



Report

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

from 23 September to 4 October 2019

The Government of Ireland has requested the publication of this report and of its response. The Government's response is set out in document CPT/Inf (2020) 38.

Strasbourg, 24 November 2020

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EXECUTIVE SUMMARY

The CPT's seventh periodic visit to Ireland provided an opportunity to assess the treatment of persons deprived of their liberty since its previous visit in 2014, notably in relation to prison matters regarding the treatment of prisoners on restricted regimes, the use of special observation cells and older persons in prison as well as the provision of health care. Particular attention was also paid to the treatment and conditions of detention of persons deprived of their liberty by the police. Further, the CPT's delegation examined the treatment of patients in three psychiatric facilities and, for the first time in Ireland, residents with intellectual disabilities in social care establishments.

Law enforcement agencies

The CPT noted that the Garda Síochána is in the midst of a comprehensive reconfiguration following the publication of the Commission on the Future of Policing in Ireland report on 18 September 2018. The CPT intends to follow the reform process closely, including as regards the establishment of the new Independent Office of the Police Ombudsman.

As regards *ill-treatment*, the great majority of detained persons interviewed by the CPT's delegation stated that they had been treated correctly by the Gardaí. However, several allegations of physical ill-treatment and verbal disrespect were received from remand prisoners who had recently been apprehended by the Gardaí. The allegations of ill-treatment mostly involved slaps, kicks and punches to various parts of the body and a few cases are illustrated in the report by way of example.

The main *safeguards against ill-treatment* advocated by the CPT - namely the right of those concerned to inform a close relative or another third party of their choice of their situation; the right of access to a lawyer; and the right of access to a doctor - continue to operate in a satisfactory manner as from the very outset of custody. Nevertheless, certain improvements should be made. The current practice of the right of access to a lawyer should be placed on a statutory basis and the way in which the provision of health care is organised in Garda stations should be reviewed. Further, steps should be taken to ensure that custody registers in all Garda stations are accurately and comprehensively filled out, and that whenever a detained person is denied contact with a third person the reasons are recorded in the custody register and the person concerned informed accordingly. Steps should also be taken now to put in place an independent system of monitoring Garda Síochána stations.

As regards *immigration* detention, the CPT's delegation found once again that immigration detainees continued to be held at Cloverhill Prison, and other prisons, together with remand and convicted prisoners and, in some cases, subjected to abuse and bullying. The CPT calls upon the authorities to put in place a specifically designed centre for immigration detainees with specific immigration rules in accordance with the Committee's requirements. Further, it wishes to receive information on the conditions and regime afforded to immigration detainees pending the opening of such a unit.

Prison establishments

The CPT acknowledges the steps taken since 2014 by the Irish authorities to reform the prison system, notably as regards the significant reduction in the number of committals to prisons, an overall reduction in violent incidents in prisons and a marked improvement in the provision of health care services. Further, the CPT welcomes the fact that children are no longer held in prison. Nevertheless, considerable challenges remain. In particular, the CPT recommends that action should be taken to address local overcrowding in prisons and to ensure that prisoners do not have to sleep on mattresses on the floor, and that all multiple occupancy cells are equipped with fully partitioned toilet facilities. The reduction in the number of prisoners who have to "slop out" is positive and the CPT trusts that this practice will be eradicated completely from Irish prisons.

Prisoners met by the delegation stated that the vast majority of prison officers treated them correctly; however, a small number of prison officers are inclined to use more physical force than is necessary and to verbally abuse prisoners. The authorities should reiterate to prison officers that no more force than is strictly necessary should be used in bringing an agitated/aggressive prisoner under control. Further, from an examination of a number of cases, the CPT considers that the current complaints system cannot be considered fit for purpose. It trusts that, in designing a new system of complaints, the basic principles surrounding complaints mechanisms as laid out in the 27th General Report of the CPT have been taken into account. Further, both the necessary resources and training are required to ensure that the new complaints system is fair, efficient and effective.

In respect of *inter-prisoner violence*, the Committee recognises the continued progress made to reduce the level of violence in prisons. Nevertheless, further action is required. In particular, all incidents of inter-prisoner violence need to be diligently and systematically recorded, and a standardised approach to the recording of all incidents should be introduced across the prison estate.

A focus of the visit was to examine the situation of prisoners on a *restricted regime* whether as a security measure or for reasons of protection. In this regard, the CPT considers that the Irish Prison Service policy on the abolition of solitary confinement (i.e. that every prisoner is offered a minimum of two hours out of cell daily with meaningful human contact) is laudable. Nevertheless, to ensure that cases of *de facto* solitary confinement are addressed it is essential that prison officers accurately record out-of-cell time for persons on restricted regimes. More specifically, further efforts are required to provide those prisoners on protection for more than a short period with a range of purposeful activities and one hour a week of visits. For persons segregated for good order, the regime on offer to these prisoners should be improved and an effective review process put in place for all placement and extension decisions. As regards the recently opened *National Violence Reduction Unit* (NVRU), the CPT considers that the intended purpose of the unit with its dual security and therapeutic approach is positive, providing that greater emphasis is placed upon delivering a purposeful regime with meaningful engagement. Further, steps should be taken to break the cycle of violence, to ensure that an overbearing security regime does not predominate and to develop interventions which are not purely carrot and stick. To this end, the Incentives and Earned Privileges system and the disciplinary rules operating throughout all Irish prisons should not apply in the NVRU. In addition, NVRU prisoners should not be handcuffed during medical consultations nor examined through metal bars.

The CPT's delegation found that there was a lot of confusion among prison staff and management about the specific purpose for the placement of prisoners in *Close Supervision Cells (CSC)* and *Safety Observation Cells (SOC)*. As a result, the CPT recommends that the Irish authorities review the use of CSCs and SOCs with a view to clarifying the procedures and management of prisoners placed in such cells and of doing away with the artificial distinction between the two types of cells. Further, the CPT reiterates that there should be no routine removal of a prisoner's clothing upon placement in a CSC and that all prisoners placed in a CSC for longer than 24 hours should be offered a shower and access to outdoor exercise. As regards the treatment of mentally ill prisoners who are placed in a SOC, the CPT recommends that a care and treatment plan be drawn up for them pending transfer to a mental health care facility.

The *cellular accommodation* in the prisons visited can generally be considered of a good standard for prisoners held in a single occupancy cell. It is less good in multiple-occupancy cells and, at Cloverhill Prison, a programme of ongoing maintenance and refurbishment should be undertaken, and efforts made to ensure cells of 11m² only accommodate two persons. As regards the *regime*, efforts were being made in the prisons visited to offer prisoners a wide range of activities. More, however, needs to be done to draw up a sentence plan for all prisoners. To this end, the number of Integrated Sentence Management co-ordinators allocated to each prison should be increased.

As regards the provision of *health care*, the findings of the 2019 visit illustrate that there has been considerable progress. The CPT's delegation found very good access to health care in prisons and a vastly improved approach to the treatment of substance use. The mental health nurses and visiting psychiatrists were also doing a good job in difficult circumstances. Further, the carers employed at Midlands Prison to assist the older population of prisoners were very good, displaying genuine warmth and affection towards their charges. Nevertheless, there remain certain areas where improvement is required, such as the poor screening of injuries upon arrival in prison and the lack of provision of interpretation services which clearly hinders communication between health care staff and the rising number of prisoners who do not have a good understanding of the English language.

The CPT's delegation again observed that Irish prisons continue to hold severely *mentally ill persons*. If the high support units at Cloverhill, Cork and Mountjoy Prisons are to provide a stepping stone towards admission to a psychiatric hospital or a step-down unit for managing persons returned to prison from a psychiatric facility, it is essential that they be provided with the appropriate resources. This is not the case currently. A programme of structured activities, including occupational therapy sessions, should be developed for prisoners held on these units. Further, steps should be taken to ensure that all prisoners kept on these units are held in clean cells, are provided with their own bed and get the necessary support to maintain their hygiene. As regards more particularly Wing D2 at Cloverhill Prison, the largest unit in the country holding prisoners who are mentally ill, there is a need to substantially reinforce the mental health team working on the unit.

Another major concern is the rising number of homeless persons with severe mental health problems who are ending up in prison. The example cited in the report demonstrates that urgent steps should be taken, including of a legislative nature, to ensure that mentally ill homeless persons in prison, who the courts are willing to bail, can be transferred rapidly to a psychiatric facility in the community to receive appropriate treatment. To this end, the CPT supports a multi-pronged approach which should also include the development of additional psychiatric beds in the community and it wishes to be updated on the development of such as well as on the new Central Mental Hospital in Portrane.

The report also looks at *staffing* issues and notably the challenge that Irish prisons often have to operate without a full complement of prison officers, due in particular to the exponential increase in prison escorts. Measures are required to ensure that prisons operate full regimes with activities and services not being hampered by staff shortages. As regards *discipline*, the procedure itself appeared to be fair and the punishments proportionate. Finally, the Committee comments on the importance of ensuring that the *Inspector of Prisons* can fulfil her mandate effectively.

Psychiatric establishments

The CPT's 2019 visit to Ireland occurred at a time when the Assisted Decision-Making (Capacity) Act 2015 (ADMCA) had been enacted but was not yet fully in force, and several amendments to the Mental Health Act 2001 were still pending. Consequently, many patients who neither objected nor consented to inpatient care continued to be admitted as voluntary patients and did not benefit from the safeguards afforded to involuntary patients. Yet, the movement of these voluntary patients could be subject to restrictions, including being physically restrained, or placed in seclusion. The new definition of "voluntary patient" laid down in the Mental Health (Amendment) Act 2018 and the deprivation of liberty safeguards to be incorporated into the ADMCA¹ should address these concerns. The CPT recommends that the new legislation be brought into force without delay.

The CPT also considers that involuntary placement and involuntary treatment are two separate issues and that the involuntary administration of medicine should be subject to a separate decision with the possibility of appeal and an independent second opinion.

In the three psychiatric units visited, patients generally spoke highly of staff who displayed a caring attitude. Nevertheless, the CPT's delegation received a few allegations of rough handling of patients and of inappropriate behaviour, including a female patient's trousers being ripped off by a nurse during restraint in the Department of Psychiatry at St. Luke's Hospital. The CPT recommends that staff use no more force than is strictly necessary and proportionate to bring an agitated patient under control, and that where staff act inappropriately, management must act to sanction them accordingly.

As regards the use of *means of restraint*, the emphasis was on de-escalation and the use of lower level holds. The CPT found that there was no excessive recourse to seclusion in the three units visited. However, some of the episodes of seclusion noted were rather lengthy and the national code of practice on seclusion was not always strictly followed. The delegation observed that a patient in seclusion at the Department of Psychiatry at St Luke's Hospital was not constantly under direct observation by a nurse and did not have direct access to a toilet. Further, security guards were sometimes involved in escorting patients to the seclusion room in St Aloysius Ward, whereas the CPT considers that patients should be placed in seclusion by nursing staff only. The CPT recommends that these shortcomings be addressed.

The CPT found that *pro re nata* (PRN) medicine was not being used in an appropriate manner at the establishments visited. It recommends that the Irish authorities carry out a review of this type of prescription at all psychiatric institutions in Ireland, particularly as regards potential overmedication, chemical restraint and involuntary treatment and that, thereafter, they draw up guidelines on the use of PRN medication.

As regards *children*, the CPT recalls that, in view of their vulnerability and special needs, children should be accommodated separately from adult patients. The Irish authorities should take the necessary steps to ensure that this is the case in practice. Action should also be taken to abolish the practice of placing patients (including voluntary patients) in pyjamas, including as a measure to prevent them from absconding.

¹ Editor's note: these safeguards will not become part of the ADMCA, but will form separate legislative provisions.

The material conditions in all three psychiatric units visited were clean and generally in a good state of repair. However, the lack of furniture and personalisation in patients' rooms with the general appearance of all units visited reflecting a somatic hospital environment did not contribute to a therapeutic setting. Furthermore, the four- and six-bedded rooms of the establishments visited were cramped, stuffy and, at times, noisy, providing hardly any personal space or privacy. The CPT recommends that the larger multi-occupancy rooms be divided into smaller units and that steps be taken to personalise all rooms. Further, it recommends that steps be taken to put in place a clear policy for promoting and facilitating the possibility of patients to access the outdoors every day, as this was not the case at the time of the visit.

The CPT's delegation found that nursing *staff* was suitably qualified and well supported by management in all three psychiatric units visited. However, the units were operating at minimum staffing levels at the time of the visit and recruiting staff at short notice was hampered by extremely bureaucratic procedures. Such procedures should be streamlined. *Information* brochures were available at all of the establishments visited. However, patients did not always understand their rights, the possibilities for appeal and how to make a complaint. Furthermore, an easily accessible, confidential method of complaining was not always in place and complaints were not always properly recorded. The CPT stresses the importance of an effective internal complaints mechanism and it recommends that the complaints mechanisms at all three establishments be reviewed accordingly.

Social Care Establishments

The delegation was impressed by the standard of care and person-centred approach taken in the social care homes it visited in Dublin and welcomed the visible shift from congregated settings to smaller, more personalised units. The small housing units at Stewarts Care Palmerstown Campus were a positive example of accommodation for persons with disabilities, with every resident having their own room and receiving a high level of care. There were also possibilities for the residents to mix with members of the surrounding community. The CPT also considers that the level of integration into the community at both establishments can be considered as an example of good practice.

Residents at both establishments spoke well of staff and the CPT's delegation observed the dedicated and caring way in which staff interacted with the residents. That said, whenever there is an incident of bullying of a resident, the staff member should be appropriately sanctioned.

As regards *treatment* and care, residents participated in the development of their own plan, medication applied was appropriate and efforts were made to assist staff in identifying symptoms of distress in residents whose communication was severely limited. The CPT did however note that financial issues had recently affected the appropriate placement of some Stewarts Care residents. Further, while staffing was generally sufficient, difficulties arose in replacing staff on sick leave due to the complex procedures in place and a lack of funding.

Restrictive practices such as locked doors were in place but limited, and they were subject to individual risk assessments and regular reviews of the residents' situation and needs. However, the CPT would like to see the development of a national policy specifically for persons with disabilities similar to the one developed for nursing homes, which advocates a restraint-free environment in such establishments.

The CPT found that the complaints policy in place appeared to be satisfactory and that information on the functioning of the homes' activities, residents' rights and how to make a complaint were clearly provided.

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 Ireland from 23 September to 4 October 2019. The visit formed part of the CPT’s programme of periodic visits for 2019 and was the Committee’s seventh visit to Ireland.

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

- Julia Kozma (Head of delegation)
- Thomas Feltes
- Georg Høyer
- Alan Mitchell
- Jari Pirjola
- Elisabetta Zamparutti.

They were supported by Hugh Chetwynd (Head of Division) and Claire Askin of the Committee's Secretariat, and assisted by an expert, Pétur Hauksson, psychiatrist, former Head of the Psychiatric Department at Reykjalundur Rehabilitation Centre, Iceland.

3. The list of establishments visited by the CPT’s delegation can be found in Appendix I.

4. The report on the visit was adopted by the CPT at its 101st meeting, held from 2 to 6 March 2020, and transmitted to the Irish authorities on 24 March 2020. 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 Irish authorities 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. Consultations held by the delegation and co-operation encountered

5. In the course of the visit, the delegation held talks with Charles Flannagan, Minister of Justice and Equality, Oonagh McPhilips, Deputy Secretary General of the Department of Justice and Equality, Caron McCaffrey, Director-General of the Irish Prison Service, as well as with officials from the Departments of Justice and Equality and Health. It also met senior representatives of the Health Service Executive, An Garda Síochána and the Irish Prison Service.

In addition, the delegation met with the Inspector of Prisons, Patricia Gilheaney, and representatives of the Health Information and Quality Authority (HIQA), the Mental Health Commission, the Irish Human Rights and Equality Commission. It also met with the Irish Penal Reform Trust, the Irish Council for Civil Liberties, the College of Psychiatrists of Ireland, Mental Health Reform and Inclusion Ireland. A list of the national authorities and organisations met by the delegation is set out in the Appendix II to this report.

The degree of co-operation received during the visit from the Irish authorities was excellent, both at the central and local levels. The delegation had rapid access to the establishments it wished to visit, to the documentation it wanted to consult and to individuals with whom the delegation members wished to talk. In particular, the delegation would like to thank the CPT liaison officers for the assistance provided both before and during the visit.

At the end of the visit, the delegation presented its preliminary observations to the Irish authorities, in which it highlighted its main concerns. By letter of 27 January 2020, the Irish authorities provided the Committee with an update on certain actions they were taking in the light of the delegation's observations. These comments have been taken into account in the drafting of the report.

C. National Preventive Mechanism

6. On 2 October 2007, Ireland signed the Optional Protocol to the United Nations Convention against Torture (OPCAT). However, the Irish authorities took the decision that they would not ratify OPCAT until after they had made provision in law for the establishment of a National Preventive Mechanism (NPM). The CPT has over the years repeatedly been informed by the Ministry of Justice that an Inspection of Places of Detention Bill, the legal basis for establishing the NPM, would soon be finalised and be submitted to the Oireachtas (Parliament). However, discussions with government and civil society interlocutors in the course of the 2019 visit made it clear that there was still no agreement on which organisation should coordinate the NPM and how the body should be structured. **The CPT encourages the Irish authorities to find a solution to the establishment of a NPM and to ratify OPCAT. The CPT would like to be informed about the envisaged structure of the National Preventive Mechanism that will be tasked to implement the Optional Protocol.**

In the absence of the establishment of a properly resourced NPM, it is essential that both prisons and Garda stations are subject to independent monitoring by professional bodies (see paragraphs 22 and 90 below).

II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

A. Law enforcement agencies

1. Preliminary remarks

7. The CPT's visit took place at a time when policing in Ireland was in the midst of a comprehensive reconfiguration following the publication of the Commission on the Future of Policing in Ireland on 18 September 2018.² The Commission was established by the Irish Government and commenced work in May 2017. It was tasked with undertaking a comprehensive examination of all aspects of policing including all functions carried out by An Garda Síochána (Ireland's single national police force). The Commission's report of September 2018 provides a vision for the future of policing in Ireland. Among its core recommendations is that there should be new legislation – a Policing and Community Safety Act – redefining policing and the role of the police service and other state agencies in harm prevention.

The Commission has also proposed changes to enhance the powers of the Commissioner of An Garda Síochána and to create a statutory board to strengthen the internal governance and management of the police organisation. The Board should help the Commissioner to reorganise the police, develop corporate strategy and annual planning, and lead it into the future, taking advantage of state-of-the-art management ideas and processes.

Further the Commission has proposed the establishment of a *Policing and Community Safety Oversight Commission* (PCSOC) which would supersede the Policing Authority³ and Garda Inspectorate⁴.

The CPT's delegation was informed that the Policing and Community Safety Bill should be sent to Parliament in the first half of 2020. **The CPT would like to be updated on the reform process and the adoption of the new legislation, including as regards the reorganisation of An Garda Síochána.**

8. The CPT has consistently stated that the existence of effective mechanisms to tackle police misconduct is an important safeguard against ill-treatment of persons deprived of their liberty. In its report on the 2006 visit, the CPT commented favourably on the proposed new independent complaints system envisaged by Garda Síochána Act 2005. The primary functions of the Garda Síochána Ombudsman Commission (GSOC) are to investigate complaints by members of the public against members of the Garda Síochána and to promote public confidence in the process for resolving those complaints. The Garda Síochána (Amendment) Act, 2015 extended the powers of the GSOC's ability to carry out investigations.

² See [Report of the Commission on the Future of Policing in Ireland](#).

³ The [Policing Authority](#) was established as an independent statutory body on 1 January 2016 to oversee the performance of the Garda Síochána in relation to policing services in Ireland. It also is involved in the recruitment of senior garda officers.

⁴ The [Inspectorate](#), set up under the Garda Síochána Act, 2005, undertakes inspections or inquiries in relation to any particular aspects of the operation and administration of the Garda Síochána, either on its own initiative or as requested to do so by the Policing Authority or the Minister for Justice and Equality and provides advice with regard to best international policing practices as required.

However, the Commission on the Future of Policing in Ireland was critical of GSOC. It found that the complaints regime as a whole to be clearly unsatisfactory from all points of view – from Garda members, complainants and GSOC itself. It recommended an urgent overhaul and proposed the establishment of a new body, the Independent Office of the Police Ombudsman (IOPO), which the Government accepted. The Commission advocated that an underlying principle of the work of IOPO should be that it investigates incidents rather than individuals, so as to find fault where appropriate, identify what needs to be learned, and make recommendations for change as required. GSOC endorsed the proposals made by the Commission. In the meantime, the resources made available to GSOC have been increased with the approval of an additional 42 new posts in 2019 bringing the sanctioned total effective to 138.⁵

The CPT would like to be provided with information about the proposed mandate and functioning of the envisaged Independent Office of the Police Ombudsman and, more particularly, about the steps being taken to address the long-standing challenge of information sharing between the Garda Síochána and GSOC, once IOPO is established.

9. The CPT's delegation visited An Garda Síochána (police) establishments in Cork (Bridewell and Cobh District Stations) and Dublin (Store Street District, Clontarf and Mountjoy Stations).

10. The legislative framework governing detention by the police remains essentially unchanged since previous CPT visits. Under the 1984 Criminal Justice Act, persons may be detained by the police for up to 24 hours. The 1996 Criminal Justice (Drug Trafficking) Act extended the time of detention to a maximum of seven days in the case of persons suspected of drug-trafficking offences; in such cases, detained persons must be physically brought before a judge within 48 hours and thereafter, if police custody is extended by the judge, within a further 72 hours (when the judge may order a further extension of police custody for up to 48 hours). Persons may also be held under the Offences Against the State Act 1939 for up to 48 hours on Garda authority, and a judge may authorise a further 24 hours of police custody.

Further, under established case law, persons under arrest and charged with offences not covered by the acts mentioned above may, in certain situations, be held overnight in a police station.

2. Ill-treatment

11. In the course of the visit, the great majority of detained persons interviewed by the delegation stated that they had been treated correctly by the Gardaí. However, the delegation did receive several allegations of physical ill-treatment and verbal disrespect by Gardaí from remand prisoners who had recently been apprehended by the Gardaí. The allegations of ill-treatment mostly involved slaps, kicks and punches to various parts of the body.

Nearly all the allegations concerned the time of arrest or during transport to a Garda station, but a few related to the time when the persons were being held in the station.

⁵ See [GSOC 2018 Annual Report](#).

12. Most of the cases of alleged ill-treatment received by the delegation pre-dated its visit by several weeks and any injuries which may have been caused by the ill-treatment alleged would almost certainly have healed in the meantime. However, in a few cases, the delegation was able to observe and record the injuries which had allegedly been inflicted by Gardaí. By way of example, the following cases are mentioned.

