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# Report

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

# from 8 to 21 June 2021

The Government of the United Kingdom has requested the publication of this report and of its response. The Government's response is set out in document CPT/Inf (2022) 14.

Strasbourg, 7 July 2022

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## EXECUTIVE SUMMARY

In the course of the June 2021 visit to the United Kingdom, the delegation examined the treatment of persons held in prisons in England. Particular attention was paid to the impact of the restrictions imposed in the context of the ongoing Covid-19 pandemic, safety and violence in prisons, the situation of female prisoners and conditions in segregation units in the various prisons visited.

In addition, the delegation examined the treatment, living conditions and legal safeguards offered to patients, including children and adolescents, held in several psychiatric establishments. Special attention was paid to the use of means of restraint and seclusion of patients in all the hospitals visited. The delegation also visited several police establishments, in order to review the treatment of and safeguards afforded to persons deprived of their liberty by the police.

The co-operation received by the delegation throughout the visit, from both the national authorities and staff at all the establishments visited, was generally very good. That said, at Shepcote Lane Police Station, Sheffield, the delegation's access to the custody suite was delayed for some 40 minutes and at Wormwood Scrubs Prison, the delegation initially encountered difficulties in accessing information, moving inside the prison and interviewing in private prisoners held in the segregation unit.

*Law enforcement agencies*

During the visit, the delegation received no allegations of deliberate physical ill-treatment by police officers of persons who were – or had recently been – in police custody. On the contrary, several persons interviewed during the visit stated explicitly that they had been treated correctly and respectfully by police officers. That said, the delegation heard several allegations of excessively tight handcuffing.

The fundamental safeguards against ill-treatment are guaranteed by the relevant legislation and the delegation found that they were generally afforded to detained persons by the police. Nevertheless, certain shortcomings were identified in the establishments visited.

In particular, it emerged that arrested persons might be kept in small holding rooms outside custody suites for a considerable time after arrival at a police station, before they were officially informed of their rights by custody sergeants. Further, detained persons were sometimes asked to attest with their signature that they had been informed of their rights without being effectively able to see what they were signing. Moreover, according to the custody records examined by the delegation, in a few cases, a duty lawyer was contacted by police officers some considerable time after access to a lawyer had been requested by the detained persons. Some deficiencies were also observed as regards the keeping of custody records. The CPT reiterates several recommendations with a view to ensuring that all persons detained by the police are fully informed of their fundamental rights as from the very outset of their deprivation of liberty and are in a position to benefit from their rights throughout the duration of police custody.

Material conditions in the police custody cells were generally good. However, several complaints were heard that detained persons were not informed of the possibility to use a shower and/or take outdoor exercise.

*Prisons for adult male prisoners*

Overcrowding is a long-standing concern to the CPT. The Committee has noted that the overall size of the prison population has decreased, but it is clear that this was principally the result of the unprecedented situation caused by the Covid-19 pandemic, in particular delays in court hearings and the reduced capacity of courts; it would appear from the latest figures available that the prison population is starting to rise again. The CPT takes note of the plans of the United Kingdom authorities to deliver additional prison places but reiterates that addressing the issue of overcrowding requires a broader coherent strategy, covering both admission to and release from prison, to ensure that imprisonment really is the measure of last resort.

The CPT's delegation heard no direct allegations of ill-treatment of prisoners by staff. On the contrary, several prisoners interviewed during the visit spoke positively of staff. However, in the light of the deficiencies identified in the use of force reporting in the establishments visited (see below), the CPT trusts that the United Kingdom authorities will remain constantly vigilant to any signs of ill-treatment of prisoners by staff, especially as the prisons resume their normal regimes after the Covid-19 pandemic.

The information gathered during the visit indicates that there has been a reduction in the levels of recorded violent attacks in prisons. However, the decrease was attributable, at least to a certain extent, to the restrictions on physical contact imposed in the context of the Covid-19 pandemic. Moreover, there were still numerous cases of serious inter-prisoner violence and violence by prisoners on staff, as a result of which prisoners and staff had sustained serious injuries. The CPT recommends that the authorities intensify their efforts to combat the phenomenon of violence in prisons. As prisons move through the various stages of relaxing Covid-19 related restrictions, particular care will be needed to avoid a new wave of violence in prisons.

As regards the recording of violent episodes, in a number of cases, reports of injuries to prisoners lacked detail, were incomplete or were even missing altogether. The CPT recommends that the overall quality of the recording of violent episodes, use of force and injuries be improved.

Material conditions at Woodhill Prison were good overall. At Durham and Wormwood Scrubs Prisons, efforts were being made to improve conditions. That said, prisoners continued to be doubled up in cells intended for single-occupancy, there was an absence of partitioning of the toilets in some cells used for double occupancy and, at Durham Prison, the CPT's delegation observed signs of dilapidation in some of the cells and common areas.

Prior to the Covid-19 pandemic, efforts were being made in all the establishments visited to engage prisoners in organised activities. However, despite these efforts to alleviate the worst effects of the regime restrictions imposed during the pandemic (such as the continuation of essential work and the provision of in-cell learning and distraction packages, as well as some access to outdoor exercise), the fact remained that the vast majority of prisoners (i.e., those not engaged in essential work) continued to be locked up in their cells for 22 to 23 hours a day, with far too little to do. This had been the situation for the duration of the pandemic.

The understandable decision that regime activities and association in prison should be severely restricted during the Covid-19 pandemic had impacted the lives of prisoners held in the Close Supervision Centre (CSC) and the Separation Centre (SC) at Woodhill Prison. The CPT invites the United Kingdom authorities to ensure that, as prison establishments transition from the Covid-19 restricted regimes, a more finely-calibrated approach to the resumption of regime activities and association is adopted, prioritising small special units such as those at Woodhill Prison, where this could be done with minimal risk.

The Committee has also recommended that, alongside the easing of Covid-19-related restrictions, prisoners held in the SC and CSC at Woodhill Prison be provided a fuller regime of activities.

As regards health care, the health-care staffing levels in the three establishments visited appeared on the whole to be adequate to meet the needs of the prison population, prisoners were comprehensively medically screened upon admission and medical records were generally well-kept. However, records usually did not contain any conclusions as to the consistency between the prisoner's statement as to the origin of injuries and objective medical findings.

At Durham Prison, the delegation gained a very good impression of the provision of mental health services. That said, at Woodhill and Wormwood Scrubs Prisons, the delegation observed considerable delays in the transfer of prisoners suffering from severe mental health problems to psychiatric hospitals and the CPT reiterates its recommendation that the authorities take all necessary measures to ensure that prisoners suffering from severe mental health problems are transferred without delay and cared for and treated in a closed hospital environment, suitably equipped and with sufficiently qualified staff to provide them with the necessary assistance.

There have recently been signs of improvement as regards the turnover of prison staff, resulting in a greater number of front-line operational staff having sufficient experience. Nevertheless, there was still a high proportion of front-line custodial staff with less than two years of experience in working in prison, and who have never seen prisons operating under normal circumstances; this will present a real challenge when regimes re-open.

Isolated instances of very long placements in administrative segregation persist in all three establishments and the regime of activities offered to segregated prisoners was impoverished.

*Prisons for female prisoners*

The delegation received no allegations from the women interviewed of ill-treatment by staff. On the contrary, some women spoke positively of staff and the way they were treated. However, the deficiencies identified in the male prison estate concerning the recording of violent episodes and injuries sustained by prisoners were also observed at Bronzefield Prison and the CPT recommends that the authorities remain vigilant to any signs of ill-treatment by staff in this establishment.

Material conditions at Bronzefield Prison were in general very good.

The delegation also gained a very good impression of the regime activities that had been offered to the women prior to the Covid-19 pandemic. Virtually all prisoners had been engaged in a broad range of activities, most of which had taken place in a spacious and well-equipped "business centre" composed of several workshops and classrooms. However, the situation during the pandemic was similarly restrictive to that observed in the prisons for men.

The health-care team at Bronzefield Prison was well-staffed and the establishment was also regularly visited by a range of specialists.

The CPT found that the establishment was accommodating a number of women with severe mental disorders who could not be provided with adequate care in a prison setting. Of the 14 patients accommodated in the establishment's in-patient unit, 13 had been placed there on mental health grounds. The unit was effectively acting as a mental health facility without any structured therapeutic activities for its women patients. The situation of four women accommodated in the in-patient unit who were acutely unwell was of particular concern to the CPT's delegation. The CPT recommends that the provision of mental health care at Bronzefield Prison be thoroughly and comprehensively

reviewed and that a rapid urgent pathway to a mental health care facility for prisoners with acute mental disorders be put in place.

The number of self-harm incidents had increased sharply at Bronzefield Prison during the pandemic. Moreover, potentially high lethality incidents involving the use of ligatures were frequent and the delegation was particularly concerned to find that, in some cases, prisoners were able to use the same ligature method on multiple occasions within a matter of hours, and for days on end. The CPT formulates several recommendations to tackle the phenomenon of self-harm, including by reviewing the current risk assessment process and ensuring that mental health assessment takes place whenever necessary.

As regards custodial staff, the CPT notes that there were several vacant posts and the turnover of staff remained relatively high.

Good efforts were made to re-integrate women placed in administrative segregation back into mainstream accommodation. However, the delegation met seven highly challenging women who had been placed in the segregation and care unit for very long periods of time. The CPT recommends that the authorities step up their efforts to avoid, as far as possible, segregating prisoners for lengthy periods. Moreover, a multi-faceted approach should be adopted, involving clinical psychologists to design individual programmes, including psycho-social support and treatment. More generally, segregated prisoners should have an individual regime plan to assist them to return to a normal regime and should benefit from a structured programme of purposeful and preferably out-of-cell activities and meaningful human contact every day.

*Psychiatric establishments*

The delegation received no allegations of physical ill-treatment of patients by staff. On the contrary, the delegation met many dedicated health professionals working hard to care for their patients. There was, however, one isolated allegation involving a complaint of verbal abuse of a racist nature at Priory Hospital Enfield, about which the CPT has requested further information.

The material conditions in the establishments visited ranged from good to excellent. That said, some of the outdoor spaces (namely, those of the secure wards at Priory Hospital Enfield and one at Cygnet Hospital Sheffield) were not conducive to a therapeutic, patient-centred environment. In some of the hospitals visited, patients had limited access to the outdoors. The CPT recommends that unrestricted access to daily outdoor exercise should be facilitated.

The treatment offered to patients was generally of a high quality. Individual care and treatment plans were mostly comprehensive, developed by a multi-disciplinary team with the involvement of the patients themselves. Most establishments also offered numerous opportunities for rehabilitation and occupational therapies. However, at Blake Ward, Priory Hospital Enfield, the treatment offered to patients and the programme of psycho-social and occupational therapies was insufficient, and patients were not aware of their care and treatment plans.

Staff numbers were generally sufficient in all hospitals visited, although there was a high reliance on bank and agency staff, notably at Priory Hospital Enfield. Furthermore, the staff turnover at Cygnet Hospital Sheffield was exceedingly high, thus impacting on the quality of care. Positively, the regular presence of peer support workers in two of the hospitals visited is considered to represent a good practice.

There was a relatively high level of use of restrictive practices, particularly at the Alnwood Unit of St Nicholas Hospital Newcastle. The CPT underlines that further efforts should be made to implement the existing strategy to reduce resort to means of restraint at this unit. Physical restraint in a prone

position (face down) was still applied in most of the hospitals visited, including with regard to children and adolescents, contrary to national guidelines. Further, the delegation received several allegations of patients who were subjected to physical restraint in the presence of other patients, including during naso-gastric feeding. Such invasive procedures should be performed out of sight of other patients.

As regards seclusion, the CPT notes with concern the situation of several patients who had been held in prolonged seclusion (up to several weeks, and in one case, for two months with the application of a high number of different restraint measures).

The report also addresses long-term segregation (LTS) which had been found to be an issue at the high secure hospitals during the CPT's 2016 visit to the United Kingdom. The CPT raises concerns about the use of LTS in the establishments visited in 2021, questioning whether its use can be conducive to a patient's treatment and noting that lengthy periods of seclusion and LTS might result in the deterioration of the patient's mental health. As regards the high secure hospitals, the report re-visits the issues of forcible administration of clozapine via naso-gastric tube and night-time confinement.

In respect of patients' legal safeguards, the CPT notes the ongoing reform of the Mental Health Act and the Government White Paper which proposes changes to the law, including increased powers for the Mental Health Tribunal. However, the CPT considers that the proposed new timeframe for involuntary treatment is still too long; an immediate external psychiatric opinion should be sought in any case where a patient objects to the treatment proposed by the establishment's doctors. In addition, the CPT recommends that patients should be able to appeal to an independent authority against compulsory treatment decisions. As regards consent to treatment, the CPT reiterates that patients should not be treated against their will merely because they have been admitted on an involuntary basis. Compulsory treatment should be a measure of last resort and every instance of its use must be fully documented; patients should also be able to sign their consent electronically.

Delayed discharge remains rather high and this was notably the case at the Alnwood Unit with a large number of children with autism and learning disabilities awaiting discharge. Delays in accessing a SOAD[1] were also noted, meaning that patients were being treated against their will for longer than the statutory three months and, during the Covid-19 pandemic, patients were not assessed in person but over the telephone, a practice which the CPT considers unacceptable. There was also insufficient access to independent mental health advocates (which provide an additional safeguard for patients' rights) at Priory Hospital Enfield.

In respect of contact with the outside world, it was positive that, at the time of the visit, patients were once again beginning to receive visits from their families in person. They were also able to contact their relatives via phone or videoconference and, in some establishments, many patients had access to their mobile phones (including smartphones), based on an individual risk assessment.

[1] Second opinion appointed doctor.

# 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 the United Kingdom from 8 to 21 June 2021. The visit formed part of the CPT's programme of periodic visits for 2021 and was the Committee's ninth periodic visit to the United Kingdom.[2]

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

- Mark Kelly (Head of the delegation)
- Per Granström
- Kristina Pardalos
- Vytautas Raškauskas
- Arman Tatoyan.

They were supported by Natacha De Roeck, Petr Hnátík and Sebastian Rietz of the Committee's Secretariat, and assisted by two experts, Birgit Völlm, Professor in Forensic Psychiatry, Medical Director of the Forensic Hospital at the University of Rostock, Germany, and Olivera Vulić, psychiatrist, former Chief of the Centre for Mental Health in Podgorica, Montenegro.

3. A list of the establishments visited by the delegation is set out in Appendix I to the report.

4. The report on the visit was adopted by the CPT at its 106th meeting, held from 25 to 29 October 2021, and transmitted to the authorities of the United Kingdom on 16 November 2021 The various recommendations, comments and requests for information made by the CPT are set out in bold type in the present report. The CPT requests the authorities of the United Kingdom to provide within six months a response containing a full account of action taken by them to implement the Committee's recommendations and replies to the comments and requests for information formulated in this report. As regards the request for information formulated in paragraph 116, the Committee wishes to receive a response within one month.

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[2] The CPT has previously carried out eight periodic visits (1990, 1994, 1999, 2001, 2003, 2008, 2012 and 2016) and fifteen *ad hoc* visits to the country, the most recent one in 2019. The reports on these visits and the responses of the national authorities have all been made public and are available on the Committee's website: https://www.coe.int/en/web/cpt/united-kingdom.

## B. Consultations held by the delegation and co-operation encountered

5. In the course of the visit, the delegation held consultations with Robert Buckland, Lord Chancellor and Secretary of State for Justice, Nadine Dorries, Minister for Mental Health, Suicide Prevention and Patient Safety, Alex Chalk and Baron Wolfson of Tredegar QC, Parliamentary Under Secretaries of State in the Ministry of Justice, Jo Farrar, Second Permanent Secretary, Ministry of Justice and Chief Executive Officer, HM Prison and Probation Service (HMPPS), Phil Copple, Director-General HMPPS and Nev Kemp, Deputy Chief Constable, Surrey Police and National Police Chiefs' Council (NPCC) Lead for Custody, as well as other senior officials from the Ministry of Justice, Home Office, Department of Health and Social Security, NHS England and HMPSS.

The delegation also met John Wadham, Chair of the National Preventive Mechanism against torture (NPM), Charlie Taylor, Her Majesty's Chief Inspector of Prisons and Anne Owers, National Chair of the Independent Monitoring Boards (IMBs), Kevin Cleary, Deputy Chief Inspector of the Care Quality Commission (CQC) and Elizabeth Moody, Deputy Ombudsman for Fatal Incidents at the Prisons and Probation Ombudsman (PPO). It also held a round table with several non-governmental organisations active in areas of concern to the CPT.

A full list of the national authorities, other bodies and non-governmental organisations met by the delegation is set out in Appendix II to this report.

6. The co-operation received by the delegation throughout the visit, from both the national authorities and staff at all the establishments visited, was generally very good. With the exceptions set out below, the delegation enjoyed rapid access to the establishments it wished to visit (including those which had not been notified in advance), was able to interview in private persons deprived of their liberty and was provided with the information it needed to accomplish its task.

The delegation wishes to express its appreciation for the assistance provided before, during and after the visit by its liaison officers, Andrew Waldren, Patricia Zimmermann and Elspeth Rainbow, of the Ministry of Justice, as well as the team of liaison officers from the various ministries appointed by the authorities.

7. However, at Shepcote Lane Police Station, Sheffield, the delegation's access to the custody suite was delayed for some 40 minutes, apparently because the police officers present were not aware of the CPT's mandate.

Further, at Wormwood Scrubs Prison, the delegation initially encountered difficulties in accessing information, moving inside the prison and interviewing in private prisoners held in the segregation unit. The delegation was grateful that the situation was resolved after the intervention of the liaison officers and the Prison Group Director for London.

**The CPT trusts that the United Kingdom authorities will continue to strive to ensure that all managers working in police stations and prisons are fully informed of the mandate of the CPT in order to avoid situations similar to those described above occurring during future visits.**

## C. National Preventive Mechanism

8. The United Kingdom ratified the Optional Protocol to the United Nations Convention against Torture (OPCAT) in December 2003 and designated its National Preventive Mechanism (NPM) in March 2009. The NPM comprises 21 statutory bodies which together cover all places where persons are deprived of their liberty in the United Kingdom. Her Majesty's Inspectorate of Prisons (HMIP) for England and Wales was tasked with co-ordinating the work of the NPM. To ensure greater independence of the NPM as a separate entity, to strengthen its governance and to advise and support the NPM in fulfilling its OPCAT mandate, the NPM has an independent Chair appointed by its members.

Insofar as relevant in the context of the CPT's 2021 visit, the bodies forming the NPM include, *inter alia*, HMIP which regularly inspects prisons, the Independent Monitoring Boards (IMBs) which are present in every prison in England and Wales, Her Majesty's Inspectorate of Constabulary (and Fire and Rescue Services) which inspects police forces in England and Wales, Independent Custody Visiting Association which visits all police stations where detainees are held to check that their rights and entitlements are being granted and their welfare is being cared for, and the Care Quality Commission which is responsible for monitoring, inspecting and regulating health and adult social care services in England.

As already noted in several previous reports, the CPT appreciates its long-standing very good co-operation with the various bodies constituting the NPM. Further, it appreciates the developing practice of the United Kingdom authorities to invite a representative of the NPM to attend the meeting at which the Committee's delegation delivered its preliminary observations to the authorities at the end of its visit.

9. The Committee takes note of the consultation process carried out by the Ministry of Justice in 2020 which aims at strengthening the NPM by providing it with a statutory footing. **The CPT would like to be informed about the outcome of the consultation process and the follow-up given to it by the United Kingdom authorities.**

# II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

## A. Law enforcement agencies

### 1. Preliminary remarks

10. The basic rules concerning the detention, treatment and questioning of persons detained by the police are contained in the Police and Criminal Evidence Act (PACE) 1984 and its Codes of Practice, which are regularly updated. By virtue of Sections 41 to 44 of PACE, a person shall as a general rule not be kept in police custody for more than 24 hours without being charged. However, when the person has been arrested in connection with an "indictable offence",[3] his or her custody may under certain circumstances be extended by the police to 36 hours. A person's detention must be reviewed at regular intervals by a senior police officer.

If the police wish to prolong detention without charge beyond 36 hours, they must seek authorisation from a magistrates' court; the detainee must be brought before the court, and they are entitled to be legally represented. The court may authorise further detention for up to 36 hours. This period may subsequently be extended by the court at the request of the police but the overall length of police custody without charge may not exceed 96 hours.

Under the Terrorism Act 2000 (as amended) (TACT), a person may be detained by the police, on their own authority, for a maximum period of 48 hours. Thereafter, a warrant for further detention of such a person prior to being charged may be obtained from a judicial authority, for a period of up to seven days, and may be extended by another period of up to seven days, for a maximum period not exceeding 14 days following arrest.[4]

### 2. Ill-treatment

11. During the visit, the delegation received no allegations of deliberate physical ill-treatment by police officers of persons who were – or had recently been – in police custody. On the contrary, several persons interviewed during the visit stated explicitly that they had been treated correctly and respectfully by police officers, both at the time of apprehension and during their detention in a custody suite. Moreover, at Durham City Police Station, the delegation observed first-hand the "booking in" process of a newly-arrived detained person and was impressed by the inter-personal skills shown by the custody sergeant when dealing with that person.

That said, the delegation heard several allegations of excessively tight handcuffing[5] (in particular at Hammersmith and Wood Green Police Stations in London and Shepcote Lane Police Station in Sheffield). In one case, a detained juvenile interviewed by the delegation bore two 5 cm

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3 I.e., in broad terms, a more serious offence that must be tried in the Crown Court, such as a murder, a manslaughter or a rape.

4 See Sections 41 of TACT and Sections 21, 29 and 36 of Schedule 8 to TACT.

5 It should be noted that excessively tight handcuffing can have serious medical consequences (for instance, sometimes causing a severe and permanent impairment of the hand(s)).

by 2 mm dark red linear marks on both wrists which were consistent with their allegations of excessively tight handcuffing.

**The CPT reiterates its recommendation that police officers be reminded regularly that when it is deemed necessary to handcuff a person, the handcuffs should under no circumstances be excessively tight and should be applied only for as long as is strictly necessary.**

### 3. Safeguards against ill-treatment

12. The fundamental safeguards against ill-treatment (i.e. the right of access to a lawyer and to a doctor and the right to inform a third person of the detention) are guaranteed by the PACE and Code of Practice C;[6] as was the case during previous visits, the delegation found that they were generally afforded to detained persons correctly by the police. However, certain shortcoming were identified in the establishments visited.

13. As regards information on rights, the majority of detained persons interviewed during the visit confirmed that they had been informed of their rights shortly after their arrival at a police station, both verbally and by being provided a leaflet containing their rights.

However, as already observed during the 2016 visit in some police establishments, it emerged at Hammersmith and Wood Green Police Stations in London (and it was acknowledged by police officers) that arrested persons might be kept in small holding rooms outside the custody suite for a considerable time – four hours or more – after arrival at a police station before their detention was formally authorised and they were officially informed of their rights by custody sergeants.[7] A few allegations were also heard that detained persons had been informed of their rights verbally but not in writing.

Further, at Durham City Police Station, the delegation noted that video screens designed to mirror the information recorded by custody sergeants, including that on rights of detained persons, on the detainees' side of the counter were not being used and detained persons were being asked to sign the screen without being able to see the text that they were signing.[8]

**The CPT reiterates its recommendation that the United Kingdom authorities take measures to ensure that all persons detained by the police are fully informed of their fundamental rights as from the very outset of their deprivation of liberty (that is, from the moment when they are obliged to remain with the police). This should be ensured by the provision of clear verbal information at the moment of apprehension, to be supplemented at the earliest opportunity (that is, immediately upon the arrival at a police establishment) by provision of a written copy of their rights.**

**Immediate steps should be taken to ensure that detained persons fully understand their rights and what they are signing for.**

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6 As regards juveniles (i.e. persons below the age of 18), the relevant legislation provides for an additional safeguard – the attendance of an appropriate adult at the police station to see the detainee must be secured and juveniles must not, as a general rule, be interviewed regarding their involvement in a criminal offence, or asked to provide or sign a written statement, in the absence of the appropriate adult (see Sections 1.5, 3.5 (c) (ii), 3.15 and 11.15 of PACE Code C).

7 Such situation is contrary to the spirit, if not the letter, of Section 3.1 and 3.2 of PACE Code C which provides that persons brought to a police station under arrest must be clearly informed of their continuing rights, including in writing.

8 A similar problem was encountered in a police establishment visited during the previous periodic visit.

14. The examination of custody records at Durham City Police Station revealed that a detained person was not informed at all of his rights throughout the duration of his custody (i.e. some ten hours). According to a custody sergeant, if detained persons are violent or likely to become violent, they would not be informed of their rights.

The CPT notes that this possibility is foreseen by Section 1.8 of PACE Code C which provides that "[i]f this Code requires a person be given certain information, they do not have to be given it if at the time they are incapable of understanding what is said, are violent or may become violent or in urgent need of medical attention, but they must be given it as soon as practicable." However, in the CPT's view, this possibility should not be used in practice to avoid providing a detained person with information on their rights throughout the whole duration of police custody.

**The CPT recommends that where violent behaviour or potential violence of a detained person impedes the provision of information on his or her rights, the information should always be provided as soon as practicable, in line with the relevant legislation.**

15. As regards notification of custody, pursuant to Section 56 of PACE and Section 5 of PACE Code C, a detained person has the right to inform friends or relatives of the fact of his or her custody as soon as is practicable, except to the extent that a lawful delay is permitted. If a delay is authorised, the detained person shall be told the reason for it; and the reason shall be noted on his custody record.

