



## **Report**

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

**from 29 August to 6 September 2017**

The Government of the United Kingdom has requested the publication of this report and of its response. The Government's response is set out in document CPT/Inf (2018) 48.

Strasbourg, 6 December 2018

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## EXECUTIVE SUMMARY

The CPT's 2017 visit to Northern Ireland provided an opportunity to examine the developments that have taken place in the province as regards policing and prison matters since the previous visit in 2008. More specifically, the Committee wanted to examine the situation at Maghaberry Prison and at Ash House, where women prisoners are held, and to look into the operation of Shannon Clinic, the only forensic psychiatric unit in Northern Ireland. The co-operation received from the Northern Ireland authorities and from the staff at the establishments visited was excellent.

### *Law enforcement agencies*

The CPT highlights the enormous culture change that has taken place within the police of Northern Ireland since the late 1990s. It notes that most persons interviewed by its delegation stated that they had been well treated by members of the PSNI at the time of their apprehension and during custody. However, reference is made to a few allegations of physical ill-treatment and excessive use of force upon apprehension as well as of complaints of excessively tight handcuffing.

The CPT found that the safeguards against ill-treatment (notably, the right to inform a third person of one's detention, the right to a lawyer and the right to a doctor) operated satisfactorily and that the manner in which they were applied in several police stations might be considered best practice. Nevertheless, recommendations are made to improve confidentiality of medical data, to provide training and supervision for forensic medical officers (and access to electronic medical files) and to draw up a protocol for the management of persons who self-harm. The CPT also proposes that the model observed at Antrim Police Station concerning the treatment of persons suspected of being body-packers be standardised across all police stations. As regards conditions of detention, the Committee notes the plan to renovate the custody suite at Strand Road Police Station in Derry/Londonderry and recommends that provision be made to build secure outdoor yards for persons detained in police stations longer than 24 hours.

### *Prisons*

Following the devolution of responsibility of prison matters to the Northern Ireland Assembly and Executive in 2010 and the publication of the "Owers Report" in October 2011, the prison system has been the subject of extensive reform. Overall prisoner numbers are down to around 1,450 with a rate of imprisonment of 76 per 100,000; nevertheless, the Committee encourages the authorities to expand further the use of alternatives to custody.

*Maghaberry Prison* remains the only high security prison in Northern Ireland and accommodates various categories of male prisoners, including remand, life sentenced and those with paramilitary affiliations. Since December 2015, its occupancy levels have hovered around the 850 mark for an official capacity of 1,100. At the time of the visit, the vast majority of prisoners at Maghaberry stated that they were treated correctly by prison officers with levels of alleged physical ill-treatment, notably by the Search Teams, having greatly diminished in recent years. Incidents of inter-prisoner violence had also decreased since 2008 and most prisoners stated they felt safe. However, a number of prisoners in Bann, Erne and Lagan Houses stated that they felt unsafe and did not leave their cells. This was particularly the case in Bann House where several inmates alleged that they had been assaulted by other prisoners, apparently because they were sex offenders. The CPT makes a number of recommendations concerning prison discipline and segregation; in particular, a psycho-social support system should be put in place for prisoners placed in the Care and Support Unit under Rule 32 for longer than two weeks.

The CPT welcomes the recent introduction of a core day regime, which potentially permits a prisoner to be unlocked from his cell for nine and a half hours a day. Further, the emphasis on work and education as tools in the prevention of re-offending after release was in evidence, with a wide range of activities and programmes on offer to prisoners. Nevertheless, far too many prisoners were effectively confined to their cells for periods of up to 22 or 23 hours a day. The prison management should pursue their efforts to provide all prisoners with purposeful activities. It is also important that every sentenced prisoner is provided with a sentence plan and is involved in drawing it up, which was not the case at the time of the visit. As regards material conditions, they ranged from good in the new build Quoile and Shimna units to generally acceptable in the square houses. The CPT recalls that cells of 7m<sup>2</sup> (i.e. a standard cell) should not be occupied by more than one prisoner and that the toilets should at least be partially partitioned; this applies equally to the new 360 cell block under construction. Comments are also made on contact with the outside world, prisoners in separated regimes and on complaints and inspection procedures.

Prison health care, under the South Eastern Health and Social Care Trust, has made significant progress since 2008. Nevertheless, action is required to appoint a prison health care coordinator; to bring together the Donard Centre and the prison health care unit under a single management structure; and to enhance medical confidentiality and the recording of injuries by doctors. There is also a need for a more comprehensive drug strategy programme. At present, opioid substitution treatment is insufficient with some prisoners subjected to “cold turkey” upon admission. Harm reduction measures to prevent the transmission of blood-borne viruses and the spread of infectious diseases should also be introduced. Further, the procedures for dealing with persons suspected of having ingested or secreted drugs within their body need to be reviewed with an emphasis on keeping such persons under medical observation. The report also raises several concerns about the inadequate provision of psychiatric care and the long waiting times for persons to be transferred to an appropriate psychiatric facility for treatment. As regards the Supporting Prisoners at Risk process, it should be enhanced by the establishment of a psycho-social team.

*Ash House*, located within Hydebank Wood College, is the only facility for women prisoners in Northern Ireland and held 54 prisoners for an official capacity of 66. Regrettably, plans to build a separate facility, staffed and run around a therapeutic model, are on hold due to lack of funding. At the time of the visit, the CPT found that the low staffing levels were threatening the maintenance of a safe environment and impacting negatively on the amount of time certain women spent out of their cells. Staffing levels should be significantly increased and staff provided with greater support from management. Particular emphasis is placed on developing the admission process to take into account the vulnerabilities of women prisoners, which should include screening for sexual abuse or other forms of gender-based violence inflicted prior to entry to prison. Recommendations are also made to review the policy and conditions under which a mother and her baby are kept at Ash House, to improve the sentence plans for prisoners and to set up specialised psychological support or counselling for women who are victims of rape, sexual abuse and other gender-based violence.

As regards health, staff should have access to a pharmacy whenever required to ensure a continuity of care for new arrivals, and prisoners should not be prescribed medication before they have been examined by a doctor. The recording and reporting of injuries and the treatment of drug addiction should also be improved. The report documents the cases of four vulnerable women held in Ash House with mental health or learning disabilities who were not getting the care and support they required. The CPT recommends that clear protocols and operating procedures among the PSNI, NIPS, the judiciary, health care and social services be established to ensure that such women are placed in an appropriate environment where they can be properly looked after. Recommendations are also made to promote family contacts and on the application of control and restraint.

***Shannon Clinic Medium Secure Psychiatric Unit***

The CPT's delegation gained a very positive impression of Shannon Clinic. The general environment was calm, caring and humane, and the staff were very committed. Material conditions were excellent, with a wide range of therapeutic activities on offer. Further, somatic and psychiatric care was found to be good and a detailed care plan, drawn up with the participation of the patient and regularly reviewed, was in place for every patient. Nevertheless, the CPT found that there is a need for increased psychological support and that steps need to be taken to overcome the operational/security issues which in practice prevented patients from engaging in the 25 available hours of activities per week. Following the complete smoking ban, greater attention should also be paid to assisting patients with addiction-related disorders. Likewise, more should be done to encourage healthy eating. Patients were afforded a good level of contact with the outside world and an efficient complaint mechanism (including mediation by a Patient Advocate) was in place.

The mixing of female patients at all stages of hospitalisation with male patients on the care and treatment ward gave rise to specific challenges and risks, and the CPT supports the plans for a future separate female ward. As regards consent to treatment, the safeguards need to be reinforced. The CPT considers that an external psychiatric opinion should be required in any case where a patient does not agree with the treatment proposed by the establishment's doctors. There is also a need to file the written consent or second opinion forms in a more coherent and complete manner.

Management of agitated patients was prompt and any restraint entailed the use of mainly manual low-level holds which were not pain compliant and were accompanied by safeguards completely in accordance with CPT standards. However, staff felt that there was a lack of systematic de-briefing after patient-on-staff violence. Also, despite good staffing levels, the high rate of sick leave (18%) placed a greater burden on remaining staff who expressed some disquiet over a lack of adequate management support.

Finally, the CPT welcomes the passing of the Mental Capacity Act 2005, which combines mental health and mental capacity law. It will cover persons with personality disorders who are not currently considered to be suffering from a mental illness and will introduce additional safeguards when it enters into force in 2005/06. The CPT requests information on the preparations being made for entry into force of the Act, including as regards any provision for high secure and low secure psychiatric places.

## **I. INTRODUCTION**

### **A. The visit, the report and follow-up**

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 Northern Ireland from 29 August to 6 September 2017. The visit was considered by the Committee “to be required in the circumstances” (cf. Article 7, paragraph 1, of the Convention). See the appendix for the list of establishments visited by the CPT’s delegation.

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

- Therese Rytter (Head of the delegation)
- Anton Van Kalmthout
- Hans Wolff.

They were supported by Hugh Chetwynd, Head of Division, and Claire Askin of the Secretariat of the CPT, and assisted by two experts, Vincent Theis, former Director of Luxembourg Prison, Luxembourg and Birgit Völlm, Professor of Forensic Psychiatry, Germany.

3. The report on the visit was adopted by the CPT at its 95<sup>th</sup> meeting, held from 5 to 9 March 2018, and transmitted to the authorities of the United Kingdom on 16 March 2018. The various recommendations, comments and requests for information made by the CPT are set out in bold type in the present report. The CPT requests the authorities of the United Kingdom to provide within six months a response containing a full account of action taken by them to implement the Committee’s recommendations and replies to the comments and requests for information formulated in this report.

### **B. Context of the visit and co-operation encountered**

4. The CPT last visited Northern Ireland in 2008. At that time, the transfer of the political, legislative and managerial responsibility for the Northern Ireland Criminal Justice System from the United Kingdom administration to the devolved Northern Ireland bodies (the Northern Ireland Assembly and the Northern Ireland Executive) had been delayed. It was only after intense negotiations resulting in the Hillsborough Agreement of February 2010 that the Northern Ireland Act 1998 (Devolution of Policing and Justice Functions) Order 2010 came into force in April 2010. It is noted that the Minister of Justice of the Northern Ireland Executive is elected under the cross-community vote which means he or she must have the support of the majority of unionists and the majority of nationalist members of the Northern Ireland Assembly.

However, since 26 January 2017, when the fifth Northern Ireland Assembly collapsed, there has been no government in place as negotiations for the formation of a unity government have yet to yield a result.

5. The CPT has been following developments in Northern Ireland closely in the period since its last visit in 2008, notably as regards the devolution of policing and justice functions. While recognising that a prison reform process was initiated in 2011 on the back of the Prison Review Team report of October 2011, the Committee's attention has on several occasions been drawn to the situation pertaining at Maghaberry Prison. The extended protests by Republican separated prisoners in 2011 and 2012 and the information received regarding violence, poor health care and conditions in this establishment during this period and up until 2016 were a cause for concern. The CPT took note of the reports issued by the Criminal Justice Inspection of Northern Ireland in 2016 which demonstrated clear progress in tackling the challenges at Maghaberry Prison and considered that the time was ripe to visit the prison again.

At the same time, the Committee wanted to examine the situation of women prisoners in Northern Ireland and to look into the operation of Shannon Clinic, the only forensic psychiatric unit in the region, and the impact that this was having in keeping severe mentally ill persons out of prison. With this in mind and taking into the account the importance the Committee attaches to following up on previous visits directly, it was decided to undertake an ad hoc visit to Northern Ireland in 2017.

6. The cooperation received by the CPT's delegation from the Northern Ireland authorities as well as from the management and staff in the establishments visited was excellent. The delegation had rapid access to the places of detention visited, was able to meet with those persons with whom it wanted to speak in private and was provided with access to the information it required to carry out its task. The CPT is also appreciative of the support provided by the Ministry of Justice liaison team in London.

7. In the course of the visit, the delegation held consultations with Nick Perry, Permanent Secretary at the Department of Justice and Ronnie Armour, Director of the Northern Ireland Prison Service (NIPS) as well as with senior officials from the Police Service of Northern Ireland (PSNI), the Departments of Health and Justice, and from the United Kingdom Ministry of Justice and Northern Ireland Office.

The delegation also met with the Criminal Justice Inspection of Northern Ireland (CJINI), the Regulation and Quality Improvement Authority (RQIA)<sup>1</sup> and the Prisoner Ombudsman. Further, it met the Committee on the Administration of Justice and the Independent Monitoring Board in prisons.

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<sup>1</sup> CJINI and RQIA are members of the UK National Preventive Mechanism, as are the Northern Ireland Policing Board Independent Custody Visiting Scheme and the Independent Monitoring Boards (Northern Ireland) in prisons.



## **II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED**

### **A. Law enforcement agencies**

#### **1. Preliminary remarks**

8. At the outset, the CPT wishes to highlight the enormous culture change that has taken place within the police of Northern Ireland since the late 1990s. The findings of the CPT's delegation clearly indicate that human rights concepts are embedded within professional policing. In the context of Northern Ireland and the ongoing paramilitary activity, this is all the more laudable.

9. The basic rules concerning the detention, treatment and questioning of persons detained by the police are contained in the Police and Criminal Evidence (NI) Order 1989 (PACE (NI)) and its Codes of Practice. The provisions concerning police detention have not been altered in substance since the CPT's last visit to Northern Ireland in 2008. The PACE (NI) stipulates that a person shall in principle not be detained in a police station for longer than 24 hours before being charged. However, in the case of an arrest for an 'indictable offence', such detention may be extended to 36 hours, under specific conditions. Continued detention is authorised for up to 96 hours, but must be authorised by a court at predetermined intervals.

It is recalled that under Article 41 of the PACE (NI) the detention of a person shall be reviewed on a regular basis (no later than six hours after the authorisation of the detention and at subsequent intervals of no longer than nine hours).

The Terrorism Act 2000 permits the police, on their own authority, to detain persons arrested under Article 41 of the Act for a maximum period of 48 hours. Thereafter, a warrant for further detention of such a person prior to his or her being charged may be obtained from a judicial authority for a period of up to seven days. This may be further extended up to a maximum of 14 days.

Further, Article 65 of the PACE (NI) provides for the issuing of Codes of Practice, which regulate in detail police procedures. Code C addresses "the detention, treatment and questioning of persons by police officers" and Code H "the detention, treatment and questioning of persons under S41 of, and Schedule 8 to, the Terrorism Act 2000". Further, Codes E and F address, respectively, the audio and visual recording of interviews with suspects at police stations. The Codes were last revised in 2015.

## 2. Ill-treatment

10. In the course of the visit, the CPT's delegation received hardly any allegations of physical ill-treatment of persons detained by the Police Service of Northern Ireland (PSNI). On the contrary, most persons interviewed stated that they had been well treated by members of the PSNI at the time of their apprehension and during custody.

Nevertheless, a few allegations of physical ill-treatment and excessive use of force upon apprehension were received. For example:<sup>2</sup>

- A young man who was apprehended in Coleraine claimed that after he was brought under control his arms were twisted and hyper-extended when handcuffed and that he was subsequently thrown into the back of a Land Rover hitting his head on a hard object. His injuries were examined by the doctor at the police station who noted down his allegation against the police and referred him to hospital for a possible fracture of the wrist. Upon examination by the delegation's doctor a couple of days later, the detained person still had bruising around the left eye and a further hospital appointment was scheduled to examine his right wrist. The person in question admitted that he had resisted arrest and that he had also repeatedly punched the inside of his police cell as he was agitated.
- Another person alleged that he was kicked in the back after having been placed on the ground and handcuffed behind his back. He also stated that he had resisted arrest.

