Tuesday, 31 October 2023

(10.00 am)

LADY SMITH: Good morning and welcome back to our hearings in Phase 8 of our case study examination.

As you know, we're looking into the provision of residential care in various settings, including secure settings for children. We move this week to a section in which we're going to hear evidence about Scottish Prison Service and the various places that they had provision, and still have in some cases, for children.

We start this morning, as I understand it, with an expert witness, Dr Alan Mitchell, who has had various roles, some of them to do with doctoring and some not, I think; is that right, Ms Forbes?

MS FORBES: Yes, my Lady. I think this week and the next two weeks we'll be hearing evidence in relation to the Scottish Prison Service and that will include applicant evidence eventually.

LADY SMITH: Thank you.

MS FORBES: I would call Dr Alan Mitchell.

LADY SMITH: Thank you.

Dr Alan Mitchell (sworn)

LADY SMITH: An easy question to begin, I hope, which is: how would you like me to address you? There are various options. I can see we can use Dr Mitchell, Mr Mitchell,

Alan; what would work for you?

A. Alan is fine, your Ladyship.

LADY SMITH: Thank you very much.

The red folder has material in it that you've held with us already. You may be referred to that. There may be reference to another document or two. I'm not sure whether we'll need them today.

Otherwise, if you have any questions, please don't hesitate to ask. So far as breaks are concerned, I normally do break at about 11.30 in the morning for a short coffee break, but if you want a break at any other time, please speak up, will you?

A. I shall.

LADY SMITH: Otherwise, if you're ready to help us with your evidence I'll hand over to Ms Forbes and she'll take it from there.

Questions from Ms Forbes

MS FORBES: My Lady.

Good morning, Dr Mitchell. If it's okay I'll call you Dr Mitchell, just because I find it difficult to call you Alan.

But I think you've provided us with a statement, that was a little while ago. That is in front of you as Her Ladyship has said.

I'll give the reference for that, it's:

WIT-1-000001201. That will be brought up on the screen in front of you, as well.

This is 30 pages long. If we go to page 30, first of all. At the end of that page, we can see although it's been blanked out, you have signed it and it is dated February 2023?

A. Yes.

Q. If we go back to page 1 and down the screen to paragraph 2, we start by looking at your professional background, if we can.

I think, first of all, we see from paragraph 2 that you attended Glasgow University and graduated with a degree in medicine in 1991; is that right?

A. It is.

Q. Then you undertook GP training in Lanarkshire?

A. Yes.

Q. Before starting work as a GP at Shotts prison in 1996?

A. That's correct.

Q. And you remained, I think, at Shotts prison until 1998?

A. I did.

Q. So just a period of two years?

A. Yes.

Q. During that period, I think you tell us that you were also one of three GPs who covered Low Moss prison in Glasgow, Longriggend remand unit, just outside Airdrie

and that was in the evenings and weekends?

A. It was.

Q. In an on-call capacity; is that right?

A. Yes.

Q. If we go to paragraph 3, we see that from 1998 to 2002 you were employed as Head of Healthcare within the Scottish Prison Service?

A. I was.

Q. You tell us that it's different from the present situation, but at that time healthcare services for prisoners in Scotland were commissioned and provided by the Scottish Prison Service?

A. They were.

Q. That's now changed and it's the National Health Service that provides that care; is that right?

A. Indeed, yes.

Q. You were employed there on a senior Civil Service contract?

A. Yes.

Q. You tell us your role there was to co-ordinate the provision of healthcare services, including nursing and pharmacy services, across each of Scotland's prisons?

A. Yes.

Q. So across the whole estate?

A. Yes.

Q. That included Polmont young offenders institution and Longriggend?
A. Indeed.
Q. And you tell us Longriggend closed in 2000?
A. Yes.
Q. Then from 2002 until 2007, at paragraph 4, you tell us that you were engaged as a GP in a practice providing services to homeless people in Glasgow?
A. Yes.
Q. So that was a move away from the Scottish Prison Service?
A. It was.
Q. And out into community practice?
A. Yes.
Q. In 2006, you were appointed Clinical Director of East Renfrewshire Community Health and Care Partnership?
A. Yes.
Q. Then I think you remained in that -- in 2007, you also took on a role as Clinical Director of the Renfrewshire Health Partnership?
A. I did.
Q. You remained as Clinical Director in NHS until 2017, when you left NHS practice?
A. Yes.
Q. Over on to page 2, from paragraph 5, from 2010 you tell

us were engaged as a GP at Dungavel House, Immigration Removal Centre?

A. Yes, I still work at Dungavel.

Q. 13 years now?

A. Indeed.

Q. Your clinical work, you tell us, is now solely within the Immigration Removal Centre?

A. It is.

Q. And you carry out around eight clinical sessions a month?

A. I do.

Q. That's providing primary healthcare services to foreign nationals, whom the Home Office detains in an immigration facility?

A. Yes.

Q. If we go down to paragraph 6, you can see that from 2016 to 2021 you were chair of the Independent Prison Monitoring Advisory Group in Scotland?

A. Yes. I was often unsure as to whether it was the Independent Prison Monitoring Advisory Group or the Independent Prison Monitoring Advisory Group.

LADY SMITH: Tease that out for me a bit, could you?

A. The advisory group, my Lady, is a group that includes the Chief Inspector of Prisons, the prison monitoring co-ordinators in Scotland, and a number of independent

experts.

Unlike in England and Wales, where prison monitoring is distinct from prison inspection, in Scotland the Chief Inspector of Prisons is responsible for monitoring as well as inspecting.

When I was appointed to the Scottish Human Rights Commission in -- I think it may have been 2015, I can't recall. 2015/2016, I was advised that it had been agreed that given my background I was to chair the newly appointed Independent Prison Monitoring Advisory Group.

The Chief Inspector of Prisons at the time was David Strang and the chair of the Scottish Human Rights Commission was Alan Miller.

The membership of the group is set out in legislation. It includes the Chief Inspector of Prisons, the prison monitoring co-ordinators and others. I'm unsure if the "others" include the provision for an independent chair. But given that monitoring sat with the Chief Inspector of Prisons, I remember asking David Strang at the time the question: am I the chair of the Independent Prison Monitoring Advisory Group or am I the chair of the Independent Prison Monitoring Advisory Group?

LADY SMITH: I see what you mean.

So are you raising the question whether in the

future is prison monitoring in Scotland going to be independent of anything else; do I have you right?

A. I'm raising the question as to how independent is the work of the advisory group, and how independent are the prison monitors in Scotland in the context of their governance, vis-à-vis it's the Chief Inspector of Prisons that has got responsibility for monitoring rather than monitoring being a standalone activity.

In England, for example, there is an independent monitoring board. In prisons and in immigration removal centres in England the independent monitors within individual establishments produce their own annual report.

That's not the case in Scotland. Independent prison monitoring reports very much to the Chief Inspector of prisons. So, in England and Wales, there are -- let me call them, two pillars. There is a monitoring pillar and there's an inspection pillar and in Scotland there is monitoring which is designed in part to inform the inspection process. Then there is the inspection process which will highlight issues that it would be helpful for independent prison monitors to follow up on a weekly basis.

LADY SMITH: I don't want to take you too much off track, but while this occurs to me: does that mean that in

a system like the English system the prison monitors could decide that an issue they have encountered is of such concern that they want to refer it directly to another body, whether it's the police, whether it's Local Authorities, social work or whatever?

A. Yes.

LADY SMITH: They don't have to report back to the inspector and say, "We're worried about this. We think you need to do something about it"?

A. That would be a good -- a neat way of summarising it in part, yes.

As I said, I remember having this conversation with David Strang as to whether I was the chair of the -- the Independent Chair of the Independent Prison Monitoring Advisory and he said to me: well, Alan, you advise me, but if you feel that I'm not going to take your advice, then I would hope you would go directly to the Cabinet Secretary.

LADY SMITH: Yes. Thank you.

MS FORBES: As Chair of the Independent Prison Monitoring Advisory Group, it wasn't the same situation as in England, where you were able produce your own reports. It was information gathered and given to the Chief Inspector; is that right?

A. No. The independent monitors gather information, which

through the prison monitoring co-ordinators is then presented to the Independent Prison Monitoring Advisory Group and within the annual report of the Chief Inspector of Prisons reference will be made to the work of the Independent Prison Monitoring Advisory Group. But the advisory group as currently constituted in Scotland is an organ of the Chief Inspector of Prisons.

Q. Thank you.

At that time you have told us as well that you were Scottish Human Rights Commissioner?

A. Yes.

Q. And that was one of the roles then that led you to be Chair of the Independent Prison Monitoring Advisory Group?

A. That's right. It was one of the -- I was one of four commissioners.

Q. If we go down to paragraph 7, you say that in 2002 -- so going back slightly -- you were appointed as an expert by the Council of Europe to the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, for short the CPT?

A. Yes.

Q. You were recommended for that role by Professor Andrew Coyle?

A. I was.

Q. And between 2002 and 2017, you were an ad hoc expert to the committee and you typically carried out about three visits a year across different member states within the Council of Europe?
A. I did.
Q. If we go over to page 3, to paragraph 8, your professional background continues. We can see in 2017 you were elected as the UK member of the CPT?
A. Yes.
Q. You tell us that that committee comprises 47 seats, with each Member State of the Council of Europe having one member elected?
A. Yes.
Q. But, as the member elected in respect of the UK, you don't represent the UK or its Government policies or positions on the committee?
A. No. Each of the elected members is very much independent of their government and their Member State.
Q. And also as the UK member you don't visit the countries of the UK that comprise the UK?
A. That's correct.
Q. In 2021, you were elected as President of the CPT?
A. Yes.
Q. And that role continues?
A. It does.

Q. If we go to paragraph 9, you tell us that you also have undertaken some court work, a fair amount of court work, in relation to extradition matters as they concern prison conditions in requesting foreign states?
A. Yes.
Q. That's usually instructed by the defence, but you have the duty to the court as an independent expert?
A. Yes.
Q. You have also been instructed by the prosecution, but given the nature of these types of cases it's more often it's by the defence?
A. Indeed.
Q. You also tell us that you recently have been engaged by the CLO, central legal office, which is the legal arm of the NHS, and one of the medical defence organisations to give an expert opinion in relation to issues arising out of doctors working in secure settings?
A. Yes.
Q. Can you just expand a little on what types of secure settings?
A. Prisons in Scotland and immigration removal centres in England. I wouldn't be instructed to give an expert opinion in relation to any prison or immigration removal centre that I had worked in, but I've only worked in the one immigration removal centre in Scotland, so I've been

asked to give opinion in relation to the conduct of doctors and immigration removal centres in England.

Also, similarly in Scotland, I wouldn't be asked to give an opinion in relation to a recent matter or a prison that I had worked in recently, but I think it's about ten years now since I last worked in Barlinnie, so it's some time ago.

Q. Is that in relation to, predominantly, questions of medical negligence?

A. Yes.

Q. If we go then just further down the page where the heading is talking about your medical work at HMP Shotts and Longriggend remand unit in north Lanarkshire.

We're going back in time now, back to 1996, I think, when you started at Shotts; is that right?

A. Yes.

Q. And we have gone over the fact that you carried out on-call work for Longriggend and it was evenings and weekends?

A. Yes. While it's described as on-call work, in reality every weekend I was on duty I would be called to Longriggend and Low Moss at the time. Both establishments were such that you could almost guarantee that you would be attending both of them over a course of a Saturday and Sunday when on call.

Q. At that time, Longriggend held young males on remand?
A. Yes.
Q. I think you say, in paragraph 10, that you recognised whilst you were carrying out that role that the young men you came across in Longriggend and subsequently in Polmont had been those who had come up through the care system?
A. Yes.
Q. But you comment that wasn't something that was specifically discussed at the time?
A. No.
Q. But it's something that you made a point of noting yourself?
A. Yes. I was aware of it in my conversations with the boys, the young men, as to where they had been previously.
Q. You say that was the one in three weekends that you would be on call and attend there out of hours. You tell us that you weren't given any particular training or introduction when you started that role?
A. That's correct.
Q. You had to make up your own mind about things very quickly?
A. Yes.
Q. When you were on call, you would be on call as the only

GP; is that right?

A. Yes.

Q. So you wouldn't have another colleague available to discuss matters with or anything at the time?

A. No. Though I knew my colleague at Low Moss and my colleague at Longriggend pretty well, and if I had a particular concern -- more often than not it related to a patient that I had seen whom I would wish to be reviewed by them on the Monday or the following working day, I could easily call them and discuss the case, as I sometimes did.

Q. The comment that you make in that paragraph about having to make your own mind up about things very quickly; can you give an example of what you mean by that, something that would illustrate that?

A. When I was engaged at Shotts in 1996, I would -- I was engaged initially on the basis that I would provide cover 24 hours a day, seven days a week, as was the GP at Longriggend and as was the GP at Low Moss.

I felt that was somewhat unsustainable and unreasonable and we agreed between ourselves to propose to the respective governors that we form a syndicate, a rota to cover each other. That was put to the governors.

The governor of Longriggend at the time was

Sandy King and he agreed. But the first time I visited Longriggend was not as any sort of induction visit. I visited when my name appeared, first of all, on the rota, and I was used to dealing in Shotts with men serving long prison sentences. And at Longriggend, I was suddenly confronted with young men, young boys, sometimes, who were there on remand and who'd had this dreadful experience of appearing in court, being remanded to Barlinnie, held overnight, transferred to Longriggend, going back to court, then going back to Barlinnie for one night, transferred to Longriggend. I suppose in part, when I say I had to make my mind up very quickly about things, initially it was quite difficult to get my head round it, this idea of this constant roundabout of young people between court, Barlinnie, Longriggend.

Q. You talk about Shotts in that paragraph, and there being adult male prisoners; were there any young people on remand in Shotts at that time?

A. No, Shotts exclusively held long-term sentence prisoners, those convicted by the courts to four years or more, aged over 21.

Q. If we move down to paragraph 11, you comment in that paragraph that in the early to mid-1990s Scottish prisons could be somewhat violent places?