- A man, met at Cloverhill Prison on 30 September 2019, stated that after he had been caught by some civilians while stealing a handbag, he had been handed over to two Gardaí who transported him to the police station. He was allegedly slapped a few times about the head while in the car. However, when he got out of the car, hands cuffed behind his back, his arms were lifted into the air forcing him to bend forward whereupon he alleges that he was punched and kicked by several other Gardaí from the station. When met by the delegation some four days later he displayed the following injuries: on the right eyebrow, a blood-crusted laceration of 3 cm and a blood-crusted abrasion of 1 x 0.5 cm; a black upper left eyelid, and a small purple hematoma below his left eye; areas of swelling on the scalp; a triangular bruise of 2 x 2 x 2 cm under his left axilla, purple in colour; on his left buttock, three parallel bruised lines of 3 cm each, purple coloured; on his left wrist (outer/upper part) a swollen, reddish L-shaped abrasion, 2 x 0.5 cm; on the left inner wrist two blood-crusted parallel lines of 1 x 0.3 and 2 x 0.4 cm. On his right wrist, he had a few minor marks caused by the handcuffs. He claims that he had no feeling in his left hand. He had been seen by a doctor in the Garda station and by a doctor upon arrival at Cloverhill Prison and his medical record stated “Right eyebrow swollen, alleges that the guards hit him. Left wrist mild swelling. No redness. Full range of movement. Sensation intact.” The photograph in his record showed bruising to his right upper eyelid. See also paragraph 77.
- A man apprehended on 24 September 2019 claimed that he had been treated roughly by the Gardaí upon arrest and in the station, where he had been pushed to the floor and had all his clothes removed and left naked in the cell, reportedly because he was a suicide risk. In the course of this procedure he had been hit in the head and, when met by the delegation in Cloverhill Prison six days later, displayed a blueish-black bruise below his right eyebrow. He had subsequently been seen by a doctor in the police station and provided with a blanket, and later a jumpsuit. Nevertheless, there can be no justification for leaving a detained person naked in a cell. Any person who is assessed as being at risk of committing suicide should only have their clothes removed upon a decision of a doctor and in such cases should be provided with rip-proof clothes. The person should also be the object of close individual monitoring by the Gardaí. **The CPT would like to be informed of the policies and procedures in place regulating the management of persons assessed as being at risk of committing suicide.**

Further, the delegation received several other consistent allegations:

- A man apprehended on warrant in the centre of Dublin on 25 September 2019 alleged that after he was handcuffed tightly behind his back, his arms were hyper-extended and he was punched a couple of times in the head by Gardaí.
- Another person apprehended on 19 September 2019 claimed that after he had been roughly flipped over and placed on the ground and handcuffed behind his back, the Gardaí allegedly kned him a few times in the back and flanks.
- A man apprehended in Dublin in mid-September 2019 alleged that while in the police station he had stretched out his hand to get a cigarette whereupon the officer had slammed down the hatch on his hand. He had subsequently been seen by a doctor and given painkillers.

13. These cases are illustrative of the information gathered by the delegation in the course of the 2019 visit and demonstrate that there can be no room for complacency in the Irish authorities' commitment to prevent ill-treatment. In this respect, the CPT has noted the efforts being undertaken by An Garda Síochána to promote a human rights approach to policing underpinned by a suite of policies and training materials issued in June 2019 by the Legal Services Unit. The CPT also acknowledges that the Irish authorities reiterated to the CPT's delegation their full commitment to preventing ill-treatment of persons in custody. Further, it trusts that steps will be taken to instruct all members of An Garda Síochána on their responsibilities when exercising lawful force and that any use of force outside those policies can be the subject of a criminal and/or disciplinary investigation. The CPT has noted that the number of complaints of abuse by An Garda Síochána officers upon arrest or at the police station appears, according to the Ombudsman Commission statistics, to have remained stable over the past few years. It is also interesting to note that none of the persons met had any faith in the complaints system.

The CPT recommends that the Irish authorities reiterate to An Garda Síochána officers that any form of ill-treatment (physical or verbal) of detained persons is not acceptable and will be punished accordingly.

14. In the course of the visit, the CPT's delegation learned that under the Mental Health Act 2001 the Gardaí may detain and transfer mentally ill patients to a hospital. In this context, a number of allegations of excessively tight handcuffing were received and one of the patient's files consulted noted marks on their wrists caused by handcuffs (see paragraph 119 below). **The CPT considers that the police are not appropriately trained to manage mentally ill persons who are agitated and that they should only be required to transfer such persons when absolutely necessary. In addition, the CPT recommends that the Garda Síochána ensure that persons apprehended are not handcuffed too tightly.**

Further, it considers that good practice dictates that where a mental health nurse works alongside the police in managing such interventions the risk of harm to both the mentally ill person and other persons is reduced. **The CPT would appreciate the comments of the Irish authorities on this matter.**

3. Safeguards against ill-treatment

15. Generally speaking, the main safeguards advocated by the CPT - namely the right of those concerned to inform a close relative or another third party of their choice of their situation; the right of access to a lawyer; and the right of access to a doctor - continue to operate in a satisfactory manner as from the very outset of custody.

16. In their response to the CPT's 2014 visit report, the Irish authorities had stated that it was the Government's intention to place the issue of access to legal advice during interview on a statutory footing by way of regulation, i.e. Statutory Instrument. Regrettably this has not happened and nor is Ireland bound by the Directive 2013/48/EU of the European Parliament and of the Council of 22 October 2013 on the right of access to a lawyer in criminal proceedings and in European arrest warrant proceedings.

However, in April 2015, An Garda Síochána issued a Code of Practice on Access to a Solicitor by Persons in Garda stations which aimed to streamline the interaction between An Garda Síochána and solicitors relating to detained persons. The Code sets out clearly that following the decision of the Supreme Court in the Gormley and White cases⁶ the Director of Public Prosecutions advised the Garda Commissioner that if requested, a suspect was entitled to have a solicitor present during interview in custody. This was in addition to the right to consult a solicitor before interview. Furthermore, the Director of Public Prosecutions advised that all suspects detained in Garda stations for questioning be advised, in advance of any questioning, that they may request a solicitor to be present at interview. Therefore, a suspect in Garda custody, unless he/she expressly waives his/her right to be given legal advice, should not be interviewed prior to him/her obtaining legal advice except in wholly exceptional circumstances. The CPT welcomes the publication of this Code.

17. In the course of the 2019 visit, none of the persons met by the CPT's delegation complained that they had been denied access to a lawyer by the Gardaí. Some stated that their lawyer could not be present at the interview but that they had managed to speak to the lawyer beforehand or that they were content for the lawyer not to be present. A few stated that they were at first interviewed without a lawyer but when they requested a lawyer, the interview was stopped for a couple of hours until the lawyer arrived. Those persons who did not have their own lawyer could have one contacted by the Garda Síochána who can consult a list of available solicitors on the [Law Society website](#).

Certain concerns were pointed out to the CPT's delegation that there was no formal list or rotation of solicitors consulted by the Gardaí which might impact on their perceived independence. However, as the list is provided and vetted by the Law Society the CPT trusts that all the members on the list are suitably qualified to carry out their duties of representing criminal suspects professionally and, more specifically, of raising any issues of alleged ill-treatment of their clients by the Gardaí.

The CPT recommends that the Irish authorities place the current practice of the right of access to a lawyer, as set out above, on a statutory basis. It would also welcome any comments by the Law Society or An Garda Síochána regarding detained persons' effective access to a lawyer, notably in more remote rural areas.

18. As regards notification of custody to a third party, only a few persons complained that they had not been allowed to contact their family while in police custody without any reasons being provided. **When such contact is denied reasons must be recorded in the custody register and the persons concerned informed accordingly.**

19. The CPT continues to have certain misgivings about the effectiveness of the right of access to a doctor. Garda stations are not equipped with medical facilities and, while a doctor attends police stations on demand, the CPT's delegation could not be assured that detained persons were appropriately assessed and examined. No medical records appeared to have been kept in respect of persons seen and little follow-up care was apparent.

⁶ See Supreme Court judgment of 6 March 2014 on People (DPP) v Gormley and People (DPP) v White (citation: [2014] IESC 17).

It is positive that Garda stations can call upon a doctor to visit detained persons whenever required, and that persons suspected of having ingested drugs are immediately sent to hospital for observation. However, there is a need to put in place clear operating standards governing the maintenance of medical records, confidentiality, the recording of injuries sustained and ensuring that there is a suitably equipped medical examination office with a locked cupboard for medication and records in all larger custody suites.

The CPT recommends that the Irish authorities review the way in which the provision of health care is organised in Garda stations, taking into account the above remarks.

20. Persons apprehended by the Garda Síochána who were met by the CPT's delegation stated that they had been provided with information on their rights orally and in a written format.

Foreign nationals met stated that they had been provided with interpretation services when they had spoken to their lawyer and during police interviews, and that they had been provided with a leaflet on their rights in a language they could understand. However, it was recognised that in certain rural areas access to an interpreter, as well as to a lawyer and a doctor, could be delayed due to isolated location of the stations.

21. The CPT's delegation also found that custody registers were not always maintained in a comprehensive and accurate manner. For example, at Store Street Garda station in Dublin, the registers did not always contain the dates and times of arrest nor any indication of whether the detained person had refused to sign the acknowledgement of receipt of notice of rights when this was the case, or whether a doctor was needed or not. Further, monitoring of detained persons sometimes consisted simply of "checked on prisoner all day". **The CPT recommends that steps be taken to ensure all Garda station custody registers are accurately and comprehensively filled out.**

22. The CPT has repeatedly stressed that the inspection of detention facilities of law enforcement agencies by an independent authority can make an important contribution towards the prevention of ill-treatment of detained persons and, more generally, help to ensure satisfactory conditions of detention.

At the time of the visit, there was still no independent system of monitoring of Garda stations. It is positive that the Garda Inspectorate decided to carry out an inspection of the effectiveness and efficiency of the custody arrangements operated by An Garda Síochána, with a focus on examining the standard of treatment, safety and wellbeing provided to persons in custody. The inspection was carried out in the last quarter of 2019 and the report should be published in 2020. Nevertheless, while the report should serve as a baseline for the current situation in Garda Síochána stations, it will be important to ensure that there is a continuous monitoring of the situation in these stations. For this reason, there remains an urgent need to mandate an independent body now to conduct regular inspections of Garda stations, with a view that such a body will be brought into the NPM structure once it is established.

The CPT reiterates its recommendation that steps be taken now to put in place an independent system of monitoring Garda Síochána stations.

4. Conditions of detention

23. The material conditions at the police stations visited were in general satisfactory for the periods of detention involved; usually less than 24 hours and only rarely exceeding 48 hours. The cells were of adequate size, equipped with toilet facilities, possessed adequate artificial lighting, sufficient ventilation and a call bell and could be properly heated. However, there were certain problems of capacity in the facilities visited, notably at Bridewell Garda District Station in Cork which is located in an old and rather dilapidated building.

The CPT understands that in the context of the police reform process the number of Garda Divisions will be reduced and that a number of Garda stations will also be closed. The CPT pointed out in its 28th General Report published in April 2019⁷ the benefits that may accrue from having larger and more centralised custody centres staffed with professional custody officers. **The CPT would appreciate the comments of the Irish authorities on this matter.**

5. Immigration detention

24. In the course of its previous visits to Ireland, the CPT has reiterated that a prison is by definition not a suitable place in which to detain someone who is neither suspected nor convicted of a criminal offence. In those cases where it is deemed necessary to deprive persons of their liberty for an extended period under aliens legislation, they should be accommodated in centres specifically designed for that purpose, offering material conditions and a regime appropriate to their legal situation and staffed by suitably qualified personnel. No such centre currently exists in Ireland.

25. At the time of the 2019 visit, a new Garda Station at Dublin airport, with four cells and two holding rooms, had started functioning as a designated place of detention for persons refused entry to or being removed from the State. However, as persons may only be held for a maximum of 24 hours in this station, prison establishments continue to be used to accommodate immigration detainees for longer periods.⁸ In particular, such persons continue to be held in the same cells as remand prisoners for periods of up to several weeks, notably at Cloverhill Prison. Once again, the CPT's delegation met persons held in prison for immigration reasons who were subjected to abuse and bullying from prisoners. For example, a middle-aged diminutive foreign national was placed in a cell with two young remand prisoners who allegedly attempted to rape him as well as physically aggressed and verbally intimidated him. He managed to be moved to another cell and the delegation brought the vulnerability of his situation to the attention of the Governor. Further, immigration detainees are still not provided with information in a language they can understand about what is happening to them, heightening their anxieties. Moreover, they are subject to prison rules, including the incentives and privileges policy, only offered screened visits and not permitted to access their mobile phones.

⁷ See [Extract from the 28th General Report of the CPT](#): Preventing police torture and other forms of ill-treatment – reflections on good practices and emerging approaches. Ref: CPT/Inf (2019)9-part, paragraphs 82 to 85.

⁸ The IPS 2018 Annual Report states that there were 414 committals in respect of immigration issues involving 406 detainees, and that the average daily number of persons in custody was 11.

26. At Cloverhill Prison, the CPT's delegation visited a small unused unit (F Block) that could be used to accommodate immigration detainees. F Block consists of six double cells on the ground floor and six single cells on the upper floor, each equipped with a partially screened toilet. The unit has three showers, an outdoor exercise yard and a recreation room. However, there were no telephone facilities and escorts would have to be provided for access to the visits area and health care. Moreover, steps need to be taken to devise an appropriate open regime for this category of detained person. In addition, it will be necessary to ensure that the facility is properly staffed by persons having the necessary language and inter-cultural skills.

At the end of the visit, the CPT's delegation requested that, pending the opening of a discrete unit with immigration specific rules, immigration detainees should be allocated designated cells on a quiet enhanced wing at Cloverhill Prison and offered a more open regime, including greater access to the telephone and unscreened visits.

The CPT calls upon the Irish authorities to put in place a specifically designed centre for immigration detainees in accordance with the Committee's requirements.⁹ Further, it wishes to receive information on the conditions and regime afforded to immigration detainees pending the opening of such a unit.

⁹ See CPT Factsheet on immigration detention of 10 March 2017 – Reference: CPT/Inf (2017) 3 (<https://www.coe.int/en/web/cpt/immigration-detention>)

B. Prison establishments

1. Preliminary remarks

a. recent developments and prison overcrowding

27. At the outset, the CPT wishes to acknowledge the ongoing steps being taken by the Irish authorities to reform the Irish Prison Service since the CPT's previous visit in 2014. In the course of the 2019 visit, the CPT's delegation observed a number of positive developments such as the opening of a new prison in Cork and the closure of the old one, a significant reduction in the number of committals to prisons following the entering into force of the Fines (Payment and Recovery) Act 2014, an overall reduction in violent incidents in prisons and a marked improvement in the provision of health care services (including drug treatment). Further, the CPT welcomes the fact that children are no longer held in prisons in Ireland.

The Irish Prison Service recognises in its most recent Three-Year Strategic Plan launched in September 2019 that the reform process is a work in progress from upgrading parts of the prison estate and recruiting staff for the future to developing a robust prisoner complaints system and the challenge of caring for both prisoners with severe mental illness and an ageing prison population. Nevertheless, this is a prison service moving in the right direction as long as the current momentum is maintained and the external scrutiny by the Inspector of Prisons becomes effective (see paragraph 90 below).

28. At the time of the visit, the prison population stood at 3,835 (i.e. 77 per 100,000) for an official capacity of 4,244 beds but September is the low point of the year following the summer recess of the courts, and by December 2019 the population was back to the pre-summer level of 4,000 prisoners. Although such figures would appear to represent only approximately 95% of the overall prison capacity, the actual prison capacity is usually lower than the official figures. For example, at Cloverhill Prison, on the first day of the visit there were 395 prisoners, three of whom were sleeping on mattresses on the floor in a cell whereas the official capacity remains 431. Likewise, at Mountjoy Prison, the actual capacity at the time of the visit was said to be 700 and yet the official capacity for the establishment remained 755.

The most evident sign of local overcrowding is the fact that on any given night many prisoners (up to 40 during the first five months of 2019) have to sleep on mattresses on the floor of cells. Further, it appears that this situation is becoming the norm as was attested to by the Governors of Cloverhill, Cork and Midlands Prisons. For example, at Midlands Prison, 16 prisoners were sleeping on mattresses at the time of the CPT's visit when the prison was accommodating 812 prisoners for a capacity of 845. On 10 December, the establishment was holding 843 prisoners.

29. The CPT acknowledges that the Irish authorities are taking steps to increase the prison estate capacity through the renovation of the Training Unit at Mountjoy Prison to provide an additional 96 places and the construction of new accommodation wings for both male and female prisoners at Limerick Prison. Nevertheless, the CPT has also noted that the number of prisoners placed in pre-trial detention has increased by 30% since 2015 and that, moreover, the number of persons being given sentences of less than six months has increased by 30% since 2014 despite legislation existing to enable judges to consider imposing a Community Service Order in lieu of a short sentence. Given the research that shows prison sentences of less than six months (and even of 12 months) to be far less effective than community sentences as well as being too short for the prison services to work meaningfully with the persons concerned, greater efforts should be made to avoid sending persons to prison for periods of less than six months.¹⁰ Further, the CPT is not convinced by the apparent policy of creating additional capacity by placing a second bed in a single occupancy cell, which over and above issues of sharing, puts an increased strain on the existing prison resources in terms of access to activities, provision of services and supervision and support by staff.¹¹

The CPT recommends that the Irish authorities take steps to tackle the phenomenon of local overcrowding in the prisons through promoting greater use of alternatives to imprisonment and remand detention, and notably as regards short sentences.¹²

Further, the CPT would appreciate an explanation of the way in which the capacity of a prison establishment is calculated; to this end, it trusts that due account is taken of the Committee's standards on living space (notably, that all multiple occupancy cells should provide 4m² of living space per prisoner excluding a fully partitioned sanitary annexe).¹³ The Committee would also like to be provided with updated information on the official capacity of each prison.

30. A long-standing concern of the CPT has been the continued existence of the practice of slopping-out within the Irish prison system, which the Committee has repeatedly stated is degrading not only for the persons using the chamber pot but also for the persons with whom the prisoner shares a cell and also debasing for the prison officers who have to supervise the slopping-out procedure. It is therefore positive that with the opening of Cork Prison the number of prisoners now having to slop-out has been reduced from around 360 to 60 prisoners between 2014 and October 2019. The opening of the new accommodation block at Limerick Prison should more than halve the remaining numbers, leaving only prisoners in E Block at Portlaoise to slop-out. This is a significant achievement which the CPT welcomes.

The CPT trusts that the Irish authorities will eradicate "slopping out" completely from the Irish prison system.

¹⁰ See, for example, Hillier, J. and Mews, A. (2018) *Do offender characteristics affect the impact of short custodial sentences and court orders on reoffending?* or [The impact of short custodial sentences, community orders and suspended sentence orders on re-offending \(2015\)](#), UK Ministry of Justice.

¹¹ For example, bed capacity has been increased at the Dochas Centre from 105 to 146, at Midlands Prison from 845 to 875 and at Wheatfield Prison from 550 to 610 by placing a second bed in a single occupancy cell.

¹² See, for example, the Council of Europe *White Paper on Prison Overcrowding* – CM (2016)121-add3, Recommendation CM/Rec (2017) 3 on the European Rules on community sanctions and measures, Recommendation Rec (2003) 22 on conditional release (parole) and Recommendation Rec (2010) 1 on the Council of Europe Probation Rules.

¹³ See Living space per prisoner: CPT standards of 15 December 2015. Reference: CPT/Inf (2015) 44 (<https://www.coe.int/en/web/cpt/living-space-prisoners>).

At the same time, the CPT notes that as of October 2019 1,802 prisoners (i.e. 45% of the prison population) share cells and have to use the toilet in the presence of other prisoners. The CPT considers that all in-cell toilet facilities should be fully partitioned up to the ceiling to provide a degree of privacy and dignity for prisoners sharing the same cell. **The CPT recommends that steps be taken to ensure that all multiple occupancy cells are equipped with fully partitioned toilet facilities.**

b. prisons visited

31. In 2019, the CPT's delegation carried out a follow-up visit to Midlands Prison and it visited for the first time Arbour Hill Prison and the new Cork Prison. Targeted visits were also carried out to Cloverhill and Mountjoy Prisons to examine the situation in the High Support and Challenging Behaviour Units (CBUs), the disciplinary procedures and the complaints system, as well as the use of close supervision and safety observation cells. Interviews were also carried out with a number of prisoners on remand at Cloverhill Prison.

In the course of the 2019 visit, the CPT's delegation also focused more generally on the conditions of detention for prisoners on protection as well as prisoners segregated from the general population due to their behaviour. Further, it examined the situation of older prisoners and of those prisoners with a mental illness. In addition, the delegation looked at the treatment of prisoners held in the recently opened National Violence Reduction Unit at Midlands Prison.

32. **Arbour Hill Prison**, located in central Dublin, was opened in 1844 as a military prison and transferred to the Irish Prison Service in 1975. The prison consists of three wings (East, West and North) and is composed of 88 single occupancy cells and 25 cells used for double occupancy. The prison accommodates long-term sentenced prisoners, primarily persons sentenced for sexual offences as well as former police officers and other prisoners who require a more settled environment. The prison generally operates close to 100% capacity, and on the day of the visit was accommodating 133 prisoners, including 37 life-sentenced prisoners, for an official capacity of 138 places.

Cloverhill Prison is primarily an establishment for remand prisoners with an operational bed capacity of 431; at the time of the visit, it was holding 395 inmates, of whom 44 were sentenced, six were immigration detainees and 20 were being held on a European Arrest Warrant.

Cork Prison, a new establishment built across the road from the old prison, was opened in April 2018. The prison is compact, with a small footprint, and consists of two accommodation blocks (A and B) of three landings each. The ground floor of B block housed the Vulnerable Prisoner Unit, the Challenging Behaviour Unit and Committals. At the time of the visit, the prison was accommodating 288 prisoners, including 17 life-sentenced prisoners, for an operational capacity of 296.¹⁴

¹⁴ The official bed capacity was 311 but in practice this was reduced as life-sentenced prisoners were accommodated alone in double occupancy cells.

Midlands Prison, adjoining Portlaoise Prison, was opened in November 2000 and built to a radial design with four accommodation wings (A to D), with an initial design capacity of 515. Two additional wings, E and G, were added in 2013 to accommodate sex offenders. At the time of the visit, the prison was accommodating 812 prisoners, of whom 75 were life-sentenced prisoners, for an official capacity of 845. Further, in November 2018, the National Violence Reduction Unit (NVRU) was opened on the ground floor of C Wing with a capacity to hold 10 persons and with its own management and staffing structures.

Mountjoy Prison is the primary committal prison for Dublin. The main prison building dates from 1850 and is built to a radial design, with four main wings (A to D). In addition, the drug detoxification unit has six wards of ten cells each. There is also a separate accommodation area in the basement of B wing, used for new arrivals and persons seeking protection from other prisoners. All wings have now been refurbished to provide each single occupancy cell with a sanitary facility. The basement of C Wing houses a Challenging Behaviour Unit and there was a High Support Unit with 11 beds located within the Medical unit. The Progression Unit, located in the former St. Patrick's facility, with 41 cells was accommodating primarily life-sentenced prisoners but the Independent Living Skills Unit was not yet operational due to staffing shortages. At the time of the visit on 2 October 2019, the prison was accommodating 652 prisoners, including 66 life-sentenced prisoners, for an operational capacity of 700 (the official bed capacity was 755).

