HMIPS
HM INSPECTORATE OF
PRISONS FOR SCOTLAND

INSPECTING AND MONITORING

FULL INSPECTION REPORT ON HMP YOI GLENOCHIL

FULL INSPECTION – 29 APRIL-10 MAY 2019

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EVIDENCE REPORT

INTRODUCTION AND BACKGROUND

HM Chief Inspector of Prisons for Scotland (HMCIPS) assesses the treatment and care of prisoners across the Scottish Prison Service 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 March 2015 that can be found at **https://www.prisonsinspectoratescotland.gov.uk**.

The Standards reflect the independence of the inspection of prisons in Scotland and are designed to provide information to prisoners, prison staff and the wider community on the main areas that are examined during the course of an inspection.

The Standards 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 Her Majesty's Inspectorate of Prisons for Scotland (HMIPS).

This report is set out to reflect the performance against these standards and has 10 main sections:

Standard 1 Lawful and transparent custody

Standard 2 Decency

Standard 3 Personal safety

Standard 4 Effective, courteous and humane exercise of authority

Standard 5 Respect, autonomy and protection against mistreatment

Standard 6 Purposeful activity

Standard 7 Transitions from custody to life in the community

Standard 8 Organisational effectiveness

Standard 9 Health and wellbeing

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

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

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

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 to each individual standard. This consists of a statement against each of the indicators contained within the standard inspected. It is important to recognise that although standards are assigned to Inspectors within the team, all Inspectors have the opportunity to comment on joint findings at a deliberation session prior to final assessments being reached. This emphasises the fairness and impartial aspect of the process ensuring an unbiased decision is reached prior to completion of the final report.

KEY FACTS

Location
Her Majesty's Prison Glenochil is located near Tullibody in Clackmannanshire, Central Scotland.

Role
HMP Glenochil manages a range of short-term, long-term, life sentence, extended sentence and Order for Lifelong Restriction (OLR) adult male prisoners.

The prison was completely rebuilt in recent years and is a large community facing prison, giving priority to Forth Valley and Fife ("FK" and "KY" postcodes). It is one of the major sites in Scotland for managing sex offenders and those prisoners with an Order for Lifelong Restriction sentence imposed. Prisoners are not admitted to Glenochil direct from the courts. They are transferred in from across the prison estate, either because of their conviction or as part of a wider management plan.

Brief history
The prison was initially built in 1966 as a Detention Centre. Following an extension to the building, it became a Young Offenders Institution and Detention Centre in 1975. It began holding long-term prisoners in the 1980s with short-term prisoners introduced in 2007. The prison was then rebuilt on the same site with two new accommodation blocks in 2010.

Accommodation
The accommodation consists of two main residential blocks; Abercrombie which houses Offence Protection Prisoners and Harviestoun Hall which houses mainstream prisoners. The Separation and Reintegration Unit (SRU); Devon Hall provides smaller accommodation.

Design capacity
The current design capacity is 668. However, with the increase in population across the Scottish Prison Service, Glenochil were in Phase 2 of a Population Contingency Plan to bring the capacity to a safe operating level of 750.

Date of previous full inspection:
16-24 March 2015

Healthcare provider:
NHS Forth Valley

Learning provider:
Fife College

OVERVIEW BY HM CHIEF INSPECTOR OF PRISONS FOR SCOTLAND

Scotland's National Performance Framework (2018) anticipates that all public bodies will contribute to the National Outcomes, including 'We live in communities that are inclusive, empowered, resilient and safe', and 'We respect, protect and fulfil human rights and live free from discrimination'.

This ambitious outcome is echoed in the previous vision and priorities for Justice in Scotland (2017), which also envisaged a proportionate and person-centred approach to justice. Flowing down from these overarching principles, the Scottish Prison Service (SPS) Corporate Plan 'Unlocking Potential Transforming Lives,' clearly recognised the need for prisons to address offending behaviour, protect public safety and drive recovery and reintegration.

The SPS corporate plan also highlights the challenges they currently face, with a rapidly changing prison population, both in terms of numbers and complexity. Despite these significant challenges, the SPS is committed to service improvement and development.

We found this strategic but pragmatic approach to be replicated in HMP Glenochil, where there was an expectation of continuous improvement and development. The Governor-in-Charge (GIC) was clear in seeing the scrutiny provided by the inspection team as a valuable and contributory element to future progress. The Inspectorate were encouraged by his understanding of the issues and his prompt responses to emerging findings during the inspection.

HMP Glenochil's inspection began on the same day the new GIC took up post and a serious incident took place. Despite these significant challenges, the inspection team were made to feel welcome across the establishment and all the formal and informal preparations were in place. The presentation to the inspection team by the Senior Management Team (SMT) was comprehensive and informative, detailing areas of strength or innovation, the outstanding challenges facing the establishment, and those areas where progress had not been achieved or was still in development following the last HMIPS inspection.

HMP Glenochil had relatively modern accommodation facilities consisting of two main residential blocks; Abercrombie Hall, which housed offence-protection prisoners and Harviestoun Hall, which housed mainstream prisoners, and a SRU; Devon Hall. Areas had been refurbished to accommodate the rising trend of older prisoners requiring additional health, mobility support and social care.

All prisoners were received from other prisons, rather than directly from court, and with the current overcrowding pressures experienced across Scotland, the prison had been forced to expand the bed capacity from 668 to 750. Despite the concomitant reduction in single cell places, HMP Glenochil still holds a significant number of Scotland's sex offenders, older prisoners and those with an Order for Lifelong Restriction imposed.

A human rights-based overview of the inspection is included in this report, which follows the PANEL (Participation, Accountability, Non-discrimination, Empowerment and Legality) headings; illustrating how human rights applied to the inspection as a whole. This is not exhaustive of all human rights engaged, but is intended as a brief synopsis to confirm

that the human dignity of the prisoner is upheld, and that prisons are productive, positive and useful places; leading to better outcomes in reducing recidivism and keeping our communities safe.

Progress from previous inspection

HMP Glenochil was last inspected in 2015. Following a revision of the Quality Indicators that support the HMIPS Standards for Inspecting and Monitoring Prisons in Scotland in May 2018, the then Governor of HMP Glenochil approached HMIPS to ask if it would be possible for us to undertake a short review against some of the new Quality Indicators in preparation for the next inspection.

A number of areas of good practice as well as recommendations for improvement were reported following the 2015 inspection. Two recommendation areas remain an area of concern. Firstly, equality and diversity frameworks[1] are still not fully embedded, and secondly the staff knowledge and application of the cell sharing risk assessment[2] process remains incomplete; a risk assessment that is increasingly important with the expanded cell-sharing requirement.

Against that, inspectors found a number of areas of good practice had been developed since the last inspection including the welcoming Family Centre and the management of older prisoners and prisoners with disabilities. Inspectors found impressive mobility and social care facilities within Abercrombie Hall, which included adapted showers, physiotherapy opportunities, admirable social care and an innovative peer carer process. The caring and compassionate approach taken by staff when dealing with older and disabled prisoners in Abercrombie Hall was particularly apparent.

Safety

Survey results indicated that prisoners and staff largely felt safe. There was some disconnect, however, between the survey results and the verbally perceived feelings of safety. All prisoner[3] groups had evidently been influenced and affected to varying extents by the increase in serious and violent incidents during 2017-2018. HMIPS welcomed the recent decrease in this area, which had been significant. Staff mentioned continued concerns around the prevalence of weapons and psychoactive substances, leading to feelings that they, at times, felt unsafe.

Inspectors also noted the environmental differences between Harviestoun and Abercrombie Halls, with the latter accorded a better safety perception by both staff and prisoners and inspectors noted it was visibly more settled.

Nonetheless, it was clear that determined efforts to reduce violence and bullying within HMP Glenochil had been made, and were continuing to be made. Recent reductions in the seriousness and frequency of violent incidents provided the evidence of successful implementation of the adopted strategies. These were noted and welcomed.

Regime

The prison offered a broad range of employment and training activities in good quality, purpose-built workshops and establishment facilities. However, the employment and training opportunities were not sufficient for all prisoners who wanted to work, and not all prison populations received equitable access to match their age, ability and preference. Opportunities for the mainstream and non-offence protection prisoners to access employment and training opportunities were severely restricted.

1 See Scottish Human Rights Commission synopsis and evidence throughout the standards.
2 Standard 1 QI 1.6
3 Staff and Prisoner focus groups

Predictable regime delivery, activity access, Personal Officer support for progression and time out of cell are critical components to good order and discipline. Inspectors were concerned with the extent of social isolation faced by non-offence protection prisoners in Harviestoun Hall, who were locked in their cell for long periods each day with very little access to any regime.

Rule 23 of the United Nations Standard Rules for the Treatment of Prisoners (**the Mandela Rules**) states that every prisoner who is not employed in outdoor work shall have at least one hour of suitable exercise in the open air daily, if the weather permits. The **CPT** provided a similar recommendation during their recent visits to the UK "steps should be taken to ensure that prisoners are guaranteed the basic requirement of at least one hour of outdoor exercise per day."

Non-offence protection prisoners were not routinely afforded or supported this basic right. This was raised with the Governor at the time of the inspection, and a subsequent visit by the inspectorate confirmed that the Governor had immediately responded and changes had been implemented to ensure compliance and provide time out of cell in a conducive atmosphere.

Relationships

The prison engaged positively with other parts of the prison service, social services and justice system, and was proactive in seeking to work with their local community, leading to an award winning white goods repair project.

Staff employed appropriate professional boundaries throughout the establishment. We commend the quality of positive informal interactions in Abercrombie Hall and in the activity areas, where prisoners were treated with evident respect and valued in the contribution they made within their work area.

Strong relationships between the SPS and partnership organisations working in the prison, in particular Health and Social Work evidenced an understanding and respect of each other's position working towards a common goal. As an example, HMP Glenochil operated a robust case management process for their enhanced Integrated Case Management (ICM) prisoners[4], which demonstrated good practice in relational management.

Leadership

Overall, the prison was competently led and run. There was evidence of action being prioritised effectively by the SMT, and issues being worked on until performance improved, e.g. reducing the number of serious incidents of violence and reducing levels of staff absence. These initiatives had been successful in reducing absence levels by 14% over the last year. HMP Glenochil had one of the best absence records of any establishment inspected in Scotland.

The SMT promoted positive partnership working between the prison and key providers in healthcare, social work and education, as well as the other partners supporting the regime delivery.

Equality and Diversity

The establishment recognised that there were still shortfalls in the Equality and Diversity framework. Information was not provided by the establishment to demonstrate equity of access to development opportunities for inclusivity, and no proportionate balance of activities across populations was evident. An Equality and Diversity Action Plan had not been finalised or implemented at the time of the inspection. However, the SMT and the Scottish Prison Service Headquarters recognised that this needed to be an area of focus, to embed a culture of support for the human rights of all prisoners, including those with protected characteristics.

4 Standard 6

Healthcare

The healthcare team at HMP Glenochil was a well-motivated and caring workforce, committed to providing a high quality of care to their patients. Positive partnership working was evident between the healthcare and SPS staff, based on an understanding and respect of each other's roles and responsibilities towards the wellbeing of prisoners. Inspectors saw many examples of the positive impact this relationship had on the prison environment, and this was reflected in conversations with patients who told inspectors that they were encouraged and supported to be directly involved in their own healthcare. Inspectors were pleased to see that the issue of rooms used for dispensing medicines being used for other purposes and inhibiting infection control and safe prescribing, was being addressed with a refurbishment programme.

Next Steps

I am pleased to see the positive developments and initiatives that have already been taken forward; they are a good platform to build on for the future. I welcome the new Governor's determination to continue the downward trend in incidents and staff absence, as well as ensuring equity of access. I look forward to seeing these improvements progressed.

HMIPS will continue to monitor, at a national and local level, the strategies to manage the population pressures and complex mix of cohorts, as well as the reduction of social isolation to comply with the United Nations Standard Rules for the Treatment of Prisoners.

HMIPS will continue to monitor the progress in HMP Glenochil through the Independent Prison Monitors (IPMs).

Wendy Sinclair-Gieben
HM Chief Inspector of Prisons for Scotland

A HUMAN RIGHTS-BASED OVERVIEW OF HMP GLENOCHIL

The human rights-based overview of the inspection of HMP Glenochil follows the PANEL[5] headings, illustrating how human rights are applied to the inspection as a whole. This overview is not exhaustive of all human rights observed and engaged, but is intended as a brief synopsis of the implementation of a human rights-based approach in HMP Glenochil.

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

PANEL:
Participation

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

Inspectors found minimal evidence of systematic prisoner participation within the prison. However, inspectors found a generally respectful and helpful staff/prisoner relationship and examples of good practice, which are highlighted below. The two halls, Abercrombie and Harviestoun served distinct populations with markedly different characteristics. These two populations shared staff and resources, while Policy and Treatment within them were found to frequently diverge.

There were higher levels of participation within Abercrombie than Harviestoun however, these were marginal. This was evident in the lack of awareness among prisoners of available processes where they could influence decision-making. A number of prisoners with protected characteristics cited a lack of engagement from their personal officers. Some prisoners did not know the identity of their personal officers and had never been introduced to them, particularly in Harviestoun. There was a sense that Harviestoun prisoners were uninterested in participation, yet when particular efforts were made to engage with them, they participated at similar levels to the Abercrombie population.

Recommendation 1: HMP Glenochil should ensure that Prisoner Information Action Committees (PIACs) are held on a regular systematic basis, and that an exchange of information is built in, feeding information from the PIACs into decision-making processes within the prison, and feeding back to prisoners on the outcome of those processes. The process in Abercrombie Hall should be replicated in Harviestoun Hall.

Recommendation 2: HMP Glenochil should establish an Equality and Diversity (E&D) forum and there should be prisoner representation in E&D meetings.

Staff felt that they had raised the issue of overcrowding but received a poor response from prison management. Many of those interviewed expressed a view that they were under-resourced and felt bound to accept the status quo. Some staff expressed frustration at the lack of response to the issues they had raised with regard to provision of services for prisoners who spoke English as a second language (ESL). It is important that prison staff receive equality and diversity training on how to respect the rights and meet the specific needs of detainees in situations of vulnerability, and the skills necessary for working with them. Rule 75 of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) is clear that the prison administration has to ensure the continuous provision of in-service training courses with a view to maintaining and improving the knowledge and professional capacity of its personnel, after entering on duty and during their career.

5 See p.5 of the Standards

There were some examples of good practice in this area, particularly in relation to the care of prisoners in Abercrombie; the work of the chaplaincy and the content of educational programmes where standards, procedures and staff practices allowed prisoners to be meaningfully involved. There was also a generally respectful and helpful staff/prisoner relationship. The family visits, and the visiting centre programme that runs alongside it, were a positive development in relation to participation and human rights. It is also important that foreign nationals equally enjoy this right. Special measures should be taken to encourage and enable foreign prisoners to maintain regular and meaningful contact with their families as is provided in the prison rules and the SPS policy. Family visits are a right and not a privilege, and upholding the right to family life is more than just about allowing the act of visits to occur.

Recommendation 3: HMP Glenochil should take a greater active role to facilitate communication of foreign nationals with their families abroad, for example via video conference.

A wide range of practical information was provided in the induction booklet, which was also supposed to be explained to prisoners on arrival at reception. This contributed strongly to the effective participation of prisoners in prison life. It could be improved by considering the volume of information provided in one sitting and, in the case of education, providing more detailed and accessible information. In particular, information about education opportunities should take account of those with limited literacy or without fluent English, for whom education may be most useful.

Induction of prisoners was, however, inconsistent in practice, with some prisoners receiving no information or receiving it too late after a few weeks in the prison. Prisoners commonly reported inductions of a few minutes to one hour and had, in practice, learned information from other prisoners, where they were able to do so. General Comment No. 2 (2008) of the Convention Against Torture on the implementation of Article 2 by States Parties makes clear that the right of detainees to be informed of their rights is a basic guarantee for all persons deprived of their liberty. This is particularly important for those prisoners who have learning difficulties or do not speak English as a first language such as foreign nationals, who had fewer connections and were therefore more isolated. The induction leaflet was not routinely given to prisoners. It was not visible to prisoners except on request and was only available in English. It is possible that, as HMP Glenochil is not a local prison, staff had the impression that prisoners were familiar with prison life from their previous incarceration. This is inadequate, particularly in this case as the prison has some unique functions.

Translation services were available for use when needed. However, a focus group with foreign nationals demonstrated that some had not in fact received such information, nor the possibility of contacting their embassies. Therefore they felt isolated. The right to information must be especially guaranteed for certain categories of detainees who, for reasons of language, age, illness or intellectual disabilities do not have equal access to information. Rule 37.1 of the European Prison rules states that 'prisoners who are foreign nationals shall be informed, without delay, of their right to request contact and be allowed reasonable facilities to communicate with the diplomatic or consular representative of their state'. It is possible that, as HMP Glenochil is not a local prison, staff had assumed that this was dealt with during the initial admission to the prison system in Scotland.

Recommendation 4: HMP Glenochil should ensure that induction information is communicated to prisoners, in all cases, in a manner that they understand. This will require proactive identification of prisoners' needs for alternative formats for communication.

Independent Advocacy is an important communication tool used to overcome incapacity and to aid useful communication. Forth Valley Advocacy Services was available to prisoners

by referral where there was a diagnosis of learning disability or Mental Health condition. There was no advocacy services identifiable. This is concerning as advocacy enables not only greater participation but also a safeguard of prisoners' rights. There are a number of forums such as Internal Complaints Committee hearings (ICC), parole board hearings and disciplinary hearings, where prisoners could be aided by having an advocate to assist them to clearly express their views and wishes when decisions are being made about their lives. The prison could introduce a number of mechanisms to enable participation and information to prisoners, including easy read leaflets and information in common foreign languages.

Recommendation 5: HMP Glenochil should make further efforts to ensure advocacy is arranged at induction for prisoners who may benefit, recognising that a prisoner who requires support may be less able to pursue this for themselves.

Components to the principle of participation include that it must be active, free and meaningful and give attention to issues of accessibility, including access to information in a form and a language that can be understood. HMIPS would expect that any barriers to participation would be identified and those prisoners would be assisted to overcome them in order to meaningfully participate.

Accountability

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

There was a framework of administrative accountability in HMP Glenochil. However, effective accountability based on human rights standards was not consistent at the time of the inspection. The provision consisted of a single E&D Manager implementing the 2019/2020 Action Plan that had very recently been conceived. The Action Plan was yet to be allocated with appropriate resources and did not include any distinct milestones and measurability criteria. At the time of the inspection there appeared to be no monitoring mechanism to record systematic or significant events and no Key Performance Indicators. Inspectors were informed that no auditing or reporting was being carried out.

While there was a general awareness of complaints mechanisms, inspectors found a low level of confidence in utilising them. Prisoners who had used the procedure reported a lack of response or a perfunctory response. Inspectors reviewed a cross section of randomly selected complaints and found this to be the case. Prisoner complaint forms were not always available in their designated place within the halls even though it was repeatedly found that other forms were available in the adjacent drawers. Prisoners were rarely aware of the ICC.

No additional resource was in place to ensure that ESL prisoners had access to the complaints system. No additional support was given to ESL prisoners and they had to rely on other prisoners in order to overcome literacy issues, in turn divulging personal details to other prisoners in order to access the accountability mechanism. ESL prisoners reported feeling isolated from other prisoners and staff.

HMP Glenochil should employ a more systematic approach to all complaints regardless of the outcome. For example, complaints could be monitored by E&D staff and reported on in a manner that takes into consideration themes and commonalities, including monitoring and evaluation of the manner in which those with additional needs and protected characteristics are provided for. Documenting of any investigation into complaints should be mandatory. Any disparity in accounts on the evidence available should be treated inquisitorially, erring on the side of caution where possible.

Recommendation 6: HMP Glenochil should employ a more systematic approach to all complaints including developing an assurance process.

Inspectors were seriously concerned about the number of hours that non-offence protection prisoners were locked in their cells (approximately 21 to 22 hours). This is particularly concerning as Article 44 of the Mandela Rules defines solitary confinement as:

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

Recommendation 7: HMP Glenochil should review the regime for non-offence protection prisoners to ensure that it does not mimic conditions for the separation and integration unit and is not a de facto punishment to incentivise the prisoner to return to a situation of potential risk.

Non-discrimination

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

The environment of the prison appeared to work well for the majority of prisoners, who reported positive relationships and a feeling of safety. However, inspectors were concerned that prisoners with needs outwith the majority were being missed. In particular, inspectors found a lack of support being provided to foreign national prisoners who were not fluent in English and disabled prisoners in Harviestoun. Robust systems are required, to identify the needs of such prisoners and to check that those needs are then provided for.

The prison must ensure that reasonable adjustments are promptly provided for all prisoners with disabilities. HMIPS understand that complications may arise where responsibility falls between the SPS and NHS or the local authority and SPS. However, the prison must ensure that matters are resolved as quickly as possible and that prisoners are not left in a vulnerable position in the interim. Inspectors noted that the treatment of prisoners with particularly high needs in Abercrombie appeared to be person-centred and sensitive. However, within Harviestoun, inspectors were concerned that the lack of engagement by staff could lead to prisoners needs not being recognised and attended to. This includes prisoners with mental health conditions that have a substantial impact on their ability to function.

HMP Glenochil need to take a more proactive approach to E&D matters. Staff should receive training to update their skills in dealing with E&D matters, which staff indicated would be welcomed. While there were commendable activities apparent within the prison in relation to reducing discrimination and advancing equality, the lack of strategic, monitoring and auditing processes meant that the required safeguards to prisoners' rights were absent and no systematic delivery could be verified. For example, the SPS had in place a Personal Care Peer Support Policy. Inspectors were concerned about a lack of awareness amongst staff of the scheme and its framework. Article 8 ECHR, requires procedural safeguards to be in place to protect the private lives of individuals. There was no evidence of consideration of this, either within the policy or amongst staff and prisoners. Inspectors inquired if equality and human rights impact assessments were undertaken before this decision, but the response was negative.

Recommendation 8: HMP Glenochil need to take a more proactive approach to equality and diversity matters, and staff should receive regular refresher training to update their skills in dealing with E&D matters.

Empowerment

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

We would expect prisoners to understand these processes and their entitlements, and that the information is in a variety of formats to cater for those with different needs. Awareness should be raised among staff of the mechanisms that are available to assist prisoners and the role they play in facilitating these, such as interpretation and funds for phone calls outside the UK, so that they feel able to have ready access to them. Inspectors noted instances of staff going above and beyond to facilitate matters for prisoners. However, sometimes this was due to a gap in the system that should have addressed the matter.

Recommendation 9: HMP Glenochil should raise awareness amongst staff of the mechanisms available to assist prisoners and the role they play in facilitating these, such as interpretation and funds for telephone calls outside the UK, so that they feel able to have ready access to them.

Legality

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

A human rights-based approach requires the recognition of rights as legally enforceable entitlements and is linked to national and international human rights law. It is important that all categories of prisoners enjoy the full range of human rights and that staff are adequately supported. While the large majority of prisoners do so, this was not the case for a minority of prisoners as described in this report. HMIPS have identified areas where we believe further action is required, in particular to ensure that more marginalised prisoners do not fall through the gap.

HMIPS were informed that the prison has instituted a protocol to expand the prison population by introducing additional beds into prisoner cells. The prison population has already expanded from its designed level of 668 to 750. This had the effect of reducing the individual living space available for prisoners. The European Committee for the Prevention of Torture (ECPT) prescribes a minimum cell size of 6m² of personal space in a single occupancy cell and a minimum cell size of 8m² for multiple occupancy between two people. It would seem that the current cell sizes should be within this range. However, the ECPT has, in a number of cases found that cells of 8m² should not accommodate more than one prisoner except in cases where absolutely necessary and where a prisoner should not be left alone. They gave a desirable reference of 10m² where two prisoners are sharing. It is to be borne in mind that these cell sizes exclude sanitary areas that must be provided in addition to the required space. It is not clear whether the figures that HMIPS were given for reference included sanitary areas or not. Where additional prisoners are being placed in single cells it is wholly unacceptable.

The manner in which cell populations are being automatically increased is a cause for concern. Cells have been observed to contain a single chair and a single safe despite having two occupants. The cells cannot accommodate a second chair. Storage space is not increased and the lack of a second safe prevents prisoners from keeping any matters confidential, including privileged legal documents and medication. This may have an impact on the prisoners' right to privacy and to private communications.

The establishment should consider the provision of additional staff to deliver rehabilitative training to prisoners prior to the end of their punishment date. A 'Moving on' taskforce should be established to determine what the barriers are to prisoners moving on. Complaints regarding Parole and movement from prison should be sifted out and dealt with directly by the governor's office.

Recommendation 10: HMP Glenochil should consider the provision of additional staff to deliver rehabilitative training to prisoners prior to the end of their punishment date.

HMP Glenochil should reconsider the criteria for providing healthier food options in order to provide further appropriate options for obese prisoners who are trying to manage their weight, rather than operating on the basis of a particular diagnosis. A combination of factors such as heart disease and obesity may have the same debilitating effect to which the prison should be attentive.

Recommendation 11: HMP Glenochil should reconsider the criteria for providing healthier options in order to provide further appropriate options for obese prisoners trying to manage their weight.

Prisoner's rights are facilitated in practice by both the provision of information and the need for proactive action to be taken to ensure prisoners are accessing their rights meaningfully. Inspectors identified areas where they believe a more proactive action is required, in particular to ensure that more marginalised and vulnerable prisoners do not fall through the gap. Along with E&D, staff could be assisted by training to understand their duties according to human rights standards.

SUMMARY OF INSPECTION FINDINGS

Standard 1 Lawful and transparent custody
Generally Acceptable Performance

Standard 2 Decency
Satisfactory Performance

Standard 3 Personal safety
Generally Acceptable Performance

Standard 4 Effective, courteous and humane exercise of authority
Satisfactory Performance

Standard 5 Respect, autonomy and protection against mistreatment
Generally Acceptable Performance

Standard 6 Purposeful activity
Generally Acceptable Performance

Standard 7 Transitions from custody to life in the community
Generally Acceptable Performance

Standard 8 Organisational effectiveness
Generally Acceptable Performance

Standard 9 Health and wellbeing
Satisfactory Performance

SUMMARY OF INSPECTION FINDINGS

HMIPS Standard 1
Lawful and Transparent Custody

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

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

Inspection Findings
Overall Rating: Generally Acceptable Performance

In respect of the PANEL principles underpinning this inspection standard, HMP Glenochil performed reasonably well on participation, empowerment and non-discrimination. Equality however was undermined by the inconsistent use of material and language line capability for prisoners who do not have a good grasp of English.

The prison's performance against the majority of the quality indicators in this Standard were found to be generally acceptable or satisfactory.

HMP Glenochil does not receive admissions directly from court. All admissions were convicted prisoners who had transferred from other prisons. During the inspection, all prisoners arrived with the requisite documents, and the information received was checked against the SPS electronic prisoner record system, PR2.

There were two separate residential blocks housing adult male convicted prisoners. Harviestoun housed mainstream prisoners and Abercrombie housed those convicted of sexual offences.

