

COUNCIL OF EUROPE



CONSEIL DE L'EUROPE

CPT/Inf (2016) 25

Report

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

from 3 to 10 September 2015

The Maltese Government has requested the publication of this report and of its response. The Government's response is set out in document CPT/Inf (2016) 26.

Strasbourg, 25 October 2016

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Copy of the letter transmitting the CPT's report

Mr Joseph St. John
Director General
Development and Policy Implementation Directorate
Ministry for Home Affairs and National Security
201 Strait Street, Valletta
Malta

Strasbourg, 24 March 2016

Dear Mr St. John,

In pursuance of Article 10, paragraph 1, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, I have the honour to enclose herewith the report drawn up by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) following its visit to Malta from 3 to 10 September 2015. The report was adopted by the CPT at its 89th meeting, held from 7 to 11 March 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 Maltese authorities to provide within 6 months a response giving a full account of action taken to implement them. However, in respect of paragraph 116, the Committee would like to receive a response within 1 month.

The CPT trusts that it will also be possible for the Maltese authorities to provide, in the above-mentioned response, reactions to the comments and requests for information formulated in this report.

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 2015 periodic visit to Malta was the Committee's eighth visit to the country. The CPT's delegation examined the treatment and conditions of detention afforded to persons held in various places of deprivation of liberty across Malta. The co-operation received from both the Maltese authorities and the staff at the establishments visited was generally very good.

Law enforcement agencies

The CPT's delegation found that, generally, the police treated arrested and detained persons correctly, and it received no allegations of ill-treatment. Nevertheless, there is a need to ensure that safeguards against ill-treatment operate effectively. To this end, the authorities should ensure that all persons detained by the police can effectively benefit from access to a lawyer throughout their police custody. Further, steps must be taken to improve the record-keeping in police stations, and district police stations should ensure that persons who need to be held longer than six hours in custody are transferred promptly to the Floriana Lock-Up. It is also important that persons in police custody are kept safe, which entails introducing a thorough risk-assessment of each detained person and a robust suicide prevention approach.

Although material conditions in police detention areas were generally adequate, a number of deficiencies were found including lack of access to potable water, no in-cell call bells, poor ventilation and lighting. The cells at Gozo Lock-Up were also found to be too small for overnight stays. Further, persons detained longer than 24 hours in police custody should be offered access to outdoor exercise. A system of independent monitoring of police detention facilities should be established.

Immigration detention

The CPT notes positively that very few persons were held in immigration detention at the time of the visit. The reduction in the numbers of persons detained should make it easier to ensure that those who are detained are held in decent conditions. To this end, the current approach towards immigration detention should be reviewed. More specifically, the living conditions at Safi Barracks should be improved and more activities offered to those persons detained longer than a few days. The role and scope of duties of detention officers should also be developed, and the authorities must ensure that detained persons are addressed by their name and not by a number. The CPT is again critical of the fact that no proper medical screening is carried out on every newly arrived detainee. As concerns the airport holding area, it is important that the log book be diligently completed and that persons are not held for periods in excess of 24 hours. As regards Dar il-Liedna open centre for young persons, the main concern of the CPT relates to the apparent frequent fighting among residents.

Corradino Correctional Facility (CCF)

At CCF, the delegation observed generally good relations between staff and inmates and hardly any allegations of ill-treatment by prison staff towards prisoners were received. At the time of the visit, there were three male to female transgender inmates and one intersex inmate, who were all accommodated within the male divisions of the prison. After reviewing their situation, the CPT considers that transgender persons should either be accommodated in the prison section of the respective gender with which they self-identify or, if exceptionally necessary for security or other reasons, in a separate section of the prison. The prison authorities are also reminded that whenever there are suspicions or allegations of inter-prisoner violence or bullying, any injuries are properly recorded and a thorough investigation carried out.

As regards material conditions, the CPT noted that some renovations had been undertaken and that two of the previously most problematic Divisions had been closed. This is positive. However, the remaining Divisions provided generally poor living conditions for the inmates. For example, in Divisions II, III and XIII the cells were hot and dirty, lacked ventilation, possessed unscreened and poorly-functioning toilets and inmates had no direct access to drinking water. Steps should be taken to remedy these and other deficiencies identified by the Committee.

The CPT welcomes the fact that more than 80% of the prison population were offered access to some kind of work and education. However, the restrictive regime on Divisions V and XIII, where the particularly problematic inmates were placed, needs to evolve and a full range of activities offered. Moreover, the placement procedure and safeguards surrounding placement on these divisions were opaque. The situation of life-sentenced prisoners was also poor in terms of lack of access to activities, no sentence plan and no access to parole. The CPT reiterates that the policy towards life-sentenced prisoners must be re-considered, notably to afford life-sentenced prisoners the possibility to apply for conditional release.

As regards discipline, the CPT considers that loss of remission should fall under the competence of an independent judge and that the law should be changed accordingly. Steps must also be taken to reduce the long delays between an alleged incident and the imposition of any disciplinary sanction, and the practice of accumulating disciplinary offences should cease. Further, the complaints' procedure was almost non-existent and the CPT recommends that a formal system of internal complaints be introduced. In addition, the external monitoring of the prison by the Prison Board remained rudimentary.

In respect of healthcare, there continued to be insufficient co-ordination of healthcare services, no strategy for those at risk of self-harm and the administration of psychotropic medication was unsafe. The CPT recommends, *inter alia*, that medical confidentiality be strictly guaranteed and that prison officers do not have access to medical records, the co-ordination of health-care by prison officers at CCF be reviewed and a comprehensive suicide prevention and management approach be introduced.

As regards the separate Young Offenders Unit of Rehabilitations Services (YOURS), the atmosphere was generally good although there were a few incidents of inter-prisoner violence. However, the young persons were not provided with a full programme of purposeful out-of-cell activities; indeed, there was no specifically tailored regime for juveniles, nor were there any programmes to help juveniles and young offenders prepare for reintegration into society. Also, staff were not specifically trained to work and engage with young persons. Action should be taken to address these shortcomings.

The CPT's delegation found that the male and female Forensic Psychiatric Units at Mount Carmel Hospital were not being properly managed, which impacted negatively on the care provided to patients. The CPT recommends that a complete review of the purpose and functioning of the forensic units be undertaken, that the Ministry of Health be tasked with the oversight of the forensic units and that the units should be brought under the management of Mount Carmel Hospital. Moreover, investment is required in the recruitment and training of qualified nursing staff to perform all the duties required of a forensic psychiatric service — only one nurse had a specialisation in psychiatry while the other healthcare staff members were all agency staff. The atmosphere and regime were extremely carceral and un-therapeutic and the material conditions for the patients were poor and there were no individualised care plans. On the male Unit, the use of means of restraint was being applied by prison officers instead of healthcare staff and the recording

of such measures was inadequate. The application of any means of restraint should only be carried out by adequately trained health-care staff and resort should never be had to the Special Response Team from the prison, and a systematic recording system should be put in place.

The CPT raises particular concerns in respect of the care afforded to two patients on the male Unit, Patients D and E. With regard to Patient D, the CPT considers that there is no good reason why a prisoner who does not have mental health needs should be required to be held in a psychiatric forensic unit, even more so when the unit is unable to cater to his somatic needs. As for Patient E, the CPT considers that nursing staff should be physically present in his room to ensure the safety of this patient until he is no longer deemed to be at risk.

Mount Carmel Psychiatric Hospital and Gozo General Hospital

Mount Carmel Psychiatric Hospital continues to serve both as a mental health facility treating patients with acute and chronic mental health disorders and a social care home for those in need of assisted care. The development of appropriate structures for care in the community should be pursued. At the hospital, the CPT's delegation observed relaxed staff-patient relations and a generally caring approach by staff. Inter-patient violence did not appear to be a problem although on Female Ward I some allegations of patients pushing slapping and pulling hair were received.

The living conditions in most of the wards were generally acceptable. Nevertheless, the CPT makes a number of recommendations inter alia to render the dormitories less austere and reduce the occupancy levels therein, and to improve access to the outdoors. The CPT is particularly critical of the Maximum Secure Unit, both as regards the material conditions and the treatment, and recommends that the unit be relocated to a place where a therapeutic living environment can be provided. More generally, the CPT considers that every patient should not only have a written individual treatment plan but be consulted in its development. Further, the range of rehabilitative and therapeutic activities on offer should be widened. As regards the application of electroconvulsive treatment, the CPT recommends that it is always performed with electroencephalogram monitoring, which was not the case at the time of the visit.

Staffing resources at the hospital were generally adequate although a few wards needed reinforcing. However, the CPT considers that patients on the Maximum Secure Ward would benefit if the nursing staff were all psychiatrically trained and directly employed by the hospital and not agency staff. As regards means of physical restraint and seclusion, there was no excessive use of the measures and the recording was generally carried out properly. Nevertheless, staff were not always aware of the written seclusion policy and patients were not debriefed once their placement in seclusion was terminated. Also, the time-out room in the Young Persons' Unit should not be used in excess of 20 minutes.

The CPT welcomes the approach taken by the 2012 Mental Health Act in placing mental health users at the forefront of the law and the establishment of an independent Commissioner for Mental Health and Older Persons. The procedures for involuntary admission and on-going placement of a patient in a psychiatric facility provide clearly for an independent authority, the Commissioner, to verify that the involuntary placement is warranted. To further enhance the safeguards in place, the possibility of legal aid should be provided for patients who wish to challenge their involuntary placement before a court. All patients should also receive an information booklet on the establishment. The CPT was concerned about the practice of placing children exhibiting challenging behaviour too readily in a closed psychiatric facility and recommends that more robust procedures be put in place to prevent such placements. Further, children should not be placed on adult wards as was the case up until July 2015 in respect of a girl who was placed on Female Ward 1.

Social Care Homes

The CPT's delegation formed the opinion that staff at the three establishments visited took great care of and interest in the well-being of the residents. The living conditions in all the homes were satisfactory, including as regards access to activities. In respect of health care, the CPT considers that all children in care homes should benefit from an appropriate interview and medical examination as soon as possible following their admission and that a programme of preventive care be established as this was not case at the time of the visit.

The CPT's delegation met a number of girls who had been placed in Mount Carmel Psychiatric Hospital on one or more occasions and found an apparent over-eager reflex to transfer a girl exhibiting challenging behaviour to Mount Carmel for in-patient psychiatric care. The CPT considers that the placement of many children at this hospital over the past few years did not appear to have been justified and vigilance needs to be exercised in this area. Staff in children's welfare homes should be provided with on-going training on how to manage juveniles exhibiting challenging behaviour.

More generally, the CPT recommends that all welfare homes should be visited by an independent body on a regular basis and that information on the role of the Commissioner for Children be made available to residents in all homes.

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 Malta from 3 to 10 September 2015.

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

- James McMANUS, Head of delegation,
- Andreana ESPOSITO,
- Costakis PARASKEVA,
- Ivona TODOROVSKA,
- Olivera VULIĆ.

They were supported by Hugh CHETWYND, Head of division and Francesca GORDON of the CPT's Secretariat, and assisted by Alan MITCHELL, former Head of the Scottish Prison Health Care Service, United Kingdom (expert).

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

Ministry of Home Affairs and National Security establishments

- Corradino Correctional Facility, including the Young Offenders Unit and the Forensic Psychiatric Units at Mount Carmel Hospital
- General Police Headquarters and Lock-up, Floriana
- Valletta Lock-up below the Courts of Justice, Victoria Lock-up (Gozo)
- Mosta, Mdina, Rabat, St Julian's, Sliema, Valletta and Victoria (Gozo) Police Stations
- Malta International Airport Detention area
- Safi Barracks Detention Centre for Immigrants
- Dar il-Liedna Open Centre for Young Persons

Ministry for Energy and Health (psychiatric care) establishments

- Mount Carmel Hospital
- Gozo General Hospital

Ministry for Family and Social Solidarity establishments

- Fejda and Jeanne Antide Homes for Girls
- St Joseph's Home for Boys
- Santa Maria project for drug and alcohol rehabilitation

B. Context of the visit and establishments visited

4. The visit was conducted within the framework of the CPT's programme of periodic visits for 2015 and was the Committee's 8th visit to Malta. This visit provided an opportunity to assess the conditions of detention and treatment of persons held in prison (Corradino Correctional Facility and the Youth Offenders Unit) and in immigration detention establishments and to assess the safeguards in place for persons deprived of their liberty by the police. The delegation also examined the situation of civil involuntary and forensic patients at Mount Carmel Psychiatric Hospital and Gozo General Hospital. Further, the delegation visited three social care homes for young persons, namely, Fejda and Jeanne Antide Homes for Girls and St Joseph's Home for Boys and the Santa Maria project for drug and alcohol rehabilitation. The list of establishments visited is contained in paragraph 3.

C. Consultations held by the delegation and co-operation encountered

5. In the course of the visit, the CPT's delegation met the Minister for Home Affairs and National Security, Hon. Carmelo Abela, the Parliamentary Secretary for Health, Hon. Chris Fearne and the Permanent Secretary for Family and Social Solidarity, Mark Musu', as well as other senior officials from these ministries including the Commissioner of Police, the Chief Executive Officer of the Prison Service and the Head of the Detention Service. The delegation also met the Attorney General of Malta, Peter Grech.

Further, the CPT's delegation met the now former Commissioner for Children, Helen D'Amato, the Commissioner for Refugees, Mario Friggieri and the Commissioner for Mental Health, John Cachia. Meetings were also held with the Boards of Visitors of the Prisons and for Detained Persons and the Office of the United Nations High Commissioner for Refugees (UNHCR) in Malta, as well as international and non-governmental organisations active in areas of concern to the CPT.

A list of the national authorities and organisations met by the delegation is set out in the Appendix to this report.

6. The co-operation received by the delegation throughout the visit was generally very good. It had rapid access to the establishments it wished to visit, to the documentation it wanted to consult and to individuals with whom it wished to talk. Indeed, senior staff encountered during the visit seemed genuinely to welcome the CPT's visit and readily shared their concerns with members of the delegation.

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

7. On 10 September 2015, the CPT's delegation met representatives of the Maltese authorities to inform them of the delegation's preliminary observations. On that occasion, the delegation made an immediate observation under Article 8, paragraph 5, of the Convention and requested that immediate action be taken to improve the quality of care afforded to three patients at the Forensic Psychiatric Unit of Mount Carmel Hospital.

In particular, the delegation requested that Patients C and D be moved out of the Forensic Psychiatric Unit to a more caring environment which could better meet their somatic needs, such as the male psycho-geriatric ward at Mount Carmel Hospital. It also requested that Patient E be transferred to a room where this patient could be under the constant supervision and care of nursing staff.

8. These requests were confirmed in a letter dated 17 September 2015. The Maltese authorities responded and provided certain information on the action taken in respect of the above patients, by letter dated 21 October 2015. The information provided in the response has been taken into account in the drafting of this report. The CPT has, however, outlined its continued concerns and has requested that certain further action be taken in respect of two of the above patients, by letter dated 2 November 2015. A response, by letter dated 15 December 2015, was received from the Maltese authorities regarding subsequent action taken in respect of one of the two above patients.

9. As regards the above-mentioned general preliminary observations made by the CPT's delegation, the Maltese authorities responded, by letter dated 4 November 2015, providing certain further pieces of information. The information provided in the response has been taken into account in the drafting of this report.

E. National Preventive Mechanism

10. Malta ratified the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) on 29 September 2003. The Board of Visitors for Detained Persons and the Board of Visitors for Prison (the Prison Board) were officially designated as the National Preventive Mechanism (NPM) in 2007, with the relevant amendments made to the Maltese legal framework.¹

11. Since the very outset of its activities, the CPT has been recommending the establishment of independent monitoring mechanisms at national level for *all types of places of deprivation of liberty*. If adequately resourced and truly independent, they can make a significant contribution to the prevention of ill-treatment of persons deprived of their liberty. The CPT considers that care should be taken to ensure that all elements of the NPM's structure and all the personnel concerned comply with the requirements laid down by the Optional Protocol to the United Nations Convention against Torture (OPCAT) and the Guidelines established by the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT).

¹ Legal Notices 265 and 341, which amended the Prisons Act (Chapter 260 of the Laws of Malta) and Legal Notice 266, which established the Board of Visitors for Detained Persons Regulations, pursuant to Article 36 of the Immigration Act (Chapter 217 of the Laws of Malta).

12. The Prison Board and Board of Visitors for Detained Persons undertake visits to the prison and immigration detention establishments and receive, and can address, various prisoner and detainee complaints. That said, the CPT's delegation has some concerns relating to the powers of the Boards. The delegation was informed by the Prison Board that it was constrained by its own legal mandate and could not publish its reports, and instead only reported directly to the Minister for Home Affairs and prison authorities, where relevant. This Board also stated that it did not possess powers to refer complaints of ill-treatment to relevant external bodies, nor did it have access to any Magisterial Inquiry Reports concerning prisoner issues. Further, the delegation gained the distinct impression that monitoring of the prison remained rudimentary (for example, the delegation came across letters addressed to the Prison Board, which were found to have been left unopened for many months). Inmates interviewed by the delegation alleged that they had never seen Board members inside prisoner accommodation areas and that they rarely received responses to external complaints made. In short, many inmates at CCF had little faith in the current complaints' and monitoring system (see also paragraph 95).

In addition, pursuant to their distinct and separate mandates,² the two Boards could only monitor specific places of detention; the Prison Board could only monitor prison establishments, while the Board for Detained Persons could only monitor places of immigration detention (including immigration detainees held in Mount Carmel Hospital and the three Police Lock-Ups). While the monitoring of all persons held in psychiatric facilities is carried out by the Mental Health Commissioner, this body does not form part of the Maltese NPM. Further, at present there is currently no regular independent monitoring being undertaken of Malta's police facilities or of its social care homes.

The CPT recommends that the Maltese authorities, as a matter of priority, establish the legal mandate for relevant independent bodies to adequately access and monitor all the different types of places of deprivation of liberty in Malta.

It further recommends that the authorities ensure that the NPM has the necessary powers for its proper functioning; including the appropriate resources, access to all relevant documentation concerning ill-treatment allegations and the power to refer complaints of ill-treatment to relevant external bodies. The CPT also recommends that efforts should be made by the authorities to ensure that the members of the NPM are equipped with a range of appropriate skills. Further, it recommends that the authorities publish the NPM's Annual Reports.

More generally, the NPM should be endowed with the relevant functions to allow it properly to fulfil the requirements laid down by OPCAT and the Guidelines established by the SPT.³

² Subsidiary Legislation 217.08 Board of Visitors For Detained Persons Regulations, 18th September, 2007, Legal Notice 266 of 2007 and Subsidiary Legislation 260.03 Prisons Regulations 1st October, 1995 (as amended, 2015).

³ Cf. SPT Guidelines on National Preventive Mechanisms, CAT/OP/12/5 and the Report on the Visit made by the SPT for the purpose of providing assistance to the NPM of Malta, 6 to 9 October 2014, CAT/OP/MLT/1, published 27 January 2016.

II. FACTS FOUND AND ACTION PROPOSED

A. Law enforcement agencies

1. Legal framework

13. Law enforcement services are provided by the Malta National Police, the Local (Wardens) Enforcement System and the Permanent Commission against Corruption. The relevant provisions governing arrest and detention of persons by the Malta Police Force are set out in Malta's Criminal Code, the Police Act and Police Code.

The Maltese Criminal Code establishes the permissible lengths of police detention and the safeguards that should be afforded to detained persons. Pursuant to Article 355AE, an arrested person shall be taken to a designated police station as soon as is practicable, and in no case later than six hours from the time of the arrest. Article 355AJ specifies that a magistrate shall be informed about an arrest carried out by the police within six hours of the moment of the arrest; otherwise, the person concerned shall be released. Persons deprived of their liberty by the police shall be brought before a court within 48 hours of the moment of the arrest, or otherwise released.