In addition, the delegation received a couple of allegations of disrespectful language and attitude by police officers at Derry/Londonderry Police Station.

11. The CPT recognises that the arrest of a suspect is often a hazardous task, in particular if the person concerned resists and/or is someone whom the police have good reason to believe may be armed and dangerous. The circumstances of an arrest may be such that injuries are sustained by the person concerned (and by police officers), without this being the result of an intention to inflict ill-treatment. However, no more force than is strictly necessary should be used when effecting an arrest. Furthermore, once arrested persons have been brought under control, there can be no justification for their being struck by police officers. In light of the information gathered during the 2017 visit, **the CPT recommends that these principles be reiterated regularly to police officers, including through practical training exercises.**

12. Several complaints of handcuffs being applied excessively tightly at the time of apprehension were also received, and the delegation observed for itself visible red marks around the wrists of detained persons; for example, a woman held at Strand Road Police Station displayed cuts on both wrists (approx. 0.5cm x 2mm) from when the handcuffs had been applied some 18 hours earlier at the time of her apprehension.

**The CPT recommends that police officers be reminded regularly, and in an appropriate manner, that the application of handcuffs should under no circumstances be excessively tight and that they should be applied only for as long as is strictly necessary.**

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<sup>2</sup> The cases described are for the purposes of illustration only.

### 3. Safeguards against ill-treatment

13. The CPT recalls that it attaches particular importance to the formal safeguards against ill-treatment which are offered to persons deprived of their liberty by the police, in particular the rights of detained persons to inform a close relative or another third party of their situation, to have access to a lawyer, and to have access to a doctor. It is also essential that all detained persons are informed of their rights. As the Committee has repeatedly stressed, these are fundamental rights, which should be guaranteed to all categories of persons from the very outset of their deprivation of liberty (that is, from the moment when the persons concerned are obliged to remain with the police).

In Northern Ireland, the operation of these formal safeguards is set out in detail in the above-mentioned PACE Order (notably Articles 57 and 59) and Code C of the PACE (NI) Codes of Practice. The CPT's delegation found once again that the safeguards operated satisfactorily. Indeed, the manner in which they were applied in several police stations might be considered as good practice.

a. notification of custody and access to a lawyer

14. The standard procedure, which is the same in England and Wales, requires that all persons apprehended by the police are brought to a police station where they are presented before a custody sergeant, located within the detention area, who is responsible for taking all the personal details of the person concerned, informing them of their rights and verifying the reasons for their arrest. The apprehended person is informed both orally and via a computer screen of their right to a lawyer and their right to inform a close relative or another third party of their situation, and is requested to sign that they have understood their rights and whether or not they wish to avail themselves of these rights. The custody sergeant also enquires whether the detainee has any health-related problems that the police should be aware of before the person is placed in a cell and whether they wish to see a doctor. The custody sergeant will also put in place a care plan depending on the detainee's physical and mental state and the risk of harm they pose to themselves or to others. This essentially involves custody staff observing the detainee every 15, 30 or 60 minutes; if required, a detained person may be placed under constant observation.

An examination of the custody records in the police stations visited regarding both current and former detained persons showed that the legal safeguards referred to above were well respected. This finding was confirmed by interviews with detained persons in police stations and persons on remand at Maghaberry Prison and Ash House. In particular, all detained persons met a lawyer in private prior to being interviewed by police officers about the offence they had allegedly committed. Lawyers were also present throughout the police interview with their clients. After six hours of custody, the Inspector responsible for the custody suite would review the detention which entailed entering the cell and explaining to the detained person the reason for their detention and why it was being extended by a further six hours. The Inspector also reviews the legal safeguards and rights to verify that they have been understood by the detained person.

b. access to a doctor

15. Access to a doctor was very good in practice; whenever a person was detained in a police station the duty doctor would be systematically informed and would thereafter attend the police station. The CPT observed that all detained persons had access to a doctor and that in many cases detained persons were only interviewed by police officers once a doctor had declared them to be in a fit state (i.e. once the effects of alcohol or drug intoxication had worn off). The medical consultation rooms at the police stations visited were suitably equipped with emergency drugs, sphygmomanometer, first aid case, defibrillator and oxygen. Further, whenever necessary, a detained person would be transferred to hospital for treatment (for example, at Musgrave Police Station 10-20 persons were transported to hospital every week).

However, the delegation observed that medical confidentiality was not always fully respected, notably at Derry/Londonderry Police Station where custody officers had access to medical information about detainees which was more than was required for managing their detention. The CPT recognises that custodial staff should have certain information about the state of health of a detained person, including medication being taken and particular health risks. On the other hand, there is no reason why non-medical staff should have access to medical diagnoses or injury reports on a systematic basis.

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

16. As regards detained persons suspected of having ingested or secreted drugs within their body (body packers), the CPT commends the practice observed at Antrim Police Station of transferring these persons to the regional hospital to be placed under medical observation until all the drugs have been expelled. As there is always a risk that the receptacle in which the drugs are placed may burst with potentially life threatening consequences, it is best practice for the persons concerned to be placed under medical observation in hospital rather than being kept in the police station.

**The CPT recommends that the best-practice model observed at Antrim Police Station concerning the treatment of persons suspected of being body packers be standardised across all police stations of Northern Ireland and throughout the United Kingdom.**

17. The Forensic Medical Officers (i.e. duty doctors - FMOs) are for the most part general practitioners in the community who undertake 6 or 12 hour shifts to ensure that each police station has a 24/7 medical coverage. The importance of having a medical presence in the police stations is borne out when taking into consideration that approximately 65% of detained persons have a mental health problem, with a large proportion of this number prone to self-harm, and that drug (mainly prescription) addiction and alcohol over-consumption are very prevalent. It is therefore important that all FMOs receive appropriate training and supervision for working in police custody suites, which is not the case at present. Moreover, the delegation found that not all FMOs had access to the electronic file systems (EMIS) in each Health Care Trust which meant that they could not access the medical files of detained persons to see what treatment and medication they were receiving in the community.

**The CPT recommends that all forensic medical officers receive appropriate training and supervision and that they are all able to access the electronic medical files (EMIS) of each Health Care Trust confidentially in every police station.**

18. More generally, it is important that staff working in custody areas are attentive to the needs of detained persons. The delegation met one person at Coleraine Police Station who had asthma and was experiencing breathing difficulties (due apparently to serious lung problems following the collapse of both lungs three years earlier) but his requests for an inhaler or to access fresh air had not been acted upon. **Custody staff should be reminded of the importance of being attentive to the needs of detained persons throughout their shifts.**

The CPT also considers that detainees who self-harm should not be hand-cuffed as part of their management. Instead, they ought to be placed on 1:1 observations or transferred to hospital, as appropriate. Further, the doctor should in all cases be informed, which is not the case at present. There needs to be a common approach in all police stations towards detained persons at risk of self-harming, which was not the case at the time of the visit, taking into account the above remarks.

**The CPT recommends that a protocol for the management of persons who self-harm in police custody which excludes the application of handcuffs be adopted throughout Northern Ireland.**

c. information on rights

19. The CPT's delegation found that detained persons were systematically informed of their rights upon arrival at the police stations and that an 8-page notice of rights and entitlements was made available to them and existed in a wide range of languages. Further, they could consult the PACE Codes of Practice, if requested.

In the police stations visited, the CPT's delegation found that information about the Police Ombudsman was readily available; posters, complaint forms and a brochure ("Dealing with Complaints against the Police").

d. custody records

20. The electronic custody record system provided a detailed account of a person's stay in a police station, with every observation (hourly, etc.), movement (police interview, doctor, solicitor, etc.) and event (meals, intervention, review of detention, etc.) noted.

Further, all cells were covered by CCTV and audio monitoring; police staff could monitor each cell from a central control centre. In order for the detained person to retain some privacy, the toilet area was blanked out on the monitor. However, detained persons did not know this and at least one person was anxious about exposing himself on the toilet. **Such information should be imparted to detained persons.**

All police interviews of detained persons take place in designated rooms, equipped with chairs and a table (all secured to the floor); all interviews are systematically audio-taped. The rooms are covered by CCTV, but there is no sound.

e. complaints and inspection procedures

21. The system concerning police complaints remains the same as that described in the report on the 2008 visit,<sup>3</sup> namely that all complaints regarding the PSNI are dealt with by the Police Ombudsman. For the year 2016/17, the number of complaints received by the Police Ombudsman's Office decreased by 8% from the previous year to 2,797 complaints. The complaints comprise 4,725 allegations, of which 1,073 were classified as "oppressive behaviour"<sup>4</sup>. Further, the Police Ombudsman recommended on 24 occasions during the year that the Director of Public Prosecutions should prosecute an officer (up from 18 the previous year and 11 in 2014/15), and on 261 occasions that a police officer should be disciplined or receive a performance enhancement measure.

**The CPT would like to be informed about how many of the cases recommended for prosecution and for disciplinary action concerned each sub-type of "oppressive behaviour" by the police and about the outcome of these procedures for each of the last three years.**

22. All police stations are visited on a regular basis at all hours of the day by the Northern Ireland independent custody visiting scheme made up of 25 volunteers divided into three geographically-based teams. Statistics for the year April 2015 to March 2016 show that the three area custody visiting teams completed 468 visits during which they spoke with 450 detained persons and checked 685 custody records. Deficiencies mainly concerned material conditions and were reported to PSNI.

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<sup>3</sup> See CPT/Inf (2009) 30, paragraphs 142 and 143.

<sup>4</sup> Oppressive behaviour consists of several sub-types: Oppressive conduct/harassment; other assaults (unjustified or excessive force or violent conduct); Serious non-sexual assault resulting in serious injury; sexual assault; Unlawful/Unnecessary Arrest/Detention.

#### 4. Conditions of detention

23. In the course of the visit, the CPT's delegation visited Antrim, Belfast Musgrave, Coleraine and Derry/Londonderry Police Stations.

Antrim Police Station, which was fully renovated in 2016, has two custody suites of 10 cells each, one of which was not being used at the time of the visit.

Belfast Musgrave Police Station has 50 cells; on the ground floor there are three blocks of 10 cells each with their own consultation and interview rooms. Each block also possesses one cell with the upper part of the cell door transparent to better observe those at risk of self-harm and one or two cells which are able to monitor the heart rate and breathing of a detained person. On the first floor is the serious custody suite where persons suspected of terrorist offences are held, as well as cells for juveniles and women and overflow from the ground floor.

Coleraine Police Station has 10 cells, one of which is exclusively used for women.

Strand Road Police Station in Derry/Londonderry has nine cells, none of which are equipped with an in-cell toilet or a sink. It is planned that the whole custody suite will be renovated. **The CPT would like to be informed when it is envisaged to upgrade the material conditions of the custody suite at Strand Road Police Station in Derry/Londonderry.**

24. The police stations visited were generally well maintained and clean. All cells visited were of adequate size for short stays. They were equipped with a low plinth and detained persons were provided with a mattress, a blanket and a pillow. Meals were provided at appropriate times. The artificial lighting (dimmed at night) was adequate, as was the heating and ventilation. Detained persons could also access a shower if needed. However, none of the police stations visited had an outdoor exercise yard but at Antrim Police Station detained persons were given access to an outdoor fenced area. At Musgrave Police Station, detainees held for longer periods could, upon request, access a secure inside covered walkway (17.5m x 3m) which had access to fresh air.

Nevertheless, **the CPT recommends that when the custody suites are built or renovated, provision should be made for the establishment of a secure outdoor yard for persons who may be detained for periods in excess of 24 hours.**

## **B. Prison establishments**

### **1. Preliminary remarks**

25. In the period since the 2008 visit by the CPT, there have been a number of significant developments. As mentioned above (see paragraph 4), criminal justice powers were devolved from Westminster to the Northern Ireland Assembly and Executive in 2010. The operation and management of prisons is the responsibility of the Northern Ireland Prison Service (NIPS), an agency within the Department of Justice of Northern Ireland. As part of the devolution agreement, a Prison Review Team was tasked with reviewing the ‘conditions of detention, management and oversight of all prisons’. The Review Team’s report (otherwise known as the “Owers report”) was published in October 2011 and highlighted the need for a reform of the Prison Service in Northern Ireland and presented 40 recommendations for change. A Prison Review Oversight Group chaired by the Minister of Justice managed the reforms and reported to the Justice Committee of the Assembly on progress. In December 2015, it was recognised that the reform of the prison system would require at least 10 years to complete, and since early 2016 the process is being led by the Prison Service Management Board.

The CPT has noted that the prison reform process so far has taken place in a context of budget restrictions but that considerable progress has been registered.

26. The legislative framework governing prisons has also evolved in recent years, with amendments to both the 1953 Prison Act (Northern Ireland) and the Prison and Young Offenders Centre Rules (Northern Ireland) 1995 (“Prison Rules”). The Prison Rules were amended by the Prison and Young Offenders Centre (Amendment) Rules (Northern Ireland) 2009 after a public consultation process.

27. At the time of the visit, the prison population stood at around 1,450 down from a high of 1,840 in 2014. The rate of imprisonment, 76 persons per 100,000 inhabitants, is only half the rate for England and Wales or Scotland (146 and 138 per 100,000, respectively). It is noticeable that the percentage of persons on remand has dropped significantly since 2008 from over 35% to 23.4%. At the same time, the authorities are seeking to expand further the use of alternatives to custody, notably for persons who abuse drugs and alcohol. **Such measures are to be encouraged. The CPT would in particular like to be informed whether the Enhanced Combination Orders<sup>5</sup> have been extended to all of Northern Ireland.**

28. In the course of the 2017 visit, the CPT’s delegation carried out a visit to Maghaberry Prison and visited for the first time Ash House, the women’s prison located within Hydebank Wood College.

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<sup>5</sup> An intensive community service combined with strict supervision was introduced on 1 October 2015 by the Probation Board and has produced positive results in reducing reoffending rates.



Maghaberry Prison remains the only high security prison in Northern Ireland and accommodates various categories of male prisoners, including remand, life sentenced and those with paramilitary affiliations. The presence of such diverse groups of inmates renders Maghaberry Prison a particularly complex prison with many differences, including in regime, between the various units. At the time of the visit, Maghaberry Prison held 810 prisoners for a capacity of around 1,100.

Women remanded or sentenced to prison are accommodated in Ash House, which is a stand-alone accommodation block within the campus of the male young offenders secure college (Hydebank Wood). Ash House holds all categories of women offenders and at the time of the visit was accommodating 54 women for a capacity of 66.

## **2. Maghaberry Prison for adult males**

29. Maghaberry Prison has been the subject of enhanced monitoring by the Criminal Justice Inspectorate of Northern Ireland since early 2015. In the report on the May 2015 visit, the prison was described as “dangerous” and “unstable”, drugs were widely available and the inspectors had serious concerns about safety. A follow up visit in January 2016 showed that leadership had improved, the prison was more stable and some important early signs of recovery were evident, and a further visit in September 2016 found that things had improved considerably.<sup>6</sup>

Occupancy levels within Maghaberry Prison have remained relatively stable since December 2015, generally hovering around the 850 mark. The number of new committals varies every week, oscillating between 50 and as many as 100. Figures for 23 August 2017 show that there were 321 unsentenced prisoners and 526 sentenced prisoners; there were 95 foreign nationals (primarily Lithuanians, Poles and Chinese) and 15 prisoners over the age of 65. The 71 Category A<sup>7</sup> as well as the 70 Category B prisoners were dispersed among various accommodation blocks within the prison. Only those prisoners designated as belonging to either loyalist or republican paramilitary groups were held on specific landings of Bush and Roe Houses, respectively.

