

COUNCIL OF EUROPE



CONSEIL DE L'EUROPE

CPT/Inf (2017) 9

Report

**to the Government of the United Kingdom
on the visit to the United Kingdom
carried out by the European Committee
for the Prevention of Torture and Inhuman
or Degrading Treatment or Punishment (CPT)**

from 30 March to 12 April 2016

The Government of the United Kingdom has requested the publication of this report.

.

Strasbourg, 19 April 2017

In accordance with Article 11, paragraph 3, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, certain names have been deleted.

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Copy of the letter transmitting the CPT's report

Ms Farah Ziaulla
Deputy Director
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Ministry of Justice
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UK - London SW1H 9AJ

Strasbourg, 29 July 2016

Dear Ms Ziaulla,

In pursuance of Article 10, paragraph 1, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, I enclose herewith the report to the Government of the United Kingdom drawn up by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) following its visit to the United Kingdom from 30 March to 12 April 2016. The report was adopted by the CPT at its 90th meeting, held from 4 to 8 July 2016.

The various recommendations, comments and requests for information formulated by the CPT are highlighted in bold in the body of the report. As regards more particularly the CPT's recommendations, having regard to Article 10, paragraph 1, of the Convention, the Committee requests the authorities of the United Kingdom to provide within **six months** a response giving a full account of action taken to implement them. The CPT trusts that it will also be possible for the United Kingdom authorities to provide, in their response, reactions to the comments and requests for information formulated in this report.

As regards the recommendations in paragraphs 48, 93 and 152 of the report, the Committee requests the United Kingdom authorities to provide a response **within three months**.

I am at your entire disposal if you have any questions concerning either the CPT's report or the future procedure.

Yours sincerely,

Mykola Gnatovskyy
President of the European Committee for the
Prevention of Torture and Inhuman
or Degrading Treatment or Punishment

EXECUTIVE SUMMARY

The CPT's 2016 periodic visit to the United Kingdom provided an opportunity to review the treatment of persons held in adult and juvenile prisons and police custody in England for the first time since 2008. It also looked at immigration detention. Further, the visit had a specific focus on in-patient adult psychiatry and medium and high secure forensic psychiatry establishments in England. A good level of co-operation was received from both the national authorities and the staff at the establishments visited. However, on a few occasions, access to places of detention was delayed, and the CPT underlines that better coordination is needed to ensure that access to all establishments is rapid and information about the Committee's mandate is disseminated more widely. More generally, in light of the principle of co-operation, the CPT trusts that prompt and effective action is now taken to address long-standing recommendations such as prison overcrowding.

Law enforcement agencies

The CPT's delegation found that most people deprived of their liberty by the police were treated in a correct manner. It did, however, receive some allegations of verbal abuse from officers towards detained persons at the moment of apprehension and during transport to custody suites and of handcuffs being applied excessively tightly at the time of arrest. The CPT recommends that the United Kingdom authorities make it clear that verbal abuse towards detained persons is unacceptable and that handcuffs should never be applied excessively tightly.

The CPT notes that there appeared to be no uniform approach to the use of means of restraint across the 43 police forces in England and Wales and it recommends that the safety of the use of 'spit helmets', velcro fixation straps and Emergency Response Belts in police custody suites be reviewed. Moreover, the CPT recommends that 'Pava' spray should not form part of the standard equipment of custodial staff and should not be used in confined spaces.

In general, persons deprived of their liberty by the police were afforded the safeguards laid down in PACE Code C. However, several deficiencies were observed such as a protection vacuum when arrested persons had to wait for up to two hours in holding rooms before their detention was formally authorised and before they were informed of their rights by custody sergeants. The CPT recommends that all detained persons should be fully informed of their rights as from the very outset of their deprivation of liberty (and thereafter of any authorised delay) and current deficiencies impeding the complete recording of the fact of a person's detention should be rectified. Access to a lawyer and a doctor or nurse was generally being facilitated promptly in all police establishments visited. However, there was a lack of respect for lawyer-client confidentiality during consultation by telephone at *Southwark* and *Doncaster Police Stations*. As regards custody records, the CPT recommends that whenever a person is deprived of their liberty this fact is formally and accurately recorded without delay and without misrepresentation as to the location of custody, which was not the case at the TACT suite at Paddington Green Police Station.

The material conditions of the custody cells in the police establishments visited were generally of a good standard. There was, however, a lack of access to natural light in many cells and most establishments visited were not equipped with proper exercise yards. The conditions at *Paddington Green 'TACT' Suite*, in particular, were inadequate and needed upgrading.

Adult and juvenile prisons

The CPT welcomes the recent recognition of the need for profound reform of the prison system at the highest political level. The CPT's delegation discussed the nature and scope of the prison reform agenda with the authorities, where it stressed the problem of violence in prisons. In the view of the CPT, taking resolute action to tackle the problem of violence in prisons in England and Wales is a prerequisite for the successful implementation of other elements of the authorities' reform agenda. The CPT recalls that the adverse effects of overcrowding and lack of purposeful regime have been repeatedly highlighted by the Committee since 1990. Over the last 25 years, the prison population has nearly doubled, and almost all adult prisons now operate at or near full operational capacity and well above their certified normal capacity. The CPT emphasises that unless determined action is taken to significantly reduce the current prison population, the regime improvements envisaged by the authorities' reform agenda will remain unattainable.

The CPT's delegation received almost no complaints about physical ill-treatment of inmates by staff in the prisons visited. Nevertheless, it did receive a few complaints about verbal abuse and observed tense relations between staff and inmates. It was, however, deeply concerned by the amount of severe generalised violence evident in each of the prisons visited, notably inter-prisoner violence and attacks by prisoners on staff. Injuries to both prisoners and staff, documented over the previous three months, included *inter alia* cases of scalding water being thrown over victims and 'shank' (make-shift knife) wounds, and frequently required hospitalisation and in one case resulted in the death of an inmate.

The CPT examined the violence through the prism of three criteria: recording incidents of violence, responding to such incidents and specific measures taken to reduce violence. Despite the considerable number of instruments established to capture data regarding violent incidents, there were systemic and structural weaknesses in the documentation process. At both *Doncaster* and *Pentonville Prisons*, the delegation gained the impression that the actual number of violent incidents appreciably exceeded the number recorded. This issue appeared to be particularly acute at *Doncaster Prison*, where the delegation established that some violent incidents had either not been recorded or recorded as being less serious than they were in practice. Moreover, the delegation observed first-hand that violent incidents were not always reported by staff. While the number of recorded violent incidents at all prisons visited was alarmingly high, the CPT believes that these figures under-record the actual number of incidents and consequently fail to afford a true picture of the severity of the situation.

Further, inmates at both *Doncaster* and *Pentonville Prisons* complained that staff responded slowly to violent incidents. This fuelled a feeling of fear and a perception of a lack of safety among inmates. The consequence was a lack of trust in the staff's ability to maintain prisoner safety. As a start, the CPT recommends that the time taken to respond to inmates' call bells be improved. The CPT is also not convinced of the effectiveness of the specific ongoing measures initiated to reduce and prevent violence and recommends that a far greater investment in preventing violence be undertaken.

The CPT's findings in the establishments visited indicate that the duty of care to protect prisoners was not always being discharged given the apparent lack of effective action to reduce the high levels of violence. The cumulative effect of certain systemic failings was that none of the establishments visited could be considered safe for prisoners or staff. The CPT recommends that concrete measures be taken to bring prisons back under the effective control of staff, reversing the recent trends of escalating violence. At *Cookham Wood YOI*, the high levels of violence were managed primarily through locking juveniles up for long periods of time, on occasion for up to 23.5 hours per day; greater investment in establishing more small specialised units to manage juveniles with complex needs should be made.

The CPT underlines that many aspects of prison life are negatively affected by the state of overcrowding in the prison system. For example, living conditions in the prisons visited, in particular *Pentonville Prison*, were adversely affected by the chronic overcrowding: cells originally designed for one prisoner now hold two. Equally, overcrowding also significantly affects the regime. The delegation found that the regimes in all prison establishments visited were inadequate, with a considerable number of prisoners spending up to 22 hours per day locked up in their cells. Many inmates stated that the long lock-up times contributed to a sense of frustration. The CPT recommends that steps be taken to ensure that inmates attend education and purposeful activities on a daily basis, with the aim that all inmates on a normal regime spend at least eight hours out-of-cell.

At *Cookham Wood YOI*, juveniles on a normal regime spent on average only five hours out of their cells each day. The situation was particularly austere for those juveniles who were placed on 'separation' lists (denoted by vivid pink stickers of 'do not unlock' on their cell doors), who could spend up to 23.5 hours a day locked up alone in their cells. In the CPT's view, holding juveniles in such conditions amounts to inhuman and degrading treatment and all juveniles should be provided with a purposeful regime and considerably more time of cell than is currently the case.

As regards the provision of health-care in the prisons visited, the delegation noted that health-care staffing levels were, with a few exceptions, adequate and there was generally good medical documentation of injuries. Medical screening of prisoners upon arrival was of a good quality and carried out promptly. That said, medical confidentiality was not always respected. For example, medication was given to prisoners in corridors or dispensed through a hatch in view of other prisoners. Also prisoners continued to be systematically handcuffed during hospital transfers; the CPT reiterates that handcuffs should only be applied after an individualised risk assessment.

Delays in prisoners with mental-health problems being transferred to psychiatric hospitals, in some cases for several months, remain a problem. Further, the placement of prisoners with acute mental-health conditions in segregation units is inappropriate. The CPT recommends that prisoners suffering from severe mental illnesses are transferred immediately to an appropriate mental health facility. In this connection, high priority should be given to increasing the number of beds in psychiatric hospitals to ensure that in-patient health-care units, such as the one at *Pentonville Prison*, do not become a substitute for the transfer of a patient to a dedicated facility. Further, all prison staff should be trained to recognise the major symptoms of mental ill-health and understand referral procedures.

Due to nation-wide budgetary cuts, the number of front-line prison officers in English prisons has dropped by some 30% over three years, while the number of inmates has continued to rise. The delegation observed at both *Doncaster* and *Pentonville Prisons* that operational safety had been compromised in part due to low staffing levels or inadequate deployment of staff on wings. The situation at *Doncaster Prison* was particularly acute, jeopardising the safety of the young adults held there. Consequently, the delegation requested that an immediate review be carried out into the staffing situation on West End Wings B and C, with a view to reinforcing staffing levels to provide for a safe environment for young adults and staff. It also recommends at both adult prisons that, *inter alia*, staffing levels are reviewed on each wing to ensure adequate staff numbers and ensure that staff are never alone on a wing and the allocated budget does not impact the core operational safety of a prison. As regards *Cookham Wood YOI*, all staff should be receive juvenile-centric professional training and benefit from appropriate external support.

At *Cookham Wood YOI*, records showed that juveniles were regularly held in conditions akin to solitary confinement for periods of 30 days and some for as long as 60 days or even, on occasion, up to 80 days for reasons of discipline and good order. Figures show a similar situation in other YOIs. The CPT recommends that the YOI Rules be amended to reflect the increasing trend at the international level to promote the abolition of solitary confinement as a disciplinary sanction in respect of juveniles. It also recommends that juveniles should not be placed in segregation for the purposes of GOOD and should instead be placed in small staff-intensive units.

Psychiatric institutions

On a general level, the report notes the year-on-year increase of patients being detained in psychiatric hospitals in England, and the CPT requests to be informed about the action being taken by the United Kingdom authorities to address issues such as overcrowding in psychiatric institutions, lack of alternatives to involuntary placement, delayed discharges and children with mental disabilities having to be sent long distances from their home for treatment.

In the course of the 2016 visit, the CPT's delegation met many dedicated mental health professionals working hard to provide care to patients and it was able also to observe many good practices in the hospitals visited. However, the CPT considers that there are a few areas which require serious reflection and change; notably, consent to treatment safeguards need to be reinforced during the first three months of involuntary placement in a hospital; the powers of the Mental Health Tribunal (the Tribunal) need to be reinforced and expanded to deal with appeals concerning such issues as consent to treatment, transfers to more secure hospitals, the use of means of restraint and the application of specific treatment measures. Additionally, steps need to be taken to recruit and retain registered mental health nurses, whose numbers have decreased by more than 8.5% since 2009. More specifically, at *Ashworth* and *Broadmoor Hospitals*, there is a need to reinforce nursing staff levels in order to offer all patients access to proper safe and therapeutic nursing care.

As regards the adult general psychiatric facilities of *St Charles Hospital* and *Highgate Mental Health Centre*, the patients' living conditions were generally good. The CPT is however critical of the lack of access to outdoor exercise for patients and recommends that a clear policy for promoting and facilitating such access every day be put in place. In respect of treatment, the CPT is mostly positive; nevertheless, there is a need to involve patients in drawing up their individual treatment plans and in prioritising more time for nurses to have 1:1 sessions with the patients under their care. The CPT's delegation found that there was no excessive use of seclusion at *St Charles Hospital*; however, resort to manual restraint and rapid tranquillisation was rather high and the Committee wishes to receive information on the ongoing steps being taken by the hospital to reduce resort to all instances of restraint.

The CPT has three main concerns in relation to safeguards for persons who are involuntary placed in hospital, First, to avoid as far as possible holding mentally ill persons in police cells under Section 136 of the Mental Health Act; the CPT acknowledges that much work has been done to reduce numbers considerably but additional measures, including of a legislative nature, are required. Second, the safeguards surrounding consent to treatment need to be reinforced. The CPT considers that an external psychiatric opinion should be required in any case where a patient does not agree with the treatment proposed by the establishment's doctors. Further, patients should be provided with the possibility to appeal against a compulsory treatment decision to the Tribunal from the outset of their hospitalisation. Third, the Tribunal should have the possibility to examine *ex officio* all sectioned patients at least once a year as the current three-yearly intervals after the first year are incompatible with modern mental health legislation and practice.

The CPT found that patients' living conditions at *Chase Farm Hospital* were generally of a good standard and that they were variable at *Ashworth* and *Broadmoor High Secure Hospitals*. At all three hospitals patients' access to the outdoor garden every day needs to be improved. The CPT re-examined the use of night-time confinement in the high secure hospitals and considers that such a practice is not acceptable in a care establishment provided there are sufficient staff, and recommends that the practice be reviewed. As regards treatment, the CPT is broadly positive of the approach followed in the forensic hospitals visited.

A major focus of the CPT's delegation was on the use of means of restraint. At *Chase Farm Hospital*, no excessive resort to seclusion was found and the safeguards in place were adequate; however, the Committee has reservations about the proportionality of force used when reviewing patients in seclusion. Care should also be taken to ensure debriefings of patients are systematically carried out and recorded at both *Chase Farm* and *Ashworth Hospitals*.

As regards the measure of *long-term segregation* (LTS) at *Ashworth* and *Broadmoor Hospitals*, the CPT has serious concerns relating to the necessity for its application, the manner in which it is applied and its duration. The 2016 visit found that patients could be kept in LTS for years on end with minimal human contact, and often the contact offered was not face-to-face and meaningful but via the hatch in the door to the patient's room. The CPT considers that, in certain cases, the impact of LTS on patients' amounts to inhuman and degrading treatment. Steps should be taken as a matter of urgency to review its use in order to reduce resort to LTS and to cut radically the amount of time patients are held in LTS. Further, patients should have the right to appeal the measure of LTS to the Tribunal and the three-monthly external reviews should be put in place. It is also important that the ward designs provide a therapeutic environment adapted to the needs of LTS patients.

The CPT observed that interventions by staff to control patients at both *Ashworth* and *Broadmoor Hospitals* were executed according to established guidelines. Nevertheless, the CPT has some misgivings as regards the overwhelming use of force deployed in particular at *Ashworth Hospital* by intervention teams in full personal protective equipment (PPE), including shields and helmets. Deploying teams in full PPE should be considered only as a last resort, for instance where a patient has a weapon.

Immigration removal centres (IRC) in England

At *Yarl's Wood IRC*, relations between staff and detainees seemed to be correct; a few complaints of abusive language by staff were received. The living conditions and regime were generally good for the average length of stay, but for persons held longer than a few months a broader range of activities should be developed. There is also a need for the management to ensure that the induction process properly identifies the language skills of women entering the Centre and that appropriate additional support is afforded to those women having no common language. The CPT is critical of women being brought to the Centre in the early hours of the morning and recommends that the relevant procedures be reviewed to avoid any arrivals between 11 p.m. and 7 a.m. As regards health care, the service should be bolstered through an increase in the presence of a psychiatrist and filling the vacant nursing posts, and the introduction of a psychological well-being programme. The medical facilities were good and medical confidentiality was respected; however there is a need to revise the health-care documentation to the specific needs of immigration detainees and to remove any reference to prisoners. Transfers to psychiatric hospital should be carried out without delay and the necessity of placing women from *Yarl's Wood* on secure forensic psychiatric wards reviewed. The CPT comments on the use of Rule 35 reports concerning alleged torture victims and recommends that all nurses be provided with training on interviewing torture victims and that general practitioners receive refresher training on a regular basis on interviewing and documenting Rule 35 cases. Detention custody officers should be provided with training on inter-personal skills on an ongoing basis.

As regards the induction unit at *Colnbrook IRC*, the Committee is again critical of the poor living conditions, including the food, and requests information on the planned refurbishment and the steps taken to improve the range of activities offered to detainees. Immediate steps should also be taken to offer all women detainees in the Sahara unit daily access to outdoor fresh air.

More generally, the CPT again expresses concern over the indefinite nature of immigration detention and it requests detailed information on the measures taken to address the recommendations made by the 2016 *Shaw Review into the welfare in detention of vulnerable persons*. The CPT also considers that foreign nationals, if they are not deported at the end of their sentence, be transferred immediately to a facility that can provide conditions of detention and regime in line with their new status of immigration detainees.

I. INTRODUCTION

A. Dates of the visit and composition of the delegation

1. In pursuance of Article 7 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as “the Convention”), a delegation of the CPT carried out a visit to the United Kingdom from 30 March to 12 April 2016. The visit formed part of the CPT’s programme of periodic visits for 2016 and was the Committee’s eighth periodic visit to the United Kingdom.¹

2. The visit was carried out by the following members of the CPT:

- Wolfgang HEINZ, Head of the Delegation and 2nd Vice-President of the CPT
- Per GRANSTRÖM
- Georg HØYER
- Mark KELLY
- Jari PIRJOLA.

They were supported by Hugh CHETWYND, Head of Division, and Francesca GORDON of the CPT’s Secretariat and assisted by three experts:

- Eric DURAND, former Head of the Medical Services at Fleury-Mérogis Prison (France),
- Harry KENNEDY, Clinical Professor of Forensic Psychiatry, Department of Psychiatry, Trinity College Dublin (Ireland), and
- Veronica PIMENOFF, psychiatrist, former Head of Department at Helsinki University Psychiatric Hospital (Finland).

¹ The CPT’s previous periodic visits to the United Kingdom took place in July-August 1990 (England), May 1994 (England and Scotland), November-December 1999 (Northern Ireland), February 2001 (England and Wales), May 2003 (England, Scotland and the Isle of Man), December 2008 (England and Northern Ireland) and September 2012 (England and Wales, Scotland). Apart from these, the CPT has also carried out ad hoc visits in July 1993 (Northern Ireland), September 1997 (England and the Isle of Man), February 2002 (England), March 2004 (England), July and November 2005 (England), December 2007 (England and Scotland), March 2010 (Channel Islands, England and Scotland), June 2010 (England) and November 2014 (Gibraltar).

B. Establishments visited

3. The delegation visited the following places of deprivation of liberty:

Police establishments

- Brixton Police Station, Metropolitan Police
- Charing Cross Police Station, Metropolitan Police
- Paddington Green Police Station, Metropolitan Police
- Southwark Police Station, Metropolitan Police
- Doncaster Police station, South Yorkshire Police
- St Anne's Police Station, Liverpool, Merseyside Police

Immigration Detention establishments

- Yarl's Wood Immigration Detention Centre
- Colnbrook Immigration Removal Centre (targeted visit)

Prison establishments

- Cookham Wood Young Offender Institution (YOI)
- HMP & YOI Doncaster
- HMP Pentonville

Department of Health establishments (psychiatric care)

- Ashworth High Secure Hospital, Liverpool
- Broadmoor High Secure Hospital, Berkshire (targeted visit)
- Chase Farm Hospital, North London Forensic Service, London
- Highgate Mental Health Centre, London (targeted visit)
- St. Charles Hospital, London

C. Consultations held by the delegation

4. In the course of the visit, the CPT's delegation met the Parliamentary Under-Secretary of State for Prisons, Probation and Rehabilitation, Andrew Selous, as well as senior officials from the Ministry of Justice (National Offender Management Service and Youth Justice Board), the Home Office (National Police Chiefs' Council and Immigration Enforcement) and the Department of Health.

Further, the CPT's delegation met Peter Clarke, Her Majesty's Chief Inspector for Prisons, Nigel Newcomen, Prisons and Probation Ombudsman, as well as representatives from the Care Quality Commission, the Office of the Children's Commissioner for England, the Royal College of Psychiatrists and the British Medical Association. Meetings were also held with representatives from non-governmental organisations active in areas of concern to the CPT. A list of the national authorities and non-governmental organisations met by the delegation is set out in the Appendix to this report.

D. Cooperation between the CPT and the authorities of the United Kingdom

5. The CPT's delegation received a good level of co-operation throughout the visit from both the national authorities and staff at the establishments visited and appreciated the assistance provided before and during the visit by the CPT's liaison officers.

Nevertheless, on a few occasions, access to places of detention was delayed, apparently because information about the CPT had not reached staff or did not fully describe the CPT's mandate. Moreover, the list of places of police detention with which the delegation was supplied initially was neither accurate nor complete.²

The CPT believes that there is a need for the authorities of the United Kingdom to establish better coordination to ensure that access to establishments not under the mandate of the Ministry of Justice is rapid, information about the Committee's mandate is disseminated more widely and the information provided to the delegation is reliable.

It was also regrettable that the delegation was not afforded the opportunity to meet with a Minister from the Department of Health to provide its feedback on the subject of mental health. These meetings represent an important opportunity to exchange views at a senior governmental level. For example, the meeting with Parliamentary Under-Secretary of State for Prisons, Probation and Rehabilitation, Andrew Selous, enabled the CPT's delegation to draw the attention of the United Kingdom authorities to the very real problem of violence in prisons, which at the time was not recognised as a clear priority. Further, it enabled the CPT's delegation to clarify that the Committee's mandate extended far beyond 'torture' and that it had a long history of co-operation with the United Kingdom.

The Committee trusts that the United Kingdom authorities will take concrete steps to improve coordination between governmental departments in order to ensure that the situations described above are not encountered during future visits. Moreover, it trusts that its report will receive the highest attention from Ministers and senior officials responsible for the areas covered in this report.

6. The principle of co-operation set out in Article 3 of the Convention is not limited to steps taken to facilitate the task of visiting delegations. It also requires that decisive action be taken to improve the situation in the light of the Committee's key recommendations. In this respect, the CPT is concerned to note that little or no action has been taken in respect of certain recommendations made in previous reports, in particular as regards overcrowding in prisons, which has been a chronic feature of English prisons ever since the CPT raised the issue in its first visit to the United Kingdom in 1990 (see paragraphs 49 to 51).

The CPT trusts that the United Kingdom authorities will take concrete measures to address the recommendations in this report, including as regards prison overcrowding, in accordance with the principle of cooperation set out in Article 3 of the Convention.

² Information provided by the authorities initially referred to Paddington Green as 'decommissioned', when both PACE and TACT suites were, in fact, either in active operation (the TACT suite) or 'moth-balled' (the PACE suite) but had been recently operational for over-spill custody from other nearby custody suites and could be quickly operational again, when required. Subsequent information provided then inaccurately described the total capacity standing at 14 cells, when in fact there were 14 cells on the PACE side and a further eight cells on the TACT side.

E. Immediate observations under Article 8, paragraph 5, of the Convention

7. On 12 April 2016, the CPT's delegation delivered its preliminary observations to the authorities of the United Kingdom outlining the main findings of the visit. On that occasion, the CPT's delegation made an immediate observation under Article 8, paragraph 5, of the Convention, notably about the high levels of violence at Doncaster Prison. It requested that an immediate review be carried out into the staffing situation (staffing levels per shift, actual presence, quality/experience and consistency of deployment of the staff) on West End Wings B and C at HMP/YOI Doncaster, with a view to reinforcing staffing levels to provide for a safe environment for young adults and staff. The delegation requested to receive, within two months, an account of the steps that have been taken to this end. This request was confirmed in a letter sent to the authorities of the United Kingdom, dated 25 April 2016.

By letters dated 10 June and 28 June 2016, the United Kingdom authorities responded to the immediate observation and the preliminary observations respectively. The responses have been reflected in the relevant parts of the report.

F. National Preventive Mechanism

8. The United Kingdom ratified the Optional Protocol to the United Nations Convention against Torture (OPCAT) in December 2003 and designated its National Preventive Mechanism (NPM) in March 2009. At the time of the delegation's visit, the NPM was made up of 20 independent inspection bodies, which together regularly inspect all places where persons are deprived of their liberty in the United Kingdom. Several of these bodies met with the CPT's delegation during the course of the visit.

9. While the Chief Inspector of Prisons for England and Wales is tasked with co-ordinating the work of the NPM, the CPT notes positively the recent appointment of an independent Chairperson of the NPM to ensure greater independence for the NPM as a separate entity.

10. The CPT, since the very beginning of its mandate, has enjoyed very good co-operation with Her Majesty's Inspectorate of Prisons for England and Wales (HMIP) and other United Kingdom inspection bodies, and the creation of the NPM has served to reinforce that co-operation. Moreover, it pays close attention to wider discussions currently underway in the United Kingdom about inspection bodies' operating models and potential developments in the NPM's future role, in the light of the maintenance of independence requirements from the United Kingdom authorities.

II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

A. Law enforcement agencies

1. Preliminary remarks

11. The basic rules concerning the detention, treatment and questioning of persons detained by the police are contained in the Police and Criminal Evidence Act (PACE) 1984 and its Codes of Practice, which are regularly updated and are supplemented by guidance issued by the College of Policing, referred to as Approved Professional Practice. These provisions were summarised in the report drawn up following the CPT's previous visit in 2008³ and remain broadly unchanged in 2016.

12. In England and Wales, policing is the responsibility of 43 different police forces, each of which falls under the operational direction and control of a different Chief of Police ("Chief Constable"). This arrangement has some advantages in that it enables policing practice to be closely tailored to the policing needs of particular geographical areas; however, it also means that the treatment of persons deprived of their liberty may vary from force to force.

The progressive digitisation of police custody records is improving data capture and retrieval of information regarding detained persons within police forces. However, police forces are installing a variety of different versions of NSPIS⁴ and related IT systems, as a result of which directly-comparable and aggregated national data regarding custody practices remains difficult, if not impossible, to obtain. In the absence of such information, the UK authorities do not currently have a nationwide overview of the application in practice of fundamental safeguards against ill-treatment, such as the proportion of persons interviewed by the police whose access to a lawyer or contact with families has been delayed or denied (under PACE Codes C & H).

No reliable nationwide disaggregated data on the use of force (e.g. batons and 'pava') or means of restraint was available (see paragraph 15) and it appears that regulations on these issues may vary from force to force. For example, at Doncaster Police Station, the CPT's delegation observed first-hand that a so-called 'spit helmet' and velcro fixation/straps were in regular use (in combination), whereas the same equipment had been withdrawn from service by the Metropolitan Police Service, apparently because of health and safety concerns. Given that detained people continue to die in police custody in England and Wales following the application of means of restraint,⁵ such inconsistencies in rules and practices are an obvious cause for concern for a body with the CPT's mandate.

³ See CPT/Inf (2009) 30, Paragraph 8.

⁴ National Strategy for Police Information Systems (NSPIS).

⁵ From 2010 to 2015, there were 108 deaths in police custody (24 of which were following use of means of restraint), according to Inquest (a specialist organisation that provides advice to bereaved people, lawyers, other advice and support agencies, among others on contentious deaths and their investigation in England and Wales).

In the view of the CPT, ensuring greater consistency in both the aggregation of nationwide data and the collection of disaggregated thematic data regarding the treatment of persons deprived of their liberty would be highly desirable. The existence of such data can help to identify patterns of best practice, as well as highlighting areas for further improvement. It can also be of great assistance to those involved in the monitoring and inspection of operational policing.

The United Kingdom authorities have acknowledged the need for greater consistency to ensure the delivery of best practice and the CPT understands that the National Police Chiefs' Council (NPCC) is working towards the adoption of a national police custody strategy and unified police vision for all 43 police forces across England and Wales.

The CPT would like to receive detailed information about the proposed content of the NPCC national police custody strategy and unified police vision, the timeline for adoption of the strategy and vision and the measures envisaged to ensure their application in practice.

The CPT recommends that greater investment is put into the aggregation of nationwide police data and the collection of disaggregated data along thematic lines, in line with the above comments.

13. The CPT has in the past⁶ raised concerns regarding the operation in practice of safeguards and the conditions of detention at Paddington Green Police Station 'TACT' Suite in London, a facility primarily used for the detention of persons detained under the Terrorism Acts 2000 and 2006. It recommended that all persons detained under terrorism legislation should be brought physically before a magistrate at the moment when an extension of their custody is being decided, instead of the hearing being conducted via video-link. Regrettably, the situation has not evolved since 2008.

The CPT calls upon the United Kingdom authorities to ensure that persons detained under terrorism legislation who have not yet been transferred to prison are always brought into the direct physical presence of the judge responsible for deciding the question of the possible extension of their detention.

2. Ill-treatment

14. During the visit, the CPT's delegation received no allegations of severe ill-treatment by police officers and observed that detained persons were generally treated correctly by the police, especially during their time in the respective custody suites visited.

