COUNCIL OF EUROPE

CONSEIL DE L'EUROPE

CPT/Inf (2018) 1

# Response

# of the Government of the United Kingdom to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to the United Kingdom

# from 30 March to 12 April 2016

The Government of the United Kingdom has requested the publication of this response. The CPT's report on the March/April 2016 visit to the United Kingdom is set out in document CPT/Inf (2017) 9.

Strasbourg, 23 January 2018

# RESPONSE OF THE UNITED KINGDOM GOVERNMENT TO THE REPORT OF THE EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT, FOLLOWING ITS VISIT TO THE UNITED KINGDOM FROM 30TH MARCH – 12TH APRIL 2016

December 2017

**Index**

**Abbreviations**

| | |
|---|---|
| APP | College of Policing's Authorised Professional Practice |
| ART | Aggression Replacement Training |
| BEH | Barnet, Enfield and Haringey NHS Foundation Trust |
| BWVC | Body Worn Video Camera |
| CPS | Crown Prosecution Service |
| CPT | Council of Europe European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment |
| CSU | Care and Separation Unit |
| DCO | Detainee Custody Officer |
| ECHR | Council of Europe European Convention for the Protection of Human Rights and Fundamental Freedoms |
| ERB | Emergency Restraint Belt |
| ESU | Enhanced Support Unit |
| EU | European Union |
| FMI | Five-Minute Intervention |
| HMICFRS | Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services |
| HMIP | Her Majesty's Inspectorate of Prisons |
| HMP | Her Majesty's Prison |
| HMPPS | Her Majesty's Prison and Probation Service (formerly NOMS – National Offender Management Service) |
| IMB | Independent Monitoring Board |
| IPCC | Independent Police Complaints Commission |
| IRC | Immigration Removal Centre |
| LSCB | Local Safeguarding Children's Board |
| LTS | Long Term Segregation |
| MDT | Multi-Disciplinary Team |
| MHA | Mental Health Act 1983 |
| NPCC | National Police Chiefs' Council |
| PACE | Police and Criminal Evidence Act 1984 |

| | |
|---|---|
| PAVA | Pelargonic Acid Vannilylamide |
| PCO | Prison Custody Officer |
| PICU | Psychiatric Intensive Care Unit |
| PIP | Positive Intervention Programme |
| PPE | Personal Protection Equipment |
| PSI | Prison Service Instruction |
| RAA | Regional Assurance Advisors |
| RJ | Restorative Justice |
| SCH | Secure Children's Home |
| STC | Secure Training Centre |
| TACT | Terrorism Act 2000 |
| UK | United Kingdom of Great Britain and Northern Ireland |
| YOI | Young Offender Institution |

**Response to the CPT report of 29 July 2016 (published 19 April 2017)**

**Paragraph 5**
**The Committee trusts that the United Kingdom authorities will take concrete steps to improve coordination between governmental departments in order to ensure that the situations described above are not encountered during future visits. Moreover, it trusts that its report will receive the highest attention from Ministers and senior officials responsible for the areas covered in this report.**

1. The Committee's visit has provided the Ministry of Justice's Liaison Officer and team with valuable first-hand experience of supporting such visits. Following the conclusion of the visit, feedback was requested from relevant colleagues to identify improvements for the handling of future visits. New routes of communication were identified and it is hoped that these will directly assist swifter access to places of detention in the future. Unlimited access will continue to be provided to the CPT, bearing in mind difficulties that exist in the context of arranging access to high secure hospitals and other places of detention at short notice during evenings and weekends.

2. Senior officials with oversight responsibility for all areas of detention visited, met with the Committee either at the commencement or conclusion of the visit, or both. The Committee also met with Andrew Selous, the then Prisons' Minister at the Ministry of Justice to discuss in detail the findings of their visit. Ministry of Justice's Ministers and senior officials across the UK Government have also approved the response to the Committee's final recommendations.

**Paragraph 6**
**The CPT trusts that the United Kingdom authorities will take concrete measures to address the recommendations in this report, including as regards prison overcrowding, in accordance with the principle of cooperation set out in Article 3 of the Convention.**

3. The UK Government welcomes the Committee's report and has given its recommendations serious consideration. As set out in the responses below, the UK Government has already taken concrete steps and published plans to reform the prison estate, also outlined in part in the "Prison Safety and Reform" White Paper released in November 2016[1].

**Paragraph 12**
**The CPT would like to receive detailed information about the proposed content of the NPCC national police custody strategy and unified police vision, the timeline for adoption of the strategy and vision and the measures envisaged to ensure their application in practice.**
**The CPT recommends that greater investment is put into the aggregation of nationwide police data and the collection of disaggregated data along thematic lines, in line with the above comments.**

4. The NPCC's "National Custody Strategy" is available on the NPCC's website[2]. This was launched in December 2016. In recognition of the importance of ensuring transparency in how police forces use force, including various means of restraint, the former Home Secretary asked former Chief Constable David Shaw to review what data should be collected and published. The review recommended that police forces record a range of data in all instances when significant force is used, including restraint techniques and the use of spit guards. This data is now being collected and includes the age, gender, ethnicity and sex of the subject, the type of force used, reason for the use of force, and the outcome of the incident. A subset of the data will be provided to the Home Office for publication as part of the 2017/18 Annual Data Requirement. This will provide vital data to help understand the scale and nature of police forces' use of force. The national use of force data review project report can be found on the NPCC's website[3].

[1] https://www.gov.uk/government/publications/prison-safety-and-reform
[2] http://www.npcc.police.uk/documents/NPCC%20Custody%20Strategy.pdf
[3] http://www.npcc.police.uk/documents/reports/2016/Use%20of%20Force%20Data%20Report.pdf

5. In 2015, the UK Government asked Dame Elish Angiolini to conduct a comprehensive independent review of deaths and serious incidents in or following police custody, looking at existing procedures and processes, including the lead up to such incidents, the immediate aftermath, through to the conclusion of official investigations. In October 2017, the review was published[4] and the UK Government simultaneously published a response[5], setting out a programme of work to address the report's findings and recommendations.

**Paragraph 13**
**The CPT calls upon the United Kingdom authorities to ensure that persons detained under terrorism legislation who have not yet been transferred to prison are always brought into the direct physical presence of the judge responsible for deciding the question of the possible extension of their detention.**

6. Provisions in the TACT and the Counter Terrorism Act 2008, reflected in PACE Code H[6], take proper account of the real risks that arise in terrorism cases, and also the interests of justice and the need to safeguard the rights of individual suspects. The relevant provisions allow a judge, after hearing representations from the applicant and the detainee, to give a direction to allow live-link video technology to be used to hear an application for a warrant for further detention under the TACT. Live-link video technology means that the detained person can see and hear the judge and any representations made to the judge, and they can see and hear those taking part.

**Paragraph 14**
**The Committee recommends that police officers should be regularly reminded that verbal abuse of detained persons is unacceptable.**
**Moreover, it recommends that police officers should be reminded regularly, and in an appropriate manner, of the application of the above-mentioned basic principles when applying handcuffs during arrest operations.**

7. The appropriate treatment of all members of the public, including persons who are detained, forms part of the Policing Code of Ethics, which is regularly communicated to all police officers and staff serving in England and Wales. This is reinforced through the Standards of Professional Behaviour, which form the basis of the system for maintaining police discipline and misconduct proceedings where these standards are not met.

8. The Standards of Professional Behaviour are set out in the Police (Conduct) Regulations 2012, which apply to all police officers in England and Wales and make clear that all police officers are expected to act with "Authority, Respect and Courtesy". Where there is a case to answer for misconduct or gross misconduct, this can lead to the bringing of disciplinary proceedings. The College of Policing's "Code of Ethics"[7] reinforces and clarifies this standard by stating: *"2. Authority, Respect and Courtesy - 2.1 According to this standard you must: carry out your role and responsibilities in an efficient, diligent and professional manner; avoid any behaviour that might impair your effectiveness or damage either your own reputation or that of policing; ensure your behaviour and language could not reasonably be perceived to be abusive, oppressive, harassing, bullying, victimising or offensive by the public or your policing colleagues"*.

9. In this respect, this recommendation is therefore implemented via the Policing Code of Ethics and the police discipline system. All police officers receive regular conflict training, which includes training on the use of force and use of handcuffs. Central to this training is the National Decision Model, which sets out that police use of force must only be used to the extent that it is necessary, proportionate and reasonable in all the circumstances.

---

[4] https://www.gov.uk/government/publications/deaths-and-serious-incidents-in-police-custody
[5] https://www.gov.uk/government/publications/deaths-and-serious-incidents-in-police-custody-government-response
[6] https://www.gov.uk/guidance/police-and-criminal-evidence-act-1984-pace-codes-of-practice
[7] http://www.college.police.uk/What-we-do/Ethics/Documents/Code_of_Ethics.pdf

**Paragraph 15**
**The CPT recommends that the authorities review the safety of the use of ERBs, 'spit helmets' and 'Velcro straps' in police custody suites. Further, it wishes to receive a copy of the IPCC investigation report into the safety of the ERB and details on any actions taken by the authorities in the light of the report's findings.**
**More generally, the CPT recommends that the authorities regularly remind police about the regulations governing the use of means of restraints established in PACE Code C and other relevant regulations. It also trusts that a review of this area be regularly conducted by the relevant monitoring and oversight bodies such as Her Majesty's Inspectorate of Constabulary (HMIC) and the IPCC, among others.**

**Paragraph 16**
**The CPT recommends that PAVA spray should not form part of the standard equipment of custodial staff and, given the potentially dangerous effects of this substance, it should not be used in confined spaces.**

10. Use of force, including forms of restraint such as ERBs and incapacitants, in individual cases is an operational matter for police forces. The decision as to whether to use spit guards and ERBs in individual cases is for Chief Officers. However, any use of force, including forms of restraint, must be lawful, necessary and proportionate. For example, in custody, PACE Code C paragraph 8.2 provides that *"No additional restraints shall be used within a locked cell unless absolutely necessary and then only restraint equipment, approved for use in that force by the chief officer, which is reasonable and necessary in the circumstances having regard to the detainee's demeanour and with a view to ensuring their safety and the safety of others*".

11. As per response to paragraph 12 above, data on police use of force will be provided to the Home Office for publication as part of the 2017/18 Annual Data Requirement; this includes restraint techniques, use of sprays and the use of spit guards. Police forces in England and Wales are also subject to regular and robust inspection from HMICFRS, which inspects forces' efficiency and effectiveness. HMICFRS' Legitimacy strand (part of the annual, all-force inspection programme) examines whether forces operate fairly, ethically and within the law.

12. HMPPS uses PAVA Incapacitant spray in the resolution of serious incidents and by nationally deployed specialist staff (National Tactical Response Group) and specially trained staff in the Long Term High Security Estate. Use is exceptional and is always risk assessed and approved by a Senior Operational Manager who has authority whilst acting as Silver or Gold Commander. PAVA Incapacitant Spray is not routinely carried by staff or stored within prisons, but we are piloting it in four prisons over the next six months to explore whether making it available to staff for use in exceptional circumstances could have a positive impact on prison safety.

**Paragraph 18**
**The CPT recommends that the United Kingdom authorities take measures to ensure without further delay that all persons detained by the police are fully informed of their fundamental rights as from the very outset of their deprivation of liberty (that is, from the moment when they are obliged to remain with the police).**
**This should be ensured by provision of clear verbal information at the very outset, to be supplemented at the earliest opportunity (that is, immediately upon their arrival at police premises) by provision of a written copy of their rights. Any deficiencies impeding the complete recording of the fact that a detained person has been informed of his/her rights (such as defective digi-pads and screens) should be rectified. All digi-pads and screens should have various language options available to ensure that detained persons fully understand their rights and what they are signing for.**

**Paragraph 19**
**The CPT recommends that the United Kingdom authorities take immediate steps to ensure that all persons detained by the police are immediately fully informed of their fundamental rights and thereafter informed of any delay, in line with PACE Code C.**

13. Persons who are detained are cautioned when arrested and informed of the reason and necessity for their arrest (unless impracticable). When an arrested person is brought to a police station, they must be brought before the custody officer as soon as practicable after their arrival. The custody officer must make sure the person is informed of their rights and this must be recorded. All reasonable steps must be taken to prevent unnecessary delay. Whilst the two-hour waits described at Brixton and Charing Cross Police Stations are regrettable, this report has been shared with the senior Metropolitan Police lead for custody who is responsible for addressing this issue.

14. PACE Codes C and H were revised in 2013 and 2014 in the light of EU Directive 2010/64 on the Right to Translation and Interpretation in criminal proceedings, and EU Directive 2012/13 on the right to information in criminal proceedings, with regard to persons arrested and detained at a police station after being arrested. The UK Government is satisfied that the provisions of the Codes concerning all matters to which the CPT report refers in respect of the rights and entitlements of such detainees are compatible with the requirements of the Directives. A copy of the CPT report and the UK Government's response will be drawn to the attention of HMICFRS / HMIP, the IPCC and the National Policing Lead for Custody.

**Paragraph 20**
**By letter dated 28 June 2016, the authorities underline that they plan to ensure that each custody suite has at least a privacy hood over the telephone that is used for detainees to speak with their lawyer. The CPT wishes to be informed when this development has been implemented and whether it affords complete privacy from the nearby microphones.**
**In the meanwhile, in the interests of due process and as a fundamental safeguard against ill-treatment, the CPT recommends that relevant and effective measures be taken to protect the confidentiality of lawyer-client consultations by telephone in Southwark and Doncaster Police Stations, as well as in other police stations across the country.**

15. A detained person's right to speak to a solicitor in private is established by section 58 of PACE. It is reflected in PACE Codes C and H which make it clear that if a detainee requests legal advice, they must be allowed to speak to a solicitor in private, as soon as practicable. When a detainee wishes to speak to a solicitor on the telephone, they must be allowed to do so in private unless this is impracticable because of the design and layout of the custody area or location of telephones. The normal expectation is that facilities will be available, unless they are being used, to enable detainees to speak in private to a solicitor either face to face or over the telephone. The chief officer of each police force has a statutory duty to designate police stations in their police area that have the necessary facilities and resources to deal with arrested persons in accordance with the provisions of PACE and the Codes of Practice.

16. The specific points concerning the use of wall-mounted telephone in open areas at Southwark and Doncaster Police Stations will be brought to the attention of the relevant chief officers.

**Paragraph 22**
**The CPT reiterates its recommendation that all FMEs [Examining Forensic Doctor] receive appropriate training on mental health disorders, including regular refresher training and be reminded that police custody is not appropriate for persons with mental health disorders. It would also like to be informed whether all persons who are deprived of their liberty under Section 136 are fully informed of their rights.**

17. The UK Government has made consistently clear that those who are experiencing a mental ill health crisis and who have committed no crime should be cared for in an appropriate health based or community setting and not in a police station. The Policing and Crime Act 2017 makes legislative changes that prohibit the use of police stations as places of safety for those under 18 and significantly limit the circumstances in which they may be used in the case of adults. The changes are expected to be brought into force shortly.

18. Where a person experiencing mental ill health has also committed a crime which needs to be dealt with through the criminal justice system, every effort is made to identify and to support individual health needs. Custody health staff (including FMEs), receive a wide range of training. However, it is not expected that serious conditions should be treated within a police custody setting. If necessary, in individual cases, ambulances may be called or the person transferred to hospital for urgent assessment and treatment. In addition, Liaison and Diversion schemes currently cover almost 70% of England and are scheduled to be rolled out across the entire country by 2021. These provide specialist mental health and substance abuse workers within custody suites and courts to identify individuals within the system with mental health or substance misuse issues and to offer referral to relevant assessment and treatment or support services. Information about the person's medical circumstances may also be used to inform charging or sentencing decisions to ensure the most appropriate and effective outcomes.

19. While every effort is being made to reduce use of police stations as places of safety the Police and Criminal Evidence Code C provides that anyone taken to a police station must be advised of their rights as a detainee there (although rights which are purely applicable to those charged with a criminal offence will not be relevant) including to notify someone of where they are, and consult a legal representative if they so wish. The provision of such information may be delayed if the person is initially incapable of understanding the information by virtue of their condition, but must be provided at the earliest suitable opportunity. The maximum period for which a person may be detained under section 136 of the MHA pending a mental health assessment will be 24 hours (reduced from 72). For those so detained the emphasis is on providing them with information about the process and providing appropriate and ongoing reassurance, care and support during that process.

**Paragraph 23**
**The CPT recommends that the authorities of the United Kingdom take the necessary measures to ensure that, in all police stations, medical examinations are always conducted out of the hearing and – unless the doctor concerned requests otherwise in a particular case – out of the sight of custodial staff.**
**Further, it recommends that information concerning detained persons' health be kept in a manner which ensures respect for medical confidentiality in all police stations. Health-care staff may inform custodial officers on a need-to-know basis about the state of health of a detained person; however, the information provided should be limited to that necessary to prevent a serious risk for the detained person or other persons, unless the detained person consents to additional information being given.**

20. The Police Custody Design Guide, PACE Codes of Practice and current operational policing practice provide that each custody suite should have a suitably equipped medical room to enable appropriate healthcare professionals to conduct examinations of detainees together with facilities

and systems to enable records and instructions concerning treatment to be made and shared, in accordance with rules and regulations of professional medical practice.

21. This approach is supported by, and is consistent with, the Caldicott Principles[8] regarding the safe, secure and confidential storage of medical information.

**Paragraph 24**
**The CPT reiterates its recommendation that the right for detained persons to be examined by a doctor of their own choice be rendered effective in practice.**

22. PACE Codes C (paragraph 9.8) and H, and the Notice of Rights and Entitlements given to all detainees, provide for the person's right, if they wish, to be examined by a doctor of their own choice and at their own expense.

**Paragraph 25**
**The CPT recommends that whenever a person is deprived of his liberty by a law enforcement agency, this fact is formally and accurately recorded without delay and without misrepresentation (for whatever reason) as to the location of custody.**
**It trusts that relevant oversight bodies and inspectorates, such as the HMIC and the IPCC, exercise regular and effective supervision of the accuracy of custody registers in police establishments, including TACT custody facilities.**

23. PACE and the TACT require accurate recording of information about individuals detained under those Acts.

24. REDACTED

25. The accuracy and completion of custody registers at all police stations is subject to supervision at various levels. Locally, it is the responsibility of individual chief officers through their local senior officers in charge of police stations to ensure frequent monitoring and nationally it is done through HMICFRS. The UK has a rigorous approach to ensuring oversight is maintained at the right level. The roles of relevant oversight bodies and inspectorates are clearly defined and limited to their respective remits. HMICFRS is mandated to inspect the efficiency and effectiveness of police forces in England and Wales. Accordingly, HMICFRS conducts annual, all-force, inspections of Police Efficiency, Effectiveness and Legitimacy. The IPCC investigates deaths and serious injuries in police custody or following police contact, as well as serious and sensitive matters including cases of alleged police misconduct. The IPCC also oversees the police complaints system in England and Wales and sets the standards by which the police should handle complaints.

**Paragraph 26**
**The CPT recommends that all staff in England and Wales who carry out custodial duties have their name and/or an identification number on their uniform, in the same manner as police officers (and prison staff).**

26. The provision of uniform and identifying names/numerals for custody staff in police stations is the responsibility of the chief officer of the force concerned. In accordance with the Police Reform Act 2002, designated civilian staff are required to wear a uniform approved by the designated chief officer. PACE Code C paragraph 2.6A and Code H paragraph 2.8 permit officers not to disclose their names if they reasonably believe that the recording or disclosing of their name might put them in danger; however, at the very least, all must disclose their identification number.