Delay is only permitted in the case of a person who is in police detention for an indictable offence and if an officer of at least the rank of inspector authorises it, for a maximum of 36 hours from arrest and where there are reasonable grounds for believing that it will lead to interference with or harm to evidence connected with an indictable offence or interference with or physical injury to other persons; or will lead to the alerting of other persons suspected of having committed such an offence but not yet arrested for it; or will hinder the recovery of any property obtained as a result of such an offence. The delay may also be authorised where there are reasonable grounds for believing that the person detained for the indictable offence has benefited from his criminal conduct and that the value of the property constituting the benefit will be hindered by telling the named person of the arrest.

16. The vast majority of detained persons interviewed in the police stations visited confirmed that they had been given the opportunity to notify a third person of their detention shortly after their apprehension.

However, the delegation received some complaints that detained persons had not been informed by police officers whether or not it had been possible to make contact with the person of their choice, when police officers had done this on their behalf.

Further, one detained person claimed that he had not been able to contact a third person until after more than 12 hours after his apprehension as his friend's phone number had been in his mobile phone which had been confiscated by the police as evidence.

**The CPT recommends that the United Kingdom authorities take steps to ensure that detained persons are provided with feedback on whether it has been possible to notify a third person of the fact of their detention when the notification is done by police officers. The feedback should be traceable in police custody records.** Further, **police officers should facilitate the efforts of detained persons to have a third person notified of the fact of their detention.**

17. The right of access to a lawyer is guaranteed by Section 58 of PACE which provides that a person arrested and held in custody in a police station or other premises shall be entitled, if he or she so requests, to consult a solicitor privately at any time. Such request and the time at which it was made must be recorded in custody records and the detained person must be permitted to consult a solicitor as soon as practicable.

Delaying access to a lawyer is only permitted in the case of a person who is in police detention for an indictable offence and if an officer of at least the rank of superintendent authorises it.[9] If the delay is authorised, the detained person must be told the reasons for it and the reasons must also be registered in custody records.[10] In any case, however, the detained person must be permitted to consult a solicitor within 36 hours of his or her arrest.

18. The findings of the visit indicate that in the vast majority of cases, detained persons benefited from access to a lawyer shortly after they requested so.

That said, according to the custody records examined by the delegation, in a few cases, a duty lawyer was contacted by police officers with considerable delays (up to some 14 hours) after access to a lawyer was requested by the detained persons.[11]

Moreover, at Durham City Police Station, the delegation observed that the confidentiality of consultations between the detainee and their solicitor was not respected; such consultations took place via the telephone at the custody sergeant's desk, within the hearing of police officers.

**The CPT recommends that the United Kingdom authorities take steps to ensure that detained persons benefit from a ready access to a lawyer throughout the duration of police custody.**

Further, **steps should be taken at Durham City Police station to ensure that the confidentiality of consultations between a detained person and his or her lawyer is guaranteed.**

19. The right of access to a health-care professional is enshrined in law[12] and appeared to operate without undue delay in all custody suites visited by the delegation. Nurses worked on shifts and ensured a permanent presence or, as at Durham City Police Station, a pool of health-care professionals was on call and readily available. The delegation received no complaints from detained persons as regards the provision of medical assistance during the time of police custody.

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9 The grounds for the delay are the same as those applicable to the delaying of notification of a third person (see paragraph 15).

10 Under PACE Code C, Annexe B, Section A. 3., the detainee must be allowed to choose another solicitor.

11 The custody records contained no information that the aforementioned possibility to delay access to a lawyer was applied in these cases.

12 See, in particular, Sections 9.5 and 9.8 of PACE Code C which guarantee the right of access to medical assistance if the person is injured or appears to be suffering from physical illness or mental disorder or appears to need clinical attention, as well as the right to be clinically examined upon the request of the detained person.

20. As already observed in 2008 and 2016, neither custody staff nor detained persons interviewed by the CPT's delegation were aware of the right of access to a medical professional of their own choice (at their own expense), as provided for in Section 9.8 of PACE Code C. Moreover, none of the information sheets on the rights of detained persons shown to the delegation during the visit contained any information on this right. **The CPT recommends once again that the right of detained persons to be examined by a medical professional of their own choice be rendered effective in practice, including by reminding police officers of the existence of this right. Information sheets on the rights of detained persons should be updated accordingly.**

21. Medical confidentiality appeared to be generally respected in most police custody suites visited and medical records were as a general rule not accessible to police officers.

However, at Forth Banks Police Station (Newcastle-upon-Tyne), nurses as a rule examined detained persons in the presence of police officers who could thus see and hear the medical examination.

**The CPT reiterates its recommendation that the United Kingdom authorities take the necessary measures to ensure that, in all police stations, medical examinations are conducted out of the hearing and – unless the health-care professional concerned expressly requests otherwise in a particular case – out of the sight of custodial staff.**

22. As regards the use of police custody suites as a place of safety for placement of persons with mental health problems under section 136 of the Mental Health Act 1983 (MHA), reference is made to paragraph 182. As was the case already during the 2016 periodic visit, it was now extremely rare to hold persons in police custody under Section 136 MHA. This is to be welcomed.

23. The CPT's delegation found that electronic custody records continued to be generally well kept and were comprehensive. Some deficiencies were nevertheless observed by the delegation.

At Durham Police Station, while the initial choice of detained persons as to whether or not they wished to benefit from their rights (e.g. to notify a third person of their detention or to contact a lawyer) appeared to be duly recorded, such information was not necessarily recorded in the custody records if detained persons decided to do so only later during their period of detention.

Moreover, at Hammersmith Police Station in London, although the name and contact details of the person to be notified of detention were recorded, the fact of whether and when the contact had been made was not.

**The CPT recommends that these deficiencies be remedied.**

## 4. Conditions of detention

24. Material conditions in the police custody cells in the establishments visited were generally good and detained persons only rarely remained in police custody for more than 24 hours. The cells were in a good state of repair, were sufficient in size for single occupancy (some 7 to 8 m²) and adequately equipped (a plinth, bedding and a call bell) and had sufficient artificial lighting and ventilation.[13] Detained persons had access to drinking water, were provided with food, including with options for specific dietary needs, at regular intervals and with hygiene items.

However, most cells at Wood Green Police Station in London (and two cells at Durham City Police Station) had no access to natural light.

25. All custody suites visited possessed a shower; however, as was the case during previous visits, several persons interviewed during the visit claimed that they had not been informed of its existence or the possibility to use it. Moreover, at Wood Green Police Station, there was no door to the shower area which meant that detained persons were not afforded any privacy if they took a shower.

26. By virtue of Section 8.7 of PACE Code C, detained persons should be offered brief outdoor exercise daily, if practicable. However, several complaints were heard that detained persons had not been offered this possibility. Moreover, at Wood Green Police Station, the only outdoor exercise facility were two small rooms (approximately 2 m² each) with a large window in one of the walls. This can hardly be regarded as a genuine outdoor yard.

27. **The CPT recommends once again that the United Kingdom authorities take steps to ensure that persons held for 24 hours or more in police custody are offered access to outdoor exercise and the possibility to take a shower.** Further, **the shower area at Wood Green Police Station in London should be fitted with a door to ensure privacy.**

In addition, **the Committee recommends once again that when custody suites are being refurbished or constructed, provision should be made for the establishment of a secure outdoor yard and that all police custody cells should have access to natural light.**

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[13] Where cells were equipped with a CCTV camera, the image of the toilet area was pixelated in the screen.

## B. Prisons for adult male prisoners

### 1. Preliminary remarks

#### a. the state of the prison system in England

28. In its visit reports on prisons in England dating back to the 1990s, the CPT has repeatedly highlighted the cumulative deleterious effects on the lives of prisoners of chronic overcrowding, poor living conditions and the lack of purposeful regimes. Moreover, during the 2016 visit, the CPT's delegation found that these long-standing problems were exacerbated by a significant escalation in levels of violence. Similar findings were made by the CPT during its 2019 visit and the Committee once again concluded that the duty of care to protect prisoners was not always being fully discharged, and that the environment in the adult male establishments visited remained fundamentally unsafe for both prisoners and staff.

The information gathered during the 2021 visit indicates that levels of violence have decreased in the male prison estate. However, it is clear, and indeed it was acknowledged by the authorities, that this was attributable, at least to a certain extent, to the restrictions imposed in the context of the Covid-19 pandemic (see paragraph 35).

Further, in the establishments visited in 2021, the delegation found that staff retention remained a real challenge, as result of which a relatively high proportion of staff had only very limited experience (1 or 2 years) of working in prisons, and many had no real experience of the pre-pandemic prison environment (see also paragraphs 73 to 77).

29. The Committee also notes that the overall prison population has decreased from 82,634 prisoners as at 31 March 2019 to 78,058 as at 31 March 2021. However, these figures were principally the result of the unprecedented situation caused by the Covid-19 pandemic, in particular delays in court hearings and reduced sentencing capacity of courts. While the overall prison population and the number of sentenced prisoners in the prison system decreased, the trend was the opposite for those held on remand: over the 12 months preceding March 2021, the remand population had increased by 22% and on 31 March 2021 stood at 12,262.[14] In addition, it would appear that the prison population is starting to rise again as at 17 September 2021 it stood at 78,768 (i.e. a rate of 131 per 100,000 inhabitants).

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[14] Over the same time period, the sentenced population has decreased by 10% and stood at 64,783. For more details, see Offender Management Statistics quarterly: October to December 2020 and annual 2020 (https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2020/offender-management-statistics-quarterly-october-to-december-2020-and-annual-2020--2) and the March 2021 monthly Population bulletin (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/977271/prison-pop-march-2021.ODS).

Moreover, it should be recalled that the in use Certified Normal Accommodation (CNA)[15] of the prison estate has never caught up to the actual prison population despite all the pledges over the past 20 years to bring the capacity of the prison estate into line with the number of prisoners. As of March 2021, the CNA was 76,575 places (i.e., around 2,000 places below the overall population), meaning that the prison estate remains overcrowded, with many prisons still operating well above their CNA. It also meant prisoners being doubled up in cells intended for single occupancy, which was particularly problematic during the period of restrictions imposed in the context of the Covid-19 pandemic (see also paragraphs 44 and 46).[16]

The CPT also wishes to stress that a prison cannot function effectively if it is operating at 100% or more of its capacity. There must always be some margin for transferring incompatible prisoners from one wing to another or for receiving additional prisoners or for taking back prisoners on temporary release. The Council of Europe's *White Paper on Prison Overcrowding* states that "if a given prison is filled at more than 90% of its capacity this is an indicator of imminent prison overcrowding. This is a high-risk situation, and the authorities should feel concerned and should take measures to avoid further congestion."[17]

30. To respond to the overcrowding, the authorities have committed over GBP 4 billion towards the delivery of 18,000 additional prison places by the mid-2020s. This includes the construction of four new prisons (10,000 places), refurbishment of the existing prison estate and the completion of the ongoing prison builds at Glen Parva (due to open in spring 2023) and HMP Five Wells (due to open in early 2022). Planning permission for the first of the four new prisons has already been secured and the establishment, construction of which is due to start in 2022, will be located next to the HMP Full Sutton and will provide 1,440 prison places.

The CPT takes note of these plans and acknowledges the clear need for modern decent prisoner accommodation and the fact that there are a number of Victorian and other older establishments which are in constant need of costly refurbishment and yet remain neither functional nor fit for purpose.

However, as noted already in the report on the 2019 visit, constructing new prisons is not likely, in itself, to provide a lasting solution to the problem of overcrowding. Addressing this problem calls for a coherent strategy, covering both admission to and release from prison, to ensure that imprisonment – including pre-trial detention – really is the measure of last resort. Such a strategy implies an emphasis on non-custodial measures in the period before the imposition of a sentence. In this regard, strict limits should be set on the use of remand in custody and alternative measures should be used wherever possible. Further, greater use should be made by the judiciary, especially in less serious cases, of the existing alternatives to custodial sentences and early releases.[18]

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15 *Certified Normal Accommodation (CNA)*, or uncrowded capacity, is the Prison Service's own measure of accommodation. CNA represents the good, decent standard of accommodation that the Service aspires to provide all prisoners. The *operational capacity* of a prison is the total number of prisoners that an establishment can hold taking into account control, security and the proper operation of the planned regime.

16 It should be added that according to Prison Population Projections 2020 to 2026, England and Wales, the prison population is projected to increase to 98,700 by September 2026 (see https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/938571/Prison_Population_Projections_2020_to_2026.pdf)

17 See Section 20 of the White Paper on Prison Overcrowding – CM(2016)121-add3, 23 August 2016.

18 See, in this respect, also the Council of Europe Committee of Ministers Recommendation No. R(99)22 concerning prison overcrowding and prison population inflation, Recommendation Rec(2006)13 on the use of remand in custody, the conditions in which it takes place and the provision of safeguards against abuse, Recommendation Rec(2003)22 on conditional release (parole), Recommendation CM/Rec(2010)1 on the Council of Europe probation rules and Recommendation CM/Rec(2017)3 on the European Rules on community sanctions and measures.

31. It is noteworthy in this respect that at Durham and Wormwood Scrubs Prisons, a relatively large proportion of inmates were serving short sentences (i.e. less than six months of imprisonment).[19] The CPT wishes to reiterate that in certain European jurisdictions every effort is made to avoid sending persons to prison for short periods, as less than six months is considered too short to tackle criminogenic behaviour yet sufficient to disrupt social and family ties. Instead, sentences are served in the community.

Moreover, as regards the prison building programme described above, and in particular the plan to provide 10,000 new places divided among four prisons, the CPT has long been concerned by the concept of very large prisons.[20] It considers that smaller and more community-orientated prisons with reduced populations are more effective at maintaining control and ensuring effective conditions and regimes, than the 'warehousing' of more prisoners in fewer larger prisons.

32. Since its first visit to the United Kingdom in 1990, the CPT has repeatedly recommended that urgent action was needed to curb overcrowding in English prisons. However, the findings of the 2021 visit indicate that significant and sustainable improvement has not yet been achieved and overcrowding continues to adversely affect many aspects of prison life.

**The CPT once again calls upon the authorities of the United Kingdom to take concrete measures and determined action to reduce the level of overcrowding in the prison estate, including through changes in sentencing policies and practices.[21] In doing so, due account should be taken of the risk of increased influx of new inmates into the prison system once the criminal justice system again becomes fully operational and tackles the backlog of criminal cases after the restrictions introduced in the context of the Covid-19 pandemic have been removed.**

Further, **the Committee once again recommends that the authorities of the United Kingdom reconsider their plans to build very large prisons and consider investing in smaller prisons.**

In addition, **the Committee would like to receive updated information about the prison building programme and the anticipated closure of the Victorian-era and other older prisons, along with details for the new prison establishments of their design, layout, cell sizes, communal spaces and the budgetary resources agreed and allocated, as well as their envisaged time-frames to completion.**

b. establishments visited

33. *Her Majesty's Prison (HMP) Durham* was visited for the first time by the CPT. It is a Category B Georgian-era reception male prison which was built at the beginning of the 19th century and is located close to the city centre, adjacent to the Durham Crown Court. The establishment comprises six accommodation wings (A to F) and several smaller units, including a separate health-care building and a segregation unit. With a CNA of 597 places and an operational capacity of 980, the prison was accommodating 917 persons, including 586 unsentenced prisoners.

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19 There were some 60 such prisoners in each of the two establishments. No such prisoners were held at Woodhill Prison as the establishment was holding prisoners with long sentences (see paragraph 33 for more details).

20 See, for example, the report on the 2008 visit to the United Kingdom (doc. CPT/Inf (2009)30, paragraph 29)

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

*HMP and Young Offender Institution (YOI) Woodhill*, located on the outskirts of Milton Keynes, was previously visited by the CPT in 2001 and 2008. The prison is composed of four identical house units (HU1 – 4), each consisting of two triangular wings (A and B), as well as separate health-care and segregation units. The establishment also comprises a Close Supervision Centre (CSC) and a Separation Centre (SC) (see paragraphs 90 for more details) which are located in a separate house unit within the prison compound. Until 2019, the prison had operated primarily as a remand prison and was then transformed into a long-term Category B prison for sentenced male prisoners.[22] With a CNA of 644 places and an operational capacity of 574,[23] the prison was accommodating 476 sentenced prisoners.

*HMP Wormwood Scrubs*, previously visited by the CPT in 2019, is a Category B Victorian local male prison located in west London, which was built between 1875 and 1891. The establishment has five main accommodation wings (A to E) and various smaller units. With a CNA of 1,178 places and an operational capacity of 1,150 places,[24] the prison was accommodating 1,098 persons, of whom 697 were unsentenced.[25]

## 2. Ill-treatment and violence in prisons

34. The CPT's delegation received no direct allegations of ill-treatment of prisoners by staff from the persons in prison interviewed in the course of the visit. Indeed, several prisoners interviewed during the visit spoke positively of staff and stated that they were treated correctly and respectfully. However, in the light of the deficiencies identified in the use of force reporting in the establishments visited (see paragraph 40), **the CPT trusts that the United Kingdom authorities will remain constantly vigilant to any signs of ill-treatment of prisoners by staff, especially as the prisons resume their normal regime.**

35. In the reports on the visits carried out in 2016 and 2019, the CPT noted high levels of violence and the severity of attacks in the male prison estate, including inter-prisoner violence and violence by prisoners on staff. It was widely acknowledged, including by the United Kingdom authorities themselves, that prisons in England and Wales were not places of safety, with a high level of generalised violence within their walls. Many inmates interviewed during these visits told the delegations that they feared for their safety during association, during movement time and especially in the showers (where there was no CCTV coverage).

The information gathered during the 2021 visit indicates that there has been a reduction in the levels of recorded violent attacks in prisons. According to the official statistics, across the prison estate, the number of prisoner-on-prisoner assaults had decreased from 23,217 in 2019 to 13,784 in 2020 and there were 2,842 assaults in the first quarter of 2021. Likewise, there had been a decrease in recorded prisoner-on-staff assaults, from 10,033 in 2019 to 7,979 in 2020; in the first quarter of 2021, there were 1,896 incidents of this type. In line with these national trends, the number of recorded episodes of violence in each of the establishments visited by the CPT in 2021 had decreased in the 18 months or so (coinciding with the lockdown measures imposed during the Covid-19 pandemic) preceding the visit.

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22 Exceptionally, the establishment could accommodate up to ten category A (high security) remand prisoners.

23 At the time of the visit, Wing A of HU4 was out of service due to refurbishment.

24 At the time of the visit, one landing was out of use due to refurbishment.

25 It should be noted, however, that although neither the CNA, nor operational capacity of the establishment was being exceeded, the CPT's delegation still observed crowded conditions in many cells (see paragraphs 46).

36. For the years 2019 and 2020, prisoner-on-prisoner assaults had decreased from 343 to 194 at Durham Prison, from 226 to 81 at Woodhill Prison and from 358 to 175 at Wormwood Scrubs Prison. For the same time period, prisoner-on-staff assaults had decreased from 80 to 45 at Durham Prison, remained relatively stable at Woodhill Prison (147 incidents in 2019 as compared to 145 cases in 2020) and went down from 268 to 134 at Wormwood Scrubs Prison.

However, these statistics alone cannot be taken as an indicator that the worrying trend of the steady increase in the number of assaults in prisons which had been noted during previous visits has been reversed and the problem of violence in prisons has been resolved. It is clear, and it was indeed acknowledged by the authorities, as well as by the management and staff in the establishments visited, that the decrease was attributable, at least to a certain extent, to the restrictions imposed in the context of the Covid-19 pandemic, most notably the lower number of inmates entering prisons and the reduced prison population, as well as limited movements within prisons and restricted association and regime activities provided to prisoners.

37. Moreover, according to the various records examined during the visit – taken together with the interviews with prisoners and staff – there were still numerous cases of serious inter-prisoner violence as a result of which prisoners sustained serious injuries, in some cases requiring hospitalisation. The assaults included spitting, biting, slaps in the face, punches in the face, head and body, head butting, assaults by groups of prisoners in the corridors, prisoners being pushed in the cell and assaulted, kicks, pushing another person down the stairs, as well as slashing with sharpened objects.

The following sample of cases examined by the CPT's delegation in the various establishments visited, most of which had occurred shortly before the Committee's 2021 visit, illustrates the severity of the attacks and injuries sustained by prisoners:

(i) On 1 June 2021, prisoner A was assaulted by his cell mate and received a head injury. According to the medical records, the prisoner concerned was examined by a nurse shortly after the incident and alleged that he had been punched twice on the left side of his forehead and on the right side of his chest and presented the following injuries: "Mild bleeding in the affected area. A deep cut V shaped 2x1 cm long is observed above his left eyebrow. The wound was cleaned. No other symptoms besides headache. Sent to hospital."

(ii) On 1 June 2021, staff were called to the landing to see prisoner B chasing prisoner C along the landing. Staff got between them and discovered prisoner C had several slash injuries to his neck and head. Prisoner B dropped two improvised double-bladed weapons when ordered to. He was walked back to his cell. Prisoner C was treated by health care staff. Following initial treatment prisoner C was taken to an outside hospital. He stated on a body-worn video camera (BWVC) that prisoner B had attacked him from behind and slashed him several times.

Prisoner C's medical file recorded the following: "Slashed with razor, laceration to the left side of forehead, multiple lacerations to left side of his neck. Top of the ear taken off into a skin flap, have managed to pull the skin back. Sterile strips and bandages applied."

(iii) On 18 May 2021, prisoners D and E had a fight in their cell following which they called the staff by pressing the cell bell. Both inmates displayed multiple injuries to the face and body and were examined by prison health care staff, then transferred to hospital in separate ambulances. According to the medical records of prisoner D the hospital had recorded: "Fist fight with a cell mate. Big haematoma in left orbital region. Unable to open his mouth. Pain in right clavicula, right elbow and left knee. Vomited multiple times. CT of facial bones and head as well as X ray of chest, clavicula and elbow performed. Nasal fracture was found."

(iv) On 21 May 2021, prisoners F and G entered the servery and attacked the cleaners with weapons. Mr F was in possession of a sharpened toilet brush handle and Mr G a wooden table leg with a screw in it. Both prisoners were restrained by staff and relocated to the segregation unit. Cleaner H suffered a cut and bruising to his head from the table leg weapon used by G.

(v) On 15 June 2021, prisoner I was bitten by another inmate on his cheek. When met by the delegation, prisoner I displayed a human bite wound (a U-shaped abrasion) on the right cheek.

His medical file contained the following record: "Altercation with inmates. Struck on the head with a bar of soap; bitten by another person. Wound cleaned by saline, dressed, declined analgesia."

(vi) On 16 June 2020, prisoner J sustained serious head and neck injuries as a result of an attack by another inmate with a sharp object and was punched in the right eye. The medical records note the following: "Cut to face and chest. Pressure applied. Arterial bleeding, the main worry was to stop bleeding. Paramedics inserted iv and gave fluids; pressure bandages applied to control arterial bleeding. Airlifted to hospital."

38. Inter-prisoner violence remains a worrying phenomenon in English prisons. The CPT notes the clear commitment expressed by various interlocutors during the visit, including the national authorities, as well as management and staff in the establishments visited, that all efforts would be made not to relapse to the situation which prevailed in the prison estate before the restrictions imposed in the context of the Covid-19 pandemic. It further notes that ensuring safety, security and well-being of prisoners is recognised as one of the priorities in the Covid-19 Custodial Recovery Guidance.

However, given the persistence of such episodes in prison and their severity despite the restrictions imposed during the Covid-19 pandemic, as documented above, **the CPT recommends that the United Kingdom authorities intensify their efforts to combat the phenomenon of violence in prisons. In particular, as prisons move through the various stages of relaxing restrictions (including increased mass movement and more association time for prisoners) as foreseen in the National Framework for Covid-19 Recovery, particular care will be needed to avoid a new wave of violence in prisons.**

39. Nor can it be said that the prisons visited provided a safe working environment for prison staff.

Records seen by the CPT's delegation in the establishments visited clearly indicated that serious assaults by prisoners on staff remain relatively commonplace, with examples of punches, bites and attempted scaldings, all within the month preceding the visit.

In the view of the CPT, **increasing the ratio of properly trained prison staff to prisoners remains a critical factor in combatting all forms of violence in prisons, including prisoner-on-staff assaults**. Increasing the numbers of frontline staff, as well as improving their training, should be a particular priority (see also paragraphs 73 to 77).

40. In the course of the visit, the CPT's delegation paid particular attention to the recording of violent episodes, use of force and injuries sustained by those involved. As already noted in the report on the 2019 visit, it is positive that monitoring and reporting procedures are in place; however, once again, the delegation observed certain shortcomings in their practical operation.

In several cases reviewed by the delegation, although the record made in the use of force log stated that control and restraint was resorted to, in some instances including the use of handcuffs and/or drawing of a baton, no use of force report was produced. Further, in a number of other cases in which the use of force report was produced, the separate report of injuries to prisoners (F213 form) which is a mandatory part of the use of force file, was missing, incomplete (e.g. the medical part of the form, including a body chart was not completed) or lacked detail. The CPT underlines in this respect that the use of force report form contains a clear guidance that "[a] F213 form must be completed on all prisoners, even if they appear not to have sustained any injuries. A copy of the F213 must be attached to [the use of force report] form. This form should then be placed in the force incident file."

For example, in the case described in more details in paragraph 37 (iv) above, despite the severity of the attack and the clear indication that force was used by staff, the use of force report noted that it was unknown whether the F213 form was completed and the establishment was unable to present it to the CPT's delegation. Further, in another case, according to the records examined by the delegation, when unlocked for health-care screening, a prisoner had assaulted an officer by elbowing him in the face and then repeatedly punching him. The prisoner concerned had received a baton strike to his side/back and a punch to his head. This had been to stop him as he had been attacking an officer. However, although significant force had been used against the prisoner concerned and the use of force report noted that the F213 form had been completed by a nurse, this was not the case and the F213 form presented to the delegation was incomplete (i.e. the part to be filled out by health-care staff, including the body chart to mark injuries sustained by the prisoner concerned, had not been completed).