14. Police custody officers are responsible for the health and safety of detained persons and should carry out reviews, together with the relevant investigating officers, of the justification for the continued detention of a person. The first such review shall take place after 12 hours of detention and will be followed by other reviews, scheduled at least every 12 hours.

2. Ill-treatment

15. From the information gathered by the CPT's delegation from its interviews with various persons detained, or who had been detained, by the police, no allegations of ill-treatment by the police were received. The delegation found that, generally, the police treated arrested and detained persons correctly.

3. Safeguards against ill-treatment

16. The CPT attaches particular importance to three fundamental safeguards for persons deprived of their liberty by the police: the right of those concerned to inform a close relative or another person of their choice of their situation; the right of access to a lawyer; and the right of access to a doctor. These three rights represent fundamental safeguards against ill-treatment of persons deprived of their liberty, which should apply from the very outset of custody. In addition, it is important that all detained persons are informed of their rights in a language they understand.

17. The CPT noted that the right of persons deprived of their liberty to inform a close relative or another person of their choice of their situation as from the very outset of custody operated in a satisfactory manner in practice. This right was listed in the information provided to detained persons upon their arrival in police custody; there were no complaints made to the CPT's delegation that it was not adhered to in practice. Further, the delegation noted that this right was guaranteed in law.⁴

18. The delegation found that while the right of access to a lawyer was enshrined in law,⁵ there remained various deficiencies in the law, which had been raised during the previous visit in 2011⁶ and have not been fully addressed. Detained persons are entitled "as soon as practicable to consult privately with a lawyer or legal procurator, in person or by telephone, for a period not exceeding one hour" (Article 355AT) and they have to be informed by the police of this right as early as is practical before being questioned. The law, however, allows for the right to access a lawyer to be delayed in certain circumstances. These include where the officer believes that the exercise of the right (a) will lead to interference with or harm to evidence connected with the offence or interference with or physical injury to other persons; or (b) will lead to the alerting of other suspects still at liberty; or (c) will hinder the recovery of any property obtained as a result of such an offence. Where delay has been authorised, police officers are allowed immediately to question the detained person. This right can be delayed for up to thirty-six hours from the time of the arrest.⁷

The Committee remains concerned by the fact that the right of access to a lawyer is still subject to important limitations which are likely to undermine the effectiveness of this right as a safeguard against ill-treatment (as distinct from a means of ensuring a fair trial). Its concerns are two-fold: first, it remains the case that some detained persons are not allowed to have access to a lawyer during all stages of police questioning; secondly, access to a lawyer may be delayed for a period of up to 36 hours in certain circumstances (listed above).

The CPT's delegation also noted that detainees were given a waiver form entitled 'declaration to renounce the exercise of the right of a lawyer' upon their arrival at the police station. This was accompanied, in practice, by an oral explanation by the investigating police officer that should a lawyer be contacted, and a statement given, it would be impossible for the detainee to change any parts of the statement later on in the investigation. The delegation was informed by the police officers interviewed that this reasoning was based on the principle of the Law of Inference. Nevertheless, the delegation was of the view that this could have a significant dissuasive effect on the detained person from contacting a lawyer.

19. The Committee reiterates its long-held view that to be fully effective as a fundamental safeguard against ill-treatment, the right of access to a lawyer must be guaranteed as from the very outset of a person's deprivation of liberty. The Committee recognises that it may exceptionally be necessary to delay for a certain period a detained person's access to a lawyer of his/her choice. However, this should not result in the right of access to a lawyer being totally denied during the period in question. In such cases, access to another independent lawyer who can be trusted not to jeopardise the legitimate interests of the investigation should be organised. It is perfectly feasible to make satisfactory arrangements in advance for this type of situation, in consultation with the Bar Association.

⁴ Article 355AS, Criminal Code.

⁵ 355AT, Criminal Code.

⁶ See paragraphs 74 to 75, CPT/Inf (2013) 12.

⁷ 355AT, Criminal Code.

In the light of the above, **the CPT calls again upon the Maltese authorities to take the necessary measures to ensure that all persons detained by the police can effectively benefit, if they so wish, from access to a lawyer throughout their police custody, including during any police questioning, and that the relevant provisions of the Criminal Code are amended accordingly.**

20. As concerns the right of access to a doctor, the CPT's delegation noted that the right of the detained person to request medical assistance was enshrined in law,⁸ which included the consultation of a medical doctor of their own choice. This right was listed in the information provided to detained persons upon their arrival in police custody; no complaints were received that it was not adhered to in practice. Nevertheless, the delegation noted that there was no immediate medical assistance onsite to be able to quickly and safely address any medical problems that might arise. In addition, the police custody staff were not trained in first-aid (in this respect see paragraph 23).

The CPT recommends that all custody officers should be given first-aid training along with regular refresher courses.

21. Information on rights was available in written form and in several languages at all police stations and custody suites visited by the delegation. Detained persons were in practice offered a copy.

22. The CPT's delegation welcomed the fact that custody for longer than six hours now requires detainees to be moved to Floriana Police Headquarters' or Gozo custody suites (the so-called 'Lock-Ups') rather than being detained in district police station cells or in the airport holding facility.⁹ It was clear from the records examined and interviews with staff and detainees that, generally, arrested persons were not held in the single holding cells of the district police stations and spent their time in the administration offices for a few hours before being transferred to Floriana or Gozo Lock-Ups.

That said, the delegation was informed in Rabat and St. Julian's Police Stations, that arrested persons, in particular those who were intoxicated, were held for longer periods of time in the single holding cells in order to sober-up/'dry out' before being transferred to the Lock-Ups (see paragraph 27). For example, in St. Julian's Police Station, the custody records showed that a person arrested at 6 a.m. on 29 September was only transferred to Floriana Lock-Up at 10 a.m. on 30 September. It was clear that, on occasion, arrested persons were held overnight, and longer than the six hour time-limit, in some of the police stations' holding cells.

The CPT recommends that the Maltese authorities ensure that the relevant national law is adhered to in practice and that a reminder be given to all district police stations that persons should be transferred to the custody suites within six hours of arrest.

⁸ Article 355AS of the Criminal Code.

⁹ Article 355AE, Criminal Code.

23. According to information received after the visit, the CPT's delegation has noted that two recent suicides have taken place at Floriana Police Headquarters' Lock-Up, in October and December 2015 respectively.

The CPT wishes to receive from the Maltese authorities a copy of any report, autopsy or inquiry that may have been undertaken pursuant to the recent suicides in the Lock-Up of Floriana Police Headquarters.

The CPT recommends that immediate steps should be taken by the authorities to ensure that persons in police custody are kept safe, which should include a thorough risk-assessment of each detained person upon admission to police custody and the introduction of a robust suicide prevention approach.

24. The CPT's delegation observed some good custody records. However, at St. Julian's Police Station and Rabat Police Station, the records were incomplete and, in some cases, inaccurate. There was generally poor recording of exit times for transfers from police stations to the Floriana and Gozo Lock-Ups.

The CPT considers that the fundamental guarantees of persons placed in police custody are reinforced if a single and comprehensive custody record is kept for each of these persons. In this record would be entered all aspects of custody and all measures taken in connection with it, including all exit times from the police station and from any custody cell.

By letter dated 4 November 2015, the Maltese authorities informed the Committee that action will be taken at District level to improve record-keeping. The CPT welcomes this development and **would like to receive information as to precisely what action has been taken.**

In the meantime, the CPT recommends that steps be taken to ensure that whenever a person is deprived of his/her liberty by a law enforcement agency, this fact is formally recorded without delay. Further, once a detained person has been placed in a cell, all instances when he/she is subsequently removed from the cell should be recorded. That record should state the date and time the detained person is removed from (or visited in) the cell, the location to which he/she is taken and the officers responsible for taking him/her, the purpose for which he/she has been taken, and the date and time of his/her return, where relevant.

25. The existence of effective procedures and mechanisms for examining complaints and other relevant information regarding alleged ill-treatment by the police is an important safeguard against ill-treatment of persons deprived of their liberty.

The CPT's delegation found that detainees were unaware of any immediate avenue for persons detained by the police to make a confidential external complaint (i.e. one not addressed to a police officer). The delegation also noted the absence of any complaints forms or boxes in the police station or any information for detainees about the Internal Affairs Unit, which was set up to investigate complaints about police conduct.

All persons deprived of their liberty by the police should be informed in written format about their right to make a complaint against the police. . This can have a significant preventive or deterrent effect as regards ill-treatment and provides management with feedback on potential problems.

The CPT recommends that information about the complaints procedures and mechanisms available should be included in the initial written information given to detained persons on arrival.

26. Further, it was clear that little or no monitoring of police stations was undertaken by an external and independent body. The NPM does not have the mandate in law to monitor police detention (other than immigration detainees held in the Police Lock-Ups). The Malta Police Force's Internal Affairs Unit is able to receive complaints and conduct internal investigations but does not have a regular monitoring function, nor is it independent of the Police Force.

The CPT believes that the inspection of detention facilities of law enforcement agencies by an independent authority can make an important contribution towards the prevention of ill-treatment of detained persons and, more generally, help to ensure satisfactory conditions of detention. To be fully effective, visits by monitoring bodies should be both frequent and unannounced. Further, such bodies should be empowered to interview detained persons in private and examine all issues related to their treatment (material conditions of detention; custody records and other documentation; exercise of detained persons' rights, etc.).

The CPT recommends that the Maltese authorities ensure that a system of independent monitoring be established to monitor all detention facilities of the Maltese law enforcement agencies. (In this respect, see also the recommendation made in paragraph 12 regarding the need for a fully effective and independent National Preventive Mechanism empowered to monitor all places of detention in Malta).

4. Conditions of detention

27. The material conditions of the cells of the seven district police stations and three Lock-Ups (Floriana and Gozo Lock-Ups as well as the Lock-Up below the Valletta Courts of Justice), visited by the CPT's delegation, varied.

In the *District police stations*, many of the holding cells had been taken out of use and were used as storage rooms (for example in Sliema or Mosta Police Stations) due to the generally short time-frames for which arrested persons were held before the required transfer to Floriana Police Headquarters or Gozo Lock-Ups. Nevertheless, in others, such as St Julian's and Rabat Police Stations, the holding rooms were clearly used on occasion.

Those police station holding cells that were in use afforded inadequate material conditions. Although they were generally of a sufficient size (on average approximately 5m²) for periods of up to six hours and possessed a bed, mattress and clean bed linen, the cells were generally very hot,¹⁰ poorly ventilated, had no ready access to drinking water nor to a toilet and lacked call bells. The location of the holding cells was also problematic. These cells were occasionally used for intoxicated arrested persons to 'sober-up' overnight. However, the cells were mainly located outside the main police administrative building or located in a basement and did not have closed-circuit surveillance (CCTV) coverage or call bells for detainees to be able to attract the custody officers' attention. Thus, the holding cells were unsuitable places in which to hold intoxicated persons.

The CPT recommends that intoxicated persons should not be held in police holding cells until such a time as appropriate supervision of such persons by healthcare staff can be provided at all times.

Further, the Committee recommends that detained persons held in police cells should have ready access to toilets, washbasins and potable water. Moreover, it recommends that the above-mentioned cells be refurbished to ensure that they are sufficiently ventilated and that a call-bell system is installed.

28. The Court holding-cells (the so-called 'Lock-Up' below the Valletta Courts of Justice) were in the basement of the Valletta Court building and were for short-term use only; detainees attended Court hearings and were required to wait there before the start of a hearing or before being transferred to a Lock-Up. Further, all of the three single cells (measuring some 4m²) had recently been taken out of use, as they were dark with opaque windows that provided no effective access to natural light and were generally unsuitable for any period of detention. The multi-occupancy holding cells remained in use. They were separated by bars from the main area that led to the Courts and were dark and bare, other than a line of wooden benches. There were no windows or toilets, nor was there any ready access to drinking water in the rooms. The whole of the detention area was worn and dusty and in clear need of refurbishment and deep-cleaning.

The CPT recommends that detained persons held in the multi-occupancy holding cells have ready access to drinking water and toilets. It also recommends that the court-holding facilities be completely refurbished and be kept in a safe and decent state of repair. Further, it requests confirmation from the Maltese authorities that the single cells have been permanently taken out of use.

¹⁰ Inside the cell at St. Julian's Police Station, the temperature was 31 degrees Celsius at the time of the visit.

29. The material conditions of the *Lock-Ups* of Floriana and Gozo were generally better than the police station holding cells. They were, however, still far from adequate in a number of aspects.

The 49 cells in Floriana and eight cells in Gozo Lock-Ups were, in the main, sufficiently spacious (measuring circa 7m²) for single person overnight use only. They each possessed a bed, mattress and clean bedding linen. The Floriana Lock-Up cells also each had a toilet and wash-basin and had sufficient artificial lighting. That said, at the time of the delegation's visit, the cells were hot and poorly ventilated and there was limited access to drinking water. In contrast to Floriana Lock-Up, the cells in the Gozo Lock-Up did not possess toilets or wash-basins and were dark with no windows and had very little access to any natural light from the corridor, as well as poor artificial lighting, and had inadequate ventilation. Further, the cells in the Gozo Lock-Up were cramped, merely affording approximately 4.5m² of living space per person.

The layout of Gozo Lock-Up was problematic. It was situated in a garage and the eight cells were located a distance away from the custody officer's office, at the top of three flights of stairs. There was no CCTV coverage of the detention area and there were no call bells to enable detainees to attract the custody sergeant's attention. The cells did not have toilets and detainees had to bang on their doors to be allowed to use the toilet, located in the corridor. Further, the location of the cells was also inappropriate for holding intoxicated persons to 'sober-up' overnight (see paragraph 27). The Gozo Lock-Up was staffed with one custody officer on duty. It was clear to the delegation that if there were more than a few persons held there at the same time, a single custody officer would find it difficult to manage a safe custody environment adequately. **The CPT invites the Maltese authorities to consider the reinforcement of the custodial officer complement in Gozo Lock-Up, when there are more than a few detained persons held there.**

30. In general, the CPT recommends that the Maltese authorities take the necessary steps to remedy the above-mentioned deficiencies. In particular, it recommends that the authorities:

- refurbish the cells in the Gozo Lock-Up to ensure that detained persons have ready access (including at night) to toilets and wash-basins, install a system of in-cell call bells, improve the access to natural light and to adequate artificial lighting, sufficient ventilation and potable water;
- ensure that all police cells where persons may be held overnight are of a reasonable size for their intended occupancy (i.e. 7 m² for single cells, and at least 4 m² per person in multi-occupancy cells);
- ensure that the holding cells in Floriana Lock-Up are properly ventilated and afford detained persons ready access to potable water;
- install call bells in every cells of the Floriana and Gozo Lock-ups..

31. The CPT has consistently recommended that persons held for 24 hours or more in police custody be offered access to outdoor exercise every day. Detained persons were often held in Floriana or Gozo Lock-Ups for up to 48 hours, particularly over weekends until the Courts opened on Monday morning. There was an outdoor area in Floriana Lock-Up and access to outdoor exercise was offered to persons detained pursuant to the Immigration Act; however, arrested persons pursuant to criminal proceedings were not allowed such access. There was no exercise area in Gozo Lock-Up and detainees spent up to 48 hours locked in their cells.

The CPT recommends that steps be taken to ensure that all detained persons held for 24 hours or more in police custody in Floriana Lock-Up be offered outdoor exercise; that an exercise area be established in Gozo Lock-Up, and that all persons detained there be offered the possibility of outside exercise.

32. The Gozo Lock-Up had one escort van, which it used to escort prisoners between Gozo and Malta for Court hearings, etc. The CPT's delegation found that the van was filthy and dangerous. There were no seat belts for the passengers and only a wooden bench as a seat. The van had no windows and no air conditioning and was extremely hot inside. Prisoners were supposed to remain inside the escort van during the boat crossing to the mainland, which per se was against the safety rules of the ferry authorities.

The CPT recommends that the Maltese authorities provide a new escort van for Gozo / Victoria Police Station and Lock-Up, as well as ensuring that a space on the Malta-Gozo ferry deck is provided for the purpose of escorting prisoners.

B. Immigration detention

1. Preliminary remarks

33. The situation regarding immigration detention had changed considerably at the time of the 2015 visit, with fewer than 10 persons held in detention compared with more than 750 at the time of the 2011 visit. This is certainly a positive development.

The reasons for so few persons being held in immigration detention are twofold. On the one hand, the Maltese authorities have undertaken a comprehensive review of the policy and law regulating the detention of irregular migrants, including through the adoption of a new Immigration Bill and the transposition of the EU Reception Conditions Directive (2013/33/EU). In this context, as from July 2014, an ex officio review of the necessity of detention for irregular migrants and asylum seekers has been conducted every three months which, by December 2014, had resulted in some 500 persons being released from detention. On the other hand, the number of persons arriving in Malta by boat has dropped to virtually zero. It would appear that persons setting out by boat from Libya are being intercepted or rescued by the Italian navy and taken to Italy and that the Maltese Armed Forces, although involved in sea rescue operations, are only taking persons requiring urgent medical care to Malta.

In 2015, with no irregular migrants arriving by boat, persons who end up in immigration detention are primarily those who have overstayed their visas (the largest group being Serbian nationals) and those arriving at the airport without a valid visa who are subject to return on the next available flight to their country of origin. Further, foreign nationals who have been sentenced to imprisonment for a period longer than 12 months are liable to be deported once they have served their term of imprisonment and may be placed in immigration detention pending the organisation of their return.

34. The CPT has also noted positively that since March 2014 unaccompanied and separated children as well as families with children are no longer detained in military detention centres. Instead, they are placed in special open immigration reception centres in Dar il-Liedna and Dar is-Sliema. Further, information was received about the establishment of an Initial Reception Centre in Hal Far intended to accommodate minors and families for up to 15 days following their arrival in Malta. **The CPT would like to receive updated information on the operation of this Centre, its capacity, staffing, daily activities and whether it is accommodating any minors or families.**

35. The CPT's delegation carried out a follow-up visit to the Safi Detention Centre and visited the airport holding facility. It also visited the open centre for young persons in Fgura, Dar il-Liedna.

2. Safi Detention Centre

a. ill-treatment

36. In the course of the visit to Safi Detention Centre, no allegations of deliberate ill-treatment were received. Persons detained at the Safi Detention Centre stated that they were treated correctly by staff although there was little in the way of interaction with detention officers.

However, it remains a matter of concern that, despite a specific recommendation made by the Committee after its previous visits, staff continued to call detainees by their immigration file/tag numbers, even when the number of detainees was so low. Not surprisingly, this practice was perceived by foreign nationals to be humiliating and degrading and it is certainly not conducive to the establishment of positive staff/detainee relations.

Visits to detention facilities in various other State Parties where large numbers of immigration detainees were held have shown that it is indeed physically possible to identify and address detainees by their name. Detention officers should be positively encouraged to do so by the management of the centres.

The CPT once again calls upon the Maltese authorities to ensure that detained persons are addressed by their name and not by a number.

b. conditions of detention and staffing

37. At the time of the visit, there were officially only six persons being held in immigration detention, three of whom were in Mater Dei Hospital. Consequently, only the ground floor of B Block in the Safi Detention Centre was operational and the three irregular migrants were accommodated in one dormitory containing four sets of bunk beds. The material conditions were satisfactory for short periods of stay (although the mattresses were very worn), and the communal sanitary facilities were in an acceptable state of repair.