Emerging concerns

- The lack of information in other languages available in the reception and First Night in Custody (FNIC) areas, compounded by minimal use of the available translation service.
- When examining the Cell Sharing Risk Assessments (CSRA) process, not all staff were adhering to the guidelines. Some staff were unsure of the process and were reliant on their colleagues to carry out the assessment; some prisoners were located before the CSRA was complete.
- Induction for new admissions was inconsistent, either delayed or lacking altogether. While work was being undertaken to review this, it was clear that at the time of inspection, new admissions either did not receive induction or it was provided too late to be of any real benefit.

Encouraging observations

- All prisoners being liberated were offered an opaque green kit bag to carry their belongings, which provided privacy and reduced any potential stigma. They were also driven to a local train station by a member of staff.
- Care was taken to allocate admissions appropriately according to their offence, and the regime had been designed to ensure the two populations were kept separate.

HMIPS Standard 2
Decency

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

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

Inspection Findings
Overall Rating: Satisfactory Performance

In respect of the PANEL principles underpinning this inspection standard, HMP Glenochil performed reasonably well on participation, empowerment, non-discrimination and equality, with good practice observed for those prisoners requiring additional support.

In general, HMP Glenochil was found to be clean and tidy and the buildings and accommodation were generally fit for purpose. Prisoners were provided with the basic physical requirements for a decent life.

The prison buildings, accommodation and facilities were largely fit for purpose.

All areas visited were of a good standard of cleanliness with clear procedures and protocols for the prevention and control of infection. Prisoners were appropriately trained to carry out their job role and were provided with appropriate Personal Protective Equipment (PPE). Staff were well aware of how to effectively and efficiently deal with a biohazard clean.

All prisoners had access to a bed, mattress and pillow that were in good condition, and there was a good process in place for replacing items if required. The laundry process was robust and worked well.

Prisoners were able to access suitable toiletries, to assist them in maintaining levels of hygiene, either provided by the prison or purchased through the canteen. Prisoners had the opportunity to voice their opinion on the variety of toiletries offered.

The clothing provided to all prisoners was of a good standard and appropriate procedures were in place to ensure it was clean and available to all.

Staff were proactive in ensuring that those who faced barriers were provided with support and knowledge on their entitlements. This was evidenced through the catering department and their provision of meals for dietary and religious requirements.

Emerging concerns

- Cells designed for single occupancy that housed two prisoners had demonstrable issues that contravened safety and decency.
- There were issues with the cleaning materials provided, and staff were either not well enough informed of the colour coding to prevent cross contamination or insufficiently pro-active in addressing.
- There were issues around the non-offence protection prisoners regime and the impact this may have on their ability to maintain levels of personal cleanliness.
- There were issues with effective lines of communication through the intercom system in one wing. However, staff were pro-active in dealing with this and worked well to maintain appropriate communication when required.

HMIPS Standard 2
Decency - Continued

Encouraging observations

- The accessible cells and the additional facilities allowed those with additional needs to maintain a level of dignity.
- Abercrombie 3 had additional equipment to allow prisoners with mobility issues the chance to practice a physiotherapy regime with a mock staircase and rails (see photo below).
- The Peer Carer process to assist the high number of prisoners who required additional support to carry out daily tasks.
- The relationship between the prison and Nurseplus.
- The use of a lost property area in the Laundry.

HMIPS Standard 3
Personal Safety

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

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

Inspection Findings
Overall Rating: Generally Acceptable Performance

In respect of the PANEL principles underpinning this inspection standard, HMP Glenochil performed reasonably well on participation, empowerment, and non-discrimination. However, non-offence protection prisoners did not receive equitable access to regime opportunities.

Throughout the inspection, staff and prisoners provided a negative response when discussing feelings of safety within the establishment. All prisoner groups had evidently been influenced and affected to varying extents by the increase in serious and violent incidents during 2017-2018. HMIPS welcomed the recent decrease in this area, which had been significant. Several initiatives had been undertaken to continue to improve all aspects of personal safety within the prison, particularly the formation of an Intelligence and Security Group and the installation of six walk through metal detectors in the residential areas. It was clear that the SMT were aware of the challenges to personal safety across the establishment, and had devised and implemented a local violence reduction strategy.

There was very good information flow between the Intelligence Management Unit (IMU), senior management and security, which produced tactical tasking registers to inform practice in this area. There had been an associated increase in finds of weapons and drugs utilising this approach. Despite the evidence of reducing violence, the perception remained that HMP Glenochil could be an unpredictable environment for staff and prisoners; with both groups reporting concerns about safety. The increase in prisoner population, prevalence of weapons and drugs, and the mixing of long-term and short-term prisoners was causing frustration and anxiety. Staff and prisoners reported that a lack of consistency in staffing was impacting on the regime, and that the prison often felt chaotic.

Emerging Concerns

- Inspectors were particularly concerned with the difficulties faced by non-offence protection prisoners in Harviestoun Hall, who were locked in their cell for long periods each day with very little access to any regime. The conditions of this group of prisoners was not in any way conducive to good physical or mental health. While the overarching strategies to address issues of violence, bullying and harassment were in place, there was some way to go in embedding a culture of mutual respect and safety across many areas of the prison.
- Inspectors observed minimal effective staff/prisoner interactions in Harvieston Hall, where the practice of closing grill gates had created a barrier to effective staff/prisoner communication. HMIPS is pleased to hear that since the inspection, the grille gates in Harvieston level 4 are now open. IPMs will continue to monitor this element.

HMIPS Standard 3
Personal Safety - Continued

- Non-offence protection prisoners consistently stated that they felt punished and victimised in their current conditions. Prisoners regularly noted that there was a reluctance to raise issues of safety with staff due to a perception that they would be moved. The communication issues, noted above, in Harvieston Hall had contributed to a culture where proactive conflict resolution was rarely practiced and issues could go unresolved for long periods. Inspectors felt strongly that efforts to improve staff/prisoner relationships and communication in Harvieston Hall would enhance feelings of personal safety for both groups.
- There was no evidence of HMP Glenochil using the SPS strategy on Anti Bullying, Think Twice, and staff training records confirmed this. There were clear procedures in place for dealing with bullying behaviour. However, there was a lack of reporting in this area.
- The continuing prevalence and use of psychoactive substances was resulting in unpredictable and unreliable behaviour and disrupting the safety of the environment, making many prisoners feel concerned. This was also reported by staff, who cited concerns over the unknown long-term effects of being exposed to these substances.

Encouraging observations

- Across the establishment, there were pockets of good practice, where collaborative working with vulnerable prisoners was utilised to negotiate the most appropriate way to meet their personal safety needs. This was clear in the collaborative approach of SPS and NHS staff in supporting prisoners at risk of self-harm or suicide. The support and assistance on offer to three prisoners on the The SPS Suicide Strategy - Talk to Me (TTM), at the time of the inspection, evidenced a compassionate and psychological approach to care that included the individual at all stages.
- Prisoners in Abercrombie Hall also felt assisted by the personal officer system. One individual explained how prison staff had gone to great lengths to ensure he received appropriate support following an upsetting bereavement.
- The physical layout and practical arrangements in Abercrombie level 3 for elderly prisoners with additional requirements was commendable.
- Emergency response and Health and Safety (H&S) protocols were embedded within the establishment and fulfilled the legislative obligations. Areas of good practice included First Line Managers (FLMs) being provided with handbooks outlining their responsibilities in these areas.

Overall, it was clear efforts were being made to improve personal safety within HMP Glenochil, and recent reductions in the seriousness and frequency of violent incidents was noted and welcomed. There was still some disconnect between strategies to reduce violence and bullying and their practical implementation in the day-to-day running of the prison. HMIPS were of the clear view that improving staff/prisoner relationships, striving to increase mutual trust, and adopting a more pre-emptive and victim-centred approach to conflict would contribute in this respect.

HMIPS Standard 4
Effective, Courteous and Humane Exercise of Authority

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

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

Inspection Findings
Overall Rating: Satisfactory Performance

In respect of the PANEL principles underpinning this inspection standard, HMP Glenochil performed well on participation, empowerment, and non-discrimination.

In this Standard, three quality indicators were rated as good, two were rated as satisfactory and five were rated as generally acceptable, giving an overall rating of satisfactory performance.

HMP Glenochil had a number of sound practices with regards to security and safety, supported by a multitude of Standard Operating Procedures (SOPs) available to staff. The electronic control room (ECR) was busy but well run. The officers dealing with security were professional and respectful, communicating with the rest of the establishment in a clear and controlled manner. Inspectors observed very good interpersonal skills when staff were dealing with delivery drivers.

Use of force (UOF) appeared to be well managed, including sound auditing process, recognised by the SPS audit team as good practice. This audit process highlight hotspots for violence, allowing strategies to be put in place to minimise disruption.

Prisoners who were removed from circulation were generally held in Devon Hall, the SRU. All prisoners were held there lawfully, within the SPS guidelines and Devon appeared to have a good regime. Relationships between staff and prisoners appeared to be positive.

Emerging concerns

- During the inspection, staff in Devon were dealing with a prisoner who had undertaken a dirty campaign over a long period of time. Despite appropriate Safe Systems of Work (SSOW), inspectors were of the opinion that the length of time staff had been exposed to this behaviour was not appropriate.
- Quarterly searches of all cells were not always completed.
- Although the reception had robust systems for managing prisoner's property, it was concerning that not all prisoners had a set of suitable clothes available to attend external appointments or on liberation.
- There appeared to be an inconsistent approach to the searching of prisoner's belongings that had gone through the Archway metal detector (AMD) leading to the regimes area.
- The non-recording of planned removals.

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

Encouraging observations

- Inspectors observed good examples of care-based discipline hearings that were consistent and fair in their approach, allowing understanding of the process and good participation by the prisoner.
- Special Security Measures (SSMs) were found to be within the SPS guidelines, with clear instructions and rationale annotated, although at times prisoners were unable to articulate their understanding of why they were under these measures. SSOW were examined and found to be similar to that of SSMs and therefore could be translated to SSM. There was good evidence that staff adhered to these plans to ensure that safety was the first priority, regardless of the circumstances.
- Inspectors observed good quality searching from the security team carried out with dignity and respect, which looked to build a rapport with the person.
- There was a good process for managing items removed from searches (productions), but occasionally staff required guidance on dealing with property being returned where the package were suspected of having suspicious articles.
- HMP Glenochil had a knowledgeable and busy Mandatory Drug Testing team, carrying out testing including suspicion and progression testing. Although there was a slight dip on testing in 2018 due to redeployment to cover escorts and staff shortages, testing levels were back on track for the coming year.
- Good examples of process were found with internal and external security. An increase in AMDs at the doors to residential areas had improved inner security, which appeared to have reduced the movement of unauthorised articles.

HMIPS Standard 5
Respect, Autonomy and Protection Against Mistreatment

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

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

Inspection Findings
Overall Rating: Generally Acceptable Performance

In respect of the PANEL principles underpinning this inspection standard, HMP Glenochil performed less well on participation, empowerment, non-discrimination and equality.

In general, prisoner survey data (from those who completed it) showed that 90% of prisoners felt they got on well with staff, and 85% felt that staff treated them with respect. Staff showed commitment to meeting prisoners needs and were well supported by experienced and consistent FLMs.

Whilst traditional processes were generally in place to meet legal requirements, the application of these was often reported by prisoners to be more task focused than individualised, and accessibility diminished because of poor communication with the prisoner group, particularly during the admission and pre-release phases. Some processes were under significant pressure because of regime timetabling, staff shortages or inconsistency, the increase in population or the specific needs of specialist populations.

Emerging concerns

- The impact of these pressures was most noticeable in Harviestoun Hall, where there was an absence of targeted support and tracking for those prisoners who were most socially isolated. The contrast with Abercrombie Hall was visible where staff and prisoners reported mutual respect and relationships were conducted positively and constructively.
- There were also some identified shortfalls against the SPS corporate priority of engagement. In some areas, such as those tasks supporting business improvement, there were examples of accountabilities located across diverse functions rather than being collected together to maximise impact.
- Particular tensions included the population mixing of long-term and short-term prisoners, and long-term prisoners in Harviestoun Hall felt particularly disadvantaged with inconsistent personal officer relationships and case management.
- Operational practice requires review with respect to the grille gate closures to maximise the staff and prisoner relationship opportunities.
- Equality and Diversity recommendations from previous inspection reports, in respect of ensuring language line availability, were not implemented and are repeated here.

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

Encouraging observations

- Some excellent examples of extended sensitive contacts made between prisoners and families in difficult circumstances.
- Privileged mail systems were robust and well tested by the population.
- PIACs in Abercrombie operated well, with records demonstrating five years of regular well-organised meetings, including thematic subject areas on issues likely to be prioritised by the prisoner population.

HMIPS Standard 6
Purposeful Activity

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

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

Inspection Findings
Overall Rating: Generally Acceptable Performance

In respect of the PANEL principles underpinning this inspection standard, HMP Glenochil performed less well on participation, empowerment, non-discrimination and equality.

The prison offered a broad range of employment and training activities in good quality, purpose-built workshops and establishment facilities.

The Learning Centre provided a welcoming, bright and comfortable space, which was fit for purpose and well equipped. Relationships between education staff and prisoners were positive and supportive.

Most prisoners had good access to sporting and fitness activities, including evenings and weekends. The prison had recently expanded the gym facility into part of the sports hall to accommodate an increase in prisoner numbers. There was a good range of physical events and initiatives available to prisoners and staff consulted prisoners on the choice of physical and health opportunities on offer.

The purpose-built library provided a pleasant and welcoming environment for prisoners and the majority of prisoners had access.

The opportunities for all prisoners to engage in cultural and recreational events and activities were however very limited.

Most prisoners were routinely offered access to fresh air on a daily basis, in conditions that were appropriate but uninspiring.

The prison chaplaincy team had appropriate multi-faith representation. Church services and prayer meetings were provided for both populations throughout the week. However, there were no church services or pastoral care available at the weekend. In addition to the church services, the chaplaincy team provided group and discursive activities for both populations, although the majority were for prisoners in Abercrombie. The chaplaincy team had provided support for both staff and prisoners around palliative care. The team also created opportunities to break down barriers providing topical discussion groups co-facilitated by chaplains of different faiths ("Faith to Faith").

HMIPS Standard 6
Purposeful Activity - Continued

Efforts had been made to recognise and address issues of social isolation with a well-used and established email a prisoner scheme, and the introduction of a Volunteer Visitor scheme. Virtual visits were being piloted.

HMP Glenochil provided a range of nationally recognised offending behaviour courses appropriate to the needs of the population however there was a considerable waiting list for Generic Programme Assessments (GPAs). Due to the nature of the population in HMP Glenochil, a significant amount of prisoners had an outstanding need for a number of programmes delivered elsewhere.

HMP Glenochil operated a robust case management process for their enhanced ICM prisoners who had developed excellent relationships with prison-based social work and psychology.

Emerging concerns

- The employment and training opportunities were not sufficient for all prisoners who wanted to work, and not all prison populations received equitable access to match their age, ability and preference. Opportunities for the mainstream and non-offence protection prisoners to access employment and training opportunities were severely restricted.
- The vocational training opportunities available to prisoners were limited and there were no progression opportunities on to more advanced qualifications.
- Learning Centre plans were developed with no routine discussion with other partners within the prison, such as the Link Centre, the library, vocational tutors or managers of the work parties. This resulted in missed opportunities and some duplication of education provision, significantly diminishing prisoners' learning experiences and opportunities. Learning Centre staff did not consult with prisoners or routinely seek their opinions about the quality and range of education provision available to them.
- Non-offence protection prisoners had no access at all to the gym or fitness activities.
- No prisoners had gained certifications or awards for health and fitness activities in the past year.
- Apart from the reference material, the services and resources provided by the library were inadequate. Prisoners did not have access to library services and resources to support them during their education, training and preparation for their release.
- The non-offence protection population were offered exercise very early in the morning, and if they accepted, it took place in isolation in the exercise areas in Devon. It was universally accepted that if all of the non-offence protection population requested exercise, their needs could not be accommodated within the existing regime.
- Abercrombie Halls exercise area was accessed via a lengthy route, down a slope of considerable gradient. This effectively meant that people with restricted mobility could not access exercise without peer support.

HMIPS Standard 6
Purposeful Activity - Continued

- There was an insufficient amount of appropriate outdoor wear for inclement weather and what was available was of poor quality.
- Although all interactions in the visits areas were observed as child friendly, the lack of designated children's visits was concerning.
- Throughcare support take up for short-term prisoners was minimal, with only six people being supported post release at the time of the inspection.

Encouraging observations

- Peer tutors and peer carers were in place and could gain an associated qualification.
- The visits area and waiting room were of a high standard, and staff working in the visit room and vestibule were polite and helpful, with unobtrusive security procedures.
- The Visitor Centre (see photo) provided a warm and welcoming atmosphere with free beverages, soup and snacks to all visitors prior to the search process. The Visitor Centre also provided free soup packs (vegetables), toothbrushes, toothpaste, and fresh fruit for visitors to take away after the visit.
- The volunteer visitor scheme and email a visitor scheme was welcomed by HMIPS.

Inspectors from Education Scotland inspected quality indicators 6.1 to 6.6.

HMIPS Standard 7
Transitions from custody to life in the community

Prisoners are prepared for their successful return to the community.

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

Inspection Findings
Overall Rating: Generally Acceptable Performance

In respect of the PANEL principles underpinning this inspection standard, HMP Glenochil performed reasonably well on participation, empowerment and non-discrimination.

The prison had responsibility for managing men on long-term sentences as well as those serving life and extended sentences. It also had a considerable number of men subject to an Order for Lifelong Restriction (OLR). A high proportion of these individuals were convicted of serious violent and sexual offences. In order to manage this population, the prison had ensured that well-trained and suitably qualified staff and appropriate agencies were based within the prison in order to work together to manage issues of risk, progression and pre-release planning.

In addition, the prison had established effective working arrangements with relevant statutory community-based agencies with responsibility for offender supervision and risk management. The prison also accommodated short-term sentenced men, the majority of whom were not subject to release on statutory supervision and were not convicted of sex offences. Senior managers understood the complexity of managing such a diverse prison population and demonstrated a sound understanding of their role and responsibilities as well as those of partner agencies with responsibility for supporting and delivering transition arrangements from custody to life in the community.

The quality of transition planning varied dependent on the duration and type of sentence that an individual was subject to. Transition planning, and the processes that supported it, were robust and well-coordinated in respect of men sentenced to long-term, life and extended sentences, and who were subject to release on a statutory licence. In respect of this group, the prison had worked collaboratively with internal agencies including prison-based social work, psychology services and the ICM team, as well as a range of community agencies, to put comprehensive resettlement plans in place. Where necessary, these plans appropriately took account of issues relating to the management of risk and included detailed information on how individuals should be supervised following release.

It was clear that robust working relationships had been established between the prison and the appropriate community agencies in order to assess risk and needs; to monitor progress through the ICM process and where required, through Multi-agency Public Protection Arrangements (MAPPA) in order to plan for sentence progression and release. In respect of men subject to an order for lifelong restriction, the prison liaised appropriately with relevant agencies both within the prison and in the community in order to meet their statutory responsibilities in respect of this group.

HMIPS Standard 7
Transitions from custody to life in the community - Continued

Transition planning for men sentenced to a short-term sentence was more variable. While a case management system had been introduced for short-term sentence management there had been a gap in the application of this. This was attributed to the resultant pressure of an increase in the prison population and staffing issues.

The ICM system in the prison operated as an enhanced process for men subject to statutory release, however there was no standard ICM process in place for the short-term population. As a result, many of these individuals did not have a community integration plan in place for their release.

The prison had established a Throughcare Support Officer (TSO) service in order to assist men on short sentences to engage with community support services to prepare for release. The TSO service utilised support from the third sector through New Routes who provided targeted support for men aged between 21 and 26 years of age. Throughcare support staff focussed on men over 26 years of age. The TSO service was highly valued by men who had access to it, but as it was a relatively small team, they were limited in the number of men they could offer a service to. While TSO and New Routes staff were knowledgeable, experienced and committed to the task, it was evident that they were unable to provide a service to all individuals who may have accepted and benefitted from it.

Emerging concerns

- The prison did not have a fully functioning system in place to plan for the resettlement of those who were sentenced to less than four years and not subject to statutory licence conditions following release.
- The backlog of GPA's and the rate of completion of post-programme reports was of concern.
- The lack of a well-established induction meant that prisoners may have missed opportunities to get information on the TSO service and other support services in the community that could assist them with community reintegration on release.

Encouraging observations

- Well-coordinated and planned enhanced ICM process for prisoners subject to statutory release and reflected high standards of professional practice.
- A throughcare service was provided to men under 26 years of age by New Routes, a third sector mentoring and support service for young men involved in offending.

Inspectors from the Care Inspectorate inspected this Standard.

HMIPS Standard 8
Organisational Effectiveness

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

In respect of the PANEL principles underpinning this inspection standard, HMP Glenochil performed reasonably well on participation, empowerment and non-discrimination. Equality however was an underperforming area of concern throughout the inspection.

Overall, the prison was competently led and run. There was evidence of action being prioritised effectively by senior management and issues being worked on until performance improved, e.g. reducing the number of serious incidents of violence and reducing levels of staff absence. Action in response to recommendations by scrutiny bodies was also satisfactory, and the management team had a good grip on training.

SPS and the Scottish Prison Service College (SPSC) should consider options for enhanced professional development for staff dealing with sex offenders and other categories of prisoners. There was a pleasing respect and understanding among staff for the roles carried out by other functional groups. The SMT worked hard to value the contribution made by staff. The health and wellbeing events and the promotion of healthier lifestyles contributed to this and were an example of good practice.

The prison engaged positively with other parts of the prison service and justice system, and was proactive in seeking to work with their local community.

However, while an Equality and Diversity Action Plan was under development at the time of the inspection, the SMT need to focus on implementing that successfully, and more effectively embedding a culture of support for the human rights of all prisoners.

Strong leadership is required to ensure equality of access to services, recreation and purposeful activity for all prisoners, irrespective of residential setting, and the development of related operational and strategic initiatives.

Improved dialogue and communication with staff would be helpful to ensure unity of purpose, with SMT setting out clearly the action they intend taking to address the population challenges, and encouraging constructive two way communication at all levels of the organisation.

HMIPS Standard 8
Organisational Effectiveness - Continued

Emerging concerns

- The need to embed a culture of support for the human rights of all prisoners, with implementation of an agreed Equality and Diversity Action Plan and systematic roll out of Equality and Diversity Impact Assessments
- The need for improved training for those dealing with sex offenders and other specific categories of prisoners.
- The need to improve dialogue with staff and encourage further constructive two-way communication on the population challenges and other issues facing the prison.

Encouraging observations

- Efforts to value the contribution made by staff and promote health and wellbeing.

HMIPS Standard 9
Health and Wellbeing

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

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

Inspection Findings
Overall Rating: Satisfactory Performance

The healthcare team at HMP Glenochil was a well-motivated and caring workforce committed to providing a high quality care to their patients. Positive partnership working was evident between the healthcare staff and SPS staff within the health centre, based on an understanding and respect of each other's roles and responsibilities towards the wellbeing of prisoners. Inspectors saw many examples of the positive impact this relationship had on the prison environment, and this was reflected in conversations with patients who told inspectors that they were encouraged and supported to be directly involved in their own healthcare.

As in many other prison estates in Scotland the population in HMP Glenochil had risen over the previous 12 months; in HMP Glenochil the numbers had increased by approximately 100 prisoners. Although this had resulted in an increase in demand for healthcare within the establishment. Inspectors were informed that no additional funding for healthcare staff had been identified to meet the increase. In addition, several nursing posts were sitting vacant and recruiting to them was proving challenging. This reflects the national picture, with many prisons having difficulties recruiting to key clinical posts. As a result, the demand on existing staff to deliver a comprehensive range of services was almost at its ceiling. Agency nursing were being utilised to meet the shortfall but some interventions had been suspended in the interim. However, overall, inspectors observed that due to positive team dynamics and working relationships between NHS and SPS staff, and clear leadership and two-way communications with stakeholders and patients, the situation was being managed and core healthcare services were being delivered.

The healthcare needs of all prisoners were assessed on admission to HMP Glenochil using a validated standard tool, and then managed and reviewed in line with national and local policy and guidelines throughout their stay in prison. Individuals with pre-existing long-term conditions, considered to be at risk of self-harm or suicide were asked to consent to information about their health being shared with relevant others, and the latter were placed onto TTM.

Although there was no formal induction process for newly admitted prisoners, NHS Forth Valley staff stated they were keen for this to be re-introduced by SPS and for NHS Forth Valley staff to be included: all prisoners were given information explaining what health services were available and how they could be accessed.

The social care needs, including social prescribing, of prisoners were assessed by the Rehabilitation Support Worker (RSW) and links had been established with a wide range of external agencies to which prisoners were referred.

HMIPS Standard 9
Health and Wellbeing - Continued

Both NHS and SPS staff were seen to proactively explain the benefits of, and encourage and support prisoners take up, the range of health promotion and prevention opportunities available to them. It was clear that there was a good understanding of the role of health promotion and prevention had towards improving the health outcomes of prisoners, both while in prison and in the community. This was further demonstrated by the prisons health promotion strategy. This had been developed by the health promotion strategic lead and focused on the specific needs of staff and prisoners in HMP Glenochil. Prisoners had access to national screening and immunisations programmes; an opt-out sexual health screening and smoking cessation programme and specialists in sexual health, Hepatitis C and HIV visited the prison.

All healthcare staff demonstrated an understanding of the health inequalities and barriers experienced by many prisoners in HMP Glenochil when accessing healthcare services. During all observed staff and patient healthcare interactions, prisoners were treated with dignity and respect by staff. This was supported by prisoners, the majority of whom described having a positive relationship with healthcare staff.

With the exception of the rooms where medications were given to prisoners, medical and clinical treatment rooms were fit for purpose, and were compliant with all aspects of infection prevention and control. Staff were able to demonstrate that they understood the principles of infection prevention, had easy access to relevant manuals, and were observed to implement the precautionary measures appropriately.

Primary care
A comprehensive dental service, including an emergency treatment and out of hours service, was delivered by a dedicated team led by the NHS Forth Valley public dental services director, who was responsible for oral health provision across the three prisons in NHS Forth Valley. Inspectors saw many examples of how prisoners and their families were supported with their oral health. They included two national health promotion initiatives; Mouth Matters which is aimed at enabling prisoners to actively care for their own oral health, both inside and outside prisons; and Childsmile aimed at improving the oral health of children by reducing inequalities and ensuring they have access to dental services.

There was no dedicated pharmacy team to deliver a comprehensive clinical pharmacy service. The Lloyd's pharmacist visited once a fortnight and adhoc support was available from an NHS Forth Valley pharmacist. Services were supported on a daily basis by two healthcare support workers and pharmacy assistant posts were out for advert. A number of security concerns around service delivery and patient safety were identified; medicine wastage was not accurately monitored or recorded, kardexes were subjected to limited checking, and because the rooms used for dispensing medicines were used for other purposes they were not physically laid out in a way that supported safe dispensing, lastly a Home Office Controlled Drug license was not in place. The last two issues were escalated as significant concerns and assurance was given that they would be prioritised for action.