The CPT must reiterate that the absence of a F213 form as part of the use of force documentation deprives the file of information regarding any injuries borne by a prisoner after the use of force, including the explanation provided by the prisoner to medical staff as to the origin of those injuries. Although it is positive in this context that most other aspects of reporting on the use of force have been digitised, that is not the case for the F213 form.

In conclusion, the findings of the visit indicate that the potential of reporting mechanism on the use of force and injuries sustained to contribute to the prevention of ill-treatment is still not being fully realised.

Consequently, **the CPT reiterates its recommendation that the overall quality of the recording of violent episodes, use of force and injuries sustained be improved, including ensuring that mandatory F213 forms are duly completed in every case involving the use of force. In this regard, consideration should be given to digitising the F213 forms and ensuring that they constitute an integral part of the use of force documentation.**

41. The CPT notes positively in this context that the minutes of a Use of Force meeting held at Durham Prison on 21 June 2021, shortly after the Committee's visit to the establishment, include the following information:

> "The purpose of Use of Force meeting was discussed. In particular the expectation that use of Force incidents would be reviewed to ensure appropriate use of force, levels of force, and completion of all required documentation. The Governor advised that following the recent visit by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, it was noted that there are gaps in our governance process which could be improved. Areas of concern were the governance of individual incidents which required evidence of governance including completion of documentation and viewing of footage following the move to the new national digital reporting system, and locally, the full completion of F213s with evidence to demonstrate that the prisoner has been seen by a member of the nursing team. Based on these comments, the Governor has committed to implementing a weekly Use of Force meeting to focus on these areas. This will commence from next week."
>
> **The CPT welcomes these steps taken following its visit to Durham Prison.**

42. At Durham Prison, the delegation also had the opportunity to participate in one of the weekly Safety and Intervention Meetings (SIM) in which the situation of the most difficult to manage prisoners was discussed. It gained a very good impression of the process and its multi-disciplinary nature. Staff from several different teams had regular contact with the most difficult to manage prisoners and appeared to know them well. Clear goals with progress indicators to be met within defined timeframes were issued to specific members of staff and CSIP documentation[26] was thoroughly reviewed during the meeting. **The CPT recommends that the good practice observed at Durham Prison be replicated more widely.**

43. Another issue examined by the delegation during the visit in the context of the prevention of violence was the use of body-worn video cameras (BWVC). During the 2019 visit, the CPT observed that far less use was being made of BWVCs than might – or should – have been the case. Consequently, the CPT recommended that the issuing and use of BWVCs should be made mandatory for all staff who may have to use force against prisoners.

However, the findings of the 2021 visit indicate that the situation remains by and large unchanged. As far as the delegation was informed, the use of BWVCs, even if encouraged, remains optional for custodial staff and Article 2.7 of the Prison Service Instruction (PSI) on BWVCs[27]

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[26] Challenge, Support and Intervention Plan (CSIP) process is the national case management model for managing those who pose a raised risk of being violent and was mandated for use across the adult prison estate from November 2018.

[27] National Security Management Framework, Security Management, Body Worn Video Cameras. Prison Service Instruction (PSI) 04/2017, issued on 20 March 2017.

continues to merely provide that "[w]hen BWVC is deployed within a prison it must be used […] [w]hen a user has or may be required to exercise force against a person or persons". Moreover, in all three prisons visited, the delegation observed that a number of front-line custodial officers were not wearing a BWVC although cameras were available in the establishments. To illustrate the situation, at Wormwood Scrubs Prison, on 12 June 2021, with 58 custodial officers on duty, only 29 of 111 available cameras had been issued.

In order to enhance the potential of BWVCs to contribute to the prevention of ill-treatment, and better to protect prison staff from unfounded allegations of ill-treatment, **the CPT reiterates its recommendation that the terms of Prison Service Instruction 04/2017 be amended to make it mandatory for BWVCs to be issued, worn and turned on by all prison staff who may have to use force against prisoners and non-compliance with this obligation (in the absence of an explanation of exceptional circumstances) should be treated as a disciplinary matter.**

## 3. Conditions of detention

### a. material conditions

44. At *Durham Prison*, efforts were being made to maintain the premises in a reasonable state of repair and cleanliness. For example, windows had been changed in most parts of the prison, flooring in certain areas had been replaced, an ongoing programme of redecoration was taking place and there were plans to replace old furniture in the cells.

However, prisoners were accommodated in cells most of which measured some 7.5 m² (including the in-cell toilet area) to as little as 6 m² (in particular in parts of Wing C). Most cells in the establishment were used for double-occupancy and provided crowded conditions, virtually all floor space being taken by the furniture.

Moreover, with the exception of a few cells located in Wings A, C and F which possessed a fully partitioned sanitary annexe,[28] the in-cell toilet area was either only partially separated from the rest of the cell with a one-metre-high screen on one side, or there was no partitioning at all (most notably in the small cells in Wing C).

Further, several cells were poorly ventilated, the delegation noted signs of dilapidation in the cells and common areas (e.g. damaged flooring and dirty walls) and, although the cells were in principle suitably equipped (bunk-beds, tables, chairs, shelves, a kettle and a TV, as well as an in-cell phone and a call bell), the fact remains that virtually all the furniture was old and worn out.

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28 These cells measured 6.7 m², excluding the sanitary annexe.

45. At *Woodhill Prison*, the delegation gained an overall positive impression of the material conditions. All the premises were clean and in a good state of repair, cells were suitably equipped and were adequately lit and ventilated. Further, following the 2019 transformation into a long-term Category B prison for sentenced male prisoners, the number of prisoners held in the establishment had significantly decreased and all inmates were now accommodated in single-occupancy cells which were sufficient in size (i.e., between 8 and 8.5 m²).

46. At *Wormwood Scrubs Prison*, the delegation noted some improvements in comparison with the situation observed in 2019. In particular, parts of the prison had been refurbished and redecorated, old windows have been replaced and, as far as the delegation could ascertain, call bells were functional in all parts of the prison. The outdoor exercise yards which had been covered with litter in 2019 had been cleaned.

However, it remained the case that a number of prisoners were doubled up in cells designed for single occupancy – measuring approximately 8m², including the sanitary area – which provided cramped conditions.[29] Moreover, the toilets in these cells were unpartitioned.

47. As repeatedly pointed out in the previous reports, the CPT considers that a single-occupancy prison cell should measure at least 6 m² (excluding the sanitary annexe) and a multiple-occupancy prison cell should provide at least 4 m² per person (excluding the fully partitioned sanitary annexe). These *minimum standards* were not being met in a number of cells at Durham and Wormwood Scrubs Prisons. Moreover, the CPT has also stated that it would be desirable for cells measuring 8 or 9 m² to hold no more than one prisoner and for double-occupancy cells to provide at least 10 m² of living space (plus a fully partitioned sanitary annexe).

**The CPT recommends that the United Kingdom authorities take steps to ensure that prison cells measuring less than 8 m² (excluding the space taken by the in-cell sanitary annexe) at Durham and Wormwood Scrubs, as well as, as relevant, in all other prisons in England and Wales, are only used for single-occupancy. It would be desirable for double-occupancy cells to measure at least 10 m² (excluding the fully partitioned sanitary area). The capacity of the establishments should be reviewed accordingly. Reference is also made in this context to the recommendation made in paragraph 32.** Further, **sanitary annexes in double-occupancy cells should be fully partitioned up to the ceiling.**

In addition, **the Committee recommends that work continue at Durham and Wormwood Scrubs Prisons to ensure that all the premises are maintained in a good state of repair, clean and adequately ventilated and that efforts are pursued to replace the worn-out furniture at Durham Prison.**

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29 There were also cells used for single-occupancy (Wings D and E) and double-occupancy cells measuring some 8 m² excluding the fully-partitioned sanitary annexe.

b. regime

48. Prior to the outbreak of the Covid-19 pandemic, efforts had been made in all the establishments visited to engage prisoners in organised activities.

According to the information provided to the delegation, at *Durham Prison*, despite the fact that the establishment was holding primarily unsentenced prisoners, most prisoners had been engaged, albeit the majority of them only part-time, in a broad range of work opportunities (e.g. barbers, painters, cleaners, kitchen work and distribution of food), vocational training (e.g. horticulture, woodwork, industrial cleaning, warehousing, waste management) and education (e.g. maths, English and English as a second language, as well as personal development and IT courses).[30] In addition, prisoners had been offered access to a gym and library and benefited from two hours a day out-of-cell time during which they could access outdoor exercise yards, associate with other persons and take a shower. There had also been plans to open additional workshops for recycling clothes and a training kitchen for persons in prison. However, the out-of-cell time for those not involved in organised activities had been rather limited; these prisoners could stay for up to 21 to 22 hours a day locked in their cells.

At *Woodhill Prison*, virtually all prisoners[31] had been engaged, either full- or part-time, in work (e.g. kitchen, laundry, re-cycling, gardening, cleaning), education (e.g. English, maths, English as a second language) and vocational training (e.g. industrial cleaning, catering, multi-skills courses, painting and decoration). They had also been offered access to a gym and a library and two to three hours a day of association time, including outdoor exercise.

The situation at *Wormwood Scrubs Prison* has been described in the report on the 2019 visit. It should be recalled that approximately two thirds of prisoners had worked or participated in organised activities, had been able to be out of their cells for around six hours and had been offered a further one and a half hours for association, exercise and showers on weekdays. However, the remaining approximately one-third of persons in prison (i.e., over 300) had remained locked in their cells for some 20 to 23 hours per day.

49. The provision of regime activities and out-of-cell time had been significantly curtailed by the restrictions imposed during the Covid-19 pandemic.

The measures introduced initially included, *inter alia*, restricting regimes to implement social distancing, limiting movement of prisoners between prisons and compartmentalising prisons into different units to isolate the ill, shield the vulnerable and quarantine new arrivals. Subsequently, the "Covid-19: National Framework for Prison Regimes and Services", published in June 2020, provided a "conditional roadmap" for easing of restrictions and how prisons will operate "while Covid-19 remains a threat but where the most severe restrictions on prison regimes are no longer proportionate or sustainable".[32]

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30 The delegation was also told that additional capacity was available in the various activities but was not filled due to a lack of interest from prisoners.

31 With the exception of some 50 prisoners who were unallocated to activities due, for example, to their disruptive behaviour.

32 The National Framework is available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1011828/prisons-national-framework-august-2021.pdf.

The National Framework provides for five stages of the process, from Stage 5 representing a complete lockdown during an active outbreak of the infection to Stage 1 when compartmentalisation is no longer required and regimes can operate without requirements for social distancing or use of PPE.

At the time of the visit, the establishments visited operated at Stage 3 and were expected to gradually start transitioning to Stage 2 of the National Framework.

50. As regards the practical impact of the measures imposed, the CPT's delegation observed that the possibilities to participate in regime activities, associate with other inmates and spend time out of cells were severely restricted throughout the duration of the pandemic in the establishments visited (as well as throughout the prison estate).

In principle, most workshops were closed and only essential work continued in the establishments visited (such as work in the kitchens, distribution of food, laundry, cleaning and gardening) which provided work opportunities, either part- or full-time, for some 100 to 150 prisoners at Durham Prison, up to 250 at Woodhill Prison and some 250 to 300 inmates at Wormwood Scrubs Prison.[33] In-cell learning packages to provide some basic educational courses were offered to 350 to 400 persons at Durham Prison, 150 persons at Woodhill Prison and 280 persons at Wormwood Scrubs Prison; "welfare/distraction" packs (composed of mazes, colouring sheets, Sudoku and crosswords) were also provided to prisoners to distract their attention during the in-cell time.

Further, prisoners in all three establishments visited were offered between 30 and 40 minutes of daily outdoor exercise and some additional out-of-cell time (to access showers, collect their meals, make orders/applications); altogether this totalled a maximum of one and a half hours of out-of-cell time per day.[34] As the establishments transitioned from Stage 4 to Stage 3 of the National Framework shortly prior to the visit, gyms were opened for restricted groups of prisoners and small-group educational classes had been re-introduced.

However, despite these commendable efforts to alleviate the worst effects of the regime restrictions imposed during the pandemic, the fact remained that the vast majority of prisoners (i.e. those not engaged in essential work) continued to be locked up in their cells for 22 to 23 hours a day, with far too little to do. Indeed, such a situation had endured throughout the duration of the pandemic. Moreover, prisoners were usually offered considerably less than one hour of access to outdoor exercise,[35] which the CPT considers to be the minimum standard that should be guaranteed to all prisoners.[36]

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33 It is recalled that, at the time of the visit, Durham Prison had an occupancy of 917 inmates, Woodhill Prison of 476 inmates and there were 1,098 prisoners at Wormwood Scrubs Prison.

34 During the out-of-cell time, prisoners had contact with a restricted number of other inmates. These small groups (sometimes referred to as "cohorts", "households" or "bubbles") consisted of 15 to 40 inmates, depending on the restrictions in place in a given moment.

35 According to the information received by the CPT from other prisons, prisoners were sometimes provided as little as 30 minutes of outdoor exercise a week.

36 See paragraph 7 of the CPT's Statement of principles relating to the treatment of persons deprived of their liberty in the context of the coronavirus disease (Covid-19) pandemic, published on 20 March 2020.

51. The Covid-19 pandemic was seen by the authorities as an opportunity to address the shortcomings in the provision of purposeful activities in prisons. The Future Regime Design Project (FRD) to design the model for Stage 1 of the National Framework (which will mark the end of prison response to Covid-19) was expected to lay down foundations for long term transformation of prison regimes. The overall aim was to develop a new purposeful activity measure focused on ensuring prisoners experience "time well spent", delivering quality rather than just quantity of activity. A wider definition of purposeful activity should be developed on the basis that purpose is defined by the impact on an individual, rather than the nature of the activity and as such a wider range of formal and informal, individual and group activities can be considered purposeful. The delivery of activities should be tailored to individual needs, giving staff and prisoners more opportunities to actively participate in the regime and creating the opportunity for progression.

**The CPT would like to receive more details about the Future Regime Design Project (FRD) and about the improvements in the provision of regime activities its implementation has so far brought and is expected to bring.**

Further, **the Committee trusts that steps will be taken as soon as the health situation permits to ease the restrictions imposed in the context of the Covid-19 pandemic in prisons, in line with the National Framework and with the lifting of restrictions in the community, to ensure that prisoners gradually benefit from more out-of-cell time and re-engage in purposeful activities. Immediate steps should be taken to ensure that all prisoners, irrespective of the Covid-19-related restrictions in place, can benefit from at least one hour of outdoor exercise per day.**

More generally, **the CPT recommends that the United Kingdom authorities continue their efforts to review the provision of purposeful activities to prisoners, with a view to ensuring that as many prisoners as possible participate in a full programme of activities. The aim should be to ensure that all prisoners, including those on remand, are able to spend a reasonable part of the day (i.e., eight hours or more) outside their cells engaged in purposeful activities of a varied nature (work; vocational training; education; sport; recreation/association). Inmates who are unemployed or do not participate in activities should be provided with more out-of-cell time than described in paragraph 48.**

52. As repeatedly emphasised in the past by the CPT, all outdoor exercise yards should possess a shelter against rain and sun and a means of rest. This was still not the case in all the yards in the three establishments visited. **The CPT recommends that steps be taken to ensure all yards are equipped with a shelter and a means of rest.**

## 4. Health care services

### a. general health care

53. The health-care staffing levels in the three establishments visited appeared to be on the whole adequate to meet the needs of the prison population.

At *Durham Prison*, the primary care team comprised a pool of three general practitioners (GPs) covering together two full-time equivalent (FTE) posts, a Primary Care Lead (advanced nurse practitioner), 22 nurse practitioners/nurses and 19 nursing assistants. There were also two pharmacists and six pharmacist technicians. An emergency response nurse was present in the establishment at all times.

At *Woodhill Prison*, there were 2.5 FTE posts of a GP, a Primary Care Lead, 14.75 FTE posts of nurses, three emergency health workers and 4.75 FTE posts of nursing assistants, as well as seven pharmacy staff members. Four nurses were present in the establishment every day until 9 p.m. and two nurses covered the night shift.

At *Wormwood Scrubs Prison*, there were four GPs on rotation (covering together 2.5 FTEs), a Head and a Deputy Head of Health Care, as well as 13 nurse practitioners/nurses, an assistant practitioner and 1.5 FTE of health-care assistants. In addition, a manager of the unit (mental health nurse) and 11 nurses were dedicated to the in-patient unit. Nursing cover was provided 24/7. The prison also employed a pharmacist and seven pharmacy technicians.

However, in all three establishments, a number of additional posts of health-care staff were vacant.[37] Although most of the posts were in practice covered, by agency health-care professionals, the CPT considers that it would be much preferable, in particular in terms of the continuity of care and establishing a proper therapeutic relationship, that health care in prison is provided by stable health-care teams and staff employed by the provider of the health care. More generally, the Committee considers that, while it may be justified to use agency staff as a short-term replacement (e.g. when permanent staff is ill), the deployment of agency staff should not replace a sustainable long-term recruitment strategy of sufficient numbers of health-care staff. **The CPT would like to receive comments of the United Kingdom authorities on these issues.**

54. All three establishments were visited by external specialist doctors, including a dentist. However, waiting times for a dental appointment at Woodhill and Wormwood Scrubs Prisons (up to 29 weeks and 20 weeks, respectively) were too long. Reportedly, the waiting time became longer due to the Covid-19-related restrictions and broadly pursued the same trajectory as in the community. **The CPT trusts that as the prison systems transitions through the various stages of easing Covid-19-related restrictions acording to the National Framework, the waiting times for dental appointments at Wormwood Scrubs and Woodhill Prisons will become significantly shorter.**

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[37] A Complex Case Lead post, Early Days in Custody Lead post and nine posts of nurses at Durham Prison; 11 vacant posts of nurses, one post of an emergency health worker and four vacant posts (of which three were about to be filled shortly) of health-care assistants at Woodhill Prison and 21.5 FTE posts of nursing staff at Wormwood Scrubs Prison.

55. As repeatedly observed in the past, it is positive that newly-admitted prisoners were comprehensively medically screened by a nurse upon admission and then, within seven days, for a second, more detailed examination. If necessary, they were also examined by a medical doctor.

Requests for medical appointments could be made by prisoners in various ways depending on the establishment, either by approaching the wing-based nurse, by placing an application in a secure box or by using an electronic kiosk. However, at Wormwood Scrubs Prison, applications were triaged by a nurse to determine the urgency of the request and priority for care within seven days. **The CPT recommends that this triage period be significantly shortened.**

56. Medical records were generally well-kept (see, however, paragraph 40 as regards the reports of injuries to prisoners (F213 form)) and contained a detailed description of injuries and body charts to mark the injuries.

That said, as observed by the CPT during previous visits, the records usually did not contain any conclusions as to the consistency between the prisoner's statement as to the origin of injuries and objective medical findings.

**The CPT recommends that steps be taken by the United Kingdom authorities to ensure that health-care professionals indicate in the record drawn up following the medical examination of a prisoner their observations indicating the consistency between any allegations/statements made by the prisoner concerned and the objective medical findings.**

57. In several previous reports, the CPT expressed its concerns about the way medication was distributed to prisoners. Prisoners usually queued in big groups in a corridor to receive medication from a nurse; these arrangements facilitated other inmates to see and hear conversations between the nurse and the persons concerned and exposed vulnerable persons to intimidation and violence by other prisoners.

It is a positive development that, because of social distancing requirement due to Covid-19 pandemic, prisoners in the establishments visited were now transferred by custodial staff to receive medication in smaller groups of four or five inmates. As acknowledged by staff, this contributed to the decrease in inter-prisoner violence and intimidation. **The CPT recommends that the United Kingdom authorities maintain these arrangements beyond the Covid-19 pandemic and take further steps to ensure that medication is not given to prisoners in an open corridor and medical confidentiality is fully respected.**

58. According to the use of force documentation relating to the case described in paragraph 37 (i), the prisoner concerned, following his return from hospital after he had been assaulted by another inmate, was seen by a nurse and then a medical doctor. According to the record made by the doctor, he was seen "through the cell door window as officers were unable to unlock him due to lockdown time".

In the CPT's view, it is totally unacceptable that health-care staff are prevented from examining a prisoner due to an alleged shortage of staff or lock-up time in place. A decision as to whether or not a prisoner needs to be medically examined must be guided by clinical criteria and must be taken by health-care staff. **The CPT recommends that the United Kingdom authorities take the necessary steps to ensure that, as necessary, health-care staff have unimpeded access to inmates at all times.**

b. mental health care

59. At *Durham Prison*, psychiatric care was provided by an In-reach team and prisoners with severe mental health problems or with complex needs were accommodated in the Integrated Support Unit (ISU). Overall, the delegation gained a very good impression of the provision of mental health services in this establishment.

The In-reach team was well staffed and comprised a psychiatrist who visited the establishment twice a week, another psychiatrist who visited once a month and who specialised in learning disability/neurodevelopmental disorders, nine mental health nurses (including two disability nurses), a speech and language therapist and two support workers. However, the team would benefit from the input of a clinical psychologist. **The CPT recommends that the In-reach team at Durham Prison benefit from the input of a clinical psychologist.**

60. The ISU[38] was opened as a regional centre to serve seven prisons and to accommodate prisoners whose mental health needs could not be adequately managed in ordinary units. It provided a therapeutic environment and benefited from the presence of a sufficient number of health-care staff: there were two to three mental health nurses between 8 a.m. and 6 p.m. on working days and the unit was visited for one day a week by a psychiatrist and several times per week by an occupational therapist and a speech and language therapist. Prison officers deployed in this unit were trained in mental health issues. The ISU team appeared to be in daily contact with the In-reach team and transfers of prisoners from ordinary units in Durham Prison were usually carried out promptly.

However, the delegation was informed that given the needs presented by the prison population at Durham Prison, it was difficult to accommodate the high number of requests for transfer to the ISU of persons from other prisons. The CPT considers that the Integration and Support Unit which operates at Durham Prison could be taken as a model for the care of prisoners with mental disorders and similar units should be established in other prison establishments. **The Committee would like to receive the comments of the United Kingdom authorities on this issue.**

61. At *Woodhill Prison*, the In-reach team was in general adequately staffed and included a mental health lead, 0.6 FTE post of a consultant psychiatrist, a specialist psychiatrist, 0.6 FTE post of a supervising clinical psychologist, one post of a clinical psychologist, an operant behavioural therapy (OBT) psychologist, two assistant psychologists, a learning disability nurse, five mental health practitioners, a mental health nurse and 3.76 posts of a nurse. However, additional two posts of a mental health practitioner, four posts of a mental health nurse and 2.24 posts of a nurse were vacant.

Moreover, there were no mental health care nurses to provide mental health care at primary level and support to prisoners with lower-level mental health needs (e.g. low mood and anxiety disorders) was provided by assistant psychologists.

**The CPT recommends that steps be taken to ensure that mental health nurses are available at Woodhill Prison to provide care to prisoners at primary level.** Further, **the vacant posts in the In-reach team should be filled.**

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38 The unit had a capacity of 13 beds (including two reserved for prisoners who worked in the unit as cleaners) and was accommodating 10 prisoners at the time of the visit

62. The primary level mental health care at *Wormwood Scrubs Prison* was provided by two mental health practitioners only (a therapist and a consultant therapist) and the waiting times for assessment (approximately six weeks) were excessively long.

Mental health care at secondary level was provided by a well-staffed In-reach team, composed of a Lead In-reach, 2.5 FTE posts of psychiatrists and 5.6 posts of community psychiatric nurses. However, one additional post of a learning disability nurse and two posts of clinical psychologists were vacant.

**The CPT recommends that the resources to provide primary level mental health care at Wormwood Scrubs Prison be significantly reinforced to meet the needs of the prison population and to shorten the waiting time for mental health assessment.** Further, **the Committee recommends that the vacant posts in the In-reach team be filled.**

63. As was the case in some of the establishments visited in the past, at Woodhill and Wormwood Scrubs Prisons, the delegation once again observed considerable delays in the transfer of prisoners suffering from severe mental health problems to psychiatric hospitals. For example, at Woodhill Prison, in two cases in the first half of 2021, the waiting time was two and three months; at the time of the visit, there were five prisoners on a waiting list whose referral was requested in February, March (two cases), April and June. At Wormwood Scrubs Prison, in five cases, the time between a referral of a prisoner to a psychiatric hospital and his admission therein was between 110 and 165 days. Seven patients were on a waiting list at the time of the visit and the waiting times ranged between 41 and 127 days.

Moreover, the CPT wishes to reiterate that long delays for transfers to hospital of prisoners suffering from serious mental health disorders is not a new issue; it was already raised in the 2009 Bradley Report on mental health services in the criminal justice system, as well as several other independent reviews. The Bradley Report recommended that such prisoners should be transferred to hospital within 14 days. The CPT considered that even this time-limit was too long.[39] Yet, as described above, during the 2021 visit, the CPT's delegation once again observed that the 14-day time limit was often not observed in practice. Several interlocutors met during the visit considered that the main reason for delays was the high number of persons who suffer from mental health disorders already upon admission to prison as well as the continuing lack of available beds in secure psychiatric hospitals.

Further, although the in-patient units at Wormwood Scrubs and Woodhill Prisons were accommodating a significant number of prisoners with mental health disorders,[40] the care offered was in principle limited to providing medication (on a voluntary basis) and there were no therapeutic activities provided to the patients.

