the core screen assessment process and updating the CIP accordingly. In addition, there was no evidence of any process in place to identify STPs who may be eligible for progression to open conditions.

The Recovery Café offered a range of therapeutic courses and there were good examples of collaborative working with external agencies and organisations.

List of Good Practice

- PTIs relationships with partners in the community to arrange football themed events that brought families together and gave prisoners the opportunity to spend time with their children.

List of Recommendations

- HMP Edinburgh should ensure all prisoners within each prison population have equitable access to participate in good quality employment opportunities.
- HMP Edinburgh need to address the issues around escorting prisoners to the Learning Centre to improve attendance levels.
- HMP Edinburgh should ensure all prisoners within each prison population have equitable access to the main library.

HMIPS Standard 6
Purposeful Activity – Continued

- HMP Edinburgh to ensure prisoners are aware of their entitlement to fresh air without being penalised.
- HMP Edinburgh should expedite the issue of waterproof jackets for fresh air.
- HMP Edinburgh should introduce a system for booking a double visit for those travelling long distances rather than hope that a double visit can be accommodated.
- The Children and Families Strategy Group at HMP Edinburgh should consider reopening the tea bar.
- SPS HQ and GEOAmey should work together to find a solution to ensure escort contract obligations are met.
- HMP Edinburgh should reinvigorate the personal officer scheme and improve awareness of their role in ICM processes to achieving the desired outcomes.
- HMP Edinburgh should ensure that those STPs who meet the criteria are considered for progression to open conditions.
- HMP Edinburgh should consider awareness training and information about the requirements of the role for staff who work with OLRs.
- HMP Edinburgh should review the governance arrangements around monthly OLR behavioural monitoring forms.

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: Satisfactory

Overview

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

This inspection coincided with a period of significant change for HMP Edinburgh. The establishment provided accommodation for a mixed population of mainstream, untried and protection prisoners. The composition of the population had recently changed significantly when the women prisoners were moved out of the establishment.

Due to challenges with recruitment and retention, staff experience was limited, impacting on their understanding and familiarity of key processes. While initiatives, including mentoring, had been implemented it was too early to assess the impact of these. Despite these challenges, staff involved in resettlement and reintegration were working hard to ensure robust planning for prisoners being released.

The collaborative approach between prison, social work and psychology staff ensured that due attention was given to planning for release and reintegration to the community. Integrated Case Management (ICM) processes were well-functioning, and prisoners were empowered to engage in their plans. Assessment of risk and need was dynamic. Timely access to accredited programmes was a barrier to progression due to national waiting lists.

The pre-release service provided to prisoners prior to liberation, ensured prisoners' needs were reviewed and referrals made to appropriate throughcare services within local communities.

List of Good Practice

- The co-location of services within 'The Hub' fostered efficient and effective collaborative working.
- The pre-release service was providing an identity verification letter to prisoners with no access to formal identification. This enabled prisoners to open a bank account more easily on release.

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

List of Recommendations

- SPS HQ should ensure timely access to accredited programmes is available to enable evidence of change for progression.

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: Generally Acceptable

Overview

In this standard, one quality indicator was rated as good, three were rated as satisfactory, two were rated as generally acceptable and two were rated as poor performance resulting in an overall rating of generally acceptable performance. There were two examples of good practice and 10 recommendations for improvement.

There had been very recent changes at Governor-in-Charge (GIC) and Deputy Governor level. Staff expressed their appreciation of the previous senior management team and in particular their visibility and face-to-face engagement around the prison. It was made clear to inspectors by staff and managers that the new Governor had already engaged with them, providing encouraging signs that she would listen to staff and people in custody and provide clarity around priorities and actions. This was good to hear as many staff indicated to inspectors a lack of awareness about the extent of the recent population reconfiguration, and frustration with the apparent haste with which it had been implemented.

The lack of any substantial evening regime was a source of grave concern to inspectors and there was a defeatist attitude amongst staff regarding their ability to introduce an evening regime due to staffing shortages in the evening, which seemed to be intrinsically linked to the shift pattern. While recognising these are not easy challenges to address, the new GIC and Deputy Governor need to make delivery of an evening regime a key priority. To enable the establishment to address the regime and staffing issues, we strongly urge SPS Headquarters to commence a reprofiling exercise to ensure the workforce matches the identified needs.

HMIPS Standard 8
Organisational Effectiveness – Continued

The Senior Management Team had ensured that processes and arrangements were in place to create a positive Equality and Diversity (E&D) culture, in which the needs of those with protected characteristics are met. This had been a focus for the prison over recent years, but inspectors found that it had required very recent reinvigoration to ensure the basic requirements of delivering meetings and achieving meaningful involvement of people in custody were in place. It is important that such critical processes are resiliently embedded, and that management ensure delivery of them, even when other factors present challenges. We welcomed the innovative thinking done by the prison about their obligations regarding the 'Fairer Scotland' duty, but there was scope to improve membership of E&D governance meetings.

HMP Edinburgh had systems in place to deliver an effective organisation, however delivering the desired outcomes was an ongoing challenge and some scrutiny/audit recommendations had been made repeatedly. Since the last inspection, HMIPS have put in place a more robust action planning process around recommendations that we make, and we expect HMP Edinburgh to match that with their own action and monitoring that progress is indeed being made.

The prison had effective systems in place to recognise good performance, and we welcomed the development of a mentoring scheme for new officers, but core training competencies and completion of staff appraisals were well below acceptable levels.

Summary of Good Practice

- The recently introduced staff mentoring scheme paired up newer staff with more experienced officers.
- The consideration of socio-economic factors in relation to E&D and Fairer Scotland obligations represented innovative thinking by HMP Edinburgh.

Summary of Recommendations

- SPS HQ and HMP Edinburgh should commence a full reprofiling exercise to ensure the workforce capacity modelling, shift systems and target operating model addresses identified need.
- HMP Edinburgh should review the membership of the E&D meeting to include staff from each area as well as a range of key partners such as the NHS.
- HMP Edinburgh should conduct an equalities impact assessment on the criteria for being placed in Ratho House.
- HMP Edinburgh should complete an assessment of the requirement for adapted rooms and hospital beds to inform any bid for resources to increase provision.

HMIPS Standard 8
Organisational Effectiveness – Continued

- HMP Edinburgh should invoke a clear process for planning and implementing actions flowing from HMIPS inspection reports to ensure all recommendations are followed up timeously.
- SPS HQ should check whether recommendations in HMIPS inspection reports resonate across the wider prison estate and take appropriate action where necessary to reduce the number of repeat recommendations.
- HMP Edinburgh should ensure that scrutiny recommendations are followed up to the point at which improved outcomes have been secured and sustained.
- HMP Edinburgh Senior Management Team should ensure that improvement priorities are effectively communicated and discussed with staff, particularly with regard to opening up the regime.
- HMP Edinburgh should ensure that following the review of the Annual Development Plan (ADP), the Senior Management Team communicate the prison's priorities to all staff, so they understand their role in supporting people in custody.
- HMP Edinburgh should ensure that all core competency training increases to the required level as a priority.
- HMP Edinburgh should improve completion of the appraisal process.

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: Generally Acceptable

In this standard, no quality indicators were rated as good, eight were rated as satisfactory, five were rated as generally acceptable and three were rated as poor, giving an overall rating of generally acceptable. There were 15 examples of good practice and 23 recommendations for improvement.

Healthcare in HMP Edinburgh was managed by Royal Edinburgh Hospital and Associated Services (REAS) which is part of NHS Lothian and reported through its governance structure. Despite some challenges with service delivery highlighted in this report and a recognition that there was a need to improve some aspect of healthcare delivery, there was evidence of strong leadership and collaboration emerging from the Senior Nursing Team to delivering good patient-centred care.

The Leadership Team comprised of a Healthcare Manager, Lead Nurse and Lead Pharmacist, who reported directly to a Clinical Service Manager and General Manager. Inspectors received consistent positive feedback from a range of professionals during the inspection about the visibility and support from the Leadership Team.

The Healthcare Manager and Lead Nurse also had operational responsibility for the Health Centre in HMP Addiewell and were trying to align systems and processes. A number of Standard Operating Procedures (SOPs) had been developed, and some were in draft stage to ensure there was a consistent approach to delivery of care across all teams. For example, a SOP for the management of patients of concern, cared for under the Mental Health Team was being developed outlining the pathway and provision available from the Mental Health Team.

The indicators graded as poor were reflective of the concerns regarding the process within the prison to manage and support prisoners placed on Talk to Me (TTM) as discussed in QI 9.12. QI 9.6 and QI 9.15 were also graded as poor due to concerns about the management of long-term conditions (LTCs), including a lack of access to LTC clinics. Risks around lack of oversight of infection, prevention and control are explained in greater detail within the narrative of the report.

HMIPS Standard 9
Health and Wellbeing – Continued

Primary Care

Clear systems and processes were in place for admissions and transfers to HMP Edinburgh. Staff were trained in using a validated health screening tool and information was collated in the electronic Vision system. Although staff were able to describe the screening process there was no SOP in place to support them. While staff provided information verbally to patients about the healthcare services available and how to access them, no information leaflets were provided on admission. There was a robust and established Advanced Nurse Prescriber (ANP) service to follow up with people on admission to the prison, and to support early identification of long-term health condition needs. A referral system was in place; however, the referral forms were not in easy read format to support patients with literacy issues or available in different languages for those people whose first language was not English.

As highlighted in previous reports, there continue to be issues nationally with late arrivals into prisons. While prisoners would have access to person-centred health screening during working hours, people who were admitted to the establishment after 9.00pm may not receive the same standard of health screening. SPS staff would place the prisoner on 15-minute observations overnight until they had seen a nurse the following day. This is a concern.

Patients were escorted to appointments out with HMP Edinburgh by GEOAmey. HMP Edinburgh continued to collate data on missed appointments and supported patients who had missed appointments to be reappointed. This was also a national issue and has been escalated by HMCIPS to the Cabinet Secretary for Justice and Home Affairs. Where GEOAmey were unable to provide transport, those appointments that needed prioritised were discussed with SPS staff to see if they could support transport to the appointment.

It was encouraging that a pharmacist had been appointed for the two prisons in Lothian to develop the pharmacy service. However, inspectors did identify risks around medicine management which is detailed within the narrative of this report.

HMIPS Standard 9
Health and Wellbeing – Continued

Mental Health

The Mental Health Team had clear processes to triage, risk assess, and allocate people for assessment if they were referred to the Mental Health Team. Following assessment, patient referrals were discussed at the Mental Health multi-disciplinary meeting (MDT) and, if appropriate, the patient would be allocated to a clinician to receive treatment or a further assessment. A weekly MDT meeting was in place, providing a forum to discuss complex patients, referrals, and required interventions for patients. Referral forms were not in easy read format to support patients with literacy issues or available in other languages.

The Occupational Therapist Team offered a range of group and one-to-one sessions to support people with daily living from a mental health perspective, to support and promote their independent functioning of everyday living within the prison, and in preparation for liberation. This is good practice.

Substance Use

Individuals requiring support with drug and alcohol dependence were identified during their initial health assessment on admission to the prison. A fast-track system was in place to support patients quickly onto Opiate Substitution Therapy (OST) following admission into prison.

There could, however, be delays for people wanting to commence OST who were already part of the prison population. This was because part of the clinical pathway for commencing treatment was that the patient would have to keep a two-week diary of drug use and produce two positive drug screens. Delays in commencing treatment could mean patients experiencing withdrawal or prolonged drug use in the prison for a longer period.

Individual person-centred and outcome-focussed care plans reflected the support needs required and were in place for all patients. There was evidence of patient involvement in writing their care plans which were regularly reviewed, monitored, and updated by the patient and their caseworker.

A standardised discharge planning tool was in place to ensure that patients were referred to community services and information was passed to these services for continuity of care.

HMIPS Standard 9
Health and Wellbeing – Continued

Long-term Conditions (LTCs), Palliative and End of Life Care

Patients with LTCs were identified as part of the admission health screening process and reviewed by the ANP the following day. The ANP managed the patients with LTC and had started to develop an LTC register. Inspectors were told that yearly reviews and checks for patients with LTC were not consistently carried out as there were no dedicated LTC condition clinics running at the time of the inspection. The ANP had made links with secondary care clinicians to support patients with LTCs. Care plans were in place but those seen did not contain condition specific interventions to support patients with LTC. Inspectors were told of an agreement to recruit an LTC nurse to support the care of patients with LTCs in HMP Edinburgh.

Systems and processes were in place within the prison to support patients identified as requiring palliative care and end of life care. Healthcare staff spoken with were able to describe and were positive about the links that had been established with community services. Community palliative care staff were invited to attend monthly healthcare meetings. Healthcare staff told us that GEOAmey would be invited to attend meetings when transport to community settings was being considered.

Infection, Prevention and Control

While the Health Centre was in a good state of repair, other areas such as the medicine dispensaries and treatment rooms in the residential areas were in variable states of repair making effective cleaning difficult. All near patient equipment was in a good state of repair, clean and ready for use. Cleaning schedules were seen to be in place, however there were notable gaps in these being completed. Staff could access infection control information and had adequate supplies of PPE.

There was a lack of any external infection control oversight from NHS Lothian in HMP Edinburgh, and staff spoken with were not aware of any external assurance visits having taken place. Although inspectors were told that a quarterly health and safety audit was completed that covered some aspects of infection prevention and control, there was no formal infection prevention and control audit programme in place.

List of Good Practice

- There was a robust ANP service to follow up people on admission to the prison.
- All patients who declined Blood Borne Virus (BBV) screening on admission were routinely reoffered testing after 12 weeks.
- Health and wellbeing information and current clinic waiting times were visible in the health centre and prisoner TV channel.

HMIPS Standard 9
Health and Wellbeing – Continued

- Training on the use of Naloxone had been extended to SPS night officers.
- The Clinical Psychology Team were working with SPS colleagues to develop a Trauma Informed Practice Strategy within the Prison.
- The Occupational Therapist Team offered a range of group and one-to-one sessions to support people with daily living and to support and promote their independent functioning of everyday living within the prison and in preparation for liberation.
- An Attention Deficit Hyperactivity Disorder (ADHD) weekly clinic was held in the prison that was delivered jointly by a psychiatrist and a learning disabilities nurse.
- Wound charts were being used. Waterlow pressure area risk assessment charts and MUST (Malnutrition Universal Screening Tool) were also available for use if required.
- A fast-track system supported patients quickly onto Opiate Substitution Therapy following admission into the prison.
- 'Change Grow Live' caseworkers supported people on liberation. Liberation packs were provided for those clients they worked with, which contains toiletries, a mobile phone and support with housing, benefits, health, and employability.
- NHS Lothian had recently appointed a clinical pharmacist to join the Pharmacy Team at HMP Edinburgh.
- The dental therapist could deliver treatments such as fillings which helped shorten dental waiting times.
- A person of concerns meeting was held weekly with attendance of SPS staff, mental health nurses, and third sector providers. This forum enables discussion and sharing of information to support people living in the prison who had complex issues including serious mental health issues and comorbidities.
- New NHS staff were given four weeks of being supernumerary to allow them to complete their induction and familiarise themselves with healthcare delivery and the prison environment, this could be extended based on individual's confidence, training, and learning gaps.
- Lead Pharmacist has introduced a monthly Datix review meeting to address incidents related to the safe and effective use of medicines.

List of Recommendations

- REAS/NHS Lothian should develop a SOP to support the admission process including the assessment of a person's fitness to remain in custody.
- REAS/NHS Lothian must ensure the doors are closed during patient consultations or seek a safe solution to address this.

HMIPS Standard 9
Health and Wellbeing – Continued

- SPS and NHS Lothian must work together to ensure that there is a robust process in place to ensure that those prisoners arriving late at the prison receive a formal health screening assessment.
- REAS/NHS Lothian should ensure that people admitted or transferred to HMP Edinburgh are provided with written information appropriate to their needs that describes healthcare services available and how they can access them.
- REAS/NHS Lothian should ensure referral forms are available in different formats to support patients with literacy issues and different languages for those patients whose first language is not English.
- REAS/NHS Lothian should ensure that patients are informed of the progress of each self-referral and the expected waiting time to access services.
- 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.
- REAS/NHS Lothian must ensure that checks on emergency equipment are carried out and consistently recorded.
- REAS/NHS Lothian should ensure patients can access a smoking cessation service for those wishing to become nicotine free.
- REAS/NHS Lothian should review their assessment, care planning and process for recording clinical information to ensure up to date clinical information is recorded.
- REAS/NHS Lothian should introduce dedicated Long-Term Conditions (LTCs) clinics to ensure that patients are reviewed in a structured manner and that yearly reviews and checks are completed consistently.
- REAS/NHS Lothian must ensure that patients with a LTC have individualised, person-centred care plans. The care plans must evidence that patients have had an explanation regarding their condition and have been involved in the planning of their care needs.
- REAS/NHS Lothian should ensure that they have a SOP including clinical prescribing guidelines for their Substance Use Service that aligns to the principles of the MAT standards.
- HMP Edinburgh should ensure that safes are available in cells and in good working order to ensure patients can store their medication securely.
- REAS/NHS Lothian should ensure healthcare staff carry out all patient identification checks as specified in the relevant SOP to ensure medications are administered safely.
- REAS/NHS Lothian should ensure that witnesses comply with the requirements of the SOP for verification of dosage at the point of administration or supply. A robust visual check as well as a verbal check of controlled drug doses during the dispensing process should be undertaken.

HMIPS Standard 9
Health and Wellbeing – Continued

- REAS/NHS Lothian and SPS staff should continue to work together to ensure that medications are administered at their therapeutic time and with the correct time between doses.
- REAS/NHS Lothian must ensure dental treatment for those patients who were on remand beyond six months is equitable to those who are convicted.
- HMP Edinburgh and NHS Lothian/REAS must ensure that there is clear communication between both organisations when an individual is placed onto the SPS Suicide Prevention Strategy Talk to Me (TTM) in order that initial Case Conferences are held when all relevant professional staff are available and at the earliest opportunity.
- HMP Edinburgh must ensure that areas where healthcare is delivered are in a good state of repair to allow for effective cleaning.
- REAS/NHS Lothian must provide external infection prevention and control oversight and carry out a programme of assurance visits to HMP Edinburgh.
- REAS/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 healthcare staff must be informed of the audit results and any actions required to improve practices.
- REAS/NHS Lothian must develop an out-of-hours on-call escalation process so that staff feel supported and have an identified contact they can speak with to raise any clinical or staffing issues.

Annex A

Summary of Recommendations

REC NO.	QI NO.	RECOMMENDATION
Standard 1 – Lawful and Transparent Custody		
1	1.1	HMP Edinburgh should prioritise the processing of warrants to prevent GEOAmey staff waiting in reception for lengthy periods.
2	1.1	HMP Edinburgh should place a phone in the interview room to allow translation interviews to take place in a private area.
3	1.1	HMP Edinburgh and the NHS healthcare team should address the issues resulting in delays in nurses attending reception and operational staff escorting prisoners to residential areas.
4	1.2	SPS HQ need to update the 2012 SPS national induction booklet as soon as possible.
5	1.2	HMP Edinburgh should ensure the FNIC booklet is available in the languages spoken in the prison.
6	1.2	HMP Edinburgh should ensure that staff are aware of foreign national prisoners' entitlements on arrival.
7	1.2	HMP Edinburgh should closely monitor completion timescales for core screen paperwork.
8	1.5	HMP Edinburgh should have a safer cell and an accessible cell freely available within the FNIC area should it be needed.
9	1.6	HMP Edinburgh should take action to ensure CSRA entries on PR2 meet the required standard to prevent potential challenges should an incident occur.
10	1.8	HMP Edinburgh should ensure that all eligible prisoners receive, or are offered, the National Induction Programme as soon as possible after admission.
Standard 2 – Decency		
11	2.1	SPS HQ should withdraw the use of single cells as double cells for contingency plans in Glenesk where they do not meet minimum space standards.
12	2.1	HMP Edinburgh should address the levels of graffiti and poor cosmetic state of many cells in Glenesk and ensure doors and handrails in the stairwell are also painted.
13	2.1	HMP Edinburgh should address the problem of poor ventilation in cells in Glenesk from blocked ventilation slats.

14	2.1	SPS HQ and HMP Edinburgh should work together to address the number of vacancies in the Estates Team and difficulties retaining skilled trades when market forces provide more attractive opportunities.
15	2.2	HMP Edinburgh should address the problem of litter being thrown out of Ingliston cell windows and collecting in the external corridor leading to the main corridor.
16	2.2	HMP Edinburgh should ensure all cells have toilet seats.
17	2.2	HMP Edinburgh should ensure all prisoners working as passmen are BICSc trained and certificated.
18	2.3	HMP Edinburgh should improve the process for disposing of used mattresses, so they do not have to be parked in storerooms holding clean bedding.
19	2.4	HMP Edinburgh should consult prisoners regularly about any changes they wished made to the canteen list.
20	2.4	HMP Edinburgh should follow through on its plan to introduce a more robust process for controlling access to towels and monitoring the number of towels sent and returned from the Laundry.
21	2.5	HMP Edinburgh should review the process for ordering new clothing to ensure it is working as effectively as possible.
22	2.5	HMP Edinburgh should ensure that those prisoners not wishing to have their clothes dried in the industrial tumble dryers do not have to resort to hanging washing in their own cells to dry.
23	2.6	The HMP Edinburgh Catering Manager should ensure that all prisoners working in the kitchen are Food Hygiene certificated.
24	2.6	The HMP Edinburgh Catering Manager should consider the scope to introduce winter and summer menus to provide some variation in the main prison menu, involving prisoners in that through Food Focus Groups.
25	2.6	HMP Edinburgh should reinforce training for pantrymen around basic food hygiene, the wearing of whites and temperature checks of food.
Standard 3 – Personal Safety		
26	3.1	HMP Edinburgh should ensure that they follow the TTM guidance and not utilise the ICP when the appropriate staff are available to hold a case conference.
27	3.1	HMP Edinburgh should ensure that the timings and surroundings are conducive to a positive environment in which to hold a TTM case conference.
28	3.1	HMP Edinburgh should ensure that TTM Co ordinator meetings are held at regular intervals, and at least once per quarter.

29	3.2	HMP Edinburgh should ensure that they have sufficient staff trained in manual handling so as to train prisoners to assist those in wheelchairs.
30	3.3	HMP Edinburgh should encourage the opening of grille gates, if necessary one wing at a time, to encourage communication with prisoners and building relationships of trust.
31	3.4	HMP Edinburgh should ensure there is an anti bullying strategy in place that meets the aims of the SPS anti bullying policy (currently Think Twice 2018).
32	3.7	HMP Edinburgh should ensure the correct FANs are in place on every cell door.
33	3.7	HMP Edinburgh should ensure the PEEPs register is updated to reflect the current population.
Standard 4 – Effective, Courteous and Humane Exercise of Authority		
34	4.1	HMP Edinburgh should with immediate effect ensure that all planned use of force removals are recorded, all paperwork completed and subject to review as per SPS guidelines.
35	4.1	HMP Edinburgh should take immediate action to address the shortfall in C&R staff competence.
36	4.1	HMP Edinburgh should implement a violence reduction strategy.
37	4.1	HMP Edinburgh should ensure supervising officers are aware what a planned removal is and the requirement to video record the removal.
38	4.1	HMP Edinburgh should encourage staff to use rigid cuffs during removals as a safer option.
39	4.2	HMP Edinburgh should maintain staff complement in the SRU.
40	4.2	HMP Edinburgh should ensure NHS staff receive invites to all case conferences.
41	4.2	HMP Edinburgh should consider options to allow prisoners access to education materials whilst in the SRU.
42	4.2	HMP Edinburgh should provide as much information as possible to prisoners during a Rule 95 case conference, and not make decisions on outcomes before they take place.
43	4.3	HMP Edinburgh should ensure that in all adjudications a formal record of previous adjudication outcomes is available for the adjudicator.
44	4.3	HMP Edinburgh should ensure that the rooms used for adjudications are fit for purpose.
45	4.4	HMP Edinburgh should ensure all review dates on SSM paperwork are carried out timeously adding a review date column in the SSM tracker document.
46	4.4	HMP Edinburgh should ensure all SSMs are signed by prisoners and uploaded to PR2.

47	4.5	HMP Edinburgh should ensure all cells are searched in line with the PRL cell searching protocol.
48	4.5	HMP Edinburgh should ensure searching processes are in place for movement of prisoners around the establishment.
49	4.9	HMP Edinburgh should implement a controlled system for mass movement of prisoners.
Standard 5 – Respect, Autonomy and Protection against Mistreatment		
50	5.2	HMP Edinburgh should ensure that all staff wear their name badge.
51	5.3	HMP Edinburgh should ensure that Data Protection privacy statements are displayed in all halls.
52	5.3	HMP Edinburgh should provide working lockable cell safes for each prisoner in every cell.
53	5.4	HMP Edinburgh should work to reduce the number of times that regimes are restricted.
54	5.4	HMP Edinburgh should seek to improve the evening regime, where staffing levels permit, if necessary on a rotating basis one area each evening.
55	5.4	HMP Edinburgh should make more use of the in cell TV channel to inform prisoners of daily regime changes, and to communicate plans in progress.
56	5.5	HMP Edinburgh should review and update the noticeboards throughout the residential halls, to ensure that information is relevant and up to date.
57	5.5	HMP Edinburgh should hold regular PIAC meetings in all areas to allow prisoners a voice.
58	5.6	HMP Edinburgh should ensure copies of the prisoner rules are available on each residential flat and that prisoners are informed of how to access them.
59	5.7	HMP Edinburgh should develop a complaints SOP that is fit for purpose and specific to the prison.
60	5.7	HMP Edinburgh should ensure PCF forms are freely available within flats and install complaints boxes so that prisoners do not need to ask for them or hand them to an officer.
61	5.7	HMP Edinburgh should ensure that all FLMs are trained in the complaints process asap and that FLMs also record all PCF forms before seeking to resolve the complaint.
62	5.7	HMP Edinburgh should cease the practice of the Governor's Personal Assistant assessing the validity of PCF2 forms.