A. Indeed.
Q. You remark that there were a lot of prisoner-on-prisoner assaults?
A. Yes.
Q. And there was a lot of prisoner-on-staff assaults?
A. Yes.
Q. And there had been a number of well-publicised staff-on-prisoner assaults?
A. Yes.
Q. And some successful civil actions indeed brought by prisoners against staff for assaults?
A. Yes.
Q. Can you remember the details of any of those?
A. There were a number of riots in Scottish prisons at that time, and just prior to my arrival at Shotts, there had been -- if I recall correctly, a riot at Shotts whereby a number of prisoners were transferred to Barlinnie and upon arrival at Barlinnie were found to have displayed injuries which they alleged were caused by prison staff.
Q. If we go over to page 4, that's the second part of paragraph 11, you remark that early on in your time at Shotts you remember the governor taking you into his office. He set out quite clearly what his view was about whether -- if you had any concerns a prisoner had been assaulted by a member of staff, you should go

directly to him?
A. Indeed.
Q. That culture -- he wanted a culture of openness, I think you said?
A. Yes.
Q. And staff-on-prisoner violence was wrong and wouldn't be tolerated?
A. Yes.
Q. And you say that he actually told the staff that he had spoken to you as a new GP and set that out?
A. Yes.
Q. And if you had the slightest concern any prisoner had been ill-treated you were to come to him?
A. Indeed.
Q. And nothing would be hidden?
A. Yes.
LADY SMITH: That would be some time shortly after 1996?
A. It was, my Lady, yes.
MS FORBES: If we move to paragraph 12, you comment that you saw a stark difference between what you describe as the culture at Longriggend and prisons for adults; by that do you mean Shotts prison?
A. Yes. Also, Low Moss, where I had some experience of -- because while Shotts was a violent place in the 19 -- mid-1990s, Low Moss was an equally violent place.

Low Moss had dormitory accommodation, rather than single cell accommodation. Men convicted to Shotts -- convicted by the courts and sentenced to short sentences basically don't want to go to Low Moss because they're fearful of Low Moss.

There was something at the time called the "chicken run", which was whereby newly admitted prisoners would have to run the length of the dormitory often and they would be assaulted by their fellow prisoners. So I saw many instances of inter-prisoner violence at Shotts, but I saw an equal if not greater number at Low Moss at the time.

Q. When you say you saw that; is that you witnessing it personally or seeing the aftermath, as in treating injuries?

A. I saw the aftermath. I would often be called in to stitch up men who had been assaulted, often very severe assaults.

Q. Were they telling you that this is how they'd come about their injuries or were you finding out from other members of staff what had been going on?

A. It was very self-evident as to how the injuries had been caused in most cases. Particularly at Low Moss, the men who had been assaulted were frequently transferred back to Barlinnie.

Q. In this paragraph you are highlighting, I think, the difference between the culture, and despite the fact you say that Shotts and Low Moss were quite violent places, the difference you noticed between them and Longriggend were that the relations between prisoners and staff were more distant at Longriggend than they were at the Shotts, for example?

A. Yes. At Shotts, staff were invested in developing a relationship with prisoners, because they had prisoners in their care and custody for a number of years.

At Longriggend, there was this constant churn of young remands, and as such I felt the staff were not as invested in developing relations with the remands as I had seen at Shotts.

Q. Longriggend at that time was holding young people of 20 years or younger on remand and also adult prisoners as workers?

A. Yes, that's right.

Q. Those would be prisoners that the Prison Service wanted to keep separate from other prisoners, such as police officers who had been convicted, prison officers, and there was a fear for their safety if they were held in other places?

A. Yes. They were typically those judged to be low-risk

offenders in terms of their behaviour while in prison, who could be trusted to work in the kitchen, for example, at Longriggend.

Q. But you comment that you had very little to do with the adult prisoners at Longriggend, who kept themselves to themselves?

A. Indeed. If there was a problem that arose, but it was very occasionally I would have to see one of the adult prisoners.

Q. Your most contact was with the young people themselves?

A. It was.

Q. If we go to paragraph 13, I think you are commenting there that you found it strange that there was Longriggend and Polmont, and they were only a few miles apart from each other and you didn't understand why there was the two or what the reason was for Longriggend?

A. Indeed.

Q. I think you have told us already, the kind of carousel of a young person being remanded by the court, spending their first night in Barlinnie and then being taken to Longriggend. Then, when they went back to court, the bus would start at Polmont, collect the young men from Longriggend. Then, after court, they were remanded back to Barlinnie rather than Longriggend?

A. Yes.
Q. And all the admissions into Longriggend were via Barlinnie?
A. Indeed.
Q. If we move down to paragraph 14, you talk about the healthcare needs of the young people that you dealt with, and you make the comment that young people tend to be fit and healthy and give an example that Polmont held about 500 young men in the late 1990s?
A. Yes.
Q. If we go on to page 5, that paragraph continues and you say that the GPs then would see some mental health issues, but issues tended to be musculoskeletal injuries and things like acne?
A. Yes, and that comment was very much based on the conversations I had with the then GPs at Polmont in my role as Head of Healthcare. Because I never worked in Polmont directly, but I had a good relationship with the GPs in an attempt to understand the type of problems that that practice had to deal with. These were the things that the practice highlighted.
Q. You do comment, though, that at Longriggend there was a fair bit of self-harm among young people and also inter-youngster violence, as you describe it?
A. Yes.

Q. Can you give us some more information about the form of the self-harming that took place at that time?
A. I recall, for example, attempted hangings at Longriggend; young people would sometimes cut themselves, cut their wrists; they would swallow objects.

Longriggend was a particularly austere facility, where young men, full of energy, were locked in their cells most of the day. There wasn't much by way of a regime. There was outdoor exercise every day, but the opportunities for the young men there to use their useful energy was somewhat limited.

Q. You go on to tell us that you felt if someone needed to be at hospital in an emergency situation it was never a problem when you were there?
A. That's correct.
Q. Prison officers generally didn't want to have someone in the prison if the GP felt that they shouldn't be there?
A. Indeed.
Q. Going on to paragraph 15, you say if a young person had a physical health problem you would get them to hospital quickly?
A. Yes.
Q. If you thought they needed assessment by a psychiatrist, the assessment route for young people on remand was

technically the same in legislative terms as for someone who had been convicted?

A. Yes.

Q. It required them to be seen by the prison psychiatrist?

A. Yes.

Q. And the necessary forms completed?

A. Indeed.

Q. Enabling them to be sectioned under the Mental Health Act and transferred to hospital?

A. Yes.

Q. Thinking about a young person with a physical health problem, at Longriggend; how was that brought to your attention at that time?

A. There was always a nurse on duty at Longriggend during the day, Monday to Friday, and at weekends, also. There wasn't a nurse on duty overnight. Typically, in the evening, if I was required, the nurse would call me. If, for example, it was perhaps after 9.00 or 10.00 at night when the nurse had left, then one of the officers would call me.

Q. You say a nurse; was that a nurse officer that we have heard about in the Inquiry, about prison officers who became nurse officers?

A. Yes. When I started in 1996, there were a number of nurse officers, but there were also a number of

colleagues who had been engaged as nurses. For example, at Shotts, I remember, I think, we had a couple of nurse officers and, at Longriggend, it may have been the case that some of my nursing colleagues were nurse officers as opposed to nurses who were recruited directly to perform nursing functions only.

Q. Thinking about a young person who had a mental health issue at that time; how would you become aware of that? Would it be the same the route?

A. It was the same route, yes.

Q. If we go to paragraph 16, you tell us about an occasion at Longriggend when you had to deal with a young person with a mental health issue; are you able to tell us about that?

A. Yes. If I recall correctly, as I've said in my statement, it happened at the weekend and I was asked to see a young man whom I thought required in-patient psychiatric review.

The system was -- I'm not sure of the current system, but the system was at the time that in order for a prisoner to be transferred to a psychiatric hospital for review, there had to be a direction on behalf of the Secretary of State. This young man, however, was on remand and the psychiatrist -- it was not possible to get the visiting psychiatrist to the prison to come in

to see that person on the weekend day.

So I spoke to the staff and reasoned that if this young person had been seen by me either earlier that morning in my capacity as a GP providing out-of-hours cover in Airdrie, just down the road, then I would have phoned the local hospital and I would have got the person assessed, using the civil mental health procedure.

I applied the same procedure in order to expedite psychiatric review, which I was felt was the thing that was absolutely required in the circumstance, that this young man needed to be seen by a psychiatrist. He, if I recall correctly, was seen by the psychiatrist and was admitted to hospital over the weekend. Then it was the following week that I got my knuckles rapped for having used the civil mental health route, as it were.

LADY SMITH: What was the problem?

A. The problem, my Lady, was that for all persons in legal prison custody in Scotland the route is through the Secretary of State authorising the transfer to hospital.

Whereas this person, young man, was not a convicted prisoner. If the situation had arisen at Polmont and I had been concerned at the weekend, given that the person -- given that the people at Polmont were convicted, I couldn't have used the civil route.

I would have had to have gone through the route whereby the prison psychiatrist would have assessed and then a recommendation went to the Secretary of State and the necessary forms were signed to effect the transfer.

LADY SMITH: If the prison psychiatrist had assessed the boy and also felt he needed to go to the hospital; would he have been dealt with any differently in the hospital?

A. No, I don't think he would have been dealt with any differently in the hospital. But, in such a circumstance, when the prison psychiatrist and the prison GP make the recommendation that transfer to hospital is required, then we have to have identified a hospital and there has to have been at least the prospect of a bed being available relatively soon within that particular hospital.

LADY SMITH: Whatever route is concerned, the hospital would be aware that the boy was a prisoner on remand and would have to have regard to the fact that he was still subject to those overarching restrictions, albeit he needed medical treatment?

A. Yes. I had a very open conversation with the duty psychiatrist at Monklands hospital on the day. I made it very clear that this was a young person on remand in Longriggend. However, it was a weekend day. It was probably a morning, because it would tend to be the

mornings that I visited. But he needed, in my view, review by a psychiatrist immediately.

The only way that I could secure an immediate psychiatric review was to use the appropriate provisions within the civil mental health legislation.

LADY SMITH: Would you have had to wait to the following week to get the prison psychiatrist there?

A. Yes.

LADY SMITH: Thank you.

MS FORBES: As far as you're aware; is the position the same at the moment? If they are not sentenced, then the Mental Health (Care and Treatment) (Scotland) Act 2003 provides that the person may be transferred to hospital under an assessment order and that application is made via the Scottish Ministers; is that your understanding?

A. That is my understanding, yes.

Q. However, are you of the view there still might be a lacuna in the law, in that the civil procedure may still be open in relation to those types of prisoners?

A. I think there may be. I'm not sure I would wish to test it again, but there may be.

Q. I think you comment in your statement that you don't think at that time there had been a previous incident whereby the civil mental health legislation had been applied in Scotland in that kind of circumstance?

A. Yes.
Q. If we move on to paragraph 17 in your statement, this is a section that you are going on to talk about segregation in prison.

You comment that at that time prisoners in segregation had to be reviewed by a doctor and you comment it's now called "care and separation"?
A. Yes.
Q. Go over to page 6, you remark that as a matter of prison management, rather than a doctor, but the prisoner in segregation had to be seen by a member of the healthcare team every day.

You say it's a matter for prison management, rather than the doctor; what do you mean by that?

I think you go on later to talk about the process, but do you want to expand on that? I think it starts on the previous page.
A. The prison rules -- sorry, I worded it rather clumsily, apologies.

The prison rules are currently such that a person held under the provisions of certain rules within a care and separation unit have to be visited, reviewed, every day by a member of the healthcare team. I think also the requirement is they be seen at least once a week by a medical practitioner.

Q. If we can go down to paragraph 18, you comment that the prison rules were the same in broad respects for young people as they were for adults offenders. Although there may have been a couple of paragraphs about younger prisoners, and as far as you're aware the rules relating to restraint, for example, were the same for young people at that time as they were for adults?

A. Yes.

Q. If physical restraint was used the prisoner had to be reviewed by a doctor?

A. Yes.

Q. How would you become aware of that?

A. I would be called by, typically, one of the prison officers on duty.

For example, if a body belt was applied, then the prison rules at the time required that the person had to be reviewed by a medical practitioner within a certain period of time and the medical practitioner had to either authorise continuation of the use of a body belt, for example, or was able to say that that should no longer be applied.

It was -- I think it was good. It was a protective mechanism to ensure that those subject to means of restraint are reviewed thereafter, unless they have suffered any physical injury. But I think it's also

helpful insofar as it lends itself to protecting against the -- preventing the overuse of means of restraint perhaps inappropriately.

Q. You are talking about a body belt there; can you describe what that was?

A. A body belt at the time was a thick canvas belt that was applied round a prisoner's waist, and he would be handcuffed to the -- there would be a handcuff applied to the right wrist and he would be handcuffed to the right side of the body belt and the left wrist to the left side of the body belt.

Q. When you say that physical restraint would have to be reviewed by a doctor; is that the type of physical restraint you are talking about?

Because we have heard of restraint being referred to in various different forms. There is something like the body belt, that you're talking about. But it could also be taking hold of someone and physically moving them and restraining them in that way?

A. When I worked in the Prison Service in the mid-1990s, I think it was the prison rules in 1991. So it would be whatever the prison rules at the time set out the requirements were that we would give effect to.

Q. Do you remember having to review individuals who had been just physically restrained, as in moved by manual

handling?
A. Yes.
Q. Again, how would that come to your attention?
A. It would come to my attention by the -- either the nurse on duty -- typically, the nurse on duty in the morning, I would be asked to review those prisoners who had -- the colloquial term was who'd been "three-man teamed" from one location within the prison to another, to ascertain if they had any injuries, if they needed any medical attention.
Q. You would review them to find out whether or not they had any injuries?
A. Yes.
Q. When you say "three-man teamed"; what is your understanding of what that would have involved?
A. It would involve one prison officer taking and controlling the head of the person who was being removed and one prison officer at each arm, as it were. The arms -- the prisoner was typically required to bend forward, their head would be bent forward, and their arms would be hyperextended behind their back at the side.
Q. You say in that paragraph that you were given guidance about what a permissible level of restraint was, and that was within the prison rules at the time, the 1991

rules?

A. Yes.

Q. You say that you had a well-thumbed copy of the rules?

A. I did.

Q. Can you remember now what the guidance was about permissible levels?

A. I can't, no.

Q. If we move on to paragraph 19, you tell us that the prison rules were revised to include a provision that if a doctor had a concern that continued isolation and segregation would have a negative effect on the prison's health, the doctor can recommend to the governor that the person be removed from segregation and that the governor had to give effect to that recommendation?