[8] https://www.gov.uk/government/publications/the-information-governance-review

**Paragraph 27**
**The CPT reiterates its recommendation that the United Kingdom authorities ensure that persons held in police custody for more than 24 hours are systematically offered access to outdoor exercise and that when custody suites are being refurbished or constructed, the above-mentioned deficiencies concerning access to natural light and adequate outdoor exercise facilities are remedied.**
**Further, detained persons held for 24 hours or more in police custody should be informed of the possibilities to shower.**

27. When custody suites are being upgraded or constructed, the Design Guide provides that the relevant facilities are included within the Custody Design Guide; however, many older police custody suites do not offer facilities for exercise out of the cell. Converting or upgrading some of these custody suites may not be possible. The Custody Design Guide strongly recommends provision of such facilities for new builds.

28. Guidance and requirements relating to exercise and showering are provided in PACE Codes C and H, with particular emphasis on their importance in terrorism cases where detention periods are often longer. This is supported by the College of Policing Detention and Custody Authorised Professional Practice, where practicability is a consideration for exercise, and washing/showering is not time-limited.

29. PACE Codes C and H paragraph 8.7 provides that brief outdoor exercise shall be offered daily where practicable, that is where there is access to an exercise area and sufficient staff for safe supervision. Code H additionally provides that, where facilities exist, indoor exercise will be offered as an alternative if outside conditions are such that a detainee cannot be reasonably expected to take outdoor exercise (for example, in cold or wet weather) or if requested by the detainee or for reasons of security. Exercise facilities and arrangements are subject to inspection by HMICFRS/HMIP.

**Paragraph 28**
**As concerns juveniles in police custody, the four designated 'juvenile cells' in Doncaster police custody suite possessed no toilets or sinks. Custody sergeants informed the delegation that as they usually kept juveniles under constant watch with the door ajar, juveniles would have access to a toilet and sink when required.**
**However, the juvenile cells measured mere 5.2m², which is too small for holding persons overnight, as such the CPT would like to receive confirmation from the United Kingdom authorities that when juveniles are held overnight at Doncaster Police Station, the cell door continues to remain ajar. Further, consideration should be given to providing juveniles held in police custody ready access to reading materials and/or television and the possibility of outdoor exercise. The CPT recommends cells of less than 7m² (including a toilet and basin) should not be used to hold detained persons overnight.**

30. With regard to access to exercise in police stations, see the response to paragraph 27 above.

31. A number of safeguards are in place to protect the rights of detainees whilst in police custody. For example, under PACE Code C: cells in use must be adequately heated, cleaned and ventilated, and they must be adequately lit (subject to such dimming as is compatible with safety and security to allow people detained overnight to sleep); if a detainee is deaf, mentally disordered or otherwise mentally vulnerable, particular care must be taken when deciding whether to use any form of approved restraints; access to toilet and washing facilities must be provided; a juvenile should not be placed in a police cell unless no other secure accommodation is available and the custody officer considers it is not practicable to supervise them if they are not placed in a cell or that a cell provides more comfortable accommodation than other secure accommodation in the station; a juvenile may not be placed in a cell with a detained adult; whenever possible juveniles and mentally vulnerable detainees should be visited more frequently.

32. The APP sets out a number of safeguards for the detention and custody of children and young persons[9], including in relation to detention rooms and cells. Reading material can be made available as appropriate.

**Paragraph 29**
**Given that more appropriate facilities are now available at the TACT Suite in Southwark, the CPT reiterates its recommendation that the TACT Suite at Paddington Green Police Station be considerably upgraded, and if this is not practicable, taken out of service.**

33. The commissioning and use of particular locations for detention under the TACT and the Counter Terrorism Act 2008 in any police force is an operational matter for the chief officer of the force concerned. Paddington Green TACT custody facility permanently closed in April 2017 under the Mayor's Office for Policing and Crime's "Estates Modernisation Programme".

34. The recommended standards and specifications are set out in the police station custody design guide, which is designed to ensure compliance with the relevant provisions of the TACT and PACE Code H. Similarly, decisions as to whether to decommission or upgrade particular facilities are for chief officers. Compliance with the standards is overseen by HMICFRS. Additionally, it is open to individuals who believe they have been detained in inappropriate conditions to complain to the relevant Chief Constable or to the IPCC.

**Paragraph 36**
**While noting that the White Paper and Prisons' Bill have yet to be finalised, the CPT recommends that concrete and effective measures to address the lack of safety and high levels of violence in English adult prisons and the youth estate be prioritised.**
**These should include urgent measures to bringing prisons back under the effective control of staff, measurably reversing the recent trends of escalating violence, self-harm and self-inflicted deaths; as well as concrete steps to significantly reduce the current prison population, without which the implementation of the wider reform programme will be unattainable.**

35. The UK Government is taking action to tackle the current levels of violence, self-harm and self-inflicted deaths in prisons in England and Wales. Improving safety and decreasing violence is an urgent priority and it is clear that in order to reform prisons and rehabilitate offenders, prisons need to be safe, decent and secure. The Government has an ambitious agenda to modernise the prison estate, improve education, create more purposeful regimes and empower governors, so that we can tackle issues, like drugs and violence, which are key to cutting reoffending and keeping staff and prisoners safe. The Prisons and Courts Bill fell as a result of the general election on 8 June 2017; the UK Government is therefore taking forward its priorities by non-statutory means

36. As set out in paragraph 6 above, the UK Government published its plans for Prison Safety and Reform in a White Paper in November 2016. This includes investing in around £100m per year on delivering 2,500 additional prison officers in public sector prisons. Following the recruitment of 400 additional prison officers into the "pathfinder prisons" (those receiving additional resource to tackle violence, self-harm and suicide), the new Offender Management in Custody Model is being rolled out, with three sites already delivering key worker sessions to the men in their care. A roll out schedule for the remaining prison estate has also been agreed. This will see the recruitment of a further 2,100 prison officers across the closed estate. Senior Probation Officers will be deployed into prisons to support the roll out of the new model.

[9] https://www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/children-and-young-persons/

37. The UK Government has already allocated additional resources of £12.9 million (£10 million new funding plus £2.9 million from existing budgets) to a significant number of public sector prisons in June 2016 to support improvements to prison safety. The allocation of funding was targeted at prisons with the most concerning levels of violence and self-harm, where it is considered the additional resources can have the greatest impact. Governors of those prisons who benefited from this extra funding, had discretion about how to spend the money, and the effectiveness of these measures will help inform our long-term approach to these issues.

38. A two-year Violence Reduction Project set up in January 2015 addressed the increase in violence with a range of measures designed to understand trends, build staff skills and capability, deter prisoners from violent behaviour and improve HMPPS's response to violent incidents to make prisons safer for all. The Project operated across public and private sectors and has taken a strong evidence-based approach to understand the causes, triggers and drivers for violence, using improved understanding to inform local Violence Reduction Strategies, whilst also developing interventions and operational practice associated with improved safety.

39. The UK Government has also rolled out a number of tools and interventions for prisons including the use of BWVCs in conjunction with training for staff which supports staff interaction with prisoners, additional CCTV and a new Violence Diagnostic Tool. Additionally, a Violence Reduction Task Force was introduced in the short term to support sites with a high rate of violence. The task force visited 39 prisons.

40. The widespread availability of psychoactive substances has contributed to making prisons less safe. The UK Government has implemented a number of initiatives to tackle their use including legislation to introduce new criminal offences, innovative new mandatory drug testing, staff training and communication campaigns with prisoners and visitors, which highlight the damaging consequences of using these drugs.

41. The work on Violence Reduction has now been subsumed into a Prison Safety Programme which has been established to support establishments in the delivery of safer prisons, and is responsible for implementing the reforms set out in the White Paper. A joint Ministry of Justice-HMPPS Prison Safety team is in place to help drive these improvements in the shorter-term, including supporting prisons to reduce violence and suicide and self-harm, using data and review findings to focus challenge and support in the establishments where it is most needed and can make the biggest impact.

42. The UK Government has put in place specialist roles - regional safer custody leads - in every region to provide advice to prisons and to spread good practice on identifying and supporting prisoners at risk, and we are bolstering these teams to provide additional resources to support establishments. Experts – including extra funding for the Samaritans – are being deployed to provide targeted support for prison staff and to prisoners directly. All deaths in custody are fully investigated by the independent Prisons and Probation Ombudsman and are subject to a Coroner's inquest. New training is being rolled out across the estate to support prison staff to identify the risks and triggers of suicide and self-harm and understand what they can do to support prisoners at risk.

*Youth Custody Service*

43. Within HMPPS, Cookham Wood, Feltham, Medway, Werrington and Wetherby are now part of the Youth Custody Service. Violence reduction measures (including a suite of psychological interventions to target the attitudes, thinking and behaviour associated with offending and challenging custodial behaviour) are already being delivered. Most notable is the progress that has been made with the recommendations from the Promoting Risk Intervention by Situational

Management (PRISM) assessment. This is a structured assessment of situational factors associated with institutional violence that identifies strategic actions. The Youth Custody Service is part of the Safer Working Group led by Ministry of Justice in order to establish strategic measures to improve safety across the whole estate. An Interventions Model is in place and a range of interventions, especially around thinking skills, are being offered. A Young People's Assessment Panel is now operating and reviews existing and proposed young person specific intervention.

44. Following the success of the Custody Support Plan pathfinder at HM YOI Werrington, a wider roll out is progressing for 2017/18. This is an evidence based and needs-led single care planning initiative for all young people in custody and is based on the belief that custody is an opportunity to provide a positive influence to change behaviours, resulting in better outcomes for young people such as reduced instances of violence inside and outside of custody and ceasing involvement in gangs.

45. A new training course to reduce violent behaviour, both in custody and as part of young people's offending, is now available at Cookham Wood, Feltham, Wetherby and Werrington. The ART is designed to address levels of violence and aggression displayed by young people. ART adopts a three-part multimodal cognitive behavioural approach to address problems in behaviour, emotions and thinking. It explicitly teaches an array of pro-social psychological skills and is delivered through group sessions.

46. HMPPS Youth Custody Service has developed a model for RJ, and is progressing with recruiting and training for prison officer specialists to deliver RJ approaches in YOIs. These officers will become RJ practitioners and will be supervised by a team of psychologists. The training is based on the application of evidence based principles of RJ to resolve conflict between young people and hopefully reduce violence. All staff, managers and young people will receive Conflict Resolution Awareness training.

47. It is recognised that the change in the population and rising levels of violence have led to increased pressure on CSUs and funding has been agreed for extra officers to work in CSUs. All sites are now able to deliver a regime to all young people, including outreach, education and psychological support.

48. Within HMPPS, there are local strategies that set out how to identify young people at risk of suicide and self-harm and provide for their care and support as well as support for staff who provide their care. All young people are assessed by a health care professional on arrival. Where appropriate, a young person may be referred to a range of individual or group mental health interventions or substance misuse treatment interventions as appropriate to their assessed need. There are higher staffing levels to meet the specific needs of young people; this is designed to provide a higher level of support to young people in custody.

49. The approach to safety is supported by a standardised casework model in which the core casework team work together with both specialist departments across the establishment and external agencies to provide a multi-disciplinary approach to all aspects of a young person's care. This includes a requirement, especially where there are significant events such as self-harm or illness, for all specialist departments and external partners involved in a young person's care to work collaboratively, share information and provide in-reach services to support the casework team.

50. Positive family contact is promoted and advocacy services for young people are provided by Barnardo's. This is a child-led service commissioned by the Youth Justice Board to provide advice, representation and support to young people, and to assist in resolving their concerns or complaints.

*Prison Population*

51. While the UK Government does not propose to set arbitrary targets for reducing the prison population, the strategy is based on a combination of early intervention upstream and on reducing reoffending after release for those who are sentenced to immediate custody.

**Paragraph 41**
**The CPT recommends that the United Kingdom authorities deliver a clear message to custodial staff that verbal abuse of inmates, as well as other forms of disrespectful or provocative behaviour vis-à-vis prisoners, are not acceptable and will be dealt with accordingly. The management of Pentonville and Doncaster Prisons should demonstrate increased vigilance in this area, by ensuring the regular presence of senior or managerial staff in the detention areas, their direct contact with prisoners, and improved prison staff training (in this respect, see also the recommendation contained in paragraph 74).**

52. The UK Government's view is that verbal abuse is never acceptable and neither is any other form of disrespectful or provocative behaviour. Measures are being put in place to monitor behaviour and ensure that any inappropriate behaviour is dealt with accordingly, for example, by using the internal disciplinary system. In addition, Prison Service Instruction 16/2015 requires prisons to have strategies for preventing the abuse of prisoners by staff, and the abuse of prisoners by other prisoners. For prisoners, the use of threatening, abusive or insulting words or behaviour is a disciplinary offence under the Prison Rules.

53. HMPPS has rolled out over 5,600 BWVCs alongside FMI training which supports staff interaction with prisoners in all public-sector prisons. The cameras are used for overt recording only in order to support the prevention or detection of crime and disorder, de-escalation of conflict, the protection of staff, visitors and prisoners, safeguarding the security of the establishment and using the footage for training purposes.

*HMP/YOI Doncaster*

54. HMP/YOI Doncaster is managed and operated by Serco on behalf of HMPPS. It is for Serco, as an integral part of its contract, to ensure compliance with all the relevant requirements applicable to safe and decent operation of prisons. As with public sector prisons, a contracted prison is required to provide specified information under its contract in response to issues of concern raised by regulatory bodies and in inspection reports.

55. Serco has appointed a new Director at Doncaster, who is expected to remain in post for at least five years. The Director routinely delivers strong leadership messages about the standard of behaviour expected and has increased management accountability for many critical aspects of custodial delivery, including visible leadership. A senior manager (Assistant Director) continues to be situated on each of the three main residential units.

56. Each Custodial Operational Manager now has an individualised management development plan which requires them to complete applied learning and development in the workplace to address areas of identified need.

57. Individualised training plans are also being put in place for all other operations staff. This will include FMI refresher training to support staff to learn new skills and build upon existing skills to engage more effectively with prisoners.

58. A programme of cultural change has commenced to ensure that staff are aware of their responsibilities in respect of the welfare of prisoners and others. The use of BWVCs is also now embedded practice.

*HMP/YOI Pentonville*

59. HMP/YOI Pentonville is delivering FMI training to all officers and a development programme to improve how staff communicate with prisoners. BWVCs are in use on residential areas. High quality CCTV has been installed in the largest wing and funding has been approved for two further wings with work due to begin in 2017. Visible management forms part of the prison's service delivery plan for 2017/18 and is a priority for senior managers responsible for the residential function.

**Paragraph 44**
**The CPT recommends that the United Kingdom authorities take swift measures to ensure that all violent incidents at Doncaster and Pentonville Prisons – and at all other prisons across England and Wales - are systematically and accurately recorded by staff, in order to gain a true picture of the situation and to be able to take specific measures to counter the violence. It also requests that a copy of the final report on the investigation commissioned into the recording of violent incidents at Doncaster Prison be sent to the Committee, as well as any action plan resulting from this investigation.**

60. All prisons are required to report incidents of violence including assaults on staff and prisoners. A new Data Quality Audit has been developed and audits have been undertaken in every establishment in 2015-16 and are being completed again in 2016-17. Indications are that the rate and quality of reporting has improved following the introduction of the audit.
    - Mean score for 2015/2016 – 3.10 (Amber/Green, 31 sites falling below the Amber/Green level, including 5 reds)[10].
    - Mean score for 2016/2017 – 3.24 (Amber/Green, with 27 sites falling below the Amber Green level, including 3 reds)[11].

61. Data quality has been further improved following the Violence Reduction Task Force visits to several establishments. Additionally, a revised Violence Reduction measure was introduced in 2015-16 on which all prisons are measured. This includes measures assessing whether all incidents that occur are properly recorded on the Incident Reporting module on Prison National Offender Management Information System (Prison-NOMIS) and whether a prison is responding appropriately to the levels of violence. As part of the Violence Reduction Project a Violence Diagnostic tool was developed to inform Governors' understanding of local violence trends and drivers to inform local operational decision making. The Violence Diagnostic tool is now available in every prison, providing analysis of local violence data that enables Governors to direct attention and resource in the most effective way possible. A regional and national tool is also available to identify wider trends.

62. The RAAs, on behalf of Prison Group Directors, monitor compliance of establishments' performance against their Service Level Agreements.

63. Incident data is audited by the Government Internal Audit Agency as part of the Governance and Operational Audit. The ratings for these audits are measured on the HMPPS Performance Hub. Establishments will draw up an action plan to address any non-compliant issues identified and the RAAs will monitor progress against these plans.

---

[10] https://www.gov.uk/government/statistics/prison-performance-statistics-2015-to-2016 ; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/541174/prs-dataset-2015-16.xlsx
[11] https://www.gov.uk/government/statistics/prison-annual-performance-ratings-2016-to-2017; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/633054/2016-17-prs-dataset.xlsx

*HMP/YOI Doncaster*

64. Consideration is being given to releasing a copy of the report into the recording of violent incidents at HMP/YOI Doncaster. Increased scrutiny of incident reporting, which includes daily checks of the wing observation books by the Professional Standards Department within the prison, has been implemented. The reporting and recording of violent incidents is also overseen by the Professional Standards Department to ensure consistency with increased accountability for violent incident follow up reports being driven through the daily operations meeting. A revised incident report follow-up form has also been introduced to inform and evidence defensible decision making.

65. HMP/YOI Doncaster also received a Substantial Rating (which is the highest possible rating) when audited by the HMPPS Audit Team in relation to the recording of violent incidents in March 2017.

*HMP/YOI Pentonville*

66. HMP/YOI Pentonville has moved the responsibility of reporting violent incidents to a new team within the prison. This has improved the consistency of reporting incidents. Improved management checks of reporting have also been introduced and the improvement has been sustained over a number of months.

**Paragraph 45**
**The CPT recommends that the United Kingdom authorities take steps to ensure that prison staff at Doncaster and Pentonville Prisons are able to respond to violent incidents and to inmates' cell call-bells within three minutes and preferably much quicker (see also recommendation in paragraph 74).**

67. In accordance with PSI 75/2011 - Residential Services - prisoners are able to summon assistance from within their living accommodation. Residential staff must respond promptly to calls for assistance. Staff must acknowledge all requests for assistance by personal contact with the prisoner and appropriate action must be taken in response to abuse of the call system. The aim of the cell call system is to provide both a visual and an audible means of alert which should be used to summon emergency assistance. Therefore, staff should provide a prompt response and get there as soon as possible.

*HMP/YOI Doncaster*

68. Revised rosters based on documented work profiles were introduced in September 2016 to improve consistency of staffing amongst frontline operational grades. These make provision for at least three PCOs on each unit to ensure adequate staffing levels and these three members of staff now have more clearly delineated roles and responsibilities which is improving accountability.

69. A cell call management system is in place at HMP/YOI Doncaster. If a cell call remains unanswered for four minutes after activation it will be escalated within the control room and the relevant unit notified. Monitoring and management of data in respect of response times to cell calls is in place and this is used to take management action to reduce response times across the establishment. Work continues to be taken to challenge the current misuse of cell calls by prisoners via the incentives and earned privilege scheme.

*HMP/YOI Pentonville*

70. Cell call reports are now printed daily and managers are accountable for the performance of their own areas. Staff have been trained to challenge the misuse of cell calls which has reduced the amount of cell call use, enabling patrol staff more opportunity to answer each bell. A re-profiling exercise has also increased staff numbers on wings which improves the speed at which cell calls can be answered.

**Paragraph 46**
**The CPT recommends that the United Kingdom authorities take concrete steps to ensure that far greater investment in preventing violence is undertaken at both Doncaster and Pentonville Prisons and at other prisons in England and Wales affected by similar levels of violence, including, *inter alia*, the thorough completion of 'follow-up' reports on violent incidents and 'concern files' to help stem and prevent future violence**.