HMIPS Standard 9
Health and Wellbeing - Continued

Long-term conditions, Palliative and end of life care
Prisoners with an existing long-term condition were identified on admission to HMP Glenochil. Their condition was subsequently managed and reviewed following relevant pathways of care, and in line with recognised best practice and clinical guidelines throughout their stay in prison. As the team had established close links with a range of specialist services within NHS Forth Valley, patients were referred promptly. Outreach and in-reach support was available to patients by the Rehabilitation and Assessment in the Community and Home team who assessed individuals' needs and arranged referrals to community and voluntary support services. All staff had undergone anticipatory care planning (ACP) and every patient with a long-term condition was offered the opportunity to complete their own ACP. In addition, patients were also asked if they wished to develop a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) plan.

An integrated palliative care service had been established by the national palliative care lead between the prison, wider NHS Forth Valley services, hospices and voluntary agencies. Both healthcare and SPS staff demonstrated a good understanding of the principles of palliative and end of life care, and an extensive palliative and end of life training programme was available to staff. Standardised mechanisms to identify patients with palliative care or end of life care were in place as well as for those requiring high support needs. A palliative care register was maintained and updated on a regular basis to reflect the changing needs of patients.

Mental Health and substance misuse
The integrated mental health and substance misuse team worked collaboratively and in partnership to ensure that patients received support from the most appropriate service. As staffing levels were below the agreed level for both mental health and substance misuse staff, some treatment interventions had been suspended such as the self-management and recovery training recovery programmes. That said, it is important to note that the waiting times for a substance misuse assessment met the national guidelines at the time of inspection.

In addition, existing patients and those receiving or requiring treatment, interventions or support were not followed up by staff as regularly as clinically indicated. The risk to patient safety and pressure on existing staff was acknowledged by the leadership team, and mental health nurses had been recruited from an agency as a temporary measure. Recruiting substance misuse caseworkers was done by a third sector agency.

Pre-liberations groups were open to all prisoners who had two to three weeks left on their sentence. The focus of these groups was harm reduction and Naloxone training.

Although clear processes for assessing and triaging mental health referrals had been established based on clinical need and risk, at the time of the inspection this was assessed by using a Situation, Background, Assessment and Recommendation (SBAR) approach and not a standardised mental health assessment or clinical risk assessment tool. Inspectors were assured by the leadership team that the introduction of these had been given priority, and that work was underway to review the tools currently used across the three prisons in NHS Forth Valley.

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Anyone identified as requiring assessment or support from the mental health team were seen within two weeks. Those who required to be seen by the psychiatrist or clinical psychologist were referred immediately and anyone identified as being at risk of self-harm or suicide was immediately placed onto TTM.

All patients were seen to be fully involved in their assessments and able to discuss the outcome of these and any proposed treatment at one-to-one meetings with staff. This included case conferences for those at risk of self-harm or suicide. This practice was reflected in the clinical notes and care plans reviewed by inspectors.

The recent appointment of a learning disability nurse allowed those with intellectual disabilities or cognitive impairment to be assessed, receive the appropriate support or be referred to specialist services.

Culture
The patient relations team, based in HMP Glenochil, had overall responsibility for managing and responding to all feedback and complaints across the three prisons in NHS Forth Valley. The team had undergone specific training in the complaints process and could seek advice about complex cases from the patient relations manager based in the Forth Valley Royal Hospital. All complaints were managed according to NHS Forth Valley procedures and logged onto the Safeguard incident reporting system. Patient forums were held every second month in Abercrombie, where forum members could discuss issues relating to healthcare. A patient representative had been identified for each level in Abercrombie. Despite efforts, prisoners in Harviestoun Hall refused to engage in the patient forums.

Some prisoners reported that because complaints and feedback forms were not always freely available in the halls they had to ask officers for forms. Prisoners should be able to freely access complaints and feedback forms. The inspection team were assured that this would be immediately addressed.

Staff were able to explain and understood the boundaries between professional and ethical issues, and demands of healthcare delivery in prison setting. Basic life support training had not been offered to staff for over a year, but assurance that this would be addressed as a matter of importance was given by the senior manager.

All staff had their Turas appraisals carried out, had completed their mandatory training and had their clinical competencies assessed. Both management and clinical supervision was available to all staff, and although a range of training and professional development opportunities were available to staff, inspectors were told that staff were not always able to benefit from these due to the current challenges around staffing. The leadership team were awaiting the outcome of an assessment of workforce and workload needs using a professional judgement tool in order to draw up plans to ensure future service delivery needs are met.

Inspectors from Healthcare Improvement Scotland inspected this Standard.

ANNEX A

SUMMARY OF RECOMMENDATIONS

For the Governor

In summary, of the recommendations listed below, there are five key recommendation areas that the Inspectorate consider important for the Governor to focus on:

1. The active development and support of a robust Equality and Diversity framework in line with the SPS Policy and Human Rights agenda.

(Recommendations: 2, 3, 5, 8, 9, 13, 68, 69, 73, 79, 93 and 96 refer)

2. The review and development of the regime including, induction, exercise, employment, education, training, fitness, and pre-release provisions, to ensure equity of access for all the prisoner cohorts.

(Recommendations: 7, 2, 10, 18, 24, 31, 50, 55, 56, 58, 59, 60, 61, 62, 63, 67, 78, 83, 87, 90, 91 and 92 refer)

3. Development of robust and consistent prisoner engagement and communication activities to ensure prisoners are informed and their views are taken into account.

(Recommendations: 4, 6, 12, 15, 20, 30, 44, 48, 49, 51, 52, 54, 57, 66 and 86 refer)

4. The establishment should continuously review their cell allocation and staffing protocols policies to continue the downward trend in incidents, particularly given the population challenges.

(Recommendations: 24, 46, 47 and 94 refer)

5. The prison should review and monitor strict adherence to SPS Policy, partnership agreements and Standard Operating Procedures.

(Recommendations: 11, 14, 17, 19, 21, 22, 23, 25, 26, 27, 28, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 43, 64, 65 and 88 refer)

The following recommendations do not fall within the five categories above and should be looked at separately by the Governor.

(Recommendations: 11, 70, 71, 72, 74, 75, 77, 80 and 84)

Recommendation 1: HMP Glenochil should ensure that PIACs are held on a regular systematic basis, and that an exchange of information is built in, feeding information from the PIACs into decision-making processes within the prison, and feeding back to prisoners on the outcome of those processes. The process in Abercrombie Hall should be replicated in Harviestoun Hall.

Recommendation 2: HMP Glenochil should establish an E&D forum and there should be prisoner representation in E&D meetings.

Recommendation 3: HMP Glenochil should take a greater active role to facilitate communication of foreign nationals with their families abroad, for example via video conference.

Recommendation 4: HMP Glenochil should ensure that induction information is communicated to prisoners, in all cases, in a manner that they understand. This will require proactive identification of prisoners' needs for alternative formats for communication.

Recommendation 5: HMP Glenochil should make further efforts to ensure advocacy is arranged at induction for prisoners who may benefit, recognising that a prisoner who requires support may be less able to pursue this for themselves.

Recommendation 6: HMP Glenochil should employ a more systematic approach to all complaints including developing an assurance process.

Recommendation 7: HMP Glenochil should review the regime for non-offence protection prisoners to ensure that it does not mimic conditions for the separation and integration unit and is not a de-facto punishment to incentivise the prisoner to return to a situation of potential risk.

Recommendation 8: HMP Glenochil need to take a more proactive approach to equality and diversity matters, and staff should receive regular refresher training to update their skills in dealing with E&D matters.

Recommendation 9: HMP Glenochil should raise awareness amongst staff of the mechanisms available to assist prisoners and the role they play in facilitating these, such as interpretation and funds for phone calls outside the UK, so that they feel able to have ready access to them.

Recommendation 10: HMP Glenochil should consider the provision of additional staff to deliver rehabilitative training to prisoners prior to the end of their punishment date.

Recommendation 11: HMP Glenochil should reconsider the criteria for providing healthier options in order to provide further appropriate options for obese prisoners trying to manage their weight.

Recommendation 12: HMP Glenochil should ensure that information is available in alternative formats and languages to allow all new admissions to fully engage with and understand the admissions process.

Recommendation 13: HMP Glenochil should ensure that FNIC information is available in the most common languages admitted to the prison, and utilise the interpretation service when required.

Recommendation 14: HMP Glenochil should ensure that FLMs are using the up to date documentation, all staff are fully aware of the processes of completing CSRAs in line with the policy, and the importance of completing these fully before allocating prisoners to a shared cell.

Recommendation 15: HMP Glenochil should review their approach to induction and ensure that all admissions are provided with the appropriate information within one week of admission.

Recommendation 16: SPS Headquarters and the Scottish Government should consider what can be done to prevent prisoners sharing in sufficient single cell accommodation as it is encroaching on their human rights

Recommendation 17: HMP Glenochil should ensure that there is sufficient colour coded equipment and cleaning materials provided throughout the prison to prevent and control infection.

Escalated Recommendation 18: HMP Glenochil should review the regime offered to non-offence protection prisoners to ensure they receive sufficient time to shower and clean their cell on a daily basis.

Recommendations 19: HMP Glenochil should ensure that there is an adequate supply of waterproof jackets and/or fleeces for those wishing to partake in fresh air in inclement weather.

Recommendations 20: HMP Glenochil should ensure that there are regular changes to the menu taking into account the views of the food forum.

Recommendations 21: HMP Glenochil should ensure that staff have the required equipment to ensure food is served at the recommended temperature.

Recommendation 22: HMP Glenochil and NHS Forth Valley must work together to ensure that any dietary requirements because of medical conditions should be dealt with quickly and efficiently to allow prisoners to receive appropriate meals.

Recommendation 23: HMP Glenochil, in line with other establishments, should provide a food parcel for all prisoners at the weekend separate from the evening meal.

Recommendation 24: HMP Glenochil were actively monitoring the number of non-offence protection prisoners in Harviestoun. However, they should look to allocate a suitable area for non-offence protection prisoners to ensure an appropriate regime is in place.

Recommendation 25: HMP Glenochil should review its practice in respect of grill gate closures in the hall sections. It is recommended that a clear operating protocol is developed and enforced to ensure both that periods when grill gates are opened and staff are in direct contact with prisoners in the sections are maximised.

Recommendations 26: Existing strategies, policies and procedures relating to bullying and harassment should be reissued and reinforced to ensure consistent implementation.

Recommendation 27: Prison staff should update and fully document assessment processes for all non-offence protection prisoners in order to identify needs.

Recommendation 28: All planned removals should be video recorded in line with SPS and local policy.

Recommendation 29: The SPS should consider a change in establishment for prisoners who engage in a prolonged dirty campaign.

Recommendation 30: HMP Glenochil should engage with those who are non-protection to support and encourage them to return to mainstream and record this engagement.

Recommendation 31: HMP Glenochil should ensure that all prisoners regardless of their situation have a regime that meets their needs. In particular, that allows access to fresh air, showers, telephone at various times to contact family and friends, and recreation to encourage socialisation.

Recommendation 32: HMP Glenochil should ensure staff are informed of the correct processes for dealing with prisoner property that has been taken as a production.

Recommendation 33: HMP Glenochil should ensure that quarterly searches in all areas are completed.

Recommendation 34: HMP Glenochil should make all efforts to minimise a prisoner's risk of identification when attending external appointments, by having a full set of clothes available for every prisoner in reception.

Recommendation 35: HMP Glenochil should ensure that any items belonging to transferred prisoners, not associated with a security issue, are allocated on leaving reception.

Recommendation 36: HMP Glenochil should ensure that all books and folders carried by prisoners are searched, regardless of whether the AMD is activated.

Recommendation 37: HMP Glenochil should ensure that all doors are locked or on a lock back where required, as per security guidelines.

Recommendation 38: All water containers should be emptied prior to leaving any area.

Recommendations 39: HMP Glenochil should ensure that all staff wear name badges at all times.

Recommendation 40: HMP Glenochil should embed a sustainable Personal Officer system.

Recommendation 41: HMP Glenochil should ensure staff are adequately trained in the principles and application of the SPS 'Think Twice' anti-bullying strategy.

Recommendation 43: HMP Glenochil should remove the small hall boards with prisoner allocations were on display behind staff desks to protect prisoner confidentiality.

Recommendation 44: HMP Glenochil should identify alternative venues where more sensitive lengthy case management discussions can routinely be undertaken.

Recommendation 46: The SPS and HMP Glenochil should work together to relocate populations locally as far as is possible to allow for a more stable regime and in particular limit the mixing of short and long-term populations.

Recommendation 47: HMP Glenochil should monitor the impact of the staff shortage protocol.

Recommendation 48: HMP Glenochil should consider either linking the in cell TV information system to induction or develop the music and media centre to support prisoner co-production.

Recommendation 49: HMP Glenochil should ensure that peer support services and prisoner engagement is extended.

Recommendation 50: HMP Glenochil should provide information to offer equity of access to development opportunities for inclusivity, and ensure proportionate balance of activities across populations.

Recommendation 51: HMP Glenochil should adopt a system where prisoners are notified as soon as an agent's visit is booked.

Recommendation 52: HMP Glenochil should do more to publicise the availability of the NHS Forth Valley advocacy service, and other services, to staff and prisoners.

Recommendation 54: HMP Glenochil should ensure that all prisoner forms are available to prisoners at all times.

Recommendation 55: HMP Glenochil should ensure there is an appropriate and sufficient range of employment and training opportunities available to all prisoners and population groups.

Recommendation 56: Fife College should consult with HMP Glenochil management team and prisoners in the planning of activities and qualifications that suit a range of interests and abilities, and that are relevant to the community on release.

Recommendation 57: HMP Glenochil should ensure that the paid work policy is understood by staff and prisoners and any changes to this policy should be clearly communicated.

Recommendation 58: HMP Glenochil should ensure that there is equality between prisoner groups when it comes to allocating work and training opportunities.

Recommendation 59: HMP Glenochil should ensure that the needs of the prisoner groups with regards to work placements should outweigh the needs of the prison.

Recommendation 60: HMP Glenochil should encourage the link between the learning centre Annual Activity Plan and other partners within the prison to maximise opportunities and minimise duplication of education.

Recommendation 61: HMP Glenochil and Fife College should ensure that the Learning Centre staff consult with prisoners on the quality and range of education provision available to them so that the planning of provision or evaluation of services meets the needs of the prison population.

Recommendation 62: HMP Glenochil should encourage a greater participation from mainstream prisoners in the education opportunities on offer.

Recommendation 63: HMP Glenochil should ensure that all prisoner groups are given an opportunity to participate in sporting and fitness activities.

Recommendation 64: HMP Glenochil should re-introduce health and fitness certificates or similar awards.

Recommendation 65: HMP Glenochil should secure a partnership with the local authority library service, or other service, to ensure that there is an adequate stock of books and other resources to meet the educational, training and personal interests of all prisoners.

Recommendation 66: HMP Glenochil should ensure that prisoner's views are taken into account by library staff regarding services and resources and encourage prisoners to contribute their ideas.

Recommendation 67: HMP Glenochil should plan and actively promote cross-establishment cultural and recreational events and activities for prisoners that will contribute to their knowledge and wellbeing. All prisoners should have an opportunity to engage in the events and activities that are relevant to their interests and abilities.

Recommendation 68: HMP Glenochil should consider an alternative area or route to exercise for prisoners with mobility issues.

Recommendation 69: HMP Glenochil should provide appropriate opportunity for the non-offence protection prisoners to access fresh air.

Recommendation 70: HMP Glenochil should consider means to enhance the exercise area to encourage prisoners to actively participate in movement and exercise.

Recommendation 71: HMP Glenochil should consider means to access pastoral care at the weekends.

Recommendation 72: HMP Glenochil should create a process to ensure that chaplains are routinely informed in the event of a personal bereavement and are included in wider disciplinary forums.

Recommendation 73: HMP Glenochil should source appropriate training in Getting it Right for Every Child (GIRFEC) and Child Protection for all visits FLMs and FCDOs.

Recommendation 74: HMP Glenochil should increase their provisions of children's sessions during the week and include sessions available for older children.

Recommendation 75: HMP Glenochil should consider an alternate means to accommodate prisoners whose visitors have not arrived.

Recommendation 77: HMP Glenochil should develop the use of virtual visits and other technology to support prisoners who cannot access visits in the normal way.

Recommendation 78: HMP Glenochil should improve the regime available for non-offence protections to allow access to the phone in the evening.

Recommendation 79: Information about access to additional phone credit for persons whose families live abroad should be more widely publicised.

Recommendation 80: HMP Glenochil should take steps to address the considerable waiting list of Generic Programme Assessment.

Recommendation 83: HMP Glenochil should develop case management for short-term prisoners and establish effective routes to refer to the TSO team.

Recommendation 84: HMP Glenochil should provide specific training to personal officers responsible for OLRs.

Recommendation 86: HMP Glenochil should consider a more fail-safe means for prisoners to be able to present their case in person at Risk Management Teams (RMTs).

Recommendation 87: HMP Glenochil should take steps to establish a more fully functioning link centre, which has the involvement, and participation of relevant community-based agencies with a role in prisoner resettlement.

Recommendation 88: HMP Glenochil should take steps to reduce the backlog of GPA's (see recommendation in QI 6.13) and improve the rate of completion of post-programme reports.

Recommendation 90: HMP Glenochil should ensure that appropriate assessments are undertaken in respect of short-term sentenced prisoners and that community integration plans are in place to suitably support their preparation for release.

Recommendation 91: HMP Glenochil should progress the implementation of the Sustainable Housing on Release for Everyone (SHORE) standards in order to ensure that prisoners housing needs are identified at an early stage in their sentence, and that they have the opportunity to access suitable housing following release from prison.

Recommendation 92: HMP Glenochil should review the TSO service and staffing level in order to ensure that all eligible prisoners have the opportunity to access the service.

Recommendation 93: HMP Glenochil's SMT should ensure that an agreed action plan on E&D is implemented effectively, and a systematic series of Equality and Diversity Impact Assessments are carried out across the establishment. This links to the need for wider action to more deeply embed a culture of respect for human rights (as discussed elsewhere).

Recommendation 94: Senior management should set out clearly the action they are taking to address the population challenges, and the longer-term strategic direction of the prison, and encourage constructive two-way communication at all levels of the organisation to support clarity and unity of purpose.

Recommendation 96: HMP Glenochil should consider further training to embed a culture of respect for human rights.

For NHS Forth Valley

Recommendation 98: SPS and NHS Forth Valley should ensure that self-referral forms are freely available to prisoners in the halls.

Recommendation 99: NHS Forth Valley must ensure that patients identified as requiring intervention, treatment and support by the mental health nursing team receive the regular planned interventions described in their care plan.

Recommendation 100: NHS Forth Valley must ensure that standardised mental health and learning disability clinical assessment documentation and clinical risk tools are in place as a priority.

Recommendation 102: NHS Forth Valley must prioritise the recruitment of staff to ensure that staffing levels are returned to the agreed level. This will reduce the pressure on existing staff and ensure patient safety.

Recommendation 103: NHS Forth Valley must ensure that patients identified as requiring intervention, treatment and support by the substance Misuse team receive the regular planned interventions described in their care plan.

Recommendation 104: NHS Forth Valley should review how the Pharmacy service in HMP Glenochil is delivered to ensure that the service is managed and delivered safely and effectively.

Recommendation 105: The SPS and NHS Forth Valley must review the storage of in-possession medication in shared cells to ensure that these medications are appropriately and safely stored.

Escalated Recommendation 106: The HMP Glenochil healthcare team and lead pharmacist within NHS Forth Valley should immediately start the process to secure a Home Office Controlled Drugs License.

Escalated Recommendation 107: SPS and NHS Forth Valley must ensure that the room that medications are dispensed from are safe and fit for purpose.

Recommendation 108: The care partner assessment and risk assessment tool must be implemented. See recommendation in QI 9.5.

Recommendation 109: NHS Forth Valley and SPS must ensure that complaints forms are available in the halls and that they are available in different languages and formats.

Recommendation 110: NHS Forth Valley must ensure that staff undertake training in basic life support as a matter of urgency.

Recommendation 111: NHS Forth Valley must ensure that all patients' opinions on the healthcare services provided to them within the prison are actively sought to further develop and improve services. This will allow patients to feel that their voices are heard and that they have a role in shaping the healthcare services they receive.

For SPS HQ

Recommendation 16: The SPS and the Scottish Government should consider what can be done to prevent prisoners sharing in sufficient single cell accommodation as it is encroaching on their human rights.

Recommendation 29: The SPS should consider a change in establishment for prisoners who engage in a prolonged dirty campaign.

Recommendation 42: The SPS should consider procuring appropriate safes across the prison estate.

Recommendation 45: The SPS should ask the Law Society of Scotland to reinforce the arrangements for sending legal correspondence to prisons in Scotland, as set out in shared memoranda, with their membership.

Recommendation 46: The SPS and HMP Glenochil should work together to relocate populations locally as far as is possible to allow for a more stable regime and in particular limit the mixing of short and long-term populations.

Recommendation 53: The SPS should consider adopting the kiosk system within private sector establishments to reduce mundane transactions between staff and prisoners and free up time for case management.

Recommendation 81: The SPS should address the extensive National Waiting List for Moving Forward: Making Changes (MF: MC).

Recommendation 82: The SPS should consider the appropriateness of the National Waiting list model, giving consideration to the current operational challenges faced through high prisoner numbers and the personal impact on the individual having to make a choice to address their offending needs at the cost of social isolation.

Recommendation 85: The SPS should consider the overall management of OLRs, lack of progression within this prisoner group and increasing demands on resources that this population create, which is particularly impacting on HMP Glenochil's ability to effectively case manage this group.

Recommendation 89: The SPS should review the level of provision and availability of the MF: MC programme in order to improve timely access to this.

Recommendation 95: The SPSC should consider options for enhanced continuous professional development for staff dealing with sex offenders and other specific categories of prisoner.

Recommendation 97: The SPS should consider the scope to amend its financial rules to allow HMP Glenochil to support local worthy causes while providing purposeful activity for prisoners.

Recommendation 98: The SPS and NHS Forth Valley should ensure that self-referral forms are freely available to prisoners in the halls.

Escalated Recommendation 107: SPS and NHS Forth Valley must ensure that the room that medications are dispensed from are safe and fit for purpose.

Recommendation 109: NHS Forth Valley and the SPS must ensure that complaints forms are available in the halls and that they are available in different languages and formats.

For the Scottish Government

Recommendation 16: SPS HQ and the Scottish Government should consider what can be done to prevent prisoners sharing in sufficient single cell accommodation as it is encroaching on their human rights.

Recommendation 76: The Scottish Government should liaise with the appropriate organisations to consider placing a bus stop outside the establishment.

Recommendation 105: The SPS and NHS Forth Valley must review the storage of in-possession medication in shared cells to ensure that these medications are appropriately and safely stored.

ANNEX B

SUMMARY OF GOOD PRACTICE

Good practice 1: All prisoners being liberated were offered an opaque green kit bag to carry belongings, which provided privacy and reduced any potential stigma.

Good practice 2: All liberations were driven to a local train station by a member of staff.

Good practice 3: The facilities available within Abercrombie level three for prisoners with mobility issues; including specially adapted showers and physiotherapy opportunities.

Good practice 4: The Peer Carer process to assist the high number of prisoners who required additional support to carry out daily tasks, including cleaning cells and transferring to and from visits, activities and appointments.

Good Practice 5: Laundry that had been misplaced was kept in a 'lost property 'area until it was claimed.

Good practice 6: Prison listeners were invited into TTM case conferences where appropriate. Transitional care plans were developed by mental health nurses and implemented for individuals coming off TTM procedures to ensure there was appropriate support and monitoring.

Good practice 7: FLMs are issued with a H&S Guidance pack, most recently updated in November '18 to ensure all H&S principles are embedded in the day-to-day running of the prison.

Good Practice 8: The UOF and incident reports are linked on PR2 and stored together to allow a better understanding of the incident.

Good practice 9: As part of the management of an incident, a Violent Incident Review form is required to be completed within 72 hours of the incident and also prior to completion of the post incident report.

Good practice 10: The PIAC system that was operated in Abercrombie Hall.

Good practice 11: Efforts had been made to develop a comprehensive reference materials library resource on legal and policy issues from which items could be loaned on request or photocopied free of charge.

Good Practice 12: The Volunteer Visitor Scheme provided social contact to some of the most isolated prisoners and should be expanded upon.

Good Practice 13: Due to the scheduling cases of RMTs in advance, prisoners and personal officers were aware of when their case is due to be heard, and had adequate time to prepare.

Good Practice 14: The Health and Wellbeing events are to be commended and we would encourage other establishments to consider similar events.

Good practice 15: Any missed appointments or refusals, often because the prisoner was unaware of the appointment, or did not know what the appointment was for, were discussed directly with the prisoner.

Good practice 16: An easy read self-referral form had been developed by the speech and language therapist.

Good practice 17: A rehabilitation support worker was an integral part of the healthcare team, and was responsible for assessing prisoners requiring social care support, to ensure they received the right level of support.

Good practice 18: Care plans inspectors reviewed were risk-informed and outcome-focused.

Good practice 19: A learning disability nurse had just been appointed to the prison and plans were in place for them to carry out assessments, and provide intervention, treatment and support to prisoners with intellectual disabilities.

Good practice 20: Prior to being released, prisoners were offered an in-reach assessment to make sure that the appropriate community support was in place.

Good practice 21: Patients with a long-term condition were offered an anticipatory care plan and a ReSPECT to be put in place.

Good practice 22: Pre-liberation groups were open to all prisoners who had two to three weeks left on their sentence. The focus of these groups was harm reduction and Naloxone training.

Good practice 23: The dental action team promoted and raised awareness of the benefits of maintaining good oral health and supported both prisoners and their families, including children, with their oral healthcare.

Good practice 24: The national palliative care lead had been pivotal in enabling HMP Glenochil to develop an integrated palliative care service and form close links with the wider NHS Forth Valley, hospices and voluntary agencies.

Good practice 25: The monthly mental health multi-disciplinary team meeting, where members demonstrated good multi-agency collaborative and partnership working. The team consisted of clinical psychology, mental health nurses, social work, SPS, forensic and clinical psychology, offender outcomes, residential and adhoc specialist input, and they discuss prisoners with complex care needs.