A. Yes.

Q. You suspect that a lot of doctors were unaware of the provision and you're not sure about how many times that's actually been invoked?

A. Indeed.

Q. Did you ever have to invoke that?

A. No. It came in the revised rules. I was one of the consultees in relation to the revised rules, and I thought this was a really good suggestion.

Around that time I was only working very occasionally in Scottish prisons. I did the occasional

Friday afternoon in Barlinnie, I suppose up until about 2012 possibly. I certainly, personally, never applied the provision of that rule in relation to anyone I subsequently saw in a care and separation unit.

Q. That was the change that came around you say in around 2006?

A. Yes.

Q. Was there any equivalent provision or process during your time at Shotts, Longriggend and Low Moss that you can remember?

A. No, there wasn't.

Q. I think you go on to say, when this change was being considered, the challenge was that the UN standard minimum rules for the treatment of prisoners, you comment that is a soft law; what do you mean by "soft" law?

A. The Nelson Mandela -- the UN standard minimum rules for treatment of prisoners are colloquially known as the Nelson Mandela Rules. They are recommended. The UN standard minimum rules are recommended by the United Nations, but they cannot be enforced.

We have, in Europe, the European prison rules, which again are recommendations. But, to be quite honest, many of the recommendations within both the Mandela Rules and the European Prison Rules are not forward, in

effect.

For example, they include that ordinarily every prisoner should have their own cell. That, for example, in many prison countries would simply -- in many European countries and, indeed countries worldwide, would be anathema. Prisoners don't have their own cell.

Q. I think you comment that UN standard set out that healthcare staff should have no part in deciding whether a person is fit for punishment or fit for segregation?

A. Yes.

Q. And that the rule in Scotland means that doctors are not asked to declare persons to be fit for segregation, but they can declare them to be unfit?

A. Yes.

Q. You then pose the question: if you don't declare them to be unfit; are you then declaring them to be fit for segregation?

A. Yes, while initially being very welcoming of the revision in 2006, subsequently in my work with the CPT, my colleagues have helpfully, in a very nice way, challenged my thinking in that. I hadn't actually thought that while it's good we can declare someone as unfit then the governor must give effect to that then by being involved in the review of persons in segregation. And not declaring them unfit; are we then saying they're

fit?

Q. If we move further down the page, this is a section that goes on to suicide prevention strategy, at paragraph 20.

You say that in 1996, when you started at the Scottish Prison Service, they had a suicide prevention strategy, but it was really a strategy which entailed seclusion?

A. Yes.

Q. And there were the three levels of supervision that you set out there. There was the first, the strict suicide supervision, SSS; the second, the intermediate suicide supervision, ISS, and the third, basic suicide supervision, BSS?

A. Yes.

Q. You start to tell us that the prison officers would take the initial decision about anyone who self-harmed, threatened to self-harm or was felt by staff to be at risk of self-harm, as to whether or not they would be put into seclusion.

I think you go on to tell us that invariably, because that decision was taken by prison staff, it was frequently the choice to put them on the first level, which was the highest level, the SSS, the strict suicide supervision?

A. Yes.

Q. Would that be then without consultation with any medically trained staff?
A. Typically, the person would be put on suicide supervision outwith the times that the doctor or nurse were in attendance. If a prison officer had a concern about the behaviour of a prisoner during the time when the doctor or nurse -- during day time hours, then that would be brought to the attention of us and we would review the person.

However, at nights and weekends, when doctors were on call from home, there was no nurse overnight in Longriggend or at Low Moss then. It was the prison officer and she or he would make the decision.

Q. And that decision, that initial decision, the strict suicide supervision, that would mean that the prisoner was placed in what was called a safe cell?
A. Yes.
Q. Which you describe was essentially a bare cell?
A. Indeed.
Q. And it was designed to be ligature free, with no physical ligature points?
A. Yes.
Q. It also involved all personal effects being removed, including their clothing?
A. Yes.

Q. And they would be provided with a rip-proof I think you describe it as a poncho?
A. A poncho.
Q. And sometimes some underwear or a blanket or two.
They would be locked in that cell on their own and you comment there would be an absolute lack of stimulation?
A. Yes.
Q. And that at that time they would be reviewed every 15 minutes, which meant somebody came and looked through the peephole in the door?
A. Yes.
Q. Would that be by prison officers?
A. Yes.
Q. If we go down to paragraph 21, you tell us that within 24 hours of being placed on that, the person would have to be reviewed by a GP?
A. Yes.
Q. Then the GP would decide whether the individual needed to continue on that level of supervision or could be reduced to intermediate or the basic, or taken off altogether?
A. Yes.
Q. You go on to tell us about the intermediate level, and that involved the GP advising what articles the person

could have within the cell?

A. Indeed.

Q. So they would be in the cell, but might be permit to have books or come out of the cell for a cigarette, for example?

A. Yes.

Q. You tell us there it was a very medical model; what do you mean by that?

A. The decision-making process in relation to their ongoing care was remitted solely to the GP. It was the GP who made the decision as to whether they would remain clothed in a poncho in a bare cell, an absolutely awful environment, a despairing environment. Or it was the GP that decided whether they could leave their cell to have a cigarette or whether they were allowed a book, whether they were allowed -- pens were not allowed, as far as I remember, typically because of the risk of harming with a pen.

So it was certainly something that I had never been -- it had never been part of my training as a GP and I felt, as the GP, the staff on the wings and the halls, they knew these prisoners far better than I knew them and as such their opinion was -- they had a view that should be heard as much as my view. They could usefully input as much as I could form a view as to the

ongoing risk of that person harming themselves.
Q. You tell us that the GP would have about ten minutes with the prisoner prior to making a decision about the level of supervision and would see the prisoner in the cell rather than in some kind of consulting room?
A. Yes.
Q. There were no chairs within a cell like that, so you would often sit on the mattress alongside the prisoner?
A. Yes.
Q. Was that assessment based on your own judgment?
A. What I mean is, the assessment as to whether they should remain in SSS or be reduced to ISS or BSS, it was very much, "It's over to you Doc, it's your decision".
Q. Is this based on information that you are getting from the individual themselves about their level of risk --
A. Yes.
Q. -- or thoughts of self-harm?
A. Yes.
Q. Did you have access to their medical records or any prior medical history?
A. No, we would also have access to their medical -- prison medical records when we reviewed them. I would review the medical records before I reviewed the patient.
Q. At Longriggend, you have told us, that these young persons that you saw there were sometimes not there for

long periods of time. So, bearing that in mind; would you have very much in the way of prison or medical records to look at?

A. The regulations at the time were subsequent to each admission a prisoner had to be seen within 24 hours by the doctor.

So, an admission to Barlinnie, the person would be seen. If they had not been transferred -- if the bus to Longriggend had not left before the doctor's rounds the following day.

On admission to Longriggend, they would be seen by the doctor. They would then go to court, they would go back to Barlinnie, the same process would be followed. They would be seen in Barlinnie if the bus hadn't left. They would then go back to Longriggend, where they would be seen by the doctor again. So there is -- the entries in the medical records were often rather brief and as before because nothing much had changed.

The thinking at the time was depending on where the individuals's case was, where the criminal proceedings were at, if there had been a negative turn, for example, then that might have caused a change in the individual's behaviour, in their well-being, that required medical review.

There were always medical notes available.

Sometimes the medical notes would be quite short and would be repetitive, ie, no change since last seen two days ago, or since -- and the frequency, one cannot underestimate how quickly the roundabout revolved with these admissions to Longriggend, court, Barlinnie, Longriggend, court, Barlinnie.

So there was always written information. How helpful it always was in each circumstance, I'm unsure.

Q. For example, if a young person had a history of self-harming or suicidal behaviour before they came into the prison estate, that's not something you would necessarily have a record of?

A. The person would be asked that on admission by the nurse who first saw them and then by the doctor.

Q. It's really just coming from the person's own mouth?

A. Yes. Because at the time the healthcare team -- the prison healthcare team had no access to the NHS records.

That's now changed. Doctors and nurses working in prisons can rather easily access the emergency care summary, for example. But, at the time, in the mid to late 1990s that wasn't the case.

Q. If we go on to paragraph 22, I think you are commenting that you were at Longriggend at the weekends and evenings in an emergency capacity and you didn't really know the young men that well as a result of that?

A. No.
Q. And there was a regular GP who worked there, who was responsible for any follow up, and the same for Low Moss. There was also a psychiatrist who visited Longriggend?
A. Yes.
Q. If we go to page 8, paragraph 23, you are continuing to tell us about the circumstances where someone's on the strict suicide regime and had to be reviewed daily by the doctor. If you saw someone on a Friday night and you were on duty for the weekend, you'd have to see him on the Saturday and then the Sunday, again?
A. Yes.
Q. You recognised that it was a very austere environment and was likely to be harmful to them?
A. Yes.
Q. Is that you commenting on the fact that there was this lack of stimulation and in a bare cell, essentially, with no contact?
A. I think the safe cells were designed purely to prevent persons taking their own lives. If someone is despairing, I think -- I remain of the view that putting them in a cell as was designed will only add -- can only add to that despair rather than ameliorate it.
Q. You say that you tended to bring them down from the

highest level to intermediate and basic, and off as quickly as possible?

A. I did.

Q. Paragraph 24, you are saying a little bit more than what you just said there about a period of enforced isolation being harmful and having a negative impact?

A. Yes.

Q. Your view there I think is that no period of enforced isolation is emotionally safe in your opinion?

A. That's correct.

Q. And there's no period which doesn't have a negative impact?

A. Indeed.

Q. And your view as a GP was that you wanted people out of that environment as quickly as possible?

A. Yes.

Q. The first time that you saw them you might reduce them to the intermediate level, but it would be rare that you went straight to the basic level from strict supervision?

A. Yes.

Q. You comment, though, that you were relatively new at the time and didn't want to reduce the level of supervision prematurely, so there was a degree of caution?

A. Yes.

Q. But that in your experience it usually lasted -- the strict suicide supervision usually lasted for a couple of days at most, but very much depended on the GP and what risks they foresaw?
A. Yes.
Q. Paragraph 25, you tell us that in your experience young people in Longriggend wouldn't be on strict suicide supervision for weeks, but rather days?
A. Yes.
Q. But a few days, in your view, was still harmful?
A. Indeed.
Q. I think you have already told us that if you are despairing enough, that you try to harm yourself, to put you in a socially unstimulating environment would only cause you to be further in despair?
A. Yes.
LADY SMITH: I suppose what you are saying is, put shortly, the model that was being used certainly was trying to address physical health in depriving the prisoner of the means to kill themselves.
A. Yes.
LADY SMITH: But it wasn't doing anything to address their mental health and indeed it may be exacerbating mental health difficulties?
A. Yes. Your Ladyship, it also caused the person, I think,

not to wish to discuss how they really felt with the doctor. Because if they said to the doctor, "I really do want to -- things are so bad that I really want to end my own life", then the doctor would be in a position whereby it would be difficult for she or he to reduce them from strict suicide supervision to intermediate suicide supervision.

So my practice was: get them out of this cell as quickly as possible, let me review them in a consulting room and in an environment whereby they're not sitting in a poncho and I'm not sitting on the mattress on the floor next to them, trying to develop a therapeutic relationship.

LADY SMITH: I can see that. Thank you.

MS FORBES: I think your concern was, you tell us in that same paragraph, 25, that if you are in that environment, then there's a danger that you tell the doctor what you think they want to hear to get out of that environment?

A. Of course.

Q. And you became aware of individuals doing that?

A. Yes.

Q. Did that include young persons at Longriggend, when you think back?

A. I can't recall the detail of individuals that I spoke to.

Q. In that type of situation, where you thought someone was just telling you what you wanted to hear; what did you do?

A. I would arrange a follow-up consultation with them the next day. I would speak with the nursing staff, and we had very good mental health nurses at Shotts at the time, for example. So I suppose I was keen to get them out of the safe cells absolutely as quickly as possible, because in my view within that environment no helpful relationship could be established. It was impossible to establish a rapport in relation to exploring: how are you feeling? What is causing you to feel that way at this moment in time? How can we work together such that you are going to feel a bit better as the days, weeks unfold?

Q. As her Ladyship said, it's a temporary fix to just stop you from being able to do anything, but doesn't address any underlying issues?

A. No. That is why we changed the system subsequently.

Q. If we go on to the next part of your statement, you are talking about the area of abuse at Longriggend.

At paragraph 26, you again tell us that Longriggend was a very austere place. Again, is that just what you told us already; you are referring there to the fact there was nothing to do and people were in their for

most of the day?

A. The physical environment was a horrible carceral, physical environment. Prison officers were dressed as prison officers. There was the clunking of keys constantly. There was a lot of noise within Longriggend, because the young men were locked in their cells for most of the day. There would be shouting.

They were typically held in single cells. They would be shouting between the cells. I think it must have been a very frightening environment for the young people who were held there.

Q. You describe the relations between staff and prisoners there as being cold?

A. Yes.

Q. But you never came across staff-prisoner violence at Longriggend?

A. No.

Q. We talked about how that relationship was different from the one you encountered as Shotts because, as you said already, those people were going to be there for a lot longer?

A. Yes.

Q. You tell us that safeguarding wasn't a word that was used in the 1990s?

A. No.

Q. But you did see prisoner-on-prisoner violence at Longriggend. When you say you saw prisoner-on-prisoner violence; is that something you witnessed or something you were dealing with the aftermath of?
A. By and large, I was dealing with the aftermath of it. Though sometimes when I was there I would see physical fights between the young people there.
Q. What would that involve? Would it involve any weapons of any kind or would it be fisticuffs?
A. It tended to be fisticuffs at Longriggend. Weapons were a real problem at Low Moss and a real problem at Shotts. But, at Longriggend, weapons, as far as I can recall, were not the issue that they were in the other two establishments.
Q. And you say that you did not see prisoner-on-prisoner sexual violence in any of the prisons that you worked in?
A. That's correct.
Q. And you never had a concern that someone had been a victim of sexual violence?
A. No.
Q. You comment that if you came across something that you considered to be abuse you weren't given guidance on how to act, other than you would have just gone to the governor about it?