In the light of these findings, **the CPT reiterates its recommendation that the United Kingdom authorities take all necessary measures to ensure that prisoners suffering from severe mental health problems are transferred without delay and cared for and treated in a closed hospital environment, suitably equipped and with sufficiently qualified staff to provide them with the necessary assistance. In this connection, given their insufficient number, high priority**

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39 For more details, see the report on the CPT's 2016 visit to the United Kingdom (doc. CPT/Inf (2017) 9, paragraph 67) and the report on the May 2019 visit (doc. CPT/Inf (2020) 18, paragraph 103).

40 Given the existence of the ISU, the in-patient unit at Durham Prison accommodated primarily patients requiring somatic care.

**should be given to increasing the number of beds in psychiatric hospitals.** Further, **placement in in-patient health-care units in prisons should not be regarded as a substitute for transfer of prisoners to psychiatric facilities.**

Moreover, **as long as persons with mental health disorders are accommodated in the in-patient units at Wormwood Scrubs and Woodhill Prisons, the CPT recommends that the United Kingdom authorities take steps to ensure that they are provided a range of suitable therapeutic activities.**

64. At Woodhill Prison, a number of vulnerable prisoners, including those suffering from mental health disorders, were accommodated in the "Compass unit". Despite the commendable aspiration to provide these inmates with a safe environment and offer enhanced support, it appeared that, at the time of the visit, the unit served merely to segregate these persons from the rest of the prison population and the inmates concerned were not being offered an appropriate range of therapeutic options and support. Moreover, due to the shortage of staff, it occurred several times a week that these vulnerable persons remained locked up in their cells for full 24 hours, with no activities and out-of-cell time whatsoever being provided to them.

The delegation was informed that there were plans to turn the Compass unit into a day centre for vulnerable prisoners, which would be staffed with an occupational therapist, art therapist, psychologists and 0.2 FTE post of psychiatrist.

**The CPT would like to receive more details about the plans to transform the Compass unit at Woodhill Prison into a day centre for vulnerable persons.** As long as the unit continues to accommodate vulnerable persons**, the CPT recommends that the United Kingdom authorities take steps to ensure that they are provided a range of suitable therapeutic activities.** Moreover, **as all other prisoners, they should be able to benefit of at least one hour of daily outdoor exercise (regardless of the Covid-19-related restrictions in place).**

65. In the report on the 2019 visit, the CPT expressed concerns about the high and steadily increasing levels of self-harm in the prison estate. In particular, according to the official statistics, 2019 set "a new record high"[41] with an alarming increase of 24% in acts of self-harm compared to 2018.

According to the latest available figures, the number of self-harming incidents in the male prison estate had decreased by 13% in the 12 months to December 2020 (there were 55,542 incidents during the referenced period) and this was also reflected in the three establishments visited.[42] However, as already noted with regard to assaults in prison, these data must be interpreted in the light of the unprecedented situation caused by the restrictions imposed in the context of the Covid-19 pandemic and cannot in itself be taken as an indicator of a sustainable decrease in the incidence of self-harm. On the contrary, several interlocutors met by the delegation expressed concerns about the longer-term effects on mental health of prisoners caused by the Covid-19-related restrictions, in particular the almost complete lack of activities and association for the majority of prisoners (see paragraphs 49 and 50) and the restrictions imposed on prisoners' possibilities to receive social visits (see paragraph 96).

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41 By way of illustration, there were 57,968 incidents of self-harm between March 2018 and March 2019.

42 The number of self-harm incidents between 2019 and 2020 decreased as follows: at Durham Prison from 727 to 536 cases, at Woodhill Prison from 705 to 426 cases and at Wormwood Scrubs Prison from 442 to 290 cases.

Certain procedures are in place in the prison system to identify those most prone to self-harm, including through a screening on admission and the possibility to place vulnerable individuals on "Assessment, Care in Custody and Teamwork Plan (ACCT)"[43]. However, given the persistently high numbers of self-harm incidents, it is clear that these procedures have yet to fully realise their potential.

66. This was borne out by a review of recent incidents of self-harm in the establishments visited, which showed a familiar pattern of ligature tying and self-cutting, often explicitly linked to social difficulties and/or mental health issues being experienced by the prisoners concerned. For example:

(i) 14/6/21 - "He had tied a ligature loosely around his neck and attached a fork to the toilet door. As [an officer] opened the toilet door … [the prisoner] dropped his weight and the ligature snapped. It was not tied tight. Hotel 1 [health care] attended and after some treatment ambulance was stood down … [prisoner] is struggling with impending court dates and not hearing from his family."

(ii) 10/6/21 - "Staff were alerted to an argument in [a cell] occupied by [two prisoners] … When staff attended [prisoner A] had made a small cut to his arm using a razor blade due to the arguments. [He] was moved to [another] cell … to separate the prisoners and an ACCT opened to support [him]. [Prisoner A] stated that these arguments were down to [Prisoner B] asking him to sell illicit substances on the wing."

(iii) 6/6/21, 2/6/21 and 20/5/21 [all in relation to the same prisoner] "ACCT re-opened in post closure after [prisoner] opened up an old wound on his head. He stated voices in his head told him to do it. Hotel 1 [healthcare] attended and dressed wound"; "caused deliberate self-harm by punching his own head"; "re-opened his wound on his forehead by banging his head against the wall repeatedly. He is an OP [own protection] prisoner who is in debt on [the] wing and wants to be moved off the wing."

(iv) 5/6/21 - "found in cell … by [officer] with two deep cuts to his left wrist. [Prisoner] states he did this as he can't cope with prison as people ply him with Spice [a new psychoactive substance] and get him in debt. He said he especially can't cope this time as his Dad has "grassed him up" and he's sick. Wounds dressed and glued by Hotel 1 [health care]".

(v) 17/5/21 - "[prisoner] self-harmed over the lunch period by making significant cuts to his left arm with a razor blade he had secreted. He allowed Hotel 1 [health care] to dress the wound but secreted the razor blade again. [Prisoner] stated his intention to kill himself and that he would self-harm further. ACCT updated and following discussion with Deputy Governor … he was placed on a constant watch and moved out of the [segregation unit]".

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[43] The ACCT process is a means whereby staff can provide individual care to prisoners who are in distress in order to help defuse a potentially suicidal crisis, help with long-term needs and better manage and reduce their distress.

67. **The CPT recommends that the United Kingdom authorities redouble their efforts to tackle the issue of self-harm in prison. The implementation of the recommendations set out in this report concerning regime of activities (paragraph 51), mental health care (paragraph 63) and staffing (paragraph 77) will facilitate these efforts.**

Further, **the Committee would like to be informed of the measures taken and/or envisaged by the United Kingdom authorities to identify and tackle the longer-term effects on mental health of prisoners of the Covid-19-related restrictions.**

68. On admission, prisoners were screened for substance use and, where appropriate, opioid agonist therapy was started or continued without interruption; if needed, prisoners concerned were provided with treatment for withdrawal symptoms in line with the relevant clinical guidelines. Prisoners with substance use disorders were provided support by clinical and non-clinical teams.

According to the information provided to the delegation, the influx of drugs into prison and their widespread availability[44] had decreased since the imposition of the Covid-19-related restrictions.

As noted in the 2019 report, the United Kingdom authorities put in place a Prison Drugs Strategy (2019). It aimed to restrict the supply of drugs into prisons and to reduce the demand for drugs in prison by developing more meaningful regimes and working closely with health and justice partners to build recovery for prisoners who want to overcome their substance misuse. It also aimed to provide prisoners who are serious about living substance free with the environment to do so successfully.

The CPT welcomes the commitment of the United Kingdom authorities to tackle the issue of substance use in prisons. **It trusts that the necessary resources will be allocated to ensure that the 2019 Prison Drugs Strategy is effectively implemented in all prisons. Reference is also made in this context to the recommendation concerning the regime of activities (paragraph 51).**

69. As regards the measures taken to prevent the spread of the SARS-CoV-2 virus into prisons, newly-admitted prisoners were isolated ("reverse cohorting") for 14 days at Durham and Woodhill Prisons and some 10 days at Wormwood Scrubs Prison.[45] They were offered PCR tests on the day of their admission and then five days later. During reverse cohorting, they were allowed contacts only within their cohort, i.e., with prisoners who arrived on the same day. However, as far as the delegation could ascertain, the daily out-of-cell time provided to these inmates (outdoor exercise, shower and domestic tasks) was often as little as half an hour per day. **The CPT recommends that the United Kingdom authorities take steps immediately to ensure that all newly-admitted prisoners, irrespective of the Covid-19-related restrictions in place, can benefit from at least one hour of outdoor exercise per day.**

Further, **as far as the Covid-19-related restrictions remain in place and there is a need to isolate newly-admitted prisoners, the CPT encourages the United Kingdom authorities to ensure that these persons are provided considerably more human contact every day, if necessary, within their cohort and in a sufficiently ventilated indoor or outdoor area, while strictly observing the necessary preventive measures (physical distancing, wearing of masks).**

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44 See also the report on the CPT's 2019 visit to the United Kingdom (doc. CPT/Inf (2020)18, paragraph108 to 111).

45 At Wormwood Scrubs, inmates were moved to normal accommodation after the negative outcome of the second PCR test, i.e. usually within seven days of their admission.

In addition, **the CPT would like to be informed to what extent the arrangements concerning newly-admitted prisoners will be affected once prisoners and staff are fully vaccinated.**

70. In all three prisons, prisoners vulnerable on medical grounds were offered accommodation in a dedicated unit/cells to be separated from the mainstream prison population ("shielding the vulnerable").

As regards the use of personal protective equipment (PPE), staff were expected to wear masks in all three establishments visited. Masks were also provided to prisoners who were expected to wear them when outside of their cells (Durham Prison), if they could not keep 2 m distance from other persons (Woodhill Prison) or in the reverse cohorting unit (Wormwood Scrubs Prison).

71. As far as the delegation was informed, the incidence of Covid-19 at Woodhill Prison was very low; however, despite the measures in place, the other two establishments visited experienced major outbreaks (at Durham Prison, 57 members of staff and some 200 prisoners tested positive in January 2021 and at Wormwood Scrubs, in October 2020, over 100 prisoners tested positive and in February 2021, there were over 200 cases among inmates).

72. Management and staff in the prisons visited were well-aware of the importance of keeping prisoners informed of the situation and of the importance of respecting the restrictions imposed.[46] This was appreciated by the inmates and **the CPT's delegation gained a positive impression of the way in which prisoners were kept informed during the pandemic in the establishments visited.**

## 5. Other issues

### a. prison staff

73. The CPT in its report on the 2016 visit had been very critical of the dangerously low staffing levels in the prisons that it visited. It, like other stakeholders, linked this to the deterioration in safety and standards in prisons and to poorer regimes for prisoners. Due to the nation-wide budgetary cuts, the number of front-line prison officers in English prisons had dropped by some 30% between 2010 and 2016; experienced prison officers had been offered voluntary redundancy or early retirement exit packages ("VEDs") and had left the Prison Service, and from around 2011 onwards, there had been a severe shortage of front-line operational officers, especially experienced officers.

The CPT also found that the low staffing levels and challenging working conditions in the prisons had led to low staff morale and increased work-related stress. Further, staff training was also considered insufficient, and other than their initial eight to twelve weeks of training, staff felt they did not get sufficient professional training support or refresher courses.

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[46] For example, at Woodhill Prison, a newsletter was regularly published; at Durham and Wormwood Scrubs, staff was in regular contact with prisoners and kept them informed of the situation at the given moment.

From late 2016 to early 2019, the Prison Service embarked on a large-scale recruitment of operational custodial officer-grade staff and over 3,000 new operational front-line prison staff were recruited. Despite that, in 2019, the CPT found that a number of challenges remained, in particular around staff retention, with the result that the actual numbers of staff in direct contact with prisoners in accommodation areas had not changed significantly since 2016, as well as in relation to the training of newly-recruited staff.

74. As regards the situation in 2021, according to the official statistics, there have recently been certain signs of improvement as regards the leaving rates and consequently the increasing experience among front-line operational staff. The leaving rate (9.1%) amongst band 3-5 prison officers[47] decreased by 3.1 percentage points in the year ending 31 March 2021 and the proportion of these officers with more than 3 years' service rose by 7.4% to 67.7% during the same period.

Nevertheless, despite information that staffing levels had slightly increased due to the ongoing recruitment[48] and the retention rates had improved,[49] a number of concerns remained in the establishments visited. In particular, there was still a high proportion of front-line custodial staff with less than two years of experience in working in prison: at Durham Prison, this amounted to some 20% (51 of 251) band 3-5 officers and at Wormwood Scrubs Prison to some 20 to 25% (of 294 band 3-5 officers). At Woodhill Prison, 185 members of all staff (i.e. 569 FTE posts, including 354 band 3-5 officers) had less than two years of experience of working in prison.

Moreover, the recruitment of new staff and filling vacant posts remained a challenge.[50] While the situation in this respect appeared to be reasonably good at Durham Prison (with only four posts of band 3-5 prison officers being vacant), at Wormwood Scrubs and Woodhill Prisons, there were 13 and 28 vacant posts, respectively.

The staffing levels and the presence of staff in the wings[51] appeared to be sufficient to maintain basic control and safety in the establishments visited given the restricted regimes in place during the Covid-19 pandemic. However, the delegation was informed that even during this period, due to a lack of staff, it regularly happened that whole wings were locked up for half a day or the whole day with no out-of-cell time whatsoever being provided. Such a situation is not acceptable. At Woodhill Prison, the delegation was also informed that there was a significant rate of failure to attend medical appointments due to the absence of staff to escort the prisoner concerned. The situation is likely to become even more critical once the Covid-19-related restrictions have been removed.

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47 Band 3 prison officers, band 4 officer specialists/supervising officers and band 5 custodial managers are the key operational front-line staff in direct contact with prisoners in accommodation areas.

48 With the exception of Woodhill Prison where staffing levels had decreased since 2019 due to the significantly reduced prison population (see also paragraph 45).

49 For example, at Woodhill Prison, the attrition rate of band 3-5 custodial officers had reduced from 8 to 5.16 in the 12 months to April 2021.

50 According to the official statistics, as at 31 March 2021, there were 21,926 FTE band 3-5 prison officers in post in the prison system which is no substantial change since 31 March 2020.

51 At *Durham Prison*, there were three to six prison officers deployed in each of the six main accommodation wings (each holding between 80 and 170 prisoners); in the night shift, there was one custodial manager and eight custodial officers for the whole establishment. At *Woodhill Prison*, there were nine custodial officers per house unit (i.e. 120 inmates accommodated on three landings) in the day shift and one custodial manager and four custodial officers for the whole establishment at night, supported by one band 2 Operational Support Grade (OSG) officer deployed in each wing. At *Wormwood Scrubs*, during the day, there were eight to ten custodial officers in each of the five main accommodation wings (each holding between 150 and 270 inmates on four landings; the night shift was composed of seven custodial officers (two posts were not covered due to shortages of staff) and five OSG officers deployed in the wings to support custodial staff.

To address the understaffing, the authorities expected that between 4,000 and 4,500 new prison officers would be recruited in 2022. Arrangements were also being put in place to facilitate progression from band 2 Operational Support Grade (OSG) officers to prison officer grades.

75. The high proportion of staff with limited experience means that many of them have never seen prisons operating under normal circumstances, with regime activities in place and mass movements of prisoners within the establishments. This will present a real challenge when regimes re-open and these custodial officers are confronted with the full reality of working in a busy prison.

This issue was acknowledged by the prison authorities in their Covid-19: Custodial Recovery Guidance, according to which one of the key priorities will be providing staff with the support and confidence to navigate the transition from a period of restricted regimes. According to the Guidance, "[s]upport, mentoring and upskilling new officers, particularly those who are early in their service and/or have joined since March 2020 and have not experienced an environment of full regime delivery to support their confidence and skills. Retention will also be critical and mentoring schemes and line management will be important elements to support retention particularly for newer officers."

76. It remained the case that the initial staff training lasted only eight weeks and was now followed by merely two weeks of shadowing; this was clearly insufficient to fully prepare new recruits for the challenging job of a front-line custodial officer or to equip them with the necessary skills.

As regards in-service training, the authorities introduced a new Level 3 Custody and Detention Professional Apprenticeship which was expected to roll out from summer 2021 and was designed for prison officers to gain additional skills and knowledge, alongside their day-to-day prison officer duties, over a period of 12 to 18 months.

77. In the light of these findings, **the CPT recommends that the United Kingdom authorities continue their efforts both to recruit new front-line custodial staff and to bolster their retention. In this context, the CPT would like to receive more detailed information with regard to:**

- **the progress achieved in the recruitment and retention of front-line custodial staff;**
- **concrete measures put in place to provide support to staff to navigate the transition from a period of restricted regimes, as envisaged in the Covid-19: Custodial Recovery Guidance;**
- **the implementation of the Level 3 Custody and Detention Professional Apprenticeship and its outcome.**

Further, **the CPT recommends that at Durham, Woodhill and Wormwood Scrubs Prisons, staffing levels and actual numbers of staff on duty in the wings should be reviewed to ensure that, as the establishments transition from the Covid-19 restricted regimes, there is a sufficient number of staff at all times to maintain efficient control over the establishment, to prevent a new outburst of violent attacks and to guarantee the safety of both prisoners and staff, as well as to facilitate the provision of a full regime of activities and the full exploitation of the potential of the Future Regime Design Project (FRD) (see paragraph 51). In particular, steps should be taken to ensure that the vacant posts of prison officers at Durham, Woodhill and Wormwood Scrubs Prisons are filled as a matter of urgency.**

b. discipline

78. The discipline and adjudication process within the prison system was described in previous reports and remained substantially unchanged (see Rules 51 to 61A of the 1999 Prison Rules (as amended)). It should be recalled that where the alleged offence is so serious that additional days in prison should be added to the prison sentence, the charge is referred to an independent adjudicator (a district judge or deputy district judge) who may impose up to 42 additional days in prison (as well as any other less serious punishment). Other, less serious, cases are heard by a governor grade in the prison.

79. As regards the situation in the three establishments visited, the information gathered through examination of the relevant records and through interviews with prisoners and staff indicates that a full spectrum of the disciplinary punishments was used, including the possibility to impose a suspended punishment, in an attempt to keep the sanctions proportionate to the disciplinary offence.

Further, it remains the case that the adjudication process is accompanied by appropriate safeguards which are respected in practice. In particular, the prisoner concerned is informed in writing of the charges against him ("Notice of report"), is heard in person during the adjudication meeting, may be represented by a lawyer and receives a copy of the written decision informing him of the disciplinary punishment, as well as the available legal remedies.

However, the inmates concerned were not asked to attest with their signature that they received a copy of the disciplinary decision ("DIS7 form"). Moreover, the copy did not contain any reasoning. In the CPT's view, **these constitute additional procedural safeguards which should be provided to prisoners.**

80. As regards more particularly solitary confinement ("cellular confinement"), the CPT's delegation found in the establishments visited that this disciplinary punishment was in practice imposed for a maximum of 14 days (and usually for shorter periods).

However, as noted already in the report on the 2019 visit, the maximum period of solitary confinement ("cellular confinement") that may be imposed on a prisoner as a disciplinary punishment is 21 days (Rule 55(1)(e) of the Prison Rules); the same maximum time period applies for several cellular confinements running consecutively if a prison is found guilty of more than one charge arising out of an incident (Rule 55(3)).

The CPT wishes to reiterate that, given the potentially very damaging effects of solitary confinement on the mental and/or physical well-being of the prisoners concerned, the maximum period for solitary confinement as a punishment for adult prisoners should be no more than 14 days for a given offence, and preferably less.[52] Further, there should be a prohibition of sequential disciplinary sanctions resulting in an uninterrupted period of solitary confinement in excess of the maximum period. If a prisoner has been sanctioned to disciplinary confinement for a total of more than 14 days in relation to two or more offences, there should be an interruption of several days in the disciplinary confinement at the 14-day stage.

**The CPT reiterates its recommendation that the Prison Rules be amended to reflect these considerations. Pending the amendments, the current practice of imposing cellular confinement as a disciplinary punishment for less than 14 days should be maintained.**

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52 See paragraph 56(b) of the 21st General Report on the CPT's activities.

81. According to the management of the establishments visited, in line with the national trends,[53] the number of adjudications and of disciplinary punishments imposed decreased since the beginning of the Covid-19 pandemic. This was not only due to the lower number of disciplinary offences committed but also as a result of the attempts to find alternative ways to address undesirable behaviour and deal with challenging prisoners, rather than resorting to the formal adjudication process and imposing a disciplinary punishment which would entail additional restriction to those already in place because of the pandemic. **The CPT welcomes this approach.**

82. Prisoners placed in solitary confinement or administrative segregation (see the following section) were generally seen by health-care staff shortly after their placement in the segregation unit and then daily thereafter. However, at Durham Prison, the delegation was informed that health-care staff were not always promptly informed of such placements. **The CPT recommends that steps be taken to remedy this oversight.**

c. segregation

83. Under Rule 45 of the 1999 Prison Rules, prisoners may be segregated from other prisoners ("removed from association") where this appears desirable for the maintenance of good order or discipline ("GOoD") or in their own interest. The initial decision of the duty governor to segregate a prisoner[54] must be reviewed after 72 hours and may be extended by the governor in writing for a (renewable) period of up to 14 days. Segregation beyond 42 days must be authorised by the Prison Group Director (i.e., an authority independent of the establishment).

This procedure appeared to be duly followed in the establishments visited and prisoners were given an opportunity to be heard in the context of the 72 hrs./14-days reviews and received a copy of the relevant decisions. The review forms summarised the current situation of the inmates, any progress made and set new targets to be achieved.

However, at Woodhill Prison, a few complaints were heard from prisoners that they were not aware that the 42-days review by the Prison Group Director had taken place and that they had not received the relevant decision. **Steps should be taken to remedy this oversight.**

84. In the three establishments visited, the segregation units were visited daily by the director, health-care staff and a chaplain.

At Durham and Woodhill Prisons, the delegation noted the attempts to re-integrate segregated prisoners into the mainstream prison population. Staff interacted with the persons concerned and attempted to de-escalate conflict situations, took steps to progressively engage the prisoners in some basic daily activities (such as taking a shower, outdoor exercise and cleaning their cells) and to motivate them to relocate back onto the ordinary accommodation wings (e.g. by short "trial" placements in these units and then returning to the segregation in the evening).

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53 According to official statistics, during 2020, the number of adjudications decreased by 24% compared to 2019.

54 The segregated prison must be seen by health-care staff and the outcome of the Initial Segregation Health Screen must be taken into account when taking the placement decision.

However, at Wormwood Scrubs, the CPT's delegation again found no evidence of staff making efforts to re-integrate prisoners back into the mainstream population. Moreover, the overall atmosphere in the segregation unit appeared to be rather tense; the unit was a noisy environment, with prisoners, located on several landings, shouting from behind the locked doors and certain members of staff shouting back to them while remaining seated on the ground floor. The delegation did not observe any attempts by staff to engage in a meaningful interaction with the segregated prisoners and certain members of staff treated their requests (as well as for example requests by health-care staff attending the unit) in a dismissive way.

85. Moreover, the regime of activities offered to persons in the segregation units was impoverished in all three establishments; these persons remained locked up in their cells for more than 23 hours per day, with only some 30 to 40 minutes daily out-of-cell time, consisting of outdoor exercise and access to a shower. On a more positive note, segregated prisoners were provided with radios and, at Woodhill Prison, TVs, to have some distraction during the day.[55]

While the CPT acknowledges that the possibility to provide meaningful activities to persons in segregation was influenced by the Covid-19-related restrictions (as it was the case vis-à-vis the mainstream prison population), it considers that particular efforts are needed in respect of this category of prisoner to foster their re-integration into mainstream prison population.

86. The majority of prisoners were held in the segregation units for less than 42 days (and, in fact, usually for less than two weeks). However, isolated instances of very long placements (e.g. more than 100 days) persist in all three establishments.

Particular reference should be made to the case of a prisoner who had been held in the segregation unit at Woodhill Prison for some 500 days at the time of the visit, pending a court hearing. The prisoner concerned had been involved in a violent incident in another prison, which had resulted in the death of a prisoner. Efforts had been made to offer him the possibility to relocate out of the segregation unit and to provide him with some activities (such as painting empty cells, cleaning in the unit and access to a gym). However, as the court hearings had been repeatedly postponed due to restricted activity of courts during the pandemic, his placement in segregation had been repeatedly extended, for his own safety and the good order in the prison.

87. In the light of these findings, **the CPT recommends that the United Kingdom authorities step up their efforts to avoid, as far as possible, segregating prisoners under Rule 45 of the Prison Rules for lengthy periods.**

**Segregated prisoners should have an individual regime plan to assist them to return to a normal regime. They should benefit from a structured programme of purposeful and preferably out-of-cell activities and be provided with meaningful human contact for at least two hours every day and preferably more, with staff and/or with one or more other prisoners.**

In addition, **the Committee recommends that steps be taken at Wormwood Scrubs Prison to develop staff capabilities to engage with prisoners.**

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[55] Further, cells in the segregation units were equipped with in-cell phones and segregated inmates were as a general rule allowed to make phone calls (see also paragraph 96).