Although the prison is relatively new, having been constructed in 1986, the original square houses have deteriorated considerably and the design is no longer considered to be optimal for managing prisoners. Two new accommodation blocks, Quoile and Shimna, were opened in late 2012, providing an additional 203 spaces. A further large panoptical 360 cell accommodation block with workshops and classrooms is in the process of being constructed and should become operational in 2019. This should enable three of the four square houses to be closed down permanently and provide all prisoners with decent and safe living conditions.

**The CPT would like to receive updated information on the development of the new accommodation block and on the official capacity of the prison once the new block comes into operation.**

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<sup>6</sup> See [Criminal Justice Inspectorate of Northern Ireland inspection reports](#).

<sup>7</sup> Category A refers to prisoners classified as high security prisoners for whom the aim of NIPS must be to make escape impossible. For the definition of Categories B, C, D and U see [Annexe A of NIPS document of 26 March 2014](#).

a. ill-treatment

30. The vast majority of prisoners stated that they were treated correctly by prison officers. Prisoners spoken to by the delegation stated that levels of physical ill-treatment by prison officers at Maghaberry, notably by the Search Teams, had greatly diminished in recent years. An examination of the use of force documentation, which was well maintained, confirmed this state of affairs.<sup>8</sup> This contrasts positively with the situation found during the CPT's previous visit in 2008. Nevertheless, some complaints of verbal abuse and insults were received and a few allegations of excessive use of force were heard. One prisoner in Bann House stated that a few days prior to the delegation's visit he had been restrained by several officers after refusing to permit his cell to be searched. He alleged that in the course of the restraint an officer stamped on the back of his leg and upper back and the bruising observed by the delegation's doctor was consistent with his allegations. He also said that he was slapped about the head. A few other prisoners alleged that they had been slapped by prison officers.

Although it is positive that a nurse attends the prisoner after each incident of use of force, there is a need to improve the documentation of injuries by health care staff both in relation to injuries sustained within the prison and to those observed on new committals (see paragraph 42).

**The CPT recalls that any form of ill-treatment is totally unacceptable and must be subject to appropriate sanctions. This demands that all senior and middle managers pay special attention to the actions of staff, notably prison officers under their responsibility, and take immediate steps to address any indications that staff are abusing prisoners. Failure on the part of supervisory staff to fulfil this role is, in itself, a serious dereliction of duty.**

31. As regards inter-prisoner violence and intimidation, the number of incidents recorded had also decreased since 2008. Most prisoners stated that they felt safe and whenever incidents of violence were detected by staff, the perpetrators were subjected to the disciplinary process and the police were systematically informed. The CPT supports such an approach as it considers that every instance of inter-prisoner violence resulting in an injury should be communicated to the PSNI as it is essential that prisons do not become places of impunity.

Nevertheless, a number of prisoners in Bann, Erne and Lagan Houses stated that they felt unsafe and therefore did not leave their cells or associate with other prisoners. In Bann House, where newly-committed prisoners are kept, the delegation met several prisoners who felt threatened and bullied by other prisoners because they were considered sex offenders. These prisoners did not associate with other prisoners or leave their cells to walk in the internal yard as there was no direct staff supervision in the yard. They all said that they had been assaulted by other prisoners since being placed in Bann House. Although staff had intervened to help them when they had been physically attacked, they felt that the officers did not care about their situation. In addition, these prisoners clearly had mental health concerns which had not been addressed during the one to two months of their placement in Bann, which increased their vulnerability.

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<sup>8</sup> For example, in 2015, use of force was applied on 534 occasions while for the first eight months of 2017 use of force was applied on 253 occasions.

Addressing the phenomenon of inter-prisoner violence requires that prison staff must be alert to signs of trouble and both resolved and properly trained to intervene. The existence of positive relations between staff and prisoners, based on the notions of dynamic security and care, is a decisive factor in this context; this will depend in large measure on staff possessing appropriate interpersonal communication skills. It is also obvious that an effective strategy to tackle inter-prisoner intimidation/violence should seek to ensure that prison staff are placed in a position to exercise their authority in an appropriate manner. In addition, the prison may need to develop the capacity to ensure that potentially incompatible categories of prisoners are not accommodated together. Moreover, the physical presence of prison officers in recreation rooms and yards where prisoners associate will have a preventive effect on inter-prisoner violence, while CCTV serves essentially as a means of identifying the perpetrators once an attack has taken place.

**The CPT recommends that the management of Maghaberry Prison pursues its efforts to address the phenomenon of inter-prisoner violence and intimidation, in the light of the above remarks. Staff should maintain a physical presence in the yards during association time.**

b. conditions of detention

32. The CPT has noted that within Northern Ireland prisons, particular emphasis is put on work and education as tools in the prevention of re-offending after release. Such an approach is reflected in the Prison Rules, which stipulate that sentenced prisoners are obliged to work and all prisoners are entitled to education.<sup>9</sup>

33. The CPT welcomes the recent introduction of a core day regime at Maghaberry which potentially permits a prisoner to be unlocked from his cell for around nine and a half hours during the day between 8.10 a.m. and 7.30 p.m. (all prisoners are locked up between 12.30 and 1.45 p.m. and between 4.30 p.m. and 5.15 p.m.). Within this period, prisoners may attend vocational and/or educational activities between 8.45 and 11.45 a.m. and between 2 and 3.45 p.m. and recreational activities between 5.15 and 6.30 p.m. (i.e. some six hours). However, not all prisoners were able to benefit from the core day, notably those on basic level.

A wide range of activities and programmes were on offer to prisoners.<sup>10</sup> Figures for 30 August 2017 show that 708 prisoners attended an activity in the morning and 528 attended an activity in the afternoon, including legal and family visits, etc. That said, it is noticeable that 140 places concerning education, sport and employment went unfilled in the afternoon. An examination of activities for the week of 14 to 20 August 2017 shows that the enrolment and attendance in Training and Employment was good with some 94% of the available 2,466 places spread over 494 sessions taken up. On the other hand, for Education only 44% of the 518 places for 66 sessions were taken up and for Sport and Recreation 72% of the 651 places for 21 sessions were filled. It was not clear why so many sessions were not filled and over and above encouraging prisoners, the delegation was concerned that a number of prisoners with mental health problems were not being appropriately supported and were not taking part in any activities.

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<sup>9</sup> See Rule 51 (2) and 52 (1), Prison and Young Offenders Centre Rules (Northern Ireland) 1995.

<sup>10</sup> Education (literacy, numeracy), vocational training (such as bricklaying, gardening, joinery, painting and decorating,) Recreational activities, Addiction services, Offender management programmes, Sport.

**The CPT recommends that further efforts be made to encourage prisoners to take up the vacant places in these activities, notably education.**

34. At the same time, the CPT's delegation met far too many prisoners who were effectively being confined to their cells for periods of up to 22 or 23 hours a day, despite the existence of the core day regime. This was notably the case for prisoners who had arrived within the previous three months in Erne and Lagan Houses who had applied for work and/or education but had yet to receive any answer. Some were offered access to the gym four times a week for one hour in addition to access to the yard while others were only offered access to the yard for one hour a day. In Bann House too, the delegation met many recently arrived prisoners who were confined to their cells for up to 23 hours. In other blocks, the delegation also met prisoners who often had little to do during the day.

**The CPT recommends that the prison management pursue their efforts to provide all prisoners with purposeful activities. In particular, the Committee would be interested to learn about the number of prisoners locked in their cells for 22 or more hours per day for each accommodation block for the dates of 1 March, 1 April, 1 May and 1 June 2018.**

**The CPT also recommends that prisoners who do not work or attend education should be able to enjoy more out-of-cell time and, as far as possible, be offered meaningful activities during association.** The aim should be to ensure all prisoners spend a reasonable part of the day (i.e. 8 hours or more) outside their cells engaged in purposeful activities.

35. A system of progressive regimes and earned privileges scheme (PREPS) operates at Maghaberry Prison similar to that which is in operation in prisons in England and Wales. The system has three levels, basic, standard and enhanced. All prisoners enter the scheme on the standard level and, through good behaviour, engagement in prison activities and acceptance of their offending behaviour, may progress to enhanced level. Conversely, poor behaviour and a lack of engagement will lead to a prisoner being demoted to basic level.

A prisoner demoted from standard to basic level will, for example, have access to the gym only once instead of three times a week, have no television, reduced association time and less credit for phone calls and the tuck shop. The decision may be appealed within seven days. Further, an action plan is drawn up to support prisoners to be promoted back to standard level. Figures for mid-August 2017 showed that 29 (3.5%) prisoners were on basic, 491 (62 %) on standard and 274 (34.5 %) on enhanced regime (separated prisoners are not included in the PREPS). All prisoners met by the delegation were keenly aware about the PREPS system and how it worked – keep drug-free, behave well and work.

However, none of the prisoners met were aware of any written sentence plan. **The CPT recommends that every sentenced prisoner is provided with a sentence plan and is involved in drawing it up. Such sentence plans should be reviewed on a regular basis with input from the prisoner concerned.**

36. As regards material conditions, Maghaberry Prison offered varied levels of accommodation. Conditions for prisoners in Quoile and Shimna units were good; the cells were bright and reasonably airy, adequately furnished and in a good state of repair. The conditions in Bush and Roe houses were satisfactory whereas in the three open square houses they were less good but nevertheless could be considered, with some exceptions, as generally acceptable.

However, a number of prisoners, primarily remand, continued to be doubled up in cells designed for single occupancy (measuring approximately 7m<sup>2</sup>). As already stated by the CPT, due to their size such cells are only suitable for accommodating one person. Moreover, prisoners were forced to comply with the needs of nature in full view of their cell mates, as the in-cell toilet facilities are still not partitioned. The delegation noted that in Quoile House and in the new 360 cell block being built a possibility exists in the design of each 7m<sup>2</sup> cell to add a second bed. The CPT recalls its principle that a cell of 7m<sup>2</sup> should not be occupied by more than one prisoner.

In Erne House, the delegation noted that some mattresses were infested with bed bugs.

**The CPT reiterates its recommendation that the 7m<sup>2</sup> cells at Maghaberry Prison are not occupied by more than one prisoner. Further, the toilet facilities in every cell should be at least partially partitioned.<sup>11</sup> Cells with deficient mattresses should be disinfected and the mattresses replaced.**

**The CPT also wishes to receive confirmation that a privacy screen for the in-cell toilets will be installed in every cell in the new accommodation block.**

37. The living conditions in Moyola unit, where 11 older prisoners and prisoners with life-threatening conditions were held, were good. Mobility scooters and personal alarms were provided to inmates, if required. The main activities for inmates were gardening and education. In addition to health care staff, the unit was visited by a specialist consultant.

c. health care services

38. Prison health care has been under the South Eastern Health and Social Care Trust (SEHSCT) since 2008 and all health care workers are employed by the Trust. The CPT's delegation found that the independence of the health care service was evident in practice and that it was, in several respects, a well-organised and professional service that had made significant progress since 2008. Nevertheless, there remains scope to improve the delivery of health care to prisoners.

As regards access to health care, the CPT's delegation received many complaints from prisoners about the delays in obtaining a medical consultation. In addition, several complaints were received about the insufficient health care and analgesia provided by a particular doctor. These complaints are not without substance. The delegation noted the high number of complaints made by prisoners through their legal representatives about access to and quality of health care. At the time of the visit, the waiting times had been reduced to two weeks.

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<sup>11</sup> See CPT standards: Living space per prisoner in prison establishments of December 2015 (CPT/Inf (2015) 44, <https://rm.coe.int/16806cc449>) and the England and Wales HMIP paper "Life in prison: Living conditions" of October 2017.

**The CPT recommends that additional steps be taken to address the issues of access to care and the complaints about the quality of health care. The Committee would also like to receive information about the manner in which the quality of care provided by each general practitioner is evaluated.**

39. At the time of the visit, health care staffing levels were generally adequate. There were 2.5 full-time equivalent (FTE) general practitioners (one post was vacant) and a general practitioner was on call at night and on weekends. They were supported by 23 nurses (eight additional posts were vacant) and 2.4 FTE nursing assistants; there were always two nurses on duty at night and on weekends. There was also a full time psychiatrist and a 0.8 FTE dentist, as well as a series of specialists who visited the prison. In addition, the Donard Centre, a day-unit where prisoners with complex needs and mental health issues were treated, was staffed with 1.8 FTE psychiatrists and a 0.2 FTE addictions doctor as well as an addictions nurse (two posts were vacant), two occupational therapists and two support workers.

Nevertheless, the CPT considers that the management of prison health care within the prison would be enhanced if the Donard Centre did not operate as a separate entity from the prison health care unit. It is important to stimulate interactions between somatic and psychiatric care teams to ensure coherence in therapeutic approaches.

**The CPT recommends that the vacant posts be filled and that a prison health care coordinator be appointed. It also recommends that the SEHSCT bring the Donard Centre and the prison health care unit together under a single management structure.**

40. All newly-admitted prisoners were examined by a nurse within an hour of admission which was followed up by a second nurse-led screening within 72 hours. The nurses reported to a doctor who would, if deemed necessary, examine the prisoners in person thereafter. The admission screening followed a structured intake form (EMIS) which covered the medical history and transmissible diseases (blood tests were offered on a voluntary basis). Medical confidentiality was assured.

However, the CPT does have some concerns that during external consultations medical confidentiality was not always respected as prisoners were examined by medical staff in the presence of prison officers and often while they were handcuffed. This was apparently always the case for separated regime prisoners. The CPT recognises that due account needs to be taken of security considerations but the principle of confidentiality requires that all medical examinations of prisoners be conducted out of the hearing and - unless the doctor concerned requests otherwise in a particular case - out of the sight of prison officers. For external medical consultations, this requires undertaking a robust risk assessment of the prisoner concerned, the provision of an escort detail sufficient to secure the area where the prisoner will be examined and, of necessity, an identified room/space in each hospital setting whereby a prisoner can be examined without his medical confidentiality being compromised. **The CPT recommends that the principle of medical confidentiality be respected taking due account of the above remarks.**

Further, the CPT's delegation heard that separated regime prisoners were examined by temporary or stand-in doctors through the hatches of their cell doors. **Such a practice should be ended immediately as it does not enable a proper medical examination to be carried out or promote a doctor-patient relationship.**

41. As regards medication, the delegation received a lot of complaints, including relating to prisoners being given the wrong medication. Medication management is stratified according to the risk of overdose and to the risk related to misuse and/or trading of medication. A high proportion of prisoners (718) were taking medication, of whom 50% under supervised swallow (all medication was distributed by nurses). The high prescription rate poses added challenges when attempting to tackle drug misuse. **The CPT considers that the procedures regulating the management of medication and, in particular their distribution, should be reviewed.**

42. The CPT has consistently pointed out that prison health care services can make a significant contribution to the prevention of ill-treatment of detained persons through, inter alia, the systematic recording of injuries, whether vis-à-vis new arrivals or following a violent episode in prison. In this respect, the health care service at Maghaberry Prison needs to record injuries better, as the quality of the files examined was not adequate. To this end, the duty doctor should be responsible for examining the prisoner and noting down any injuries on the form (IMR12); such a task should not be left to a nurse as is the current practice. In addition to a description of any injuries, the doctor should note down a full account of the statements made by the person concerned which are relevant to the medical examination. Further, the doctor should indicate the consistency between any allegations made and the objective medical findings; this will enable the relevant authorities to properly assess the information set out in the record. Such an approach was not being followed.