A. I would have gone to the governor, yes.
Q. But you don't remember any type of situations like that occurring whilst you were at Longriggend?
A. No. There were none that I was required to go to the governor with at Longriggend.
Q. On to page 9, paragraph 27. You say that you don't remember having any concerns that a young person had been the victim of violence at the hands of a prison officer?
A. That's correct.
Q. But you do remember the harsh environment and distant relationships between the prisoners and the prison officers?
A. Yes.
Q. When you say "harsh environment"; can you describe a little bit more about what you mean by that?
A. The ethos, at Longriggend at the time, I would describe, probably, as one of containment rather than engagement. Because these young boys, as many of them were, were on this merry-go-round, whereby court, Barlinnie, Longriggend. And at the time and the Criminal Procedure Rules may have changed, but by and large people spent a fairly short time on remand as compared what they may be able to do now. So unless someone was at Longriggend and they were being tried before the High Court, if they

were there for a matter before the Sheriff Court, they were not there for any real -- any discernible length of time that allowed a relationship to be established.

Though many of them were frequent attenders at Longriggend. They would come back to the establishment frequently on different charges, but there was a visible lack of any relationship or any interest of the staff with the prisoners.

Many of the prison staff, I remember, were older and I was always struck with young people, to have those charged with the security, but importantly the care, to have them in prison officer uniforms, to have them with truncheons in their long pockets, I think such an environment is a harsh environment.

Q. You say that during the day they would be spending their time mostly in their cells; were there any work opportunities that you were aware of at the time or education?

A. I think there might -- would have been opportunities to be employed as so-called pass men, landing cleaners for want of a better description.

But one has to remember also at that time that there was no TV in cells in Scottish prisons, so these young people, many of whom who would have real challenges in reading and writing, were confined to their cells for

most of the day, with nothing to usefully occupy their time.

Q. I think you do tell us, though, that you were aware of disrespectful language being used by prisoners and prison officers. Young people would swear at officers and officers would swear back at them?

A. Yes.

Q. And some of what was hurled by the prisoners at the officers was what you describe as pretty awful and the retorts from staff were also pretty awful; can you remember any specific examples or give us any indication?

A. There would be frequent use of swear words among prisoners and some of the young men would goad the older officers by making disrespectful remarks about their wives, their girlfriends, their mothers, in a sense that -- it's not going to lend itself to the development of a positive relationship between the young person and the prison officer.

Q. You say that at the time you didn't feel that there was a requirement to be challenging of that; what do you mean by that? Is that in relation to your role as a GP?

A. Yes. Now, I would be challenging to both the prisoner and to the officer. But, at the time, it was part of the culture. It was seen as the norm. It was -- every

day I would go into Longriggend. If I went on the landings, then that was the behaviour of prisoners and staff.

Q. Looking back; would you consider that now to be emotional abuse?

A. I'm not sure that I would describe it as emotional abuse. I think on the part of the present staff, it was a very inappropriate reaction. I'm not so sure I would describe it as abuse. I think if I encountered it now I would be challenging both parties to say: hey, guys, come on, what's this all about?

Q. And you finish on that paragraph by telling us there was no inspection or oversight of your work at Longriggend by any healthcare regulator?

A. That's correct.

Q. You were employed as a GP by the Scottish Prison Service and not through the NHS?

A. Yes.

Q. If we go on now to your work as the Head of Healthcare at Scottish Prison Service and in relation to the reform of suicide prevention strategy.

You start by telling us, at paragraph 28, that in 1999/2000 the system of suicide prevention was changed whilst you were at headquarters. There had been a number of suicides in Scottish prisons in the late

1990s and often these were young people on remand, at the start of their sentence?

A. Yes.

Q. It was a degree of political pressure in the late 1990s, and looking at the number of suicides in Scottish prisons over the years you could understand the concern?

A. Yes.

Q. I think you comment that you didn't know why so many people were taking their lives in prisons at the time?

A. No.

Q. But you comment that if someone is determined to take their own life, then they will try to do so irrespective of how hard you try to prevent it?

A. Yes. I recall a really sad instance at Greenock prison when I was in that role, whereby two prisoners were sharing a cell and one prisoner was awoken during the night by his cellmate attempting to hang himself.

The prisoner who was awoken assisted his cellmate. The cellmate then beat up the person who had prevented him from taking his own life. He beat him up and tied him up in the cell and gagged him and, thereafter, proceeded to hang himself while his cellmate was made to watch.

That's why I say that -- that's why I make that comment, that there are circumstances whereby if someone

is really determined to take their own life, then they will do it.

Q. If we go on to paragraph 29, you tell us that at this time, when there was this concern about this number of suicides, Henry McLeish was the Minister and you went to his office at St Andrew's House with the then Chief Executive of the Scottish Prison Service, Eddie Frizzell?

A. Yes.

Q. You were setting out what you were going to do about the high number of suicides in Scottish prisons?

A. Yes.

Q. They were committed, the Government was committed to a review of the system of managing those considered at risk of self-harm or suicide?

A. The outcome of the meeting was the Prison Service were committed to a review, which was supported by the Minister.

Q. You refer to a psychologist from Stirling called Kevin Power, and that you and he in particular felt that the system of identification and management of those at risk of self-harm needed to be more multi-disciplinary?

A. Yes.

Q. And the medical model was inappropriate?

A. Yes. We had a high number of suicides at Cornton Vale.

We had a spate of suicides at Barlinnie. I can't remember the numbers, but I remember if we had a week without a prisoner committing suicide, then we noted that that was a week that there had been no suicides.

Q. I think you say, and you have told us this earlier in your evidence, that you felt that staff working with prisoners knew them the best, who were working with them during the day, and not the GP coming in, even if it was a regular GP?

A. Yes.

Q. Page 10, you felt staff should be much more involved in that whole process?

A. Yes.

Q. Paragraph 30, you say that you adopted a different approach, which was called ACT, and that was an acronym, assessment, care and teamwork.

You got prison officers on board, albeit there was some initial scepticism?

A. Yes.

Q. There was a suicide risk management group at that time in the Scottish Prison Service and there were a number of events held in prisons across Scotland to discuss the proposals and set out the vision to move away from that medical model?

A. Yes.

Q. To try to get the message home that consideration, management of self-harm was everybody's job?
A. Indeed.
Q. I think you comment there was a bit of pushback from medical colleagues, who quite liked the medical model?
A. There was some push back from some medical colleagues. There was also some push back from custody colleagues, from some prison governors at the time.

But, in reality, given that we had a high number of suicides, those persons whom we identified as at risk of self-harm, whom we were placing in safe cells, we were preventing their deaths, but we had a real issue in identifying those who were despairing and who were actively considering self-harm.

I was and remain very much of the view that prisoners knew that if they expressed to a member of staff that they were despairing and felt that life was not worth living, then automatically they would be placed in a safe cell, they would be denied their clothes.

Yes, the people that we did know of we were able to keep safe, but the system as was at the time was not a system that was designed to offer real support to those people who felt that life was no longer worth living for them.

Q. It wasn't proactive, it was reactive?
A. It was not proactive at all, no. And the ACT system, every new admission to prison would be ACT assessed initially by officers, by nursing staff. There was an algorythm that was followed. So it became the norm when you came into prison that you were asked: have you ever harmed yourself? Have you ever thought about harming yourself? How do you feel just now?
Q. You go on to say, at paragraph 31, that revised strategy was very much a team decision, rather than the decision of only the single doctor, as to how the person should be managed?
A. Absolutely.
Q. It was a conversation that involved the prisoner?
A. Yes.
Q. And they were part of the conversation?
A. Yes.
Q. You say the discussion was to include a member of the healthcare team, the prisoner's personal officer; is that something that was in place when you started in 1996 or did that come about afterwards?
A. It was in place -- it was certainly in place in Shotts. I'm unsure whether it was in place for all persons held on remand or short-term convicted prisoners, but at Shotts it was in place.

Q. There would be a representative from the mental health team and, if they were involved, the Chaplaincy services?
A. Yes.
Q. And the safety net was that if one person's view was more cautious then that was the determining factor and their view would be taken?
A. Indeed, yes.
Q. And your view was that was an appropriate position to take --
A. Yes.
Q. -- to listen to the voice of caution, if there was one?
A. Yes, but there was a discussion. There was a healthy discussion. Everyone has a view and everyone's view is as important as the others.

I think there was probably more caution when the new system was introduced at the beginning and that's natural, but then the various actors felt -- developed a confidence in the process and a confidence in each other.

Q. Would that process be initiated as a result of information coming to you by a prisoner or by another member of staff? How would it start?
A. The ACT process is such that any member of staff, irrespective to their professional background, who has

a concern can initiate the opening of the ACT process. It might be the prison nurse on admission. It might actually be the officer who first sees the person in the reception area, before they see the nurse on admission. It might be the officer in the wing, the hall, during an individual's period of imprisonment.

Q. And that would then start the process of -- there would then be a discussion that followed that?

A. Yes.

Q. I think you comment, at paragraph 31, that it would often be a prison officer who made the decision with input from one of the senior officers because of the nature of when these issues would arise?

A. Yes.

Q. Typically, again, the person would initially be placed on the strict suicide supervision?

A. Though it wasn't called -- I've said -- yes, SSS at the time, that would be the old descriptor. They would have been placed in a safe cell, and the conditions in which they would be placed would be akin strict suicide supervision, yes.

LADY SMITH: Ms Forbes, we're now at 11.30; would that be a suitable place?

MS FORBES: Yes, my Lady.

LADY SMITH: I'll take the coffee break now and sit again in

about 15 minutes or so.

(11.30 am)

(A short break)

(11.50 am)

LADY SMITH: Alan, are you ready for us to carry on?

A. I am.

LADY SMITH: Thank you very much. Where you're ready, Ms Forbes.

MS FORBES: Dr Mitchell, just before the break we were talking about the change to the suicide approach -- prevention approach at the Scottish Prison Service.

I think you said that it was then changed to be a much more multi-disciplinary process. But it was only the doctor, I think you tell us, who could reduce the supervision level?

A. Once it became a multi-disciplinary process, it was a team decision. The old system, it was only the doctor. But it was a team decision, though the most cautious voice was taken -- given regard to.

Q. Okay.

When it changed to become a discussion; did that mean that any member of the team could take the decision themselves or would the ultimate decision --

A. It was always a team decision. But, for example, if it was felt that the person should not -- if most of the

members of the team felt that it was appropriate that the person be afforded their own clothing at all times of day and yet one of the members of the team felt that, "Actually, overnight, I think it would be safer if they were given rip-proof clothing", then that decision was given effect to.

LADY SMITH: The team that you mention would consist of who, or which roles would be represented in the team?

A. It would always be a member of the nursing staff, a prison officer, a prison manager, and then could involve, for example, the chaplain, could involve a member of the educational staff. We tried to get together a group of people that knew who the prisoner was and what their needs were.

LADY SMITH: If we take a member of the educational staff, for example, that might happen if you had a young person who had been engaging in some educational matter and that member of staff had come to know them through helping them to progress through the education?

A. Yes.

LADY SMITH: Thank you.

MS FORBES: I think if we go on to page 11, you tell us that the system remains in use in Scottish prison in a modified form and there is a similar approach in England and Wales, as far as you're aware?

A. Yes, that's correct.
Q. If we go on to 33, as soon as any member of staff expresses concern that someone was at risk of self-harm, you tell us there has to be an assessment involving more than one member of staff and typically one of the nurses and the duty manager would be involved?
A. Yes.
Q. It would have an initial case conference to decide the most appropriate environment that the person could be managed in, and it was not always the case that they needed to be placed in a bare cell?
A. Correct.
Q. Or what would have formally have been called a "safe cell"?
A. Yes.
Q. You tell us that previously it was unidirectional and there was only one outcome if there was the slightest concern someone was at risk of self-harm, but it then became a much broader assessment?
A. Yes.
Q. In your view, you say that there is not nearly as many people placed initially in the safe bare cells as was previously the case?
A. That's what I observed, yes.
Q. Your understanding is that they're used less frequently

now?
A. Indeed.
Q. You comment that there is a greater appreciation, not only among the healthcare staff, but among custody staff, about the negative impact that placing someone in isolation can have?
A. There is, yes.
Q. And the culture's changed. It's now about working with the person to explore reasons for their thoughts of self-harm and trying to find a way through it?
A. Indeed.
Q. If we go on to paragraph 34, you tell us that ACT was designed as a care-planning process and it set in place a number of aims by way of intervention that might be helpful and who should be involved?
A. Yes.
Q. It's a process that can last for several weeks?
A. Indeed.
Q. And it includes, importantly, engagement with mental health professionals?
A. Yes.
Q. You tell us that prisons now have dedicated mental health teams; was that not the case in 1996, when you started?
A. No, it wasn't. There were some mental health nurses

engaged as part of the complement of nursing staff that we had, but -- who would take on a caseload, but there was no identified primary care mental health team as there often is now in many Scottish prisons.

Q. You comment there is much more engagement with prisoners who are placed, ultimately, in these cells nowadays as well?

A. Yes.

Q. But, in the late 1990s, the door would be closed most of the time?

A. Absolutely.

Q. I think you comment that you don't work in Scottish prisons now, so your information might not be operationally up-to-date, but that is your understanding?

A. Yes. The last time I worked in prisons was -- I helped out a bit during COVID and did some work in Shotts and Glenochil, but these were occasional days only.

Q. We then go into a section of your statement that is talking about observations on the current healthcare provisions in Scottish prisons.

A. Yes.

Q. Paragraph 35, you tell us that the situation in Scotland is different to that you find in England and Wales. And that someone in prison whom a psychiatrist has assessed

as requiring treatment, hospital treatment, you are unlikely to find someone who has been waiting any significant period of time for an in-patient psychiatric bed?

A. Yes.

Q. However, if we go over to page 12, you tell us that's where the exception of what was Cornton Vale.

A. Indeed.

Q. Move over to page 12. Cornton Vale's obviously closed now, you're aware of that, and Stirling is in its place?

A. Yes.

Q. You tell us, on page 12, that the psychiatrists at the State hospital at Carstairs have an excellent relationship with prisoners, in your view, and many of them will have allocated prisons where they undertake regular sessions?

A. That was always my experience.

Q. The treating psychiatrist in the prison may well be the psychiatrist who has the available bed, either in the State hospital or in one of the insensitive psychiatric care units in a community health facility?