71. As set out in the responses to paragraphs 36 and 41 above, HMPPS is taking action to tackle violence in prisons and to ensure that follow-up actions are taken by prisons following violent incidents. HMPPS is fully committed to making prisons safer and addressing the increase in violence and assaults by increasing staffing levels and the ways of working in our prisons. The White Paper on Prison Reform announced a major shake-up of the prison system with 2,500 extra prison officers and new security measures to tackle drones, phones and drugs. All prisons are required to have a local Violence Reduction Strategy in place. Prisons are also required to investigate incidents of serious assaults on staff, prisoners and others and ensure that any lessons are learned from the incident.

*HMP/YOI Doncaster*

72. The prison has increased scrutiny of violent incidents reporting. This includes daily checks of the wing observation books by the Professional Standards Department within the prison. The reporting and recording of violent incidents is overseen by the Professional Standards Department to ensure consistency across the prison, with increased accountability for violent incident follow-up reports being driven through the daily operations meeting of all staff. Investigations of serious assaults are now undertaken by an internal investigator to ensure greater learning from incidents.

73. The Director has taken steps to strengthen the existing safer custody team and to appoint a new Assistant Director for Safer Custody. This in turn will provide closer oversight of the use of concern files to support staff in the management of both victims and perpetrators of violence. The Assistant Director for Safer Custody has also further developed the establishment's violence reduction strategy and has also developed a strategy designed to tackle the issue of debt.

74. Additionally, as part of continued violence reduction efforts, the establishment has also:
    - Piloted an HMPPS Timewise course. A new programme devised specifically to address custodial violence, targeting those with a history of violence in custody including short termers.
    - Opened a Social Responsibility Unit to seek to challenge and address individuals who behave in a violent manner.
    - Implemented a wing incentive scheme to encourage pro-social behaviour.
    - Developed the use of Violence Reduction Prisoner Peer Mentors within the establishment.
    - Developed a closer relationship with South Yorkshire Police to ensure that where violent and other relevant crimes are reported to them in line with the national Memorandum of Understanding that is in place that these are responded to more appropriately.
    - Incorporated the need to respond appropriately to low-level abuse within the establishment's violence reduction strategy.
    - Incorporated violence reduction into safer custody training.
    - Installed security gates along the secure corridor.
    - Installed security netting in identified high risk areas to reduce the supply of drugs into the prison which is recognised as being a key driver of violent incidents within the establishment.

75. Since May 2016 there has been a downturn in the number of violent incidents at HMP/YOI Doncaster. The HMPPS Violence Reduction Task Force visited HMP/YOI Doncaster in September 2016 and their subsequent report provided powerful evidence of the recent improvements that have been made and was particularly positive about the Social Responsibility Unit, the use of violence reduction representatives and incident reporting processes.

*HMP/YOI Pentonville*

76. HMP/YOI Pentonville has invested in a new gang services intervention to help reduce violence between rival gangs. The prison has also set up a prisoner (peer) mediator service. Capital investment has been made to provide greater physical security to reduce the trafficking of drugs, mobile phones and weapons into the establishment. Anti 'throw over' netting has been replaced and new barriers introduced. Improved metal detector units have been installed and greater searching of prisoners now occurs.

77. There has also been an increase in resource allocated to the safer custody department to ensure the violent incident investigations are completed for every violent incident with actions being agreed during a new intelligence meeting which is held fortnightly.

78. BWVCs are used by all officers who have undertaken the FMI training. A training programme is therefore in place to ensure all officers are trained in FMI and to wear a BWVC on every shift. A cell window replacement programme is also underway.

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

79. Security gates were initially placed at key points along the secure corridor at HMP/YOI Doncaster. Following the subsequent decision to increase the number of sex offenders held at the prison, a further set of gates have been placed near to the house block on which these prisoners will be held. All mass movement is supervised by staff lining the route and all individual prisoner movement is escorted.

**Paragraph 48**
**Overall, the delegation's findings in the establishments visited indicate that the duty of care to protect inmates from those who wish to cause them harm was often not being discharged given the apparent lack of effective action to reduce the high levels of violence.**
**More generally, the CPT recommends that immediate attention be given to initiating concrete measures (including those recommended above) to bringing prisons back under effective control of the staff, reversing the recent trends of escalating violence, self-harm and self-inflicted deaths.**

80. As set out in the responses to paragraphs 36, 41 and 46 above, HMPPS is fully committed to making prisons safer and addressing the increase in violence and assaults in our prisons. Violence in prison is unacceptable and may be an offence. Any prisoner who commits an act of violence can expect to have action taken against them. The internal prison discipline process may result in loss of privileges and a range of other sanctions. Independent Adjudicators may already impose consecutive additional days on prisoners who assault staff and there are clear guidelines in place in relation to this process.

81. If the prison determines the internal prisoner discipline process is insufficient, and where the circumstances indicate that a criminal prosecution is appropriate, the incident should be referred to the police for investigation. HMPPS is working closely with the Police, the Crown Prosecution Service and others across the criminal justice system to ensure we have a robust response to criminality in prison. We are encouraging the wider use of prison community impact statements so that the police, CPS and courts understand the wider implications of crime in prison and the harm caused.

**Paragraph 51**
**Since its first visit to the United Kingdom in 1990 the CPT has repeatedly recommended that urgent action was needed to curb overcrowding in English prisons, yet the situation has progressively deteriorated. The CPT calls again upon the authorities of the United Kingdom to take concrete measures and determined action to significantly reduce the current and future prison population, as a matter of priority, in line with the European Prison Rules.**

82. Whilst the UK Government does not propose to set arbitrary targets for reducing the prison population, we are embarking on a prison reform programme in England and Wales. The average percentage of prisoners in crowded accommodation was 24.5% in 2016-17, unchanged compared to 2015-16. Our reforms will see us close down ageing and ineffective prisons and replace them with buildings fit for today's demands. There will be an investment £1.3 billion to build modern establishments, with up to 10,000 uncrowded prison places that create the physical conditions for Governors to achieve better educational, training and rehabilitation outcomes.

**Paragraph 52**
**The CPT recommends that the United Kingdom authorities take urgent steps to cease the doubling up of prisoners in cells designed for single use at Pentonville and Doncaster Prisons, and that sanitary annexes in double occupancy cells be fully partitioned, in line with the above CPT standards (in this respect see also the recommendation contained in paragraph 51 on the issue of overcrowding).**

83. The occupancy of prison cells is determined by establishments and certified by the Director of the Prison Group or the Head of Custodial Contracted Services in accordance with PSI 17/2012, which provides clear guidelines for determining cell capacities. The certification arrangements are also set out in domestic legislation in the Prison Act 1952 and the Prison Rules 1999. Cells will only be shared where a Director of the Prison Group or the Head of Custodial Contracted Services has assessed them to be of adequate size and condition for doing so.

*Sanitary annexes*

84. All new built prisons provide a sanitary annex in cell which affords privacy, even where prisoners are doubled up in single cells. Ministry of Justice Estates will also deliver projects to refurbish older cells to bring them to this standard where requested by HMPPS and in line with Ministry of Justice Estates asset management plan. In some very old prisons, the layout and construction of the cells makes it either not economically viable or impossible to create a separated sanitary annex where none exists at present (in these cases, the cell call system provides an alternative). The Prison Estate Transformation Programme within HMPPS and the MoJ are in the process of delivering up to 10,000 modern prison places which will provide cells with suitable sanitary facilities. It is anticipated that the new prisons will allow the closure of older prisons where it is not possible to provide suitable sanitary facilities.

*HMP/YOI Doncaster*

85. Regular cell checks have been introduced at HMP/YOI Doncaster to ensure that where privacy curtains are not in place, this is rectified at the earliest opportunity.

*HMP/YOI Pentonville*

86. It is not possible for HMP/YOI Pentonville to provide full partitions as this creates problems when undertaking planned interventions. Retractable partitions have been trialled on one wing and this has been a success. Consideration will be given to roll these out across the prison.

**Paragraph 53**
**The CPT recommends that immediate repair where required, deep cleaning and a regular programme of refurbishment of the entirety of Pentonville Prison be undertaken.**

87. HMP/YOI Pentonville has improved cleanliness across the prison and the painting programme has continued. All showers have been deep cleaned and two sets of showers refurbished. There is now a team of 'grime busters' who deep clean areas of the prison. A deep clean of all cell toilets is complete.

**Paragraph 55**
**The CPT recommends that United Kingdom authorities take concrete steps to change the regime, staff rotas and/or numbers and remove obstacles to inmates' attendance, to ensure that all inmates at Pentonville and Doncaster Prisons can attend education and other purposeful activities on a daily basis. The overall aim, should be offer to all inmates a normal regime of at least eight hours out of cell.**
**It also recommends that inmates who are unemployed or do not participate in activities are provided with more out-of-cell time than the current daily 2.5 hours and, as far as possible, be offered meaningful activities during association time.**
**The CPT trusts that the recommendations in the Coates' review of adult prison education concerning in particular the provision and quality of education for prisoners will be implemented in practice and would like to be updated on the actions taken to this end by the United Kingdom authorities.**

*HMP/YOI Doncaster*

88. A review of the core day has taken place; the review had as one of its main objectives to increase attendance in available activity spaces, and a computer-based scheduling system has been introduced to maximise prisoners' attendance at activities and improve attendance rates. Additionally, one of the three PCOs on each unit now undertakes the role of Movements Officer to provide a greater focus on, and more accountability of, encouraging prisoners to attend activities.

89. Whilst the regime for those prisoners accessing full-time activity is in excess of eight hours, not all prisoners at HMP/YOI Doncaster are currently able to access full-time activity. Efforts continue to increase the availability of activity places at HMP/YOI Doncaster.

90. Prisoners who do not participate in activities are currently provided with more than 2.5 hours out-of-cell time a day. Additional leisure facilities (for example, board games and gym equipment) form an important element of the recently introduced wing incentive scheme which is designed to encourage pro-social behaviour

*HMP/YOI Pentonville*

91. HMP/YOI Pentonville has increased the attendance at activity to over 80%. Additional work spaces have been brought on line and the number of prisoners without employment has reduced. Enhanced association and gym is also now provided for 10% of the population Monday to Friday. HMP/YOI Pentonville also plans to implement the HMPPS Offender Management Model in 2017/18. This new model will significantly increase the number of officers on duty and allow the Governor to expand current regime delivery.

92. HMP/YOI Pentonville now has enough jobs for every prisoner to be employed if they choose to be.

*Coates' Review*

93. The White Paper "Prison Safety and Reform" published in November 2016, set out the UK Government's plans to implement recommendations from the Coates review of Prison Education. As described in the White Paper, the UK Government has already stripped out unnecessary rules and governance from education contracts to allow governors more oversight and control of existing services. An agreement has been reached with the Education and Training Foundation to take forward a range of activities that develop the skills and capabilities of governors, managers and education staff to ensure that appropriate education for prisoners is commissioned and delivered. As set out in the White Paper, we will also:
    - Drive continuous improvement in prison education by developing new performance measures to be used by all prisons;
    - Assess all prisoners' education needs on entry into custody to create a personalised learning plan as part of their sentence plan;
    - Introduce a core common curriculum across the estate, focusing on maths and English, and seek to use the same awarding bodies for particular types of provision so those starting a course at one prison can bank and build on their progress if they move elsewhere;
    - Encourage more employers to work in prisons to support prisoner training, help prisoners on to our Apprenticeship Pathway and offer other employment on release;
    - Challenge all the organisations working with prisoners in custody to offer opportunities for prisoners on release, whether that be interview practice or work experience if they are not able to offer full employment opportunities;
    - Free governors to re-design the way probation, Prison Work Coaches and careers advisors work together to enable offenders who want to continue with education or training to do so.

**Paragraph 56**
**The CPT again calls upon the authorities of the United Kingdom to ensure that inmates are guaranteed at least one hour of outdoor exercise every day, which is also provided for explicitly in Rule 27(1) of the European Prison Rules**.
**Moreover, it recommends that all exercise yards at Pentonville and Doncaster Prisons provide some shelter from inclement weather.**

94. Prisoners are given time outdoors as part of a formal activity, for example outdoor work or watching or participating in exercise. The national policy is set out in the PSI 75/2011 - Residential Services - which states that prisoners are afforded a minimum of 30 minutes in the open air daily, as defined in the service level agreement / contract. This provision is mandatory subject to weather conditions and the need to maintain good order and discipline. This is also governed by domestic legislation, in rule 30 of the Prison Rules 1999. It is open to Governors to provide more than the minimum requirement where operationally possible.

95. The provision of shelter on the exercise yards will be explored subject to security and financial implications.

**Paragraph 57**
**Health-care services for prisons in England and Wales are run by the National Health Service (NHS) and each prison falls under the responsibility of a local Primary Care Trust; the system has remained broadly unchanged since the CPT's 2008 visit.**

96. Primary Care Trusts were abolished in 2013. The responsibility for commissioning (planning and purchasing) healthcare services in secure settings (including prisons) transferred to NHS England on 1 April 2013 as a result of the Health and Social Care Act 2012.

**Paragraph 58**
**The CPT's delegation noted that, generally, inmates could have access to healthcare staff within a reasonable amount of time and that health-care staffing was, on the whole, adequate at Pentonville Prison. For some 1300 inmates, there were two full-time permanent general practitioners (GPs) and three part-time GPs, and some 40-nursing staff who provided 24-hour nursing cover. Pentonville Prison was also visited regularly by relevant specialists (dentists, optician, physiotherapist, podiatrist and sonographer, among others) and dental care was generally adequate. There was, however, a vacancy for the position of the Lead GP, which was under recruitment at the time of the visit and the CPT wishes to receive confirmation that this position had been filled.**
**At Doncaster Prison, the delegation noted that there was an adequate number of nursing staff and 24-hour nursing cover. That said, there was only one equivalent full-time permanent GP for general health care and two rotational part-time GPs, which was clearly insufficient to meet the needs of over 1,000 inmates. The delegation also noted with concern that there were various vacancies within the health-care team, notably, five posts were vacant in the general health-care medical team and four in the Substance Misuse team. The prison had regular access to relevant specialists (dentist, podiatrist, transmissible diseases optician specialists, among others) and dental care was, on the whole, adequate.**
**By letter dated 28 June 2016, the United Kingdom authorities informed the CPT that as of 5 May 2016, five posts within the primary health-care team had been filled; however, 2.6 vacant positions remained. The CPT welcomes this development.**
**The CPT recommends that the number of full-time GPs be increased by at least one and that serious efforts are undertaken to fill the remaining vacancies within the health-care and substance misuse team.**

97. Care UK is the prime provider (with whom the local Clinical Commissioning Group contracts the service from) for the healthcare contract at HMP/YOI Pentonville and has responsibility for filling primary care healthcare vacancies. The lead GP post was filled during July 2017.

98. Healthcare at HMP Doncaster is currently provided by Nottinghamshire Partnership NHS Foundation Trust. All funding for workforce, including filling vacant posts is within scope of the contract and service commissioned by NHS England. The service specification held with NHS England is not specific about the number of GP sessions required, and the Trust has discretion on how best to meet the health needs of the population. More recently, reflecting the changes in modern General Practice, the Trust has implemented new innovative models to reduce the reliance on GPs (for example, Clinical Pharmacists, Non-Medical Prescribers, Advanced Nurse Practitioners and Paramedics). These innovations are evidence based and have been actively supported by NHS England Commissioners.

99. NHS England Health and justice commissioning team are undertaking an urgent provider market mapping. This includes a workforce training and skill mix audit and programme of workforce development across prisons, IRCs and liaison and diversion services across England. This work is being undertaken in consultation with all current providers, clinicians, commissioners and HMPPS to support recruitment, retention and confidence in working in criminal justice settings. It has been driven in partnership with the Royal College of General Practitioners Secure Environment Group and NHS England Health and Justice Clinical Reference Group. NHS England has recently re-procured the contract for healthcare services for prisoners at HMP Doncaster and awarded a new contract to a new healthcare provider. The new contract makes provisions for additional clinical capacity. The new contract commenced from 1 September 2017.

**Paragraph 59**
**As regard access to healthcare staff at *Doncaster Prison*, the delegation received several complaints from inmates that they did not understand how to use the computerised pin system installed on the wings for electronic application to see health-care staff. The CPT considers that inmates should be able to have access to a doctor at any time. The health care service should be so organised as to enable requests to consult a doctor to be met readily and without undue delay. In light of the above, the CPT recommends that Doncaster Prison management invest more time in each inmate's induction process to explain how the new electronic application system works for prisoners to fully understand how to contact health-care service, if and when needed.**

100. The Prison Induction Package for all new Receptions consists of a PowerPoint presentation regarding healthcare provision at HMP/YOI Doncaster. The presentation includes health services available, how to make applications to the service, location of health services and all aspects of medicine management including times to access all services. Specific instruction in respect of the use of ATMs and how to access healthcare services is included in the induction process and supported by peer mentors. These instructions are in the process of being further enhanced with the installation of a "Dummy ATM" in the Induction Room on the First Night Centre Unit which will enable prisoners to be taught how to use the system by a peer-mentor.

101. Following a review of induction as part of a review titled 'Bus to Bed' a revised Early Days in Custody process is being introduced which will be more prisoner-led and includes a refreshed prisoner mentor scheme known as Insiders.

102. As commissioner of the service, NHS England continues to monitor both the delivery of healthcare provision for prisoners and complaints from prisoners. Should any reported service delivery issues persist, including induction as part of the overall healthcare reception process, then these would be discussed at quarterly contract management meetings and action agreed between NHS England and its healthcare provider.

**Paragraph 61**
**The CPT recommends that steps be taken so that the prison medical services at the establishments visited fully play their role in the system for preventing ill-treatment, ensuring that:**

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

*HMP/YOI Pentonville*

103. Care UK as prime provider sub-contracts mental health service delivery to BEH. Each of the three recommendations for the completion of Traumatic Injury Reports have been accepted and actioned to improve processes for future cases. Both NHS England and Care UK have identified the need for an independent advocate role to support patients through any investigations and communicate on their behalf when required. This role is not in the current contract. In light of this,

NHS England has asked Care UK and BEH to explore pathways to introduce this service. NHS England will monitor the agreed pathway with Care UK at contract review meetings. Care UK will monitor the activity of the independent advocate and include this role in their governance processes to ensure good communication.

*HMP Doncaster*

104. Both the contracted healthcare provider (Nottinghamshire NHS FT) and the commissioner/contracting authority (NHS England) already have policies, strategies and operational policies and procedures in place to identify and escalate concerns about safeguarding, including potential abuse of prisoners to their accountable directors and/or the Police and/or NHS Protect.

**Paragraph 62**
**The CPT recommends that the United Kingdom authorities take steps to ensure that, at Doncaster prison, medication is not given to inmates in an open corridor, nor dispensed through a barred window; instead, an environment that enables full respect for medical confidentiality and for adequate health-care staff and patient relations should be developed.**

*Doncaster/NHS England*

105. The requirement to provide safe and appropriate areas from which to dispense medicines rests with the Prison. Medication continues to be issued in the same locations but with much closer supervision by prison staff to ensure the safety and confidentiality of the patient whilst critically, keeping the healthcare staff safe from abuse. Confidentiality is affected by the specific conditions of imprisonment and the fact that security personnel play a gatekeeper role for the access to healthcare. Guidance (PSI 45/2010) issued by HMPPS states that: *"1.10. It is essential that individuals receiving either clinical treatment or psychosocial interventions do not do so at the expense of their involvement in the wider prison regime. They should be allowed to take their medication with a reasonable degree of privacy and confidentiality"*.

106. Confidentiality is also maintained through the current policy of allowing patients to the dispensary on a one-to-one basis to avoid other patients having the ability to see and hear what the patients are receiving. Patients are protected by the duty of confidence between a patient and clinician as well as the provisions of the Data Protection Act 1998. The dispensing process is task orientated and not an opportunity to engage patients in confidential medical conversations. Appointments are made for this purpose.