Further, **the Committee would like to be informed of what steps are being taken by the United Kingdom authorities to place the prisoner referred to in paragraph 86 in ordinary accommodation. More generally, while the Committee understands that such cases present complex challenges for the prison management, it has serious reservations as to whether placement in a segregation unit for such a long period pending investigation of a criminal case is a proportionate measure; it would like to receive comments of the United Kingdom authorities on this issue.**

88. The delegation found certain shortcomings in the recording of data on the use of the segregation units at Durham[56] and Woodhill Prisons.[57] In particular, the date of release from the segregation units was sometimes not recorded. **The CPT recommends that steps be taken at Durham and Woodhill Prisons to ensure that data on the use of the segregation units are properly recorded.**

89. Material conditions in the segregation units were on the whole adequate. At Wormwood Scrubs, the state of repair of the cells in the unit had improved since the 2019 visit. That said, the findings set out in paragraph 52 concerning a lack of shelters/means of rest also apply to the outdoor yards attached to the segregation units.

d. Close Supervision Centre and Separation Centre at Woodhill Prison[58]

90. The overall aim of the *Close Supervision Centres (CSC)* system is to remove the most disruptive and challenging prisoners, whose previous behaviour indicated that they presented a high-security risk, from ordinary location and manage them within small, highly supervised units. Such a setting permits an assessment of individual risks to be carried out, followed by individual and/or group work to try to reduce the risk of harm to others, in principle, enabling a return to normal location as risk reduces. Under Rule 46 (2) of the Prison Rules, the placement of a prisoner in a CSC is for a period not exceeding one month and may be repeatedly renewed.

*Separation Centres (SC)* hold prisoners who have been deemed to present a risk to security, order and control as a result of their extreme views or ideology and who are considered to present a risk that cannot be managed on normal location. Referral criteria include, for example, interests of national security (protection against terrorism, espionage and sabotage), the prevention of the commissioning of an act of terrorism and the prevention of dissemination of views that might encourage others to commit such acts. Under Rule 46A (3) of the Prison Rules, the placement of a prisoner in a SC must be reviewed every three months.

91. The CSC at Woodhill Prison, located in house unit 6, was holding 14 prisoners at the time of the visit. The eight persons in A Wing were being held under a very restrictive regime (i.e. one prisoner unlocked at a time) while the six persons in B Wing were held under slightly more relaxed conditions (i.e. with some small group association). The SC, located in a completely separate wing of the same house unit, was accommodating four prisoners.

Material conditions in these units were the same as those offered to the general prison population (see paragraph 45) and call for no particular comments.

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56 "Separation and Care Unit – Monthly Record."

57 "Segregation, Monitoring and Review Group (SMARG)" spreadsheets.

58 The CPT last visited this unit in 2008 – see CPT/Inf (2009) 30, paragraphs 52 to 57.

92. The CPT acknowledges that, in any prison system, there will be a small number of prisoners who present a particularly high security risk and who require special conditions of detention. However, as stressed in previous reports, as a general principle, such prisoners should, within the confines of their detention units, enjoy a relatively relaxed regime by way of compensation for their more severe custodial situation. In particular, they should be able to meet their fellow prisoners in the unit and be granted a good deal of choice about activities. Special efforts should be made to develop a good internal atmosphere within high-security units. The aim should be to build positive relations between staff and prisoners. This is in the interests not only of the humane treatment of the unit's occupants but also of the maintenance of effective control and security and of staff safety.

The existence of a satisfactory programme of activities is just as important – if not more so – in a high security unit than on normal location. It can do much to counter the deleterious effects upon a prisoner's personality of living in the bubble-like atmosphere of such a unit. The activities provided should be as diverse as possible (education, sport, work of vocational value, etc.). As regards, in particular, work activities, it is clear that security considerations may preclude many types of work which are found on normal prison location. Nevertheless, this should not mean that only work of a tedious nature is provided for prisoners.

93. As regards the situation at the time of the visit, it cannot be said that these principles were being fully respected in the CSC at Woodhill Prison. Nominally, A Wing served for the initial assessment of prisoners. However, in practice, a number of prisoners on both A and B Wings had been held within the CSC system for very long periods of time, and the Woodhill CSC did not offer them an adequate range of activities. Regime activities and daily out-of-cell time were in principle limited to daily outdoor exercise (up to one hour per day together with two other persons from the CSC), access to a gym and some limited association in the communal area of the unit, totalling a maximum of three hours per day.

Moreover, the suspension of therapy programmes during the pandemic had also deprived them, for more than a year, of the means to demonstrate the progression in their behaviour that might lead to their de-selection from the CSC system.

94. At the time of the visit, all prisoners held in the SC were refusing to engage with radicalisation assessment programmes offered to them, which could have enhanced the range of activities offered to them. Consequently, they had no regime activities other than some 2.5 hours per day of association time and no prospect of being moved back to the general prison population.

Moreover, several of them complained that they were only allowed to take outdoor exercise in a large unwelcoming yard covered with a mesh roof while a pleasant secured “walled garden” was adjacent to their unit. To use the latter yard, they had been requested to sign a written “compact” which prohibited communication with prisoners from a different wing. However, this requirement had been misunderstood as a prohibition to speak with each other during exercise. At the end of the visit, the governor of the establishment assured the delegation that the obligation to sign the “compact” would be removed and the SC prisoners will be allowed access to the “walled garden”.

**The CPT would like to receive confirmation that prisoners held in the Separation Centre at Woodhill Prison now may take daily outdoor exercise in the “walled garden” adjacent to their unit.**

95. More generally, the CPT observed that the understandable decision that regime activities and association in prison should be severely restricted during the Covid-19 pandemic had an acute impact on small special units such as the CSC and the SC.

**The CPT invites the United Kingdom authorities to ensure that, as prison establishments transition from the Covid-19 restricted regimes, a more finely-calibrated approach to the resumption of regime activities and association is adopted, prioritising small special units, such as those at Woodhill Prison, where this could be done with minimal risk.**

Further, **the Committee recommends that, alongside the easing of Covid-19-related restrictions, prisoners held in the SC and CSC at Woodhill Prison are provided a full regime of activities, in line with the principles set out in paragraph 92.**

e. contact with the outside world

96. As a part of the restrictions imposed in the context of the Covid-19 pandemic, social visits had been suspended until approximately April/May 2021 when the establishments started transiting from stage 4 to stage 3 of the National Framework for Covid-19 Recovery.

At the time of the CPT's visit, social visits had been re-introduced to varying degrees and with limitations. At Durham Prison, prisoners could receive, as a minimum, one social visit (approx. 45 minutes) per month and no physical contact was allowed between the inmate and the visitors (with the exception of children below the age of ten who were allowed to hug the parent at the beginning and the end of the visit). At Woodhill Prison, there was a possibility to receive at least one visit per week. Wormwood Scrubs Prison was piloting the possibility for inmates to receive contact visits if both the inmate concerned and his visitors tested negative for Covid-19.

In all three establishments visited, every cell had an in-cell phone and prisoners were receiving an extra GBP 5 per week to make phone calls during the pandemic. Further, to compensate for restricted visits, the possibility to make video calls (so-called "purple visits") had been introduced in the establishments. **The CPT encourages the United Kingdom authorities to maintain beyond the pandemic the possibility for prisoners to make video calls to facilitate their contact with the outside world. It would like to be informed of the plans of the United Kingdom authorities in this regard.**

## C. Prisons for female prisoners

### 1. Preliminary remarks and the establishment visited

97. In many countries, prisons are largely designed by men for male prisoners and to be managed, primarily, by male staff. Women prisoners are often treated like male prisoners with no specific rules and regulations addressing their particular needs as women. In fact, many prison systems and the conditions of detention they afford prisoners lack a gender focus, and prison policies and daily practices within prisons usually range from being gender-neutral to being gender-biased. In European countries, women make up a small minority of the overall prison population and the focus of prison systems is often oriented toward the standard male prisoner. However, women have particular biological and gender-specific needs and vulnerabilities that require an alternative prison policy oriented toward their requirements. It is important that a number of factors are taken into account when dealing with women prisoners, notably any physical, sexual or psychological form of violence (including domestic violence) they might have suffered before imprisonment, specific health-care needs, caretaking responsibilities for their children and/or their families, and the high likelihood of post-release victimisation and abandonment by their families.[59]

Further, women prisoners generally pose a lower security risk than male prisoners and therefore it is necessary for any gender-sensitive risk and needs assessment and classification of prisoners to take this fact into account. Such a requirement is reflected in the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the "Bangkok Rules") of October 2010.[60]

In practical terms, there is much to be said for developing a network of small dedicated women-oriented custodial centres around the country to accommodate women who need to be held in secure accommodation. Such centres should be oriented towards preparing women to re-enter the community, enable women to be held closer to their families and homes and have a security regime commensurate with the risks posed by the women.[61]

98. In England and Wales, women steadily make up around 5% of the overall prison population[62] and the aforementioned principles are broadly accepted by the authorities. According to the information provided to the CPT, in the next three to four years, it was expected that 500 new places for women "designed by women for women" would be created in prisons for women (which would include an increase in the number of single-occupancy cells and an overall improvement in the material conditions). Further, the authorities were preparing a new policy paper on women in prison which should strengthen the "therapeutic and gender-specific approach" throughout the women's prison estate; for example, newly-recruited staff should be specifically selected to work with female prisoners.

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59 See also the CPT's thematic factsheet on women in prison (CPT/Inf (2018) 5).

60 "Rule 41: The gender-sensitive risk assessment and classification of prisoners shall:
(a) Take into account the generally lower risk posed by women prisoners to others, as well as the particularly harmful effects that high-security measures and increased levels of isolation can have on women prisoners".

61 See in this context "The Corston Report: A review of women with particular vulnerabilities in the criminal justice system" of 2007 which advocated *inter alia* for the establishment of a network of centres in England and Wales.

62 For example, on 11 June 2021, there were 3,175 female and 74,957 male prisoners.

The authorities also intended to reconfigure the women's prison estate to increase the number of women's prisons which serve the courts to enable women to be able to remain closer to home.

**The CPT would be interested to receive more details about the United Kingdom authorities' plans regarding the women's prison estate in England and Wales, in particular as regards new gender-specific policies and their practical implementation, the selection process of newly-recruited staff to work with female prisoners and an update on the plans to create additional places for women in prison and, more generally, to reconfigure the women's prison estate and to open new establishments. In this respect, it would also like to be informed of the steps being taken to promote a network of centres in line with Baroness Corston's review of 2007.**

99. In 2021, the CPT visited for the first time HMP and YOI Bronzefield, a privately-operated prison for women, run by Sodexo Justice Services, which was opened in 2004. The purpose-built premises of the establishment are composed of the main building (containing, *inter alia*, a health-care unit and a segregation and care unit, as well as workshops, classrooms and a gym), four separate two-storied cross-shaped accommodation units (house blocks 1 – 4) and a mother and baby unit (located in a separate building). With a CNA of 527 places and an operational capacity of 542, the prison was accommodating 498 women (of which 17 were young offenders), including 169 on remand.

### 2. Ill-treatment and violence

100. In the course of the visit, the CPT's delegation received no allegations from the women interviewed of ill-treatment by staff. On the contrary, some women spoke positively of staff and the way they were treated. The delegation observed that the overall atmosphere in most parts of the establishment was relatively relaxed and staff interacted well with the women prisoners.[63]

However, the deficiencies identified in the male prison estate concerning the recording of violent episodes and injuries sustained by prisoners were also observed at Bronzefield Prison (in particular, the missing or incomplete separate report of injuries to prisoners (F213 form) which is a mandatory part of the use of force file); see also paragraph 40).

**The CPT recommends that the United Kingdom authorities remain vigilant to any signs of ill-treatment by staff at Bronzefield Prison.** In addition, **steps should be taken in the establishment to ensure that the overall quality of the recording of violent episodes, use of force and injuries sustained be improved, including ensuring that mandatory F213 forms are duly completed in every case involving the use of force. In this regard, consideration should be given to digitising the F213 forms and ensuring that they constitute an integral part of the use of force documentation.**

63 See, however, paragraphs 111 and 112 as regards the situation of women prisoners with severe mental disorders.

101. According to the statistics provided to the CPT's delegation, over the 12 months to April 2021, total incidents of violence have decreased by 53% compared to the previous 12 months; prisoner-on-staff assaults fell by 56% (28 cases against 64 cases) and prisoner-on-prisoner assaults by 56% (51 cases against 109).

Moreover, the majority of the incidents appeared to be of a relatively minor nature (one of the more severe incidents included a prisoner punching another inmate as a result of which the latter sustained a small scratch) and staff appeared to react swiftly and proportionately to separate the women and de-escalate the situation.

**The CPT trusts that the management and staff at Bronzefield Prison remain vigilant as the establishment moves through the various stages of relaxing restrictions (including increased mass movement and more association time for prisoners) as foreseen in the National Framework for Covid-19 Recovery and make efforts to avoid an increase in the number of violent episodes.**

### 3. Conditions of detention

102. Material conditions at Bronzefield Prison were in general very good. All the premises seen by the delegation were clean and in a good state of repair.

Most prisoners were accommodated in single-occupancy cells which measured between 6 and 7 m² (excluding the in-cell sanitary annexe[64]); the establishment also had 30 purpose-built double-occupancy cells which measured some 9 m² (excluding the sanitary area). All the cells were suitably equipped with a bed/bunk bed with full bedding, a table and chair(s), shelves or a wardrobe, as well as a TV, an electric kettle, a fan and an in-cell phone. Access to natural light and ventilation was sufficient and the heating and artificial lighting appeared to be adequate.

However, at the time of the visit, 17 single-occupancy cells were being used for double-occupancy and conditions in these cells were crowded. Moreover, the in-cell sanitary annexes in the purpose-built double-occupancy cells were only partially screened from the rest of the cell.

**The CPT recommends that the purpose-built single-occupancy cells at Bronzefield Prison be used to accommodate only one prisoner.** Further, **the in-cell sanitary annexes in double-occupancy cells should be fully partitioned.**

103. Outdoor exercise yards adjacent to the house units were pleasantly decorated with plants and vegetation and were equipped with a shelter and means of rest. However, there was no shelter from the rain or sun in the two yards attached to the segregation and care unit. **The CPT recommends that this deficiency be remedied.**

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64 In house block 4, the in-cell sanitary annexe contained a washbasin, a shower and a toilet and was fully partitioned. In house blocks 1 to 3, the in-cell toilets and washbasins were partially screened and there were communal showers accessible from the corridors.

104. The delegation gained a very good impression of the regime activities offered to the women prior to the Covid-19 pandemic. Virtually all prisoners had been engaged in a broad range of activities, most of which took place in a spacious and well-equipped "business centre" composed of several workshops and classrooms. The activities included work (kitchen, cleaning, call centre, arts and crafts), education (Maths, English classes, basic IT qualifications) and vocational training (hair and beauty course, starting one's own small business, running a coffee shop). The women also had regular access to a gym, a sports hall, an outside sports ground and a library and could participate in various therapeutic courses (e.g. prevention of re-offending and anger management). In addition, they were offered at least one hour of daily outdoor exercise and some association time in their accommodation wings.

105. The situation during the pandemic was similar to that observed in the prisons for men (see paragraphs 49 and 50). More particularly, workshops were closed and only essential work continued (kitchen, servery, laundry and cleaning) which involved up to 150 women (often part-time). Prisoners also received in-cell learning and distraction packs.

However, throughout the pandemic, for the vast majority of prisoners the only daily out-of-cell time was 45 minutes to one and a half hours, including for outdoor exercise (which they could take in small groups), to take a shower, collect meals and make applications. Consequently, the women remained locked up in their cells for more than 22 hours per day, with very little to do, except watching TV, reading and making phone calls.

Shortly before the CPT's visit, as the establishment transitioned form stage 4 to stage 3 of the National Framework, some small group educational classes were re-introduced and workshops gradually re-opened and the work opportunities expanded.

**The CPT recommends that immediate steps be taken to ensure that all prisoners, irrespective of the Covid-19-related restrictions in place, can benefit from at least one hour of outdoor exercise per day.**

**Further, with the lifting of restrictions in the community and the roll out of the vaccination programme throughout the country, the CPT would like to receive details of the out-of-cell time and purposeful activities now being offered to women prisoners.**

### 4. Health care services

#### a. general health care

106. The health-care team at Bronzefield Prison was well-staffed and included a pool of seven GPs working on a rota basis, with at least one GP present every day, a GP with an additional training in substance abuse ("GPwER" – a GP with an extended role), 15 full-time nurses and 13 full-time health-care assistants, as well as several non-medical prescribers, pharmacists and pharmacy technicians. At least two nurses and one nursing assistant were present in the establishment at all times.

In addition, the establishment was regularly visited by a range of specialists, including a gynaecologist, a dentist, a podiatrist and a physiotherapist. Arrangements concerning transfers of

prisoners to community hospitals to receive specialist medical care appeared to work satisfactorily (see, however, paragraph 111 as regards transfer to psychiatric facilities).

That said, ten posts of nurses and two posts of health-care assistants were vacant at the time of the visit and were covered by agency staff or through overtime. **Reference is made in this context to the considerations and request for comments set out in paragraph 53 above.**

107. Newly-admitted prisoners were comprehensively screened immediately upon admission by a nurse and then within seven days for a more thorough medical examination. Medication was continued from the day of admission.

The initial health-care examination included screening for suicide and self-harm, mental health issues, substance use, transmissible diseases and female health conditions, including pregnancy (see also paragraph 121).

Requests for medical appointments were made confidentially via electronic kiosks located on each accommodation wing and medication was distributed by wing-based pharmacy teams.

b. mental health care

108. Primary level mental health care was provided by three mental health nurses and two more were in the process of being recruited.

109. The In-reach team providing secondary level mental health care comprised a Team Lead, two visiting psychiatrists covering together one FTE post, two full-time assistant psychologists, a cognitive behavioural therapy (CBT) practitioner and two mental health practitioners. Two additional posts of mental health practitioners were covered by agency staff and there were two vacancies for clinical psychologists.

The In-reach team received referrals from the primary care team for acceptance of women to the secondary care level, and those accepted were allocated to the caseload of one of the mental health practitioners who coordinated the care. However, the threshold for acceptance appeared to be rather high. For example, between January and June 2021, only approximately one third of those referred by the primary care team to the In-reach team were accepted on the caseload (see also the second example referred to in paragraph 117). Moreover, at the time of the visit, while 27 patients were formally accepted to the secondary level, they had been waiting for more than two weeks to be allocated to a mental health practitioner.

**The CPT recommends that the number of mental health practitioners in the In-reach team providing secondary level mental health care at Bronzefield Prison be increased to ensure that all women prisoners requiring secondary mental health care can be accepted by the team and are allocated to a mental health practitioner without undue delay.** Further, **the two vacant posts of clinical psychologists in the In-reach team should be filled.**

110. Prisoners identified as presenting highly complex needs who were unable to access broader interventions (i.e., persons diagnosed with personality disorders with a history of complex trauma and prolific self-harmers) who were deemed unsuitable for transfers to a mental health facility (25 women at the time of the visit) were receiving mentalisation based treatment (MBT) from an Out-Reach/EOS team (a forensic psychologist, a clinical psychologist and two assistant psychologists). The team also provided training to prison staff.

111. The CPT notes the aforementioned efforts to provide mental health care to inmates held at Bronzefield Prison.

However, the establishment was accommodating a number of women with severe mental disorders who could not be provided with adequate care in a prison. By way of illustration, according to the information provided to the delegation, between November 2020 and April 2021, there was a 32% increase in the number of women entering the establishment with mental health issues, compared to the previous six months; as community services reduced their activity during the pandemic, access to care in the community became more difficult and many women entered prison in a state of mental decompensation. In the 12 months to April 2021, 52 women had to be transferred to a mental health facility. However, as identified also in the establishments for male prisoners (see paragraph 63), there had been considerable delays (up to 47 days) in the transfer of these women from Bronzefield Prison to a mental health facility.

As a consequence, of the 14 patients accommodated in the establishment's in-patient unit at the time of the visit, 13 had been placed there on mental health grounds and the unit was effectively acting as a mental health facility. However, no structured therapeutic activities were offered to the women patients.

112. The situation of four women accommodated in the in-patient unit in respect of whom a referral to a psychiatric facility had been requested was of particular concern to the CPT's delegation.[65] It should also be noted that all four women refused to take medication.[66]

The first woman was referred by a prison psychiatrist for hospital treatment on 5 May 2021. She was assessed by a receiving psychiatrist from a clinic on 18 May and was regarded as suitable for admission. At the time of the visit, a bed place for admission was being sought. When interviewed by the delegation's medical expert on 9 June 2021, she was in a psychotic state.

The second woman was recalled to prison on 1 June 2021, just a few days after she had been released from prison. On reception to the prison, she was found to be naked in the prison van; and she had urinated inside her cubicle within the van. According to her medical records, she had been diagnosed with a learning disability, bipolar disorder, borderline personality disorder and alcohol dependency. She was referred to a psychiatric intensive care unit (PICU) by a prison psychiatrist; at the time of the visit, she was waiting for a second assessment by a PICU psychiatrist. When interviewed by the delegation's medical expert, she was acutely mentally ill.

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65 The procedure for the transfer of a prisoner to a psychiatric hospital under Section 47 and 48 of the 1983 Mental Health Act requires a referral by a psychiatrist, an assessment by a receiving psychiatrist to determine whether the criteria for detention are met (i.e. that the mental disorder from which that person is suffering is of a nature or degree which makes it appropriate for him or her to be detained in a hospital for medical treatment); these two medical recommendations are then submitted to the Mental Health Casework Section (MHCS) of Her Majesty's Prisons and Probation Service (HMPPS) to issue a warrant on behalf of the Secretary of State. The transfer then depends on the availability of a bed.

66 There is no possibility to administer medication involuntarily in prison.

The third woman was being seen by community mental health professionals; she displayed delusions and little insight and affirmed to have been previously sexually abused. Although she was contacted by the court diversion team, she refused to engage with them and was remanded in custody. When admitted to prison on 26 May 2021, she was in a psychotic state, according to her medical file. Her transfer to a mental health hospital was requested on 7 June 2021.

The fourth woman was found to be urinating and defecating in her cell, smearing faeces on the walls and furniture and sweeping urine under the door into the corridor. She was referred to PICU on 2 June 2021 and, at the time of the visit, was waiting for a second assessment.

The CPT wishes to underline in this context that it is a well-established case-law of the European Court of Human Rights that the detention of a person who is ill may raise issues under Article 3 of the European Convention on Human Rights and that the lack of appropriate medical care may amount to treatment contrary to that provision.[67]

In a meeting with the United Kingdom authorities at the end of the visit, the CPT's delegation raised the situation of these four women and requested to receive confirmation, within one month, that they had been transferred from Bronzefield Prison to a suitable health-care environment.

113. By e-mail of 7 July 2021, the United Kingdom authorities informed the CPT that the transfer of these inmates was still pending. According to an update submitted on 17 August 2021, the first and third women listed above had been transferred to a hospital, while the second woman no longer required hospital transfer and was receiving treatment in prison. The referral process was in place for the fourth women.

It follows that the time between the referral request and the transfer to hospital in the case of the third woman took more than a month and in the case of the first woman more than two months. The transfer of the fourth woman was still pending more than two months after the referral had been requested. During all that time, these women were locked up in their cells in the in-patient with no other regime activities than up to 30 minutes of daily outdoor exercise being provided. Such situation is totally unacceptable.

114. On a more positive note, the CPT acknowledges that staff in the in-patient unit were well-aware of the complex needs of the individual women patients, demonstrating a caring attitude towards them and reacting adequately to challenging behaviour.

115. The delegation was informed that the National Health Services (NHS) Commissioner[68] visited Bronzefield Prison on 25 May 2021 and made a commitment that a full mental health needs assessment would be carried out in the establishment and that an "enhanced support package" (including regular contacts with dedicated specialists/psychologists) for women accommodated in the in-patient unit would be introduced.

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67 See, for example, *Sławomir Musiał v. Poland*, no. 28300/06, 20 January 2009, paragraph 87.

68 Mental health care at the secondary level was provided by Central and North West London NHS Foundation Trust (primary level was provided by Sodexo).

116. In the light of these profoundly worrying findings, **the CPT recommends that the United Kingdom authorities take urgent steps to ensure that the provision of mental health care at Bronzefield Prison is thoroughly and comprehensively reviewed; in doing so, the needs presented by the prison population should be duly taken into account.**

**The recommendations set out in paragraph 63 concerning transfers without delay to suitable hospital environment and provision of assessment, adequate treatment and care equally apply to the in-patient unit at Bronzefield Prison.**

Further, **the CPT would like to be informed of the outcome of the mental health needs assessment carried out by the NHS and the steps subsequently taken, including more details on the "enhanced support package". It would also like to be informed, within one month, of the date on which the fourth woman patient referred to above was transferred to an appropriate mental health facility and to be informed on how she was managed during her time in the prison in-patient unit, including as regards personal hygiene, cell cleanliness and food management.**

More generally, given the delays in the referral process currently in place, **the CPT recommends that a rapid urgent pathway to a mental health care facility for prisoners with acute mental disorders be created.**

117. Unlike in the establishments for male prisoners (see paragraph 65), the number of self-harm incidents had increased sharply at Bronzefield Prison, with 2,408 incidents in the 12 months to March 2021, which represents an increase of 33% over the previous 12 months. The increase was in fact much greater *pro rata* given the reduction in the prison population during the pandemic and represented a 60% increase when measured as the rate of incidents per 1,000 prisoners.[69] It should be noted that 63% of all 2,408 incidents were committed by a small group of 11 women (i.e. some 2% of the prison population). The methods of self-harm fluctuated in severity ranging from low lethality (scratches, swallowing objects) to a high lethality (ligaturing).

Moreover, the potentially high lethality incidents involving the use of ligature were frequent and the delegation was particularly concerned to find that in some cases, prisoners were able to use the same ligature method on multiple occasions within a matter of hours, and for days on end.