A. Yes.

Q. But you comment on that Carstairs doesn't take women?

A. That is correct.

Q. It's male only?

A. Yes.
Q. There is no -- you tell us a little more later, that there is no high-secure facility for women in the UK. The only place available for women in the UK at that security level is Rampton in England?
A. Yes. There is no high security facility in Scotland. The only facility for women, for the whole of the United Kingdom, is in Rampton. The only high secure forensic facility.
Q. You tell us that the last two published CPT reports in relation to Scotland set out the committee's concerns in relation to the now-closed Cornton Vale and in respect in particular of women who were requiring mental health treatment in the high security provision?
A. Yes.
Q. I think you comment that it's challenging, because of the different mental health legislations in England, having a situation where you have to send someone from Scotland down there, never mind all the other factors that would also affect them?
A. It's a real challenge. Women in custody in Scotland unfortunately remain disadvantaged if they are assessed as requiring high secure forensic mental healthcare, because there is no facility in Scotland. The legislation is different in England, and I believe in

recent years, having visited Rampton previously, there is a reluctance to accept women from Scotland in Rampton.

Q. Are you aware of the reason for that?

A. My understanding is that a number of years ago there was a lady held in Cornton Vale prison who was assessed as requiring high secure forensic mental health in-patient care, who was transferred to Rampton, where she subsequently took her own life. And I'm unsure as to whether since that incident any woman has in fact been transferred from Scotland to Rampton.

LADY SMITH: Can you remind me, Alan, where Rampton is?

A. It's in Northamptonshire, my Lady.

LADY SMITH: Thank you.

A. Or Nottinghamshire.

LADY SMITH: Not that far apart. Thank you.

MS FORBES: I think you tell us there are medium secure facilities in Scotland, Perth and Rowanbank clinic in Glasgow, but no high secure facilities.

A. Yes.

Q. However, is the provision for -- what is your view of the provision of medium-secure facilities at, for example, Rowanbank as they compare to the conditions that someone would be held in, in Cornton Vale, when it was open?

A. I visited Rowanbank on a couple of occasions. It's a purpose-built, very modern, very secure facility. And I could never quite square with the idea that women held in Cornton Vale could be held in Cornton Vale while awaiting high secure forensic mental healthcare.

While at the same time Rowanbank, in my view, provides -- provided -- provides a far more secure environment physically than Cornton Vale.

Rowanbank was a modern facility recently built. Cornton Vale is no more. But, at the time -- I think it was opened in the 1970s. So we had this situation whereby women would be held in Cornton Vale, who were designated as requiring high secure forensic mental health. Rowanbank was a designated medium secure forensic mental health facility, but in my view was more secure than Cornton Vale.

Q. In paragraph 36, you talk about the challenges that have been facing the NHS provision of healthcare since they took over in Scottish prisons in 2011 and your view is that there are big challenges?

A. Yes.

Q. That relates to staffing challenges and the huge organisational differences you see between the healthcare providers and prison staff?

A. Yes.

Q. You comment there are often tensions between healthcare and prison staff?
A. There are.
Q. You comment that is one of the reasons you no longer do locums in Scottish prisons, because latterly you didn't enjoy it?
A. Yes.
Q. Is there anything else you can expand upon in relation to that and tell us about?
A. I think before the NHS took responsibility prison governors were responsible for everything that happened in their prisons. That included security; it included education; it included healthcare; chaplaincy services. The governor, he or she had responsibility for everything.

As such, my experience was that we were all part of the one team. For example, when I was a prison GP at Shotts, the Monday afternoon meeting, all the managers within the prison, the Chaplain, the education lead, the healthcare lead, we would meet as one and discuss a number of issues. Since the NHS has taken responsibility -- the NHS thinks in a different way to the Scottish Prison Service, the priorities are different.

I've seen the evolvement of two distinct groups of

staff. Previously, doctors and nurses were employed by the Scottish Prison Service. They are no longer employed by the Scottish Prison Service. Many of my nursing colleagues, their employment was transferred to the NHS, and that has some benefits for those colleagues, but it is a bit of a them and us.

Previously, if, as a GP, I felt someone needed to be transferred to hospital, then I would have a conversation with the relevant operations lead, who would say, "If you're telling me they need to be transferred, they need to be transferred".

When I was at -- I think it was Glenochil, one of the last shifts I did at Glenochil, I had a patient who had to be transferred to hospital and the operations lead told me, "We already have two people out of hospital. You will need to arrange for one of those to be brought back to hospital before I can have the staff to transfer this person to hospital", which I thought was a very unreasonable request of me.

If -- hospitals do not keep people in hospital longer than absolutely necessary and to ask the prison GP to phone up the hospital, to have a conversation as to whether it's possible for a patient to be discharged in order that another patient can be admitted, I think is simply wrong.

Q. Did you see that as an issue about, perhaps, quotas and operational targets?

A. Yes. Because, in reality, when it comes to escort staffing, it's often the case -- and doctors and nurses who work in prisons now will recall -- that they're allowed two outpatient appointments in the morning and two outpatient appointments in the afternoon and prisoners frequently have appointments cancelled because there are insufficient staff to take them to their appointment.

There have been recent reports of prisoners not being brought before the court, so if the escort agents can't bring them before the court in due time, then it's little surprise they can't bring them to the hospital appointments in due time.

I think doctors and nurses in prisons are being put in an invidious position by the system as currently is. We cannot programme individuals' care needs into a neat Monday to Friday, two appointments in the morning, two appointments each afternoon.

Q. I think in the next few paragraphs you give a few more examples about that and we can read that. I'm not going to go through it with you. It's the same type of issue that you've told us about, which is prisoners being restricted from attending appointments and the like.

A. Yes.
Q. If we go on to the next page, go down to paragraph 39. This is monitoring of Scotland's prisons.

Before I move on to that section, there are just a couple of questions I want to ask you about what we were talking about earlier, and in particular in relation to the restraint, the mechanical restraint that you described, the body belt.

Can you give us an idea of how frequent that was used, that type of --
A. It was really infrequent. It was.
Q. Separate from that, what other types of mechanical restraint were you aware of being used in prisons, at the time that you were there?
A. Handcuffs could be applied to prisoners. That was it. That, I think, was it, the body belt and handcuffs.
Q. When we hear -- an image of a straitjacket or something like that, the body belt; is that the most akin to that type of thing that there was or was there something else?
A. Yes. I can't recall having seen what you describe as a straitjacket, because in effect the body belt was such that when this was applied to the individual person, they could not -- their arms were by their side. They could not move their arms.

LADY SMITH: Might they feel as though they were in what they would call a straitjacket?

A. Absolutely, my Lady, yes.

MS FORBES: In relation to your involvement with that; would you have to, firstly, approve the use of it before it was used?

A. If I recall correctly, the regulation was such that it could be applied by a prison officer, but the doctor had to be informed thereafter and had to then physically review the person -- had to review that prisoner in person as soon as practicable.

For example, if it had been applied overnight, then as soon as I would arrive at Shotts prison in the morning, the first person I would see would be the person whom the body belt had been applied to.

There was a standard operating procedure, which was really quite closely adhered to and was strictly observed. Because it happened so infrequently, the first time it happened to me, as it were, I was struck by the fact that when I arrived at the prison that morning I was told: please, Doc, can you go and see this person, because a body belt has been used?

Q. When you went to see that person; would the body belt still be on them at the time?

A. Yes, because had the body belt been removed I wouldn't

have been required to see them with the same urgency.
Q. In your experience; how long were people mechanical restrained in that manner?
A. Typically a couple of hours. It was that sort of period of time.
Q. But if it had been overnight, as you said, or during the course of the night, it might be it would be until you reviewed them the next day that it would change?
A. I never attended -- I attended prisons during night. I never attended a prison during night to review someone in a circumstance where a body belt had been applied.
LADY SMITH: When you got there in the morning; would you know how long the body belt had been on?
A. Oh, yes, absolutely, my Lady.
LADY SMITH: How would you know?
A. Because a register had been kept by the prison officer as to when -- it was required that the time of application of the body belt be annotated.
LADY SMITH: Could that mean then that the body belt had been applied for more than a couple of hours, depending on when, during the night, it had been put on?
A. I suppose it could. But this was a rare occurrence. At no time did I have any complaint from -- we would have -- the officers and myself and the person to whom the body belt had been applied would be in the same room

at the same time and an open conversation would have been had, and at no time do I recall a person who had a body belt applied, say: no, he told you it was applied at 6 o'clock this morning. Actually, it was applied at 2.00 am.

LADY SMITH: Thank you.

MS FORBES: On those occasions -- I think you said they were infrequent, but were you being asked to agree to a continued period of time using the body belt?

A. My recollection is that after my assessment, the body belt was immediately removed thereafter, but these were instances that were few and far between.

Q. In relation to the use of handcuffs; was that something you were also called upon to review, or not?

A. It would have been. But, again, it -- handcuffs are used routinely during escort purposes, for example. But I can't recall.

Q. When I asked you earlier about your knowledge of any abuse at Longriggend, you said that you weren't aware of any sexual abuse having been reported to you?

A. Yes.

Q. I just wanted to ask you about that. How would you be able to judge if something like that had occurred? Would it just be reliant on the prisoner telling you that something had happened?

A. If there were any concerns about sexual abuse, then staff were -- nursing staff were pretty good at picking up on whether someone's behaviour, for example, had changed over the past period.

At no time did anyone bring any concerns to my attention and, of course, consenting sexual relations occur in -- same -- same sex sexual relations occur in prisons, and that's fine, but I had never any -- I didn't have any concerns that anyone who I met had suffered unwanted sexual relations.

Q. Would you agree that's the type of thing that wouldn't be immediately obvious from looking at someone?

A. Yes, of course.

Q. You wouldn't be carrying out a full medical examination of a prisoner or individual?

A. No.

Q. You would be reliant on either them telling you or someone, as you said, noticing a change in behaviour?

A. Yes. Subsequently, in my professional work with the CPT, I have met a number of prisoners who have suffered sexual abuse. I have examined a number of prisoners who very recently have been sexually abused by other prisoners, but it was not my experience when I was working in the Scottish Prison Service. That wasn't my experience.

Q. Just before I move on to the next part of your statement, we were talking about the changes to the suicide prevention strategy that you were involved in whilst you were at headquarters.

At that time; were you aware of the review that had been carried out by Dr Chiswick in the 1980s in relation to Glenochil?

A. No.

Q. This Inquiry has heard about Dr Chiswick's report in the 1980s, which recommended a number of changes to the prison system as a result of a number of suicides that had occurred in the early 1980s, but that report wasn't something that you were specifically made aware of?

A. No. I remember Dr Chiswick's name, if I recall correctly. He was a forensic psychiatrist from Edinburgh. His name would sometimes come up in conversations, but I never met Dr Chiswick. I don't recall having read the report that you refer to.

Q. Just moving -- there is one further thing I wanted to ask you.

When you were talking about Low Moss and how that had a bit of a reputation and people didn't want to go there because it seemed like a violent place, thinking back to Longriggend at that time; were you aware of any similar reputation in respect of Longriggend?

A. I wasn't. But one had to remember that young people had -- didn't have the option of going to Longriggend. You went to Longriggend.

If you were convicted -- if you had been remanded in Barlinnie or were remanded to Barlinnie post-conviction and sentencing, if you were doing a short-term sentence, the norm would be that if you were from the Glasgow or west of Scotland area you would be sent to Low Moss, but you could request to stay at Barlinnie.

If you were a young person, as far as I understand, on remand, you could not request to stay at Barlinnie more than one night. You were automatically transferred to Longriggend the following day.

Q. Anecdotally; were you aware of Longriggend having a reputation at all at the time you worked there?

A. I wouldn't say -- not a reputation. The thing that -- Low Moss had a reputation because it was dormitory accommodation. There were -- the only single cells in Low Moss were what would have been -- they would have had a few separation cells, if I recall correctly.

These were long, army huts, if you like, with around ten beds on each side, and that's where I learned about the phrase the "chicken run", when newly admitted prisoners would be subject to abuse by those whom they were required to share a dormitory with.

Longriggend was single cell. If I recall correctly, it was single cell accommodation in the main.

Q. If we move on then to monitoring of Scotland's prisons. At paragraph 39, you have already told us that you were the chair of the Independent Prison Monitoring Advisory Group in Scotland from 2016 to 2021, and that the responsibility for prison monitoring in Scotland sits with the office of the Chief Inspector of Prisons?

A. Yes.

Q. When prison monitoring was introduced in Scotland, there was this advisory group established and you told us that was something that you were involved in, you would advise the Chief Inspector on the monitoring of prisons. You have said that sometimes that would be referred to in the Chief Inspector's report?

A. Indeed.

Q. You were involved in that because of the fact you were involved in the Human Rights Commission?

A. Yes.

Q. You then tell us about independent prison monitors and that they are lay persons, and the legislation requires that there is a weekly visit by a monitor to each prison in Scotland?

A. Yes.

Q. And inspections themselves, though, happen every four or

five years and can be announced or unannounced.

If we go to paragraph 40, you talk about the previous system, which was the visiting committees in Scottish prisons. These were persons who weren't independently appointed and, typically, comprise of local councillors and others appointed by the Secretary of State.

I think you point out that the visiting committee at Polmont was actually chaired by the wife of Lord Cullen.

If we go on to page 14, you say that was felt to be a visiting committee that actually looked and engaged and sought to have a real understanding of what was happening in the prison.

At 41, you tell us that independent prison monitors have replaced the visiting committees and these lay people volunteer their time by going into prisons and monitor what is happening there?

A. Yes.

Q. They have the opportunity to talk to prisoners in private. They can choose which prisoners to talk to. A prisoner can make a request to speak to an independent prison monitor, and if there are incidents in the prison, they are supposed to be informed?

A. Yes.

Q. If there is a death in custody, they're supposed to be

informed.

They don't have a role to investigate complaints, but if a prisoner has a complaint they can approach a prison monitor who can assist in advising them how to progress that?

A. Yes.

Q. And the monitor can speak to prison staff on behalf of the prisoner. So there is a liaison role between prisoners and staff for that member.

If we go on to paragraph 42, you are talking about the advisory group again. You tell us that this included representations in the group from ex-governors, also academics. There was a former chair of the Parole Board and your predecessor as the UK CPT member as well?

A. Yes.

Q. That role was to advise the Chief Inspector of prisons on what you felt as a group effective monitoring should look like in Scotland's prisons?

A. Yes.

Q. At paragraph 43, you tell us that there's four monitoring co-ordinators across Scotland who are civil servants and their job is to co-ordinate the activities of the volunteers.