That said, a couple of allegations were received by the delegation of verbal abuse consisting primarily of insulting remarks made by officers towards detained persons during transport to custody suites (St. Anne's (Liverpool) and Doncaster Police Stations) from the moment of apprehension.

Several complaints of handcuffs being applied excessively tightly at apprehension were also received, and the delegation observed for itself visible red marks around the wrists of detained persons; this was particularly the case in Brixton, St Anne's (Liverpool) and Doncaster Police Stations.

⁶ See CPT/Inf (2009) 30, Paragraphs 7 to 24.

The CPT underlines that no more force than is strictly necessary should be used when effecting an arrest. Where it is deemed essential to handcuff a person at the time of apprehension or during the period of custody, the handcuffs should under no circumstances be excessively tight and should be applied only for as long as is strictly necessary.

The Committee recommends that police officers should be regularly reminded that verbal abuse of detained persons is unacceptable.

Moreover, it recommends that police officers should be reminded regularly, and in an appropriate manner, of the application of the above-mentioned basic principles when applying handcuffs during arrest operations.

15. The regulation of use of means of restraints by the police is governed by PACE Code C. This stipulates that ‘no additional restraints shall be used within a locked cell unless absolutely necessary and then only restraint equipment, approved for use in that force by the chief officer, which is reasonable and necessary in the circumstances having regard to the detainee’s demeanour’.⁷

As mentioned above, the CPT delegation observed that there is no uniform approach across police forces in England and Wales concerning the question of means of restraint. For example, the Emergency Response Belt (ERB) is authorised for use by Devon and Cornwall police but not by the Metropolitan Police Service. The case of T.O., who died while in custody after having being restrained by the police with an ERB, raises serious concerns. The Committee notes that an investigation by the Independent Police Complaints Commission (IPCC) is currently underway with a view to examining Devon and Cornwall police’s use of the ERB. At Doncaster Police Station, the CPT’s delegation learnt that a ‘spit helmet’ and velcro-/fixation straps were used (sometimes in combination) approximately once a month on detained persons in the cells.

The CPT considers that ‘spit helmets’, ‘ERBs’ and ‘velcro-/fixation straps’, especially when used in combination, are not appropriate in a secure place of safety, such as police custody.

The CPT recommends that the authorities review the safety of the use of ERBs, ‘spit helmets’ and ‘velcro straps’ in police custody suites. Further, it wishes to receive a copy of the IPCC investigation report into the safety of the ERB and details on any actions taken by the authorities in the light of the report’s findings.

More generally, **the CPT recommends that the authorities regularly remind police about the regulations governing the use of means of restraints established in PACE Code C and other relevant regulations. It also trusts that a review of this area be regularly conducted by the relevant monitoring and oversight bodies such as Her Majesty’s Inspectorate of Constabulary (HMIC) and the IPCC, among others.**

⁷ PACE Code C, Paragraph 8.2, as amended in May 2014.

16. Further, the delegation was concerned to note from the custody records in St. Anne's Police Station, that on 3 April at 7.37 a.m. the police had administered 'Pava' (Pelargonic Acid Vannilylamide) spray against a reportedly violent detainee in his cell (MS18).

The CPT believes that any use of pepper spray, other incapacitant sprays or potentially dangerous substances should not be used in confined spaces. Further, if exceptionally it needs to be used in open spaces, there should be clearly defined safeguards in place. For example, persons exposed to pepper spray should be granted immediate access to a medical doctor.

The CPT recommends that Pava spray should not form part of the standard equipment of custodial staff and, given the potentially dangerous effects of this substance, it should not be used in confined spaces.

3. Safeguards against ill-treatment

17. The CPT's delegation found that, in general, the PACE safeguards, established in Code C (specifically, notification of custody, access to a doctor and access to a lawyer) were being afforded by the police correctly. That said, there were a few notable exceptions.

18. As regards information on rights and the notification of detained persons of their rights from the moment of their apprehension by the police, the delegation found that at Charing Cross and Brixton Police Stations, arrested persons might have to wait for some considerable time – up to two hours – after arrival at the station in holding rooms before detention was formally authorised and they were "given" their rights by custody sergeants. The CPT considers that detainees inherently have their rights from the moment of apprehension and that police officers have a duty to inform them of those rights at the earliest possible opportunity, and to provide detained persons with written information immediately upon their arrival at the police station.

Custody staff acknowledged that waits for up to two hours in the holding rooms were not unusual; indeed, in the Charing Cross Police Station's holding room a poster on the wall warned about such delays and provided information about senior officers who could be contacted by arresting officers in the case of even lengthier delays.

The CPT is concerned by the protection vacuum created by this interval, during which a person could be physically held on police premises and investigative steps could proceed despite the fact they have not been informed of their rights. This is certainly contrary to the spirit, if not the letter, of PACE and, in particular Code C, paragraph 3(1)(a)), which specifies that the detained person should be informed of their continuing rights and that they may be exercised at any stage during the period in custody.

Moreover, the CPT's delegation observed some instances where no proper record was made of the fact that the person had been informed of their rights. For example, at Charing Cross some of the 'digi-pads' used to collect the electronic signatures of detainees were defective, resulting in a number of detainees' records showing up as 'incapable of signing for their rights'; in Doncaster Police Station, video screens designed to mirror the information on rights available to custody sergeants on the detainees' side of the counter were not systematically being used, resulting in some detained persons being asked to sign 'blind' to the actual content. Understandably, some declined to do so.

While some detained persons interviewed by the delegation had been given written information of their rights, many had not (for example, at Brixton, Charing Cross and Doncaster Police Stations). This was similarly the case during the previous CPT visit to various English police stations.⁸

By letter dated 28 June 2016, the authorities underline that informing detainees of their rights, as from the point of arrest, is challenging in practice; for example, all requests for legal advice are made through the Defence Solicitor Call Centre and require certain information, such as the custody number, which is only available after the booking in process had started.

Moreover, the authorities provide information that nine out of 23 detainee records at Charing Cross on the day of the CPT delegation's visit were not signed for because *inter alia*, the digi-pads were not working (four cases), the screen was not working (one case), the detainee was unable to read English (two cases).

The CPT recommends that the United Kingdom authorities take measures to ensure without further delay that all persons detained by the police are fully informed of their fundamental rights as from the very outset of their deprivation of liberty (that is, from the moment when they are obliged to remain with the police).

This should be ensured by provision of clear verbal information at the very outset, to be supplemented at the earliest opportunity (that is, immediately upon their arrival at police premises) by provision of a written copy of their rights. Any deficiencies impeding the complete recording of the fact that a detained person has been informed of his/her rights (such as defective digi-pads and screens) should be rectified. All digi-pads and screens should have various language options available to ensure that detained persons fully understand their rights and what they are signing for.

19. As regards notification of custody, pursuant to Article 56 PACE and Code C, a detained person has a right to inform friends or relatives of the fact of his or her custody as soon as is practicable, except to the extent that a lawful delay is permitted. If a delay is authorised, the detained person shall be told the reason for it; and the reason shall be noted on his custody record.

Delay is only permitted in the case of a person who is in police detention for an “indictable offence”⁹ and if an officer of at least the rank of inspector authorises it, for a maximum for 36 hours from arrest and where there are reasonable grounds for believing that it will lead to interference with or harm to evidence connected with an indictable offence or interference with or physical injury to other persons; or will lead to the alerting of other persons suspected of having committed such an offence but not yet arrested for it; or will hinder the recovery of any property obtained as a result of such an offence.¹⁰

⁸ See CPT/Inf (2009) 30, Paragraph 14.

⁹ An offence is indictable if it itself may be tried on indictment or is triable either way (i.e. the most serious crimes that pass from the Magistrates' Courts to the Crown Court (e.g. murder, rape, robbery).

¹⁰ Article 52 (2), PACE, as amended.

In general, detained persons were clearly informed of their right of notification of custody. However, as regards the delay in notification, the delegation observed first-hand that at Charing Cross Police Station, a detained person had her right of notification of custody delayed by an inspector in the interests of the criminal investigation before she had been informed of her rights. The authorisation of the delay in the detained person's exercise of the right of notification - before they had been informed of any of their rights - is of concern to the CPT.

The CPT considers that all detained persons should be fully informed of their rights immediately (as mentioned above) and at that moment informed (and given an explanation of the reason and procedure) about any delay of the right of third party notification of custody.

The CPT recommends that the United Kingdom authorities take immediate steps to ensure that all persons detained by the police are immediately fully informed of their fundamental rights and thereafter informed of any delay, in line with PACE Code C.

20. The CPT's delegation was pleased to observe that access to a lawyer (regulated by PACE Code C¹¹) was generally being facilitated promptly and detained persons were being offered access to legal advice before being interviewed by the police. Moreover, the duty solicitor scheme appeared to operate smoothly and many detained persons interviewed had benefited from free legal advice. Interpretation was also readily available through either a telephone interpretation service or the presence of interpreters, as required.

However, the delegation noted the lack of respect for the confidentiality of lawyer-client consultation by telephone in a few police stations. At the TACT suite at Southwark Police Station and at Doncaster Police Station, the delegation observed that such consultations in practice took place at a wall-mounted telephone in an area where police officers freely circulated and that was subject to audio- and visual recording; this is not acceptable. At Southwark TACT custody suite, while this had been identified as a problem by custody sergeants, the mobile phone bought to replace the wall-mounted phone (located under a microphone) did not have reception and had not been used since its purchase four months previously.

By letter dated 28 June 2016, the authorities underline that they plan to ensure that each custody suite has at least a privacy hood over the telephone that is used for detainees to speak with their lawyer. **The CPT wishes to be informed when this development has been implemented and whether it affords complete privacy from the nearby microphones.**

In the meanwhile, in the interests of due process and as a fundamental safeguard against ill-treatment, **the CPT recommends that relevant and effective measures be taken to protect the confidentiality of lawyer-client consultations by telephone in Southwark and Doncaster Police Stations, as well as in other police stations across the country.**

¹¹ Article 58 PACE, Code C.

21. The right of access to a doctor or nurse is enshrined in law¹² and operated without undue delay in all custody suites visited by the delegation. Nurses (psychiatric and somatic), employed by the National Health Service (NHS) worked on shift and, in all police stations visited, at least one nurse was always present. Doctors visited regularly or were on call on a rota basis 24/7. Further, all custody suites visited either had a permanent (Charing Cross, Brixton, St. Anne's) or at least rapid (Doncaster, Paddington Green) access to a mental health team night and day. Brixton also had two psychologists available on its psychiatric team.

22. As regards the use of police custody cells as a place of safety under Section 136 of the Mental Health Act, see paragraph 119 below. In the police stations visited, the CPT's delegation found that it was now extremely rare to hold a person in police custody under Section 136.

Nevertheless, the delegation met a detained person in Brixton Police Station, who displayed clear acute psychotic behaviour and yet had been certified by the examining forensic doctor (FME) as being 'fit to be detained' in police custody. This example and other information gathered by the delegation in the psychiatric hospitals visited, demonstrate that there continues to be a need for all forensic medical examiners and custodial staff to receive appropriate training on mental health issues,¹³ especially those in police stations where there is no registered psychiatric nursing presence or Mental Health In-reach Team.

The CPT reiterates its recommendation that all FMEs receive appropriate training on mental health disorders, including regular refresher training and be reminded that police custody is not appropriate for persons with mental health disorders. It would also like to be informed whether all persons who are deprived of their liberty under Section 136 are fully informed of their rights.

23. Generally, medical confidentiality was respected in all police stations visited and digitised/electronic medical files were stored securely and were not accessible to police staff.

That said, medical examinations were regularly conducted with doors kept open at some of the police stations visited (in particular, Charing Cross and Doncaster). Further, at St Anne's (Liverpool) Police Station, it appeared that custody sergeants ask for information on the mental health of every detained person from members of the Mental Health In-reach Team, because local knowledge was important for intelligence gathering.

While the CPT recognises that custodial staff should have certain information about the state of health of a detained person, including medication being taken and particular health risks, there is no reason why non-medical staff should have access to medical diagnoses or injury reports on a systematic basis.

The CPT recommends that the authorities of the United Kingdom take the necessary measures to ensure that, in all police stations, medical examinations are always conducted out of the hearing and – unless the doctor concerned requests otherwise in a particular case – out of the sight of custodial staff.

¹² Paragraph 9.5, Code C, PACE.

¹³ See CPT/Inf (2009)30, Paragraph 15.

Further, it recommends that information concerning detained persons' health be kept in a manner which ensures respect for medical confidentiality in all police stations. Health-care staff may inform custodial officers on a need-to-know basis about the state of health of a detained person; however, the information provided should be limited to that necessary to prevent a serious risk for the detained person or other persons, unless the detained person consents to additional information being given.

24. PACE Code C, Section 9.8 provides that "the detainee may also be examined by a medical practitioner of their own choice at their own expense". However, as was the case in 2008,¹⁴ the delegation found that neither custody officers nor detained persons were aware of this right.

The CPT reiterates its recommendation that the right for detained persons to be examined by a doctor of their own choice be rendered effective in practice.

25. The CPT's delegation observed that the electronic custody records generally were well kept and comprehensive, in line with CPT requirements.

However, the custody records concerning the 'TACT' suites of Paddington Green and Southwark Police Stations were paper-based and, in the case of Paddington Green, the TACT custody records were kept at Southwark Police Station.

Moreover, files of detained persons held in Paddington Green TACT suite referred to another police station as the location of their detention. The delegation was informed by the authorities that it was in the interests of 'trade-craft' that the location of Paddington Green as the place of detention be kept secret. Yet, lawyers visited their clients at Paddington Green, as the delegation was able to observe for itself when it visited Paddington Green TACT suite.

The CPT acknowledges there is a continual balance to be struck between the interests of security and the rights of persons in custody. That said, the CPT underlines that it is a fundamental safeguard against ill-treatment and incommunicado detention that whenever a person is deprived of his liberty by a law enforcement agency, for whatever reason, this fact is formally and accurately recorded without delay - and without misrepresentation.

The fact that the CPT's delegation was initially provided with information that Paddington Green had been 'decommissioned' and then was not permitted to visit the site on its first visit, tends to only reinforce its concerns about the above practices and the necessity for such TACT suites to be regularly and closely monitored (see also paragraph 5).

The CPT recommends that whenever a person is deprived of his liberty by a law enforcement agency, this fact is formally and accurately recorded without delay and without misrepresentation (for whatever reason) as to the location of custody.

It trusts that relevant oversight bodies and inspectorates, such as the HMIC and the IPCC, exercise regular and effective supervision of the accuracy of custody registers in police establishments, including TACT custody facilities.

¹⁴ See CPT/Inf (2009)30, Paragraph 17.

26. During the visit to Doncaster Police Station, the CPT's delegation observed that while arresting officers all wore identification numbers on their uniforms, the civilian dedicated detention officers (DDO) merely wore black clothes, with no identifying emblems or numbers for identification purposes. When questioned about this, the DDO informed the delegation that this was for purpose of safeguarding the security of the DDO from possible later reprisals.

The Committee considers that only exceptional circumstances can justify measures to conceal the identity of officials who have direct contact with detained persons when carrying out their duties. Where such measures are applied, appropriate safeguards must be in place in order to ensure that the officials concerned are accountable for their actions (e.g. by means of a clearly visible number on the uniform).

The CPT recommends that all staff in England and Wales who carry out custodial duties have their name and/or an identification number on their uniform, in the same manner as police officers (and prison staff).

4. Conditions of detention

27. The majority of persons in police custody in England and Wales are only detained for short periods of time¹⁵ and, in the main, the custody suites visited by the CPT's delegation offered conditions ranging from acceptable to good. Most cells were adequate in size (ranging from approximately 7 to 9m²) and were used for single occupancy only; they were equipped with a toilet, a plinth and bedding (pillow and blanket), call bell and had adequate artificial lighting and ventilation. In all police stations visited, there were dedicated cells designed to hold persons with physical disabilities and cells for intoxicated persons with lower bed plinths. Cells were covered by closed-circuit television (CCTV) with the toilet 'blacked-out' to maintain privacy. In the custody suites visited, prayer mats and religious books were available on demand.

All custody suites visited possessed showers but detained persons were not systematically told about the possibility to take a shower. Moreover, access to natural light in all cells was extremely limited. In most custody suites, the cells were located either on the lower ground or ground floor and all had opaque or blue thick window-panes, which limited the amount of natural light considerably.

Further, detained persons could be offered access to outdoor exercise if they spent more than 24 hours in police custody; however, most of the police stations visited were not equipped with proper outdoor exercise yards, with the exception of Southwark Police Station (that afforded a 48m² partially covered courtyard with an exercise bicycle) and St Anne's Police Station.

The CPT reiterates its recommendation that the United Kingdom authorities ensure that persons held in police custody for more than 24 hours are systematically offered access to outdoor exercise and that when custody suites are being refurbished or constructed, the above-mentioned deficiencies concerning access to natural light and adequate outdoor exercise facilities are remedied.

Further, detained persons held for 24 hours or more in police custody should be informed of the possibilities to shower.

¹⁵ The average stay in the police stations visited was approximately 13 hours; however, in some police stations, it was possible to stay from late Friday evening until Monday morning, until the Magistrates' Courts re-opened.

28. As concerns juveniles in police custody, the four designated ‘juvenile cells’ in Doncaster police custody suite possessed no toilets or sinks. Custody sergeants informed the delegation that as they usually kept juveniles under constant watch with the door ajar, juveniles would have access to a toilet and sink when required.

However, the juvenile cells measured mere 5.2m², which is too small for holding persons overnight, as such **the CPT would like to receive confirmation from the United Kingdom authorities that when juveniles are held overnight at Doncaster Police Station, the cell door continues to remain ajar. Further, consideration should be given to providing juveniles held in police custody ready access to reading materials and/or television and the possibility of outdoor exercise. The CPT recommends cells of less than 7m² (including a toilet and basin) should not be used to hold detained persons overnight.**

29. The CPT’s delegation noted positively that the new ‘TACT’ custody suite at Southwark Police Station, established since its 2008 visit, generally provided reasonable conditions for detained persons. However, as regards Paddington Green Police Station, the CPT’s delegation again found that conditions of detention were inadequate and had not been improved, with poor outdoor exercise facilities and limited access to natural light in cells.¹⁶ Further, the in-cell entertainment system installed in Paddington Green’s cells was non-operational.

The CPT takes note of the information provided by the authorities dated 28 June 2016, that Paddington Green is subject to an ongoing programme of maintenance but is considered by the authorities to meet current standards in all areas except for the lack of in-cell entertainment.

Given that more appropriate facilities are now available at the TACT Suite in Southwark, **the CPT reiterates its recommendation that the TACT Suite at Paddington Green Police Station be considerably upgraded, and if this is not practicable, taken out of service.**

¹⁶ See CPT/Inf (2009) 30, Paragraph 9; CPT/Inf (2008) 27, Paragraph 13; CPT/Inf (2006) 26, Paragraphs 20 to 24; and CPT/Inf (2006) 28, Paragraph 39.

B. Prison establishments

1. Preliminary remarks

- a. the prison system of England and Wales and the need for reform

30. In the eight years since the CPT last examined the situation in prisons in England and Wales, there have been several positive developments; notably, the number of women in prison has been reduced through a focus on alternatives to detention for female offenders,¹⁷ and the number of juveniles in detention has fallen from 2,905 to 882 in March 2016.

However, a number of chronic issues raised during previous CPT visits, including severe overcrowding, poor living conditions and a lack of purposeful regimes (see paragraphs 49 to 51, 52 and 53 and 54 to 56), continue to blight the prison system.

During the 2016 visit, the CPT's delegation found that these long-standing problems were being exacerbated by a significant escalation in levels of violence, rendering them unsafe places for prisoners and staff alike (see Section 2 below). These findings reinforce the sustained criticism by civil society and HMIP regarding the safety of juvenile institutions and the male adult prison estate. The British Prime Minister described the system as 'scandalous' and 'failing prisoners', and characterised the high levels of violence in prisons as 'shameful'.¹⁸

31. Depriving persons of their liberty carries with it a duty of care to protect them from those who wish to cause them harm, including other prisoners. The delegation's findings during this 2016 visit indicate that this duty was often not being discharged in the establishments visited.

Shortly after the delegation's visit, the House of Commons Justice Committee published its own report on prison safety,¹⁹ which examined 'the Government's response to the ongoing and rapid deterioration in prison safety' in England and Wales. It found that there have been 100 suicides in the past year (sic) and a 20% rise in assaults in the second half of 2015 among the 85,000-strong prison population. There were also nearly 2,000 fires in prisons in 2015 – a rise of 57% on 2014. It concluded that 'overall levels of safety in prisons have not stabilised as the Ministry [of Justice] hoped, let alone improved and continue to deteriorate significantly'. It recommended that 'the Ministry of Justice and the National Offender Management Service [NOMS] must produce an action plan for improving prison safety, addressing the factors underlying the rises in violence, self-harm and suicide'.

The Justice Committee has also directly criticised prison staffing levels and linked this to the deterioration of safety in prisons. The Justice Committee notes a particular concern 'that despite a sustained recruitment exercise, described by the [Prisons] Minister as going at "full throttle", the net increase in public sector prison officers was only 440 last year. In our view this demonstrates a serious and deep-rooted issue of staff retention by NOMS'.

¹⁷ As of April 2016, women in custody numbered 3,821; the reduction of women in custody has been widely acknowledged as, in part, due to recommendations made in the report by Baroness Jean Corston 'A review of women with particular vulnerabilities in the Criminal Justice system' (2006), among others factors.

¹⁸ See the British Prime Minister's 2016 prison reform speech at the Policy Exchange, Westminster, London on 8 February 2016.

¹⁹ House of Commons Justice Committee, [Report on 'Prison Safety'](#), Sixth Session, 2015-2016; 10 May 2016.

32. The CPT was informed by the authorities about the challenges associated with national budgetary cuts. Prison budgets have been progressively reduced, in some cases by some 25% over the past three years²⁰ and staff numbers have dropped by around one third, while the inmate population has continued to rise.²¹

33. Concerns about decreased safety and increased violence clearly interweave into widespread reports of failing education and a purposeful regime provision in adult and juvenile prison establishments. Recent independent reviews into the prison education system by Dame Coates,²² into the youth justice system by Mr. Taylor²³ and into self-inflicted deaths in custody of 18-24 year olds by Lord Harris²⁴ to some extent underline this. For instance the Harris Review highlights ‘in practice, it is clear that young adults in prison are not sufficiently engaged in purposeful activity and their time is not spent in a constructive and valuable way’. The Review concluded that ‘overall the experience of living in a prison or a Young Offender’s Institution is not conducive to rehabilitation’ and that ‘there needs to be an inherent shift in the philosophy of prison in this country [...] where the primary purpose is rehabilitation, and which acknowledges that all persons deprived of their liberty shall be treated with respect for their human rights’.²⁵

34. The United Kingdom authorities recognise that the prison system of England and Wales requires profound and properly-resourced reform. During the CPT’s 2016 visit, a prison “reform agenda” was being championed by the Secretary of State for Justice and has since been included as a key priority in the “Queen’s Speech” to both Houses of Parliament, setting out the legislative priorities of the Government.

A White Paper on prison reform is due to be published in summer 2016, followed in 2017 by a Prisons’ Bill to create “Reform Prisons” focused on education, training, healthcare and security for prisoners, led by governors with the power to enter into contracts and establish their own Boards with external expertise. Overall, the reforms are aimed at the progressive decentralisation of the prison service. To start with, the authorities have announced that they will be closing down nine (mainly Victorian-era) prisons and building a number of new prisons – with places for 1000 prisoners. Further, six prisons will be designated as ‘Pilot Reform Prisons’ to give prison governors greater operational and financial autonomy, for example, in selecting education and mental health care service providers according to their prison’s needs.

²⁰ For example, the 2015-2016 budget for HMP Pentonville has been reduced since 2011/12 by some 30%. This is not unusual; other prisons face similar cuts, such as HMP Leeds, which has seen a 25% budgetary reduction in three years.

²¹ The prison population stood at 85,457, as of the 15 April 2016, according to the Ministry of Justice (Population and Capacity Planning Statistics).

²² Education specialist Dame Sally Coates, [Unlocking Potential: A Review of education in prisons](#), May 2016.

²³ Review of the Youth Justice System, An interim report of emerging findings by Charlie Taylor (child behavioural expert and former head teacher), 9 February 2016.

²⁴ Lord Harris of Haringey (Chairperson of the Independent Advisory Panel on Deaths in Custody), [the Harris Review](#), July 2015.

²⁵ The Harris Review, July 2015, Paragraph xii.

35. At the end of the 2016 visit, the CPT's delegation discussed the nature and scope of the prison reform agenda with the authorities, including the Parliamentary Under-Secretary of State with Responsibility for Prisons. These discussions allowed the delegation to stress the problem of violence in prisons and to observe that, at that point, the issue of safety in prisons appeared not to have been articulated as a Ministerial-level reform priority. In the view of the CPT, taking resolute action to tackle the problem of violence in prisons in England and Wales is a prerequisite for the successful implementation of other elements of the authorities' reform agenda.

Subsequently, by letter dated 28 June 2016, the United Kingdom authorities informed the CPT that the Justice Secretary has pledged an additional £13 million in "emergency funding" for English and Welsh prisons for extra prison staff, more training, including on suicide awareness, additional equipment, including body cameras and CCTV, and additional and improved drug testing, including for psychoactive substances. These measures represent a welcome first step in tackling the consequences but are insufficient to address the root causes of the prisons' crisis.

36. The CPT wishes to recall that it has repeatedly highlighted the deleterious effects of overcrowding, poor living conditions and lack of regime since its first visit to the United Kingdom in 1990. Over the last 25 years the prison population has nearly doubled, and almost all adult prisons now operate at or near full operational capacity and well above their certified normal capacity. In the light of the findings made during the 2016 visit, the CPT wishes to emphasise that unless determined action is taken to significantly reduce the current prison population the regime improvements envisaged by the authorities' reform agenda will remain unattainable.

While noting that the White Paper and Prisons' Bill have yet to be finalised, **the CPT recommends that concrete and effective measures to address the lack of safety and high levels of violence in English adult prisons and the youth estate be prioritised.**

These should include urgent measures to bringing prisons back under the effective control of staff, measurably reversing the recent trends of escalating violence, self-harm and self-inflicted deaths; as well as concrete steps to significantly reduce the current prison population, without which the implementation of the wider reform programme will be unattainable.

b. establishments visited

37. The CPT's delegation visited two local prisons, *HMP Pentonville* in London and *HMP/YOI Doncaster*, and one Young Offender Institution (YOI), *Cookham Wood* in Rochester.

38. *HMP Pentonville* is a large Category B Victorian-era prison located in north London and opened in 1842. The prison consists of seven wings (A to G) set out in a radial pattern around the 'Centre'. Each wing is divided into five landings. There is a separate healthcare centre, visits centre and works/programmes department. As a local prison, it accepts all 'suitable' male prisoners from the London area. Pentonville has been visited by the CPT twice before (1994 and 2001).²⁶

²⁶ See CPT/Inf (96) 11 and CPT/Inf (2002) 6.

Pentonville's Certified National Accommodation (CNA) is 906, but its operational capacity is 1,306. It was built with 860 cells for single prisoner occupancy and while it has undergone some developments, further expansion is not possible as it is situated in central London surrounded by residential buildings. At the time of the visit, it was holding 1,254 inmates, of whom 484 were on remand and 159 were young offenders (18 to 21 years old); five inmates were aged between 70 to 80 years old. There were 354 foreign national prisoners and 64 immigration detainees.

The wide spectrum of inmates combined with a rapid turnover (known colloquially as 'churn') - with some 40,000 prisoner movements per year and over 100 new prisoners entering the establishment every week (with an average stay of 56 days) present the prison with some considerable challenges.

39. *HMP/YOI Doncaster* is a large Category B local resettlement prison situated near the city centre and is a relatively modern facility, opened in 1994. It is currently operated by the private contractor Serco and serves the courts in the South and West Yorkshire. The prison holds male adult and young adult (18-21 years old) inmates.

Doncaster Prison is set on an island, surrounded by the rivers Don and Cheswold, and situated close to the town centre of Doncaster. It consists of three large residential units, recently re-branded by the Prison's Director as 'Bridges', 'Riverside' and 'West End', divided into six wings. It also has a separate social care unit ('the Orchards') and control and separation unit (known as 'the Dock'). There is also a healthcare centre, reception and discharge unit, visits centre, sports hall, education unit, and work/programmes' unit.

The prison has a CNA of 738 and an operational capacity of 1,145, but due to various refurbishment and violence reduction programmes, the prison had reduced its population capacity to 1,045 temporarily. At the time of the visit, the occupancy was 1,021 of whom 188 were on remand and 148 were young offenders. There were 73 foreign national prisoners and three immigration detainees. 11 inmates were aged over 70 years old.

The prison's operation is currently contracted to Serco by the Ministry of Justice on the basis of a service contract. The current contract started in April 2011 and had an original term of up to 15 years. However, the performance of the prison is closely monitored by a small in-house team of public servants headed by an official known as "the Controller" and appointed by the Ministry of Justice. The contract provides "delivery indicators" and, if these are not met - as was the case at Doncaster Prison - the Ministry of Justice may require the contractor to take specific steps. Serco had to produce a detailed revised Rectification Plan which was accepted by the Ministry of Justice on 14 September 2015 and ran for a period of six-months. The plan was intended to address several systemic problems notably an increase in levels of violence in the establishment, the inadequate staffing levels and deficient middle management response. As part of the plan, a new Director had been recruited on a short-term contract with the specific aim of tackling the various issues identified.