For example, one woman (AA) ligatured on 13 different occasions during two days (including after her transfer from ordinary accommodation to the in-patient unit) and was repeatedly able to use the same clothing items (in particular, elastic from her underwear) to create ligatures. On various occasions, she was provided with anti-ligature clothing but then her own items of clothing had been returned to her in an attempt to de-escalate the situation. She was also offered time out of her room and a visit by a family member. However, despite these interventions, her ligature attempts continued. According to her medical file, she had an extensive history of self-harming using various methods and was referred to the In-reach team by primary care but was rejected. At the time of the visit, she was waiting for a full psychiatric assessment in order to "assess needs before a hospital referral is considered".

Another woman (BB) tied a ligature on 15 different occasions within two days, using items of clothing and bedding and was repeatedly found by staff naked in her cell and hiding under the bed. Following the third case of ligaturing, a nurse recommended her transfer to the in-patient health-care unit but there was no place available. The transfer was only carried out at a later stage. According to her medical file, she had a long history of trauma with repeated hospitalisations.

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69 A similar trend was observed at national level; for example, the rate of self-harm incidents per 1,000 prisoners increased by 13% in female establishments in 2020.

118. Women prisoners at risk of self-harm were managed under the "Assessment, Care in Custody and Teamwork Plan (ACCT)" process and staff in the in-patient unit was familiar with self-harm triggers related to individual women and tried to find a balance between the restrictions imposed (e.g. provision of anti-ligature clothing and removal of items from the cells) and the need to offer some distraction.

However, it would appear that additional steps are required to improve the effectiveness of the arrangements currently in place. In particular, while it is commendable that a policy is in place that anti-ligature clothing should be provided as a last resort and for the shortest possible time, **the CPT recommends that the current risk assessment process be reviewed, in order to ensure that such clothing is used as early as necessary, and for as long as genuinely needed. More particularly, it is not acceptable that a person is able repeatedly to tie ligatures with items of clothing which have been left in her possession over an extended period of time.**

Further, **the interventions by staff vis-à-vis self-harming prisoners should not be limited to the identification and removal of ligatures** (as would appear to have been the case in the first example described above) **and, whenever a clear pattern of self-harm is identified, a mental health assessment should take place at the earliest opportunity.**

More generally, **reference is made to the recommendations set out in paragraph 63 concerning transfers without delay to suitable therapeutic environment and provision of therapeutic activities and paragraph 116 concerning the need to comprehensively and thoroughly review the provision of mental health care at Bronzefield Prison.**

**The CPT would also like to receive information on the care provided to the above-mentioned two women either within the prison or in a mental health facility and what steps were taken to prevent them from seriously self-harming or attempting to commit suicide.**

119. The United Kingdom authorities acknowledged the challenges posed by the rising number of self-harm incidents in the women's prison estate. In response to this worrying trend, the *Self-harm in the Women's Estate Task Force* was established; its task is to "coordinate and drive current work underway or in development including research" and it should seek to identify innovative and evidence-based strategies to address self-harm. The Task Force should also look at how best to influence sentencers regarding the appropriateness of custody for some women who commit offences and raise the profile of alternatives to custody in these cases at the pre-sentence stage. In this regard, the work of the Task Force should include the pre-sentence stage and not simply the custodial element of an individual's offender journey.

**The CPT notes with interest these commendable efforts and would like to receive more information about the outcomes of the work of the Task Force and their practical implementation.**

120. The measures taken to prevent Covid-19 entry into prison were virtually identical to those introduced in the prisons for men and the recommendation set out in paragraph 69 equally applies to Bronzefield Prison.[70]

[70] At Bronzefield Prison, the incidence of Covid-19 was very low - there were only five positive cases among prisoners (in December 2020).

## 5. Other issues

### a. admission procedure

121. The admission procedure at Bronzefield Prison was spread over two days. The 1st night procedure included the initial health-care screening (see also paragraph 107), the provision of basic information concerning the functioning of the prison and a cell sharing risk assessment. Newly-admitted women were given the opportunity to take a shower and make a phone call. If necessary, the ACCT process could be opened already during the interviews. On the second day, a more detailed interview was carried out on the basis of a Basic Custody Screening Induction Form, which included screening for a history of any sexual abuse and other gender-based violence, drug and/or alcohol misuse and responsibilities towards families/children.

### b. prison staff

122. Custodial staff at Bronzefield Prison comprised 160.6 FTE posts of prison custody officers (PCOs) and 28.5 FTE posts of senior prison custody officers (SPCOs);[71] 42% of these officers were male and 58% female. Despite an increase in the number of PCOs in recent years,[72] it remained the case that 16 additional PCO posts were vacant at the time of the visit (even if nine officers were already in training at the time of the visit).

Due to these vacancies, the number of staff allocated to house blocks 1 to 3 (each accommodating around 120 women) on a day shift was reduced to eight or nine PCOs (and one SPCO), rather than the planned ten to 11 PCOs (and one SPCO).[73]

Moreover, according to the data provided to the CPT's delegation, the turnover of staff remained relatively high; for example, in the 12 months prior to the visit, some 25% of PCOs (the vast majority of whom had less than one year experience of working in the establishment) and approximately 16% of SPCOs had left the establishment.

**The CPT recommends that the vacant posts of prison custody officers at Bronzefield Prison be filled. Further, the Committee would like to be informed of the measures which will be put in place to provide support to staff to navigate the transition from a period of restricted regimes, as envisaged in the national Covid-19: Custodial Recovery Guidance and, more generally, of the measures to increase the staff retention rates.**

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71 These officers are the equivalent of band 3-5 custodial officers in public sector prisons.

72 For example, between May 2019 and May 2021, the number increased from 144.55 FTE posts to the current 160.6 FTE posts.

73 In house block 4 which was accommodating enhanced prisoners, there was one SPCO and four PCOs during the day. In the night shift, there were two SPCOs for the whole establishment, a response team (composed of four PCOs) and one PCO in each house block.

c. discipline

123. The discipline and adjudication process outlined in paragraph 78, the findings described in paragraph 79 and the considerations concerning the length of solitary confinement set out in paragraph 80 equally apply to the situation at Bronzefield Prison.

However, unlike in the three establishments for male prisoners, the number of adjudication procedures had significantly increased since the beginning of the pandemic. According to the prison management, this increase could be explained by the fact that the system of incentives and privileges (such as additional visits and additional out-of-cell time) could not be used during the pandemic because of the restrictions in place. However, the disciplinary punishments imposed were often of a relatively minor nature (such as a caution). Consequently, **given the particular context, this begs the question whether minor breaches of discipline could not be better dealt with in a less formal way, e.g., through interviews with prisoners, without the need to open a formal adjudication procedure in every case.** Disciplinary procedures should not be used as a substitute for positive measures to encourage good behaviour by prisoners, especially during a period when the pandemic imposed so many other restrictions on the lives of women prisoners.

d. segregation

124. The procedure described in paragraph 83 applied equally in the segregation and care unit (SCU) at Bronzefield Prison and was duly followed. Material conditions in the unit were adequate and do not call for particular comments.[74]

125. Prisoners placed in segregation had daily contact with a nurse and a chaplain, a medical doctor visited the unit every second day and the director once a week. The delegation noted the attempts by staff to re-integrate the women in segregation into the mainstream prison population. For example, steps were taken to progressively engage them in basic daily activities (outdoor exercise, shower, cleaning the cell) and to keep contact with the outside world, as well as to provide them with re-adaptation periods by accompanying the women to an ordinary house block for short periods of time and then returning them to the SCU. Individual therapeutic support was provided to the women where appropriate and some women participated in work while being accommodated in the SCU. The progress achieved and further steps to be taken were considered during the regular review of the placement in the SCU.

However, the regime provided to these women at the time of the visit was impoverished and was limited to daily outdoor exercise, taking a shower and making requests via electronic kiosks, which all together was some 40 minutes a day.

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[74] The unit consisted of 13 cells and was accommodating nine women at the time of the visit, of whom three were placed there in administrative segregation (and had been in the SCU for one, 12 and 27 days) and the rest to serve cellular confinement as a disciplinary sanction (up to 14 days).

126. As regards the usual length of placement in the SCU, the vast majority of women were placed there for less than 42 days.

However, despite the re-integration efforts described above, in 2020 and 2021, seven highly complex and challenging women were placed in the SCU for very long periods of time, either uninterrupted or for several consecutive periods (ranging between two and a half months and almost one year).[75] Moreover, two of these women had been held in segregation units in other prisons and had been transferred to the SCU at Bronzefield Prison as the establishment was used as a "national resource" and received the most complex and challenging female prisoners.

127. **The CPT recommends that the United Kingdom authorities step up their efforts to avoid, as far as possible, segregating prisoners under Rule 45 of the Prison Rules for lengthy periods.** Further, **efforts should be increased to ensure that the specific needs of female prisoners held in segregation for prolonged periods of time are adequately addressed, including by adopting a multi-faceted approach, involving clinical psychologists to design individual programmes, including psycho-social support and treatment.**

More generally, **segregated prisoners should have an individual regime plan to assist them to return to a normal regime. They should benefit from a structured programme of purposeful and preferably out-of-cell activities and be provided with meaningful human contact for at least two hours every day and preferably more, with staff and/or with one or more other prisoners. Further, they should be able to benefit from at least one hour of daily outdoor exercise (regardless of the Covid-19-related restrictions in place).**

e. contact with the outside world

128. The arrangements concerning contact with the outside world at Bronzefield Prison were similar to those described in paragraph 96 in respect of the establishments for male prisoners. In particular, women were allowed to make phone calls from their cells and the possibility to make video calls ("purple visits") had been introduced to compensate for suspended social visits. Social visits had resumed shortly before the CPT's visit (children under the age of 11 were now allowed physical contact with their mothers during visits). Reference is also made to the comment and request for information above concerning the possibility for women to continue to make video calls to facilitate their contact with the outside world even after the pandemic is over (see paragraph 96).

f. mother and baby unit

129. The mother and baby unit, located in a separate building within the prison compound, consisted of 12 rooms (each for one mother and her baby). At the time of the visit, it was accommodating six women and six babies. Material conditions in the unit were very good. The rooms, located on the 1st floor of the unit, were spacious and adequately equipped. The ground floor contained a laundry, a kitchen and a TV lounge; there was also a spacious child-friendly outdoor playground. Overall, the unit provided a comfortable, safe and stimulating environment for children. As a general rule, children could stay in the unit until the age of 18 months.[76]

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75 In most cases, these women were highly disruptive, being aggressive towards staff and other women prisoners and refusing to engage with staff.

76 Exceptionally, if the mother had only a few more months to serve, they could stay until 24 months of age.

130. The doors of the accommodation rooms were never locked and women were free to move within the unit. As a general rule, mothers could work and babies were placed in a nursery in the meantime (which was staffed with three nursery nurses).

131. The unit was visited by a health visitor once a week and midwives visited twice weekly during the first 28 days upon delivery.[77] There was also a perinatal mental health team, composed of a psychiatrist, a psychologist an assistant psychologist and an occupational therapist, which provided support to the mothers (as well as to pregnant prisoners accommodated in the house blocks) and also visited two other prisons.[78]

As regards custodial staff, there was a pool of nine custodial officers (7 women and two men). Three officers were present during the day and one at night.

g. fatal incident concerning a new-born

132. Regrettably, despite these general efforts to provide adequate environment and care to pregnant prisoners and mothers and babies, a new-born died at Bronzefield Prison in September 2019. The investigation commissioned in October 2019 by the Secretary of State for Justice and carried out by the Prisons and Probation Ombudsman identified a series of failings in the care provided to the pregnant prisoner;[79] in particular, according to the investigation report, the woman concerned gave birth alone in her cell overnight without medical assistance which should not have happened, the approach to managing the woman was uncoordinated, there was a lack of clarity about the estimated delivery date and staff on shift did not know that she might give birth imminently.

The report formulated a series of recommendations, including to re-profile and update the maternity service provision at Bronzefield to reflect the increased demand since the closure of HMP Holloway; to develop a maternity pathway for prisoners that includes a process for those women who decline to engage with services and access to psychological and psychiatric services for support; and to establish a clear process for emergency responses to births at Bronzefield to ensure that immediate practical basic assistance can be provided.

**The CPT would like to receive an account of the steps taken to implement the recommendations made in the report by the Prisons and Probation Ombudsman.**

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77 Babies were registered with a GP in the community.

78 The team was introduced as a response to the fatal incident referred to in the following paragraph.

79 The report is available at: https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/09/F4055-19-Death-of-Baby-A-Bronzefield-26-09-2019-NC-Under-18-0.pdf.

## D. Psychiatric establishments

### 1. Preliminary remarks

133. In England, involuntary hospitalisation for persons with a mental disorder is regulated under the Mental Health Act 1983, as amended in 2007 (hereinafter "the MHA"). Persons may be detained and treated against their will under the MHA if they have or appear to have a "mental disorder", meaning "any disorder or disability of the mind"[80] which is of a "nature and degree" which warrants detention in hospital "in the interests of his own health or safety or with a view to the protection of other persons".[81] If admission is for treatment (as opposed to a shorter period for assessment) "appropriate medical treatment" must be "available".[82]

For children (under 16) or young people (16-17) the criteria for detention under the MHA are similar to those for adults, with or without capacity. However, compulsory admission under the MHA of a minor who is a ward of court requires leave from the court. Section 131 MHA clearly states that patients aged 16 or 17 years with the relevant capacity can consent to informal admission regardless of the opinion of someone who has parental responsibility for them. Furthermore, if they refuse, they cannot be admitted on the basis of parental consent.

The revised Mental Health Act 1983 Code of Practice of April 2015 provides statutory guidance to registered medical practitioners, approved clinicians, managers and staff of providers and approved mental health professionals (AMHPs) on how they should proceed when undertaking duties under the Act.[83]

134. At the time of the visit, a long-overdue reform of the MHA was underway. A Government White Paper which contained many of the recommendations presented in the final report of an independent review commissioned in 2017 had recently undergone a public consultation. A bill was expected to be introduced into Parliament shortly and the delegation was informed by Government interlocutors that the new legislation should come into force in 2023/2024.

135. The Care Quality Commission (CQC) in England, part of the UK NPM, is responsible for the registration, inspection and monitoring of health and care providers, including mental health providers, under the Health and Social Care Act 2008. This Act sets out specific duties for the CQC to act as a general protection for patients by reviewing, and where appropriate, investigating the exercise of powers and the discharge of duties in relation to detention, community treatment orders (CTO) and guardianship under the Act.

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80 Learning disability is only considered to be a mental disorder within the meaning of the Act if it is associated with abnormally aggressive or seriously irresponsible conduct. Dependence on alcohol or drugs are not considered a disability of the mind for the purpose of this act (sections 1(2a) and 1(3) MHA).

81 Section 2 MHA.

82 Section 3 MHA.

83 See paragraph 105 of the CPT's report on its 2016 visit to the United Kingdom: CPT/Inf (2017) 9.

136. In its report on the 2016 visit to the United Kingdom, the CPT noted an increase in the number of detained patients, year on year, from 46,348 in 2010/11 to 58,399 in 2014/15, an increase of more than 25% in four years. The latest official figures[84] show that for the year 2019/20 this number had dropped to 50,893. **The CPT hopes that there will continue to be a drop in the number of detained patients and would like to receive detention figures for 2020/21 and to be informed of the official number of mental health beds and the number of patients detained on 31 January 2021.**

137. During the 2021 visit, the CPT's delegation carried out visits to five psychiatric facilities in England.

The Alnwood Unit in St Nicholas Hospital, Newcastle, is part of the national network of medium secure adolescent units and provides specialist services for children from 12-18 years with mental health disorders or ASD[85]/learning disabilities. It consists of two wards: Ashby and Lennox, each of which have seven beds. At the time of the visit there were four patients on Ashby (of whom one was on leave) and five on Lennox. All patients were detained under the MHA. The average length of stay in the unit was two years.

Bamburgh Clinic, also located within St. Nicholas Hospital, is a medium secure mental health service for male forensic patients and part of Newcastle and the Northumberland, Tyne and Wear NHS Foundation Trust. It consists of four wards: Aidan Ward (a 10-bed acute admissions ward), Cuthbert Ward (a 15-bed rehabilitation ward providing treatment and rehabilitation), Oswin Ward (an 11-bed unit providing assessment and treatment for offenders suffering from personality disorders, most of them having been transferred from prison) and Cuthbert Annex (a 5-bed step-down ward). At the time of the visit, Cuthbert Ward and Annex were fully occupied and there were nine patients on both Aidan and Oswin wards. The average length of stay in Oswin is 8-10 months, in the other wards it is usually two to three years.

Cygnet Hospital Sheffield, a private establishment at which the NHS commissions beds, is a 55-bedded facility offering low secure services for women (Spencer Ward, 15 beds)[86] and mixed-gender Child and Adolescent Mental Health Services (CAMHS) services on three wards. These three wards include a 15-bed low secure unit (Griffin), a 13-bed general adolescent unit (Pegasus) and a 12-bed Psychiatric Intensive Care Unit (PICU) called Unicorn. At the time of the visit there were 44 patients, 42 of whom were detained under the MHA.

Priory Hospital Enfield in North London is a private institution accepting NHS patients and consists of four wards: Blake Ward (opened in the summer of 2020) is a mixed, general acute ward with 12 beds (six for men, six for women) which was fully occupied at the time of the visit; Coleridge Ward is a 15-bed male medium secure admission ward which accommodated 14 patients at the time of the visit; Keats Ward is a 16-bed male medium secure ward which was half full at the time of the visit; and Byron Ward, a 10-bed low secure ward accommodated nine patients. Patients usually stay on Blake Ward for four to five weeks before primarily being discharged home. Forensic patients are usually admitted to Coleridge Ward for initial assessment (six to nine months) before moving to Keats Ward (nine to twelve months) and then Byron Ward (nine to twelve months) before being discharged. At the time of the visit, 33 of the 43 patients present in the hospital had been detained under the MHA.

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84 From the NHS Mental Health Dashboard.

85 Autism spectrum disorder.

86 Spencer Ward is the only low secure unit for women in South Yorkshire.

The CPT also visited the headquarters and largest hospital of St Andrews Healthcare, a mental healthcare charity set up in 1838, in Northampton. The site provides both women's, men's and CAMHS services, including PICU, long-stay, forensic, learning disabilities/autism. At the time of the visit, there were 432 patients for a capacity of 498 beds in 39 wards. The delegation focused on the following wards: Church (10-bed low secure female ASD/learning disabilities)[87] and Upper Harlestone (12-bed female low secure),[88] as well as Sitwell (15-bed medium secure CAHMS ward for young men with learning disabilities)[89] and Seacole (10 beds, mixed-gender CAMHS rehabilitation).[90] It also visited the male adult wards of Cranford (17-bed medium secure),[91] Sunley (15-bed medium secure learning disabilities)[92] and Heygate (10-bed PICU).[93]

138. The delegation did not receive any allegations or indications of deliberate physical ill-treatment of patients by staff. On the contrary, the vast majority of patients were positive about the staff and said that they had a caring attitude towards them. Furthermore, the delegation met many dedicated health professionals working hard to care for their patients.

However, at Priory Hospital Enfield, some patients indicated a dismissive attitude on the part of medical and nursing staff and one patient alleged verbal abuse of a racist nature by nursing staff and even by his consultant. A written complaint had been made. **The CPT would like to be informed of the outcome**.

The CPT considers that verbal abuse and racist behaviour constitute forms of ill-treatment and **recommends that the management of Priory Hospital Enfield remind staff that such behaviour is unacceptable and unprofessional and will be dealt with accordingly.**

### 2. Living conditions

139. The living conditions in the establishments visited ranged from good to excellent, with some wards pleasantly decorated, containing various communal areas and rooms for activities. Patients were generally free to move about their respective wards and associate with other patients throughout the day.

140. At both the Bamburgh Clinic and the Alnwood CAHMS Unit at St Nicholas Hospital in Newcastle, the living conditions observed were of an excellent standard. All premises were clean and spacious, and patients' rooms were personalised, appropriately furnished, sufficiently ventilated and lit, and of an adequate size. The various common and activity rooms on the wards were all pleasantly decorated and well equipped, providing a friendly and patient-centred environment. The outdoor exercise and sports yards of the Alnwood Unit were colourful and welcoming, well-equipped and provided for a wide range of physical activities. At Bamburgh Clinic, each ward had a pleasant internal courtyard with greenery, benches and a gazebo as well as a garden adjacent to a large covered outdoor exercise and sports area. All patients at this clinic had unrestricted access to outdoor space.

[87] All 10 patients on the ward at the time of the visit were detained under the MHA.
[88] All 10 patients on this ward at the time of the visit were detained under the MHA.
[89] Three of the four patients on this ward at the time of the visit were detained under the MHA.
[90] All six patients on the ward at the time of the visit were detained under the MHA.
[91] 13 out of the 14 patients on the ward at the time of the visit were detained under the MHA.
[92] 14 of the 15 patients on the ward at the time of the visit were detained under the MHA.
[93] All 8 patients on the ward at the time of the visit were detained under the MHA.

141. The Priory Hospital Enfield was housed in a former convent, which was not conducive to a modern, therapeutic and patient-centred environment. For example, the corridors in Keats Ward were very narrow and the individual bedrooms were rather sombre. The recently opened Blake Ward was more modern with each room having en-suite sanitary facilities.

There was a pleasant green park with plants and flowers and benches to sit on which many patients could access every day, although some patients could not access outdoor areas without staff support. At the medium-secure wards, access to the outdoor areas was only possible for three twenty-minute periods a day. Furthermore, the secure outdoor yards for the forensic patients provided an unfriendly, austere environment with their high black fences and black tarmac, lack of shelter from rain and sun and lack of any equipment for exercising or resting. Many patients were discouraged from taking outdoor exercise in such bleak conditions. Availability of staff also restricted the possibilities to do so in practice. The CPT considers that spending time outdoors has a beneficial impact on patients' well-being and recovery and that every effort should be made to create a pleasant walking space and to proactively promote access to such outdoor areas.

142. The living conditions at Cygnet Hospital Sheffield were very good with most communal areas of a welcoming design and patients' rooms appropriately furnished, sufficiently ventilated and lit, and of an adequate size. It was also positive that patients were involved in the personalisation of their rooms and wards. Nevertheless, while it is understandable that adolescents' bedrooms may not always be the tidiest, additional efforts should be made to ensure that they are suitably clean.

The secure outdoor exercise yards contained plants in pots, were colourfully decorated, well-equipped and allowed for a wide range of physical activities. All patients had unrestricted access to outdoor space. However, the outdoor yard of Unicorn Ward (a small, fenced concrete terrace without any physical exercise equipment) was unwelcoming and austere.

143. St Andrew's Healthcare Northampton is situated in pleasant large green grounds with lawns and parklands, a sports field and two swimming pools. The living conditions on the wards visited were very good: premises were clean and, generally, in a good state of repair and the design in most communal areas was welcoming. Patients' single occupancy rooms were suitably furnished, sufficiently ventilated and lit, and of an adequate size. There were multiple rooms for activities which were well equipped, as were the grassy secure outdoor-exercise yards which provided for a wide range of physical activities. However, access to fresh air was limited for patients on Upper Harleston Ward to when staff was available to escort them.

At this hospital, there were various levels of regime which affected patients' access to their bedrooms during the day. For example, patients with eating disorders on levels 1 and 2 were barred from their bedrooms from 8 am to 6.30 pm; those on level 3 could only go to their rooms for two hours a day (from 4.30-5.30 pm and 6.30-7.30 pm) and those on level 4 had unlimited access. This meant that there was no room where those on levels 1 and 2 could go if they needed some privacy, to make phone calls for example. If they needed a nap, this had to be taken on a chair in the communal day area.

The CPT recommends that, **if it is deemed essential for the safety of the patient concerned that access to their bedroom be denied during the day, a room should be set aside for relaxation and private phone calls, with a clear glass door and large windows which would enable observation of the patient by staff.**

144. **The CPT recommends that steps be taken to ensure that:**

- **the secure outdoor exercise yards at Priory Hospital Enfield and the outdoor yard of Unicorn Ward, Cygnet Hospital Sheffield be made more attractive so that patients are encouraged to access the fresh air every day. Unrestricted access to daily outdoor exercise should be facilitated for all mental health patients unless there are clear medical contra-indications or treatment activities require them to be present on the ward.**

- **efforts be made at Cygnet Hospital Sheffield to ensure that the rooms accommodating adolescents are kept clean.**

145. Patients in the establishments visited were able to go on escorted or unescorted ground leave, based on a risk assessment by the patients MDT,[94] which meant they could go out of the wards and walk in the grounds of the hospital. For example, at Priory Hospital Enfield, escorted ground leave usually lasted 30 minutes to one hour a day, while at Bamburgh Clinic, some patients were able to go to the coffee shop, patients' bank and shop as well as walk about in the large garden areas.

146. The vast majority of the patients interviewed in the establishments visited indicated that the food was generally good in terms of both quality and quantity. However, at Priory Hospital Enfield the delegation received a few complaints, including one concerning the wrong food being provided to a patient with an allergy. **Staff at Priory Hospital Enfield should be vigilant and make sure that patients with allergies are served appropriate food.**

### 3. Treatment

147. The treatment offered to patients was generally of a high quality, comprising a wide range of pharmacological and psycho-social treatment options that reflected patients' individual needs and preferences. Patients were generally examined by a psychiatrist within 24 hours of their arrival. All patients had individual care and treatment plans (an initial care plan was set up within 72 hours of admission),[95] and staff worked in multidisciplinary therapeutic teams with all patients being allocated a primary/named nurse. Medical records were detailed and well kept, and medical confidentiality duly respected.

The CPT was pleased to hear from patients that they were involved in both the drawing up and review of their plans and that they were provided with a copy. At Bamburgh Clinic, the 'My Shared Pathway' model[96] and the 'Recovery Star Secure' tool[97] were used to involve patients in their care and treatment and provide them with meaningful goals and outcomes during their stay. Furthermore, at Cygnet Hospital Sheffield, a mobile application had been devised so that patients could store their care plans on their mobile phones which made them easily available at all times. The CPT considers this to be a good practice.