The Inquiry has heard some evidence about that already.

There are monitoring frameworks in place in relation to decency, activities, access to healthcare and the like. When you were chair of the advisory group, you felt personally that the monitors needed to pay more attention to those held in segregation units in particular?

A. It wasn't me, personally; it was the advisory group. We had a discussion and I recall that one of the members of the advisory group was Dan Gunn the former governor of Polmont and David Croft, who was the former governor of Edinburgh. Both Dan and David, I think, had also been, previously, Director of Operations within the Scottish Prison Service.

We felt that the information coming to us -- and that greater attention should be paid to the -- I call them segregation units, they are segregation units -- to the segregation units than was -- the information coming before the advisory group suggested.

Q. Moving on to paragraph 44, you tell us that things were difficult during the pandemic and the CPT suspended its in-person on-site monitoring between March 2020 and July 2020?

A. Yes.

Q. And restarted then in July 2020. Your view is that the only way you can effectively understand what is

happening in a place of detention is to be there in person, asking staff to unlock the doors that you want unlocked, looking, listening, engaging with staff and prisoners?

A. Yes.

Q. You remark that COVID was a very unhealthy period for Scottish prisons and that the Scottish Prison Service is still struggling get out of it; can you give us any more information about what you mean by that?

A. COVID was a period whereby we were all locked down, but people in prison were locked down more so than ever before.

There was initially a real fear that prisons may be a vector for the transmission of COVID and indeed in some Prison Services across the world that was the case. For example, in the US, because of the design of the prisons, whereby prison cells typically have grilles rather than walls, and prisoners, even if you keep them physically apart from each other, the air that they're breathing can circulate very easily. There were prison systems whereby COVID spread very quickly.

In Scotland's prisons, most prisoners -- I think I'm right in saying -- most prisoners in single cells, and there are still many prisoners who, for example at Barlinnie, are two or three to a cell. If you lock

people in a room away from others, then you will of course reduce the risk of the transmission of any airborne virus.

Scottish prisons did that rather well. We had, I think, three main phases to the pandemic. We didn't have the number of deaths of prisoners in Scotland that I think were anticipated as a potential at the beginning of the COVID pandemic, but that came at a cost to individual prisoner's liberties.

The CPT very early on published a statement of principles, such that taking due regard of public health concerns there are certain rights that are fundamental rights. The right of access to soap and hot water; the right of access to at least one hour of outdoor daily exercise; the right to be in communication with your lawyer; with your family. These are rights that cannot be suspended.

But the reality was that because of the fear that COVID might spread and the impact that would have on both the prison population and, importantly, the prison staff, then lockdown was something that was continued in Scotland for a longer period.

There were less prisoner-on-prisoner assaults and less prisoner-on-staff assaults because people were locked in their cells for significant periods of time,

but the -- as Chair of the Prison Monitoring Advisory Group and as one of the Commissioners with the Human Rights Commission, at the beginning of the pandemic I was involved in regular teleconference calls with the Cabinet Secretary and we expressed where we -- Jim McManus, the Vice Chair, and I expressed our concerns that full regard had to be given to the fundamental rights of persons irrespective.

I cite it at paragraph 46 of my report, someone who was held incommunicado in a cell in Greenock prison for three weeks. That person's family, I'm sure, were concerned that he was unable to contact them and they were unable to contact him.

Arrangements were developed, mobile phones were then introduced into prisons, such that prisoners legitimately could have a mobile phone in their possession.

Ameliorations were effected, but they were very slow. And when I last worked in -- I think it was Glenochil, those of us in the wider community were enjoying a much greater level of freedom in our movement and the choices that we were able to have and to make as compared with people in prison.

Q. I think if we go to page 15, down to paragraph 46, where you talk about that individual, you comment that he had

no access to a shower, no access to outdoor exercise or a telephone for those three weeks?

A. Yes.

Q. I'm just going to move on in your statement to talk about your work on the Committee for the Prevention of Torture, the CPT.

At 47, you tell us that the CPT is a treaty monitoring body and the UK is party to the European Convention on Human Rights.

Page 16, you tell us that the UK is also party to the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment and you point out that the word "prevention" is key?

A. Yes.

Q. You say that if you look at reports for inspectorates of prisons, you find very little reference, if any, to ill-treatment, and the prevention of ill-treatment, you say, is the key to the mandate of the CPT.

In all your reports of the committee, the CPT committee, one of the first things you reference is in relation to any allegations of deliberate ill-treatment of prisoners by staff and then you discuss any allegations of inter-prisoner violence.

But you point out you are not a judicial body, you are not a investigative body. However, during the

course of the work that is carried out, you interview staff and prisoners. When you visit places of detention -- and you try to ascertain the situation in relation to the safeguards for the prevention of ill-treatment.

At paragraph 48, you tell us that there is no single internationally agreed definition of torture, but when you visit prisons you will often introduce yourself as being a member of a committee for the prevention of ill-treatment, because if you use the word "torture" people then think something more severe and say: no, we don't torture prisoners?

A. Yes.

Q. You say that denying someone access to a shower for a significant period of time could be described as inhuman or degrading, but the reports also consider work opportunities, vocational training and education.

Going on to paragraph 49, again you point out the CPT is not a prisons inspectorate and the core of the mandate is Article 3 of the European Convention on Human Rights.

If you go to paragraph 50, you explain that the work of the committee undertakes both periodic and ad hoc visits and, in July of each year, they will devise which countries are intended to receive a periodic visit the

following year. The size of the country will depend on how often a periodic visit might take, could be every four years or every six to seven years or so?

A. Yes.

Q. You then tell us about the selection of committee members. You say that when committee members are being selected the process in the UK is such that there is an open competition. Anyone who meets the person specification in relation to experience, which is usually experience of the criminal justice system or healthcare system, particularly as it relates to persons deprived of their liberty, can apply.

Over to page 17, you tell us there is an initial sift and then a number of candidates are invited for an interview with the Ministry of Justice in England, which is the co-ordinating body; that is because it's a UK position?

A. Yes.

Q. Thereafter, UK Ministers propose a list of three candidates to the Parliamentary assembly of the Council of Europe for their consideration. Then the assembly will then approve or otherwise the list of the three candidates.

At paragraph 51, you go on to say the three candidates proposed by the Member State all have to be

appointable. States can't seek to have their preferred candidate elected. It has to be at least one man and one woman on each of the country lists.

The Parliamentary assembly have to be content that the three names suggested have the competence that they can serve as independent experts. If all that happens, then a vote is held at the committee of Ministers who elect the members of the CPT?

A. Yes.

Q. At paragraph 52, you tell us that the President of the CPT, of which you currently are; is that correct?

A. Indeed.

Q. Is elected biannually by the members of the committee. Every two years the members choose the president and the two vice-presidents who constitute the bureau, and you tell us who the vice-presidents are at the moment.

Each of the bureau members serves two years, but they can be re-elected and typically members are elected for a four-year term and re-elected only twice?

A. Yes.

Q. Like the US presidency. Two terms and that's it.

A. Yes. I wouldn't quite put the presidency of the CPT in the same footing as the presidency of the United States. But, yes, your analogy is a fair one in relation to length of term.

Q. You then talk about judges in the European Court of Human Rights and how they're elected, and we can read that.

You say the CPT is different, in that the member must leave at the end of his or her term irrespective as to whether a successor has been identified and there are sometimes periods where, for various reasons, there are only 39 members rather than the 47 that should be there, as happened recently?

A. Indeed.

Q. You tell us, at paragraph 54, that you were first appointed as a member in 2017, and at the time of you giving your statement that was your sixth year and second mandate as a member. Your predecessor was also Scottish, Jim McManus, who was an academic lawyer and the previous chair of the Parole Board for Scotland. He was also the Scottish Prison Complaints Commissioner when you first started, in 1996?

A. He was.

Q. At page 18, you tell us that the previous president of the CPT was a man from Ukraine, who is now a judge at the European Court of Human Rights. His predecessor was from Azerbaijan, who is also a judge now at the European Court of Human Rights?

A. Indeed, as to where the current president goes when his

term of office ends, there is one thing certain, that it's not to the European Court of Human Rights.

LADY SMITH: Have I picked you up correctly in paragraph 52? This is to do with the maximum length of your term as a member; it can be 12 years? You say it can be re-elected twice?

A. Yes.

LADY SMITH: Three four-year terms?

A. Yes.

MS FORBES: Apologies, then it's not the same as the US presidency --

LADY SMITH: No, that was presidency. The presidency is two years, but the membership of the committee can be up to 12 years.

A. That's right. The president's re-elected every --

LADY SMITH: Every two. Members are re-elected -- if they want to be re-elected, I suppose -- every four.

A. Yes.

LADY SMITH: But only for three terms?

A. Only for three terms.

LADY SMITH: Thank you.

MS FORBES: I'm grateful, my Lady.

Moving on to the training for the CPT. At paragraph 55, you tell us that many members of the committee have quite a close working knowledge of the

criminal justice system, the social care system and the psychiatric healthcare system in their own country, and they may have had a role in inspecting or working directly in places of deprivation of liberty in their own country?

A. Yes.

Q. As a committee, whenever you meet in plenary you dedicate time to training activities as suggested and recognised by committee members?

A. Yes.

Q. At 56, as members you all have expertise in your own individual fields, and the plenary meeting allows you to share expertise with fellow committee members and the staff group, and often involves external experts who assist with the training activities in monitoring places of deprivation of liberty?

A. Yes.

Q. That term, "deprivation of liberty"; is that how you prefer to refer to places such as prisons in general terms?

A. The work of the CPT extends not only to prisons, but also to police stations, to immigration detention centres, to social care homes in respect to those who are subject to guardianship orders for example, to psychiatric hospitals and in relation to involuntary

patients.

So our mandate is the prevention of ill-treatment in the context of persons who are deprived of their liberty by the State.

Q. You go on then, further down the page, to talk about the process of committee visits.

At paragraph 57, you tell us that when the committee visits a particular country it familiarises itself, firstly, with the national legislation and the local prison regulations.

There is usually about seven committee members on a visiting delegation, but it depends on the size of the country being visited. You take with you ad hoc experts and interpreter colleagues?

A. Yes.

Q. Additionally, you are assisted by Secretariat colleagues, many of whom who have been with CPT for many years?

A. Indeed.

Q. So some delegations can be quite large, but sometimes split into groups?

A. Yes.

Q. If you are doing a periodic visit you might have a group that looks at prisons and police, and another group that looks at psychiatry and social care homes?

A. Yes.
Q. When you undertake the monitoring work, you form an assessment as to how well or otherwise the safeguards within either the national legislation or local regulations are being applied in practice?
A. Yes.
Q. Is that really what you are looking at; the safeguards to prevent ill-treatment?
A. Yes. We're considering the safeguards as provided for within the legislation, but also the applicability of the safeguards or otherwise.

If we look at the legislation, we look at the rules to see what they include in respect of safeguards. Then through our interviews with persons who are deprived of their liberty, then -- and staff, we form a view as to how effective those safeguards are in practice.
Q. It may be that on paper the safeguards look quite good, but actually in practice it could be a different story?
A. Indeed.
Q. On to page 19, paragraph 58. Then you tell us that the CPT is not carrying out Inspectorate functions; it's monitoring the treaty provisions. There is the Inspectorate of prisons in the UK context.

Again, you talk about the mandate being the prevention of ill-treatment for the CPT and in

exercising that mandate you enter prisons and ask yourselves: what are the safeguards that prevent ill-treatment within this prison?

A. Yes.

LADY SMITH: Are you telling me then, your principal interest is to find out what systems are in place and working?

A. Yes. As they contribute to the prevention of ill-treatment.

LADY SMITH: Of course.

MS FORBES: You are asking what are the conditions within this prison, which may lend themselves to a culture whereby there may be ill-treatment.

A. Yes.

Q. You talk about issues such as overcrowding and lack of staffing, as perhaps contributing to that?

A. Yes.

Q. Whether prisoners have their own cells or whether they're sharing cells?

A. Yes.

Q. Whether there are risk assessments carried out before prisoners are required to share cells with one another?

A. That is key, actually. Risk assessments should always be carried out before prisoners are placed in a cell together.

Q. You say that in some countries the norm would be for persons to share a large dormitory together, as you have described was the position at Low Moss?
A. Low Moss. Yes, indeed.
Q. You say as a committee you recognise that large dormitories are the type of environment where inter-prisoner violence flourishes?
A. It does.
Q. You look at the role of healthcare staff and the documenting of injuries, and the reporting of injuries and access to healthcare staff, accurate recording of injuries and reporting of injuries as appropriate, all adds to the safeguards that prevent ill-treatment?
A. They do.
Q. In paragraph 59, you say there are instances where you come across the deliberate ill-treatment of prisoners by prison staff?
A. Yes.
Q. And that that ill-treatment happens for a number of reasons?
A. Yes.
Q. You talk about overcrowding in the prisons and low staff to prisoner ratios?
A. Yes.
Q. You make the comment that staff numbers in prisons tend

to be set according to what the designed operational capacity is rather than actual number of persons that are held there at any one time?

A. Indeed.

Q. Is the reality that many prisons are housing far more people than they were designed to hold?

A. Absolutely.

Q. You comment that prison overcrowding is a blight on many countries across Europe?

A. It is.

Q. Is that your experience from the work with the CPT?

A. It is.

Q. You also comment that many of the prisons in the UK are overcrowded and understaffed, which is a situation that lends itself to increased physical violence between prisoners and staff?

A. Yes.

Q. Go on to paragraph 60. You talk about the mandate that you have as a CPT when you visit a country. I think you outline there that you start, first of all, by talking to non-governmental agencies. You find that information helpful because they often visit places of deprivation of liberty?

A. Indeed.

Q. These are independent organisations?

A. Yes.
Q. But, ultimately, at the end of a visit, you would routinely have final talks with the Government Ministers of that countries?
A. Yes.
Q. At paragraph 61, you say during the visits you have access to all documentation, both hard copy and electronic, that you think might be helpful. That can include disciplinary registers and access to CCTV recordings that may be held, and you can interview prisoners in private?
A. Yes.
Q. In relation to documentation that is made available to you; does that very much just depend on the trust of the individual organisation handing that information over to you?
A. No. It's irrespective of that.

The Convention requires that the State party co-operates and there is provision within the Convention that if we request information that we consider would be helpful to us, then there is a requirement for that information to be made available.
Q. The people making it available are the individual organisation, the individual prison that you are requesting it from; is that right?