In addition, the premises of the former Mountjoy Prison Training Unit, consisting of six units of 16 cells, were being renovated with the intention of providing accommodation for prisoners who were older and less mobile as well as for a number of prisoner carers. The new unit will hold 96 prisoners who will primarily be transferred from Midlands Prison. The unit itself is composed of cells measuring some 6m² each with every unit having a shared sanitary facility consisting of three toilets and three showers as well as a kitchen and a communal room. Although on the small size, the cells will remain unlocked at all times, unless the prisoners decide to lock the doors to their cells themselves, and prisoners will only be expected to be in their cells from 10 p.m. until breakfast time the next morning. Meals will be offered in a large communal dining area next to the kitchen. Wheelchair access to the sanitary facilities on one unit will be offered and a few rooms will be equipped with hospital beds. Further, workshops focussed on hobbies and soft skills will be on offer to the prisoners. The CPT's delegation had a favourable impression of the proposed unit and **the CPT would like to receive updated information on its opening and operation, including as regards staffing provisions.**

2. Ill-treatment

33. As was the case in 2014, prisoners met by the CPT's delegation stated that the vast majority of prison officers treated them correctly, and relations between staff and prisoners could be categorised as respectful in most of the prisons visited. However, a small number of officers seem to be inclined to use more physical force than is necessary and to verbally abuse prisoners. Once again, allegations were received of prison officers deliberately provoking prisoners, for example, by referring to their crimes or their family in an inappropriate manner or calling them names, notably as regards members of the Traveller community and persons of African descent.

For example, on the D2 unit of Cloverhill Prison, the delegation met a prisoner who had recently arrived from Cork Prison; he had a black haematoma around his right eye and the area around his left eye had purplish bruising. According to the prisoner, the injuries had been sustained while he was being restrained by prison officers at Cloverhill. However, the incidents' register contained no entry involving this prisoner while at the same time the medical records had no recording of any injuries upon his arrival from Cork. Another prisoner on D2 unit also had several bruises and abrasions on his right shin, left wrist and lower right arm, injuries which had apparently been inflicted by the escorting staff or the Gardai. However, the injuries had not been recorded in the medical record or in any incident register. Both of these cases were brought to the attention of the Governor of Cloverhill Prison. Further, at Mountjoy Prison, the CPT's delegation found that a use of force and removal from a cell (which resulted in a Category A complaint) was also not registered in the incidents' book.

The CPT recommends that the Irish authorities reiterate to prison officers that no more force than is strictly necessary should be used in bringing an agitated /aggressive prisoner under control. Further, prison officers should be reminded that they will be held accountable for any act of ill-treatment (including verbal abuse) or any excessive use of force. To this end, it is essential that all prison officers receive regular refresher training in the use of control and restraint techniques and that communication skills and de-escalation techniques be promoted among all prison officers. See also paragraph 77 below on the recording of injuries.

34. In all prison systems there will be some incidents of alleged staff abuse and violence, and therefore it is important that all incidents are properly recorded and investigated. This is not the case at present. The current complaints system cannot be considered as fit for purpose. Category A¹⁵ (and B) complaints relating to staff abuse are not always investigated in a timely fashion, with investigators often only initiating the investigation three or more months after a complaint is made. Further, prisoners receive no feedback on their complaints and several prisoners alleged that they were subjected to bullying by prison officers after they had submitted a complaint. Many prisoners consider, with some justification, that it is not worth making a complaint. As a result, a situation of impunity may emerge within prisons of prison officers not being held to account for their actions.

For example, at Cloverhill Prison, long delays were noted both in assigning investigators for Category A complaints and in the carrying out of the investigations. One complaint submitted on 28 January 2019 only had an investigator assigned on 13 September while another, relating to an incident on 10 January, had an investigator assigned on 15 March but as of the end of September 2019 there was no information as to whether any further action had been taken. At Midlands Prison, a Category A complaint submitted on 4 January 2019 was recorded as not upheld and yet the files contained no report on the results of the investigation and the complainant had received no feedback.

¹⁵ Category A complaints concern assault or use of excessive force against a prisoner or ill treatment, racial abuse, discrimination, intimidation, threats or other conduct against a prisoner of a nature and gravity likely to bring discredit on the Irish Prison Service; Category B complaints are complaints of a serious nature, but not falling within any other category of complaint (e.g. verbal abuse of prisoners by staff, inappropriate searches or any other conduct against a prisoner of a nature likely to bring discredit on the Irish Prison Service); (see Rule 57A and 57B Prison Rules 2007 – S.I No. 11 of 2013 Prisons Rules (Amendment) 2013).

At Mountjoy Prison, a prisoner complained on 25 April 2019 that he was punched in the face and legs by prison officers (primarily an Assistant Chief Officer (ACO)) when he was forcibly removed from his cell on 18 April after wrecking it. The incidents' register contained no trace of the removal or use of force and no use of force form was filled in. CCTV footage shows five prison officers entering the cell with shields, removing him onto the landing and placing him in the prone position. The episode takes six minutes before he is brought to another cell. The Gardai apparently interviewed him two weeks after his complaint was made. However, thereafter the prisoner had heard nothing more and the files contained no further information.

Another illustration of the shortcomings of the current complaints system concerned a case submitted by a prisoner at Cork Prison on 24 January 2018 alleging that he had been punched in the face by a prison officer on 5 January 2018, apparently because the prisoner had obstructed the closing of his cell door. The prisoner also alleged that he was threatened with being transferred to Mountjoy Prison if he did not keep his mouth shut. On 8 May 2018, the investigator submitted a very detailed and well-reasoned report finding that the most credible explanation was that the officer had lost patience with the prisoner and lashed out. Thus, the complaint was upheld. The investigator also criticised the "head in the sand attitude" of the medical orderly for not properly recording the injuries or enquiring about the causes of the injury. The Governor of Cork Prison disagreed with the investigator, did not initiate any disciplinary proceedings against the officer concerned and asked his Chief Officer to re-investigate the case. However, he did write to the prisoner stating that the complaint had been upheld as certain procedures, notably the recording and reporting by the health care service, had not been properly carried out.

35. In sum, the deficiencies in the complaints system regarding alleged ill-treatment and abuse of prisoners by prison staff have not been addressed since the publication in April 2016 of the Review, Evaluation and Analysis of the Operation of the Prisoner Complaints Procedure by the Inspector of Prisons. The CPT understands that a new model of complaints is being drawn up by the Irish Prison Service which should be rolled out towards the end of 2020. It trusts that the basic principles surrounding complaints mechanisms as laid out in the 27th General Report of the CPT¹⁶ have been taken into account in the designing of the new system.

The CPT recommends that the Irish authorities invest the necessary resources to ensure that the new prisoner complaints system is fair, efficient and effective. To this end, sufficient training must be provided to all the actors concerned and clear information about the system provided to prisoners.

36. As regards inter-prisoner violence and intimidation, which in the past has been a notable concern for the Committee, the findings of the 2019 visit show that the progress noted in 2014 has been sustained. Considerable efforts are made within each of the prisons visited to ensure that prisoners are protected from other inmates who wish to cause them harm. The result is that individual prisons may have to manage a large number of protection prisoners who all have to be kept separate from one another. For example, at Mountjoy Prison there were 208 prisoners on protection spread across 16 separate groups who could not mix with one another while at Midlands Prison there were some 47 prisoners held on protection divided among 10 groups.

¹⁶ See [Complaints mechanisms](#) - Extract from the 27th General Report of the CPT (CPT/Inf(2018)4-part).

The inter-prisoner violence stems not only from feuding gangs but from a high prevalence of drug use, with pressure placed upon “clean” inmates and their families to bring drugs into the prison. Combating this phenomenon requires good intelligence and the capacity to ensure that potentially incompatible categories of prisoner are not accommodated together nor associate with one another. In addition, 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.

At the High Support Unit (HSU) of Mountjoy Prison, the delegation came across two very recent incidents of inter-prisoner violence, both of which had been captured on CCTV. In one case, a prisoner approached another prisoner from behind and punched him to the ground; staff intervened rapidly but no support was provided to the prisoner who was assaulted nor was the incident recorded anywhere. Moreover, no measures were taken to prevent a further assault given that both prisoners remained on a unit with an open-door regime.

The CPT recommends that the Irish authorities pursue their efforts to design robust measures to tackle inter-prisoner violence and intimidation, and to manage victims of inter-prisoner violence.

37. The findings of the 2019 visit showed once again, with the notable exception of Cork Prison, that there was a rather poor and inconsistent recording of incidents of inter-prisoner violence in some of the prisons visited. At Midlands Prison, as was the case in 2014, all incidents were registered in one of the two record books – “Incidents book (unusual incidents)” or “Accident/incident report book” (although the criteria for deciding the classification remained unclear to the delegation) and the delegation had real concerns about the integrity of the data. In the above mentioned two cases at Mountjoy Prison, neither of the incidents had been recorded in the class journal or reported to the hierarchy.

By contrast, the CPT’s delegation found that the recording of incidents of inter-prisoner violence at Cork Prison was far more rigorous and systematic. In the first nine months of 2019, Cork Prison registered 60 incidents for a population of 300 whereas at Midlands Prison during the same period only 16 incidents were recorded for a population of over 800 prisoners and yet Cork Prison was not a more violent establishment. Without an accurate recording of all incidents, the integrity of the data cannot be relied upon which in turn means that it is not possible to have any meaningful analysis of the extent of violence in the prisons nor of any comparisons between prison establishments.

The CPT recommends once again that the Irish authorities reiterate the importance of diligently and systematically recording all the incidents of inter-prisoner violence to the management and staff of all the penitentiary establishments. A standardised approach to the recording of all incidents in prisons should be introduced across the prison estate.

3. Restricted regimes

38. A focus of the visit was to examine the situation of prisoners on a restricted regime whether as a security measure (Prison Rule 62) or for reasons of protection (Prison Rule 63). At the time of the 2014 visit, the numbers on 22-hour and 23-hour lock up had dropped to 42 from 211 as of July 2013. The official figures provided to the CPT for 16 July 2019 showed that no prisoner was confined to his or her cell for 23 hours or more a day, while 67 prisoners were on 22-hour lock up and 305 on 21-hour lock up. The vast majority of these prisoners, approximately 325, were recorded as having chosen to go on protection voluntarily.

On 29 June 2017, the Minister of Justice and Equality signed into law an amendment to Rule 27 (1) of the Prison Rules, the purpose of which was to abolish solitary confinement. In line with Rules 44 and 45 of the UN Mandela Rules, all prisoners wishing to do so, will receive a minimum of two hours out-of-cell time with the facility for meaningful human contact.¹⁷ The CPT considers that the Irish Prison Service (IPS) policy on the abolition of solitary confinement is laudable.

The principal features of the Policy are that prisoners are statutorily entitled to a minimum of two hours out of cell daily, and that this period shall allow for meaningful human contact. Governors have to ensure that the daily out-of-cell activities of prisoners detained under Rules 62 and 63 of the Prison Rules are recorded and retained securely and that where a prisoner refuses to leave his/her cell in order to participate in out-of-cell activities, that same is recorded and retained. The Policy allows for very restricted exemptions including immobility, incapacitation, psychiatric illness where it is the view of the medical professional that the prisoner concerned poses a real and serious threat of harm to himself/herself or others and to maintain good order and safe and secure custody in the event of a serious disturbance or other serious incident in the prison or part of a prison.

39. The CPT's delegation observed that genuine efforts were being made to ensure that all prisoners were offered at least two hours of out-of-cell time. However, the delegation did come across prisoners who were *de facto* in a situation of solitary confinement (i.e. more than 22 hours locked alone in their cells) but whose situation was not being recorded as such. It is essential to have an accurate recording of association and out-of-cell time which enables prison management and IPS HQ to address cases of *de facto* solitary confinement.

The CPT recommends that the Irish authorities reiterate to prison management and prison officers the importance of ensuring an accurate recording of out-of-cell time for persons placed on restricted regimes.

a. prisoners on protection

40. Rule 63 of the Prison Rules provides that a prisoner may, either at his or her own request or when the Governor considers it necessary, be kept separate from other prisoners who are reasonably likely to cause significant harm to him or her. Such a prisoner may participate with other prisoners of the same category in an authorised structured activity if the Governor considers that such participation is reasonably likely to be beneficial to the welfare of the prisoner concerned.

¹⁷ See IPS Policy Document - *Elimination of Solitary Confinement* issued on 11 July 2017.

The CPT's delegation observed varying practices towards protection prisoners in the different prisons visited. Providing a meaningful regime to prisoners who state that they cannot associate with prisoners on an ordinary landing, and who are often confined to associating with only a small number of other prisoners, is a challenge. The CPT acknowledges that the prison authorities have to tread a fine line not to encourage prisoners to seek protection while at the same time not punishing those prisoners whose safety is at real risk from other prisoners. Several prisoners with whom the CPT's delegation met complained that they had warned the authorities not to transfer them to a particular prison (or even another wing within the same prison) as their physical integrity would be at risk but that they had nevertheless been transferred and that soon afterwards they had been assaulted. In at least one case examined, the prisoner concerned had been attacked with a makeshift knife leaving his face scarred. The documentation on this case supported the allegation.

41. At Midlands Prison, there were 47 protection prisoners, with 34 accommodated on the ground floor of Wing A. These prisoners were offered one hour on the landing (during which time they had to clean their cells, make a phone call and have a shower) and one hour of outdoor exercise. They were not offered any activities whether school, gym or work and were not provided with access to the recreation room on the corridor, which in any case was not equipped with any furniture or recreational games. Moreover, all prisoners who asked to go on protection were automatically placed on the "Basic" level of the Incentives and Earned Privileges (IEP) scheme which meant that they were able to make only three phone calls of 6 minutes per week and to have a visit of half an hour to one hour every second week (i.e. half the entitlement of the "Standard" level of the IEP). The delegation was particularly concerned about a few prisoners who were being held alone in their cells for more than 23 hours a day and hence were in a situation of *de facto* solitary confinement.

For example, one prisoner located on C2 landing had been alone in his cell for six weeks; he had attacked his cellmate on 15 August, spent two nights in a Close Supervision Cell and received a 40-day disciplinary punishment on 18 August (no evening recreation, one phone call a week, one screened visit a week, no access to the canteen). He said that he heard voices and had not been provided with his medication prior to the incident. At the time of the visit, he was allowed out of his cell for 20 minutes a day to shower and clean his cell and was offered 20 minutes in the yard on his own three times a week, which he declined. He had not requested to be on protection nor signed any forms. He had asked to see the governor but had not been visited by any member of the management team nor had he seen a doctor; he saw a mental health nurse in the infirmary every now and again to receive his medication. He was not offered any activities (gym, school, library). Before his disciplinary sanction he had been out of his cell for six hours a day.

42. At Cloverhill Prison, the 47 prisoners requiring protection from all other prisoners were held on the ground floor of C Wing and, at the time of the visit, were split among four factions (Blue, Green, Orange and Red) who could not associate together. Prisoners were offered access to the yard, the recreation room and showers every day. The landing log book showed that all prisoners had been offered between 150 and 380 minutes out of their cell per day during the month of September 2019. However, no purposeful activities were offered and collecting meals (breakfast, lunch and tea) was noted as 30 minutes of out-of-cell time which was an exaggeration as meals were rapidly collected and eaten in the cells.

At Cork Prison, there were 33 protection prisoners located primarily on A1 landing. They were generally offered around one and a half hours of outdoor exercise every day and access to school on Friday evenings (although this activity was often cancelled due to staff shortages). No access to the gym or library was offered. It is positive that, unlike at Midlands Prison, prisoners on protection at Cork Prison were not automatically placed on the Basic level of the IEP but remained on Standard level which afforded them more contacts with family and friends. **This should be the standard practice.** However, at the time of the visit, the delegation found that the five prisoners assigned to the “Blue” group, who were on protection from all other prisoners, were locked in their cells for 23 hours a day.

43. The Committee understands that progression or regression from one regime level to another should be based on the behaviour of each individual prisoner as well as his participation in activities. However, prisoners on protection who have not committed any disciplinary offence but are unable to access activities due to their protection status should not be *de facto* punished by being placed on the basic level of the incentivised regime system.

Moreover, it is very important for prisoners to be able to maintain good contact with the outside world. This is all the more the case for prisoners on protection who may have a greater need to maintain contact with family and friends since they cannot have any safe contact with other inmates.

In addition, while the policy of the Irish prison system to ensure every prisoner is offered at least two hours of out-of-cell time is positive, confinement to a cell for 21 or 22 hours per day may nevertheless have an extremely damaging effect on the mental, somatic and social health of the prisoner. Therefore, while pursuing their goal of ensuring that all prisoners can serve their sentences under safe conditions, the Irish authorities should also strive to minimise the deleterious effects of such segregation, especially where it continues for more than a few weeks. Additional measures should be taken in order to provide them with appropriate conditions and treatment; access to activities, educational courses and sport should be feasible.

The CPT recommends that the Irish authorities pursue their efforts to provide prisoners on protection in Cloverhill, Cork, Mountjoy and Midlands Prisons for more than a short period with a range of purposeful activities, taking into consideration the above remarks. Further, it recommends that all prisoners on protection be offered one hour a week of visits, preferably under open conditions.

In addition, it is important that the management of the prisons visited pay close attention to those challenging prisoners who through a combination of mental health issues, being on protection and having committed a disciplinary offence may find themselves in a situation of *de facto* solitary confinement.

b. prisoners segregated for good order

44. The CPT recognises that in every country there will be a certain number of prisoners considered to present a particularly high security risk and hence to require special conditions of detention. The perceived high security risk of such prisoners may result from the nature of the offences they have committed, the manner in which they react to the constraints of life in prison, or their psychological/psychiatric profile. This group of prisoners will (or at least should, if the classification system is operating satisfactorily) represent a very small proportion of the overall prison population. However, it is a group that is of particular concern to the CPT, as the need to take exceptional measures vis-à-vis such prisoners brings with it a greater risk of inhuman treatment.

In Ireland, Rule 62 of the Prison Rules provides for a Governor to remove a prisoner from structured activity or association on grounds of maintenance of good order or safe or secure custody. The order must be reviewed at least every 7 days and the prisoner must be provided with reasons in writing. The doctor and chaplain are informed immediately. If the order is to continue beyond 21 days, the Governor must inform the Director General of Prisons and include any representations by the prisoner. Any extension thereafter must be authorised by the Director General in writing.

45. In the course of the visit, the CPT's delegation examined the situation of prisoners placed on Rule 62 and visited the specific units where they were accommodated.

At Cloverhill Prison, the seven Rule 62 prisoners were held on Wing D1 in either single or double occupancy cells. They were offered between one and one and a half hours a day of access to a large outdoor yard, thirty minutes out of their cells to shower, clean the cell and make a phone call and thirty minutes was calculated to collect their food. In addition, they had recently been offered 30 minutes in the small unit gym once or twice a week.

At Cork Prison, five prisoners were accommodated in the Challenging Behaviour Unit but only one of them was on Rule 62. This prisoner was only offered half an hour of outdoor exercise every day on his own and the rest of the time he was confined to his cell. He had been visited by a nurse and a chaplain, both of whom had had to converse with him from the entrance to his cell within hearing of the prison officers. The management recognised that he was in *de facto* solitary confinement and their solution was to transfer him to another prison within seven days.

At Midlands Prison, four prisoners on Rule 62 were held two to a cell on Wing C2 and were offered one hour of outdoor exercise each morning, half an hour to shower and clean their cell and access to the gym as a group. The other two Rule 62 prisoners were held on Wing C1 left under similar conditions.

At Mountjoy Prison, the six Rule 62 prisoners were held in the eight-cell Challenging Behaviour Unit in the basement of C Wing as described in the report on the 2014 visit.¹⁸ Prisoners were offered one hour of outdoor exercise and 30 minutes to shower and clean their cell each day, usually with one other prisoner. The caged exercise yard was small and dirty with a mesh ceiling partly covered by a corrugated screen in one corner to provide shelter from the rain. No activities were offered. Two prisoners however did not associate with anyone and interaction with staff was minimal placing them in a situation of *de facto* solitary confinement. Moreover, as was the case in 2014, the unit was staffed by officers on duty in the adjacent committal area who only checked the unit every 30 minutes, **which is not appropriate**.

46. The placement of a prisoner under Rule 62 should also be viewed as an opportunity to engage more intensively with that prisoner to see whether the underlying causes of their behaviour can be addressed. To this end, the CPT considers that such prisoners should be provided with a tailored programme of purposeful activities of a varied nature. This programme should be drawn up and reviewed on the basis of an individualised needs/risk assessment by a multi-disciplinary team (similar to that in place in the NVRU), in consultation with the prisoners concerned. Interaction/association between prisoners should be the norm; conditions akin to solitary confinement should only be used when absolutely unavoidable in order to deal with a person who is assessed as acutely dangerous to others and for the shortest period necessary.

The CPT recommends that the Irish authorities improve the regime on offer to prisoners in the Challenging Behaviour Units and other similar units, in the light of the above remarks.

47. The CPT remains of the opinion that there is insufficient oversight of the placement and review procedures for keeping a prisoner on Rule 62. An examination of the documentation surrounding the decision-making process for persons subject to Rule 62, showed that the official forms provided little information to justify the initial placement or the seven-day extensions made by the Governor. Moreover, the 21-day reviews carried out by the Director General (DG) of Prisons appeared to be little more than a rubber-stamping exercise.

For example, at Cloverhill Prison, one prisoner was placed on Rule 62 on 4 September 2019 for “operational reasons – organising contraband and influencing others”. When informed that an extension beyond 21 days would be sought, the prisoner stated: “I didn’t break any prison rules”. On 25 September, at 3.40 p.m. an email was sent to the IPS HQ requesting an extension and at 4.50 p.m. a response was returned to the prison stating that the DG of Prisons approved the extension. In the case of another prisoner, a request to extend the Rule 62 beyond 21 days was sent to the DG on 18 September at 4.49 p.m. and 15 minutes later an email response on behalf of the DG of Prisons stated: “Application for extension approved”. The only justification contained in the document sent to the DG was in paragraph 3: “prisoner continually exhibits a level of violence towards all persons ... extension necessary for maintenance of good order or safe or secure custody of Cloverhill Prison”.

On the other hand, one prisoner at Mountjoy Prison was found to have in his cell large quantities of contraband¹⁹ which clearly raised questions about security within the establishment and a necessity to remove this prisoner from the general population until the necessary investigations had been carried out. Hence the reasoning for placing him on Rule 62 was clear.

¹⁸ See CPT/Inf (2015) 38, paragraph 73 for a description of the unit.

¹⁹ Including, 10 hacksaws, 16 phone chargers, 7 syringes, 9 needles, a pair of tactical gloves, 7 phone batteries, a body cam unit with button recording, 2 screwdrivers, 2 UniHertz phones, etc.

48. At present, decisions on Rule 62 placements are not infrequently based upon information which is not documented and, in the words of one deputy prison governor, result from a “gut feeling” decision. Hence, the DG of Prisons is unable to make a reasoned review of any such placement. Indeed, there was no written record either about what information was provided to the DG of Prisons to assist her make her decision nor about the reasoning behind her decision to extend a placement. The lack of reasoning provided to prisoners means that they are not in a position to challenge the Rule 62 placement or extension decision. For these reasons, the CPT considers that there is a need to put in place an independent review process which is able to examine all the evidence underlying the placement of a prisoner on Rule 62.