2. Ill-treatment

40. The CPT's mandate is not limited to assessing the ill-treatment of persons deprived of their liberty which is inflicted by prison staff. The Committee is also concerned with examining the discharge of the duty of care which is owed by the prison authorities to prisoners in their charge, which includes the responsibility to protect them from other prisoners who might wish to cause them harm. The prison authorities must act in a proactive manner to prevent violence by inmates against other inmates. The duty of care to maintain a safe prison extends to all persons held or working within its walls, including the prison staff. Thus, the CPT focuses on three levels of violence: that directed by staff on prisoners, inter-prisoner violence and intimidation, and prisoner attacks on staff.

41. The delegation received no complaints about physical ill-treatment by staff of inmates during its visit. In general, the delegation observed that staff treated inmates correctly and some staff were clearly extremely dedicated. Nonetheless, documentation at both *Pentonville* and *Doncaster Prisons* showed there had been some past allegations against staff during 2015-2016 (for example, there were 32 such allegations recorded at *Doncaster* and a similar number at *Pentonville*), which had resulted in internal and/or criminal investigations and the officers involved had been appropriately sanctioned.

Nevertheless, it did receive a few complaints at both *Pentonville* and *Doncaster Prisons* about verbal abuse: several prisoners complained that certain staff appeared stressed and often shouted at them, while others appeared distant and allegedly ignored prisoners' questions. Overall, this manifested itself in clearly tense relations between some staff and prisoners across the prison (see also Section 6 (a)).

The CPT recommends that the United Kingdom authorities deliver a clear message to custodial staff that verbal abuse of inmates, as well as other forms of disrespectful or provocative behaviour vis-à-vis prisoners, are not acceptable and will be dealt with accordingly. The management of Pentonville and Doncaster Prisons should demonstrate increased vigilance in this area, by ensuring the regular presence of senior or managerial staff in the detention areas, their direct contact with prisoners, and improved prison staff training (in this respect, see also the recommendation contained in paragraph 74).

42. It is widely acknowledged, including by the United Kingdom authorities themselves,²⁷ that prisons in England and Wales are not safe places with a high level of generalised violence within their walls. As mentioned above, a recent report by the House of Commons Justice Committee underlines there were 2,690 assaults against staff in the six months to December 2015, an increase of 18% compared to the previous six months. From January 2015 until March 2016, during each quarter, there have been over 150 serious assaults between prisoners. A prison officer working for Serco tragically died in July 2015 after being attacked by a prisoner she was escorting from court. In the 12 months to March 2016, there were 100 self-inflicted deaths – up from 79 in the previous year. According the Prison Officers’ Association, deployment of tactical intervention teams from the National Tactical Response Group (NTRG) – which attends incidents such as hostage taking and concerted indiscipline of inmates – have reached “unprecedented levels” of 30 to 40 times a month.²⁸

43. The delegation found a high level of violence in each of the prisons visited, including inter-prisoner violence and violence of prisoners on staff. The amount of violence and the severity of such violence at both *Pentonville* and *Doncaster Prisons* was staggering. Injuries to both prisoners and staff, documented over merely the past three months, included *inter alia* two separate cases of buckets of scalding water being thrown over victims from a higher floor, both resulting in severe burns over 10% of the victims’ bodies (in one case, this resulted in the victim having to stay for 10 days in hospital), ‘shank’ (make-shift knife) wounds, head wounds, broken noses and broken teeth (see below). In a number of very recent cases, these injuries required hospitalisation after the assault and in one case resulted in the death of an inmate. The situation was exacerbated by overcrowding (see section 3) and poor regimes (see section 4(b)).

Many inmates told the delegation that they feared for their safety during association, during movement time and especially in the showers – where there was no CCTV coverage. Assaults could, and did, happen anywhere. At *Pentonville*, in the course of one interview the delegation noticed that the inmate was still bleeding from a ‘shank’ attack that had just occurred in his own cell by another prisoner; the prisoner in question was both too scared of reprisals to report it to staff and had no faith that staff would do anything to protect him. At *Doncaster Prison*, the delegation met inmates who did not take showers because of the frequency and severity of the attacks from other prisoners that happened there, and because they had witnessed slow staff reactions to previous violent incidents. Prisoners repeatedly underlined to the delegation that they perceived themselves as being ultimately in control. Overall, it was clear that both *Doncaster* and *Pentonville Prisons* were unsafe places for inmates and staff alike.

44. The CPT’s delegation examined the violence through the prism of three criteria: recording incidents of violence, responding to such incidents and specific measures taken to reduce violence.

First, as regards recording incidences of violence, the CPT noted that there were a considerable number of instruments available to capture data regarding violent incidents at both *Doncaster* and *Pentonville Prisons*. The authorities and management had acknowledged that violence was a serious concern in both prisons, measures to track hot-spots or flash points of violence and record numbers of violent incidents were underway.

²⁷ See the British Prime Minister’s 2016 prison reform speech, at the Policy Exchange, Westminster, London on 8 February 2016; the Queen’s Speech 2016, at the Houses of Parliament on 18 May 2016; and the Justice Secretary’s speech to Parliament on 26 May 2016.

²⁸ House of Commons Justice Committee, Report on ‘Prison Safety’, Sixth Session, 2015-2016, Chapter 2, ‘Indicators of prison safety’, 10 May 2016.

The delegation was concerned, however, by systemic and structural weaknesses in the documentation process. Across the establishments visited, the delegation gained the impression that the actual number of violent incidents appreciably exceeded the number recorded. This issue appeared to be particularly acute at *Doncaster Prison*, where the delegation established that some violent incidents had not been recorded or had been recorded as less serious than they actually were, with the inevitable impact on the accuracy of the data that NOMs received. By way of example, reference might be made to the following four recent entries in Doncaster Prison's "Violence Reduction Database":

- 3 March 2016 – "Following an incident, Officer [X] was called to C Wing. [Prisoner A] was in the showers with scalds to his face, neck and legs. CCTV was viewed and [Prisoner B] was seen to pour a boiling liquid from the top landing over [Prisoner A]. [Prisoner A] was taken to DRI [Doncaster Royal Infirmary] by ambulance and later transferred to Hallamshire Hospital. [Prisoner B] was located to the Dock and placed on report" – the Police, NOU and MOJ were informed;
- 7 March 2016 – "At approx. 1510hrs [Officer Y] saw [Prisoners C, D, E and F] kick and stamp on [Prisoner G]. All four have been placed on report";
- 13 March 2016 – "Staff observed [Prisoner H] assault [Prisoner I] by striking him across the head with a broom handle, [Prisoner H] has been placed on report"; and
- 21 March 2016 – "[Officer Z] was searching prisoners in the Gym when he witnessed prisoner [Prisoner J] punching [Prisoner K], after checking CCTV it was apparent that multiple prisoners joined in the assault of [Prisoner K]".

Notwithstanding the clear NOMs guidance as to when an assault is to be classified as "serious", each of these attacks by inmates on fellow prisoners had been recorded in Doncaster Prison's Violence Reduction Database only as "alleged / attempted" assaults, even though staff had actually witnessed an attack, victims had been bleeding / burnt and required medical treatment and the perpetrators had been identified.

Moreover, the delegation observed first-hand that violent incidents were not always reported. For example, a prisoner-on-staff assault occurred during the delegation's visit to *Doncaster Prison* and the staff member involved was reluctant to report it; the incident remained unreported by the end of the visit. The delegation also interviewed several prisoners at *Pentonville Prison* who deliberately did not report attacks from other prisoners because of the fear of prisoner reprisals.

The number of recorded violent incidents at both establishments in the twelve months prior to March 2016 (i.e. from March 2015 to February 2016 inclusive) was extremely high. At *Doncaster Prison*, there had been 554 recorded prison-on-prisoner assaults (of which 97 classified as ‘serious assaults’) and 125 recorded prisoner-on-staff assaults (of which 125 classified as ‘serious assaults’). The association areas in Doncaster Prison appeared to be particular flashpoints for attacks of this nature. At *Pentonville Prison*, there had been a total of 396 recorded assaults during the same period: 277 recorded prisoner-on-prisoner assaults (of which 37 classified as ‘serious assaults’) and 119 recorded prisoner-on-staff assaults (of which 12 classified as ‘serious assaults’). Many attacks at Pentonville took place in association areas and exercise yards; however, it was also striking that a significant percentage of assaults (varying from month-to-month from around 30% to close to 50% of attacks) were recorded as having taken place in cells.²⁹ Dramatic as these figures are, on the basis of its delegation’s findings during the visit, the CPT believes that they under-record the actual number of incidents and consequently fail to afford a true picture of the severity of the situation.

By letter dated 28 June 2016, the United Kingdom authorities informed the CPT that they had had previous concerns regarding potential misreporting of violent incidents at *Doncaster Prison* and that a formal investigation had been commissioned led by a senior Prison Governor to cover the timeframe of 1 April 2015 to 31 May 2016. This investigation was scheduled to produce a final report by 30 June 2016.

The CPT recommends that the United Kingdom authorities take swift measures to ensure that all violent incidents at Doncaster and Pentonville Prisons – and at all other prisons across England and Wales - are systematically and accurately recorded by staff, in order to gain a true picture of the situation and to be able to take specific measures to counter the violence.

It also requests that a copy of the final report on the investigation commissioned into the recording of violent incidents at Doncaster Prison be sent to the Committee, as well as any action plan resulting from this investigation.

45. As regards prison staff response to violent incidents, the CPT’s delegation received a considerable number of complaints from inmates at both *Doncaster* and *Pentonville Prisons* that staff responded slowly to violent incidents. This fuelled a feeling of fear and a perception of a lack of safety, according to inmates, as they did not know when staff would be able to stop an incident. This bred a lack of trust in the staff’s ability to maintain prisoner safety. The delegation observed generally that responses to inmates’ call bells were slow with many responses over the three (*Pentonville*) to five (*Doncaster*) minute internal time limits. At *Doncaster Prison*, over 50% of staff responses to call bells were over five minutes, with some delays as long as an hour. At *Pentonville*, some delays were as long as 55 minutes and the majority were not dealt with within preferred time-limits (3 minutes) (see also paragraph 72).

The CPT recommends that the United Kingdom authorities take steps to ensure that prison staff at Doncaster and Pentonville Prisons are able to respond to violent incidents and to inmates’ cell call-bells within three minutes and preferably much quicker (see also recommendation in paragraph 74).

²⁹ NOMs’ Violence Diagnostic Tool – Doncaster and Pentonville Prisons.

46. Regarding specific ongoing measures initiated by management to reduce and prevent violence, the CPT's delegation observed that some measures had been undertaken, such as Safer Custody and violence reduction meetings and the establishment of violence reduction representatives. Nevertheless, such measures remained at an early stage of development and the delegation was not convinced of their effectiveness. For instance, the delegation analysed a representative sample of recent cases involving serious injury to inmates. This showed that while measures were in place to oblige follow-up to the incidents, the follow-up reports were not completed and often contained minimal detail (reporting merely on the location of the violent incident but lacking any analysis of the reasons for the violence and context). Moreover, while the delegation welcomed the initiative to compile 'concern files' (regarding vulnerable inmates or potential future victims or perpetrators of possible violence), none of the files from cases in February to April 2016 examined by the delegation had been completed.

The CPT recommends that the United Kingdom authorities take concrete steps to ensure that far greater investment in preventing violence is undertaken at both Doncaster and Pentonville Prisons and at other prisons in England and Wales affected by similar levels of violence, including, *inter alia*, the thorough completion of 'follow-up' reports on violent incidents and 'concern files' to help stem and prevent future violence.

47. It is notable that the unprecedented levels of violence at *Doncaster Prison* often materialised in the corridors and common areas where internal prisoner movements meant that prisoners from different units could come across each other. The prison had attempted to separate out gangs, but gang affiliation and rivalry was endemic throughout the units. Common areas and movements along the corridors that linked up the units were flashpoints of cases of extreme violence. The prison management had identified this problem and were considering putting security doors along the corridors, which they considered would help improved safety.

The CPT would like to receive confirmation that this has now been completed.

48. Overall, the delegation's findings in the establishments visited indicate that the duty of care to protect inmates from those who wish to cause them harm was often not being discharged given the apparent lack of effective action to reduce the high levels of violence.

More generally, the CPT recommends that immediate attention be given to initiating concrete measures (including those recommended above) to bringing prisons back under effective control of the staff, reversing the recent trends of escalating violence, self-harm and self-inflicted deaths.

3. Overcrowding

49. The prison system in England and Wales continues to suffer from chronic overcrowding and, increasingly, a severe shortage of staff due to budget cuts (see paragraph 70). The CPT has repeatedly raised concerns of the impact of overcrowding in a number of previous reports; equally, it has recurrently found overcrowding to be a source of additional serious shortcomings in the prison system (impacting, for example, on material conditions, regime, outdoor exercise, reception procedures and health-care services (see below)).³⁰

The CPT believes that this situation is the result of a trend of steadily increasing prison population figures. These rose sharply between the previous 2003 and 2008 CPT visits (by 10,400 in 5 years) and have continued to steadily increase from 83,292 in 2008 to 85,457 at the time of the visit.³¹

At the time of the visit, 65% of the prisons in England and Wales were operating at well above their Certified Normal Accommodation (CNA); the CNA should 'represent the good, decent standard of accommodation that the Prison Service aspires to provide to all prisoners'. *Pentonville* (141%) and *Doncaster* (152%) were among those prisons that operated at far beyond their envisaged respective CNAs. Equally, some 70% of prisons were also operating at full operational capacity³² (including Pentonville Prison).

50. Once again,³³ the CPT's delegation found during the course of the 2016 visit that many aspects of prison life were negatively affected by the state of overcrowding in the prison system. For example, living conditions in the prisons visited were adversely affected by the chronic overcrowding: cells originally designed for single use now had double occupancy (see paragraph 52). Equally, overcrowding also significantly affected the prisoners' regimes. The delegation found that the regimes in all three prison establishments visited were inadequate, with a considerable number of prisoners spent up to 22 hours per day, and occasionally even longer, locked up in their cells, often due to staff shortages and the limited number of inmates' - and their movements - that staff could manage safely (see Section 4 (b) and paragraphs 89 to 93).

51. The CPT has repeatedly highlighted the deleterious effects of overcrowding, poor living conditions and lack of regime. The issue of prison overcrowding has been the source of ongoing dialogue between the CPT and the UK authorities since 1990.³⁴ In 1990, when the prison population of England and Wales was roughly half of the current 85,000, the CPT underlined that the Prison Service was not meeting the standards it had set itself in terms of prisoner accommodation and recommended that due consideration be given to the possibility of introducing an enforceable ceiling on the inmate population of each prison. The situation has not changed notwithstanding the steady increase of the prison population. The CPT has recurrently underlined that for as long as overcrowding persists, the risk of prisoners being held in inhuman and degrading conditions of detention will remain. Regrettably, the situation has deteriorated over the years to an unacceptable situation.

³⁰ See the CPT reports on the 2003 and 2008 visits: CPT/Inf (2005) 1, paragraphs 16 to 41 and CPT/Inf (2009) 30, paragraphs 25 to 34 respectively.

³¹ As of 15 April 2016, [Population Bulletin](#), 15 April 2015, Ministry of Justice.

³² 82 of the 121 prisons were at over 100% of their CNA according to Ministry of Justice April 2016 statistics.

³³ See, for example, *op cit* 35 and CPT/Inf (91) 15.

³⁴ See CPT/Inf (1991) 15, paragraphs 37 to 71.

In light of the findings made during the 2016 visit, the CPT believes that unless determined action is taken to significantly reduce the current prison population it will not be possible to deliver the significant regime improvements envisaged by the prison reform agenda; many aspects of prison life will continue to be adversely affected by the state of overcrowding in the prison system.

The solution to overcrowding in English and Welsh prisons is clearly not merely one where the United Kingdom can 'build its way out'. The - as yet unspecified - number of new prisons proposed by the Justice Secretary may help to temporarily alleviate certain problems caused by overcrowding. Nonetheless, if the steady increase of the prison population continues upon its current trajectory, these too will rapidly become overcrowded and start to face the same problems as those currently facing the rest of the prison system.

Since its first visit to the United Kingdom in 1990 the CPT has repeatedly recommended that urgent action was needed to curb overcrowding in English prisons, yet the situation has progressively deteriorated. The CPT calls again upon the authorities of the United Kingdom to take concrete measures and determined action to significantly reduce the current and future prison population, as a matter of priority, in line with the European Prison Rules.³⁵

4. Conditions of detention and regime

a. material conditions

52. At *Doncaster Prison*, the delegation observed that cells measuring from some 7 to 9m² were largely used for double-occupancy, which provided cramped living conditions for the inmates. Toilets and sanitation annexes were not fully screened. At *Pentonville Prison*, the majority of the prisoners were also doubled up in cells - measuring some 8m² - designed for single use, with the toilet only partially screened or even un-screened. Many of the toilets were filthy. Prisoners and staff alike complained about the unhygienic and cramped conditions in which prisoners had to live, eat and sleep. The situation had clearly not improved since the CPT's previous visit to *Pentonville* in 2003.³⁶

The CPT considers that a single-occupancy prison cell should measure at least 6m² plus the space required for a sanitary annexe (usually 1m² to 2m²). For double occupancy, this should be at least 8m² plus a fully partitioned sanitary annex. Moreover, it is desirable for double occupancy cells to measure 10m² plus a sanitary annex.³⁷ These basic requirements were not being met in the vast majority of cells at both *Doncaster* and *Pentonville Prisons*.

The CPT recommends that the United Kingdom authorities take urgent steps to cease the doubling up of prisoners in cells designed for single use at Pentonville and Doncaster Prisons, and that sanitary annexes in double occupancy cells be fully partitioned, in line with the above CPT standards (in this respect see also the recommendation contained in paragraph 51 on the issue of overcrowding).

³⁵ Recommendation Rec(2006)2 of the Committee of Ministers of the Council of Europe and Recommendation No. R (99)22 regarding overcrowding and the prison population inflation.

³⁶ CPT/Inf (2005) 1, Paragraph 29.

³⁷ See CPT/Inf (2015) 44, 'Living space per prisoner in prison establishments: CPT standards', 15 December 2015.

53. More generally, *Pentonville Prison* was in a state of dilapidation and filth. The exercise yards were strewn with ankle-deep litter, and graffiti and mould covered the walls. The paint of cell-floors was cracked and chipped, many of the toilets and shower rooms were dirty and/or malfunctioning and needed refurbishing. This situation was evident despite a general programme of painting work underway. The rapid turnover of prisoners exacerbated the general wear and tear to which the physical environment was subjected.

At *Pentonville Prison*, the delegation observed that netting erected to try to counter the large in-flow of drugs (mainly New Psychoactive Substances (“NPS”)) and contraband flowing into the prison was torn and hung down in large areas, negating its effectiveness.

The CPT recommends that immediate repair where required, deep cleaning and a regular programme of refurbishment of the entirety of Pentonville Prison be undertaken.

b. regime / ‘purposeful activity’

54. Inmates are formally entitled to educational activities and vocational training, work, organised physical exercise, cultural and recreational activities.³⁸ Nevertheless, in previous visit reports the CPT has underlined that activities and association time offered remained insufficient for the number of prisoners. More recently, widespread criticism³⁹ has been levelled at the provision and quality of education, poor attendance rates and performance and ineffective mechanisms to rectify this situation in adult prisons in England, and by the body responsible for inspecting the provision of education in prison – the Office for Standards in Education, Children's Services and Skills (Ofsted).⁴⁰

An independent review of prison education conducted by Dame Sally Coates⁴¹ and published just after the delegation’s visit, points to fundamental deficiencies in the provision, attendance rates and quality of education in adult English prisons and the need for wide-scale change. The independent review made a series of recommendations required to put ‘education at the heart of the prison system’. These include, *inter alia*, explicitly making Prison Governors responsible and accountable for education, instilling a culture of education from the very first day of a prisoner’s time inside, reforming the reception process to include a Personal Learning Plan for every prisoner, holding Prison Governors to account for the progress of each prisoners’ plans.

Equally, another independent review commissioned by the authorities into deaths in custody of young adults (18-24 year olds), the Harris Review, has highlighted that ‘in practice, it is clear that young adults in prison are not sufficiently engaged in purposeful activity and their time is not spent in a constructive and valuable way. Current restricted regimes do not even allow for the delivery of planned core day activities that might help with rehabilitation. Our evidence demonstrates that young adults do not have enough activities, such as education or work, which will enable them to live purposeful lives’.⁴²

³⁸ Prison Rules, Rules 31 and 32.

³⁹ See for example ‘[Unlocking Potential: A review of education in prison](#)’, Dame Sally Coates, published May 2016 (the Coates Independent Review), the British Prime Minister’s 2016 prison reform speech at the Policy Exchange, Westminster, London on 8 February 2016, among others.

⁴⁰ Ofsted’s ‘Overall Effectiveness’ judgements in 2014/15 showed only two prisons were ‘Outstanding’. Nine Prisons were ‘Good’, 27 prisons ‘Required Improvement’ and seven were ‘Inadequate’.

⁴¹ ‘[Unlocking Potential: A review of education in prison](#)’, the Coates Independent Review, May 2016.

⁴² The Harris Review, Paragraph xii, p.10.

55. At both *Doncaster* and *Pentonville Prisons*, the delegation found that a range of activities was on offer to prisoners, including education classes (English, Maths and IT), textile and art workshops, sports and internal prison employment (gardening, kitchen work, etc.). It also included some vocational courses such as radio production, painting and decorating, barbering and industrial cleaning courses. Additionally, at *Doncaster*, there were also vocational training courses in railway engineering and food safety.

Nevertheless, in practice many prisoners did not, or could not, benefit from these courses. For example, at *Pentonville*, despite a regime in place for at least three hours of activities per inmate per day and the availability of 1,338 spaces⁴³ (for an operational capacity of 1306), at the time of the visit 474 inmates remained without any employment or education (i.e. 36%). Moreover, out of those employed (some 800), only approximately 60% attended on average each day. Those inmates who had employment or took part in selected activities were able to be out of their cells for at least 3 hours for activities and 2.5 hours for association, exercise and showers per day. However, the 36% of unemployed inmates and those who did not attend (see below), remained locked in their cells for 21.5 hours per day, with little to occupy themselves. This situation was exacerbated by the cramped conditions in the double occupancy cells (see also paragraph 52).

At *Doncaster Prison*, the available education and training spaces numbered 1,654 per working day.⁴⁴ Education staff acknowledged, however, that attendance rates over the past year had been poor⁴⁵ and the management was undergoing a review on how to address this. Similarly, *Pentonville Prison* also had poor, if not worse, attendance rates.⁴⁶ According to staff, this was due to a number of factors, including times when the prison was in lock-down for reasons of security or when there simply were not enough staff to accompany the inmates to the education department from their wings. Indeed, at *Pentonville Prison*, information provided by staff⁴⁷ showed that the 'lock-downs' had become a regular feature and happened on a systematic basis due to staff shortages. The delegation observed that as a result, each wing was shut one half day per week on a rotation basis. Thus, the low number of staff and high levels of violent incidents, which required staff time, had clearly started to adversely affect the lives of all the inmates.

The overall effect of this, however, was that a large number of inmates were spending a large proportion of the day (around 21.5 hours) locked in their cells. The delegation also heard from detained persons and staff that long lock-up times contributed to the inmates' sense of frustration and boredom, which could materialise into outbursts of violence. The CPT believes that a poor regime could well be a contributory factor for the current spike in violence in English prisons (see also paragraph 43).

The CPT recommends that United Kingdom authorities take concrete steps to change the regime, staff rotas and/or numbers and remove obstacles to inmates' attendance, to ensure that all inmates at Pentonville and Doncaster Prisons can attend education and other purposeful activities on a daily basis. The overall aim, should be offer to all inmates a normal regime of at least eight hours out of cell.

⁴³ Total Activity Spaces per day (split shift) (note bene: one inmate can do more than one activity).

⁴⁴ Total Activity Spaces per day (split shift) 829 (for the 2.5 hour morning slot) and 825 for the 2.5 hours afternoon slot.

⁴⁵ For example, in 2016: January 2016 had had 65.17% attendance; February 2016 had had 60.71% attendance.

⁴⁶ For example, according to information provided by education staff, on 24 March 2016, while 414 inmates were enrolled in education, only 260 actually attended. That morning, education and activities had a class capacity of 175, 184 inmates were enrolled (because of anticipated attendance problems), and 130 did not attend (approximately a 74% non-attendance rate).

⁴⁷ Regime Timetable, no. 23/2016, w/c 3 April 2016; implementation date: 31 March 2016 until 9 April 2016.

It also recommends that inmates who are unemployed or do not participate in activities are provided with more out-of-cell time than the current daily 2.5 hours and, as far as possible, be offered meaningful activities during association time.

The CPT trusts that the recommendations in the Coates' review of adult prison education concerning in particular the provision and quality of education for prisoners will be implemented in practice and would like to be updated on the actions taken to this end by the United Kingdom authorities.

56. The CPT's delegation received many complaints at both *Pentonville* and *Doncaster Prisons* that time out-of-cell and outdoor exercise entitlements (Rule 30 of the Prison Rules)⁴⁸ were being curtailed in practice to 30 minutes or even cancelled. Staff confirmed this and acknowledged that on occasion, outdoor exercise or association would not be provided due to staff shortages.

The CPT raised this concern during its previous visits,⁴⁹ as well as its misgivings about the very flexible wording of Rule 30. The Committee recalls, once again, that the basic requirement of at least one hour of outdoor exercise is a fundamental right for all inmates. Further, all prison exercise yards should provide shelter from inclement weather; not all of the yards visited at both prisons provided such shelter. The CPT regrets that its previous recommendations in this respect have not been implemented.

The CPT again calls upon the authorities of the United Kingdom to ensure that inmates are guaranteed at least one hour of outdoor exercise every day, which is also provided for explicitly in Rule 27(1) of the European Prison Rules.

Moreover, it recommends that all exercise yards at Pentonville and Doncaster Prisons provide some shelter from inclement weather.

5. Health care services

a. general health care

57. Health-care services for prisons in England and Wales are run by the National Health Service (NHS). The responsibility for commissioning healthcare services in secure settings, including prisons, transferred to NHS England on 1 April 2013, as a result of the Health and Social Care Act 2012.

⁴⁸ Prison Rules 1999, Rule no. 30: 'If the weather permits and subject to the need to maintain good order and discipline, a prisoner shall be given the opportunity to spend time in the open air at least once every day, for such period as may be reasonable in the circumstances.'

⁴⁹ See CPT/Inf (2009)30, Paragraph 42 and CPT/Inf (2005)2, Paragraph 90.

58. The CPT's delegation noted that, generally, inmates could have access to healthcare staff within a reasonable amount of time and that health-care staffing was, on the whole, adequate at *Pentonville Prison*. For some 1300 inmates, there were two full-time permanent general practitioners (GPs) and three part-time GPs, and some 40 nursing staff who provided 24 hour nursing cover.⁵⁰ *Pentonville Prison* was also visited regularly by relevant specialists (dentists, optician, physiotherapist, podiatrist and sonographer, among others) and dental care was generally adequate. There was, however, a vacancy for the position of the Lead GP, which was under recruitment at the time of the visit and **the CPT wishes to receive confirmation that this position had been filled.**

At *Doncaster Prison*, the delegation noted that there was an adequate number of nursing staff and 24 hour nursing cover.⁵¹ That said, there was only one equivalent full-time permanent GP for general health care and two rotational part-time GPs, which was clearly insufficient to meet the needs of over 1,000 inmates. The delegation also noted with concern that there were various vacancies within the health-care team, notably, five posts were vacant in the general health-care medical team and four in the Substance Misuse team. The prison had regular access to relevant specialists (dentist, podiatrist, transmissible diseases optician specialists, among others) and dental care was, on the whole, adequate.

By letter dated 28 June 2016, the United Kingdom authorities informed the CPT that as of 5 May 2016, five posts within the primary health-care team had been filled; however, 2.6 vacant positions remained. The CPT welcomes this development.

The CPT recommends that the number of full-time GPs be increased by at least one and that serious efforts are undertaken to fill the remaining vacancies within the health-care and substance misuse team.

59. As regard access to healthcare staff at *Doncaster Prison*, the delegation received several complaints from inmates that they did not understand how to use the computerised pin system installed on the wings for electronic application to see health-care staff.

The CPT considers that inmates should be able to have access to a doctor at any time. The health care service should be so organised as to enable requests to consult a doctor to be met readily and without undue delay. In light of the above, **the CPT recommends that Doncaster Prison management invest more time in each inmate's induction process to explain how the new electronic application system works for prisoners to fully understand how to contact health-care service, if and when needed.**

60. The CPT's delegation was pleased to note that all inmates at both *Doncaster* and *Pentonville Prisons* were medically screened by a nurse within 24 hours of arrival and were also seen, if necessary, by a medical doctor. Moreover, the CPT's delegation found that the medical screening was of a good quality.

⁵⁰ Nursing staff positions at *Pentonville Prison* included: one Primary Care Lead, one Clinical Lead, 16.5 Primary Care nurses' positions and three health care assistants, as well as one Substance Misuse Lead, one independent Prescriber, 19.5 Substance Misuse staff nurses and Charge nurses' positions and two healthcare assistants.

⁵¹ Nursing staff at *Doncaster Prison* included: nine nurses, three managing nurses, one clinical manager, 10 healthcare assistants and two registered nurses.

61. The delegation noted positively that the level and quality of medical documentation was generally good at both *Doncaster* and *Pentonville Prisons*. There was generally a full description of injuries and the use of body maps, as well the systematic use of the reporting procedures (Form 213) for injuries to prisoners. That said, there was little evidence of any conclusions made by doctors as to the causal link between the injuries seen and any allegations of ill-treatment made by the prisoners. Further, it was not clear to the delegation that Form 213s were automatically forwarded to an independent body empowered to conduct investigations, including criminal investigations.