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94 Multi-disciplinary team which exists in all mental health facilities and is usually made up of nursing staff, a doctor/consultant, psychologist, occupational therapist/activity specialist and social worker.

95 The CPT was pleased to learn at the beginning of the visit that care and treatment plans will be placed on a statutory level once the reform of the MHA has been implemented.

96 A Department of Health-led initiative to involve users of secure mental health services in their own care and treatment.

97 Developed by the Association of Mental Health Providers to enable patients to measure their own recovery progress.

148. All patients were involved in their own Care Programme Approach (CPA) meetings after the first three months of their stay and thereafter every six months. During these meetings, which take place at all mental health facilities in Britain, a comprehensive plan for treatment based on assessments undertaken is developed. However, on the acute ward of Priory Hospital Enfield, not all patients interviewed appeared to be aware of their care and treatment plans.

149. At Bamburgh Clinic, the good practice of new patients being allocated a "Ward Buddy" (i.e. another patient who is familiar with the ward) to help them settle in was observed on Cuthbert and Oswin Wards.

150. **The CPT recommends that patients on Blake Ward, Priory Hospital Enfield, be more involved in the development of their care and treatment plans so that they are fully aware of these plans.**

Further, **the Committee would be interested to learn how the good practices noted in the hospitals visited or in other facilities are shared throughout the mental health system**.

151. Evidence-based psychological sessions were carried out individually and in groups. For example, in Newcastle, the Bamburgh Clinic had a Psychosis Awareness Group and there was a well-staffed psychology department at the Alnwood Unit, made up of a number of professionals including clinical psychologists, consultant clinical psychologists, nurse therapists and assistant psychologists.

The CPT's delegation also found that numerous opportunities for rehabilitation and occupational therapies were offered to patients in the different wards visited. The exception was the acute ward at Priory Hospital Enfield, where the treatment offered to patients and the programme of psycho-social and occupational therapies was insufficient. This was partly due to the absence of a psychologist on this ward.

**The CPT recommends that steps be taken to increase the offer of psycho-social treatment on Blake Ward at Priory Hospital Enfield and that patients be encouraged to actively participate in occupational therapy. In addition, the presence of psychologists on this ward should be ensured.**

152. At St Andrew's, the NHS England pilot Women's Secure Blended Service, part of the national Mental Health Secure Care Programme, was being trialled. This model aims to substantially reduce transitions for women by 'blending' medium and low secure adult services in a single location and improve the experience and outcomes for women through a focus on relational security and trauma-informed care and environments.[98] This is an example of good practice and the CPT encourages the UK authorities to expand its use.

98 See https://www.england.nhs.uk/mental-health/adults/secure-care/.

153. As regards somatic health, patients received physical examinations by a healthcare professional upon admission and thereafter, benefited from regular health check-ups and visits by a local general practitioner (GP) at the establishments visited. A doctor specialising in geriatrics attended St Andrew's Healthcare Northampton two hours a week, which was particularly important given the presence of older patients at the hospital.

The required blood tests for patients receiving clozapine were carried out appropriately in all the establishments visited. In addition, high dose antipsychotic monitoring (ECG and urea and electrolytes) and lithium monitoring was carried out, as necessary. However, at Priory Hospital Enfield, there were separate monitoring forms for each type of medication and these were not always correctly filled out and, on occasion, certain information had not been recorded at all. **The CPT recommends that at Priory Hospital Enfield a clear centralised system for monitoring the effects of certain medication be established.**

Dental care was facilitated at all establishments visited, with dentists coming in to provide treatment to patients who could not go to appointments outside the hospital concerned.

154. The CPT found that a wide range of therapeutic and occupational activities was on offer in all the places visited.

For example, at Bamburgh Clinic, activities included music, cooking, art, woodwork, minibus outings, a walking group, films, photography, board games, various sports (football, basketball, cycling, cardio, boxing, cricket, badminton, table tennis, pool) and access to a gym, as well as high intensity workouts, yoga, Tai Chi and Pilates. In addition, patients could enrol for a wide range of courses at the Gateway Recovery College for secure services such as Dialectical behavioural therapy (DBT) skills awareness, environmental issues, creative writing, recovery through music, astronomy etc. In addition, each ward had a computer which could be accessed following an individual risk assessment. This allowed patients to have access to videoconferencing or online educational tools. Occupational therapy took place six days a week.

All patients had an individual and structured timetable of activities which was discussed with them according to their needs and preferences. Patients were encouraged to participate in activities to gain life skills, daily living skills (cooking, shopping, budgeting, etc.), and there were some very good health and wellbeing initiatives (healthy food, exercise and stress management). Patients were also encouraged to work and receive training and education. This level of patient engagement in such a wide range of activities with excellent facilities is to be commended.

The only exception found concerned Blake Ward, Priory Hospital Enfield, where some patients complained of a lack of activities and the delegation gained the impression that activities were effectively limited on this ward. **Efforts should be made to ensure that patients on this ward are offered the same opportunities to participate in daily activities as those on the other wards at Priory Hospital Enfield.**

155. There was some recourse to pro re nata (PRN) medication at the establishments visited and the appropriate safeguards appeared to be in place. At Priory Hospital Enfield the medication was usually administered in tablet form, but also by injection. PRN prescriptions were reviewed once a week at this hospital and at Cygnet Hospital Sheffield. At Cygnet Hospital Sheffield, PRN medication could be given upon the decision of two nurses, but where the medication needed to be administered by injection, a doctor was called. At St Andrew's, PRN medication was used appropriately and its administration was well documented.

### 4. Staff

156. Staff numbers were generally adequate in all hospitals visited. In general, the number of psychiatrists, psychologists, nurses and health care assistants was sufficient and enabled patients' needs to be adequately catered to. That said, there was a high reliance on bank[99] and agency staff, notably at Priory Hospital Enfield.

157. The staffing levels at Priory Hospital Enfield were generally adequate. For example, for a hospital of 55 beds, there were four full-time equivalent (FTE) consultant psychiatrists, and on each day shift there was one per ward (including the Medical Director), six registered mental health nurses (RMN), 12 staff nurses and 41 health care assistants (HCA). They were supplemented by a further four RMN, nine staff nurses and 39 HCA bank staff. At nights there was a junior doctor from a private healthcare company (NES) who would look at new seclusions and attend to any medical emergencies. Blake Ward had a dedicated FTE speciality doctor. In addition, there were two forensic social workers, two fully qualified FTE psychologists two FTE assistant psychologists and one FTE occupational therapist. The delegation found that there was a particular lack of occupational therapy and a psychologist on Blake Ward. The CPT recommends that **an increased presence of an occupational therapist on Blake Ward at Priory Hospital Enfield be ensured.[100]**

Staff retention for the 60% permanent staff was excellent and the delegation found that staff morale at this hospital was good. The management had a recruitment strategy to reduce reliance on bank and agency staff. **The CPT would like to receive information about the progress of this strategy**.

158. At Bamburgh Clinic, staffing levels were similarly adequate[101] with good staff retention rates. At the time of the visit, there were 10 nursing and eight HCA vacancies which the management hoped to fill before the end of 2021. **The CPT would like to receive confirmation that these vacancies have been filled.**

It is positive that the service had an excellent peer-support programme in place and there were also a number of paid peer-support workers in employment, including one FTE peer support leader who had experience as a service user in mental health settings and who also carried out therapeutic activities at the Recovery College. Such a programme represents good practice and should be encouraged at all mental health units.

159. At the Alnwood Unit for children, the staffing levels were excellent for the12-bed unit.[102] This enabled the complex needs of the young patients to be met.[103] For example, on Ashby Ward, there were two qualified nurses and eight HCAs between 6.30 a.m. and 7.30 p.m., and at night there was one nurse and eight HCAs. In general, staff turnover was low and staff were happy working at the unit.

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99 Part of a pool of qualified temporary workers working on zero-hour contracts.

100 See also paragraph 151 above.

101 3.5 consultants and 4 non-consultant psychiatrists, 19 nurses and 44 HCAs as well as three psychologists, 11.5 occupational therapists, one physical health nurse, three social workers, one senior social worker and a speech and language therapist - all FTE. There were also two sports instructors and various activity workers.

102 Two consultant psychiatrists, one psychiatric registrar per ward and occasionally senior house officers on both wards as well as 52 FTE nursing posts for each of the two wards.

103 In addition to having a mental disorder, they had an autistic spectrum disorder or a learning disability.

160. Staffing levels at St Andrew's Northampton were very good and it was noted that over 70% of staff were permanent. A further 20 % of staff were from Work Choice, St Andrew's own staffing bank and in the period between January 2019 and May 2021, only 5% were agency staff.

161. At Cygnet Hospital Sheffield, staffing levels were also good. The MDTs for each of the wards visited were sufficiently staffed with each having its own ward manager, consultant (forensic or CAMHS), ward doctor, occupational therapist, occupational therapist assistant, social worker, forensic or clinical psychologist, assistant psychologist and activity coordinator. In addition, the CAMHS wards visited had one nursing lead shared across the three wards, a family therapist also shared across the three wards and speech and language therapists. However, the staff turnover rate remained exceedingly high[104] which undermined the stability of teams and hence impacted on the quality of care. **The CPT would like to receive information on the progress made in addressing this issue.**

### 5. Restrictive practices

162. The MHA Code of Practice states that restrictive interventions should only be used where there is a real possibility of harm to the person or others and to end or significantly reduce the danger to the patient or others. They should be proportionate, the least restrictive option and should not be used as a punishment, nor for longer than necessary to prevent harm. They must also only be undertaken in a manner that is compliant with human rights and be regularly reviewed and updated. "Restrictive intervention reduction programmes" should be put in place by mental health providers to reduce their use.

163. Detailed information about all individual instances of use of restraint measures was recorded in the respective electronic patient record system in the hospitals visited. However, the delegation was not always able to assess in a comprehensive manner the use of means of restraint with the information which was made available to it, particularly in relation to the frequency and duration of seclusion of patients. Furthermore, at St Andrew's, there was no dedicated register for recording the use of means of restraint.

**The CPT recommends that each mental health facility has a central register which includes not only the number of instances of restraint but also their duration in an accessible manner.**

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[104] The yearly staff turnover at this hospital fluctuated between as much as 40 and 50% from January 2019 to May 2021.

164. At Priory Hospital Enfield, the use of restrictive interventions did not appear excessive. All use of means of restraint was recorded electronically and audited. All related policies were reviewed regularly. There was also a debriefing with a patient after the use of any type of restraint measure.

On the other hand, there was a very high level of the use of restraint at the Alnwood Unit with 391 instances of restraint (involving 7 patients) on Lennox Ward from 1 July 2020 to 12 June 2021and 160 instances of restraint, involving 5 patients on Ashby over the same period. The CPT understands the difficulties faced by staff when dealing with extremely aggressive patients, but does not consider that such a high level of restraint should be used on children and young patients who are particularly vulnerable. A strategy to reduce the resort to means of restraint was in place at the unit. **The CPT underlines that further efforts must be made to effectively implement this strategy in practice and would like to receive information on the impact of this strategy as of 31 December 2021.**

a. Physical restraint

165. The MHA Code of Practice states that patients must not be restrained in the prone position unless "there are cogent reasons" for doing so, and NICE[105] Guidelines recommend the supine position if patients have to be forced to the floor. It was positive that at Priory Hospital Enfield, the prone position was no longer applied following a clear commitment by the management to phase out its use. In fact, there was the same commitment to reducing supine restraint and they were looking into the more comfortable alternative of "restrained sitting" (e.g. in so-called Sensit chairs or bean bags).

On the other hand, the CPT's delegation found that restraint in the prone position was still applied in the other hospitals visited, to a greater or lesser extent. For example, at the Alnwood Unit, from 1 July 2020 to 12 June 2021, 205 out of 391 instances of restraint on Lennox Ward were in the prone position and 62 out of 160 instances on Ashby Ward.[106] The unit was equipped with safety pods for restraining the young patients in a more comfortable manner with less risk to their health and these safety pods should be preferred to holding patients in a prone position.

At St Andrew's Healthcare Northampton site, prone restraint was used 2,095 times between 1 April 2019 and 31 March 2021. The average length of time ranged from one to eight minutes, but one instance lasted 30 minutes; whenever the restraint lasted for more than five minutes there was an internal investigation into the incident carried out by staff (including from another ward) to see how such occurrences could be avoided in the future.

105 National Institute for Health and Care Excellence.

106 The high numbers could be explained by the fact that even when the patient accidentally fell into this position or chose to be placed face down, the instance was recorded as prone restraint.

166. Staff at the hospitals visited were trained in various techniques of manual restrictive practices and de-escalation.

At Priory Hospital Enfield, Prevention and Management of Violence and Aggression (PMVA) training was overseen by two PMVA instructors who regularly examined CCTV footage of incidents in order to identify areas for improvement and to check whether the level of force used was proportionate. New staff members underwent a five-day training course and thereafter there were yearly three-day refresher courses.

At Bamburgh Clinic, the "Safer handling" model was applied and the delegation noted a downward trend in the use of physical restraint from 225 applications to 135 over the past two years.

At Cygnet Hospital Sheffield, staff were trained in the MAPA[107] model for managing aggression. While some instances of manual restraint lasted only 30 to 60 seconds, the delegation nevertheless noted a disproportionate number of instances of manual restraint, with 1,159 recorded uses since January 2021. Furthermore, the average duration of these holds was almost 18 minutes and the maximum duration was 370 minutes (i.e. over 6 hours). Periods of physical restraint in the supine position were also long at St Andrew's Healthcare Northampton, with the maximum duration on Church Ward for the period 1 April 2019 to 31 March 2021 lasting 360 minutes. On Cranford the maximum duration was 270 minutes and on Sitwell 240 minutes.

**The CPT recommends that the UK authorities ensure that the NICE guidelines and the MHA Code of Practice be strictly adhered to in all mental health units across the country when resort to physical restraint is deemed necessary to manage a patient. All health care staff need to be properly trained in restraint techniques that enable them to avoid having to place a patient in the prone position.**

**Further, greater efforts should be made to limit the time that patients are physically restrained.**

167. At the Alnwood Unit, the delegation was informed that in rare cases, concerning very serious incidents, the police were called in as was the case with one patient on two occasions in late 2020 and early 2021. The CPT is generally not in favour of the police being called into a mental health facility to restrain a patient. Nevertheless, it recognises that it may be necessary in exceptional circumstances.

In this context, the CPT welcomes the enactment of the Mental Health Units (Use of Force) Act 2018 which provides for a responsible person to be appointed for each mental health unit, more effective investigations into deaths and serious injuries and the wearing of a body camera by police officers entering mental health units to assist staff, as well as increasing accountability and reporting. This act however has not yet been implemented. The delegation was informed during the initial talks with the authorities that it is expected to come into force in December 2021. **The CPT would like to be informed about the measures being taken to ensure that the new law can be applied effectively throughout the country.**

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[107] Management of Actual or Potential Aggression, which places the emphasis on alternatives to physical restraint and seclusion and least restrictive practice.

b. Mechanical restraint

168. Mechanical restraint was occasionally used at some of the establishments visited, notably during transport of patients (in accordance with Ministry of Justice directions), including medical transfers, or in cases of the administration of food via naso-gastric tube (see paragraph 186).

There was evidence of a significant reduction in the use of mechanical restraint at Bamburgh Clinic and every use was based on an individual risk assessment and subject to director-level authorisation. The delegation noted the use of soft restraints such as soft belts with Velcro strips (for the body, arms or legs) as part of the "Safer handling" model, which restrained the patients in the most comfortable way possible. Such soft belts and cuffs provide a safer alternative to handcuffs as they can be released easily in case of emergency. Mechanical restraint could also be used together with chemical restraint (rapid tranquillisation). It was also used to transfer patients to the seclusion room, but, based on a risk assessment, the restraint equipment would then be removed immediately. Adequate safeguards were in place, with a debriefing after the use of mechanical restraint and a physical examination of the patient, using a body map to document any lesions or injuries.

The CPT's delegation was pleased to note that strategies had been established with the involvement of the patients concerned in order to avoid resorting to mechanical restraint.

However, in the year 2020/2021, there were a total of 83 instances of mechanical restraint, compared with 78 for the year 2019/2020 which represents a slight increase. **The CPT considers that efforts should be made to further reduce the use of mechanical restraint at Bamburgh Clinic Newcastle.**

The use of mechanical restraint at the Alnwood Unit appeared to not be excessive[108] and was used proportionately.

c. Rapid tranquillisation

169. Recourse was had in all of the establishments visited to rapid tranquillisation (RT)[109] which, whether administered orally or by injection, is defined in guidance issued by the Mental Health Services Data Set (MHSDS) as chemical restraint which must be reported to the MHSDS.

At Priory Hospital Enfield, RT was resorted to less than 10 times a year. Similarly, at St Andrew's, rapid tranquillisation was rarely applied on certain wards and its use overall had decreased significantly since 2019. Likewise, at the Cygnet Hospital Sheffield, the resort to rapid tranquillisation appeared not be excessive and all use was reviewed each month. At Bamburgh Clinic, the delegation noted that of the 66 cases of RT applied between January 2019 and the end of May 2021 39 concerned one patient.

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108 There were 17 instances of mechanical restraint between July 2020 and June 2021 on Ashby and 30 on Lennox over the same period.

109 The MHA Code of Practice defines rapid tranquillisation as "the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression."

By contrast, rapid tranquillisation, particularly by intramuscular injection at the small Alnwood Unit appeared too high. Official figures showed that from 1 July 2020 to 11 June 2021, rapid tranquillisation was used on Ashby Ward 20 times by injection and 77 times orally and on Lennox Ward 248 times by injection and 119 times orally. **The CPT recommends that, at the Alnwood Unit, Newcastle, efforts be made to reduce the use of rapid tranquilisation, in particular by intramuscular injection, and that alternative, less intrusive, means of restraint be explored.**

d. Seclusion

170. All establishments visited had policies relating to the use of seclusion which were in conformity with the MHA Code of Practice.[110] Furthermore, the delegation noted that secluded patients at all the hospitals visited were under constant direct supervision and were escorted outside for exercise daily**.**

171. At Priory Hospital Enfield, every effort was made to avoid seclusion[111] (verbal de-escalation, offering PRN medication, observation, nursing away from others, etc.). That said, periods of seclusion were lengthy at this hospital,[112] as well at the Alnwood Unit,[113] Bamburgh Clinic[114] and St Andrew's,[115] where data showed that the average length of seclusion had risen from 12 to 30 hours over the past two years. In addition, the number of seclusions was rather high at the Alnwood Unit, given the number of patients.[116]

**The CPT reiterates that seclusion, as in the case of any other means of restraint, should always be a measure of last resort to prevent risk of harm to the individual or others and that it should normally only be resorted to for the shortest possible time (minutes rather than hours).**

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110 The seclusion can be authorised by a psychiatrist, other approved clinician or nurse in charge of the ward (if the approved clinician is not a doctor or seclusion must be authorised by the nurse in charge of the ward; a medical review must take place within one hour) and must take place in a room or suite of rooms specifically designed for that purpose, patients have to be observed continuously with regular medical reviews every four hours, a nursing review at least every two hours, as well as MDT and independent MDT reviews at regular intervals. In addition, a seclusion care plan should be prepared.

111 There had been 71 instances of seclusion between January 2019 and May 2021 involving 17 patients.

112 Since January 2019, there had been 32 episodes of seclusion lasting longer than 72 hours and of these, 10 episodes longer than one week, including one in May 2021.

113 For example, on Ashby Ward 24 of the 152 instances lasted between 25 and 48 hours and 30 instances lasted for periods in excess of 48 hours.

114 Between 1 June 2020 and 31 May 2021, there were a total of 24 instances of seclusion of patients, most of which lasted for over 20 hours, with the longest being just over seven days.

115 3,878 episodes of seclusion took place between 1 April 2019 and 31 March 2021, some of which lasted several weeks or even as long as two months.

116 Between April 2019 and March 2021, there were 152 instances of seclusion on Ashby Ward and 286 instances on Lennox Ward in relation to two six-bedded units.

172. As regards material conditions, at Priory Hospital Enfield there were three seclusion rooms, all on Coleridge Ward, none of which possessed a call button on the inside and the lights could not be dimmed. There was a nursing observation area for constant observation and the room, including the toilet area, was covered by CCTV which was monitored from the observation lounge as well as in the nurses' station. The seclusion areas were in need of refurbishment, with one of the rooms painted a murky shade of green. Further, the hatches in the doors of the rooms were at floor level (the reason being that items handed through could not be dropped, but making patients bend down to pick them up was rather demeaning). The delegation was informed of plans to refurbish the seclusion areas. **The CPT trusts that the refurbishment will be carried out to ensure the rooms provide a more conducive and calming environment to uphold patient dignity**. Further, **the rooms should be equipped with a call bell and the lighting should have a dimming mechanism.**

There were two state-of-the-art seclusion suites at the Bamburgh Clinic, one on Aidan Ward and one on Oswin Ward. Both suites provided excellent conditions with the one on Oswin Ward containing a comfortable de-escalation room as well as the seclusion room, the policy being that de-escalation should be preferred to placing patients in seclusion. From the de-escalation room there was access to a secure outdoor exercise yard which was used for secluded patients. The de-escalation room itself was not intended for overnight stays.

The two seclusion rooms at the Alnwood Unit were in a good state of repair, with sufficient access to natural light, en suite bathrooms, call systems and CCTV monitoring. In addition, there was a sound system through which patients could play their own music and a television could be placed against the window from the outside.

At Cygnet Hospital Sheffield, conditions were less good. For example, the seclusion room on Spencer Ward was in a poor state of repair, sombre and with no shower, while that on Unicorn Ward had a mattress on the floor and a separate toilet and sink, but no shower. **The CPT recommends that steps be made to upgrade the seclusion rooms at Cygnet Hospital Sheffield.**

### e. Long-term segregation

173. Long-term segregation (LTS) is regulated by Chapter 26 of the MHA Code of Practice and by each NHS Trust, and is the result of a clinical judgment that "if the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time".

In the course of the 2016 visit to the UK the CPT's delegation examined the issue of LTS in Ashworth and Broadmoor high secure hospitals. [117] In the report on this visit, the CPT had criticised the necessity for the application of LTS, as well as the manner in which it is applied and its duration. It had been found that patients could be kept in LTS for years on end with minimal human contact, and often the contact offered was not face-to-face and meaningful but via the hatch in the door to the patient's room. The CPT considered that, in certain cases, the impact of LTS on patients could amount to inhuman and degrading treatment and that steps should be taken as a matter of urgency to review its use and radically cut the amount of time patients are held in LTS.[118]

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117 See the report on the 2016 visit, document CPT/Inf (2017) 9, paragraphs 150-168

118. In this regard see the report of the CQC "Out of sight – who cares?: Restraint, segregation and seclusion review" (October 2020).

174. Information provided to the CPT in June 2021, demonstrated that LTS was still resorted to regularly in the high secure hospitals.[119]

**The CPT would like to be informed of the number of cases of LTS in each of the high secure hospitals for 2021 and, more particularly, the number of patients that have been held in LTS for more than six months, one year, two years or longer (with a precision of the time period).** Further, **it would like to be informed of the reasons leading to a continued high resort to LTS when the emphasis should be on decreasing the resort to such a measure. The CPT would also like to receive a copy of the latest three-monthly "external review" carried out on LTS in each of the high secure hospitals.**

175. In the five hospitals visited in 2021, the CPT's delegation found that LTS was also resorted to in medium and low secure mental health units. Each establishment visited had a written policy on the use of LTS, which aimed to comply with the MHA Code of Practice. Appropriate safeguards appeared to be in place with regular reviews, including a review at least every week by the MDT. An independent review takes place every two weeks by a senior professional not involved in the case. After the first three months, a review is carried out by an MDT from an external hospital (involving the patient's independent mental health advocate and the service commissioner), which is repeated thereafter on a three-monthly basis.

176. At Priory Hospital Enfield there were four cases of LTS in 2020 and it appeared that the relevant procedures and safeguards had been followed

At Bamburgh Clinic, there were 12 instances of LTS recorded on the incidents register for the period 1 April 2018 to 11 June 2021, with LTS last applied in early 2021 and the longest period four months in 2020. The delegation learned that one patient had been held in prolonged segregation between 2 October 2019 and 25 February 2021, during which a high number of different restraint measures were applied due to a high level of aggression. Despite the fact that the MDT had made considerable efforts to terminate the situation and the patient concerned had access to outdoor exercise and access to family visits during their time in seclusion, 17 months is far too long for this form of restraint. That said, the delegation noted efforts to involve secluded patients in activities, such as sports (exercises in the seclusion room with an instructor) and they still received therapy.

At Cygnet Hospital Sheffield, LTS was more frequent with 44 cases since April 2019. At the time of the visit, there was one adult on LTS on Spencer Ward who was managed by six members of staff.

177. Children could also be subjected to this type of restrictive measure. At the Alnwood Unit, two adolescent patients had been in LTS for several years[120] with their environment restricted to their residential unit although they were offered a full programme of activities. Further, two out of sixteen patients in LTS at St Andrew's at the time of the visit were in CAMHS and it appeared that there was a greater use of LTS in the CAMHS low secure services as opposed to the medium secure services.

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119 For instance, for quarter 4 of 2020/2021 there were 45 instances at Ashworth, 60 at Rampton (male, female and learning disabilities services) and 49 at Broadmoor.