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

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

**Further, it would be desirable for photographs to be taken of the injuries, and the photographs should also be placed in the medical file. In addition, a special trauma register should be kept in which all types of injury observed should be recorded.**

43. The presence in prison of inmates with drug-related problems gives rise to a number of particular difficulties for the prison authorities. These include health and security issues, as well as the choice of forms of assistance which are to be offered to the prisoners concerned. Further, the widespread availability of drugs within a prison is bound to have very negative repercussions on all aspects of prison life, and may undermine the motivation of prison officers.

The CPT's delegation observed that drug misuse and a high prevalence of drugs was a problem at Maghaberry Prison. There is a particular challenge of opioid addiction within the community of Northern Ireland which is reflected among prisoners. However, while everyone who has an addiction to opioids in the community may access treatment, at Maghaberry Prison the caseload was limited to 17 persons, all of whom must already be on such treatment in the community prior to entering prison. No new opioid substitution treatment (OST) cases were started in prison.

In addition to opioid substitution treatment, an "Alcohol and Drugs: Empowering people through therapy" (AD:EPT) service funded by SEHSCT was in place providing therapeutic interventions for prisoners' problems associated with the misuse of substances. AD:EPT has eight full time posts and a case load of 120 prisoners. Their interventions were appreciated by prisoners and staff alike; however, interaction and coordination between AD:EPT and the prison health care unit should be improved.

44. From the findings of the visit, the CPT considers that there is a need to expand access to opioid substitution treatment and that all persons entering prison with an opioid addiction ought to be offered the possibility of entering a substitution treatment programme. It is not humane to subject prisoners to "cold turkey" when they first enter the prison; the delegation met a prisoner in such a situation in Bann House and other prisoners alleged that they had experienced similar treatment. Lack of treatment may also lead certain prisoners to seek illicit access to prescription medication. In seeking to address this matter, reference might be had to international standards as well as to the United Kingdom National Institute for Health & Clinical Excellence (NICE) Guidelines.<sup>12</sup>

**The CPT recommends that the opioid substitution treatment policy be reviewed in the light of the above remarks and that formal interaction and coordination be set in place between AD: EPT and the prison health care unit. In particular, access to OST should be made available to all opiate dependent prisoners.**

More generally, at the time of the visit there was still no multi-disciplinary substance misuse strategy in place.<sup>13</sup> **The CPT recommends that the Northern Ireland authorities elaborate a drug strategy programme designed to put an end to the supply of drugs, to reduce as far as possible the demand for drugs and to provide appropriate assistance to prisoners with drug-related problems, including substitution treatment.**

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<sup>12</sup> See, for example, "Health and social responses to drug problems: a European guide" published in October 2017 by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

<sup>13</sup> In the report on the October 2014 joint inspection by CJINI and RQIA on "The Safety of Prisoners held by the Northern Ireland Prison Service" one of the three strategic recommendations made concerned the elaboration of a drug misuse strategy.



45. Harm reduction measures represent an important component in preventing the transmission of blood-borne viruses and the spread of infectious diseases. The CPT found that measures such as needle-exchange programmes and the availability of condoms were not in place at Maghaberry Prison, although they existed in the outside community. These are simple measures that can make a positive difference to the health of prisoners as part of an overall strategy. Information gathered by the delegation shows that prisoners are injecting at Maghaberry and repressive measures alone will not result in its eradication. Studies show that harm reduction measures do make a difference and limit the spread of infectious diseases, in particular of blood-borne viruses.<sup>14</sup>

**The CPT recommends that the Northern Irish authorities introduce harm reduction programmes in prison to reduce the transmission of blood-borne viruses (introduction of needle and syringe exchange programmes, access to condoms). In undertaking such programmes, attention should be paid to the fact that not all prisoners are literate. Full information on the existence of such harm reduction programmes should be given to inmates by health care staff immediately after committal.**

46. In this context, the CPT also considers that persons entering prison who are suspected of having ingested or secreted drugs within their body (body packers) should not be placed in a dry cell in the Care and Supervision Unit (i.e. the segregation unit - CSU) under the observation of prison officers. Instead, they should be placed under supervision in a medical environment. As there is always a risk that the receptacle in which the drugs are placed may burst with potentially life-threatening consequences, it is best practice for the persons concerned to be placed under medical observation in hospital rather than being kept in the prison. The delegation was informed about a recent case at Magilligan Prison where an inmate in a dry cell collapsed after the package he had swallowed leaked and he had to be evacuated in extremis to the local hospital for emergency treatment. Further, the CPT also considers that where a prisoner is suspected of having ingested drugs, a radiography examination (x-ray or preferably low dose CT scan) is the most effective means of determining whether this is the case. If confirmed, the person should be placed under medical observation.

The CPT's delegation also found that prisoners suspected of being body packers appeared to be held in a dry cell and in some instances punished under Rule 32 of the Prison Rules instead of Rule 39<sup>15</sup> (see paragraph 53 below). For example, an inmate who entered prison on [...] was found in possession of some cannabis and was also suspected of having secreted drugs. He was placed in a dry cell for 12 days during which he underwent a full strip search each day. Thereafter, he spent an additional 30 days in the CSU under Rule 32. First, it should be noted that any drugs ingested by a person will be evacuated naturally within a period of five days, and usually within 72 hours. Second, it was not clear from the documentation examined why the prisoner was not subject to a disciplinary inquiry and sanction instead of being placed on Rule 32, nor why he was held for as long as 42 days under Rule 32 in the CSU.

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<sup>14</sup> See, for example, the June 2013 UNODC/WHO/ILO/UNDP/UNAIDS Policy brief: HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions; and the 2008 NICE publication: Drug Misuse: Opioid detoxification - National Clinical Practice Guideline Number 52

<sup>15</sup> Rule 32 regulates the restriction of association of a prisoner for the maintenance of good order or discipline, or to ensure the safety of other persons while Rule 39 concerns the disciplinary sanctions which a Governor may impose.

**The CPT recommends that persons entering prison who are suspected of having ingested or secreted drugs within their body should be subject to a radiography examination and, if positive, placed under observation in a medical setting until the evacuation of the packs.**

**The CPT wishes to receive information on the specific case referred to above, notably as regards the length of time he spent in a dry cell and, more generally, on the application in practice of Rule 32 as well as the reasoning for the inmate being subject to Rule 32 and not the disciplinary process.**

47. In light of a large proportion of the prison population suffering from a mental disorder, the CPT considers that the current provision of psychiatric care at Maghaberry Prison should be reinforced. As mentioned above, there was a dedicated team working out of the Donard Centre providing some 50 to 85 psycho-social activities<sup>16</sup> per week for prisoners in need. Further, in some cases, there was the option of transferring prisoners to the Shannon medium secure psychiatric clinic (see Section C below), although this was not an option for prisoners requiring accommodation in a high-security facility. Furthermore, the waiting time for transfers was approximately 10 weeks, which is far too long. For prisoners requiring treatment in a high secure setting such as Carstairs Hospital in Scotland, the transfer delay was even greater. The CPT considers that the proposed time limit of 14 days for transferring prisoners to a psychiatric facility set out in the 2009 Bradley Report,<sup>17</sup> which is equally relevant for Northern Ireland, should be considered as a maximum time limit. However, immediate transfer to a psychiatric hospital should be possible in the case of emergencies.

Another major concern remains how to manage and treat prisoners diagnosed as having a personality disorder as it is not recognised as a psychiatric illness under the Northern Ireland Mental Health Order (MHO) 1986, with the consequence that such prisoners cannot be transferred to or treated in the Shannon Clinic. At present, challenging prisoners with a diagnosis of personality disorder end up in the CSU where they are subject to a 23-hour lock-up regime which is totally inappropriate for addressing their needs. Unfortunately, the Mental Capacity Law 2016 which will enable persons with personality disorders to be treated at Shannon Clinic will only enter into force in 2020 or even 2021.

**The CPT recommends that the United Kingdom and Northern Ireland authorities take all necessary measures to ensure that prisoners suffering from severe mental disorders (i.e. including personality disorders and intellectual disabilities) are cared for and treated in a closed hospital environment, suitably equipped and with sufficiently qualified staff to provide them with the necessary assistance.**

**Further, prisoners suffering from severe mental illnesses should be transferred to hospital immediately.**

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

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<sup>16</sup> Such as music therapy, relaxation, social interaction, depression management, gym, cooking, art workshop, boccia, positive steps.

<sup>17</sup> See for example, Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system (the Bradley Report), 30 April 2009.

48. The delegation met several prisoners, notably in Bann House who had been (re-) admitted to prison in the months prior to the visit, who appeared to be suffering from a mental health condition and who lacked social awareness. They were clearly in need of psychiatric treatment and psycho-social support. None of them had been seen by a psychiatrist since their admission to prison.

Further, the CPT considers that it is positive that all staff are trained to identify prisoners who may be at risk of self-harming or suicide. At Maghaberry Prison, the process in place, Supporting Prisoners at Risk (SPAR), operated adequately in terms of identifying prisoners, but those prisoners placed on a SPAR were provided with insufficient psychological support to address their underlying issues. A psycho-social team including clinical psychologists should be involved in the management of all prisoners placed on a SPAR.

**The CPT recommends that the admission procedures are adapted to ensure that persons with mental illnesses are clearly identified and steps are thereafter taken to provide them with the care they need in prison. Further, the Committee recommends that the SPAR process be enhanced by the establishment of a psycho-social support team to provide support to those prisoners placed on SPAR.**

d. other issues

*i. prison staff*

49. At the time of the visit, staff at Maghaberry Prison consisted of 15 senior managers, 60 senior prison officers and a total of 504 prison officers, as well as 41.6 FTE administrative staff and 20 civilian contractors. Although the numbers of staff are high for a prison inmate population of around 850, the particular complexities of the establishment should be borne in mind, notably as regards the staffing of the separated regime units. According to the staffing table, there were 70 prison officer vacancies. **The CPT would like to be informed whether the vacancies have been filled.**

The CPT's delegation observed that prison officers were equipped with extendable batons which they wore on their belts. The CPT has long advocated that prison officers should not be routinely equipped with batons and **recommends that prison officers at Maghaberry Prison no longer routinely carry batons.**

ii. *discipline and segregation*

50. The discipline and adjudication process within prisons in Northern Ireland was outlined in the report drawn up after the 2008 visit by the CPT and the overall process has remained essentially unchanged.<sup>18</sup> In the first eight months of 2017, there were 1,718 adjudications and prisoners were found guilty in 1,037 cases with 300 cases still pending. The punishment of cellular confinement (i.e. solitary confinement), was imposed 136 times, 13 of which were for the maximum period of 14 days. An examination of a sample of disciplinary cases at Maghaberry Prison indicated that the procedures were strictly followed and that the paperwork pertaining to the cases was properly kept. However, there is currently no right to appeal against any disciplinary sanction to an authority outside the prison.

The CPT also considers that the cumulative imposition of several sanctions (governor's awards) such as 28 days loss of evening association, loss of tuck shop, loss of cell radio, loss of earnings or cell crafts may result de facto in the prisoner being placed on 23 hour lock up for the whole time without any possibility of association with other prisoners, not even during outdoor exercise, if they do not have a job or another activity. The delegation met several prisoners in such a situation. Further, from a number of the files consulted, the delegation had some concerns over the proportionality of the disciplinary sanctions imposed.

**The CPT recommends that all prisoners should have the right to appeal a disciplinary sanction to an authority outside the prison. Further, care should be taken to avoid prisoners being given cumulative punishments which de facto result in them being placed in cellular confinement for periods in excess of 14 days.<sup>19</sup>**

51. The CPT's delegation again found that doctors were being asked to certify prisoners as fit for punishment before they were placed in segregation in accordance with Prison Rule 41 (2). The CPT has taken note of the response of the Northern Ireland authorities to the report on the 2008 visit whereby NIPS argues that it is necessary "to identify whether a prisoner has underlying mental health or other problems which would preclude them from spending periods in a cell confined" and therefore "the arrangement is necessary [...] to protect individual prisoners." The CPT recognises the importance of persons placed in solitary confinement whether for disciplinary reasons or good order being visited on a regular basis by a doctor or nurse. However, the medical staff should not be endorsing a disciplinary sanction by certifying the prisoner as being fit for punishment. Such an approach is not conducive to promoting a positive doctor-patient relationship between health care staff and prisoners which represents a major factor in safeguarding the health and well-being of prisoners. For this reason, **the CPT recommends that Prison Rule 41(2) be abrogated.**

52. In addition to a disciplinary sanction of cellular confinement, Rule 32 of the Prison Rules provides for restriction of association, either generally or for particular purposes, where necessary for the maintenance of good order or discipline, or to ensure the safety of officers, prisoners or any other person or in his/her own interests. The initial period must not be longer than 72 hours without the agreement of the Department of Justice but may thereafter be extended for periods not in excess of one month (Rule 32).

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<sup>18</sup> See Prison Rules 35 to 44, The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 and CPT/Inf (2009) 30, paragraph 177

<sup>19</sup> See paragraph 56(b) of the 21<sup>st</sup> General Report of the CPT of November 2011 concerning the CPT's standards on solitary confinement of prisoners as a disciplinary sanction (<https://rm.coe.int/16806cccc6>)

The 2009 amended Prison Rules (Rule 32, (2A-2K)) provide for the involvement of the Independent Monitoring Board (IMB) in cases of restriction of association (the IMB should be involved in the case conference regarding each prisoner placed on Rule 32 and should independently scrutinise decisions being taken in relation to a prisoner being placed on Rule 32).

53. Prisoners subject to Rule 32 or to a disciplinary sanction of cellular confinement or who are separated under Rule 35(4) for a maximum of 48 hours pending adjudication for a disciplinary sanction are placed in the Care and Supervision Unit (CSU). The CSU is a punishment block in all but name although efforts are being made to develop its purpose.

The two-storey building has narrow corridors and low ceilings and contains two observation cells, two dry cells and 23 ordinary cells. At the time of the visit, 23 prisoners were being held (19 under Rule 32, one under Rule 35(4) and three were serving a period of cellular confinement under Rule 39).<sup>20</sup> The regime is the same for all CSU inmates: the possibility to shower on weekdays, to make a phone call once a day and to exercise alone for up to one hour a day in a small enclosed yard (weather permitting).

A major concern for the CPT is that prisoners may be held in the CSU in conditions of solitary confinement for prolonged periods. One prisoner had been in the CSU for nearly three years and three others for periods in excess of five months. It also appeared that several of the prisoners who had been in the CSU for one or two months were in need of mental health support but had received none. Two prisoners had been on a “dirty protest”<sup>21</sup> for more than a month as they refused to go back to an ordinary accommodation block as they considered all of the blocks “to be awash with drugs”. In this respect, it should be noted that access to medical care for prisoners in the CSU is insufficient, as security exigencies mean that health care staff are not always able to access the prisoners and to speak with them confidentially. There is a need for much greater psychiatric and psychological input and for improved synergies between security issues and health care needs.

**The CPT would appreciate the observations of the Northern Ireland authorities on these matters. As regards access to daily outdoor exercise, the CPT considers that it should be a right for all prisoners regardless of the weather conditions.**

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<sup>20</sup> In the first eight months of 2017, 344 prisoners were held in the CSU under Rule 32.

<sup>21</sup> A dirty protest is where a prisoner has deliberately chosen to defecate or urinate in a cell. In the majority of cases the walls, floor or ceiling are smeared and a prisoner may also smear faeces on himself as part of the protest.