The three detainees spent their time sitting in the communal dining room watching television or talking. From midday, they could also access the courtyard from the dining room but with its concrete floor and high walls, no benches, no shade from the sun and no sports equipment, it was not used much. The food provided was generally satisfactory but the detainees complained that dinner was served at 4.45 p.m. which meant that they were extremely hungry by the next morning.

The CPT considers that the reduction in the numbers of persons detained should make it easier to ensure that those who are detained are held in decent conditions. The conditions at Safi Barracks, however, remain carceral and the regime restrictive. The CPT has noted the Maltese authorities' response to its preliminary observations stating that activities are provided to persons in detention but the fact remains that no activities were being offered to those persons in detention at the time of the visit. Further, much of the furniture of the multi-occupancy rooms should be removed to provide detained persons with at least 4m² of living space each; currently, rooms of 30m² are equipped to accommodate 22 persons (11 sets of bunk beds), whereas rooms of such a size should hold no more than seven persons.

The CPT recommends that steps be taken to improve the living conditions at B Block of Safi Detention Centre, notably as regards:

- **the amount of living space afforded to each detained person within the dormitories;**
- **the removal of surplus beds and the provision of new mattresses;**
- **the equipping of the courtyard with a means of rest, a shelter and sports equipment;**
- **the provision of activities for those persons detained longer than a few days.**

Consideration should also be given to serving the evening meal later in the day.

38. The CPT has repeatedly stressed that persons detained under aliens' legislation should be accommodated in centres specifically designed for that purpose, offering material conditions and a regime appropriate to their legal situation. Care should be taken in the design and layout of such premises to avoid, as far as possible, any impression of a carceral environment.

The current low number of detainees provide an ideal opportunity to move away from the warehousing approach to one that addresses the specific needs of immigration detainees both as regards material conditions and in relation to the activities on offer to them.

The CPT recommends that the Maltese authorities review the current approach towards immigration detention, in light of the above remarks.

39. The CPT has consistently placed a high priority upon the supervisory staff in immigration detention centres being carefully selected and receiving appropriate training. As well as possessing well-developed qualities in the field of interpersonal communication, the staff concerned should be familiarised with the different cultures of the detainees and at least some of them should have relevant language skills. Further, they should be taught to recognise possible symptoms of stress reaction displayed by detained persons (whether post-traumatic or induced by socio-cultural changes) and to take appropriate action.

At the time of the visit, staffing numbers were not a problem.¹¹ Nevertheless, while the staff behaved correctly towards the detained persons, there was little effort to engage with them. The officers were not present within the accommodation areas, nor were they interacting with detained irregular migrants or taking a proactive role to resolve potential problems. The emphasis is on passive security only. This is a waste of resources and does not provide for much job stimulation for staff. A dynamic security approach with properly trained staff engaging with detained persons should be put in place.

The CPT recommends that the Maltese authorities consider developing the role and scope of duties of detention officers, as well as their skills and training, in light of the above remarks.

¹¹ Each of the four shifts was composed of 32 detention officers and a sergeant; each shift worked 12 hours. Detention officers were also stationed at other facilities in Malta, such as the open centre at Dar il-Liedna, where two detention officers were on security duty.

c. health-care

40. The health-care staffing arrangements in place at B Block were good. A doctor was present Monday to Friday from 9 a.m. to 2 p.m. and two nurses worked Monday to Saturday from 8 a.m. to 5 p.m. The premises on the ground floor outside the locked accommodation area were, however, extremely basic, consisting of a surgery and an office with no waiting area and no toilet (for staff or detainees).

Further, little action seems to have been taken to implement the CPT's previous recommendations. There was no systematic medical screening in place, including for transmissible diseases, for every newly arrived detainee by the doctor or by a nurse reporting to the doctor. Nor was there any screening to identify possible victims of torture nor clear procedures on action to be taken whenever a medical practitioner submitted a report on a person who may have been a victim of torture. Given the resources available, this was particularly unacceptable.

Equally, despite Detention Service Standing Order (Section 14 on Medical and Health Care Services) requiring that a "clinical record must be opened for every new detainee", a record was only opened if a detainee visited the health care centre. In addition, no proper medical file was maintained.

The delegation did note that medical confidentiality was generally respected.

The CPT recommends that the Maltese authorities take steps to address the above-mentioned deficiencies.

41. When a detained person did not speak English, another detained person with the necessary language skills was requested to act as an interpreter. In the CPT's experience, detained persons often do not feel comfortable conveying personal or other sensitive information (especially in relation to health problems) through another detained person. **The CPT considers it inappropriate to use detained persons as interpreters other than in emergency situations.**

d. other issues

42. None of the persons placed in detention at the time of the visit was informed about the house rules of the detention facility, either verbally or in writing. The only information imparted was that visits were not allowed.

It is important that detained persons be provided with clear information, in a written form, on the house rules of the detention facility. **The CPT recommends that every detained person be systematically provided with written information, in a language they understand, on the house rules immediately upon their arrival in the facility.**

43. As regards contact with the outside world, detained persons could use a telephone and receive calls. However, they were not allowed to keep and use their mobile phones and visits were not permitted in practice.

The CPT considers it important for detained persons to have the possibility to receive visits from NGO representatives, family members or other persons of their choice on a regular basis (i.e. at least once a week for a minimum of one hour), in a suitable setting which should include appropriate furniture and decoration for welcoming children. As for mobile phones, detained persons should at least be granted access to them at set times.

The CPT recommends that the Maltese authorities introduce the right for detained persons to receive visits on a regular basis in an appropriate setting. Further, they should be allowed to have access to their mobile phones at set times.

3. Airport holding area

44. Persons to be deported by air may be kept in the holding area in the basement of the airport terminal, which consists of a room with seven beds, two metal benches and two tables, as well as two showers and a toilet. Whenever a person is held in the room, a police officer is stationed at the entrance area which is separated from the room by a wire grille. The room provided basic conditions for short periods of stay of less than 24 hours given the lack of access to natural light and the absence of any possibility for outdoor exercise.

An examination of the log book showed that in the two and a half months prior to the visit, some 34 persons had been held in the room, most for a few hours. However, the log book was incomplete with basic information missing on the length of stay of some persons. In one case, a person had spent 46 hours in the room.

The CPT recommends that the log book be diligently completed with all the relevant details of a person's stay in the holding room. Also, the facility should not be used for holding persons for periods in excess of 24 hours.

4. Dar il-Liedna open centre for young persons

45. The open centre for young persons in Dar il-Liedna has an official capacity of 30 and was accommodating seven boys and three girls at the time of the visit. The centre was staffed by care workers from the Agency for the Welfare of Asylum Seekers (AWAS), with three members (primarily women) on each shift. In addition, two Detention Service officers were deployed within the centre. The young persons were allowed to come and go throughout the day with the staff's permission but had to be back in the centre by 9 p.m. The young people were accommodated in multi-occupancy rooms of two to four beds, with their own lockable cupboards and a key to lock their rooms. The material conditions were generally good. A range of activities was available to the young persons outside of the centre, notably school from Monday to Friday, and some of them worked. In addition, they were tasked with cleaning their rooms and washing their clothes.

The main concern for the staff was the frequent fighting among the residents, usually between different ethnic groups, and the not inconsequential vandalism. There were no formal disciplinary rules in place and the staff were not trained in control and restraint methods. The police would be systematically called, but only if there was a criminal act committed would the matter be taken any further.

Residents who absconded were usually returned by the police. At 18 years of age, the residents are transferred to an open centre for adults.

The CPT would like to be informed about the measures being taken to reduce the number of violent incidents between the young persons accommodated at the Dar il-Liedna open centre, including appropriate staff training in conflict prevention.

C. Corradino Correctional Facility

1. Preliminary remarks

46. The visit to the Corradino Correctional Facility (CCF) was of a follow-up nature, with the purpose of examining developments since the previous 2011 visit.¹²

The inmate population stood at 557, down from over 600 inmates in December 2014, for a reportedly official capacity of 570; moreover, two wings had been de-commissioned. However, the management was unable to confirm on what basis this capacity had been calculated. At the time of the visit, CCF was accommodating 422 sentenced prisoners and 135 remand prisoners (including 43 female inmates).

Changes had taken place regarding the male juvenile and young offenders' accommodation and facilities at CCF since the 2011 visit. In Malta, juveniles can be held criminally responsible from the age of 14 and sentenced to a term of imprisonment from the age of 16, resulting in placement in the young offenders' unit of CCF pursuant to Article 35(1) of the Criminal Code. The CPT's delegation was pleased to note that in 2013, the Young Offenders Rehabilitation Services (YOURs) Unit was moved from the main CCF prison to separate premises in Mtahleb (see Section 8).

47. The relevant legal framework (the Prison Act and related Prisons Regulations)¹³ has undergone some reform since the 2011 visit. Many of the changes were introduced pursuant to the recent Restorative Justice Act.¹⁴ These included the establishment of a parole system (see paragraph 62), and the introduction of a Prison Addiction Rehabilitation Management Board for the purpose of referring each inmate who required treatment for substance abuse to a specific rehabilitation programme according to their care plans, as well as the establishment of a Remission Board, a Victim Support Unit and a Victim-Offender Mediation Committee.¹⁵

2. Management issues and staff

48. After its 2008 visit, the CPT expressed grave concerns about the lack of proper management of CCF, which resulted in ineffective control over the prisoners.¹⁶ New management of CCF was appointed in 2011, and following the 2011 visit, the CPT considered that efforts were being made to regain effective control over the prisoners and to develop proper management structures. However, during the September 2015 visit, the CPT's delegation once again observed a lack of established management and the absence of a clear operational strategy for CCF. This had a negative impact in a variety of fields (for example, see section 7(b)).

¹² CCF has been visited six times by the CPT (in 1990, 1995, 2001, 2005, 2008 and 2011).

¹³ Prison Act, Chapter 260 of the Laws of Malta (1976, as amended) and the Prison Regulations, Subsidiary Legislation 260.03 (1995, as amended in 2015).

¹⁴ Restorative Justice Act, 2012.

¹⁵ Restorative Justice Act, 2012.

¹⁶ See paragraphs 9 to 10, CPT/Inf (2013)12 and paragraph 130, CPT/Inf (2011)5.

3. Ill-treatment

49. The delegation observed a relatively relaxed atmosphere in the prison, with generally good relations between staff and inmates. It received almost no allegations during the visit of physical or psychological ill-treatment by prison staff towards the prisoners.

Some tensions between prisoners did exist, but there was no evidence of generalised inter-prisoner violence or intimidation evident. Prisoners reported that they generally felt safe and that there was very little gang culture present in CCF.

4. Transgender prisoners

50. At the time of the CPT delegation's visit there were three inmates who had been identified as male to female transgender and one intersex inmate.¹⁷ They were all accommodated within the male divisions of the prison. In the case of the transgender inmates, these persons had been living as women before their incarceration and identified themselves as being women. While each of them was taking the female sex hormone oestrogen at the time of their admission to CCF and had continued to have this prescribed while in prison, none had yet undergone gender reassignment surgery. Two had, however, changed their official documentation and status and expressly wanted to live, be recognised and treated as women.

The three transgender prisoners had requested to be moved to the female unit of CCF or to a separate section of the prison. However, the delegation was informed by staff that while the request had been allowed initially, the prisoners had subsequently withdrawn their request.

51. The CPT's delegation noted one alleged incident of prisoner violence towards one of the three transgender prisoners at CCF at the time of the visit. Prisoner A's medical notes stated that on 6 March 2015, Prisoner A was "allegedly hit by thermos", with no motive recorded. No official complaint, however, had been submitted by the inmate and it was unclear whether any investigation had been initiated into this allegation. The records also showed that on 13 April 2015, Prisoner B was offered admission to the Female Forensic Psychiatric Unit on the account of the fact that she was struggling with the environment in which she was located in the male prison. Prisoner B retracted her request for transfer shortly after its submission. However, upon interview by the delegation, it was clear that this prisoner still wished to be transferred out of the male division and was still struggling in the all-male environment.

According to information received after the visit, the other transgender inmates, who were held on different divisions of CCF, also had orally requested to be moved from the male section of the prison to either the female section or a separate section, staffed by female officers, which could allow them to interact more with each other. Some of them reportedly felt uncomfortable in the all-male setting, had to have different shower times, felt unsafe and were humiliated by constantly being referred to by their male names, as well as being prohibited from wearing female clothing and generally hindered from self-identifying as women.

¹⁷ As of November 2015, there were five transgender inmates and one inter-sex inmate at CCF.

52. The CPT wishes to emphasise that the duty of care which is owed by the prison authorities to prisoners in their charge 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, especially those who might be considered vulnerable, such as transgender prisoners.

53. **As regards transgender prisoners, the CPT recommends that the Maltese authorities put in place policies to combat discrimination and exclusion faced by transgender persons in closed institutions and that these should be implemented by the prison. In particular, the authorities should put in place a comprehensive anti-bullying strategy to reduce any incidences of inter-prisoner violence and intimidation, especially those directed against transgender prisoners. Such a strategy should include systematic recording, reporting of all such incidents and adequate investigation into all allegations of targeted bullying of, or violence against, transgender prisoners.**

Further, the CPT recommends that the Maltese authorities review the treatment of transgender prisoners in CCF with a view to establishing clear guidelines to guarantee that their rights are adequately respected. In this respect, it considers that transgender persons should either be accommodated in the prison section of the respective gender with which they self-identify or, if exceptionally necessary for security or other reasons, in a separate section. If accommodated in a separate section, they should be offered activities and association time with the other prisoners of the gender with which they self-identify.

54. **The CPT also recommends that steps be taken to prevent inter-prisoner violence and that whenever there are allegations of inter-prisoner violence, or suspicions by staff or medical staff thereof, that:**

- **injuries are properly recorded;**
- **systematic reporting is conducted by medical staff to the relevant authorities; and**
- **a thorough investigation is conducted into the alleged violence.**

As regards the above-mentioned case of alleged violence, the CPT requests more information from the authorities on the outcome of any investigation that might have been undertaken.

5. Conditions of detention

a. material conditions

55. The CPT considers that the standard of accommodation is important to the quality of life within a prison. More particularly, cells should offer, *inter alia*, sufficient living space for the prisoners they are used to accommodate and benefit from adequate ventilation. Sanitary arrangements should permit inmates to comply with the needs of nature when necessary in clean and decent conditions. Each cell should possess a toilet and a washbasin as a minimum. In multiple-occupancy cells the sanitary facilities should be fully partitioned (i.e. up to the ceiling).¹⁸ Running water should be available within cellular accommodation. All facilities/equipment should be in a good state of repair.

56. The delegation noted that some renovations had been undertaken in CCF (for example, of Divisions IV and VII). Further, two of the previously most problematic divisions (Divisions VI and XV) had been closed down.

Nevertheless, the remaining divisions provided generally poor living conditions for the inmates, and this was particularly the case in Divisions II, III and XIII. While most cells were sufficient for single occupancy (measuring some 9m²), the dormitory rooms at CCF (for example in Division XIII) were cramped, with nine inmates held in approximately 30m² (i.e. significantly less than the minimum standard of 4m² of living space per prisoner in a multiple-occupancy cell recommended by the CPT).¹⁹

Many of the cells were excessively hot (over 30 degrees Celsius at the time of the visit) with poorly functioning ventilation. Further, some of the cells were in a bad state of repair, with mould or ingrained dirt evident on the walls and around the windows. Many of the washrooms were dirty, some showers lacked shower-heads and there were problems with drainage, which reportedly caused water to leak into the nearby cells (especially on the ground floor of Division XIII). The in-cell toilets were unscreened, had mal-functioning flushes, and the water was cut off intermittently. This was particularly problematic given an outbreak of diarrhoea among the prisoners during the delegation's visit (see paragraph 76).

Prisoners did not believe that in-cell water from the sinks was safe to drink and the staff concurred with them. Many prisoners, especially those inmates who only lived off the basic €27 monthly allowance, complained to the delegation about the lack of ready access to safe drinking water and the need to buy bottled water.

The divisions had individual or shared exercise yards, which consisted merely of a stretch of bare tarmac. They were not equipped with any means of rest (let alone any sports or recreational equipment) or any shelter to protect prisoners from sun or rain. The yards were extremely hot, and at the time of the visit, the delegation noted that not a single prisoner made use of them during the day.

¹⁸ See 'Living space per prisoner in prison establishments: CPT standards', CPT/Inf (2015) 44, page 7.

¹⁹ See 'Living space per prisoner in prison establishments: CPT standards', CPT/Inf (2015) 44, paragraph 16.

57. By letter dated 4 November 2015, the Maltese authorities informed the Committee that renovations of Divisions II and III were envisaged and would be completed by the end of 2017. Further, the authorities planned to connect each division to the main water supply and to install two taps in each division to enable inmates to access drinking water.

58. The CPT welcomes these initiatives. Nevertheless, **the CPT recommends that the Maltese authorities take the necessary steps to improve the living conditions at CCF and, in particular, to:**

- **reduce the occupancy levels in multi-occupancy dormitories to ensure that each prisoner has at least 4m² of living space;**
- **undertake a systematic refurbishment of the cells and sanitary facilities in Division XIII;**
- **expedite the planned refurbishment works of Divisions II and III;**
- **provide, until such time as ready access to potable water is assured, inmates with an appropriate amount of free drinking water; and**
- **equip the exercise yards with a shelter to protect inmates from inclement weather and a means of rest and, preferably, provide sports/recreational equipment.**

b. regime and activities

59. As regards the regime of activities on offer, the aim should be for all inmates to spend a large part of the day engaged in purposeful activities of a varied nature. At the time of the visit, the activities on offer included access to the gym and football ground, educational courses on music, information technology and languages, technical courses on stone masonry and carpentry and life-skills programmes including on positive parenting and first aid. Work was also on offer to prisoners, mainly in the form of toy doll construction. The CPT's delegation welcomed the fact that more than 80% of all the inmates had access to some kind of work or education;²⁰ the situation in this respect had improved since the 2011 visit.

60. The CPT's delegation was informed of the developments regarding sentence and care planning that had taken place since the 2011 visit, pursuant to the adoption of the Restorative Justice Act.²¹ The delegation welcomed the introduction of the Offender Assessment Board and the CCF Care and Reintegration Unit (comprised of social workers, psychologists and psychiatrists), which issued the first prisoner care plans in 2013. Between March 2013 and the date of the visit, 181 care plans had been prepared for parole applicants.

Nevertheless, the delegation noted that care plans were only compiled for prisoners applying for parole and not for all prisoners. Moreover, prisoners were not given a copy of their care plan.

²⁰ At the time of the visit, 155 inmates were working on prison industry contracts, in addition to the 338 inmates who were engaged in maintenance work, kitchens and cleaning within the prison. This gave a total of 493 in employment of some kind for at least a few hours each week. Male inmates recorded 203 attendances at education classes (some were enrolled in more than one) while females, five of whom were studying at the Malta College of Arts, Science and Technology, recorded 122 attendances at classes. Organised sports activities attracted 149 inmates in CCF.

²¹ Article 10, Restorative Justice Act 2012.

61. By letter dated 4 November 2015, the Maltese authorities informed the Committee that additional Care Plan Co-ordinators would be recruited, to enable the drafting of care plans for all prisoners, including life-sentenced prisoners. The CPT welcomes this development and recommends that priority be given to prisoners serving long or life sentences. To this end, **it would like to receive a clear timetable for the progressive introduction of care plans for all prisoners and information on the nature of the plans and the frequency of their reviews.**

62. The parole system has been reformed at CCF as a result of the introduction of the care-planning policy and reforms created by the Restorative Justice Act. That said, as of the date of the visit, only 45 inmates (out of 272 applicants) had actually been granted parole since March 2013.