63	5.7	HMP Edinburgh should ensure that ICC findings are incorporated within the PCF paperwork, rather than on a separate form and the Chair of ICCs should be more involved in investigating complaints coming before the committee.
64	5.7	SPS HQ should introduce a complaints system that will evidence when a complaint has been made and is able to track the progress electronically, with the prisoner receiving a written acknowledgment that his complaint has been logged and is offered progress reports when requested.
65	5.8	The local IPM team should develop a strategy to raise the profile of their work with prisoners and staff.
Standard 6 – Purposeful Activity		
66	6.2	HMP Edinburgh should ensure all prisoners within each prison population have equitable access to participate in good quality employment opportunities.
67	6.3	HMP Edinburgh need to address the issues around escorting prisoners to the Learning Centre to improve attendance levels.
68	6.5	HMP Edinburgh should ensure all prisoners within each prison population have equitable access to the main library.
69	6.7	HMP Edinburgh to ensure prisoners are aware of their entitlement to fresh air without being penalised.
70	6.7	HMP Edinburgh should expedite the issue of waterproof jackets for fresh air.
71	6.9	HMP Edinburgh should ensure that staff and prisoners are aware that there is a system for booking a double visit.
72	6. 10	The HMP Edinburgh Children and Families Strategy Group should consider reopening the tea bar.
73	6.11	SPS HQ and GEOAmey should work together to ensure crucial escort obligations are met, particularly for attendance at family funerals.
74	6.14	HMP Edinburgh should reinvigorating the personal officer scheme and improve awareness of their role in ICM processes to achieving the desired outcomes.
75	6.14	HMP Edinburgh should ensure that those STPs who meet the criteria are considered for progression to open conditions.
76	6.15	HMP Edinburgh should consider awareness training and information about the requirements of the role for staff who work with OLRs.
77	6.15	HMP Edinburgh should review the governance arrangements around monthly OLR behavioural monitoring forms.

Standard 7 – Transitions from Custody to life in the Community		
78	7.3	SPS HQ should ensure timely access to accredited programmes is available to enable evidence of change for progression.
Standard 8 – Organisational Effectiveness		
79	8.1	HMP Edinburgh should review the membership of the E&D meeting to include staff from each area as well as a range of key partners such as the NHS.
80	8.1	HMP Edinburgh should conduct an equalities impact assessment on the criteria for being placed in Ratho House.
81	8.1	HMP Edinburgh should complete an assessment of the requirement for adapted rooms and hospital beds to inform any bid for resources to increase provision.
82	8.2	HMP Edinburgh should invoke a clear process for planning and implementing actions flowing from HMIPS inspection reports to ensure all recommendations are followed up timeously.
83	8.2	SPS HQ should check whether recommendations in HMIPS inspection reports resonate across the wider prison estate and take appropriate action where necessary to reduce the number of repeat recommendations.
84	8.3	SPS HQ and HMP Edinburgh should commence a full reprofiling exercise to ensure the workforce capacity modelling, shift systems and staff target operating model addresses identified need.
85	8.3	HMP Edinburgh should ensure that scrutiny recommendations are followed up to the point at which improved outcomes have been secured and sustained.
86	8.3	HMP Edinburgh Senior Management Team should ensure that improvement priorities are effectively communicated and discussed with staff, particularly with regard to opening up the regime.
87	8.4	HMP Edinburgh should ensure that following the review of the ADP, the Senior Management Team communicate the prison's priorities to all staff, so they understand their role in supporting people in custody.
88	8.4	HMP Edinburgh should ensure that all core competency training increases to the required level as a priority.
89	8.6	HMP Edinburgh should improve completion of the appraisal process.
Standard 9 – Health and Wellbeing		
90	9.1	REAS/NHS Lothian should develop a SOP to support the admission process including the assessment of a person's fitness to remain in custody.
91	9.1	REAS/NHS Lothian must ensure the doors are closed during patient consultations or seek a safe solution to address this.

92	9.1	SPS HQ and NHS Lothian must work together to ensure that there is a robust process in place to ensure that those prisoners arriving late at the prison receive a formal health screening assessment.
93	9.1	REAS/NHS Lothian should ensure that people admitted or transferred to HMP Edinburgh are provided with written information appropriate to their needs that describes healthcare services available and how they can access them.
94	9.2	REAS/NHS Lothian should ensure referral forms are available in different formats to support patients with literacy challenges and available in different languages for those patients whose first language is not English.
95	9.2	REAS/NHS Lothian should ensure that patients are informed of the progress of each self referral and the expected waiting time to access services.
96	9.2	SPS HQ 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.
97	9.2	REAS/NHS Lothian must ensure that checks on emergency equipment are carried out and consistently recorded.
98	9.3	REAS/NHS Lothian should ensure patients can access a smoking cessation service for those wishing to become nicotine free.
99	9.5	REAS/NHS Lothian should review their assessment, care planning and process for recording clinical information to ensure up to date clinical information is recorded.
100	9.6	REAS/NHS Lothian should introduce dedicated LTC clinics to ensure that patients are reviewed in a structured manner and that yearly reviews and checks are completed consistently.
101	9.6	REAS/NHS Lothian must ensure that patients with a LTC 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.
102	9.7	REAS/NHS Lothian should ensure that they have a Standard Operating Procedure including clinical prescribing guidelines for their Substance Use Service that aligns to the principles of the MAT standards.
103	9.8	HMP Edinburgh should ensure that in cells safes are available and in good working order to ensure patients can store their medication securely.
104	9.8	REAS/NHS Lothian should ensure healthcare staff carry out all patient identification checks as specified in the relevant SOP to ensure medications are administered safely.

105	9.8	REAS/NHS Lothian should ensure that witnesses comply with the requirements of the SOP for verification of dosage at the point of administration or supply. A robust visual check as well as a verbal check of controlled drug doses during the dispensing process should be undertaken.
106	9.8	REAS/NHS Lothian and HMP Edinburgh SPS staff should continue to work together to ensure that medications are administered at their therapeutic time and with the correct time between doses.
107	9.9	REAS/NHS Lothian must ensure dental treatment for those patients who were on remand beyond six months is equitable to those who are convicted.
108	9.12	HMP Edinburgh and NHS Lothian/REAS must ensure that there is clear communication between both organisations when an individual is placed onto TTM in order that initial Case Conferences are held when all relevant professional staff are available and at the earliest opportunity.
109	9.15	HMP Edinburgh must ensure that areas where healthcare is delivered are in a good state of repair to allow for effective cleaning.
110	9.15	REAS/NHS Lothian must provide external infection prevention and control oversight and carry out a programme of assurance visits to HMP Edinburgh.
111	9.15	REAS/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 healthcare staff must be informed of the audit results and any actions required to improve practices.
112	9.16	REAS/NHS Lothian must develop an out of hours on call escalation process so that staff feel supported and have an identified contact they can speak with to raise any clinical or staffing issues.

Annex B

Summary of Good Practice

REC NO.	QI NO.	GOOD PRACTICE
Standard 1 – Lawful and Transparent Custody		
1	1.2	The peer mentor/tutor process for prisoners that speak English.
Standard 2 – Personal Safety		
2	2.3	Laundry staff had a good process for reminding staff in residential areas when bedding from particular cells had not been washed for a long time so they could encourage the occupant to put it out for washing.
Standard 3 – Personal Safety		
3	3.2	The support offered to veterans, allowing them a safe environment to support each other and share common experiences.
Standard 4 – Effective, Courteous and Humane Exercise of Authority		
4	4.2	HMP Edinburgh SRU prisoners receive regular visits from a GP and mental health nurse.
5	4.6	Having an officer assigned to deal with property daily so prisoners are able to receive their belongings timeously.
6	4.6	Good request system which was used for all reception requests keeping the process consistent.
Standard 6 - Purposeful Activity		
7	6.6	PTIs relationships with partners in the community to arrange football themed events that brought families together and gave prisoners the opportunity to spend time with their children.
Standard 7 – Transitions from Custody to Life in the Community		
8	7.2	The co location of services within 'The Hub' fostered efficient and effective collaborative working.
9	7.5	The pre-release service was providing an identity verification letter to prisoners with no access to formal identification. This enabled prisoners to open a bank account more easily on release.
Standard 8 – Organisational Effectiveness		
10	8.1	The consideration of socio-economic factors in relation to E&D and fairer Scotland obligations represented innovative thinking by HMP Edinburgh.
11	8.5	The recently introduced staff mentoring scheme paired up newer staff with more experienced officers.

Standard 9 – Health and Wellbeing

12	9.2	There was a robust ANP service to follow up people on admission to the prison.
13	9.3	All patients who declined BBV screening on admission were routinely reoffered testing after 12 weeks.
14	9.3	Health and wellbeing information and current clinic waiting times were visible in the health centre and prisoner TV channel.
15	9.3	Training on the use of Naloxone had been extended to SPS night officers.
16	9.4	The Clinical Psychology Team were working with SPS colleagues to develop a Trauma Informed Practice Strategy within the Prison.
17	9.5	The Occupational Therapist Team offered a range of group and one to one sessions to support people with daily living and to support and promote their independent functioning of everyday living within the prison and in preparation for liberation.
18	9.5	An ADHD weekly clinic was held in the prison that was delivered jointly by a psychiatrist and a learning disabilities nurse.
19	9.6	Wound charts were being used. Waterlow pressure area risk assessment charts and MUST (Malnutrition Universal Screening Tool) were also available for use if required.
20	9.7	A fast track system supported patients quickly onto Opiate Substitution Therapy following admission into the prison.
21	9.7	'Change Grow Live' caseworkers supported people on liberation. Liberation packs were provided for those clients they worked with, which contains toiletries, a mobile phone and support with housing, benefits, health, and employability.
22	9.8	NHS Lothian had recently appointed a lead pharmacist to join the Healthcare Team at HMP Edinburgh.
23	9.9	The dental therapist could deliver treatments such as fillings which helped shorten dental waiting times.
24	9.12	A person of concerns meeting was held weekly with attendance of SPS staff, mental health nurses, and third sector providers. This forum enables discussion and sharing of information to support people living in the prison who had complex issues including serious mental health issues and comorbidities.
25	9.16	New staff were given four weeks of being supernumerary to allow them to complete their induction and familiarise themselves with healthcare delivery and the prison environment, this could be extended based on individual's confidence, training, and learning gaps.
26	9.17	Lead Pharmacist has introduced a monthly Datix review meeting to address incidents related to medicines management.

Annex C

Summary of Ratings

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

QI 4.7	Satisfactory
QI 4.8	Satisfactory
QI 4.9	Poor
QI 4.10	Satisfactory
Standard 5 – Respect, Autonomy and Protection Against Mistreatment	**Generally Acceptable**
QI 5.1	Satisfactory
QI 5.2	Generally Acceptable
QI 5.3	Satisfactory
QI 5.4	Generally Acceptable
QI 5.5	Poor
QI 5.6	Satisfactory
QI 5.7	Poor
QI 5.8	Generally Acceptable
Standard 6 – Purposeful Activity	**Satisfactory**
QI 6.1	Poor
QI 6.2	Poor
QI 6.3	Generally Acceptable
QI 6.4	Good
QI 6.5	Generally Acceptable
QI 6.6	Satisfactory
QI 6.7	Generally Acceptable
QI 6.8	Satisfactory
QI 6.9	Satisfactory
QI 6.10	Satisfactory
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 to Life in the Community	**Satisfactory**
QI 7.1	Generally Acceptable
QI 7.2	Generally Acceptable
QI 7.3	Satisfactory
QI 7.4	Satisfactory
QI 7.5	Satisfactory

Standard 8 – Organisational Effectiveness	Generally Acceptable
QI 8.1	Satisfactory
QI 8.2	Generally Acceptable
QI 8.3	Poor
QI 8.4	Poor
QI 8.5	Good
QI 8.6	Generally Acceptable
QI 8.7	Satisfactory
QI 8.8	Satisfactory

Standard 9 – Health and Wellbeing	Generally Acceptable
QI 9.1	Generally Acceptable
QI 9.2	Generally Acceptable
QI 9.3	Satisfactory
QI 9.4	Satisfactory
QI 9.5	Generally Acceptable
QI 9.6	Poor
QI 9.7	Satisfactory
QI 9.8	Generally Acceptable
QI 9.9	Satisfactory
QI 9.10	Generally Acceptable
QI 9.11	Satisfactory
QI 9.12	Poor
QI 9.13	Generally Acceptable
QI 9.14	Satisfactory
QI 9.15	Poor
QI 9.16	Satisfactory
QI 9.17	Satisfactory

Annex D

Prison Population Profile on 21 July 2023

Status	Number of prisoners	%
Untried Male Adults	208	24.44
Untried Female Adults	0	0.00
Untried Male Young Offenders	0	0.00
Untried Female Young Offenders	0	0.00
Sentenced Male Adults	601	70.62
Sentenced Female Adults	0	0.00
Sentenced Male Young Offenders	0	0.00
Sentence Female Young Offenders	0	0.00
Recalled Life Prisoners	14	1.65
Convicted Prisoners Awaiting Sentencing	27	3.17
Prisoners Awaiting Deportation	1	0.12
Under 16s	0	0.00
Civil Prisoners	0	0.00
Home Detention Curfew (HDC)	6	0.71

Sentence	Number of prisoners	%
Untried/ Remand	208	24.44
0 – 1 month	8	0.94
1 – 2 months	4	0.47
2 – 3 months	2	0.24
3 – 4 months	5	0.59
4 – 5 months	6	0.71
5 – 6 months	10	1.18
6 months to less than 12 months	23	2.70
12 months to less than 2 years	64	7.52
2 years to less than 4 years	59	6.93
4 years to less than 10 years	252	29.61
10 years and over (not life)	68	7.99
Life	52	6.11
Order for Lifelong Restriction (OLR)	48	5.64

Age	Number of prisoners	%
Minimum age:	**21**	2.47
Under 21 years	0	0.00
21 years to 29 years	189	22.21
30 years to 39 years	264	31.02
40 years to 49 years	193	22.68
50 years to 59 years	127	14.92
60 years to 69 years	55	6.46
70 years plus	23	2.70
Maximum age:	**90**	10.58

Total number of prisoners	851

Annex E

Update on Recommendations from 2019 Report

Update on key recommendations:

	Evidence	Open/Closed
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.	On inspecting a selection of Use of Force forms, viewing CCTV evidence of a selection of incidents and speaking to staff and FLMs, there seemed to be some confusion on what a planned removal was, and they were not being video recorded when they should be. There were examples of good practice where this had been done, but practice was inconsistent. From the Use of Force forms it was clear when they had planned to move a prisoner from one location to another and gathered appropriate staff to do so before opening a locked door to engage with the prisoner, however in the forms it was marked as unplanned. There was no Violence Reduction Strategy or forum to discuss or review Use of Force and how it was applied, and still only 61% of staff were trained appropriately in C&R. Body cams were not in use.	Open

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. 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. All RAs and SSOWs 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.	The RRA process was being followed as per the guidance. All admissions, transfers and returns from court with a change of circumstance were seen by a NHS nurse during the reception risk assessment process. There were issues with individual CSRAs identified during this inspection.	Closed

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.	All reception staff were competent in TTM. There was an audit and assurance process in place but there were examples of the process being poorly followed. There were sufficient trainers in place to deliver TTM training. The Think Twice Strategy has not been implemented, a recommendation has been made around this. Not all prisoners on admission received a health assessment due to them arriving after the nurse had finished for the day.	Open

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 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.	Some cells in Glenesk hall contained several pictures of women semi-naked and it appeared to be accepted by staff. HMP Edinburgh should review whether this meets the terms of current guidance on posters, pictures and photographs displayed in cell. There was evidence of poor hygiene control in the pantries. A significant number of prisoners working in the pantries and in the kitchen who were not certificated in Food Hygiene. Temperature checks not being carried out, whites were not being worn by those working in the pantries, and residential passmen did not have BICS certification. All of this indicates that the underlying issues in this recommendation have not been addressed.	Open
Key Recommendation 5: Accomodation: 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.	Action had been taken to reduce the number of different populations in the prison, with all women now transferred out of HMP Edinburgh. Glenesk hall was now almost solely remand, apart from a small number of convicted prisoners who were due to move shortly. The fabric of Glenesk hall remained poor – doors and stairwell banisters were in need of paint, there were excessive amounts of graffiti in several cells, sockets ripped from walls with wiring exposed and a lack of toilet seats in Glenesk 3.	Open

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.	PIACS were not embedded within the prison. There was a sufficient range of employment and training opportunities, but due to workshop closures and difficulties escorting prisoners attendance levels were poor. The Regime was still restricted, particularly in the evenings. The Personal Officer system was not operating at the required standard, including engagement with ICM. Personal Officer attendance remained low at 5%, and reports submitted in where they did not attend in 59% of cases.	Open
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.	HMP Edinburgh had a good awareness of areas used to introduce illicit articles. They had introduced an additional fence to combat throw overs and used Rapiscan to check property and mail.	Closed

Update on Remaining Recommendations from 2019 inspection

Standard 1 - Lawful and Transparent Custody	Evidence	Open/Closed
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.	The RRA process was being followed as per the guidance.	Closed
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.	There were sufficient staff working in reception.	Closed
3. QI 1.1 HMP Edinburgh should ensure that all reception staff are within competency for Talk to Me Training.	All were within competence but having difficulty booking training as courses were not being run as regularly.	Closed
4. QI 1.2 HMP Edinburgh should consider reintroducing untried and convicted first night in custody units.	First Night Area opened the week of the inspection in Ingliston 1 South. It was too early for inspectors to assess its performance.	Open
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.	Peer mentors were meeting almost all prisoners that came through reception. In the last six months almost 90% were seen. However foreign nationals were missing out as peer mentors were unable to converse with them, as they did not have access to translation services.	Open

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.	Local induction information was now contained within a FNIC booklet that peer mentors gave to prisoners in reception. TVs were working in holding cells. However holding cells were sparse and would benefit from having information displayed on the walls.	Closed
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.	Not an issue during this inspection.	Closed
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.	Only mainstream convicted prisoners were attending national induction in the induction workshop. Offence-protection prisoners were offered it in their residential area but attendance was poor due to clashes with other activities. Remand prisoners were not offered it at the time of the inspection. Induction staff were in talks with Glenesk staff to identify a time to deliver it in the hall. All categories should be offered it in the induction area.	Open
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.	Prior to the inspection there were huge backlogs. The FNIC area were taking over completion so it is hoped this will help but it was too early for inspectors to assess. HMP Edinburgh need to monitor this closely and IPMs will follow up.	Open

Standard 2 - Decency	Evidence	Open/Closed
10. QI 2.1 HMP Edinburgh should take action to improve the building conditions in Glenesk Hall.	The fabric of Glenesk hall remained poor, doors and stairwell banisters were in need of painting, there were excessive amounts of graffiti in several cells, sockets ripped from walls with wiring exposed, also a lack of toilet seats in Glenesk 3.	Open
11. QI 2.1 HMP Edinburgh should review the posters on display in cells in male halls.	Some cells in Glenesk contained several pictures of women semi-naked. HMP Edinburgh should review whether this meets the terms of current guidance on posters, pictures and photographs.	Open
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.	There was evidence of a mattress replacement programme and stocks of additional bedding were available in most residential areas. However the process for removing old mattresses was flawed, with some placed in the same store room as clean bedding and clothing.	Open
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.	Inspectors observed shortages of large and smaller sizes, partly due to larger sizes shrinking with repeated washing.	Open
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.	N/A – All women had now transferred out of HMP Edinburgh.	Closed
15. QI 2.5 HMP Edinburgh should review the contingency plans for women's laundry.	N/A – All women had now transferred out of HMP Edinburgh.	Closed

Standard 3 – Personal Safety	Evidence	Open/Closed
16. QI 3.1 HMP Edinburgh should implement an audit and assurance process for TTM documentation.	An audit process was in place, but FLM and Unit Manager checks need to improve.	Closed
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.	Screen had been fitted.	Closed
18. QI 3.1 HMP Edinburgh should recruit and train more TTM trainers to meet the demand.	TTM competencies were at appropriate levels so there were a sufficient number of trainers.	Closed
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.	There was no evidence of a VRS.	Open
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.	There was no evidence of an anti-bullying strategy.	Open
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.	Peer mentors mention bullying but no formal training was in place as there was no strategy in place.	Open

22. QI 3.5 The VRS should identify clear lines of responsibility to include the referral and recording of bullying incidents.	There was no evidence of a VRS.	Open
23. QI 3.5 A clear process should be established to collate and record the Think Twice Strategy paperwork and actions.	There was no evidence of an anti-bullying strategy.	Open
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.	Appropriate evidence received.	Closed
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.	C&R training stats were low – see standard 8.	Open
26. QI 3.7 All RAs and SSOWs should be reviewed immediately.	Up to date.	Closed
27. QI 3.7 Staff should be trained in Health and Safety and Fire Response to meet the required competency level for HMP Edinburgh.	H&S managers training competencies were at 41% - this requires attention.	Open

Standard 4 - Effective, Courteous and Humane Exercise of Authority	Evidence	Open/Closed
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.	Having reviewed Use of Force (UoF) forms and the recent SPS audit on UoF, it was clear that planned removals were still being recorded as unplanned and were not being video recorded in line with policy. Body cameras are not in use across the SPS.	Open
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.	UoF forms were being audited by Head of Operations and the quality of reporting had improved. However there was no process in place for reviewing incidents and no VRS was in place.	Open
30. QI 4.3 Hall Management should ensure that any mitigations received during the adjudication process are followed up by the Hall Manager.	On observing and reviewing adjudication paperwork it was clear mitigations were considered.	Closed
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.	Unit Managers demonstrated that they fully understood the adjudication process and ensured the prisoner understood the process. On more than one occasion inspectors witnessed the adjudicator explaining both the process and charges.	Closed
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	HMP Edinburgh had created a good system for managing and recoding SSMs on SharePoint. However the system was not being used properly, leading to out of date documents and a lack of uploading documents to PR2	Open

33. QI 4.5 HMP Edinburgh should ensure that all items carried on the route are searched for illicit articles.	There was no route movement in HMP Edinburgh. Inspectors witnessed several prisoners leaving areas carrying items that were not checked or searched, with no rub down searches or metal detection of the prisoner prior to leaving areas.	Open
34. QI 4.8 HMP Edinburgh should ensure that MDT testing for women takes place on a regular basis.	N/A - All women had now transferred out of HMP Edinburgh	Closed
35. QI 4.9 HMP Edinburgh should ensure that all doors are locked in accordance with SPS locking policy.	There were no evidence of doors being left open.	Closed
36. QI 4.9 HMP Edinburgh should ensure that all items being carried by prisoners leaving accommodation areas are searched.	Inspectors witnessed several prisoners leaving areas carrying items that were not checked or searched. In these incidents it was observed that no rub down searches or metal detection were used prior to prisoners leaving these areas.	Open
37. QI 4.10 HMP Edinburgh should carry out a review of external camera coverage	External camera coverage was good and trees had been cut down to provide better sight of specific areas.	Closed

STANDARD 5- Respect, Autonomy and Protection Against Mistreatment	Evidence	Open/Closed
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.	Regimes were still being restricted on a daily basis to redeploy staff to residential areas.	Open

39. QI 5.4 HMP Edinburgh should try to reduce the mix of populations held on Glenesk 2.	Glenesk was now all remand prisoners.	Closed
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.	No issues found.	Closed
41. QI 5.5 The systems in place for ensuring PIACs take place should be reviewed.	PIACs were not held on a regular basis.	Open
42. QI 5.6 HMP Edinburgh should review the systems in place for managing agents visits.	The visits system was running well.	Closed
43. QI 5.6 HMP Edinburgh should look to improve the technological arrangements for virtual court appearances.	HMP Edinburgh had two main virtual court rooms which served a number of courts. No technological issues were outstanding.	Closed

STANDARD 6 - Purposeful Activity	Evidence	Open/Closed
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.	This recommendation had not been progressed. The lack of a route movement is hampering most purposeful activities.	Open

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.	There was evidence of some waterproof jackets being available. However, both staff and prisoners highlighted the lack of appropriate clothing. SMT confirmed that jackets had been procured, however they had not been distributed and were not available during inspection.	Open
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.	There was little evidence of consistency or any improvements to the Personal Officer scheme. Prisoners were generally aware of who their identified personal officer was and this was recorded on PR2. Pockets of good practice were evident, but the process was inconsistent. Reinvigoration of the personal officer role in short-term case management took place early in 2022, but lost momentum when robust oversight was removed. This needs to be addressed.	Open
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.	It is often unavoidable to transfer prisoners due to population issues. However, Offender Outcomes FLMs were aware of the negative impact this could have on prisoners and the external partners who managed pre-release planning. Decisions had recently been reversed based on mitigation presented i.e. Employment on release organised by SACRO/Job Centre Plus.	Closed

STANDARD 7 - Transitions from Custody to Life in the Community	Evidence	Open/Closed
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.	Prisoners were able to access appropriate services to support reintegration in the majority of instances. There had been occasions where the Links Centre had to close to cover staffing absences on residential halls.	Closed
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.	Personal Officer attendance remained low at 5%, and reports were submitted where they did not attend in 59% of cases.	Open
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.	Social Work were meeting the expectations of HMP Edinburgh. All risk assessments and reports were submitted on time. It was noted however that with the change of population in Ratho hall from women to offence-protection, the workload is likely to increase.	Closed

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.	While generic programme assessments were operating effectively, there remained a significant waiting list for access to programmes, particularly for offence-protection prisoners.	Open
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.	The establishment of a pre-release service had mitigated the impact of the loss of the TSO service. However, similar to the links centre, staff indicated they were occasionally redeployed to the residential halls to cover staff shortages. This was the exception rather than the norm.	Closed

HMIPS Standard 8 - Organisational Effectiveness	Evidence	Open/Closed
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.	Staff were not aware of the ADP despite it being accessible on SharePoint.	Open

HMIPS standard 9 – Health & Well-being (SPS recommendations only. Healthcare recommendations will be monitored by HIS)	Evidence	Open/Closed
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.	GEOAmey were still not attending a number of appointments.	Open

Annex F

Inspection Team

Kerry Love, Standard 1, HMIPS

Stephen Sandham, Standard 2, HMIPS

David Dalziel, Standard 3, SPS

Calum McCarthy, Standard 4, HMIPS

Reverend Graham Bell, Standard 5, SPS

Kristie Clelland, Standard 6, SPS

Sheila Brown, Standard 6, Education Scotland

Joseph Mulholland, Standard 6, Education Scotland

James Black, Standard 7, Care Inspectorate

Jacqueline Clinton, Standard 8, HMIPS

Sophie Dias-Cavaco, Standard 9, HIS

Catherine Haley, Standard 9, HIS

Jamie Thomson, Standard 9, HIS

Liz Taylor, Standard 9, HIS

Elaine Rogerson, Standard 9, HIS (Shadow)

Annex G

Acronyms used in this Report

AAB	Activity Allocation Board
ADHD	Attention Deficit Hyperactivity Disorder
ANP	Advanced Nurse Practitioner
ASN	Additional Support Needs
BBV	Blood Borne Virus
BICSc	British Institute of Cleaning Science
C&R	Control and Restraint
CBSW	Community-Based Social Worker
CGL	Change Grow Live
CIP	Community Integration Plan
CCTV	Closed-Circuit Television
CGF	Common Good Fund
COVID-19	Coronavirus Disease 2019
CSCS	Construction Skills Certification Scheme
CSRA	Cell Sharing Risk Assessment
ECR	Electronic Control Room
EDF	Equality and Diversity Form
EEDA	Exceptional Escorted Day Absence
EYS	Early Years Scotland
E&D	Equality and Diversity
FAN	Fire Action Notice
FCO	Family Contact Officer
FLM	First Line Manager
FNIC	First Night in Custody
GIC	Governor-in-Charge
GPA	Generic Programme Assessment
H&S	Health and Safety
HDC	Home Detention Curfew
HIS	Healthcare Improvement Scotland
HMCIPS	His Majesty's Chief Inspector of Prisons for Scotland

HMIPS	His Majesty's Inspectorate of Prisons for Scotland
HMP	His Majesty's Prison
ICC	Internal Complaints Committee
ICM	Integrated Case Management
ICP	Immediate Care Plan
IMU	Information Management Unit
IPM	Independent Prison Monitor
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer (Questioning)
LTC	Long-Term Condition
LTP	Long-Term Prisoner
MAT	Medication Assisted Treatment
MAPPA	Multi-Agency Public Protection Arrangements
MDT	Multi-disciplinary Meeting
MF2C	Moving Forward to Change
MORS	Management of Offender at Risk Due to Substance
MUST	Malnutrition Universal Screening Tool
NPM	National Preventive Mechanism
OBP	Offender Behaviour Programme
OLR	Order for Lifelong Restriction
OPCAT	Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
OST	Opiate Substitution Therapy
PANEL	Participation, Accountability, Non-discrimination and equality, Empowerment, and Legality
PBSW	Prison-Based Social Work
PCF	Prisoner Complaint Form
PCMB	Programmes Case Management Board
PEEP	Personal Emergency Evacuation Plan
PER	Prisoner Escort Record
PGD	Patient Group Directions
PIAC	Prisoner Information Action Committee
PLC	Play Learn Connect
PPE	Personal Protective Equipment
PR2	SPS Prisoner Records Version 2

PT	Physical Training
PTI	Physical Training Instructor
QI	Quality Indicator
REAS	Royal Edinburgh Hospital and Associated Services
RMP	Risk Management Plan
RMT	Risk Management Team
RRA	Reception Risk Assessment
RRC	Refuse to Return to Circulation
SAR	Subject Access Request
SCP	Self Change Programme
SCQF	Scottish Credit and Qualifications Framework
SOP	Standard Operating Procedure
SPS	Scottish Prison Service
SPS HQ	SPS Headquarters
SPSO	Scottish Public Services Ombudsman
STP	Short-Term Prisoner
SQA	Scottish Qualifications Authority
SRU	Separation and Reintegration Unit
SSM	Special Security Measures
TARL	Throughcare Assessment for Release on Licence
TDU	Tactical Dog Unit
TTM	Talk to Me
UoF	Use of Force

Evidence report

Quality Indicators

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

Rating: Satisfactory

According to the HMIPS pre-inspection survey, 53% of prisoners said they were treated well in reception on arrival, with a further 34% reporting being treated neither well nor badly.