54. The CPT considers that once it becomes clear that solitary confinement is likely to be required for a longer period of time, a body external to the prison holding the prisoner, for example, a senior member of headquarters staff, should become involved in providing oversight. A right of appeal to an independent authority should also be in place. When an order is confirmed, a full interdisciplinary case conference should be convened and the prisoner invited to make representations to this body. A major task for the review team should be to establish a plan for the prisoner with a view to addressing the issues which require the prisoner to be kept in solitary confinement. Among other things, the review should also look at whether some of the restrictions imposed on the prisoner are strictly necessary – thus it may be possible to allow some limited association with selected other prisoners. The prisoner should receive a written, reasoned decision from the review body and an indication of how the decision may be appealed. After an initial decision, there should be a further review at which progress against the agreed plan can be assessed and if appropriate a new plan developed. The longer a person remains in this situation, the more thorough the review should be and the more resources, including resources external to the prison, made available to attempt to (re)integrate the prisoner into the main prison community. The prisoner should be entitled to require a review at any time and to obtain independent reports for such a review. The prison director or senior members of staff should make a point of visiting such prisoners on a regular and frequent basis and familiarise themselves with the individual plans. Health-care staff should visit prisoners immediately after placement and thereafter, on a regular basis, at least once per day, and provide them with prompt medical assistance and treatment as required.<sup>22</sup>

55. At Maghaberry Prison, the CPT's delegation found that there is a need to reinforce the procedural safeguards in place and to develop individual plans tailored to the needs of the prisoners. At present, a prisoner placed in the CSU under Rule 32 is not provided with a written decision. A case conference is held for every prisoner held in the CSU under Rule 32 within the initial 72 hour period and thereafter prior to the end of the extended period. The case conference is chaired by a governor and attended by two senior prison officers and a representative of the IMB. Prisoners are afforded an opportunity to put their side of the case and, in the conferences observed by the delegation, mitigating elements put forward by the prisoner were taken into consideration. Each decision taken by Maghaberry Prison concerning a Rule 32 decision is reviewed by a Governor grade from NIPS headquarters. However, prisoners are not provided with the decision in writing and no avenues exist for appealing the measure.<sup>23</sup>

**The CPT recommends that all prisoners subject to Rule 32 should have a right to appeal the measure. Further, all decisions should be properly documented and reasoned. The prisoner should receive a reasoned written decision on the measure and the extension of any stay under Rule 32 and information on how to challenge the measure.**

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<sup>22</sup> See Rule 43.2 of the European Prison Rules (2006).

<sup>23</sup> A complaint to the Prisoner Ombudsman cannot be considered as an appeal, as the Ombudsman is not competent to overturn the decision. Further, a Judicial Review cannot be considered as an appeal; the Court generally examines how the body arrived at its decision rather than the merits of the actual decision itself.

56. For persons segregated in the CSU for periods in excess of a month, Maghaberry Prison has instituted a process of monthly overviews during which the situation of specific prisoners is reviewed. Some initial work to establish an individualised plan including counselling and activities such as gym has been undertaken in respect of a few prisoners on the initiative of a senior prison officer in the Prisoner Safety and Support Team. However, there is a need to do much more to develop individualised treatment plans for prisoners and the support mechanisms required for their implementation. Many of the prisoners in the CSU have serious psychological and mental health issues and keeping them locked up for 23 hours a day for prolonged periods is not conducive to their well-being and, moreover, makes it far harder to reintegrate them into an ordinary accommodation block.

The CPT considers that there is a real necessity to provide prisoners in the CSU under Rule 32 with a psycho-social support system which should be oriented towards progressively engaging with the prisoners, individually and in small groups. These prisoners should be offered the opportunity to spend more time out of their cells associating with one or more prisoners, notably during periods of outdoor exercise or in the gym. The aim should be to provide them with a regime similar to that in operation in the rest of the prison and to maintain the level of engagement when they leave the CSU. The delegation met a number of prisoners who had spent a month or more in the CSU on 23 hour lock-up which, in practice, continued when they returned to a house block as they were offered no activities (education, work, etc.). The prison must engage more proactively with challenging prisoners. To this end, it would be preferable that inmates in the CSU under Rule 32 for protection reasons or for extended periods were placed in a step-down unit which would facilitate psycho-social support input. At the time of the visit, consideration was being mooted of the adjacent Glen House being used for such a purpose.

**The CPT recommends that the Northern Ireland authorities put in place a psycho-social support system for Rule 32 prisoners held in the CSU for longer than two weeks and provide them with greater opportunities for association and engagement in activities, in the light of the above remarks.**

**The aim should be for all prisoners under Rule 32 to be offered at least two hours of meaningful human contact<sup>24</sup> every day and preferably even more. Further, it wishes to receive the comments of the authorities about the feasibility of establishing a step-down unit from the CSU.**

**The Committee would also like to be informed of the number of prisoners who have spent more than one month, six months and one year in the CSU on 1 March and 1 June 2018.**

*iii. contact with the outside world*

57. In general, the CPT's delegation observed that the visits system operated satisfactorily. The Prison Rules (Rule 65 to 68C) allow every prisoner to receive one visit every four weeks with the system of privileges (PREPS) providing for additional visits. Sentenced prisoners (both those on basic and standard) may have three privileged visits and one statutory visit of one hour every 28 days and remand prisoners two visits a week of 30 minutes. Prisoners on enhanced regime are offered an additional visit of up to two hours every month. In the CPT's view, all prisoners should be entitled to the equivalent of one visit a week of at least one hour as a right rather than as a privilege.

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<sup>24</sup> See Essex paper 3 of February 2017 on the "Initial guidance on the interpretation and implementation of the UN Nelson Mandela Rules" and in particular pages 88 and 89.

**The CPT recommends that the Northern Ireland authorities ensure that all prisoners are entitled to a minimum of one visit a week of one hour as a minimum and that they revise the Prison Rules accordingly.**

*iv. prisoners in separated regimes*

58. Prisoners with “paramilitary affiliations” may opt for placement in separate accommodation within Maghaberry Prison which must be authorised by the Northern Ireland Office. As was the case in 2008, prisoners with loyalist affiliations are held in ‘Bush House’ (landings 1 and 2) and members of dissident republican organisations in ‘Roe House’ (landings 3 and 4). The conditions of detention on these landings are of a decent standard.

At the time of the visit, Bush House held 15 “separatist” prisoners and Roe House 22 “separatist” prisoners. Both units functioned as stand-alone entities, with separate outdoor exercise yards, gyms and educational facilities. Prisoners who had opted to be placed in either of these units were prevented from having contact with the other prisoners, which meant they could not work. They were unlocked from their cells for 11 hours a day but had considerably fewer activities offered to them (art and guitar classes twice a week in Roe House; art classes once a week and gym every day in Bush House). **Efforts should be made to increase the level and range of activities offered to “separatist” prisoners.**

59. The CPT is aware of the challenges for the prison in managing “separatist” regimes for the prisoners held in Bush and Roe Houses. Nevertheless, for the CPT, all prisoners should be treated with respect and dignity and offered a meaningful regime. At the time of the visit, there was room for improvement. Further, it is also clear that stand-offs between “separatist” prisoners, notably Republicans, and NIPS over “points of principle” increase tensions on the landings. The Committee has taken note of the numerous written complaints made by the Republican inmates to the Ombudsman, notably concerning strip searches, controlled movement and forced isolation, since the beginning of 2016 and which were also conveyed directly to its delegation.

*v. complaints and inspection procedures*

60. The internal complaints procedure is laid down in the Prison and Young Offenders Centre Rules (Northern Ireland) 1995; Part VIII (Rules 75 to 79) and consists of two stages.

In the first stage, the complaint is passed to a residential manager who shall interview the prisoner within 24 hours of the complaint being recorded, and thereafter pass the complaint to an appropriate person with supervisory responsibility for the subject matter of the complaint within three days. This appropriate person shall consider the complaint and provide a response to the complaint as soon as possible and in any event within ten days. The response is passed on to the prisoner via the residential manager. If the prisoner is not satisfied with the response or if he has not received a response within 14 days he may make the complaint a second time. In this second stage, the residential manager will pass the complaint to someone who is senior to the appropriate person who considered the complaint in the first stage. Once these two stages are exhausted, the complainant may submit his complaint to the Northern Ireland Prisoner Ombudsman.



An examination of the complaints showed that the procedures were carried out properly. Prisoners were provided information on the procedure, complaint forms were available in the most common languages (English, Cantonese, Latvian, Lithuanian, Mandarin and Polish) and complaint boxes existed throughout the prison. In the first six months of 2017, 3,429 complaints were registered, of which 1,681 were dealt with at stage one, 1,573 at stage two, 137 were pending and 38 were at the interview stage. It is noticeable that 45% of complaints emanated from the “separatist” prisoners in Roe House.

That said, there is no means of making a confidential complaint to the Governor or directly to the Prison Ombudsman concerning serious matters such as an allegation of ill-treatment of a prisoner by a prison officer(s). In other jurisdictions, prisoners are able to address directly either the Governor of the Prison or an independent authority outside the prison whenever they have a serious allegation concerning the running of the prison.<sup>25</sup>

**The CPT recommends that the Northern Ireland Prison Rules be revised accordingly.**

61. Complaints concerning medical issues are not clearly laid down in law nor are prisoners informed of the avenues concerning how they should make a complaint. Instead, many complaints are submitted by prisoners’ lawyers. There also appeared to be no time limits for addressing medical complaints.

**The CPT recommends that the procedure for making complaints about medical issues be clearly regulated and prisoners be informed about the procedures upon admission. Further, all complaints, including those made by lawyers, should be recorded.**

62. The role of the Prisoner Ombudsman in investigating complaints is rightly recognised as an essential component in the proper functioning of the Northern Ireland Prison Service and it is positive that a practice has developed whereby the Prisoner Ombudsman investigates ex officio certain incidents, such as deaths and serious self-harming in prison. The CPT also welcomes the adoption of the Justice Act (Northern Ireland) 2016 which places the tasks and powers of the Prisoner Ombudsman on a clear statutory basis.

63. The CPT has noted that of the 228 decisions on complaints submitted to the Prison Ombudsman between 1 January 2015 and 15 August 2017 some 50% upheld (fully or partially) the prisoners’ complaint. The NIPS accepted 170 recommendations made by the Ombudsman but rejected 48, some of which concerned unjustified adjudications where the NIPS did not quash the adjudication decision or refund the loss of earnings as recommended by the Ombudsman. The decision not to act upon the Prisoner Ombudsman recommendations in such cases undermines the effectiveness of the complaints system. **The CPT would appreciate the comments of the Northern Ireland authorities on this matter.**

64. Maghaberry Prison is regularly inspected by the Northern Irish Criminal Justice Inspectorate with support from HM Inspectorate of Prison from England and Wales and the Regulation and Quality Improvement Authority of Northern Ireland. The International Committee of the Red Cross carries out routine monitoring in the prison, notably in respect of the separated prisoners. An Independent Monitoring Board (IMB) is also present.

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<sup>25</sup> See also Rule 56.3 of the Nelson Mandela Rules (i.e. the revised United Nations Standard Minimum Rules for the Treatment of Prisoners adopted on 15 December 2015 by the UN General Assembly).

### **3. Ash House (female prison establishment)**

65. In many countries, women prisoners are treated like male prisoners with no specific rules and regulations addressing their particular needs as women. In European countries, women make up a very small minority of the overall prison population and the focus of prison systems is oriented toward the standard male prisoner (i.e. how to provide a safe and secure environment and, if feasible, to prepare them for reintegration into the community). However, women have particular biological and gender-specific needs and vulnerabilities that require an alternative prison policy oriented toward their requirements. The physical environment is an important aspect of this. The Northern Ireland government agreed in principle to recommendation 36 of the Owers Report that women prisoners, who make up some 4.5% of the prison population, should be held in a new small custodial facility which is built, staffed and run around a therapeutic model. However, lack of funding means that for the foreseeable future women will continue to be accommodated in Ash House, which is located adjacent to the young offender accommodation blocks within Hydebank Wood College.

**The CPT would like to be informed about any plans to provide a separate facility for women prisoners in Northern Ireland or to upgrade the existing facilities to better meet the specific needs of women prisoners.**

66. As a general principle, imprisonment should be a last resort when other less restrictive measures are not considered effective or appropriate. In the course of the visit to Ash House, the CPT's delegation was struck by the number of women who were being committed to the establishment for weekends or for one or two nights.<sup>26</sup> Such placements are inappropriate as they drain scarce resources, are traumatic for the women and their families, and are far too short for any type of meaningful interventions to be made. In this context, consideration might be given to introducing a presumption to avoid imprisonment for short periods; for example, the Scottish Government recently announced after extensive research and consultations that the presumption against imprisonment should be extended up to sentences of 12 months.<sup>27</sup> Indeed, the promotion of non-custodial measures should be pursued in Northern Ireland.

There is equally a need to have a far better coordination between the various community services, the judiciary and prison authorities to avoid women with mental health or learning disabilities ending up in Ash House where they cannot cope with the regime and after which they appear even less able to cope in the community. One such woman was committed 13 times to Ash House between July 2014 and July 2017 (see paragraph 80 below). Prison was clearly an inappropriate environment for her and caused disruption and distress to staff and other inmates alike.

**The CPT recommends that these general issues be addressed by the Northern Ireland authorities within the context of the Justice Strategy and the reforms relating to the new Mental Capacity Act 2016.**

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<sup>26</sup> For example, in mid-August 2017, six women who were committed to Ash House on a Friday night were subsequently released on Saturday, the next day.

<sup>27</sup> See Scottish Government Programme for 2017-2018; Scottish Parliament, Official Report, Meetings of the Parliament, 5 September 2017. See also UK Ministry of Justice 2015 Analytical series on the impact of short custodial sentences, which found that short-term custody (less than 12 months in prison) was consistently associated with higher rates of proven re-offending than community orders and suspended sentence orders.

a. ill-treatment

67. The CPT received no allegations of ill-treatment of women prisoners by staff. On the contrary, the inmates generally spoke positively about the staff in Ash House.

It was also noted that there were few incidents of physical inter-prisoner violence. Bullying was an issue, often around obtaining prescription medication but staff appeared to be alert to signs of bullying and intervened appropriately. However, severe staff shortages were resulting in several women not feeling safe to leave their cells (see also paragraph 82 below). The delegation also received a number of complaints about verbal abuse from the male offenders who regularly shouted sexual insults at the women from their adjacent accommodation block.

**The CPT recommends that the Northern Ireland authorities ensure that there are adequate staffing levels in Ash House to maintain a safe environment, while ensuring that the full regime of activities can be delivered. Further, additional action should be taken to tackle the abusive language employed by male young offenders towards women prisoners.**

b. admission procedure

68. The admission procedure is generally well organised. All women committals receive clear information on the running of the establishment both orally and in writing and can also watch a short film on Ash House and on making a complaint to the Ombudsman. However, it would be beneficial if the basic information also contained information on the disciplinary procedure and restriction of association and not just on the consequences of breaking the rules.

New committals are usually seen by a nurse upon admission (see paragraph 76). However, the Prison Rules regulating the admission process do not contain gender specific provisions for women, other than for pregnant women (Rule 92). The Prison Rules and admission process should be reviewed to ensure that they meet the general requirement laid down in the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) of October 2010, notably Rules 2(1) and 6(e).<sup>28</sup> This requires looking at their particular vulnerabilities at the time of admission. For example, at present there is no screening for sexual abuse or other forms of gender-based violence inflicted prior to admission. Such screening is essential as violence experienced prior to admission is likely to have a direct correlation with the woman's behaviour and even offending behaviour, and should clearly impact on the way in which the care plan for the woman in question is drawn up for her stay at Ash House (i.e. whether she needs specialised psychological support or counselling). The lack of such an approach means that the management is unable to take appropriate steps to ensure that victims of sexual abuse are not re-traumatised (see also paragraph 73).