ANNEX C

PRISON POPULATION PROFILE ON 11/04/2019

Status	Number of prisoners	%
Untried Male Adults	0	0
Untried Female Adults	0	0
Untried Male Young Offenders	0	0
Untried Female Young Offenders	0	0
Sentenced Male Adults	730	100%
Sentenced Female Adults	0	0
Sentenced Male Young Offenders	0	0
Sentenced Female Young Offenders	0	0
Recalled Life Prisoners	10	1.36%
Convicted Prisoners Awaiting Sentencing	0	0
Prisoners Awaiting Deportation	11	1.50%
Under 16s	0	0
Civil Prisoners	0	0
Home Detention Curfew (HDC)	4	0.54%

Sentence	**Number of prisoners**	**%**
Untried/Remand	0	0
0 – 1 month	0	0
1 – 2 months	0	0
2 – 3 months	5	0.68%
3 – 4 months	8	1.10%
4 – 5 months	2	0.27%
5 – 6 months	12	1.64%
6 months to less than 12 months	51	6.99%
12 months to less than 2 years	74	10.14%
2 years to less than 4 years	97	13.29%
4 years to less than 10 years	260	35.62%
10 years and over (not life)	81	11.09%
Life	65	8.90%
Order for Lifelong Restriction (OLR)	75	10.27%

Age	Number of prisoners	%
Minimum age:	21	
Under 21 years	0	0
21 years to 29 years	153	20.95%
30 years to 39 years	224	30.69%
40 years to 49 years	162	22.19%
50 years to 59 years	119	16.30%
60 years to 69 years	56	7.67%
70 years plus	16	2.19%
Total number of prisoners	**730**	

ANNEX D

INSPECTION TEAM

Wendy Sinclair-Gieben, HMIPS
Stephen Sandham, HMIPS
Calum McCarthy, HMIPS
Chris Collins, HMIPS
Kerry Love, HMIPS
Ian Beach, Education Scotland
Juliet McAlpine, Education Scotland
Adam Banner, Sodexo Justice Services
Siobhan Taylor, Scottish Prison Service
Rozanne McCurrach, Scottish Prison Service
Ray Jones, Care Inspectorate
Winnie Burke, Care Inspectorate
Catherine Haley, Healthcare Improvement Scotland
Kenneth Crosbie, Healthcare Improvement Scotland
Laura Wilson, Healthcare Improvement Scotland
Elaine Racionzer, Healthcare Improvement Scotland
Taffy Madiva, Healthcare Improvement Scotland
Irene Robertson, Healthcare Improvement Scotland
Diego Quiroz, Scottish Human Rights Commission
Tatora Mukushi, Scottish Human Rights Commission

ANNEX E

ACRONYMS

ACP	Anticipatory Care Planning
AMD	Archway metal detector
CSRA	Cell Sharing Risk Assessment
E&D	Equality and Diversity
ECR	Electronic Control Room
FLM	First Line Manager
FNIC	First Night in Custody
GIC	Governor-in-Charge
GIRFEC	Getting it Right for Every Child
GPA	Generic Programme Assessments
H&S	Health and safety
HDC	Home Detention Curfew
ICC	Internal Complaints Committee
ICM	Integrated Case Management
IMU	Intelligence Management Unit
IPM	Independent Prison Monitor
MAPPA	Multi-Agency Public Protection Arrangements
MF: MC	Moving Forward: Making Changes
OLR	Order of Lifelong Restriction
PANEL	Participation, Accountability, Non-discrimination, Empowerment and Legality
PIAC	Prisoner Information Action Committee
PPE	Personal Protective Equipment
PR2	The SPS Prison Record System – version 2
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RMT	Risk Management Team
RSW	Rehabilitation Support Worker
SBAR	Situation, Background, Assessment and Recommendation

SHORE	Sustainable Housing on Release for Everyone
SMT	Senior Management Team
SOP	Standard Operating Procedure
SPSC	Scottish Prison Service College
SRU	Separation and Reintegration Unit
SSM	Special Security Measure
SSOW	Safe Systems of Work
TSO	Throughcare Support Officer
TTM	The SPS Suicide Strategy - Talk to Me
UOF	Use of force

Evidence Report

HMIPS Standard 1

Lawful and transparent custody

Quality Indicators

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

Rating: Generally acceptable performance

Reception staff interacted effectively with all admissions on arrival at HMP Glenochil, to gauge their level of understanding. During the inspection, all new arrivals spoke English. Staff informed inspectors that on occasion they had used prisoners of the same nationality as translators. Although this practice was adopted with the best intentions, there was a risk that what was being translated was not accurate and breached prisoner confidentiality.

No information was available in alternative formats or languages. It was evident that staff had limited resources available to assist with this, other than the use of the language translation and interpretation service, and the evidence showed it was rarely used.

Recommendation 12: HMP Glenochil should ensure that information is available in alternative formats and languages to allow all new admissions to fully engage with and understand the admissions process.

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

Rating: Generally acceptable performance

All those admitted to HMP Glenochil were asked if they had been in the prison before. An information leaflet was available in the waiting rooms and copies were available to take away. However, they were not routinely offered to people and it was not made clear that they could have their own copy. As reported in QI 1.1, all new admissions observed during the inspection spoke English and staff were able to explain the admission process effectively. Waiting rooms had information boards with current and relevant information.

Prisoners were provided with a photographic identity card, and it was explained to them that they needed to keep it with them at all times when moving around the prison.

Recommendation 13: HMP Glenochil should ensure that FNIC information is available in the most common languages admitted to the prison, and utilise the interpretation service when required.

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

Rating: Satisfactory performance

HMP Glenochil does not receive admissions directly from court; they receive convicted prisoners who have transferred from other prisons. All admissions observed had a valid warrant and reception staff checked that each person was aware of their sentence and liberation dates. Warrants were checked to confirm details on the SPS electronic prisoner record system (PR2).

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

Rating: Satisfactory performance

As HMP Glenochil did not receive prisoners directly from court, therefore completing the Prisoner Supervision System was not required on arrival. During the inspection, officers working in reception were observed checking the admission paperwork against records held on PR2, and ensuring the supervision level was up to date.

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

Rating: Satisfactory performance

HMP Glenochil had two residential house blocks, one for mainstream prisoners, Harviestoun and Abercrombie for those convicted of sexual offences. During the inspection, staff were observed checking the nature of each individual's offence to ensure that they were allocated to the correct house block. Personal Escort Records (PERs) and PR2 were checked for any information highlighting vulnerability, risks or medical information. All admissions were interviewed by a reception officer and a nurse in a confidential setting. Suicide prevention risk assessments were completed in line with the SPS Talk to Me Strategy (TTM).

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

Rating: Poor

In order to examine the Cell Sharing Risk Assessment (CSRA) process in full, inspectors followed the admission and cell allocation process for a number of prisoners, examined documents, and interviewed staff working in reception and in the house blocks that prisoners were being allocated to.

CSRAs were carried out in line with the policy in reception. However, on moving to the residential areas some First Line Managers (FLMs) were using obsolete documentation. Also, inspectors observed prisoners being taken directly to allocated cells to share with another prisoner before the full CSRA was completed for both individuals.

The PR2 CSRA was later completed by staff in the allocated residential area. However, it was noted that some staff appeared unsure of how to complete the process and had to call another colleague to complete this for them. Assurance checks on admissions were however carried out by the FLM on duty the following morning.

Recommendation 14: HMP Glenochil should ensure that FLMs are using the up to date documentation, all staff are fully aware of the processes of completing CSRAs in line with the policy, and the importance of completing these fully before allocating prisoners to a shared cell.

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

Rating: Good performance

All admissions were asked if they knew and understood their liberation and critical dates, and warrants were checked against PR2 to ensure they were properly recorded.

Furthermore, all warrants were checked on the day following admission by the Criminal Administration team. The Criminal Administration staff were able to describe occasions when they had calculated different dates to those recorded, and had rectified errors having checked with relevant bodies.

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: Poor performance

Inconsistent information was provided to inspectors regarding the provision of induction sessions. Residential staff reported that it was currently under review, with a view to sessions being delivered in the Link Centre. Link Centre staff provided information on the revised pack that had been developed and advised that sessions were currently running weekly however, due to an operational incident, it was cancelled the week of the inspection. It was explained that these sessions were only for mainstream prisoners and that the offence protection prisoners received induction in the hall from residential staff.

The information used by link centre staff, to identify those who had transferred in over the relevant period, indicated different numbers of prisoners to that being held. There is a concern therefore, that some prisoners who had transferred from other prisons may be missed, and consideration should be given to using a different process to ensure all relevant prisoners are identified and invited to attend induction.

The induction session for offence protection prisoners was observed during the inspection. Six out of the eight prisoners invited attended. It was noted that of those

listed some had been in HMP Glenochil as long as six-weeks and the newest had been transferred in nine days earlier.

The officer delivering the induction session advised that she was the only person who delivered induction sessions within the hall, and could only deliver it on a certain day and shift; therefore, it may be some weeks between sessions. Whilst the information provided was comprehensive, much of it was too late to be of any real value. Any questions asked were answered, and where the officer was unsure notes were taken to followed it up. Inspectors noted that no information was provided on the role of the personal officer, and through discussion with the group, it was highlighted that only one of them knew their personal officer and had met with them to discuss their case management.

Recommendation 15: HMP Glenochil should review their approach to induction and ensure that all admissions are provided with the appropriate information within one week of admission.

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

Rating: Good performance

The manager of the Criminal Administration team checked all warrants to confirm the liberation scroll the day prior to release. In his absence, there was a list of people designated as competent to carry out this task. Release licences were prepared and explained to prisoners by a duty manager prior to their release date.

All liberations observed during the inspection were dealt with positively and professionally. Reception staff ensured that those being liberated had adequate and appropriate clothing for their journey home. Opaque kit bags were offered to carry their belongings, which provided privacy and reduced any potential stigma. Travel warrants were issued and journey details explained, and all those observed were driven to the local train station by a member of staff.

Good practice 1: All prisoners being liberated were offered an opaque green kit bag to carry belongings, which provided privacy and reduced any potential stigma.

Good practice 2: All liberations were driven to a local train station by a member of staff.

HMIPS Standard 2

Decency

Quality Indicators

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

Rating: Satisfactory

All buildings within HMP Glenochil appeared to be fit for purpose and were maintained to the expected standard.

A range of cells was inspected across the prison, all had adequate ventilation and lighting, and they were reasonably sized for initial intended use. The cells designed to hold two prisoners had adequate floor space, with secure storage for both prisoners to hold medication, valuable property and privileged mail.

However, several cells that had been designed for single occupancy were now holding two. The single occupancy cells had no secure space or safe to hold personal belongings or medication; there was insufficient floor space and only one chair for prisoners to sit on. Those sharing a single cell spoke of their discomfort and lack of dignity using the toilet facilities as the toilet area was close to the beds.

Accessible cells within the prison were of a good size, which contributed to providing a good quality of life to individuals in a wheelchair. They were able to move freely and access the toilet without issue. There were sufficient numbers of these available for use. Abercrombie 3 had additional equipment to allow prisoners with mobility issues the chance to practice a physiotherapy regime with a mock staircase and rails.

On inspectors first visit to Harviestoun, it was brought to their attention that the intercom system was not working and therefore prisoners did not have access to communicate with staff, which is in breach of prison rule 29 (1). Staff were aware of this and stated that it had been reported, the Estates Manager confirmed this. Prisoners had access to alert staff to any emergencies through the system of the emergency bell and staff were aware of how to respond appropriately. Upon visiting Harviestoun the next day, this had been rectified. All other residential areas had means to communicate with staff through the intercom system.

All other areas were clean and well maintained, had appropriate furnishings and were well lit. Outside spaces were fit for purpose in line with prison rules.

The estates department confirmed that they had maintenance schedules for ensuring that the buildings are maintained, but prioritised reported work within

residential areas to ensure all areas that prisoners access are safe and fit for purpose.

Recommendation 16: SPS Headquarters and the Scottish Government should consider what can be done to prevent prisoners sharing in sufficient single cell accommodation as it is encroaching on their human rights.

Good practice 3: The facilities available within Abercrombie level three for prisoners with mobility issues; including specially adapted showers and physiotherapy 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: Generally acceptable

All areas visited during the inspection were clean and well maintained and the estates department were able to evidence cleaning schedules. A number of cells were visited and overall were clean and well presented. However, there was a small number, which had graffiti and/or were untidy and had posters displayed out with the area provided.

All pass men were British Institute of Cleaning Science (BICs) trained to allow them to complete their duties to a high standard; however, the colour coding to reduce cross contamination or infection control was not always followed. Prisoners were observed using red mops and cloths within pantries, which were designated to high-risk areas such as toilets etc. When asked prisoners stated they could not get enough green cloths or mops so they used red ones. When staff were asked about this situation, the inspector was met with multiple reasons such as they were not aware, there was not any green equipment, they were not BICs trained so were not aware or they were content so long as it was cleaned.

To double check the process inspectors asked every residential area to produce there infection control check/cleanliness checks. In a minority of cases, not all residential areas could provide them and when they did, some were not up to date. There was a store cupboard within each house block with cleaning materials, but on three separate checks it was clear that there was an issue with quantities. Prisoners were provided with appropriate Personal Protective Equipment to ensure their safety when cleaning.

All prisoners had personal responsibility for the cleanliness of their cells and were afforded ample time to perform this task, with the exception to the 27 non-offence protection prisoners held on a mainstream wing. They were afforded roughly one hour in the morning to shower and clean their cell. If they did not do so in the allocated time, they had to wait until the next day, and so on. On two consecutive days, the one hour was interrupted due to incidents within the prison, leaving those who wished to shower and take time to clean their cell with an inadequate time to do

so. This matter should be resolved as a matter of urgency to allow a better quality of life.

When questioned, staff were fully versed on how to deal with a biohazard situation, and were able to confirm who the biohazard trained pass men were. The estates manager was also able to provide details of the contractors used for large biohazard incidents

There were really good peer carer processes in place to assist the high number of prisoners who required additional support to carry out daily tasks, including cleaning cells and transferring to and from visits, activities and appointments. This scheme operated between 08:30 and 21:00, allowing those who required this support a better quality of life.

Recommendation 17: HMP Glenochil should ensure that there is sufficient colour coded equipment and cleaning materials provided throughout the prison to prevent and control infection.

Escalated Recommendation 18: HMP Glenochil should review the regime offered to non-offence protection prisoners to ensure they receive sufficient time to shower and clean their cell on a daily basis.

Good practice 4: The Peer Carer process to assist the high number of prisoners who required additional support to carry out daily tasks, including cleaning cells and transferring to and from visits, activities and appointments.

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: Satisfactory

The bed frames were old but still fit for purpose. During the inspection, a number of single frames were being replaced with bunk beds to accommodate the rising population. Inspectors raised an issue regarding a bed frame that had been damaged, and it was rectified by the afternoon. This evidenced that the maintenance team effectively prioritised essential works. There appeared to be deliberate damage to some bunk bed frames in an effort to avoid having to share the cell and staff were very aware and were monitoring and challenging any damage.

The mattresses checked were of a satisfactory standard to allow for a good quality of sleep. Staff showed a stock of brand new mattresses available to replace unsuitable ones when required, and inspectors observed this taking place on multiple occasions. Several prisoners complained that the beds were not big enough, however they were of an adequate size.

There was an adequate amount of bedding available in the areas visited, which was regularly laundered onsite, evidenced by a laundry schedule. Laundry pass men reported any deterioration and staff replaced it.

The laundry is a busy service at HMP Glenochil, particularly given the increased numbers. At the time of the inspection, two machines were out of service. The machines in use looked aged so inspectors queried the contingency plan if the service failed. Staff reported that laundry would be taken to HMP & YOI Cornton Vale to be laundered then returned. Taking account of the amount of laundry and the insufficient stock to offer multiple sets of bedding, clothing and towels, inspectors were concerned that this contingency was inadequate.

Since the inspection took place, HMIPS has been informed that additional funding has been approved to procure additional washers and dryers and they will be installed by the end of the summer 2019.

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

Rating: Satisfactory

On arrival at HMP Glenochil, all prisoners were provided with a hygiene pack free of charge, which provided them with adequate materials to maintain a good hygiene standard. The canteen system provided a range of toiletries at an appropriate price for purchase bought by all prisoners, and there were several Prisoner Information and Consultation meetings (PIACs) were held throughout the year, which allowed prisoners to participate in discussions surrounding the range available.

All areas had appropriate toilet facilities in cell and in activity areas.

Each residential area had shower areas that were accessible and of a good standard of cleanliness. Within Abercrombie level 3, one of the showers was adapted so it was wider and had a ramp fitted for use by prisoners in wheelchairs. There were opportunities for most prisoners to shower on a daily basis. However, the same could not be said for the non-offence protection prisoners on the mainstream area as reported in QI 2.1, which should be resolved as a matter of urgency.

There were a number of prisoners who required assistance with personal care. Some were assisted by Peer Carers who were available to assist NHS staff within the prison with a number of tasks. However, if NHS staff assessed the individual as requiring more specialist care, then they reported this to HMP Glenochil managers who arranged for an external agency, Nurse Plus, to provide this service. This was a very good and well-used process that staff were aware of, and the positive relationship between the Nurseplus staff and the prison officers was great to see.

Towels were provided and regularly cleaned and changed following the laundry schedule. However, during a visit to Harviestoun there were no additional towels available. Staff claimed this was due to the increase in their numbers and it was rectified when inspectors visited the following day.

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: Satisfactory

Upon admission to HMP Glenochil, all prisoners were issued with suitable clothing for all activities and it was generally of a good condition. However, there were some issues with larger sizes but staff were aware how to rectify this and order appropriate sizes.

Prisoners were permitted to wear their own clothing whilst on the residential areas, allowing them to maintain a sense of personal identity. They were required to change their clothing before leaving the wing, which was adhered to.

The laundry process was clear and well followed. The loss of items was minimal and there was a clear process in place to investigate any lost or damaged property. Laundry that had been misplaced was kept in a 'lost property 'area until it was claimed, which was a good practice.

When an inspector requested to see the outside waterproof jackets available to prisoners, staff were unable to produce them. However, another member of the inspection team saw limited numbers of them. Prisoners were able to request a fleece to wear for exercise; however, there was insufficient stock should all prisoners wish to take this offer up.

Recommendations 19: HMP Glenochil should ensure that there is an adequate supply of waterproof jackets and or fleeces for those wishing to partake in fresh air in inclement weather.

Good Practice 5: Laundry that had been misplaced was kept in a 'lost property 'area until it was claimed.

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: Satisfactory

The catering service at HMP Glenochil was of a good quality. The Catering Manager was able to evidence the nutritional value of each meal selected on the menu, including the Halal menu. At a food forum, inspectors observed the Catering Manager and Catering Officer discussing the health values of certain menus and explaining to prisoners why certain foods were on the menu. The staff within the catering department were knowledgeable and the food produced was well presented.

At the food forum prisoners complained that there had been no change to the menu in three years. The Catering Manager confirmed this; however, he had only been in post a matter of months, but was able to evidence plans to change the menu by the end of May. This was presented to the prisoners at the forum and was well received. Prisoners were given the opportunity to suggest changes and alter the menu.

Food temperatures leaving the catering department met all legislation at time of the inspection. However, whilst observing food serving within the residential areas, inspectors noted that not all staff checked temperatures prior to serving. This was also evidenced during recent pantry inspections by the catering team, as some food probes had no batteries or were missing. Catering staff confirmed that the Duty Manager sampled the meals and any issues raised were recorded and rectified.

There was a range of different dietary requirements available at HMP Glenochil.

Prisoners were aware that they are entitled to food in line with any medical condition they may have. However, NHS staff must approve this, and there appeared to be a breakdown in communication between NHS and catering staff, often resulting in a delay in prisoners receiving their required meals.

Prisoners were provided with additional snacks alongside their evening meal to account for the additional lock up hours at a weekend. In line with other establishments, prisoners should be provided with a food parcel separate from their evening meal.

Within all pantries and catering area there were sufficient PPE and they demonstrated high levels of cleanliness.

Recommendations 20: HMP Glenochil should ensure that there are regular changes to the menu taking into account the views of the food forum.

Recommendations 21: HMP Glenochil should ensure that staff have the required equipment to ensure food is served at the recommended temperature

Recommendation 22: HMP Glenochil and NHS Forth Valley must work together to ensure that dietary requirements because of medical conditions should be dealt with quickly and efficiently to allow prisoners to receive appropriate meals.

Recommendation 23: HMP Glenochil, in line with other establishments, should provide a food parcel for all prisoners at the weekend separate from the evening meal.

HMIPS Standard 3

Personal Safety

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

Rating: Good

An assessment of risk of self-harm or suicide is made on admission or transfer to HMP Glenochil, and is carried out by both SPS and NHS staff. The TTM Strategy is used and at the time of the inspection there were three prisoners on it. Their case files were examined and were current and up to date. On speaking to them, they informed inspectors that they were given suitable information about their treatment and the opportunity to discuss any concerns. There was evidence of good collaborative working between SPS and NHS staff to ensure that individuals on TTM were appraised of actions being taken and that they were included in the discussions and decisions that affected them. Each individual had a personalised care plan that was communicated with them and regularly reassessed. Case conferences were held regularly for those on TTM and adequate monitoring was undertaken by SPS staff. NHS staff were well trained in managing those in crises. Prisoners were asked what their expectations of the process were with detailed explanations offered.

Good practice 6: Prison listeners were invited into TTM case conferences where appropriate. Transitional care plans were developed by mental health nurses and implemented for individuals coming off TTM procedures to ensure there was appropriate support and monitoring.

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: Poor

The Mental Health Multi-Disciplinary meeting provided evidence of good collaborative working within HMP Glenochil for vulnerable prisoners with complex needs. The meeting received detailed input to cases from NHS, Social Work Scotland and the SPS and was recorded, well-structured and minuted.

Inspectors spoke with various prisoners in Abercrombie residential area who were consistent in their view that they felt safe, had good access to personal officers and would be able to seek appropriate assistance if they felt vulnerable. Several commented on the high standard of support and mental health provision in HMP Glenochil.

There were twenty-seven non-offence protection prisoners in Harviestoun level one at the time of the inspection, some of whom had been on protection for over 100 days, with an extremely limited regime. Six of these prisoners were on a work party in the garden but this did not run every day. Non-offence protection prisoners were afforded up to one hour each day to take showers, make telephone calls, have

breakfast and clean their cell, which is inadequate given the facilities available. One of the three telephones on the landing was not in use and staff were unable to say how long this had been the case or when it was likely to be fixed. Prisoners' inspectors spoke to reported that being on protection felt like a punishment. Prisoners were consistent in their view that communication between staff and prisoners in Harviestoun level one was poor, and the grill gates in the landing were observed to be closed for the majority of the time during the inspection. Staff were observed operating with basic consideration for prisoner needs, but were generally stationed at the desk with limited observations of their presence on the halls.

Recommendation 24: HMP Glenochil were actively monitoring the number of non-offence protection prisoners in Harviestoun. However, they should look to allocate a suitable area for non-offence protection prisoners to ensure an appropriate regime is in place.

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

Rating: Generally Acceptable

HMP Glenochil had devised and implemented a Violence Reduction Strategy following a series of significant incidents in 2017 and 2018. This strategy had helped in lowering instances of violence within the establishment in the last six months. Six new Archway Metal Detectors (AMD) had been installed in each landing. An Operational Strategic Threat Assessment was carried out every twelve months to provide an overall assessment of risk to safety in HMP Glenochil.

There was a good flow of information between the Intelligence Management Unit (IMU), senior managers and residential staff to identify risks to prisoner and staff safety. IMU staff attended hall managers meetings to present information and there were good processes in place for tactical tasking arising from intelligence, including an intelligence security group that met weekly. Analysts provided a monthly intelligence briefing to all staff in the prison.

Despite this, there is a prevailing mood in the establishment among staff and prisoners that were spoken to, that the prison could feel unsafe. Staff and prisoners reported a high prevalence of bladed weapons, drug related debts and regular instances of violence. In particular, prisoners in Harviestoun were consistent in their view that there was very little in the way of proactive lowering of risks or conflict resolution by staff, and that problems were left unaddressed. Staff were observed to operate with basic consideration for prisoners, but there was an overall absence of good interpersonal relationships that would assist problem solving in the residential areas.

Recommendation 25: HMP Glenochil should review its practice in respect of grill gate closures in the hall sections. It is recommended that a clear operating protocol is developed and enforced to ensure both that periods

when grill gates are opened and staff are in direct contact with prisoners in the sections are maximised.

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: Generally Acceptable

First Line Managers (FLMs) were trained in the SPS Think Twice Strategy and had implemented various initiatives to decrease instances of bullying within the establishment. The prison organised an Anti-bullying week in November 2018 which was held in the Family Visitor Centre. This was well attended by families and prisoners. The education department also ran an incentivised anti-bullying e-learning package to all prisoners in the last twelve months.

There was good anti-bullying signage and literature displayed in various areas of the establishment.

Good processes and procedures were in place for identifying and dealing with bullying behaviours and had been disseminated to all staff via SharePoint. These included suspected bullying report forms and processes for officers to deal with persons displaying bullying behaviours. However, staff who were spoken to were not fully aware of these processes and would benefit from refresher briefings. Staff noted that they would see and manage intimidating behaviour but it was not always recorded as such, regularly going through intelligence rather than recorded formally as bullying. Among the non-offence protection prisoners, there was a strong collective sense that being victimised resulted in poorer conditions and loss of regime, with little or no attempt to resolve the core problem or behaviours.

As noted in QI 3.3, the lack of staff/prisoner engagement within the halls may present a problem with instances of bullying being missed. Recording of bullying, harassment or intimidation seems dependent on self-reporting by prisoners rather than the observations of staff.

Recommendations 26: Existing strategies, policies and procedures relating to bullying and harassment should be reissued and reinforced to ensure consistent implementation.

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

Rating: Generally Acceptable

As noted above in QI 3.4, good processes and procedures were in place for identifying and dealing with bullying behaviours and had been disseminated to all staff via SharePoint. These included suspected bullying report forms and processes for officers to deal with persons displaying bullying behaviours. However, the overarching framework to assist victims of bullying and harassment could be

implemented more broadly than it is at present. At the time of the inspection, there was limited recorded evidence of bullying report forms being completed. Where allegations of bullying, harassment or intimidation were included in prisoner complaints, the process was followed thoroughly with relevant outcomes and actions documented.

Prison officers informed inspectors that they carried out one to one assessments with non-offence protection prisoners in Harviestoun level one, to identify individual needs and requirements for assistance. Some prisoners told inspectors that this was very informal and others had no recollection of the conversations happening. Prisoners in Harviestoun also complained that officers were often dealing with something else and that requests for assistance went unanswered.

Recommendation 27: Prison staff should update and fully documented assessment processes for all non-offence protection prisoners in order to identify needs.

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

The Head of Operations was responsible for the management of a suite of Standard Operating Procedures (SOPs) aimed at ensuring the prison operated in a safe and secure manner. These SOPs were available to all staff.

Regular alarm testing was carried out and fully documented in accordance with response protocols. Learning and Action Plans were developed in the aftermath of emergency incidents to ensure that a proportionate and rapid response could be made to threats to safety or life.

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

Rating: Satisfactory

HMP Glenochil employed a full-time and fully qualified H&S Co-ordinator who was visible and active in the day-to-day running of the prison.

All H&S roles and responsibilities were clearly allocated and outlined, and the prison had produced a H&S Strategy for 2017-20, which was accompanied by appropriate documentation to ensure the requirements of Health and Safety (H&S) legislation were observed throughout the prison. The Governor chaired H&S Committee meetings and a staff newsletter was circulated to all staff via Sharepoint, detailing relevant H&S incidents and updates across the establishment.

The establishment had a number of key processes to assess and mitigate presenting risks, particularly in the work areas where risk assessments and safe systems of work (SSOW) were available.
There had been some logistical challenges in ensuring all staff competencies were kept up to date in all areas, though these were generally manageable.

Good practice 8: **FLMs are issued with a H&S Guidance pack, most recently updated in November' 18 to ensure all H&S principles are embedded in the day-to-day running of the prison.**

HMIPS Standard 4

Effective, Courteous and Humane Exercise of Authority

Quality Indicators

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

Rating: Generally acceptable

Although most of the observations under this QI confirmed good processes and practice, the non-recording of planned removals lowered the rating from good to generally acceptable.

The use of force (UOF) was not observed during the inspection. UOF forms were inspected within the Intelligence Management Unit (IMU), who had responsibility for recording and filing all incidents where UOF was required. The IMU received notifications of UOF through the prison significant incidents inbox, and received the hard copy once it had been scrutinised by the Head of Operations to ensure it was complete.