HMP Edinburgh received prisoners predominantly from courts in Edinburgh, the Lothians and the Borders as well as other prison establishments. There was adequate space within the reception area to safely process and accommodate all prisoner categories held within the establishment. There was also a sufficient number of staff working in reception. They were able to keep the additional post allocated to them when women were held in the establishment, which meant they were able to action property requests and deal with the mail the same day.

The bulk of new admissions tended to arrive at the establishment after 4.00pm. On the Monday and Wednesday of the inspection new admissions were still being processed after 9.30pm. Some NHS nurses were staying on beyond their 8.00pm finish time as a goodwill gesture. Where this was not possible, prisoners were correctly being placed on Talk to Me (TTM) until they could see a nurse the following morning. However, this placed additional pressure on residential staff having to complete 15-minute observations and disrupted new admission's sleep during what may already be a stressful time.

There was a Standard Operating Procedure (SOP) covering the admissions process. Inspectors observed staff following the instructions within them and PR2 was updated appropriately. Reception staff were able to talk knowledgably about the admissions process.

Prisoners were brought off the GEOAmey van one at a time and processed at the staff desk. They were then placed in a holding cell relevant to their category and status. Inspectors witnessed GEOAmey drivers waiting in reception for more than an hour whilst prisoners were individually brought off the van and fully processed. HMP Edinburgh should consider prioritising the checking of warrants to prevent delays and allow GEOAmey staff to leave.

Once initial checks and searching were completed, the prisoner was taken into a private room to assess their ability to understand and provide them with an opportunity to engage in the admissions process, via the Reception Risk Assessment (RRA) form. The officers that were observed completed the interview in a caring, friendly, and supportive manner, providing reassurance where necessary, for example how to ask for help if needed once they arrived in the residential area.

All prisoners covered by the RRA were seen by a nurse in a dedicated room in reception. Most admissions were processed within the 60-minute timeframe.

However, this was not always the case. Reception staff reported that there were regular delays in nurses arriving, particularly during 3.30 and 5.00pm when they were administering medication in the residential areas. This meant that prisoners were staying in the reception area for far too long, resulting in prisoners becoming frustrated and reception staff having to manage this, particularly those returning from court with a change of circumstances who were keen to get back to their cell. Delays were also caused by not having operational staff available to escort prisoners to the residential areas.

Prisoners were offered a sandwich or a hot meal if it was at mealtimes, provided from the kitchen.

All staff were observed to be friendly, engaging, and professional when interacting with prisoners. Inspectors spoke to prisoners who had recently been admitted and they were positive about their experience and the staff working in reception. Inspectors sampled some RRAs and were content that they met the required standard. A peer mentor was based in reception, and their role is explained more fully in QI 1.2.

It was evidenced that reception staff were making use of translation services where necessary. There was a private room available for these interviews to take place but there was no phone in it. This meant that conversations with translators were taking place at the reception desk with the telephone on speaker. This did not offer enough privacy and HMP Edinburgh should install a phone in the interview room to allow private conversations to take place.

Inspectors were pleased to see the SPS national induction booklet available in reception in seven other languages. However, the English version was out-of-date so this may have been the case for the translated versions too. Staff were not able to show inspectors the descriptive cards or pictograms referred to in the reception SOP.

The reception area would benefit from a body scanner. Staff reported that the full sized one did not fit so they had made a business case for a portable one, which HMIPS hope is approved.

Recommendation 1: HMP Edinburgh should prioritise the processing of warrants to prevent GEOAmey staff waiting in reception for lengthy periods.

Recommendation 2: HMP Edinburgh should place a phone in the interview room to allow translation interviews to take place in a private area.

Recommendation 3: HMP Edinburgh and the NHS healthcare team should address the issues resulting in delays in nurses attending reception and operational staff escorting prisoners to residential areas.

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

HMP Edinburgh had an impressive peer mentor/supporter programme in place, introduced and overseen by an experienced and very enthusiastic member of staff. Almost every new admission and transferred-in prisoner met with a peer mentor and peer supporter as part of the admission process. The peer mentor had an allocated area within reception to meet with prisoners, where they were given a FNIC booklet that provided lots of helpful information. Inspectors were pleased to see it included how to make a complaint and access the IPM service but would like to see the Prisoner Information Action Committee (PIAC) process added to it, so that new prisoners know how to contribute their views on life in the prison. The peer mentor then completed an Inductee Admission Checklist and took them through the most important information then passed the checklist to the peer supporter on the hall.

All new admissions would spend their first 24 hours in the FNIC area for assessment. Once transferred to their final location within the prison, they were met by a peer supporter who took them through the regime for the hall and offered to go over the Inductee Admission Checklist and any of the information provided to them by the peer mentor or within the FNIC booklet. This was a fantastic process for providing prisoners with the information they required before being offered the opportunity to attend national induction.

Inspectors were pleased to see the SPS national induction booklet available in seven other languages in reception. However, it was based on the 2012 version that talked about Visiting Committees and smoking in cells and needs updated as soon as possible, as it is the only information available to those that do not speak English. Unfortunately, the FNIC booklet was not available in other languages. Those who did not speak or understand English did not meet with the peer mentor or supporters as they were unable to communicate with them. Therefore, these prisoners were not receiving the same information as those who spoke English. This was made worse by them also not having access to national induction as reported in QI 1.8.
HMP Edinburgh should have the FNIC booklet translated into the most common languages used in the prison.

Reception staff advised they were not part of the process for notifying foreign national prisoners that they were entitled to contact diplomatic services free of charge, and residential staff spoken to had no knowledge of this either. Therefore, inspectors were unable to establish who was responsible for ensuring it was offered.

Inspectors were pleased to see the TVs working in the holding cells. This was an ideal opportunity to share information about the prison via the prison TV channel whilst prisoners were waiting to be processed or moved to a residential area. However, there were some challenges in keeping information updated - see Standard 6.

The reception noticeboards would benefit from being reviewed. The holding areas in reception had some graffiti on the walls that needed to be painted over, and they would also benefit from having information displayed on the walls to brighten them up.

Sampling of paperwork and discussions with staff evidenced that core screen paperwork was not being completed within the 72-hour deadline, with backlogs averaging between 40 to 65 each week. This appeared to be down to staff inexperience and unwillingness to prioritise it. Links Centre staff had delivered training sessions with staff at all levels to address this, and backlog statistics were being shared with the Deputy Governor on a weekly basis. Now that the FNIC area was up and running they were responsible for completing the paperwork, so it was hoped this would improve completion timescales. As stated, the FNIC area had recently opened so it was too early for inspectors to know if this would make a difference. HMP Edinburgh should closely monitor this, and we will ask our IPMs to also follow this up.

Prisoners spoken to were content with the information provided to them during the admission process.

Good Practice 1: The peer mentor/tutor process for prisoners that speak English.

Recommendation 4: SPS HQ need to update the 2012 SPS national induction booklet as soon as possible.

Recommendation 5: HMP Edinburgh should ensure the FNIC booklet is available in the languages spoken in the prison.

Recommendation 6: HMP Edinburgh should ensure that staff are aware of foreign national prisoners' entitlements on arrival.

Recommendation 7: HMP Edinburgh should closely monitor completion timescales for core screen paperwork.

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

Rating: Satisfactory

The SOP for the admissions process covered the identification and registration of prisoners, and reception staff were observed to complete this process as per the guidance. This included checking the Prisoner Escort Record (PER) and querying any issues/concerns with the escorting staff, completing the seven-point warrant check and confirming the prisoner's identity using the warrant for reference.

There were sufficient staff trained in warrant checking and TTM. Staff reported to inspectors that there had been issues getting people on the warrant training as courses were not being run as often.

The PER should identify any special needs, including risk factors and the RRA provided a further opportunity for this. PR2 was updated as appropriate, and the warrant was passed to the Court Desk the following day to be confirmed. See QI 1.7 for more about this process.

As stated previously, staff were aware of and utilised translation services where needed.

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

Rating: Satisfactory

All the key information relevant to classification of prisoners was collected during the reception admission process and recorded on PR2.

As per the admissions SOP, all new admissions to the prison were automatically placed on a high supervision level prior to the assessment interview. It was reviewed within six months and then annually. The Prisoner Supervision System (PSS) process appeared to be running smoothly. The paperwork was being completed by the FNIC staff and appropriate sign-offs were being completed by FLMs and Unit Managers.

The FNIC booklet explained the supervision process to prisoners.

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: Generally Acceptable

HMP Edinburgh were part-way through a reconfiguration of the population at the time of the inspection. Previously, due to high prisoner numbers, there were different categories of prisoners living together throughout the establishment. The prison was moving towards areas designated to specific prisoner groups.

All admissions were initially allocated to the FNIC area in Ingliston 1 South to allow staff to complete the PSS and core screen paperwork with them, before they were moved to their final location.

Inspectors were delighted to see the FNIC area up and running as this was a recommendation from the previous inspection. However, it had only opened the week of the inspection, so it was early days. At the time of the inspection, there were seven double cells available on the hall for new admissions. The immediate concern was that space was limited for admissions as the area was also shared with a cohort of 15 non-offence protections, because Ingliston 3 was full, and four mainstream passmen. This was proven to be the case as the area had filled up by the end of the inspection week and therefore admissions were going to other areas that had space.

The two safer cells and one accessible cell held prisoners from other areas. Staff aimed to provide single cell accommodation; however, it was difficult for the staff there to manage so many different regimes and there were no safer or accessible cells available should they be needed. There were no dedicated safer or accessible cells for FNIC as these had been taken up by prisoners from other areas. What did not help was that safer cells in other areas were out of use during the inspection.

Once the FNIC area is settled, HMP Edinburgh may wish to consider keeping admissions there until they have completed their induction. This would help improve attendance rates and ensure all categories of prisoners were offered national induction. However, it would need more of the hall available for this to work. See QI 1.8 for more detail on this.

The desk staff in the FNIC area liaised with other halls about where prisoners would be placed next, depending on their classification and prisoner category.

> **Recommendation 8**: HMP Edinburgh should have a safer cell and an accessible cell freely available within the FNIC area should it be needed.

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

Rating: Generally Acceptable

There was a SOP available covering the Cell Sharing Risk Assessment (CSRA) process.

Reception staff recorded relevant information on PR2 during the admissions process. CSRAs were being completed by hall staff when required and there was an appropriate assurance process in place. FLMs ensured compliance and secondary assurance was completed by residential Unit Managers.

The SOP stated that the Business Manager ran a daily report to highlight non-compliance and it was sent to the FLMs to rectify. Inspectors confirmed that it was in fact a monthly report. FLMs completed a monthly audit and recorded it on the relevant audit document. As per the CSRA guidance document, FLMs checked the daily alerts at the end of each shift.

Checks on some CSRAs revealed a lack of detail where a risk was identified and accepted and the need for this to improve was confirmed by FLMs and the Business Improvement Manager. There were desk instructions available and the mentor for the establishment had been going over the process with staff. HMP Edinburgh might want to think about what else they can do to improve completion and prevent potential challenges should an incident occur.

> **Recommendation 9**: HMP Edinburgh should take action to ensure CSRA entries on PR2 meet the required standard to prevent potential challenges should an incident occur.

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

Rating: Satisfactory

Reception staff completed an initial calculation of the warrant on admission which was followed up the following day by the court desk who confirmed the warrant on PR2 the following morning. It was double-checked by a second member of the team with an assurance check completed by the team manager.

There were good relationships with the clerks at the relevant courts should staff need to query something. All staff involved were trained in Intermediate Warrant and Sentencing Calculation.

Prisoners were notified of their critical dates via the internal mail within 24 hours of arrival, unless there was a query which could cause a delay. This was done daily, so prisoners were notified of their dates the day after admission.

All paperwork was held securely and there was a retention policy in place.

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: Generally Acceptable

In the HMIPS pre-inspection survey, 66% of respondents said that they were offered an induction on arrival at HMP Edinburgh. During the inspection, this reflected the population that were being offered national induction.

All prisoner categories started their induction journey in reception. They were provided with a FNIC booklet and had a full and helpful discussion with a peer mentor who completed an Inductee Admission Checklist, followed by a meeting and an opportunity to go over the checklist with a peer supporter once they arrived at their final location. As reported in QI 1.2 this does not happen for those who do not speak English. They were provided with the SPS national induction booklet, but it was significantly out-of-date. The checklists were then passed to the induction workshop.

National induction was delivered in the induction workshop within 10 days of arrival. The induction workshop was a bright area, with hugely dedicated and enthusiastic staff and peer mentors/supporters working there. The induction slides were customised to suit HMP Edinburgh and co-presented by the peer mentor/supporters and induction staff.

There were very clear processes in place and accompanying paperwork, with good statistical information being produced on attendance at induction with a peer mentor in reception, with a peer supporter on the hall and at the induction workshop.

National induction took place regularly and there was a £7 incentive to attend. It was not compulsory, and attendance was affected by clashes with other activities in the regime. Only mainstream convicted prisoners that met the criteria were invited to the induction workshop. Those who refused signed a disclaimer.

Induction staff attended the offence protection hall to deliver it as the lack of a traditional route movement restricted prisoners' ability to get to the induction workshop. Uptake for offence-protection was not good and this was partly attributable to the regime and the lack of dedicated time to deliver induction. Prisoners opted to go to physical training (PT) or exercise rather than attend induction. Peer mentors/supporters encouraged attendance in reception and on the halls.

Untried prisoners were not being offered national induction due to lack of resource in the induction workshop but also the regime. Induction staff were being taken from their day job to help cover absences in residential areas. Induction staff were working with Glenesk to identify, as a minimum, untried prisoners in prison for the first time and asking the staff there to identify a suitable time in the day for them to deliver it. However, this had not been possible to date.

There was no process in place to offer national induction to those that did not speak English.

In summary, there was a fantastic local induction process in place for all prisoners that is worthy of sharing with other prisons. This is reported as good practice in QI 1.2. National induction was being offered to all mainstream convicted prisoners and they were attending the induction workshop, offence-protection prisoners were being offered induction once per week, but uptake was poor because it clashed with the regime, and untried prisoners and those that did not speak English were not being offered it at all. HMP Edinburgh must review this as a priority to ensure that all categories of prisoners have equal access to the national induction programme. Had this been the case this QI would have been rated as good.

> **Recommendation 10**: HMP Edinburgh should ensure that all eligible prisoners receive, or are offered, the National Induction Programme as soon as possible after admission.

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

Rating: Satisfactory

Staff within the Court Desk and reception were able to clearly explain the liberation processes and there were SOPs available to guide them through it.

The Court Desk completed the final check of critical dates for prisoners being liberated. They also notified relevant external agencies. All liberation dates were entered into a liberations book once the date was calculated following admission to the establishment. A liberation scroll was printed off a day in advance of a liberation taking place and checked against the liberation book, the warrant and PR2. The

liberation scroll was double-checked and signed-off by the team manager. If he was on leave, there were three Unit Managers able to sign it off.

Reception staff collected all completed documentation from the Court Desk the day before the liberation was due to take place and stored it in a safe in the reception area. They also retrieved any property from the storeroom within reception.

Inspectors observed liberations during the inspection, and it followed the guidance in the SOP. Prisoners left the prison via the agents visit area, the cashier and were escorted out of front-of-house.

Prisoners are treated well by reception staff who checked they had everything they needed and PR2 was updated as required.

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

Rating: Poor

As a result of the rising prison population the prison had been asked by SPS HQ to make use of contingency accommodation, which had resulted in some cells designed as single cells being used as double cells. The ones in Glenesk were particularly small and did not comply with internationally recognised minimum space standards of 4m^2 of living space per prisoner in a multi-occupancy cell. A number of these contingency double cells also only contained one chair seat when they should have had two chairs.

Although the standard of accessible cells was excellent in Ratho, one of the newer accommodation blocks, in Glenesk the accessible cells were of older design and significantly poorer décor. Given the increase in the number of older prisoners and the projected rise in the overall prison population, the SPS must plan for prisons of the size of HMP Edinburgh to have more accessible cells in future.

Ventilation was a problem in some cells such as those in Glenesk 3. This allegedly was partly because of previous occupants trying to push material through the ventilation slats, which had then become blocked, but the result was some cells had almost no free flow of air and were hot and stuffy even in November. Staff expressed concern about the health and safety impact on both prisoners and staff if the occupant was taking illegal substances and had to be placed on management of offender at risk due to substance (MORS).

A lot of cells in Glenesk had significant levels of graffiti, which was unacceptable and needed painting, while one cell in Glenesk 3 had its plug socket plate pulled out revealing live wiring. The general décor in many cells in Glenesk was poor and in need of improvement.

There was evidence of a structured maintenance programme where faults and defects were logged and dealt with efficiently and some staff reported that faults were addressed speedily when reported. However, some defects logged on the system had been outstanding since May 2023 while awaiting parts with the

maintenance team unable to find alternative suppliers. The Estates Team were also grappling with vacancies for electricians, plumbers, joiners, and painters, with market forces making alternative employment opportunities more attractive. The Estates Team expressed concern that the maintenance budget for HMP Edinburgh was smaller than that for some other comparable establishments, but senior management felt that SPS HQ was supportive when seeking additional funding for major projects.

The prison had been completely rebuilt between 1998 and 2009. Some parts of the prison were now showing their age, with the long narrow main corridor out of keeping with the wider communal corridors that would be commonplace in more modern prisons. This very long narrow main corridor made the movement of prisoners and separation of prisoner groups potentially longer and trickier, but it is recognised that any change would require substantial alterations. Although the main corridor was clean and bright, with evidence of regular paintwork, other parts of the prison looked old and tired, notably the oldest building Glenesk where doors and handrails in particular were clearly in need of painting.

Recommendation 11: SPS HQ should withdraw the use of single cells as double cells for contingency plans in Glenesk where they do not meet minimum space standards.

Recommendation 12: HMP Edinburgh should address the levels of graffiti and poor cosmetic state of many cells in Glenesk and ensure doors and handrails in the stairwell are also painted.

Recommendation 13: HMP Edinburgh should address the problem of poor ventilation in cells in Glenesk from blocked ventilation slats.

Recommendation 14: SPS HQ and HMP Edinburgh should work together to address the number of vacancies in the Estates Team and difficulties retaining skilled trades when market forces provide more attractive opportunities.

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: Poor

The Industrial Cleaning Party worked hard, regularly cleaning the communal areas of the prison to an agreed cleaning schedule and for the most part these areas looked clean. However, there was a significant problem with litter in some external areas of the prison, notably in the external corridor between Ingliston Hall and the main internal corridor. Despite the Party clearing litter from this area every Monday, Wednesday and Friday, more litter quickly appeared in the same areas, apparently because of material being deliberately thrown out of windows by prisoners in Ingliston. Consideration should be given to extending even further the frequency of the litter pick-up in this area and what else can be done to discourage prisoners from throwing litter out of cell windows.

The cleanliness of some residential areas was at times observed to be poor by inspectors; notwithstanding the acknowledged staffing challenges the situation could have been addressed by getting passmen out for short periods in the evening.

Many of the cells in Glenesk 3 did not contain a toilet seat, which is not conducive to comfort or hygiene. Inspectors were told this arose from prisoners damaging the toilet seats, but nevertheless this needs to be addressed. However, it was reassuring to hear prisoners report that passmen did help keep the accessible cells clean when an occupant was unable to do so.

The Industrial Cleaning Party Team were alerted by residential staff whenever a new passman started and sought to provide BICSc awareness training as quickly as possible, following up with full BICSc certification when opportunity arose, subject to the passmen meeting the appropriate standards. However, as of 20 September 2023 there were a number of passmen in both Ingliston and Glenesk who had received no training at all and not everyone in Hermiston was BICSc qualified:

Glenesk
28% full BICSc certification
53% BICSc awareness trained
19% untrained

Ingliston
35% full BICSc certification
53% BICSc awareness trained
12% untrained

Hermiston
78% full BICSc certification
22% BICSc awareness trained

There was a slightly better picture on biohazard training, with eight trained in Ingliston, six in Glenesk and four in Hermiston. The Industrial Cleaning Party were not helped by having to cope with a long-term sick absence, and it is recognised that the temporary nature of residency in a remand hall like Glenesk is an additional challenge. Nevertheless, further efforts need to be made to secure full BICSc certification for anyone working as a passman. Not just to ensure cleanliness and hygiene but because such qualification can assist with securing employment when liberated.

Recommendation 15: HMP Edinburgh should address the problem of litter being thrown out of Ingliston cell windows and collecting in the external corridor leading to the main corridor.

Recommendation 16: HMP Edinburgh should ensure all cells have toilet seats.

Recommendation 17: HMP Edinburgh should ensure all prisoners working as passmen are BICSc trained and certificated.

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

There was evidence of a three-year mattress replacement programme in operation in HMP Edinburgh, with a number of prisoners also confirming that a significant number of new mattresses had been provided within the last year. The mattresses were thin, and some prisoners were using two mattresses to provide an improved night's sleep. It was disappointing from a hygiene perspective to see some old mattresses temporarily parked in the same storerooms where clean bedding and clothing was stored. While a mattress had been thrown out of broken windows following cell damage and left to get damp in external areas of the prison. To their credit the Waste Collection Team agreed during the inspection to deal with this.

There were stocks of clean bedding in most of the halls, but some of the laundry passmen complained about difficulties in sourcing new sheets and duvet covers, and some of the foam pillows observed by inspectors were in poor condition. Old mattresses were being recycled into pillows.

Bedding could be washed when required, and the laundry staff had a good process for reminding residential staff when it had been a long time since bedding from particular cells had been washed. This was good practice.

> **Good Practice 2**: Laundry staff had a good process for reminding staff in residential areas when bedding from particular cells had not been washed for a long time so they could encourage the occupant to put it out for washing.

> **Recommendation 18**: HMP Edinburgh should improve the process for disposing of used mattresses, so they do not have to be parked in storerooms holding clean bedding.

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: Generally Acceptable

Prisoners had access to toiletries and personal hygiene products from the canteen. Any prisoner who arrived with no such possessions, or who had insufficient money to purchase such items from the canteen, was provided with basic commodities by the prison. The canteen did cater for prisoners who may have special requirements as a result of their religion or culture (for example, special hair products).

Prisoners had been consulted about the canteen list in October 2023, but staff acknowledged they had not been able to do that as frequently as they had intended over the last year.

All prisoners could access showers daily at reasonable times.

Although no prisoners complained about not being able to get a towel, some prisoners indicated to inspectors that they only had one towel and because laundry did not always get returned the same day, they could be left without a towel overnight. Both staff and prisoners expressed frustration that towels regularly appeared to go missing. The laundry passmen blamed this on towels going missing at the Laundry, while the staff supervising the Laundry were adamant that their records indicated the same number of towels were returned to residential areas, and that the apparently high number of lost towels related to prisoners retaining multiple towels to 'fish' for items thrown over the fence. Laundry staff indicated that over 200 spare towels had recently been sent to one hall, which was again complaining of shortages.

Regardless of the actual cause, it was clear that a more robust process for controlling access to towels in the residential areas and monitoring the number of towels sent to the Laundry and returned from the Laundry is needed. It was encouraging, however, that the prison was already aware of the problem, had taken steps to order more towels, and intended to introduce a more robust process for control of towels.

> **Recommendation 19**: HMP Edinburgh should consult prisoners regularly about any changes they wished made to the canteen list.
>
> **Recommendation 20**: HMP Edinburgh should follow through on its plan to introduce a more robust process for controlling access to towels and monitoring the number of towels sent and returned from the Laundry.

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

Some landings in some halls had access to an adequate range of clothing. Unfortunately, this varied between residential areas and even between landings in the same hall. Many laundry passmen complained of shortages of large and extra-large t-shirts due to the number of shirts that shrunk in the heat of the industrial tumble driers. Laundry staff acknowledged that shrinkage was hard to avoid after repeated washings. Conversely a few landings seemed to be short of smaller sizes.

There was wide variation across halls and landings in the quality of rain jackets for outside exercise, with some having robust fleece lined waterproof jackets and other areas only having thin jackets that would give minimal protection in winter. However, the prison had ordered 200 of the better-quality fleece lined type.