The CPT recommends that steps be taken so that the prison medical services at the establishments visited fully play their role in the system for preventing ill-treatment, ensuring that:

- **the doctors indicate at the end of their traumatic injury reports, whenever they are able to do so, any causal link between one or more objective medical findings and the statements of the person concerned;**
- **traumatic injury reports relating to injuries likely to have been caused by ill-treatment (even in the absence of statements) be automatically forwarded to an independent body empowered to conduct investigations, including criminal investigations, into the matter; and**
- **the doctors advise the prisoner concerned that the writing of such a report falls within the framework of a system for preventing ill-treatment, that this report automatically has to be forwarded to a clearly specified independent investigating body and that such forwarding does not replace the need for the prisoner to lodge a complaint in proper form.**

62. Medical confidentiality at both prisons visited was generally respected. Nonetheless, an exception to this was evident at *Doncaster Prison*, where the CPT's delegation observed that medication was given in an open corridor where other inmates could easily overhear the conversations between the nurse and inmates concerned. Moreover, medication was dispensed through a barred window, which, in the CPT's view, is not conducive to facilitating adequate relationships between health-care staff and inmates.

The CPT recommends that the United Kingdom authorities take steps to ensure that, at Doncaster prison, medication is not given to inmates in an open corridor, nor dispensed through a barred window; instead, an environment that enables full respect for medical confidentiality and for adequate health-care staff and patient relations should be developed.

63. From interviews with health-care staff and inmates at both *Pentonville* and *Doncaster Prisons* it became clear that a practice had developed of systematically handcuffing prisoners during hospital transfers and during the period that inmates spent in hospital. Moreover, this was apparently also the case for extremely sick and infirm prisoners at end of life.

The Committee understands that it may sometimes be necessary to make special arrangements in respect of security. However, to restrain systematically prisoner patients during transfer is not acceptable; such a measure, as well as the practical arrangements for its application in each case, should be envisaged on the basis of an individualised risk assessment. Furthermore, examining or treating patients subjected to means of restraint is a highly debatable practice, both ethically and from the clinical viewpoint; the decision on this matter should be taken by health care staff on the basis of an individualised risk assessment.

The CPT recommends that the United Kingdom authorities take measures to reverse the practice of systematically restraining prisoner patients with handcuffs during hospital transfers and instead apply handcuffs during transfer only on the basis of an individualised risk assessment.

It also recommends that prisoners should not be handcuffed during a medical examination or treatment; if exceptionally the application of handcuffs is deemed necessary on the basis of an individualised risk assessment, the decision on this matter should be taken by the health care staff involved. Moreover, consideration should be given to creating secure patient rooms in hospitals treating prisoners.

64. The CPT noted that at both establishments visited, there was a number of prisoners over 70 years old, and some in their 80s,⁵² as well as some severely or terminally ill prisoners, suffering from some debilitating diseases. According to both prisons' management, for various reasons this number was steadily increasing. In light of the considerable challenges facing elderly or infirm persons or persons suffering from disabilities in prison, the CPT welcomes the establishment at *Doncaster Prison* of a specific 'welfare' unit for such inmates (the 'Orchards'). The unit was based on the ground floor allowing more ready access to outdoor exercise, had a specific regime and had a more relaxed environment facilitated by some very dedicated staff.

Nevertheless, the delegation observed that in some cells designed for double occupancy, wheel-chair bound inmates had extremely restricted space for wheelchair movement. **The CPT recommends that inmates in wheelchairs be allocated to single occupancy cells in the Orchards Unit that can afford them sufficient space for wheelchair movement.**

b. mental health care

65. Mental health-care services are provided by Barnet, Enfield and Haringey Mental Health NHS Trust on behalf of CareUK at *Pentonville Prison* and by Nottinghamshire Healthcare NHS Foundation Trust for *Doncaster Prison*. Health-care services at *Pentonville* include a 22 in-patient health-care unit for patients prior to transfer to a NHS psychiatric hospital or for those who are suffering from mental health problems that cannot be managed on the prison wing. There is also a Mental Health In-Reach Teams at both prisons who provide a secondary level of care. The CPT's delegation observed that there appeared to be an adequate level of staffing in mental health-care at both establishments.⁵³

⁵² Pentonville Prison held five and Doncaster 11 of this age group at the time of the delegation's visit.

⁵³ At Pentonville Prison, the mental health team included: two and a half psychiatrists, one Team Leader, 0.8 clinical psychologist Lead; one In-Patient Unit Lead, one Mental Health In-Reach Lead, two senior occupational therapists; two forensic social workers, six mental health staff nurses, six senior mental health nurses, four health-care assistants, two junior occupational therapists, two technical instructors and two assistant psychologists. At Doncaster Prison, the mental health team included: one manager, five registered mental health nurses, six registered mental health nurses in psychiatric care, one part time psychologist and one counsellor.

66. However, at both prison establishments visited, the delegation observed considerable delays in several cases of prisoners with mental-health problems who had been referred to psychiatric hospitals and were awaiting transfer. In some cases this was for several months because of a lack of available beds in specialised psychiatric facilities. Equally, the delegation noted with concern that the in-patient health-care unit at *Pentonville Prison* was primarily being used to hold psychiatric patients. Care should be taken to ensure that this unit does not become a substitute for the transfer of a patient to a dedicated facility that can better respond to their mental-health needs.

Further, at both prisons establishments visited, the delegation met several prisoners with severe mental illnesses who were held on normal accommodation wings. In one case, at *Doncaster Prison*, the delegation interviewed a young adult, who was clearly delusional (and had been on an ACCT⁵⁴), who was being accommodated in a cell on a normal accommodation wing with no toilet or wash basin. After he apparently heard voices and subsequently caused damage to his cell (covering it with blood and faeces), he was subjected to control and restraint and taken to the segregation unit. This was an unsuitable environment for a prisoner with severe mental health needs (see also paragraph 68).

67. Various independent reviews and oversight bodies have highlighted a fundamental need for improving mental health provision in prisons.⁵⁵ As the Prisons and Probation Ombudsman (the PPO) has underlined in his recent review on prisoner mental health,⁵⁶ a very high proportion of the prison population have one or more mental health issues and ‘some mental health conditions cause sufferers to present difficult and challenging behaviour, which staff may deal with as a behavioural rather than a mental health problem. When this leads to a punitive rather than a therapeutic response, this may only worsen the prisoner’s underlying mental ill-health.’

Equally, long delays for transfers to hospital of prisoners suffering from acute mental health illnesses is not a new issue; it was already raised in the 2009 Bradley Report on mental health services in the criminal justice system⁵⁷. The Bradley Report recommended that prisoners suffering from severe mental health illnesses should be transferred to a hospital within 14 days. In the CPT’s view, this 14-day limit is still too long. Yet, the CPT found during the 2016 visit that even this recommended maximum 14 day time-limit before transfer to a hospital was clearly not the case in practice at either prison visited. By letter dated 28 June 2016, the United Kingdom authorities informed the CPT that NHS England is revising transfer guidance and the expectation is that transfers from prisons to hospitals, under the MHA, will be carried out within 14 days as the norm.

The CPT notes that the United Kingdom authorities have underlined that 49% of prisoners have an identifiable mental health problem,⁵⁸ and rates of self-harm have increased by 13% in the last two years. In 2015, out of a prison population of some 85,000, there were 257 deaths in prison, of which 8 were murders/homicides and 89 were self-inflicted, which is the highest figure of self-inflicted deaths recorded in a calendar year since 1979.⁵⁹

⁵⁴ Assessment, Care in Custody & Teamwork (ACCT); see Paragraph 68.

⁵⁵ See for example, Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system (the Bradley Report), 30 April 2009; Prisons and Probation Ombudsman, Nigel Newcomen, ‘Learning from PPO Investigations: Prisoner Mental Health’, January 2016, among others.

⁵⁶ The PPO, ‘Learning from PPO Investigations: Prisoner Mental Health’, January 2016.

⁵⁷ [Lord Bradley’s review](#) of people with mental health problems or learning disabilities in the criminal justice system, Executive Summary, 30 April 2009.

⁵⁸ The British Prime Minister’s speech on prison reform, London, 8 February 2016.

⁵⁹ There were 25,775 self-harm incidents in 2014 with 1,749 requiring a hospital attendance, Ministry of Justice (2015) Safety in custody statistics; ‘Deaths in prison custody and rates by apparent cause by calendar year since 1978’, Safety in Custody Statistics, Ministry of Justice, 2016.

The British Prime Minister has underlined that ‘we’ve got to sort out mental health treatment and drug treatment [...]. There’s been a failure of approach, and a failure of public policy. In terms of approach, frankly, we are locking up some severely mentally ill people in prison who should not be there.’⁶⁰

The PPO has highlighted from his various investigations into deaths in prisons across England and Wales between 2012 and 2014, that all prison staff need to be able to recognise the major symptoms of mental ill-health. The PPO has found that this was not always the case. Further, the PPO has found many cases of poor monitoring of compliance with medication, superficial and inappropriate care plans and a general finding that the provision of mental health-care in prisons was simply inadequate.⁶¹

The CPT recommends that the United Kingdom authorities take all necessary measures to ensure that prisoners suffering from severe mental illnesses are cared for and treated in a closed hospital environment, suitably equipped and with sufficiently qualified staff to provide them with the necessary assistance.

In this connection, high priority should be given to increasing the number of beds in psychiatric hospitals (in this respect see also Section II. D (*Psychiatric institutions*)) to ensure that the in-patient health-care unit at Pentonville Prison does not become a substitute for the transfer of a patient to a dedicated facility and that prisoners at both Doncaster and Pentonville Prisons with mental-health problems - who had been referred to psychiatric hospitals - are not held on normal accommodation wings.

More generally, the CPT recommends that prisoners suffering from severe mental health illnesses should be transferred to hospital immediately.

Moreover, the CPT recommends that the authorities ensure that all prison staff are trained to recognise the major symptoms of mental ill-health and understand where to refer those prisoners requiring help.

68. Further, the delegation observed first-hand the placement of prisoners with acute mental-health conditions in segregation units, as an alternative to normal accommodation. The delegation was informed by the authorities that the official policy was that only in very exceptional circumstances would prisoners identified as being at risk of self-harming or attempting suicide and thus placed on an ‘ACCT’ (Assessment, Care in Custody and Teamwork) review be held in segregation. This was not the case in practice. In both *Pentonville* and *Doncaster Prisons*, there were several prisoners on ACCTs placed in the segregation unit and while special approval was needed, staff informed the delegation it was not at all unusual to have prisoners on ACCTs in segregation. Moreover, it was also not unusual that prisoners on ACCTs attempted self-harm or suicide while in segregation; indeed, attempts to commit suicide occurred during the delegation’s visit.

The use of segregation for an inmate at serious risk of attempting self-harm or suicide is considered by the CPT to be totally unsuitable for such vulnerable persons and to be unacceptable.

⁶⁰ British Prime Minister’s speech on prison reform, Westminster, London, 8 February 2016.

⁶¹ The PPO, ‘Learning from PPO Investigations: Prisoner Mental Health’, January 2016.

The CPT recommends that prisoners with severe mental-health conditions should not be placed in segregation units as an alternative to normal accommodation; instead, such prisoner patients should be treated in a closed hospital environment, suitably equipped and with sufficient qualified staff to provide them with the necessary assistance.

6. Other issues

a. prison staff

69. The House of Commons Justice Select Committee, in its recent report on prison safety,⁶² has directly criticised staffing levels and linked this to the deterioration in safety and standards in prisons. In that report, the Justice Committee received evidence from the Prison Officers' Association and noted that there were 7,000 fewer officers in 2015 than in 2010 when the prison population was 2,500 lower, and that it believes that budget cuts and resulting reductions in staffing are intrinsically linked to the increase in violence, deaths and suicides'. The Harris Review⁶³ also found that insufficient staff for escorts was the reason for medical and mental health appointments frequently being missed.

70. In the course of the 2016 visit, the CPT's delegation noted a radically different picture of prison staffing levels than compared to that observed in 2008.⁶⁴ Due to the nation-wide budgetary cuts, the number of front-line prison officers in English prisons has dropped by some 30% over three years. Various senior managerial staff informed the delegation that to achieve the cuts, prison officers were offered voluntary redundancy or early retirement exit packages ("VEDs") from around 2010 onwards. Many experienced staff left the prison service on such packages. The result of this, however, was that from around 2011 onwards there has been a severe shortage of staff, especially experienced staff, which prisons have to address.

For example, the overall 2015-2016 budget for *Pentonville Prison* was a little over £20 million, which had been reduced since 2011/12 by some 30%. Staffing levels had also been reduced by approximately one third. However, the number of inmates has continued to rise. At the time of the delegation's visit, there were, in theory, 196 'Band 3' prison officers (i.e. front-line officers) for some 1,300 inmates; but due to sickness or blocked posts the numbers were down on average by 15%. *Pentonville Prison* is not unique in facing such challenges.⁶⁵

71. At *Doncaster Prison*, an ongoing recruitment drive meant that at the time of the visit the prison had nearly a full staff complement. However, the majority of those applying for prison officer roles have been predominantly young and relatively inexperienced; information provided to the delegation by staff and the IMB⁶⁶ point to many staff being unable to cope in the pressurised environment and a high number quitting within months of starting.

⁶² House of Commons Justice Committee, [Report on 'Prison Safety'](#), 6th Session, 2015-2016; 10 May 2016.

⁶³ The Harris Review, Paragraph xii.

⁶⁴ See CPT/Inf (2009)30, Paragraphs 74 to 77.

⁶⁵ The director of Wandsworth Prison, for example, has underlined in his interview with the Guardian Newspaper in February 2016 that his prison's budget has been cut from about £30m in 2010 to £21m last year, and the number of staff per inmate has dropped by at least 15%.

⁶⁶ Independent Monitoring Board, HMP Doncaster, Annual Report October 2014 to September 2015.

The delegation observed generally that at *Doncaster Prison* inexperienced staff members were being placed on the most volatile House-blocks, where there have been high number of severe assaults both prisoner-on-prisoner and prisoner-on-staff. Indeed, as regards the most problematic House-block 'West End' Wing B, which houses the young adults, there were initially two and subsequently only one staff member on the wing during the time of the delegation's visit for around 50 inmates. Moreover, these staff members had almost no experience of working in prisons, having only recently completed the mandatory eight weeks' training and been in the prison for some three months. The lone staff member had been assaulted by a prisoner earlier in the day. This staff member underlined that it was other prisoners who had stopped the assault; there had been no other staff around to help her.

It is totally unprofessional and even negligent for management to allow a single officer to be left alone to manage a known volatile wing of some 50 inmates.

Moreover, at *Doncaster Prison*, Assistant Director grades had been allocated to each of the three House-blocks to counter the inexperience of the new officers located there. Nevertheless, at the time of the visit, the delegation observed that they were placed outside the main wings and were rarely inside the main residential blocks.

72. Inmates interviewed by the delegation repeatedly stated that staff at *Doncaster Prison* had lost control; that the prison felt unsafe and that too few staff were on the wings to be able to react quickly in the event of a violent incident. Some even raised concerns for the safety of the staff on the wings, having witnessed regular prisoner-on-staff violence. It is not surprising that under such conditions staff were stressed and their behaviour affected (complaints were received from inmates that some staff shouted at them or ignored them).

Overall, this manifested itself in palpably tense relations between staff and prisoners. The delegation noted first-hand that staff response to call-bells was problematic; bells went unanswered for long periods of time or were switched off with a promise that the staff member would return later. Information logged centrally provided by both prisons showed long waits for cell call-bells to be responded to (see paragraph 45).

It was clear that in both establishments visited the operational safety had been compromised because of low staffing numbers or inadequate deployment.

73. The delegation found that the situation at *Doncaster Prison* was particularly egregious, impacting especially on the safety of the young adults held there. Consequently, the delegation invoked Article 8, paragraph 5, of the Convention and requested that an immediate review be carried out into the staffing situation (staffing levels per shift, actual presence, quality/experience and consistency of deployment of the staff) on West End Wings B and C, with a view to reinforcing staffing levels to provide for a safe environment for young adults and staff.

By letter dated 10 June 2016, the United Kingdom authorities responded that in light of the immediate observation, *Doncaster Prison* would remain at a reduced operating capacity of 1,045 (as opposed to 1,145) for a further period of time to support the provider [Serco] in their efforts to address these concerns. Moreover, the authorities confirmed that the transfer of suitable sentenced young adults from *Doncaster Prison* has been expedited in order to reduce the number of young adults currently held there. As at 6 June 2016, the population of young adults at *Doncaster Prison* had been reduced by 25% to 107.

Furthermore, the authorities confirmed that ‘an independent review of the treatment of young adults at *Doncaster Prison* by NOMs Commissioning’ had recently been completed to address the concerns raised by the delegation and an action plan was under development. The authorities confirmed that they will closely monitor the provider’s progress in relation to this action plan via the formal contractual performance management processes until the existing concerns have been satisfactorily addressed.

The CPT welcomes the response by the authorities and the initiatives taken. It would like to receive a copy of the review and subsequent action plan and regular updates on progress.

74. The delegation found that the low staffing levels in both prisons had led to low staff morale and increased work-related stress. Further, other than their initial eight weeks of training, staff felt they did not get sufficient professional training support or refresher courses. Staff at both prisons readily acknowledged that the low staffing complement, resulting in a deteriorating regime for prisoners, with prisoners locked up for longer, had an adverse effect on the overall safety of the prisons.

The CPT has repeatedly stated that there must be enough staff to correctly supervise the activities of prisoners and support each other in the performance of their duties; further, management must be prepared to support staff fully in the exercise of their authority. An overall low staff complement will certainly impede the development of positive relations; more generally, it will generate an insecure environment for both staff and prisoners. In addition to creating a potentially dangerous situation for vulnerable prisoners, it also poses dangers for staff. Equally, a low staff complement will have a negative influence on the quality and level of the activities programme developed and make it nearly impossible to provide an acceptable regime for prisoners. Moreover, it is clear that continued exposure to highly stressful or violent situations can generate psychological reactions and disproportionate behaviour.

In light of the above, **the CPT recommends that the United Kingdom authorities take measures to ensure that, at both Doncaster and Pentonville Prisons:**

- **staffing levels are reviewed in each wing or block to ensure adequate staff numbers – and ensure that staff are never alone on a wing;**
- **prison staff benefit from adequate psychological support;**
- **the training needs of new prison officers are met and regular refresher courses provided;**
- **management ensure that sufficient staff are allocated to, and actually present on, each wing at all times;**
- **the skills set and mix of staff deployed to each wing is adequate for the level of risk assessed;**
- **cell call-bells are responded to promptly and appropriately (i.e. query answered rather than the call-bell merely turned off); and**
- **the allocated budget does not impact the core operational safety of a prison.**

b. discipline

75. The discipline and adjudication process within the prison system in England and Wales was outlined in the report drawn up after the 2008 visit by the CPT and the overall process has remained essentially unchanged.⁶⁷ That said, the CPT's delegation notes that revised guidelines issued by the Chief Magistrate in April 2015 increased the number of extra days (i.e. days taken off remission) to be imposed for various disciplinary offences.

76. The adjudication process appeared to operate smoothly, with regular reviews by multi-disciplinary teams at both *Doncaster* and *Pentonville Prisons*. The numbers of adjudications in both prisons visited were clearly rising, often as a result of the increasing violence or assaults (see section 2). For example, at *Doncaster* the assault charges more than doubled between 2013 and 2015 from 202 to 474 per year and the number of 'disobeying lawful orders' rose from 301 in 2013 to 516 in 2015. It was unsurprising that the number of inmates held in segregation has consequently also increased in both prisons (for instance, at Doncaster Prison, inmates held in segregation rose from 621 in 2013 to 703 in 2015).

The general increase in the use of adjudications and the imposition of extra days in prisons has been a source of widespread concern and public discussion in the United Kingdom, and the CPT notes that 172,596 extra days (i.e. 472 years) of imprisonment were imposed in 2014 as a result of adjudications. Since 2010, the number of adjudications where extra days could be imposed has increased by 47 per cent over four years to 21,629 in 2014/15.

77. Conditions in both prisons' segregation units were spartan and generally only acceptable for short periods of stay. The conditions in the "special accommodation" cells in *Pentonville* (where inmates could be held due to violent or aggressive behaviour for periods of up to 24 hours and longer thereafter upon approval by the Governor) were only equipped with a mattress on the floor, had poor artificial lighting and no window for access to natural light and were enclosed by a double sound-proof door. Moreover, the cells were not equipped with toilets or wash basins. Further, the delegation found that prisoners serving a disciplinary sanction of cellular confinement were only offered 30 minutes of outside exercise. This is not sufficient.

The CPT recommends that the United Kingdom authorities refurbish the "special accommodation cells" at Pentonville Prison to ensure that they afford adequate artificial lighting and access to natural light and ready access to a toilet and wash basin, as a matter of priority. Further, all prisoners held in cellular confinement must be offered at least one hour of daily outside exercise.

⁶⁷ See Prison Rules 53 to 55, Prison Service Order 2000 and CPT/Inf (2009)30, Paragraphs 71 and 72.

c. complaints procedures

78. Effective internal and external complaints systems are basic safeguards against ill-treatment in prisons. The operation of the complaints systems was described in the CPT's 2008 visit.⁶⁸ The delegation noted that at both *Doncaster* and *Pentonville Prisons* various improvements have been made since 2008 to make the complaints' system more effective, including the detailed tracking and analysis of patterns of complaints by dedicated staff. Deadlines for responses to complaints and reminders sent to staff, as well as recurrent patterns of top complaints' issues raised at the monthly Senior Management Team (SMT) meetings have all contributed to improving the overall complaints process. In response to the October 2015 inspection by HMIP,⁶⁹ which found no quality assurance process in place at *Doncaster Prison*, the management provided information that they had subsequently put in place monthly quality assurance of 10% of staff replies to inmate complaints.

The delegation observed that a sophisticated complaints' system was in place and it operated relatively well at both prisons. An analysis of a sample of complaints since 2015 found that both prisons received a high number of complaints - on average around 200-300 complaints per month - which were generally responded to adequately. However it did find that some complaints were responded to in a perfunctory fashion and did not address the issue at hand.

More importantly, the delegation gained the impression from interviews with inmates in both prisons that limited faith was held in the complaints' system. A good number of inmates complained that responses were late and did not sufficiently address the root cause of the complaint. An examination of the relevant documentation by the delegation showed that in some cases responses to prisoner complaints were cursory.

The CPT recommends that the management at both Pentonville and Doncaster Prisons instruct staff to address clearly the issues raised by inmates in their replies to complaints.

d. transgender prisoners

79. At both *Pentonville* and *Doncaster Prisons*, the delegation observed some positive developments in the provision of equality and diversity support. Transgender prisoners, for example, all interviewed in both prisons, were clearly supported by various staff equalities' representatives and the Safer Custody teams in both prisons. Support manifested itself in a variety of ways; for instance, ensuring that make-up and wigs were available if requested, inviting prisoners to increase staff awareness of transgender issues (*Doncaster*), ensuring different shower times (*Doncaster and Pentonville*), creating prisoner equality representative roles for transgender prisoners and monthly meetings with custodial managers to check on their well-being (*Doncaster and Pentonville*).

⁶⁸ See CPT/Inf (2009)30, Paragraphs 78 to 79.

⁶⁹ Report on an unannounced inspection of HMP Doncaster by HM Chief Inspector of Prisons, 5–16 October 2015.

C. Juvenile imprisonment

1. Preliminary remarks

80. The youth justice secure estate in England and Wales consists of three types of establishment – four young offender institutions (YOIs), three secure training centres (STCs) and some ten secure children's homes (SCH). Each varies in terms of size, staff to child ratios, the nature of the children accommodated and ethos. More than two thirds of juveniles (some 600) are accommodated in YOIs (for 15 to 17 year olds), which are accountable to NOMs and are similar in ethos to adult prisons. The STCs are privately managed custodial institutions for juveniles (12 to 17 years old) and hold younger and/or more vulnerable juveniles (some 170 juveniles). SCHs, the smallest establishments with the highest staffing levels,⁷⁰ hold approximately 80 juveniles aged 10 to 17 years old, who have been assessed as particularly vulnerable.

The CPT welcomes the reduction in the number of juveniles detained in England and Wales from 2,905 at the time of the CPT's 2008 visit, to 882 in March 2016.⁷¹ However, the reduction in numbers has apparently resulted in a greater concentration of those juveniles with the most complex needs being held in juvenile detention facilities, notably in the YOIs.

81. The CPT notes that over the last two years (2013 to 2015), there has been an increase in the number of assaults and deaths, including self-inflicted deaths of young persons in prison, three of whom were juveniles. It also observes that the increase in violence in the young person custody estate has come under sustained scrutiny and widespread criticism from a variety of stakeholders.⁷²

82. Further, it has followed closely the situation at Medway STC after a BBC Panorama programme, aired on 11 January 2016, highlighted allegations of physical and emotional abuse of young people by staff employed by the private security firm G4S. It notes the follow-up visits undertaken by HMIP and Ofsted in January 2016 as well as the establishment of the independent Medway Improvement Board and the ongoing criminal investigations into staff behaviour.

The Medway Improvement Board found that 'leadership within the STC has driven a culture that appears to be based on control and contract compliance rather than rehabilitation and safeguarding vulnerable young people', and underlined the need for a clearer child-based vision driven by strong leadership.⁷³ Further, the Board underlined that the various organisations that oversaw safeguarding at Medway STC were not coordinated, which increased the risk of safeguarding issues falling through a gap. The CPT had similar concerns in this respect in its findings at Cookham Wood YOI, the YOI situated next door to Medway STC (see paragraph 85).

⁷⁰ Approximately 1:2 staff to juveniles compared with approximately 1:10 staff to juveniles in YOIs.

⁷¹ Youth Justice Board (YJB), Monthly Youth Custody Report, April 2016.

⁷² See, for example, the 'Review of the Youth Justice System; An interim report of emerging findings (the "Taylor Review")', 9 February 2016 ; HMIP and YJB, 'Children in Custody 2014–15; An analysis of 12–18-year-olds' perceptions of their experience in secure training centres and young offender institutions', 2015; and 'Unlocking Potential'; A study of the isolation of children in custody in England', the Children's Commissioner, 2015; and 'Changing Prisons, Saving Lives Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds' (the "Harris Review"), July 2015.

⁷³ Final Report of the Medway Improvement Board, Board's Advice to Secretary of State for Justice, 30 March 2016.

Overall, the Board highlighted its continued concerns about how the YJB manages their contract and monitors safeguarding at the STC. It underlined the need for formal separation of the often conflicting YJB monitoring functions of ensuring contractual compliance and monitoring safeguarding.

The CPT would like to be informed about the steps taken by the United Kingdom authorities to implement the recommendations made by the Medway Improvement Board, HMIP and Ofsted.

83. Equally, the CPT notes that a review of the general operation of youth custody has recently been undertaken by child behavioural expert and former head teacher Charlie Taylor (the Taylor Review).⁷⁴ Interim findings of the Taylor Review point to some systemic failings in the youth justice system, especially in the provision of a purposeful regime for detained children and access to a proper education (see paragraphs 89 to 93). It recommended that young offenders should serve their sentences in secure schools rather than youth prisons. Moreover, it pointed to problems with staffing – ‘too many staff working in YOIs and STCs do not have the skills and experience to manage the most vulnerable and challenging young people in their care’. It also underlined inadequacy of regimes, with children spending too much time in cells and getting inadequate access to health care, due to staff shortages in YOIs. It concluded that the youth justice system would be more effective and better able to rehabilitate young people if education was at its heart. Smaller, local, secure schools would draw on educational and behavioural expertise to rehabilitate children and give them the requisite skills they need on release.

The CPT has visited a number of juvenile establishments in several countries, which are juvenile-centred and based on the concept of small living units.⁷⁵ These establishments are composed of small well-staffed units, each comprising a limited number of single rooms (usually no more than ten) as well as a communal area. Juveniles are provided with a range of purposeful activities throughout the day, and staff promote a sense of community within the unit. The CPT considers that this type of centre represents a model for holding detained juveniles in all European countries.

In light of the interim findings of the Taylor Review and the Medway Improvement Board, which have underlined certain systemic weaknesses and protection gaps in the overall operation and functioning of the young persons’ estate and which call for a wide-scale system change, **the CPT recommends that the United Kingdom authorities urgently review the current operating model of the YOIs and STCs with a view to ensuring that, if exceptionally necessary to hold juveniles in detention, the secure juvenile estate is truly juvenile-centred and based on the concept of small well-staffed living units.**

⁷⁴ Review of the Youth Justice System: An interim report of emerging findings, 9 February 2016; the “Taylor Review”; <https://www.gov.uk/government/publications/review-of-the-youth-justice-system>.

⁷⁵ See CPT/Inf (2015) 1, 24th General Report of the CPT, pages 49 to 58.

2. Establishment visited

84. Cookham Wood YOI is one of four establishments that the Youth Justice Board (YJB) commissions from NOMs to provide specialist custodial places for juveniles aged 15 to 17 years old.⁷⁶ Cookham Wood is located on the outskirts of Rochester city and was built in the 1970s. In 2008, it was converted into a juvenile centre/YOI to accommodate 15 to 17 year-olds to reduce capacity pressures in London and the South East. It is located in a small enclave surrounded by two other secure facilities, the HMP/YOI Rochester and Medway STC. At the time of the visit, Cookham Wood had an operational capacity of 196 and a CNA of 188 and was accommodating 152 juveniles, of whom approximately 25% were on remand and 75% sentenced.

3. Ill-treatment

85. It should be noted from the outset that the CPT's delegation received no allegations of physical ill-treatment of juveniles by staff at Cookham Wood YOI, with one exception. The one allegation involved a juvenile who alleged that staff had broken his arm during a control and restraint operation. The delegation raised its concerns with the management and has noted the subsequent findings of an Independent Medical Advisor that the injury was not caused by the restraint but rather during the course of the inter-prisoner assault incident in which the inmate was involved.