The IMU transferred any appropriate information from the UOF onto PR2 and stored this along with the incident form keeping all relevant information together and allowing a better understanding of each situation. This was recognised as good practice and corroborated the SPS audit team who also recognised this as good practice. The IMU responsible for the management of the UOF followed the guidelines for retention purposes.

Of the 73 of incidents of UOF since January 2019, only 10 were planned removals. Of the 10 removals, only four were video recorded. It is SPS policy that unless there are exceptional circumstances all planned removals should be recorded and the establishment SOP confirmed this. This was also identified by the SPS audit team, who in March 2019 recommended that all planned removals be recorded. Since this audit there have been no planned removals. The Head of Operations assured inspectors that all planned removals would be recorded in the future. To assist those in video recording planned removals, an SOP was available that explained how to use the equipment. All recorded incidents were retained by the security group, and the Head of Operations reviewed them on a monthly basis.

As part of the management of an incident, a Violent Incident Review form is required to be completed within 72 hours of the incident and also prior to completion of the post incident report. This report highlighted the outcomes of the incident, any actions required and an FLM checklist to ensure all processes were complete. Tis was deemed good practice.

Recommendation 28: All planned removals should be video recorded in line with SPS and local policy.

Good Practice 9: The UOF and incident reports are linked on PR2 and stored together to allow a better understanding of the incident.

Good practice 10: As part of the management of an incident, a Violent Incident Review form is required to be completed within 72 hours of the incident and also prior to completion of the post incident report.

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

Rating: Generally Acceptable performance

Devon is HMP Glenochil's Separation and Reintegration Unit (SRU). The staffing shift system maximised the time available to provide a comprehensive regime. Devon is one of only two SRUs nationally that remain open all day.

For those prisoners entering Devon a regime plan was developed and a copy provided, but only in English.

During the inspection, Devon appeared to be busy with an average of 11 prisoners being held there on a daily basis. Case files for prisoners located in Devon, were checked, to ensure appropriate lawful detention on Rule 95 (11) or (12) or 95(1) and included those on an extended Rule 95. The case files detailed the reason for location, any self-representation made by the prisoner, and case conferences minutes prescribing activities identified to encourage engagement with staff and partner agencies. Inspectors noted that routines and support were annotated on the paperwork. During interviews, all prisoners knew why they were in Devon but could not explain what they needed to do to return to the residential areas.

Prisoners spoke highly of the staff; describing positive relationships and the effort staff made to ensure they received their entitlements and their encouragement to return to mainstream conditions. To support the prison staffing levels, there had been times where Devon was placed on patrol in the evening. Although this was not ideal, good pre-planning resulted in prisoners receiving their entitlements during the day[6].

Visits were easily accessible with an SOP to manage this. However, a recent improvement was the introduction of a closed visiting area. This allowed more opportunities for prisoners to meet agencies without disturbing the routine of the unit, and reducing the need for staff to observe meetings.

It was noted that one prisoner had been on a dirty campaign since February 2019, with a slight interruption of four days in April. History showed that he had embarked on this type of behaviour over a number of years. His current behaviour made it difficult for staff and partner agencies to engage with him. There was evidence that

[6] Confirmed during prisoner interviews

a number of strategies had been used to attempt to influence him to change his behaviour, without success. This prolonged protest put enormous strain on those that worked with him on a daily basis. It is HMIPS opinion that a shorter period of exposure for staff and other prisoners to this type of protest should be considered, and that other SPS establishments should look to support prisons where these cases arise.

As previously reported, an area of concern was the non-offence protection prisoners held in the mainstream residential block. HMP Glenochil did not have a strategy to deal with non-offence protections and therefore there was no official area identified to manage them. It was clear during the inspection that due to the amount of prisoners within Harviestoun South level, it was to all intense and purposes a protection area with a small number of mainstream prisoners also situated there. On observing this area throughout the week of inspection, there appeared to be very little in the way of a regime for non-offence protection prisoners.

There was limited evidence of any management of this prisoner group with regards to seeking resolution to their issues or encouraging them to return to mainstream. Added to the limited regime referred to elsewhere in this report, this is unacceptable, HMP Glenochil should ensure that all prisoners groups have a regime that meets their needs, where they have access to fresh air, showers, recreation and telephones at a reasonable time to keep in contact with family, particularly their children,.

Recommendation 29: The SPS should consider a change in establishment for prisoners who engage in a prolonged dirty campaign.

Recommendation 30: HMP Glenochil should engage with those who are non-protection to support and encourage them to return to mainstream and record this engagement.

Recommendation 31: HMP Glenochil should ensure that all prisoners regardless of their situation have a regime that meets their needs. In particular, that allows access to fresh air, showers, telephone at various times to contact family and friends, and recreation to encourage socialisation.

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

Rating: Good performance

Inspectors witnessed a number of disciplinary procedures during the inspection, all of which were held within Devon Hall. The hearings were consistent in delivery with each case attended by the Devon FLM, a scribe and two attending officers for security and safety. The hearings were supported by a number of SOPs, including a Guidance on disciplinary hearings. There was an audit register for the hearings, facilitated by the Governor or Deputy Governor, with actions to be taken if required. In all cases the necessary documentation was completed. Resumptions and new hearings were carried out by different adjudicators. CCTV was used during a resumption hearing, where the adjudicator articulated to the prisoner his observation

that the charge was correct. Following some delicate discussion the prisoner admitted to having breached discipline. Following the punishment part of the process the adjudicator challenged the prisoner on his motives, offered support and explained the processes in which to obtain that support.

In the new hearings, the adjudicator took all aspects of the report into consideration as well as the prisoners' mitigation before coming to any conclusions. A good example of this was where there was more than one prisoner involved in the report i.e. damage to a cell or fighting. They ensured evidence was heard from both parties and despite the prisoners not wishing the officer present, the adjudicator insisted the officers appeared to gain a better understanding of the case. In another case, the adjudicator suspended the disciplinary hearing for a short period to gain more information from staff in the residential areas, which supported the prisoner at the conclusion of the hearing. During the new hearings the adjudicator offered various avenues of support and challenged prisoners on their behaviour, particularly where substance misuse was prevalent or where they had been abusive to staff. The adjudicator worked through the scenario discussing why such behaviour was not acceptable. This method of engagement resulted in the prisoners agreeing that they had to change their behaviour.

Where prisoners were found guilty of the charges against them, they were given the opportunity to appeal and the adjudicator explained the appeal process, the paperwork required, and inquired as to any assistance the prisoner might need. The hearing outcomes appeared fair and consistent with all hearings delivered, and were as per prison service guidelines.

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

Rating: Satisfactory performance

There were two prisoners on SSM at the time of the inspection, and another four were on SSOW. An SOP on SSM explaining the process was available to staff and included directions, a guide on defensible decision-making and Governors Management and Action Note references.

Inspectors reviewed the SSM paperwork and found it was all completed to a good standard. The forms explained the conditions of the SSM and the rationale behind it. There was evidence that the SSM was being adhered to. For example, a request was received from an external agent to carry out an interview in open conditions. This request was denied by the FLM who stuck rigidly to the SSM.

Prisoners spoken with on SSOW understood the reasons for it, and the rationale was fully explained in the prisoner's paperwork. The SSOW gave clear guidelines on how to deal with each prisoner, including where to sit at visits if a compassionate visit was required.

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

Rating: Generally Acceptable performance

Inspectors observed cell searching being carried out to a good standard. Most tactical searches were carried out by the security team who were knowledgeable and carried them out lawfully, in a professional manner and with the dignity of those they searched intact at all times.

The search teams arrived with a box of equipment to allow a thorough search to be undertaken, along with the prisoner property card to cross check against items in use. The prisoner was informed of why he was being searched, and although the prison rules were not quoted, the prisoner had experienced many searches in the past, and was able to explain why he thought he was being searched. The prisoners were in attendance during the search and were able to ask and answer questions when they arose. After the searches were completed, the cell was left in an organised fashion. There were SOPs on searching, and given the significant population of older and disabled people, HMIPS welcomed the SOP on searching people with significantly impaired mobility. This was good practice.

Inspectors observed that Abercrombie hall had completed their quarterly searching targets. However, in Harviestoun hall, in some cases, less than 50% had been completed.

Although there were no productions from the searches observed, the search team and reception staff were able to explain and evidence a process for the safekeeping or for destruction of any items removed. There were a number of confiscated articles and correspondence stored in reception that had been removed from prisoners' cells that were suspected as containing unauthorised articles. When questioned, staff explained that these articles were kept for a year and then destroyed. There was no evidence of these articles being returned to a prisoner as stated in the prison rules.

Where a letter clearly addressed to a prisoner was suspected to contain contraband and confiscated, staff were unclear on the process for returning the items. Staff suggested that the letter would be destroyed rather than issued to the named prisoner, as there were concerns they would be returning drugs to the person. Staff need clarity on how they deal with property, when to return it to the prisoners property or when to destroy it.

Recommendation 32: HMP Glenochil should ensure staff are informed of the correct processes for dealing with prisoner property that has been taken as a production.

Recommendation 33: HMP Glenochil should ensure that quarterly searches in all areas are completed.

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: Generally acceptable performance

Reception staff were responsible for managing prisoner property. All items were noted on a record card and all prisoners were allowed the same items in use, with the exception of those held in Devon. Valuables were held in a locked cabinet within a locked room. There were two keys available to access the cabinet, one for the early shift staff and one for the backshift staff. The cabinet key was held within a safe in a lockable cupboard.

Where valuables were transferred from another prison, it was reported that invariably the items inside the sealed bag were not checked. The assumption from staff was that as they had come from another prison, the items would be accurately recorded. This was identified as a risk as HMP Glenochil staff members were signing for valuables without checking. This was escalated and immediately rectified by the prison.

HMP Glenochil had a good process in place for receiving and issuing property received during a visit or handed in at the front of house. Any property to be handed out went through the request system. Any property handed in was accompanied by a pro-forma. Prisoners were given regular access to check their belongings in reception by request. Arrangements were made for prisoners to pick up their items taking into account security or safety issues. The store for clothing and belongings was well organised and easily accessible. Inspectors noted that not all prisoners had a set of clothes on the rack in reception. It was explained that some prisoners arrived from other prisons without any clothes other than what they were wearing, and were allowed to keep them in use. Staff try to furnish prisoners with suitable clothes from their store to go on a rack but this was not always possible. This may become an issue if prisoners do not have a full set of clothes available for external appointments.

Prison rules state under - Provision of clothing to prisoners
33 (1) The Governor must provide suitable clothing for every prisoner
(b) where required to be worn by the prisoner on occasions when out with the prison, not give any obvious indication that the prisoner is such a person.

There are a number of reasons why this must be adhered to including for example delays in liberation, attendance at hospital appointments or court. The prison should make all efforts to ensure every prisoner has a set of clothes for use outside the prison.

To combat the use of psychoactive substances all clothing was washed before being allowed in use. Prisoners attended the reception and signed a form agreeing to have their clothes washed. Prisoners were then taken back to reception where they were issued with their clothes. It was noted that if the prisoner had other property such as DVDs or books, these items were not given to the prisoner until the clothing had been washed and returned. This meant that prisoners could be without their

other belongings for a considerable period of time. Inspectors recommend that following searching, HMP Glenochil release all other items that are not a risk to the prisoner at the time of admission.

As HMP Glenochil does not admit people directly from court, dealing with cash from those entering the prison is rare. Cash mainly arrives if a prisoner has been to hospital, is returned from the Open Estate to closed conditions, or has been out on Home Detention Curfew (HDC). When this occurs, reception had a good process for recording, keeping safe and transferring the cash to the persons prison cash account via the cashier. Seven claims had been made since January 2019 for loss of or damage to personal items. Only two were found in favour of the complainant.

Recommendation 34: HMP Glenochil should make all efforts to minimise a prisoner's risk of identification when attending external appointments, by having a full set of clothes available for every prisoner in reception.

Recommendation 35: HMP Glenochil should ensure that any items belonging to transferred prisoners, not associated with a security issue, are allocated on leaving reception.

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 performance

Inspectors observed a number of prisoner leaving and returning to reception under escort. Handcuffs were applied as per the risk assessment, with the FLM checking the cuffs and checking with staff for any issues with the escort. Escorting staff were briefed by an FLM and provided with a folder that included an aide memoir on escorting, a completed escort approval certificate, a completed PER, a footprint or plan of the local hospital and details of the cuffing process. Staff were also provided with a closet chain and overnight bag where appropriate. The escort approval certificate included risk factors and the rationale for hand cuffing decisions, the escort officer's details and a written briefing on departure checks. The folder also included an information sheet on being a hospital detainee.

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

Rating: Good performance

Under The Prisons and Young Offenders Institutions (Scotland) Rules 2011 Rule 93 and 94 for the compulsory testing for controlled drugs and alcohol. HMP Glenochil had six Mandatory Drug Testing (MDT) officers who all worked in the operations group and there were two officers on duty at any one time.

It was evident that the officers had a good level of knowledge. HMP Glenochil had two fit-for-purpose areas for testing which were well stocked. To support the role and understanding there was an SOP and the SPS compulsory substance misuse testing

guidance manual December 2014 was also readily available. There was clear evidence of the use of the SPS guidance and policy documents, and the recording of data was accurate. The team kept positive test records for five-years and negative test records for one-year.

Testing was spread across the establishment and was carried out for various reasons including; progression, voluntary, intelligence led, risk assessment and prevalence testing. Between 2016-2018, they had carried out 1302, 1314 and 1053 respectively. Staff confirmed the reduction in 2018 was due to carrying out escorts and other redeployments. At the time of the inspection, the team had carried out 333 tests for 2019, which was on track to be higher than the previous year. There was good evidence of requests from a number of areas i.e. Personal Officers for Risk Management Team (RMT), Lifer Liaison Officer for parole or progression. These requests were logged and carried out depending on priority. Inspectors observed the drug testing of a prisoner. Staff engaged positively with the person, explained the reasons why he was being tested and the process. Due to circumstances out with the control of the officer the process was stopped. Following the interrupted test, the officers completed the process to a satisfactory conclusion, explaining the different actions likely to be taken depending on test results. The results were fed back to the IMU through a dashboard that highlighted trends of drug use i.e. within certain areas or prisoner groups. This information was then used in wider intelligence meetings.

There were no records of any alcohol tests having taken place but staff could explained the process.

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: Generally acceptable

Inspectors observed numerous route movements throughout the week. HMP Glenochil move prisoners four times per day during the week. At 08:25, 11:45, 13:00 and 15:30. It was observed to be carried out in a controlled manner with staff positioned throughout the route to ensure there was a good line of sight. During these route movements, an FLM from Regimes was responsible for the movement. The FLM ensured each area was clear before allowing the next area to move. There was good communication between the different areas.

All prisoners leaving the residential areas were required to walk through an AMD. HMP Glenochil had recently placed extra AMDs at the doors leaving the residential areas. It was reported by senior management that this had reduced the volume of unauthorised articles moving around the prison. An AMD was also situated at the end of the corridor leading to the regime areas. Staff were positioned there to ensure prisoners were searched if the AMD was activated, or to search a prisoner in a wheel chair with a handheld metal detector. Prisoner's books and folders went through the AMD however, not all folders or books were manually searched. This was a concern, particularly as HMIPS were informed that weapons had changed from metal to other materials such as plastic, which would not activate the AMD. Inspectors also observed prisoners walking along the route with clear water bottles

with liquid in them. It is HMIPS understanding that these bottles should be empty of liquid.

Other large movements were when prisoners took fresh air. In Harviestoun for example, going to the exercise yards involved moving through an access point on the ground floor. Staff were well positioned in the exercise areas and grill gates were closed to ensure there was controlled movement. Inspectors also observed movement to visits and the good communications with the electronic control room (ECR) to ensure the passage was clear; staff were correctly positioned behind those they were escorting. There were a number of SOPs available to support staff including, escorting prisoners internally, route movement and radio communication.

It was disappointing that on numerous occasion inspectors came across entrance doors that had been left unlocked or wedged open. This was highlighted to the senior management team (SMT) who said they would ensure this practice stopped.

Recommendation 36: HMP Glenochil should ensure that all books and folders carried by prisoners are searched, regardless of whether the AMD is activated.

Recommendation 37: HMP Glenochil should ensure that all doors are locked or on a lock back where required, as per security guidelines.

Recommendation 38: All water containers should be emptied prior to leaving any area.

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

Rating: Good performance

The procedures for monitoring the prison perimeter, activity through the vehicle gate and the searching of buildings and grounds were robust, and supported by a suite of SOPs including alarm response, area searching, vehicles access/egress, escorting of vehicles internally and Personal Intrusion Detecting (PID) System testing.

Inspectors accompanied an officer on an inner perimeter patrol, which was one of three inner perimeter and one outer perimeter checks carried out daily. The emphasis was on checking the activation of the PID system as well as noting any potential security risks. This was carried out in a professional manner and the officer was able to explain a number of procedures when dealing with potential risks to the establishment. Following patrols, the officer circulated a report to the security FLM on their findings and used the report as part of the handover to the next shift. The process for checking the PID was undertaken by the ECR staff, who signed a checklist on completion of this task. Any issues around non-activation of the PID system was reported to estates for action.

Inspectors observed the process for allowing vehicles access and egress to the establishment through the gate area. Inspectors observed an excellent process where the officers dealt with various vehicles, the drivers and passengers. The officer was well organised and respectful to all those dealt with. Security equipment

was utilised to ensure vehicles were clear to enter and leave. There was also a member of staff on duty to escort all vehicles through the sterile area of the establishment.

The ECR was a busy area and the officers were constantly engaging with prison staff. The ECR duties were split between two officers, one dealt with phone calls, gates, alarms and PIDs, and the other dealt with opening doors, radio messages and emergency calls. During the shift, they swapped roles to keep their concentration focussed.

It was noted that some camera footage was not of good quality. HMP Glenochil had embarked on replacing them but the refurbishment been limited due to cost.

HMIPS Standard 5

Respect, Autonomy and Protection Against Mistreatment

Quality Indicators

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

Rating: Generally acceptable

Focus groups with prisoners raised issues about access to telephones becoming increasingly difficult. Issues cited varied but included insufficient numbers of phones for the increased population, phones damaged or without covers for periods and some populations such as non-offence protections consistently having access at times when relatives were not readily available. Staff had access to an emergency phone facility for prisoners (which was time limited) and could explain its use.

An FLM from Harviestoun provided some excellent examples of extended sensitive contacts he had initiated between prisoners and families in difficult circumstances. These involved making more than one change to visit arrangements for privacy, supporting families to complete documentation during a visit session, arranging follow up referrals and support and ensuring personal property could be collected easily through liaison with another establishment. The thoughtful approach and attitude of this FLM is to be commended.

A detailed SOP in respect of death or illness of a relative was in place. Staff were aware that prisoners could ask family to attend TTM case conferences, but indicated that this was rare. Escorted exceptional day's absence arrangements were available and used. Difficult decisions in respect of closed visits were stated to be delivered in person to the prisoner by the visits co-ordinator, with families receiving a letter of explanation.

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

Prisoners reported mixed relationships with staff, which often differed depending which hall they were living in. Abercrombie hall was more settled with relationships that were more consistent and personal officer support, which impacted positively on the quality of relationships. Had the inspection been solely on Abercrombie this quality indicator would have been good.

Inspectors witnessed positive informal interactions in Abercrombie and in the activity areas, where prisoners spoken to reported feeling treated with respect and valued in the contribution they made within their work area.

In both halls, staff employed appropriate professional boundaries, though name badges were not always in evidence and this needs to be addressed.

Complaints about inappropriate staff comments were passed to inspectors from a variety of different sources, and on one occasion was witnessed. Prisoners located in Harviestoun level 3 cited specific differences between the behaviour of staff on alternative shifts. This culture requires to be addressed with immediate effect and is indicative of a wider inspectorate concern about a lack of focus on equality and diversity issues.

Despite these issues, prisoner survey data (from those who completed it) showed that 90% of prisoners felt they got on well with staff, and 85% felt that staff treated them with respect. The Chaplaincy team reported a positive shift in culture over time with respectful attitudes between staff and prisoners, indicating examples where staff had behaved sensitively and with genuine concern.

Whilst personal officer allocation was noted to be in place in both halls, prisoners indicated that contact was variable and had worsened as the population had increased. Long-term prisoners in Harviestoun felt particularly disadvantaged, and staff shortages were reported by staff to be having an impact on consistent personal officer relationships and case management. It is recommended that further efforts be made to embed a sustainable Personal Officer system.

Prisoners did however provide some good examples of practice where individual members of staff had made a positive impact as personal officers during case management case conferences or progression discussions. Staff indicated that the lack of professional development training in respect of the personal officer role or working with specialist populations was impacting on the quality of case management delivery and the establishment of an asset based culture.
As reported in QI 3.3, generally relationships would be likely to be more productive if operational practice was reviewed in respect of grille gate closures in the hall sections. It is recommended that a clear operating protocol is developed and enforced to ensure both that periods when grille gates are opened and staff are in direct contact with prisoners in the sections are maximised. See recommendation on QI 3.3.

There was no evidence of use or staff understanding of the SPS ‘Think Twice’ anti-bullying strategy, or of a restorative practice culture. This is unfortunate at a time of increasing numbers of non-offence protection prisoners, and approaches to these issues should be reviewed.

Recommendations 39: HMP Glenochil should ensure that all staff wear name badges at all times.

Recommendation 40: HMP Glenochil should embed a sustainable Personal Officer system.

Recommendation 41: HMP Glenochil should ensure staff are adequately trained in the principles and application of the SPS ‘Think Twice’ anti-bullying strategy.

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

Rating: Generally acceptable

Focus groups indicated that privacy was becoming more of an issue as the population increased in number and cell sharing was required for some individuals. Storage safes in rooms were available, but were too small to hold personal case information/correspondence and were often damaged. Procurement of appropriate safes should be considered across the prison estate, as this is a recurring issue.

In general, efforts had been made to ensure that confidential information was not on display in public areas. However, small hall boards with prisoner allocations were on display behind staff desks. While the information on them was not generally visible by prisoners standing on the other side of the staff desk, it nevertheless represented an unnecessary risk. It is recommended that this information is removed from sight altogether.

Searching procedures observed dealt appropriately with confidential items. Interview space in hall areas was available and accessed as required. Social work staff indicated that whilst staff made every effort to make space available in the halls, the quality of the space did not allow for sensitive discussion of case management and offence related issues. It is recommended that alternative venues be considered where more sensitive case management discussions can routinely be undertaken.

The Chaplaincy team indicated that staff respected confidentiality and professional boundaries when seeking support on sensitive issues.

Privileged mail systems were robust and well tested by the population. Issues in respect of confidential mail were not a significant factor in either complaints or information security breaches. Information security processes were in place and well managed, with trained staff and good audit outcomes. Improvement issues where identified and rectified promptly as required.

Proactive attempts had been made to improve practice by upgrading filing facilities and spot-checking parole dossiers. Governance arrangements were in place and the establishment was now moving to develop management information further by mapping trends and patterns in data. Breaches when they occurred were most often due to external parties failing to employ protective arrangements for double enveloping/clearly marking as legal correspondence as set out in shared memoranda. It is recommended that the SPS raise this with the Law Society of Scotland and ask that they reinforce these requirements to their membership.

Recommendation 42: The SPS should consider procuring appropriate safes across the prison estate.

Recommendation 43: HMP Glenochil should remove the small hall boards with prisoner allocations were on display behind staff desks to protect prisoner confidentiality.

Recommendation 44: HMP Glenochil should identify alternative venues where more sensitive lengthy case management discussions can routinely be undertaken.

Recommendation 45: The SPS should ask the Law Society of Scotland to reinforce the arrangements for sending legal correspondence to prisons in Scotland, as set out in shared memoranda, with their membership.

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

Rating: Poor

As reported in Standard 3, both staff and prisoner groups expressed concern about apparent rising levels of violence. Data showed that violence appeared to have peaked in 2018 reducing since the start of 2019, though this could not yet be considered a sustained reduction over an extended period. HMIPS welcome the reduction, and with all strategies in place, hope to see it sustained. Violence and cell damage was felt to be related to changing patterns of drug misuse (psychoactive substances) across community/custody boundaries, and increasing population pressures. Staff recounted these issues having settled a little since the recent period of increased admissions and initial cell sharing began.

Particular tensions include the population mixing of long-term and short-term prisoners. Substantial numbers of long-term prisoners live in Harviestoun hall and it was recommended that immediate measures should be taken to relocate populations locally as far as is possible to allow for a more stable regime. Territoriality between different prisoner groups from different postcode areas is also an issue as it is difficult to disperse factions within the limited confines of one hall.

A significant incident on the first day of inspection was managed calmly and appropriately, with visits being continued. The establishment had experienced staff and sufficient incident command capability on site with SOPs in place. Major prisoner movement to and from activity was calm and controlled with sufficient management presence. Activity areas visited appeared calm and purposeful.

Overall, prisoner survey results indicated that 70% of prisoners who responded stated that their hall was relaxed and 94% said that they got on well with other prisoners. Inspection evidence however suggested significant environmental differences between Harviestoun and Abercrombie halls, with the latter being much more settled. The senior management team may wish to request further analysis of survey data based on individual hall/population responses to better understand and address emerging pressure points.

Consistency of regime provision varied across the two halls, with Harviestoun particularly suffering from the impact of population increases and staff shortages. Staff shortages were being managed sensibly through recognised operational practice. Although a staff shortage protocol was in place and measures taken seemed generally appropriate to cover shifts, there was no evidence of active

monitoring of the balance of impact on different areas or populations within the establishment.

Impacts included reductions in daily activity spaces, reduced or inconsistent regimes for isolated populations, and inconsistent availability of staff who understood the hall regime to which they were deployed or were unable to undertake identified personal officer delivery. Sustaining consistency of relationships can be as important as overall available numbers of staff especially when operating under pressure.

As already reported, the morning regime in Harviestoun was overly pressured because of second exercise timings and observation confirmed this. Staff and prisoners reported that the tight morning timescale meant that regime timings had to be adjusted frequently. Basic regime timetables and items in use lists were available to the inspection team but were not on obvious display in the halls or routinely accessible to prisoners. It is recommended that the morning regime timetable in Harviestoun is reconsidered with input from both the prisoner and staff group and that staff meetings are established which promote effective ongoing contribution to practice improvement. It is possible that staff would also benefit from the production of refreshed clear and accessible regime operating manuals, especially during periods when staff who are unfamiliar with the operating regime in specific areas are being deployed to cover posts.

Recommendation 46: The SPS and HMP Glenochil should work together to relocate populations locally as far as is possible to allow for a more stable regime and in particular limit the mixing of short and long-term populations.

Recommendation 47: HMP Glenochil should monitor the impact of the staff shortage protocol.

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

Basic communication systems to prisoners were in place but were not monitored and updated. Noticeboards were in evidence but were untidy with no clear themed approach or apparent governance. It is recommended that efforts are made to improve communication with prisoners, especially those who may be most isolated or vulnerable. Communications officers in halls were identified as part of secondary duties, as well as Equality and Diversity officers in some areas but these duties seemed to be largely historic, operating on the goodwill and personal interest of the staff concerned. Special events took place sporadically but there was little evidence of a co-ordinated programme to encourage inclusion. Information was generally not translated into other languages and use of translation services was comparatively rare. An in cell TV information system had potential but required senior management oversight in order to flourish, with regular input from functional areas.