Several laundry passmen and some residential staff complained that a new budget control process had been introduced requiring the First Line Manager (FLM) to approve orders for new clothing and that this was now delaying the order and delivery of clothing. Inspectors recognise the need to control budgets, but there would be merit in reviewing the new process to see if it is working as effectively as possible, or whether further improvements in the ordering process can be achieved.

There was a regular laundry schedule for each hall; most prisoners were able to have their clothes washed several times a week and there was a good process for identifying the laundry of individual prisoners.

Some prisoners complained that their clothing sometimes came back damp from the laundry, but the Laundry Team argued that this was simply the result of prisoners putting too many items into their laundry bag. To their credit the Laundry Team informed inspectors they would put a reminder out to prisoners not to overload their laundry bags and encourage them to split the wash over two days to ensure their clothing came back fully dry.

The other main problem with the laundry arose from those prisoners who requested the laundry use non-biological washing powder and not to dry their clothes for fear of the clothes shrinking in the high heat of the tumble driers. This resulted in their clothing being returned damp and prisoners hanging their wet washing up to dry in their cells, creating condensation and potential fustiness from being left damp for too long. Laundry staff suggested this was sometimes because of residential staff not coming quickly enough to pick up laundry when informed it was ready for collection. Some residential landings now had their own washer/driers to allow prisoners to dry their clothes at their own desired temperature. However, this was not universally the case, and both staff and prisoners suggested it still left issues about who controlled access to these appliances.

> **Recommendation 21**: HMP Edinburgh should review the process for ordering new clothing to ensure it is working as effectively as possible.
>
> **Recommendation 22**: HMP Edinburgh should ensure that those prisoners not wishing to have their clothes dried in the industrial tumble dryers do not have to resort to hanging washing in their own cells to dry.

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

The pre-inspection survey of prisoners and focus groups with prisoners were highly critical of the food. Most survey respondents (80%) rated the quality of food negatively and less than a third (28%) reported always or usually getting enough to eat at mealtime. Prisoners also raised their frustrations about the food with inspectors during the inspection, complaining that the chicken would sometimes arrive pink and undercooked. However, the food observed during the inspection

week was of a reasonable quality and the catering manager was adamant that the chicken was thoroughly cooked, and all food was checked properly before it left the kitchen. Similarly, the quantities of food provided during the week of the inspection appeared reasonable, noting, however, that some prisoners chose to only take very small portions (for example, a burger but no bread or soup at lunchtime).

The prison catered for a variety of different diets such as vegan, Halal, Kosher, and people with specific dietary requirements such as gluten free, onion free, etc. The prison accommodated religious beliefs and supported prisoners to observe religious festivals such as EID and Ramadan. Some prisoners on special diets complained about a lack of variety, with the same items constantly appearing on the menu, but this appeared to be partly due to individuals rejecting some of the other options on the menu.

Inspectors sympathised with the challenges facing the catering manager in trying to accommodate so many different menus and dietary requirements, particularly on such a tight financial budget which equated to about £3.19 per prisoner per day. It was commendable, therefore, that the prison had won a Healthy Eating award in 2020 and the menus provided helpful information on the nutritional content in each menu option. We would encourage the catering manager, however, to vary the menu for mainstream prisoners more frequently as even mainstream prisoners alleged they had seen only minimal changes over many years. Many prisons operate a winter and summer menu to provide some visible variation; we encourage the catering manager to consider that and involve Food Focus Groups in decisions around that.

Although SPS staff working in the kitchen had been trained and achieved the Intermediate Diploma in Food Hygiene, and prisoners working in the kitchen had received training in food hygiene from the catering team, less than 10% of prisoners working there had Food Hygiene certificates. As the only member of the catering team with the Advanced Hygiene qualification, the catering manager was the only one qualified to put prisoners through the Elementary Food Hygiene certification process and he had not had time to do that since being promoted from his previous role in the Catering Team. This needs to be addressed quickly so that everyone working in the kitchen has achieved at least an elementary level of food hygiene certification.

Similar challenges existed in the pantries in ensuring passmen were appropriately trained. Although all pantry passmen wore gloves when serving food, a sizeable number were not wearing whites. One pantry man was observed bouncing a ball up and down on the floor while waiting for food to arrive and then proceeding to serve food with the same gloves on. Although records of temperature checks were provided for scrutiny, inspectors observed that temperature checks were not always carried out before food was served.

> **Recommendation 23**: The HMP Edinburgh Catering Manager should ensure that all prisoners working in the kitchen are Food Hygiene certificated.

Recommendation 24: The HMP Edinburgh Catering Manager should consider the scope to introduce winter and summer menus to provide some variation in the main prison menu, involving prisoners in that through Food Focus Groups.

Recommendation 25: HMP Edinburgh should reinforce training for pantrymen around basic food hygiene, the wearing of whites and temperature checks of food.

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

Rating: Generally Acceptable

Throughout the prison, staff evidenced a varied understanding of the Talk to Me (TTM) policy. The more experienced staff were able to articulate more accurately the process for dealing with someone at risk of self-harm or suicide, some of the newer staff were not so comfortable.

On the day of inspecting this quality indicator (QI), 11 prisoners were on TTM. Inspectors sampled a number of TTM files. In most cases the files were of a good standard with the correct processes being followed. However, the most common mistakes were that First Line Manager (FLM), or staff signatures were missing. In some cases the responsible person was not annotated, and dates were missing. Some of the staff narratives had minimal information, with just one line, but worryingly had been signed off by an FLM. Unit Managers audit the TTM files on a weekly basis and should have picked up on these mistakes and rectified them before it went to the TTM Co-ordinator for a closed file review. Based on the closed file review findings, it was clear that there was more work to be done in the residential halls by the staff, FLMs and Unit Managers to ensure that when a file is closed there are minimal corrections to be carried out during its review. There were a number of self-harm incidents where the person was placed on TTM when it was clear that the person was using this to cope rather than attempt to take their own life. Managing someone on observations particularly 15 minutes can be traumatising for the individual, particularly when there is no need. It was disappointing to hear from SPS HQ that a self-harm policy separate from TTM did not exist. A pilot scheme had been running in 2021 with the view of managing those who self-harmed differently from TTM, but this had not been followed through when the lead person left the SPS. The reason given for not continuing was the depletion of staff resources and a review of TTM. It was disappointing to learn that after two to three years the SPS were no further ahead with managing self-harm differently from TTM. SPS indicated that they would now wait to align any SPS self-harm policy with the Scottish Government national self-harm policy. This is in its final stages, however there are no timescales for this to be completed.

The current TTM Co-ordinator had recently taken over the role and had inherited a reasonable audit process. However, it was clear that there was some work to be done to improve the management of TTM. One of the issues was that there had not been any TTM meetings during 2023. The Co-ordinator planned to rectify this at the earliest opportunity.

Another area of concern identified was the use of the ICP. Inspectors acknowledge that ICP is an appropriate action when there is not the correct staff available to carry out a full case conference, such as late arrivals from court. However, records showed that people were being placed on an ICP at a time of day when a case conference could have been held. This was a regular occurrence and appeared to be common practice, which should cease. This goes against TTM policy which clearly states that a person should only stay on ICP if it is not possible to hold a case conference. The correct process is that a pre-case conference risk assessment should be undertaken, allowing for a comprehensive discussion via a case conference, to include any health care risks, such as the person being on medication or any health needs that could influence the care of that person.

A lack of communication between residential areas and healthcare was raised, where at times the Healthcare Team were not informed when a person was placed on TTM. This was escalated to the Deputy Governor, and an instruction was put out to FLMs to ensure that residential staff notify NHS staff of any new TTM cases.

Prisoners spoken to reported that they had been generally treated well by staff and felt that they had a say in their management plan. However, they did make comment that some staff were less supportive than others.

There were seven safer cells in the prison. During the inspection there was as many as three cells out of use at any one time. On inspection, the cells were bleak and there was no media available. The cells that were ready for use had the appropriate bedding and safer clothing. There was ample safer clothing and bedding in the hall stores. Most, if not all cells, needed painted.

Inspector observed one case conference held on Ingliston 1 at 8.30am. At this time prisoners were out in their sections and also moving to work. The noise was a distraction to the staff and the prisoner, and at one point in the case conference the officer left to check on their colleagues. The room was cluttered with a number of items including a phone and filing cabinets, which should not be in a case conference room. The time and the surroundings were not conducive to a positive environment in which a case conference could be held. However, inspectors applaud most of the case conference members for conducting a reasonably good case conference despite the challenges, and there was some good evidence of a person-centre approach by the FLM and the healthcare staff.

It was surprising to note the lack of knowledge of some staff around the TTM process, particularly as there was only 14 staff out of competence, including eight who were currently attending the prison college.

> **Recommendation 26**: HMP Edinburgh should ensure that they follow the TTM guidance and not utilise the ICP when the appropriate staff are available to hold a case conference.
>
> **Recommendation 27**: HMP Edinburgh should ensure that the timings and surroundings are conducive to a positive environment in which to hold a TTM case conference.

Recommendation 28: HMP Edinburgh should ensure that TTM Co-ordinator meetings are held at regular intervals, and at least once per quarter.

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

All admissions, returns from court or transfers were met by reception staff. The reception was visited on a number of occasions and staff were observed speaking to prisoners to identify circumstances that could heighten the risk of harm or abuse by others. All information available to staff was utilised to ensure those that may be at risk were separated from others. Those that self-disclosed potential issues around their own safety were able to request protection.

A potential improvement to keeping people safe was the recent reconfiguration of the population. This had been made possible due to the female prisoners being transferred out. The result of the reconfiguration was that there were less examples of protection prisoners sharing the same section, level or indeed hall with mainstream prisoners. However, the spaces left because of the reconfiguration were filled up quickly by males from other prisons.

The Intelligence Management Unit (IMU) looked at the admissions list daily to check on potential enemies and were able to inform residential managers of where best to place those at risk.

Inspectors observed a 'Person of Concern' meeting. This was a multi-disciplinary meeting that included the Deputy Governor, Unit Mangers, FLMs, Healthcare Practitioners, Psychology, Social Work and the TTM Co-ordinator. Prisoners were discussed who may be a risk to themselves or others such as on TTM, have health issues or Special Security Measures (SSM). Each prisoner was discussed and either a plan was put in place, or they were removed from the list as no further action was required.

A lesser-known vulnerable group were those that had served in our armed forces and who had now found themselves in prison. Admissions are asked if they are ex-service personnel Army, RAF or Navy. At the time of our inspection 49 individuals had revealed themselves as being a veteran however, the likelihood is there will be others who have not disclosed.

One of the Induction officers is also the Veteran in Custody Support Officer (VICSO) who organises monthly coffee mornings for those who have divulged they are ex services. This offers the group time away from their regular routine to meet up in a safe space allowing them an opportunity to provide and receive support from their peer group, internal & external partner agencies. Recently some of these veterans attended HMP Edinburgh Memorial Service for Armistice Day, with one of the group laying a wreath. The support given to the veterans was good practice.

HMP Edinburgh had a significant number of prisoners who required wheelchairs. Prisoners were trained to assist those in wheelchairs, however due to the recent population reconfiguration most of the helpers had moved to Ratho Hall so there was a need to train new prisoners to help. The wheelchair training is part of the Manual Handling course but unfortunately there were no staff competent to deliver this at the time of our inspection. Due to the high numbers using wheelchairs HMP Edinburgh should take action to address this quickly.

Recommendation 29: HMP Edinburgh should ensure that they have sufficient staff trained in manual handling so as to train prisoners to assist those in wheelchairs.

Good Practice 3: The support offered to veterans, allowing them a safe environment to support each other and share common experiences.

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: Satisfactory

HMP Edinburgh was a complex prison with regards to potential risks of subversive, aggressive or violent behaviour. It dealt with a number of challenges to keep prisoners safe and the prison running in an orderly fashion. There was a clear strategic approach led by the IMU, with support from all other areas. A number of strategies were utilised from checking admissions, intelligence reports, intelligence meetings with FLMs and staff and external information streams.

The IMU reported that they received a high number of intel reports which were then analysed and acted upon either by taskings or operations, such as area or cell searches. This information along with a number of other information streams fed into a tactical assessment meeting. They were held on a regular basis to inform the GIC and attendees of the intelligence picture, highlighting recent activity and possible threats and risks to the prison, as well as keeping them updated on individuals or groups of interest. Any actions required were logged, actioned, and reported back to the meeting.

Staff could access important information on PR2, designed to minimise contact between those required to be separated. However, understanding behaviours, preventing conflict, and building and maintaining relationships required close contact between staff and those they looked after. During the week of inspection, it was common to enter a residential area and see staff around the desk with the grille gates shut. On a number of occasions inspectors reported that staff were communicating with prisoners from the desk with the grille gates shut, which was not conducive to building relationships.

Recommendation 30: HMP Edinburgh should encourage the opening of grille gates, if necessary one wing at a time, to encourage communication with prisoners and building relationships of trust.

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

The HMIPS 2018 inspection report commented that "it remains uncertain how the new SPS anti-bullying approach 'Think Twice' will be implemented, local management should ensure that staff training and prisoner awareness in relation to Think Twice is instigated as soon as possible".

It was disappointing to note that there was still no evidence of a strategic approach to managing those that bully, intimidate or harass other individuals despite the Think Twice policy being in place since 2018. Although the IMU was able to capture the more prominent bullying, mostly related to serious organised crime groups, the lower-level incidents were not dealt with in a structured or appropriate manner. There was no evidence of any recognised reporting method such as a submission of Subject of Bullying Reports. There were only intelligence reports, and there was no recording system which could be used to inform staff of those bullying or being bullied, and no analysis, monitoring or reviews carried out other than PR2.

In discussion with staff, there was a mixed view on how they would deal with those that were displaying bullying or intimidatory behaviours towards others. The less experienced staff had no real knowledge of what to do and stated that they would put in an intelligence report rather than challenge the individual. Experienced staff were able to articulate a more low-level intervention and would likely challenge this behaviour while protecting the victim. The prison's approach to this type of behaviour was ad hoc.

It was pleasing however that posters and leaflets were available, but this must go hand-in-hand with an embedded anti-bullying strategy.

As there was no record of those that had been challenged for bullying behaviour and it was difficult to identify anyone to interview that had been challenged or supported in this process. The only place information could be found was on PR2 under risk and conditions.

> **Recommendation 31**: HMP Edinburgh should ensure there is an anti-bullying strategy in place that meets the aims of the SPS anti-bullying policy (currently Think Twice 2018).

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

Rating: Poor

Although the pre-inspection survey reported that the majority (58%) of respondents reported feeling safe all or most of the time in HMP Edinburgh, 20% reported rarely or never feeling safe. With 31% of those surveyed reporting having been abused, bullied, threatened or assaulted by other prisoners it was a real concern that those who were victims of this type of behaviour were not offered the appropriate support.

As outlined in QI 3.4, there was a lack of a structured system in place to deal with these negative behaviours. Due to no formal recording system, the inspector was unable to speak to those that had been a victim of bullying or harassment, which was disappointing.

More experienced staff were able to articulate an understanding of how to support those being bullied without identifying them to the perpetrator and would work through a plan. The less experienced staff were less confident. The more experienced staff, those employed before COVID-19, observed that with the lack of traditional recreation or any type of evening activity, the opportunity to observe or be approached by victims had limited their ability to spot such behaviours and they relied on being approached by the victim. This was particularly concerning as most prisoners (69%) said that they would not report abuse, threats, bullying or assault by other prisoners to staff. It was therefore really important that staff know the signs and how to approach those that are being bullied. It was disappointing to hear that in most cases, where less experienced staff were asked, they thought that placing the person on a Rule 95 and isolating him until an investigation was carried out, was the best way to deal with this, rather than support the person. The Think Twice policy has good advice for staff and there are flowcharts that would enable them to take the right actions at the right time.

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: Satisfactory

Where a staff alarm was activated during the inspection the response was swift. Although there did not appear to be a first or second responder identified at the start of a shift, staff were knowledgeable on when to attend when a personal alarm was activated.

The alarms and radios were tested weekly but there did appear to be a sufficient number available.

There was a suite of SOPs and contingency plans to respond to a variety of threats to safety of life and they were available on the local SharePoint site.

The prison was well-prepared for all levels of incident, with ICT roles up to compliment and over compliment for mutual aid, to support other prisons when required.

The command room was set up on a weekly basis. A person was identified as responsible for it setting up and testing it, with others identified as a contingency. The command room had been tested recently at a level two incident and it was reported to have worked well.

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

Rating: Satisfactory

Inspectors met with the local H&S co-ordinator who was also the Fire Safety Officer for the prison. There was a local H&S policy statement outlining roles and responsibilities, which was accessible to all staff on SharePoint. He carried out his duties as per the policy statement, ensuring that accidents and near misses were reported and investigated, and followed up with any actions. They had a clear plan of cell evacuation as well as all other areas in the prison requiring to be tested. He also produced the H&S statistics for the Governor. 2022 to 2023 showed a decrease in accidents within the prison. Although not a full reporting year yet, it was reported by the H&S Co-ordinator that this year's figures would be similar to the previous reporting year with a decrease in overall accidents.

Out of the 70 Accidents at Work recorded, only six had failed to meet the two-week window for a response from the manager. These would be escalated to the next level for attention. The fire reports carried out by the H&S Co-ordinator also informed the Scottish Fire and Rescue Service post-attendance at a fire. The H&S Co-ordinator was also responsible for supporting any new initiatives where there may be a H&S risk. He met with the GIC on a quarterly basis as well as accompanying him on H&S walkabouts.

From an E&D perspective, inspectors were told that a foreign national unable to read English was given a Fire Action Notice (FAN) in reception. Inspectors sampled some cells in all areas and found that not all cells had FANs, including those in a foreign language. This was surprising considering cell certifications were carried out by staff regularly.

HMP Edinburgh may want to give responsibility for issuing FANs to foreign nationals to the residential areas, similar to other prisons, as this would allow staff to replace damaged FANs or where the prisoner came from another area without having to contact reception. For those with mobility issues the Personal Emergency Evacuation Plans (PEEPs) register was checked. It was an extensive list which required updating. With only 41% of managers competent in H&S there is a need to increase training to a more acceptable level.

Recommendation 32: HMP Edinburgh should ensure the correct FANs are in place on every cell door.

Recommendation 33: HMP Edinburgh should ensure the PEEPs register is updated to reflect the current population.

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

Rating: Generally Acceptable

Use of Force (UoF) undertaken within HMP Edinburgh was in line with SPS Rule 91 of the Prisons and Young Offenders Institution (Scotland) Rule 2011 and SOP Use of Force.

UoF was observed during the inspection as part of an incident that occurred. The staff involved were calm and professional throughout and used good communication to de-escalate the incident as quickly as possible, taking into consideration the prisoner's needs and mental health.

All UoF forms were checked and signed by the Head of Operations or the Operations Unit Manager. Narratives and explanations of removal were of a reasonable quality and level of detail.

All instances of UoF were stored within the IMU and recorded on the IMU database, and the IMU followed the guidelines for retention purposes. A random sample of UoF forms were checked. All indicated the appropriate level of force was used and there was good evidence of removals being carried out using 'come along holds' and consideration of de-escalation. Following the 2019 inspection, published in 2020, HMIPS made recommendations in the report to achieve compliance with standards when UoF was applied by staff. The month prior to this inspection, Audit and Assurances Services conducted an audit of use of force (UoF). It was disappointing to learn and worryingly, that their recommendations echoed our previous and current findings that some incidents of UoF were treated as 'unplanned' in circumstances where there was clear opportunity to plan and record the event. In addition, not all planned UoF was video recorded in accordance with standards, and most of the records did not record the identity of the authorising officer. These discrepancies need to be addressed as a matter of urgency.

There was limited evidence of rigid cuffs being used. FLMs had received the appropriate training but staff training was below suitable levels. There was good evidence of the Head of Operations requesting clarity from staff if the information on the UoF form was not clear or did not meet the requirement.

The IMU database had good information and was linked to CCTV for most, if not all, incidents providing good support evidence. However, there was no violence reduction strategy to look at current trends or how to address them.

At the time of the inspection, C&R training compliance was 61%, with Personal Protection Training (PPT) at 88%. The prison was aware of this and were attempting

to address it, but training variables were often used to cover vacancies resulting in less staff attending training.

Recommendation 34: HMP Edinburgh should with immediate effect ensure that all planned use of force removals are recorded, all paperwork completed and subject to review as per SPS guidelines.

Recommendation 35: HMP Edinburgh should take immediate action to address the shortfall in C&R staff competence.

Recommendation 36: HMP Edinburgh should implement a violence reduction strategy.

Recommendation 37: HMP Edinburgh should ensure supervising officers are aware what a planned removal is and the requirement to video record the removal.

Recommendation 38: HMP Edinburgh should encourage staff to use rigid cuffs during removals as a safer option.

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 affected, 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: Generally Acceptable

HMP Edinburgh SRU had 16 cells which included a safer cell and a silent cell which was no longer in use. At the time of the inspection there were 13 prisoners held in the SRU. Eleven were held under Rule 95 conditions and two held under Refuse to Return to Circulation (RRC) conditions.

The area was clean and professionally managed. Staffing comprised of three staff and a FLM working a dayshift. A concern to the inspectors was that, if required, a member of staff could be used to carry out escorts which occurred during the inspection. This reduced the ability for the SRU to function as it requires three staff when a prisoner is moved which would then require the FLM to be utilised as the third person. As SRU staff covered their own lunch, it meant the SRU was on reduced capacity for a longer period over the lunch time. The patrol and evening patrol was covered by the operations group.

All case files were noted on PR2. The files included self-representations from the prisoner, case conference minutes and appropriate approval of the Rule. The Rule 95 process was managed by the prisoner's residential area unless the prisoners were transferred from another establishment. Therefore, the responsibility lay with the residential area to arrange case conferences in accordance with timescales. The personal officer or an officer from the hall attended the SRU to speak to the prisoner weekly to maintain contact to encourage the reintegration process.

Inspectors observed a Rule 95(11) case conference chaired by a Unit Manager. The discussion focused on the reason why the prisoner had been located within the SRU however this proved difficult as the prisoner had been given limited information on the reason why they had been removed from circulation. There was no reference to his management plan, access to activities or his next location. Nobody from the NHS was in attendance. Inspectors spoke to a number of other prisoners in the SRU, who were aware of the reason they were located there and what their current management plan was. Prisoners felt they had a voice in case conferences and could speak to staff and FLMs daily if they had any issues. Although they were allowed to discuss their future at a case conference, they felt that some senior managers did not listen to their needs and that they felt that some decisions were made prior to case conferences and their input. PR2 was updated providing daily narratives, but due to the frequency, the information could be limited and repetitive.

A GP visited each prisoner on a weekly basis which was good practice. Inspectors also witnessed each prisoner being visited by a mental health nurse, who worked closely with SRU staff and prisoners to provide support and participate fully in the Rule 41 process if required.

Although there was no prescribed Rule 95s at HMP Edinburgh during the inspection. SRU staff and FLMs were able to provide evidence of several management plans of individuals who had a variety of conditions added to their Rule 95 conditions. Disappointingly there were no education materials within the SRU, and inspectors were surprised to learn that staff did not think SRU prisoners could access education.

The Deputy Governor attended the monthly Prisoner Monitoring and Assurance Group meetings, where those serving three months or more within an SRU were discussed. The purpose was to support the movement of prisoners who were less able to be reintegrated into mainstream circulation. There was frustration on the time it took for prisoners to transfer to alternative establishments, which is consistent with other inspection reports.

There were several cases of prisoners being held on Rule 95 within the residential function, and each had authority to be held on a Rule 95. In HMP Edinburgh prisoners were routinely placed on Rule 95 after incidents pending the adjudication process. Inspectors discussed this with Residential Unit Managers who provided rationale around safety of prisoners and behaviours after being searched and found with contraband. Prisoners on management of offender at risk due to substance (MORS) were also placed on Rule 95 to ensure the safety of staff and to evidence authority to keep them separated from others.

Good Practice 4: HMP Edinburgh SRU prisoners receive regular visits from a GP and mental health nurse.

Recommendation 39: HMP Edinburgh should maintain staff complement in the SRU.

Recommendation 40: HMP Edinburgh should ensure NHS staff receive invites to all case conferences.

Recommendation 41: HMP Edinburgh should consider options to allow prisoners access to education materials whilst in the SRU.

Recommendation 42: HMP Edinburgh should provide as much information as possible to prisoners during a Rule 95 case conference, and not make decisions on outcomes before they take place.

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

Rating: Satisfactory

Disciplinary hearings were held in a specified office in each residential area and the SRU. The offices varied in standard and size. Some of them doubled up as the FLM office and had a variety of items which should not be in a room used for adjudications and efforts should be made to ensure rooms used for adjudications are fit-for-purpose.

Inspector observed two orderly rooms (adjudications) with different Unit Mangers (adjudicators). The process was similar - two residential staff attending with the prisoner. The FLM and adjudicators were already in the room. The adjudicator was given the paperwork at the start of each adjudication and ensured that each hearing was individualised and person-centred. The adjudicators were mindful of the individual and, where appropriate, offered support or signposting to support services. They ensured the prisoner understood the charge and their rights and gave them an opportunity to enter any mitigation and to explain fully what had happened. Where a punishment was the outcome, the adjudicator considered behaviours and mitigation. As the staff attending the adjudications were from the residential area, they knew the prisoner and could provide good feedback on recent behaviours and interaction with staff and the regime. However, there was only one area that had a formal record of previous adjudication outcomes offered to the adjudicator to assist in the decision-making process, but this should be available in all adjudications.

Punishments observed included suspended punishments, cautions and straight punishments. One case was dismissed as the process had not been followed, evidencing it was an impartial process. The appeal process was explained at the time of the orderly room outcome.

There was good, detailed, information on each misconduct report within each section of the paperwork filled out correctly and was stored securely within the prisoners warrant file. A copy of the orderly room guidance and Prison Rules were available in each hall for prisoners and staff to read if required.

Recommendation 43: HMP Edinburgh should ensure that in all adjudications a formal record of previous adjudication outcomes is available for the adjudicator.

Recommendation 44: HMP Edinburgh should ensure that the rooms used for adjudications are fit-for-purpose.

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

Rating: Poor

At the time of the inspection there were 16 prisoners on SSM within the establishment.

Staff and FLMs were aware of the SSM prisoners in their areas and had good knowledge of the process. Although there was a local SharePoint site that had details of prisoners on SSM within the establishment that FLMs and staff could update, with a tracker system some of the information on the site was not up-to-date and there was no column on the tracker for a review date.

On investigation, two prisoners listed on the site were no longer in HMP Edinburgh, and several others had missed review dates and SSMs that had not been updated in recent months.