**Paragraph 63**
**The CPT recommends that the United Kingdom authorities take measures to reverse the practice of systematically restraining prisoner patients with handcuffs during hospital transfers and instead apply handcuffs during transfer only on the basis of an individualised risk assessment.**
**It also recommends that prisoners should not be handcuffed during a medical examination or treatment; if exceptionally the application of handcuffs is deemed necessary on the basis of an individualised risk assessment, the decision on this matter should be taken by the health care staff involved. Moreover, consideration should be given to creating secure patient rooms in hospitals treating prisoners.**

107. HMPPS policy on external escort of prisoners applies to prisons in England and Wales only. The policy requires that prison management undertakes a risk assessment to decide the level of escort and restraint required for the safe custody to hospital and during any hospital stay, including during a medical examination or treatment, of each prisoner being escorted. In general, all prisoners taken outside the security of a closed secure prison will be escorted by a minimum of two prison officers and will have handcuffs applied unless the risk assessment completed by the prison identifies that this is unnecessary in the particular circumstances of the case, for example where the prisoner's medical condition or physical impairment makes application of restraints

inappropriate. The risk assessment must take into account all the circumstances of the individual case, including assessment of the risk that the prisoner may attempt to escape, including with outside assistance, the risk posed to the public and hospital staff and must consider how these risks are impacted by the prisoner's medical condition. The Prison Service Order (PSO) 3050 on Continuity of Health for Prisoners and the PSI 33/ 2015 on External Prisoner Movement, both document that the healthcare role is advisory and the ultimate decision to restrain a prisoner on escort is the responsibility of prison management. In an emergency (for example if the use of a defibrillator is required), escorting staff will comply immediately with the medical professional's request to remove restraints and will inform the prison by telephone as soon as is practicable so that security arrangements can be re-assessed.

108. HMP Doncaster has a local Operating Procedure. Each prisoner is individually risk assessed. HMP/YOI Pentonville have security risk assessments in place and the patient's medical condition is taken into account during this process. All prisons have arrangements in place within their own Local Security Strategy, which must comply with PSI 33/2015: External Prisoner Movement.

*Use of handcuffs during a medical examination or treatment*

109. The decision to handcuff patients is the responsibility of the prison management and the risk assessment completed by clinicians is a recommendation on the appropriateness of applying handcuffs in the context of the prisoner's medical and physical condition. Prison management has the overall responsibility for the prisoner for the duration of the security escort to hospital and bed watch although the opinion of the medical practitioner on the appropriateness of applying handcuffs in the circumstances of an individual case will be taken into account. This is supported by the PSI on Prisoner Escort.

110. In line with PSI 33/2015: External Prisoner Movement, restraints may be removed in certain circumstances during a prisoner's treatment in hospital, for example where the restraints are impeding treatment or examination. Restraints may also be removed if the prisoner's medical condition deteriorates to the extent that application of handcuffs is inappropriate. In such cases, prison management must consider putting in place additional security measures to mitigate any identified risks, including the risk posed by the prisoner in terms of escape, both independently or with outside assistance, and any potential risk of harm to the public and staff. The individual risk assessment must be updated so that it reflects the prisoner's current medical condition and risks.

**Paragraph 64**
**The CPT noted that at both establishments visited, there was a number of prisoners over 70 years old, and some in their 80s, as well as some severely or terminally ill prisoners, suffering from some debilitating diseases. According to both prisons' management, for various reasons this number was steadily increasing. In light of the considerable challenges facing elderly or infirm persons or persons suffering from disabilities in prison, the CPT welcomes the establishment at *Doncaster Prison* of a specific 'welfare' unit for such inmates (the 'Orchards'). The unit was based on the ground floor allowing more ready access to outdoor exercise, had a specific regime and had a more relaxed environment facilitated by some very dedicated staff.**
**Nevertheless, the delegation observed that in some cells designed for double occupancy, wheel-chair bound inmates had extremely restricted space for wheelchair movement. The CPT recommends that inmates in wheelchairs be allocated to single occupancy cells in the Orchards Unit that can afford them sufficient space for wheelchair movement.**

111. HMPPS is committed to appropriately supporting and catering for all prisoners' needs. HMPPS has introduced specific instructions to ensure compliance with relevant duties under the Equality Act 2010 and the Care Act 2014 in a prison setting. PSI 32/2011 - Ensuring Equality, PSI 06/2016 - Adult Social Care, PSI 16/ 2015 - Adult Safeguarding and PSI 17/ 2015 - Prisoners Assisting Other Prisoners outline HMPPS responsibilities in this area. Governors of individual prisons are required to implement the actions in the PSIs as they relate to their unique prison environment.

There will be a £1.3 billion investment in the estate transformation programme which provides an opportunity to ensure that new-built facilities (both male and female) enhance HMPPS delivery of its equalities objectives by providing modern facilities and services which better meet the needs of prisoners with disabilities, including more adapted accommodation for elderly prisoners.

112. At HMP/YOI Doncaster, additional social care capacity is being provided in another similar small, discrete unit known as The Loft. A number of cells within these two residential units have wide door access and sufficient space for wheelchair movement. As a result of this additional capacity and current levels of need all prisoners who require full time wheelchair use will now be offered a single cell on one of these residential units. There are occasions when a wheelchair user requests a double cell as they prefer to share the cell with a preferred cell mate and in these cases the wishes of the wheelchair user will be respected.

**Paragraph 67**
**The CPT recommends that the United Kingdom authorities take all necessary measures to ensure that prisoners suffering from severe mental illnesses are cared for and treated in a closed hospital environment, suitably equipped and with sufficiently qualified staff to provide them with the necessary assistance.**
**In this connection, high priority should be given to increasing the number of beds in psychiatric hospitals (in this respect see also Section II. D (*Psychiatric institutions* )) to ensure that the in-patient health-care unit at Pentonville Prison does not become a substitute for the transfer of a patient to a dedicated facility and that prisoners at both Doncaster and Pentonville Prisons with mental-health problems - who had been referred to psychiatric hospitals - are not held on normal accommodation wings.**
**More generally, the CPT recommends that prisoners suffering from severe mental health illnesses should be transferred to hospital immediately.**
**Moreover, the CPT recommends that the authorities ensure that all prison staff are trained to recognise the major symptoms of mental ill-health and understand where to refer those prisoners requiring help**.

113. NHS England is working across the entire criminal justice pathway to improve services for offenders with mental health difficulties. Optimum Service Modelling work is taking place for prison mental health services to utilise the expertise of those staff working within prisons, commissioners of health services, clinicians and patients to redesign current services to develop prototypes of new service models. The models will be piloted and further developed with the intention that they will be included within NHS England's Mental Health Service Specification for Secure Estates, which is due to be updated in 2017/18.

114. NHS England are also carrying out a service review across all adult high, medium and low secure services which commenced in June 2016. The review is considering a number of issues including the capacity (bed numbers) required against a number of criteria including levels of security, gender, service types and geographical location.

115. Department of Health Prison Transfer and Remission Guidance published in 2011 sets out best practice to achieve urgent transfers from prison to hospital within 14 days. NHS England are currently reviewing the guidance, with a focus on ensuring that the most appropriate timescales are developed and implemented in relation to prison transfers and remission, taking into account clinical urgency and need. Mental health awareness training is provided as part of the initial training received by all new prison officers and a training module on the subject is available for use as refresher training for existing staff. All establishments have been encouraged to prioritise this training.

**Paragraph 68**
**The CPT recommends that prisoners with severe mental-health conditions should not be placed in segregation units as an alternative to normal accommodation; instead, such prisoner patients should be treated in a closed hospital environment, suitably equipped and with sufficient qualified staff to provide them with the necessary assistance.**

116. Prisoners may be segregated under Rule 45 of the Prison Rules 1999 where it is desirable for the maintenance of good order and discipline in a prison, or in their own interests. Segregation under these circumstances is always for the shortest time necessary and the prisoner must be returned to normal location as soon as practicable or safe. Under Rule 53, prisoners may also be segregated pending the start of an adjudication, and under Rule 55, they may be segregated by way of punishment where they are found guilty of an offence against discipline. HMPPS' policy on segregation is clear that prisoners at risk of suicide or self-harm can be segregated only in exceptional circumstances and where they are such a risk to others that no other allocation is judged to be appropriate. While segregated, these prisoners must be subject to monitoring, including by healthcare professionals, according to individual assessment of need.

117. The initial decision to segregate a prisoner is taken by a prison governor with advice from a healthcare professional who has assessed the prisoner's health and wellbeing in terms of being segregated. This must be done within 2 hours of the prisoner first being segregated. Segregated prisoners are seen daily by a healthcare professional and every 3 days by a doctor. Any concerns about the prisoner's wellbeing can be raised at any time and must be taken into account. Alternatives to segregation are sought for those with mental health problems. Location in the healthcare centre, or closer management on normal location may be possibilities. As a last resort, those prisoners with mental health problems placed in segregation will be supported by a mental health in-reach team. Prisoners at risk of suicide or self-harm will have a mental health assessment if placed in segregation and will be observed in line with their individual Assessment, Care in Custody and Teamwork plan.

118. At Pentonville, in accordance with the Prison Rules, mentally ill patients are not held in segregation for longer than necessary. Following an assessment from the mental health team the prisoner will either be relocated to normal location with a care plan in place, or admitted to inpatients or a secure hospital when clinically appropriate.

119. At HMP Doncaster, the health care service provider is investigating what additional and suitable service provision can be commissioned (for example, for intermediate care) for patients in order to negate the use of segregation.

**Paragraph 71**
**At Doncaster Prison, an ongoing recruitment drive meant that at the time of the visit the prison had nearly a full staff complement. However, the majority of those applying for prison officer roles have been predominantly young and relatively inexperienced; information provided to the delegation by staff and the IMB point to many staff being unable to cope in the pressurised environment and a high number quitting within months of starting.**
**The delegation observed generally that at Doncaster Prison inexperienced staff members were being placed on the most volatile House-blocks, where there have been high number of severe assaults both prisoner-on-prisoner and prisoner-on-staff. Indeed, as regards the most problematic House-block 'West End' Wing B, which houses the young adults, there were initially two and subsequently only one staff member on the wing during the time of the delegation's visit for around 50 inmates. Moreover, these staff members had almost no experience of working in prisons, having only recently completed the mandatory eight weeks' training and been in the prison for some three months. The lone staff member had been assaulted by a prisoner earlier in the day. This staff member underlined that it was other prisoners who had stopped the assault; there had been no other staff around to help her.**
**It is totally unprofessional and even negligent for management to allow a single officer to be left alone to manage a known volatile wing of some 50 inmates.**

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

120. A staff rotation policy has been put in place which seeks to provide a better balance of custodial experience across the establishment. The establishment's recruitment strategy has been reviewed in order to draw a greater number of candidates, thereby increasing the likely diversity of successful candidates. The establishment's training and induction of new Prisoner Custody Officers has also been reviewed and the Prisoner Custody Officer initial training course now includes two weeks of shadowing with a mentor. The programme of cultural change which has commenced, to ensure that staff are aware of their responsibilities in respect of the welfare of prisoners and others, has included the selection and training of Cultural Champions who have an active role within the training and induction of new staff. Residential unit practices have been reviewed in order to lend more structure, routine and accountability to the working day of the residential prison custody officers and, alongside this, more robust management oversight of staff leaving the unit has been put in place.

121. The new House Block staffing model, which has been introduced, minimises the risk of the event mentioned by the Committee from reoccurring, with managers on the House Block being required to police and enforce the new model.

**Paragraph 73**
**The CPT welcomes the response by the authorities and the initiatives taken. It would like to receive a copy of the review and subsequent action plan and regular updates on progress.**

122. Consideration is being given to releasing this document.

**Paragraph 74**
**The CPT recommends that the United Kingdom authorities take measures to ensure that, at both Doncaster and Pentonville Prisons:**

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

*HMP/YOI Doncaster*

123. Revised rosters based on documented work profiles were introduced in September 2016 to improve consistency of staffing amongst frontline operational grades. These make provision for at least three PCOs on each unit. A more effective system of monitoring planned and actual staffing levels is now in place. Other action which has been taken to make resource management more effective includes the introduction of a new absence management strategy, increasing the resources of the Central Department and the introduction of monthly work force planning meetings. A staff rotation exercise has taken place which has resulted in an increase of the levels of custodial experience on the residential units. Residential unit practices have been reviewed in order to lend more structure, routine and accountability to the working day of the residential PCOs and, alongside this, more robust management oversight of staff leaving the unit has been put in place.

124. Each custodial operational manager, having undertaken an assessment, now has in place an individualised management development plan which requires them to complete applied learning and development in the workplace to address areas of identified need. Individualised training plans are also being put in place for all other operations staff which will include FMI refresher training to support staff to learn new skills and build upon existing skills to engage effectively with prisoners. A programme of cultural change has commenced to ensure that staff are aware of their responsibilities in respect of the welfare of prisoners and each other. One of the strategic objectives in the establishment's three-year strategic plan is to put in place effective structures that support the well-being of staff, and a number of work streams will be put in place to support this objective.

125. Monitoring and management of data in respect of response times to cell calls is in place and this is used to take management action to reduce response times across the establishment. Work continues to be taken to challenge the current misuse of cell calls by prisoners via the incentives and earned privilege scheme.

126. The provider of custodial service at Doncaster (Serco) is contracted to deliver a safe and decent prison. Both challenge and support continues to be provided by HMPPS / Ministry of Justice to Serco to ensure that this contract objective is achieved. The core allocated budget is considered every month at the Finance meeting held between the Director and the Finance and Commercial Manager, and at the monthly Workforce Planning meeting chaired by the Director.

*HMP/YOI Pentonville*

127. Staffing levels on residential units are as per nationally agreed benchmarking levels and staff are not alone on those units. The offender management review increases the prison's budget and recruitment has begun to provide an increased number of officers. HMP/YOI Pentonville submitted a request for a small number of additional officers in the interim which was approved. These officers are being used to support delivering consistent regimes and to reduce violence. Regimes are delivered according to the staff available and a local regime management plan is in place to assist with that. Staff are currently undergoing FMI training as well as the local HMP/YOI Pentonville development programme.

128. Work continues to improve the response to cell calls and provide education to our prisoner population on when to use cell calls, stressing that they are for emergency use only. HMP/YOI Pentonville is now trialling an onsite psychological support service for staff.

**Paragraph 77**
**The CPT recommends that the United Kingdom authorities refurbish the "special accommodation cells" at Pentonville Prison to ensure that they afford adequate artificial lighting and access to natural light and ready access to a toilet and wash basin, as a matter of priority**. **Further, all prisoners held in cellular confinement must be offered at least one hour of daily outside exercise.**

129. Refurbishment of the special accommodation at HMP/YOI Pentonville will be explored.

130. In accordance with PSI 75/2011 - Residential Services, it is a mandatory requirement, subject to weather conditions and the need to maintain good order and discipline, that prisoners are afforded a minimum of 30 minutes in the open air daily.

**Paragraph 78**
**The CPT recommends that the management at both Pentonville and Doncaster Prisons instruct staff to address clearly the issues raised by inmates in their replies to complaints.**

*HMP/YOI Doncaster*

131. Robust quality assurance processes have been implemented to ensure that complaints are answered appropriately and in a timely manner.

*HMP/YOI Pentonville*

132. Responses to complaints are monitored and quality checked. Prisoner surgeries will be delivered on residential units to deal with complaints quicker.

**Paragraph 82**
**The CPT would like to be informed about the steps taken by the United Kingdom authorities to implement the recommendations made by the Medway Improvement Board, HMIP and Ofsted.**

133. The Medway Improvement Board made 25 recommendations for improvements to the current operating model at Medway STC. These recommendations are now being taken forward jointly between the Youth Custody Service in HMPPS and Ministry of Justice.

134. Work has been undertaken to review Revised Suicide and Self -Harm (SASH) procedures and young people's plans. There is also a clear focus on workforce development with many frontline staff at Medway STC signed up and working towards the new foundation degree in youth custody.

135. A new behaviour management policy has been introduced based solely around rewarding positive behaviour and a conflict resolution model has been fully implemented at Medway STC. In addition, monitoring processes have been updated and strengthened including:
- greater levels of oversight by senior staff;
- a greater focus on practice and engaging young people;
- A review of whistleblowing and matters of concern policies, which have been reviewed and policy distributed to staff.

136. The Youth Justice Board (YJB) has also developed a new performance framework which integrates a "rights based" approach in a new model of scrutiny, support and performance improvement. The new framework was introduced in April 2017. At this point, responsibility for the youth custodial estate passed over from the YJB to the newly formed Youth Custody Service which is located within HMPPS.

**Paragraph 83**
**In light of the interim findings of the Taylor Review and the Medway Improvement Board, which have underlined certain systemic weaknesses and protection gaps in the overall operation and functioning of the young persons' estate and which call of a wide-scale system change, the CPT recommends that the United Kingdom authorities urgently review the current operating model of the YOIs and STCs with a view to ensuring that, if exceptionally necessary to hold juveniles in detention, the secure juvenile estate is truly juvenile-centred and based on the concept of small well-staffed living units.**

137. The principle of custody being the last resort for young people is firmly established in the youth justice system. In recent years, there has been a significant and continued decline in the number of young people in custody. An increased focus on diversion, rehabilitation and RJ has played a key part in achieving this. Despite this success there remains a cohort of young people whose offending is so severe or so repetitive that they require a custodial sentence. The safety and rehabilitation of these young offenders is extremely important.

138. Charlie Taylor's comprehensive review of the youth justice system and the UK Government's response[12] to it, was published on 12 December 2016. The UK Government's response sets out a comprehensive plan in order to make youth custody both a safe place for children and those who work there; and to improve the life chances of children in custody. The programme established to take forward the reforms is structured in four strands:

- An individualised approach: developing an integrated framework of care encompassing education, health, and behaviour support into youth custody, to ensure each young person has had a full needs assessment and a tailored care and support plan,
- A professional, specialist workforce: creating a bigger more resilient and stable workforce who have specialist skills to support the rehabilitation of young people.
- Strong leadership and governance: developing strong leaders who create the right culture and who are held to account for outcomes,
- The right estate: Changing youth custody so that it consists of smaller units with a therapeutic environment. As part of this, we intend to pilot secure schools that were recommended by the Taylor report. These establishments will be located close to the communities they serve and have a strong focus on education and health.

139. The reform programme will be underpinned by changes we have already made to governance including appointing a single director for youth custody who will have clear oversight of the youth custodial estate.

**Paragraph 85**
**The CPT recommends that the United Kingdom authorities take steps to ensure that co-ordination between the different bodies involved in investigating allegations of staff ill-treatment against juveniles in detention is more effective, and the management of the prison should take steps itself to address the matter, as outlined above.**

140. The UK Government is taking forward a number of strands of work to ensure young people in custody are safe and there are a number of guidance documents that set out good practice. Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) sets out the legislative requirements and expectations on individual services to safeguard and promote the welfare of children; and a clear framework for LSCBs to monitor the effectiveness of local services.

[12] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/576553/youth-justice-review-government-response.pdf

141. Within the youth justice sector, child protection and safeguarding is top priority and there is a high level of scrutiny from a range of agencies and organisations, including HMIP and Ofsted. Under section 11 of the Children Act 2004, governors/directors of secure establishments (YOIs and STCs) and local authorities (for SCHs) have a statutory duty to ensure their functions are discharged having regard to the need to safeguard and promote the welfare of children.

142. For YOIs, PSI 08/2012 - Care and Management of Young People – Chapter 2 'Maintaining a Safe and Secure Environment' implements the mandatory actions that relate to section 11 of the Children Act 2004. In particular, all sites have:

- dedicated Safeguarding teams in all sites.
- agreed protocol with LSCBs for dealing with allegations against people who work with children.
- an advocacy service in all, HMPPS under 18 establishments which is operated by Barnardo's,
- dedicated social workers who, like the Barnardo's advocates, are independent of the HMPPS Youth Custody Service and can offer confidential advice.