The CPT recommends that the Irish authorities put in place an effective review process for all Rule 62 placement and extension decisions, which has access to all the necessary information to make an informed decision.

c. National Violence Reduction Unit (NVRU)

49. The NVRU, located on the right side of Wing C1 of Midlands Prison, is a stand-alone unit with its own management and dedicated staff. The unit, opened in November 2018, is designed to provide more effective management of the small number of high-risk violent and disruptive prisoners within the Irish prison system. The unit is jointly managed by an Assistant Governor and a Senior Psychologist. The aim is for prisoners to benefit from a purposeful regime where they will be supported to address their problematic behaviour with a clear focus on progression and re-integration into an ordinary prison setting.

The unit has 10 accommodation cells with an operational capacity of nine as well as a Close Supervision Cell and a Special Observation Cell. Four of the cells are for assessment purposes, where new arrivals from other prison establishments are located while they undergo a four-month period of assessment to determine whether they are suitable for placement on the unit. If a prisoner is assessed as being suitable for placement on the unit, he will be transferred to one of the six cells on the Violent and Disruptive Prisoner (VDP) Section, where the capacity is limited to five prisoners. The unit also contains two consultation rooms, a visits room, a multi-purpose room (equipped with two bean bags, a table and chairs, a television), a gym and a search room. The two outdoor exercise yards were bleak with little access to direct sunlight; it was planned to equip the yard with some fitness bars and a basketball hoop and a Perspex screen to facilitate communication between prisoners exercising in the adjacent yards at the same time.

50. A considerable investment had been made to ensure the unit is properly staffed. The staff complement consisted of an Assistant Governor, a Chief Officer, two ACOs, 20 prison officers and a full-time psychologist who was supported by the lead Senior Psychologist three days a week. All staff had been given seven weeks of specialist training and were provided with psychological supervision every two weeks. During the day, an ACO and eight prison officers were on duty. Discussions with prison officers demonstrated that they were highly motivated and were eager to make a difference and engage with the prisoners. Each prisoner was assigned a personal officer who was tasked with taking the lead in interacting with the prisoner.

The regime on the unit was designed to encourage as much out-of-cell time as possible engaged in various activities, preferably with other prisoners. Out-of-cell time was nominally 9.15 a.m. to 12 p.m., 2.15 to 4 p.m. and 5.15 to 7 p.m. (i.e. some 6 hours and 15 minutes).

51. At the time of the visit, the unit accommodated four prisoners, all of whom were considered to have had a prolonged history of violence against staff and other prisoners. Two had been on the unit since January 2019, one since June 2019 and the fourth since 29 August 2019. All of them were placed on Rule 62 which appeared rather redundant as their placement in and discharge from the NVRU was determined by the NVRU Committee. Consequently, their Rule 62 files were somewhat meaningless as was the periodic review by the Director General. That said, the same issue of establishing an independent review, as raised above, pertains to the placement and stay of prisoners in the NVRU. More generally, given that the NVRU is an end of the line facility for prisoners transferred to it, there is a strong case for not applying the general IEP system and other Rules, but of having a bespoke regulation for the NVRU. Discussions with staff and prisoners by the CPT's delegation confirmed the need for such an approach. **The CPT would appreciate the comments of the Irish authorities on this matter.**

52. Despite the stated intentions to promote a varied regime, at the time of the visit all four prisoners were spending 23 or 24 hours alone in their cells. The only activities being offered were access to the outdoor exercise yard and the gym, which the four prisoners regularly declined. Moreover, the two prisoners with whom the delegation held structured interviews were dismissive of the regime and of the approach towards them which they felt infantilised them (for example, extra CDs would be allowed to be kept in the cell if they behaved well). For two of the inmates, the once-a-week meetings with a psychologist were considered inadequate and not meaningfully impacting on their lives while the other two inmates refused to talk to a psychologist.

The challenge of such a unit is to break the cycle of violence and to develop interventions which are not purely carrot and stick. The threat of using a "stick" in the NVRU would appear rather ineffective given that there is no other unit to which these prisoners can be transferred and that three of them have life sentences. The first step must concern the unlock protocols. At the time of the visit, the two prisoners with whom the delegation spoke both had their hands cuffed in front of their body before the inner grille gate of their cell was unlocked. They were then escorted by five officers and an ACO to a consultation room where all meetings with staff were conducted through a barred and Perspex-screened hatch (80 cm x 80 cm). Both prisoners were surprised to have these barriers removed and to have a face-to-face encounter with CPT delegation members. One of the prisoners complained that even consultations with the doctor were through the barred hatch and that he had had to give a blood sample through the bars while handcuffed. Although the doctor had been against such an arrangement the management of the unit had deemed it necessary; the CPT considers that such a practice undermines the development of any doctor-patient relationship as well as being contrary to medical ethics.

The CPT recommends that measures be taken to ensure that prisoners are neither handcuffed during medical consultations nor examined through metal bars. In addition, steps should be taken to ensure that medical examinations of prisoners are conducted out of the hearing and – unless the doctor concerned expressly requests otherwise in a given case – out of the sight of non-medical staff. Alternative solutions can and should be found to reconcile legitimate security requirements with the principle of medical confidentiality. One possibility might be the installation of a call system, whereby a doctor would be in a position to rapidly alert prison officers in those exceptional cases when a prisoner becomes agitated or threatening during a medical examination.

Further, the CPT recommends that all non-medical formal interactions in the consultation rooms between staff and prisoners of the NVRU be conducted without the metal bars and Perspex screen in place. Where concerns for safety exist, it would be preferable for an additional member of staff (e.g. the personal prison officer) to be present in the consultation room.

53. The CPT recognises that these prisoners may be violent and that all of them have assaulted staff, including a teacher, since their arrival in the NVRU. It also acknowledges that a few of these prisoners may have been subjected to even more restrictive management such as “barrier” handling when the six escorting staff are always in PPE (personal protection equipment) – prior to their arrival at the NVRU, which staff at the NVRU were at pains to avoid. At the same time, the CPT’s delegation observed that the personal officer of one prisoner engaged in long conversations through the grille gate of the cell with him. Such interactions should be built upon to move swiftly to a situation where the prisoner is unlocked and escorted to activities without applying handcuffs and by one or two officers only.²⁰ Further, staff should not carry extendable batons within the unit but keep them in the staff office. Treating the prisoners as normally as possible is more likely to elicit a positive response than constantly reminding them that they are to be feared and micro-managed.

Likewise, the CPT considers that the IEP system and the disciplinary rules operating throughout all Irish prisons should not apply in the NVRU. As the head psychologist acknowledged at the time of the visit, the prisoners on the NVRU have to be constantly motivated to participate in the few activities on offer. Thus, if a prisoner is hardly engaging in the regime on the NVRU and thereafter is punished following an incident by being placed on “Basic” and receives a disciplinary punishment depriving him of access to certain activities, the purpose of the unit is undermined and there is no incentive for the prisoner to engage. Instead, there is a need to promote a more dynamic and less rigid interaction approach which offers the prisoners some perspective to engage in meaningful activities.

54. In sum, the CPT considers that the intended purpose of the NVRU with its dual security and therapeutic approach is positive providing that greater emphasis is placed upon delivering a purposeful regime with meaningful engagement. The provision of educational classes should be restored and offering other activities in the multi-purpose room should be explored. Staff on the unit are clearly motivated and willing to try new approaches to ensure an overbearing security regime does not predominate. The management must support them and provide the appropriate structures and rules as outlined above. There is a real opportunity to develop the NVRU into a centre of excellence for managing challenging prisoners but there is also a risk that it will become simply another segregation block.

The CPT recommends that the Irish authorities review the way in which the prisoners on the unit are managed in the light of the above remarks. Further, it looks forward to continuing its dialogue with the Irish authorities on the evolution of this unit.

²⁰ The staff resources present on the unit would enable a swift intervention if required.

4. Observation cells in prisons

55. According to Rule 64 of the Prison Rules 2007, a prisoner shall be accommodated in a special observation cell only if “it is necessary to prevent the prisoner from causing imminent injury to himself or herself, or others and all other less restrictive methods of control have been or would, in the opinion of the Governor, be inadequate in the circumstances”. There are two types of special observation cell: Close Supervision Cell and Safety Observation Cell. In 2010, the CPT was deeply concerned by the situation of prisoners placed in special observation cells and urged the Irish authorities to clearly identify the purpose of such cells and to ensure clear operating standards governing the placement of inmates were in place.

In November 2013, the Irish Prison Service introduced separate standard operating procedures for the use of safety observation and close supervision cells. The findings of the CPT’s 2014 visit showed that there was a degree of confusion among prison staff and management as to the specific purpose of each category of cell as well as several other deficiencies in the management of prisoners placed in these cells.

In April 2019, new Standard Operating Procedures (SOPs) were introduced for both Close Supervision and Safety Observation Cells, as well as new policies for “Monitoring of Prisoners”, “Healthcare Special Observation” and “Monitoring of Prisoners during periods of Night Guard”. The findings of the 2019 periodic visit demonstrated not only a continued confusion over the use of these special cells but also that they are not being managed according to the SOPs. At the end of the visit, the CPT’s delegation requested a wholesale review of the use of both Close Supervision and Safety Observation Cells. By letter of 27 January 2020, the Irish authorities informed the CPT that the Irish Prison Service would undertake a review of the use of both CSCs and SOC.

56. According to the revised SOPs on *Close Supervision Cells* (CSCs), such cells may be used for managing a prisoner who poses an immediate threat of serious harm to self and/or others (i.e. as a security measure). A prisoner must be observed by a prison officer every 15 minutes in a CSC and seen by a nurse during the relocation or as soon as possible thereafter. The Governor and doctor must visit each prisoner accommodated in a close supervision cell on at least a daily basis. After the initial period of 24 hours, the measure may be extended by the Governor for an additional 24 hours. If a prisoner is accommodated in a CSC for longer than five days, the Governor shall submit a report to the Director General of the Irish Prison Service, who thereafter must provide written authorisation to a Governor for the measure to be extended every 24 hours thereafter.

The SOPs also state that the prisoner should be offered not less than one hour of outdoor exercise every day unless this is considered unsafe.

57. According to the SOPs on *Safety Observation Cells* (SOCs), such cells may only be used when a prisoner poses an immediate threat of serious harm to him/herself and/or others arising from a health care condition (i.e. as a medical measure). The authority to direct that a prisoner be accommodated in a SOC can be taken by medical practitioners and registered nurses only. A prisoner placed in a SOC must be observed by a prison officer at least once every 15 minutes. A registered nurse should review the patient at least every two hours and a medical review must be carried out by a registered medical practitioner every 24 hours. After the initial period of 24 hours, a new order may be issued by the Governor after consulting with the registered medical practitioner/nurse/orderly for a further period not exceeding 24 hours up to a maximum of four renewals (120 hours).

Thereafter, written authorisation from the Director General of Prisons must be obtained and the Executive Clinical Lead and National Operational Nurse Manager notified. The SOPs also state that the prisoner's individual care and treatment plan must address the assessed need of the prisoner in the SOC, that the prisoner should be offered not less than one hour of outdoor exercise and that clothing should only be removed and protective clothing issued if there is a risk that the prisoner may use the clothing to harm him/herself.

58. In the reports on the 2010 and 2014 visits, the CPT had stressed that after placing a prisoner in a CSC or a SOC, rip-proof clothing should only be provided where necessary, after an individual risk assessment. However, during the 2019 visit, the CPT's delegation found once again that prisoners placed in a CSC at all the prisons visited routinely had all their clothing removed (including at times their underwear) and were provided with rip-proof ponchos. Although some placements in a CSC were for the "own safety" of the prisoner, many of the cases examined were for reasons of security (refusing an order by staff, following a fight with another prisoner or suspicion of secreting contraband). One prisoner at Cloverhill Prison who had been in a CSC for four days at the time of the delegation's visit for refusing to go to a particular wing had had all his clothes removed and had been provided with a rip-proof poncho; every time he went to the outdoor exercise yard he was allowed to put on his own clothes but was stripped naked and given the poncho each time he re-entered the CSC.

It is noteworthy that the revised SOPs on CSCs now state that "a prisoner's clothing, including underwear, may be removed, before the prisoner is accommodated in a CSC, where considered necessary by the Governor." This provision makes no sense as any prisoner who is at risk of committing suicide should be placed in a Safety Observation Cell whereas forcibly removing the underwear from an agitated/violent prisoner would appear to be a punitive measure (which is contrary to the stated policy in the SOPs) as well as placing both the prisoner and prison officers in further harm's way and being degrading for the prisoner.

The CPT recommends once again that the Irish authorities ensure that there is no routine removal of a prisoner's clothing upon their placement in a CSC. To this end, the SOPs regulating CSCs should be amended to state that only where there is a risk of suicide by the prisoner concerned should his/her clothing be removed, and the prisoner provided with rip-proof bottoms and top.

59. With minor differences, the CSCs in the prisons visited were all of similar layout (each measured approximately 8m² and were equipped with a washable mattress, a plinth, a moulded table and chair, a TV in protective casing, a call bell and in-cell sanitation). Lighting and ventilation were sufficient. Although the temperatures in the cells were monitored and apparently would not be used if below 24°C, almost every prisoner who had spent a night in a CSC complained that the air conditioning in the cell had been extremely cold and that besides the poncho they had only been provided with a small rip-proof cover.

Further, with the exception of some prisoners held in a CSC at Cloverhill Prison, inmates kept for more than 24 hours in all other prisons visited in either a CSC or a SOC were not offered a shower (even though it was usually located right outside the CSC/SOC) or daily access to outdoor exercise.

The CPT recommends that all prisoners placed in a CSC for longer than 24 hours be offered a shower and access to outdoor exercise (see below regarding persons placed in a SOC). Further, staff should be attentive in ensuring that the CSCs and SOCs are not too cold at night and that prisoners are provided with sufficient blankets to keep warm.

60. The CPT's delegation again found that there was a lot of confusion among prison staff and management about the specific purpose of a CSC and of a SOC. Consequently, it appeared that a CSC and a SOC were at times used interchangeably. This is not surprising when in some prisons there appeared to be no difference between a CSC and a SOC. For example, on Wing C1 (left side) at Midlands Prison, both the cells 9/10 and 13/14 were identified by staff as being a SOC but both had a sign outside the door that said CSC.²¹ Likewise, at Mountjoy Prison, the CSC and SOC on C Wing were considered to both have a dual function. Records at both these prisons showed that a prisoner might be placed in a CSC for a variety of reasons from "own request" and "disruptive" to "threatening self-harm" and "feeling suicidal". Moreover, at Cloverhill Prison, the reasons for placement was invariably "medical and "operational" but the records showed that prisoners were at times moved to a SOC for operational reasons and to a CSC for medical reasons. Further, it seemed that medical staff had authorised placement in a CSC and that on occasion persons were brought to a SOC on a Chief Officer's order.

One inmate at Midlands Prison, who frequently self-harmed, had been placed in a SOC from 31 May to 3 June 2019 after which he was transferred to a CSC where he remained for 37 days until 14 July 2019. The prisoner in question had been seen frequently by the mental health team and the nursing and medical notes were comprehensive. However, there was no clear reasoning for his prolonged accommodation in a CSC.

61. In the light of the above findings and the very real confusion that exists between the use of a CSC and a SOC, the CPT considers that there is a need to streamline the procedures for the placement of a prisoner in a CSC or a SOC. In the CPT's view, the most effective approach would be to do away with the differentiation between a CSC and a SOC and instead focus on the reasons for the placement of a prisoner in one of these cells. In the prisons visited, there was in many instances no visible difference between a CSC and a SOC and, indeed, they were at times used interchangeably. In theory, the only real difference appears to be that a SOC should have a Perspex window on the door to the cell to allow for enhanced observations, but this was not always the case.

If a CSC and a SOC were considered as inter-changeable, this would allow for the policies governing the use of these cells to focus on the reasons for the placement. That is, if a prisoner is placed in one of these cells as a security measure, it is for the Governor and senior prison officers to manage the placement; whereas, if the placement is as a medical measure, it is for the health care staff to manage the placement. A single policy regulating the use of these cells (CSC and SOC) would be more effective and efficient.

The CPT recommends that the Irish authorities review the use of CSCs and SOCs with a view to clarifying the procedures and management of prisoners placed in such cells and of doing away with the artificial distinction between the two types of cells, in the light of the above remarks.

²¹ At the time of the visit, these cells were out of use which caused further difficulties as the other designated SOC in the prison was on E Wing, a considerable distance from the medical unit on C Wing especially as there was only one nurse on duty for the whole prison at night who had to carry out checks every two hours on prisoners accommodated in a SOC.

62. The CPT's delegation also found that the recording of data on the use of a CSC and a SOC both in the Prisoner Information Management System (PIMS) and in the paper logbooks kept on the wings could not be relied upon. The wing registers often lacked information concerning the reason for placement, the time and date a prisoner was released from a CSC/SOC and no information was given on how the prisoner was managed and whether they were offered a shower, outdoor exercise or food and drink. Even the 15-minute officer checks and, where required, the two-hourly nurses' visits and whether the Governor and doctor visited daily were not always recorded.

A review of the records on the use of a SOC rarely included authorisation by the Governor and in many cases there was no information as to whether permission had been sought every 24 hours from the DG of Prisons to extend the placement measure once it had exceeded 120 hours. Nor was there any note as to whether the IPS Nurse Manager and IPS Clinical Director had been notified. Moreover, there was no written record either about what information was provided to the DG of Prisons to assist her in making her decision nor about the reasoning behind her decision to extend a placement in a SOC. Indeed, in the prisons visited the Director General's authorisations were not recorded.

The CPT recommends that the Irish authorities ensure that the integrity of data relating to all procedures surrounding the placement and stay of prisoners in CSCs and SOCs is guaranteed in accordance with the SOPs.

63. The use of SOCs is also integrally linked to one of the most pressing issues within Irish prisons, namely the treatment of prisoners who are mentally ill. At the time of the visit, there were some 25 prisoners on the waiting list for admission to the Central Mental Hospital (CMH) and the delegation met many of them in the prisons it visited (see section 6.d below). The most acutely unwell prisoners awaiting transfer to the CMH were being managed in a SOC.

At the time of the delegation's visit to Cloverhill Prison on 29/30 September, two of the 10 prisoners awaiting transfer to the CMH had been managed in a SOC since 17 September. When the CPT's delegation met one of the men (PM), he was lying naked in his cell, with the cell smeared with faeces and puddles of urine on the floor. There were no blankets in the cell and his poncho lying next to him was soaked in urine. Prison officers explained that the door to the SOC was only opened using the protection of a shield to pass him food. During his time in the cell he had not been provided with a shower or let out of the cell.²² The other man (MS) was in a similarly distressed state and he too had not been afforded a shower or allowed out of his cell since his placement.

Despite both of these men being very unwell neither of them had had an individual care and treatment plan drawn up as directed by the recently revised SOPs for a SOC (see point 4.1.f). Moreover, nursing staff were unable to engage with either man inside the SOCs as prison officers were not willing to unlock the cells. Further, there was poor recording of any interventions, including whether the two men had taken food. In the CPT's view, such a situation might amount to inhuman and degrading treatment.

²² From 19 to 24 September PM and another prisoner MS were transferred to Mountjoy Prison, due to a suspected tuberculosis outbreak, where they were held in SOCs in the High Support Unit. During this period, they were not provided with a shower or afforded any other care out of their cell.

64. While one of the men (PM) was bailed by the High Court to a psychiatric hospital in the community on 2 October 2019, it was disappointing to learn that he had still not been afforded a shower prior to his transfer. As regards the other person (MS) held in a SOC, the CPT learned that due to his homeless status he would not be accepted by a community hospital and would have to wait for a bed to become available in the CMH. The CPT's delegation requested the Irish authorities to ensure that a care plan be put in place immediately for this man, and for any other persons accommodated in a SOC pending transfer to a mental health care facility; such a plan should include being monitored directly by a psychiatric nurse (1:1), the door to the SOC being left unlocked during the day, access to a shower and outdoor exercise and increased access to chaplaincy and psychology services.

By email of 28 November 2019, the CPT was informed that MS was held in a SOC until his transfer to the CMH on 26 November (i.e. for 10 weeks). The communication confirmed that he was seen by a nurse every two hours and a doctor daily but no information was provided regarding whether a care and treatment plan had been drawn up for him and whether such had included the elements requested by the CPT's delegation at the end of the visit.

The CPT recommends that the Irish authorities ensure that a care and treatment plan be drawn up for all prisoners accommodated in a SOC pending transfer to a mental health care facility, and that such a plan include being monitored directly by a psychiatric nurse (1:1), the door to the SOC being left unlocked during the day, access to a shower and outdoor exercise and increased access to chaplaincy and psychology services.

5. Conditions of detention

a. material conditions

65. The cellular accommodation in the prisons visited can generally be considered of a good standard for prisoners held in a single occupancy cell. At Cork, Cloverhill, Midlands and Mountjoy Prisons, single occupancy cells were of an adequate size (between 8m² and 11m²), suitably equipped (bed, desk, chair, shelving unit, a call bell and a partially screened toilet and a sink) with sufficient lighting and ventilation. At Arbour Hill, the cells were rather cramped, measuring only 6m² including an unscreened toilet and sink, and access to natural light was limited on the ground floor; however, these deficiencies were offset by the open regime within the establishment.

On the other hand, the conditions in the cells with double (Arbour Hill, Cork, Cloverhill and Midlands Prisons), triple (Cloverhill Prison) and quadruple (Midlands Prison) occupancy provide less good accommodation. In particular, the multiple occupancy cells, including at the new build Cork Prison, did not have fully partitioned sanitary annexes.

In Cloverhill Prison, the vast majority of cells (119) are designated as triple occupancy despite the fact that they are only 11m², including the semi-partitioned toilet. This means prisoners are not offered 4m² of living space each. Further, the four committal cells on Wing E2 were dilapidated, malodorous and dirty and need to be refurbished. The cells on Wing C1 were in a similarly poor state. At Midlands Prison, the CPT's delegation took note of the ongoing refurbishment of all broken cell windows.

The CPT recommends that, at Cloverhill Prison, a programme of ongoing maintenance and refurbishment be undertaken and that efforts progressively be made to ensure that cells of 11m² (including the sanitary facility) accommodate no more than two prisoners. Further, toilets in multiple-occupancy cells should be fully partitioned up to the ceiling.

66. It goes without saying that every prisoner who has to stay overnight in a prison should be provided with his/her own bed. At Midlands Prison, the CPT's delegation met a prisoner who had spent almost a month on a mattress on the floor. Such situations should not occur. The CPT recognises that the situation is complicated by the necessity to keep incompatible groups of prisoners apart and the general policy to provide all life-sentenced prisoners with their own cell. Nevertheless, as this phenomenon persists, it is incumbent on the authorities to reduce the official capacities of the prison establishments affected, to promote alternatives to imprisonment, to bolster the community return schemes and to guarantee every prisoner their own bed. Further, it is important to ensure that vulnerable prisoners are not forced to sleep on a mattress on the floor as occurred at Cork Prison when a foreign national prisoner who suffered from Parkinson's disease (he had paucity of movement and shook uncontrollably) returned to the prison after a few days in hospital.