There was some evidence of quality of the information on the SSM documents such as evidence to ranging from no lone female workers to violent and aggressive individuals who required two staff at all times.

The prisoner's confirmed they understood the SSM process, and although some disagreed that they should be on SSMs they were aware they were on them and had been given an opportunity to provide self-representation. Unfortunately, many SSM documents were not on PR2 and had not been signed by the prisoner which was poor.

Recommendation 45: HMP Edinburgh should ensure all review dates on SSM paperwork are carried out timeously adding a review date column in the SSM tracker document.

Recommendation 46: HMP Edinburgh should ensure all SSMs are signed by prisoners and uploaded to PR2.

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

Rating: Poor

The establishment had a process in place to ensure compliance with PRL cell searching protocols. This process was understood by FLMs and staff across the establishment, who explained that FLMs identified the searches for the week and provided staff with the list of who to search, which were then to be completed at a time which suited the staff. Unfortunately, evidence showed that in most cases these records were incomplete. Only two flats out of nine could evidence search sheets and none had been completed. Some staff informed inspectors that they

searched at night or weekends, with others stating they searched early afternoon but had not recorded them. Some staff admitted they had not completed a search in a long time. This was confirmed by a PR2 check which showed that PRL searching protocols were not being met.

Inspectors observed a targeted search operation of four cell searches, and reception searches on entry and exit from HMP Edinburgh from escorts. Each search was carried out by two staff in accordance with searching guidance. Although the pre-inspection survey stated that prisoners reported never being given an explanation of why they were searched, on observing searches the inspectors witnessed the prisoners were clearly informed why the search was taking place.

There was evidence of regular use of the Tactical Dog Unit (TDU) within HMP Edinburgh to support staff, cell, and area searches. During the inspection, the TDU supported staff in a targeted search which was witnessed by inspectors. It was completed in a very professional manner, with respect and dignity shown to prisoners during body searches, and due care and attention was given to their property during cell searches.

On admission to reception all prisoners were searched, with staff taking cognisance of prisoner's dignity and treating them with respect throughout. Reception also had cell sense and handheld metal detectors if required.

Prisoner movement to regimes was observed with some rub-down searches completed but no use of metal detectors or cell sense, and the rub-downs were not consistent with standards. On many occasions staff were witnessed moving prisoners from one area of the establishment to another with no searches completed which was concerning with regards to security.

> **Recommendation 47**: HMP Edinburgh should ensure all cells are searched in line with the PRL cell searching protocol.
>
> **Recommendation 48**: HMP Edinburgh should ensure searching processes are in place for movement of prisoners around the establishment.

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: Satisfactory

Inspectors followed the process for receiving, recording and storage of prisoners' personal and valuable property and cash.

On admission to HMP Edinburgh, prisoners had their property checked and it was logged onto their individual property cards. Valuables were logged and placed into a sealed pack which was then sealed using a plastic seal. The seal number was logged on the property card and valuables were stored on a rack in the staff office area of the Reception. This area could be locked but at the time of observation reception and administration staff were working in this area. Prisoner checked the

property card and signed for all items. There was detailed information available listing items that were allowed in use, on their rack or in the property store. Prisoners were permitted personal clothing and valuables in line with the pro forma system which doubled as an 'articles in use' list, evidencing the maximum amount permitted in use.

The reception operated using a pro forma system which was completed in the residential area then sent to reception to check against current property in use, before being sent out to family or friends. Edinburgh accepted property through the mail and handed in to the prison in person. An officer was assigned to property every day and attempted to distribute all property and parcels within 24 hours of arrival in the establishment. This was a good process and worked well most of the time but could be affected by staff shortages.

There was a reception request process which allowed prisoners to request to destroy or hand/post out old property to create space for new items to be permitted in use. They used the same form to request to attend reception and check property. It worked well with most requests being completed at weekends. On occasion, reception was closed at weekends to facilitate escorts or cover staff shortages, and this had a direct impact on completing requests at this time.

All items were searched appropriately, and any suspicious items were sent to security for further testing by x-ray or rapiscan.

> **Good Practice 5**: Having an officer assigned to deal with property daily so prisoners are able to receive their belongings timeously.
>
> **Good Practice 6**: Good request system which was used for all reception requests keeping the process consistent.

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: Satisfactory

Inspectors observed prisoners leaving and returning to reception under escort. The escort provider GEOAmey escorted most of the prisoners and the reception FLM was responsible for overseeing these escorts.

All SPS escorts were managed by the Operations FLM between 8.00am to 5.00pm and the Security FLM in the evening. They completed Personal Escort Records (PERs) and risk assessment documents, giving consideration to the handcuffing risk assessment and ensured appropriate staff are available. Where possible, one experienced operations officer and one operations officer still in probation went on each escort. This provided experience for new staff but maintained security standards through the experienced member of staff. Inspectors observed the staff briefing prior to a hospital escort taking place. The Operations FLM fully explained the strength of escort, make-up and risk factors. Police Scotland were informed of

the escort. Staff were issued with handcuffs, closet chain, mobile phone and an escort approval certificate.

Handcuffs were applied as stated on the PER and checked by the reception FLM as per the escort procedures.

HMP Edinburgh had the following SOP in place, OPS 014 - Emergency Escort Procedures.

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

Rating: Satisfactory

HMP Edinburgh did not conduct any alcohol testing.

It conducted mandatory drug testing in a designated area within the Health Centre. The staff were very knowledgeable of the process and explained it fully to inspectors and provided written evidence of the full process and the chain of custody. They also explained the process of splitting the urine sample and retaining a sample if required for further testing or confirmation.

Inspectors attended the mandatory drug testing area and observed two tests being conducted. The staff completed the process to a very high standard ensuring the prisoner's dignity was considered throughout.

Inspectors spoke to both prisoners after the test, and they were very complimentary of the staff and the manner in which they completed the testing. They reported that staff explained things well, and although it was not a nice process they felt respected.

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: Poor

HMP Edinburgh CCTV and movements of prisoners was staffed and managed through the Electronic Control Room (ECR). The quality of the camera footage was good with all individuals clearly identified. At all times, the ECR had an experienced and competent member of staff rostered to ensure consistency and knowledge of systems.

Gates and doors had CCTV and intercom systems requiring staff to identify themselves before allowing access or egress. The inspection team noted that they were not always asked to identify themselves at any doors.

Radio communication was used to request prisoner movements and cameras were viewed prior to any prisoner movement request taking place.

Unusually for the inspection team, the movement of prisoners attending regimes was managed by the ECR in the mornings and by a regimes FLM in the afternoon. The movements of prisoners to and from the residential areas was witnessed by inspectors who observed that there was no real control on who was leaving the residential areas in the mornings whereas in the afternoon there was more control, which would suggest that best practice would be to have a FLM co-ordinating regime movements in the morning also.

Prisoners were also moving within the hall to different flats for medication during mass movement of prisoners creating confusion around numbers in the hall. This was witnessed in two residential halls and more than one flat in each hall. Regimes staff and residential staff voiced concerns about these movements and the lack of secure processes. An inspector highlighted this at the time to a Unit Manager as he felt the lack of control posed a risk to the establishment's safety.

Numbers checks were carried out four times per day in line with SPS policy.

CCTV viewing of incidents was available on the authority of the Head of Operations. The IMU evidenced good use of CCTV to record incidents in residential areas.

> **Recommendation 49**: HMP Edinburgh should implement a controlled system for mass movement of prisoners.

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

Rating: Satisfactory

Staff used appropriate equipment to search vehicles, completed all paperwork and instructed drivers to place mobile phones within the lockers and checked their identity. The vehicle searching observed was of a good standard.

All records were up-to-date regarding vehicles entering and leaving the prison. Vehicles did not move from the locked area until staff checking the vehicles notified the ECR that their checks were complete.

There was evidence of regular attendance from the TDU, who supported the establishment with various searching exercises. They were welcomed by staff and seen as positive support. The TDU were not searching vehicles during the period of inspection but confirmed they attended when requested.

External and internal perimeter checks of the establishment were observed. They were conducted by early/late and night duty staff. The staff completing perimeter checks had good knowledge of risks to the establishment with good awareness of what to look for, both in terms of structural security and possible introduction of contraband.

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

Rating: Satisfactory

There was a Standard Operating Procedure (SOP) available to advise staff on the procedures to be adopted when the prison was contacted to inform of the death or serious illness of a relative, although the form referred to in the SOP did not correspond to the one on SharePoint and in general use. Nevertheless, the process appeared to be working well with both the Electronic Control Room (ECR) and residential First Line Managers (FLMs) aware of their respective roles. Information was normally passed to the prisoner in the FLM office, with phone calls offered where appropriate and support offered from the Chaplains. The Chaplaincy Team however advised that they were not routinely informed when a prisoner received news of a death. With the introduction of in-cell telephony, it is more common for prisoners to hear critical news direct from their family.

There was also a process in place for notifying a prisoner's next of kin if they became seriously ill, with responsibility resting with the residential FLMs, who would ensure that consent had been provided by the prisoner before passing information on. Next of kin details were provided on arrival and recorded on PR2.

Except for Glenesk 1, all halls had rooms available where staff could conduct confidential conversations with prisoners.

Eighteen per cent of ICMs had family members in attendance, but families were not routinely invited to Risk Management Teams (RMTs).

Prisoners generally received mail and emails on the same day they were received by the prison.

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: Generally Acceptable

The HMIPS pre-inspection survey found that 55% of respondents said they were treated with respect by staff all or most of the time, with 16% reporting that they were never or rarely treated with respect. Only 46% of respondents said they had a personal officer, although 63% of these reported that their personal officers were helpful or very helpful. During the inspection, several prisoners complained of staff swearing at them and calling them names. Swearing had also been witnessed by and commented on in recent IPM monthly reports. Nevertheless, inspectors observed that interactions between staff and prisoners appeared good, with first names being used, and some good examples of positive relationships. The general atmosphere throughout the prison appeared relaxed and calm.

Due to staffing issues, there could be a lack of consistency with staff on the halls. It was noted that most staff did not wear their name badges. The wearing of badges aids relationships and increases accountability and should be encouraged.

Inspectors noted that, except for Ratho Hall, grille gates generally remained closed, with staff either shouting from the staff desk or conducting conversations through bars. These physical barriers do not aid good relationships and prevent prisoners from accessing noticeboards and other resources. See recommendation in QI 3.3.

Inspectors noted that senior managers were generally not visible on the halls and similar comments were made by both staff and prisoners.

> **Recommendation 50**: HMP Edinburgh should ensure that all staff wear their name badge.

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

Rating Generally Acceptable

As stated, there were generally sufficient rooms available on the residential halls for staff to have confidential conversations with prisoners, except for Glenesk 1 where staff had to take prisoners to another landing. These were being well-used by officers and agencies throughout the inspection.

Staff desks were generally clear and free of confidential information. Although on several occasions inspectors observed TTM paperwork being left open and in one case unattended, on two halls. Staff informed inspectors that they had nowhere else to put it, and if it was stored away they may forget about it.

Treat as Confidential (TOC) was dealt with by the Governor's Personal Assistant who detailed the correct processes to be followed, with records maintained.

Staff were aware of the process for reporting information security breaches. Staff and prisoners were also aware of subject access request (SAR) forms. Inspectors looked at the information security breaches and SARs for the last 12 months and were content that the correct process was being followed.

Data protection prisoner privacy statements were only displayed on a few of the halls and there was no evidence of this information in other languages. The prison should ensure they are displayed on every hall and in the languages of those spoken on the hall.

There were few cell safes in workable order throughout the prison for prisoners to store confidential items and medication. There appeared to be an issue with Estates resetting the PIN numbers on these, with requests not being responded to. Steps should be taken to rectify this, especially given the higher number of prisoners required to cell share.

Prisoners were able to always contact staff, day and night, via the cell call points. Inspectors were informed they worked well, and they were included in daily cell certification checks.

Recommendation 51: HMP Edinburgh should ensure that Data Protection privacy statements are displayed in all halls.

Recommendation 52: HMP Edinburgh should provide working lockable cell safes for each prisoner in every cell.

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

Rating: Generally Acceptable

With the recent departure of female prisoners from HMP Edinburgh, the prison was in a process of reconfiguring the population, with new Gym and visiting timetables being developed to meet the needs of the new regimes. The spaces left with this departure meant that quickly prisoners were transferred in from other prisons. Although HMIPS recognises the pressures of overcrowding of the male estate, it would have been advantageous to allow the prison more time to reconfigure and get the new regimes in place. With the changes happening so quickly prisoners initially were misinformed about the new plans. An example of this was in Ratho Hall where staff and prisoners commented that the regime had changed twice in three weeks. Delaying these transfers would also have allowed the prison the chance to refurbish some of the cells before new prisoners arrived.

Due to staffing issues, offender outcome areas were frequently being disrupted to provide officers for the residential areas. This was also an issue raised during the last inspection. Also, there was no structured route movement. In the previous 12 months there had been 72 recorded complaints about the regime, 11% of all complaints recorded.

Prisoners throughout the prison complained to inspectors about the amount of time they were locked within their cells, especially those within Glenesk. Prisoners who did not have pass jobs often spent 22 hours a day in their cell. This is far too long.

Where activities did exist, including visits, exercise, gymnasium and mealtimes, these seemed to run consistently, well, and in a predicable manner.

Staff and prisoners commented on a lack of communication and uncertainty as to what work parties would be running on a day-to-day basis. Where possible, prisoners were notified of regime changes by way of notices distributed through cell doors.

There were no evening activities taking place during the week of the inspection, despite some residential areas having a full complement of staff. The previous Governor had plans to introduce a more focussed set of evening activities away from open recreation and provide time for personal officers to meet prisoners and write up case management reports, but staffing shortages seemed to have prevented this

approach being realised. Inspectors were concerned that no activities had now become the accepted norm post COVID-19, with staff seemingly unable to provide activities for even one level at a time on a rotating basis. HMP Edinburgh should seek to offer evening out-of-cell activities where staffing levels permit, even if that is only on a rotating basis one level or one residential area at a time.

The prison had a well-resourced in-cell TV channel, operated by an enthusiastic officer who proactively shared information with prisoners. However, this officer was more often than not required to work in the residential halls. It seemed to inspectors that this was an under-used resource, which could be used more effectively to communicate daily changes and longer-term intentions regarding regime changes and keep prisoners better informed. Consideration should be given to safeguarding the provision of this resource to disseminate useful information.

Recommendation 53: HMP Edinburgh should work to reduce the number of times that regimes are restricted.

Recommendation 54: HMP Edinburgh should seek to improve the evening regime, where staffing levels permit, if necessary on a rotating basis one area each evening.

Recommendation 55: HMP Edinburgh should make more use of the in-cell TV channel to inform prisoners of daily regime changes, and to communicate plans in progress.

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: Poor

Noticeboards throughout the residential halls were generally of a poor standard and there was little information on activities available. A number of halls had posters about education and classes which referred to a previous education provider and were dated 2010, some noticeboards were empty. Because grille gates were frequently closed, prisoners had limited access to the noticeboards in the central areas. Not all sections had noticeboards within the prisoner area. Information notices on visits timetables was usually very small. One noticeboard on Ratho 1 was at ceiling height and difficult to read. Ratho 3 displayed a folder of prisoners' notices, but with the exception of one recent notice, all others were on average seven years old. A number of halls had sign-up sheets, usually for Chaplaincy activities, but again prisoners had limited access to this. Noticeboards need to be fully reviewed and information brought up-to-date, with a process in place to ensure that this is on-going.

The HMIPS pre-inspection survey results showed that 61% of respondents believed that the prison did not consult prisoners for their opinions on issues such as food, canteen and healthcare. A further 28% of respondents believed that prisoners were

consulted, but things do not change as a result. This means that 89% of prisoners responding do not believe that there is meaningful consultation by the prison.

At the time of the inspection, there was evidence of three Prisoner Information Action Committees (PIACs) having recently taken place: one for Ratho Hall; one for the canteen; and one on Equality and Diversity (E&D) issues, although minutes displayed for this were not dated.

The Canteen PIAC was overseen by the Finance Manager, who stated that this PIAC also discussed the Common Good Fund (CGF). The last PIAC for this took place in July this year and it was acknowledged that this may have been the first one of the year. The CGF balance was displayed on most halls.
As reported in Standard 1, there was no mention of PIACs in the national induction slides.

Apart from Ratho Hall, staff on the other halls could not remember any residential PIACs having been held, sometimes for many years. This was a matter raised at the last inspection and is still outstanding. A system to establish regular PIACs needs to be implemented.

> **Recommendation 56**: HMP Edinburgh should review and update the noticeboards throughout the residential halls, to ensure that information is relevant and up-to-date.
>
> **Recommendation 57**: HMP Edinburgh should hold regular PIAC meetings in all areas to allow prisoners a voice.

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

The Prison Rules were available in most residential halls, but four flats could not evidence a copy. A copy should be available in every hall and signs put up to inform prisoners how they can access them.

The library, which was located in the Hub, held an extensive range of legal texts. However, at the time of the inspection, only prisoners attending education and the laundry work-party had access to the library and therefore access to legal texts. Many of the legal texts were reference books which could not be removed from the library, although the librarian advised inspectors that copies of relevant texts could be photocopied and sent to prisoners on request. The librarian also advised that copies of Prison Rules could be provided in other languages on request.

The agents' visit area contained rooms for mainstream, protection and video-link appointments, offering 55 sessions per working day of 45-minutes duration. The virtual court room was well used with a number of courts using the facility. Agency appointments could be made up to seven days in advance. Inspectors spoke to a

number of agents, from both legal and social work, and all spoke positively of the process, ease of booking, accommodating staff and prisoners waiting in advance for the appointments to begin.

As reported in QI 1.2, no staff spoken to knew when foreign nationals were advised of and given the opportunity to make a free call to Diplomatic Services. This process needs to be clarified to ensure that this is being offered.

Posters advising how to contact the Scottish Public Services Ombudsman (SPSO) were displayed on most, but not all, halls. Contact information was also given on Internal Complaints Committee (ICC) responses.

> **Recommendation 58**: HMP Edinburgh should ensure copies of the prisoner rules are available on each residential flat and that prisoners are informed of how to access them.

5.7 The prison complaints system works well.

Rating: Poor

The HMIPS pre-inspection survey informed us that only 16% of respondents felt that the complaints system worked well, while 84% felt that it worked poorly.

Prisoners commented to inspectors, both during the inspection week and the pre-inspection focus groups that staff “will give you a hard time” and apply pressure on them not to make complaints. One prisoner commented that he had been informed that he would be “taken off protection” if he pursued his complaint.

There was a SOP available that covered the requests and complaints process. However, on inspection this SOP referred throughout to another prison, using terminology about that prison, and referred to ‘Visiting Committees’ which were no longer in existence. Staff, including residential FLMs, seemed unaware of the existence of a SOP. HMP Edinburgh needs to develop a fit-for-purpose SOP that is relevant to the prison.

Complaint forms were not available in all of the residential areas. Forms were normally kept within the central core area, sometimes in staff desks, which meant that prisoners always had to ask for a form. There was no method of submitting the complaint form except to hand it to an officer. Complaint forms should be readily available without prisoners having to ask officers for them and complaints boxes should be installed in every flat.

Inspectors spoke to FLMs across all residential halls. None of the FLMs spoken to could correctly detail the process for complaints, nor the timescales required. FLMs generally did not know that they had first responsibility to investigate complaints, but only sought to resolve matters by speaking with the prisoner. This was confirmed by the business improvement assistants who administer the ICC process, who noted that many of the ICC investigations should have been done at PCF1 stage.

FLMs informed inspectors that they would often try to resolve complaints with prisoners through dialogue. If this resolved the issue, then the complaint would not be logged. This is not the correct process. All complaints should be logged before the FLM tries to resolve matters with the prisoner.

Prisoners informed inspectors that PCF1 complaints were often lost, or no response was given. This was confirmed by residential staff who had witnessed the forms being submitted or even did so on behalf of the prisoner. There was also further confirmation of this through ICC and other PCF1 forms that confirmed that previous complaints had been lost. The SPS should introduce a complaints system that will evidence when a complaint has been made and is able to track the progress electronically with the prisoner receiving a written acknowledgment that his complaint has been logged and offered progress reports when requested.

Many of the FLMs were new to role or acting up and had not received training on their roles and responsibilities within the complaint process. This needs to be addressed quickly.

Over the past 12 months 631 PCF1s had been received. The main area of complaint was property (16%) followed by regime issues (11.4%). In the past six months 161 PCF1s were progressed to the ICC of which 34 were upheld.

PCF2s were administered by the Governor's Personal Assistant, who sifted them to decide whether they were legitimate matters for a PCF2 or not. Logs for the past 12 months were provided to inspectors. From the approximately 255 PCF2s received, 200 had been rejected at this stage without being seen by the Governor. This practice was not in line with policy and should cease.

It was recognised that too many complaints were being submitted as PCF2s due to a lack of confidence in the PCF1 process. Inspectors were advised that it was recognised that residential FLMs needed training in the process, and that there were plans in place to organise training for them by the SPSO.

There was no secondary assurance in place for the complaints process, nor anyone assigned oversight to ensure that complaints were being handled timeously. There was no log of ICC recommendations nor SPSO recommendations given to the establishment.

Inspectors witnessed an ICC in progress which was chaired by a Unit Manager and operated well. Most of the investigations had been conducted by the business improvement assistants before the ICC sat. The assistant also took minutes and offered advice to the chair where necessary. While this may offer consistency, the Chair admitted on a number of occasions to not having seen elements of evidence. The Chair should be more involved in the investigating process.

ICC responses were typed on a separate document, which were not signed by the ICC chair or the Governor. The original PCF1 had no transcript of the ICC hearing but was signed by the Governor and chair. This means that in practice there was no assurance that the outcome of the ICC had been seen and approved by the

appropriate signatories. ICC outcomes should be completed on the PCF1 form and not be a separate, unsigned, document.

Prisoners were advised on the ICC response of the possibility to further appeal to the SPSO.

Visitor complaints were handled by the visitors' centre and logged as TOC by the Governor's Personal Assistant. Since the start of 2023, 14 complaints had been received. There was no log of outcomes.

Recommendation 59: HMP Edinburgh should develop a complaints SOP that is fit-for-purpose and specific to the prison.

Recommendation 60: HMP Edinburgh should ensure PCF forms are freely available within flats and install complaints boxes so that prisoners do not need to ask for them or hand them to an officer.

Recommendation 61: HMP Edinburgh should ensure that all FLMs are trained in the complaints process asap and that FLMs also record all PCF forms before seeking to resolve the complaint.

Recommendation 62: HMP Edinburgh should cease the practice of the Governor's Personal Assistant assessing the validity of PCF2 forms.

Recommendation 63: HMP Edinburgh should ensure that ICC findings are incorporated within the PCF paperwork, rather than on a separate form and the Chair of ICCs should be more involved in investigating complaints coming before the committee.

Recommendation 64: SPS HQ should introduce a complaints system that will evidence when a complaint has been made and is able to track the progress electronically, with the prisoner receiving a written acknowledgment that his complaint has been logged and is offered progress reports when requested.

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

Rating: Generally Acceptable

Posters advising prisoners of the availability and contact details of the IPMs were displayed in most, but not all, of the residential landings. The contact number was also on prisoners' in-cell phones.

The most recent IPM Monthly Reports confirmed that IPMs had visited the prison on average six times a month over the last seven months and had dealt with 42 prisoner requests over that same period.

According to the HMIPS pre-inspection survey, most respondents (55%) reported that they did not know the role of an IPM, and that they did not know how to contact an IPM (61%).

Of those who had contacted an IPM, just over a fifth (21%) had found the experience helpful, while the same number (21%) had not found it unhelpful. Nearly a third (31%) reported that they had been unable to contact an IPM when they had tried to do so. A number of prisoners had also commented to inspectors that messages they had left when calling the IPM number had received no response.

Most staff who were spoken to during the inspection were not aware of who the IPMs were, nor were aware of seeing them around the halls. Most staff did know that there was a telephone number which prisoners could call but were unaware that this was already on the prisoners' approved telephone list.

The IPM visiting during the inspection reported that they were made to feel welcome and generally assisted well by staff, although acknowledged that not all staff seemed to understand their role. This particular IPM commented on the lack of structured support for IPMs and stated that they personally chose not to respond to individual prisoner requests and instead concentrated on their observation role.

> **Recommendation 65**: The local IPM team should develop a strategy to raise the profile of their work with prisoners and staff.

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

The prison had an appropriate range of planned employment opportunities for prisoners including laundry, meal preparation, cleaning, waste and recycling, domestic appliance repair, horticulture, joinery, woodcraft, painting and decorating, hairdressing, tool repair, poultry management, community engagement projects and general maintenance duties. However, a significant number of work parties were often cancelled at short notice due to staff shortages in residential areas so in effect were not available. This left workshops underutilised. The prison provided employment for passmen in a variety of roles within the prison that operated well.

Prisoners engaged well in the work parties that were available. These activities provided good quality employment opportunities to support essential functions within the prison such as the prison laundry, horticulture, and meal preparation. Most workshop areas contained a good standard of equipment. All prisoners in work parties participated in a comprehensive induction session before engaging in any work activities. The prison prioritised Health and Safety for all activities, including the use of appropriate personal protective equipment (PPE).

During their induction, prisoners discussed their labour allocation preferences. This was finalised at the Activity Allocation Board (AAB). Waiting lists for most work parties were oversubscribed. Prison managers effectively tracked the attendance of prisoners at work parties to evaluate when work parties ran, who attended, and to record the instances of work parties being cancelled.

All prisoners preparing for their release had access to training opportunities that could support employment at liberation, such as the Construction Skills Certification Scheme (CSCS) card. This had provided approximately 200 cards in the last six years. Prison staff collaborated well with Access to Industry to provide opportunities to develop prisoners' skills for employment. Activities available included preparing a CV, mock interviews and letter writing. This supported prisoners well to enter the employment market.

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: Poor

The prison communicated the system for paid work to prisoners during a well-considered induction process. Most prisoners understood the rationale of selection for paid work. The process was thorough and fair, although a few prisoners perceived rates of pay between jobs to be unfair. Staff had good relationships with prisoners and encouraged them to participate in the employment opportunities available in the prison. All prisoners could apply for employment, or discuss a change to a work party, by applying to the AAB. Sentenced prisoners were prioritised for work parties and untried prisoners were more likely to gain employment in their hall. The AAB would consider prisoner requests based upon work party availability and prisoner suitability.

The prison offered employment opportunities to prisoners that reflected the needs of the prison. A few prisoners gained experience and skills through vocational training and successfully gained employment after their release.

Prisoner participation in work parties was influenced by the competing demands of other activities such as the gymnasium, education, prison programmes and the administration of medication and health services. At the time of inspection, participation by prisoners in most work parties was less than half except for essential services such as the laundry and kitchens.