143. CCTVs cover different areas in different sites. The majority provide cover of all residential and classroom areas, which helps to ensure potential abuse is prevented, detected, reported, and dealt with appropriately. In accordance with Working Together guidance, CCTV records pertaining to any child protection referrals are retained for 10 years or until the staff members' retirement age (whichever is the latter). A significant number of BWVCs has been funded in sufficient number to be deployed to all front-line custody staff on duty in STCs. To support safeguarding, improvements to telephone access are being made so young people can more easily contact their families and carers during times of distress.

**Paragraph 87**
**The CPT recommends that the United Kingdom authorities take measures to put in place a long-term strategy to reduce the levels of violence in Cookham Wood. In this respect, consideration should be given to investing in the establishment of more small specialised units, such as the Cedar Unit, to manage juveniles with complex needs. Further, every effort should be made to avoid placing juveniles into conditions of *de facto* solitary confinement (see paragraphs 91 to 93).**

144. Reducing violence is the highest priority for the Governor and Senior Management Team at Cookham Wood. There is a local violence reduction strategy and patterns and trends of violent behaviour are reported and analysed at both the monthly and quarterly Safeguarding meetings to determine what actions are taken.

145. The HMPPS Youth Custody Service has a strategy in place for managing the behaviour of children and young people that has been developed by the psychology team. Integral to this strategy is the development of multi-disciplinary Enhanced Support Teams in each secure setting, made up of professionals from establishments, health, psychology and NHS England. As part of reforms, we are also planning to develop ESUs to improve support for children with exceptionally complex needs. Feltham YOI is on track to open the first ESU in November 2017.

146. HMPPS does not use solitary confinement. Segregation must only be used under specified safeguards and regular review, where young people are putting themselves and others at risk. Use of segregation is closely monitored and there are careful limits placed on the length of time for which a young person can be separated and placed on a segregation unit before further reviews must take place. The Deputy Director of Custody for young people must give leave in writing for continued placement in a care and separation unit beyond 21 days and this authority cannot be delegated. Segregation should be accompanied by a strategy of intervention and the young person will continue to have regular contact with staff. However, there are some occasions when it is necessary to remove young people from association because their behaviour is likely to be so disruptive that allowing them to associate would be unsafe, or because their own safety and wellbeing cannot reasonably be assured by other means.

**Paragraph 88**
**The CPT recommends that a regular deep clean of the residential Unit and, in particular B wing, be undertaken on a regular basis.**
**It also reiterates its recommendation that shelters from inclement weather be installed in the exercise yards and that all juveniles should be allowed to exercise regularly, for at least two hours every day, of which at least one hour should be in the open air and, preferably, considerably more, including when it is raining.**

147. A deep clean and de-scale of all the bathrooms on the residential units has been undertaken and will continue at regular intervals.

148. We believe that every child and young person should have access to, and be engaged in, meaningful activities, including education and physical activities. The current requirement for one hour of exercise in the open air per day is a minimum. As part of current youth custody reforms, we are reviewing the range of education and physical activities that young people take part in with a specific aim to strengthen the sports and physical education offer to improve young people's health and wellbeing.

**Paragraph 90**
**The CPT recommends that the United Kingdom authorities take concrete steps to improve the regime for juvenile inmates at Cookham Wood; obstacles to attendance at education or other purposeful activities on a daily basis should be removed. The overall aim should be offer to all juveniles a normal regime of at least eight hours out of cell engaged in purposeful activities.**

149. All young people in HMPPS run establishments are offered a regime of at least eight hours out of their room unless there are exceptional reasons. Education (including physical education) is a major component of the current regime, alongside other activities such as offending behaviour interventions, resettlement and sentence planning, social and professional visits and religious, healthcare and domestic services.

**Paragraph 93**
**The CPT recommends that the United Kingdom authorities take urgent steps to provide all juvenile prisoners - especially those on 'separation' or 'protection' lists - with a purposeful regime, including physical activities and considerably more time out-of-cell than currently provided.**
**The CPT also recommends that the authorities of the United Kingdom invest in establishing more small units specifically tailored to managing juveniles with complex needs at Cookham Wood (in this respect, see paragraph 87).**

150. At an absolute minimum, young people removed from association in YOIs will be given time in the open air, outreach education provision, access to the chaplaincy service and legal advice. Individual regime plans are agreed for each young person by a multi-disciplinary team taking account of all of these issues and any other information. These are reviewed frequently on an individual basis.

151. Young offenders in YOIs cannot be removed from association and placed in a care and separation unit for more than 72 hours without the authority of senior managers in conjunction with the Independent Monitoring Board and healthcare. If authorised by senior management, separation cannot be for longer than for 14 days, but it may be renewed after review for the same period again. The Deputy Director of Custody within the YOI must review the segregation of any offender that continues to 21 days and at each subsequent 21 day periods. The responsible Director must review any case where segregation continues to 3 months.

152. In STCs, Rule 36 of the STC Rules states that a young offender who has been removed from association cannot be left unaccompanied for more than three hours in any 24-hour period. Additionally, young offenders detained in STCs can only be removed from association where it

appears to be necessary in the interests of preventing the young offender from causing significant harm to themselves or others or significant damage to property.

153. Please see also the response to paragraph 87.

**Paragraph 95**
**The CPT recommends that the cells in the Phoenix Unit be refurbished and undergo a deep clean on a regular basis, taking into consideration the above remarks. Further the activities' room should be repaired.**

154. The activities room in the Phoenix Unit has been repaired and the unit is regularly cleaned.

**Paragraph 98**
**The CPT recommends that the United Kingdom authorities take urgent steps to ensure that the YOI Rules are amended to reflect the increasing trend at the international level to promote the abolition of solitary confinement as a disciplinary sanction in respect of juveniles.**
**It also recommends that juveniles should not be placed in segregation for the purposes of GOOD and should instead be placed in small staff-intensive units.**
**More generally, until such a time as the above two recommendations are fully implemented, the authorities should ensure that the separation, removal from association, cellular confinement or segregation of juveniles - in whatever form it takes - should be applied only as a means of last resort, and that the juveniles concerned should continue to be granted access to education, physical exercise and possibilities of association.**

155. The safety and welfare of young people held in custody is our highest priority. The UK Government is clear that children should only be segregated under careful control and regular review, where they are putting themselves and others at risk. We do not use solitary confinement and we are also clear that segregation must be subject to specified safeguards and regular review. Use of segregation is closely monitored and there are careful limits placed on the length of time for which young people can be separated and placed on a segregation unit before further reviews must take place. Young people cannot be segregated as a punishment. Please also see the response to paragraph 87.

*YOIs*

156. GOAD ("Good Order And Discipline") applies to a form of separation based on risk. This can be done on normal location and not just on the CSUs. All young people receive a written copy of the reasons why they are to remain on GOAD and the behavioural targets they must achieve to be taken off GOAD as well as engagement with services from the CSUs including education and mental health. This is in line with national standards. GOAD documentation records who is present at the review and is signed by the Governor who chairs it and the member of the Independent Monitoring Board when they are present. If the Independent Monitoring Board are not present for the review, this is noted on the paperwork.

157. As previously indicated, the UK Government is clear that segregation must only be used under specified safeguards and regular review, where young people are putting themselves and others at risk. The young person must be informed of the reasons for their segregation. They must also be given the opportunity to make representations to the segregation review board and to participate in the review process. There are some occasions when it is necessary to remove young people from association because their behaviour is so disruptive that keeping them on ordinary location would be unsafe, or because their own safety and wellbeing cannot reasonably be assured by other means. While removed from association, young people will be given time in the open air, outreach education provision, access to showers, access to the chaplaincy service and legal advice. Individual regime plans are agreed for each young person by a multi-disciplinary team taking account of all of these issues and any other information.

**Paragraph 99**
**The CPT recommends that all staff, including those with custodial duties and on temporary cross-deployment or on detached duty, who are in direct contact with juveniles should receive juvenile-centric professional training, both during induction and on an ongoing basis, and benefit from appropriate external support and supervision in the exercise of their duties. Further, the CPT would like to receive information regarding what measures have been taken to counter potential staff 'burn out' or exhaustion at work due to long commuting times for staff on detached duty at Cookham Wood YOI.**

158. HMPPS have developed a new child-centred Prison Officer Entry Level Training (POELT) course. The structure of the 10-week course allows learners to understand the ethos, values, morals and ethics that are integral to working with young people. This includes supporting staff to undertake the Diploma in Custodial Care and it is planned that this will shape the way new staff are trained and enhance the child centred culture of the Youth Custody Service. The Working with Young People in Custody training programme is being rolled out across HMPPS Young People's Estate for all staff who have contact with young people. Additionally, the custody reform programme is developing, alongside external partners, a comprehensive model of vocational training for those working in the youth estate. This recognises the specialist skills and knowledge required to work with the complex young people in custody. This training will be completed on the job and will combine practice assessments with theoretical modules that will enable staff to develop an in-depth understanding of reasons young people commit crime, child development and the impacts of trauma. Currently a pilot is being run with partners to give staff the opportunity to complete a foundation degree in youth justice.

159. All staff on detached duty from Dover chose to come to Cookham Wood as one of their options when Dover closed. They are credited for their additional travel time and can claim back these accrued hours at a mutually convenient date. Within HMPPS, all employees adhere to the Working Time Regulations of 48 hours per week however they can voluntarily opt out of this agreement should they wish to. Individuals undertaking periods of Detached Duty do so voluntarily, and any travel time is included within their total shift time spent at work. Individuals who are commuting long distances can book hotel accommodation, at the employer's expense, near the site they are working at to decrease travelling time.

160. Prison Officers undertaking Detached Duty are under supervision as with staff employed directly at the site. Staff can discuss any issues they have over their health and wellbeing with supervisors on a daily basis as well as the local Care Team. The Care Team is made up by individuals trained to act as a confidential support to individuals who feel they may need some support. They will listen and signpost individuals to relevant services.

161. In addition, HMPPS operates an Employee Assistance service provided by professional wellbeing and counselling practitioners via a Ministry of Justice contract with Help Employee Assistance Programme; they offer confidential, independent and unbiased support, information and guidance. This can include services such as counselling, Cognitive Behavioural Therapy, Eye movement desensitization and reprocessing and Physiotherapy services. Employees are also able to access an online Wellbeing Zone including the following: personal training programme; weight management plan; healthy eating and nutritional advice; stress management solutions; ten-minute wellness; general advice centre.

162. All HMPPS sites have access to Occupational Health Advisors, and cases can be referred to an Occupational Physician or Therapist where applicable.

**Paragraph 100**
**The CPT's delegation noted that general health-care staffing levels at Cookham Wood were adequate: there were four part-time GPs, four nurses and five assistant nurses on rota. There were also specialist medical teams available for mental health (see below) and addiction problems, as well as regular visits by a dentist, optician, dietician and physiotherapist. Two nurses, assisted by several nursing assistants, were present from 7 a.m. to 7.45 p.m. seven**

**days a week. However, there was no health-care presence at night and, in case of emergencies, an ambulance would be called. There were also two vacant nursing staff posts at the time of the delegation's visit.**
**During the course of the visit, the delegation received a few complaints from juvenile inmates about access to, and the poor quality of, health-care services at Cookham Wood YOI.**
**The CPT recommends that there should always be someone competent on the premises who is trained to provide first aid - including at night.**
**The CPT would also like to receive confirmation that the two vacant nursing posts at Cookham Wood have now been filled.**

163. There are competent staff on the premises who are trained to provide first aid at all times – this includes through the night. On-call out of hours GP provision is in place, plus specific on-call provision and arrangements for the provision of substance misuse and mental health services.

164. The posts concerned have been filled.

**Paragraph 102**
**The CPT recommends that the management at Cookham Wood stops the practice of medication being dispensed through a hatch; instead, an environment that enables full respect for medical confidentiality and for adequate health-care staff and patient relations should be developed.**

165. Arrangements have been reviewed to ensure that confidentiality is given priority. Working practices around the dispensing of medication need to ensure that confidentiality is maintained. Current practice involves the young person being brought to the treatment hatch on an individual basis. Should the young person ask to discuss other issues, they are seen after medication dispensing is completed, either in healthcare or in their cell.

**Paragraph 103**
**The CPT recommends that Cookham Wood should ensure that the mental health-care team has a designated consultation room to avoid consultations or clinics being cancelled.**

166. The mental health team now has some new dedicated accommodation for consultations which has reduced cancellations significantly.

**Paragraph 107**
**The number of patients being detained in England under the MHA is increasing year on year from 46,348 in 2010/11 to 58,399 in 2014/15, an increase of more than 25% in four years. The number of patients detained on 31 March 2015 was 19,656 whereas the official number of available mental health beds was 19,273.**
**In 2014, the Royal College of Psychiatrists (RCPsych) established "The Commission to review the provision of acute inpatient psychiatric care for adults" to address problems in accessing acute inpatient care for adults and recommend ways of improving the service. In its report, published February 2016, the Commission concludes that access to acute care for severely ill adult mental patients in England is inadequate. The findings include bed occupancy rates of over 100%, 16% of patients being admitted to acute psychiatric care due to lack of alternatives, 16% of patients having delayed discharges and up to 500 patients per month having to travel more than 50 kilometres to access an inpatient psychiatric service that should be provided locally. The CPT is particularly concerned that children who are mentally disordered may have to be sent long distances from their home. Further, the CPT's findings from its visits to prisons, a YOI and an immigration removal centre demonstrated that there were delays in transfers of patients to psychiatric hospitals.**
**The CPT wishes to be informed about the action being taken by the United Kingdom authorities to address these issues.**

167. The Independent Mental Health Taskforce brought together health and care leaders, people who use services and experts in the field to create a Five Year Forward View for Mental Health[13] (FYFV-MH) for the NHS in England. Chaired by Paul Farmer, MIND CEO, it published a national strategy and set out an ambitious vision for transforming mental health services by 2020/21. The UK Government's response published in January 2017 accepted all the recommendations, announced an additional investment of £1.4 billion, and set targets to increase access so that by 2020 an additional 1 million people will be able to access the care they need.

168. In July 2016, NHS England published an Implementation Plan[14] to set out the actions required to deliver the FYFV-MH. The Implementation Plan brings together all the health delivery partners to ensure there is cross-system working to meet the recommendations made by the Taskforce.

169. NHS England is currently carrying out a service review across all adult high, medium, and low secure services. The service review is considering a number of issues including the capacity required against a number of criteria including levels of security, gender, service types and geographical location. Planning is based on local population need, in keeping with strategy and policy direction for mental health and learning disabilities.

170. The current Prison Transfer and Remission Guidance published in 2011 is being reviewed. A particular focus of the work is about ensuring that the most appropriate timescales are developed and implemented in relation to prison transfers and remission, taking into account clinical urgency and need.

171. Inappropriate out of area placements are unacceptable and the UK Government has set a target to eliminate these in non-specialist, acute mental health care by 2020/21 for both children and adults. NHS England is using new data on the issue to support local health systems to develop and deliver trajectories to eliminate inappropriate out of area placements. Shared learning and best-practice advice on reducing out of area placements through improved system capacity management will be included in acute care commissioning guidance.

172. Clinical Commissioning Groups also have the opportunity to gain a financial Quality Premium if they successfully reduce their out of area bed days by 33% during 2017/18. This will also be available in 2018/19.

173. NHS England is carrying out a comprehensive review of inpatient services and has a major programme underway to improve inpatient care, by opening between 150 and 180 new specialist inpatient beds in children and young people's mental health services (as set out in *Next Steps on the Five Year Forward View)*. This will ensure that the right beds are in the right place in the country and help to reduce travel distances for treatment, rebalancing beds from parts of the country and enhancing community services to reduce inpatient use. Our ambition is that by 2020/21 no children are inappropriately admitted or sent out of area to receive anything but the most specialist mental health care.

174. The New Care Models in Tertiary Mental Health programme also supports more appropriate local provision by jointly commissioning between NHS England and providers so that children and young people in need of inpatient beds access a bed close to home.

[13] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[14] https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

**Paragraph 112**
**The CPT reiterates that the possibility for a patient to be outside, preferably in a pleasant garden area, should be a right for every patient. Further, spending time outdoors has a beneficial impact on patients' well-being and recovery. Hence, access to outdoors should be proactively promoted.**
**The CPT recommends that steps be taken to put in place a clear policy for promoting and facilitating the possibility of patients to access the outdoors every day at both St. Charles Hospital and Highgate Mental Health Centre. The CPT would like to receive information from both establishments on how this policy is being implemented.**

*St. Charles Hospital*

175. Each ward has two patient safe balcony areas which allow access to the outdoors. There is currently a local project underway to refurbish the balcony areas on every ward with the support of the Advocacy Service and Arts in Health. This will improve the access to outdoor spaces for all patients. Additional work is underway to develop the garden areas within both PICU's with patient involvement to extend the therapeutic outdoor space within the most restrictive environment. Patients leave status is reviewed on a daily basis via the Multi-Disciplinary Team whiteboard meetings, and there is an escalation protocol in place if ward staff are unable to facilitate leave due to staffing issues.

*Highgate Mental Health Centre*

176. The centre has policies in place which include patients having access to the outdoors. There are landscaped gardens at the centre which are used for this purpose. The centre is in the process of reviewing its Inpatient Clinical Model and related policies. The review will include updating the section on promoting least restrictive practices, and will look at improving policies for promoting and facilitating daily access to outdoors spaces.

**Paragraph 113**
**The CPT recommends that every effort be made to involve patients in drawing up their individual treatment plans. Further, more time should be prioritised for nurses to have 1:1 sessions with the patients under their care.**

177. The MHA Code of Practice sets out that "wherever possible, the whole treatment plan should be discussed with the patient. Patients should be encouraged and assisted to make use of the advocacy support available to them, if they want it. Where patients cannot (or do not wish to) participate in discussion about their treatment plan, any views expressed previously should be taken into consideration".

178. St Charles Hospital uses a Multi-Disciplinary Team Care Plan which allows all persons involved in providing care to the patient to contribute to the patient specific care plan. All staff attempt to develop the care plan with the patient present, who will contribute where they are able to. This includes 1:1 sessions with staff. Patients are asked to sign that they have had their care plan explained to them and have received a copy. Processes are in place to revisit the plan where patients lack capacity to understand or are too unwell to comprehend at the point of admission. The hospital conducts a weekly audit on each ward which audits patient involvement in developing their care plans and that patients are receiving 1:1 sessions with staff. Any anomalies are acted upon immediately with the named nurse. Audit results are reported to the Local Care Quality Meeting on a quarterly basis.

**Paragraph 114**
**The CPT recommends that the United Kingdom authorities ensure that all patient injuries are diligently recorded, including on body maps, and that an investigation and safeguarding measures are triggered whenever injuries are noted. Further, clear policies should be in place to ensure that staff know what to do if they detect possible ill-treatment by other staff members.**

179. When patients are referred to secondary mental health services, they are assessed upon admission to hospital. They receive a mental and physical health assessment by a multi-disciplinary team to inform a care plan through the Care Programme Approach.

180. The Care Programme Approach, first introduced in 1990, and then refocused in 2008, provides a framework for effective mental health care for people with severe mental health problems. Its four main elements are:

- systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- the formation of a care plan which identifies the health and social care required from a variety of providers;
- the appointment of a key worker (care coordinator) to keep in close touch with the service user, and to monitor and co-ordinate care; and
- regular review and, where necessary, agreed changes to the care plan.

181. As part of the assessment process specially trained professionals will ask patients questions about physical and sexual abuse and record any injuries as part of the assessment process, body maps are one of the ways in which this can be done. Where prior physical abuse has been identified prior to admission to hospital and during a patient's stay in hospital, it is reported to the appropriate authorities and investigated. Care plans are regularly reviewed and assessments undertaken during a person's stay in hospital.