Nevertheless, upon review of complaint files during the 12 months prior to the visit, the delegation observed at least eight cases of allegations by juveniles of staff violence or abusive behaviour. A couple of these had resulted in referral to the police and community services and a few had resulted in internal disciplinary proceedings,⁷⁷ however, at least three cases resulted in no recorded action at all.

The delegation was informed that allegations of violence against juveniles must be reported to community child safeguarding services, where there are designated officers ("LADO") responsible for investigation of such cases. However, according to staff, delays in responses from the LADO could take weeks and even in some cases several months. Delays were also experienced with responses from the police, when such cases were occasionally referred to them. In the meanwhile, the hands of management were apparently tied and any internal investigations had to wait for the LADO or external body findings to be provided, which could take several months.

The CPT found that this system caused protection gaps for the juveniles involved and uncertainty for the staff members concerned. It found this contrary to the spirit of the overarching requirement to safeguard the welfare of the child, which should lie at the heart of the juvenile detention system. Further, the CPT considers that the management of juvenile institutions should conduct their own administrative investigations in parallel to the LADO and police investigations. Staff members allegedly involved in ill-treatment should be allocated duties that do not bring them into contact with the alleged victim until the results of the disciplinary proceedings are clear.

⁷⁶ Some 18 year olds are held while transfer to the young adult estate is being finalised.

⁷⁷ Three staff members have been subject to disciplinary proceeding over a period of a year for excessive use of force.

The CPT recommends that the United Kingdom authorities take steps to ensure that co-ordination between the different bodies involved in investigating allegations of staff ill-treatment against juveniles in detention is more effective, and the management of the prison should take steps itself to address the matter, as outlined above.

86. The CPT's delegation found that the levels of inter-juvenile violence, which required use of force by staff to resolve, were extremely high. Records showed that for a population of 152, force by staff against juveniles had been used 96 times in March 2016 and had reached as many as 150 times in December 2015.

The levels of recorded violence between the juveniles and by the juveniles on staff were alarming. In the twelve months prior to March 2016 (i.e. from March 2015 to February 2016 inclusive) there had been a total of 535 assaults recorded in the establishment (or an average of over 44 a month). Of these, 425 were recorded assaults by juveniles on each other (of which 15 had been recorded as 'serious assaults') and 110 were recorded assaults by juveniles on staff (of which 10 had been recorded as 'serious assaults').⁷⁸ The recorded flashpoints were most often in the corridors and during movements on the way to education and activities, as well as in the association and education areas. Many juveniles informed the delegation that they were too scared to leave their cells.

The levels of violence adversely affected many other areas of life at Cookham Wood YOI for all its juvenile inmates. For example, when an alarm went off for a violent incident all staff – wherever they were – had to run to the incident. This meant that juveniles were locked on wing or in rooms to allow for all staff to attend the incident. Indeed, during one three-hour period, the delegation noted that alarm bells signalling a violent incident, went off five times and members of the delegation were also temporarily locked on the wings where they were conducting private interviews with juveniles.

The violence was not always solely inter-juvenile inmates; the delegation noted that ten 'serious' juvenile on staff assaults occurred during the 14 months prior to the visit, in addition to numerous non-serious assaults.

87. The CPT's delegation examined how Cookham Wood was addressing the violence, using a similar three-prong approach as outlined above (see section B (2)), namely, how the institution records the violence, how it reacts and responds to the violence and how it is effectively reducing it.

It found that considerable efforts were being undertaken to capture and record data on the violence and that there was some analysis of the causes of the violence and the likely flash-points. Further, the creation of the Cedar Unit - a specialised unit for juveniles with some of the most complex needs and who presented the most challenging behaviour – represents a positive development. However, the Cedar Unit is a small (some 20 places) specialised unit, which is unable to cater for the needs of all Cookham Wood's population. Thus many juveniles were not getting the support they required. Instead, the violence was primarily being managed through locking up juveniles in their cells for 23 hour a day.

⁷⁸ Source: NOMs Violence Diagnostic Tool – Cookham Wood.

Such an approach may represent a stop-gap solution, but it is not a long-term strategy to reduce the levels of violence. Indeed, its effectiveness in the short-term appeared questionable as the general wings and areas on the route to and from the education block clearly did not provide a safe environment for juvenile inmates or staff alike.

The CPT recommends that the United Kingdom authorities take measures to put in place a long-term strategy to reduce the levels of violence in Cookham Wood. In this respect, consideration should be given to investing in the establishment of more small specialised units, such as the Cedar Unit, to manage juveniles with complex needs. Further, every effort should be made to avoid placing juveniles into conditions of *de facto* solitary confinement (see paragraphs 91 to 93).

4. Material conditions and regime

88. Material conditions at Cookham Wood were generally good. Juveniles were accommodated in a modern residential unit and the Cedar Unit. The main residential unit was divided into two wings (A and B) with 3 floors with around 30 cells per floor. The cells were of sufficient size (approximately 9m²), well equipped (each possessed a table and chair, shelves and a television and/or radio and a partitioned sanitary annex comprising a toilet, shower and wash basin) and had adequate artificial lighting and ventilation, as well as access to natural light. The cells in the Cedar Unit were similar to those on the main residential block.

That said, at the time of the visit, a couple of cells on the main residential unit in B wing were dirty, covered in graffiti and poorly ventilated.

There were three large exercise yards and a grass sports pitch but none of the exercise yards afforded any cover from inclement weather and many juveniles complained that exercise was curtailed when it rained. Moreover, outdoor exercise,⁷⁹ according to information provided by staff, was confined to 30 minutes every second day, due to the nature of the split regime.

The CPT recommends that a regular deep clean of the residential Unit and, in particular B wing, be undertaken on a regular basis.

It also reiterates its recommendation that shelters from inclement weather be installed in the exercise yards and that all juveniles should be allowed to exercise regularly, for at least two hours every day, of which at least one hour should be in the open air and, preferably, considerably more, including when it is raining.

89. As regards regime, the CPT believes the juveniles should be able to spend at least eight hours a day outside their cells (including at weekends and on public holidays) and participate in programmes of purposeful and structured activities tailored to their individual needs and intended to fulfil the functions of education, personal and social development, vocational training, rehabilitation and preparation for release, in the light of the European Rules for juvenile offenders subject to sanctions or measures.

⁷⁹ Not including the gym, which was permitted for 45 minutes every second day.

For the majority (two thirds) of juveniles held at Cookham Wood, there was a wide range of courses on offer including education courses (English, Maths and ICT), art and vocational courses (painting and decorating, engineering, catering, computing, business studies prison radio, healthy living and life environmental services, community projects, horticulture, drama).

Nevertheless, the CPT's delegation observed that while the range of courses remained sufficient, there were difficulties of access and attendance problems. Information gathered from staff and juveniles alike showed frustration on all sides by the number of times juveniles were delayed or hindered from attending classes - causing low attendance levels or classes to be delayed or cancelled. For instance, in March 2016 alone, 1,756 learner hours were lost because of 'lock-downs / security' issues, maintenance issues and staffing issues (staffing errors or 'no prison officers available' to accompany the juveniles to their allocated class). In other words, while courses were available in principle, many juveniles could not actually access them in practice.

90. Further, according to the regime timetable provided by the establishment, due to a split regime in operation,⁸⁰ the amount of hours juveniles spent out of their cells engaged in purposeful activities was six and half hours on three days of the working week and a mere four hours on two days of the working week. This is far below the CPT's standard of least eight hours a day out of their cells. On a more positive note, on weekends, juveniles spent approximately seven hours out of their cells.

The CPT recommends that the United Kingdom authorities take concrete steps to improve the regime for juvenile inmates at Cookham Wood; obstacles to attendance at education or other purposeful activities on a daily basis should be removed. The overall aim should be offer to all juveniles a normal regime of at least eight hours out of cell engaged in purposeful activities.

91. The situation was particularly bleak for the 43 juveniles on the main accommodation wings who, for various reasons, could not take part in education or activities. The majority of these juveniles were offered around three and a half hours to exercise, associate and eat communally. However, a large minority were placed on a so-called 'separation' list by management, as far as the delegation could ascertain, for reasons of repeated violence or for their own protection from gang or personal rivalries. This was denoted by a vivid pink sign stuck on the cell door that read 'do not unlock'. In effect, this meant that the juvenile was not unlocked other than for 30 minutes for a solitary period of exercise and for meal times - when he was accompanied to pick up his food, which he ate alone in his cell. These juveniles were locked up alone in their cells for 23 and a half hours per day, with only a television for company.

The delegation interviewed one juvenile who spent 23.5 hours a day lying on his bed, under his covers, blankly looking at a TV screen, talking and meeting no one. It also met a 15-year-old who had been held in these conditions for several weeks and he had no information about how much longer he would be held under such a restricted regime. They were effectively being held in conditions of solitary confinement. In the CPT's view, holding juvenile inmates in such conditions amounts to inhuman and degrading treatment.

⁸⁰ The juveniles were divided into two groups; these swapped timetables morning and afternoon on a rota basis during the week.

92. Interviews with many of the juveniles on the ‘separation’ list concerned showed a heightened sense of frustration, which in the juveniles’ own words provoked anxiety and fed a tendency to ‘lash out’ at others. For example, an inmate interviewed by the delegation who had been placed on this regime underlined that such isolation made him so frustrated that as soon as he was allowed out –took out his frustration on the nearest available people – staff or other inmates – by attacking them.

Staff also acknowledged that long lock-up times contributed to the inmates’ sense of frustration, which often materialised into outbursts of violence. Further, many staff members voiced their concerns about the appropriateness of such long periods of lock-up. At the same time, they perceived it as the only way to manage gang rivalries and other security issues.

93. In the CPT’s view, the length of time that juveniles spent locked in their cells for reasons of violence or for protection from violence contributed to causing a negative spiral effect, with the inevitable result of more frequent outbursts of violence and the regime for all juveniles being curtailed.

The CPT recommends that the United Kingdom authorities take urgent steps to provide all juvenile prisoners - especially those on ‘separation’ or ‘protection’ lists - with a purposeful regime, including physical activities and considerably more time out-of-cell than currently provided.

More generally, it is quite clear that the management of those challenging juvenile inmates who are not placed in the small Cedar Unit is not working. There is a clear need for more smaller units specifically tailored to managing juveniles with complex needs.

The CPT also recommends that the authorities of the United Kingdom invest in establishing more small units specifically tailored to managing juveniles with complex needs at Cookham Wood (in this respect, see paragraph 87).

5. Discipline and GOOD

94. Juveniles who commit a disciplinary offence may be sanctioned for up to seven days of ‘cellular confinement’.⁸¹ Juveniles can also be placed in ‘removal from association’ for reasons of good order violations (‘GOOD’).⁸² ‘Removal from association’ specifies that for the maintenance of good order or discipline or in his own interests, the governor may arrange for the prisoner’s removal from association for up to 72 hours. Removal for more than 72 hours may be authorised by the governor in writing who may authorise a further period of removal of up to 14 days. Such authority may be renewed for subsequent periods of up to 14 days. The governor must obtain leave from the Secretary of State, in writing, to authorise removal where the period in total amounts to more than 42 days.⁸³ The Secretary of State may only grant leave for a maximum period of 42 days, but such leave may be renewed for subsequent periods of up to 42 days by the Secretary of State. The YOI Rules governing ‘removal from association’ for juveniles are virtually identical to those governing its use for adult prisoners.⁸⁴

⁸¹ Young Offender Institution (YOI) Rules 59 to 64.

⁸² YOI Rules, Rules 59 to 64.

⁸³ Prison Rules, Rule 45 (as amended, 2005 and 2015).

⁸⁴ YOI Rules, Rule 49 (as amended in 2015).

Juveniles disciplined with cellular confinement or removed from association were usually held in the segregation unit, known as the Phoenix Unit.

95. The Phoenix Unit, a separate 12-cell unit, was in a poor state of repair at the time of the delegation's visit. Five of its cells were out of use – despite there being a need for them – due to damage caused by inmates, which had not been repaired. The cells were dark, dirty, poorly lit and inadequately ventilated.

While there was notionally an education “outreach programme” brought to the unit for some of the juveniles, the room for education or other activities had been damaged and had not yet been repaired and had been taken out of use.

The CPT recommends that the cells in the Phoenix Unit be refurbished and undergo a deep clean on a regular basis, taking into consideration the above remarks. Further the activities' room should be repaired.

96. Pursuant to many complaints received from juvenile inmates about excessive lengths of time spent locked alone either in their cells or in segregation, the delegation reviewed records provided to it, which showed that in January 2016, five juveniles had spent over 20 days in segregation – three of whom had spent 31 days. In September 2015, one juvenile had spent 52 days in segregation. On average over the 13 months prior to the visit, records showed that, per month, between five juvenile inmates spent more than 30 days in segregation. Moreover, periods of 80 days in segregation had been recorded at Cookham Wood. In total, over 13 months, 2556 days in segregation had been recorded.

97. These figures are, regrettably, not unique to Cookham Wood. The lengths of ‘separation’ (essentially segregation) for juvenile institutions nation-wide were staggering. For instance, according to the authorities, in Werrington and Wetherby YOIs, there were recorded cases of juveniles being held in ‘separation’/segregation for 42 days in September and October 2015. Worse, at both of these YOIs, there were cases of juveniles held for 63 days and even one juvenile held for 84 days in segregation.

During its 2008 visit, the CPT raised concerns about the placement of juveniles in conditions akin to solitary confinement at Huntercoombe YOI.⁸⁵ More recently, HMIP has found that too many children were being locked up for too long in segregation.⁸⁶ The CPT's delegation found the situation had not changed at the time of the 2016 visit; indeed, the lengths of time that juveniles spent in segregation in conditions akin to solitary confinement appeared to be even longer.

⁸⁵ CPT/Inf (2009), Paragraphs 83 to 96.

⁸⁶ See, for example, findings from various HMIP reports in 2014 and 2015, which highlighted that at Feltham, during 2015, 394 children had been held in segregation, one for 39 days; at Wetherby, in 2014, one child had been segregated for 66 days and 2 others for 46 days.

98. The CPT wishes to stress that any form of isolation may have a considerably detrimental effect on the physical and/or mental well-being of juveniles. In this regard, the Committee observes an increasing trend at the international level to promote the abolition of solitary confinement as a *disciplinary sanction* in respect of juveniles. Particular reference should be made to the United Nations Standard Minimum Rules on the Treatment of Prisoners (Nelson Mandela Rules) which have recently been revised by a unanimous resolution of the General Assembly and which explicitly stipulate in Rule 45 (1) that solitary confinement shall not be imposed on juveniles.⁸⁷ The CPT fully endorses this approach. The CPT considers that the current YOI Rules concerning cellular confinement of up to seven days as a disciplinary punishment discipline should be amended and brought in line with the above precepts.

The CPT also considers that juvenile inmates should never be placed in conditions akin to solitary confinement for the purposes of *GOOD* (i.e. 'removal of association' to the segregation unit), as regulated by the YOI Rules.⁸⁸ There may be occasions when particular juveniles may need to be managed separately for short periods, but this should involve providing the juvenile inmate concerned with additional support from staff and ensuring access to purposeful activities, including physical exercise and education.

More generally, juveniles who require management under GOOD should in fact be placed in small staff-intensive units, where their behaviour can be better managed and they can be gradually reintegrated into the main inmate population.

The CPT recommends that the United Kingdom authorities take urgent steps to ensure that the YOI Rules are amended to reflect the increasing trend at the international level to promote the abolition of solitary confinement as a disciplinary sanction in respect of juveniles.

It also recommends that juveniles should not be placed in segregation for the purposes of GOOD and should instead be placed in small staff-intensive units.

More generally, until such a time as the above two recommendations are fully implemented, the authorities should ensure that the separation, removal from association, cellular confinement or segregation of juveniles - in whatever form it takes - should be applied only as a means of last resort, and that the juveniles concerned should continue to be granted access to education, physical exercise and possibilities of association.

⁸⁷ See also Rule 67 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (General Assembly Resolution A/RES/45/113, Annex).

⁸⁸ Prison Rules, Rule 45 and YOI Rule 49.

6. Staff

99. The CPT noted positively that in comparison to the adult prisons establishments visited, Cookham Wood faces less severe budgetary constraints. It had an adequate budget⁸⁹ and while the numbers of dedicated ‘Cookham Wood’ staff were down by around 30 posts, this had been made up with cross-deployment of custodial staff on ‘detached duty’ from other YOIs (Wetherby, Werrington) and from Dover Immigration Removal Centre. These cross-deployed staff still wore their identification badges from their original establishment and were thus readily identifiable as such to the juvenile inmates. Many were still living near their original work-place during their period of cross-deployment to Cookham Wood. Some were commuting from Wetherby or Dover on a daily basis and travelling for hours to be at work by around 7.30 a.m.

The delegation, however, received many complaints from juvenile inmates that there was a marked difference in their perceived treatment by the different staff; staff from Dover (an adult establishment), in particular, were apparently generally less helpful and more distant towards the juveniles. From interviews with juveniles and staff, it was clear to the delegation that while many of the staff appeared extremely dedicated, some appeared to be extremely tired.

The CPT considers that the custody and care of juveniles deprived of their liberty is a particularly challenging task. Consequently, the staff called upon to fulfil this task should be carefully selected for their personal maturity, professional integrity and ability to cope with the challenges of working with – and safeguarding the welfare of – this age group. Staff should be committed to working with young people, and be capable of guiding and motivating them.⁹⁰

In light of the above comments, the CPT recommends that all staff, including those with custodial duties and on temporary cross-deployment or on detached duty, who are in direct contact with juveniles should receive juvenile-centric professional training, both during induction and on an ongoing basis, and benefit from appropriate external support and supervision in the exercise of their duties.

Further, the CPT would like to receive information regarding what measures have been taken to counter potential staff ‘burn out’ or exhaustion at work due to long commuting times for staff on detached duty at Cookham Wood YOI.

7. Health care

100. The CPT’s delegation noted that general health-care staffing levels at Cookham Wood were adequate: there were four part-time GPs,⁹¹ four nurses and five assistant nurses on rota. There were also specialist medical teams available for mental health (see below) and addiction problems, as well as regular visits by a dentist, optician, dietician and physiotherapist. Two nurses, assisted by several nursing assistants, were present from 7 a.m. to 7.45 p.m. seven days a week. However, there was no health-care presence at night and, in case of emergencies, an ambulance would be called. There were also two vacant nursing staff posts at the time of the delegation’s visit.

⁸⁹ Approximately £9.2 million (for an operational capacity of some 170 juveniles).

⁹⁰ See CPT/Inf (2015) 1, 24th General Report of the CPT, Paragraphs 119 to 120.

⁹¹ Equivalent to half of a full-time doctor.

During the course of the visit, the delegation received a few complaints from juvenile inmates about access to, and the poor quality of, health-care services at Cookham Wood YOI.

The CPT recommends that there should always be someone competent on the premises who is trained to provide first aid - including at night.

The CPT would also like to receive confirmation that the two vacant nursing posts at Cookham Wood have now been filled.

101. It is positive that all newly arrived juvenile inmates were medically screened within 24 hours of arrival by a nurse and, if necessary, thereafter by a doctor. The delegation also noted medical documentation was of a good quality, and there was systematic and detailed recording of injuries, including the completion of relevant Forms 213 (injuries to prisoners) and the use of body maps.

102. Medical confidentiality appeared to be generally respected, with one notable exception; medication was given to inmates through a small hatch. This meant that other prisoners could see and overhear medical details. Moreover, this practice, in the CPT's view, was not conducive to facilitating adequate relationships between health-care staff and inmates.

The CPT recommends that the management at Cookham Wood stops the practice of medication being dispensed through a hatch; instead, an environment that enables full respect for medical confidentiality and for adequate health-care staff and patient relations should be developed.

103. As regards mental health provision at Cookham Wood, mental health services are run by the Central North West London NHS Trust and there was an adequate number of mental-health care staff; a psychiatrist worked three days a week, along with a part-time assistant psychiatrist, three psychiatric nurses, one full-time and one part-time psychologist, as well as a part-time assistant psychologist and a part-time art therapist. At the time of the visit, around 50 juvenile inmates were being supported by the mental-health team at Cookham Wood.

However, the mental-health team had no designated consultation room and, according to staff, lost valuable inmate consultation time while waiting for detainees to be brought to them or while finding alternative rooms for consultation. Whenever there was a medical emergency at Cookham Wood, the main consultation room was occupied and the second consultation room was used by general health care, which resulted in various mental-health clinics having to be cancelled. According to staff, some 33 hours of consultation were lost in January 2015 alone.

The CPT recommends that Cookham Wood should ensure that the mental health-care team has a designated consultation room to avoid consultations or clinics being cancelled.

104. While transfers to a psychiatric hospital were done relatively quickly for juvenile inmates at Cookham Wood, with a waiting time of a couple of weeks, there were considerable delays of several months for those juveniles about to turn 18 years old (see paragraphs 66 and 67 regarding the delays in transferring adult inmates with severe mental health illnesses to psychiatric hospitals).

D. Psychiatric institutions

1. Preliminary remarks

105. In England, involuntary hospitalisation for persons with a mental disorder is regulated under the Mental Health Act 1983 (amended 2007) (hereinafter “the MHA”). Persons may be detained and treated against their wishes under the MHA if they have or appear to have a mental illness which is sufficiently serious that it is putting their own or other people’s health or safety at risk. They must also be unable or unwilling to agree to voluntary (informal) admission.

On 1 April 2015, the revised Mental Health Act 1983: Code of Practice entered into force following Parliamentary approval. The Code of Practice (450 pages divided into 40 chapters) provides statutory guidance to registered medical practitioners (‘doctors’), approved clinicians, managers and staff of providers and approved mental health professionals (AMHPs) on how they should proceed when undertaking duties under the Act. These professionals should have detailed knowledge of the Code, including its purpose, function and scope. It also gives statutory guidance to registered medical practitioners and other professionals in relation to the medical treatment of patients suffering from a mental disorder.

The revised Code seeks to provide stronger protection for patients and clarify roles, rights and responsibilities. This includes involving the patient and, as appropriate, their families and carers in discussions about the patient’s care at every stage; providing personalised care; minimising the use of inappropriate blanket restrictions, restrictive interventions and the use of police cells as places of safety. The Code also states that providers and professionals need to consider relevant developments in professional practice, National Institute for Health and Care Excellence (NICE) and professional guidelines, legislation and case law to ensure they are consistently delivering the highest standards of care and professional practice.

106. The Care Quality Commission (CQC) is responsible for the registration, inspection and monitoring of health and care providers, including mental health providers, under the Health and Social Care Act 2008. The CQC has specific duties in the Act to act as a general protection for patients by reviewing, and where appropriate, investigating the exercise of powers and the discharge of duties in relation to detention, community treatment orders (CTO) and guardianship under the Act. The CQC monitors, inspects and regulates services to make sure providers meet fundamental standards of quality and safety. The CQC visits places of detention in England as part of the UK’s NPM.⁹²

107. The number of patients being detained in England under the MHA is increasing year on year from 46,348 in 2010/11 to 58,399 in 2014/15, an increase of more than 25% in four years.⁹³ The number of patients detained on 31 March 2015 was 19,656 whereas the official number of available mental health beds was 19,273.⁹⁴

⁹² See Mental Health Act 1983: Code of Practice; Introduction, pp. 12-16.

⁹³ Health and Social Care Information Centre, Community and Mental Health Team, 2015.

⁹⁴ The reason why it is possible for the number of patients to exceed the available beds is that the beds of patients who are on leave in the community may be occupied by new patients. Nevertheless, there have been instances of patients sleeping on sofas or having to travel long distances due to the lack of bed capacity.

In 2014, the Royal College of Psychiatrists (RCPsych) established “The Commission to review the provision of acute inpatient psychiatric care for adults” to address problems in accessing acute inpatient care for adults and recommend ways of improving the service. In its report, published February 2016, the Commission concludes that access to acute care for severely ill adult mental patients in England is inadequate. The findings include bed occupancy rates of over 100%,⁹⁵ 16% of patients being admitted to acute psychiatric care due to lack of alternatives, 16% of patients having delayed discharges and up to 500 patients per month having to travel more than 50 kilometres to access an inpatient psychiatric service that should be provided locally.⁹⁶ The CPT is particularly concerned that children who are mentally disordered may have to be sent long distances from their home. Further, the CPT’s findings from its visits to prisons, a YOI and an immigration removal centre demonstrated that there were delays in transfers of patients to psychiatric hospitals.

The CPT wishes to be informed about the action being taken by the United Kingdom authorities to address these issues.

108. In the course of the 2016 visit, the CPT’s delegation met many dedicated mental health professionals working hard to care for the patients under their care. It also was able to observe many good practices in the hospitals visited. However, the CPT considers that there are a few areas which require serious reflection and change; notably, consent to treatment safeguards need to be reinforced during the first three months of involuntary placement in a hospital; the powers of the Mental Health Tribunal need to be reinforced and expanded to deal with appeals concerning such issues as consent to treatment, transfers to more secure hospitals, the use of means of restraint and the application of specific treatment measures. The CPT also has serious misgivings about the measure of long-term segregation as currently applied in the high secure hospitals.

Further, the CPT’s delegation learned about a recent treatment procedure at Ashworth Hospital for certain patients with treatment resistant schizophrenia which involved the forcible administration of clozapine via a naso-gastric tube (NGT). The delegation had an opportunity to speak with the consultant psychiatrists who initiated the procedure, read about the team’s approach and findings and meet with patients who had undergone the NGT procedure while being restrained manually by a number of nurses. The CPT has some reservations about this procedure. However, before drawing any firmer conclusions it wishes to examine carefully the individual patient documentation provided very recently by Ashworth Hospital. Consequently, the Committee will return to this issue in a separate communication to the United Kingdom authorities.

⁹⁵ A Survey of some 30% of acute adult psychiatric wards in England, carried out from May to July 2015, found that 93% of wards were operating above the RCPsych’s recommended 85% occupancy rate.

⁹⁶ The Commission to review the provision of acute inpatient psychiatric care for adults – Old Problems, New Solutions: improving acute psychiatric for adults in England, February 2016, pp.12 to 32.

2. Adult general psychiatry

109. In the course of the 2016 visit, the CPT's delegation visited St Charles Hospital, an adult general psychiatry facility, and carried out a targeted visit to Highgate Mental Health Centre at the Whittington Hospital.

St. Charles Hospital is located in Ladbrooke Grove in west London. The delegation visited the Mental Health Unit, where it focused on the male and female psychiatric intensive care units (PICU) (Nile and Shannon), an adult in-patient triage ward (Danube) and three mixed-sex adult in-patient rehabilitation wards (Amazon, Ganges and Thames). At the time of the visit, the wards were operating at full capacity accommodating 93 patients.

Highgate Mental Health Centre, located in Islington, London, consists of a PICU, a rehabilitation ward, five adult inpatient wards and two older people's wards. The delegation carried out a targeted visit to Coral Ward, the 12-bed PICU, and to the two 14-bed older people's wards (Garnet and Pearl).

110. The CPT's delegation received no allegations of ill-treatment of patients by staff at either hospital. On the contrary, it found a positive and caring approach by staff towards patients in both facilities.

Figures for 2015 and the first three months of 2016 showed that there were quite a number of incidents of inter-patient violence and assaults on staff, notably on the female PICU (Shannon ward) where 219 such incidents were recorded.⁹⁷ None of them resulted in serious injuries and from the information gathered by the CPT's delegation staff reacted appropriately to deal with any incidents.

a. patients' living conditions

111. The living conditions on the wards visited at St Charles Hospital and at Highgate Mental Health Centre were generally good. Patients had individual rooms equipped with a bed, wardrobe, bed-side table, desk, and chair, as well as en-suite toilet and shower facilities, all in good condition. A few of the rooms were specifically adapted to the needs of patients with reduced mobility. At St. Charles Hospital, female and male patient rooms were on separate corridors, and male patients were not allowed to access the female patient areas. Patients' rooms were not locked at night. All wards had an art and music room, quiet room, a suitably furnished day area (with sofas and a television) and a dining room, and patients had unrestricted access to association and other communal facilities.

No problems were reported or observed as regards the supply of personal hygiene items and the food served to patients. The rehabilitation wards at St. Charles' also had coffee and tea making facilities that could be used by patients. The delegation also noted positively that the diet, food texture, cutlery and eating assistance were individually planned on both Pearl and Garnet wards at Highgate Mental Health Centre.

⁹⁷ There were also 176 incidents of disruptive behaviour on this ward during the same period.

It is also noteworthy that patients' clothing at both hospitals visited, including the older patient wards, was individualised – patients were allowed to wear their own clothes and could wash them themselves using washing machines on the units.

112. On the ground floor of St. Charles, notably Nile ward, rooms overlooking the hospital possessed windows which could not be opened to allow in any fresh air. Indeed, access to fresh air was a general problem. The two PICU wards had small gardens and the other wards located on the 1st and 2nd floors had small enclosed balconies; however, the balconies appeared to always be locked since the entry into force of the smoking ban on the hospital premises in January 2016. Patients who were not satisfied with the smoking substitution measures (patches, inhaler) were granted Section 12 leave and would congregate outside the main entrance of the mental health building to smoke. It was not clear where patients could go to get fresh air other than the car park of the hospital. For the two PICU wards, there appeared to be some confusion among staff and patients as to when patients could access the small gardens and how many patients at one time, and there was no written policy in place.

The CPT reiterates that the possibility for a patient to be outside, preferably in a pleasant garden area, should be a right for every patient. Further, spending time outdoors has a beneficial impact on patients' well-being and recovery. Hence, access to outdoors should be proactively promoted.