Consideration should be given to linking this function either to induction or to the developing music/media centre to support prisoner co-production.

Inclusion for prisoners with literacy difficulties had been recognised with a computer based profiler being offered as part of the education induction process, as well as a literacy and numeracy screen. Peer support services were available and worked well with targeted linkage between peer tutors and those identified as needing support and qualifications in volunteering awards. Overall, there were opportunities to further develop peer support services. The establishment placed little focus on co-design, empowerment or prisoner delivery in areas like reception and induction where this would have been of especial value. However, inspectors were impressed by peer carer support in Abercrombie Hall. It is recommended that peer support services and prisoner engagement be extended.

Information was not provided by the establishment to demonstrate equity of access to development opportunities for inclusivity, and no proportionate balance of activities across populations was evident. This matter requires attention.

PIACs presented a mixed picture, with prisoner focus groups in advance of the inspection questioning their effectiveness. Those in Abercrombie operated well (with minutes produced and posted on notice boards for prisoner information) and the member of staff concerned should be commended for his diligence. Records were available over the last five years to show regular well-organised meetings including thematic subject areas on issues likely to be prioritised by the prisoner population such as visits, canteen and hall regime for the most vulnerable. Information was available to the prisoner group and an action log was in place that demonstrated clear outcomes and resolution of issues raised. An outline of the purpose of the PIAC system had been created and circulated to the prisoner group. Prisoner representatives were in place and examples were provided of how they were involved. Sensitive consideration had been given to how best to support communication of decisions to the wider prisoner group where prisoner representatives might feel exposed to criticism.

Whilst PIACs might seem a simple process, they are an essential part of positive engagement and are often neglected. The Abercrombie system should be regarded as an example of best practice.

Whilst some reported exchange took place between the PIAC co-ordinators of the two halls on shared issues, systems for consultation in Harviestoun and on wider issues by other functional areas did not appear to be either as regular or as frequent, and it is possible that the interests of specific prisoner groups such as non-offence protections were insufficiently prioritised.

The canteen was not an issue of significant concern raised in prisoner focus groups prior to inspection. It was noted that choices were reasonably good and that PIACs took place, but were not responsive to suggestions made for product changes. The prisoner survey noted that 71% of prisoners who responded expressed overall satisfaction with canteen services, with issues of pricing and selection receiving lower satisfaction ratings.

Recommendation 48: HMP Glenochil should consider either linking the in cell TV information system to induction or develop the music and media centre to support prisoner co-production.

Recommendation 49: HMP Glenochil should ensure that peer support services and prisoner engagement is extended.

Recommendation 50: HMP Glenochil should provide information to offer equity of access to development opportunities for inclusivity, and ensure proportionate balance of activities across populations.

Good practice 11: The PIAC system that was operated in Abercrombie Hall.

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

Agent's visit facilities in the establishment were small but adequate for a sentenced population. The facilities were generally well used and bookings were stated to be busy. Neither the Treat Officially Correspondence or complaints systems identified issues from solicitors in respect of limited access. An official visitor spoken to indicated that he felt the service was appropriate and that although when he first phoned he got through to an answer phone, someone had phoned him back quickly to arrange his visit. Agents visits were booked through the office administrators and cover arrangements were in place during absences, though answer phones may be used during staff break periods. Staff noted that prisoners were not always aware that official visitors were coming to see them and that this could cause anxiety and tension in the visit area. Inspectors recommend that HMP Glenochil adopt a system where prisoners are notified as soon as an agent's visit is booked. No evening or weekend sessions were advertised, but examples were given of official visitors being accommodated in special circumstances on request. Video courts and video links were available and used as required, though the technology in place (albeit relatively new) was stated to be unreliable on occasion.

Facilities across the establishment to access any translated materials were poor, and the library did not have books available in other languages. Recommendations from previous inspection reports in respect of ensuring language line was readily available had not been effectively implemented and are repeated here. Staff indicated that they used other (less reliable) techniques to provide translation support and that they felt discouraged from using language line because of the cost. This is symptomatic of a wider establishment lack of focus on equality and diversity issues. Staff need to be encouraged to recognise the importance of talking to someone in your own language for health and wellbeing issues as well as for task focused support.

The library was small but well organised by committed staff and prisoners despite a lack of Local Authority support. Satellite libraries operated in designated areas around the establishment and access was scheduled for the majority of populations.

Efforts had been made to develop a comprehensive reference materials library resource on legal and policy issues from which items could be loaned on request or photocopied free of charge. This is an item of best practice worthy of sharing. Qualified peer literacy tutors were available to support access by prisoners with additional learning needs.

An NHS Forth Valley advocacy service was available but was not known about by either staff or prisoners. More should be done to publicise this and other services. In common with other issues, notice boards had some information displayed in respect of IPM and the Scottish Public Services Ombudsman but this was inconsistently available across the establishment.

Subject access requests and freedom of Information systems were well tested by the population, robustly managed and tracked. Resource requirements had been monitored and as a result administration support had been increased to manage demand.

Given the increasing pressure on staff time, the benefits of kiosk systems within private sector establishments could usefully be explored by SPS as a national issue. HMP Glenochil continued to use a daily request book system and whilst this had been phased out in some establishments (and could be regarded as quite traditional) this was nevertheless providing a clear method of access to services, which was understood by all and closely monitored. Staff were able to evidence clear outcomes to requests.

Recommendation 51: HMP Glenochil should adopt a system where prisoners are notified as soon as an agent's visit is booked.

Recommendation 52: HMP Glenochil should do more to publicise the availability of the NHS Forth Valley advocacy service, and other services, to staff and prisoners.

Recommendation 53: the SPS should consider adopting the kiosk system within private sector establishments to reduce mundane transactions between staff and prisoners and free up time for case management.

Good practice 12: Efforts had been made to develop a comprehensive reference materials library resource on legal and policy issues from which items could be loaned on request or photocopied free of charge.

5.7 The prison complaints system works well.

Rating: Generally acceptable

Evidence demonstrated an overall reduction in complaints by around half between the years 16/17 and 17/18. Particular reductions were evident in issues related to communications, prisoner records, physical environment, health and welfare, privileges and property. Home Detention Curfew (HDC) complaints had however increased, probably related to national system changes. Current complaint issues

tend to illustrate those concerns most frequently impacted by population pressures such as laundry and property matters.

Stacking boxes for a variety of prisoner forms were available in hall sections but were often observed to be empty. This needs to be addressed immediately and monitored. Healthcare referral forms had helpfully been adapted with visuals by speech and language therapists (though not all of the full range of SPS forms had been adjusted in this way, and some were potentially quite difficult to read). Prisoners sometimes described feeling that NHS complaints issues were not listened to or responses properly explained. IPM notices and forms were available alongside boxes to post requests confidentially.

Given concerns expressed here about access to complaint forms and materials it is concerning that the current SPS Prison Resource Library (PRL) audit was noted as 100% compliant.

A business improvement manager is in place with robust complaints database tracking systems to ensure that copies are placed on file and staff responses are challenged where felt to be inadequate (this had been identified as a development area and as a result awareness sessions had been facilitated by SPS Headquarters for FLMs). Confidential complaints to the Governor had a similarly well-organised separate database and follow up system (though one recent HDC complaint was noted to have become time barred which was unsatisfactory). The Treat Officially Correspondence system was in place and actively monitored. Complaints information was fed into the establishment compliance structure and meetings. Property loss systems were managed by the halls, which meant that multiple complaints systems were located across different functional areas. It is possible that centralising these under the business improvement function may have advantages when monitoring patterns and trends.

IPMs were available and regularly support prisoners at ICC hearings. IPMs noted that the ICC process was efficient and well run. Both the establishment and IPM members indicated that prisoners would benefit from further clarity about the role of IPM members during ICC hearings. Inspectors attended and observed ICC hearings, which were managed with dignity and a desire to resolve prisoner concerns. ICC information was well prepared in advance of the hearing with preliminary investigation if required. Good tracking and data base systems were in place with evidence of ICC hearings overturning previous decisions. Evidence was also provided which showed follow up of ICC outcomes by the designated co-ordinator to ensure closure. ICC Chairs should continue to generate and explore all potential options for resolution and ensure that these are both focused on meeting the needs of the individual and are followed through to a satisfactory outcome.

Recommendation 54: HMP Glenochil should ensure that all prisoner forms are available to prisoners at all times.

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

Rating: Satisfactory

IPM information was posted around the establishment with confidential boxes for posting complaints and regular contact visits took place, including individual contact with prisoners. IPMs generally had free access to all parts of the prison, though sometimes felt inhibited in accessing Devon hall because of the regime in operation and orderly room commitments. This should no longer be an issue as a closed visits area has been introduced within Devon.

IPM and staff relationships were described as friendly and approachable. IPMs had ready access to members of the senior team to escalate concerns where required. IPM concerns broadly reflected those of the inspection team and focused on the impact of an increasing population, areas in the establishment where social isolation was pronounced and lack of continuity or reduction in service as a result of staff shortages. In this context, the capacity of the local laundry service to cope with demand and the potential limitations of current contingency arrangements was particularly noted. IPM members commended the establishment for the successful introduction of the national smoke free prison initiative and noted the unintended but welcome consequence of a reported reduction in homemade weapons because of the loss of cigarette lighters with which to manufacture them.

IPM members recognised that in order to be effective in challenging practice they might require information from the establishment in advance of meetings in an enhanced standard and accessible format, as well as potential further training input as part of a national development programme.

IPM members would potentially also benefit from a more strategic relationship with senior teams in order to recognise the wider impact of systemic issues across inspection standards, and better utilise their own skill base as part of the inspection cycle to promote continuous improvement.

HMIPS Standard 6

Purposeful Activity

Quality Indicators

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

Rating: Poor Performance

The prison offered a broad range of employment and training activities in good quality, purpose-built workshops and establishment facilities. These included workshops for engineering, general purpose assembly and timber assembly, work parties in laundry, catering, recycling and gardens, a creative workshop for music, and vocational training workshops for industrial cleaning, barbering and painting and decorating.

All employment activity places were fully allocated to prisoners, except for the catering work party, which rarely achieved its full quota. Participation in employment opportunities was much higher by protection prisoners than by mainstream prisoners. Almost all work parties available to prisoners were to meet challenging production contract targets, or to support essential establishment services, and the prison population engaged in these work parties remained largely unchanged. For mainstream prisoners, there were only three employment options available and for non-offence protection prisoners, there were no employment or training activities scheduled, apart from a very recent work party for six prisoners.
Overall, the employment and training opportunities were not sufficient for all prisoners who wanted to work, and not all prison population groups received equitable access to match their age, ability and preference.

The vocational training opportunities available to prisoners was limited to Scottish Qualifications and Credit Framework (SCQF) levels 4 and 5 in painting and decorating or barbering. Very few certificates had been awarded in the past year and there were no progression opportunities on to more advanced qualifications. The range of training opportunities did not match well with the variety of different work parties in the prison and did not suit the abilities or interests of mainstream prisoners, who were keen to obtain qualifications that could be useful in their communities on their release. Some prisoners gained useful employability certificates in H&S, BICS, food safety, manual handling and risk assessment.

The prison encouraged the majority of prisoners to take part in employment and training opportunities. However, the facilitation and support for all prisoners to have equal access was severely diminished as barriers to participation were not systematically identified, analysed or removed. There were no arrangements for prisoners to be consulted about employment opportunities in the prison, apart from prisoners attending the PIAC. Prison managers did not proactively or regularly review the scheduling and range of employment and training opportunities to improve access for the mainstream and non-offence protection prison populations.

Recommendation 55: HMP Glenochil should ensure there is an appropriate and sufficient range of employment and training opportunities available to all prisoners and population groups.

Recommendation 56: Fife College should consult with HMP Glenochil management team and prisoners in the planning of activities and qualifications that suit a range of interests and abilities, and that are relevant to the community on release.

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

Rating: Generally Acceptable Performance

The paid work policy was clear, fair and thorough. However, the detail had not been communicated sufficiently well to staff and prisoners. This caused confusion amongst staff and prisoners in relation to the wages paid and what activities prisoners could, and could not, undertake without a wage penalty. This was a significant issue for prisoners when changes were made recently to pay levels. The rationale for allocating paid work roles was defined and understood by staff and prisoners. However, the opportunities for the mainstream and non-offence protection prisoners to access employment and training opportunities, or to move to a different work party, were severely restricted by the preferences for workers from the offence protection population. This population were favoured over mainstream prisoners, as prison staff believed their work rate was superior and their work ethic helped to meet challenging external contract targets.

Although the prison did seek to understand the reasons why a prisoner wished to change their work party, the options for alternative employment were very limited. Prisoners did not have sufficient opportunities to discuss and influence aspects of the employment and training activities, or their skills and learning objectives. Although work allocation was reviewed regularly and monitored, this was based on establishment needs rather than those of the individual prisoner.

There were some good examples of the prison supporting individual prisoners who required extra assistance or confidence to participate in the work allocation system.

The prison provided full information to prisoners in relation to the work placements available. However, their personal preferences were not always taken into account, as this was dependent on the need for highly productive work parties to meet prison production contracts and essential prison services. Therefore, the needs of the prisoner did not always take precedence over the needs of the establishment.

Recommendation 57: HMP Glenochil should ensure that the paid work policy is understood by staff and prisoners and any changes to this policy should be clearly communicated.

Recommendation 58: HMP Glenochil should ensure that there is equality between prisoner groups when it comes to allocating work and training opportunities.

Recommendation 59: HMP Glenochil should ensure that the needs of the prisoner groups with regards to work placements should outweigh the needs of the prison.

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 Performance

The Learning Centre provided a welcoming, bright and comfortable space, which was fit for purpose and well equipped. Relationships between education staff and prisoners were positive and supportive. The engagement in, and attendance at, education courses by offence protection prisoners was higher than that of mainstream prisoners. However, at the time of the inspection, the Learning Centre was unable to meet the demand from prisoners for education.

A reasonable range of educational opportunities was available to all prisoners, with the exception of the non-offence protection group, who received no access to education. Courses were largely provided at lower SCQF levels, consisting of core skills provision, as well as a range of subjects such as English for Speakers of Other Languages, art and music. A limited range of Scottish Qualifications Authority (SQA) National 5 and Higher courses and examinations, as well as units from the SQA Employability award were also available. A few prisoners were studying distance-learning qualifications at an advanced level, and a few prisoners were studying through the Open University.

Prisoners participated in an informative induction session to educational opportunities, and all prisoners attending education activities completed a useful skills profile to inform their core skills requirements and educational preferences. Learning Centre staff worked with prisoners on an individual Personal Learning Plan, which was reviewed formally every six months. However, prisoners were unclear about the purpose and benefit of this process. Learning Centre staff met the needs of prisoners who had additional learning support needs well, removing potential barriers to their learning and participation. Tutors led well-planned and interesting discussion groups in the residential areas. Prisoners enjoyed these groups and engaged well.

Learning Centre managers had produced an Annual Activity Plan, which detailed the intended education provision for 2019/2020. The current year's plan contained targets that they monitored throughout the year. However, these plans were developed in isolation, with no connection to, or routine discussion with, other partners within the prison, such as the Link Centre, the library, vocational tutors or managers of the work parties. This resulted in missed opportunities and some duplication of education provision, significantly diminishing prisoners' learning experiences and opportunities.

Learning Centre staff did not consult with prisoners, or routinely seek their opinions, about the quality and range of education provision available to them. There were no attempts to engage prisoners in planning of provision or evaluation of services, which significantly limited opportunities for improvement of provision and the engagement of prisoners. The prison did not encourage the further participation of mainstream prisoners and education opportunities were not promoted across the prison.

Recommendation 60: HMP Glenochil should encourage the link between the learning centre Annual Activity Plan and other partners within the prison to maximise opportunities and minimise duplication of education.

Recommendation 61: HMP Glenochil and Fife College should ensure that the Learning Centre staff consult with prisoners on the quality and range of education provision available to them so that the planning of provision or evaluation of services meets the needs of the prison population.

Recommendation 62: HMP Glenochil should encourage a greater participation from mainstream prisoners in the education opportunities on offer.

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: Satisfactory Performance

Most prisoners had good access to sporting and fitness activities, including evenings and weekends. The prison had recently expanded the gym facility into part of the sports hall to accommodate an increase in prisoner numbers. This arrangement was working well and was appreciated by those prisoners using the facilities.

However, one prison population, non-offence protection prisoners, had no access at all to the gym or fitness activities and this prevented this indicator from achieving good.

Most prisoners valued the sporting facilities and used them regularly. A few prisoners used the small satellite gyms available on each level of the accommodation halls. All prisoners completed an induction prior to accessing the fitness equipment. Prisoners made good use of the well-equipped gymnasium that had a wide range of exercise and training equipment. Prisoners also engaged enthusiastically with activities such as such as badminton, indoor bowls, softball and circuit training in the indoor games hall. However, outdoor activities in the gardens, including football, Pétanque and chess had rarely been used in the past year.

There was a good range of physical events available such as fitness challenges and health initiatives to educate prisoners in health and wellbeing. Prisoner participation was encouraged by the prison and staff planned activities to suit the age, abilities and fitness levels of prisoners. Staff consulted prisoners on the choice of physical

and health opportunities on offer, and took their views into consideration when organising or varying fitness activities. Individual prisoners were supported well to overcome barriers to participation and some received extra assistance to help them to access physical and health facilities. However, the barriers to the non-offence prison population had not been analysed or addressed, and the scheduling of activities did not provide equal access for all prisoner populations.

No prisoners had gained certifications or awards for health and fitness activities in the past year.

Recommendation 63: HMP Glenochil should ensure that all prisoner groups are given an opportunity to participate in sporting and fitness activities.

Recommendation 64: HMP Glenochil should re-introduce health and fitness certificates or similar awards.

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: Poor Performance

The purpose-built library provided a pleasant and welcoming environment for prisoners. Most prisoners had access to the library and arrangements were in place to provide books to prisoners in Devon.

Prisoners had adequate access to legal texts and reference resources. However, there was no partnership agreement in place with the local authority library, or Fife College library. Random stock was donated to the prison library by a charity and there was no qualified librarian to manage the library, or to advise those prison staff who currently work there.

Library staff were not proactive in working with the Learning Centre, or staff organising the work parties, to provide texts and resources that would support prisoners in their education and training activities, or their personal interests. Occasionally, requests for certain texts from prisoners would be made, although this process was lengthy and not always successful. Alternatively, reference resources were sometimes downloaded from the internet for prisoners. Prisoners had no access to books or other resources in the accommodation blocks, apart from a small, random provision in Devon. Overall, library resources available to all prisoners were inadequate and limited. The provision of texts and resources in foreign languages was unsatisfactory.

Library staff did not engage with prisoners to ascertain their views on library services or the resources available and there was no systematic consultation with prisoners about the materials available within the library. Group activities arranged by library staff were limited to a Scrabble group for offence protection prisoners.

The library and its services did not have a visible presence across the prison and was not actively promoted to prisoners, particularly those from the mainstream population.

Recommendation 65: HMP Glenochil should secure a partnership with the local authority library service, or other service, to ensure that there is an adequate stock of books and other resources to meet the educational, training and personal interests of all prisoners.

Recommendation 66: HMP Glenochil should ensure that prisoner's views are taken into account by library staff regarding services and resources and encourage prisoners to contribute their ideas.

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: Poor Performance

The chaplaincy provided a range of services, including courses and fellowships to support prisoners during their sentence. There were well-appointed and spacious areas for worship, which were used well by prisoners from a range of religious backgrounds and faiths.

Prisoners had access to an active Listener service and to peer tutors and mentors. These services were used well by prisoners. The Listeners, peer tutors and mentors enjoyed their roles and found them rewarding. However, the mainstream prisoner population did not have equal access to peer support services, as there were fewer peer tutors, mentors and Listeners within this population.

No individual member of the prison management team had a cross-establishment overview of the planning, promotion and running of events and activities. However, oversight was provided by SMT. There was no planned cross-prison programme of events and activities. The range of cultural events and activities for prisoners was extremely limited and not promoted well across the prison. A small number of events, including a music concert, events organised by prison gym staff, and events organised by the chaplaincy had taken place. However, they had been organised in isolation by different areas of the prison. This significantly limited opportunities for prisoners to engage in events and recreational activities.

Staff did not consult with prisoners on the range of cultural and recreational activities and events.

Recommendation 67: HMP Glenochil should plan and actively promote cross-establishment cultural and recreational events and activities for prisoners that will contribute to their knowledge and wellbeing. All prisoners should have an opportunity to engage in the events and activities that are relevant to their interests and abilities.

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: Poor Performance

Exercise was offered daily in the fresh air for the majority of prisoners. The exercise areas were tidy and the flooring was of an acceptable standard. However, both areas were uninspiring and could be enhanced to encourage active participation in exercise. Prisoners from all levels in the main residential areas were offered exercise following the afternoon route movement, with an additional session having been added to the Harviestoun regime in the morning for the non-workers. This had helped to reduce the pressure of high prisoner numbers and had reportedly contributed to a reduction in instances of violence.

A small quantity of fleeces were available in the clothing store on each level. However, there were only a very small number of waterproof jackets available, with none on two of the flats in Harviestoun.

Non-offence protection prisoners were offered time in the open air early in the morning which was facilitated, if required, in the small exercise areas in Devon. This was also applicable for prisoners being managed on Rule 95 in both halls. As this was routinely offered at 07.30, few prisoners elected to engage in this activity. At the time of the inspection, there were 27 non-offence protection prisoners, and staff acknowledged that if they all wished to participate in exercise, the current regime could not facilitate this.

It appeared that a Harviestoun gym session in the morning coincided with the exercise period, with staff having to facilitate the movement of prisoners to both activities at the same time.

In Abercrombie, the quality of the fleeces was noted to be poor. There was a limited amount of the raincoats available, but clearly insufficient for the amount of prisoners accessing exercise.

The exercise area for Abercrombie was accessed via a lengthy route that included a hill of steep gradient. Prisoners from all levels attended exercise at the same time. A lift was available for people with limited mobility, but this could only cater for one wheel chair bound person at a time. Due to Abercrombie having a considerable amount of men with restricted mobility and requiring assistance to participate in exercise, these challenges are concerning.

Abercrombie had only one exercise session, and this coincided with an allocated physical training session. There was no provision made for the prisoners who attended this session to access exercise.

The numbers observed attending exercise were reasonable in both halls. However, staff report that in fine weather, numbers attending exercise for Abercrombie could often exceed 200 people.

Devon prisoners accessed daily exercise in reasonable sized areas, which were clean and in good condition, although again uninspiring.

Recommendation 68: HMP Glenochil should consider an alternative area or route to exercise for prisoners with mobility issues.

Recommendation 69: HMP Glenochil should provide appropriate opportunity for the non-offence protection prisoners to access fresh air.

Recommendation 70: HMP Glenochil should consider means to enhance the exercise area to encourage prisoners to actively participate in movement and exercise.

6.8 Prisoners are assisted in their religious observances.

Rating: Satisfactory

The chaplaincy team had appropriate multi-faith membership. Church services were held on different weekdays for Harviestoun and Abercrombie. Roman Catholic Mass, including communion, was held each week for the prisoners in both areas. The Imam attended on a Thursday and provided a prayer meeting for both populations.

The chaplains advised that recent improvements to Devon had meant that they were more easily able to meet with prisoners housed in that area. They advised however that the non-offence protection population in Harviestoun was more problematic to gain access to, with the Harviestoun regime providing little opportunity for face-to-face meetings or attendance at church services.

There were no chaplains present at the weekend and as such, no faith services took place on a Sunday.

As most prisoner transfers were received on a Friday, there would be no spiritual support for new admissions until the following Monday. It was noted however, that should a person be in crisis, pastoral care could be provided on request, although it was unclear who was the point of contact should the need arise.

Prisoners could access items such as rosary beads and prayer mats on request.

Examples were provided of responding to individual care needs that could not be met by the team, including examples of a Rabbi travelling from Glasgow to meet with a Jewish prisoner and sourcing a bible in Lithuanian for a non-English speaking prisoner.

Chaplains were routinely informed by reception when prisoners were detained in hospital and provided pastoral care throughout their stay.

Notifications of bereavement were found to be dependent of the area and staff member, and at best the approach could be described as inconsistent.

The chaplaincy team had supported both staff and prisoners to cope with dealing with end of life care and death.

In addition to the church services all staff contributed to providing additional activity linked to faith which included a “Rosary Group”, “Bible Study Group”, “Alpha Group”, “Sycamore Tree”, “Just Ten” and “Habits and Hang Ups”. The latter groups provided participants the opportunity to consider making changes to behaviours relating to offending and substance misuse. Although some of these groups were available to both populations, the majority were assigned to Abercrombie.

The team also created opportunities to break down barriers providing topical discussion groups co-facilitated by chaplains of different faiths (“Faith to Faith”).

The chaplaincy team considered their relationship with both the SMT in HMP Glenochil and the chaplaincy advisors at headquarters to be supportive and non-intrusive. A quarterly meeting with the Head of Offender Outcomes allowed a formal discussion to take place, with ad hoc meetings being easily arranged should anything require discussion in the interim. The duty manager did not routinely attend services, although the chaplains indicated that they would come along to organised events when invited.

Some inter-departmental working was evidenced with the “McMillan Coffee Morning” taking place in the multi-faith area and carol services in the visits room. The team used their community links to provide added value activities, which had included a palliative care talk for the mobility prisoner carers and visits from musicians and bands.

The team were not routinely included in wider multi-disciplinary forums like mental health, health promotion, children and families events and considered that they were often an afterthought when events were being planned.

Chaplains did not routinely become involved in prisoners case management, but advised that they attended when requested or had specific knowledge of an individual case.

Recommendation 71: HMP Glenochil should consider means to access pastoral care at the weekends.

Recommendation 72: HMP Glenochil should create a process to insure that chaplains are routinely informed in the event of a personal bereavement and are included in wider disciplinary forums.

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: Generally Acceptable

The visit room in HMP Glenochil was light and airy, with panoramic views of the neighbouring Ochil hills. The seating and tables were of good quality. Visitors could purchase a variety of hot and colds snacks, drinks and confectionary from a privately run kiosk. Visitors were allocated a number on arrival and were called up two at a time to avoid excessive queuing. A small but well stocked children's play area was located to the rear of the room and children were allowed to take items to their table to play with.

The visits room was on the first floor and was accessible by lifts for both prisoners and visitors.

A monthly visits timetable was produced and circulated to the residential areas. Abercrombie and Harviestoun halls had access on alternate days, insuring equity of access. Prisoners currently located in Devon were unrestricted and could access any session according to their usual location. Harviestoun protection prisoners were also accommodated within normal Harviestoun visits.

Tables were allocated to prisoners on arrival to the visit room, ensuring that families with children were closest to the play area and those with additional security needs were located closest to the staff desk.

Prisoners booked their own visits through the residential staff. Prisoners had the option to request double visits and these were accommodated if possible.

Visit staff ran a daily report from PR2 that indicated which prisoners had booked visits. All prisoners were collected and taken to the visit room, irrespective of whether their visitors had arrived. As such, there could be several prisoners in the visit room who did not have a visitor in attendance. For some, this merely meant that their visitor was running late. However for many no visitor had arrived, and after some 15 minutes they elected to return to the hall, which was facilitated. This could cause an unnecessary risk due to people potentially becoming bored and/or anxious and could ultimately result in unhappy prisoners accumulating in an area where other visits are taking place.