63. The situation of life-sentenced prisoners at CCF raises a number of issues. In total, there were 14 ‘lifers’ (persons sentenced to whole life sentences with no prospect of being released) at CCF at the time of the visit, including two who had been in the prison since 1988. These inmates had no structured regime, no sentence plans nor any psychological support. Moreover, a few life-sentenced prisoners were allocated to extremely restrictive regimes (such as on Division XIII) and thus did not have access to any form of work or activities. The situation was further exacerbated for life-sentenced prisoners given that they were not eligible for parole. Overall, the situation concerning life-sentenced prisoners at CCF had not changed since the 2011 and 2008 visits, and the Maltese authorities have still not taken any steps to improve their situation.²²

In this context, reference should be made to the European Prison Rules²³ which state in Rule 103.8 that “particular attention shall be paid to providing appropriate sentence plans and regimes for life-sentenced prisoners”, taking into consideration the principles and norms laid down in the Council of Europe Recommendation (Rec (2003)23) on the “management by prison administrations of life-sentence and other long term prisoners”. The CPT also draws the attention of the Maltese authorities to its 2015 General Report in which the Committee sets out its thinking regarding the management of life-sentenced prisoners.²⁴

The CPT calls again upon the Maltese authorities to take steps as a matter of urgency to draw up and implement a specific programme aimed at supporting life-sentenced and other long-term prisoners throughout their stay, in the light of the remarks made above and in paragraphs 120 and 26 of the reports on the 2008 and 2011 visits, respectively.

64. More importantly, the CPT has already expressed its serious reservations about the concept according to which life-sentenced prisoners are deprived of any hope of being released (except by Presidential pardon). It is highly regrettable that the recent Restorative Justice Act²⁵ explicitly excludes the possibility of conditional release being granted to life-sentenced prisoners, and that the detailed remarks and recommendations outlined in the Committee’s previous reports have not been acted upon.²⁶

²² See paragraphs 26 and 31, CPT/Inf (2013)12 and paragraphs 119 to 121, CPT/Inf (2011)5.

²³ Adopted on 11 January 2006 by the Council of Europe’s Committee of Ministers [Rec (2006) 2].

²⁴ See the forthcoming 25th General Report of the CPT [CPT/Inf (2016) 10].

²⁵ Article 10(3)(g), Restorative Justice Act 2012.

²⁶ See paragraph 27, CPT/Inf (2013)12 and paragraphs 119 to 121, CPT/Inf (2011)5.

In this regard, the CPT would like to refer to the European Prison Rules²⁷ as well as to paragraph 4.a of the Committee of Ministers' Recommendation on conditional release (parole),²⁸ which clearly indicate that the law should make conditional release available to all sentenced prisoners, including life-sentenced prisoners. The explanatory memorandum to the latter recommendation emphasised that life-sentenced prisoners should not be deprived of the hope of being granted release. First, no one can reasonably argue that all lifers will always remain dangerous to society. Secondly, the detention of persons who have no hope of release poses severe management problems in terms of creating incentives to co-operate and address disruptive behaviour, the delivery of personal development programmes, the organisation of sentence plans and security and the maintenance of the mental and physical health of the prisoners.

It is noteworthy that the most authoritative judgment of the European Court of Human Rights (ECHR) on this matter to date, delivered by the Grand Chamber in *Vinter and Others v. the United Kingdom* (Applications nos. 66069/09, 130/10 and 3896/10) on 9 July 2013,²⁹ states that it was incompatible with human dignity, and therefore contrary to Article 3 of the ECHR, for a state to deprive a person of their freedom without at least giving them a chance to someday regain that freedom. Three consequences can be drawn from the Court's case law. The legislation of member states must henceforth provide for a time during the serving of the sentence when there will be a possibility to review that sentence. Furthermore, member states must establish a procedure whereby the sentence will be reviewed. Finally, detention in prison must be organised in such a way as to enable life-sentenced prisoners to work towards their social reintegration, to pursue programmes designed to help them address the identified risk factors and to enhance the possibility of conditional release.

In light of these comments, the CPT recommends that the Maltese authorities reconsider their policy towards life-sentenced prisoners with a view to ensuring that:

- **the law provides for a possibility, during the sentence, for prisoners to apply for conditional release, after having served a defined period of their sentence;**
- **a procedure is put in place for prisoners to be able to lodge such requests; and**
- **detention in prison is organised in such a way as to enable life-sentenced prisoners to progress towards their social reintegration.**

6. Health-care services

a. medical care

65. The CPT's delegation noted that all newly-arrived prisoners in general were given, as soon as possible, and no later than 24 hours after their admission, a comprehensive medical examination by a health-care professional.

²⁷ Committee of Ministers' Recommendation Rec (2006) 2 on the European Prison Rules of 11 January 2006.

²⁸ Rec (2003) 22, of 24 September 2003.

²⁹ See also a Chamber judgment in the case of *László Magyar v. Hungary* (Application no. 73593/10), issued on 20 May 2014.

66. In respect of health-care staffing at CCF, there were three General Practitioners (GPs) on contract with the prison, who provided a clinic onsite from Mondays to Fridays, from 4 p.m. until 8 p.m. Two of these GPs also provided on-call services overnight and at weekends. Five or six nurses were on duty every day, from 7 a.m. to 8.30 p.m., and one nurse attended to the administration of methadone between 7 a.m. and midday every day, including weekends. A psychiatric clinic was held on Mondays and Fridays with the services of two consultant psychiatrists, who were supported by a staff-grade psychiatrist. Now, inmate patients wishing to see the psychiatrist had to be first referred by the GP. A dentist visited CCF every Tuesday and Wednesday (and a dental hygienist visited on Thursdays) and examined 12 to 15 patients every week. There was also a pharmacist, who attended CCF from Mondays to Fridays between 11 a.m. and 3 p.m.

67. The CPT's delegation had some serious concerns about the co-ordination of health-care services and the guarantee of medical confidentiality at CCF. At the time of the visit, two experienced (and committed) prison officers were responsible for co-ordinating the activities of the health-care service. They were also responsible for ensuring the security as part of their ordinary role as prison officers and the administration of hospital appointments. In the delegation's view, the management was over-relying on prison officers to co-ordinate and manage health-care services at CCF. Further, these officers had ready access to the medical records and indeed were responsible for the filing of correspondence. In this respect, medical confidentiality was not guaranteed.

The CPT recommends that the Maltese authorities take steps to:

- **ensure that medical confidentiality is strictly guaranteed and that prison officers do not have access to medical records; and**
- **review the co-ordination of health-care by prison officers at CCF and, in this respect, it invites the authorities to consider the possibility of recruiting a full-time health-care staff member to oversee co-ordination and management of the health-care services provided at CCF.**

68. The delegation was also concerned about the management of medicines and the procedure and manner in which medicines were distributed to inmates at CCF. Staff interviewed by the delegation also raised several concerns in this respect.

For instance, psychiatric medicines were mixed together and dissolved in a cup of water, every morning, and issued to inmates either once, twice or three times later that same day. Such an arrangement takes no account of the pharmacokinetics of the individual drug, its bioavailability or any potential interactions with other psychiatric drugs. The pharmacist explained that sometimes such a mixture might be green in colour and at other times the same drugs are pink in colour. This concern was also raised by some inmates in subsequent interviews with the delegation.

69. The delegation also observed that medicines were removed by nursing staff from their original packets and put into open containers, whose labels did not include any expiry date. The containers were simply topped up by the nursing staff as stocks dwindled, with the result that the expiry dates of individual tablets within these containers were not known at the time that they were administered. If a particular stock ran low, then it was likely that tablets taken from the bottom of the container would have passed their expiry date. Moreover, in making up the medicines for inmates, the nursing staff took a number of pills from the open containers and placed them in a tub which had the inmate's name on the lid only. In essence, this meant that if the wrong lid was put on the wrong tub, an inmate would get the incorrect medication.

70. The delegation had significant concerns about the management of methadone at CCF, which concerned the 40 inmates on methadone at the time of the CPT delegation's visit. Methadone is a controlled drug pursuant to the Maltese Dangerous Drugs Ordinance³⁰ and, as such, there are regulations around its storage. In the controlled drugs' cupboard at CCF, there were two pots of what was presumed to be methadone, insofar as it was an unlabelled green liquid and not accounted for within the Controlled Drugs Register. Such a practice is unsafe as well as being at variance with domestic regulations and safe clinical practice in respect of the identification, labelling, storage and administration of opiate drugs.

In addition, while prescriptions were annotated by doctors, there was often no review date of prescriptions with the result that it was unclear, in many cases, how long the medicines should be continued to be administered. Overall, the current administration of medication at CCF, and particularly the administration of psychotropic medication, was unsafe.

The CPT recommends that the authorities review the current practices around the management of medicines at CCF in light of the above remarks, and ensure that unsafe practices around the administration of psychotropic medication cease.

71. By letter dated 4 November 2015, the Maltese authorities informed the Committee that a review of the health-care system at CCF was being undertaken, in order to terminate the current contractual system. The employment of full-time medical staff was also under consideration. The CPT welcomes the review and **would like to receive a copy of the review report and recommendations.**

b. self-harm and suicide prevention

72. The delegation observed that there was no strategy in place regarding the management of those thought to be at risk of self-harm. For instance, there were no clear guidelines available to health-care staff on how to address incidences of food refusal.

73. The CPT's delegation noted that cases of self-harm and attempted suicide were not systematically recorded at CCF and there was no specific self-harm or trauma register. One of the reasons for this, according to staff interviewed, was that ordinarily at-risk prisoners were transferred from CCF to the Forensic Unit at Mount Carmel Hospital, where they usually remained for a few days. While the fact of the transfer was recorded, only in very few of these cases was any reference made to the risk of self-harm/ suicide attempts. It was more common to simply find the word "confused" written in the records. Moreover, there were no hand-over or follow-up procedures concerning those prisoners who returned to CCF from the psychiatric forensic units in Mount Carmel Hospital. Thus, **appropriate handover and follow-up procedures should be established at CCF for returning prisoners from the psychiatric forensic units at Mount Carmel.**

³⁰ Laws of Malta, Chapter 101.

74. As regards suicide prevention policies, it is clear that CCF needs to put in place procedures for the identification of prisoners who may be at risk of suicide or self-harm and draw up a protocol for the management of prisoners identified as presenting a risk. To begin with, medical screening on arrival, and the reception process as a whole, has an important role to play in suicide prevention; performed properly, it should assist in identifying those at risk and relieve some of the anxiety experienced by all newly-arrived prisoners. The screening process should include a suicide risk assessment using an identified screening tool.³¹

Moreover, it is essential that the prevention of suicide, including the identification of those at risk, should not rest with the health-care service alone. All prison staff coming into contact with inmates – and, as a priority, staff who work in the reception and admissions units – should be trained in recognising indications of suicidal risk. The sharing of information concerning suicidal tendencies with prison staff can be considered as an ethical necessity in light of the possible consequences that inaction may entail. In this connection, it should be noted that the periods immediately following admission to prison as well as before and after trial and, in some cases, the pre-release period, are associated with an increased risk of suicide.

Upon identification of prisoners potentially at risk, steps should be taken to ensure a proper flow of information within the establishment. All persons identified as presenting a suicide risk should as a first step benefit from appropriate support and association. Further, if required, such persons should be subject to special precautions (placement in a ligature-free room and provision of suicide-proof clothing) and, where there is a high risk of suicide, the prisoner should be under constant observation by a member of staff who should engage in a dialogue with the prisoner. The need for enhanced contacts (i.e. family visits and telephone calls) should be individually assessed.

The CPT recommends that the Maltese authorities ensure that a comprehensive suicide prevention and management approach is introduced at CCF, taking into account the above remarks.

c. other health-care issues

75. In respect of those inmates who misuse benzodiazepines, there was no standard regime for the management of benzodiazepine withdrawals, other than possible referrals to the general hospital.

The CPT recommends that prisoners dependant on benzodiazepines, who need to be detoxified, should be offered a benzodiazepine detoxification regime in order to prevent the effects of sudden withdrawals from this drug.

³¹ Including a checklist of standard questions, e.g. the Viennese Instrument for Suicidality in Correctional Institutions, or “VISCI”.

76. In the course of the delegation's visit to CCF, there was an outbreak of diarrhoea. On 4 September 2015, 15 prisoners complained of diarrhoea at CCF, followed by another 20 inmates the following day. Various stool samples from inmates were also sent by CCF to the hospital laboratory on the evening of 4 September. Health Inspectors attended the prison on the morning of 5 September and took samples of water and food from the kitchen. Initially, prison management stated that all inmates affected had been in single cell accommodation and remained there; however, the delegation found nine of the affected prisoners were sharing cells with at least one other person and one inmate was in a large dormitory. The prison management explained that this was their first experience of a new phenomenon and the delegation observed that they were unsure how to contain and deal with the outbreak. On 9 September, some five days after the outbreak had commenced, it was confirmed that the cause of the outbreak was salmonella, which was presumed to have come from tuna in the kitchen. In total, 41 prisoners had been affected by this outbreak.

77. The CPT knows that the risk of disease transmission is enhanced in a closed institution (such as a prison), in particular when general hygiene and environmental conditions are poor. Consequently, prison health-care services should adopt a proactive approach, with a view to minimising the risk of the spread of certain infections.

The CPT recommends that the Maltese authorities put in place robust policies to deal immediately with health (and other) crises that may take place within the prison, including adopting a proactive approach, with a view to minimising the risk of the spread of certain infections and ensure the speedier analysis of test results. To this end, regular health checks of the food quality, storage procedures and hygiene standards and procedures in the CCF kitchen should be undertaken.

7. Other issues

a. prison staff

78. At the time of the visit, CCF had a full complement of 258 custodial staff and 22 administrative/non-uniformed staff for a prison population of 557 at the time of the visit (see paragraph 46). This represented a clear improvement on the situation found during the 2011 visit. There were also plans to recruit a further 60 custodial officers in the course of 2016.

Further, along with the planned new classification system and the progressive drawing up of care plans for each new prisoner, CCF intended to recruit more psychologists, psychological assistants, care plan co-ordinators and social workers. The CPT welcomes the developments in this area and **would like to receive information on the number recruited to each post.**

79. Nevertheless, CCF still lacked a permanent prison director and the prison suffered from a clear lack of management structure; instead, there had been a series of temporary acting directors, who were rarely present in the prison. Daily control was exercised by the Executive Head, who had little authority to engage in proper strategic planning over the long term; moreover, his line management responsibilities for other managers was far from clear. The CPT's delegation noted that this had been the situation for quite some time and the result was a very poor management structure, despite there being some keen and able managers in place. The delegation was informed that a permanent post of director had recently been advertised and that an appointment should be made shortly.

The CPT wishes to be notified when a permanent director has been appointed and has taken up his/her post.

- b. disciplinary procedures, segregation and solitary confinement

80. It is in the interests of both inmates and prison staff that clear disciplinary procedures be both formally established and applied in practice; any grey zones in this area involve the risk of unofficial (and uncontrolled) systems developing. Disciplinary procedures should provide prisoners with a right to be heard on the subject of the offences that they allegedly had committed, and to appeal to a higher authority against any sanctions imposed.

Further, if other procedures exist - alongside the formal disciplinary procedure - under which an inmate may be involuntarily separated from other inmates for discipline-related/security reasons (e.g. in the interests of good order within an establishment), these procedures should also be accompanied by effective safeguards.

81. As regards the disciplinary procedures at CCF, according to the law an inmate found guilty of a disciplinary offence may undergo the following punishments: caution; forfeiture or postponement for any period of any of the privileges; exclusion from associated work for a period not exceeding fifty-six days; cellular confinement not exceeding thirty days; or forfeiture of not more than one hundred and twenty days of remission.³² By letter dated 4 November 2015, the authorities informed the Committee that despite the high number of days of loss of remission allowed for by law, in practice the sanction imposed was normally a 28-day period.

82. The CPT delegation noted that when a prisoner is found guilty of more than one charge arising out of an incident, the punishments can be ordered to run consecutively. It also observed that in CCF there was a practice of accumulating or 'saving up' disciplinary charges; the Adjudication Board met approximately monthly, although on occasion only quarterly. One example of this involved a prisoner, who had failed five monthly drug tests that were saved up and all of them were later adjudicated upon in one single hearing. As 28 days was the standard punishment for failing a drugs test, this resulted in five times 28 days' loss of remission (a total of 140 days loss of remission). The Maltese Prison Regulations require that a prisoner be charged with a disciplinary offence within 48 hours of commission of the disciplinary offence. This was clearly not complied with in practice at CCF.

83. The CPT believes that prison disciplinary proceedings are by their nature summary proceedings. Their function is to respond as quickly as possible, consistent with the need to give adequate notice of hearings and charges to be faced, after the alleged offence has been discovered. The sooner the punishment is imposed the more likely it is to be effective. Waiting for weeks – or sometimes months – to hold the hearing and impose any penalty renders the procedure ineffective. In CCF, the irregular meetings of the Adjudication Board resulted in long delays between the alleged incident and the imposition of any disciplinary sanction. Justice requires that a sanction for a disciplinary offence be adjudicated upon and executed as soon as possible, not months later (as specified in national law).³³

³² Section 78, Prison Regulations.

³³ Where a prisoner is to be charged with a disciplinary offence, the charge shall be laid as soon as possible and,

84. Further, loss of remission should not fall under the competence of the Director but of an independent judge, in line with the ECHR judgment of *Ezeh and Connors v. the United Kingdom* (9 October 2003, Applications nos. 39665/98 and 40086/98).

The CPT recommends that the Maltese authorities take the necessary steps to amend the Prison Regulations, as well as any other relevant legislation, which still provide for the Prison Director to be able to impose up to 120 days of loss of remission per offence on inmates, with a view to ensuring that loss of remission falls under the competence of an independent judge.

85. By letter dated 4 November 2015, the Maltese authorities informed the Committee that efforts were being made to reduce the time between reports and the corresponding disciplinary procedures. Disciplinary hearings had started to take place once a week to address the backlog of cases. This represents a step in the right direction. Nevertheless, more needs to be done. **The CPT recommends that the practice of accumulating disciplinary offences cease and that disciplinary charges be adjudicated on as soon as possible after the commission of the alleged disciplinary offence; in this regard, the Adjudication Board should be convened far more regularly, on an on-going basis.**

86. Prisoners can appeal to an Appeals Board but only where sanction consists of six days or more of solitary confinement or forfeiture, continuously or cumulatively, of more than 28 days of remission.³⁴ This problem was raised as a matter of concern in the CPT's 2011 report but has not yet been remedied.

The CPT again recommends that the necessary steps be taken to ensure that prisoners are formally entitled to appeal to an independent authority against any disciplinary sanctions imposed, irrespective of their duration and/or severity.

87. The CPT's delegation noted that 'problematic' prisoners placed on Divisions V and XIII were subjected to a particularly restrictive regime compared with other prisoners. On both divisions, the inmates had little to do and were locked in the divisions for long periods of the day, save for a couple of hours when they were allowed to exercise in the divisions' exercise yards. The vast majority of these inmates (including all those on Division XIII) had no access to education, activities, work or regular religious worship; all those interviewed by the delegation complained about the lack of any purposeful activities. Moreover, on Division V, some inmates had even resorted to hunger strikes in order to be allowed to attend the prison church. The restrictive regimes on Divisions V and XIII applied to all inmates, regardless of their classification, and included some life-sentenced prisoners.

By letter dated 4 November 2015, the Maltese authorities informed the Committee that a limited education service would be introduced on Division V and that work opportunities in maintenance would be offered to a greater number of inmates on Division V. The CPT welcomes these initiatives. **It would like to receive confirmation from the authorities when these measures have been introduced.**

save in exceptional circumstances, within forty-eight hours of the discovery of the offence, cf. Section 76(1), Prison Regulations.

³⁴ Article 80, Prison Regulations.