The prison has no regular route for prisoners to get from halls to work areas. Prison officers were required to collect prisoners from the accommodation blocks to escort them to purposeful activities. If these escorts were not available, delays were created for prisoner movements, which limited the opportunities for prisoners to participate in work parties and other prison activities.

> **Recommendation 66**: HMP Edinburgh should ensure all prisoners within each prison population have equitable access to participate in good quality employment opportunities.

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: Generally Acceptable

The Learning Centre provided a welcoming, bright, and comfortable environment for prisoners to engage in learning activities. The Learning Centre was well-equipped with a range of learning resources, including computers and an art room. Prisoners engaged well with staff and the relationships were positive. Most prisoners used self-directed study whilst working towards a wide range of qualifications, for example learning Spanish or History. However, access to education was restricted due to a lack of a regular route movement and prison officer staffing issues escorting prisoners to the Learning Centre. This significantly hampered the numbers of prisoners attending classes. Attendance at classes compared to places available was less than half. Inspectors spoke to several prisoners in Glenesk Hall who had come from convicted halls where they had commenced education classes, and who had to cease their studies. The Education Centre manager advised that reviews are taking place and was hopeful that Glenesk prisoners would have access to education classes soon.

Prisoners benefited from the national induction process which included information regarding educational opportunities. This induction also included a screening process for literacy and numeracy and the use of a Learning Disabilities Tool that identifies those with additional support needs (ASN). Peer Tutors were on hand to work with incoming prisoners, helping them to settle into education more easily. A few prisoners reported that it was difficult to access education. However, once they did attend, they found the experience positive.

The prison offered a wide range of Scottish Qualifications Authority (SQA) qualifications at Scottish Credit and Qualifications Framework (SCQF) levels two to six. These qualifications were selected to help prisoners gain employment upon release, in particular certification for the British Institute of Cleaning Science (BICSc), food preparation qualifications, and CSCS cards.

Some prisoners participating in education were successful in gaining awards such as the 2023 Adam Smith Scholarship. Prisoners in art classes produced 101 entries for the 2023 Koestler Awards, and prisoners were supported to participate in the Open University programme studying degree level subjects.

> **Recommendation 67**: HMP Edinburgh need to address the issues around escorting prisoners to the Learning Centre to improve attendance levels.

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

All prisoners were eligible to access the gymnasium and sports hall and attendance was high across the prison populations. Around 800 spaces were timetabled for prisoners each week, some attending more than one session.

A range of health and fitness activities were on offer including free weights, exercise machines, football, circuit training, boxing and racquet sports. Prisoners accessed timetabled activities from early morning to late evening during the week, and for short periods of the day at weekends. All prisoners completed an induction prior to accessing the facilities and equipment. PTIs enjoyed good relationships with gymnasium users, offering advice and guidance when requested. Events such as Fathers in Football and charity events, helped to enrich the range of activities on offer. Satellite gymnasiums were available for prisoner use in most of the halls. These were used regularly by prisoners during the day.

Participation in physical activity was encouraged by the prison and access to the gymnasium and sports hall was valued by prisoners. PTIs adjusted the programmes to meet the needs of prisoners based on their feedback. Barriers to prisoner participation were identified by PTIs and alternative activities were offered. For example, in order to increase participation by less able and older prisoners, bespoke sessions were made available. When restrictions on gymnasium access for a prisoner were imposed, this was dealt with sensitively by PTIs and appropriate alternatives were arranged. PTIs escorted prisoners from the halls to and from the gymnasium, this occasionally led to delays.

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

The prison library offered a good range of quality materials including books and DVDs. There was an appropriate selection of fiction, non-fiction, large print, graphic novels and books in 30 different languages. Library staff engaged well with prisoners, supporting them to access library materials of interest to them.

Library staff also offered a drop-off service to the residential halls for prisoners who were unable to attend the library. Formal links with the City of Edinburgh Library Service were well-established. This partnership allowed all library users within the prison to order books, DVDs, CDs, audio books and games from other libraries within Edinburgh. The requested material was delivered to prisoners in the halls each week.

Since March 2022, when external borrowing was reintroduced, the uptake of borrowing from the library increased from an average of 600 resources per month to between 1,000 and 1,200. In order to improve further the services, library staff conducted a survey. They have used the responses to this survey effectively to shape the services, making them more relevant to the prisoner population. Library staff were aware of barriers that might exclude some users, for example they have introduced a good range of books for prisoners with dyslexia.

The library provided a good range of legal texts, and often photocopied pages from legal texts or online pages, in response to prisoner requests. This supported prisoners well.

Prisoners also participated regularly in awareness raising events such as Black History Month and LGBTQ+ awareness.

At the time of the inspection, the library was only available to prisoners' undertaking education with Fife College. A variety of satellite libraries were available in the residential halls. However, this did not address adequately the lack of access for most prisoners, as they had to be engaged with education to get access to the main library.

> **Recommendation 68**: HMP Edinburgh should ensure all prisoners within each prison population have equitable access to the main library.

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: Satisfactory

Education Centre staff promoted their services through a range of activities to allow prisoners to see what services were on offer. This included leaflets and posters and targeted initiatives like the Black History Month learning project.

Prison staff used induction, prison radio, and a comprehensive booklet to raise awareness of the cultural, recreational, and self-help activities available to all prisoners. However, some barriers to participation existed, such as clashes with the administration of medication, the gym timetable or work party allocations.

Prison officers in the gym enjoy good relationships with prisoners. Working with partners from Bonnyrigg Rose Football Club, a Fathers and Football event was arranged at the prison by PTIs. Staff used the event to help bring families together and give prisoners the opportunity to spend time with their children in a relaxed and fun way as an alternative to the visiting room.

> **Good Practice 7**: PTIs relationships with partners in the community to arrange football themed events that brought families together and gave prisoners the opportunity to spend time with their children.

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

The arrangements for prisoner access to daily fresh air was documented within timelines provided. Each hall had its own exercise yard, with one-hour provision for each area being built into the regime; except for Ratho, where there was opportunity to access fresh air twice a day. Access to fresh air varied between halls but were within the range of 8.30am and 4.00pm. This information correlated with inspectors' observations. The SRU had individual enclosed areas available for the purposes of fresh air, with all prisoners being offered the opportunity to take fresh air once a day.

Hall managers and prison officers were aware of the times to access fresh air and recognised the importance of this activity. Prisoners were generally happy with the arrangements. However, a small number of prisoners who attended work reported that if they wished to attend fresh air this would be facilitated, but if this was more frequent, their wages would be docked. Inspectors clarified this matter, and it was confirmed that this would not be the case, however clarity around this should be provided to prisoners.

Inspectors observed some prisoners wearing showerproof jackets. However, both prisoners and staff highlighted the limited stock available, with not all prisoners having access to them. Ratho prisoners had access to fleece jackets; originally provided to the women when they were housed in Ratho. On the basis that two sessions of fresh air were available in Ratho, if the jackets became wet following the morning session, they remained wet for the afternoon session and did not provide the protection necessary.

During the inspection, it was confirmed by the Senior Management Team that the procurement of waterproof jackets had been made, but hoods had to be removed before they could be issued. Inspectors therefore could not see evidence that all prisoners had access to weather appropriate clothing before the inspection concluded.

> **Recommendation 69**: HMP Edinburgh to ensure prisoners are aware of their entitlement to fresh air without being penalised.
>
> **Recommendation 70**: HMP Edinburgh should expedite the issue of waterproof jackets for fresh air.

6.8 Prisoners are assisted in their religious observances.

Rating: Satisfactory

The physical structure and location of the multi-faith centre was good. It provided a very warm and welcoming environment where prisoners could come together as a group or seek individual solace with the Chaplaincy Team.

The Chaplaincy Team consisted of a team of seven, who represented Church of Scotland, Free Church of Scotland, Roman Catholic/Orthodox and Muslim faith. Their work involved conducting worship and providing pastoral care within the establishment, including individual and group work concerning prayer, the study of holy books and discussions of matters spiritual and ethical. On a weekly basis the Chaplaincy Team facilitated a Roman Catholic Mass, Reformed Church of Scotland service, and Muslim prayers to each mainstream and protection group of prisoners.

An individual's religion or belief was recorded on PR2 during the reception process, should they wish to declare it at that time, and the Chaplaincy Team were proactive in identifying those individuals' following admission. Likewise, the Chaplaincy Team routinely visited residential areas to provide support to all prisoners regardless of their faith or beliefs, including the SRU. During the local induction programme, prisoners were made aware of the availability of Chaplaincy services. Leaflets and referral forms were available within all residential areas offering reading materials, faith packs, pastoral care and support and referrals were dealt with timeously. However, it was noted that leaflets still included a service specifically for women, who are no longer located at HMP Edinburgh. A bereavement leaflet was also available for those in need which explained the Exceptional Escorted Day Absence (EEDA) process and other services associated with bereavement, including the provision of virtual and memorial services.

Due to staff shortages, the Chaplaincy Team conceded that it had been difficult to facilitate the range of group activities they would have liked. However, a Standard Operating Procedure (SOP) was recently introduced to enable services to take place without a prison officer being present. Inspectors visited the multi-faith centre whilst the four-week Alpha Course, which had three prisoners in attendance. Inspectors observed positive and meaningful interaction between everyone in a relaxed and reflective environment.

The Chaplains were supportive of each other and talked openly about being a fully integrated team in providing support, guidance and pastoral care. They talked of having a good relationship with staff and prisoners alike and felt included within the Senior Management Team. It was evident to inspectors that all prisoners had the opportunity to pray, read religious texts and to meet other requirements of their religion and the team remained pivotal in organising and supporting a range of events for staff and prisoners throughout the year. This included: a staff family memorial, recovery walk, To Absent Friends, a bereavement event, and Recovery Café.

In general terms, prison staff were aware of prisoners who observed different religions and the range of services provided by the Chaplains. The Chaplains were also available to any member of staff who wished to discuss matters of a spiritual, pastoral, religious or belief nature.

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: Satisfactory

A SOP was available to outline the process and behaviours expected from all staff during family visit sessions. In addition, Guidance on Children's Visits in the form of Play Learn Connect (PLC) was available; with Inspectors finding a satisfactory level of access to visits to enable prisoners to interact and engage with family and friends.

In the pre-inspection survey, of those who were aware of the availability of in-person and video visits, the majority (64%) reported having access to in-person visits every week, and almost half (49%) reported weekly access to video visits.

Daytime visit sessions were of 30-minutes duration, with evening sessions lasting 45-minutes. Visitors were encouraged to arrive at the establishments 30-minutes prior to start times. Inspectors could not find any evidence that double visits could be booked, although prisoners and staff confirmed that if extra time was required, for example due to distance travelled, this would be accommodated if resources permitted. However, this is not an appropriate method to follow. Families should not have to travel long distances in the hope that they get a double visit. These should be organised in advance.

The prison had four full-time prison officers undertaking the role of Family Contact Officer (FCO). Recent events included pizza making and a Halloween event. Prisoners' friends and families indicated that the FCOs were visible and available during visit sessions to assist. In addition, a full-time parenting officer was in place to support family connection during PLC visits and to support Early Years Scotland (EYS) in their work. All were enthusiastic and committed to their role and provided an excellent service to ensure that prisoner/family relationships were supported.

PLC visits took place three days per week. In addition, EYS in partnership with HMP Edinburgh parenting officer, also delivered Stay, Play, and Learn sessions over a 10-week programme on a Wednesday and Thursday. These sessions consist of a 1.5-hour play session with children (pre-birth to five-years old) in the morning, followed by the participating prisoner attending a classroom session in the afternoon. Additional features had been included such as breakfast during the family session and cooking during the afternoon session.

During the inspection, it was noted that a new visit timetable had been drafted. The proposed new timetable would streamline visits, taking advantage of recent population changes; enabling afternoon visits to be increased from 30 minutes to one hour and evening PLC visits from one per week, to two. Feedback on the proposal was positive from those who had seen the new timetable. However, inspectors were informed that these proposals also included changes to virtual visit times. Consequently, consultation with the virtual visit provider was required before any change could take place. This created confusion from prisoners and staff

around when, and if, the new schedule would commence and whether existing visits would be cancelled to accommodate the new timetable. Greater consultation and communication would have been advantageous to avoid uncertainty.

During the local induction programme, prisoners received information about visit times, visit allowances, and visit rules. In addition, detailed information was available to visitors within the Visitor Centre to keep them informed. Visit times were varied throughout the week to allow for family and friends, including children, to visit out with normal working and school hours. Inspectors felt that the information provided was sufficient to encourage prisoners to grasp the opportunity to initiate early engagement with family and friends.

A local Children and Family Strategy Group convened quarterly and provided oversight of all children and family-related arrangements. The group consisted of various staff and partners and up to now had been chaired by the Head of Offender Outcomes. Inspectors were informed that local arrangements had changed, with this forum now aligned with Head of Operations. Inspectors were provided with the minute and action plan from the last three meetings and good representation came from management, FCOs, Chaplaincy, Education and prison-based social work (PBSW), as well as Partner involvement from Barnardo's EYS and Families Outside. Previous minutes tended to focus on operational practice, event planning and dealing with local issues.

> **Recommendation 71**: HMP Edinburgh should ensure that staff and prisoners are aware that there is a system for booking a double visit.

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: Satisfactory

HMP Edinburgh had a designated Visitor Centre run by Barnardo's, who consistently sought to interact and engage with prisoner's friends and families and improve the visitors' experience, by providing independent and impartial advice, information and support. Visitor Centre staff commented on the positive relationships between FCOs who connected daily with them to achieve positive outcomes for families.

The facilities were warm and inviting, with families and friends being offered refreshments and food. In addition, other services in support of families included the free school uniform scheme and cakes for kids to celebrate birthdays and special occasions. Inspectors observed the visitor's admission process and noted that Visitor Centre staff showed courtesy and consideration for all visitors and demonstrated thorough knowledge of the systems involved.

Inspectors found lots of information about visits, prison regimes and key services on offer to prisoners, and Barnardo's also regularly attended prisoner induction. Having spoken to prisoners' families and friends, inspectors heard they were complimentary of the service offered and felt the environment was relaxed, friendly, and inviting.

The physical environment of the open visits room was in good condition and appeared bright, airy, and spacious. A new sensory area for children was being developed, with toys and activities to suit a range of ages also available. In terms of facilities within the visit room, vending machines were available to purchase cold drinks and snacks. The tea bar, previously run by Friends of HMP Edinburgh, was closed, except to enable parents to make breakfast provisions during Play, Stay and Learn visits. Warm refreshments were available in the Visitor Centre, but inspectors felt that a tea bar would be a good alternative to the vending machine and consideration should be given to it reopening.

In the pre-inspection survey 56% of those who responded more than half (56%) reported that their visitors were treated with respect by staff all or most of the time. However, 23% reported that their visitors were rarely or never treated with respect by staff. During the inspection visitors and prisoners commented on the positive atmosphere in the visits area and inspectors observed a relaxed feel with friendly interaction between staff, prisoners, and visitors. During the inspection, staff were visible during visit periods, staff were well organised and gave consideration to families at each stage of the process. Inspectors spoke with families who confirmed that they were treated with respect by visit staff.

> **Recommendation 72**: The HMP Edinburgh Children and Families Strategy Group should consider reopening the tea bar.

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

The original closed visit area had been repurposed to enable six virtual visit booths to be facilitated for the duration of 30-minutes. Prisoners and their families commented on the reasonable level of the picture and sound quality, except for one prisoner who experienced poor connectivity. Prisoners were able to comment on some of the key benefits associated with virtual interactions, not least a reduction in travel time and expenses and a perceived increase in the level of privacy during these types of visits, given the use of headphones. The virtual visits also provided a key channel for prisoners to maintain family contact with people who were unable to travel to the prison or were living a distance away.

Inspectors reported that prison managers and staff in the visits and residential areas appeared to be knowledgeable about inter-prison visits, accumulated visits, and assisted prison visiting schemes. In addition, prisoners and staff appear to have a good understanding of the provision of EEDA.

However, the escort contactor's ability to fulfil escorts, and in this case EEDAs, remained an ongoing challenge. It was deeply concerning that during the inspection a prisoner was unable to attend his brother’s funeral due to the escort contractor cancelling at short notice. HMP Edinburgh staff had been able to undertake an

escort for another funeral, when the contractor had cancelled that one, but were not able to do so on this occasion.

The Email a Prisoner Scheme continued to provide another positive channel for prisoners to maintain close family links.

> **Recommendation 73**: SPS HQ and GEOAmey should work together to ensure crucial escort obligations are met, particularly for attendance at family funerals.

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

The prison had one cubicle available for those prisoners who were deemed to require closed visits with family and friends. The visit manager and visits staff confirmed that visits were not withdrawn punitively because of poor behaviour or as a punishment. At the time of inspection, six prisoners were subject to closed visits and a process had recently been established to review and monitor this appropriately. The prison policy was to avoid the use of closed visits whenever possible, and they were only to be used in exceptional circumstances. Inspectors were satisfied that the new process that had recently been put in place to ensure that closed visits arrangements were applied consistently in accordance with prison rules was fair. Inspectors were able to view records from October onwards, which clearly documented that those on closed visits were reviewed monthly by a committee, with relevant representatives in attendance including the visit manager. Prisoners were able to put forward their representations during the process. Prisoners were informed of any decisions taken by the committee by letter. Members of the public who were placed on restrictions were also considered during the same meeting and informed of any outcomes by letter.

Although the visits manager and staff informed inspectors that they managed these visits with the same level of professionalism and courtesy as they did in the open visits area, inspectors were unable to test this during the inspection week.

Staff appeared to be aware of the negative impact that closed visits had on prisoner's friends and families. It was clear that staff involved in this process were clear on their expectations and the procedures involved, including all relevant paperwork required to manage these arrangements.

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 aim was to ensure that prisoners felt safe, settled and supported, had their individual needs met and were supported in their progression. The prison provided

an appropriate range of therapeutic treatment and cognitive development opportunities and a good range of social and relational programmes. However, the pre-inspection survey highlighted that 44% of those that responded were unaware of the programmes they needed to do to progress.

The personal officer scheme, in principle, is designed to promote rehabilitation through constructive relationships that guide, encourage, and motivate all prisoners to make the most effective use of their time in custody. Prisoners generally knew how to access programmes and support services and understood how places were prioritised. Inspectors felt that prisoners generally had their individual needs met, but this continues to be managed, co-ordinated and actioned centrally by Hub staff. Although there appeared to be pockets of good practice, these roles do not dovetail effectively, particularly for those being managed within Standard ICM.

The prison delivers five recognised programmes; the Self-Change Programme (SCP) (currently under pilot), Discovery, Constructs, Pathways and MF2C.

Like other prisons, prisoners were subject to the national waiting lists that were in place for specialist Offender Behaviour Programmes (OBPs) that were delivered in HMP Edinburgh and other establishments. This had resulted in longer delays accessing these programmes and consequently having a negative impact on progression arrangements. Prisoners within Hermiston and Ratho were particularly aggrieved with the lack of progress and the impact this had on them with 66% reporting in the pre-inspection survey that it was very difficult to access programmes.

The prison had concentrated its efforts on delivery of MF2C and SCP, where seven and five programmes had been delivered respectively over the past year. Ongoing challenges had been experienced including a lack of national MF2C facilitators. However, MF2C is to be relaunched in January 2024, with an increase in output expected. A number of bespoke and top-up interventions had also been completed following Risk Management Team (RMT) recommendations.

Attempts had been made to reinvigorate the core screen process within the First Night in Custody (FNIC) unit in Ingliston, but this area had only just opened. Consequently, a quantity of core screen assessments were outstanding during the inspection and on-going efforts were being made by staff within the Hub to have assessments completed, and to manage any resulting referrals through the internal and external partner agencies including Change Grow Live (CGL), which had a dedicated areas within the Hub available to offer throughcare support.

A Recovery Café situated within the Cove was open, with access to regular events throughout the week for all prisoner groups to offer therapeutic interventions and training opportunities. These services were supported by two full-time recovery officers, a CGL worker and a lived experience worker who supported delivery of: SMART recovery groups; recovery coaching certifications, Alcoholics Anonymous, and visits made by recovery officers for those who had been the subject of management of offender at risk due to substance (MORS). Prisoners and staff were generally aware of these services and viewed them as being supportive.

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

The Head of Offender Outcomes provided central oversight of the ICM Team, Links Centre and administrative support, along with structured interactions and engagement with the psychology department and PBSW Team. All these functions were in close proximity to each other, which engendered positive and productive relationships to the benefit of the prison as a whole and indeed the prisoners themselves.

There was a well-established system for identifying the needs of LTPs and taking account of their critical dates for parole and progression. Inspectors witnessed efficient and effective processes and procedures for managing the Generic Programme Assessment (GPA), through the core screen and induction arrangements, through to the six-month ICM case conference and on to the full case management plan. Fundamentally, ICM staff undertook all the preparatory work as well as co-ordinating and scheduling all ICM and RMT activity. The ICM staff also provided the main channel for linking ICM with progression cases and the RMT.

Prison officers were generally aware of critical dates, as calculations were posted in staff areas for all to refer to. Prisoners also stated that they knew their own critical dates and of their associated responsibilities for engaging in their own case management, with evidence being provided to suggest that prisoners were being encouraged by ICM staff to participate fully in case management discussions. Inspectors observed a range of ICM-related activity where the risks and needs of prisoners were assessed with care.

Prisoners appeared to have been allocated personal officers, and PR2 reflected this. However, inspectors found that views were varied, with some knowing who their personal officers were and others never having met them. This was also confirmed in the prisoner focus groups where the overwhelming comments were that they did not know who their personal officer was. Again, prisoner's views were mixed on how proactive their personal officers were and those located in Hermiston and Ratho were less complimentary.

Inspectors could find no mechanisms in place to monitor those STPs who may be suitable for progression to less secure conditions, with one STP having been told that he would not be eligible for consideration as he was serving a short-term sentence. In addition, a prisoner information leaflet regarding progression and ICM omitted the fact that STPs may be eligible.

Although the prison demonstrated good oversight of ICM and RMT arrangements, there appeared to be a complete disconnect from the day-to-day operations of the personal officers, with little evidence to suggest that these activities linked with ICM. However, a mentoring programme incepted early 2023 indicated that some staff were proactive in seeking out support, guidance, and development opportunities.

Prisoners generally indicated that it was the ICM function who were managing plans for parole and progression, and that staff attendance at ICMs and personal officer reports were very low. However, on a more positive note, personal officers were routinely in attendance at RMT.

Recommendation 74: HMP Edinburgh should reinvigorating the personal officer scheme and improve awareness of their role in ICM processes to achieving the desired outcomes.

Recommendation 75: HMP Edinburgh should ensure that those STPs who meet the criteria are considered for progression to open conditions.

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

Inspectors were able to witness a good level of joint working between different agencies during ICM activity and RMT preparations. In particular, the relationship between the ICM Team, PBSW and Psychology was good. Risk management assessments were carefully considered at an early stage of sentence plans and underpinned intervention and support services thereafter. Information sharing was good among these teams with shared access to key case management documents, supplemented by regular and focused meetings between key departments.

For Multi-Agency Public Protection Arrangements (MAPPA) cases, there was sufficient evidence to suggest that the appropriate agencies were working together in the assessment and management of risk. There were clear lines of communication, co-ordination, and collaboration that were proportionate to the risk and complexities associated with each case. Information sharing arrangements appeared to be managed in a responsible way that helped to inform risk management planning.

Risk assessments were conducted in an evidence-based, structured manner, incorporating the appropriate tools and a good level of professional decision-making.

For OLR prisoners within six-months of being sentenced, an ICM case conference was held. The OLR Case Manager was always present, along with the ICM Co-ordinator, PBSW and Community-Based Social Worker (CBSW). The Risk Management Plan (RMP) was formulated following the ICM Case Conference, and responsibility for the plan's implementation fell to the OLR Case Manager. The RMP sets out the assessment of risk, the measures to be taken for the minimisation of risk and how such measures were to be co-ordinated within custody. The Plan included an assessment and analysis of factors that may increase or prevent re-offending and gave recommendations for action going forward.

Once the plan had been created, the Case Manager sent it to all members of the RMT and provided them with a minimum of five working days in which to read the

plan. The RMT convened to consider and ratify the plan. Once ratified, the plan was sent to the Risk Management Authority (RMA) for approval. There was a requirement for behavioural monitoring forms to be completed monthly by prison officers, to collect observable data and information which was then forwarded to the OLR case manager, in line with OLR guidance. However, inspectors found that the quality of work was mixed, with return rates over the past three months having declined. Given this decline, the assurance process around this required to be more robust.

Having spoken to prison officers, some were unaware of their role when managing OLRs and would like further awareness training. The Psychology Department confirmed that an OLR awareness package was available for staff and there was an appetite to deliver this. However, various inhibitors existed which made this difficult.

Annual Implementation Reports were submitted to the Risk Management Authority if there were any significant developments in the OLRs case, such as moving between prisons, transferring to less secure conditions or a significant change in behaviour.

> **Recommendation 76**: HMP Edinburgh should consider awareness training and information about the requirements of the role for staff who work with OLRs.
>
> **Recommendation 77**: HMP Edinburgh should review the governance arrangements around monthly OLR behavioural monitoring forms.

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

Prior to the restrictions imposed by COVID-19, HMP Edinburgh facilitated Multi-agency Information Network Events to enable agencies to set up stalls within halls providing greater access for prisoners. This had recently been reinstated.

Staff shortages and redeployment were having an adverse impact on the Links Centre functioning. Staff were not always available to escort prisoners to the Links Centre, and the Links Centre was on occasion required to close in order for their staff to be redeployed to halls, leading to cancellation of pre-arranged meetings.

HMP Edinburgh facilitated access to a range of agencies focused on providing continuing support in the community. Links Centre managers actively co-ordinated access for community agencies, based on the needs of the prisoners within the establishment.

Community support agencies met prisoners within the Links Centre as required, even at short notice, and were proactive in establishing relationships with prisoners referred to their service. Agencies were clear about their role in the planning for prisoners on their release from custody. While visiting agencies communicated

effectively with each other informally, this could be strengthened by the establishment of a formal multi-agency forum.

Central to the effectiveness of prisoner needs being identified and addressed is core screening on admission to custody. As previously reported, core screening was not always happening within the prescribed timescales. This therefore limited the opportunity to match prisoners' needs to appropriate interventions and supporting agencies. There had been a period of improvement following targeted oversight by hall managers, however this was not sustained. It was hoped the First Night in Custody (FNIC) area taking over completion of core screens will improve this, but it was too early to tell at the time of the inspection. The relevant recommendation for this is in Standard 1.