Visits took place Monday to Friday in the afternoons and evening, and both morning and afternoon at the weekend. This approach maximised the opportunities for visits at the weekend, a popular time for both halls.

Children's sessions were very limited, with only a single fortnightly afternoon weekday visit in place for Harviestoun, none weekday for Abercrombie and one children's visit available for each area at the weekend. The weekday session was during school hours and as such was not available to older children. Prisoners

whose families had some distance to travel reported that their families could not get to the prison in time for the weekend family visits, which took place in the morning. In response to this, the last weekend of the month had family visits for both halls in the afternoon.

No family sessions took place during the inspection. However, staff provided pictorial evidence of examples of activities provided, and reported that the sessions were always supported by both Family Contact Development Officers (FCDOs) and volunteers from the visitor centre. Prisoners had to apply for consideration for children's visits and input was sought via Prison Based Social Work and Children and Families to insure contact was approved.

Both FCDOs and Visits FLMs reported not having received any formal training for role in relation to "Get it Right for Every Child" (GIRFEC) or child protection. There were two full-time equivalent FCDOs, who had a dedicated phone line and provided information and assistance to both prisoners and family members.

In partnership with FCDOs, the Stirling Interfaith Community Justice Group delivered a short parenting course called "Families Together", focusing on how to continue to be a good dad while in prison. Fife College also hosted a course run by Community Learning and Development, "7 Habits of Successful Parenting" for prisoners, and the families of participants were encouraged to attend the same course in the community.

A range of seasonal and themed events were facilitated by the FCDOs, and external provider "Vox Luminis" provided prisoners and their children the opportunity to participate in a music workshop programme.

Recommendation 73: HMP Glenochil should source appropriate training in GIRFEC and Child Protection for all visits FLMs and FCDOs.

Recommendation 74: HMP Glenochil should increase their provisions of children's sessions during the week and include sessions available for older children.

Recommendation 75: HMP Glenochil should consider an alternate means to accommodate prisoners whose visitors have not arrived.

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

Rating: Good performance

HMP Glenochil was fairly remote and not easily accessible by public transport. The nearest bus stop was around one kilometre away and as such, visitors using public transport had a long walk or were obliged to rely on taxi services. There was a large car park with adequate spaces for visitors' cars.

HMP Glenochil has a small area designated as a Visitor Centre within the main building, prior to secure entry to the prison. The area was staffed by "Stirling Interfaith Community Justice Group" along with local volunteers. The area had a café like appearance, with a well-stocked children's play area. The café provided hot and cold drinks, fruit and soup free of charge for all visitors, and had achieved the NHS Healthy Living Award. Fresh fruit, soup packs, toothbrushes and toothpaste were available to be taken home by the visitors.

The Family Centre provided a sign posting service to supportive organisations and hosted "Drop In" sessions delivered by agencies including Victim Support and The Citizen's Advice Bureau.

In addition, the area had offered a work placement for HMP & YOI Cornton Vale prisoners, although there was no-one working with them at the time of inspection.

Staff at the vestibule were observed to be polite and helpful. This was particularly noted when a visitor had not been booked correctly onto the system. Although the visitor was for a Devon prisoner, arrangements were made for the visit to take place with minimal waiting time for the visitor.
Visitors were guided towards lockers to safely store their personal items and a supply of "coins" were available for anyone who asked.

Visitors were permitted to take essential items into the visit room for baby changing or childcare, and were provided with plastic boxes that were retained by the staff and made available on request.

Procedures to admit visitors to the establishment were observed and search procedures were sensitively and appropriately managed.

The visitor waiting area had seating of good quality and a wall hung television. Hot drinks were available via a vending machine. The area had a toilet and baby change area for the use of visitors, but at the time of inspection the baby change area was noted to be out of order. When questioned, staff were not aware how long it had been unavailable or the nature of the problem. This meant that should a visitor with a baby require to use baby change facilities, they would have to return beyond the secure line and go through the process again. Repairs were done later in the inspection week to resolve this issue.

Staff in the visit room were unobtrusive but responsive when asked for assistance.

Recommendation 76: The Scottish Government should liaise with the appropriate organisations to consider placing a bus stop outside the establishment.

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: Generally Acceptable Performance

HMP Glenochil had the "e-mail a prisoner" scheme in place and staff reported the service was well used. The service supported the prisoner to reply if pre-paid by the initiator.

It was disappointing to note that HMP Glenochil did not have virtual visits operating despite having the facilities in place to support this. The establishment had the facility for virtual agents visits that was booked via the agents booking administrator.

Prisoners with family who lived abroad could access additional phone credit to support family contact, and there were nine prisoners currently accessing the scheme, receiving funds on the first Friday of the month.

Each section had a number of telephones available, however prisoners reported in focus groups there were insufficient phone lines dedicated at times of high demand.

Disappointingly, the protection prisoners in Harviestoun reported that their limited regime meant they could not access the phones in the evening.

The establishment had recognised that a considerable number of prisoners did not receive any visits from family, particularly in Abercrombie. In response to this, Stirling Inter Faith Community Justice Group had recently started a Volunteer Visitor Scheme. Volunteers were provided with some supportive training by the SPS including "Professional Boundaries" and "Talk to Me" and given some guidance about self-protection and what to report. At the time of the inspection, two prisoners with no family contact were accessing the scheme, with four volunteers trained to date. It was envisioned that this scheme would be expanded upon.

HMP Glenochil offered and accommodated prisoners for accumulated visits in line with the national policy.

Recommendation 77: HMP Glenochil should develop the use of virtual visits and other technology to support prisoners who cannot access visits in the normal way.

Recommendation 78: HMP Glenochil should improve the regime available for non-offence protections to allow access to the phone in the evening.

Recommendation 79: Information about access to additional phone credit for persons whose families live abroad should be more widely publicised.

Good Practice 13: The Volunteer Visitor Scheme provided social contact to some of the most isolated prisoners and should be expanded upon.

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 Performance

In general, HMP Glenochil managed visit restrictions in accordance with national processes and took account of the best interests of any children. Evidence was provided showing robust review panel and appeals processes. A decision to place a person on restricted visits would trigger a review of their children's visit status, but not automatically result in withdrawal of that opportunity.

Only a very small number of prisoners were on closed visits at the time of inspection. Examples of decision letters were acceptable, giving detail of timescales and how to appeal against the decision. There had only been two banned visitors throughout 2019 and only one visitor placed on closed visits. The closed visits cubicles were of reasonable size and were clean.

There were no closed visits review panels during the time of inspection; however, staff reported that the panel sat monthly and reviewed all current cases. The panel was of suitable seniority and prisoners were invited to provide written self-representation for consideration.

A closed visits database maintained a current position for each restriction and PR2 was kept up to date for all restrictions.

Any restrictions to phone calls were done via the IMU and only following a written request from an individual wishing not to be contacted, explaining why they wished the contact to stop. Rule 60 paperwork was completed by a senior manager and retained in the IMU. There had not happened since 2017.

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 Performance

HMP Glenochil provided a range of nationally recognised courses including the "Self-Change Programme (SCP)" (for violence), "Pathways" (for substance misuse), "Constructs" (for cognitive skills), "Discovery" (for violence) and "Moving Forward: Making Changes (MF: MC)" (sex offender treatment programme). The establishment was currently being supported by colleagues from HMP Shotts with the delivery of SCP, alongside recently trained HMP Glenochil programmes staff.

The establishment complied with the national processes for programme assessment, allocation and notification to prisoners. There were around 60 prisoners awaiting GPAs, who were prioritised according to critical dates.

A high number of prisoners had MF: MC as an outstanding need, with a national waiting list of 243, 114 of these were located in HMP Glenochil. Eighteen were on the national waiting list for this intervention on a 2:1 basis and 15 of them were living in HMP Glenochil.

The national waiting list for programmes was a concern, both in relation to the extensive waiting list for MF: MC, but also in relation to the requirement to transfer to other establishments to participate in programmes. This was unsettling for all prisoners, but it was particularly applicable to Abercrombie prisoners who often relied on their peers as their only social contact, and expressed fear for their safety in other establishments.

The chaplaincy team provided a number of recognised group activities including The Sycamore Tree and Alpha Group, in addition to discussion forums. The Links Centre staff had a life skills course for short-term prisoners close to release.

The Learning Centre provided project based learning for both prisoner populations covering a range of topical subjects. Of particular note was the recent “moon project” supported by Stirling University, where prisoners learned about and problem solved the challenges faced should the moon be colonised.

As the Learning Centre had a full-time music lecturer, a choir and music therapy was in place.

Both prisoner groups contributed to a quarterly magazine that was circulated throughout the prison.

Music was also available in the activities area through the creative use of an old office that had been converted into a music area. Prisoners had the opportunity to form bands and practice, writing songs and music in addition to performing cover versions. These bands provided quarterly concerts for both the population of the prison and for the visiting families.

The gymnasium provided a range of health and wellbeing courses, with session dedicated to the aging population encouraging mobility.

Recommendation 80: HMP Glenochil should take steps to address the considerable waiting list of Generic Programme Assessment.

Recommendation 81: The SPS should address the extensive National Waiting List for “Moving Forward: Making Changes.

Recommendation 82: The SPS should consider the appropriateness of the National Waiting list model, giving consideration to the current operational challenges faced through high prisoner numbers and the personal impact on the individual having to make a choice to address their offending needs at the cost of social isolation.

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: Satisfactory Performance

HMP Glenochil operated a robust case management process for their enhanced ICM prisoners. The recent rise in operating numbers had increased the short-term prisoner population, and systems were not so well established for this population.

The establishment held a large amount of OLR prisoners, requiring significant formal risk management and annual updates to the RMA.

HMP Glenochil had a hugely experienced ICM team with some having been in role since the ICM process was initiated. ICM initial and annual case conferences were chaired by the designated ICM team member, while the pre-release/parole/ progression were chaired by a member of the prison based social work team. The establishment held around 50 ICM case conferences per month, and statistics revealed that a personal officer attended around two thirds. The prisoners were given paperwork in advance to invite their family member if they wished.

The establishment had created two dedicated FLMs to manage the OLR caseload due to the considerable workload that the cases brought, which could not be resourced in its entirety from the psychology team. The psychology team retained the most complex cases and any work associated with updating and amending the individual risk management plans in response to changes of circumstance.

The majority of the OLR prisoners were housed in Abercrombie, with each residential officer having at least one OLR on their personal officer caseload. Staff reported that they had not received any specific training for working with this population.

Prison based social work had a relativity small but dedicated team, with each social worker managing a caseload of around eighty prisoners. Due to lack of resource, the team required to prioritise their workload and gave priority to assessing the risk of those being considered for progression or parole.

Parole was an issue due to a large number of postponements and rescheduling, (update reports required) and social work staff being cited to appear at tribunals. This placed additional burden on an already stretched resource.

Due to prioritisation of workload, it was not usually possible to have risk assessments prepared for initial and early ICMs and there was a waiting list for Risk of Serious Harm assessments.

Excellent relationships between the OLR case managers, prison based social work and psychology were evidenced, with all the roles and responsibilities clearly defined.

There were two full-time equivalent Throughcare Support Officers (TSO), with one having recently being appointed following a lengthy period of the post being uncovered. Take up by short-term prisoners was low, with only six people being supported post prelease at the time of the inspection.

Recommendation 83: HMP Glenochil should develop case management for short-term prisoners and establish effective routes to refer to the TSO team.

Recommendation 84: HMP Glenochil should provide specific training to personal officers responsible for OLRs.

Recommendation 85: The SPS should consider the overall management of OLRs, lack of progression within this prisoner group and increasing demands on resources that this population create, which is particularly impacting on HMP Glenochil' s ability to effectively case manage this group.

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: Satisfactory Performance

The Deputy Governor chaired a weekly RMT. Each meeting was divided into two parts, with cases being presented for "Risk" and "Progression".

The multi-disciplinary meeting was attended by appropriate representation from healthcare, psychology, prison based social work and case management. The meeting was noted to be lengthy and could take in excess of three hours. The minute was created, considered and agreed by the RMT before moving onto the next case.

The ICM team presented the cases for progression and the OLR case managers and/or the Early Release Liaison Officer /Lifer Liaison Officer presented the cases for risk.

Prisoners were encouraged to complete written self-representations for consideration at the meeting and to appear in person to ensure that their views were considered. An invited prisoner was observed to be treated with respect throughout, with all parties being fully introduced and their role explained. His personal officer supported him at the meeting.

The only route to the boardroom for prisoners, where the RMT was held, was through the parole tribunal room. This meant that if a tribunal was sitting, prisoners could not attend the RMT. This was observed during the inspection, although reported to be unusual that tribunals took place on a Friday. As such, one person who expected to attend and present his views was unable to do so.

Due to the high volume of OLRs and long-term prisoners held in HMP Glenochil, the RMT cases were, in the most part, scheduled in advance. This meant that both the

prisoner and the personal officers were well informed as to when their case would be heard. A number of prisoners interviewed were able to advise that their case would be heard on a specific date.

The outcome of the RMT was routinely fed back by the residential manager of the area where the prisoner was located, and would be done by the case manager or ICM coordinator for more complex cases.

The ICM team held responsibility for MAPPA referrals, and both experience of the team and the population had resulted in excellent relationships with MAPPA coordinators from all regions.

National changes to HDC had resulted in a national reduction in numbers eligible to accessing this opportunity. Local processes followed national guidelines, and appeals in respect of HDC decisions were managed through the ICC process.

Good Practice 14: Due to the scheduling cases of RMTs in advance, prisoners and personal officers were aware of when their case is due to be heard, and had adequate time to prepare.

Recommendation 86: HMP Glenochil should consider a more fail-safe means for prisoners to be able to present their case in person at RMTs.

HMIPS Standard 7

Transitions from custody to life in the community

Quality Indicators

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

Rating: Generally acceptable performance

The prison had a well-equipped Link Centre, which was used to deliver programmes, religious services and a life skills course. It was underutilised in terms of maintaining the regular involvement of community based services and agencies with a role in supporting men on short-term sentences on release. It should be noted that the prison did not have responsibility for processing a high number of prisoner releases, as the majority of men would progress to other establishments for release preparation and planning. Nevertheless, the absence of an active Link Centre limited the potential for prisoner contact with community based services and supports. The aforementioned life skills course was a notable exception to this as it was well organised and included inputs from individuals from community based agencies and services. The provision of additional resources and facilities would potentially enhance the quality and effectiveness of this.

Senior managers demonstrated a sound understanding of the role and responsibilities of partner agencies with responsibility for supporting and delivering transition arrangements from custody to life in the community. Managers understood the challenges facing agencies such as prison based criminal justice social work, in delivering the wide range of tasks relevant to the large population of individuals subject to statutory supervision on release. Structures were in place to facilitate effective partnership working and regular discussion took place to identify potential solutions to address any gaps in provision.

Clear processes were in place to support the participation of individuals subject to statutory supervision on release in sentence and pre-release planning. Appropriate agencies worked together to prepare jointly agreed release plans for these individuals. However, for individuals serving a short-term sentence and not subject to statutory supervision, the service was more limited. The prison had not established efficient case management processes for this group and therefore community integration planning for non-statutory release was not taking place routinely. As such, the quality of pre-release planning, prisoner involvement and the extent to which community integration needs of prisoners was being met was variable.

The prison recognised the needs of the older prisoner population and had established appropriate care support for those who required it within the prison. The prison collaborated well with community health and care agencies in order to plan to meet identified care and health needs of older prisoners following their release.

Recommendation 87: HMP Glenochil should take steps to establish a more fully functioning link centre, which has the involvement, and participation of relevant community based agencies with a role in prisoner resettlement.

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

Rating: Satisfactory performance

The prison had established effective processes to ensure that relevant legislation and guidance was adhered to in respect of individuals subject to release on statutory licences and supervision. An effective and efficient ICM process had been established, and both prison based and community based agencies worked collaboratively in order to put case management and risk management plans in place. Given the nature of the prison population within the establishment due consideration was given to undertaking comprehensive risk assessments and post-release supervision plans which prioritised issues of community safety. The work of ICM coordinators, prison based social work staff and the psychology team (as it related to the contribution to assessment and planning for release) was well-organised and reflected high standards of professional practice. ICM coordinators were proactive in engaging prisoners and their families in the ICM process.

Appropriate support was provided to men where they faced barriers such as speech and language difficulties, mental health issues or disabilities. Independent advocacy services were not used.

The ICM process was well embedded in practice and was delivered in accordance with relevant standards. Community based social workers maintained a high level of attendance at ICM meetings and prison based social work staff made an effective contribution to the process. The prison had established a personal officer role and function however, the effectiveness of the role varied. Prison managers recognised this and work was being undertaken to increase the skill set of personal officers and to further imbed the role in day-to-day practice. The frequency of personal officer attendance at ICM meetings was inconsistent. Effective communication and partnership working was established and maintained between prison based staff and community agencies and statutory bodies in relation to planning for the release of individuals on statutory supervision.

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: Poor performance

The programmes team was well staffed and provided an appropriate range of offence focussed and personal change programmes. Individuals who had participated in programmes such as MF: MC were provided with an opportunity to continue programme work following release, where an outstanding treatment need

had been identified. Timely access was dependent on the availability of community resources for the delivery of the programme. While a suitable range of programmes was available to meet identified need, as reported under Standard 6 there was a backlog in respect of GPA being undertaken and a considerable number of these were outstanding. This resulted in delays in men being assessed and included in an appropriate programme. There was a lengthy waiting list for access to the MF: MC programme. In some cases, this had an impacted on how quickly an individual could move on to the next stage of their progression. The programmes case management board operated efficiently, however was at times hampered as a result of limited programme availability, a backlog of GPAs and delays in the completion of relevant risk assessments relevant to the progression process. There was also a backlog in the completion of post-programme reports that required to be completed and provided to other prison based and community agencies, to assist with sentence planning and post-release management.

Recommendation 88: HMP Glenochil should take steps to reduce the backlog of GPA's (see recommendation in QI 6.13) and improve the rate of completion of post-programme reports.

Recommendation 89: The SPS should review the level of provision and availability of the MF: MC programme in order to improve timely access to this.

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

Rating: Generally acceptable performance

Individuals serving long-term, life and extended sentences and subject to statutory supervision on release, had the opportunity to contribute to a co-ordinated pre-release plan in order to address individual community integration needs. The prison had a robust process in place for assessments to be undertaken and for regular reviews to take place. This included early assessment of risks and needs and identification of the appropriate level of intervention and resources required. This was co-ordinated through the ICM process. A prison based ICM team coordinated and chaired regular case review meetings and made a concerted effort to include prisoners and their families in the process. The prison based criminal justice social work team ensured that relevant assessments were carried out to a high standard. They engaged effectively with individuals in order to ensure that they understood their release conditions and any specific restrictions. Working in close partnership with community based social workers; they played a central role in identifying and agreeing actions and sources of support, which can contribute to successful community reintegration. The prison and statutory partners had a sound understanding of the risk and needs of the statutory population. They collaborated effectively in terms of assessment and case management planning and had formed strong working relationships with community agencies and statutory bodies in order to put in place case management plans, which were aimed to address individual needs and ensure that community safety is prioritised.

However, many individuals on short-term prison sentences and not subject to statutory supervision on release had limited opportunity to engage in preparation or planning for release. While case management systems had been introduced to drive community integration planning for this group, the prison has not been able to deliver it routinely or effectively. This was with the exception of the throughcare support service provided for men under 26 years of age delivered by New Routes, and for some individuals over 26 years who received a support service from TSOs. See QI 7.5 for more information about this.

The prison was at an early stage of implementation of the Sustainable Housing on Release for Everyone (SHORE) standards. While suitable arrangements were made with housing providers in respect of statutory release plans, men on short-term sentences had a more variable experience.

Recommendation 90: HMP Glenochil should ensure that appropriate assessments are undertaken in respect of short-term sentenced prisoners and that community integration plans are in place to suitably support their preparation for release.

Recommendation 91: HMP Glenochil should progress the implementation of the SHORE standards in order to ensure that prisoners housing needs are identified at an early stage in their sentence, and that they have the opportunity to access suitable housing following release from prison.

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

Rating: Generally acceptable performance

The prison had a TSO service in place. This was delivered by a small staff team and was appropriately targeted at short-term sentenced individuals. A throughcare service was provided to men under 26 years of age by New Routes, a third sector mentoring and support service for young men involved in offending. This service was highly valued by those individuals who accepted and participated in it. The service for men over 26 years of age was the responsibility of the TSOs. Staff demonstrated drive and enthusiasm for working with the men to achieve positive outcomes, and were flexible in the support provided to ensure that it met individual needs. However, the team were limited in the number of individuals that they could provide a service to due to the size of the team. As a result, the majority of men over 26 years of age were not offered or provided with a throughcare service. The TSO staff presented as knowledgeable and committed to the task and for those who were provided with a service it was considered to be very helpful. There was however a lack of awareness of the service among the prison population. This was attributed to a limited induction process.

The lack of a well-established induction meant that prisoners might have missed opportunities to get information on the TSO service and other support services in the community that could assist them with community reintegration on release. The gap in induction provision was recognised by prison managers and an improved induction process was being piloted.

Recommendation 92: HMP Glenochil should review the TSO service and staffing level in order to ensure that all eligible prisoners have the opportunity to access the service.

HMIPS Standard 8

Organisational Effectiveness

Quality Indicators

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

Rating: Poor

It was encouraging to note that 99% of staff at HMP Glenochil had completed SPS E&D e learning, and 99% had completed a classroom session on it.

Nevertheless, HMP Glenochil acknowledged in its own PRL self-assessment that it had work to do to develop an E&D Action Plan and meet other related E&D expectations.

A committee had been established to oversee activity on E&D, but at the time of inspection, it did not yet have the full membership recommended by SPS HQ.

Although a draft action plan had been developed, there was no agreement at the time of inspection on timescales or which individuals would lead the different actions proposed.

Moreover, no systematic process of E&D impact assessments had been carried out, leaving the prison without a comprehensive assessment of need in this aspect. While a senior unit manager had been tasked with progressing development of an action plan, and a coherent plan was now being pulled together, it had inevitably been hard to prioritise that alongside other tasks.

It was encouraging, however, that production and implementation of an E&D Action Plan now featured as a priority in the Annual Delivery Plan for 2019, and that the Governor would chair the new committee.

Recommendation 93: HMP Glenochil's SMT should ensure that an agreed action plan on Equality and Diversity is implemented effectively, and a systematic series of Equality and Diversity Impact Assessments are carried out across the establishment. **This links to the need for wider action to more deeply embed a culture of respect for human rights (as discussed elsewhere).**

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

Rating: Satisfactory

An action tracker was used to summarise the activity required to address scrutiny body reports, and this was reviewed on a monthly basis by the SMT. The monthly business review meeting also looked at performance with compliance checks. There was evidence that PRL self-assessment submissions were completed diligently by HMP Glenochil with credible results, including for example a recognition of limited assurance only being appropriate in relation to E&D.

A report on progress with implementation of recommendations from the 2015 inspection painted a realistic picture on action taken to address the various 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: Generally acceptable

The SMT meet to develop an annual delivery plan, which includes a business improvement plan and a 'business as usual' plan. Activity established under the business improvement plan may subsequently appear in the 'business as usual' plan as part of further efforts to embed cultural change and cement new approaches.

The annual delivery plan for 2019-20 had been circulated to all staff at the start of the new financial year, with encouragement for the plan to be discussed at staff meetings. At the end of the year, staff are provided with a copy of the delivery plan showing progress made against each objective and action.

The SMT keep performance across the prison under review in a range of ways, for example tracking:

- the number of complaints received by establishment area
- the number of Freedom of Information requests addressed within the target timeline
- the number of Parole Board dossiers submitted on time

While staff welcomed the visibility of the SMT, and the efforts made to circulate information about the Annual Delivery Plan are commendable, there did appear to be a gap between senior management and staff in expectations around communication.

The focus group discussions with staff indicated they would welcome more information on the strategic direction for the prison, and better feedback on the suggestions they make for addressing the regime challenges facing the prison, while senior management felt they had listened and explained their decisions.

Some of our other findings, particularly under Standards 5 and 7, also indicated that HMP Glenochil may not have been providing equality of access to services for all prisoners, or maximising the opportunities to support purposeful activity and encourage progression to qualifications.

The arrival of a new Governor provides an opportunity to re-energise existing relationships with stakeholders and staff, and promote open and constructive dialogue with staff and trade union representatives.

Inspectors welcomed the commitment in the Annual Delivery Plan to develop a comprehensive communications strategy**.**

Recommendation 94: Senior management should set out clearly the action they are taking to address the population challenges, and the longer-term strategic direction of the prison, and encourage constructive two-way communication at all levels of the organisation to support clarity and unity of purpose.

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

Rating: Generally acceptable

A good range of training statistics were collected, which provided a strong grip on progress against the targets for core mandatory training and where reminder action is needed. Where the SMT had themselves missed mandatory training this was brought to their attention, so that they could address the issue and set an example.

Succession planning was on the radar of the SMT who had ensured that it was included as a priority for the 2019-20 Annual Delivery Plan. Acting up opportunities are provided as developmental opportunities, and a 360-degree feedback was provided for senior management and reflective practice sessions were run with the SMT in October 2018. Efforts had also been made to develop FLMs with a fortnightly communication and development forum introduced in May 2018 with eight FLMs, and further training events for FLMs taking place in August and October 2018. This investment in FLM development is commendable.

General awareness training on specific categories of prisoner, such as sex offenders, is provided for staff. However, more ongoing continuous professional development training would be helpful for staff dealing with specific cohorts of prisoners, such as sex offenders.

Recommendation 95: The SPSC should consider options for enhanced continuous professional development for staff dealing with sex offenders and other specific categories of prisoner.

Recommendation 96: HMP Glenochil should consider further training to embed a culture of respect for human rights.

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

Rating: Satisfactory

The pre-inspection focus groups with staff, and discussions held with staff during the inspection, indicated that there was respect amongst staff for the challenges faced by other groups of staff and a good understanding of respective roles.

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

The inspection team also welcomed the way in which the Staff Recognition Committee had been set up to ensure representation from different functional groups of staff across the establishment, which again helped encourage appreciation of the contribution made by all groups of staff.

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: Good

Completion rates for annual appraisals were carefully monitored.

The prison ensured that long service was recognised visibly at the entrance to the prison and individuals were nominated for local and SPS Chief Executive excellence awards.

Action was taken where performance was deemed ineffective or disciplinary action was judged necessary.

Sickness absence levels were closely monitored by senior management and a robust process had been put in place for discussing the scope to return to work with individuals on sick leave. Human Resources (HR) had clarified the type of information they would expect to be recorded by line managers when the individual was off sick or did not return to work. HR had also made efforts to encourage a more proactive approach by line managers to stress management, encouraging discussion on mental health issues with staff to reduce the risk of stress related sick leave. These initiatives had been successful in reducing absence levels by 14% over the last year. HMP Glenochil had one of the best absence records of any establishment.

Inspectors noted that the 2015 inspection report had highlighted that staff felt undervalued, with only 32% in a staff survey feeling valued at work. Unfortunately, the position had not improved with only 28% of those completing the 2018 SPS staff survey feeling valued. This was disappointing, with a participation level of only 14% in the staff survey also troubling. Inspectors understand, however, that participation levels and results in the 2018 survey may have been influenced by frustration with

pay and the outcome of the Prison Officer Professionalisation Programme proposals, which are issues beyond the control of local management.