**Paragraph 115**
**The CPT would like to be informed of the steps being taken to address staff retention and ensure wards are adequately staffed not only to ensure a safe environment but to deliver the necessary therapeutic care to patients.**

182. There has been a renewed focus on staff retention which has reduced the number of staff leavers at St Charles' Hospital from 64 in the six months from June 2016 to November 2016 compared with 33 leavers in the 6 months between December 2016 to May 2017. Some of the steps taken include:

- Staff listening events delivered by the trust management from which action plans to address important issues were developed;
- Active engagement with Trust reward strategy delivering benefits to staff;
- A review of volunteers and their deployment across the borough to support the workforce in delivering patient care;
- Occupational Health and staff counselling services working with staff to discuss support following an incident of staff abuse or violence from a patient;
- Implementation of a zero-tolerance approach to staff abuse with follow up and prosecution of patients abusing staff;
- Development of a trust wide Recruitment and Retention Strategy;
- A project is underway to support the appropriate use of Health Roster to improve staff rostering.

**Paragraph 116**
**More generally, the CPT has noted the large number of vacancies for registered mental health nurses in England and the seemingly high rates of drop-out, more recently in respect of experienced nurses; the number of mental health nurses decreased by some 8.5% between 2009 and 2013 and the trend appeared to continue in 2014 and 2015.**
**The CPT would appreciate the observations of the United Kingdom authorities on this matter and would like to be informed about what steps are being taken to recruit and retain registered mental health nurses.**

183. The FYFV-MH (Five Year Forward View on Mental Health) set out an ambitious vision for transforming mental health services by 2020/21. Mental Health Workforce Plan, published in July 2017, underpins the start of one of the biggest expansions of mental health services in Europe, creating 21,000 new posts by 2021.

184. In December 2017, Health Education England published for consultation their draft Workforce Strategy for England which, amongst other key areas, considers the outputs of major workforce plans for the priorities laid out in the Five Year Forward View, including mental health. The Government will consider the conclusions of the consultation carefully once this is finalised.

185. The FYFV-MH recognised that meeting its ambition to transform mental health services by 2020/21 would require a significant expansion of staff. Additional funding for staffing, including improving retention, is included in planning for implementation by 2020. The Mental Health Workforce delivery plan, published in July 2017, sets out clear actions for providers and the national Arms-Length Bodies to deliver the workforce growth and transformation needed to deliver on the FYFV-MH. Alongside plans to recruit new staff, the plan also sets out actions to improve staff retention.

**Paragraph 118**
**The CPT wishes to receive updated information on steps taken at St Charles Hospital to reduce the resort to all instances of restraint, including data on the 18-month period to June 2016.**

186. Currently all restraints are reviewed by the Ward Manager with the use of CCTV to ensure this is safely managed. All staff are subject to an immediate debrief following a restraint, and patients are offered a debriefing session to offer alternative strategies to enhance quality patient care within 72 hours. This is captured via the Datix system, which is audited weekly by the Division and exceptions are reported to Senior Management Team.

187. All Wards have ‘Datix Huddles’ which provides ‘Live Data’ on use of restraint within clinical area, which is discussed within weekly MDT meetings across the unit. Restraint Data and the Restrictive Intervention Strategy are discussed monthly.

188. The trust has a multidisciplinary Restrictive Interventions Working Group which meets monthly, and reports to the trust’s Quality and Performance Committee. The working group membership includes staff from St Charles, including the Consultant Psychiatrists from both the PICU wards, the Service Manager, Matron, Ward Manager and Clinical Team Leader.

189. The Trust has a detailed action plan to reduce the use of restraint. A review of the training on de-escalation skills has been conducted by the Recovery College and as a result a new training package has been co-produced with experts by experience which is currently being co-delivered to all in-patient staff. All Staff currently undergoing training to ensure that on all occasions where restraint has to be used that ‘Supine’ is the preferred position which reduces complications to the patient’s airway or positional injuries.

190. In October 2017, NHS Improvement and the Care Quality Commission launched a national mental health patient safety initiative. It will be supported by a national mental health quality improvement programme, led by NHS Improvement and informed by CQC intelligence as part of a joint strategic objective to ensure a shared view of quality. All mental health providers will be involved in this initiative, which has an emphasis on shared learning and the embedding of sustainable quality improvement approaches as integral to the way mental health services are delivered across the sector. The initiative will include support for Trusts to reduce use of restraint.

**Paragraph 120**
**The CPT recommends that additional measures be taken, including of a legislative nature, to avoid holding mentally ill persons in police cells as far as possible. Further, inter-agency co-operation between police and mental health services in respect of those patients detained pursuant to Sections 135 and 136 of the MHA should be strengthened.**

191. The use of police cells as a place of safety for people detained under sections 135 and 136 of the MHA is now less than 25% of the numbers in 2011/12, and the UK Government's ambition is to reduce it further. The Department of Health is spending an additional £15m to increase the number of health-based places of safety during 2016-2018.

192. A joint Department of Health/Home Office review of the use and operation of the sections 135-136 powers in 2014 identified a number of areas for change or improvement, particularly in relation to the use of police stations as places of safety. The Policing and Crime Act 2017 makes legislative changes that prohibit the use of police stations as places of safety for those under 18 and significantly limit the circumstances in which they may be used in the case of adults.

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

193. St Charles hospital is currently awaiting Planning Consent for a major refurbishment of both the reception and assessment suite areas. This will include a café style environment and complete refurbishment of the Health Based Place of Safety. The hospital no longer offers a walk-in service which has reduced the need for unplanned patients to wait for a bed. Changes to Section 136 ensure that the timeframe for detention has reduced from 72 hours to 24 hours for completion of an assessment. Daily and Weekly Bed Management Meetings are conducted across the Division and several times daily at St Charles hospital to identify factors with current patients that are causing delays in the admission process.

**Paragraph 124**
**The CPT recommends that the relevant legislation should be amended so as to require an immediate external psychiatric opinion in any case where a patient does not agree with the treatment proposed by the establishment's doctors; further, patients should be able to appeal against a compulsory treatment decision to the Mental Health Tribunal. Patients should provide their consent to treatment in writing on a specific form.**

194. Where a patient does not agree with the treatment proposed by the establishment's doctor they are able to request a second opinion to discuss the treatment proposed through their own GP or consultant psychiatrist. They may also raise concerns directly with the Care Quality Commission who may investigate further where necessary. The Care Quality Commission, as the regulator of care quality, monitors the use of the MHA, inspects registered mental health providers

regularly to assess the quality and safety of the care provided. This route for complaint has been emphasised since the updating of the Code of Practice in 2015.

195. As noted by the CPT, the First-Tier Tribunal (Mental Health) is a judicial body whose purpose is to determine the appropriateness of a person's detention under the MHA. The Tribunal's remit does not extend to consideration of compulsory treatment decisions proposed by the establishment's doctors. Should a patient not agree with the treatment proposed, the process of appealing their detention to the First-Tier Mental Health Tribunal would also result in the Tribunal considering whether the treatment is appropriate for the patient. Patients can also speak to an Independent Medical Health Advocate if they do not agree with proposed treatment, or their psychiatrist or named nurse in the first instance.

196. One of the guiding principles of the MHA Code of Practice is that patients should be involved in their care as much as possible. The Code of Practice also requires mental health providers to ensure that patients understand and can consent to treatment wherever possible. Where treatment is being provided without the patient's consent, mental health providers must communicate this to the patient and their carer, family and independent mental health advocate where appropriate. The Code of Practice is clear that multi-disciplinary teams should always consider what is in the patient's best interest when making decisions about treating them without their consent. Decisions about consent are recorded using the relevant MHA statutory reporting form.

197. There are provisions within the MHA and guidance in the Code of Practice about treatments that require special approval by qualified Second Opinion Approved Doctors such as electro-convulsive therapy to provide extra safeguards that treatment is in the best interests of the patient.

198. Mental Health providers are required to make information available to patients in a format and language that they understand and care should be taken to ensure patients understand their rights in terms of consenting to treatment and being treated without consent and that they fully understand the procedures for raising concerns and/or complaints about their treatment. This includes being able to raise concerns and complaints with the Care Quality Commission about their care and treatment which may be investigated where appropriate.

199. The Government has commissioned an independent review of the Mental Health Act and associated practice. The review will report by autumn 2018.

**Paragraph 125**
**The CPT wishes to receive confirmation that patients in all psychiatric hospitals can have free access to their medical records.**

200. Patients already by law have a right to access to their medical records free of charge under the Data Protection Act 1998. Details of the records may be withheld if for clinical reasons if the content is deemed to be potentially harmful to a person's physical or mental health. In relation to preparations for Mental Health Tribunals, where the patient consents, legal representatives and independent doctors are given prompt access to the patient's medical records.

**Paragraph 127**
**The CPT recommends that complaints boxes be installed on all wards where involuntary patients are placed with access available only to the safeguarding team.**

*St Charles Hospital*

201. All wards display comment/complaint posters sign-posting service users and carers on how to make a complaint. All wards have regular access to an advocate who supports patients to raise complaints or safeguarding issues, with local procedures in place for reporting them to the Ward

Manager or Matron. A robust Safeguarding Process has been established which ensures that all staff are aware of how to raise any safeguarding concerns, and that Safeguarding Alerts are screened by the Safeguarding Lead and managed appropriately.

*Highgate Mental Health Centre*

202. Subject to managing ligature and patient safety risks, complaints boxes will be installed in each clinical area. Currently, Matrons are responsible for reviewing any complaints or issues raised, they are all trained Safeguarding Adults Managers and will raise safeguarding concerns or complaints relating to organisational abuse, which will be overseen by the Trust's Safeguarding Adults Lead.

**Paragraph 133**
**The CPT would like to receive confirmation about the steps being taken to improve the food offered to patients.**

203. During 2017, Chase Farm Hospital will start to introduce self-catering, which aims to develop skills and competencies for service users that will greatly assist in terms of budgeting and community living further down the line. Primarily this is seen as being beneficial in terms of skills acquisition however it also leads to greater food satisfaction. One of the wards is now entirely self-catering, and many of the others are self-catering at lunch time. The plan is for all wards to become self-catering by the end of August 2017, which has involved a considerable degree of positive challenge within the secure environment. This will be extended further in due course but will need to continue to balance the safety and security needs of the environment. Discussions have taken place with catering colleagues in relation to extending the choice and improving quality within the current contractual arrangements. The North London Forensic Service has been working in liaison with the service user forum to make further improvements.

**Paragraph 134**
**The CPT recommends that proactive steps be taken by staff to encourage patients to access the outdoor garden every day.**

204. Chase Farm Hospital became a no smoking service on 17 January 2016, leading to significant changes in the use of the garden space. Outdoor gym equipment has been introduced, and each ward has a minimum standard for fresh air breaks for its patients. The wards have a range of four to six fresh air breaks every day agreed with service users. All wards are encouraged to be flexible where possible in terms of extending access times as requested, particularly at times when the weather is warmer. Service users are members of the service-wide Inpatient Management Meeting which reviews all issues raised on an ongoing basis. The hospital is not aware of there being any particular ongoing issues around the level of access to the garden for fresh air breaks, however they will continue to monitor. The hospital is considering the introduction of facilitated garden tours for service users who currently do not have leave to do so.

**Paragraph 135**
**The CPT considers that daily access to outdoor exercise / garden is a right for all patients and every effort should be made to facilitate such access. Moreover, walking outside in a garden area is known to have beneficial effects for a person's physical and mental well-being and should generally be an integrated part of every patient's care plan. Particular attention should be paid to the design and equipment of the garden for all seasons.**
**The CPT recommends that steps be taken at Ashworth Hospital to offer all patients in high dependency wards daily access to the ward gardens and to adapt the design and equipment in the garden to the needs of the patients.**

205. The garden areas on the high dependency wards at Ashworth Hospital are suitable for the needs of the majority of patients. The hospital is currently exploring options to reduce the risks associated with the movement of LTS patients from their rooms to the garden areas. This will

ensure that LTS patients can also benefit from daily access to the ward garden. All patients have an individual care plan that explicitly highlights access to fresh air. This is being implemented by giving priority to sufficient staffing at a dedicated time each day so that the gardens can be unlocked.

**Paragraph 136**
**At Broadmoor Hospital, there was a carceral feel to the environment on the wards visited which ran counter to the therapeutic purpose of the hospital. However, as mentioned above, the hospital is being re-developed and the new hospital should be opened in 2017.**
**The CPT would like to receive detailed information about the material conditions and design of the high dependency wards and the intensive care ward in the new hospital, including any special arrangements for patients in seclusion or LTS. It would also like to be informed about the arrangements for outdoor exercise and the design of the garden areas.**

206. The new hospital accommodation has been built in accordance with the High Secure Building Design Guide: Overarching Principles for Ashworth, Broadmoor and Rampton, published by the Department of Health in 2010 (additional information is provided separately). To assist with both patient and staff familiarisation when moving from ward to ward, the layouts across all ward areas are the same. General ward design principles for the high dependency and intensive care wards include the following:
- Both ICU (Intensive Care Unit) and Intensive Support Assertive Treatment (ISAT) wards have an exercise room equipped with a rowing machine and static bicycle;
- All patients will have access to a personal food locker and a refrigerated locker;
- There is a quiet day room and a TV day room;
- A resource room is available to all the ICU and ISAT wards (one room shared between two adjacent wards) which can be used for occupational therapy type patient activities;
- Every ward has a room for social visits. This room has an adjacent courtyard for visits outside when appropriate, furnished with comfortable garden furniture;
- The wards in Jubilee House ICU and Treatment Resistant ISAT also have the benefit of an interconnecting screen between the social visits room and the adjacent multi-function room which would enable a non-contact social visit to take place on the ward;
- The ICU ward has additional space which can be used flexibly – depending on patient needs.

207. Bedrooms in the high dependency and intensive care wards are all designed to include the following:
- en-suite facilities;
- a view out across gardens to the adjacent countryside;
- Shower water temperature which can be adjusted by the patient (within set parameters);
- Room temperature which can be adjusted by the patient (within set parameters);
- Natural ventilation which can be adjusted by the patient;
- Two nurse call buttons – one at the bed head and one in the en-suite;
- A secure hatch in the door of every bedroom to enable food and drink to be safely given to the most unwell patients;
- Every bedroom in the ICU or ISAT (High Dependency Unit - where patients can be cared for more extensively than on a normal ward, but not to the point of intensive care) wards has a television within a protective shroud;
- ISAT bedrooms are furnished with a fixed bed, desk, wardrobe, shelves and a lightweight, but robust bedroom chair;
- The ICU ward has a range of bedrooms which offer flexibility depending on the patient's needs: fixed bed, desk, shelving and a bedroom chair (if appropriate); demountable bed (that is, able to be removed from the bedroom) only – enabling a patient to have a mattress only if risk assessment requires it.

208. ICU and ISAT wards each have a seclusion room and a seclusion suite. The suite comprises of:

- A bedroom, dayroom and external space for access to fresh air;
- The seclusion room and bedroom will have piped radio/music;
- The seclusion day room will have TV in a protective shroud;
- All the seclusion rooms are monitored by CCTV;
- Both have en-suite facilities;
- Both have cooling to the rooms.

209. Every ward has been designed to have ward level gardens access, they also include:

- ICU ward has the benefit of 3 separate gardens;
- Treatment Resistant ISAT ward has 2 separate gardens;
- All other ISAT wards have 1 large garden;
- All gardens are equipped with a number of comfortable bench seats;
- The gardens have a range of lawned areas, flower/shrub beds and hard surface area.

**Paragraph 139**
**The CPT recommends that the United Kingdom authorities, in close consultation with the high secure hospitals, review the use of night-time confinement, including staffing levels, in the light of the above remarks.**

210. The High Security Hospitals (Arrangements for Safety and Security) Directions 2013 apply to providers of high security hospitals and set out the requirements for providers to make sure they have robust arrangements for safety and security, including security at night. The Department of Health conducted a public consultation, including patients in the high security hospitals, on these Directions. The high security hospitals engaged patients on these arrangements when they were introduced. Since introducing these arrangements, the National Oversight Group for High Secure Services has required the high security hospitals to provide ongoing monitoring reports on the implementation of these arrangements. The use of night time confinement will be reviewed by the Department of Health and the high secure hospitals in the light of the above remarks through the National Oversight Group.

**Paragraph 142**
**The CPT would like to be informed about the proposed developments at Ashworth Hospital to provide more therapeutic and rehabilitative activities on the wards, and the steps being taken to ensure that patients are able to access activities as planned.**

211. A dedicated piece of work was undertaken with regards to the provision of rehabilitative activities at Ashworth Hospital to meet the changing needs of the population to a younger, more acutely unwell and shorter stay cohort of patients. In summary, this comprised:

- greater in-reach by rehabilitation staff into wards, especially high dependency;
- each high dependency ward has a named Occupational Therapist;
- introducing activity support workers (band 3/4), one on every ward, with 2 on each high dependency ward, whose remit is to develop robust and meaningful programmes of activity at ward level, to link in with the wider rehabilitation service.

212. Changes to the rehabilitation service have given rise to more ward based sessions for those patients who find it difficult to access centralised activities. The hospital is meeting the contracted 25 hours of meaningful activity per week for patients. Ashworth Hospital will continue to monitor the success of this process through a robust data monitoring and reporting system for meaningful activity.

**Paragraph 145**
**The CPT recommends that the United Kingdom authorities provide the necessary resources to enable Ashworth and Broadmoor Special Hospitals to increase their nursing staff levels in order to offer all patients access to proper safe and therapeutic nursing care during the day.**

213. NHS England commissions services at the 3 high secure hospitals to a common clinical standard that ensures safe nursing care throughout the day at each site. All three high secure hospitals are actively recruiting new staff, and making improvements in the ways they engage staff to help improve staff morale and retention. As a result of recent Care Quality Commission inspection findings, both Broadmoor and Rampton have action plans in place to continue to make improvements in staffing numbers. Very robust and well tested contingency and Major Incident Plans are in place to ensure safety is maintained at all times so that if, for unplanned reasons, either Ashworth or Broadmoor are not fully staffed the safety of the patients will not be compromised. Broadmoor Hospital is working with NHS England to ensure that Broadmoor can maintain staffing levels which enable the full range of therapeutic interventions for patients.

**Paragraph 147**
**The CPT recommends that every measure of seclusion be diligently recorded in the restraint register, notably: the start and end of the measure, any time offered out of seclusion to the patient, the reason for initiating seclusion and cogent reasons for continuing seclusion beyond 24 hours. The name of the persons authorising and ending seclusion should also be recorded.**
**It goes without saying that the existence of a systematic recording system would allow for a proper monitoring of the restraint and seclusion procedures and would ensure that a complete picture of resort to such measures is available.**

214. The hospitals' own policies and the MHA Code of Practice require the recording of all episodes of seclusion and restraint, to include the decision, who authorised the decision and the reason for it, how the intervention was implemented and how the patients responded, the start time and date and observations throughout. This information is readily available within the service.

215. The information noted in the recommendation is routinely recorded. The hospital carries out regular audits of seclusion information and documentation in order to ensure that these are of a satisfactory nature. The hospital has also introduced a system to upload written observation sheets onto an electronic patient record system (Rio).

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

**developed a relation. Indeed, this is what the CPT's delegation observed on Tamarind ward when staff had to enter a seclusion room holding a patient with a history of violence. Further, the CPT considers that the three-nurse human shield leads to an increase in tension and may hamper proper communication between the patient and the doctor.**
**The CPT would appreciate the observations of the United Kingdom authorities and Chase Farm Hospital on the above remarks.**

216. Safeguarding is an important part of providing mental health care. There is however, a need to balance the needs of service users and to ensure staff and patient safety in challenging environments. There are times when restrictive interventions may be required to protect staff or other people who use services, or the individuals themselves and each situation will be based on the judgement of the establishment's health care professionals.