The CPT recommends that inmates on Division XIII be provided with access to a full range of education services, work opportunities, access to a place of worship and sports and recreational activities. It also encourages the authorities to further expand the opportunities available to prisoners on Division V.

Further, it would like to receive information on the number of inmates in Division V who attend education and are involved in work, and for how many hours per day such activities are performed.

88. Removal from association and placement on Division V was part of the formal discipline and good order procedure of CCF. In contrast, the placement procedure and the safeguards surrounding placement on Division XIII, which resulted in a restrictive regime for the inmate concerned, were opaque and little understood by the inmates. Inmates did not know why they had been placed on such a division, or for how long they would be accommodated there. Inmates were also unaware of any avenues to appeal or challenge the placement decision. Moreover, some inmates were placed there immediately upon arrival due to the lack of a formal induction procedure or area at CCF as well as due to the lack of other available accommodation on any other division. In the delegation's view, placement on Division XIII was treated by the staff as an informal punishment, and was perceived as such by the inmates.

Similar concerns about the existence of an informal punishment system on the so-called "high-security unit" of Division VI had been raised by the CPT in 2011.³⁵

At the time of the 2015 visit, staff acknowledged that the same type of inmate, who had previously been placed on Division VI, was now being placed on Division XIII. Further, the delegation noted that the Prison Regulations had still not been amended to provide a remedy against the placement decision entailing segregation from the mainstream prison population.³⁶

89. In the CPT's view, placement on a restricted regime or in special security conditions should be based on an individualised assessment of the actual risks, and the prisoner concerned should as far as possible be kept fully informed of the reasons for the measure in writing. In addition, the prisoners concerned should be entitled to appeal the decision on placement, or its renewal, to an independent authority.

The CPT recommends that the Maltese authorities amend the Prison Regulations to ensure that, in particular:

- **placement on a restricted regime or in special security conditions should be based on an individualised assessment of the actual risks;**
- **the prisoner concerned should as far as possible be kept fully informed of the reasons for the measure in writing; and**
- **the prisoner concerned should be entitled to appeal the decision on placement, or its renewal, to an independent authority.**

³⁵ See paragraph 22, CPT/Inf (2013)12.

³⁶ Article 67, Prison Regulations ("removal from association").

90. As regards solitary and cellular confinement for discipline purposes, section 68 of the Prison Regulations stipulates that ‘the Director may order a violent prisoner to be confined temporarily in an appropriate cell [and] if the Director keeps such order in force for more than forty-eight hours he shall consult the Medical Officer and shall inform the Chairman of the Board’.³⁷ In CCF, solitary confinement on account of violence was resorted to in one of three adjoining cells, built in 2000 and designated as single rooms used for medical and disciplinary isolation purposes, situated next to the Infirmary. Each of the three cells had a bed plinth with a mattress and a toilet annexe. The cells had access to natural light and adequate ventilation and each had a call-bell. From examination of the relevant registers and interviews with prisoners and staff, it was clear that these cells were only occasionally used.³⁸ Of the nine placements from January 2015 until the date of the CPT delegation’s visit, seven had been for medical observation reasons and two for disciplinary purposes. The disciplinary cases had both involved the same person and each had lasted less than 48 hours. The seven medical cases had lasted seven, four, seven, five, two, one and three days respectively.

As regards the sanction of cellular confinement for up to a period of 30 days,³⁹ the CPT understands that this measure means that the inmate is kept in his or her cell. Therefore, in most cases in CCF (given that most of the prisoners have single-cell accommodation) this measure means being placed in effective solitary confinement for 30 days.

The CPT recalls that solitary confinement as a disciplinary sanction should not last for a period of more than 14 days consecutively. **Thus, it recommends that the Prison Regulations be amended to reflect this.**

c. classification system

91. The CPT’s delegation noted that some positive changes in respect of the classification system at CCF had occurred since the 2011 visit. The male juvenile inmates were being separated from adult inmates in a different location (the YOURs Unit) (see Section 8) and there were plans to introduce a new classification system that would separate remand from sentenced prisoners and even to prepare a sentence care plan for each newly-arrived prisoner, according to assessed risk and needs (see paragraph 78). Nevertheless, the CPT considers that these developments are far too limited and far too slow. At the time of the visit, remand and sentenced prisoners were accommodated together and juvenile female inmates were accommodated with adult female inmates.

92. The CPT considers that classification and allocation of inmates, enabling each convicted person to be assessed in terms of security risk, skills, and needs, should occur on admission to prison. A well-designed classification procedure will provide the authorities with the necessary information to treat inmates as individuals and to deal with their special needs; such a procedure will make it possible to distinguish the small number of inmates who are likely to present a threat to security or control from the majority who will be suitable for inclusion in a normal, developed programme of regime activities.

³⁷ Section 68, Prison Regulations.

³⁸ The register showed a total of nine placements in one of these cells from January until September 2015 and a total of 17 in 2014.

³⁹ Section 78, Prison Regulations.

The CPT calls, once again, upon the Maltese authorities to take immediate steps to set up a proper classification and allocation system for inmates at CCF, taking into account the criteria set out in the European Prison Rules.⁴⁰

As a start, female juveniles should not be accommodated with female adult inmates; consideration should be given to moving female juvenile inmates to a separate section of the YOURs Unit.

d. prison induction procedures

93. Reception and first night procedures for all prisoners have an important role to play; performed properly, they can identify at least certain of those at risk of self-harm and relieve some of the anxiety experienced by all newly-arrived prisoners. The CPT's delegation noted that the induction procedure at CCF was almost non-existent. Certain newly-arrived inmates were being placed on a restricted-regime division for many months for no apparently valid reason.

The CPT recommends that the Maltese authorities introduce a proper induction process for all prisoners being admitted to CCF, and that newly-admitted prisoners be held in a dedicated reception unit to allow for a proper assessment and classification process to be carried out. Thereafter, they should be allocated to appropriate accommodation units.

e. complaints and inspections procedures

94. Effective complaints and inspection procedures are basic safeguards against ill-treatment in prisons. As regards complaints procedures, prisoners should have avenues open to them, both within and outside the prison system, and be entitled to confidential access to an appropriate complaints authority. In addition to addressing the individual case involved, the CPT considers that a careful analysis of complaints can be a useful tool in identifying issues to be addressed at a general level.

95. As mentioned in paragraph 12 (*'National Preventive Mechanism'*) above, the CPT is of the view that the external complaints system (i.e. the Prison Board) does not function effectively. Further, the internal complaints system, which consisted merely of an oral complaint to any given staff member, or request to speak with a member of the management team, was under-developed. The procedure was totally informal with no register of the various complaints, the conversations that took place or of any action taken subsequent to the request.

⁴⁰ Adopted on 11 January 2006 by the Council of Europe's Committee of Ministers [Rec (2006) 2], Rule 17.1.

96. The CPT considers that a proper internal complaints system needs to be put in place; for example, prisoners ought to be able to make written complaints at any time and place them in a locked complaints box on a prison landing (forms should be freely available); all written complaints should be registered centrally within the prison before being allocated to a particular service for investigation or follow up. In all cases, the investigation should be carried out expeditiously (with any delays justified) and prisoners should be informed within clearly defined time periods of the action taken to address their concern or of the reasons for considering the complaint not justified. In addition, statistics on the types of complaints made should be kept as an indicator to management of areas of discontent within the prison. Of course, prison officers should be encouraged and empowered as far as possible to resolve complaints themselves.

97. By letter dated 4 November 2015, the Maltese authorities informed the Committee that a review of the current external complaints' procedure would be initiated shortly. The CPT trusts that the review will be comprehensive. Further, **the CPT recommends that the Maltese authorities introduce a formal system of internal complaints, taking into account the above remarks. It would also like to receive a copy of the review on the external complaints' procedure and information about any subsequent action taken.**

8. Young Offenders Unit of Rehabilitation Services (YOURS)

98. The YOURS unit, located in a rural setting near Mtahleb, consists of a single-storey horse-shoe shaped building with a courtyard in the middle. The Unit is supposed to accommodate 15-21 year olds who have been sentenced to a term of imprisonment or are on remand. The official capacity is 20 and at the time of the visit, the Unit was holding 13 young adults from 18-21 years of age.

99. The atmosphere between staff and inmates was generally good and no allegations of deliberate ill-treatment by staff were received. However, there were a few allegations of incidents of inter-prisoner violence between Maltese and foreign nationals from the African continent and, in that context, a couple of allegations were made of discriminatory attitudes by staff towards foreign national inmates.

The CPT recommends that staff be vigilant in preventing acts of inter-prisoner violence. Further, staff should be reminded that acting in a discriminatory manner undermines their standing within the establishment and further jeopardises good order.

100. The Unit is composed of two dormitories, a classroom, a common room with games and a billiards table, a weights room and a room in the process of being converted into a crafts workshop.

The dormitories measured some 36m² and were equipped with five sets of bunk beds. The dormitories had good access to natural light, the artificial lighting and ventilation were sufficient, and each person had his own metal locker for personal belongings. The separate sanitary facilities were in an acceptable state of repair. Complaints were received that the rooms were locked at night (8.30 p.m. to 7.45 a.m.) ever since a fight some three months prior to the delegation's visit, and that it was not easy to attract one of the two officers' attention to come and open the door to allow inmates to go to the toilet, especially as there was no call-bell system in place.

As for activities, a number of courses were organised on an ad hoc basis (life skills, English or Maltese language, art, music) and a few positions of paid work (36 Euros per month) were available, primarily cleaning and kitchen work. A sports coach visited on Wednesdays for a couple of hours to supervise football in the courtyard or games in the common room. However, the inmates spent much of their time in the Unit with little to do. There was no specifically tailored regime for the young persons, nor were there any programmes to help the juveniles and young offenders prepare for reintegration into society.

The CPT recommends that a full programme of education, sport, vocational training, recreation and other purposeful out-of-cell activities should be provided to all inmates. Further, all inmates should be provided with a minimum of 4m² of living space in multi-occupancy dormitories.

In addition, if the doors to the dormitories are to remain locked at night, staff must be attentive to any requests for access to the toilet; in this respect, the CPT recommends that the authorities install a call-bell system.

101. As regards health-care, the Unit is attended by an agency nurse every day from 8 a.m. to 8 p.m. and by a doctor whenever needed. A psychologist runs individual and group sessions on Mondays. No comprehensive medical assessment was carried out when young persons were admitted to the Unit as all the administrative admission procedures were done at the CCF main prison and not at YOURS. At the time of the visit, the agency nurse assigned to YOURS had only just started working there and had no experience of working with young people; indeed she had specialised in working with the elderly. The lack of continuity of care by health-care staff makes it more difficult to build up any positive relationships or to get to know the young people requesting treatment. Further, medical confidentiality was not respected as a prison officer was always present during consultations.

There should be a comprehensive strategy for the management of substance abuse and prevention of self-harm and suicide, and health education about transmissible diseases should be provided. No such policies were in evidence at YOURS and the delegation noted that the hygiene in the kitchen could be improved.

The CPT recommends that the health-care assessments of young offenders also be carried out upon admission to YOURS, and that a proactive preventive health-care approach be put in place. Further, medical confidentiality should be respected and hygiene standards in the kitchen improved.

102. As regards staffing, during the day there were four custodial officers (7 a.m. to 8.45 p.m.) plus a head of shift and the unit manager; at night two officers were on duty (5 p.m. to 7 a.m.). The officers had been provided with some courses for working in the unit but from interviews with the staff it was clear that they were not specifically trained to work and engage with young persons.

The CPT recalls that all staff in direct contact with juveniles and young persons should receive professional training and benefit from appropriate external support and supervision in the exercise of their duties. Particular attention should be given to staff training in the management of violent incidents, especially in verbal de-escalation to reduce tension and professional restraint techniques. Further, staff should be alert to signs of bullying and adopt a pro-active attitude to prevent such incidents from occurring.

The CPT recommends that steps be taken to ensure all staff working at YOURS are specifically selected and professionally trained to work with young persons.

103. The CPT's delegation was informed by the Unit manager that there were advanced plans to build an extension to the current YOURS facility, notably adding 15 double-occupancy cells for male young offenders and five double-occupancy cells for female young offenders. Further, two single rooms would be equipped for accommodating challenging young persons who infringed the prison rules or disturbed the good order of the facility. There were also plans to transform the existing dormitories into activity rooms.

The CPT welcomes these plans. Nevertheless, the YOURS facility in its current form is not designed to assist juveniles and young adults in preparing for their reintegration into the community but is more of a "warehousing" facility with a few activities. In parallel with the material extensions and renovations, it is important that the Maltese authorities put in place specific detention rules for young offenders and design a full daily regime with purposeful activities (education, vocation, work, sport recreation) which aims to assist and support the inmates in preparing for their release. The ethos of the facility should not be the same as that of the CCF but instead oriented towards young people.⁴¹

The CPT recommends that, in the context of the extension and renovation, the YOURS facility becomes a fully autonomous unit of the CCF responsible for the admission, care and treatment of the young inmates, with its own detention rules.

The CPT would like to receive detailed information on the plans for the extension of the YOURS facility, including the timelines for its completion.

⁴¹ See the 24th General Report of the CPT – CPT/Inf (2015) 1, paragraphs 101 to 132 concerning the Committee's standards for detention centres for juveniles.

9. Forensic Psychiatric Units, Mount Carmel Hospital

a. preliminary remarks

104. The delegation paid a follow-up visit to the Male Forensic Psychiatric Unit (MFPU), and also visited the Female Forensic Psychiatric Unit (FFPU), both of which are located at Mount Carmel Hospital, to assess the implementation of the CPT's recommendations made following previous visits, and notably that of 2011.⁴² Both units are under the authority of CCF.

105. The MFPU is located to the side of the Mount Carmel Hospital compound, and is accessed from the outside through secure metal gates constituting a separate entrance to that of the main hospital. At the time of the visit, the MFPU was accommodating 42 patients. The Unit comprised two sections; Section A held 23 patients in eight rooms and Section B, 19 patients in four rooms. Three of the rooms within Section A were single rooms. In terms of layout, little had changed from the previous visits in 2008⁴³ and 2011.

106. The FFPU, adjacent to female Ward 1 of the Hospital, has a capacity of five patients and was holding three women at the time of the visit.

107. At the outset, the CPT wishes to express its serious misgivings regarding the management of the male and female forensic units at Mount Carmel Hospital. The findings of the visit demonstrate clearly that the CCF is not the appropriate body to manage a health-care facility and that there is no proper supervision from within the Ministry of Home Affairs and National Security.

In addition to the serious concerns over the treatment of patients in the forensic units as outlined below, there is an urgent need to revise the purpose and placement criteria for placing prisoners/patients in these units. Some of the patients met by the delegation clearly did not have a mental illness or were not in need of in-patient care. It appeared that the units were, to a certain degree, being used as a "dumping ground" for difficult or challenging prisoners with behavioural problems or as a protection measure.

The forensic units are within the Mount Carmel Hospital compound and ought to operate to the same high standards as a civil mental-health care facility. This was not the case at the time of the visit. There is a necessity for the Ministry of Health to be tasked with oversight of the forensic units and for these units to be brought within the ambit of the management of Mount Carmel Hospital. Such a process should be carried out in close co-operation with the Ministry of Home Affairs and National Security and CCF, as particular security arrangements need to be in place which should be managed by health-care staff.

⁴² See paragraphs 67 to 73, CPT/Info(2013)12.

⁴³ See paragraphs 167 and 171, CPT/Info(2011)5.

The CPT recommends that the Maltese authorities undertake a complete review of the purpose and functioning of the forensic units at Mount Carmel Hospital, with a view to making them fit for purpose. To this end, the Ministry of Health should be tasked with the oversight of the forensic units and the units should be brought under the management of Mount Carmel Hospital. There is also a need to invest more in the recruitment and training of qualified nursing staff, who should be able to perform all the duties required of a forensic psychiatric service (in this respect, see the recommendation contained in paragraph 123).

b. ill-treatment

108. At the Male and Female Forensic Units, the majority of patients interviewed by the CPT's delegation stated that they were treated correctly by staff. That said, a couple of allegations were received regarding the rough pushing of a patient by prison staff and of verbal abuse by prison staff towards patients.

The CPT recommends that the Maltese authorities deliver a clear reminder to staff that the ill-treatment of patients, in any form, is illegal and that the perpetrators will be punished accordingly.

c. living conditions, treatment, activities and regime

109. The material conditions on the MFPU were especially poor, with no improvements having been made since the 2011 visit.

The rooms were cramped and crowded (for example, with 8 beds and 1 mattress in a room of 33m², affording a mere 3.6m² of living space per patient), dilapidated and dirty, with unscreened toilets, no in-room wash basins and no ready access to drinking water. One patient was sleeping on a mattress on the floor at the time of the visit. Patients alleged that when they first arrived on the Unit they had to sleep on mattresses on the floor of the single rooms, in some cases for up to five days, until a dormitory bed was allocated to them.

110. The FFPU was smaller and the material conditions were slightly better. The rooms were clean, more personalised, had access to natural light and artificial lighting, and had adequate ventilation (ceiling fans and air-conditioning). However, the rooms lacked wash basins and the toilets were unscreened.

Further, the CPT is of the view that the official capacity of the FFPU should be reduced as one room, measuring some 8.5m², possessed three beds.

The CPT recommends again that the Maltese authorities take steps in the male and female Forensic Units to ensure that:

- **all patients are provided with their own bed, as well as with lockable space to store their personal belongings;**
- **toilets in double- and multi-occupancy rooms are fully partitioned to the ceiling;**
- **wash basins are installed in all of the rooms;**
- **patients have ready access to drinking water;**
- **the general level of hygiene is improved; and**
- **the capacity levels of both units are reviewed to ensure that there is sufficient living space for each patient; rooms of 8.5m² should preferably not be used to accommodate more than one patient.**

111. The CPT's delegation received numerous complaints about the quality of the food on the MFPU, which was provided by an outside caterer in a plastic meal box. Patients complained that it was monotonous, bland and insufficient in quantity. Many patients supplemented it or replaced it with food from their families, but those who could not had to rely on fellow patients for additional food. Such a situation could create a dependence on other patients, and could incentivise informal avenues to obtain food and expose patients to bullying or power relationships.

In the absence of a specialised service, it is the responsibility of CCF - in conjunction with the competent authorities - to supervise catering arrangements (quality, quantity, preparation and distribution of food). **In this respect, the CPT recommends that the Maltese authorities ensure that the menus at the Forensic Units are overseen by a qualified dietician and nutritionist, and that the quality and quantity of food distributed to patients comply with relevant minimum standards on daily food intake as regards proteins and vitamins.**

112. For those patients on MFPU Section A, the regime was a semi-open one (i.e. unlock between 7:30 am and 7:30 pm) and the patients could wander in the outside areas and front garden. In contrast, patients on Section B lived under a semi-closed regime, with six and a half hours of unlock a day, and for whom access to the garden was prohibited. Most of these patients sat in a drab environment, with nothing to occupy their time, other than to watch the television in the impersonal and dirty communal dining room or walk in the spartan concrete yard, which provided no protection from the sun or the rain. There were almost no activities on offer to the majority of the patients, and one of the most common complaints received by the delegation from the patients, especially those held on Section B, was the issue of boredom.

As for the FFPU, there was a semi-open regime in operation; in general, unlock was from 9.00 a.m. until 12.00 p.m. and 2 p.m. until 8.30 p.m., and the women were allowed out of their rooms, into the communal areas, for most of the day. There was a small common room, with a communal table and chairs, a television and some personal lockers and a bench. A concrete exercise yard adjoined the Unit, though it provided no shelter or means of rest for the patients. Nevertheless, there were almost no regular purposeful activities on offer to the patients and they complained to the delegation of extreme boredom. Repeated requests for the opportunity to undertake some form of work or partake in other activities, on a regular basis, had gone generally unanswered.