120 One of the two patients had (severe) autism and had been awaiting transfer to a specialist unit for six months.

178. It was positive that, across all the establishments visited, patients in LTS were able to access the fresh air, escorted by members of staff, and even leave the ward or hospital grounds. At St Andrew's, one autistic patient on LTS was allowed to go to the onsite swimming pool and even into the community (shopping or to a café), escorted by staff. He also received visits from his family. From the records, it was clear that the patient also had regular meetings with a psychologist and occupational therapist.

Nevertheless, the CPT has concerns over the practice of LTS. The Code of Practice and NICE Guidelines acknowledge that environmental factors and restricting a service user's liberty and freedom can be a trigger for violence and aggression.[121] Further, confronting patients with as many as six members of staff whenever their room door is opened is unlikely to diminish any tendency towards violence. In the long term, the question arises as to whether LTS can be considered conducive to a patient's treatment. In some cases, lengthy seclusion and LTS results in reduced human contact and a restrictive regime which carries a risk of engendering a deterioration in the mental health of the patients concerned. Indeed, one patient at Priory Hospital Enfield who had been in LTS for about two months said that his situation made him feel "like an animal".

**The CPT recommends that efforts be made in all mental health units across the United Kingdom to reduce recourse to LTS by using less restrictive measures as far as possible and that the length of time patients are held in LTS also be reduced.**

f. "Enhanced observation"

179. The MHA Code of Practice also refers to "enhanced observation" for patients whose disturbed behaviour poses a particular risk to others. This approach focuses on engaging the person therapeutically and enabling them to address their difficulties constructively (e.g. through sitting, chatting, encouraging/supporting people to participate in activities, to relax, to talk about any concerns etc.). The patient may be on 1:1 or even 2:1 observation.

The delegation was able to witness this form of restrictive practice on Church Ward at St Andrew's Healthcare Northampton. Even though the patient concerned was still able to move around the ward and engage with others, this measure appeared extremely restrictive (with the patient being constantly accompanied by staff members and their every movement watched). The justification provided for the measure was that the patient had given another patient's phone number to her boyfriend which was against the rules. Nevertheless, it does seem rather disproportionate to institute such a restrictive practice of "enhanced observation" in this case when other measures could have been applied.

**The CPT recommends that the United Kingdom authorities remind the hospitals that the use of "enhanced observation" should always be proportionate to the risk posed by the patient.**

180. At Bamburgh Clinic there were four levels of observation: general ("know where they are"), intermittent (e. g. hourly), "within sight and sound" and enhanced one on one observation. As part of the "Sleep well" project, unnecessary observations at night were limited as far as possible, which is positive.

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

g. Night-time confinement

181. In its report on the 2016 visit, the CPT had expressed its misgivings as to the use of night-time confinement (NTC) in the high-security hospitals and had recommended that the United Kingdom authorities, in close consultation with the high secure hospitals, review the use of night-time confinement, including staffing levels. While it appears that night-time confinement is no longer used on rehabilitation wards, which is positive, it continues to be applied on the other wards at Ashworth and Rampton Hospitals and on the intensive care unit at Broadmoor Hospital.

**The CPT reiterates its recommendation that the United Kingdom authorities, in close consultation with the high secure hospitals, further review the use of night-time confinement and inform the Committee accordingly.**

## 6. Safeguards

182. The general procedure for involuntary placement is regulated by the MHA and has not changed since the previous periodic visit to the UK in 2016.[122] The CPT is pleased to note that, in line with its recommendation in the report on the 2016 visit, action has been taken to avoid holding persons with mental disorders in police cells as far as possible. Under the Policing and Crime Act 2017, police stations are no longer allowed to be used as a place of safety for children and, adults may only be taken to such places in circumstances specified in the MHA (Places of Safety) Regulations 2017, which are much more restrictive.[123] The CPT also notes that the Government White Paper pledges to remove police stations as a designated place of safety by 2023-24, provided that sufficient funding is available to provide the estate needed. **The CPT would like to receive updated information from the United Kingdom authorities on the measures being taken to ensure that police stations are no longer used to hold persons with mental health disorders.**

183. Mental Health Act Administrators were present in all the hospitals visited. They were appointed by the management of each hospital and were responsible for carrying out a whole range of duties including giving advice to patients on their rights under the MHA, ensuring the establishment's compliance with the MHA and co-ordinating Mental Health Tribunals. The CPT found that these administrators provided an important safeguard for patients detained under the MHA.

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122 See document CPT/Inf (2017) 9 (paragraph 119).

123 That is: where there is imminent risk of serious injury or death; the removal to a police station must be authorised by an officer of at least the level of inspector where the officer making the decision is a constable; the constable making the decision must consult, where reasonably practicable, a healthcare professional.

184. The legislation regarding consent to treatment has not changed since the CPT's 2016 periodic visit.[124]

Under section 3 MHA, a patient may be given "appropriate medical treatment" for their mental disorder without their consent and without a second medical opinion issued by a SOAD[125] for three months. Under section 63, patients may be given treatment without their consent by or under the direction of the approved clinician in charge of the treatment. The SOAD safeguard does not apply in this case. The MHA only requires a patient's consent to treatment in respect of specific interventions such as electro-convulsive therapy and neurosurgery (see sections 57 and 58). However, such consent is not necessary if any treatment is immediately necessary to save the patient's life, to prevent a serious deterioration of his/her condition or to prevent the patient from behaving violently or being a danger to him/herself or to others (see section 62). More generally, good practice and the MHA Code of Practice require that a patient's consent should still be sought before any medication is administered.

Further, according to the Code, the administration of medication without consent should comply with Article 8 of the European Convention on Human Rights (i.e. it should be proportionate to the aim of reducing the risk posed by a person's mental disorder and the improvement of their health). The Code also points out that "compulsory treatment is capable of being inhuman treatment" but notes that "the European Court of Human Rights has said that a measure which is convincingly shown to be of medical necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading." **The CPT wishes to reiterate that the fact that a patient has been admitted on an involuntary basis should never be regarded as granting a licence for that patient to be treated against their will. Compulsory treatment should be a measure of very last resort and every instance of its use must be fully documented.**

185. In the report on the 2016 visit,[126] the CPT recommended that consent to treatment safeguards needed to be reinforced during the first three months of detention and that the relevant legislation should be amended so as to require an immediate external psychiatric opinion where a patient does not agree with the treatment proposed by the establishment's doctors. In their response, the United Kingdom authorities stated their keenness to continue to make improvements where possible and that they would take the CPT's comments into account. The White Paper on the reform of the MHA does indeed propose a change in the law, namely, that the current period of three months be reduced to fourteen days in the case of a capable patient objecting to the treatment and two months for those without capacity to decide. While representing a step in the right direction, the CPT considers that the proposed revised time frames are still too long to undergo forced treatment without a second opinion.

**The CPT recommends that the relevant legislation should be amended so as to require an immediate external psychiatric opinion in any case where any patient actively or passively objects to the treatment proposed by the establishment's doctors; further, patients should be able to appeal against a compulsory treatment decision to an independent authority, such as the Mental Health Tribunal, and the patient should be informed both orally and in writing of this right.**

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124 See paragraph 175 of document CPT/Inf (2017) 9.
125 Second opinion appointed doctor.
126 See paragraph 124.

186. The CPT has always considered the issue of force feeding to be a very sensitive issue that raises many fundamental questions, in particular of a legal, medical, deontological and ethical nature. At Cygnet Hospital Sheffield and St Andrew's Healthcare Northampton "treatment" in the form of food was being administered to patients with eating disorders by naso-gastric tube (NGT) under section 63 of the MHA.[127] Treatment administered under this section does not need a SOAD opinion and there is no review of the treatment. The CPT does not contest the necessity for such invasive treatment after all other options have been explored but it nevertheless considers that there ought to be an independent regular review of such treatment. Furthermore, the delegation received several allegations of patients who were subjected to naso-gastric feeding in the presence of other patients. **The CPT recommends that all invasive procedures such as forced feeding via NGT should be subject to regular independent review and should be performed out of sight of other patients to preserve the dignity and safety of the patient concerned.**

187. In the course of the 2016 periodic visit, the CPT had examined the forcible treatment of patients at Ashworth high secure hospital with clozapine via NGT. The decision-making process had been surrounded by a series of safeguards including consultations with family members of the patient, the MHT and a MDT examination of alternatives. Nevertheless, the CPT had reservations over the necessity of such a measure which required a team of nurses in full personal protective equipment forcibly holding down the patient on a bed while a tube was inserted up his nostril and the medication applied. In 2016, the procedure had been applied sparingly as most of the patients had decided to no longer refuse clozapine after having had it administered forcibly via NGT one or two times.

However, it appears that, as of June 2021, the procedure has now been extended with six patients at Ashworth and two patients at Broadmoor Hospital being forcibly administered clozapine. Over the period from June 2020 to June 2021, one of the patients at Ashworth had had clozapine administered forcibly by NGT 365 days in a row and it was scheduled to continue on a daily basis. Despite the safeguards established, the CPT considers such a procedure highly invasive and the longer that the forcible administration continues the greater must be the necessity for its application and the stronger the safeguards in place surrounding its use.

**The CPT would appreciate the comments of the United Kingdom authorities on this matter, including as regards the question as to how long such forced treatment via NGT can be sustained when the clozapine does not appear to be having any beneficial effect on the patient. The CPT would also like to be informed about the outcome of the review carried out by the Ethical Committee[128] regarding the case of one person at Ashworth Hospital who had been administered clozapine via NGT every day between June 2020 and May 2021.**

188. Moreover, the CPT understands that an injectable form of clozapine may be due for approval which would negate the need for forcible administration via NGT. **The Committee would like to know whether it is likely that this form of clozapine will be authorised in the United Kingdom in the future.**

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127 Section 63 MHA states that the consent of a patient shall not be required for any medical treatment given to them by their approved clinician for the mental disorder from which they are suffering.

128 A committee established to provide ethical advice set up by the regional health and care system.

189. In its report on the 2016 periodic visit to the United Kingdom, the CPT was also concerned that not all patients had provided their consent to treatment in writing on a specific form ("T2" form under section 58a MHA). During the 2021 visit, the CPT's delegation found that the T2 forms did not contain the patient's signature consenting to treatment as the forms had been digitalised and it was no longer possible for the patients' signatures to appear. In addition, a written form showing a patient's consent to treatment would not be included in the future statutory care plan as it was reasoned that a patient might change their mind and it would be more difficult to go back on the initial decision if it were in writing. However, even though T2 forms do not expire, they should be regularly reviewed and become invalid if the patient loses capacity or if they withdraw their consent,[129] upon which a T3 form[130] should be drawn up. There is therefore provision in law for such a situation and the signature is not set in stone.

**The CPT recommends that the United Kingdom authorities take steps to enable patients to sign T2 forms, even electronically. Further, it recommends that such a form be included in the care and treatment plan that will be placed on a statutory footing.**

190. Capacity assessments are carried out upon admission and regularly reviewed. In all establishments visited, the delegation found that second opinion appointed doctor (SOAD)[131] assessments were carried out over the telephone. This is a completely unacceptable way for such a procedure to take place and does not provide sufficient safeguards, particularly for the young autistic patients at the Alnwood Unit who had multiple additional diagnoses. The CPT understands that due to restrictions related to the Covid-19 pandemic, it was not always possible for these assessments to take place in person, but they should at the very least take place in a manner that enables the SOAD to gain a better idea of a patient's situation than merely by hearing their voice over the telephone. In fact, the High Court of England and Wales recently ruled in an advisory opinion[132] that "personally seen" (section 11 MHA) and "personally examined" (section 12 MHA) require physical presence. **The CPT recommends that the United Kingdom authorities take action to ensure that patients in all mental health facilities are seen in person during a SOAD assessment.**

191. The CPT's delegation also noted that there were often delays in accessing a SOAD, particularly at St Andrew's Healthcare Northampton where SOADs took six weeks or even longer before they came to carry out the assessment. In the meantime, patients were treated under section 62 MHA which should only be used in emergency situations. This state of affairs is completely inappropriate, as not only are patients treated against their will for longer than the current statutory period of three months, but it also represents a misuse of section 62 and means that there is no effective legal basis for the involuntary treatment.

**The CPT recommends that the United Kingdom authorities take steps to reduce the time limits for SOADs to carry out their assessment to ensure that patients are not subjected to involuntary treatment beyond the current statutory period of three months without a second opinion.**

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129 Section 60 MHA.

130 A "certificate of second opinion" (under section 58b MHA), drawn up for patients who do not consent to treatment or does not have the capacity to consent to treatment.

131 The Royal College of Psychiatrists describes the role of the SOAD as "to decide whether the treatment recommended is medically necessary, clinically defensible, and whether due consideration has been given to the views and rights of the patient, and to reach a view on capacity and consent".

132 In the case of Devon Partnership NHS Trust v SSHSC [2021] EWHC 101 (Admin)

192. At the Alnwood Unit, the delegation noted from one of the prescription charts that a T3 form had not been reviewed for over two years contrary to the Care Quality Commission guidance. The CPT stresses that regular review of the patients' compulsory treatment and their capacity is an important safeguard to protect patients' rights and should be applied at regular intervals. **The CPT recommends that all T3 forms be reviewed at least once a year.**

193. In its report on the 2016 periodic visit to the United Kingdom, the CPT had recommended that patients be able to appeal against a compulsory treatment decision to the Mental Health Tribunal. Although the situation had not evolved at the time of the 2021 visit, the CPT notes that the planned reform of the MHA will make it possible for patients to be able to challenge a specific treatment before a single-judge tribunal (in a "permission to appeal" stage before the case goes to a full MHT hearing). The judge will not be able to make a clinical decision but will be able to make a finding that the responsible clinician should reconsider their treatment decision. **The CPT supports this proposed additional role for the MHT.**

194. Currently, a patient detained under Part II of the MHA can appeal their detention to the hospital managers as well as to the MHT. Patients admitted for assessment under section 2 MHA have 14 days to appeal the decision. Those admitted for treatment under section 3 of the Act have six months to appeal. Patients detained under section 37 of the Act (upon a hospital order) may appeal after the first six months of their detention and not more than twice in a year.

The White Paper on the reform of the MHA proposes that the frequency of review of patients' detention be increased and it will be possible for section 2 patients to appeal within 21 days instead of 14. Furthermore, section 3 patients will be able to appeal three times within the first year of detention instead of twice and there will be an automatic review every 12 months. This would be a positive development.

195. The CPT's delegation found that in all establishments visited, review procedures appeared to function appropriately. Provision was made for MHTs to take place on the premises, although during the height of the pandemic, the tribunals were held via videoconference. At Bamburgh Clinic, during the first lockdown, there was no hearing of the person either physically or remotely; reviews were only carried out on paper. Even though a tribunal without a hearing is permitted, particularly during the pandemic, in exceptional circumstances by the First-tier Tribunal (Health, Education and Social Care Chamber) Rules, which the MHT must follow, the CPT considers this not to be a good practice, as the possibility for the patient to attend tribunals preserves their interest in the decision-making process.

**The CPT recommends that even during public health crises, patients with mental health disorders have an effective right to be heard by the MHT at the very least by audiovisual means when the court reviews the lawfulness of their continued involuntary hospitalisation.**

196. For patients detained under sections 2, 3 and 37 MHA, discharge will take place upon an order to that effect made in writing by the responsible clinician, the management of the hospital, or the nearest relative (subject to approval by the responsible clinician).[133] The MHT also has power under section 72 MHA to discharge a patient upon application by or in respect of a patient who is detained under the Act.

Restricted patients subject to a section 37 hospital order with a section 41 restriction who no longer meet the statutory test for detention in hospital must be discharged. The discharge may be either absolute, or, if deemed appropriate by the tribunal or the Justice Secretary, conditional.

197. According to the NHS England Delayed Discharge Reduction Programme statistics, there was a total of 155,700 delayed days in February 2020 (an average of 5,370 people delayed per day), of which 103,000 were in acute care. This represented an increase of more than 20% since February 2019. Since the Covid-19 pandemic, no further national data has been collected. However, the delegation noted during its June 2021 visit that the number of delayed discharges was still quite high. For example, at Cygnet Hospital Sheffield, between February and May 2021, 38 delayed discharges were noted, mostly due to lack of appropriate placement or funding. Two of these cases had each lasted for almost a year. As regards St Andrew's, there were 228 delayed discharges in 2020, mainly because of a lack of further non acute NHS care and from January to May 2021 there had been 38 cases of delayed discharge (15 of which were a result of a lack of alternative care or funding). The delegation noted the management's efforts to reduce these numbers, notably by accepting CAMHS patients only when an alternative for the next step would be certain.

The situation was particularly worrying at the Alnwood Unit where a third of the patients detained there were awaiting discharge. Children with autism and learning disabilities are particularly vulnerable and keeping them in secure mental health facilities when they no longer need to be there is unacceptable.

The CPT welcomes the existence of the Delayed Discharge Reduction Programme which aims to improve hospital discharge and flow across all parts of the health and social care system**. Nevertheless, the CPT recommends that the United Kingdom authorities take further steps to effectively reduce the number of delayed days before discharge from mental health units. This is especially important for children in secure mental health facilities. The CPT would like to receive updated information on delayed discharges for the year 2021.**

133. Section 23 MHA.

198. Complaints procedures were in place at all establishments visited. Generally they appeared to function correctly. However, patients were encouraged to first make a complaint openly to the staff involved in their care which does not permit anonymity and could lead to reprisals. For example, at Priory Hospital Enfield, a patient had been treated coldly by staff after making a complaint and this had the additional effect of deterring other patients from complaining thereafter. The delegation noted that more confidential means of complaining were available at all establishments visited (for example it was possible to contact a complaints manager or the trust concerned directly by phone or e-mail, an independent advocate, ombudsman or the CQC[134]). **Patients should be encouraged to take advantage of these means of making a complaint. Alternatively, efforts could be made to provide complaints boxes on the wards which can only be opened by specially designated persons, in confidence. In addition, it should be ensured that staff understand that it is unacceptable to take reprisals against patients who have made a complaint.**

All patients in mental health units in England have access to independent mental health advocates who help patients express their views and concerns, including when making a complaint. However, not all patients in Priory Hospital Enfield were aware of the existence of these advocates and some said that they had never seen one. **The CPT stresses the importance of independent mental health advocates as providing an additional safeguard for patient's rights and recommends that all patients be informed of their existence and provided greater access to them.**

### 7. Other issues

199. At all establishments visited, patients were provided with a welcome pack upon admission and given information on their rights. Both were made available in easy read formats. In addition, patients were informed about their rights at regular intervals after admission, including by the Mental Health Act Administrators. At Priory Hospital Enfield, the delegation was informed that the initial process of informing a patient of their rights was repeated daily until it was certain that they were understood; however, some patients interviewed did not appear aware of the role of the SOAD. **Further efforts should be made at Priory Hospital Enfield to ensure that patients fully understand the procedure in place as regards involuntary treatment, including the role of the SOAD.**

200. Generally, records were well kept and up-to-date at all establishments visited, with the exception of the medication forms at Priory Hospital Enfield. However, as mentioned above, the electronic patient systems used in the establishments were complex and not easy to use, even by staff working in the hospitals. At Priory Hospital Enfield, files appeared to be appropriately kept but whereas all use of means of restraint was well recorded and audited, the delegation did not gain access to all relevant information due to the difficulties in extracting this information in a timely and comprehensive manner and at Cygnet Hospital Sheffield, the delegation was not able to gain a precise overview of the duration of seclusion episodes because of some deficiencies in the system. **The CPT stresses the importance of user-friendly record-keeping in contributing to effective monitoring of mental health units and it encourages the hospitals visited to review the more complex systems to ensure easier and quicker retrieval of data.**

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134 Under sections 120 and 134A MHA.

201. As regards inspections, in addition to those carried out by the CQC (see paragraph 135 above), the Royal College of Psychiatrists have set up a Quality Network for Forensic Mental Health Services. This is a peer support scheme whereby professionals and service users inspect mental health units to assess certain standards. It is a voluntary scheme, but most units take part. Establishments may also undergo internal inspections by senior management within their service provider group or NHS Trust and NHS Commissioners.

202. As regards contact with the outside world, patients received regular visits from their families which had been temporarily halted at most of the establishments during the pandemic, except for at the Alnwood Unit and "essential" visits at Priory Hospital Enfield. It is, however, positive that all patients were able to contact their families via videoconference and that at most establishments they could have access to their mobile phones based on an individual risk assessment.

At Bamburgh Clinic, although mobile phones were not allowed on Aidan and Oswin Wards, there was a payphone on each ward that could be used for unlimited personal calls. As regards Cuthbert Ward, some patients had access to mobile phones and tablets based on an individual risk assessment and free WiFi was available.

In general, at the time of the CPT's visit, physical visits for patients were slowly starting to be resumed under certain conditions. Promoting face-to-face visits is important both for the patients and their families and friends.

203. During the Covid-19 pandemic, the NHS provided detailed guidance and a checklist and monitoring tool for the management of the virus to all NHS services. The CPT notes positively that each establishment visited also had a dedicated Covid-19 protocol. In addition, measures were in place regarding hygiene, cleaning, and such issues as the maximum number of people allowed in a room, non-mixing of patients in activities across wards and taking the temperature of staff and patients daily. Some activities took place outside.

## APPENDIX I:

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

Police establishments

- Durham City Police Station
- Forth Banks Police Station, Newcastle-upon-Tyne
- Hammersmith Police Station, London
- Shepcote Lane Police Station, Sheffield
- Wood Green Police Station, London

Prison establishments

- HMP and YOI Bronzefield
- HMP Wormwood Scrubs
- HMP Durham
- HMP Woodhill

Psychiatric establishments

- Priory Hospital Enfield, London
- Bamburgh Clinic, St Nicholas Hospital, Newcastle-upon Tyne
- Alnwood Unit, St Nicholas Hospital, Newcastle-upon-Tyne
- Cygnet Hospital, Sheffield
- St Andrew's Healthcare, Northampton.

## APPENDIX II:

## LIST OF THE NATIONAL AUTHORITIES, OTHER BODIES AND NON-GOVERNMENTAL ORGANISATIONS WITH WHICH THE DELEGATION HELD CONSULTATIONS

### A. National authorities

**Home Office**

| | |
|---|---|
| Nev Kemp | Deputy Chief Constable, Surrey Police, and a representative of the National Police Chiefs' Council (NPCC) |
| Jonathan Bradshaw | Staff Officer to the Deputy Chief Constable |
| Samantha Newsham | Home Office, Public Safety Group |

**Ministry of Justice (MoJ) and Her Majesty's Prisons and Probation Service (HMPPS)**

| | |
|---|---|
| Robert Buckland | Lord Chancellor and Secretary of State for Justice |
| Alex Chalk | Prisons Minister, Parliamentary Under Secretaries of State, MoJ |
| David Wolfson | Human Rights Minister, Parliamentary Under Secretaries of State, MoJ |
| Katherine Ridley | Deputy Private Secretary to the Lord Chancellor |
| Jo Farrar | Second Permanent Secretary, MoJ, and Chief Executive Officer, HMPPS |
| Phil Copple | Director-General, HMPPS |
| Michelle Jarman Howe | Director-General, Chief Operating Officer Prisons, HMPPS |
| Helga Swidenbank | Executive Director, Youth Custody Service |
| Steve Bradford | Prison Group Director for Women's Prisons, HMPPS |
| Jerome Glass | Director-General, Policy and Strategy Group, MoJ |
| Jack Cole | Director, Prisons Policy, MoJ |
| Andrew Waldren | Deputy Director, Rights Policy, MoJ |
| Patricia Zimmermann | Head of International Human Rights, MoJ |

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| Elspeth Rainbow | Senior Policy Advisor, International, Rights and Constitutional Policy Directorate |

**Department of Health and Social Care**

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|---|---|
| Nadine Dorries | Minister for Mental Health, Suicide Prevention and Patient Safety |
| Fiona Walshe | Joint Director, Mental Health and Disabilities, Shielding and Volunteering |
| Rachel Whittaker | DHSC liaison officer |

**National Health Service**

| | |
|---|---|
| Cathy Edwards | Clinical Programmes Director, Specialised Commissioning |
| Teresa Fenech | Director of Nursing & Taskforce Director, Specialised Commissioning |
| Sarah Warmington | Head of Mental Health, Specialised Commissioning |
| Zoe Seager | Deputy Director Mental Health Policy and Operations |
| Esther Horner | Head of Serious Mental Illness and Offender Health |
| Kate Davies | National Director of Commissioning |
| Zoe Seager | Deputy Director Mental Health Policy and Operations |
| Chris Kelly | Assistant Head, Health and Justice |
| Caroline Twitchett | Youth custody estate |

**B. <u>Other bodies</u>**

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|---|---|
| Charlie Taylor | Her Majesty’s Chief Inspector of Prisons |
| Martin Lomas | Her Majesty’s Deputy Chief Inspector of Prisons |
| John Wadham | Chair of the United Kingdom National Preventive Mechanism (NPM) |
| Norma Collicott | Superintendent, Her Majesty's Inspectorate of Constabulary |
| Anne Owers | National Chair of the Independent Monitoring Boards (IMBs) |
| Tanya Ossack | IMB representative |

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| Vic Lee | IMB representative |
| Elizabeth Moody | Deputy Ombudsman for Fatal Incidents at the Prisons and Probation Ombudsman (PPO) |
| Sherry Ralph | Chief Operating Officer, Independent Custody Visiting Association |
| Lucy Gregg | Head of the Secretariat, NPM |
| Kevin Cleary | Deputy Chief Inspector of the Care Quality Commission (CQC) |
| Mat Kinton | National Mental Health Policy Adviser (CQC) |
| Kim Forrester | Head of Mental Health Act (CQC) |

## C. Non-governmental and other organisations

The Howard League for Penal Reform

INQUEST

Prison Reform Trust