217. The Positive and Proactive Care 2014 Guidance emphasises the need to identify causes of challenging behaviour, and to work to prevent a situation from escalating to a point where restrictive intervention is needed. It also highlights the need to use the least restrictive measure possible, and to follow the principles of positive behaviour support. Furthermore, it sets out the principles under which lawful restraint interventions must be performed, including the real possibility of harm to the person or to staff, the public or others if no action is undertaken, and that the nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.

218. Some services support people whose needs and histories mean that individuals can reasonably be predicted to present with behaviours that challenge. The guidance emphasis the need for an individualised approach to each patient, which means it is up to the healthcare staff involved to determine the number of staff required to manage the risk, this may include the use of a three-nurse human shield (where assessed as appropriate).

219. Chase Farm Hospital has a robust process in place for the management of safeguarding, which includes alerts, management meetings, action plans, user involvement, thematic reviews, lessons learnt and cascading evidence. The hospital has identified key staff in place as per the requirements of the Code of Practice and the Positive and Proactive Care guidance. The relevant staff will make every effort to ensure that wherever possible staff familiar to the patient will be involved with any intervention, and that the number of staff involved is proportionate to the risk posed by the patient.

220. As mentioned in the response to paragraph 118 above, in October 2017, NHS Improvement and the Care Quality Commission launched a national mental health patient safety initiative. It will be supported by a national mental health quality improvement programme, led by NHS Improvement and informed by CQC intelligence as part of a joint strategic objective to ensure a shared view of quality. All mental health providers will be involved in this initiative, which has an emphasis on shared learning and the embedding of sustainable quality improvement approaches as integral to the way mental health services are delivered across the sector. The initiative will include support for Trusts to reduce use of restraint.

**Paragraph 149**
**The CPT recommends that debriefings of patients be systematically carried out and recorded. Further, the CPT would like to be informed whether all patients were properly debriefed and to what extent the debriefings fed into the patient's treatment plan and the seclusion policy on the wards at both Ashworth and Chase Farm Hospitals.**

221. The recommendation is noted, and the comments in relation to debriefings following a period of seclusion will be considered as part of the overall review of seclusion and LTS (as explained in the response to paragraph 152 below). Both hospitals are continuing to make improvements in this area.

222. At Ashworth Hospital, all debriefs following episodes of seclusion are monitored by the Restrictive Practice Monitoring Group to ensure compliance with policy and Code of Practice. A March 2017 inspection of the hospital by the Care Quality Commission found that the recording and monitoring of seclusion and long term segregation to be compliant with the MHA Code of Practice.

223. Debriefings take place with all service users and staff at Chase Farm Hospital, both in terms of immediate conversation at the point of seclusion termination and during the following clinical team review. The service has recently been working on a seclusion checklist which sets out all the minimum requirements for staff members and clinical teams to observe. There is an expectation (set out in the checklist) that a formal documented opportunity for debrief takes place, and that treatment plans are updated where necessary. This was ratified at the Inpatient Management meeting in July 2017.

**Paragraph 152**
**The CPT recommends that the application of LTS in Ashworth and Broadmoor Hospitals be reviewed urgently with a view to reducing resort to the measure and radically cutting the amount of time patients are held in LTS.**

224. The Department of Health is working with the three high security hospitals, NHS England and the Independent Clinical Advisor to the National Oversight Group (NOG) for High Secure Services to undertake a review of seclusion and LTS at the three hospitals. The CPT's comments will be considered as part of the overall review.

225. Both hospitals have made progress in reducing the number of patients held in LTS since the CPT's visit. A project was undertaken between the three High Secure Hospitals to understand the use of LTS and to develop best practice guidelines in the use of LTS. The ultimate aim of the project was to minimise the frequency and duration of LTS and to ensure that those subject to its use receive the best care and treatment they can, in a safe and therapeutic environment.

226. Ashworth Hospital has recently approved a "zero LTS" initiative, whereby they are aiming to eliminate the use of LTS within the hospital. This is a long-term programme with specific target reduction of 20% of days confined year on year for each of the next three years. This has been agreed by the hospital management and will be implemented alongside the HOPE(s) model of care and barriers to change checklist.

227. The HOPE(s) model describes **H**arnessing the system through key attachments and partnerships; providing **O**pportunities for positive behaviours, meaningful and physical activities; identifying **P**rotective and preventative risk and clinical management strategies; **E**nhancement of coping skills of both staff and patients and attention to maintenance. Throughout engaging in these tasks, the (**S**)ystem needs to be managed and developed to provide support throughout all stages of the approach.

228. Broadmoor Hospital is using a co-ordinated approach to reduce LTS which includes localised plans that identify a reduction strategy. In addition, they have recruited a Clinical Nurse Specialist whose sole role is to support and oversee a reduction in LTS. Weekly meetings to monitor local (ward) LTS take place to monitor practice and share good practice.

229. The High Secure Services restrictive practice implementation and reduction plan for Broadmoor was formulated by Nursing and PMVA (Prevention Management of Violence and Aggression) leads for 2016/2017. The plan incorporates a pilot project on a high dependency ward within the personality disorder pathway and an intensive care ward within the mental illness pathway. The plan is underpinned by the principles set out in the Barriers to Change Checklist and HOPES model which aim to aid planning and progress to end segregation.

230. Additional wards were introduced to the initiative in the course of 2017.

**Paragraph 155**
**The CPT wishes to be informed of the steps being taken at Ashworth Hospital to end the LTS of the two above-mentioned patients and to receive information on the concrete therapeutic interventions and activities offered to these two patients in the second and third quarters of 2016.**

231. Detailed information about individual patients has been provided to the CPT separately from this overall response.

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

232. The recommendation is noted, and the comments in relation to access to outdoor, preferably grassed garden areas for at least one hour per day for LTS patients at Ashworth and Broadmoor Hospitals will be considered as part of the overall review of seclusion and LTS (as previously explained in the response to paragraph 152).

233. At Ashworth Hospital access to fresh air is explicitly highlighted in each patient's care plan, with all efforts made to facilitate this on a daily basis. The hospital is considering environmental changes to the HDU wards that will allow easier and less risky egress for LTS patients from the ward into the garden area.

234. At Broadmoor Hospital, all patients in LTS are offered access to activities including garden access subject to a dynamic risk and mental state assessment. There are external ward areas that patients can access but not all areas are grassed. However, subject to a risk assessment patients can have access to the hospital terrace which is a grass tree lined area.

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

235. The recommendation is noted, and the comments in relation to offering and recording meaningful activities at Ashworth and Broadmoor Hospitals will be considered as part of the overall review of seclusion and LTS (as previously explained in the response to paragraph 152). Improvements have already started at both hospitals.

236. Currently a range of activities and therapies are provided which will improve and maintain the wellbeing of the patient, not only focusing upon recovery but gaining life skills. It should contribute

towards the recovery and treatment of the patient and should enhance the quality of life by meeting identified needs. Each activity is appropriately considered for each individual taking into account their unique needs and any risks associated with the requested or offered activity.

237. At Ashworth Hospital patients in LTS all have individual care plans that define what constitutes meaningful activity for each individual. This process of recording meaningful activity is monitored to ensure accuracy and relevance (that is, to ensure that the activity is therapeutic and meaningful for that patient) and is reported on to the commissioners.

238. The LTS reduction pilots have included increasing the amount of meaningful activity for patients. The National Oversight Group and Clinical Secure Practice Forum have reviewed the definitions of meaningful activities. These have been adopted by Broadmoor Hospital, and recirculated to all staff to aid in recording patient's activity. The Reducing Restrictive Practice initiative emphasises the importance of activity and supports wards in developing and carrying out an activity plan.

**Paragraph 160**
**The CPT recommends that hospital staff should avoid as far as possible communicating with patients on LTS through the hatches of the door and that all medical and therapeutic interventions should be conducted face to face. Meals should be served to patients in a dignified manner.**

239. The recommendation is noted, and the comments in relation to face to face communication with patients in LTS will be considered as part of the overall review of seclusion and LTS (as previously explained in the response to paragraph 152).

240. At Ashworth Hospital face to face communication with seclusion and LTS patients is now explicitly taught on the hospital's personal safety training and is highlighted in LTS care plans to be undertaken whenever risk allows. Patients' meals are served to them on a face to face basis, again where the balance of risk allows.

241. Broadmoor Hospital supports this statement and promotes open door reviews of LTS. This is understandably done on a risk assessed basis. In addition, attempts are always made to avoid providing meals through the door hatch and this should only be done in exceptional circumstances. Broadmoor Hospital is currently developing an electronic ("RIO") system that will enhance monitoring open door LTS reviews and we will continue work to increase the percentage of open door reviews. Design improvements have been made in the new hospital to aid better communication with patients when face to face communication and delivery of meals is not appropriate following a risk assessment.

**Paragraph 161**
**The CPT's delegation met and observed a number of very committed and professional staff on wards managing LTS patients. Notable mention should be made of the PIPS programme at Ashworth to manage LTS patients and of the Cranfield ward manager at Broadmoor whose policy was to challenge why a patient was locked in his room. The graduated approach on this ward entails managing patients on LTS progressively by initially taking them out of their rooms in holds requiring six staff and then reducing to four and two staff and finally no holds as cooperation and trust is developed. That said, as mentioned above, the CPT is concerned that patients whose conditions require the highest risk and the greatest needs are being denied sufficient human contact which is likely to reinforce their isolation and the symptoms**

**of their illness and lead to a deterioration in basic social skills. In the CPT's view, LTS over a long period cannot be considered to be supporting the recovery of the patient but is more likely to further damage their health. Such a situation results in patients effectively being held in conditions which may be described as degrading. The CPT would appreciate the comments of the United Kingdom authorities and of the Ashworth and Broadmoor Hospitals on this subject.**

242. The issue of patients being held in LTS for long periods forms part of the overall review of seclusion and LTS (as previously explained in the response to paragraph 152), and the resulting ongoing improvements being brought in. However, there are a small number of patients whose historic risks are so high (for example, completed or attempted inpatient homicide, with little or no prior behavioural disturbance) that, although superficially settled, cannot be managed out of LTS. These are patients who would be managed in segregation in the Closed Supervision Centres if they were not in high secure hospitals. For these patients, optimising their underlying mental states and maximising their quality of life are the primary objectives. Access to daily fresh air, daily periods of meaningful social contact and structured rehabilitative activities are available and optimised. There are also groups of patients with severely damaged personalities whose ability to tolerate interpersonal and social contact is extremely limited for whom LTS at times is appropriate.

243. As previously explained, the three high secure hospitals are working closely together with a shared aim of significantly reducing the number of patients held in LTS and sharing best practice. Ashworth Hospital has developed the HOPE(S) clinical model of care to reduce the use of LTS, and has provided training for both Rampton and Broadmoor hospitals resulting in a positive reduction of LTS and an increase in meaningful activity on their pilot wards. The trust has made a commitment to reduce the use of LTS to zero. Following LTS training from Ashworth Hospital, Rampton Hospital has reduced the numbers in LTS and implemented the No Force First model which has seen a reduction in the use of restrictive practices and improved relations between staff and patients. Following the training from Ashworth Hospital, Broadmoor Hospital has produced best practice guidance for staff, had the use of LTS independently reviewed by a team from Ashworth Hospital, and has significantly reduced the numbers held in LTS since the CPT's visit.

**Paragraph 162**
**The CPT recommends that the documentation regarding the reasons for initiating and continuing LTS be fully recorded in the patient's file and that a clear pathway out of LTS should be drawn up and the patient fully informed about such a care plan.**
**Further, it recommends that in each hospital a formal register of all incidents of seclusion and long-term segregation be established. This register should include a record for each incident, notably time commenced, who authorised the measure, the reason for the measure being commenced. Further, each review of the measure (by nurse, doctor or consultant) should include the time, date and signatures (and professional registration numbers) and the termination of the measure should record the time, date and name of the authorising person.**

244. Patients do not enter LTS without a clinical decision being recorded by the multidisciplinary care team which notes the reasons for initiation and continuation, the date of commencement and who authorised the LTS. All patients are then subject to internal checks and safeguards through the hospital's governance processes, and internal and external (independent reviews of LTS) scrutiny through the safeguards put in place by the MHA Code of Practice. At any point the data for individual patients and data for all LTS or seclusion episodes over a defined period (months to years), can be reviewed and retrieved as a formal register. We will continue to consider improvements in the ongoing review of LTS (as previously explained in the response to paragraph 152), particularly how to ensure clear recording and transparency of MDT decisions are part of standard practice.

**Paragraph 163**
**At the time of the visit the three-monthly review by an "external hospital" had not yet been put into practice at Ashworth Hospital as there was some dispute as to whether the external hospital should be an institution outside of the Mersey Care Trust. At Broadmoor Hospital, an expert external review of 12 patients on LTS had taken place in November 2015 but not thereafter.**
**The CPT trusts that the question of an external hospital has now been clarified and that three-monthly reviews by an external hospital are now being conducted regularly for LTS patients at both Ashworth and Broadmoor Hospitals. Further, it would be interested to receive information on which hospital service is carrying out the review respectively for Ashworth and Broadmoor Hospitals, the nature of the review and the outcome of the reviews to date of all LTS patients.**
**The CPT also welcomes the Mersey Care Trust's policy commitment to request a full clinical review from peers from other similar services for those patients held in LTS for longer than 12 months and wishes to receive details of the first such review and its outcome concerning all patients held in LTS longer than 12 months.**
**The CPT recommends that at Broadmoor Hospital a similar policy of a peer review of LTS patients after 12 months be put in place. Further, it would be like to receive details of the first such review.**

245. Since January 2017 the three High Secure Hospitals have implemented a reciprocal arrangement to independently review LTS. At Ashworth Hospital, this work has commenced and will continue in order to meet the requirements of the MHA Code of Practice at paragraph 26.156 which requires a 3-monthly review by an external hospital, which should include a discussion with the patient's IMHA (Independent Mental Health Advocacy), if they have one, and a representative of the local commissioning authority.

246. Broadmoor Hospitals LTS patients were reviewed in December 2016 by the Bracton Centre (Oxleas NHS Trust) and in March 2017 by Ashworth Hospital (Mersey Care NHS Trust). An additional review took place in July, and a further review is planned for October 2017. Broadmoor Hospital currently review all patients subject to LTS on a monthly basis at their SMARG (Seclusion Monitoring and Review Group) meeting. This is attended by senior clinicians from within the hospital, the NHS England commissioner and Care Quality Commission. Each patient is discussed and the reasons for remaining on LTS are reviewed. In addition, LTS reviews are carried out by all the consultants within the hospital and therefore each patient subject to LTS will have a number of reviews by clinicians other than the responsible clinician for that patient. In addition, catchment area forensic services are invited to the 6 monthly Care Programme Approach meetings where care is discussed in detail.

**Paragraph 164**
**The CPT recommends that the United Kingdom authorities introduce the right for a patient to appeal the measure of LTS to the MHT and that the MHT be empowered to review the measure of LTS ex officio after a defined period.**

247. The remit of the First-Tier Tribunal (Mental Health) is to determine the detention of a person under the MHA and it has the power to discharge a person from detention if necessary. LTS is covered by the MHA Code of Practice which provides for regular multi-disciplinary teams to review the ongoing need for LTS. The Code of Practice also requires reviews by an external hospital should the LTS extend beyond 3 months to ensure independence in the review process. The Department of Health is working with the three high security hospitals, NHS England and the Independent Clinical Advisor to the National Oversight Group for High Secure Services to undertake a review of long term segregation at the three hospitals.

**Paragraph 165**
**The CPT recommends that once there is no longer a necessity for a person to be kept in LTS arrangements should be put in place to ensure that the patient can be integrated into general ward life rapidly.**

248. We take note of the recommendation. Broadmoor Hospital is currently working to continue the improvements in all practices relating to LTS, and agrees that when LTS is no longer required patients should be re-introduced to the open ward environment as soon as possible. As previously noted the hospital has recruited a Clinical Nurse Specialist whose sole role is to support and oversee a reduction in LTS. Weekly meetings to monitor local (ward) LTS take place to monitor practice and share good practice.

**Paragraph 166**
**The CPT recommends that due care be taken in the re-design of the wards at Ashworth Hospital to build in a therapeutic environment adapted to the needs of LTS patients.**

249. Ashworth Hospital has a long-term plan to redevelop high dependency wards with a particular remit to build therapeutic environments which can be adapted to the needs of LTS patients but are not specific to them and so does not inadvertently create environments which increase the likelihood of isolation from other patients.

250. The CPT's comments in relation to the environment which LTS patients are held in will be considered as part of the overall review of seclusion and LTS (as previously explained in the response to paragraph 152).

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

251. Within the redeveloped Broadmoor Hospital, each ward has access to at least one garden, which has grassed areas. Patients who are subject to LTS invariably are located within their bedrooms, unless they are required for a period to be managed in a more sterile area because of their presentation. The items they have access to within their bedroom is dependent on the assessment of their risk and management of that risk. Each bedroom within the new build has an en-suite bathroom, as do all the bedrooms within the Paddock Centre. The bedrooms do not have separate day areas and do not have separate access to fresh air, except within one area. Although there are four seclusion suites within the new build, which have separate day and bed areas, it would not be practical to incorporate separate day areas for each patient who is subject to long term segregation. The design of the new building will provide a more pleasant and stimulating environment for patients.

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

252. Access to primary health care and dental services for LTS patients at Ashworth Hospital are explicitly highlighted in each patient's individual care plan. These care plans are regularly updated by care teams and monitored by the Restrictive Practice Monitoring Group on a regular basis.

253. At Broadmoor Hospital, all patients subject to LTS have access to primary health care and dental services. Patients will access the Physical Health Department to visit a clinic or the GP. In

addition, the Physical Health nursing team and GP will visit the ward. Patients receive at least twice yearly physical health reviews and monthly NEWS (National Early Warning Score) assessment. NEWS is a scoring system in which a score is allocated to physiological measurements already undertaken when patients present to, or are being monitored in hospital. There is a diabetic specialist nurse who visits once a week, who will visit patients subject to LTS on the wards, and an endocrinologist who visits the hospital every 6-8 weeks. Other specialists visit as and when required. A dentist and podiatrist will visit patients in LTS on a weekly basis.

**Paragraph 171**
**The CPT recommends that the deployment of the PIP's team in full PPE should only be considered as a last resort, for instance where a patient has a weapon and poses a real threat to the safety of other persons or to himself.**

254. The CPT's general recommendation will be considered as part of ongoing national programme to reduce the use of restrictive practices in mental health services.

255. The High Secure Hospitals always consider intervention in PPE as a last resort but this will not only be when a patient has a weapon. The CPT should note that in recent times, staff have suffered near fatal or life changing physical injury by patients where no weapons have been used. Consequently, whilst the High Secure Hospitals take all steps to be proportionate in their response to potential violence, they also have a responsibility and duty of care to their staff.

**Paragraph 173**
**The CPT wishes to receive the observations of the authorities on this matter and to be informed of whether any issues were raised by the patient in the subsequent debriefing.**

256. The use of restraint and protective equipment is always considered in every individual case and will be used in a lawful, necessary and proportionate manner.

257. Broadmoor Hospital have reviewed this case and confirmed that on this occasion, the risk remained sufficient to proceed with the three additional staff members present, as the patient had very recently presented with significant risk and impulsive behaviour. No issues were raised by the patient about this in the subsequent debriefing.

**Paragraph 175**
**The CPT recommends that the relevant legislation should be amended so as to require an immediate external psychiatric opinion in any case where a patient does not agree with the treatment proposed by the establishment's doctors; further, patients should be able to appeal against a compulsory treatment decision to the Mental Health Tribunal and the patient should be informed in writing of this right.**

258. One of the guiding principles of the MHA Code of Practice is that patients should be involved in their care as much as possible. The Code of Practice also requires mental health providers to ensure that patients understand and can consent to treatment wherever possible. Where treatment is being provided without the patient's consent, mental health providers must communicate this to the patient and their carer, family and independent mental health advocate where appropriate. The Code of Practice is clear that multi-disciplinary teams should always consider what is in the patient's best interest when making decisions about treating them without their consent. Decisions about consent are recorded.