The CPT recommends that steps be taken to put in place a clear policy for promoting and facilitating the possibility of patients to access the outdoors every day at both St.Charles Hospital and Highgate Mental Health Centre. The CPT would like to receive information from both establishments on how this policy is being implemented.

b. treatment

113. As for the range of treatments at St Charles, pharmacotherapy appeared to be adequate. Further, all patients had individual treatment plans (an initial care plan was set up within 72 hours of admission), and staff worked in multidisciplinary therapeutic teams. Medical records were detailed and well kept, and medical confidentiality duly respected. That said, while care plans were shared with patients, patients were not properly involved in drawing up their treatment plans; they did not participate in the process of setting targets and discussing challenges and strengths; only the results were shared with them. Patients interviewed on the various wards complained about a lack of 1:1 sessions with nurses.

A number of occupational therapies were offered to patients such as tree of life, creative writing, fitness, arts and crafts, music therapy, healthy living and community links. Activities such as bingo, board games and a newspaper group were also on offer. Although the range of activities was not large (given also that stays in the hospital were generally of short duration), patients met by the delegation appreciated them.

The CPT recommends that every effort be made to involve patients in drawing up their individual treatment plans. Further, more time should be prioritised for nurses to have 1:1 sessions with the patients under their care.

114. The CPT wishes to recall that particular attention should always be paid to the somatic health of patients being admitted to a psychiatric hospital. It is important that newly-admitted patients benefit from medical screening on the day of their arrival by a doctor. This initial screening will inter alia ensure that any injuries which the patient may display when entering the hospital are recorded in good time. Further, there should, as soon as possible, be a thorough examination of the somatic health condition of new arrivals by a doctor. As far as the delegation could ascertain, newly-admitted psychiatric patients were usually subjected to a somatic medical examination by a doctor.

However, there appeared to be no clear policy in place for documenting any injuries upon admission, particularly those that may allegedly have been inflicted by the police. At St Charles hospital, a pilot project (SHINE) was in progress to introduce body maps to record all injuries, both those sustained upon admission and those sustained within the hospital. It is essential that all injuries sustained by patients are properly recorded and where there is an allegation of ill-treatment or an unexplained injury that an investigation into the matter be carried out.

The CPT recommends that the United Kingdom authorities ensure that all patient injuries are diligently recorded, including on body maps, and that an investigation and safeguarding measures are triggered whenever injuries are noted. Further, clear policies should be in place to ensure that staff know what to do if they detect possible ill-treatment by other staff members.

c. staff

115. The staffing levels at St Charles appeared adequate. Each ward had a dedicated consultant psychiatrist and multi-disciplinary team. For example, the Danube triage ward had a consultant psychiatrist, two staff grade psychiatrists and two junior doctors, a half-time matron, a ward manager; an occupational therapist, an activity coordinator and a peer support worker. There were 3 registered mental health nurses (RMN) and 2 health care assistants (HCA) during the two day shifts and, as with all wards, 2 RMN and 1 HCA at night. The two PICUs had similar staffing arrangements although there was an additional RMN during the two day shifts. Other staff included seven pharmacists, two FTE therapists, two psychologists, a service manager and various administrative support staff.

The CPT's delegation noted that the wards rarely operated below 90% of nursing staff in the four months prior to the visit. Nevertheless, on certain shifts the requisite number of staff was not available and this impacted on the 1:1 time staff could spend with patients. Further, the delegation was informed that there was a high turnover of nurses and health care assistants.

The CPT would like to be informed of the steps being taken to address staff retention and ensure wards are adequately staffed not only to ensure a safe environment but to deliver the necessary therapeutic care to patients.

116. More generally, the CPT has noted the large number of vacancies for registered mental health nurses in England and the seemingly high rates of drop-out, more recently in respect of experienced nurses; the number of mental health nurses decreased by some 8.5% between 2009 and 2013 and the trend appeared to continue in 2014 and 2015.⁹⁸

The CPT would appreciate the observations of the United Kingdom authorities on this matter and would like to be informed about what steps are being taken to recruit and retain registered mental health nurses.

d. seclusion and manual means of restraint

117. The CPT considers that any resort to seclusion of patients should be the subject of a detailed policy spelling out, in particular: the types of cases in which it may be used; the objectives sought; its duration and the need for regular reviews; the existence of appropriate human contact; the need for staff to be especially attentive.

Seclusion in psychiatric hospitals in England is regulated in Chapter 26 of the MHA Code of Practice (2015) and, more specifically, by each NHS Trust whose policy and procedure on this matter incorporates the principles of the Code. There are no strict time limits for the duration of seclusion but there are detailed safeguards and reviews set out in the Code designed to limit the duration of seclusion and to end its use as soon as it is no longer considered necessary. Notably, for patients in seclusion there is a nursing review of their situation every two hours and a medical one every four hours for the first 24 hours and thereafter twice a day, and the Responsible Clinician should see the patient every day.

118. The Central and North West London NHS Trust, which is responsible for St Charles Hospital, adopted a policy on seclusion in October 2014 which was updated in June 2015 taking into account comments by the CQC. The policy document sets out clearly the approach towards seclusion and the responsibilities of all staff and includes the obligation to document in detail all seclusion episodes. The delegation noted from the records that there was no excessive use of seclusion – 93 episodes during the 12 months up to 31 March 2016 – which did not usually exceed a few hours. A nurse was present throughout the period of seclusion carrying out one-to-one observations and written comments were made every 15 minutes. Two-hourly nursing reviews were carried out and a four-hourly medical review (at night by the on-call doctor).

At St Charles Hospital, there was one seclusion suite which consisted of a bare room with an adjoining sanitary annexe (toilet and shower). A member of staff would also be stationed in the adjacent room which had a large observation panel through which the patient could be monitored. There was also an intercom.

As regards restraint, from 1 April 2015 to 29 March 2016, there were 214 episodes of restraint at St Charles Hospital; patients were placed in the prone position 123 times, in the supine position 18 times and were seated and/or standing 83 times. Women patients on the PICU (Shannon ward) were restrained 104 times and were administered with a rapid tranquilliser; an intra-muscular injection (lorazepam) on 96 of these occasions and an oral dose of lorazepam in the remaining instances.

⁹⁸ See, for example, Kings Fund Briefing of November 2015: Mental health under pressure p.13; and Centre for Workforce Intelligence (2014): In-depth review with the psychiatrist workforce, pp 8-10.

In response to the delegation's comment that resort to manual restraint and rapid tranquillisation was rather high, St Charles' Hospital replied that the Trust had set a target to reduce all restraint by 50% over an 18 month period up to June 2016 and that they considered they were on course to achieve this. Further, there was also a concerted effort to reduce the use of restraint in the prone position in line with the Department of Health April 2014 publication, Positive and Proactive Care: reducing the need for restrictive interventions.

The CPT wishes to receive updated information on steps taken at St Charles Hospital to reduce the resort to all instances of restraint, including data on the 18 month period to June 2016.

e. safeguards

119. Involuntary placement in hospital is regulated by the 1983 Mental Health Act (amended 2007) and is usually referred to as "Sectioned" following the various sections of the Act. In order to be involuntarily admitted to hospital, either for assessment under Section 2 (28 days) or for treatment under Section 3 (six months initially, followed by a further six months and thereafter 12 months), a person should be seen by the three people, namely: an Approved Mental Health Professional (AMHP), who is usually a social worker, a doctor who has been given special training (known as a Section 12 approved doctor) and a registered medical practitioner. One of the doctors should preferably know the patient.

The two doctors must agree that the person is suffering from a mental disorder and needs to be detained in hospital for assessment or treatment. They must also agree that it is in the interests of the person's own health or safety or to protect the safety of other people. The AMHP has 14 days to decide whether involuntary placement is the best way of accessing treatment and to make an application to a hospital for a bed.

A person may also be admitted to hospital under Section 4 in an emergency based on the opinion of one doctor and the proposal of an AMHP or nearest relative for a period of 72 hours maximum unless a second doctor assesses that hospitalisation is required under Section 2.

120. In addition, Section 136 allows for the police to bring a person in need of immediate care or control to a place of safety which includes a cell in a police station where they may be held for 72 hours during which time they should be seen by a doctor and by an AMHP. There have been sustained attempts over the past few years to reduce recourse to police stations as a place of safety and the police have been at the forefront of moves to stop using police cells for mentally ill persons. Police forces in England are increasingly introducing pre-custody interventions such as Street Triage, with mental health nurses providing advice to police officers on the ground, and employing mental health nurses in the main custody suites. Further, a number of hospitals, such as St Charles, have a Section 136 suite which enables the police to bring persons suspected of having a mental illness directly to the hospital where they can be admitted and assessed.

Figures for 2014/15 from the Health and Social Care Information Centre show that Section 136 was used by the police in England on 19,403 occasions, an increase of 14% compared to the year before. Policing data from National Police Chiefs' Council cites that police cells were used under Section 136 to hold adult mentally ill persons on 3,996 occasions and juveniles 145 times during this period. The good news is that these figures represent a decrease of over 30% on the previous year. Nevertheless, more needs to be done to limit the use of police custody cells as a place of safety such as occurs within the MPS in London. Moreover, there was a consensus among persons from police and mental health services met by the delegation during the visit that co-operation between the two services concerning patients detained pursuant to section 136 could still be improved.

Following a public consultation, in December 2014 the Department of Health and Home Office published the legislative and non-legislative recommendations to improve the operation of Section 136 of the MHA, reducing the maximum length of detention under Sections 135 and 136 to 24 hours from 72 hours. Further, they recommend that children (i.e. persons aged under 18) are never taken to police cells.⁹⁹ The CPT welcomes these proposals as it also considers that a police cell is a totally inappropriate place in which to keep a mentally ill person. Nevertheless, it would go further and subscribe to the Royal College of Psychiatrists' proposal that police cells should only be used *in extremis* to hold adults for periods no longer than four hours rather than 24 hours, which it considers too long a period.

The CPT recommends that additional measures be taken, including of a legislative nature, to avoid holding mentally ill persons in police cells as far as possible. Further, inter-agency co-operation between police and mental health services in respect of those patients detained pursuant to Sections 135 and 136 of the MHA should be strengthened.

121. As regards more particularly the Section 136 suite at St Charles Hospital, it was suitably furnished for short stays. However, on occasion patients could remain in the suite for many hours after it had been decided to "section" the patient due to the lack of available bed space on the wards. During this period, patients could be medicated. **The CPT considers that the suite does not offer an appropriate therapeutic environment for stays of longer than a few hours and recommends that every effort be made to ensure that patients are transferred rapidly to an appropriate ward as soon as a decision is taken to involuntarily detain.**

122. All persons admitted involuntarily to hospital under Sections 2 and 3 of the MHA have the right to appeal their detention to the First-tier Mental Health Tribunal, an independent quasi-judicial body; within 14 days for Section 2 placements and at any time for Section 3 placements during the six month placements and thereafter once a year. Long-term patients who do not apply to the Tribunal will have their cases reviewed *ex officio* every three years, which in the CPT's opinion is far too long (see recommendation in paragraph 176 below). The Tribunal is composed of three persons (a lawyer, a doctor and a lay person) and has the power to discharge patients or to recommend discharge at a future date, to grant a leave of absence, transfer to another hospital or into guardianship (see Section 72 MHA).

⁹⁹ Department of Health and Home Office Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983: Review Report and Recommendations of December 2014.

Patients held under Sections 2, 3 and 4 of the MHA may also be discharged by hospital managers according to Section 23 MHA. In most hospitals, this function is carried out by hospital panels which consist of three or more persons appointed for a fixed period who are not employees of the hospital or NHS Trust in which the hospital is located. These panels must review all cases where an extension of the involuntary placement is requested and may undertake a review of whether or not a patient should be discharged at any time at their discretion or following a request from a patient.

123. An examination of a sample of files at St Charles Hospital and Highgate Mental Health Centre showed that there were clear procedures in place to ensure that all patients were detained according to the requirements of the Act, including a review by a medical doctor of the medical reasons for admission. Further, all patients were informed about their right to appeal their involuntary placement to the Mental Health Tribunal and the hospital manager's panel.

Hearings of appeals made to the Mental Health Tribunal were held within 7 days following the application for Section 2 patients and within 6-8 weeks for Section 3 patients. The decisions were delivered orally on the day of the hearing and in writing within seven days.¹⁰⁰

124. As regards consent to treatment, the CPT's delegation found that staff at St Charles Hospital sought the patients' consent before any medication was administered. However, there was no written form to record the consent. When patients did not consent to take medication, staff would attempt to talk to the patients to persuade them of the benefits of taking the medication and in most cases they were successful. However, it was not infrequent for medication to be forcibly administered due to a patient's non-consent.

For those cases where a patient with capacity does not consent to treatment, the CPT considers that an external psychiatric opinion should be required in any case where a patient does not agree with the treatment proposed by the establishment's doctors and patients should be provided with the possibility to appeal their forced treatment from the outset of their hospitalisation.

The CPT recommends that the relevant legislation should be amended so as to require an immediate external psychiatric opinion in any case where a patient does not agree with the treatment proposed by the establishment's doctors; further, patients should be able to appeal against a compulsory treatment decision to the Mental Health Tribunal. Patients should provide their consent to treatment in writing on a specific form.

125. The CPT considers that an information booklet setting out the establishment's routine and patients' rights should be issued to each patient on admission, as well as to their families. Any patients unable to understand this booklet should receive appropriate assistance.

¹⁰⁰ For the period 2014/15, the Tribunal received 25,436 applications; in 7,799 cases the patients were discharged before the hearing, and of the 15,048 hearings that took place, discharge was ordered in 1,220 cases and no discharge was decided in 10,997 cases (the remainder of cases were pending at the end of the year) – as quoted in Appendix B of the CQC Monitoring the Mental Health Act 2014/15.

At St Charles Hospital, there were patients' leaflets on each section of the MHA concerning admission to hospital both for voluntary and involuntary patients. The leaflets provided information on why the person was in hospital, the length of stay, how to appeal, consent to treatment and the right to refuse treatment (and that they may subsequently be treated against their wishes), how to make a complaint, visits, telephone call and that they could receive help about their rights. There was also a leaflet on the right to complain to the CQC. At Highgate Mental Health Centre, the delegation was able to see that patients were provided with a similar range of information.

However, the CPT's delegation learned that patients' may be charged the sum of 10 GBP if they asked to see their medical file. The sum was apparently waived if the request came directly from the patient as opposed to from their solicitor. All patients should have a clear right not only to see their medical files but to be able to do so without having to pay. **The CPT wishes to receive confirmation that patients in all psychiatric hospitals can have free access to their medical records.**

126. As regards visits, patients at St Charles could receive visitors on the wards Monday to Friday from 4.30pm to 8.30pm and at weekends from 2.30pm to 8.30pm. There is a public telephone on all wards for patients. In addition, patients on all wards except the male PICU (Nile) were allowed to retain their mobile phones, laptops, tablets and any other computing and recording devices.¹⁰¹ The CPT considers that allowing patients to retain their mobile phones is a good practice given how much a phone is often an integral part of a person's daily life, used to keep not only contacts and personal information but to manage day to day activities. Any restrictions on access to mobile phones should be clearly regulated by hospitals and explained to patients.

127. There was a mental health advocacy project at both hospitals that visits patients and assists them with resolving small problems and making written complaints, including to the CQC. Most complaints would be addressed to the hospital management which had an internal policy of responding within 25 days although issues of "concern" would be addressed within three days. The number of complaints received was low (15 in the last three months of 2015 at St Charles Hospital).

If an issue raised by a patient concerns a safeguarding matter (i.e. places a patient at risk of harm whether physical, financial or exploitation), the hospital safeguarding team would carry out an investigation (for example, three of 22 references received were investigated by the team at St Charles Hospital in January and February 2016).

The CPT considers that it would be beneficial for all the wards to contain locked complaints boxes for patients to place written complaints/comments which should only be accessible to the safeguarding team. The complaints would be logged and dispatched to the relevant service for follow up.

The CPT recommends that complaints boxes be installed on all wards where involuntary patients are placed with access available only to the safeguarding team.

¹⁰¹ Mobile phones were not allowed to be used for recording or photographing other patients.

3. Adult forensic psychiatry

128. In the course of the 2016 visit, the CPT's delegation visited the North London Forensic Service at Chase Farm Hospital. It also visited Ashworth and Broadmoor Hospitals, two of the three high secure hospitals in the country (the third being Rampton), which provide treatment for psychiatric patients who require a high security setting because of their potential dangerousness.

129. *The North London Forensic Service at Chase Farm Hospital* includes six medium secure adult male wards (106 beds), a female medium secure ward (12 beds), four low secure wards (56 beds) and the off-site 24-bed Avesbury House rehabilitation centre. It also has a dedicated activities building (Kingsway) which can be accessed securely from all the medium secure wards. The CPT's delegation focused on the medium secure wards.

130. *Ashworth Hospital*, located just outside Liverpool, consists of 14 single storey semi-detached wards, each with its own garden. The Hospital, spread over a large area with lots of green space, an activities building, workshops, swimming pool and horticultural area, is surrounded by a high perimeter wall. The hospital is under the administration of Mersey Care NHS Trust and the majority of patients come from the West Midlands and North West of England and from Wales. All patients were detained under the Mental Health Act 1983 and most under Part III of the Act, notably convicted offenders who had been committed to the hospital under Section 37/41 (75 patients) or transferred from prison under Section 47/49 (79 patients) of the Act, with a view to psychiatric treatment. 11 were civil patients committed under Section 3 of the Act. The average length of stay in the hospital was 5.45 years (median 3.29 years) with the periods for patients under Section 37/41 being longer (average of 7 years and a median of 5 years).

At the time of the visit, the hospital was accommodating 195 patients for a capacity of 210. One ward was closed for refurbishment and the delegation focused its attention on the six admission and high dependency wards (Arnold, Blake, Johnson, Keats, Lawrence and Tennyson).

131. *Broadmoor Hospital*, opened in 1863 and located in Berkshire west of London, is in the process of a major redevelopment. A new 10-ward unit and new administrative and activities buildings are under construction on part of the current site. The six wards of the 2005 Paddock centre will be incorporated into the new build while the old Victorian Buildings will be finally decommissioned having been declared unfit for purpose as far back as 2003. The new hospital will have a bed capacity of 234 and is expected to start accepting patients in 2017.

At the time of the visit, the hospital was accommodating 190 patients for a capacity of 212. The delegation focused its attention on patients in Long term segregation (LTS) in the intensive care unit (Cranfield), the three admission wards (Kempton, Newmarket and Sandown) and the three high dependency wards (Ascot, Epsom and Woburn).

132. It should be stated at the outset that the CPT's delegation received no allegations of deliberate ill-treatment of patients by staff in any of the three hospitals visited. On the contrary, the delegation observed that in general staff had a caring approach towards patients.

a. patients' living conditions

133. Patients' living conditions at *Chase Farm Hospital* were generally of a good standard. The main medium secure building (Camlet 3) had been rebuilt following a 2008 fire and comprised a male admission ward (Sage), two male rehabilitation wards (Cardamon and Tamarind) and a female ward (Juniper). Each patient had their own room which was suitably furnished with a bed, built-in shelving and cupboard space, a table and chair and personal lockable space. Access to natural light was good. Each room also possessed an adjoining sanitary annex with toilet, sink and shower. There were common open spaces around the central staff nursing station, notably a television area with armchairs and sofas, and dining area, a kitchen and an activities area (table tennis). There was also a quiet room that patients could access.¹⁰²

The living conditions in the Paprika and Mint wards in the original hospital building (Camlet 1) were adequate though of a less high standard. However, the rooms did not possess an adjoining sanitary annex and on both wards patients had access to shared facilities (four toilets and two shower rooms). At the time of the visit, one of the toilets on Paprika ward was blocked.

As regards food, patients could order take-away twice a week and cook for themselves. Otherwise, they had to eat the vacuum-packed pre-cooked meals about which virtually every patient complained. **The CPT would like to receive confirmation about the steps being taken to improve the food offered to patients.**

134. The wards each had their own garden. However, since the coming into force of a smoking ban at the beginning of 2016 there was some confusion around accessing outdoor area. The wards each ran a policy of permitting patients access twice a day for half an hour to the garden area but patients did not seem to understand when these times were. Staff should be more proactive in encouraging patients to go outside, even when the weather is less inviting, as outdoor exercise is important for a patient's health.

The CPT recommends that proactive steps be taken by staff to encourage patients to access the outdoor garden every day.

135. The living conditions in the various wards of *Ashworth Hospital* varied. The recently renovated Owen medium dependency ward provided good conditions and the improved access to natural light in the corridors gave the impression of greater space. The high dependency wards visited offered less good conditions. Each patient had a single room with an adjoining sanitary annexe (toilet and sink). The rooms were equipped with a bed, built-in cupboards and a desk, a television and a call bell; there was good access to natural light and artificial lighting and ventilation were generally satisfactory. However, the overall design had a carceral feel rather than a therapeutic one associated with a hospital.

Each ward possessed a large sitting and television area, off which there was usually the kitchen, dining room, an activities room and lockable cupboard space for each patient to keep certain food items. A second sitting room area was located near the rooms to which certain patients were restricted. There was also a quiet room available to patients.

¹⁰² On each ward, there was a board which recalled what patients had asked for (You said) and next to it the action taken by the hospital to meet the request (We did). Such positive communication approaches are to be encouraged.

Each ward had its own garden which was enclosed by a fence. Nevertheless, patients on the high dependency wards were not offered access to the garden unless there were sufficient staff present to supervise patients (three members of staff, one with radio communications, were required for four patients). Several patients complained to the delegation that they were frequently not able to access the garden on a daily basis due to lack of staff. Indeed, staff on these wards confirmed to the delegation that it was often not feasible for them to facilitate access to the garden if the ward had several patients on long-term segregation.

The CPT considers that daily access to outdoor exercise / garden is a right for all patients and every effort should be made to facilitate such access. Moreover, walking outside in a garden area is known to have beneficial effects for a person's physical and mental well-being and should generally be an integrated part of every patient's care plan. Particular attention should be paid to the design and equipment of the garden for all seasons.

The CPT recommends that steps be taken at Ashworth Hospital to offer all patients in high dependency wards daily access to the ward gardens and to adapt the design and equipment in the garden to the needs of the patients.

136. At Broadmoor Hospital, there was a carceral feel to the environment on the wards visited which ran counter to the therapeutic purpose of the hospital. However, as mentioned above, the hospital is being re-developed and the new hospital should be opened in 2017.

The CPT would like to receive detailed information about the material conditions and design of the high dependency wards and the intensive care ward in the new hospital, including any special arrangements for patients in seclusion or LTS. It would also like to be informed about the arrangements for outdoor exercise and the design of the garden areas.

137. The policy of night-time confinement was addressed by the CPT in its report on the visit to Rampton Hospital in 1994, and the Committee was content to note that the policy was ended in 1995. However, in 2012, following a consultation by the Department of Health it was decided to reinstate progressively night-time confinement in the high secure hospitals. Ostensibly the aim of this policy was to generate savings by reducing the number of staff required on the wards between the hours of 9.15 p.m. and 7.15 a.m. and to use the savings to invest in the provision of more activities for patients during the day time. Further, it was felt that night-time confinement would reduce bullying.

Specific powers to authorise night-time confinement were set out in NHS England Directions 2013,¹⁰³ and the 2015 revised MHA Code of Conduct specifically states that locking patients in their rooms at night in accordance with these directions does not constitute seclusion. It should be noted that the Guidance issued by the Department of Health in relation to the 2013 Directions states in the Annex B Protocol on night-time confinement that these arrangements "should only be put in place where it is considered that this will maximise the therapeutic benefit for patients as a whole in the hospital". Further, it states that no patients should be locked in their room at night if it is considered that this will have a detrimental effect on their well-being and that there should be a periodic review whether individual patients should be routinely locked in at night.

¹⁰³ NHS England (2013), The High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013, section 35.

138. In its Monitoring the Mental Health Act in 2012/13 Report, the CQC noted that feedback from patients was less positive than that presented by the three hospitals about patients' experiences of being locked in their rooms at night. Further, the CQC pointed to complaints about cancelled or otherwise lacking activities when night-time confinement was supposed to improve the offer of activities. The CQC has not pronounced on the issue in its two subsequent reports referring only to research commissioned by Ashworth on the impact of night-time confinement.

In February 2015, the findings of the research were published¹⁰⁴ which concluded that confinement does not exert any consistent influence, positive or negative, on patients' sleep hygiene, behaviour or engagement with therapy. However, as the authors of the study note, the methodological shortcomings of the study meant that it was not possible to draw general conclusions.

139. The CPT continues to believe that the systematic locking-in of patients at night, which amounts to ten hours of de facto seclusion, is not acceptable in a care establishment provided there are sufficient staff. Among some patients this policy of systematically locking rooms may cause distress and anxiety and the CPT's delegation did not find any evidence of an individual patient review. Alternative arrangements exist to be able to ensure safety of patients at night and the availability of adequate staff when necessary. Certainly, from a therapeutic point of view, there was little evidence that night-time confinement was beneficial for patients' well-being. In light of the savings that Ashworth Hospital must make every year, the use of night-time confinement has not led to an increase in day-time activities. The Committee considers that as patients are stepped down from the high to the medium dependency wards within the high secure hospitals in preparation for being transferred on to a medium secure hospital, night-time confinement should not be applied. Institutionalisation of patients should be avoided and developing personal autonomy is important. On the high-dependency wards, an individual risk assessment should be undertaken concerning the use of night-time confinement with the rule being that all patients not in seclusion or long-term segregation should not be locked in their rooms.

The CPT recommends that the United Kingdom authorities, in close consultation with the high secure hospitals, review the use of night-time confinement, including staffing levels, in the light of the above remarks.

b. treatment

140. Psychiatric treatment should be based on an individualised approach, which implies the drawing up of a treatment plan for each patient, indicating the goals of treatment, the therapeutic means used and the staff member responsible. The treatment plan should also contain the outcome of a regular review of the patient's mental health condition and a review of the patient's medication.

The treatment should involve a wide range of therapeutic, rehabilitative and recreational activities, such as access to appropriate medication and medical care. Procedures must be in place to ensure that medication prescribed is in fact provided, and that a regular supply of appropriate medicines is guaranteed.

¹⁰⁴ The impact of a night confinement policy on patients in a UK high secure inpatient mental health service (February 2015). *Journal of Forensic Practice*, 17 (1) pp. 21-30.

Patients should be involved in the drafting of their individual treatment plans and be informed of their progress.

Those managers and clinicians entrusted with the delivery of these programmes should be empowered with the necessary resources.

141. In the three forensic hospitals visited, the above precepts were clearly followed; they are also reflected in Chapter 24 of the MHA Code of Practice 2015 on medical treatment.

All patients at the three establishments visited received treatment based on an individualised approach and staff worked in multidisciplinary therapeutic teams. Patients were normally associated with drawing up their care plans and were provided with feedback from staff following all reviews.

As for the range of treatments, pharmacotherapy appeared to be adequate but there was not a wide range of non-pharmacological treatment available to individual patients. Medical confidentiality was duly respected (both as regards consultations and documentation). The patients' individual medical files and other medical documentation were held on computer.

142. At Ashworth and Chase Farm Hospitals, the delegation was able to see that a range of therapeutic and rehabilitative activities were offered (individual psychotherapy, support and group therapy, special education, work therapy, life skills training, art, sports, etc.). For the 70 patients in the high dependency wards at Ashworth Hospital, most of the treatment was done on a one to one basis on the wards. Further, the CPT's delegation was informed that the central workshop rehabilitation building no longer safely catered to the needs of the current patient population¹⁰⁵ and that more would be done to develop activities on the wards.

As regards recreational activities at these two hospitals, patients had access to common areas on the units, where they could watch TV/DVD, and could listen to the radio, read books, newspapers and magazines, play computer and board games, table tennis and billiards. Further, at Ashworth Hospital, patients had access to a large indoor sports hall, an outdoor football pitch, an astro turf pitch and a swimming pool. At Chase Farm Hospital, the Kingsway centre included a large sports hall, fitness and weights rooms and other recreational activities to which patients could have access seven days a week.

At Ashworth Hospital, some complaints were received that at times staff shortages resulted in patients not being able to access activities and staff working at the Rehabilitation College and gym confirmed this problem.

The CPT would like to be informed about the proposed developments at Ashworth Hospital to provide more therapeutic and rehabilitative activities on the wards, and the steps being taken to ensure that patients are able to access activities as planned.

¹⁰⁵ Patients were younger and spent less time in the hospital, and the capacity of the hospital had halved.

c. staff

143. At Ashworth Hospital, there were 12 consultant psychiatrists, including the medical director, a general practitioner and 3.8 FTE other doctors. There were 10 clinical psychologists, seven approved social workers, two dieticians and a range of other staff, notably six modern matrons, five nurse managers, 24 charge nurses and 173 registered mental health nurses (RMN) and 254 health care support workers and assistants (HCA).

Ward-based staff during the two day shifts (7am to 2.30pm; 2pm to 9.30pm) consisted of a ward manager, four RMN and five HCA on the six high dependency wards (one 10-bed and five 12-bed); and a ward manager, two RMN and four HCA on each of the seven 20-bed medium dependency wards. All the wards were staffed with 1.5 RMN and 1 HCA at night (8.50pm to 7.30am). At the time of the visit, there were shortages of staff on a number of wards which did have an impact on activities, especially as concerns the high dependency wards. Further, the hospital had a 5% long-term absence rate and a 2.5% short-term absence rate which meant that staffing numbers were stretched.

Ward-based staff spoken to by the delegation referred to the ongoing work-to-rule by staff but stated that morale had improved over the past year from a real low.