The CPT recommends that steps be taken to ensure that prisoners do not have to sleep on a mattress on the floor and that they are provided with their own bed. Moreover, specifically vulnerable prisoners should never have to sleep on a mattress on the floor. Further, the CPT wishes to be informed of the steps being taken to put an end to the practice of prisoners having to sleep on mattresses on the floor. It also wishes to receive statistics on the number of prisoners sleeping on mattresses on the floor for the months of May, June and July 2020.

67. As regards food, a common complaint received was that tea was served at 4.15 p.m. which meant prisoners had to wait almost 16 hours before their next meal. Certainly, for those with money there is the possibility to buy certain basic foodstuffs from the canteen to ward off hunger. The Committee understands that the timing of tea suits the organisation of the day with prisoners getting their food and eating it in their cells while the prison is locked down and prison officers have their break. Nevertheless, if it is not possible to push back the afternoon meal consideration should be given to providing prisoners with a snack later in the evening.

Ideally, the CPT considers that meals should be eaten communally. Nevertheless, for security and logistical reasons, this is not viable at present in many prisons. However, at Arbour Hill, where there are few security concerns given the nature of the prisoner population there are strong arguments to introduce communal eating of meals at least once a day. The small size of the cells in which prisoners have to eat their meals combined with the available space in which such communal eating could be organised strengthen the case for such an approach.

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

b. reception and regime

68. All persons entering prison underwent a proper reception and first night procedures which included being provided with information on the establishment and a risk and needs assessment carried out prior to them being allocated to a wing. The CPT's delegation again noted the existence of a comprehensive information booklet. However, many prisoners with whom the delegation met stated that they had not received such a booklet and that the information provided to them about the operation of the prison had primarily come from other prisoners. Further, foreign national prisoners stated that they had to rely on a translation provided by other prisoners and prisoners with reading and writing difficulties complained that they were not provided with any oral explanation of what was contained within the booklet.

The CPT reiterates its recommendation that the Irish authorities take steps to ensure that foreign nationals and prisoners with reading and writing difficulties be provided with information on the regime in force in the establishment and on their rights and duties, in a language which they understand; such information should be provided both orally and in the form of a brochure.

69. In the report on the 2014 visit, the CPT commented on the introduction of the 2012 Policy on Incentivised Regimes in Irish prisons.²³

In the course of the 2019 visit, the CPT's delegation was able to note the efforts being made in the prisons visited to offer prisoners a range of activities. The general regime within the Irish Prison system provides for a reasonable out-of-cell time of some seven-and-a-half hours per day.

Arbour Hill offers an impressive range of activities including workshops in carpentry, printing, textiles, repairing brail machines, waste management and an IT lab and prisoners could also work in the kitchen and laundry.²⁴ Recreational activities included pottery, chess, gym, snooker, ping pong, music and a well-stocked library and the education centre offered courses on a wide range of subjects.²⁵ There were a number of offender management programmes on offer, including a specific therapy programme for high-risk sex offenders.²⁶

At both Cork and Midlands Prisons, a wide range of activities were on offer to prisoners (school, workshops, vocational courses, recreational and sport). The two greenhouses at Midlands Prison, which employed some 50 inmates, were particularly appreciated. In both prisons, efforts had been made within the context of the Regime Management Plan to ring-fence the school and workshop activities whenever staffing numbers fell below the scheduled complement. Nevertheless, lack of prison officers to escort prisoners did lead to classes being cancelled notably towards the end of each quarter of the year.

The CPT recommends that the Irish authorities pursue their efforts to ensure that there is always sufficient staff on duty to escort prisoners to school and workshop activities.

²³ See CPT/Inf (2015) 38, paragraph 33.

²⁴ At the time of the visit, some 65 prisoners were engaged in these workshops.

²⁵ 11 prisoners had been accepted on to an Open university course in September 2019.

²⁶ The three stage Canadian programme had 8 prisoners in the "Establishing Better Lives" stage and 9 prisoners in the "Building Better Lives" stage and no participants in the "Maintaining Better Lives" stage.

70. Since 2006, the Irish Prison Service has been progressively rolling out the Integrated Sentence Management (ISM) system. Under ISM, a newly committed prisoner with a sentence of one year or greater should be assessed by an ISM co-ordinator and a personal plan drawn up. However, the system has never been fully implemented. In their response to the 2014 visit report, the Irish authorities informed the CPT that ISM Co-ordinators were now tasked with engaging with prisoners serving sentences of between 3 and 12 months in order to identify suitable candidates for the Community Support Scheme²⁷ as well as for identifying suitable prisoners for the Community Return Scheme.²⁸

In the prisons visited, the whole ISM system was being undermined by the lack of dedicated ISM co-ordinators, many of whom also had to undertake normal prison officer duties within the prison. The result was that there was virtually no follow-up of prisoners serving sentences of more than one year and insufficient support provided to life-sentenced prisoners. Most of the resources of the ISM co-ordinator were devoted to finding suitable candidates for the Community Support System and identifying programmes for them to follow in the community. One consequence of this state of affairs is that the necessary documentation required for the Parole Board to consider life-sentenced prisoners up for review is often not produced on time resulting in hearings being delayed by up to 18 months or more. Many inmates stated that they thought they had a sentence plan but that they were not aware of it and that they had not met an ISM co-ordinator for three or more years. Only at Arbour Hill Prison, where there was a full-time ISM co-ordinator in place for a prisoner population of around 135 persons, was there a regular follow up of each prisoner's Personal Integration Plan (PIP).

The CPT considers that the adoption of the Parole Act 2019, establishing an independent parole board which can issue binding decisions, is a positive development. However, given that the Act also increases the number of years that a person sentenced to life-imprisonment must serve before being eligible for parole (from 7 to 12 years), it is even more important for sentence management plans to be drawn up and reviewed on a regular basis for this cohort of prisoners.

The CPT reiterates its recommendation that a sentence plan be drawn up for all prisoners, with particular attention paid to the needs of persons sentenced to life-imprisonment and other prisoners serving lengthy sentences. Such plans should be reviewed on a regular basis together with the prisoner concerned. To this end, the number of ISM co-ordinators allocated to each prison should be increased. Further, efforts should be made to ensure all reports are submitted to the Parole Board on time.

²⁷ The number of prisoners benefiting from this scheme have risen from 389 in 2014 to 631 in 2018.

²⁸ The number of prisoners accessing the Community Return Scheme fell from 455 in 2014 to 218 in 2018 and as of 16 September 2019 only 125 prisoners had accessed the scheme during the year.

6. Health care services

71. In the report on the 2014 visit, the CPT recommended that the Irish authorities identify an appropriate independent body to undertake a fundamental review of health care services in Irish prisons, which was in a state of crisis in some prisons. Following the appointment of a Clinical Lead in the Irish Prison Service in July 2018, a tender to carry out a Health Needs Assessment (HNA) to plan for the future delivery of health services and a model of clinical governance for health care professionals in Irish prisons was published in July 2019. **The CPT wishes to be informed of the outcome of the Health Needs Assessment.**

72. At the outset, the CPT wishes to acknowledge the progress that has been made in the delivery of health care in Irish prisons since the 2014 visit. In sum, the CPT's delegation found very good access to health care in prisons and a vastly improved approach to the treatment of substance use. The mental health nurses and visiting psychiatrists were also doing a good job in difficult circumstances. Further, the carers employed at Midlands Prison to assist the older population of prisoners were very good, displaying genuine warmth and affection towards their charges. Nevertheless, there remain certain areas where improvement is required such as the poor screening of injuries upon arrival in prison and the lack of provision of interpretation services which clearly hinders communication between health care staff and the rising number of prisoners who do not have a good understanding of the English language. **The CPT trusts that the Irish authorities will build upon the progress made and take steps to address the areas where there is a need for improvement.**

a. staff and facilities

73. At Arbour Hill Prison, there was a health care manager and six full-time equivalent (FTE) nurses, with two nurses on duty from 7 a.m. to 7 p.m. every day of the week and one nurse on duty at night. A General Practitioner (GP) attends three mornings a week. A dentist visits once a week as does a psychiatrist and two community psychiatric nurses each provide one session per week. Other specialist services visit on a less regular basis such as a chiropodist, an optometrist, a speech therapist and a physiotherapist. For a prison population of around 138 such staffing levels can be considered as adequate.

At Cork Prison, there were 10 FTE nurses as well as a nursing manager and a care assistant. Between 8 a.m. and 8 p.m. four nurses were on duty and from 8 p.m. to 8 a.m. one nurse was on duty. A GP attends the prison Monday to Saturday from 9.30 a.m. to 1 p.m. and is on call each day until 10 p.m. A dentist visits every Thursday morning and typically sees 17 patients. There are also monthly visits by a chiropodist and an optometrist. Further, a psychiatrist provides three half-day sessions a week and a mental health nurse visits the prison four days a week. For a prison population of around 300 such staffing levels can be considered as satisfactory.

At Midlands Prison, there were 21 FTE nurses. From Monday to Friday between 8 a.m. and 8 p.m. 10 nurses and four carers were on duty as well two addiction nurses up until 5 p.m. and, at weekends, eight nurses and four carers. At night, from 8 p.m. to 8 a.m., one nurse and one carer were on duty. There was one full-time GP supported by two doctors covering the morning and afternoon surgeries between Monday and Friday, and another doctor provided services exclusively to E and G Wings on Mondays, Tuesdays and Fridays. At weekends, a doctor who also covered the adjacent Portlaoise Prison visited for a few hours. Given the layout of the prison with E and G wings being a considerable distance from the medical unit as well as the obligation on nurses to visit all placements in a CSC (at least initially) or a SOC, to look after vulnerable prisoners and to examine new arrivals, **the CPT considers that consideration should be given to providing for a second nurse to be on duty at night.**

It was positive to observe that the organisation and management of health care services at Midlands Prison had improved since the 2014 visit. Access for prisoners was good and there was a structured follow-up to incidents such as self-harming. Further, the previous situation of a lack of prison officers being available to provide escorts to and from the health centre had been addressed by designating three officers to be permanently assigned to this task. While not all three posts were filled every day, the situation had improved significantly.

The health care facilities in all the above prisons can be considered as being well-equipped.

74. As regards medical confidentiality, the CPT's delegation observed that, as was the case in 2014, it was generally respected in the prisons visited, both as regards medical consultations and the storing of medical documentation.

However, the practice of handcuffing a prisoner to a prison officer during external medical consultations in the hospital, at all times, even when the consultation takes place in a secure room, has still not changed. The CPT recognises that there is a duty upon the IPS to assess whether a prisoner poses a potential risk to medical/health care staff, or represents an escape risk, and to take appropriate measures. Nevertheless, in the CPT's view, to routinely apply handcuffs to a prisoner undergoing a medical consultation/intervention is not acceptable from the standpoint of medical ethics and human dignity. Practices of this kind prevent an adequate medical examination from being carried out, will inevitably jeopardise the development of a proper doctor-patient relationship, and may even be prejudicial to the establishment of objective medical observations.

The CPT reiterates its recommendation that the Irish authorities take the necessary steps to ensure that external medical consultations of prisoners respect the principle of medical confidentiality and human dignity, taking due account of the above remarks.

75. In the course of the visit, the CPT's delegation met several foreign national prisoners who did not have a command of the English language and could not make themselves understood. For such cases, it is important that health care staff are able to access language interpretation services in order to communicate with these prisoners. Further, when necessary, medical notes in a foreign language should be translated into English. For example, the CPT's delegation raised the necessity for the medical notes of a vulnerable foreign national prisoner with Parkinson's disease at Cork Prison to be translated, which the Governor of the prison undertook to do.

The CPT recommends that health care services in prison be provided with the means to access telephone interpretation services when required.

b. medical examination on admission and recording of injuries

76. The 2011 Irish Prison Service Health-Care Standards require that an initial assessment carried out by nursing staff on the day of reception. Further, within 24 hours of reception a doctor should undertake a clinical assessment of the prisoner's physical and mental state.

In the prisons visited, the CPT's delegation found that all new arrivals were seen by a nurse on the day of their arrival who would fill out a standardised nursing proforma and that a GP would review the patient the following day. An examination of a number of medical records in all the prisons visited showed that this procedure was followed and that the information was input onto the electronic health care record for each prisoner.

77. The situation as regards the recording of injuries (on admission or during imprisonment) was such that injuries were usually recorded when they were observed but the quality of the records was again variable (see paragraph 12 above).

The IPS policy places the onus on the Governor of a prison to take the lead regarding the recording and reporting of allegations of assaults, to secure the evidence and to liaise with the Garda Síochána. On the other hand, health care staff are required to document and treat all injuries sustained by prisoners and to objectively document them on the Prison Healthcare Medical System (PHMS) database. In their response to the CPT's 2014 visit report, the Irish authorities stated that it was not for health care staff to report alleged ill-treatment to any third party.

Such an approach is fine when a prisoner makes a complaint. However, where a newly arrived or other prisoner is found to bear injuries which are clearly indicative of ill-treatment but refuses to reveal their cause or gives a reason unrelated to ill-treatment, his/her statement should be accurately documented and reported to the authority concerned together with a full account of the objective medical findings.

A corollary of the automatic reporting obligation is that the health care professional should advise the prisoner concerned of the existence of that obligation, explaining that the writing of such a report falls within the framework of a system for preventing ill-treatment and that the forwarding of the report to the relevant authority is not a substitute for the lodging of a complaint in proper form.

The CPT recommends that the Irish authorities review the existing procedures in order to ensure that whenever injuries are recorded by a health care professional which are indicative of ill-treatment, that information is immediately and systematically brought to the attention of the Governor and An Garda Síochána, regardless of the wishes of the person concerned.

The record drawn up after the medical screening should contain:

- i) an account of statements made by the person which are relevant to the medical examination (including his/her description of his/her state of health and any allegations of ill-treatment),**
- ii) a full account of objective medical findings based on a thorough examination, and**
- iii) the health care professional's observations in the light of i) and ii), indicating the consistency between any allegations made and the objective medical findings.**

The record should also contain the results of additional examinations carried out, detailed conclusions of specialised consultations and a description of treatment given for injuries and of any further procedures performed.

Recording of the results of the medical examination in cases of traumatic injuries should be made on a special form provided for this purpose, with body charts for marking traumatic injuries that will be kept in the medical file of the prisoner. 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.

The results of every examination, including the above-mentioned statements and the doctor's opinions/observations, should be made available to the prisoner and, upon request, to his/her lawyer.

c. drug-related issues

78. The CPT's delegation observed once again that drug misuse and a high prevalence of drugs remained a major problem in all the prisons visited, with the exception of Arbour Hill Prison. Prison staff admitted that there were still significant problems with illicit drug misuse and that many of the incidents in the prisons were drug related.

In this regard, the Irish Prison Service drugs policy and strategy paper "Keeping drugs out of prison" remains relevant. Nevertheless, a new drugs strategy is under preparation which will *inter alia* include a review of measures to prevent drugs getting into prisons taking account of issues such as technological advances (e.g. drones) and changing patterns of illicit drug use as well as seek to implement the recommendations from the recent "Review of Drug and Alcohol Treatment Services for Adult Offenders in Prison and in the Community".

The CPT's delegation observed positively that a "stepped" drug assessment and treatment approach including non-pharmacological interventions was the essence of the methadone treatment programme introduced at Cork Prison since its previous visit to this establishment. Further, such programmes were again in evidence at Midlands and Mountjoy Prisons.

Further, the CPT recalls that harm reduction measures represent an important component in preventing the transmission of blood-borne viruses and the spread of infectious diseases in prison establishments. Consequently, **the CPT would like to receive further information on the harm-reduction measures in place or planned in prisons, such as needle and syringe exchange programmes, access to condoms. Full information on the existence of such harm reduction programmes should be given to inmates by health care staff immediately after committal.**

The CPT recommends that the Irish authorities continue to pursue vigorously the various strands of the drugs strategy programme. Further, it would like to be informed when the new drugs strategy is adopted.

d. psychiatric care in prisons

79. The approach towards the provision of mental health services for prisoners is set out in the 2006 policy document “A vision for change” and the system described in previous CPT visit reports regarding mental health in-reach service and high support units in certain prisons remained in place at the time of the 2019 periodic visit.²⁹ Moreover, the same challenges outlined in the report on the 2014 visit were again in evidence. In the course of the visit, the CPT’s delegation paid follow up visits to the D2 unit in Cloverhill Prison and the High Support Unit (HSU) at Mountjoy Prison, and it visited the Vulnerable Prisoner Unit (VPU) at Cork Prison for the first time.

80. At Cork Prison, the VPU consisted of six cells and was accommodating five prisoners at the time of the visit. The cells were sombre with poor access to natural light, the environment was noisy and the prisoners were offered no purposeful activities apart from access to the exercise yard. Further, there was minimal staff interaction with the vulnerable men located on the unit.

As regards the nine-cell HSU in Mountjoy Prison, where eight prisoners were being held at the time of the visit (one had just been transferred to the Central Mental Hospital), it was disappointing to note there was still a complete lack of structured activities for this group of prisoners, nearly all of whom had a severe and enduring long-term mental health illness. The proposed programme of activities remained theoretical and unengaging. There was still no occupational therapy, individual or group psychotherapy or recreational therapy; only pharmacotherapy. In sum, the prisoners wandered idly around the unit or the yard and watched television. Further, the delegation met one prisoner who was completely neglected, living in a dirty and squalid cell.

As was the case in 2014, the mental health team, which is comprised of a psychiatrist and a mental health nurse, visited the HSU once a week.

The CPT recommends that at both the VPU in Cork Prison and the HSU in Mountjoy Prison a programme of structured activities be developed for prisoners held on these units. It also recommends that steps be taken to ensure that all prisoners kept on these units are held in clean cells and provided with the necessary support to maintain their hygiene. Further, the HSU should introduce occupational therapy sessions for the prisoners.

81. The largest unit in the country holding prisoners who are mentally ill is located in Wing D2 of Cloverhill Prison. Over the past 10 years the unit has had to expand as more and more severely unwell persons have entered prison. The landing was comprised of 15 single cells (three of which were occupied by cleaners) and five double cells. In addition, it had two SOCs and four CSCs, which often accommodated mentally ill prisoners. On the first day of the delegation’s visit, the unit was accommodating 29 prisoners, including two persons in the SOCs (see paragraph 63 above), 10 of whom were on the waiting list to enter the Central Mental Hospital. Three days later, the unit was overflowing with seven prisoners having to sleep on mattresses on the floor, which the duty doctor confirmed was a regular feature for the landing.

The CPT recommends that steps be taken to ensure that mentally ill prisoners do not have to sleep on mattresses on the floor in Wing D2 of Cloverhill Prison (see also paragraph 66 above).

²⁹ See CPT/Inf (2015) 38, paragraphs 59 to 64.

82. The Prison In-reach and Court Liaison Service based at Cloverhill Prison will assess around 300 prisoners a year, of whom some 100 are actively psychotic. Studies have shown that the percentage of remand prisoners with psychotic disorders in Ireland (9.3%) is more than twice the percentage of prisoners with psychotic disorders found internationally (3.6%).³⁰ Despite this evident increase in the number of mentally ill prisoners entering Cloverhill Prison, the resources provided for the care and management of these persons has been cut. At the time of the visit, the mental health team consisted of 1.3 FTE consultant, 2.8 FTE junior doctor posts and 1.6 FTE senior registrar and only two nurses (one of whom was on long-term sick leave). This team needs to be reinforced urgently. There should be at least six mental health nurses, as well as an occupational therapist, a psychologist, a social worker and some administrative support.

Further, the current focus seems to be solely around the psychiatric diagnoses, drug treatment and whether the prisoner is waiting for a place in a psychiatric hospital. On the other hand, there was a lack of discussion or planning about the day to day care of the men on D2 Wing. The CPT's delegation observed that they were offered no structured activities and that there was little engagement with staff. Given that prisoners can spend months on the unit much more needs to be done.

The CPT recommends that the mental health team working on the D2 Wing at Cloverhill Prison be substantially reinforced in the light of the above remarks. Further, a programme of structured activities should be developed for prisoners held on the wing.

83. A major concern is the rising number of homeless persons who are ending up in prison and more particularly on Wing D2 which had risen to 32% in 2014 and was thought to be closer to 50% in 2019. Many of the persons coming to D2 could be granted bail by the courts but because of their homeless status they are excluded from Health Service Executive (HSE) community mental health team services so they are left to languish in prison.³¹ Moreover, their mental health condition continues to deteriorate as they are too ill to consent to treatment.³² Prison must not become a solution for managing mentally ill homeless persons and the Irish authorities need to put in place a comprehensive policy (i.e. one that includes housing, welfare, primary care, mental health care, substance misuse) in order to tackle this issue.

The CPT recommends that urgent steps be taken, including of a legislative nature, to ensure that mentally ill homeless persons in prison, who the courts are willing to bail, can be transferred rapidly to a psychiatric facility in the community to receive appropriate treatment.

84. The Irish authorities have in the past agreed with the CPT that a prison setting cannot be expected to offer the full range of therapeutic options that should be available in a psychiatric hospital and, as highlighted again above, even as regards pharmacotherapy a prison setting imposes restrictions.

³⁰ Curtin, K., Monks, S., Wright, B., Duffy, D., Linehan, S., & Kennedy, H. (2009). Psychiatric morbidity in male remanded and sentenced committals to Irish prisons. *Irish Journal of Psychological Medicine*, 26(4), 169-173.

³¹ This was the case of MS cited above in paragraph 62 who was confined to a SOC for 10 weeks awaiting a place at the CMH because no community psychiatric hospital would accept him due to his homeless status.

³² There is no legal provision for involuntary treatment in prisons.

Consequently, while these measures recommended above may alleviate the situation, the fundamental principle is that mentally ill persons should not be held in prison but transferred to an appropriate health care facility or, more specifically, the Central Mental Hospital (CMH) given its statutory role. However, the CPT's delegation received several accounts that the new expanded CMH in Portrane, due to open in mid-2020, will not result in enough additional beds being available for mentally ill prisoners despite an increase in the number of beds in the hospital.³³

The CPT recognises that there needs to be a multi-pronged approach to addressing the mental health needs of prisoners. Addressing access to care in the community for homeless persons who are mentally ill is one. In addition, the CPT supports the proposal for the development of two new Intensive Care Rehabilitation Units (ICRUs) to be located in the southern and western regions of the country and **the Committee would like to be updated on the feasibility of such units being opened and the timeline. It would also like to be informed whether there are plans to create additional step-down beds in the community and to increase the provision of psychiatric low-secure settings.**

85. Further, as the CPT highlighted in 2014, if the HSUs and VPUs in prisons are to provide a stepping stone towards admission to a psychiatric hospital or a step-down unit for managing persons returned to prison from a psychiatric facility, it is essential that they be provided with the appropriate resources. This means that an HSU should not only be visited on a regular basis by a mental health team (psychiatrist, psychologist and psychiatric nurse) but that the staffing complement should include psychiatric nurses, occupational therapists and officers with special training to work with mentally ill prisoners, and a structured programme of activities should be offered to all prisoners accommodated within an HSU.