A. Yes.
Q. It's not the case that you go in and interrogate their systems or look through paper files?
A. No, we do.
Q. You do?
A. We do look -- we look at registers, we look at disciplinary registers. We look at registers of injuries. We look at registers -- we ask for information about the number of complaints made by prisoners against staff; the outcome of disciplinary procedures; whether there have been any criminal procedures brought against members of staff and, in certain countries, authorities have been -- often separate prosecutorial authorities have been established to investigate complaints made against police officers or prison officers, and during our country visits would go to those authorities. We would often request to see their investigation files and these are made available to us.
LADY SMITH: When you talk about requesting or requiring information or documents; are the provisions setting out a formal way in which you have to do this in writing or do you do it otherwise?
A. No. We do it orally.
LADY SMITH: Thank you.

A. We treat the information that is provided to us sensitively and, obviously, if there is information of a particularly sensitive nature we would have a discussion with our interlocutors in respect of that.

LADY SMITH: I can understand that and I wasn't suggesting otherwise. Thank you.

I take it most of the States you are engaging with have data protection legislation that they will need to comply with, and then you will need to adhere to whatever the data protection requirements are and may have to go through a formal process for assuring them of confidentiality or suchlike; would that be right?

A. Yes, yes.

MS FORBES: Is there an element at all, when you are provided this information, that you know what you have, but an issue about not knowing what you don't have?

A. Sometimes there can be.

Q. In those circumstances; is there anything you can do other than just to ask more questions or ask for more information?

A. If we believe the information exists and we are being denied access to that information, then, if necessary, we will raise the issue, including at the highest political level.

Q. If we go to page 20, back to paragraph 61, in your work

with the CPT you are able to talk to members of staff or anybody that you think could be helpful to you in your evaluation of the situation in respect of any ill-treatment that exists or more so the safeguards for the prevention of ill-treatment?

A. Yes.

Q. You have, for obvious reasons, professional interpretations services to hand as well.

At paragraph 62, you say you speak to the management of the establishment. You might speak to a prisoner's lawyer with the prisoner's permission if there is a particular issue the lawyer is handling for them that is relevant. You don't consider individual complaints as a committee --

A. That's correct.

Q. -- but you do look at the complaints register when you visit prisons?

A. Yes.

Q. You look at the complaints handling process, review that?

A. Indeed.

Q. You state, I think at the end of paragraph 62, that an effective complaints system is a good safeguard in the prevention of ill-treatment?

A. It is.

Q. Do you want to expand upon that at all in relation to your view?
A. If a person deprived of their liberty has confidence that if something goes wrong they can raise that issue, make a complaint, that the complaint will be appropriately investigated, that they will be heard, then that in itself -- and appropriate sanctions applied thereafter as necessary, that is a strength in relation to protecting people from being ill-treated, without a doubt.
LADY SMITH: What about designing the complaints system so that it has in mind the particular group that it may be dealing with? No doubt in different places, different types of prisons, different countries. You'll have different levels of literacy and culture. It has to be designed with the potential complainer in mind, doesn't it?
A. Yes, yes.

In many countries within the European region, the majority of prisoners are foreign nationals and they may have very little understanding as to the local language and, therefore, it's important that information on how to access the system as well as the system itself is made available in a form that the person can easily understand.

MS FORBES: Is accessibility of a complaints system something you pay attention to?

A. Absolutely.

Q. Go to paragraph 63. You talk about the fact that you speak to staff as a CPT and it's important you do that, but you spend most of the time engaging with prisoners because they're key to the work?

A. Yes.

Q. The length of time you spend at the institution is at the discretion of the committee?

A. It is.

Q. But, typically, you start early in the morning and finish late in the evening?

A. Yes.

Q. You need to interview a representative sample depending on what the issues are.

You seek to interview all groups of prisoners and you are aware that certain groups of prisoners are more vulnerable than others.

There are certain groups that in your view are more likely to be ill-treated than others?

A. Yes.

Q. You have a particular focus on those groups who you believe to be at greatest risk of ill-treatment.

A. Yes.

Q. At paragraph 64, you give examples of the types of groups that you say fall into that category.

One is prisoners secluded in segregation units for punishment reasons or administrative segregation purposes. You explain that might be because they have a particular profile in relation to their index offence that requires them to be held apart from other prisoners. They might be at risk from other prisoners because of that?

A. Indeed.

Q. The people held in isolation for medical purposes because they have a communicable disease, such as TB, you identify juveniles as being a group who are identified as being at increased risk.

People who have committed sexual offences, particularly sexual offences against children and transgender people are often at greater risk as well, in your view?

A. Yes.

Q. Over to page 21, and this is a section of your statement titled "Juveniles".

At paragraph 65, you say you consider the condition of detention and treatment of juveniles as a committee. Some of the visits will be to juvenile institutions?

A. Indeed.

Q. One of the things you are looking for is a regime of purposeful activities, and that's one of the things you are keen to talk to young men in custody about?
A. Indeed.
Q. Can I just ask you about "purposeful activities"? When you use that term; what do you mean? Is that education, training?
A. It's education. It's vocational training as appropriate. It's engagement in sport. It's engagement in team games. It's about: how does life in this particular establishment lend itself to allowing young men and young women to expend their energy and preparing for their release?

Most young people in prison will only be in prison for a very short period of time. They come from their communities. They'll go back to their communities. Prisons have an obligation, a duty, to do what they -- all they possibly can to prepare people for re-socialisation, reintegration into society.

Locking people in a cell for 23 hours a day does not lend itself well to that.

Q. One of the things you particularly mention in that paragraph is parenting issues and trying to educate individuals and young persons who may have very young children about how to look after children and prepare

them, as you said, for reintegration back into the family unit?

A. Yes. A lot of young men in prison do have children. They often don't know their sons or their daughters very well, and the period that they spend in prison, custody, should be optimising the opportunities in there through family visits, for example, through parenting classes, to prepare these young men -- and they are young men innermost -- for life beyond the walls, as it were.

Q. The last thing you mention, at paragraph 66, is that bullying is common among juveniles, so you talk to them about that?

A. Yes.

Q. In your experience with the CPT; is that something that is prevalent?

A. It's prevalent in many countries that we visit. It's important that prison establishments have a zero tolerance towards bullying and that that's communicated -- there is a culture of no bullying within the prison and bullying will not be tolerated.

Bullying is unhealthy and bullying is -- it's certainly unhealthy for the victim, but bullying is also unhealthy for the perpetrator of the bullying.

LADY SMITH: Ms Forbes, it's now 1 o'clock. I think, Alan, if it works for you, we'll stop for the lunch break and

resume at 2 o'clock.

(1.00 pm)

(The luncheon adjournment)

(2.00 pm)

LADY SMITH: Good afternoon.

Alan, are you ready for us to carry on?

A. Yes.

LADY SMITH: Ms Forbes, when you're ready.

MS FORBES: My Lady, thank you.

Good afternoon, Dr Mitchell.

Just before we broke for lunch we were talking about bullying and you were saying that in relation to juveniles it was common and that you thought that a zero tolerance approach needed to be taken and a culture formulated that didn't allow for that.

I'm just wondering: do you have any views on how, in practice, you could give effect to that?

A. I think it's by having an open conversation with the -- all the young people involved within a setting such as a young offenders institution, both those who may have resorted to bullying and those who are the victims or the recipients of bullying in talking through the reasons there for why is there a "need" for bullying within this establishment. What does it achieve? What are the harms associated with it? What are the

advantages in having an environment whereby everyone can live respecting of each other's views and opinions and feel safe?

Q. That would require a sort of education of the young people in relation to that.

A. Yes.

Q. In your experiences with the CPT; are there any examples you can think of, of places that are getting it right? And, if so, what are they doing that is getting it right?

A. Within the CPT we never name individual countries as being good examples or poor examples, to be honest. But there are a number of examples, including here in the UK, where it's very evident that as soon as you get into the establishment what is being sought is a culture whereby bullying is absolutely not tolerated in any way, shape or form; where there's an open conversation about bullying and the problems associated with bullying, and there is an open conversation about the advantages of having an environment whereby young people, in particular, are able to live together and get along with each other without fear.

Q. Just looking again at your statement, at paragraph 67, safeguarding concerns. You tell us in that paragraph that if a visiting delegation has a safeguarding concern

they would discuss that issue with the relevant person on site at the time, such as the prison governor?

A. Yes.

Q. And there is a provision within Article 8, paragraph 5 of the Convention which enables the committee to make an immediate observation to the authorities.

You can make that immediate observation with a request that action be taken immediately and that the committee are informed as to the outcome.

I think we'll come in a little while to look at one of the CPT reports, where immediate observations are made.

You say you see that very much as an example of co-operation between yourselves, as the committee, the staff at the establishment that you visit and the Member State?

A. Yes.

Q. Because there is no power for you to compel them to comply with any immediate observations, but you are hopeful that they will co-operate and they'll take that on board and do something about it?

A. Yes, absolutely. It would be unusual for an immediate observation of the committee to be given no regard. It's very much seen as a co-operation issue. When the committee make immediate observations, they're in

respect of matters that can be resolved on the spot with immediate effect, often at no financial cost to the establishment.

So, in the main, we make -- when we make immediate observations, we do so in the context that an immediate solution can be effected. We don't make observations that are unreasonable that cannot be achieved within a relatively short period of time, if not immediately.

Q. These are separate from the recommendations that are made in the ordinary course of the CPT reporting?

A. Yes. During some country visits there will be no immediate observations. There may be one or two, three or four, but they're used sparingly.

Q. I think you say, in paragraph 68, that the immediate observation as well as being made orally at the time would also be made in writing to the State party; would that normally be part of the report once it's published or would that be separate in advance of a report?

A. Typically, within two weeks of a country visit, the preliminary oral observations are transmitted in writing to the State party.

Q. As you have said, there might be visits whereby there are no immediate observations and there might be times when there are a number of immediate observations?

A. Indeed.

Q. The follow-up thereafter depends on what the immediate concern is?
A. Yes.
Q. You state in that paragraph that the Member State is often asked to confirm, typically within a month, that the action requested by the committee has been given effect to?
A. Yes.
Q. If the authorities of that country tell you that they've acted, then you take that on trust?
A. We do.
Q. You also have a system of ad hoc visits that you can do?
A. Yes.
Q. And you can go back to a country. You can check what action has been taken when you return to that establishment?
A. And we do.
Q. Paragraph 69, you tell us there have been occasions when the committee's visiting delegation has come across a young person for whom they've made an immediate observation?
A. Yes.
Q. Can you give us a particular example of that or the circumstances of that?
A. I remember occasions, sadly, rather than occasion,

whereby we have come across a young person who was sharing a cell with others and they have been sexually assaulted. And we have raised that with the Governor of the establishment and it will often -- we often request -- we request in such a circumstance that the person be transferred to another suitable facility for their safety and well-being.

Q. You go on in that paragraph to say that there are occasions where members of the committee have been concerned about a particular detainee and engaged with the management of the establishment and recommended the transfer of that person to another cell or another prison; is that the circumstance you are talking about?

A. Yes.

Q. Paragraph 70, you state that you consider abuse or torture to be deliberate, physical or mental ill-treatment that inflicts pain, be that physical or emotional pain, with the intention of causing harm?

A. Yes.

Q. That's your working definition that you have for yourself?

A. It's my working definition, my day-to-day work in the immigration removal centre, where I'm required to prepare reports for the Home Office in respect to those patients whom I have within the immigration removal

centre who raise concerns with me that cause me to believe that they may have been a victim of torture.

Q. I think in that definition you are using "abuse" or "torture" together; is that right?

A. Yes.

Q. Could it be the case that there are circumstances where it's not deliberate and with the intention of causing harm, but nevertheless it can amount to abuse, like, for example, an abusive regime?

A. Of course.

LADY SMITH: I was thinking also, Alan, of recklessness?

A. Yes.

LADY SMITH: A person doesn't care whether they hurt someone else or not because they're just so intent on doing what they're doing.

A. Yes. Abuse can often -- it can be negligent, it can be recklessness, yes.

MS FORBES: I think you say in that paragraph that one of the roles you have as a GP within an immigration removal centre is to report to the Home Office any concerns that an individual may have been a victim of torture?

A. Yes.

Q. And there is a Home Office definition of torture, but there are a number of other definitions, so there's not one single definition used by the CPT?

A. There isn't, no.
Q. In your reports, because you say you are not a judicial body, you use the phraseology that an act or acts could be described as amounting to torture or inhuman or degrading treatment?
A. Yes.
Q. Going on to paragraph 71, you talk about situations where in some countries mothers can have their children stay with them in prison for quite a while and that presents a number of issues in respect of very young people being in prison with their mother.

It might be conditions in which both child and mother are detained. You give the example that the child may be held in a regime as restrictive as the mother and may not enjoy as much outdoor time as other children who are held with their mothers who may be in a more open regime, albeit in the same prison?
A. Yes.
Q. These children in custody are often not afforded the full range of activities that children in the community get, and it's important for children who are in prison with their mothers to have as full access to play and education as possible?
A. Indeed.
Q. Going over to page 23, there is a section that starts:

"Reports of the committee and Member State responses."

At paragraph 72, you say that a draft report that is compiled by the visiting delegation is then presented to the plenary for consideration and adoption by the whole committee?

A. Yes.

Q. So the reports are the reports of the committee and not the delegation. Immediate observations are formulated and then conveyed to the relevant parties?

A. Yes.

Q. As we have said before, the national member for that country has no role in commenting on a report for their own country for independence purposes?

A. Yes.

Q. At paragraph 73, you state that any report of the CPT in respect of a visit to any part of the UK is addressed to the UK Government. But, obviously, the UK is a more complex -- it's more complex legislatively because there are three devolved nations within it, but -- so the report, in practice, in respect of Scotland is transmitted to the UK Government, rather than the Scottish Government directly.

However, it would be the Scottish Government that then would formulate the response?