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: Generally Acceptable

The Integrated Case Management (ICM) process at HMP Edinburgh was well-embedded and functioning effectively. Co-ordinators were clear in their purpose of preparing people for release back to the community. There was an appropriate emphasis on ensuring the prisoner was enabled to participate in the process and contribute to discussions. Communication and collaboration between prison-based social work (PBSW), Psychology and programme delivery staff was enhanced by co-location within 'The Hub'.

PBSW and CBSW regularly attended case conferences. They prepared assessments, reports and plans which were forward-facing and focused on the prisoners' return to the community, which contributed meaningfully to planning for release. PBSW provided important links with adult social care for prisoners with complex needs. For prisoners with mobility needs, access to timely occupational therapy assessments from the community was variable.

There was effective communication and partnership working between social work, Psychology and programmes staff which ensured a comprehensive understanding of the risks and needs of prisoners.

Risk Management Team (RMT) processes operated in line with guidance. Social Work, Police Scotland and Psychology were core members of the team and collaborated effectively to identify and manage risk.

As reported in Standard 6, personal officer participation in the ICM process needed to improve. Attendance at ICM case conferences by personal officers was low. Where they are unable to attend in person a report should be submitted in all instances, this was happening in just over half of all cases. Where reports were submitted, they were often considered to be of limited value. Officer hall duties were being prioritised over ICMs. See QI 6.13 for the relevant recommendation, this is the reason for the generally acceptable rating.

Good Practice 8: The co-location of services within 'The Hub' fostered efficient and effective collaborative working.

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: Satisfactory

Prisoners with drug and alcohol issues had access to a range of interventions through individual organisations and the Recovery Café. The agencies providing advice and support as an in-reach service ensured there was continuity of service when the person was liberated to the community. For prisoners participating in the MF2C programme, there was opportunity to continue this on their return to the community.

PBSW completed LS/CMI risk/needs assessments within expected timescales and, where appropriate, other specialist assessment tools were applied. These were used alongside Generic Programme Assessments (GPAs) and informed the Programmes Case Management Board (PCMB) which was operating effectively.

There was a sense of frustration by staff and prisoners about delays in access to programmes due to waiting lists. This was a national issue, not limited to HMP Edinburgh. Prisoners were not always clear on their lack of movement up the waiting list. These problems with access to programmes limited prisoners' opportunities to evidence change or progress, which is necessary for progression.

HMP Edinburgh is part of a pilot for new programmes offering more targeted intervention proportionate to assessed risk, leading to a shorter programme duration for those assessed as a moderate risk. It is anticipated that this may reduce waiting times, but at the time of the inspection it was too early to gauge progress toward this intended outcome.

The Programme Delivery Team was not operating at full capacity, due to new team members awaiting access to planned training in programme delivery. However, they were usefully redeployed to undertake GPAs during the interim.

Recommendation 78: SPS HQ should ensure timely access to accredited programmes is available to enable evidence of change for progression.

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: Satisfactory

The sentence planning for prisoners subject to statutory supervision upon release was effective in identifying and meeting needs. The central focus of the ICM was the prisoners' preparation for release back into the community. ICM Co-ordinators

ensured that prisoners were encouraged to contribute their views both verbally and in writing.

CBSW and PBSW were actively involved in the ICM process and worked effectively to co-ordinate resources. The introduction of Throughcare Assessment for Release on Licence (TARL) had increased joint interviewing in preparation for compiling the report. TARL is intended to enable prison and community-based social workers to co-produce an integrated parole board report for long-term prisoners.

Where they attended, prisoners and their families were provided with opportunities to express their views at RMT and ICM case conferences. Forward-facing plans were presented and prisoners' understanding of expectations were explored.

For prisoners with no statutory supervision on release, the pre-release service and the Links Centre were central to preparations. Assessments undertaken at six to eight weeks prior to liberation identified individual needs and, where appropriate, services to support them. This service was operating effectively but as referenced elsewhere in this report, was occasionally impacted by staffing issues in the establishment.

The pre-release service found it challenging to address the integration needs of prisoners who were released from custody at short notice, having had a sentence backdated following a period of remand. This limited opportunities to assess needs and identify supports.

When prisoners requested it, they were appropriately supported by advocacy services.

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

Rating: Satisfactory

HMP Edinburgh was not directly supporting prisoners after their return to the community. However, following the cessation of the Throughcare Support Officer role, the prison developed a Pre-release Officer role which aimed to support prisoners planning for release. Staff in this role were highly committed and innovative in supporting prisoners prior to liberation. Prisoners were referred between six to eight weeks prior to release and a needs assessment was undertaken. In addition to planned releases, the pre-release officers actively reviewed weekly liberation sheets to check for prisoners being released at short notice. The service supports prisoners with practical needs including housing, benefits, travel arrangements and access to bank accounts and onward referral to relevant throughcare services. Prisoners being liberated to Edinburgh had access to a City of Edinburgh council housing officer.

There were a range of voluntary throughcare services providing regular in-reach for prisoners due for release back to the community.

Good Practice 9: The pre-release service was providing an identity verification letter to prisoners with no access to formal identification. This enabled prisoners to open a bank account more easily on release.

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: Satisfactory

Inspectors found that the establishment continued to embrace and deliver a positive approach to E&D. The comprehensive signposting manual aimed at improving operational knowledge of the Strategy, and effectiveness in delivering it, was a truly impressive resource with which staff were familiar. This was practice worth sharing. Conversely, when inspectors looked at the maintenance of competency levels it was disappointing to find that 27% of the staff group had not completed core online Equality and Diversity (E&D) training.

The E&D Co-ordinator acknowledged a hiatus in regular delivery of meetings over the last couple of years. However, following recent reinvigoration inspectors observed that three meetings had taken place in the last six months. It was clear from the records that recent action had been taken resulting in reinstatement of a prisoner representative and identification of ambassadors across the protected characteristics. Inspectors considered the membership of the forum to be limited.

Inspectors were reassured by the weekly management checks that were conducted on electronic markers and the volume of reasonable adjustments in place. Prisoners spoken to were positive about the staff role in their care.

The departure of women had reduced the complexity of the population mix. Inspectors welcomed this progress in taking forward a previous recommendation. This enabled the management team to reorganise the accommodation to better meet the discrete needs of each cohort, in line with the Prison and Young Offenders Institution Rules (Scotland) 2011. It had also assisted the establishment to take forward another previous recommendation, to reinvigorate the First Night in Custody (FNIC) approach. However, given the initiative commenced as we embarked on our inspection, inspectors will be interested to see how this is maintained and embedded.

The population reconfiguration plan included the creation of additional capacity in Ratho House for the offence-protection group, a response inspectors considered appropriate in the context of the population demographic.

Inspectors were told that the establishment had created a five-year development plan to improve the physical estate and this included consideration of available adapted rooms. This was a welcome focus given the poor state of some parts of the establishment, and the under-provision of adapted rooms that had resulted in availability restricted to those with the most acute needs.

In terms of E&D complaints, inspectors found that Equality & Diversity Forms (EDFs) were often not understood or deployed properly, and there was no examination of them in the analysis of the wider complaint information. Although it was apparent this was understood at the E&D forum, and inspectors observed that corrective action was programmed.

The establishment had taken account of the nine protected characteristics identified in the PLR standards but had gone on to consider socio-economic status as a potential tenth factor, reflecting the "Fairer Scotland Duty" that came into force in 2018. This was an example of innovative thinking.

During the inspection we saw the event to mark "Black History Month" which was well attended, and inspectors were impressed by the "Arrows to Mecca" highlighting the direction for prayers for those of Muslim faith. As reported in Standard 4, the SPS Anti-bullying Strategy was not being used. This had potential to impact on more vulnerable groups.

Over the three months preceding this inspection, PIACs had begun taking place based on the themes of the protected characteristics. Inspectors saw notes from these relating specifically to the experience of people in custody affected by disability, religion, gender and race in which a number of important issues were helpfully brought to the attention of management for action. We considered this good practice.

Whilst the restricted regime we found at HMP Edinburgh is commented upon elsewhere in this report, it is worth pointing out here the potential disproportionate effect of limited social interaction on the mental health and wellbeing of those who are not able to attend work or interact with others in the evening.

Inspectors were shown evidence that translation services were deployed frequently which was positive. This came at significant financial cost. Documents translated included a trial judge report and parole outcome letters. Consideration could be given to these services being provided at source by the organisations generating the documents.

Inspectors were told about a funded plan to deliver a sensory area in the visit room to create more inclusive play space. HMIPS will be interested in how this is developed and receive feedback on the benefits.

Good Practice 10: The consideration of socio-economic factors in relation to E&D and fairer Scotland obligations represented innovative thinking by HMP Edinburgh

Recommendation 79: HMP Edinburgh should review the membership of the E&D meeting to include staff from each area as well as a range of key partners such as the NHS.

Recommendation 80: HMP Edinburgh should conduct an equalities impact assessment on the criteria for being placed in Ratho House.

Recommendation 81: HMP Edinburgh should complete an assessment of the requirement for adapted rooms and hospital beds to inform any bid for resources to increase provision.

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: Generally Acceptable

HMP Edinburgh had a Business Improvement Manager who tracked actions identified from SPS audits. A comprehensive suite of reports and data were in place to support the monitoring and management of performance. A business meeting took place monthly, chaired by the Governor. A track of actions in response to HMIPS recommendations was not implemented nor was this on the agenda of the monthly business meeting inspectors attended.

Recommendation 82: HMP Edinburgh should invoke a clear process for planning and implementing actions flowing from HMIPS inspection reports to ensure all recommendations are followed up timeously.

Recommendation 83: SPS HQ should check whether recommendations in HMIPS inspection reports resonate across the wider prison estate and take appropriate action where necessary to reduce the number of repeat recommendations.

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: Poor

As stated previously, performance information was generated and reviewed. However, inspectors found that some recommendations were made repeatedly because the tracking and programming of actions had not resulted in improved outcomes. An example of this was found in the tracker for the PRL audits in which there were numerous open actions, two of which were high risk; one concerning the recording of observations for management of offender at risk due to substance (MORS) which was identified in November 2022 and scheduled for completion in December 2022. The other concerned the shortfall in Control and Restraint (C&R) competence and the failure to ensure only competent staff participated in this.

As detailed in the QI 8.2, HMIPS recommendations were not routinely reported on and as a result there was long standing failure to implement important processes such as the SPS Anti-bullying Strategy, Think Twice.

A full breakdown of the outcomes made in the 2020 recommendations are in Annex E.

Staff were not aware of the issues and plans due to the absence of leadership communication on improvement priorities.

Inspectors received overwhelming feedback from staff and prisoners that the ongoing attempts to replace evening recreation with a programme of small-scale activities was not working out. There appeared to be a defeatist attitude amongst staff to the ability to open up the regime more fully due to the staffing constraints, which in turn appeared linked to the shift pattern. Notwithstanding the legitimacy of these challenges, the prison was badly in need of a fresh impetus with regard to delivering change, opening up the regime in the evening and making sustained improvements. The arrival of a new GIC and Deputy Governor provides an ideal opportunity to refresh the staffing model, reinvigorate the change process, clarify team objectives, energise staff and deliver lasting improvements to the regime, which in turn will re-motivate staff as well as securing benefits for prisoners.

Recommendation 84: SPS headquarters and HMP Edinburgh should commence a full reprofiling exercise to ensure the workforce capacity modelling, shift systems and staff target operating model addresses identified need.

Recommendation 85: HMP Edinburgh should ensure that scrutiny recommendations are followed up to the point at which improved outcomes have been secured and sustained.

Recommendation 86: HMP Edinburgh Senior Management Team should ensure that improvement priorities are effectively communicated and discussed with staff, particularly with regard to opening up the regime.

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: Poor

Inspectors were advised by the Senior Management Team that we were likely to find that staff were largely unaware of the aims in the ADP, because it was being reviewed and finalised by the new Governor. Inspectors did find that staff were not familiar with the plan, although it had predated the arrival of the new Governor by some time. Whilst inspectors found that staff were positive about their role in supporting people in custody, they expressed frustration about the absence of a clear set of priorities.

Scrutiny of staff training records indicated this was also an area for improvement. Attainment levels were much lower than they should be in every core competence except for TTM and C&R Supervising Officer package. Critically on 9 November 2023 almost 37% of the staffing group were not certified in C&R. Inspectors were told this was largely because the training resource variable had been subsumed into the roster.

A Learning and Development Annual Plan was in place linked to the ADP and staff survey outcomes. A staff learning and development group considered applications for non-core funding through the SPS College. It was encouraging to note that the HR Team had recently commenced issuing a quarterly staff newsletter. Given the effect of staffing issues, it was also encouraging that between May and September 2023 the number of vacancies in operational officer roles had reduced from 29 to 15.

> **Recommendation 87**: HMP Edinburgh should ensure that following the review of the ADP, the Senior Management Team communicate the prison's priorities to all staff, so they understand their role in supporting people in custody.

> **Recommendation 88**: HMP Edinburgh should ensure that all core competency training increases to the required level as a priority.

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

Rating: Good

Inspectors spoke to staff across the groups, and it was apparent that there was respect for each other's roles, resulting in positive relationships. NHS staff reported that they enjoyed effective relationships with SPS colleagues, although they expressed frustration that the disciplinary hearings could interrupt the morning medication routine. The Partnership Liaison Representatives also said that relationships with managers and service providers were respectful and positive.

Inspectors were impressed by a recently introduced staff mentoring scheme, in which newer officers were supported in a formal way by more experienced officers. This will become vitally important as more new staff are employed particularly direct entrants to the residential function who will have no previous experience working with prisoners, that is not progressing from an operational role. Inspectors were also encouraged by the Human Resources Business Partner's approach to arranging meaningful work for colleagues on restricted duties.

Colleagues in social work and psychology told inspectors that historically they had enjoyed productive relationships with personal officers in their role, but in recent times this had sadly fallen away.

Learning providers spoke highly of the support provided by the Head of Offender Outcomes.

> **Good Practice 11**: The recently introduced staff mentoring scheme paired up newer staff with more experienced officers.

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: Generally Acceptable

When inspectors requested the up-to-date position on delivery of the appraisal process, they were presented with data that demonstrated only 57% were completed. In the management category this reduced to 36%. Although inspectors were told that verbal recognition was regularly offered, it is difficult to demonstrate that performance is recognised effectively when the formal system for assessing it is not used by so many.

A staff recognition meeting was taking place quarterly. Inspectors attended this and found active consideration of nominations for meritorious conduct awards at all levels. The recognition group would benefit from being extended to operational and non-operational staff, at least for part of it, so that they could participate in the generation of recognition ideas and communicate the benefits of the group to colleagues. The PLR spoke positively about the approach and the impact on staff. It was clear that he had been consulted with.

> **Recommendation 89**: HMP Edinburgh should improve completion of the appraisal process.

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: Satisfactory

Inspectors found that HMP Edinburgh had worked effectively with a wide range of organisations to build up a broad range of services, many of which were detailed in the informative Links Referral Form, which set out the purpose of each organisation across five categories: Housing and Benefits, Counselling and Support, Addictions Issues and Advice, Throughcare, and Education and Training

The form could be used to make a self-referral to services which was an empowering feature inspectors considered positive. The team had also supported a recovery approach to addictions and were working with the NHS to develop a trauma-informed approach. Inspectors will watch with interest how this develops.

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

In common with other SPS prisons, most external media engagement was delivered through SPS HQ communications specialists. Inspectors found that HMP Edinburgh was active in providing positive developments to report on. A recent example was

work done by prisoners to construct 22 feet tall effigies to support the Dusshera Festival, the flagship event of the Scottish Indian Arts Forum at local landmark, Calton Hill.

Earlier this year an officer attracted positive media coverage when he received a Butler Trust commendation for his work over the preceding 22 years to deliver a scheme, in partnership with 24 local churches, providing gifts at Christmas to children with a parent in custody.

A further valuable community contribution was the project to refurbish garden tools for distribution to local community projects.

The Human Resources Business Partner had built connections with local colleges ensuring the SPS gained a profile in their SQA Level 5 Uniformed Services qualification. This was primarily in response to the need to promote recruitment in the local area but had the dual benefit of raising awareness of the important role of a prison officer.

Connections had also been made with an organisation that assisted people leaving the armed forces to find a new career.

HMP Edinburgh had recently delivered a communications event for the families of staff. Over 300 people had attended many of whom are from the local area.

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: Generally Acceptable

There was clear systems and processes in place to screen the healthcare needs of new admissions and transfers to HMP Edinburgh. Healthcare screening was undertaken by staff who were trained in using a standardised health screening tool and the outcome was recorded on the patients' Vision record. Screening included an assessment of the person's immediate mental and physical health requirements to ensure they were fit for custody. Although staff were able to describe the screening process there was no Standard Operating Procedure (SOP) in place to support them in the process. For example, the process for informing the decision about a person's fitness to remain in custody. This is a concern.

The admitting nurse also completed the second part of the prison's suicide prevention strategy: Talk to Me (TTM). Screening for substance use would be undertaken using validated withdrawal scales and clinical assessments. This ensured that people were assessed, and if clinically indicated, were provided with appropriate medication using Patient Group Directions (PGD). Interpretation services were available to support patients if required in the admission process.

Healthcare staff told inspectors that the treatment room door was generally left open whilst they carried out patient health screening assessments. SPS officers would also sometimes be in attendance for safety reasons. This meant that patient confidentiality was not always maintained.

There was an effective communication pathway to pass on information to the wider healthcare team following admission. Inspectors saw a copy of the admission and transfer sheet which summarised the outcome of the completed admission screening. A copy of the sheet was given to the Advanced Nurse Practitioner (ANP) the following day to review all people who had been admitted or transferred to HMP Edinburgh as described in QI 9.2.

The room used for the initial screening was spacious and in a good state of repair. The environment and equipment were visibly clean apart from some marks on the ceiling and walls. Staff described how they would decontaminate equipment and surfaces after use in line with infection control measures.

The ongoing national issue of late arrivals into prisons continued to be an issue for HMP Edinburgh. While prisoners would have access to person-centred health screening during working hours, people who were admitted to the establishment after 9.00pm may not receive the same standard of health screening. SPS staff would place the prisoner on 15-minute observations overnight until they had seen a nurse the following day. This is a concern. Health screening should be undertaken by a registered health professional to ensure that people coming into custody have their immediate health needs assessed and any health concerns identified and actioned. SPS staff would have access to out-of-hours medical services if required. However, there is a risk that SPS would not have the most up-to-date relevant healthcare information to identify if a prisoner was deteriorating or required healthcare intervention if prisoners had not received a health screening.

On admission to HMP Edinburgh patients were given verbal information about the healthcare services available and how to access them, however, no information leaflets were provided.

Peer mentors (described in QI 9.3) also discussed healthcare with patients as part of the admission process.

Recommendation 90: REAS/NHS Lothian should develop a SOP to support the admission process including the assessment of a person's fitness to remain in custody.

Recommendation 91: REAS/NHS Lothian must ensure the doors are closed during patient consultations or seek a safe solution to address this.

Recommendation 92: SPS HQ and NHS Lothian must work together to ensure that there is a robust process in place to ensure that those prisoners arriving late at the prison receive a formal health screening assessment.

Recommendation 93: REAS/NHS Lothian should ensure that people admitted or transferred to HMP Edinburgh are provided with written information appropriate to their needs that describes healthcare services available and how they can access them.

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

Rating: Generally Acceptable

The healthcare services in HMP Edinburgh and the model of care delivery supported accessible and co-ordinated person-focused care.

The healthcare service in HMP Edinburgh was a nurse-led model delivered using ANP, GPs, and nurse-led clinics. This was supported by an out-of-hours service.

There was a robust and established ANP service to follow up people on admission to the prison. This is good practice. All patients were seen the day after admission by an ANP who carried out a full medical assessment including reviewing the patient's past medical history and identifying those with LTC.

Medicine reconciliation was completed as part of the review by the ANP. Confirmation of prescribed medications was obtained from the patient's community prescribers and by checking the patient's emergency care summary. The ANP prescribed the patient's medication after medicine reconciliation was completed.

Following assessment review the ANP would refer the patient on to other services such as mental health or addictions where required.

Referral forms were available for people to self-refer to healthcare. However, these were not in easy read format to support patients with literacy challenges or available in different languages for those people whose first language is not English.

Lockable boxes were seen in the residential areas for patients to confidentially post their self-referral forms. Inspectors were told that referral forms were collected after the morning medicine round before being triaged. Due to the length of time medicine rounds could take, inspectors were concerned that triage could be delayed and in turn, urgent referrals may not be actioned until later in the day. Inspectors discussed this with healthcare staff during the inspection and were assured the process would be reviewed immediately.

Patients were not informed when their referral had been received by the health service or when an appointment had been given for a particular clinic.

At the time of the inspection, the waiting times to see a GP, ANP, or to attend a nurse clinic, were in line with current general practice waiting times.

Some patients had missed their secondary care appointments (such as hospital and nurse specialists) due to variations in the performance of the prisoner transport provider, GEOAmey. This has been previously escalated by HMCIPS to the Cabinet Secretary for Justice and Home Affairs. HMP Edinburgh continues to collate this data and supports patients who have missed appointments to be reappointed. If GEOAmey were unable to provide transport, those appointments that needed prioritised were discussed with SPS staff to see if they could support transport to the appointment. This is good practice.

Patients requiring social care were identified by SPS officers and discussed with healthcare staff, who developed a care plan. Inspectors saw that care plans were based on a patient's activities of daily living and had a section for the patient to sign, indicating that they agreed with the care plan. However, as the care plans were generally managed electronically, this section was not completed. Social care staff had access to the patient's care plan and were on-site in HMP Edinburgh 24/7. A weekly meeting took place between healthcare staff and social care staff.

Nursing staff were trained to immediate life support level which had been enhanced to reflect the health conditions that patients in custody experience, such as addictions. Training records showed most staff were compliant with this training. Emergency equipment, which included automated external defibrillator, oxygen and suction units, was accessible and ready for use, and emergency drugs were in date. There was evidence of emergency equipment being checked, however this was not consistently recorded.

A SOP was in place to support the management of the acutely unwell patient. The GP or ANP supported the care of emergencies in hours, whilst out-of-hours, the out-of-hours service or 999 ambulance was available.

Recommendation 94: REAS/NHS Lothian should ensure referral forms are available in different formats to support patients with literacy challenges and available in different languages for those patients whose first language is not English.

Recommendation 95: REAS/NHS Lothian should ensure that patients are informed of the progress of each self-referral and the expected waiting time to access services.

Recommendation 96: SPS HQ 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.

Recommendation 97: REAS/NHS Lothian must ensure that checks on emergency equipment are carried out and consistently recorded.

Good Practice 12: There was a robust ANP service to follow up people on admission to the prison.

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

Rating: Satisfactory

Blood Borne Virus (BBV) screening is undertaken on admission and patients can opt out of testing at this point. Further opportunities for BBV testing were also available for patients who had opted out at admission. All patients who declined were routinely reoffered testing after 12 weeks. This is good practice. A process was in

place between the Addictions Team and specialist nurses to ensure patients could access vaccinations for Hepatitis A and B and testing for BBV and sexually transmitted diseases.

Access to national screening programmes continued in line with community provision and eligible patients were sent screening invitation letters. For example, national bowel screening letters were sent to patients when they met the requirements for screening programmes. Healthcare staff would encourage patients to attend screening when invited, as part of a health promotion approach.

A range of health promotion support materials were visible in the halls, health centre and on the prisoner TV channel promoting awareness and encouraging uptake. Support materials included access to sexual health services. Up-to-date clinic waiting times were also visible in the health centre and shared on the prisoner TV channel. This is good practice.

Smoke Free Services ceased during the pandemic; however, patients were still offered Nicotine replacement therapy (NRT) on admission. Inspectors were told ANPs managed prescriptions for NRT on an individual basis. This was due to no specific smoking cessation service being available for those wishing to become nicotine free from using vaping devices through NRT and behaviour change support.

Naloxone, which can reverse the effects of an opioid--related overdose for long enough for professional medical intervention, was available for patients in the form of injectable and nasal naloxone kits. There was a proactive approach by the Healthcare Team to ensure all patients had access during pre-liberation appointments and training had recently been extended to SPS night officers. This is good practice.

The Recovery Cove had several groups and resources that patients could access, aside from support offered by the Addiction Team. This included access to peer support workers, and groups on relapse management led by external facilitators and SPS colleagues.

The Oral Health Promotion Team was in the process of being reintroduced to deliver the ‘mouth matters’ programme within the prison. We were told that the Dental Team could provide patients with information to support them in managing their oral health. Toothbrushes and toothpaste were available in the residential areas.

Recommendation 98: REAS/NHS Lothian should ensure patients can access a smoking cessation service for those wishing to become nicotine free.

Good Practice 13: All patients who declined BBV screening on admission were routinely reoffered testing after 12 weeks.

Good Practice 14: Health and wellbeing information and current clinic waiting times were visible in the health centre and prisoner TV channel.

Good Practice 15: Training on the use of Naloxone had been extended to SPS night officers.

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

Rating: Satisfactory

Staff appeared to understand health inequalities and were knowledgeable about the potential barriers that patients could face when accessing healthcare. Staff demonstrated a respectful and professional approach to all patients. Observed interactions with patients were supportive, with staff providing an explanation of care while gaining the patient's consent.

There was evidence of trauma-informed practice embedded through staff awareness, observations of delivery of care and a high compliance with training available online. The Clinical Psychology Team were working with SPS colleagues to develop a Trauma Informed Practice Strategy within the Prison. The strategy will include staff wellbeing and support and staff training in trauma informed practice.

Mandatory training records showed that all staff had completed Equality & Diversity online training. Inspectors spoke with staff who were aware of the Equality Act 2010 and were aware that up-to-date policies were available on the staff intranet.

All new arrivals to the prison were made aware on admission about how to access healthcare and received an SPS induction. Previously healthcare staff have attended the SPS induction meeting to promote awareness of the healthcare services available. However, due to low staffing and workforce challenges NHS Lothian had not been able to release staff to attend. Inspectors were told there were plans to reintroduce this due to their improved staffing levels.

Good Practice 16: The Clinical Psychology Team were working with SPS colleagues to develop a Trauma Informed Practice Strategy within the Prison.

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: Generally Acceptable

At the time of the inspection, the Mental Health Team had clear processes to triage, risk assess and allocate referrals. Access times for assessment and treatment for people referred to the service was equitable with community waiting times. Patients were seen within the same day if urgent, and within four weeks for a routine assessment. Following assessment, patient referrals were discussed at the MDT and if appropriate, the patient would be allocated to a clinician to receive treatment or a further assessment.

As discussed in QI 9.2 the referral forms were not in easy read format to support patients with literacy issues or available in different languages.

A review of Vision records indicated that validated assessments and risk assessments tools were used as standard. However, inspectors saw that although patients were involved in their assessment and had the opportunity to discuss the purpose and outcome of the assessment, patient care plans were not fully person-centred.