The CPT recommends that the Irish authorities enhance the availability of beds in psychiatric care facilities for acute mentally ill prisoners.

Further, it recommends that the staffing at all HSUs and VPUs be reviewed in order to include the appropriate expertise to offer a structured programme of activities beneficial to the prisoners, in the light of the above-mentioned remarks.

Moreover, the CPT would like to be informed when the new CMH in Portrane is opened and fully functional. It would also like to be informed how many prisoners were waiting to be admitted to the CMH as of 1 May, 1 July and 1 September 2020 and how many of these prisoners were being managed in a SOC.

³³ The new CMH will comprise a 120-bed new main hospital, along with a 10-bed Child and Adolescent Mental Health Service (CAHMS) unit and a 10-bed Mental Health Intellectual Disability facility and a new 30-bed Intensive Care Rehabilitation Unit (ICRU). Thus, the overall capacity will increase from 103 beds at the current Dundrum hospital to 170 beds (including 10 CAHMS) at the new CMH in Portrane.

7. Other issues

a. prison staff

86. The CPT has repeatedly emphasised that the climate in a prison is largely dependent on the quality and resources of its personnel. Ensuring a positive climate requires a professional team of staff, who must be present in adequate numbers at any given time in detention areas and in facilities used by prisoners for activities. Prison officers should be able to deal with prisoners in a decent and humane manner while paying attention to matters of security and good order. The development of constructive and positive relations between prison staff and prisoners will not only reduce the risk of ill-treatment but also enhance control and security. In turn, it will render the work of prison staff far more rewarding. Recognising the importance of supporting prison staff in their challenging duties, the Council of Europe published a set of *Guidelines Regarding Recruitment, Selection, Education, Training and Professional Development of Prison and Probation Staff* in April 2019.

87. The Irish Prison Service has comparatively one of the more favourable staffing to prisoner ratios among Council of Europe member States. According to the SPACE statistics for 2018, there were 2,547.8 FTE prison officers which is roughly a ratio of 1.5 inmates per custody officer. In addition, there were 342 work training officers (WTOs) responsible for supervising workshops and vocational training but who were also deployed, at times, to cover other prison officer duties.

In spite of this seemingly positive staffing complement, prisons in Ireland often find that they are unable to operate with a full complement of prison officers which results in certain activities having to be cancelled or access to health care and other services being delayed or prisoners spending longer periods locked up in their cells. This problem is notably acute at the end of each quarter of the year as the agreement for an annualised hours system (negotiated between the Prison Officers' Association (POA) and the IPS) only allows for a certain amount of overtime pay for officers.

The underlying reason for the staff shortages lies in the massive increase in staff resources required for escort purposes. For example, at Cork Prison, 11,000 escorts were budgeted for the year but 36,000 were required so the management must draw on prison officers carrying out other duties in the prison to run escorts. At Midlands Prison, a similar picture was painted with escorts rising by 220% in the past five years. In addition, there is a daily absence rate of staff throughout the prison system which impacts the running of the prisons. For example, at Midlands Prison, there is on average an absenteeism rate of 15-25 staff for a daily complement of 156 work training and prison officers; on the day of the visit, staffing numbers were 45 below the scheduled complement.

The IPS has attempted to mitigate the impact of reduced staffing levels by requiring each prison to draw up a Regime Management Plan which clearly identifies the priority services within a prison that should be kept open when staff numbers fall below their scheduled levels. This is a necessary tool to manage such scenarios. Further, initiatives have been agreed with the POA to enable certain activities such as the supervision of outdoor exercise yards to be carried out with fewer staff. However, it is evident that additional measures are required to ensure that prisons operate full regimes with activities and services not being hampered by staff shortages.

The CPT would like to be informed about the measures being taken to address the increasing burden of escorts on prison-based staff and to tackle absenteeism rates among prison staff.

b. discipline

88. In its previous visit reports, the CPT has expressed its major reservations over the effect in practice of the sanction of “loss of all privileges” for a period of up to 60 days based on Article 13.1(d) of the Prisons Act 2007.³⁴ At the time of the 2014 visit, prisoners were still, in practice, being sentenced to periods of up to 56 days of “loss of all privileges” which often also entailed a transfer to another prison such as A Block in Portlaoise Prison or D Block in Cork Prison or the CBU in Mountjoy where the prisoners were kept in conditions akin to solitary confinement. This was in spite of the April 2014 Guidelines on the Imposition of Disciplinary Sanctions which had introduced an upper limit of 40 days of “loss of all privileges” in conditions which would not result in 23-hour lock-up.

The CPT is pleased to note that the findings of the 2019 visit demonstrate that the above Guidelines were being applied in all the prisons visited. An examination of the relevant documentation showed that in the majority of disciplinary cases, the sanction imposed according to Article 13.1(d) of the Prisons Act 2007 was one or more of the following: prohibition of evening recreation, use of gym, using money/credit for periods ranging from 7 to 40 days. The Committee welcomes the fact that prisoners subject to a disciplinary punishment are now always guaranteed a minimum of one phone call and one family visit a week.

Further, the procedure itself in those cases examined appeared to be fair. The CPT’s delegation was informed that the IPS was drawing up revised guidelines on the imposition of disciplinary sanctions and **the Committee would like to be provided with a copy once they have been adopted.**

89. As regards the conditions in which prisoners who had received a sanction of loss of all privileges were kept, the vast majority served their disciplinary punishment in their own cell and would only be placed on a special unit (CBU in Cork and Mountjoy Prisons, D1 Wing in Cloverhill Prison and C1 left in Midlands Prison) if they were also placed on Rule 62.

c. inspection procedures

90. Following the death of the former Inspector of Prisons for Ireland, Judge Michael Reilly, in November 2016, it was decided to fill the position of Inspector through an open competition for the first time. The current Inspector of Prisons took up her office in May 2018 for a five-year term. At the time of the 2019 visit, the resources allocated to the Office of the Inspector were insufficient (three persons) to enable her to carry out any proper inspections of prisons, especially as her Office was responsible for carrying out an investigation into each death in custody³⁵ and of having some oversight of the complaints system as well as having to undertake, at the behest of the Minister of Justice, an investigation into alleged surveillance by the IPS on its own staff between 2009 to 2013.

³⁴ See most recently CPT/Inf (2015) 38, paragraphs 67 to 71.

³⁵ 16 in 2018 and 16 in 2019 (up to 2 September).

In July 2018, the Inspector of Prisons commissioned a review of her Office which was submitted to the Minister for Justice and Equality in December 2018, essentially stating that her Office was not fit for purpose and that, above all, it required sufficient resources in order to carry out the mandate of inspecting prisons. It is positive that the 2020 budgetary allocation for the Office has been increased from 0.5 to 1.2 million euros. **The CPT trusts that the Inspector of Prisons is now sufficiently resourced to enable her to start carrying out prison inspections.**

C. Psychiatric institutions

1. Preliminary remarks

91. In the course of the 2019 visit to Ireland, the CPT's delegation carried out visits to three psychiatric facilities, all of which are "approved centres" for the purposes of the Mental Health Act 2001; i.e. they are authorised to accommodate patients involuntarily placed under the provisions of that Act and are subject to regular inspections at a national level by the Mental Health Commission (MHC).

92. The Department of Psychiatry of St Luke's General Hospital in the city of Kilkenny provides adult mental health care and consists of two wards: Sycamore (sub-acute) and Oak (acute). Sycamore Ward has 25 beds and Oak Ward 19. At the time of the visit, the department was operating at around full capacity with a total of 44 patients, six of whom had been detained under the Mental Health Act 2001. One patient had an intellectual disability. The average length of stay was around 20 days.³⁶

Sliabh Mis Mental Health Admission Unit is situated in the University Hospital Kerry, Tralee. It provides acute adult mental health care and has two wards: Reask (acute) and Valentia (sub-acute) as well as a high-observation unit, Brandon. In total there are 34 registered beds; 15 in Reask, 15 in Valentia and 4 in Brandon. At the time of the visit, there were 35 patients, six of whom were on leave. One patient was a child of 17 years old and had been in the unit for just over 6 months. Six patients had been detained under the Mental Health Act 2001. The average length of stay was 25 days.

St Aloysius Ward, opened in 1994, is part of the Mater Misericordiae University Hospital, Dublin and can accommodate up to 15 patients. At the time of the visit, there were 11 patients on the ward, including one patient who also suffered from a physical disability. One patient was detained under the provisions of the Mental Health Act 2001. The most common length of stay was between three and six weeks.

93. The CPT's visit to Ireland took place at a time when the legislative framework governing mental health care was undergoing a major overhaul, with many amendments to the previous, outdated, legislation either already enacted, but not yet in force, or existing in draft form and due to be enacted in the near future.

The Assisted Decision-making (Capacity) Act 2015 (ADMCA) which supports decision-making by adults and enables them to retain as much autonomy as possible, even when they lack capacity, will have the most impact when implemented. Part 6 of the Act provides for a review of the situation of all persons who were made Wards of Court under the antiquated Lunacy Regulation (Ireland) Act of 1871 which remains in force until the relevant provisions of the ADMCA become law (see the section on safeguards below).

³⁶ The CPT welcomed the fact that the hospitals visited maintained comprehensive statistics on the lengths of stay of patients enabling the delegation to have figures for the average, mean and median periods. For example, at St Luke's the median length of stay was 11 days.

94. The CPT's delegation received hardly any allegations of ill-treatment of patients by staff in the establishments visited. On the contrary, patients mainly spoke highly of staff and the delegation observed their commitment to provide care and treatment to patients, often in difficult circumstances. That said, the delegation received a few allegations of rough handling of patients by one or two members of staff and there was one allegation of inappropriate use of force having taken place in the Department of Psychiatry at St Luke's Hospital, Kilkenny, when a female patient's trousers had been ripped off by a male nurse during restraint. Such behaviour is completely inappropriate.

The CPT recommends that the management of the Department of Psychiatry at St Luke's Hospital reiterate to staff that no more force than is strictly necessary and proportionate should be used to bring an agitated patient under control. Due regard should be had to gender-specific concerns. Where staff act inappropriately, management must act to sanction them accordingly.

2. Patients' living conditions

95. Regarding living conditions, all three psychiatric units visited were clean and generally in a good state of repair, with the wards at Sliabh Mis and St Luke's having been recently renovated.³⁷ However, patients' rooms in all the units were impersonal and equipped with minimal furniture reflecting a clinical environment, rather than a therapeutic setting. Further, the four- and six-bedded rooms of the establishments visited were cramped, stuffy and, at times, noisy, providing hardly any personal space or privacy. Curtains could be drawn between the beds, but this just accentuated the impression of a hospital-type environment. Patients were disturbed by other patients walking around at night, or even climbing on their beds asking for cigarettes. **The CPT recommends that the four- and six- bedded rooms be divided into smaller units and that steps be taken to personalise the rooms.**

96. At St Aloysius, the CPT noted that a patient with a physical disability had been living on the ward for 16 months and yet accommodation on the ward was not adapted for wheelchair users. The ensuite bathroom in the patient's room was not wheelchair-accessible and there was no disabled toilet which meant that the patient had to ask a staff member each time she wanted to go to the toilet and had to be assisted to have a shower. She no longer needed to be on the ward for clinical reasons and was on a waiting list for accommodation in a step-down unit. **The CPT recommends that action be taken to make the ward wheelchair friendly.**

97. Generally, the food served at all establishments visited was very good, although the evening meal at Sliabh Mis was served from 4.30-5 p.m., which meant that patients were at risk of being hungry at night as no substantial snack was served after that time. **Consideration should be given to adjusting the evening mealtime or serving a snack later in the evening.**

³⁷ At all three establishments there was a focus on eliminating ligature points in the accommodation areas.

98. All the units visited possessed yards and gardens for relaxing in the fresh air. Patients were also able to smoke in these areas. Small shelters were provided for use in inclement weather. However, patients did not always have effective access to the garden at all times of the day. Some patients, including voluntary ones, had to ask for the door to the garden to be opened. Several of the patients interviewed in Sliabh Mis also stated that they were not aware of the times when the door to the garden was open or did not know whether they could go out into the garden at all.

The CPT recommends that steps be taken to put in place a clear policy for promoting and facilitating the possibility of patients to access the outdoors every day at all three establishments visited.

3. Treatment

99. The Mental Health Act 2001 (Approved Centres) Regulations 2006 stipulate that each patient should have their own individual care plan. In each of the establishments visited the CPT's delegation noted that a patient-centred approach was taken in the development of such plans, including the active participation of patients. This care plan was furthermore regularly reviewed by the multidisciplinary care team³⁸ allocated to each patient. In addition, patients were assigned a "key worker" (individual nurse).

In all three establishments visited, treatment consisted of pharmacotherapy, psychological interventions, occupational therapy and other therapeutic activities.

100. Various activities were provided at Sliabh Mis, with occupational therapy being provided four days a week; a gym area to which patients had free access without having to be accompanied by a member of staff; an activity room with art and music equipment; television; a training kitchen which could be used by patients under supervision and a pool table. Bingo was also organised. However, several patients complained that there were not enough activities.

The CPT recommends that a review of the activities on offer at Sliabh Mis be carried out, in consultation with the patients, to ensure that activities more suited to patients' needs are made available.

101. At the Department of Psychiatry at St Luke's, in addition to occupational therapy, the range of therapeutic activities consisted of recovery groups, discharge planning, relaxation, art therapy, a closed breakfast group and walking groups. These were mentioned in the information booklet provided to patients upon admission, discussed with the patient's key worker and the chosen programme of activities was noted on their care plan. In addition, yoga classes were offered at weekends, a musician came in once a fortnight and canine therapy was on offer for one hour a week. There was no gym, but fitness classes took place several times a week and sports days were organised. However, while patients on the sub-acute ward (Sycamore) were generally engaging in the various activities on offer, patients on Oak appeared to spend their time lying on their beds or wandering aimlessly along the corridors. Some patients on this ward told the delegation that they were not aware of the activities on offer. One patient was not even aware that there was a television.

³⁸ This consists of a consultant psychiatrist, hospital doctor(s), nursing staff, a social worker, occupational therapist and psychologist(s).

The outdoor areas of the two wards also differed considerably. Patients on Oak had access to a central courtyard, mainly paved, with a covered smoking area, littered with cigarette ends as bins provided for these were overflowing. Patients on Sycamore had access to a large, green garden with a gazebo, rose bushes, benches, statues, plants and hedges. This garden also had a shelter for smokers, who were supervised while they smoked. Neither garden, however, possessed a shelter for non-smokers to enjoy fresh air during inclement weather.

The CPT recommends that daily meaningful activities be made readily available for patients on both wards alike and that patients on Oak be made fully aware of the activities on offer. In addition, the courtyard for patients on Oak should be made more attractive and the bins provided for cigarette butts should be regularly emptied. Non-smoking patients from both wards should also be provided with a shelter where they can enjoy smoke-free fresh air during inclement weather.

102. There were various activities on offer at St Aloysius Ward with a large activity room containing arts and crafts equipment, musical instruments, games, DVDs (patients could make requests for films, etc.), self-help books and a kitchenette with coffee and tea-making facilities. In addition, there was a small library containing a good selection of books where patients could sit and read. Group therapy sessions were held in the activity room. There was also a common room with a television, an exercise room (small gym) and a relaxation room was being developed.

There was a large enclosed garden at the rear of the building and patients participated in (and led) gardening groups and could study horticulture under a University of Dublin programme.

103. Files showed that patients receiving high doses of olanzapine over a long period of time at the establishments visited did not always have their blood sugar levels regularly tested and yet, prolonged use of a high dose of this drug can cause high levels of glucose and obesity. **The CPT recommends that all patients taking olanzapine be properly monitored, including as regards their blood sugar levels.**

104. Recourse was had to PRN medication (“*pro re nata*” medication prescribed to be taken “when required”) in all three psychiatric units visited. However, there did not appear to be any Mental Health Commission guidelines on the use of this type of prescription³⁹ nor did any of the establishments visited have any written policies concerning the administration of PRN.

The delegation learned that haloperidol and other sedative drugs were prescribed as PRN medication almost routinely upon admission at Sliabh Mis. The concern is that the use of PRN medication may entail overmedication with drugs that can have serious side effects. Several patients interviewed at Sliabh Mis, who were on regular as well as PRN medication, said they were constantly tired and slept a lot. They effectively appeared to be drowsy and the speech of a few of the patients was slurred during interviews. In addition, there did not appear to be a specific review of the PRN medication administered to patients. At the Department of Psychiatry at St Luke’s Hospital, some medication noted as PRN was distributed on a daily basis. This should call for a review of the medication.

³⁹ The Health Information and Quality Authority (HIQA) does however provide guidelines for the use of PRN in social care establishments.

In the CPT's opinion, PRN medication may be appropriate in the case of patients with an occasional need for medication in specific situations, where PRN prescriptions can offer a rational, safe and efficient tool. In such cases, the medical doctor responsible for the treatment of the patient can discuss the future need for such medication with the patient in a non-acute situation, when there will be an opportunity to identify a safe and efficient use of medication and tailor it as appropriate to patients' needs. Such a review would eliminate the continued prescriptions of PRN for lengthy periods as observed by the delegation. The patient's doctor would also have an opportunity to evaluate the patient's response to medication, which may be unique.

PRN medication could also, in certain instances, amount to involuntary treatment; indeed, at St Aloysius Ward, PRN medication was sometimes administered when the patient refused treatment. **Where this is the case, the procedure for involuntary treatment, including safeguards, should apply.**

The CPT recommends that the Irish authorities review the use of PRN at all psychiatric institutions in the light of the above comments, particularly as regards potential overmedication or chemical restraint, and thereafter draw up guidelines on the use of PRN medication. These guidelines should specify that PRN medication should always be prescribed by a fully qualified psychiatrist, preferably the patient's treating psychiatrist, with the consent of the patient, the prescription must clearly state the maximum dose for single use, intervals for use over a period of 24 hours, the route of application and the need to observe the patients' reactions. Long-acting psychotropic drugs (depot and acutard formulations) should not be used as PRN medication. In addition, every use of PRN medication should be documented, it should be administered by a fully qualified registered nurse on duty and should be regularly reviewed.

105. As regards electro-convulsive therapy (ECT), this is regulated by Section 59 of the MHA, as amended. The Mental Health (Amendment) Act 2015, which came into effect at the beginning of 2016, removed the words "or unwilling" from this section, meaning that ECT must not be administered to a person able to give consent against their will. The CPT welcomes this change in legislation which addresses the recommendation made in its report on the 2010 visit to Ireland.⁴⁰ Where the patient is unable to give consent, the programme of therapy must be approved by two consultant psychiatrists. The administration of electro-convulsive therapy is surrounded by an appropriate range of safeguards as provided by both Rules and a Code of Practice established by the MHC, which are fully in line with CPT standards on the matter.⁴¹

The only unit visited that carried out the treatment on site and had a dedicated ECT suite was the Department of Psychiatry at St Luke's. The suite comprised a treatment, clinical and recovery room and was appropriately equipped. The department had its own written electro-convulsive therapy policy in accordance with the MHC Rules. Use of ECT was relatively rare, with four patients undergoing the treatment voluntarily between April and October 2019. All instances of ECT were recorded in a dedicated register.

⁴⁰ See paragraph 125 of document [CPT/Inf \(2011\) 3](#).

⁴¹ i.e., the patient is appropriately informed; a cognitive assessment must be carried out prior to the procedure; the procedure is carried out under anaesthesia and with the use of a muscle relaxant (Dantrolene); ECT must be administered by a registered medical practitioner; there should be at least two registered nurses in the ECT suite at all times; the procedure should be documented; protocols relating to the storage of Dantrolene, management of cardiac arrest, anaphylaxis, malignant hypothermia and the patient's consent to the initiation and continuation of the procedure should be developed.

4. Staff

106. Part 5 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 covers staffing and stipulates that a centre must have written policies and procedures relating to the recruitment, selection and vetting of staff and that there must be sufficient numbers of staff with an appropriate mix of skills to meet the needs of patients. There must be an appropriately qualified member of staff on duty at all times. Staff should also receive sufficient and up-to-date training.

It is positive that almost all staff working on the wards of the units visited were qualified psychiatric nurses. In addition, staff appeared to be well supported by the management with procedures in place for counselling after incidents in which they had been adversely affected.

107. At Sliabh Mis the staff complement was very good, with a 24-hour presence of psychiatrists working in three shifts during the week (9 a.m. to 1 p.m., 1 to 5 p.m. and 5 p.m. to 9 a.m.) and one or two consultant psychiatrists on call per day. A psychiatrist was also present on the wards at weekends (one on Saturday, one on Sunday) with a consultant psychiatrist on call both days. In addition, there was a consultant psychiatrist specialised in the psychiatry of later life and one working in the rehabilitation team.

As regards nurses, there was an average ratio of one nurse to six or seven patients. On the high observation ward (Brandon), even when operating at full capacity, the ratio was three nurses to four patients. In Reask and Valentia wards, four nurses were on duty during the day and two at night, together with a 0.5 FTE night supervisor, which for wards of 15 patients each could be considered sufficient. In addition, student nurses were integrated into the staff complement from January to September each year.

108. At the Department of Psychiatry at St Luke's, there was a total of 13 consultant psychiatrists who were shared with other regions in the catchment area (Carlow, Kilkenny, South Tipperary, Waterford and Wexford). In addition, a principal psychologist was shared with the facilities in Carlow. Other staff included a social worker, two occupational therapists and a fitness instructor who came in three times a week. In addition, a non-consultant hospital doctor (NCHD) was always on site.

Regarding nurses, at the time of the visit there were 25 vacant posts, a situation which was further exacerbated by sick leave absences. During the day, there was a clinical nurse manager (CNM) on each ward as well as five registered nurses on Oak for 19 patients and four on Sycamore for 25 patients. At night, there was a CNM (shared between both wards), four staff nurses on Oak and two staff nurses on Sycamore.

At St Aloysius Ward, there were 4 consultant psychiatrists and 17 nurses. In addition, there was one part-time social worker, one part-time psychologist, one full-time occupational therapist, one full-time assistant occupational therapist, one part-time social worker and one part-time psychologist. During the day there were 4 nurses on duty (13-hour shifts), with the assistant director of nurses present from Monday to Friday. At night there were three nurses on duty for a 12-hour shift. Agency staff were used to replace absent staff members, but once again the procedure for recruiting replacements was not an easy one. There was the same minimal staff presence as that observed in the Department of Psychiatry, St Luke's.

109. The CPT's delegation was informed that there were extremely bureaucratic procedures for recruiting staff at short notice which often meant that no replacement staff were hired. The minimal staffing situation had an impact on patients. For example, they were not accompanied out of the wards (even just into the garden) as often as they would have liked and did not benefit from longer term one-on-one accompaniment as much as would be necessary. With fewer staff on the wards, older patients were more at risk of falling. In addition, due to the low numbers of staff on duty, there was hardly any time to talk to patients, which is as an important part of therapy as clinical care. Furthermore, the resort to agency staff meant that continuity of care was affected. Staff shortages also led to security staff being called upon to assist in restraining patients (see paragraph 111 below).

The CPT recommends that the procedures for seeking short-term replacement staff be streamlined in order to ensure that all psychiatric establishments are always fully staffed.