113. As concerns treatment and the availability of therapeutic activities, the atmosphere and regime were extremely carceral and un-therapeutic in both of the forensic units. Indeed, there was very little occupational therapy being carried out in either forensic unit, and the primary intervention was pharmacological. Moreover, in both forensic units, there were no individualised care plans.

The CPT's delegation has particular concerns about the quality of medical care afforded to patients in these units. The situation concerning three patients on the MFPU prompted it to invoke Article 8, paragraph 5, of the Convention at the end of the visit, making an immediate observation for action to be taken to improve the quality of their care.

114. Two of the patients, Patients C and D, were very ill and elderly. One of them did not have any mental health issues that required him to be kept in a forensic psychiatric unit. Both had multiple somatic needs and had been, in the CPT delegation's view, generally neglected by staff. One patient (Patient C) was blind, had heart failure and had thrice weekly renal dialysis. He had no care plan (somatic or psychiatric). During the delegation's visit, he was lying on a filthy mattress. He required to be assisted onto the edge of his bed and to the toilet by the other very ill patient (Patient D), with whom he shared the room, who himself had very limited mobility on account of having had a stroke.

There was no oversight of Patient C's physical health-care needs. Examination of his medical records established that he had been seen on a number of occasions by the on-call doctor from Mount Carmel Hospital due to varying problems, and on many of these, an admission to Mater Dei Hospital had been required. Upon discharge from Mater Dei Hospital, little regard was paid to his health-care needs other than to facilitate his transfer for renal dialysis.

Patient D had been transferred from CCF to the Forensic Unit after his stroke. However, on account of the lack of engagement by nursing staff, he spent all day in bed watching TV. His bed was filthy. The room that these two patients shared was dirty and unhygienic, since their health limitations made it impossible for them to clean their room – something that all forensic patients were expected to do. Clearly, they both were in need of a more caring environment, which properly met their somatic needs.

115. The third patient, Patient E, was very uncommunicative, guarded and suspicious. He was accommodated in a single room, where he had been for much of the previous two months since his arrival. Despite his room being extremely hot (over 31.8C), there were two bottles of water unopened. Staff explained that, at times, it was unclear as to whether this patient was eating or drinking, and indeed he had been observed, via the CCTV, drinking water from the toilet. This man was clearly very unwell and had been so since his admission to the Forensic Unit.

Patient E was one of the very few patients placed involuntarily in the MFPU, and as such fell under the Mental Health Act. As part of an application for a treatment order a mental health care plan has to be submitted and approved by the Commissioner for Mental Health, which was done in Patient E's case, but no effect was given to it. By way of example, his care plan stated that nursing staff would observe his food and water intake and attempt to engage him in a therapeutic relationship. In speaking to nursing staff, the delegation observed that no record had been kept of his food and fluid intake and indeed, his most basic care needs were being neglected insofar as

nursing staff rarely engaged with him and he stayed in his room for 24 hours a day, hardly talking to or meeting any one. He was unwashed and his room was very malodorous. Despite his non-responsiveness to antipsychotic medication, no attempts had been made to consider why he was not responding to the medication, in contrast to the previous occasions when he had been an in-patient. Nor had the opinion of a second psychiatrist been sought, at the time of the delegation's visit. While he was designated to be on 'Level 1' constant observation, which meant that a member of nursing staff should have been with him 24 hours a day, at arm's length, this was not the case in practice. He was left alone in the room which was located furthest from the nursing station and was basically ignored by nursing staff.

116. In response to the above-mentioned immediate observation regarding the three patients, the Maltese authorities informed the Committee that Patient C had since died, and acknowledged that Patient D needed to be transferred to another room more suited to his needs. However, they stated that he could not be transferred elsewhere given the nature of his prison sentence. Such a response appears merely to confirm the Committee's suspicions that the MFPU is used as a dumping ground for difficult patients to manage. There is no good reason why a prisoner who does not have mental health needs should be required to be held in a psychiatric forensic unit, even more so where the unit is unable to cater to his somatic needs. A suitable alternative must be found, such as transferring him to a geriatric ward, as proposed by the delegation and agreed to by the medical director of Mount Carmel Hospital.

The CPT recommends that the Maltese authorities transfer Patient D to a place where his serious somatic needs can be appropriately catered for.

117. As for Patient E, the CPT's delegation requested that his medical care be reviewed by a second psychiatrist and that he be moved to a room closer to the nursing staff, to enable him to be under the constant physical supervision and care of the nursing staff. The Maltese authorities responded that Patient E had been given a different treatment plan and medical regime and had been transferred to another room. In subsequent correspondence (see paragraph 8), the authorities informed the CPT that a second opinion for this patient had been sought. The CPT has noted these developments but remains concerned about the quality of the care being afforded to this patient. **The CPT recommends that nursing staff be physically present in his room to ensure the safety of this patient until he is no longer deemed to be at risk.**

118. On the FFPU, the delegation met a young woman (Patient F) with behavioural problems, who was not getting appropriate care; she had no individualised care plan and her epilepsy was regarded by health-care staff as a pretence rather than as a condition requiring care. Further, Patient F was being regularly secluded in her single room; she had been locked, some 22 times, in her room for 23 hours a day over the two months prior to the delegation's visit.

The CPT recommends that the medical care afforded to this patient be reviewed, and that an individualised treatment plan be drawn up for her. Further, the use of seclusion should be properly regulated and subject to the appropriate safeguards (in this respect see the recommendation contained in paragraphs 115 and 128).

119. The CPT believes that the care and custody of persons subject to placement in a penitentiary mental health-care facility as a therapeutic measure should be based on treatment and rehabilitation, while taking account of the necessary security considerations. This approach should be reflected in the living conditions and other facilities offered to this particular patient population, as well as in their treatment and activities.

In light of the general situation, as highlighted by the specific cases above, **the CPT recommends that the Maltese authorities conduct an overarching review of the quality of medical care afforded to patients on both of the Forensic Units with a view to initiating the necessary improvements. The CPT would like to receive information on the outcome of this review.**

The CPT also recommends that the Maltese authorities develop a range of rehabilitative psycho-social activities for forensic psychiatric patients at Mount Carmel Hospital; occupational therapy should be an integral part of the rehabilitation programme.

Further, an individual treatment plan should be drawn up for each forensic psychiatric patient, including the goals of the treatment, the therapeutic means to be used and the staff members responsible. Patients should be involved in the drafting of their individual treatment plans and the evaluation of their progress, and such treatment plans should be reviewed and updated on a regular basis.

The CPT recommends that the environment in which forensic patients are held should be made as therapeutic to their needs as possible, and in general, subject to individualised risk-assessments, patients should be able to benefit from a semi-open regime, partake in purposeful activities and have ready access to the outside areas. Lastly, the exercise yards should be equipped with benches and shelter against inclement weather.

120. Contacts with the outside world were generally satisfactory. Male and female patients could receive visitors four times per week in Section A and twice per week in Section B and visits could last up to 90 minutes. Phones were available at all times, with no restriction on access, save the need to pay for calls.

d. staffing

121. Two psychiatrists shared the case-load for the forensic units and there was a general health-care physician on call 24 hours per day. Four agency nurses and two prison officers were on duty per shift. An additional female prison officer was present every day, except Monday and Friday, to carry out searches on female visitors. Nevertheless, the delegation observed that the number of health-care staff was insufficient during the day shift to be able to adequately carry out all essential basic tasks, with the result that some patients had to assist other patients who needed help, for example, with showering or taking them to the toilet.

122. All the health-care staff were agency staff, none of whom had mental health expertise save for the head nurse, who had a specialisation in psychiatry. Agency staff, by their nature, can vary from shift to shift and many of them were not Maltese. Indeed, the delegation was informed that it was challenging to recruit local staff to work with forensic patients. In addition, staff informed the delegation that some of the agency nurses had very limited Maltese or English language skills, which was clearly an impediment to their work. The delegation observed that the nurse in charge was unfamiliar with the patients as individuals and had little knowledge of their care needs.

In addition, the health-care staff clearly relied on officers from CCF, or the Special Response Team, to assist them in the management of the patients within both forensic units. On occasion, health-care staff requested that CCF staff restrain patients to enable medication to be given forcibly (see paragraph 124).

123. It is a long-held view of the CPT that the health-care team in a psychiatric institution should include an adequate number of qualified psychiatric nurses, and specialised psychiatric nursing training should be available to other care staff who may wish to develop their skills; this can have a positive impact upon the quality of care which can be delivered to patients. Deficiencies in staff resources will often seriously undermine attempts to offer activities; further, they can lead to high-risk situations for patients, notwithstanding the good intentions and genuine efforts of the staff in service. Health-care staff should be able to cover all of the duties required in a psychiatric setting, including security.

The CPT recommends that the Maltese authorities increase the number of qualified psychiatric nurses and general health-care staff in both forensic units, to ensure that essential care tasks, including showering or taking patients to the toilet, are performed by trained health-care staff. It also recommends that specialised psychiatric nursing training should be available to other care staff who may wish to develop their skills. Further, every effort should be made to limit the turnover of care staff. Moreover, it recommends that the authorities ensure the regular presence of a consulting physician specialised in general internal medicine at the forensic units.

e. restraints and seclusion

124. The CPT's delegation noted that physical restraint was applied on both forensic units by custodial staff as well as health-care staff, to hold patients down in order for health-care staff to forcibly administer medication. Further, the delegation observed that staff had clearly not been trained in conventional control and restraint methods. In addition, no register was kept of the use of the single rooms which were, in effect, seclusion rooms in both forensic units and no separate register was kept for the recording of the use of means of restraint. Further, it was clear that staff did not give patients the opportunity to discuss their experience during and or shortly after the end of a period of restraint.

For example, Patient E, who was on an Involuntary Admission Treatment Order, was restrained by the Special Response Team (SRT) from CCF on 8 August 2015, on the orders of E's treating psychiatrist, so that 50 mg of the depot injection haloperidol could be administered. On 5 September 2015, E was held down by six custody staff while a member of the nursing staff gave him another injection of IM depot haloperidol. In discussion with the Head of Custody of the Forensic Unit, it became clear that the staff had no formal training in control and restraint and that custodial staff had simply applied some Tae Kwon Do techniques to restrain the patient. Further, the Head of Custody acknowledged that the forcible medication process could sometimes be chaotic and that, on a previous occasion, he himself had been accidentally injected rather than the patient.

125. The CPT wishes to underline that, as a general rule, a patient should only be restrained as a measure of last resort; an extreme action applied in order to prevent imminent injury or to reduce acute agitation and/or violence. It also wishes to stress the importance of appropriate training in control and restraint techniques (i.e. manual control). Restraining an agitated or violent patient properly is no easy task for staff. Not only is training essential but refresher courses need to be organised at regular intervals. Such training should not only focus on instructing health-care staff how to apply means of restraint but, equally importantly, should ensure that they understand the impact the use of restraint may have on a patient and that they know how to care for a restrained patient. The possession of such skills will enable staff to choose the most appropriate response when confronted by difficult situations, thereby significantly reducing the risk of injuries to patients and staff.

Further, the existence of a systematic recording system is crucial for enabling proper monitoring of the restraint procedures as well as enabling a complete picture of resort to such measures in forensic psychiatric units.

126. The CPT recommends that the Maltese authorities ensure that the application of any means of restraint should only be carried out by adequately trained health-care staff and resort should never be had to the Special Response Team from the prison.

Further, a systematic recording system should be put in place to enable the proper monitoring of the restraint procedures applied in the forensic units. The record of the use of means of restraint should be distinct from other registers. The fact of the use of means of restraint should be also duly noted on the concerned patients' individual medical files.

In addition, the patient concerned should be given the opportunity to discuss his/her experience, during and, in any event, as soon as possible after the end of a period of restraint. The patient concerned should also be informed of the relevant procedure, and avenues available, for making a complaint.

127. The delegation also received a few general allegations from a couple of patients on the MFPU that pepper spray or CS gas was used inside accommodation areas, on occasion, to subdue and control patients who refused medication. It did not, however, find any supporting evidence for such allegations. Nevertheless, similar allegations had been received at the time of the time of the 2011 visit⁴⁴ to the MFPU. Clearly, it is unacceptable for CS gas to be applied to a patient inside a hospital room for the purposes of administering medication that has been refused.

The CPT wishes to receive confirmation that CS gas and pepper spray are not deployed at Mount Carmel Hospital.

128. The CPT's delegation also noted that seclusion as a means of restraint was being applied in both forensic units, in some cases for prolonged periods.

On the FFPU, according to health-care staff, one of the patients (Patient F) had been secluded in her single room for 23 hours a day for most of the month that she had spent in the Unit (early August until early September 2015), owing to her disruptive behaviour. On the Male Forensic Unit, one patient (Patient E) had been held in conditions akin to solitary confinement, spending 24 hours a day in his room, since his arrival on the Unit two months prior to the delegation's visit, due to being at risk of self-harming. It was not clear whether regular reviews were being conducted into the need for continued isolation.

129. The CPT believes that locking up a vulnerable mentally-disordered patient alone in a room must be very carefully applied and should only be a measure of last resort and for the shortest possible period. Seclusion should not be resorted to due to a lack of alternative strategies, staff and regime provision. Further, patients should always be debriefed after the end of the seclusion measure, in order to explain the rationale behind it. It goes without saying that the existence of a systematic recording system would allow for proper monitoring of the seclusion procedures and would ensure the emergence of a complete picture of resort to such measures in a psychiatric setting. At the time of the visit, the delegation noted that there was no written seclusion policy for the forensic units, unlike in the rest of Mount Carmel Hospital.

The CPT recommends that the Maltese authorities take steps to ensure that the measure of seclusion be properly regulated and subject to the same safeguards as other means of use of restraint; in particular:

- **it should only be a measure of last resort and for the shortest possible period;**
- **a systematic recording system should be established for every use of seclusion;**
- **the existence of appropriate human contact should be ensured for, and individualised staff supervision of, those patients placed in seclusion;**
- **that a written seclusion policy should be made available in the forensic units;**
- and**

⁴⁴ See paragraph 70, CPT/Info(2013)12.

- **the place where a patient is secluded should be specially designed for that specific purpose. It should be safe and promote a calming environment for the patient.**

Further, the CPT would like to receive a copy of the seclusion policy for the forensic units.

- f. safeguards in the context of involuntary placement and treatment

130. Involuntary placement and treatment of persons having committed a criminal offence is regulated in Malta by the Criminal Code⁴⁵ and the recently adopted new Mental Health Act (MHA), Part VIII.⁴⁶ As regards the legal safeguards for patients undergoing compulsory psychiatric treatment at the forensic units, the situation was very much the same as that observed during the 2008 and 2011 visits. This was the case despite the introduction of a new MHA,⁴⁷ which had had no significant impact on forensic patients.

131. In practice, the CPT's delegation observed, from interviews with patients and staff and from an examination of the relevant records, that some patients in both the male and female forensic units were being treated *de facto involuntarily* despite being considered as 'voluntary'. Further, the delegation noted some cases where, although involuntary treatment orders had expired, treatment continued forcibly without the patient's consent (see paragraph 124).

By way of illustration, Patient F was transferred to the Female Forensic Unit from CCF (after an incident at CCF with the custodial staff) under involuntary admission for observation under the Mental Health Act⁴⁸, which was effected at 7.15 pm on 2 August 2015. On 3 August 2015, Patient F was seen by a psychiatrist who opined that the criteria for involuntary admission did not apply as the patient was willing to stay in the Hospital. During the interview with the CPT's delegation, this patient repeated several times that she had been in the Unit for over a month and wanted to leave and was being involuntarily detained. The patient presented challenges, with disruptive behaviour in both CCF and with staff in the forensic unit, and as stated above, had been confined to her single room for long periods (see paragraph 128). That said, her medical records made no mention of any psychotic illness and, from interviewing her, the CPT delegation's doctor gained the impression that she had no thought-disorder suggestive of a psychotic illness and, in fact, her mood was normal. Staff also informed the delegation that she was being given daily anti-psychotic medication in small doses to treat depressive illness as opposed to psychotic illness.

⁴⁵ Articles 402(4), 502(4) 525(3), 620, 623 of the Criminal Code.

⁴⁶ Mental Health Act 2012, Articles 36 to 39.

⁴⁷ MHA adopted in 2012, in force in 2013; Chapter 525, Laws of Malta.

⁴⁸ Mental Health Act 2012, Article 9(1) and 10(2).

As another example, Patient E, had been admitted to the MFPU on 13 July 2015 as a voluntary patient. However, he had been refusing to take the antipsychotic medicines prescribed for him. On 18 July 2015, he was seen by his treating psychiatrist, who recorded in the notes that he was agitated and ordered that he be given 5mg of antipsychotic haloperidol intramuscularly as a stat dose. In a subsequent conversation between the treating psychiatrist and the delegation's doctor, it was agreed that on this occasion there had been no concern documented that Patient E was a risk to himself or any others and that the administration of medicine had been ordered without there being provision in law for such. Subsequently, on 28 July, an Involuntary Admission for Treatment Order was applied for and issued the same day.

132. The CPT wishes to stress that psychiatric patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis – be it in the context of civil or criminal proceedings – should not preclude seeking informed consent to treatment. Every patient, whether voluntary or involuntary, should be informed about the intended treatment. Further, every patient capable of discernment should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances, such as the requirement of the doctor to intervene to prevent death.

The CPT recommends that the Maltese authorities ensure that every patient, regardless of their civil or forensic status (and, if they are incompetent, their legal representatives) should:

- **be provided systematically with information about their condition and informed about the intended treatment;**
- **be given the opportunity to refuse treatment or any other medical intervention, and that doctors be instructed that they should always seek the patient's consent to treatment prior to its commencement;**
- **be provided with relevant information during and after treatment; and**
- **be able to appeal against a compulsory treatment decision to an independent outside authority.**

The CPT also recommends that, if it is considered that a given patient who has been voluntarily admitted and who subsequently expresses a wish to leave the hospital (and return to the prison), still requires in-patient care, the patient should be assessed with a view to transforming the voluntary status of the patient into an involuntary status in accordance with the procedures contained in the Mental Health Act.

D. Mount Carmel Psychiatric Hospital & Gozo General Hospital

1. Preliminary remarks

133. Mount Carmel Hospital is the main mental health institution in Malta and was first visited by the CPT in 1990.⁴⁹ It is housed in a listed 19th century building, with most of the single-storey wards leading off the main imposing administration building. Some units such as those for young persons and male learning disabled patients were located in two-storey houses outside the main gates of the hospital. The process of refurbishing and renovating the hospital compound continues with a view to providing modern hospital standards. Nevertheless, it should be mentioned at the outset that Mount Carmel Hospital continues to serve both as a mental health facility treating patients with acute and chronic mental health disorders and as a social care home for those in need of assisted care. Many patients do not need to be accommodated in a hospital setting, but the appropriate structures for their care do not exist in the community although some progress has been made in recent years to find assisted-living accommodation in the community.

The CPT would like to be informed about the future plans for Mount Carmel Hospital and notably about the progress in developing assisted-living accommodation in the community and the deinstitutionalisation of the hospital.

134. At the time of the visit, Mount Carmel Hospital had a total of 492 psychiatric beds, including 42 male forensic and five female forensic beds under the jurisdiction of Corradino Correctional Facility. Of the remaining 443 beds, some 400 were occupied at the time of the visit. There were also 94 beds in three wards for older persons, which were fully occupied.