Further, given the vulnerability of certain women prisoners entering prison, it is vitally important that the admission process is carried out properly whenever women are admitted to Ash House. At the time of the delegation's visit, the shortage of staff meant that the admission procedures were hurried and incomplete. Steps should be taken to ensure that this does not happen.

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<sup>28</sup> Adopted by UN General Assembly resolution 2010/16, A/C.3/65/L.5, on 6 October 2010.

**The CPT recommends that the Northern Ireland authorities further develop the admission process at Ash House to take into account the vulnerabilities of women prisoners. This should include screening for sexual abuse or other forms of gender-based violence inflicted prior to entry to prison and ensuring that such information is considered in the drawing up of a care plan for the woman in question. Further, steps should be taken to ensure that the admission procedure is always comprehensively carried out.**

c. conditions of detention

69. Ash House has five accommodation landings on three floors: landing 1 on the first floor is for committals (and prisoners separated from other prisoners for disciplinary or other reasons) who progress on to landings 3 and 4 on the second floor. Prisoners who are on an enhanced regime are located on landing 2 on the first floor and thereafter on landing 5 on the ground floor. Also on the ground floor is the health care centre, a common area and a hairdressing workshop. There is an outside yard (25 x 18m) with a lawn, trees and bushes and furnished with chairs and three tables; the yard is surrounded by a fence to prevent male young offenders watching the women. **There was however no shelter in the yard against rain or sun.**

70. The material conditions were generally adequate. Each landing had a common area with sofas, chairs, tables and a television as well as a kitchen area. Prisoners on enhanced regime could cook their own meals. The cells were suitably equipped and the toilets in them were fully partitioned. For inmates located on landings 2 and 5 with an enhanced status under the PREPS system, the cells were of an adequate size (8m<sup>2</sup>) and the cell doors are unlocked between 8 a.m. and 10 p.m. However, a number of cells on landings 3 and 4 and all the cells on landing 1 measured only 6m<sup>2</sup>, including the toilet, which is below the minimum size advocated by the CPT. All cells should be at least 6m<sup>2</sup> not including the sanitary annexe. For the women held on landing 1 the impact was all the greater given that they are locked in their cells for around 20 hours a day. Further, none of the cells were of an adequate size for doubling up (apart from the two cells designated as mother and baby rooms) and should not be used as such.

**The CPT recommends that none of the ordinary cells should be used to accommodate more than one prisoner. No inmate should be placed in a cell of 6m<sup>2</sup> or less (excluding the sanitary annexe). Until such a recommendation is completely fulfilled, inmates in cells of this size should be provided with more opportunities for out-of-cell time.**

71. At the time of the visit, the CPT's delegation was informed that no mother and baby had been held in Ash House for three years. Nevertheless, whenever such a situation occurred, a converted double cell on landing 4 was designated for the mother and baby; the room would never be locked and there would be a nominated carer. The general policy was to keep the mother and baby in the prison for up to nine months as decided by the social services.

Ideally mothers and babies should not be held in prison but if it is considered necessary, the CPT considers that the current arrangements need to be reviewed. It is not appropriate for a mother and her baby to be placed among the general female population. They ought to have suitable and non-carceral accommodation facilities – for example, in a separate stand-alone bungalow similar to the one used for extended family visits – which offers a child-friendly environment to nurture the development of mother-baby relations and which offers appropriate nursing facilities. It is important that the mother be offered support and be given the opportunity to associate with other prisoners and to engage in activities. The CPT also has misgivings about the current policy of taking the baby away at the age of nine months and believes the period should be extended significantly as is the case in many other European countries; of course, each case should be based on an individual assessment looking at the best interests of the child. Particular care should be taken to prepare any separation of the baby from the mother.

**The CPT recommends that the policy and conditions under which a mother and her baby are kept at Ash House be reviewed, in the light of the above remarks.**

72. The regime varied according to whether the women were on basic, standard or enhanced level under the PREPS system. A wide range of activities were on offer, some of which aimed at meeting the prisoners' gender specific needs.<sup>29</sup> Women on enhanced status spent around four to five hours a day engaged in work and education and, in the main, were satisfied with their programme of activities. Nevertheless, several life-sentenced prisoners complained that despite complying fully with the regime, they felt that they were treading water until the expiry of their tariff approached and they could start having community visits. Indeed, they stated that their sentence managers no longer engaged with them as there were no more benchmarks for them to achieve.

As for women prisoners on standard status, many of them said that they were unable to have a choice of what activities to attend which they found demotivating; they claimed that often the activities merely involved sitting around drinking tea. This extended also to education where those wanting to learn were disrupted from doing so by those who did not. It is positive that women prisoners are encouraged to participate in activities every day but it seems rather wasteful for prisoners to undertake a course, for example on plumbing, for which they have no interest merely to fill up places. The delegation gained the impression from staff and inmates that the allocation of work and educational courses was primarily to comply with goals set by management and not to address the needs of prisoners.

**The CPT recommends that increased efforts be made to establish sentence plans with purposeful activities of a varied nature that meet the individual needs of the prisoner. Prisoners should actively participate in the establishment of their sentence plans.<sup>30</sup> Particular efforts shall be made to provide appropriate services for prisoners who have psychosocial support needs, especially those who have been subjected to physical, mental or sexual abuse.**

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<sup>29</sup> For example, one inmate's activities were garden work, bee-keeping, baking, art, playing the piano, furniture restoration and gym. The occupational therapist led several programmes (Just Right State Programme and Wellness Recovery Action Plan) and promotes others (Building a sensory garden as a safe space, cooking, resettlement work/life skills, animal care, recovery café (working outside and aimed at reducing stigma), etc.).

<sup>30</sup> See Rule 103.3 of the European Prison Rules 2006.

73. More generally, despite some inspirational work being promoted by the occupational therapy department, the evidence base for the interventions (such as the Just Right State Programme) and various activities was not clear. Further, the physical environment was not conducive to learning, and motivating women to attend classes was problematic. Consideration might be given to offering fewer well-validated evidence-based programmes rather than many with a limited evidence base. Also, there were few interventions addressing the risk of reoffending. **The CPT would appreciate the comments of the Northern Ireland authorities on these matters.**

The lack of screening for sexual abuse or other forms of gender-based violence upon admission also meant that prisoners who had suffered from such violence (several of whom were interviewed by the delegation) and were in need of specialised psychological support or counselling<sup>31</sup> were not being offered it. **The CPT recommends that Ash House set up specialised psychological support or counselling for women who are victims of rape, sexual abuse and other gender-based violence.**

74. At the time of the visit, one sentenced woman who was affiliated to a Republican paramilitary organisation was, at her own request and upon the authorisation of the Northern Ireland Office, being held in separate accommodation. She had been held alone in the health care centre of Hydebank Wood College since being sentenced in June 2017. She associated with no other prisoner and spent her days confined to her cell and an adjacent living room area and took part in no activities, apart from attending the library once a week and receiving two visits a week. She complained about her treatment by staff, notably male prison officers, and the health care provision.

**The CPT would like to be informed about the steps being taken to ensure that “separatist” prisoners are provided with meaningful human contact every day. It would also like to know what activities the current “separatist” prisoner could attend and whether she could associate with other prisoners if she so desired.**

d. health care services

75. The health care services were responsible for both Ash House and the young offenders at Hydebank Wood College. The staffing levels and facilities were generally adequate.<sup>32</sup> That said, dental care seemed to be problematic in terms of gaps between the needs and the service available. There is also a need to reinforce the psychology and psychiatry input

As regards access to health care and record keeping, the CPT’s delegation found that the organisation of the individual care plans for each prisoner could be improved. Further, the doctor should not be prescribing medication without first examining the patient, which occurred all too frequently for women held at Ash House. Conversely, prisoners committed over the weekend (Friday night) or on a bank holiday often had no access to their prescription medication for one or more days which could be extremely distressing. As it is not possible for their relatives to bring in the medication, arrangements should be put in place to access a pharmacy that is available 24/7 (such as exists in surrounding hospitals). The existence of electronic medical records means that health care staff are able to check quite easily the medication that prisoners are being prescribed in the community.

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<sup>31</sup> See Rules 10.1 and 38 of the Bangkok Rules.

<sup>32</sup> 0.3 FTE female general practitioner, 12 primary care nurses, including a nurse manager, 2.5 FTE mental health nurses, an occupational therapist, 0.4 FTE psychiatrist and 0.2 FTE psychiatrist for addictions and a number of visiting specialists such as a podiatrist, mid-wife, optician, physiotherapist.

**The CPT recommends that the Northern Ireland authorities put in place arrangements to enable health care staff to have access to a pharmacy whenever required to ensure a continuity of care for new committals to Ash House who have a prescription for particular medication. Further, the prescribing of medication for prisoners should only be made once the prisoner has been examined by a doctor.**

**The provision of dental care at Ash House should be reviewed to assess whether it sufficiently meets the needs of the inmate population.**

76. As regards the admission procedures, a nurse interviews the prisoner upon arrival and again within 72 hours. The screening template applied is specific to women and goes through their history, including any mental health issues, self-harm and medical care. It does not however address sexual abuse and other gender-based violence. HIV and hepatitis screening is offered. A referral to a doctor is made on the basis of the admission screening, if deemed necessary.

**The CPT recommends that the admission screening should include a history of any sexual abuse and other gender-based violence and that this should inform any care plan established for the woman to ensure appropriate care and avoid re-traumatisation.**

77. At the time of the visit, there were women on remand who were pregnant. One of the women was not eating properly or getting appropriate nutrition. Further, in addition to being confined for nearly 20 hours in a cell, she found that she was adversely affected by the other prisoners smoking in the corridor and common areas. The management of Hydebank Wood told the CPT's delegation at the end of the visit that they would examine the possibility of her cooking her own food.

**The CPT trusts that this prisoner was able to improve her daily diet. More generally, it recommends that the Northern Ireland authorities ensure that all pregnant women admitted to Ash House are accommodated in suitable conditions and afforded appropriate care, including protection from passive smoking.**

78. The CPT found that the same concerns relating to the recording and reporting of injuries and the treatment of prisoners with drug addiction or with a record of substance abuse (opioid substitution treatment and harm reduction measures) were in evidence at Ash House as those noted above in relation to Maghaberry Prison (see paragraphs 42 to 44). Action needs to be taken to facilitate access to OST and harm-reduction measures. Several women also stated that consensual sexual relations with male offenders were not uncommon; both male and female prisoners should have access to condoms. **The recommendations in paragraphs 42 to 44 above apply *mutatis mutandis* to Ash House.**

79. Many women prisoners met at Ash House had a history of self-harming and a few continued to self-harm in prison, as the delegation witnessed for itself during the visit. Those identified as being at risk were placed on a SPAR but, as was the case at Maghaberry Prison, they were not provided with sufficient psychological support to address their underlying issues. For example, a woman who had been on a SPAR for six weeks had still not seen a psychologist or a psychiatrist.

**The CPT recommends that a psycho-social team including clinical psychologists be involved in the management of all prisoners placed on a SPAR and that all staff working in Ash House be trained to identify women at risk and to provide daily support.**

80. In the course of the visit to Ash House the delegation's attention was drawn to the situation of four prisoners who staff working on the landings felt ought to be placed in a more caring environment with specialised support and who, through their behaviour, were challenging staff and prisoners alike. The four women had been taken off the PREPS system as it was felt that they were not capable of managing their behaviour based upon incentives. However, two of them clearly stated that they were bored with the lack of activities on offer to them.

- i. One of the women met (M) had a schizo-affective disorder in combination with mental retardation and appeared very disturbed. She had been in Ash House five months and was incapable of communicating and clearly should have been placed in a psychiatric hospital or socio-educative institution. The delegation learned when it visited Shannon Psychiatric Clinic that her transfer to the Clinic was imminent. Such a transfer is to be welcomed but the question arises as to why she was held at Ash House in totally inappropriate conditions for four and a half months prior to her transfer.
- ii. Another young woman (J), who was clearly unwell and who appeared to be dissociated and not fully engaging with her current environment required transfer to a psychiatric hospital for further assessment and treatment. Due to her severe self-neglect, other prisoners helped her with personal hygiene, cleaning her room and food intake. However, no plans were in place at the time of the visit for her transfer to a more appropriate care environment.
- iii. A third women (L), who had a history of self-harm, drug misuse, and severe depression was also not getting the appropriate treatment. As she was diagnosed with having a borderline personality disorder and substance abuse she could not be transferred to a psychiatric facility under the MHO 1986. A review of her case showed that when she was admitted to Ash House in mid-December 2016, it was noted that her behaviour was bizarre and that she was disorientated and later she was found to be hysterical, shouting in her cell and seeing spiders. Despite her worrying mental state she was only seen by a general practitioner after almost 4 weeks and not seen by a psychiatrist before being released on 21 January 2017. She was committed and released again from Ash House in April and committed again on 1 May 2017. Although seen by the mental health team and referred to a short course on living with a personality disorder, she had still not been seen by the general practitioner or psychiatrist at the time of the CPT's visit four months later. However, she was repeatedly displaying challenging behaviour which had resulted in several instances of control and restraint by staff. Again, no plans were in place at the time for her transfer to a more appropriate care environment and the CPT particularly laments the lack of psychiatric input into the care of this woman.



- iv. The case of the fourth woman (J-A), referred to above in paragraph 66, was particularly concerning. From the beginning of her frequent committals (13 in total) to Ash House since July 2014, her problems were assessed as being 'behavioural' and not mental illness, and hence it was deemed that she did not need to be seen by a psychiatrist. Nevertheless, psychotropic medication was prescribed to her without the patient being seen by a doctor, with no documentation of consent to take the medication or documentation of the understanding on the part of the patient as to why the medication was being prescribed and its side effects, and no statement as to whether the patient had capacity to consent to treatment. **This is a serious issue.** Her records show clearly that her condition continued to deteriorate over time and her clear vulnerability; she was discharged repeatedly into situations where she was apparently the victim of sexual assaults. The documentation showed a failure to put in place appropriate continuity of care from prison to the community whenever she was released. Not only is prison in general a totally inappropriate environment for such a vulnerable woman, but Ash House is notably under-resourced to provide the care that this woman requires. This case raises issues of great concern around the quality of care and support for vulnerable persons in Northern Ireland, including as regards the role of criminal courts. At the time of the visit, it appeared that the long-planned transfer of the woman to a private psychiatric clinic in England for treatment was unlikely to take place due inter alia to the fact that she cannot be detained under the MHO 1986.

**The CPT would like to be provided with an update on the current care being provided to these four women.**

81. A review of these women's medical files revealed that while the women were seen by general nurses relatively frequently, input from the mental health team was sparse and that of the psychiatrist or even the general practitioner minimal. Further, there was no proper liaison with mental health teams or social services in the community to prepare for the release of these women back into the community. Their challenging behaviour and the inability of Ash House to care for them meant that their condition in detention deteriorated.

These prisoners were the most extreme cases at Ash House of women suffering from personality and behavioural disorders, and/or having a history of self-harming, abuse and abandonment. Where such prisoners are not eligible for transfer to a psychiatric hospital, a multifaceted approach should be adopted, involving clinical psychologists in the design of individual programmes, including psycho-social support, counselling and treatment.