5. Restraint

110. The use of means of restraint in psychiatric establishments is highly regulated in Ireland. Seclusion and mechanical bodily restraint are governed by Section 69 of the Mental Health Act 2001 which lays down that a patient shall not be placed in seclusion or be mechanically restrained unless this is necessary for the purposes of treatment or to prevent harm to the patient themselves or to others. The use of seclusion or mechanical restraint must comply with the rules laid down by the MHC. Physical restraint is regulated by a specific MHC Code of Practice. The rules and Code of Practice largely comply with the CPT's standards.⁴² The one exception concerns where a registered nurse has initiated the measure of seclusion or mechanical restraint - the medical review of the patient might be as long as four hours after the commencement of the measure, which in the CPT's view is too long. When such a measure is initiated, **a medical doctor should be informed immediately and a review should be carried out as soon as possible.**

In the three psychiatric facilities visited, recourse was only had to physical restraint (manual holds) and seclusion and in general, the emphasis was on prevention and de-escalation. For example, the Dynamic Appraisal of Situational Aggression (DASA) tool to assess the likely aggressiveness of a patient was used at Sliabh Mis.

111. As regards physical restraint, a different manual technique was used in each of the establishments visited. In Sliabh Mis admission ward, the programme endorsed by the Health Service Executive (HSE), "Professional Management of Aggression and Violence (PMAV)", was used.⁴³ Records showed that there had been a notable decrease in the use of physical restraint since 2018 with 31 instances of physical restraint between April and July 2019, as opposed to 60 instances during the same period in 2018. This is positive and the CPT trusts that this encouraging trend will be continued.

⁴² See [Means of restraint in psychiatric establishments for adults \(Revised CPT standards\)](#), published in March 2017.

⁴³ This technique consists of three different levels of hold with the prohibition of neck holds, the application of heavy weight on patients' abdomen, chest or back and holds that inflict pain.

At St Aloysius, the Therapeutic Management of Violence and Aggression (TMVA) technique was used. There did not appear to be an excessive recourse to physical restraint on the ward, with eight instances recorded over the previous three months. However, hospital security guards (trained in the use of the Management of Actual or Potential Aggression (MAPA) technique and restraint procedures) were often involved in restraining patients for the purposes of removing them to the seclusion room. In the CPT's view, such interventions are inappropriate and frightening for the patient concerned as well as for other patients observing them. The presence of security guards and the use of force by them could well result in a patient being traumatised. Psychiatric establishments should have a sufficient number of properly trained staff to manage agitated patients with psychiatric disorders.

The CPT recommends that the Irish authorities end the practice of involving hospital security guards in managing agitated patients in psychiatric establishments. Further, all nursing staff in psychiatric establishments should be trained in the appropriate ways of managing agitated patients and they should be offered refresher courses at regular intervals.

112. At the Department of Psychiatry, St Luke's, the restraint technique in which staff were trained was the "Management of Violence and Aggression", which placed the emphasis on alternatives to physical restraint and seclusion and least restrictive practice. There were 51 episodes of physical restraint at the centre recorded from January to the end of August 2019.

113. Generally, no excessive recourse to seclusion in terms of the number of episodes was noted in any of the three units visited.⁴⁴ However, some patients were secluded for long periods, for example, 86 consecutive hours at Sliabh Mis, and over 573 almost consecutive hours in the case of one patient at St Luke's, with another patient being secluded for 108 consecutive hours. In all cases where episodes of seclusion lasted for more than 72 hours (or 7 orders in 7 days), these were notified to the Mental Health Commission, according to normal practice. However, the CPT has serious doubts as to whether the seclusion of patients for such lengthy periods is justifiable.

In addition, the justification of the use of seclusion was questionable at times and not always in accordance with the Mental Health Commission's rules. For example, a patient at the Department of Psychiatry, St Luke's, who had been displaying exhibitionist behaviour, had been placed in the seclusion room to protect her dignity. However, the area in front of the seclusion room was at times accessible to other patients and the mobile screen placed in front of the window to the room was not effective in ensuring that she could not be seen by other patients.

Further, the patient was not constantly monitored by a nurse in accordance with the MHC rules. The CPT does not consider that CCTV is a substitute for personal direct monitoring. The delegation also noted that the door to the adjoining bathroom facilities in the seclusion room was locked and that the patient had to ask to use the toilet by calling out. Several patients also complained that the seclusion room was freezing cold and that the one blanket provided was not sufficient.

⁴⁴ For example, at Sliabh Mis there had been 5 instances recorded between 26 July and 24 September 2019 and at the Department of Psychiatry at St Luke's, 12 instances during the period from June to the end of August.

In the CPT's view, every patient held in seclusion should be under continuous direct personal supervision from the very outset of the measure (so that the patient can fully see the staff member and the latter can continuously observe and communicate with the patient at all times). **The CPT recommends that the necessary steps be taken to ensure that these precepts are implemented in practice**

In addition, patients should be secluded for the shortest possible time, have ready access to sanitary facilities without having to ask to use them and it should be ensured that the room itself is kept at a moderate temperature, with the provision of sufficient blankets.

114. At Sliabh Mis, the delegation learned that the 17-year-old accommodated on the ward had been placed in seclusion twice in August 2019 and once since her readmission to the unit in September, despite her status as a voluntary patient. The Committee is of the view that children should in principle never be subjected to means of restraint on account of their vulnerability. In extreme cases where it is deemed necessary to intervene physically to avoid harm to self or others, the only acceptable intervention is the use of manual restraint, that is, staff holding the child until he/she calms down. **The CPT recommends that such an approach be systematically applied to any child in a psychiatric hospital.**

115. More generally, less intrusive alternatives to seclusion should be available. A relaxation room had been set aside in St Aloysius Ward several months prior to the visit, but it had yet to be refurbished. At the Department of Psychiatry, St Luke's Hospital, a de-escalation room was planned for some point in the future.

The CPT also welcomes the existence of a seclusion reduction group at the Department of Psychiatry at St Luke's, along with the awareness that physical activity helps relieve frustration and may thus reduce the need to resort to this measure of restraint. An already very popular punch bag was available in this unit and there were plans to set up another one in the garden.

The CPT would like to be informed whether the de-escalation/relaxation rooms referred to above are now operational.

116. The practice of placing some patients in pyjamas day and night was particularly prevalent at Sliabh Mis, where patients at risk of absconding were prescribed the wearing of pyjamas to prevent them from leaving the unit. All instances of enforced pyjama-wearing were recorded in a night attire log. Apart from the risk of absconding, reasons for the wearing of night attire included risk of self-harm, for purposes of assessment, first admission, or placement in the high observation unit. As an example, 37 patients were subjected to this pyjama regime from 2 to 27 September 2019. While some of these patients were only in the pyjamas for a few days, others remained in them for weeks. Furthermore, many of these patients were voluntary. One voluntary patient complained that the pyjama policy made her feel "crappy" and thought that wearing normal clothes would help her to obtain a normal routine. Placing patients in pyjamas does not necessarily reduce the risk of self-harm. Where the risk of harm is suicide-related, increased supervision and more appropriate, refractive, clothing should be used.

Patients were also prescribed pyjamas at the Department of Psychiatry at St Luke's, for risk-related reasons. Furthermore, some patients were seen to be in pyjamas on St Aloysius Ward.

The CPT has always considered the practice of continuously dressing patients in pyjamas not to be conducive to strengthening personal identity and self-esteem and that individualisation of clothing should form part of the therapeutic process. In addition, regarding those patients placed in pyjamas upon admission, the CPT has already expressed the view that the systematic use of pyjamas as a means of surveillance of newly arrived patients is highly questionable and it has recommended that other supervision methods for newly arrived patients should be applied without restricting their freedom of movement.⁴⁵ The additional restrictive element of the use of night attire to prevent absconding is all the more problematic as it concerns voluntary patients, who should be free to leave the psychiatric unit whenever they like. Even where the wearing of pyjamas was not forced on patients, those concerned had no alternative clothing provided, as their own clothes had been taken from them and clothing provided by the Health Service Executive was in the form of pyjamas. The practice was also unnecessary where involuntary patients were concerned since those patients most at risk were not allowed to leave the wards (or even go into the garden) unaccompanied. The practice of forcing patients to wear pyjamas should therefore be abolished.

The CPT recommends that the Irish authorities ensure that the above pyjama policy in psychiatric facilities in Ireland be reviewed. Patients should be able to wear their own clothes as much as possible during their stay. Even patients who prefer to wear pyjamas should be encouraged to change into other clothes during the day in order to preserve a sense of normal routine which contributes to a therapeutic environment.

6. Safeguards

a. placement and review

117. The procedure for involuntary placement of adults in a psychiatric establishment is laid down in the Mental Health Act 2001 and remains the same as described in the report on the 2010 visit to Ireland.⁴⁶ The initial admission order is valid for 21 days. Before the end of that period, a Mental Health Tribunal shall review the patient's admission. The MHC will arrange for legal representation for the patient and appoints a psychiatrist. The admission order may be extended by a renewal order for a maximum period of three months. Further renewal orders may be issued for periods, each of which does not exceed six months. The CPT welcomes the reduction from 12 to 6 months for the third and subsequent renewal orders as introduced by the Mental Health (Renewal Orders) Act 2018.⁴⁷

118. The Mental Health Act 2001 also lays down a separate procedure for the involuntary placement of voluntary patients who are already accommodated in a psychiatric institution. Under Section 23 of the Act, where a voluntary patient wishes to leave and a consultant psychiatrist, registered medical practitioner or nurse is of the opinion that the person is suffering from a mental disorder,⁴⁸ the person may be detained for a period not exceeding 24 hours during which time the patient will be examined by a second consultant psychiatrist. If the second psychiatrist considers that the patient is suffering from a mental disorder, an admission order for the reception, detention and treatment of the person in the approved centre shall be made by the patient's own consultant psychiatrist (Section 24 of the Act).

⁴⁵ See for example [CPT/Inf\(2013\)4](#), paragraph 112.

⁴⁶ See [CPT/Inf \(2011\) 3](#), paras 136 and 137.

⁴⁷ This Act also provides that a patient may apply to the Mental Health Tribunal for a review of the renewal order three months after the date the renewal order was made.

⁴⁸ The definition of a mental disorder for the purposes of the Act is set out in Section 3 and includes where there is a serious likelihood of the person concerned causing immediate and serious harm to themselves or to others.

119. Regarding transfers of involuntary patients to psychiatric establishments, in the CPT's view, persons with mental health-care needs should, in principle, always be transported by health-care staff.⁴⁹ The CPT is therefore pleased to note the existence of the Allied Admissions Service in Ireland which provides specialised mental health patient transport on behalf of the Health Service Executive to transfer a person to an approved centre (when an applicant does not wish to or is incapable of doing so), or return a person to an approved centre if they abscond. The Committee commends the authorities for providing such a service, which aims to ensure that patients are treated in a professional and sensitive manner with due regard for their dignity and privacy.

However, the Garda are given special powers under the 2001 Act to detain persons who pose a risk to themselves or others and may apply to a registered medical practitioner for a recommendation and take the patient to the approved centre themselves. Several of the persons interviewed by the delegation complained that they had been too tightly handcuffed during transfer to the establishment and in one patient's file, there was a note that his wrists had been injured by the handcuffs. Furthermore, staff commented that they saw bruises caused by handcuffs on some persons upon arrival.

The CPT encourages wider use of the Allied Admissions Service (for example including when persons are transferred from Garda stations to approved centres). Where the involvement of members of the Garda is unavoidable, these should receive sufficient training in how to deal with persons with mental disorders and no more force than is necessary should be used when transferring them to approved centres. Furthermore, handcuffs should in no circumstances be excessively tight. **The CPT would appreciate the comments of the Irish authorities on this matter.**

120. Despite the existence of CAMHS (Child and Adolescent Mental Health Services), children are often admitted to adult psychiatric units as there are only six inpatient CAMHS units for the whole of Ireland: four in Dublin, one in Cork and one in Galway. At Sliabh Mis, an adolescent was being accommodated with the adults on the sub-acute ward. She had been in the unit for six months at the time of the visit and it was not the first time she had been admitted to this ward. **The CPT reiterates that, in view of their vulnerability and special needs, children requiring psychiatric care should be accommodated separately from adult patients. It recommends that the Irish authorities take the necessary measures to ensure this is the case in practice.**

b. safeguards during placement

121. The full entry into force of the ADMCA should resolve the problem observed by the CPT's delegation as regards "voluntary" patients in Ireland. Currently, many so-called voluntary patients do not have the capacity to give valid consent to their admission, stay and treatment in psychiatric establishments. Further, due to the stigma attached to being involuntarily placed in a psychiatric unit in Ireland, patients are generally encouraged to admit themselves voluntarily. Faced with the alternative of what they fear will consist of rougher treatment and a longer period of detention, they often prefer to be admitted as a voluntary patient.

⁴⁹ See [CPT/Inf \(2019\) 4](#), paragraph 56.

Voluntary patients are not afforded the same legal safeguards as involuntary ones, with no regular review of their legal status. And yet, the delegation observed that they are often *de facto* deprived of their liberty, being kept in a closed environment with restrictions on their movements; having to ask to leave the ward or to go into the garden. Furthermore, some voluntary patients are subject to measures of restraint, including seclusion, prevented from leaving the unit altogether and if they do leave without permission, they are forcibly brought back to the unit.

122. The CPT welcomes the passing of the Mental Health (Amendment) Act 2018 (not yet in force), which amends the definition of a “voluntary patient” to mean a person who has capacity (within the meaning of the ADMCA), has been admitted to an approved centre, and who has given consent to their admission, as opposed to the current definition of a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order. By letter of 27 January 2020, the Irish authorities confirmed that the new definition, together with the deprivation of liberty safeguards which will be incorporated into the ADMCA,⁵⁰ will address the currently problematic situation of voluntary patients. In welcoming this response, **the CPT recommends that the Irish authorities ensure that the above-mentioned new legislation, as well as the outstanding provisions of the ADMCA, is brought into force as soon as possible.**

123. Part 4 of the Mental Health Act 2001 regulates consent to treatment as regards involuntary patients only. The patient’s consultant psychiatrist must be satisfied that they are capable of understanding the nature and likely effects of the treatment and must give the patient information on this, in a form and language the patient can understand. Consent is required for all treatment, unless the consultant psychiatrist considers that it is necessary to safeguard the life of the patient, to alleviate his/her condition or suffering and the patient concerned is unable to give their consent, by reason of their mental disorder.

Patients may however be treated without their consent for an initial period of three months, after which time, the administration of medication may not be continued unless the patient gives their consent in writing or, where the patient is unable to give their consent, authorisation for the continued administration of medication by both the patient’s consultant psychiatrist and a second consultant psychiatrist is given. The administration of medicine shall be continued only for a period of three months, after which further consent or approval must be obtained for additional periods of no longer than three months (Section 60, as amended by the Mental Health (Amendment) Act 2015). The CPT considers that a second opinion should also be required for the initial three-month period and that an involuntary placement order should not automatically enable the administration of treatment without consent. The CPT considers that involuntary placement and involuntary treatment are two separate issues and **it recommends that the involuntary administration of medicine should be subject to a separate decision with the possibility of appeal and an independent second opinion.**

124. Voluntary mental health patients are currently covered by common law rules regarding consent to treatment and have an unqualified right to refuse treatment. However, this is not always clearly understood by patients, nor clearly communicated to them upon admission, as confirmed in interviews with patients during the visit. Furthermore, several patients interviewed by the delegation said that they consented to treatment, even though they did not want it, either because they did not think they could refuse, or because they did not wish to be forcibly medicated.

⁵⁰ Editor’s note: these safeguards will not become part of the ADMCA, but will form separate legislative provisions

The CPT considers that every patient capable of discernment - whether voluntary or involuntary - should be given the opportunity to refuse treatment or any other medical intervention. It welcomes the fact that the Mental Health (Amendment) Act 2018 (see above) will link the Mental Health Act 2001 with the ADMCA in affirming that everyone should be presumed to have capacity to make decisions, with support where necessary. **The CPT trusts that this legislation will enter into force without delay.**

i. complaints

125. Regulation 31 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 lays down that there should be written policies and procedures in place at the centre as regards complaints; that patients should be made aware of the procedure; that there should be a nominated person in each centre to deal with complaints; that all complaints should be investigated promptly; that relevant records should be kept of complaints and that there should be no reprisals.

Where patients are not satisfied with the resolution of their complaint, they may apply to the Ombudsman or Ombudsman for Children.

126. At all three psychiatric establishments visited, written complaints procedures existed, and complaints officers had been designated. However, patients were not made sufficiently aware of the procedures to follow and were not always provided with the tools necessary to make a complaint easily (such as complaints forms, complaints/suggestions boxes, etc.). Furthermore, at the Department of Psychiatry at St Luke's, despite the existence of regular service-user community meetings to discuss suggestions and complaints in addition to the designated complaints officer, the complaints procedure did not appear to function properly with complaints not always being registered or followed up.

An examination of the complaints book at St Aloysius also revealed that complaints were not always properly recorded. In sum, it was not clear when a complaint was made, what the subject of the complaint was, nor how it was dealt with.

127. In the CPT's view, a complaints register is an important management tool; for instance, it may show that many of the complaints relate to the same members of staff or to the same shortcoming, and thus may allow recurrent problems to be addressed in a more systematic manner. It should therefore be meticulously maintained.

Further, the CPT considers an effective internal complaints mechanism to be crucially important as this can help not only to identify and resolve problems as soon as they arise but can also assist the management and frontline staff to prevent abuses. Such a mechanism should be immediately accessible.⁵¹ **The CPT recommends that the complaints mechanisms at all three establishments be reviewed in the light of these remarks.**

⁵¹ See the CPT's standards on complaints mechanisms ([CPT/Inf\(2018\)4-part](#)).

ii. *record-keeping*

128. The delegation noted that the keeping of records in the psychiatric establishments visited was more or less entirely paper-based and involved lengthy procedures whereby nursing staff had to fill in forms by hand, taking valuable time that could be spent caring for patients. The intricate procedure also meant that inevitable mistakes were made in filling in the forms.

The CPT recommends that a review of the record-keeping procedures be carried out with a view to simplifying and modernising them so as to render them more accurate and to enable nursing staff to spend less time on paperwork and more on caring for patients.

c. *other issues*

129. The situation as regards contact with the outside world was generally satisfactory. Patients were allowed visits from family and friends and could use their personal mobile phones in all three units visited, except in the high observation ward at Sliabh Mis.

130. The possibility existed at all three establishments for patients to go on leave, as long as they passed a risk assessment. The patient's status did not seem to affect the decision; some voluntary patients were not permitted to go on leave, whereas some involuntary patients were. Leave could be accompanied (by a member of staff or family), or unaccompanied.

131. Sufficiently detailed brochures/leaflets existed at all three psychiatric establishments visited containing information about the establishments themselves and patients' rights and responsibilities. However, a number of patients claimed that they had not received such information. **The CPT recommends that steps be taken in all psychiatric hospitals in Ireland to ensure that information brochures or sheets are systematically provided to newly admitted patients (and their families) and that patients unable to understand the brochures/information sheets receive appropriate assistance.**

132. Concerning inspections, the Inspector of Mental Health Services, appointed by the MHC, carries out thorough annual inspections of all approved centres. If centres do not meet the Mental Health Act Regulations or MHC Rules or Codes of Practice, they risk closure. The MHC in general also has the power to bring a case before a court in its corporate name. The CPT welcomes the existence of this effective inspection mechanism which has led to the improvement of patients' material conditions and treatment in Ireland.

133. Searches were carried out in accordance with Regulation 13 of the Mental Health Act 2001 (Approved Centres) Regulations 2006. At Sliabh Mis and the Department of Psychiatry at St Luke's, searches (either of persons or property) were not carried out systematically, however, one (voluntary) patient at St Luke's complained that she was strip-searched after every outing with a visitor and this appeared to be a standard practice on the ward. The CPT considers that strip-searches should not be a routine measure, in particular within a hospital setting. Further, **the CPT has serious reservations about strip-searching civil psychiatric patients, even more so where voluntary patients are concerned, and would like to receive the comments of the Irish authorities on this issue.**

The written policy at the Department of Psychiatry at St Luke's stated that the assistance of the Garda Síochána may be sought in carrying out searches. The CPT considers that the involvement of law enforcement officers is highly inappropriate as it may cause unnecessary alarm not only to the person being searched, but to other patients on the ward. **It therefore recommends that this practice be ceased without delay.**

At St Aloysius Ward, body searches were routinely performed upon arrival and there was an environmental search twice a day. If any illegal drugs were found, these were handed over to the Garda, but the CPT is concerned that the name of the patient found in possession of the drugs was given to the Garda. Such a breach of confidentiality is contrary to the establishment of a therapeutic relationship between staff and patients based on trust. **The CPT would like to receive the comments of the Irish authorities on this matter.**

D. Social care homes

1. Preliminary remarks

134. The CPT's delegation visited, for the first time, two social care homes: the Hazelwood Centre in Dublin, operated by St Michael's House and Stewarts Care Residential Services for adults with intellectual disabilities located on the Palmerstown Campus in Dublin. Both establishments were registered as designated centres under the Health Act 2007 and as such were subject to regular inspections by the Health Information and Quality Authority (HIQA), a body which could also refuse registration if the centre concerned did not comply with its standards.

The delegation was pleased to note that the general policy of the Irish government to move away from institutionalised "congregated settings" and provide more personalised care in smaller units and the community was in evidence at both centres visited. At both establishments visited, the level of integration of residents into the community can be considered as an example of good practice. Further, the CPT's delegation was impressed by the person-centred approach and standard of care it observed.

135. The Hazelwood Centre consists of a two-storey, five-bedroomed house in a suburban area of Dublin and has been operating for 18 years. Although this residential service is provided by St Michael's House, a company funded by the HSE, the house runs independently under the management of the "Person in Charge", a clinical nurse manager. At the time of the visit, there were five residents with moderate to severe intellectual disabilities, one of whom was also autistic. The door to the house was kept locked, but residents could leave the house if accompanied.

136. Stewarts Care is a voluntary organisation providing comprehensive community-based and campus-based residential care and support in Dublin and County Kildare to both adults and children with an intellectual disability. It was founded in 1869, originally as a hospital for persons with intellectual disabilities, and its services are funded by the HSE. Palmerstown Campus provides a village-type environment for mainly adult residents, consisting of small living units. At the time of the visit, the campus accommodated 150 residents with moderate to severe intellectual disabilities living in some 30 homes. The campus stopped accepting new residents in 2017, as the aim was to move everyone into community accommodation over the next few years. The delegation also had the opportunity to visit one of Stewarts Care's community houses in a suburban area of Dublin; a two-storey house capable of accommodating four adults. At the time of the visit, four Stewarts Care residents were wards of court and therefore had no legal capacity and had had a guardian assigned to them, while the remainder were considered as voluntary residents. The doors to some houses were locked and in others, residents' movements were subject to close supervision. Not all residents could come and go as they wished.

At the outset, the CPT would like to highlight the impressive number of written policies of a very good quality concerning every aspect of life at Stewarts Care and an exemplary standard of record-keeping.