144. At Broadmoor Hospital, there should be four RMN and four HCA in the high dependency wards during the morning and afternoon shifts. In practice, staff numbers were frequently below the planned level (for example, on Epsom Ward in the month of February 2016, there were 16 shifts when staffing levels were two or more below the planned level and 17 shifts when the shift was one below). It was also evident that the absences primarily concerned RMN and that even on those shifts where there were eight staff the breakdown was not infrequently six HCAs and only two RMNs. Staffing shortages naturally have an impact on activities for patients and disproportionately so on the high dependency wards when there are one or more patients in long-term segregation.

145. An examination of staff attendance over the three months prior to the delegation's visit to both hospitals showed clearly that the wards were operating at the limit of safety on a number of occasions and frequently were not fully staffed. Many patients on LTS stated that due to staff shortages on some days, they were not offered any possibilities to exit their rooms or to attend activities such as the gym. Moreover, in the CPT's opinion, there is a need for additional nursing staff to be present on the high dependency wards in both hospitals in order to manage the challenging patients and reduce the resort to long-term segregation (see section d. ii. below).

The CPT recommends that the United Kingdom authorities provide the necessary resources to enable Ashworth and Broadmoor Special Hospitals to increase their nursing staff levels in order to offer all patients access to proper safe and therapeutic nursing care during the day.

d. use of means of restraint

146. As a matter of principle, hospitals should be safe places for both patients and staff. Psychiatric patients should be treated with respect and dignity, and in a safe, humane manner that respects their choices and self-determination. The absence of violence and abuse, of patients by staff or between patients, constitutes a minimum requirement. That said, on occasion the use of physical force against a patient may be unavoidable in order to ensure the safety of staff and patients alike.

The CPT has come across various methods of controlling agitated and/or violent patients, which may be used separately or in combination: shadowing, manual control, mechanical restraints, chemical restraint (medicating a patient against his/her will for the purpose of controlling behaviour) and seclusion (involuntary placement of a patient alone in a locked room). As a general rule, the method chosen in respect of a particular patient should be the most proportionate (among those available) to the situation encountered.

As one might expect, using oral persuasion (i.e. talking to the patient to calm him/her down) would be the CPT's preferred technique but, at times, it may be necessary to resort to other means directly limiting the patient's freedom of movement. In the course of the visit, the CPT's delegation paid particular attention to the use of seclusion; long-term segregation, as well as the use of special intervention teams and manual means of restraint.

i. *seclusion*

147. As stated above, seclusion and manual means of restraint are set out in Chapter 26 of the MHA: Code of Practice 2015. At Chase Farm Hospital, the CPT's delegation found that resort to seclusion was not excessive and that the safeguards in place were adequate and conformed to the MHA Code of Practice. There were two seclusion rooms in Camlet 3 building which housed four medium secure units and two seclusion rooms in Camlet 1 for two medium secure units. In the cases examined, seclusion was authorised by the nurse in charge and brought to the attention of the responsible clinician or duty doctor who carried out a medical review shortly afterwards. The patients were placed under either fifteen minute observations or constant observation either via CCTV or with a staff member located in the adjacent observation room. Nursing reviews were carried out every two hours and a medical review after four hours, and a multi-disciplinary team review was enacted after eight hours and thereafter once every 24 hours.

The seclusion rooms in Camlet 3 (one on Tamarind and one on Sage wards) consisted of a bare room with only a mattress on the floor; an adjoining sanitary facility could be accessed directly by the patient through a door. The room had good access to natural light. Between the seclusion room and the wards was a de-escalation area with a cushioned bench upon which a patient could be sat with two staff members in holds if it was felt that a short calming down period would suffice rather than placing a patient in seclusion. The whole area was covered by CCTV and the seclusion rooms possessed intercom phones which were connected to the nurses' station.

The seclusion rooms were ligature free and were acceptable for managing an agitated patient for a short period. However, the documentation on the use of seclusion did not always record the length of seclusion. The delegation noted that of the 101 times that seclusion was applied to a patient between 1 April 2015 and 31 March 2016, in only 56 instances did the records contain information on the length of the seclusion, and in more than half of these cases the seclusion measure lasted longer than 24 hours, with one patient secluded for 395 hours (16 days).

The CPT recommends that every measure of seclusion be diligently recorded in the restraint register, notably: the start and end of the measure, any time offered out of seclusion to the patient, the reason for initiating seclusion and cogent reasons for continuing seclusion beyond 24 hours. The name of the persons authorising and ending seclusion should also be recorded.

It goes without saying that the existence of a systematic recording system would allow for a proper monitoring of the restraint and seclusion procedures and would ensure that a complete picture of resort to such measures is available.

148. The delegation observed several interventions and reviews by staff of patients in seclusion. In one case, the patient had refused to remain on the mattress in the corner of the seclusion room and the clinician had carried out the review of the patient in the seclusion room behind a shield of three staff members, while two staff cleaned the room and several more staff members were present in the doorway to provide further support if necessary. When the review was completed, the three-man shield exited the room backwards at speed and another nurse slammed the door shut without knowing whether the patient had been advancing towards the door. The CPT is not convinced by the proportionality of the force deployed in this case with the patient confronted by a wall of three nurses from behind whom a clinician posed a number of questions following which there was a rapid exit and the slamming of the door. The patient may well have been injured by the door slamming on him if he had followed the three man team. The whole approach of force was likely to further agitate the patient as his blood pressure and heart rate indicated that he was already stressed at the outset of the review. The CPT's delegation also noted there was a great deal of noise pollution coming from the ward and from the staff members outside the seclusion room which impacted on the communication with the patient.

The CPT recognises that there is a need for safety procedures to be in place for highly agitated and violent patients. However, the procedures should be adapted to the situation. For example, it is preferable for staff from the ward who knows the patient to be involved in a seclusion review as the patient is more likely to respond to a nurse with whom he or she has developed a relation. Indeed, this is what the CPT's delegation observed on Tamarind ward when staff had to enter a seclusion room holding a patient with a history of violence. Further, the CPT considers that the three-nurse human shield leads to an increase in tension and may hamper proper communication between the patient and the doctor.

The CPT would appreciate the observations of the United Kingdom authorities and Chase Farm Hospital on the above remarks.

149. At Ashworth Hospital, the six high dependency wards together possessed 34 seclusion rooms, some of which were in the process of being upgraded. At the time of the visit, five patients were secluded and figures between January 2014 and April 2016 showed that the number of seclusion episodes per month at the hospital had fluctuated between 15 and 35 but since July 2015 had hovered around 20.

The procedures for the placement and review of patients in seclusion were carried out in accordance with the MHA Code of Conduct (2015) and Mersey Care NHS Trust policy on seclusion. In the first three months of 2016, there had been 65 episodes of seclusion involving 30 patients (one patient had been secluded seven times and another four times). It should also be noted that six patients were recorded as only spending five minutes out of seclusion before a further period of seclusion was applied which meant they were secluded effectively for periods between eight and 45 days. Five patients were placed in seclusion for 30 days or more and one patient as long as 59 days. Six of the 30 patients had their seclusion measure transformed into long-term segregation¹⁰⁶ (see below). It was not possible from the files to see whether all the patients had undergone a debriefing following the end of the seclusion measure and if so whether the debriefings were analysed and had contributed to either changes in an individual patient's treatment or in the seclusion policy on particular wards.

The CPT recommends that debriefings of patients be systematically carried out and recorded. Further, the CPT would like to be informed whether all patients were properly debriefed and to what extent the debriefings fed into the patient's treatment plan and the seclusion policy on the wards at both Ashworth and Chase Farm Hospitals.

ii. long-term segregation

150. Long-term segregation (LTS) is regulated by Chapter 26 of the MHA Code of Practice (2015) and by each NHS Trust. It is primarily applied in the high secure hospitals and the CPT's delegation examined its application in detail at Ashworth and Broadmoor Hospitals. LTS is the result of a clinical judgment that "if the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time." LTS almost invariably follows a period of seclusion (7 to 14 days depending on the hospital) and for some patients may last many years. Patients on LTS may be accommodated in a seclusion room, an intermediate suite or their own room, and the amount of time they will spend out of their room might vary from 30 minutes every other day to several hours a day, including accessing off-ward facilities.

¹⁰⁶ For three of the patients, this occurred only after their third measure of seclusion.

151. The Mersey Care NHS Trust's policy on LTS of November 2015 for Ashworth Hospital includes the criteria and standards of Chapter 26 of the MHA Code of Conduct (2015) regarding LTS. In summary, for LTS to be initiated, a multi-disciplinary team (MDT) should consider it necessary and agreement from the commissioning authority, medical director and director of patient safety should be sought. In addition, the views of the family/carers should be elicited where appropriate as well as those of the IMHA. Patients in LTS should be observed every 30 minutes and should be seen by the nurse in charge of the ward at each shift handover. A responsible clinician should review the patient's situation in LTS once in any 24 hour period, there should be at least three face-to-face medical reviews each week and a multi-disciplinary care team review once a week. A monthly review should be carried out by the Seclusion Monitoring Group and an external hospital should undertake a three-monthly review. A full clinical review should be sought from peers from other similar services in the event LTS exceeds 12 months. The decision to end LTS should be taken by the multi-disciplinary team.

Patients in LTS should have access to a bedroom and bathroom facilities as well as a relaxing lounge area, secure outdoor area and a range of activities of interest and relevance to the patient. Further, each patient in LTS should have a segregation care plan which inter alia spells out the conditions under which LTS may be terminated and summarises the planned treatment.

The underlying approach towards patients in LTS should be to end the isolation as soon as practicable and to re-integrate patients into the wider ward community. Patients in LTS should be cared for in conditions of least restriction to maintain safety.

152. The CPT has serious concerns relating to the measure of LTS as regards the necessity for its application, the manner in which it is applied and its duration. The 2016 visit found that patients could be kept in LTS for years on end with minimal human contact, and often the contact offered was not face-to-face and meaningful but via the hatch in the door to the patient's room. The Code of Practice and NICE guidelines acknowledge that environmental factors and restricting a service user's liberty and freedom can be a trigger for violence and aggression.¹⁰⁷ Further, confronting patients with four, six or more staff whenever their room door is opened is unlikely to diminish any tendency towards violence. The CPT considers that, in certain cases, the impact of LTS on patients amounts to inhuman and degrading treatment and that steps should be taken as a matter of urgency to review its use.

The CPT recommends that the application of LTS in Ashworth and Broadmoor Hospitals be reviewed urgently with a view to reducing resort to the measure and radically cutting the amount of time patients are held in LTS.

153. At Ashworth Hospital, the number of patients on LTS has remained steady at 25 for the six months prior to the visit.¹⁰⁸ The CPT's delegation was informed about discussions among the three high secure hospitals to try and harmonise the timing as to when seclusion should be transformed into LTS. Nevertheless, at Ashworth Hospital a more flexible approach to timing was adopted depending on the assessment of the clinical team which meant that in practice seclusion was usually transformed into LTS after 13 days. As the requirements for reviewing a patient in seclusion are more rigorous than those subjected to LTS, the CPT considers that it is appropriate that no strict deadline for transforming seclusion into LTS be decreed. The aim should be to avoid resort to LTS as far as possible.

¹⁰⁷ See Violence and Aggression: Short-term management in mental health, health and community settings (NICE Guideline NG10) commissioned by the National Institute for Health and Care Excellence (2015).

¹⁰⁸ From 16 in April 2014, it had risen steadily to 29 in January 2015 before falling to 25 thereafter.

In the course of the visit, the CPT's delegation to spoke with all 25 patients who were in LTS as well as with a number of patients who had previously been in LTS but who had reintegrated into the ward community during the six months prior to the delegation's visit.

154. At Broadmoor Hospital, the number of patients on LTS at the time of the visit was 34 and the CPT's delegation spoke with 22 patients on LTS and a number of patients who had been on LTS in the past, focusing on Cranfield, Epsom, Newmarket and Woburn wards.

An examination of the data concerning the number of patients and the number of hours spent in LTS illustrates clearly that there was a paradigm shift in the application of LTS between 2008 and 2010 at Broadmoor Hospital, with a subsequent continuing year on year increase in the number of hours spent by patients in LTS (see table). Senior staff at Broadmoor attribute the rise in the use of LTS to the emergence of a risk-averse culture following the murder of one patient by another in 2004 and the subsequent Francis Report into the homicide published in 2009.

Years	2008	2009	2010	2011	2012	2013	2014	2015	2016 (3 months)
Patient Nos	23	33	> 40	48	47	64	76	81	56
Total Hours	30 021	45 204	75 606	91 848	177 999	205 732	229 084	173 663*	42 337*

* Does not include the hours of night-time confinement (i.e. 9.30 pm to 7.15 am) when all patients in the hospital are confined to their rooms. If night-time confinement hours are added for the year 2015, the total number of LTS hours would be c. 295 000.

155. The CPT considers that patients are placed in hospital for treatment and, as such, LTS cannot be considered as conducive to their treatment. It understands that seclusion followed by LTS is supposed to be an extreme measure for patients who are considered to be a threat to themselves and/or to others. Nevertheless, in some cases it would appear that LTS is simply a containment measure with patients receiving medication but an almost total lack of human contact.

One patient at Ashworth Hospital who had been in LTS for almost four years and who had previously been in LTS for two years (2007 and 2008) seemed to have minimal contacts outside of his room. In the first three months of 2016, there were whole weeks when no activity was recorded for him and in other weeks the only activity might be to open the door of his room for half an hour to enable him to "associate" alone in a "sterile" area of the ward. Access to the yard for 30 minutes at most was facilitated by the Positive Intervention Programme (PIP) team and occurred five times in January, once in February and once in March. Yet the meaningful activities recorded for the month of 7 February to 7 March was 105.78 hours (including meals, shower, TV and one to one engagement by staff).

A second patient at Ashworth Hospital had spent almost eight years in LTS and prior to that had been four and a half years in LTS with only a month out of LTS in between the two periods. The recorded activities for him were few and far between for the first three months of 2016. Access to the garden occurred only twice, both times in March, and association in a specific room only once. Other activities recorded related to three telephone calls, one family visit and three association periods to attend to hygiene. Yet, for the month of March it was recorded that of the 161 hours of activity offered he had taken up 72.

The CPT wishes to be informed of the steps being taken at Ashworth Hospital to end the LTS of the two above-mentioned patients and to receive information on the concrete therapeutic interventions and activities offered to these two patients in the second and third quarters of 2016.

The delegation met another patient who had been in LTS for over seven years, interrupted only by a three month period in mid-2015 and several other patients interviewed at Ashworth Hospital who had spent periods of two years or more in LTS. Further, the delegation noted that nine patients had been placed in seclusion and thereafter LTS within one month of arriving at Ashworth Hospital and one of them was still in LTS three and a half years later; these patients had not been given an opportunity to integrate into the wards.

156. At Broadmoor Hospital, at least three patients had been in LTS for periods in excess of five years; one of them was being managed in a special two-room suite with direct access to a secure outdoor area on Cranfield ward. Several other patients had spent two years or more in LTS.

157. It should be noted that the CPT's delegation did meet a number of patients on LTS at both Ashworth and Broadmoor Hospitals who spent or could spend as much as seven hours a day out of their room in association with other patients, eating their meals in the dining room and having access to the garden areas. However, they represented a minority of the LTS patients.

158. As mentioned above, walking outside in a garden area is known to have beneficial effects for a person's physical and mental well-being and patients should be encouraged to spend time outdoors. The CPT's delegation met many patients on LTS at both Hospitals who stated that they were rarely granted access to fresh air. **The CPT recommends that all patients in LTS should be offered, as a first step, at least one hour every day of access to the outdoors, and preferably to a grassed garden area.**

159. Setting monthly targets for the number of hours patients should be involved in activities and then defining activities as eating or washing or exchanging a few words with staff seems more oriented towards ticking a box than ascertaining whether any meaningful therapeutic activities and exchanges have taken place with the patient. While it is essential to monitor and support patients eating and hygiene habits, they should not be counted as therapeutic activities. Further, it would be more interesting to record the reasons why patients declined to take up particular activities. The activities should of course be adapted to the individual patient, taking into account his interests and history and linked to the therapeutic goals for the patient concerned.

The CPT recommends that the approach towards offering and listing meaningful activities be critically reviewed at both hospitals, in the light of the above remarks.

160. At both Ashworth and Broadmoor Hospitals, the CPT's delegation observed that communication with patients on LTS by hospital staff (doctors, nurses, psychologists) was regularly conducted through the small hatches in the doors of their rooms.¹⁰⁹ Many patients complained about this practice. Clinical/therapeutic discussions with patients cannot be conducted through hatches; indeed such an approach is incompatible with treatment. In the medical notes of certain patients on LTS, the treating doctor recorded that he could not "acoustically understand the patient". Indeed, due to the noise on the wards, voices had to be raised which distorted communication; moreover, eye contact and body language, important benefits of face to face communication, were lost. Further, at times patients had to provide blood samples by placing their arms through the hatch of the room door. The delegation also observed paper plates with food being squeezed through small hatches¹¹⁰ or left on the floor of the rooms – this is certainly not conducive to the dignity of the patients.

The CPT recommends that hospital staff should avoid as far as possible communicating with patients on LTS through the hatches of the door and that all medical and therapeutic interventions should be conducted face to face. Meals should be served to patients in a dignified manner.

161. The CPT's delegation met and observed a number of very committed and professional staff on wards managing LTS patients. Notable mention should be made of the PIPS programme at Ashworth to manage LTS patients and of the Cranfield ward manager at Broadmoor whose policy was to challenge why a patient was locked in his room. The graduated approach on this ward entails managing patients on LTS progressively by initially taking them out of their rooms in holds requiring six staff and then reducing to four and two staff and finally no holds as cooperation and trust is developed. That said, as mentioned above, the CPT is concerned that patients whose conditions require the highest risk and the greatest needs are being denied sufficient human contact which is likely to reinforce their isolation and the symptoms of their illness and lead to a deterioration in basic social skills. In the CPT's view, LTS over a long period cannot be considered to be supporting the recovery of the patient but is more likely to further damage their health.¹¹¹ Such a situation results in patients effectively being held in conditions which may be described as degrading. **The CPT would appreciate the comments of the United Kingdom authorities and of the Ashworth and Broadmoor Hospitals on this subject.**

162. None of the records reviewed by the CPT's delegation regarding patients on LTS contained a formal decision with clear reasoning and a description of the risks posed by the patient prior to placing the patient on LTS. Further, while the patient was seen by a nurse and a doctor every day, it was the MDT which decided on continuing or ending the LTS measure at their weekly meetings. Yet from the patients' files it was not clear what a patient's pathway out of LTS was, and certainly the patients spoken to by the delegation were not aware of what was required of them other than to be "good" and "not violent". From the information gathered, the decision to continue LTS was in the hands of the MDT and the patient has no real safeguard against the MDT's decision. The information in the records did not demonstrate the necessity for continued LTS nor explain why the patient could not be supported in a less restrictive manner.

¹⁰⁹ This included so-called 1:1 time with nurses.

¹¹⁰ Patients stated that after a CQC inspection the practice of squeezing meals on paper plates through the hatches had stopped for a little while but had subsequently resumed.

¹¹¹ It should be noted that quite a few patients had never been given an opportunity to adapt to ward life as they had been placed in seclusion and LTS soon after arriving in hospital from prison (where they had usually be held in a segregation unit for a considerable amount of time).

The CPT recommends that the documentation regarding the reasons for initiating and continuing LTS be fully recorded in the patient's file and that a clear pathway out of LTS should be drawn up and the patient fully informed about such a care plan.

Further, it recommends that in each hospital a formal register of all incidents of seclusion and long-term segregation be established. This register should include a record for each incident, notably time commenced, who authorised the measure, the reason for the measure being commenced. Further, each review of the measure (by nurse, doctor or consultant) should include the time, date and signatures (and professional registration numbers) and the termination of the measure should record the time, date and name of the authorising person.

163. At the time of the visit the three-monthly review by an "external hospital" had not yet been put into practice at Ashworth Hospital as there was some dispute as to whether the external hospital should be an institution outside of the Mersey Care Trust. At Broadmoor Hospital, an expert external review of 12 patients on LTS had taken place in November 2015 but not thereafter.

The CPT trusts that the question of an external hospital has now been clarified and that three-monthly reviews by an external hospital are now being conducted regularly for LTS patients at both Ashworth and Broadmoor Hospitals. Further, it would be interested to receive information on which hospital service is carrying out the review respectively for Ashworth and Broadmoor Hospitals, the nature of the review and the outcome of the reviews to date of all LTS patients.

The CPT also welcomes the Mersey Care Trust's policy commitment to request a full clinical review from peers from other similar services for those patients held in LTS for longer than 12 months and wishes to receive details of the first such review and its outcome concerning all patients held in LTS longer than 12 months.

The CPT recommends that at Broadmoor Hospital a similar policy of a peer review of LTS patients after 12 months be put in place. Further, it would be like to receive details of the first such review.

164. In addition to the monthly management oversight and these peer reviews, the CPT considers that patients ought to be granted the right to appeal the LTS measure to the Mental Health Tribunal or another independent body which should be empowered to rule on the necessity for continuing the measure or alleviating its restrictions. The Committee recognises that this would entail an extension of the powers of the MHT. Nevertheless, patients should be placed in a position to appeal the LTS measure and an ex officio review by the MHT should be introduced after a defined period.

The CPT recommends that the United Kingdom authorities introduce the right for a patient to appeal the measure of LTS to the MHT and that the MHT be empowered to review the measure of LTS ex officio after a defined period.

165. As regards the November 2015 review of 12 LTS patients at Broadmoor Hospital, the panel of experts concluded that six patients no longer needed to be maintained on LTS and that for a seventh patient it was questionable whether LTS was required. However, almost five months later a few of these patients continued to be kept on LTS despite the expert panel and MDT having concluded that their condition did not warrant the measure any longer. Such a situation is not acceptable and may well be harmful to the patient's well-being.

The CPT recommends that once there is no longer a necessity for a person to be kept in LTS arrangements should be put in place to ensure that the patient can be integrated into general ward life rapidly.

166. As to the material conditions of patients in LTS at Ashworth Hospital, all patients were accommodated in rooms which afforded them access to en suite bathroom facilities. While some patients were being managed in seclusion rooms with only a mattress, a pillow and a blanket others were accommodated in an intermediate room or in their own bedroom. The design of the wards, however, was not conducive in most cases to nurturing a therapeutic environment; there was always a lot of noise and there was no easily accessible quiet area or low stimulus room where a patient could begin to adapt to ward life. Further, few of the LTS rooms afforded easy access to an outdoor area. At the time of the visit, Ashworth Hospital recognised that the wards were not suitable for managing LTS patients and was considering new designs. The CPT considers that the design of the wards is very important and that every effort needs to be made to provide for discrete accommodation areas for patients placed in LTS with possibilities for association in a secure low stimulus area, easy access to an outdoor garden area and arrangements for enabling good clear communication between the patient and staff.

At the same time, care must be taken not to create numerous special LTS suites as the temptation will be to fill them.

The CPT recommends that due care be taken in the re-design of the wards at Ashworth Hospital to build in a therapeutic environment adapted to the needs of LTS patients.

167. As regards Broadmoor Hospital, patients on LTS were usually accommodated in their own rooms which consisted of a moulded bed attached to the floor, built-in shelving and table unit and an en suite shower and toilet annex. The rooms were spartan. Further, the design of the wards meant that there was a lot of noise and no quiet areas for patients. However, as noted above, many of the wards visited will be closed down once the new Broadmoor Hospital open. **The CPT would like to receive information on the conditions in which LTS patients are being cared for following the opening of the new hospital building.**

168. As regards primary health care, **the CPT would like to receive confirmation that all patients on LTS are reviewed by primary health care and dental care services at intensive frequencies.**

iii. use of special intervention teams and manual restraint

169. The CPT pays particular attention to the use of force by staff to control patients. At both Ashworth and Broadmoor Hospitals, the CPT's delegation was able to observe the manner in which staff intervened to manage non-compliant patients from whom it was necessary to take a blood sample or to whom other health-related interventions had to be performed. It was also able to obtain information from both hospitals on the number of such interventions.

170. At Ashworth Hospital, the Positive Intervention Programme (PIP) team was an auxiliary group of trained nurses whose role was specifically to manage challenging patients on LTS, encouraging them to participate in activities and facilitating their ability to associate outside their rooms and access fresh air. The PIP's team was also responsible for carrying out interventions on the wards to restrain non-compliant patients manually, usually in their rooms. In such cases, a PIP's team would be composed of a Controller, a Scribe and two or three three-person teams depending on the risks presented. The Controller is responsible for heading the team and deciding when and how it should intervene as well as monitoring the vital signs of the patient and engaging with the patient to gain cooperation to end the restraint measure. The Scribe documents the intervention. The PIP's team wear personal protection equipment (PPE) (i.e. protective clothing, helmets and shields) as the hospital considers that if staff are focused on trying to protect themselves from assault they or the patient are more likely to be harmed.

The deployment of the PIP's team emanates from a request from the ward staff to the security manager. However, once permission to deploy the PIP's team is made, it is up to the Controller to assess the situation and decide on the necessary response. To this end, the Controller will attempt to engage with the patient and secure his compliance before any intervention.

In the course of 2015, the PIP's team was deployed 325 times in full PPE in respect of 20 patients; 238 times concerned the forced medication on one patient (although on 228 occasions he was apparently compliant despite threatening resistance).¹¹² In addition, there were 247 crisis interventions by the PIP's team not wearing PPE concerning 31 patients; secondary holds (i.e. the least restrictive holds that staff are taught) were applied 196 times and no holds were applied the remaining interventions. The reason for the vast majority of the interventions concerned the medication compliance. Ward-based staff also used manual restraint in reaction to emergency situations such as when a patient attacked another patient or staff member.

¹¹² Overall, out of the 325 times that the PIP's team deployed in PPE, 274 were for medication (on 30 occasions the patients resisted); 28 times for room damage, dirty protest, barricade and weapons, 10 times room transfer, 6 times for bloods and 6 times for a room search and one escort.

171. In the course of the visit, the CPT's delegation was able to observe the deployment of the PIP's team to restrain a non-compliant patient in seclusion from whom it was necessary to draw blood. The patient concerned was a young very thin man in poor mental and physical health. He had recently arrived from prison where he had spent considerable time in a segregation unit. Attempts to gain compliance from the patient were unsuccessful. Prior to deploying the 9-man PIP's team in full PPE, the Controller attempted a last time to talk with the patient and to gain his compliance to allow blood to be taken without using force. Also present was a junior doctor, a paramedic and three primary care nurses. The PIP's team entered the ward, put on their helmets outside the room and rushed into the room, with the first member of the team carrying a shield and the 9th member of the team remaining in the doorway with a shield to block any possible exit. The patient was rapidly immobilised and placed on his bed in the supine position where he was held while health care staff intervened to take blood and check his BP, and to care for a wound on his head. Subsequently, the patient was placed in a prone position on the bed and the last three members of the PIP's team exited the room backwards at great speed (thumping into the door of the room on the other side of the corridor) and the seclusion room door was slammed shut.

The intervention was executed according to established guidelines in a controlled and safe manner, and staff behaved professionally. A second identical intervention on the same patient took place two hours later to medicate him with three neuroleptics by injection. Nevertheless, the CPT does have some misgivings about these two interventions, notably as regards the overwhelming use of force and the potentially traumatising effect this has on the patient. The CPT has in the past raised serious concerns over the use of seven-man unlock teams in full PPE in prison to manage a single prisoner considering that such a practice may well foster, rather than attenuate, confrontational attitudes on the part of everyone. Ashworth is a hospital not a prison and the No Force First approach should equally aim to apply the minimum force necessary to ensure compliance. In the above-mentioned case, the patient was clearly unwell and an intervention was necessary but he was not a strong man and deploying 11 persons in black overalls and full PPE seemed excessive and scary for the patient.

The CPT recommends that the deployment of the PIP's team in full PPE should only be considered as a last resort, for instance where a patient has a weapon and poses a real threat to the safety of other persons or to himself.

172. At Broadmoor Hospital, interventions requiring the use of manual restraint were either part of the hospital's emergency response strategy in which staff in PPE were deployed or were carried out by ward-based staff trained in utilising a hierarchy of responses to manage risk (planned and unplanned).¹¹³ At the time of the visit, some 70 staff members were trained in PPE interventions. A hospital-wide violence reduction team consisting of seven persons provided advice and support to ward-based staff who carried out all interventions.

In the course of 2015, there were 57 incidents managed by the violence reduction team. In 39 instances staff deployed in PPE, 31 of which related to facilitating the enforced medication of one patient on Cranfield ward.¹¹⁴ On five occasions, no physical force was applied at all. In addition, ward-based staff used manual restraint on patients 290 times in the course of 2015, which involved from two to six staff members restraining a patient.

¹¹³ All staff were trained in Prevention and Management of Violence and Aggression (PMVA) which entailed a five day training course with three-day refresher course every year.

¹¹⁴ The remaining incidents concerned inter alia weapons (x12), dirty protest (x3), video link (x3), self-harm (x2), barricade (x1) and forced medication (x1).

173. The CPT's delegation was able to observe two interventions on Woburn ward. One of them concerned the transfer of a patient from a seclusion room in Woburn ward to Cranfield ward. The patient allowed his arms to be held by two staff members and he walked compliantly to Cranfield ward. The second intervention concerned a patient who had refused to take his medication the day before and who stated that he would not comply in giving a blood sample. A member of the violence reduction team led the pre-briefing of the ward-based staff to ensure that each member understood their role. The team did not know if the patient would be compliant and in the case he was not the plan was to place him prone on the bed. A staff member who had the patient's trust was assigned to communicate and engage the patient and, when the team went to intervene, the communicator was able to get the patient to comply. The patient slid one arm out of the room door and then the other arm, each of which was taken in a hold by a staff member. He was led to the bed and seated while the communicator engaged with him. Additional staff members provided back support to the two staff members holding the patient's arms and a third staff member was behind the patient to control his head movements if necessary. Healthcare staff took the blood and the patient complied in lying prone on the bed while a depot injection was administered. Staff exited the room calmly and there was no door slamming. A debriefing on the intervention took place immediately afterwards.