259. There are provisions within the MHA and guidance in the Code of Practice about treatments that require special approval by qualified Second Opinion Approved Doctors such as electro-convulsive therapy to provide extra safeguards that treatment is in the best interests of the patient.

260. Mental Health providers must make information available to patients in a format and language that they understand; care should be taken to ensure patients understand their rights in terms of consenting to treatment, and that they fully understand the procedures for raising concerns and/or

complaints about their treatment. This includes being able to raise concerns and complaints with the Care Quality Commission about their care and treatment which may be investigated where appropriate. The remit of the First-Tier Tribunal (Mental Health) is to determine the detention of a person under the MHA and it has the power to discharge a person from detention if necessary. Whilst we believe that these arrangements provide sufficient safeguards, we are keen to continue to make improvements where possible and the CPT's comments will be taken into account.

261. Please refer to the response to paragraph 124 above, for comments on appeals against compulsory treatment decisions.

262. The Government has commissioned an independent review of the Mental Health Act and associated practice. The review will report by autumn 2018.

**Paragraph 176**
**The CPT recommends that relevant legal provisions be amended and that in the meantime, the Mental Health Tribunal institute a practice of yearly reviews for all patients placed involuntarily in hospital. Further, all patients transferred from either prison or from a less secure hospital should automatically trigger a review by the Mental Health Tribunal of the transfer measure.**

263. Currently, the detention of patients under civil powers is monitored and reviewed by hospital managers, which must make referrals to the Mental Health Tribunal at least every three years. Patients have a right to refer to the tribunal in the first six months of detention, and annually thereafter. The Secretary of State for Health may make a discretionary referral at any time. The MHA does not give power to the Tribunal to consider the conditions in which a patient is kept; the Tribunal's consideration is currently restricted solely to whether the criteria for detention are met.

264. Restricted patients (that is, mentally disordered offenders who are subject to the special restrictions set out in section 41 of the MHA) may apply to the Tribunal in the second six months of their detention in hospital, and annually thereafter. Additionally, patients who have been transferred from prison to hospital have the right to have their cases reviewed by the Tribunal in the first six months after they are transferred. The Secretary of State for Justice has a discretion to refer the case of a restricted patient to the Tribunal at any time, and where a restricted patient has not had their case considered by the Tribunal within the last three years, the Secretary of State must make a referral.

265. As indicated in previous responses above, the Government has commissioned an independent review of the Mental Health Act and associated practice. The review will report by autumn 2018.

**Paragraph 179**
**The CPT reiterates its recommendation that the United Kingdom authorities reconsider their policy of indefinite immigration detention.**
**Further, it would like to receive detailed information on the measures taken to address the Shaw Review recommendations.**

266. Although there is no fixed time limit on immigration detention in the UK, published Home Office detention policy is clear that there is always a presumption of liberty and that detention should only ever be used sparingly, and domestic case law is clear that detention powers can be exercised only if there is a reasonable prospect of an individual's removal from the UK within a reasonable timeframe. However, detention may be prolonged where individuals fail to comply with the re-documentation and/or removal processes, or submit very late, or multiple applications or appeals, or pose a risk of harm to the public.

267. Once an individual has been detained their detention remains under review at least at monthly intervals to ensure that it remains lawful and in line with Home Office policy. Where this no longer applies, they will be released from detention. More specifically, if at any point, it becomes clear

that there is no longer a realistic prospect of removal from the UK within a reasonable period a person's detention will end at that point. Detainees can also apply for release on immigration bail or challenge the legality of their detention in the courts via Judicial Review or application for a writ of habeas corpus and the courts have the power to order release if detention is no longer lawful.

268. Following consideration of views expressed during the passage of the Immigration Act 2016 that there should be a greater level of judicial oversight of immigration detention, the Act was amended to impose a duty on the Secretary of State to arrange consideration of bail before the First-tier Tribunal at four months from the point of initial detention, or the date of the last Tribunal consideration of bail, and every four months thereafter. These automatic bail referrals, when in operation, will ensure that individuals who do not make a bail application themselves for whatever reason will have independent judicial oversight of their ongoing detention.

*Shaw Review*

269. The UK Government accepted the broad thrust of Mr Shaw's recommendations. In particular, the UK Government accepted Mr Shaw's recommendations to adopt a wider definition of those considered at risk of harm in detention, including victims of sexual violence, individuals with mental health issues, pregnant women, those with learning difficulties, post-traumatic stress disorder and elderly people, and to recognise the dynamic nature of vulnerabilities.

270. An "adults at risk" concept has been introduced into decision-making on immigration detention with a clear presumption that people considered to be at risk should not be detained, building on the existing legal framework. Section 59[15] of the Immigration Act 2016 placed part of the policy on a statutory basis. The policy came into force on 12 September 2016. It operates on the basis of a case-by-case evidence-based assessment of the appropriateness of the detention of any individual who is considered in some way vulnerable, balanced against the immigration control considerations that apply in their case (for example, proximity of removal, risk of absconding, threat of harm to the public). An individual considered to be "at risk" will be detained only when the immigration control considerations that apply in their particular case outweigh the risk factors.

271. Section 60 of the Immigration Act 2016, which came into force on 12 July 2016 places a statutory 72-hour time limit on the detention of pregnant women for the purposes of removal/deportation, extendable to up to an absolute maximum of one week in total with Ministerial authorisation. The Act is clear that a pregnant woman will be detained for the purpose of removal only if the Secretary of State is satisfied that she can be removed from the UK shortly or if there are exceptional circumstances which justify the detention. It also places a duty on those making detention decisions in respect of pregnant women to have regard to the woman's welfare. Processes are in place to support the operation of the restrictions. Separately, a new Detention Services Order on the care and management of pregnant women in detention was published in November 2016[16] to replace interim guidance issued in June 2016.

272. A more detailed mental health needs analysis in IRCs, using the expertise of the Centre for Mental Health, has been carried out and was published in January 2017[17]. NHS commissioners have used this analysis to support a review of the Mental Health and Learning disability specification for IRC's to be delivered against from 2017. Our approach to delivery of Mental Health services across the estate will also be compliant with the 5 Year Forward View for Mental Health published in February 2016[18].

---

[15] http://www.legislation.gov.uk/ukpga/2016/19/section/59/enacted
[16] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564431/DSO_05_2016_-_Pregnant_Women_In_Detention.pdf
[17] https://www.centreformentalhealth.org.uk/immigration-removal-centres
[18] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

273. In response to a number of other recommendations, the Home Office has also implemented an internal Detention Gatekeeper team to oversee admissions to the detention estate going forward. With effect from February 2017, it has also established regular Case Progression Panels to review all cases of those in immigration detention, quality assuring detention decisions and suggesting actions to ensure that cases are progressed at pace.

274. The UK Government has invited Stephen Shaw back to review the implementation of his previous report. This was announced in early 2016 and he started work on 4 September 2017.

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

275. All foreign national prisoners are risk assessed at the end of their sentence to determine their suitability for a transfer into the immigration detention estate, ensuring that the security and safety of the estate is maintained. Assessment is based on factors such as the individual's criminal history, behaviour in custody and any medical needs. Individuals considered suitable for the immigration detention estate will be placed on a waiting list for transfer but will remain in prison accommodation pending that transfer. For those not considered suitable for transfer to the immigration detention estate at the end of their sentence, their continued detention will, as with all immigration detainees, remain under review at least at monthly intervals. This will include consideration of whether there has been any change in circumstances which may make them suitable for transfer. Individuals may also request a transfer from prison accommodation to the immigration detention estate at any time.

276. Immigration detainees held in prisons are held in conditions equivalent to remand prisoners.

**Paragraph 185**
**There was a variety of activities on offer to detainees, such as English and IT-courses, Gardening and Arts & Crafts classes; the IT room contained 21 terminals, all with internet access, and was open from 9 a.m. to 9 p.m. Detained persons could access games (such as table tennis, and board games), a gym, a multi-purpose sports hall and a "cultural kitchen". The centre also has a post room, a hair salon, a multi-lingual library, a cinema, different places of worship (a chapel, a mosque, a Sikh and Hindu religious room and a multi-faith room) and a kiosk-type shop and a clothes market. In sum, the activities available were very good for short periods of stay. However, there should be a broader range of purposeful activities (vocational and work) for persons staying for more than a few months. The CPT invites the UK authorities to develop such activities for the detainees concerned.**

277. An activity review at Yarl's Wood IRC has resulted in the introduction of new job roles, including shop and market assistants. Detainees can now take part in paid work in the cultural kitchen assisting other detainees to plan, prepare and cook meals.

278. Through Hibiscus (a charity providing support and specialist services to promote the welfare of detainees at Yarl's Wood) detainees are now able to attend sessions to improve their CV writing skills and First Aid (Red Cross). Changes have been made to improve the education provided with access to online learning supported by a Tutor.

279. A detainee survey has been completed and an action plan compiled to further enhance the activities provision based on detainees' feedback.

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

280. The menus are currently on a 4-week cycle and are provided separately. Changes are made to take into account cultural variations in the Yarl's Wood population. Additional information is provided separately.

**Paragraph 188**
**The CPT recommends that the management of Yarl's Wood ensure that the induction process properly identifies the language skills of women entering the Centre and that appropriate additional support is afforded to those women having no common language.**

281. An additional check has been added to the induction checklist for staff to review language spoken and ensure that it is correct. If an error occurs, it should be rectified at this point to ensure appropriate communication with the resident.

**Paragraph 189**
**The CPT recommends that the United Kingdom authorities review the procedures regulating the transfer of women immigration detainees to avoid them travelling at night and arriving at Yarl's Wood between the hours of 11 p.m. and 7 a.m.**

282. The Home Office and the escort contractor seek to avoid routine night time transfers. All proposed moves consider the impact on the care and welfare of individual detainees, including the time and length of the move. Night time moves are sometimes unavoidable due to high numbers of time-specific priority moves such as taking detainees to flights, court appearances, embassy appointments, and medical appointments.

**Paragraph 190**
**The CPT recommends that at least two of the cells in Kingfisher be made ligature-free and a partition be installed to screen the toilets from external observation.**

283. Rooms certified and used for removal from association are furnished with wooden wardrobes, desks and a toilet privacy screen. Since the inspection, the group of 8 cells/rooms in the area previously known as Kingfisher have been refurbished. The environment is now much softer, bars on the windows have been removed, doors have been replaced, and the appearance of the unit now provides a more supportive environment for detainees.

284. There are 2 ligature free rooms which are primarily used for temporary confinement but have been certified for use for removal from association. These are used for instances where detainees are violent or where their behaviour is unpredictable. These rooms do not currently have toilet privacy screens because of the need to monitor detainees' behaviour. Rooms used for both temporary confinement and removal from association do not have internal window latches. New doors have been installed and their handles have been risk assessed and are considered appropriate.

285. The use of this facility was reviewed, and the unit previously used for removal from association has been refurbished.

**Paragraph 191**
**Medical services were contracted to G4S by NHS England. Three general practitioners assured a daily, seven days a week, service and one of them provided an out-of-hours service. They were supported by nine nurses (of whom the equivalent of three were mental health nurses)**

**and three health care assistants. Three further nursing posts were vacant at the time of the delegation's visit. There were also two pharmacy technicians, a mental health support service and a clinical lead for the health care service. Once the vacant posts are filled, such staffing levels as regards general practitioners and nurses could be considered as sufficient for a detainee population of up to 400 persons. The CPT wishes to receive confirmation that the vacant posts have been filled.**

286. The UK Government cannot give confirmation that all the vacancies have been filled on a permanent basis. Yarl's Wood IRC uses local and agency staff who regularly work in IRC settings to ensure appropriate staffing levels at all times.

287. It remains a contractual responsibility of providers of healthcare services in IRCs to recruit staff to meet the demands of service delivery. In this way, the staffing levels observed by the CPT at the time of the visit were sufficient to safely meet the service needs, although it is noted that filling the vacant posts with permanent staff will continue to increase the clinical care available.

288. NHS England is working with Health Education England to develop career pathways and competency frameworks for all healthcare roles within the criminal justice system, including IRCs. This work is underway and is being scoped.

**Paragraph 192**

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

289. At the time of the CPT's visit the psychological service had been delivering a service for 3 months, it has now been in operation for more than 2 years. It has been well received by detainees, many of whom have left positive comments when they have ceased using the service. Some have reported that they have continued to use the techniques they learned from their sessions after having ceased to use the service. This is a clear demonstration of the application of the service specification, which requires the provider to offer a service which equips detainees with techniques to enable them to manage feelings and mood.

290. NHS England commissions Health Needs Analysis (HNA) which informs the commissioning of psychiatry sessions according to health needs expressed in these reports. The most recent HNA for Yarl's Wood was in May 2017. The assessment does not make any recommendation in relation to increased need for secondary care mental health services which would include psychiatry sessions. This will be kept under review through further HNAs when necessary.

**Paragraph 193**

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

291. The UK Government has noted the CPT recommendation and will consider this further.

**Paragraph 194**
**The CPT recommends that steps be taken to ensure that transfers to psychiatric hospital are carried out without delay and that the United Kingdom authorities review the necessity of systematically placing women from Yarl's Wood, who do not have the status of prisoners, on secure forensic psychiatric wards.**
**Further, it would like to receive a copy of the report commissioned by the Home Office for the Centre for Mental Health to conduct a mental health needs assessment in IRCs.**

292. The UK Government shares the Committee's view that transfers to psychiatric secure placements should take place as quickly as possible, and within 14 days. At Yarl's Wood transfers to secure mental health placements continue to be relatively few, and are mainly achieved within 14 days. The position is monitored by the local partnership board.

293. As previously noted, Department of Health Prison Transfer and Remission Guidance published in 2011 sets out best practice to achieve urgent transfers from prison to hospital within 14 days. The guidance also applies to those persons detained in IRCs. NHS England are currently reviewing the guidance, with a focus on ensuring that the most appropriate timescales are developed and implemented in relation to prison (and IRC) transfers and remission, considering clinical urgency and need. When it is necessary to transfer a detainee from Yarl's Wood to a psychiatric hospital for treatment they are placed in secure forensic psychiatric wards because whilst they are not prisoners they are detainees in lawful custody and therefore need to be placed in secure accommodation.

294. As requested, a more detailed mental health needs analysis in IRCs, using the expertise of the Centre for Mental Health, has been carried out and was published in January 2017[19].

**Paragraph 195**
**The CPT wishes to be informed in more detail of the steps being taken to address the conclusions made on Rule 35 in the Shaw report.**

295. The "adults at risk in immigration detention" policy, came into effect on 12 September 2016. The policy is predicated on a clear presumption that people who are at risk should not be detained. It strikes a balance between protecting vulnerable individuals and maintaining effective and proportionate immigration control. Revised guidance on Rule 35 was also issued on 12 September. The revised guidance includes the adoption of revised report templates to support improved reporting quality and improved consideration of reports. Under the adults at risk policy, a Rule 35 report is just one of the ways of providing evidence in respect of an individual's possible vulnerability.

**Paragraph 196**
**The CPT recommends that all nurses be provided with training on interviewing torture victims and that general practitioners should receive refresher training on a regular basis.**

296. NHS England delivered Rule 35 training for GPs who work in immigration removal centres in 2015 and are leading on the Rule 35 training of GPs planned for 2016/17.

297. The recommendation to train all nurses on interviewing torture victims will be assessed and considered by NHS England and the Home Office.

298. The providers of health services across the secure and detained estate are contractually (through the NHS Standard Contract) obliged to field competent, trained and informed staff, and therefore continuous professional development is scheduled into working practices. The revised mental health specification for delivery of mental health services across the detained estate requires services to deliver a trauma–informed service across all points of intervention. The revised specification has been through consultation which concluded in May 2017 and will be

[19] https://www.centreformentalhealth.org.uk/immigration-removal-centres

published in line with the commissioning cycle. To this end, we would expect that all staff have a degree of trauma-informed training to ensure a systemic understanding of trauma-informed engagement.

**Paragraph 197**
**The CPT recommends that training on inter-personal skills be provided on an ongoing basis, in particular as regards interacting with potentially vulnerable detainees. It would also like to be informed about the ongoing recruitment of custody officers and the gender breakdown.**

299. DCOs undergo a full day course on Conflict Management which is a HABC (Highfield Awarding Body for Compliance) Level 2 in Conflict Management which includes: differences between aggressive, passive and assertive behaviours; active listening; positive behaviours; triggers and Inhibitors (inhibitions in people that may be a barrier in a conflict situation); body language; tone of voice; conflict arising from a gap between expectations and delivery; control Measures in a conflict situation; self-positioning; techniques for 2 officers to deal with conflict without becoming over powering and threatening; the law surrounding use of force. The course is a full day, starting at 08:30 and running up to an exam at 16:00 - which is a multiple-choice exam and is certificated upon successful completion.

300. The service provider takes gender into account when recruiting DCOs and has adapted working hours in order to accommodate, for example, working mothers. The service provider is participating in job fairs and is currently exploring other avenues for advertising vacancies.

301. Overall, the staffing breakdown is currently 46% men and 54% women. The breakdown for operational staff is currently 48% men and 52% women.

**Paragraph 200**
**In the course of the 2016 visit, the CPT's delegation undertook a targeted visit to the Induction unit at Colnbrook Immigration Removal Centre, where detainees can now spend much longer than seven days, to see whether the poor conditions of detention observed in 2012 had improved.**
**The unit consisted of 50 double-occupancy rooms on three floors and was accommodating 77 men at the time of the visit. The rooms were adequately equipped, including with a call bell. However, the rooms were far too small (6m²) to accommodate two persons and many of the rooms were dilapidated and dirty. Once again, the delegation observed broken pipes, with water dripping into the rooms below, and water from the showers leaking onto the floors of the rooms.**
**Complaints were also received about the lack of hot water and infestations of vermin. The delegation noted that detainees were unlocked from their rooms from 8 a.m. until 9 p.m. and that during this time they could access the outdoor exercise yard freely. However, there were few activities for the detainees (a TV room and four computers with restricted access to internet and some sports equipment in the yard) and the common areas were in a poor state of repair.**
**The management of the centre acknowledged the poor state of the material conditions and referred to a refurbishment project which was scheduled to start in June 2016. Part of the project was intended to convert the rooms into single occupancy. The CPT has noted positively this information. However, in light of the fact that it received written assurances in February 2013 that the problems with the leaking pipes had been resolved and would not re-occur in the future, the Committee would like to receive detailed information on the measures taken to improve the material conditions of the Induction unit and the range of activities offered to detainees.**

302. The service provider in conjunction with the Home Office has completed a full refurbishment of this previous induction accommodation at Colnbrook including a reduction in room capacity (from two to one per room). There has been a complete refurbishment of all bedrooms and detainees now have access to the same regime provision as all other detainees located in the main accommodation through a new purpose built transition corridor. This area will no longer serve as

the induction unit (which has now been established in the existing D wing) and will now simply form part of standard accommodation.

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

303. Heathrow IRC operates a 4-weekly menu cycle which provides a balanced and nutritious food selection in accordance with contract specification guidelines. This menu is reviewed by the Home Office and external auditors from HMPPS. The main choices at lunch and dinner time are restricted (for portion control purposes) however; all vegetables, chips and rice are unlimited. Additional information is provided separately.

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

304. The current regime permits a number of fresh air opportunities which will often exceed one hour but the service provider accepts this needs to be more consistent and a fixed element of the regime. The physical location of the unit (top floor of the visits building) means it is not always possible to extend this to several hours each day; however, the unit is only designed to hold female detainees for a maximum period of 5 days or 7 where removal directions are in place. The typical number of days held on the unit (average less than 3 days). There are various on unit activities available to the female detainees including gym/fitness equipment, computer and faith rooms, TV and games stations as well as pool tables and reading material.