The delegation focused its visit on Male Ward 1 (20 beds), the Secure Unit (4 beds), the Mixed Admission Ward for men (18 beds) and for women (20 beds), Female Ward 1 (29 beds) and the Maximum Secure Unit (5 beds). It also looked at the Young Persons' Unit (12 beds), and the learning disability units for men (23 beds) and women (25 beds). The situation in the forensic wards is addressed in section C (9) above.

The delegation also visited the 12-bed, mixed sex, short-stay ward at Gozo General Hospital.

135. The main development since the CPT's previous visit has been the adoption of the Mental Health Act 2012 which entered into force in two phases on 10 October 2013 and 10 October 2014, with the provisions regulating involuntary placement coming into effect on the latter date.

⁴⁹ Subsequent visits were carried out in 1995, 2001, 2004, 2008 and 2011.

The new Mental Health Act introduces the concepts of rights of users and their carers (Part II of the Law) and is designed to provide new models of care with reduced hospital stays and increased community services. Special provisions for the care of minors are also included. Moreover, it establishes the Commissioner for Mental Health and Older Persons (“the Commissioner”), who is provided with a broader remit than the former Mental Health Review Tribunal. In addition to making decisions on the compulsory placement of patients, the Commissioner is tasked with promoting and safeguarding the rights of persons suffering from mental disorders and to review any policies with a view to recommending changes, as necessary, to the competent authorities. The Commissioner has the authority to receive complaints and carry out investigations, and more specifically to inspect mental health facilities to ascertain that patients’ rights, as set out in the provisions of the Act, are upheld.

The various procedures and safeguards in force relating to compulsory admission and treatment of patients under the Mental Health Act 2012 are examined below.

136. In the course of the visit to Mount Carmel Hospital and to Gozo General Hospital short-stay ward, the CPT’s delegation received no allegations of deliberate ill-treatment of patients by staff. On the contrary, it observed relaxed staff-patient relations and a generally caring approach by staff who were, on the whole, professional.

Nevertheless, its attention was drawn to the alleged incident of forced feeding and irregular use of injections by nurses of a patient on 20 May 2014. A board of inquiry appointed by the Commissioner for Mental Health reported on 22 July 2014 that force had been used to control the patient, and injections were given in an irregular manner. It recommended further investigation of the irregularities committed, and stated that charges should be brought against those found guilty of administering unregulated medicine. Further training for staff in communication skills and emotional intelligence was also recommended to ensure that staff are sensitive to patients’ needs.

The CPT would like to be informed of the actions taken further to the report of the Board of Inquiry in this particular case.

137. As regards inter-patient violence, this did not appear to be a problem and staff were generally vigilant. However, on Female Ward 1 several allegations of patients pushing, slapping and pulling hair were received, which apparently were sparked by allegations that items of one patient had been stolen by another patient. Indeed, the head nurse on duty at the time of the visit stated that stealing was an issue. The provision of keys to secure the individual lockers would foster a sense of autonomy as well as reducing the incidence of theft. At the same time, staff must remain vigilant to prevent and intervene to stop all incidents of inter-patient violence.

The CPT recommends that steps be taken on Female Ward 1 to prevent incidents of inter-patient violence.

2. Living conditions and treatment

138. The living conditions for patients on *Female Ward 1* and the *Mixed Admission Ward* (male and female sections) as well as the *short-stay ward at Gozo General Hospital* were generally acceptable. Patients were accommodated in dormitories of four to six beds with good access to natural light and ventilation. In addition to a bed, each patient had his/her own cupboard for personal possessions. However, the rooms were rather austere, lacking decoration and personalisation, and they afforded little privacy to patients.

As to the regime, patients in the Mixed Admission Ward could remain on their section (on the corridor, in their dormitory, or watching television) or go to the communal male/female visiting area and smoking room to associate. Access to the secure gardens was in theory possible but patients rarely went outside and staff did not encourage it as it would require a staff member being present. On Female Ward 1, patients spent most of the day in the large dayroom or in the adjoining courtyard. There was also a properly equipped relaxation room available in which up to three patients and a nurse could spend an hour or so; in practice, few patients appeared to have access to this room. Patients could not access their dormitories between 8.30 a.m. and 10 p.m. except for the afternoon siesta between 12 p.m. and 2.30 p.m.

The CPT favours the approach of allowing patients who so wish to have access to their room during the day, rather than being obliged to remain assembled together with other patients in communal areas.

The conditions in the *male long stay psycho-geriatric ward* were generally good. However, two of the four dormitories did not possess lockers, apparently because some of the patients had no belongings; and the patients were permanently dressed in pyjamas, which is not conducive to strengthening their personal identity and self-esteem. Also, there was no access to the veranda leading off the ward, and transporting patients to the gardens was cumbersome and required the presence of the nurses. Constructing a means of access to the veranda from the ward would enable patients to wander outside freely.

The CPT recommends that patients be allowed to wear their own clothes during the day or that appropriate clothing (non-uniform garments) be provided to them.

139. *Male Ward 1* consisted of three dormitories of nine, six and five beds. The dormitories were Spartan and only furnished with beds, and provided little privacy; it was possible to see into the other dormitories through several large open window spaces in the partitioning walls. The sanitary facilities were adequate in number but dirty with faeces on the floor. Patients spent their days sleeping, sitting in the smoking/television room or wandering the corridors. Access to the garden was not possible every day although many patients were offered leave of a day or a week or even longer (with reviews held every three months until a patient was discharged).

The male *Secure Unit* consisted of three single rooms (measuring approximately 8m²) with a bed fixed to the floor and a floor-level toilet and a fourth room (7m²) with a mattress on the floor and no toilet, which was primarily for vulnerable patients. The rooms, which were usually left unlocked, had direct access to a large open communal area with a concrete bench and a television. Unfortunately, the view from the rooms was limited by a series of screens running the length of the corridor at the back of the rooms. Allowing the patients increased access to natural light and to see

the trees and gardens from their rooms would be far preferable to the current set-up. Placement in the unit was for security or safety reasons and could be arranged either directly from the community or from another ward. While the average placement period was only a few days, one recent patient had spent two and a half months in the unit.

140. The *Young Persons' Unit* was located in two recently renovated adjacent houses just outside the main gate to Mount Carmel Hospital. The material conditions for the 12 bedded unit (seven girls and five boys) were generally very good; administrative, therapeutic and time-out rooms were on the ground floor and single and double occupancy accommodation rooms on the first floor. Due to the fact that there were only three young patients at the time of the visit, the sole male patient attended the female part of the unit during the day.

The *Male Ward for Patients with Learning Disabilities* was also located in a two-storey house; however, the material conditions were far less good. The unit was operating at full capacity, with the 23 residents accommodated in three five-bed dormitories and one eight-bed dormitory on the first floor. The dormitories were cramped with little space available besides the beds. Many of the adult residents had been accommodated in the unit since they were children, the longest stay being 34 years. As to the regime, the residents spent most of the day in the large dayroom or wandering the corridor on the ground floor.

The conditions in *Female Ward 8 for Women with Intellectual/Learning Disabilities* were dilapidated and the 25 patients, accommodated in three dormitories of six, eight and 11 beds respectively, had little privacy and no personal lockers. Due to a paucity of staff, there was little in the way of any activities offered; a couple of patients went to the rehabilitation centre and an occupational therapist visited the ward once every two weeks. Otherwise, watching television, feeding and washing/showering were the main activities on the ward.

141. The situation in the *Maximum Secure Unit (MSU)*, where the most aggressive and "unmanageable" male civil patients of the hospital were accommodated, was of considerable concern to the CPT's delegation. The unit consisted of two three-bed rooms, a single room for seclusion purposes and a windowless dilapidated common area containing a table and two benches. The rooms themselves were sufficient in size but dilapidated and the toilet was only partially partitioned. The five patients were effectively confined to this small space all day every day, with no access to outdoor exercise or any occupational activities; one of the patients had been on the unit for three years, another for two years and two others for over a year and a half. In sum, the unit was run down, had an oppressive feel to it and certainly did not provide a therapeutic environment for the patients.

142. Many patients in all the wards visited complained that they were not provided with enough to eat. In particular, they stated that following the afternoon meal at 3 p.m., they received no food until the next day which meant they were hungry at night.

143. In light of the above, the CPT recommends, as regards living conditions for patients, that measures be taken by the Maltese authorities to:

- increase the opportunities for therapeutic and occupational activities for all patients;
- ensure all patients are offered the possibility of outdoor exercise every day; for the Long-stay Psycho-geriatric ward this may require constructing a means of access to the veranda from the ward;
- provide all patients with their own lockable space (e.g. lockers to which staff may have master keys) in which to place their personal belongings;
- render the dormitories less austere and more personalised;
- ensure that patients are provided with sufficient food, particularly in the evenings;
- reduce the number of residents in the Male Learning Disabled Unit; and
- completely refurbish the Maximum Secure Unit to create a therapeutic living environment; if that is not feasible, to re-locate the MSU to a place where the appropriate environment can be provided.

More generally, the CPT considers that the provision of accommodation structures based on small groups is a crucial factor in preserving/restoring patients' dignity, and also a key element of any policy for the psychological and social rehabilitation of patients. Structures of this type also facilitate the allocation of patients to relevant categories for therapeutic purposes. To this end, **the CPT recommends that steps be taken progressively throughout the hospital to reduce the number of beds in any one dormitory to no more than four beds.**

144. In the CPT's view, psychiatric treatment should be based on an individualised approach, which implies the drawing up of a treatment plan for each patient. It should involve a wide range of rehabilitative and therapeutic activities, including access to occupational therapy (OT), group therapy, individual psychotherapy, art, drama, music and sport. Patients should have regular access to suitably-equipped recreation rooms and have the possibility to take outdoor exercise on a daily basis; it is also desirable for them to be offered education and suitable work.

Treatment at Mount Carmel Hospital was primarily based on pharmacotherapy with some occupational therapy activities (cooking, computer courses, knitting, recreational activities and handicrafts) offered in the OT department building. However, most patients were not engaged in any OT and those that did attend appeared not to be engaged in any purposeful activity. The situation in the MSU was the starkest where patients only took medication and did not engage in any activities.

A multi-disciplinary care plan is required as part of the application for Involuntary Admission for Treatment Order under Article 12 of the Mental Health Act. However, an examination of a sample of such plans from different wards showed that none of the patients had a proper multi-disciplinary care plan. Indeed the care plans appeared formulaic: to continue medication; to engage with psychologist, to engage with the rehabilitation therapist, etc. Indeed, even at the Young Persons' Unit there was no written individual care plan, with the staff working according to verbal instructions from the psychiatrist following a ward round. A similar lack of individualised care plans was in evidence at the short-stay ward at Gozo General Hospital.

The CPT recommends that a written individual treatment plan be drawn up for every patient and that the patient be consulted in this process and the plan explained to the patient. Further, increased efforts should be made to widen the range of rehabilitative and therapeutic activities on offer at Mount Carmel Hospital.

145. As was the case in the past, a detailed policy governed the use of electroconvulsive treatment (ECT) and its application continued to take place in a specific room equipped for this purpose. The procedures and safeguards in force, as well as the implementation of ECT in practice, were in general satisfactory. However, ECT was not performed with EEG (electroencephalogram) surveillance.

The CPT recommends that steps be taken by the authorities to ensure that ECT is always performed with EEG monitoring.⁵⁰

146. Each patient had a personal medical file opened upon admission to the hospital and an examination of those files on the wards visited showed that they were generally well kept and medical confidentiality respected.

147. Article 14 of the Mental Health Act provides that prior to the administration of any treatment, informed consent shall be given by the patient and in those cases where the patient lacks the mental capacity to consent, such consent shall be obtained from the responsible carer.

An examination of patients' files showed that in almost all cases a consent form for treatment was signed by the patient and/or the responsible carer and the treating doctor. Nevertheless, it was not systematic and **the CPT recommends that care be taken to ensure a signed consent form is always obtained prior to treatment.**

3. Staff resources at Mount Carmel Hospital

148. At the time of the visit, there were 13 psychiatric consultants, 17 additional medical staff and 302 nurses supported by 12 care workers and assistants as well as 73 nursing aides and 44 health assistants who act as care workers. There were also four pharmacists and four pharmacist technicians.

The four para-clinical departments offered occupational therapy (a team of 14 occupational therapists), psychology services (13 psychologists), social work services (20 social workers) and physiotherapy services (2 physiotherapists). In addition, there was a dentist.

In general, the staffing resources in the hospital were adequate.⁵¹ However, the delegation did observe that the nursing staff on the Ward for Male Learning Disabilities were at times overwhelmed and it felt that additional care workers would be beneficial. Further, the staffing levels on Female Ward 8 appeared insufficient as the three staff members struggled to cater to the diverse needs of the 25 patients. **The CPT recommends that staffing levels on these two wards be reviewed.**

⁵⁰ Without EEG surveillance it can occasionally be impossible to determine whether any seizure activity has been induced in the patient's brain and what its duration has been. As a consequence, it cannot be ensured, on the one hand, that an adequate seizure is induced and, on the other hand, that a potentially dangerous prolonged seizure activity will be detected.

⁵¹ For example, on Male Ward 1, there were six nurses during the day and three at night for some 13 to 20 patients, on Female Ward 1 the staffing ratios were similar for between 20 and 29 patients, and on the Mixed Admission Ward, the female section had six nurses during the day and three at night and the male section four nurses during the day and two at night. At Gozo General Hospital short stay ward, there were two qualified nurses and four nursing aides on duty during the day and one qualified nurse and two nursing aides at night.

149. As regards the Maximum Security Unit, the CPT considers that the nursing staff should all possess mental health qualifications and should preferably be staff employed directly by the hospital and not agency nurses with no psychiatric training as is the case at present. Moreover, having hospital nurses rather than agency ones would also result in less turnover of staff and staff getting to know the patients better.

The CPT recommends that the Maximum Security Unit be staffed by psychiatrically trained nurses who are directly employed by the hospital.

150. The CPT understands that of the current 302 nurses, 31 male and 42 female nurses currently have a psychiatric nursing qualification and that the intention is to continue to increase the number of professionally-qualified psychiatric nurses at Mount Carmel Hospital. It was positive to note that the nurses and even nursing aides had a good understanding of the provisions of the new Mental Health Act. **The CPT would like to receive updated information on the on-going training possibilities for nurses and the numbers currently enrolled in such courses.**

4. Means of physical restraint and seclusion/ “time-out” rooms

151. At Mount Carmel Hospital, patients representing a danger to themselves or others and who did not react to verbal persuasion would be physically restrained by staff and, if necessary, administered a sedative injection and moved to a seclusion room.

The Mixed Admission Ward had two time-out rooms located in the middle of both the male and female sections. The rooms were equipped with a metal-framed bed fixed to the floor (with a fireproof mattress and two Luna blankets) and a floor-level toilet. However, the rooms did not provide for any privacy as other patients on the wards could look into the rooms from the corridor. Further, the ceiling in the time-out rooms on the male section was falling down and the brickwork was damp. The five seclusion rooms on Female Ward 1 and the four rooms on the Secure Unit could not be considered as safe due to the existence of ligature points.

The CPT recommends that steps be taken to render the seclusion rooms on Female Ward 1 and the Secure Unit safe. Further, the time-out rooms in the male section of the Mixed Admission Ward should be renovated and the privacy of patients placed in these rooms, as well as in the time-out rooms in the female section, assured.

152. The use of seclusion was authorised by a psychiatrist and was reviewed every 12 hours. Nurses completed a six-hourly review for patients locked in their rooms and a twelve-hourly one on the Female Ward if the patients’ rooms were unlocked and they were confined to the five-room seclusion unit (which included a corridor and small communal area with a television). The seclusion records were properly filled in on all wards, and were especially well-recorded on the Secure Unit.

However, staff did not appear to be fully aware of the written seclusion policy and patients were not debriefed once their placement in seclusion was terminated.

The CPT recommends that staff be fully apprised of the operational policy on restrictive care and seclusion and that a mandatory debriefing be offered to all patients following the termination of the measure of seclusion.

153. Further, voluntary patients were supposed to give their consent to a psychiatrist before being placed in seclusion but such consent was verbal only. The CPT considers that if a patient represents a danger to him/herself and to others, the patient is unlikely to be in a fit state of mind to consent to a period of seclusion in a locked room. In such cases, the patient should be assessed with a view to transforming temporarily the voluntary status of the patient into an involuntary status in accordance with the procedures contained in the Mental Health Act, even if this does represent an additional time and paperwork duty on nurses and psychiatrists. **The CPT would appreciate the comments of the Maltese authorities on this matter.**

154. The CPT noted that the time-out room in the Young Persons' Unit was intended for short periods of up to 20 minutes. This is acceptable. However, in the case of one young female patient, her files showed that she had been kept in the time-out room on two separate occasions for two and a half hours and 12 hours respectively. This juvenile patient had also been kept in the seclusion cells for prolonged periods when placed on Female Ward 1 several months prior to the delegation's visit.

The CPT recommends that the time-out room in the Young Persons' Unit should not be used for periods in excess of 20 minutes, in accordance with the stated policy.

5. Legal safeguards

155. As mentioned above, a new Mental Health Act was passed in 2012 and the provisions regulating involuntary placement entered into force on 10 October 2014.

The CPT welcomes the approach taken by the Act of placing mental health users at the forefront of the law and of enumerating patients' rights, notably: full respect for the patient's dignity; the equivalence of care; the multidisciplinary care plan approach (and the patient's active participation in its formulation); the priority given to community care, aftercare and rehabilitation; the notion of free and informed consent before any treatment or care is provided; the confidentiality of medical information and access to one's own medical file.

a. the initial placement decision and discharge

156. The criteria for involuntary placement are laid out in Article 8 of the Mental Health Act and Article 9 provides that "prior to an involuntary admission for observation, an initial medical assessment shall be made by two medical practitioners, one of whom shall be a specialist, within a maximum of seventy-two hours from each other and who shall fill the recommendation" in a specific application form for involuntary admission. In cases of emergency, when there is a risk of physical harm to the patient or to third parties, an initial single medical assessment will suffice and a second medical assessment by a specialist in mental health shall be carried out within 24 hours of admission to the facility. Further, no involuntary treatment shall be given before the second assessment has been carried out unless it is emergency treatment intended solely to prevent physical harm to the patient and others or to prevent mental deterioration.

Article 10 provides for the Commissioner to receive the specific application form for involuntary admission for observation within 48 hours of the patient being admitted, and Article 11 states that an involuntary patient shall be initially detained for a period of observation not exceeding two hundred and forty hours [10 days] from the time of admission.

Article 12 outlines the criteria for involuntary treatment after the observation period. An application for an Involuntary Admission for Treatment Order shall be made to the Commissioner by the responsible specialist supported by a multidisciplinary care plan outlining the patient's needs, how and by whom these will be addressed, specifying expected outcomes and timeframes. The Commissioner shall, within 5 days of receipt of the application, interview the person and approve or reject the application. The Treatment Order shall not exceed ten weeks after the lapse of the initial 10 day period of observation. Before taking his decision, the Commissioner will meet with the patient and the responsible carer and the patient may be represented by legal counsel.

Under Article 13, the Treatment Order may be extended for a further period not exceeding five weeks as approved by the Commissioner, following an application by the responsible specialist. Further, after an independent review by a specialist that the person still has a mental disorder that requires treatment and should continue to be detained for his own safety or that of others, the Commissioner may grant a Continuing Detention Order for a maximum period of six months which may be renewed for further periods of up to six months after a new application accompanied by a modified multidisciplinary care plan is submitted to the Commissioner.

A patient may be discharged according to Article 15 as soon as the patient's mental health status improves and the criteria for involuntary admission and treatment cease to exist or at the end of the approved involuntary treatment period. The Commissioner is informed accordingly.