Assessments and care planning were recorded on paper and scanned on to the Vision system. By not having electronic active assessments there is a risk that care plans and risk assessments are not reflective of up-to-date information.

On review, much more is needed to be done to fully realise the benefits of improving clinical IT systems in the prison to share information and improve the quality of clinical documentation for the Mental Health Team. This had been identified as an area requiring improvement by the Healthcare Management Team. Inspectors were told that the clinical educator and clinical academic for REAS were reviewing and auditing care plans and assessments to ensure that the care and support plans are developed with the person receiving care. Furthermore, that the conversation is led by the person who knows best about their needs and preferences.

A weekly MDT meeting was in place, providing a forum to discuss complex patients, referrals, and required interventions for patients. This was attended by a range of clinical staff including, psychiatry, psychology, occupational therapy as well as nursing staff and the ANP for addictions and mental health. Inspectors had the opportunity to attend the meeting which was observed to be an effective way of sharing information about patients. A supportive culture was evident between professionals. Psychiatry was available in the format of weekly psychiatry clinics, with the capability to respond to any emergency or urgent care requests.

Due to staff turnover, only a couple of members of the nursing team were trained in the delivery of low intensity psychological interventions. Previously, staff had been able to offer a range of interventions including anxiety management, safety and stabilisation, and relapse prevention. This has been identified as a gap in provision by the Healthcare Team and an action to review, skill, and develop the team should be progressed.

It was positive to see that there was an established mental health occupational therapist service in HMP Edinburgh. This service had established MDT working collaboratively with the wider healthcare team and SPS colleagues to support people referred to their service. The Occupational Therapist Team offered a range of group and one-to-one sessions to support people with daily living, to support and promote their independent functioning of everyday living within the prison and in preparation for liberation. This is good practice.

The Psychology Team supported the team with complex case discussions and formulations to support people with their care. At the time of the inspection, waiting times for clinical psychology was 20 weeks for assessment and treatment. Breathwork and yoga sessions were currently running in the prison via the

psychology service which delivered two group work sessions, with a 10-week block at a time. Although the group could facilitate 24 spaces, there was a waiting list for these sessions.

There was an established pathway for patients to access specialists in intellectual disabilities, autistic spectrum disorder, neuropsychiatric disorders and cognitive impairment.

An ADHD weekly clinic was held in the prison that was delivered jointly by a psychiatrist and a learning disabilities nurse. This is good practice.

Relationships between mental health and substance use services were good and inspectors observed clear communication and discussion between both teams and the wider prison to support, address, and treat those with comorbidity issues.

Systems and processes were in place to ensure that any patient requiring inpatient mental health care was assessed and transferred promptly to the hospital under the Mental Health (Care and Treatment) (Scotland) Act 2003. At the time of the inspection there were no patients awaiting transfer; however, inspectors were told that there were occasions when identifying available beds was challenging.

> **Recommendation 99**: REAS/NHS Lothian should review their assessment, care planning and process for recording clinical information to ensure up-to-date clinical information is recorded.
>
> **Good Practice 17**: The Occupational Therapist Team offered a range of group and one-to-one sessions to support people with daily living and to support and promote their independent functioning of everyday living within the prison and in preparation for liberation.
>
> **Good Practice 18**: An ADHD weekly clinic was held in the prison that was delivered jointly by a psychiatrist and a learning disabilities nurse.

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: Poor

There is an increasingly aging population in HMP Edinburgh with complex healthcare needs, including comorbidities and LTCs.

As described in QI 9.1 and QI 9.2, patients with LTCs were identified as part of the admission health screening and when patients were reviewed by the ANP the day after admission. An ANP had taken responsibility for the management of patients with LTCs and had started to develop a LTC register. Patients were reviewed in general clinics run by the ANP, as there were no dedicated LTC condition clinics. Inspectors were told that yearly reviews and checks for patients were not consistently carried out.

The ANP had made links with secondary care clinicians to help support the management of LTCs. Link nurses were in place for palliative care and tissue viability. Inspectors were told that there had been an agreement to recruit a LTC nurse to support the care of patients with LTCs in HMP Edinburgh.

Inspectors saw examples of care plans as described in QI 9.2. However, these care plans did not contain condition specific interventions to support patients with LTCs. Inspectors were told that patients would be given NHS Lothian patient information leaflets to help them manage their LTC.

Wound charts were being used. Waterlow pressure area risk assessment charts and MUST (Malnutrition Universal Screening Tool) were also available for use if required. This is good practice.

System and processes as described in QI 9.2 were in place to access social care for patients who required this. Healthcare staff were able to describe the process if patients required a functional assessment and how to obtain assistive equipment if required. We saw accessible cells, which were in variable states of repair which could make effective cleaning difficult. Assistive equipment, such as wheelchairs, shower chairs and toilet raises in place to promote patients' independence were seen to be available.

Inspectors were told that some patients with LTCs would be discussed at the weekly patient of concern group which both healthcare and SPS attended. Inspectors saw minutes of this meeting.

Recommendation 100: REAS/NHS Lothian should introduce dedicated LTC clinics to ensure that patients are reviewed in a structured manner and that yearly reviews and checks are completed consistently.

Recommendation 101: REAS/NHS Lothian must ensure that patients with a LTC 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 19: Wound charts were being used. Waterlow pressure area risk assessment charts and MUST (Malnutrition Universal Screening Tool) were also available for use if required.

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

The Addiction Team in HMP Edinburgh was focussed on providing the best quality of care and treatment for people who had substance use issues in the prison. The team presented as a cohesive team that was constantly evolving to keep pace with providing the most up-to-date, high-quality care for their patients.

As the service was evolving, inspectors observed there was not always clear consistent pathways for people to access equitable substance use services. To ensure a consistent approach to care, the Addictions Team recognised that there was a requirement to have safe, consistent, and clear prescribing guidance and a SOP for the Substance Use Team which should be aligned to the principles of the Medication Assisted Treatment (MAT) standards. To ensure a consistent and equitable access of care and treatment this should be progressed as a priority.

As described in QI 9.1, patients requiring support with drug and/or alcohol dependence were identified at health screening during core hours using a validated screening tool.

A fast-track system to support patients quickly onto OST following admission into prison was in place. If a patient was positive for opiates on admission, they would be seen by the ANP the following day. The ANP would assess the patient's dependence through clinical assessment and a prescribing decision would be made at this first appointment. The patient would then have a choice to begin medication on the day they are seen. This is good practice and aligns with Standard 1 Same Day Access of the MAT standards.

There could, however, be delays for people wanting to commence OST who were already part of the prison population. This was because the clinical pathway stipulates that to commence treatment a patient is required to keep a two-week diary of drug use and produce two positive drug screens. Delays in commencing treatment could mean patients experiencing withdrawal or prolonged drug use in the prison for a longer period. This is a concern. There was limited evidence of a consistent approach to promoting patient choice for OST in line with the MAT standards at the time of the inspection. OST was limited to Buvidal[1] and methadone. Oral buprenorphine would not be prescribed or offered for OST. However, if a patient was transferred from another prison or if this was prescribed in the community, then it would be continued. The rational for this was that oral buprenorphine is a currency within the prison and would make individuals prescribed this a target. Therefore, this would not be safe to offer this as a choice. In line with the MAT standards, patients should be assessed on an individual basis, then prescribing should be made dependent on this assessment. A blanket approach to prescribing does not support individual assessment and patient choice for their care and treatment.

Patients would receive OST prior to going to court as discussed in QI 9.8.

Observation of care planning and assessment showed that patients referred to the team had individual person-centred and outcome-focussed care plans, which reflected their support needs. There was evidence of patient involvement in writing their care plans which were regularly reviewed, monitored and updated by the patient and their caseworker. Like the Mental Health Team, as described in QI 9.5, care plans and assessments were paper copies that were scanned onto the Vison IT system and were not active or live documentation.

[1] Buvidal **is a** prolonged release buprenorphine **product which is administered as a subcutaneous** injection.

Patients who were referred to, and seen by, the Addiction Team and 'Change Grow Live' a third sector provider, were provided with evidence-based pharmacological, harm reduction and psychological interventions. These interventions included psychosocial clinical interventions, relapse management and harm reduction interventions.

A standardised discharge planning tool was in place. This tool ensured that patients were referred to community services and information was passed to these services for continuity of care. This included the early identification of community prescribers and pharmacies.

Supporting people after release has been shown to enable successful rehabilitation and preventing re-offending. Inspectors were therefore encouraged to see that 'Change Grow Live' caseworkers would support people on liberation, returning to Edinburgh and the Midlothian area. They could also provide a 'liberation pack' for clients they work with, which contains toiletries, a mobile phone and signposting for support with housing, benefits, health, and employability. This is good practice.

At the time of the inspection, there were no vacancies within the Addictions Team. As described in QI 9.5, they worked closely with the Mental Health Team. The ANP for Mental Health and the Addiction Teams attended both clinical meetings to share insights and progress of the plan of care from each team. This supported decisions in care planning decision making regarding planned interventions. Several nurses within the team were also non-medical prescribers.

At the time of the inspection, there was no waiting lists for referrals. Patients would be seen promptly if referred.

> **Recommendation 102**: REAS/NHS Lothian should ensure that they have a Standard Operating Procedure including clinical prescribing guidelines for their Substance Use Service that aligns to the principles of the MAT standards.
>
> **Good Practice 20**: A fast-track system supported patients quickly onto Opiate Substitution Therapy following admission into the prison.
>
> **Good Practice 21**: 'Change Grow Live' caseworkers supported people on liberation. Liberation packs were provided for those clients they worked with, which contains toiletries, a mobile phone and support with housing, benefits, health, and employability.

9.8 There is a comprehensive medical and pharmacy service delivered by the service.

Rating: Generally Acceptable

NHS Lothian had recently appointed a lead pharmacist to join the healthcare team at HMP Edinburgh. This is good practice. They worked as part of an MDT providing support and advice in line with local and national guidelines. The lead pharmacist

described how they were looking at ways of improving the length of time medicines took to be administered and the safety of medicine administration.

As discussed in QI 9.1 and Q 9.2 medicine reconciliation was carried out as part of the health screening and assessment process. Medicine reconciliation and initial prescribing was generally carried out by an ANP. The GP or nurses trained as a non-medical prescribers also prescribed and reviewed medications.

It was encouraging to see that prescribing audits were completed, and any issues identified with prescribing were discussed with the responsible prescriber. Further to this, the lead pharmacist carried out informal spot checks on drug Kardexes.

Inspectors were told that cells should have safes for patients to safely store in-possession medication, however on review by HMIPS inspectors, many of these safes were found to be broken. This is a concern. Compliance spot checks were carried out and an MDT approach was taken to discuss any issues with compliance.

There were clear, robust systems and processes to ensure all medicines were handled safely and stored securely in line with national and professional guidance and legislation. A home office license was in place for the storage of controlled drugs.

Medication was administered on a twice-daily basis. Inspectors observed a medicine administration round and saw this was carried out in a calm and organised manner. Patients SPIN numbers and names were checked before medications were administered. However, the patient's date of birth was not consistently checked. Verbal confirmation of controlled drug doses was heard to be carried out, however a visual check of the dose by the witness was not robustly completed. This is a concern. Concealment checks were completed where indicated and patient confidentiality was maintained.

Inspectors were concerned, however, to see that due to current healthcare staffing and the SPS regime, the medicine round in one of the residential areas in particular took a long time to complete. This extended period of medicine administration could contribute to the large number of Datix incidents recorded relating to medicine management as described in QI 9.17. The length of the medication round may also prevent medications being administered at the prescribed time intervals. The last medication round started at 6pm, this meant that some medications were administered out with therapeutic times. This is a concern. However, some patients were provided with a daily supply of in-possession medication so that they could take their medication at a more appropriate time.

Drug administration charts and controlled drugs registers were generally well completed, with no overwriting. However, inspectors observed that the nurse who had administered the controlled drug did not sign the controlled drug register immediately after administration which would be in line with good practice.

Inspectors were told that there were processes in place to ensure that patients received their supervised medication, including OST, before attending court. Patients being liberated were issued with a prescription for seven days of their

medication that could be dispensed in a community pharmacy. Processes were in place for patients on OST being liberated to ensure there was no interruption to their OST.

Recommendation 103: HMP Edinburgh should ensure that in cells safes are available and in good working order to ensure patients can store their medication securely.

Recommendation 104: REAS/NHS Lothian should ensure healthcare staff carry out all patient identification checks as specified in the relevant SOP to ensure medications are administered safely.

Recommendation 105: REAS/NHS Lothian should ensure that witnesses comply with the requirements of the SOP for verification of dosage at the point of administration or supply. A robust visual check as well as a verbal check of controlled drug doses during the dispensing process should be undertaken.

Recommendation 106: REAS/NHS Lothian and HMP Edinburgh SPS staff should continue to work together to ensure that medications are administered at their therapeutic time and with the correct time between doses.

Good practice 22: NHS Lothian had recently appointed a lead pharmacist to join the Healthcare Team at HMP Edinburgh.

9.9 Support and advice is provided to maintain and maximise individuals' oral health.

Rating: Satisfactory

The dental surgery environment and all equipment was compliant with national guidelines. The environment was intact and visibly clean, as was patient equipment, such as the dental chair. Systems and processes were in place to ensure that all sterile instruments were appropriately stored before use and were safely transported off-site for decontamination.

As discussed in QI 9.2, inspectors saw that patients could access dental services through self-referral forms. Referrals were initially triaged by the Primary Care Team and then by the Dental Team. Dental care was also provided by a dental therapist as well as a dentist. The dental therapist could deliver treatments such as fillings which helped shorten dental waiting times. This is good practice.

On reviewing dental waiting times, inspectors observed that routine appointments and treatments for convicted prisoners were shorter than the current community waiting times in Lothian. However, inspectors were concerned that dental services for remand patients in HMP Edinburgh were still limited to emergency care and some limited treatments.

There was clear prioritisation for emergency appointments and systems were in place for patients to access emergency dental care in and out-of-hours. Inspectors

saw the NHS Lothian management of dental problems in prisons 2023 algorithm to support staff decision making. Patients could also be seen by primary care staff who could facilitate the prescription of analgesia or antibiotics, if required out with the dental clinics.

Oral health promotion has already been described in QI 9.3.

> **Recommendation 107**: REAS/NHS Lothian must ensure dental treatment for those patients who were on remand beyond six months is equitable to those who are convicted.
>
> **Good Practice 23**: The dental therapist could deliver treatments such as fillings which helped shorten dental waiting times.

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

HMP Edinburgh does not hold female prisoners and there were no pregnant people in the prison during our 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: Satisfactory

Systems and processes were in place within the prison to support patients identified as requiring palliative care and end of life care. Healthcare staff spoken with were able to describe and were positive about the links that had been established with community services.

Although one of the ANPs had been identified as the link nurse for palliative and end of life care, initial assessments were completed by the Marie Curie specialist nurse with input from a consultant if required.

Do Not Attempt Cardiopulmonary Resuscitation forms were in use, copies of which were held by the patient and SPS officers. Inspectors saw an example of an anticipatory care plan that would be used for palliative and end of life care patients.

A process was in place as described in QI 9.2 and QI 9.6 to access assistive equipment and social care.

Some registered nurses had completed ‘confirmation of death training’ and it was planned that all staff would complete this.

Community palliative care staff were invited to attend monthly healthcare meetings. Healthcare staff told us that GEOAmey would be invited to attend meetings when transport to community settings was being considered.

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

As discussed in QI 3.1 earlier in the report, HMIPS escalated with the Deputy Governor concerns regarding the process within the prison to manage and support those prisoners that were placed on to the SPS Suicide Prevention Strategy TTM. First Line Managers (FLMs) were not immediately informing health centre staff that a prisoner was being placed onto TTM. They started to complete an ICP instead of attempting to arrange a case conference to enable immediate joint discussion and to arrange a healthcare risk assessment. The escalation of concerns and action taken are detailed earlier at QI 3.1.

As described in QI 9.1, on arrival or transfer to the prison, every patient at risk of self-harm or suicide was assessed using a standardised health screening tool as part of the screening process. Patients identified at risk were then placed on TTM.

Inspectors observed the process in which a mental health nurse was allocated daily TTM case conferences, including updating associated documentation. There was a clear lack of timely communication between SPS and Healthcare when someone has been placed on TTM. This is a concern.

Inspectors saw that patients being managed on the TTM strategy would have suicide and self-harm risk assessed at every case conference to inform their ongoing risk management. However, as discussed above, this was not in a timely manner. Mental health nurses would attend all case conferences during the working week and Registered Mental Health Nurses would attend any case conferences at the weekend.

Inspectors saw that a person of concerns meeting was held weekly with attendance of SPS staff, mental health nurses, and third sector providers. This forum enables discussion and sharing of information to support people living in the prison who had complex issues including serious mental health issues and comorbidities. This is good practice.

> **Recommendation 108**: HMP Edinburgh and NHS Lothian/REAS must ensure that there is clear communication between both organisations when an individual is placed onto TTM in order that initial Case Conferences are held when all relevant professional staff are available and at the earliest opportunity.

> **Good Practice 24**: A person of concerns meeting was held weekly with attendance of SPS staff, mental health nurses, and third sector providers. This forum enables discussion and sharing of information to support people living in

the prison who had complex issues including serious mental health issues and comorbidities.

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: Generally Acceptable

A robust process was in place for compliments, comments, concerns, or complaints to be made at HMP Edinburgh in line with NHS Lothian's policy.

Feedback forms were available in the halls and could be posted to a secure mailbox which was collected daily by health centre staff. The team were aware of the importance of having forms available in alternative easy read formats and different languages. However, at the time of inspection, alternative easy read formats were under development and different languages were only available on request through the Patient Experience Team. Forms being readily available in other languages and formats will be followed up at future inspections.

A process was in place for complaint forms to be checked daily and allocated to the appropriate team. Evidence was seen of a clear system to record all complaints including the date received. The complaints process indicated that complaints would be responded to within three working days or if an investigation was required, acknowledgement would be within three working days. Most complaints had been responded to within the set timescales. While there was a small number of complaints that had breached this timeframe, inspectors were assured this would be addressed with immediate effect.

The primary care, mental health and addictions teams reviewed complaints relevant to their team. Training had recently been provided by the Patient Experience Team which most staff had the opportunity to attend.

There were processes in place to regularly review and identify any learning from complaints at the leadership team meetings and, in turn, learning disseminated during staff meetings to the wider team. Daily handovers also provided an opportunity to share any learning, as and when required, if there was a theme to highlight to the team.

All feedback, comments, and complaints were seen to be managed in accordance with relevant data protection legislation and confidentiality protocols. The feedback forms included details on patients' rights to contact the Scottish Public Services Ombudsman (SPSO) if they were not satisfied with the outcome or response to their complaint.

9.14 All NHS staff demonstrate an understanding of the ethical, safety and procedural responsibilities involved in delivering healthcare in a prison setting.

Rating: Satisfactory

Healthcare staff had a clear understanding of their roles and responsibilities in reporting any situations that could result in physical or psychological harm to those in prison. Healthcare staff described their responsibilities to inspectors to assess, record, and report any medical evidence of mistreatment of people in the prison and to offer treatment as required.

Systems were in place to ensure the safe storage of patients' electronic care records and hard copy health information. All healthcare staff had personal secure access to the electronic system Vision and all hard copies of patient care records were appropriately kept within lockable storage.

All staff spoken with indicated that the relationship between healthcare staff and SPS staff were supportive and professional. This was also observed in practice by inspectors.

9.15 The prison implements national standards and guidance, and local NHS Board policies for infection prevention and control.

Rating: Poor

The Health Centre in HMP Edinburgh was in a good state of repair and could be effectively cleaned. However, the medicine dispensaries and treatment rooms in the residential areas were in variable states of repair making effective cleaning difficult. A five-year plan was in place for the refurbishment of the residential areas with HMP Edinburgh.

All near patient equipment was also in a good state of repair, clean and ready for use. Adequate supplies of PPE were in place and were stored appropriately. The Health Centre was tidy and visibly clean. Healthcare staff reported that the standard of cleaning was acceptable and that any issues with cleaning or cleanliness would be escalated through SPS. Cleaning of the staff areas was carried out by an external company contracted by SPS. The dispensary areas and treatment rooms in the residential areas were cleaned by healthcare staff, whereas the patient areas were cleaned by passmen and healthcare staff. Cleaning schedules were seen to be in place, however there were notable gaps in these being completed.

HMP Edinburgh does not have any external infection control oversight from NHS Lothian. Staff spoken with were not aware of any external assurance visit having taken place. This is a concern. Although inspectors were told that a quarterly health and safety audit was completed that covered some aspects of infection prevention and control, there was no formal infection prevention and control audit programme in place. This is a concern.

Healthcare staff told inspectors that support with infection prevention and control issues could be obtained through REAS, NHS Lothian's infection prevention and control team or public health. Staff could access infection control information, including the infection prevention and control manual, on the staff intranet. Staff mandatory training included infection and prevention modules; inspectors saw good compliance with mandatory training.

Healthcare compliance with the national uniform policy was variable at the time of inspection. Inspectors were informed that senior staff monitor this along with compliance of other areas of infection prevention and control, and that areas of non-compliance would be highlighted at the safety brief or handover.

The Governor highlighted challenges with recruitment to the Prison Estates Team. Despite this, healthcare staff reported a good service with a quick response especially for urgent issues. Inspectors were told that estates issues were discussed at a monthly meeting with the offender outcomes lead.

> **Recommendation 109**: HMP Edinburgh must ensure that areas where healthcare is delivered are in a good state of repair to allow for effective cleaning.
>
> **Recommendation 110**: REAS/NHS Lothian must provide external infection prevention and control oversight and carry out a programme of assurance visits to HMP Edinburgh.
>
> **Recommendation 111**: REAS/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 healthcare 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: Satisfactory

The Prison Healthcare Leadership Team regularly reviewed staff competency, training needs and staff skill-mix to ensure the delivery of safe, effective and person-centred care.

Safe staffing levels have improved within HMP Edinburgh due to a proactive recruitment drive. Staff were supported with a comprehensive induction on appointment. Upskilling the workforce by enhancing training and development opportunities was identified by the Leadership Team as a priority for healthcare staff at HMP Edinburgh.

At the time of the inspection there were two primary care nurse vacancies. Regular bank or agency nurses were booked to fill gaps due to vacancies, maternity, or sick leave. HMP Edinburgh's Leadership Team demonstrated commitment to address the staffing levels by facilitating open days, recruitment events, and having a social media presence.

It was evident from reviewing rotas, that efforts were made to cover duties in advance and staff demonstrated awareness of how to escalate concerns about staffing levels. This often involved contacting the Healthcare Manager or senior

charge nurse (even when they were not on duty) as there was no formal process to escalate staffing gaps, especially out-of-hours.

Inspectors saw evidence of staff completing NHS Lothian's induction, SPS induction and recently developed induction programmes specific to the primary care, mental health and addictions teams. All staff have a four-week supernumerary period. Management told inspectors they were supportive in extending supernumerary status based on individual's confidence, training, and learning gaps. This is good practice.

Student nurse placements were supported, and a number of newly qualified registrants had been successfully recruited following their placement.

Staff maintained their competencies by completing NHS Lothian's mandatory training. Inspectors saw over 90% compliance with mandatory training for all of staff. Healthcare staff told inspectors that training and learning needs were identified during one-to-one meetings, and through completion of appraisals. Appraisals were recorded electronically, and the Healthcare Manager provided monthly reports to REAS on their direct report compliance with appraisals. Inspectors saw that all the staff had received a current appraisal.

The service had identified that training in low intensity psychological interventions was a priority for staff in the Mental Health Team as discussed in QI 9.5. Inspectors were told by healthcare staff that training and staff development was generally encouraged and supported.

Whilst supervision compliance records were not available to view during the inspection, most staff told inspectors they had access to supervision in the last month. Reflective practice was also available, facilitated by the psychologist to each healthcare team.

Inspectors observed good communication systems between healthcare teams in the format of a morning safety brief and afternoon handover. Patients causing concern or with complex needs were shared on a night report with healthcare and SPS staff.

> **Recommendation 112**: REAS/NHS Lothian must develop an out-of-hours on-call escalation process so that staff feel supported and have an identified contact they can speak with to raise any clinical or staffing issues.
>
> **Good Practice 25**: New staff were given four weeks of being supernumerary to allow them to complete their induction and familiarise themselves with healthcare delivery and the prison environment, this could be extended based on individual's confidence, training, and learning gaps.

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

Healthcare in HMP Edinburgh was managed by REAS which is part of NHS Lothian and reported through its governance structure. The Healthcare Team at HMP Edinburgh had a clear vision for prison healthcare which supported person-centred and compassionate care.

The Leadership Team comprised of a Healthcare Manager, Lead Nurse and Lead Pharmacist, who report to directly to a clinical service manager and general manager. Inspectors received consistent positive feedback from a range of professionals during the inspection about the visibility and support from the Leadership Team.

The Healthcare Manager, lead pharmacist and lead nurse also had operational responsibility for the Health Centre in HMP Addiewell and were trying to align systems and processes. A number of SOPs had been developed and some were in draft stage to ensure there was a consistent approach to delivery of care across all teams. For example, a SOP for the management of patients of concern, cared for under the Mental Health Team was being developed outlining the pathway and provision available from the Mental Health Team.

Incidents and adverse events were reported through an electronic incident report system, Datix. There was evidence of processes in place to report and learn from incidents and adverse events. The Healthcare Manager had oversight of adverse events and reported these monthly to REAS. Learning or feedback was shared with staff involved, individually or as a group. Debriefs take place as and when required following clinical incidents to support staff wellbeing and promote learning from incidents. There was evidence of identifying trends such as a high number of medication errors that had triggered the Lead Pharmacist at HMP Edinburgh to recently introduce a medicines electronic incident report system, Datix review meeting, this is good practice.

Minutes from team meetings showed a structured agenda with multidisciplinary attendance from the Healthcare Team. It was encouraging to see that this provided the opportunity to share updates and discuss any current issues faced by the Healthcare Team.

Feedback from patients was gathered using complaint or feedback forms, as described in QI 9.13. There was evidence of responding to learning and changing practice to improve services, for example the introduction of displaying up-to-date waiting times to keep patients informed.

Regular meetings take place between healthcare staff and SPS staff as discussed in QI 9.16. As referenced in QI 9.12, the person of concern meeting also provided a multidisciplinary forum for patients to be discussed across all teams involved, including SPS colleagues and evidenced good collaborative team working.

Feedback from staff indicated a good relationship between the two staff groups with evidence of joint working. Inspectors were told that the Healthcare Manager held regular meetings with the Governor to discuss healthcare delivery and to look at how this could be improved. The service had also developed connections with secondary care clinicians such as opticians, podiatrists, and nurse specialists.

Good Practice 26: Lead Pharmacist has introduced a monthly Datix review meeting to address incidents related to medicines management.

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