HMIPS welcomed the creation of a Staff Recognition Committee and the efforts made to value staff as well as promote healthier lifestyles through the Health and Wellbeing events. These events were well attended and feedback from staff was positive.

Good Practice 15: The Health and Wellbeing events are to be commended and we would encourage other establishments to consider similar events.

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

The prison contributed to development and implementation of the Stirling Council Reducing Offending 2018-2021 strategy and has developed its own Community Justice Action Plan tracker to monitor progress with actions agreed with the Stirling and Clackmannan community justice groups.

The prison was now looking in its Business Improvement plan for 2019-20 to build on the success of the partnership with the Castle Furniture charity in Fife, which culminated in an award for the renovation of white goods by Glenochil prisoners. Inspectors welcomed efforts to forge similar links with local organisations in Clackmannan during 2019-20.

The prison was active in other ways in engaging with local communities, for example welcoming visits from secondary schools (for pupils over the age of 16). The one observed by the inspection team was very sensitively handled. The family centre developed with the Stirling Interfaith Group had also been a good initiative. The prison had provided an outdoor shelter for a nursery in Perth and produced timber products for other community projects. The prison is hoping to start a new project this year looking after bees and producing honey. The prison would like to do more in this area, selling some products produced in the prison to raise money for charities and other worthy causes, but SPS financial rules hinder their ambitions at present.

The partner organisations inspectors spoke to enjoyed a positive working relationship with staff at HMP Glenochil, and felt well informed of operational issues that affected them. They did note however that planning horizons tended to be limited to the current financial year. While budget uncertainties make that understandable, it would be helpful if possible to engage partner organisations more fully in longer term strategic planning.

Recommendation 97: The SPS should consider the scope to amend its financial rules to allow HMP Glenochil to support local worthy causes while providing purposeful activity for prisoners.

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 line with normal SPS protocols, SPS HQ dealt with all requests for media comments. There were therefore limited opportunities for direct proactive engagement with local or national media, although the prison would cooperate where practical with any media request.

HMP Glenochil instead seeks to cement positive impressions of the prison through its various community focussed activities, maximising any opportunities presented by such things as the award achieved for its work renovating white goods in partnership with Castle Furniture in Fife.

HMIPS Standard 9

Health and Wellbeing

Quality Indicators

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

Rating: Good performance

On arrival at HMP Glenochil, the immediate health needs of all prisoners were assessed by a member of the primary care team.

The health screening was carried out in a room that maintained the prisoners' dignity and confidentiality throughout. Staff explained the health screening process to prisoners, made sure that they understood its purpose; actively encouraged and supported prisoners to be fully involved in their screening, and sought prisoners' consent regarding treatment options or to share information with relevant others.

Staff recorded all health screening information onto the Vision patient electronic record system, including medication already prescribed to prisoners for pre-existing health conditions.

Staff followed a pathway to determine whether a prisoner was fit to be in custody and anyone identified as being at risk of self-harm or suicide were commenced onto TTM.

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

Rating: Satisfactory performance

Following admission to HMP Glenochil, prisoners were seen the next working day by a member of the healthcare team for a more detailed health assessment; this was carried out following a standardised assessment process. At this time, prisoners were given an information leaflet explaining the range of health services available, and how they could be accessed. Inspectors were told that this was available in different formats.

Information about prisoners with a long-term condition was recorded on Vision and their ongoing care needs were met in line with national guidance and best practice. Inspectors reviewed several patient's clinical notes and found them to be comprehensive and accurate.

NHS and SPS staff within the health centre had a good understanding of each other's roles and responsibilities and were seen to have a supportive working relationship. Effective two-way communication meant prisoners were supported to attend appointments within the health centre and within the community. Staff followed up with prisoners to check that they had received appointment letters or

reminders. Any missed appointments or refusals, often because the prisoner was unaware of the appointment, or did not know what the appointment was for, were discussed directly with the prisoner. This is good practice.

Self-referral forms were not freely available to prisoners in the halls. Completed forms were placed in a locked mailbox by the prisoner (to maintain confidentiality) available on each level. These boxes were emptied every morning Mon-Friday by the HCA. An easy read self-referral form had been developed by the speech and language therapist. This was good practice.

At the time of the inspection, newly admitted prisoners did not undergo a formal induction process. Both NHS and SPS staff stated that this was something they were keen to reintroduce. Information about the range of health services available to prisoners was displayed in the halls. Inspectors were told that if staff had serious concerns about a prisoner's healthcare, and felt more specialist care was required, the prisoner would be transported to hospital immediately. Out of hours services were available for prisoners.

Social care was provided by an external care agency. The rehabilitation support worker (RSW) was an integral part of the healthcare team, and was responsible for assessing prisoners requiring social care support, to ensure they received the right level of support. This was good practice. They also assessed the social care needs of prisoners who had returned to prison after having been admitted to hospital. In addition, they had a key role in promoting the benefits of social prescribing and had established strong links with a wide range of community and voluntary agencies where prisoners could be referred.

Recommendation 98: SPS and NHS Forth Valley should ensure that self-referral forms are freely available to prisoners in the halls.

Good practice 16: Any missed appointments or refusals, often because the prisoner was unaware of the appointment, or did not know what the appointment was for, were discussed directly with the prisoner.

Good practice 17: An easy read self-referral form had been developed by the speech and language therapist.

Good practice 18: A rehabilitation support worker was an integral part of the healthcare team, and was responsible for assessing prisoners requiring social care support, to ensure they received the right level of support.

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

Rating: Satisfactory performance

The health promotion strategic lead had developed a health promotion strategy specifically for HMP Glenochil. The strategy focuses on issues specific to both staff and prisoners and covers issues such as violence reduction, supporting the journey of recovery, smoke free prisons and staff health and wellbeing.

A range of national screening and immunisation programmes were available to prisoners including blood borne viruses (BBV), bowel screening and flu vaccinations. An opt-out model had been adopted for both the sexual health screening and the smoking cessation programmes. Staff told inspectors they would follow up with prisoners who had initially opted out of these at their admission, to check whether they wished to participate. A number of specialist staff attended the prison on a regular basis including a specialist sexual health doctor and Hepatitis C and HIV specialist.

Health promotion information was provided to prisoners by the patient relations team. Information was available via leaflets and posters, and displayed on health promotion boards within the health centre. The patient relations team also ran the patient forum at which prisoners could raise issues about their healthcare provision. Prisons could request leaflets in other languages and in easy read format. SPS and NHS staff were observed to proactively support and encourage prisoners to take up the health promotion opportunities available to them.

A programme of social prescribing, such as an exercise programme in the gym, had recently been introduced.

As a result of reduced staffing levels and because a formal induction was not carried out during the admission process, the peer support programme was not being fully implemented. This had been raised with the governor and inspectors were told that the situation was under review.

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

Rating: Good performance

Staff possessed a good understanding of the health inequalities experienced by many of their patients. They understood the barriers that many prisoners faced when accessing healthcare in prison and were seen to adapt their approach accordingly. The majority of patients spoken with described having a positive relationship with healthcare staff. Inspectors observed a range of healthcare interactions between staff and patients. Patients were treated with dignity and respect by staff who were polite, respectful and positive.

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 performance

On average patients waited two-weeks for a routine assessment by a mental health nurse. From Monday to Friday, anyone requiring an urgent assessment was seen the same day. There were no waits for patients who required to be assessed by a psychiatrist or clinical psychologist. During the inspection, inspectors observed that the mental health nursing team was not working at its full complement, which

necessitated tasks to be prioritised on a daily basis in order to manage the workload. Inspectors saw that this was having an impact on the team's ability to commit to baseline work for existing patients, and those patients who had been identified as suitable for intervention, treatment and support were not being seen as regularly as required. NHS Forth Valley had recognised this as a risk and had recruited agency nurses on a temporary basis to address the shortfall and to support the nursing team.

There was an integrated mental health nursing team and substance misuse team. Clear processes were in place for assessing and triaging referrals to their service in a consistent manner based on clinical need and risk. The team, which included the clinical nurse manager, clinical psychologist and nursing staff, met on a weekly basis for triaging and case discussions of their patients. The clinical psychologist also provided clinical supervision and complex case discussion to the team.

At the time of the inspection, the consultant psychiatrist from the State Hospital had six sessions per fortnight on set days in the prison; which did not allow time for them to attend these meetings. However, going forward, inspectors were told that psychiatrist input was going to be provided by NHS Forth Valley. It was anticipated that this change would enable the psychiatrist to have a more active leadership role and attend the multi-disciplinary team meetings.

On receipt of a referral to the mental health team, a situation, background, assessment and recommendation (SBAR) tool was completed to determine whether a further global mental health assessment was required. Although a suicide risk assessment was carried out and incorporated into the SBAR, at the time of the inspection this was not carried out using a recognised mental health risk assessment tool. A review of the assessment documentation used across all three prisons in NHS Forth Valley was underway and inspectors were told that implementing standardised documentation into clinical practice was a priority.

Observation of interactions between the mental health nursing team and their patients showed that patients were fully involved in their assessment, and were given the opportunity to discuss the purpose and outcome of the assessment. Verbal information was given on any interventions and treatments being offered, and the risks and benefits of these interventions were discussed with the patient during one-to-one interviews. On reviewing clinical records inspectors found that this was reflected in their healthcare records, and the care plans inspectors reviewed were risk informed and outcome focused. This was good practice.

Pathways and local arrangements for patients who needed to access specialists in intellectual disabilities, autistic spectrum disorder, neuropsychiatric disorders and cognitive impairment were in place within NHS Forth Valley.

A learning disability nurse had just been appointed to the prison and plans were in place for them to carry out assessments, and provide intervention, treatment and support to prisoners with intellectual disabilities. This was good practice.

Where admission to a psychiatric unit was indicated, arrangements were made to transfer prisoners. The level of illness and offence determined whether this was a low secure environment (intensive psychiatric care unit), medium or high secure environment. Inspectors were told that there were currently no delays in accessing medium secure beds.

Where a prisoner requires community follow-up on release from prison, a referral was made to the relevant community mental health service. Patients were kept informed of their planned care following liberation practice.

Recommendation 99: NHS Forth Valley must ensure that patients identified as requiring intervention, treatment and support by the mental health nursing team receive the regular planned interventions described in their care plan.

Recommendation 100: NHS Forth Valley must ensure that standardised mental health and learning disability clinical assessment documentation and clinical risk tools are in place as a priority.

Good practice 19: Care plans inspectors reviewed were risk informed and outcome focused.

Good practice 20: A learning disability nurse had just been appointed to the prison and plans were in place for them to carry out assessments, and provide intervention, treatment and support to prisoners with intellectual disabilities.

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: Good performance

Prisoners with existing long-term conditions were identified during their health screening on admission to the prison. Information about their condition, health and social care needs, treatment plans, appointments and medications was stored on an electronic database to facilitate the management of their condition.

The long-term health condition clinic had not been running since January 2019 due to staff shortages. However, the healthcare team had in place a process whereby people with long-term conditions would continue to be seen by the Advance Nurse Practitioner and be monitored through the Long-term Condition database. This meant that those patients continued to receive care that was in line with local and national best practice, and followed the relevant pathways for care.

The Rehabilitation and Assessment in the Community and Home team was responsible for arranging outreach and in-reach support to patients. The RSW assessed an individual's physical support and equipment needs and arranged referrals to community and voluntary support services. Prior to being released, prisoners were offered an in-reach assessment to make sure that the appropriate community support was in place. This was good practice.

By observing several interactions between nursing staff and their patients', inspectors saw that patients were aware of and understood their health condition, and were seen to be fully involved in developing their personal care plans.

Primary care, mental health and SPS staff had undergone anticipatory care planning training and every patient with a long-term condition was offered an anticipatory care

plan. Patients were also offered a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) to be put in place. This was good practice.

Good practice 21: Prior to being released, prisoners were offered an in-reach assessment to make sure that the appropriate community support was in place.

Good practice 22: Patients with a long-term condition were offered an anticipatory care plan and a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) to be put in place.

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: Generally acceptable performance

Prisoners with drug and/or alcohol dependence were identified during their initial health screening. If the patient had an existing prescription for opiate replacement therapy, there was a process for the patient to continue ORT medication during their stay in prison.

As previously discussed in QI 9.5, the mental health team and substance misuse team had been integrated. This facilitated joint working and identifying which services were best to manage the patient care. Regular clinical meetings were held and attended by a GP, mental health nurses and an addiction worker, to discuss assessments and develop individualised treatment plans.

Inspectors were told that the main challenge for the team was recruiting and maintaining a stable workforce. Recruiting substance misuse staff was via a third sector agency service called Signpost and some posts had been vacant for long periods. Inspectors were told that following a tender process a new third sector agency would be taking over this service. Inspectors were informed that there was one substance misuse team caseworker and three vacant posts, which placed responsibility solely on the caseworker to manage the majority of patients on the substance misuse caseload. The mental health nursing team supported joint working between the two teams however, as already described in QI 9.5 the mental health team also struggled with staff shortages.

Due to staff vacancies and sickness, inspectors were told that the full range of interventions and treatments available, such as the self-management and recovery training programmes, had temporarily ceased. That said, it is important to note that the waiting times for a substance misuse assessment met the national guidelines at the time of inspection.

On liberation, the patients' GP and community addiction team were informed of their proposed treatment prior to discharge, therefore allowing follow-up appointments and support to be put in place quickly.

Pre-liberation groups were open to all prisoners who had two to three weeks left on their sentence. The focus of these groups was harm reduction and Naloxone training. This was good practice.

On reviewing patient's healthcare records, inspectors were able to see that every patient had an individual care plan and had been fully involved in its development. However, the care plans were not being reviewed regularly due to staff shortages.

Recommendation 102: NHS Forth Valley must prioritise the recruitment of staff to ensure that staffing levels are returned to the agreed level. This will reduce the pressure on existing staff and ensure patient safety.

Recommendation 103: NHS Forth Valley must ensure that patients identified as requiring intervention, treatment and support by the substance Misuse team receive the regular planned interventions described in their care plan.

Good practice 23: Pre-liberation groups were open to all prisoners who had two to three weeks left on their sentence. The focus of these groups was harm reduction and Naloxone training.

9.8 There is a comprehensive medical and pharmacy service delivered by the service.

Rating: Generally acceptable performance

The Lloyd's pharmacist provided a clinical pharmacy service once a fortnight, and an NHS Forth Valley pharmacist was available for advice on an ad-hoc basis to the health centre and clinical managers across the three prisons in NHS Forth Valley. Two healthcare support workers supported the pharmacy process on a daily basis, which impacted on the clinical resources available for the wider healthcare team. Inspectors were told that two pharmacy assistant posts were under recruitment.

Inspectors noted that there was an excessive wastage of medications and that there was no mechanism to accurately monitor and record wastage. Kardexes were also subject to limited checking and monitoring.

Furthermore, at the time of the inspection the healthcare team did not have a Home Office Controlled Drugs License in place. This was escalated as a significant concern, and inspectors asked the healthcare team and lead pharmacist within NHS Forth Valley for assurance that they would immediately start the process to secure this.

Each cell had a safe to store any in-possession medication. However, there was only one safe per cell that would need to be shared if two people were sharing a cell.

Prisoners who were due to attend court would receive their prescribed medication before going to court.

The rooms used in the halls for dispensing medicines were staff rooms and contained kitchen equipment and staff lockers. As a result, staff had to transport

medications for every drug round in locked boxes. The physical layout of the rooms made it difficult for staff to keep them at the appropriate level of organisation and cleanliness, and the doors separating the medications dispensing and the prisoners were a potential security risk and they were not compliant with infection control guidelines. This was escalated as a significant concern, and inspectors asked the healthcare team and SPS for assurance that they would immediately start the process to ensure the room was fit for purpose.

Recommendation 104: NHS Forth Valley should review how the Pharmacy service in HMP Glenochil is delivered to ensure that the service is managed and delivered safely and effectively.

Recommendation 105: The SPS and NHS Forth Valley must review the storage of in-possession medication in shared cells to ensure that these medications are appropriately and safely stored.

Escalated Recommendation 106: The HMP Glenochil healthcare team and lead pharmacist within NHS Forth Valley should immediately start the process to secure a Home Office Controlled Drugs License.

Escalated Recommendation 107: SPS and NHS Forth Valley must ensure that the room that medications are dispensed from are safe and fit for purpose.

9.9 Support and advice is provided to maintain and maximise individuals' oral health.

Rating: Good performance

A dedicated dental team was led by the NHS Forth Valley public dental services director, who has responsibility for the delivery of dental services across the three prisons in NHS Forth Valley. A comprehensive range of services was available to prisoners' five-days a week and emergency referrals were dealt with on a daily basis by either the dental nurse or registered general nurse. An out of hour's medical emergency pathway was also in place.

The dental action team promoted and raised awareness of the benefits of maintaining good oral health and supported both prisoners and their families, including children, with their oral healthcare. This was good practice. The team had established links with national health promotion initiatives such as Mouth Matters, aimed at supporting prisoners with their own oral health both inside and outside prison, and Childsmile an initiative aimed at supporting families with maintaining their children's oral health.

The waiting time for an initial dental examination was five-weeks, and once an individual had been examined by the dentist, they automatically commenced treatment. Patients could see the hygienist out with any dental treatment and without a referral from the dentist.

Patients who had been seen by the dentist, or who had completed the oral health or smoking cessation programmes were given a toothbrush and a supply of toothpaste every three-months.

The dental surgery was clean and fit for purpose, and unused instruments were appropriately stored. The dental treatment rooms were subject to regular audit and inspection in line with national standards around decontamination. Used instruments were decontaminated at the NHS Forth Valley area decontamination and sterilisation.

Good practice 24: The dental action team promoted and raised awareness of the benefits of maintaining good oral health and supported both prisoners and their families, including children, with their oral healthcare.

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, or transfer and on release.

Rating: Not applicable

9.11 Everyone with palliative care or end of life care needs can access treatment and support equitable to that in the community, and is supported throughout their stay in prison, on transfer and on release.

Rating: Good performance

Both NHS and SPS staff in HMP Glenochil possessed a good awareness of the principles of palliative and end of life care. An extensive palliative and end of life care training and education programme was offered to staff, covering aspects such as ReSPECT training, what is palliative care, anticipatory care planning workshops, and the Macmillian foundations in palliative care course. In addition, a multi-disciplinary supportive and palliative care meeting was held every three-months.

Prisoners identified as requiring palliative or end of life care had their ongoing support needs assessed using a standardised assessment tool. Any prisoners who were transferred into HMP Glenochil and had high care needs were assessed using the support and palliative care indicators tool. An enhanced care folder was kept in the cells of prisoners as well as at each SPS station and in the health centre. Inspectors spoke to prisoners with palliative care needs and were told that they were involved in their ongoing care and were asked to consent to information being shared to relevant officers if required.

Details about prisoners with palliative or end of life care needs were recorded on the HMP Glenochil electronic palliative care action register. Each prisoners' ongoing care needs were assessed on a monthly basis using the palliative performance scale for custodial environments. Every prisoner on the register was given the opportunity to have an ACP, which they developed in partnership with trained NHS and SPS staff. All the ACPs reviewed set out and covered both what the patient wanted and

what they did not want to happen in terms of their ongoing care needs. They also gave the individual the opportunity to state where they wished to die. In addition, the development of an individual ReSPECT was offered to these prisoners.

The national palliative care lead had been pivotal in enabling HMP Glenochil to develop an integrated palliative care service and form close links with the wider NHS Forth Valley, hospices and voluntary agencies. This is good practice.

Good practice 25: The national palliative care lead had been pivotal in enabling HMP Glenochil to develop an integrated palliative care service and form close links with the wider NHS Forth Valley, hospices and voluntary agencies.

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: Generally acceptable performance

As discussed in QI 9.1 all prisoners' risk of self- harm or suicide was assessed on admission via TTM, and anyone identified as being at risk of self-harm or suicide was immediately commenced onto TTM. The majority of TTM case conferences were attended by a mental health nurse. Inspectors saw SPS officers and mental health nurses being compassionate and respectful to the prisoner, whilst demonstrating knowledge and skills in the area of mental distress and subsequent risk. Of the case conferences observed inspectors saw that the prisoner was fully involved and had the opportunity to discuss the purpose and outcome of their case conference.

As discussed in QI 9.5 review of the assessment documentation used across all three prisons in NHS Forth Valley was underway and inspectors were told that implementing standardised documentation into clinical practice was a priority.

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

Recommendation 108: The care partner assessment and risk assessment tool must be implemented. See recommendation in QI 9.5.

Good practice 26: The monthly mental health multi-disciplinary team meeting, where members demonstrated good multi-agency collaborative and partnership working. The team consisted of clinical psychology, mental health nurses, social work, SPS, forensic and clinical psychology, offender outcomes, residential and adhoc specialist input, and they discuss prisoners with complex care needs.

9.13 All feedback, comments and complaints are managed in line with the respective local NHS Board policy. All complaints are recorded and responded to in a timely manner.

Rating: Satisfactory performance

A dedicated patients' relation team based within HMP Glenochil had responsibility for managing and responding to all feedback and complaints from prisoners across the three prisons within NHS Forth Valley. The team had undergone specific training in the complaints process and could seek advice about complex cases from the patient relations manager based in the Forth Valley Royal Hospital. All complaints were managed according to NHS Forth Valley procedures and logged onto the Safeguard incident reporting system.

Prisoners had to ask a member of staff for a complaints form in some of the halls thereby compromising their privacy and confidentiality. This was communicated to the prison governor, healthcare manager and HMIPS at the time of the inspection. Inspectors were given assurances that this would be immediately addressed.

Information about how to give feedback, comment or make a complaint was available to prisoners, but forms were only available in English. Inspectors were told that forms in alternative formats and languages could be obtained from the patient relations team.

Patient forums were held every second month in Abercrombie at which forum members could discuss issues relating to healthcare. A patient representative had been identified for each level in Abercrombie. Despite efforts, prisoners in Harviestoun Hall refused to engage in the patient forums. Health centre staff met on a regular basis to discuss any concerns or complaints that had been upheld, and the prisons patient relation team and the healthcare manager met to discuss any identified themes.

Recommendation 109: NHS Forth Valley and SPS must ensure that complaints forms are available in the halls and that they are available in different languages and formats.

9.14 All NHS staff demonstrate an understanding of the ethical, safety and procedural responsibilities involved in delivering healthcare in a prison setting.

Rating: Good performance

Staff were able to explain the boundaries between professional and ethical issues. They were aware of the demands of delivering healthcare within the prison setting and knew how to alert others in the event of concerns about the safety of a patient, staff member or visitor.

Processes were in place to ensure that all staff had completed their mandatory training however; inspectors noted that training in basic life support had not been carried out during the previous 12 months. Inspectors were told that this was due to

difficulties securing places within NHS Forth Valley and had been raised as a concern with the SMT.

Recommendation 110: NHS Forth Valley must ensure that staff undertake training in basic life support as a matter of urgency.

9.15 The prison implements national standards and guidance, and local NHS Board policies for infection prevention and control.

Rating: Satisfactory performance

All NHS staff spoken with were aware of, and understood the principles of infection prevention and control and were seen practicing all standard infection control precautions. National guidance and infection control manuals were easily accessible to staff for reference purposes. All clinical rooms in the health centre and the dental examination room were fit for purpose and compliant with all aspects of infection prevention and control. However, as discussed in QI 9.7, the main room where medications were given to prisoners was not compliant with all aspects of infection prevention and control due to the sink being non-compliant with SHTM 64 guidance for hand washing.

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 performance

HMP Glenochil has adopted a nurse-led model, supported by a GP and ANPs to deliver healthcare. Care was provided on a day-to-day basis by the core healthcare team, which comprised of the primary care team and the mental health and substance misuse teams. In addition, psychology, psychiatry, sexual health/BBV services, dental, podiatry, optician, physiotherapy and dermatology services were also available.

As in many other prison estates in Scotland the population in HMP Glenochil had risen over the previous 12 months; in HMP Glenochil the numbers had increased by approximately 100 prisoners. Although this had resulted in an increase in demand for healthcare within the establishment, inspectors were told that no additional funding for healthcare staffing had been provided to address this.

Ongoing challenges with recruitment meant NHS Forth Valley was utilising agency staff and using bank-nursing shifts as a temporary measure. At the time of the inspection eight whole time equivalent posts were unfilled however, some had been appointed to and the rest were out to advert. As a result, some healthcare interventions such as the recovery group and low intensity interventions had been temporarily suspended. Despite this, it was clear to inspectors that the healthcare team was functioning as a cohesive and supportive team.

Nursing staff told inspectors that they felt supported by managers to undertake their role and were assured that senior managers gave priority to supporting staff on an ongoing basis.

Staffs' clinical competences were assured following a clear process and all staff received managerial and clinical supervision. The psychologist provided clinical supervision to the mental health nurses each month, of which the uptake was good.

On reviewing the training records, inspectors saw that all staff had undergone their annual appraisals following Turas; a new staff appraisal system introduced across NHSScotland in 2019. Their objectives and personal development plans had been completed and it was clear that they had the opportunity to discuss any training and developmental needs, or discuss any concerns they had about their roles. Learnpro and mandatory training were available; inspectors noted that not all staff had completed their mandatory training in basic life support, see recommendation in QI 9.14.

A range of training and professional development opportunities were available to staff, but inspectors were told that due to the below agreed staffing levels and the impact this was having on their workload, they were not always able to take up these opportunities.

All new staff were required to complete a formal induction programme designed specifically for working within a prison environment.

HMP Glenochil was recently been awarded funding from the health and social care improvement fund, to deliver a training and education programme for NHS and SPS staff around the mental health wellbeing programme of adult prisoners.

The healthcare leadership team had recently assessed the current workforce structure against workload using a validated professional judgement tool. The team were awaiting the outcome of this, and planned to use the findings to help reshape the healthcare team to ensure they had the right skill mix in place to deliver services in the future.

Inspectors were impressed by the excellent communication across all staff, both health and SPS, and observed the positive impact this had on the prison environment.

9.17 There is a commitment from the NHS Board to the delivery of safe, effective and person-centred care which ensures a culture of continuous improvement.

Rating: Satisfactory performance

NHS staff received information about the wider NHS board through staff newsletters and executive's letters. Some staff information was also displayed on the notice board within the health centre.

All staff spoken to understood how to use Safeguard, the system used by NHS Forth Valley to report incidents and near misses.

Patient forums were held every second month in the Abercrombie Wing, at which forum members could discuss issues relating to healthcare. A patient representative had been identified for each hall in Abercrombie. Despite efforts, prisoners in Harviestoun Hall refused to engage in the patient forums.

The healthcare managers and the deputy governor met each month to discuss concerns within the prison. In addition, the prison healthcare clinical governance subgroup, a multi-disciplinary group that reports into the wider community services clinical governance and risk group, met every second month.

Inspectors found that there was strong collaborative working between health and partner organisations such as the SPS and community services.

Recommendation 111: NHS Forth Valley must ensure that all patients' opinions on the healthcare services provided to them within the prison are actively sought to further develop and improve services. This will allow patients to feel that their voices are heard and that they have a role in shaping the healthcare services they receive.

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