157. The procedures for the involuntary admission and on-going placement of a patient in a psychiatric facility provide clearly for an independent authority, the Commissioner, to verify that the involuntary placement is warranted. The CPT's delegation was able to observe for itself that the Commissioner and his Office study each application on its merits and that whenever there are applications that do not meet the requirements of the Mental Health Act, the Commissioner will reject an application for involuntary placement.

The Committee acknowledges that in a small community such as Malta, the Commissioner is obliged to use a psychiatrist working at Mount Carmel Hospital as an independent expert to assess the merits of any involuntary placement application. The only criteria that can be rigorously applied is that the independent psychiatrist is not the treating doctor and has a certain number of years of experience.

Notwithstanding this generally positive assessment of the Commissioner as an oversight body for all involuntary placements, the CPT considers that a person who is involuntarily placed in a psychiatric establishment by a non-judicial authority must have the right to bring proceedings by which the lawfulness of his detention shall be decided speedily by a court. Patients can appeal to the Court of Voluntary Jurisdiction but they have to pay for legal representation. In the CPT's view, patients should not have to pay for such representation.

The CPT recommends that the Maltese authorities provide for the possibility for legal aid in those cases where a patient wishes to challenge his/her involuntary placement before a court.

158. As regards minors, the initial involuntary placement is regulated by Articles 8 to 10 of the Mental Health Act as well as Article 30, which states that the involuntary admission for observation application must be made by a clinical specialist working with minors. Further, following the 10-day observation period, the Commissioner may grant a Treatment Order for a maximum of four weeks, renewable up to 12 weeks and thereafter a Continuing Detention Order for up to three months renewable.

In the course of the visit, the delegation heard from young persons and staff from, for example, the Fejda and Jeanne Antide Homes for Girls, that the reasons for being placed involuntarily at Mount Carmel Hospital were linked to disruptive behaviour rather than a mental disorder. Further, an examination of the medical files at the Young Persons' Unit at Mount Carmel Hospital seemed to show that the young persons were not diagnosed with a disorder under the ICD-10 classification.⁵² Instead, the reasons for placement given were, for example: "jumped from window in order to run from Jeanne Antide", "she stole a mobile phone", "9 and a half years old referred to YPU after being seen at child Guidance Clinic; had a tantrum inside the car which was transporting her back to Angela House".

Children should not be placed in a closed psychiatric facility unless their mental health requires such a placement; placement should not be for exhibiting challenging behaviour. If the role of the Young Persons' Unit is to serve as a respite with greater care resources than those available in a social welfare home then placement should not be justified under the Mental Health Act. Indeed, if there is no internationally recognised (ICD-10) mental illness, very cogent reasoning justifying why it is in the best interests of the child to be placed at the Young Persons Unit should be put forward. Further, the child should always benefit from representation by an independent advocate and the Commissioner for Mental Health or his delegate should always meet the child in question. In addition, the Commissioner for Children should also be informed.

The delegation met one young female patient who had been transferred from the Young Person's Unit to the adult Female Ward 1, where she was held in the seclusion unit for several weeks, as her behaviour was considered particularly challenging. She was subsequently returned to the Young Persons Unit in July 2015. The CPT considers that placing a juvenile patient in an adult ward is not appropriate and that, moreover, every effort should be made to avoid placing a juvenile patient in seclusion. The hospital management assured the delegation that the new policy was not to transfer juvenile patients to adult wards but to manage them on the Young Persons Unit.

The CPT recommends that the Maltese authorities put in place robust procedures to ensure that young persons exhibiting challenging behaviour are not automatically moved from care homes to Mount Carmel Hospital.

The CPT wishes to receive confirmation that there is a strict policy in place at Mount Carmel Hospital not to place juvenile female patients on adult wards, notably Female Ward 1, as was the case up until July 2015.

⁵² The International Classification of Diseases (ICD) is the standard diagnostic tool for epidemiology, health management and clinical purposes. This includes the analysis of the general health situation of population groups. It is used to monitor the incidence and prevalence of diseases and other health problems, proving a picture of the general health situation of countries and populations. ICD-10 came into use in World Health Organisation Member States as from 1994.

b. safeguards during placement

159. 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 brochure should receive appropriate assistance. At the time of the visit, no such booklet existed at Mount Carmel Hospital. Patients should also be provided information on the establishment orally.

The CPT recommends that a comprehensive information booklet is produced and that it is issued to all patients on admission, as well as to their families. Patients unable to understand this brochure should receive appropriate assistance.

160. As mentioned above, the Mental Health Act has established a Commissioner for Mental Health and Older Persons, appointed by the Prime Minister in consultation with the Leader of the Opposition. The Commissioner acts independently but is accountable for his performance to the Minister.

The Commissioner is entrusted with a range of tasks in addition to the reviewing, granting and extension of any Order issued under the Act. In particular, the Commissioner should ensure that patients are not kept in hospital longer than necessary; investigate cases of alleged breaches of human rights and take appropriate action as necessary; authorise or prohibit special treatments, clinical trials or other medical or scientific research; and review all the patient incident reports and death records from licenced mental health facilities.

The Commissioner is also responsible for investigating any complaints alleging a breach of patients' rights and taking any subsequent action, and for investigating any complaint about any aspect of care and treatment provided by a mental health facility. Moreover, the Commissioner conducts regular inspections of all facilities to ascertain that the rights of patients are upheld and that all the provisions of the Act are respected.

161. The Commissioner and his Office on the one hand gather statistical information in relation to involuntary applications (numbers, age, sex, length, disorders, etc.), and on the other hand survey users about their experience in hospital, including whether they are aware of their rights. In particular, emphasis is placed on making sure that there is no disguised involuntary placement of patients whenever hospital care continues.

The rights of patients are at the heart of the Mental Health Act and the Commissioner is the guardian of the Act so it is essential that the Commissioner possesses the necessary resources to fulfil his remit effectively. In particular, care must be taken to ensure that the role of upholding patients' rights through the complaints and inspections tasks is not compromised by the Commissioner's role in issuing involuntary placement orders. With this in mind, the CPT very much supports the establishment of a patients' advocate service to speak to patients about their rights as well as to provide on-going training to nurses.

The CPT would appreciate the comments of the Maltese authorities on these matters.

E. Social Care Homes

1. Preliminary remarks

162. The CPT's delegation visited, for the first time, St Joseph's Home for boys in St Venera, which accommodates up to 12 young boys between the ages of 9 and 13 who are placed in the Home on a care order as well as up to five young adults with learning disabilities; the occupancy at the time of the visit was 11 and three, respectively.

It also carried out follow-up visits to the adjacent Fejda and Jeanne Antide Homes for girls, which are still located in the Conservatorio Vincenzo Bugeja. At the time of the visit, the Fejda Home (for girls aged 12 to 16) was accommodating nine residents for a capacity of 11 and the Jeanne Antide Home (for girls aged 16 to 19) was accommodating seven residents for a capacity of 11.

The CPT recalls that the Children and Young Persons' (Care Orders) Act of 1980 as amended provides for the possibility to place a minor under the age of 16 under a so-called "care order",⁵³ either by court or administrative decision. The placement comes to an end, at the latest, when the minor concerned turns 18. During the placement period, parental authority is exercised by the Minister responsible for social welfare. The placement of a minor under a care order expressly provides the possibility to deprive the minor concerned of his/her liberty.⁵⁴

The procedure for placing a person under the age of sixteen under a care order remains the same as that outlined in the report on the 2008 visit (see Article 4 of the Care Orders Act).⁵⁵

The CPT understands that the review period for keeping a juvenile in a care home will be reduced from six to four months and that it is proposed that children will be allowed to participate in the review procedure. **The Committee would like to receive more details about these proposals and the timetable for their adoption.**

163. The CPT's delegation did not receive any allegations of deliberate ill-treatment of minors by staff in any of the three establishments visited. On the contrary, the delegation formed the opinion that staff took great care of and interest in the well-being of the residents. The atmosphere in St Joseph's Home for boys was particularly positive.

⁵³ A child or young person is deemed to be in need of care, protection or control, if he/she is beyond the control of his/her parent(s) or guardian, or he/she is not receiving proper care, protection and guidance, and as a result is either falling into bad company or is seriously exposed to moral danger, or the lack of care, protection or guidance is likely to cause the child or young person to suffer or seriously affect his/her health and development (Article 7 of the Care Orders Act).

⁵⁴ The minister exercises parental authority over the child or young person under his care, including by restricting the liberty of such a person as he may consider appropriate (see Article 8 of the Care Orders Act). If any child or young person committed or taken into the care of the minister absconds from the premises of the facility where he/she is being held, he/she may be apprehended by the police and brought back to the facility (Article 12 of the said Act).

⁵⁵ See CPT/Inf (2011) 5, paragraph 140.

2. Living conditions and health care

164. At St Joseph's Home, the boys were accommodated in three living units according to their ages (8-11 years; 12-15 years; and over 16). Each unit consisted of a large communal space with a dining room, kitchen and a relaxation area as well as a number of single-occupancy rooms (bunk beds are sometimes installed in the rooms for the youngest boys). The units are self-contained apartments converted from large dormitories (two in 1993 and two in 2012) and provide decent, homely living conditions. The rooms are all unlocked although boys over 16 may have a key to lock their rooms from the outside. A fourth apartment is used for weekends or holidays when most of the boys are away with their families as it is more economical, easier to manage and provides a different setting for the boys. In sum, the living conditions were good.

165. The living conditions in the recently renovated Jeanne Antide Home were good with primarily single rooms and a couple of double occupancy rooms; the rooms were all equipped with personal lockable space, good access to natural light and adequate ventilation and individually decorated with posters and pictures. It was a big improvement on the former set-up and the large open room which had formerly been partitioned into several bedrooms was now used as a common area for games, reading, television and activities. The conditions in the Fejda Home were adequate and there were plans to refurbish the rooms to the same standard as those in Jeanne Antide. The CPT's delegation also heard about the proposal to develop semi-residential accommodation to assist girls turning 18 in their transition into the community. The new management had also taken the right decision to remove the heavy padlocks from the windows which this has contributed to a more homely and less austere and institutionalised atmosphere.

166. The regime in all three homes was similar. During weekdays, the residents attended different schools outside the establishments for most of the day. At St Joseph's (outside school hours and the time set aside for homework) the boys were offered a range of activities (football, swimming, communal games) and every effort is made to enable them to attend social events outside the home such as birthday parties of schoolmates. The older boys are also responsible for cleaning and cooking in their living unit. At Fejda and Jeanne Antide, the girls did not have access to any sports fields or outdoor areas but were allowed to stay outside the homes until 10.30 p.m. or even 11 p.m. for the older girls. Within the homes, besides homework period, they could access the computer for up to an hour per day and play games in the communal area, and counselling sessions (group and individual) were also organised. The girls were also assigned weekly chores, notably cleaning and a few of the older girls had day jobs. Day outings were also organised and recently some of the girls had been on a trip to Wales.

The CPT would like to receive updated information on the refurbishment plans for the Fejda Home and the proposal to develop semi-residential accommodation for young adults turning 18.

167. As regards health care, a nurse visited the two girls' establishments once a week, primarily to prepare the medication that many of the girls took. Otherwise, all health-care needs, including dental and psychiatric, were provided by external consultants.

The CPT considers that all minors placed in a care home should be interviewed and examined by a doctor as soon as possible after their admission and that there ought to be regular health-care check-ups (at least yearly), in addition to any specific health-care issues which may need to be addressed. The medical assessment on admission, preferably on the day of admission, should make it possible to identify those young persons with potential health care problems (such as drug and alcohol dependency or self-harm/suicidal tendencies). Identification of these problems at a sufficiently early stage will facilitate the taking of effective preventive action within the establishment's medico-psycho-social programme of care.

It is also important that there is a programme of preventive care in place in the home notably as concerns the nutrition, relevant vaccinations and provision of health education for juveniles. The visiting nurse and doctor should play an active role in monitoring the quality of the food provided as the consequences of inadequate nutrition may become evident more rapidly – and may be more serious – for juveniles than for those who have reached full physical maturity. It is also widely recognised that juveniles have a tendency to engage in risk-taking behaviour, especially with respect to drugs (including alcohol) and sex. The findings from the visit to the Fejda and Jeanne Antide Homes show that such risk-taking behaviour is common among the female residents. Consequently, the provision of health education for young persons should be an important aspect of any preventive health-care programme. Such a programme should, in particular, include the provision of information about the risks of drug abuse, pregnancy and about transmissible diseases.

The CPT recommends that the Maltese authorities take the necessary steps to ensure that all children and juveniles admitted to St Joseph's, Fejda and Jeanne Antide homes, as well as other children's care homes, benefit from an appropriate interview and medical examination as soon as possible following their admission.

Further, the CPT recommends that a programme of preventive care be established in the homes visited as well as in other children's care homes.

168. In the course of the visit, the delegation met a number of girls who had been placed in Mount Carmel Psychiatric Hospital on one or more occasions and it had the opportunity to examine a number of girls' medical files. The findings point to an apparent over-eager reflex to transfer a girl exhibiting challenging behaviour to Mount Carmel for in-patient psychiatric care. While recognising that some young persons can present real challenges to staff, in-patient psychiatric care should be reserved for clinically appropriate cases only. The CPT has taken note of the response of the Ministry for Family and Social Solidarity to the delegation's preliminary observations that "only minors with a genuine need for such treatment are transferred to Mount Carmel Hospital following consultation and recommendation of professional medical staff". Nevertheless, vigilance needs to be exercised in this area as the placement of many children at this hospital over the past few years does not appear to have been justified. On a practical level, staff in children's welfare homes should be provided with on-going training on how to manage juveniles exhibiting challenging behaviour.

The CPT would appreciate the comments of the Maltese authorities on this matter (see also paragraphs 116 and 131 above)

3. Staff

169. At St Joseph's Home, there was one female care worker on duty during the day and one male care worker at night for each flat. There was also a social worker and a priest who was Head of Care. The mixed staffing was considered extremely important in providing the children with appropriate male and female role models.

At Fejda and Jeanne Antide Homes, there were three shifts of two female workers on duty in both establishments at all times. In addition, there was a coordinator for each establishment and an overall Head of Care, who together formed the management team and who had been responsible for removing the padlocks and making the homes more open.

At present, all the staff at the two homes are women and most of the care workers have been in place for many years. The Committee is sensitive to the fact that many of the girls come from dysfunctional families and may have histories of having been abused. The goal of the homes is to provide a stable and safe environment for the girls and to prepare them to be able to live within the community once they reach adulthood. To this end, mixed-sex staffing would contribute towards the normalisation of their lives and provide additional options for managing challenging behaviour.

The CPT would appreciate receiving the comments of the Maltese authorities on this matter. Further, the Committee would like to be informed of the training provided to care workers to manage challenging behaviour, including as regards training in non-violent interventions.

4. Discipline

170. In none of the homes were there any house rules as management wanted to focus on the provision of a caring and supportive environment rather than emphasise the fact that the homes were institutions. Nevertheless, notably at Fejda and Jeanne Antide, the girls were expected to abide by the individual duties and behaviour charts, and consequences of poor behaviour or not respecting the time by which they had to be back in the homes at night were clearly communicated. The sanctions were usually a reduction in pocket money and the amounts of time they were allowed to be outside the homes or, if it involved material damage, additional common duties. **The CPT would like to be informed of any written rules/procedures regarding the imposition of sanctions.**

At St Joseph's Home, boys who misbehaved would be placed in a room next to the office of the Head of Care as a time-out for 10 to 20 minutes but the door was never locked; the room was not often resorted to. Nevertheless, a systematic record of the placement of a boy in the time-out room should be made (name, time in and time out, any other notable events and the reason for the placement). **The CPT recommends that such a record be maintained at St Joseph's Home.**

More generally, **the CPT would be interested to learn about the interaction between the care workers at the Advisory Board on Children (ABOCH) and the management of the care homes as regards the individual children for whom the ABOCH care workers are responsible.**

5. Complaints and inspection procedures

171. The CPT recalls that effective complaints and inspection procedures are basic safeguards against ill-treatment in establishments accommodating children and juveniles. Residents should have avenues of complaint open to them, both within and outside the establishments' administrative system, and be entitled to confidential access to an appropriate authority. Further, the CPT attaches particular importance to regular visits to all juvenile establishments by an independent body with authority to receive - and, if necessary, take action on - juveniles' complaints and to inspect the accommodation and facilities.

Regrettably, there is currently no independent monitoring of children's welfare homes in Malta nor is there any independent complaints system in place. Residents can make complaints internally to the management of the institution and to their care worker but the procedures are very informal. Further, no information about the role and function of the Office of the Commissioner for Children⁵⁶ is imparted to the residents. In addition, the CPT was surprised to learn that the Commissioner does not carry out regular monitoring visits to all welfare homes.

The CPT recommends that information on the role of the Commissioner for Children be made available to residents in all welfare homes. Further, the Maltese authorities should ensure that all homes are visited by an independent body on a regular basis. To this end, the CPT would welcome the intervention of the Commissioner for Children.

⁵⁶ The Office of the Commissioner for Children was set up to promote the welfare of children and the compliance with the UN Convention on the Rights of the Child, as ratified by Malta on the 26 January 1990, and other international treaties relating to children that have been ratified by Malta. The Commissioner acts as a focal point which monitors the current social and cultural situation regarding children on the Maltese Islands.

APPENDIX

**LIST OF THE AUTHORITIES AND ORGANISATIONS WITH WHICH THE
CPT'S DELEGATION HELD CONSULTATIONS**

A. National authorities

Ministry for Justice, Culture and Local Government

Office of the Attorney General

Peter GRECH	Attorney General
Victoria BUTTIGIEG	Assistant Attorney General

Ministry for Home Affairs and National Security

Carmelo ABELA	Minister for Home Affairs and National Security
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Operations Directorate

Joseph ST. JOHN	Senior Official
Lavinia SEGUNA	Assistant Director (International Affairs)
John TESTA	Principal

Malta Police Force

Mario SPITERI	Assistant Commissioner
Neville XUEREB	Superintendent

Department of Correctional Services

Raymond ZAMMIT	former Acting Director
Simon BUTTIGIEG	Executive Head
Mariella CAMILLERI	Assistant Director
Carmen BORG	Correctional Manager (Operations)

Detention Service

Mario SCHEMBRI	Head
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Agency for the Welfare of Asylum Seekers (AWAS)

Mario SCHEMBRI	Chief Executive Officer
Alexander TORTELL	Director Operations

Ministry for Health

Chris FEARNE	Parliamentary Secretary for Health
Clifton GRIMA	CEO, Mount Carmel Psychiatric Hospital
Stephanie XUEREB	former Consultant Public Health Medicine

Ministry for Family and Social Solidarity

Mark MUSU	Permanent Secretary for Family and Social Solidarity
Alfred GRIXTI	Chief Executive Officer, Foundation for Social Welfare Services

Office of the Commissioner for Refugees

Mario Guido FRIGGIERI	Refugee Commissioner
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Office of the Commissioner for Children

Helen D'AMATO	former Commissioner for Children
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Office of the Commissioner for Mental Health

John CACHIA	Commissioner for Mental Health
Jesmond SCHEMBRI	Head, Customer Services
Antonella SAMMUT	Specialist in Public Health

B. National Preventive Mechanism (NPM) under the Optional Protocol to the United Nations Convention against Torture (OPCAT)

Michael BUTTIGIEG	Board of Visitors for Detained Persons
Susan SACCO MULVANEY	Board of Visitors for Detained Persons
Maria CARDONA	Chairperson of the Board of Visitors for the Prisons

C. International Organisations

Office of the United Nations High Commissioner for Refugees (UNHCR) in Malta

D. Non-Governmental Organisations

Aditus
Jesuit Refugee Service
Mid-Dlam ghad-Dawl