The interventions observed were carried out professionally. Nevertheless, once it was clear that the patient would comply in having his blood taken, it is questionable whether it was necessary for an additional three staff members to enter the patient's room to provide support to the two staff members holding the patient's arms and to the communicator. The presence of so many staff members seemed disproportionate to the risk posed by the patient. **The CPT wishes to receive the observations of the authorities on this matter and to be informed of whether any issues were raised by the patient in the subsequent debriefing.**

e. safeguards

174. At Ashworth Hospital, there are approximately 30 to 40 admissions and discharges per annum, with 70% of admissions coming from prison and about 50% of discharges to prison with the remainder transferring to medium secure units. Broadmoor Hospital has between 40 and 50 admissions per year and Chase Farm Hospital some 50 admissions to the medium secure units.

All patients admitted were provided with their rights both orally and in writing, in accordance with Section 132 of the MHA, and this was often performed on several occasions as the patients did not always understand their rights. To this end, there was an Independent Mental Health Advocacy service in the hospitals visited whose task was to meet patients, apprise them of their rights and assist them in making complaints.

The maintenance of patients' contacts with their families and friends, through unrestricted visits (which took place in pleasantly furnished visiting rooms in all three hospitals) and telephone calls was promoted.¹¹⁵ Further, at Chase Farm Hospital, many patients were allowed to exit the hospital for periods ranging from 15 minutes to half a day or longer upon permission of their treating psychiatrist (Section 12 leaves).

¹¹⁵ At Ashworth and Broadmoor Hospitals, many patients had been abused as children and had spent much of their lives in institutional care (prison and hospital), and had limited or no contacts with their families.

175. The MHA only requires a patient's consent to treatment in respect of specific interventions such as electro-convulsive therapy and neurosurgery (see Sections 57 and 58). However, such consent is not necessary if any treatment is immediately necessary to save the patient's life, to prevent a serious deterioration of his/her condition or to prevent the patient from behaving violently or being a danger to himself or to others (see Section 62). More generally, the MHA allows patients suffering from a mental disorder to be treated without their consent (Section 63). Good practice and the MHA Code of Practice require that a patient's consent should still be sought before any medication is administered. Further, according to the Code, the administration of medication without consent should comply with Article 8 of the European Convention on Human Rights (i.e. it should be proportionate to the aim of reducing the risk posed by a person's mental disorder and the improvement of their health). The Code also points out that "compulsory treatment is capable of being inhuman treatment" but notes that "the European Court of Human Rights has said that a measure which is convincingly shown to be of medical necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading." For its part, the CPT wishes to emphasise that the fact that a patient has been admitted on an involuntary basis should never be regarded as granting a licence for that patient to be treated against their will. Compulsory treatment should be a measure of very last resort and every instance of its use must be fully documented.

An examination of a sample of records at the hospitals visited showed that the relevant documentation had been filled out to inform and ascertain the consent of a patient to be treated. Likewise, documentation existed where consent was not provided and it was considered necessary to treat the patient without such consent.

Patients treated without their consent during the initial three months of their stay in hospital have no legal recourse to appeal the measure. After three months, if the patient still does not consent to treatment a Second Opinion Appointed Doctor (i.e. an independent doctor who is registered with the CQC) must determine if treatment without consent is appropriate.¹¹⁶ Thereafter, a patient may be treated without consent. In the CPT's view, these safeguards are not sufficiently robust. An external psychiatric opinion should be required in any case where a patient does not agree with the treatment proposed by the establishment's doctors and patients should be provided with the possibility to appeal their forced treatment from the outset of their hospitalisation.¹¹⁷

The CPT recommends that the relevant legislation should be amended so as to require an immediate external psychiatric opinion in any case where a patient does not agree with the treatment proposed by the establishment's doctors; further, patients should be able to appeal against a compulsory treatment decision to the Mental Health Tribunal and the patient should be informed in writing of this right.

176. Part V of the Mental Health Act 1983 regulates the Mental Health Tribunal and the frequency by which patients may apply to the Tribunal to challenge their involuntary placement, whether they are detained under Part II of the Act (civil) or Part III (hospital orders and transfers from prison), including those on restricted orders and subject to Ministry of Justice monitoring.

¹¹⁶ For the year 2014/15, the CQC reported that there were 11,610 SOAD visits in relation to medication and on 3,511 instances the medication plan was changed (i.e. 30%).

¹¹⁷ Reference might also be made to the case *X v Finland* (Application no. 34806/04) of 19 November 2012, in which the European Court of Human Rights found that the decision-making to force medicate a patient (a serious interference with a person's physical integrity) was solely in the hands of the treating doctors with no judicial scrutiny. Therefore the measure could not be considered to be "in accordance with law".

Patients may apply to the Tribunal once within the first six months of their involuntary placement and thereafter once a year. The Tribunal will examine cases ex officio if a patient does not apply to the Tribunal within a period of three years.

Hospital managers are under a duty to inform patients of their right to apply to the Tribunal and of their right to legal representation and to an independent psychiatric opinion and to facilitate the procedure. The CPT's delegation noted that patients were informed of their rights and that many patients made applications to the Tribunal. However, a number of patients did not exercise this right and consequently their cases were only examined by the Tribunal every three years.

The CPT considers that the Mental Health Tribunal should have the possibility to examine ex officio all sectioned patients on a more regular basis as the current three-yearly intervals after the first year are incompatible with modern mental health legislation and practice. All patients should have their involuntary placement reviewed at least once a year.

The CPT recommends that relevant legal provisions be amended and that in the meantime, the Mental Health Tribunal institute a practice of yearly reviews for all patients placed involuntarily in hospital. Further, all patients transferred from either prison or from a less secure hospital should automatically trigger a review by the Mental Health Tribunal of the transfer measure.

E. Immigration detention

1. Preliminary remarks

177. At the time of the 2016 visit, the immigration detention estate in the United Kingdom comprised nine Immigration Removal Centres (IRCs),¹¹⁸ three short-term holding facilities, and a unit for families. Seven of the nine existing IRCs are run by private “service companies”, contracted and overseen by the Home Office (Visas and Immigration).

On 31 March 2016, 2,925 people were in immigration detention, down from 3,485 on the same day a year earlier, for a capacity of some 3,500 places.¹¹⁹ The number of persons entering immigration detention continues to rise each year; in the course of 2015, 32,446 people entered immigration detention (up from 30,364 in 2014), while 33,189 persons left detention (up from 29,674 in the previous year). However, the proportion of persons being removed or departing voluntarily from detention is declining year on year and stood at 45% in 2015,¹²⁰ down from 61% at the time of the 2012 visit.

178. The legal framework regulating administrative detention of foreign nationals remains essentially unchanged since the previous visit in 2012, and is governed by Schedules 2 and 3 of the 1971 Immigration Act (as amended). The decision to detain is a purely administrative one taken by Immigration Officers or Home Office caseworkers. The criteria to detain are set out in the Home Office’s Operational Enforcement Manual. It states that a person may be held in immigration detention to: effect removal where there is a risk of absconding or reason to believe that the person will fail to comply with any conditions attached to the grant of temporary admission or release; when a risk of harm to the public has been identified; or to establish a person’s identity or basis of claim. Undocumented migrants found in the United Kingdom may be detained pending a decision on whether they are to be removed or pending arrangements for their removal.

179. The decision to detain a foreign national is not automatically reviewed by a court or an independent review body. However, a detained person can apply to a judge for review of his or her detention. There is no time limit on the length of detention under the Immigration Act 1971, but active measures must be ongoing to deport an individual for the detention to remain legal and there is a duty on the Home Office to carry out a monthly review. When there is no reasonable likelihood of being able to deport a person, for example, due to the situation in the country of origin, persons should not – or no longer - be detained.

A snapshot of the 6,937 persons who left immigration detention during the first quarter of 2016, revealed that 2,036 were detained for three days or less; 3,708 for less than 2 months; 992 between two and six months; and of the 201 remaining, 44 had been in detention for between one and two years and 8 for two years or longer. At the time of the visit, 287 had been in detention for longer than six months, of whom 87 had been in detention for between one and two years and seven for two years or longer.

¹¹⁸ In the course of 2015, Dover and Haslar IRCs were closed down.

¹¹⁹ At the time of the 2012 visit, 3,091 people were in immigration detention, for a capacity of 3,395 places.

¹²⁰ This represents 15,086 people of whom 70% were enforced removals, 20% were refused entry at port and subsequently removed and 10% left voluntarily.

The CPT remains concerned by the number of persons detained for lengthy periods in IRCs. Indeed, the negative impact that the open-ended nature of detention caused in individuals was again noticeable to its delegation during the 2016 visit. The CPT has noted that a number of inquiries have recently also challenged the lack of time limits and other aspects of immigration detention. The cross-party Parliamentary Inquiry into the Use of Immigration Detention¹²¹ made several recommendations in March 2015 for systemic change, notably: the introduction of a 28 day limit on immigration detention, less use of detention, introduction of non-punitive alternatives to detention and a swift and meaningful judicial oversight of each individual case of detention. The new Chief Inspector of Prisons has also reiterated his predecessor's call for a time limit on immigration detention after finding at Harmondsworth IRC that one man had been detained on separate occasions adding up to a total of five years.¹²²

More recently, at the request of the Home Office, an Independent review of welfare of vulnerable people in detention was carried out by Stephen Shaw and published in January 2016.¹²³ The report makes important recommendations for change in the way in which vulnerable people are treated in detention, calls for a reduction in the use of detention, and proposes a 'strengthening of the legal safeguards against excessive lengths of detention'. In its preliminary response to the report, the Government announced that it accepted the broad thrust of the recommendations proposed, that it intended inter alia to introduce a clear presumption against detention of vulnerable people and that as a result of the reforms and changes to be introduced it expected both to reduce the number of persons detained and the duration of detention before removal. The CPT welcomes the proposed changes; nevertheless, it considers that they should be complemented by the introduction of a defined time limit for detention.

The CPT reiterates its recommendation that the United Kingdom authorities reconsider their policy of indefinite immigration detention. Further, it would like to receive detailed information on the measures taken to address the Shaw Review recommendations.

180. The CPT also wishes to reiterate that prisoners who have completed their sentences and who are subsequently liable to be deported to their country of origin should not be held in prison. At the time of the visit, there were 480 immigration detainees held in prison. **The CPT recommends that foreign nationals, if they are not deported at the end of their sentence, be transferred immediately to a facility which can provide conditions of detention and a regime in line with their new status of immigration detainees.**

181. Persons held in Immigration Removal Centres are subject to the *Detention Centre Rules 2001*, which were complemented by the "*Detention Services Operating Standards manual for Immigration Service Removal Centres*". The Detention Centre Rules set out the rights of detained persons and the purpose of the IRCs as being to provide for the secure but humane accommodation of detainees in a "relaxed" regime, with as much freedom of movement and association as possible consistent with maintaining a safe and secure environment; and to encourage and assist detained persons to make the most productive use of their time, whilst respecting in particular their dignity and the right to individual expression.

¹²¹ *The Report of the Inquiry into the Use of Immigration Detention in the United Kingdom*. A Joint Inquiry by the All Party Parliamentary Group on Refugees & the All Party Parliamentary Group on Migration (2015).

¹²² *Report on an unannounced inspection of Heathrow Immigration Removal Centre Harmondsworth site* by HM Chief Inspector of Prisons 7–18 September 2015.

¹²³ *Review into the Welfare in Detention of Vulnerable Persons*, A report to the Home Office by Stephen Shaw (January 2016).

2. Yarl's Wood Immigration Removal Centre

a. introduction

182. The CPT's delegation visited Yarl's Wood IRC in Bedfordshire for the first time in 2016. Yarl's Wood, opened in 2001, is managed by a private contractor (Serco) and consists of three distinct sections: adult women, adult family groups and a small short-term holding facility (STHF) for adult males who have arrived in the UK as clandestine migrants on freight lorries. The Centre has a capacity of 410 places and held 319 persons at the time of the visit; the 262 single women were accommodated in three residential units, Crane (induction), Avocet and Dove. The family unit (Hummingbird), with a capacity of 58, was holding 38 men and women and the STHF (Bunting) accommodated 19 men for a capacity of 34. The CPT's delegation focused its attention on the adult women's section.

In April 2015, Her Majesty's Inspectorate of Prisons (HMIP) carried out an unannounced visit to Yarl's Wood by some 20 inspectors over the course of a three week period. The report, published in August 2015, did not find evidence of a widespread abusive or hostile culture among staff – although there were some matters of concern – but it did state that “Yarl's Wood is rightly a place of national concern”. In particular, it stated that “Yarl's Wood is failing to meet the needs of the most vulnerable women” and that staff, notably female staff members, are both too few and not trained to meet the needs of the women detainees.

The CPT's delegation noted that significant efforts were being made to address the findings contained in the HMIP report.

183. The CPT's delegation found that relations between staff and detainees in Yarl's Wood seemed to be correct. No allegations of ill-treatment were received and the women met by the delegation stated that staff generally acted appropriately although a few complaints of abusive language by staff were received. Further, nearly all women interviewed stated that they felt safe.

b. conditions of detention

184. The conditions of detention could generally be described as good. The women were accommodated in double-occupancy rooms equipped with two beds, a television, two lockable cupboards (with a mini-safe inside each one) and a table and chair. Access to natural light was good and artificial lighting and ventilation adequate. Each room had a fully partitioned sanitary annexe comprising a toilet, sink and shower. The rooms were in a good state of repair. All women were provided with keys to lock their rooms. There were also five rooms adapted to accommodate women with physical disabilities. Each wing contained a laundry room.

185. The management of the IRC explained that the whole security approach had been revised in the light of HMIP recommendations and that certain carceral elements such as the existence of razor wire outside, controlling the women's movements and monthly room searches had all ended. Women were able to move freely throughout the centre from one accommodation unit to another, and to access the pleasant outdoor exercise yards throughout the day. Along the corridors (the Avenue), information was provided in up to 10 of the most common languages providing advice on various services that could be accessed. Further, all women were provided with a pin code and could access several terminals to book appointments, order food, sign up for activities and manage their finances.

There was a variety of activities on offer to detainees, such as English and IT-courses, Gardening and Arts & Crafts classes; the IT room contained 21 terminals, all with internet access, and was open from 9 a.m. to 9 p.m. Detained persons could access games (such as table tennis, and board games), a gym, a multi-purpose sports hall and a "cultural kitchen". The centre also has a post room, a hair salon, a multi-lingual library, a cinema, different places of worship (a chapel, a mosque, a Sikh and Hindu religious room and a multi-faith room) and a kiosk-type shop and a clothes market. In sum, the activities available were very good for short periods of stay. However, there should be a broader range of purposeful activities (vocational and work) for persons staying for more than a few months; **the CPT invites the United Kingdom authorities to develop such activities for the detainees concerned.**

186. Each unit had its own dining room area and the women were expected to eat in their respective units. The delegation received many complaints about the food and was informed that the budget allocated for food items had been reduced in December 2015 and the supplier had changed. Menus should be sufficiently diverse and contain the requisite daily requirement of proteins and vitamins, and should include fresh fruit every day. **The CPT wishes to be informed about the weekly menus on offer.**

c. induction and removal from association

187. All new arrivals at Yarl's Wood immediately undergo the admission procedure which contractually had to be completed within three hours. Women arriving would be searched, offered a drink and sandwich, and placed in one of several suitably furnished waiting lounges where they would be shown a 15 minute induction video and provided with an information leaflet (both of which existed in a range of languages). Their property and personal documents would be checked and they were all offered the possibility of a shower and a five minute phone call. All new arrivals are seen by a nurse and provided with a basic hygiene pack and, if required, an emergency clothing pack.

All women spend up to three nights on Crane induction ward before being allocated a room on one of the two main accommodation units. During their time on Crane unit, various induction programmes were organised to familiarise themselves with the rules and functioning of the IRC. The one led by a detainee "greeter" was considered particularly helpful.

188. In general, the induction process functioned well. However, the delegation came across two women whose language skills had not been properly assessed upon admission and they had been misidentified as having some knowledge of English and, in one case, of speaking French. In fact, the women spoke no English nor any French nor any other common language. As a result these women were completely lost and had no clue about the functioning of the centre or how to seek assistance; in addition, one of the women was using a wheelchair to get about. It is absolutely essential that the needs of women, notably their language abilities, be accurately identified upon admission and that once women with no common language skills are identified that they be afforded with greater support to ensure that they can function in the centre and do not become isolated.

The CPT recommends that the management of Yarl's Wood ensure that the induction process properly identifies the language skills of women entering the Centre and that appropriate additional support is afforded to those women having no common language.

189. Further, the delegation received a number of complaints about the fact that many women had arrived at Yarl's Wood between the hours of 11 p.m. and 6 a.m., and that some of these women recalled the induction process as a blur. An examination of the records of recent arrivals showed that the night prior to the delegation's visit six women had arrived at 1.15 a.m. and that their admission procedures were only completed between 3.30 and 4.15 a.m. Another woman only arrived at the centre at 4.20 a.m. from a police station.

The CPT considers that that every effort should be made to avoid detainees travelling at night and arriving at Yarl's Wood between the hours of 11 p.m. and 7 a.m. as the women are often disoriented upon arrival and it is not possible to carry out the induction process effectively.

The CPT recommends that the United Kingdom authorities review the procedures regulating the transfer of women immigration detainees to avoid them travelling at night and arriving at Yarl's Wood between the hours of 11 p.m. and 7 a.m.

190. According to Rule 40 of the *Detention Centre Rules*, a detained person may be removed from association (i.e. separated from other detainees) in the interests of security or safety. In such cases, the removal cannot last longer than 24 hours without the Secretary of State's authorisation and such authorisation cannot be for longer than 14 days. The detained person should be provided with written reasons within two hours of that removal. Further, Rule 42 provides for the possibility of temporary confinement of refractory or violent detainees for up to three days, with an authorisation of the Secretary of State also being necessary after the first 24 hours. Under both Rules, the Centre's manager, a medical practitioner and an officer of the Secretary of State should visit the person at least once a day, and the delegation noted that this requirement was observed in practice.

The information gathered during the visit, including from relevant registers, indicated that removal from association and temporary confinement were applied sparingly and rarely for more than 24 hours. As for the conditions in the cells of the segregation unit (known as Kingfisher), they were totally unsuitable for placing women who were at risk of self-harming or suicide as the cells in the Kingfisher unit contained many ligature points (window latches and door handles). Further, the toilets in the cells were not partitioned **The CPT recommends that at least two of the cells in Kingfisher be made ligature-free and a partition be installed to screen the toilets from external observation.**

d. health care

191. Medical services were contracted to G4S by NHS England. Three general practitioners assured a daily, seven days a week, service and one of them provided an out-of-hours service. They were supported by nine nurses (of whom the equivalent of three were mental health nurses) and three health care assistants. Three further nursing posts were vacant at the time of the delegation's visit. There were also two pharmacy technicians, a mental health support service and a clinical lead for the health care service. Once the vacant posts are filled, such staffing levels as regards general practitioners and nurses could be considered as sufficient for a detainee population of up to 400 persons. **The CPT wishes to receive confirmation that the vacant posts have been filled.**

192. The IRC was visited by a psychiatrist every Thursday, a sexual health team every Monday and a dentist once a week. Given the number and the high turnover of detainees, as well as the particular psychological profile of many detainees, there is a need to increase the presence of the psychiatrist. At the time of the visit, there was a lack of psychological input and counselling services. The CPT was subsequently informed by Serco that a service to improve general psychological well-being and resilience would be introduced at Yarl's Wood. Given the very transient nature of the population at the centre, emphasis would be given to interventions that can be delivered that do not depend on completing a formal course of an intervention over a period of weeks. **The CPT welcomes this approach and would like to be informed about the operation of the programme since its introduction in May 2016. Further, the CPT recommends that the presence of the psychiatrist be increased.**

193. The medical facilities were adequate and in a good condition. Medical confidentiality was well respected and files were kept in good order. However, the delegation noted that the health-care service used the prison System 1 template for the first reception screening which is designed for prison and refers to all women as prisoners. **The CPT recommends that the health care documentation should be revised accordingly for the specific needs of immigration detainees and any reference to prisoners removed.**

194. Upon arrival, all new detainees undergo a medical screening by a nurse, which includes general questions about medication, drug use, allergies, physical injuries, incidents of self-harm, chronic diseases and mental health problems. A risk assessment form for the first night is also filled out. The nurse will refer women to a general practitioner or to the mental health team or a midwife as necessary and all women may request a second screening within five days.

For specialised medical expertise and treatment, or in case of emergencies, detained persons were escorted to the nearby Bedford general hospital. Arrangements also existed for the transfer of women requiring in-patient psychiatric treatment to Brockfield House in Essex, a facility operated by South East Partnership NHS Trust (SEPT), which had the sub-contract to provide mental health services at Yarl's Wood. However, there were often delays in accessing beds as the women had to be placed on a secure forensic psychiatric ward under Section 48 of the MHA (which regulates transfers of prisoners to psychiatric hospitals) even when there was no requirement for such a secure placement. In addition to such placements being more expensive than adult in-patients psychiatric units, they are inappropriate from a treatment perspective.

The CPT recommends that steps be taken to ensure that transfers to psychiatric hospital are carried out without delay and that the United Kingdom authorities review the necessity of systematically placing women from Yarl's Wood, who do not have the status of prisoners, on secure forensic psychiatric wards.

Further, it would like to receive a copy of the report commissioned by the Home Office for the Centre for Mental Health to conduct a mental health needs assessment in IRCs.

195. Under Rule 35.3 of the 2001 Detention Centre Rules, the Home Office or its contractors have to ensure that the medical practitioner reports on any detained person who may have been the victim of torture. Persons who claim to have been tortured should not be held in immigration detention and, based on the independent evidence of torture from a general practitioner, should be released unless there are very exceptional circumstances to justify detention. In spite of this, repeated deficiencies in the system have led to the continued detention of torture survivors and the operation of Rule 35 has been much criticised. Most recently, *the Review into the welfare in detention of vulnerable people* (2016) by Stephen Shaw looked at the operation of Rule 35 and also demonstrated the failings in the system designed to protect this group of persons; the Review calls for the replacement of the current policy in order to ensure that torture survivors are not detained.¹²⁴ The Shaw Review highlighted several systemic weaknesses including, *inter alia*, that doctors almost systematically did not include in Rule 35 reports any opinion as to whether there was a causal link between the diagnosis and the detained person's allegation or torture or ill-treatment, and that case workers had a tendency to reject hundreds of asylum claims without a thorough assessment into every individual's circumstances. The findings of the CPT's delegation at Yarl's Wood show that steps are being taken to address these deficiencies, and an apparent increase in the rate of releases on the basis of a Rule 35.3 report since the publication of the Shaw report was noted. **The CPT wishes to be informed in more detail of the steps being taken to address the conclusions made on Rule 35 in the Shaw report.**

196. In the course of the visit to Yarl's Wood, the CPT's delegation noted that all detainees were asked upon admission whether they may have been tortured and whether they wanted to be examined by a GP. The general practitioners at Yarl's Wood received some training on how to carry out Rule 35.3 interviews and how to document any scars with a view to forming an opinion as to whether a woman may or may not have been tortured. However, there was still some confusion about what constituted torture, notably as regards the question of rape. In this regard, the CPT wishes to emphasise that in international law an act of rape *per se* may amount to torture. Further, the nurses who initiated the questions about torture had received no training and no thought had been given as to whether it was appropriate for a male nurse to initiate a discussion about torture with a female detainee at the moment of admission to the Centre.¹²⁵

The CPT recommends that all nurses be provided with training on interviewing torture victims and that general practitioners should receive refresher training on a regular basis.

¹²⁴ Opcit 124, pp. 100-107.

¹²⁵ The perpetrators of torture on women are almost invariably men and in many cases male members of the extended families from which the women come.

e. other issues

197. Staffing levels seemed adequate, with 33 detention custody officers (DCOs) on duty during the day (9 a.m. to 9 p.m.) and 12 at night and an overall complement of 163 staff.¹²⁶ The delegation noted that the staff was ethnically diverse and there was a reasonable gender balance. However, given the vulnerabilities of the detainee population increasing the number of female DCOs should be promoted. Further, in discussions with staff it emerged that there is a need for further training on inter-personal skills and the delegation received many comments that the DCOs did not understand the backgrounds and needs of the women detainees.

The CPT recommends that training on inter-personal skills be provided on an ongoing basis, in particular as regards interacting with potentially vulnerable detainees. It would also like to be informed about the ongoing recruitment of custody officers and the gender breakdown.

198. Contacts with the outside world were generally good. Visits could be booked every day of the week and took place in a large suitably furnished and decorated room and included a children's play area. Detainees were provided with a mobile phone by Serco upon admission to the Centre and their private mobile phones and Sim cards were placed in storage. Access to internet and email via the computers was available in the centre.

199. The complaints system remains essentially the same as that described in the past.¹²⁷ However, few women met by the delegation expected much from the complaints system as for most of them the fundamental issue was their uncertain future about which they felt helpless.

¹²⁶ Of whom, 9 operational managers and 99 DCOs, and six DCOs assigned to administrative functions.

¹²⁷ See the report on the 2012 visit to the United Kingdom - CPT/Inf (2014) 11, paragraph 136.

3. Induction unit at Colnbrook Immigration Removal Centre

200. In the course of the 2016 visit, the CPT's delegation undertook a targeted visit to the Induction unit at Colnbrook Immigration Removal Centre, where detainees can now spend much longer than seven days, to see whether the poor conditions of detention observed in 2012 had improved.

The unit consisted of 50 double-occupancy rooms on three floors and was accommodating 77 men at the time of the visit. The rooms were adequately equipped, including with a call bell. However, the rooms were far too small (6m²) to accommodate two persons and many of the rooms were dilapidated and dirty. Once again, the delegation observed broken pipes, with water dripping into the rooms below, and water from the showers leaking onto the floors of the rooms. Complaints were also received about the lack of hot water and infestations of vermin.

The delegation noted that detainees were unlocked from their rooms from 8 a.m. until 9 p.m. and that during this time they could access the outdoor exercise yard freely. However, there were few activities for the detainees (a TV room and four computers with restricted access to internet and some sports equipment in the yard) and the common areas were in a poor state of repair.

The management of the centre acknowledged the poor state of the material conditions and referred to a refurbishment project which was scheduled to start in June 2016. Part of the project was intended to convert the rooms into single occupancy. The CPT has noted positively this information. However, in light of the fact that it received written assurances in February 2013 that the problems with the leaking pipes had been resolved and would not re-occur in the future, **the Committee would like to receive detailed information on the measures taken to improve the material conditions of the Induction unit and the range of activities offered to detainees.**

201. The delegation received a lot of complaints about the quantity of food at both breakfast and lunch. **The CPT trusts that this matter has been adequately addressed in the meantime and would like to receive details about the menus (including quantities) offered provided to detainees.**

202. As regards the female Sahara unit (capacity 27) where women could be held for seven days, there was no access to any outdoor exercise. Such a situation is not acceptable. **The CPT recommends that immediate steps be taken to offer all women daily access to outdoor fresh air for several hours a day.**

APPENDIX

**LIST OF THE NATIONAL AUTHORITIES
AND NON-GOVERNMENTAL ORGANISATIONS
WITH WHICH THE DELEGATION HELD CONSULTATIONS**

A. National authorities

Home Office

Nick EPHGRAVE	Temporary Chief Constable, Surrey Police
Simon ROSE	Superintendent, Metropolitan Police Service
Philippa ROUSE	Director of Immigration Policy
Clare CHECKSFIELD	Director, Returns, Immigration Enforcement

Ministry of Justice

Andrew SELOUS	Parliamentary Under-Secretary of State for Prisons, Probation, Rehabilitation
Digby GRIFFITH	National Offender Management Service (NOMS) Director of National Operational Services
Paul BAKER	Deputy Director of Custody for London, NOMS
Nick PASCOE	Deputy Director for Youth Estate, NOMS
Paul KEMPSTER	Deputy Director for contracted prisons, NOMS
Graham WILKINSON	Head of Foreign National Offender Policy, NOMS
Eila DAVIES	Head of Women and Equalities, NOMS
Alison STRADLING	Head of UN Human Rights Conventions, Security and Gender Recognition Team, Human Rights and Security Police Team and CPT Liaison Officer
Josie DELVES	Policy Adviser, Human Rights and Security Police Team and CPT Liaison Officer

Department of Health

Huw STONE	Clinical Adviser to the National Oversight Group on High Secure Hospitals and a Forensic Psychiatrist at Surrey and Borders Partnership Trust
Anne MCDONALD	Deputy Director, Armed Forces and Offender Health and Mental Health Legislation

Other authorities

Peter CLARKE	Chief Inspector of Prisons, England and Wales
Martin LOMAS	Deputy Chief Inspector of Prisons, England and Wales
Nigel NEWCOMEN	Prisons and Probation Ombudsman, England and Wales
Victoria BLEAZARD	Head of Mental Health Policy, Care Quality Commission (CQC)
Mat KINTON	National Mental Health Act Policy Advisor, CQC
Anna HENRY	Director Children's Rights, the Children's Commissioner

B. Non-governmental and other organisations

The Howard League for Penal Reform

Prison Reform Trust

The Children's Rights Alliance for England

INQUEST

The British Medical Association

The Royal College of General Practitioners

The Royal College of Psychiatrists

Association of Visitors to Immigration Detainees

Medical Justice

Campaign to Close Campsfield and Barbed Wire Britain

Detention Action

Citizens Commission on Human Rights