**The CPT recommends that the authorities of Northern Ireland establish clear protocols and operating procedures among the PSNI, NIPS, the judiciary, health care and social services to ensure that vulnerable women who cannot be treated under the Mental Health Order 1986 are afforded the necessary care in an appropriate environment, in the light of the remarks made above. Ash House is not suitably equipped or staffed at present to provide proper care for such vulnerable women as those described above.**

e. other issues

i. *prison staff*

82. The prison officers met by the delegation displayed a caring and professional attitude towards the women inmates. However, Ash House was severely understaffed and the officers on duty overworked, and several appeared exhausted.<sup>33</sup> The official staffing level for Ash House is 10 officers on the day shift but, at the time of the visit, there were only four (one of whom was a senior officer), and that was only made possible due to certain officers working overtime. Four officers is not sufficient given the needs of the various women prisoners. Prisoners incapable of looking after themselves were largely left in the care of other prisoners which is not appropriate. Ash House should be responsible for the care of all prisoners. Further, due to the insufficient staffing, the admission procedures during the weekend of the delegation's visit were partly handled by a male prison officer which is not in accordance with the proper procedures.

A further visible effect of the understaffing was that prisoners were being locked in their cells for longer periods, particularly over weekends, and dinner was being served at 4 p.m. which meant prisoners might not eat for 17 hours until breakfast at 9 a.m. the next morning. Not only are the women locked in for long periods but the staff on duty during the day are unable to provide the support that the women require, many of whom have complex mental health and psycho-social needs. For example, a woman who self-harmed could only be taken to hospital after a long delay due to lack of staff.

More generally, staff met also felt that the management did not understand their needs or provide them with the necessary support. There is an urgent need to increase the numbers of staff working in Ash House, at a minimum to ensure that all the women can be held safely. To this end, the CPT notes that by letter of 20 December 2017, the Northern Ireland authorities informed the Committee that staffing levels were in the process of being increased.

**The CPT recommends that the staffing levels at Ash House be increased significantly and preferably to the designated official numbers so that the women kept within the unit can be held safely and the full regime of activities can be operated. Further, staff should be provided with the necessary understanding and support from managers, and, more generally, steps should be taken to improve staff-management relations at a structural level. The CPT would like to be informed of the exact staffing levels in Ash House throughout the week (for example the weeks of 11-17 June and 3-9 September 2018).**

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<sup>33</sup> At the time of the visit, the number of staff in post for the whole establishment of Hydebank Wood College was 167 for an official complement of 186. Out of the 167 staff members, 4 were suspended and 26 were on sick leave.

*ii. discipline, separation and use of force*

83. The CPT's delegation found that the disciplinary procedures were well-documented and the number of sanctions imposed was not at all excessive.<sup>34</sup> Indeed, it was positive that more than one-third of the sanctions imposed were suspended. Further, the cumulative imposition of sanctions was very low and the maximum penalty was rarely applied.

Likewise, all incidents at Ash House were very well documented.<sup>35</sup> In the first eight months of 2017, use of force was applied 23 times in respect of 14 prisoners, and in 18 cases the control and restraint was carried out by three prison officers (in the other cases by one or two officers). Although no complaints were submitted to the Ombudsman, the delegation received a direct complaint concerning a recent episode of control and restraint. The woman in question stated that she had been restrained by several male prison officers who had placed her on the floor holding her arms and legs which, given her history of having been a victim of rape and sexual abuse, she found particularly traumatising. Her history of victimisation meant she had a problem with male authority and had such information been captured upon her admission, the management of this prisoner could have been better tailored and the presence of a female officer assured in case of use of force against her. Indeed, there ought always to be a female prison officer or member of staff present whenever control and restraint is being applied to a female prisoner.

**The CPT recommends that the necessary steps be taken to ensure female prison officers are always present throughout Ash House and that the control and restraint of women prisoners is always carried out by well-trained staff and in the presence of at least one female member of staff.**

84. As was the situation at Maghaberry Prison, doctors were being asked to certify prisoners as fit for punishment at Ash House. As was pointed out in paragraph 51 above, this practice should be ended and Prison Rule 41(2) abrogated. **The recommendation contained in paragraph 51 applies equally to Ash House.**

*iii. contact with the outside world*

85. Women interviewed at Ash House by the CPT's delegation complained that they did not have enough physical contact with their families. A high percentage of the inmate population are mothers and the primary caretakers in the family. Separation from families and children can have a particularly detrimental effect on both the women and their families and children. The CPT is particularly attentive to the measures in place to ensure that the visits of children take place in an environment which is as conducive as possible to creating a positive visiting experience. Every effort should be made to enable children to carry out a visit to their mother which avoids further traumatising them or their mother – the visiting environment should be child-friendly and mothers should be permitted to have physical contact with their children (i.e. hug and kiss them) and the entry and search procedures should not be invasive or excessive (searches should be based upon a clear risk assessment) and the journey to and from the visiting area should mitigate as far as possible a carceral setting.

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<sup>34</sup> In the first eight months of 2017, 162 adjudications were held which resulted in 132 disciplinary punishments, of which 48 were suspended, in respect of 28 women. One woman had 30 adjudications and another 11.

<sup>35</sup> 106 incidents took place between 1 January 2017 and 1 September 2017, most of which were not serious.

The Rules governing contact with the outside world are the same as those described above for male prisoners (see paragraph 57). The visiting area at Hydebank Wood College – for male young offenders and female prisoners – consisted of a large visiting hall with a niche for children and an adjacent family room with a child-friendly atmosphere. Further, female prisoners on enhanced status under PREPS could have extended family visits in a caravan located behind Ash House, which was equipped with a kitchen, two small bedrooms and a living room. This is generally positive.

Nevertheless, the CPT considers that the first few weeks of imprisonment are particularly traumatic for children and their incarcerated mothers and that providing opportunities for extended visits in a welcoming environment during this period would be particularly beneficial for both the children and their mothers. For example, access to the caravan could be provided for all prisoners with children. Obviously, abuse of such arrangements might result in them being forfeited. **The CPT would appreciate the comments of the Northern Ireland authorities on this matter.**

86. Women could have access to a pay phone on each landing whenever they were out of their cells and it was positive that women on landing 5 could have access to tablets with Skype. However, for certain prisoners with children, such as those on remand, a problem arose that they would be unlocked at 9 a.m. after their children had gone to school and locked up again in their cells by 4.30 p.m. before their children returned to the house. Arrangements should be put in place to ensure that mothers are effectively able to remain in regular contact with their children; this is all the more important when the children are unable to visit regularly (for example, when they live in another part of the United Kingdom).

**The CPT recommends that steps be taken to ensure women prisoners with children can effectively maintain phone contact with them by adjusting the times at which such calls can take place.**

87. In the course of the visit, the delegation received a few complaints from women concerning the fact that they were not allowed to have contact with their sons who were being held in Hydebank Wood Young Offenders College (i.e. within the same grounds as Ash House) and that they would be disciplined if they called out to them whenever they passed one another in the common areas. It goes without saying that unless there are particular reasons linked to security or child protection issues that mothers and their sons should be able to have regular contact. **The CPT wishes to be informed of the current arrangements in place to promote contacts between mothers and their sons held within the Hydebank Wood campus.**

*iv. complaints and inspection procedures*

88. The complaints and inspection procedures are the same as those described above for Maghaberry Prison (see paragraphs 60 and 61). In the period between 1 February and 1 September 2017, 41 women lodged 143 complaints, out of which 116 were dealt with at stage 1 and 26 at stage 2 (one case was pending). All complaints examined were responded to within a few days, which is positive.

**C. Shannon Clinic Medium Secure Psychiatric Unit**

**1. Preliminary remarks**

89. The CPT examined for the first time the situation of forensic psychiatric patients in Northern Ireland. The current legal framework governing compulsory admission to and treatment in a psychiatric hospital as regards Northern Ireland is laid down in the Mental Health (Northern Ireland) Order 1986 (MHO). Part II governs compulsory admission to hospital for persons suffering from mental disorders where there is a substantial likelihood of serious physical harm to him/herself or to other persons and Part III concerns persons suffering from mental illness or severe mental impairment who are awaiting trial for, or have been convicted of, a criminal offence.

Shannon Clinic is a medium secure establishment for adults situated in the Knockbracken Healthcare Park, Belfast. The Clinic has a 34-bed capacity and consists of three wards: Ward 1 (admission and assessment unit for male patients); Ward 2 (care and treatment for male and female patients) and Ward 3 (rehabilitation for male patients). At the time of the visit, all 34 beds were filled, as was usually the case. Of the 4 women and 30 men accommodated, two patients were there voluntarily, six had been admitted under Part II of the MHO and 24 had been admitted under Part III MHO, 19 of whom were subject to special restrictions (i.e., leave of absence only granted upon consent of the Secretary of State; continuing detention until absolute discharge; restricted possibilities of appeal). The average length of stay in the Clinic for those discharged in 2016 was 421 days.

90. Shannon Clinic is the only forensic psychiatric unit in Northern Ireland and does not seem capable of meeting the demand for psychiatric in-patient beds. In particular, there is no high secure facility, despite a large number of prisoners in the country with severe psychiatric disorders. At present, those persons requiring detention in a high security psychiatric setting are sent either to The State Hospital, Carstairs in Scotland (in the case of males), or Rampton Hospital in Nottinghamshire, England (females). This makes it difficult for the patients' friends and relatives to visit them. Further, there is no low secure psychiatric unit to provide step-down facilities for patients on Ward 3. In the light of the forthcoming entry into force of the Mental Capacity Act 2016, whereby persons with personality disorders may be involuntarily treated in mental health institutions, there will be a greater need to increase the number of forensic psychiatric beds and to provide provision for high secure and low secure places.

**The CPT would like to receive the observations of the Northern Ireland authorities on these matters.**

91. The CPT's delegation gained a very positive overall impression of Shannon Clinic. It was well managed, provided a calm and caring environment for patients and staff were very committed.

92. At the outset, it should be emphasised that the delegation did not hear any allegations of physical ill-treatment or verbal abuse by staff at Shannon Clinic from the patients with whom it spoke. On the contrary, patients spoke positively about staff and the care they received. It was noted that staff demonstrated a caring and professional attitude towards the patients. There were some documented instances of inter-patient violence and verbal abuse, but staff reacted promptly whenever they occurred.

However, as regards assaults by patients on staff members, there appeared to be a lack of systematic debriefing after such incidents and staff felt that insufficient support was provided to them afterwards. **The CPT recommends that the management of Shannon Clinic ensure that there is always a systematic debriefing of staff whenever any incident of violence occurs in order to provide support to the person(s) concerned and draw lessons where necessary.**

## 2. Patients' living conditions and activities

93. Material conditions at the Clinic were of a high standard. All patient bedrooms were single occupancy and were light, airy and modern with ensuite facilities. They measured approximately 10-12 m<sup>2</sup> and were in an excellent state of repair and cleanliness. Patients had keys to their own rooms which were not locked by staff at any time of the day or night. The communal areas were of a high quality, with ample facilities for activities and recreation. Each ward had a large living room (with sofas and TV). There were also a few smaller living rooms for patients needing some peace and quiet. The wards accommodated wheelchair users and catered for Braille readers. There was CCTV in the communal areas, but not in the bedrooms.

The CPT has emphasised that it should be a right for every patient to spend time outside, preferably in a pleasant garden area. Further, being outdoors has a beneficial impact on patients' well-being and recovery. The delegation was therefore pleased to note that each ward had its own garden. Access to fresh air was sufficient: patients on Ward 1 were able to go into the garden, in theory, whenever they wished, but had to ask a member of staff to open the door; the same arrangement applied to patients on Ward 2, but with the addition of periods of free accessibility during the day, and patients on Ward 3 had open access to their garden at all times of the day.

94. There was a wide range of therapeutic activities on offer, including occupational therapy, stress and anxiety management, a drug and alcohol treatment programme and a transitions group. In addition, educational opportunities were good with patients being able to obtain qualifications in catering, woodwork, ICT, essential skills and horticulture. In addition to being able to go to the gym and sports hall, Pilates and yoga classes were on offer (which appeared to be quite popular) and there were pool tables in the communal areas of each ward. In theory, patients were offered 25 hours of activities a week, but this was not the case in practice, either for operational/security reasons or because the patients themselves did not wish to engage in such activities. The staff shortages present at the time of the visit had a negative impact on the participation of patients in the activities provided, many of whom had to be escorted to various classes. Access to the gym was restricted by the fact that the five gym instructors were health care staff working on the wards who were not always able to be present on their allotted day. Several patients complained that they were gaining weight and that not being able to exercise sufficiently was adversely affecting their mental health.

**The CPT recommends that steps be taken to ensure that patients have effective access to 25 hours of activities per week. For example, access to the gym could be increased through hiring additional staff or by allowing all staff to supervise gym activity.**

95. Ward 2 contained both male and female patients. The women's bedrooms were in a separate corridor, however, and they usually only mixed with the men when eating in the communal dining room, or outside in the garden (as the female garden had been closed after apparently being used to smuggle in cigarettes). The delegation was informed that plans for a separate ward for women were being examined.

96. At the time of the visit, female patients were admitted directly to Ward 2 and they received care and treatment and rehabilitation all on the same ward. This meant that the individual needs of the women were not being met (for example, female patients at the rehabilitation stage did not benefit from the same freedom of movement as male patients on Ward 3) and that male patients at the second stage of their treatment were exposed to the more disturbed behaviour of recent female admissions which could adversely affect their progress. Furthermore, there had been allegations by female patients of sexual abuse in the past. The mix was also challenging from a management perspective, as there had to be at least one member of female staff on duty at all times.

**The CPT welcomes the plans for a separate female ward and recommends that such a ward should meet the needs of women at all stages of treatment, as is already the case for men. It would like to be kept informed of the progress of these plans.**

97. As was the case in England during the CPT's 2016 visit, the delegation received complaints from patients about the complete ban on smoking throughout the establishment, including the garden areas and even on the entire Knockbracken Park site. The vast majority of restrictions placed upon patients was due to them being caught smoking or possessing cigarettes. The delegation received many complaints about this from patients, including patients who had addiction-related disorders. Furthermore, several patients were not satisfied with the smoking substitution measures on offer (patches, inhaler). **Greater attention needs to be paid in assisting all patients to overcome their addiction, which should include counselling and therapy.**

98. It is positive that there is a dietician working at the Clinic. However, many patients interviewed by the delegation complained about the quality and quantity of the food: not enough fruit and vegetables were provided; no healthy option was offered and vegetarians felt that they did not have enough to eat. Healthy living is an important component of well-being and **the CPT invites the Northern Ireland authorities to take steps to increase patients' access to healthy food. Further, additional efforts should be made to teach patients to prepare and cook their own food within the ward kitchens.**

### 3. Staffing and treatment

99. The staffing complement was in principle good, consisting of some 104 posts, including 45 nurses, 31 health care assistants, 6 part-time consultant psychiatrists, 1.5 full-time equivalent (FTE) psychologists, 3 occupational therapists, 3 social workers and 3 ward managers.

100. When the Clinic was fully staffed, there were sufficient numbers of health care staff present on the wards both day (six on Ward 1, five on Ward 2 and four on Ward 3) and night (four on Ward 1, three-four on Ward 2 and three on Ward 3). At least two of the members of staff on duty in all wards during the day and at night were mental health nurses.