2. Safeguarding issues

137. No complaints about staff behaviour or allegations of ill-treatment were received at either establishment. On the contrary, residents spoke well of staff and the delegation noted their dedication and the caring way in which they interacted with the residents.

138. An impressive Safeguarding of Vulnerable Adults Policy was in place at Stewarts Care, covering physical, sexual, psychological, financial, institutional and discriminatory abuse as well as neglect. The emphasis was on prevention and early intervention which was achieved through informing residents of their rights and providing them with support to exercise those rights; providing a well-trained workforce and having a zero-tolerance approach to abuse and a person-centred approach to the provision of services.

At Stewarts Care, there had been four incidents affecting residents caused by staff in the three months prior to the visit. These consisted, respectively, of poking, bullying, pulling a resident by their backpack on a bus and mimicking which had led to anxiety among the residents. Follow-up to these incidents ranged from reassurance to a verbal warning issued to the staff member concerned and a complaint being submitted. In addition, human resources were informed, and safeguarding was notified. The incidents were also well documented in accordance with the policy of the establishment which reflected national policy.

The CPT considers that in the case of more serious incidents, such as bullying, it would be important that staff members not only receive a verbal warning, but also receive appropriate training to upgrade their professionalism and understand why their actions were completely inappropriate.

139. There was little to no inter-resident violence at the establishments visited due to the staff's preventive actions and de-escalation. Where violence did occur, there was a safeguarding procedure in which HIQA would be involved. Most rough inter-resident interaction involved pushing, shouting and obstructing another resident's path. Where a resident was repeatedly violent or aggressive, that resident would be moved to a different home. In the three months prior to the visit, there had been 76 peer-to-peer incidents involving 33 residents. None however were severe and there had been no physical injuries inflicted by a resident on a fellow resident in the six months preceding the visit. Some residents were however bothered by screaming and the rough behaviour of other residents.

At the Hazelwood Centre, a resident with autism felt uncomfortable around the other residents and found the noisy environment (constant screaming) upsetting. He had been on the waiting list for individualised care for many months. **The CPT would like to be updated regarding the situation of this resident.**

140. Incidents at the Hazelwood Centre were recorded in the records held at the house and entered into the HIQA incident portal. HSE and the National Safeguarding Team were also notified. As was the case at Stewarts Care, incidents included near misses. In cases of abuse, St Michael's House Policy and Procedures for the Protection of Adults from Abuse and Neglect was followed. This meant that preliminary screenings and full investigations would be carried out when necessary in consultation with both HIQA and HSE.

3. Living conditions

141. The homes visited provided a good level of comfort and quality, and the homely atmosphere observed was conducive to a feeling of normal everyday life. Further, residents had regular contacts with the community, whether in suburban areas, or on the Palmerstown Campus, where the sports centre, swimming pool and restaurant were used by residents and non-residents alike.

142. At the Hazelwood Centre, each resident had their own well-furnished room which was personalised. Two bedrooms for less mobile residents were situated on the ground floor and there was a large, suitably equipped, wheelchair-accessible bathroom. All equipment was regularly assessed and serviced. The living room was bright and airy, furnished with comfortable sofas and provided a pleasant environment in which the residents could relax and watch TV. In addition, there was a large, wheelchair-accessible garden at the rear of the house.

143. Stewarts Care Palmerstown Campus occupied large green leafy grounds on the outskirts of Dublin. It resembled a small village consisting of 30 residential houses, 16 of which were bungalows. There was also a school for children with intellectual disabilities which was attended by non-residents as well. Each of the bungalows and many of the houses were on their own plot and had wheelchair-accessible gardens. From its visit to nine of the homes, the delegation noted that the premises were clean, and each resident had their own adequately sized bedroom which was well furnished and decorated in a personalised manner. There were also comfortable communal spaces in the houses. Some homes had a multi-sensory room. Dwellings housed from one to 10 residents. The homes were suitably equipped for the physically disabled (adapted bathrooms, hoists, etc.).

That said, the bedrooms in bungalow No. 5 were on the small side and there was no activity room and no privacy for phone calls. Some residents in that bungalow, as well as some in other homes, were bothered by screaming from other residents. **Where possible, residents who find it difficult to live in such close proximity to noisy housemates should be moved to more suitable, individualised accommodation.**

144. The two-storey Westhaven community house accommodated three residents at the time of the visit. The house consisted of four bedrooms of adequate size, a suitably equipped bathroom, a kitchen with a dining area, living room and a garden. Carers worked at the house from early evening when residents came home from their activities until 10 am the next morning and slept over at weekends. This house, just as the Hazelwood Centre, was an excellent example of how persons with intellectual disabilities can be integrated into the community.

The food provided to residents was generally very good at both establishments. At the Hazelwood Centre, all meals were prepared on the premises and the delegation was able to witness the preparation of a wholesome meal at the time of its visit.

4. Staff

145. Staff were present at the Hazelwood Centre 24 hours a day, with a total of 10 staff on the roster at the time of the visit. This number was less than it should have been (13), but seemed sufficient for the five residents, with three members of staff on duty during the day⁵² and two at night (including at weekends). The staff roster was reviewed every six months. An additional member of staff was recruited for trips. It was always ensured that there was a good skill mix among staff members.

The “Person in Charge” was a clinical nurse manager. He was always available on call. Otherwise, in addition to the qualified social care workers on the roster, there was one psychologist, one speech therapist and one physiotherapist. The members of staff that the delegation met during the visit were caring and had a calm attitude.

146. Stewarts Care employed just over 1,000 staff members across all their services; some 870 full-time equivalents. However, staffing numbers had been reduced in the few months prior to the visit because of financial difficulties.

At the time of the visit, there were 28 “Persons in Charge”, a principal safeguarding officer, director of nursing, one full-time psychiatrist, a psychologist and 60-70 nurses supported by health-care assistants. There were also occupational therapists, speech and language therapists, social workers (since 2017), physiotherapists, paediatricians and behaviour support staff. There was a GP service 36 hours a week provided by two doctors five days a week. There was, however, no dentist and the dental hygienist was on maternity leave. Residents needing dental care were provided with transport to attend off-campus consultations.

Staff were present 24 hours a day inside the individual houses. In most homes, one nurse was present during the day, accompanied by one to four care staff, depending on the number of residents and their needs. At night, there was at least one health-care assistant present and, where necessary, houses shared the services of a nurse. Management wanted to bolster nursing coverage, especially nurses with specific specialisations, such as dementia.

147. The delegation was informed that when staff members were on sick leave there were lengthy administrative procedures to secure extra funds to employ replacement staff, and that funds were often refused for such purposes. During the August Service User Council Representatives meeting, a zero-growth budget as of July had been noted, which meant that no agency staff could be recruited to cover staff on sick leave and that people leaving jobs would not be replaced unless staff were urgently needed. A temporary solution was to redeploy staff members from homes where they might be needed less; the aim being that there were enough staff to keep people safe in their homes.

The CPT recommends that in addition to simplifying the procedures for recruiting staff to replace those absent, more funding be allocated to enable their replacement.

⁵² On weekdays, one staff member was present from 8 a.m. to 8 p.m., one from 2 p.m. to 8 p.m. and one from 3 p.m. to 9 p.m.; at weekends there were three members of staff on 12-hour shifts.

5. Treatment and care

148. The delegation was generally impressed by the person-centred approach taken at both social care facilities visited. This approach was integrated into the training course for nurses at Dublin's Trinity College School of Nursing and was encouraged by management. Residents were fully involved in the development of their own care plans. Even where they could not communicate verbally, efforts were made to involve them by using signs or pictures to help them indicate their wishes.

149. At the Hazelwood Centre, this was exemplified by the creation of special books called "All about me", containing photos enabling residents to express their wishes and dislikes. The autistic resident had a separate book for each day of the week.

At Stewarts Care, the PATH (Planning Alternative Tomorrow with Hope) method was used to enable even persons with the most severe intellectual and physical disabilities to express their aspirations and own personal choices in matters concerning their everyday lives. PATH is a graphic representation of these, drawn by an artist in consultation with the resident. The basis for a three-year individual plan was a large colourful wall chart consisting of words, symbols and images which is posted on the wall of the resident's bedroom. Even a resident who was paralysed and could only make facial expressions had been able to participate in the drawing up of her PATH graphic (by blinking or expressing her like or dislike at various proposals). This level of resident participation in their own plan is commendable.

In addition to PATH, each resident had a personal support plan developed in consultation with the resident, their family, and key worker. This plan was reviewed once a year by the multidisciplinary team working with the resident. The person-centred approach could also be seen through regular meetings between the resident and their key worker, weekly service user meetings involving the resident's multidisciplinary team and monthly meetings of the Service User Council (SUC) which was represented by residents (elected by the other residents) with key workers and facilitators. Issues identified during the SUC meetings were raised with the relevant Stewarts Care service departments.

150. At the Hazelwood Centre, residents received excellent somatic health care.⁵³ Staff were trained in the safe administration of medicine and, on the whole, although all residents were on benzodiazepine medication and three received neuroleptics as well, they did not appear to be over-medicated. However, one of the residents appeared to be receiving rather high doses of medication, including olanzapine. Reference is made to paragraph 103 above.

151. There was a medical unit on the Stewarts Care campus where the two GPs held their surgeries. Residents went to the surgery for consultation and those having difficulties communicating were referred by their careers. If residents refused to go to the surgery however, a doctor would go and see them at their home. GPs could also be called upon outside working hours. Residents benefitted from an annual medical review.

⁵³ An example of the efforts made to ensure that residents understood procedures relating to their physical health was that a female resident on dialysis was provided with a pictorial presentation of a kidney transplant as part of the process to prepare her for the operation.

Regarding medication, some residents were on several antipsychotics, but the reasons for this were well-documented and the drugs could not be considered to be used as chemical restraint. Furthermore, residents did not appear to be sedated or over-medicated and were closely followed with regular reviews of their individual medication and health-care plans.

Each house had its own nurses' station where the medical records of the residents of that house were kept. These existed in the form of a Kardex (a paper record, replaced daily) and were also entered into a computerised system, Helix, which helped reduce errors. In smaller houses, the nurses' station consisted of a small area set aside in a communal room with a computer. Medicine was kept in a locked cupboard in the kitchen.

152. Medicine was not administered in a covert manner (i.e., hidden in food). In theory, residents with capacity could refuse treatment, even if there would be life-threatening results, but the establishment was under a duty of care and would rely on this in order to treat a person without consent if required. There was a protocol for involuntary medication and a consent policy to ensure that residents were given all appropriate help and support in making decisions and that where a resident lacked capacity to make a particular decision, that decision was made in the best interests of the resident. Indeed, a best interests team existed, which included relevant members of the resident's multi-disciplinary team. This approach however reflects the paternalistic thinking of the Mental Health Act 2001, which is in the process of being reformed to enable persons without capacity to make their own decisions with the relevant support. As regards residents who were wards of court, the court-appointed guardian was contacted for consent to medical tests or treatment.

153. Some PRN medication was used at both establishments visited. At the Hazelwood Centre, Ativan (Lorazepam) and Diazepam were used.

At Stewarts Care, there was a PRN protocol in place in every house. PRN prescriptions were only valid for a fixed period (unlike in the psychiatric establishments the delegation visited). Its use was well documented with reasons given for its prescription. At the time of the visit, out of 148 residents, nine were on PRN medication.

154. Approximately 50% of Stewarts Care residents could not communicate verbally. A Disability Distress Assessment Tool (DisDat) was in place at the establishment to assist staff in identifying symptoms of distress in residents whose communication was severely limited. A document was drawn up for the individual concerned and included a "distress passport". Such a tool gives even the most severely disabled residents a voice, enabling them to express their discontent and therefore obtain some sort of redress. This is to be commended. However, the effects of this policy were limited, as there were many cases of self-harm due to feelings of isolation or fear that could not be communicated in the case of autistic or elderly residents. In 2017, 333 incidents of self-harm in Stewarts Residential Services as a whole were recorded, which rose to 408 in 2018; but the number of incidents appeared to have decreased in 2019 with 118 cases recorded during the first eight months of the year.

Residents who were at risk of suicide at Stewarts Care were referred to special psychiatric services. Any unexplained injuries were referred to the safeguarding officer. All deaths were reported to the coroner who concentrated on unexpected deaths and deaths of those who had not seen a doctor in the recent past. Autopsies were carried out, but there was sometimes a long delay before the establishment received a copy of these reports. From 2017 to the end of August 2019, there had been a total of 14 deaths, only one of which (caused by extensive peritonitis) was scheduled to have a public inquest. **The CPT would like to be informed of the outcome of this inquest.**

Unfortunately, financial issues had recently affected the appropriate placement of some Stewarts Care residents. One had had to wait far too long to be placed on the campus, and others who were perfectly able to live in the community with adequate support were prevented from moving because of financial constraints. Lack of funds also prevented agitated individuals from being removed to individualised services in the community. **The CPT would like to be informed of the steps being taken to address these challenges.**

6. Activities

155. All residents at the Hazelwood Centre attended day services run by the provider, St Michael's House, from 8 or 9 am to 3 pm. One resident benefitted from individual day services. When not attending day service, residents could watch television in the living room, listen to music on their tablets, go into the garden at the back of the house whenever they liked, or go to the local shops. Residents also engaged in neighbourhood activities. Daily plans were posted on the notice board in the kitchen in a pictorial format that was easy for residents to understand.

156. Stewarts Care provided an impressive range of activities for its residents. These activities were made accessible to them at the level most suited to their needs and residents could choose the activities in which they wished to engage through their person-centred plan. Transport was provided to enable residents to attend activities that were held outside their place of accommodation. In addition to the large sports centre which included a swimming pool, residents could engage in massage therapy, yoga, Zumba, musical bingo, art and events, pastoral care activities, exercise and community activities, including day trips and cultural activities. A former athlete was responsible for organising the sports activities. The adapted physical activities included weightlifting, tennis, swimming, gym, walking, tag rugby, aqua aerobics, dance classes, yoga, athletics and boxing.

The sports centre, swimming pool and restaurant on campus were used by people from the outside community as well as the residents. Some of the residents were employed at the restaurant, which also sold products made by residents, and the café in the administrative building of the campus.

Apart from the array of activities available on campus, Stewarts Care residents were also able to take advantage of a holiday home in Kinvara, County Galway where they could engage in further activities, such as golf, boat trips, music sessions with local artists, beach walks, shopping trips and outings to local places of interest and beauty spots.

157. In sum, residents of both establishments visited were provided with a good range of activities and were able to mix with the local community.

7. Restrictive practices

158. The Health Act 2007 regulations concerning older people and children and adults with disabilities⁵⁴ define a restrictive procedure as “...the intentional restriction of a person’s voluntary movement or behaviour” and specify that the use of restraint or a restrictive procedure must be in accordance with national policy and, where persons with disabilities are concerned, with evidence-based practice. A national policy has been developed specifically for nursing homes (for the elderly) which advocates a restraint-free environment in these establishments.⁵⁵ The CPT welcomes such an approach but would like to see the establishment of a similar policy specifically for persons with disabilities. At the moment, the national policy for nursing homes is also used as the reference for establishments for persons with disabilities, whose needs may be different. **The reference to “evidence-based practice” in the Health Act regulations concerning persons with disabilities should be developed in such a policy paper to provide more clarity in the matter.**

159. There were no means of mechanical restraint and no cooling down or observation rooms in either of the establishments visited, nor were residents ever locked in their bedrooms. However, as mentioned above, restrictive practices were in place at both establishments. These usually consisted of locked doors, for the safety of one or more residents, but which impacted on all residents living in the house concerned. The front door of the Hazelwood Centre was kept locked because one resident was at risk of wandering outside, but this measure obviously affected all residents. In general, restrictive measures were reviewed and were subject to approval by the Positive Approaches Monitoring Group of St Michael’s House Services. It had to be shown that less restrictive measures had been tried before applying to this group. Consultation of the files revealed that the authorisation for restrictive measures was formalistic and not based on a clinical assessment of the residents’ changing needs. **The CPT recommends that a more personalised approach be applied for the use of restrictive measures.**

160. At Stewarts Care, there was a written policy on the use of restrictive practices in place, reflecting national policy. Three main types of restrictive practices existed: special clothing/aids to preserve the dignity or safety of the residents such as body suits (one-piece comfortable clothing worn under the residents’ everyday clothes), sleep suits (one-piece pyjamas which zipped up at the back), soft ankle huggers, wrist splints and walking belts; physical restraint in the form of manual holds (see below) and environmental restraints such as locked doors. These restrictive practices were applied purely for the safety of the residents. None of them were used as a punishment.

The method of physical restraint used at Stewarts Care was the Management of Actual or Potential Aggression (MAPA) technique in which all staff received obligatory training.⁵⁶

⁵⁴ Namely, the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

⁵⁵ See [“Towards a Restraint Free Environment in Nursing Homes”](#).

⁵⁶ This consisted of three levels of manual hold: low, medium or full. Full-level holds were applied rarely and were released once the resident had responded positively to the simple question “Are you ok now?”. Residents were debriefed once the hold had been released. In addition to the training on the MAPA technique itself, staff were also trained in non-verbal communication for this purpose.

In general, resort to manual restraint was rare as staff were trained to recognise behaviour that could lead to violent outbursts and prevent the aggressive behaviour by looking at its causes. The emphasis was on de-escalation. There were only three instances of the use of MAPA holds (one medium-level, two low) in cases of inter-resident violence between January and the end of September 2019 and 10 holds in 2018 (some of which were applied in order for medical tests to be carried out). In the case of special clothing or environmental restraints, the practice was reviewed every three months by the restrictive practice committee with a view to ending or minimising its application. When a restrictive practice had to be used, it triggered a re-assessment of the resident's situation in order to reduce the need to use such a practice for a similar occurrence.

A detailed restrictive practices protocol was drawn up for each Stewarts Care resident who had been prescribed one or more restrictive practices, a copy of which was kept at the home of the resident. Restrictive measures were also documented in the Restrictive Practice Database. In addition, the restrictive practice committee ensured that the practices were used as a last resort, were regularly reviewed and appropriately documented.

8. Other issues

161. Both establishments visited followed the HSE's complaints policy and encouraged residents to complain locally first.

At the Hazelwood Centre, residents were encouraged to make their complaint known (either verbally or non-verbally) firstly to the staff of the centre. In fact, complaints were permanently on the agenda of the weekly house meetings, with the question being asked whether a resident would like to raise an issue with staff in private. A complaint could also be made in writing on behalf of a resident by family members or an advocate. The possibility for a staff member to make a complaint on behalf of non-verbal residents who seem unsatisfied had also been recently introduced. Further avenues of complaint were the Chief Executive Officer's Office, the HSE and, ultimately, the relevant Ombudsman. The complaints procedure was made available in an easy-to-understand booklet posted on the notice board in the kitchen. Where the complaint concerned possible abuse of a resident, this would be addressed by the St Michael's House safeguarding policy.

162. At Stewarts Care, a well-developed complaints mechanism was in place and was constantly monitored and revised if necessary. Easy-to-understand information was provided on how to make a complaint, for residents as well as families. Complaints forms were available in the individual houses, or at the campus reception. These were sent to the Complaints Coordinator and forwarded to a complaints officer. Staff members could also make a complaint on the resident's behalf. Residents could request the help of an advocate from Sage,⁵⁷ the national advocacy service or a family network. Residents could also complain to the Ombudsman or the Office of the Confidential Recipient which had similar powers.

In the case of serious complaints, there was a formal investigation sometimes involving an independent investigator, or the HSE would carry out its own investigation. The safeguarding manager would be notified if the complaint concerned staffing or a safeguarding issue.

⁵⁷ The support and advocacy service for vulnerable adults and older people.

An Excel file of complaints made was sent to the HSE each quarter. The quarterly complaints report for January to March 2019 showed that 40 complaints had been made, 10 of which related to safeguarding issues. **The CPT would like to be informed about the investigation and outcome of these 10 complaints.**

163. At both establishments, information on the functioning of the homes' activities, how to make a complaint, residents' rights, etc. could not be more clearly provided. For example, at Stewarts Care, a Charter of Rights and Residential Service User and Family Information Booklet containing pictures and simple sentences were provided to residents upon admission. In addition, the minutes of the Service User Council meetings were circulated in a suitable format to residents and there was a "right of the month" scheme, whereby each month, information on a particular right was circulated to residents. The CPT welcomes these efforts to ensure that residents are well informed about all issues relating to their everyday life.

APPENDIX I

List of the establishments visited by the CPT's delegation

Police stations

- Bridewell District Garda Station, Cork
- Clontarf Garda Station, Dublin
- Cobh District Garda Station, Cork
- Mountjoy Garda Station, Dublin
- Store Street District Garda Station, Dublin

Prisons

- Arbour Hill Prison
- Cloverhill Prison
- Cork Prison
- Midlands Prison
- Mountjoy Prison*

Social care homes

- Hazelwood Centre, Dublin
- Stewarts Care residential services for adults with intellectual disabilities, Palmerstown Campus, Dublin

Mental health establishments

- Department of Psychiatry, St Luke's Hospital, Kilkenny
- Sliabh Mis Mental Health Admission Unit, University Hospital Kerry, Tralee
- St Aloysius Ward, Mater Misericordiae University Hospital, Dublin.

*Targeted visit to the Challenging Behaviour and High Support Units and to persons on restricted regimes.

APPENDIX II:

**List of the national authorities, other bodies and non-governmental organisations
with which the CPT's delegation held consultations**

A. National authorities

Department of Justice and Equality

Charles FLANAGAN T.D.	Minister for Justice & Equality
Oonagh MCPHILLIPS	Deputy Secretary General
John O'CALLAGHAN	Assistant Secretary
Michael FLAHIVE	Assistant Secretary
Noel DOWLING	Principal Officer and CPT Liaison Officer
Willie O'DWYER	Principal Officer
Gerard COOLEY	Assistant Principal Officer
Keith LYNN	Assistant Principal Officer and CPT Liaison Officer
Patrick O'LEARY	Assistant Principal Officer
Caron McCAFFREY	Director General, Irish Prison Service
Fergal BLACK	Director of Care & Rehabilitation, Irish Prison Service
Donna CREAVEN	Director of Corporate Services, Irish Prison Service
Emma BLACK	Head of Psychology Services, Irish Prison Service
John DEVLIN	Clinical Lead Irish Prison Service
Seamus SISK	Principal Officer, Irish Prison Service
Paul MANNERING	Principal Officer, Irish Prison Service
Kieran MOYLAN	Principal Officer, Irish Prison Service
John McDERMOTT	Assistant Principal Officer, Irish Prison Service and CPT Liaison Officer
Kate MULKERRINS	Executive Director, An Garda Síochána
Matt NYLAND	Chief Superintendent, An Garda Síochána
Tara GOODE	Inspector, National Liaison Office, An Garda Síochána and CPT Liaison Officer

Department of Health

Colm DESMOND	Assistant Secretary
Brendan TUOHY	Higher Executive Officer
Patsy CARR	Principal Officer
Sarah COONEY	Principal Officer
Dave MAGUIRE	Principal Officer
Bevin DOYLE	Assistant Principal Officer
Catherine GIBSON	Assistant Principal Officer
Patricia LEE	Assistant Principal Officer
Michael MURCHAN	Assistant Principal Officer
Gerry STEADMAN	Assistant Principal Officer