However, at the time of the visit, 18% of the staff of the Clinic were on sick leave which had a negative impact on the functioning of the individual wards and contributed to a feeling of burnout among some members of staff. Furthermore, some staff members felt that the management was not seen to be giving enough support and were not sufficiently visible on the wards. **The CPT recommends that staff should be given more support by the management to safeguard their well-being at work and thus diminish the need for sick leave to be taken. The Committee would like to be informed about the steps being taken to reduce the level of sick leave.**

101. At the time of the visit, there was only one psychologist working in the Clinic and although most patients regularly saw this psychologist on an individual basis, some patients were being temporarily sent back to prison to participate in offender management programmes, which interrupted the flow of therapeutic care and was, in the opinion of at least one of the consultant psychiatrists, nonsensical. There was a need for more courses concerning evidence-based work around risk reduction. **The CPT recommends that provision be made for more group psychology sessions to be organised at the Clinic itself, if necessary by employing more clinical psychologists.**

102. The somatic and psychiatric needs of patients were sufficiently catered for. All patients were requested to see a doctor and undergo a physical examination upon admission, in the presence of a nurse. Furthermore, a general practitioner attended the Clinic twice a week and junior doctors were present on a rotational basis. A dentist was available on site. There was also a health and well-being nurse and a dietician. In addition to the therapeutic activities available, patients were allocated a forensic consultant psychiatrist and a named nurse and were able to attend weekly multidisciplinary case conferences to discuss his/her particular situation and needs with their doctor, a nurse, a social worker, an occupational therapist and, upon specific request, a psychologist. There was also pharmacological treatment and rare recourse to electroconvulsive therapy (ECT), which was carried out in a hospital. However, several patients complained that they did not receive any psychotherapy. Indeed, there was just one psychotherapist, who delivered EMDR and psychodynamic therapy.

Patients were in principle able to see their treating psychiatrist on average once or twice a week. It is positive that a care plan was drawn up for every patient and regularly reviewed and that patients were encouraged to participate in the formulation of this plan.



103. The CPT was pleased to note that there had been no cases of serious self-harm at the Clinic, nor of any deaths within the past five years.

104. Whereas health care in prisons is provided by the South Eastern Health and Social Care Trust, responsibility for the delivery of care at the Shannon Clinic lies with the Belfast Health and Social Care Trust. Despite the existence of an inter-agency group, it was felt that co-operation between the two trusts could be improved. Considering that the majority of patients at the Clinic are detained under Part III of the MHO, it would seem more efficient for the same trust to manage the provision of health care both in prisons and in the forensic psychiatric unit. The fact that there was not one single trust responsible for all forensic care caused some difficulties for the health care staff, some of whom found it challenging to be working with several different trusts from an administrative point of view. **The CPT recommends that, in the interests of efficiency and coherence, the authorities consider placing responsibility for all forensic care in Northern Ireland under the same health care trust.**

#### **4. Seclusion and means of restraint**

105. Seclusion, the supervised confinement and isolation of a patient in a locked room, is not used at Shannon Clinic. The management of the Clinic applies instead a time-out measure in an unlocked observation room where patients are placed for short periods of time (from a few minutes to a few hours) at the discretion of the nursing staff for the purpose of calming them down. Nevertheless, the need for developing a separate seclusion suite for the management of particularly agitated patients out of sight of the other patients had emerged and at the time of the visit, plans were being put forward to establish such a suite.

The CPT emphasises that a place of seclusion should ensure the safety of the patient, provide a calming environment and that its use should be accompanied by appropriate safeguards such as written guidelines, lasting for the shortest possible time (minutes, rather than hours) with continuous supervision of the patient by a member of staff and recording of the measure.

**The CPT notes the project for the development of a seclusion suite at Shannon Clinic and would like to be kept informed of its progress and the regulations that surround its use.**

106. The CPT is pleased to note that the means of restraint used on patients at the Clinic are primarily manual, consisting of only lower-level holds that are not pain-compliant.<sup>36</sup> Patients interviewed by the members of the delegation confirmed that where they had been restrained, no excess force or violence had been used. The CPT welcomes this technique of low-level physical restraint which fully complies with its standards on the matter.<sup>37</sup> Most cases of use of physical intervention occurred on Ward 1, with 22 instances being recorded in the period from January to June 2017 as opposed to six on Ward 2 and no physical interventions at all on Ward 3 during this time.

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<sup>36</sup> All BHSCT staff were trained in the MAPA (Management of Actual or Potential Aggression) technique, the key policy principles of which are laid down in the BHSCT document "Use of Restrictive Interventions for Adult and Children's Services" and include that restrictive interventions should only be carried out as a last resort, following a risk assessment and for the shortest time possible.

<sup>37</sup> See [Means of restraint in psychiatric establishments for adults \(Revised CPT standards\) of 21 March 2017 \(ref: CPT/Inf \(2017\) 6\)](#)

107. In exceptional cases, resort could be had to chemical restraint in the form of rapid tranquillisation, either orally or by intramuscular injection.<sup>38</sup> The procedure for this is laid down in guidelines set out by the Trust<sup>39</sup> and provides adequate safeguards (e.g., sufficient staff training, monitoring, recording, individualisation of dosage, presence of a doctor). Consultation of patients' files confirmed that the use of rapid tranquillisation was well documented and in compliance with the Trust guidelines.

## 5. Safeguards

108. In 2016, the Mental Capacity Act (Northern Ireland) was passed, which will replace the MHO in relation to persons over the age of 16. The new Act, combining mental health and mental capacity law, will introduce protection from liability for acts in the best interests of the person lacking capacity and will cover persons with personality disorders who are not currently considered to be suffering from a mental illness and are therefore more likely to end up in prison rather than a psychiatric establishment. Furthermore, additional safeguards will be provided as regards interventions such as restraint and treatment and interventions with serious consequences. The Act will be accompanied by a code of practice and secondary legislation. Unfortunately, due to the amount of implementation work required and the uncertainty surrounding the restoring of the Northern Ireland Executive, it is estimated that the whole legislative package will not come into force before 2020/21. Until then, common law will continue to apply, with the general UK Mental Capacity Act April 2005 being referred to for guidance as regards capacity issues.

**The CPT welcomes the new Northern Ireland-specific mental capacity legislation and would like to be kept informed of its progress and entry into force.**

109. As mentioned above, the current legal framework governing civil psychiatry (compulsory admission to a psychiatric hospital) is laid down in the MHO. Under Part II of the Order, a person may be detained in hospital for assessment upon a medical recommendation where that person is suffering from a mental disorder and is likely to cause serious physical harm to him-/herself or to other persons. The person making the medical recommendation should not, except in the event of an emergency, be a medical practitioner on the staff of the hospital to which admission is sought. The patient cannot be detained for assessment for a period exceeding 14 days. Thereafter, a person may be detained for a maximum period of six months, renewable once, followed by further periods of one year.

Concerning compulsory forensic psychiatric placement, where a person is awaiting trial for a criminal offence, or has been convicted of one, they may be remanded to hospital by a court for a report on his/her mental condition, sent to hospital by the court under a "hospital order" or transferred to a hospital from prison (Part III MHO). Of the 34 patients at Shannon Clinic at the time of the visit, 24 had been admitted under this part of the MHO, many directly from prison.

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<sup>38</sup> This measure was rarely used (e.g. 4 times on Ward 1 and once on Ward 2 during the period January – June 2017).

<sup>39</sup> Rapid tranquillisation Guideline for the Pharmacological Management of Violent and Aggressive Behaviour in Adults, Children and Young People in Inpatient Units.

110. Patients admitted under Parts II and III of the Order have the possibility to appeal against the decision before the Mental Health Review Tribunal, an independent judicial body, within a period of six months following admission. They may be represented by a lawyer, be present at the hearing and receive information about the outcome of the hearing. Several patients interviewed confirmed that they had been granted a lawyer and had received a written copy of the decision. Some of those patients had, however, not been present at the hearing, but this was because their lawyer had advised them against doing so. Some patients interviewed said that they had not received information as to how to appeal their placement decision. **The CPT recommends that steps be taken to ensure that all patients are informed both orally and in writing about the avenues and deadlines for lodging an appeal against the placement decision.**

111. As regards consent to treatment, under existing common law in Northern Ireland, all mentally competent adults have an absolute right to give or withhold consent to any medical treatment. Where a person is considered incapable of consenting, treatment is given if it is deemed to be in the person's best interest. Where patients detained in a hospital are unable or unwilling to provide consent for treatment, the MHO provides for treatment without consent with specific safeguards. Under Part IV of the Order, a certificate must be issued by an independent medical practitioner to the effect that the patient is either not capable of understanding the nature, purpose and likely effects of that treatment or has not consented to it and that the treatment is necessary to alleviate or prevent a deterioration of the patient's condition. The Regulation and Quality Improvement Authority (RQIA) must be notified of such a certificate and the patient may appeal against their detention for compulsory treatment to the Mental Health Review Tribunal.

Medication can be administered for a period of up to three months (from the first administration) without the patient's consent, after which time the period may be extended provided certain safeguards are put in place. These include the approval of the responsible medical officer, referral for a second opinion, the recording of the Treatment Plan in the patient's file, informing the RQIA and reassessment of consent to treatment every time the detention is renewed. Where a patient consents to treatment, the responsible medical officer must validate the consent and the results of the assessment must be recorded and a Treatment Plan drawn up. The RQIA must once again be informed. All documentation must be kept in the patient's file.

**The CPT is concerned that a second opinion is not required for the first three months of involuntary treatment and recommends that the relevant legislation be amended so as to require an immediate external psychiatric opinion (i.e. outside that of the treatment team) in any case where a patient does not agree with the treatment proposed.**

112. At Shannon Clinic, very few consent or second opinion forms were found in the patients' paper files kept on the individual wards. At the same time, several patients stated that they would rather not take certain medication that was being administered to them, but felt that they had no choice, with one patient fearing the forcible injection of his medication if he did not comply. By contrast, at least one patient explained that he had refused pharmacological treatment and that his wishes had been respected. The delegation was informed that originals of consent forms were kept in the central registers of Knockbracken Healthcare Park and that a copy should normally be included in the patient's file on the ward, but this was not always the case. Further, some documentation was only stored in the electronic system (PARIS) and could not be found in the paper file which meant that the delegation could not easily obtain a coherent picture of the patient's situation. Such dispersion of documentation relating to patients' treatment and condition could lead to some confusion and impact adversely on their care.

**The CPT recommends that patient files be stored in a coherent manner and that they be systematically kept up-to-date with all the relevant documentation; consent and second opinion forms should always be included.**

113. A patient advocate service, run by an independent organisation, Mindwise, has been operating at the Clinic since 2009. The Patient Advocate provides an independent advice and information service to patients, addresses specific concerns with ward staff and may represent the patient at all levels (from multidisciplinary team meetings to the governance committee and senior management team of Belfast Mental Health Services). They are also a point of contact for families. In the CPT's opinion, this mechanism is a valuable contribution to ensuring the patient's well-being and acts as an important safeguard.

114. The CPT was pleased to note that information about the Clinic and the rights and responsibilities of the patient was provided to newly admitted patients in the form of a Patients Information Booklet. In addition, the information contained in the brochure could be explained personally to the patient by the Patient Advocate. Furthermore, named nurses were appointed to inform patients of their legal status and rights under the MHO and to ensure that information on rights under Articles 5, 8 and 14 of the European Convention on Human Rights was conveyed in a clear and understandable way. Other information, such as that concerning the MAPA technique and the complaints procedure, was posted on the walls of each ward. However, the information booklet and the explanation about patients' legal status and rights was only provided the first time a patient was admitted to the Clinic. Patients readmitted to the Clinic should also be fully informed about the facility both in writing and verbally if necessary. **The CPT recommends that all patients be provided with full information on the Clinic whenever they are admitted to the facility.**

115. The policy for managing patients' finances is laid down in the Belfast Health and Social Care Trust document: "Patient's Finances and Private Property – Policy for Inpatients within Mental Health and Learning Disability Hospitals". When a patient is admitted to the Clinic an assessment tool is used to determine whether the patient lacks capacity. Any qualified member of the multi-disciplinary team may use this tool. That member will then find the patient capable, incapable, or temporarily incapable. One patient interviewed by the delegation, who had been deemed incapable of managing his own finances, was unclear as to when he would be able to access his money, which caused him much frustration and anxiety (in particular, he wanted to buy some new clothes as his current ones did not fit him anymore). Furthermore, there appeared to be no means of appealing the decision declaring a patient incapable of managing their own finances, nor any regular review of this decision (the incapability was considered to be a permanent feature of their condition and was only reviewed upon a "significant change in circumstances"). The ability to manage one's own finances represents an important aspect of a patient's ability to preserve a minimum degree of his or her dignity and autonomy and taking it away might be considered as degrading treatment. Therefore, it is important to surround any such decisions with appropriate safeguards.

**The CPT recommends that steps be taken to ensure that patients fully understand arrangements concerning their finances, are able to appeal the decision declaring them incapable of managing their finances and that they benefit from a regular review of this decision.**

## 6. Other issues

### a. contact with the outside world

116. Patients were afforded a good level of contact with the outside world with visits being possible every day (after 24-hour notice given by the patient to the nurse in charge of the ward). Two female patients on Ward 2, however, complained they were only allowed one visit per week lasting one hour. All visits were supervised, taking place within the sight of a nurse outside the door of the visiting room, but out of their hearing. The special room for family visits provided a child-friendly environment and was additionally covered by CCTV to ensure the safety of visiting children.

It was possible to make unlimited phone calls via the telephone available on each ward. Some patients were allowed mobile phones, subject to an individual risk assessment.

117. As part of the process of leaving Shannon Clinic, patients on Ward 3 were offered the possibility of escorted and unescorted leave, both within the grounds of Knockbracken Healthcare Park and also in Belfast. In addition, patients from all wards could be granted home leave.

### b. complaints and inspections

118. Any complaints by patients are first dealt with at a local level by the Nurse in Charge/Patient Advocate. If there is no resolution, the complaint will be brought to the attention of the Facility Manager. If still unresolved, the matter is brought to the attention of the Chief Executive who will investigate the matter fully and keep the complainant and/or relative informed of progress or outcome in writing. If this internal procedure still provides no remedy, a formal complaint may be sent to the BHSC. Finally, if the patient is not happy with the Trust's response, he/she may contact the Northern Ireland Public Service Ombudsman (NIPSO). Each ward in the Clinic displayed a poster informing the patients about how to make a complaint and complaints forms were readily available. In addition, information on complaints was contained in the patient booklet provided upon admission. Nevertheless, several patients said they were unsure as to how to complain. **The CPT recommends that the patient's named nurse ensures that every patient clearly understands the complaints procedure.**

The delegation learnt that most of the complaints were resolved through mediation by the Patient Advocate. Only a few complaints were sent to the Trust.

119. The Regulation and Quality Improvement Authority (RQIA) is an independent body set up in 2005 which is responsible for monitoring and inspecting health and social care services in Northern Ireland. Although it does not have legal powers to investigate complaints, from 1 April 2009 the RQIA was given responsibility for various other functions under the MHO, including making an inquiry into cases of apparent ill-treatment, improper detention or reception into guardianship, or where the property of the patient may be lost or damaged.

**APPENDIX:**

**List of the establishments visited by the CPT's delegation**

**Police stations**

- Antrim Police Station
- Musgrave Police Station, Belfast
- Coleraine Police Station
- Strand Road Police Station, Derry/Londonderry.

**Prison establishments**

- Ash House Women's Prison in Hydebank Wood College
- Maghaberry Prison

**Psychiatric institutions**

- Shannon Medium Secure Psychiatric Clinic