A. Yes.
Q. They would liaise with the UK Government in doing so, and then that would be forwarded on to the CPT from the UK Government?
A. Yes. That happens in a number of countries with devolved arrangements. Germany would be a good example. There are several landers in Germany. The prisons are administered not on a federal basis, but at the level of the individual landers. So the report is to Germany as a contracting party, but the responses will be generated at the level of the landers, for example.
Q. At 74, you say that you are not involved in visits to the UK and you don't take a view on whether a visit to the UK is required or otherwise because you are a national member and you are precluded from having a discussion in relation to the substance of reports about the UK or influence as to when a visit should take place or what should be looked at?
A. Yes.
Q. At paragraph 75, you remark that the CPT visited Scottish prisons in 2018 and made various observations. There were some references made to the dog boxes, which we have heard about, which are the holding cubicles in the reception area at HMP Barlinnie?
A. Yes.

Q. You commented that they've been there for far too long at that time, and that you had worked at Barlinnie for a short period of time, almost ten years ago, and they have been criticised by the CPT since 1994, but they were still there in 2018.

I think we have heard evidence that they have now been removed.

A. Okay.

Q. You then tell us that the publication of CPT reports and government responses send a strong message and the government response includes both the political and practical commitments as to what action the authorities are going to take in relation to the committee's recommendations.

Over to page 24, paragraph 76. You outline that the CPT's work is based on the twin pillars of co-operation and confidentiality, and reports are not published without the State party's invitation to publish and you say that as you often set out in your reports, co-operation extends to more than facilitating visits. It extends to taking the recommendations seriously and actually implementing them?

A. Yes.

Q. And where the committee feels that no discernible progress has been made in relation to particular issues

they may take the decision to make a public statement in respect of that.

However, you outline that in the history of the committee there have only been ten public statements ever made?

A. There have.

Q. You see the public statement as a sign of a failure of co-operation?

A. Yes.

Q. How long has the committee been ongoing?

A. The first visit of the committee was in 1990.

Q. In that period, in that long period, there's only been ten --

A. Yes.

Q. Paragraph 77, you tell us that the transmission report is to the government of the Member State rather than to the establishments. However, your practice is to encourage Ministers to transmit the report to the governors of the establishments when they receive it?

A. It's always disappointing to visit a prison that the committee have visited before and to speak to the governor whom you have spoken to before and she or he has no knowledge of report of the previous visit.

Q. I think you point out that the interlocutor is to the State party?

A. It is.
Q. At 78, you say that some countries choose not to make the reports public?
A. Yes.
Q. In terms of the Convention, they can do that. But if the committee feels that continued recommendations are being ignored, then the option is to make a public statement?
A. Yes.
Q. That's something that is discussed at the Committee of Ministers of the Council of Europe in Strasbourg, and the Committee of Ministers comprises the ambassadors of each of the member states?
A. Yes. It's very much a political level discussion.
Q. Your view is that reports of the CPT and public statements of the CPT can have considerable political influence on member states to bring about improvements that the committee has sought?
A. Yes.
Q. In paragraph 79, you outline the last time the committee visited Scotland was in 2019. The report references findings of the committee made during the 2018 visit. As well as those reports being published the response of the UK Government has also been published, and you say that reading all those together enables you to take

a view as to what extent the committee has followed up on recommendations previously made?

A. Yes.

Q. For example, you say the 2018 report -- I think that is the 2019 report, isn't it, but in relation to the 2018 visit?

A. I think the committee went to Barlinnie in 2018. I'm not sure if they went back to Barlinnie in 2019. The UK is not one of the countries that I follow most closely.

Q. That report, in any event, about Barlinnie refers to previous recommendations of the committee from 1994, 2003 and 2012, all about the dog boxes?

A. Yes.

Q. Going over to page 25, at paragraph 80, you talk about being in regular dialogue with a number of the non-governmental organisations within countries. Prisoners' lawyers might write to you if they have a particular concern in relation to their clients or broader concern in relation to the prison system, and that can be helpful in informing the committee thinking as to whether there is a need to return to a country and whether in actual fact effect has been given to previous recommendations and immediate observations?

A. Yes.

Q. If there's a concern that effect hasn't been given to an immediate observation you can return to the country to check?

A. Yes.

Q. As you have said, the CPT's powers are really the powers of political persuasion.

The role is to try to encourage State parties to fully implement the recommendations of the committee?

A. Yes.

Q. If I could just leave your statement for a moment and go to the report that was carried out by the CPT on the visit to the United Kingdom. The reference is INQ-0000000495.

On page 1 there, you can see that says it's a report to the Government of the United Kingdom on the visit to the UK carried out by the CPT from the 17th to 25 October 2018?

A. Yes.

Q. I appreciate this is not something that you as the UK member were involved in, the visiting delegation, nor involved at all in the preparation or formulation of the recommendations in the report or the immediate observations that we'll see.

At page 2, you can see that section A looks at law enforcement agencies and the CPT visited police stations

as places of deprivation of liberty.

Section B deals with prison establishments.

B2 on that page, looking at prison establishments for men, has subsections (a), ill-treatment; (b), conditions of detention and regime for male prisoners; (c), segregation of prisoners.

Then, over to page 3, B3 there says prison establishments holding women and female juvenile inmates. That is a section.

Subsections (b) deal with admissions and reception; (c), segregation; (d) conditions and regime.

Then section 4 on that page, healthcare services, and it includes, at 4(c), screening on admission and suicide prevention; 4(d), deaths in prison; 4(e), psychiatric and psychological care and (f), substance abuse?

A. Yes.

Q. At 5, we see "other issues" as a section. Then they're looking at (a), prison staff; (b), contact with the outside world and (c), complaints procedures.

That is just to give an overview of the types of areas that this report was looking at on that visit?

A. Yes.

Q. If we go briefly to page 70 of that report, it's appendix 1, that has a list of the establishments

visited. We can see the list there for prisons is HMP Barlinnie, HMP and YOI Cornton Vale, HMP Edinburgh, HMP and YOI Grampian and HMP Shotts?

A. Yes.

Q. If we go to page 4, this is the executive summary. Firstly, it deals with law enforcement and the visits to police stations?

A. Yes.

Q. Looking at the detention facilities there.

If we go over to page 5, you can see that it then starts dealing with prisons in the second paragraph down.

I'll go through this, if that's okay with you.

It says:

"The Scottish Government has clearly embarked on an agenda of reform, especially as concerns women prisoners and young offenders. The female prison estate, in particular, has been the subject of reconceptualisation and structural reform. Nonetheless, the overall number of prisoners has remained at some 8,000 (147 per 100,000) and the reforms were still at a nascent phase. The CPT's delegation visited Barlinnie, Cornton Vale, Edinburgh, Grampian and Shotts prisons ..."

Just one second:

"Positively, at the five prison establishments visited, the vast majority of prisoners stated that they were treated correctly by prison officers and the delegation received no allegations of deliberate ill-treatment of prisoners by staff. The CPT noted a few allegations of excessive use of force during control and restraint operations in different prisons, (Grampian, Edinburgh and Shotts) and recommends that prison staff be reminded that no more force than is strictly necessary should be used to control prisoners. It also invites the Scottish authorities to consider taking measures to ensure that body cameras are worn by front-line prison staff and turned on for all control and restraint operations."

A. Yes.

Q. It goes on for the prison establishments for men:

"The CCTV noted the gradual rise of inter-prisoner and inmate-on-staff violence notably in Edinburgh prison, which was officially attributed to a combination of increase in use of novel psychoactive substances (NPS), mental health issues and organised crime. At Grampian prison, there was also a tangible perception held by staff, as well as by some inmates, of a general lack of safety due to the frequent staff turnover, staff absences, and some new and inexperienced staff. Greater

investment in preventing violence is necessary at both prisons. Linked to the gradual rise of this violence is the issue of the large amounts of synthetic drugs flowing into Scottish prisons. The relative ease of access to almost undetectable NPS render policing drug flow and abuse in the prison estate a complex and challenging task. The CPT urges the authorities to continue to invest in measures designed to identify the drugs flowing into prisons, stem and prevent abuse within the prison, and invest further in substance addiction programmes.

"The conditions of detention in the prisons visited were in several cases adversely impacted by overcrowding."

That is something that you have commented on in your statement?

A. Yes.

Q. Issues that you had come across in Europe:

"This was particularly notable at Barlinnie prison, where inmates had less than three metres squared each of living space in doubled up cells of six metres squared, including the partitioned toilet and at Grampian prison, where mattresses were put on the floor under the bunk beds temporarily, resulting in tripling up of double occupancy cells. Given the intended refurbishment of

Barlinnie prison the CPT recommends that cells of eight metres square hold no more than one prisoner and cells of 12 metres squared hold no more than two prisoners. It also recommends that Grampian prison utilise the available space in Cruden Hall, such as designating half of the hall for non-juvenile inmates. This reorganisation could also take the strain off the staff in Ellon 1, who had to balance the needs of many different categories of prisoner.

"Moreover, the very small waiting cubicles, less than one metre squared in Barlinnie's prison reception area termed dog boxes by the prisoners have been consistently criticised by the CPT since 1994. Urgent action must now be taken to develop larger reception waiting areas at Barlinnie prison."

When you look at the paragraph that deals with the living space and the recommendation by the CPT, there was quite a difference in the size of what is actually happening and what the CPT recommends happens?

A. Yes. Actually, the reference to Barlinnie prison, where inmates had less than three metres squared of living space, that could find itself subject to a breach of Article 3 by the European Court of Human Rights if challenged before that court. I recall the judgment of the court in Muršic v Croatia, where the court ruled

that if prisoners are afforded less than three square metres of living space then there should be a presumption, if I recall correctly, of a breach of Article 3, and the criticism of the small waiting cubicles at Barlinnie. I'm glad to hear now that those waiting cubicles have been taken out of service, but they were taken out of service more than 20 years after the CPT made that recommendation.

Q. In Grampian prison, there is not only doubled up, but a tripling up of double occupancy cells, with a mattress being placed underneath the bunk?

A. Yes.

The Nelson Mandela Rules, the European Prison Rules set our very clearly that each prisoner should have their own bed, and their own bed is taken to mean their own bed frame as well as their own mattress.

Q. If with go over to page 6 of that report, I'll just continue on:

"In three of the five prisons visited, the regime was restricted primarily due to overcrowding and staff shortages, which resulted in many prisoners being locked up in their cell for extended periods of the day. The regime was particularly restrictive for remand prisoners and had deteriorated since the CPT's 2012 visit. The CPT recommends that the number of purposeful activities

on offer to remand prisoners be developed and the daily programme for these inmates be improved."?

A. Yes.

Q. These are remand prisoners who haven't actually yet been convicted or sentenced?

A. Many of whom will not be convicted, yes.

Q. And also the sentence that relates to the deterioration since the visit in 2012, the matters aren't getting better but worse?

A. They're getting worse. That's -- that should be of real concern to the Scottish Prison Service.

Q. Just continuing on:

"The regime was also extremely restrictive for prisoners in segregation for protection reasons and for those being held on monthly extensions under rule 95(11) of the prison rules (where a prisoner can be removed from association for reasons of maintaining good order and discipline protecting the interests and safety of other prisoners). The delegation met several inmates who were locked in their cells for 23 to 24 hours per day for several weeks, if not months, at a time. The situation was most severe at Grampian and Edinburgh prisons where a number of inmates who were on non-offence protection and extended rule 95(11) segregation were not even offered one hour of outdoor

exercise every day."

Some of these prisoners in segregation, that are being referred to in this paragraph, are ones that -- they're there for safety reasons?

A. Yes.

Q. "In response to the CPT's request that immediate action be taken the Scottish authorities announced that a governor's and manager's action notice would be issued to all senior management teams to remind them of the legal requirement to provide exercise for not less than one hour every day. The CPT trusts that this action notice is complied with in practice. Further, the CPT recommends that prisoners placed on non-offence protection for more than a short period are provided with a range of purposeful activities, education and sport and risk-assessed association time and that all segregated prisoners should be offered at least two hours of meaningful human contact every day."

A. Yes.

Q. It would seem from this that if for reasons of protection you needed to go into segregation that essentially you were prevented from engaging in a normal everyday prison life?

A. Yes. You were subject to solitary confinement.

Q. Just continuing then:

"The CPT visited the male separation and reintegration units, SRU, in Edinburgh, Barlinnie, Grampian, and Shotts prisons and found inter alia that the staff/prisoner relations were positive, that efforts to reintegrate prisoners were being made and noted that these prisoners benefited from individual assessments. However, the intractable issue remained that many of these prisoners were being segregated for extremely long period of time, for several months and occasionally years, either in carousel (moved between different prison, SRUs) or a yo-yo situation, moved between the SRU to the mainstream and then back to the SRU. They lack the middle ground in between the SRU and mainstream environments for these prisoners who cannot deal with the high stimulus environment of mainstream prison accommodation."

Now, are these talking about people that perhaps are not there for safety and protection and are not there because they have breached some rules and the other prisoners need to be protected from them, but these are people who can't cope in the mainstream environment of a prison?

A. They will be people whom the Prison Service find particularly difficult to manage. They will be people who have often committed disciplinary infractions,

a number repeatedly so. They will have found themselves subject to imposition of time and a separation and reintegration unit as a disciplinary punishment.

They're likely to have been punished on several occasions by such cellular confinement. They will struggle to deal with being back in a situation whereby they may be compelled to share a cell with another person. They will have a more open regime if they're a sentenced prisoner than they would have if they were accommodated within a separation and reintegration unit.

But the problem is the committee has described that in Scotland -- and the committee noted that some -- many of these prisoners were being segregated for extremely long periods of time, for several months and occasionally years, either in carousel.

So there are prisoners in Scotland who are transferred from one SRU to another SRU, to another SRU, to another SRU. And that culture within Scottish prisons has been a culture that's been around since I first started working in prisons in Scotland in the mid-1990, and probably before.

Q. I think, as they go on to say, the difficulty with that is institutionalisation:

"The CPT found that many of these prisoners had become institutionalised into the SRU environment and

did what they could to remain in the comparative quiet and ordered atmosphere, despite living in virtual solitary confinement. The result was that every SRU visited by the CPT's delegation was operating at almost full occupancy. Moreover, persons held on extended rule 95(11) orders who would otherwise have been held in the SRU were being held in their own cells in the main part of the prison (and also faced equally poor regimes)."

A. Yes. A number of these prisoners may well be serving life sentences or indeterminate sentences. But many of them will be serving determinate sentences and as I -- as was my experience when I worked in prisons, persons were literally released from the then-called segregation units back into the community on a number of occasions.

Q. In those circumstances, the opportunities for proper preparation for release or reintegration to society are non-existent?

A. They're absolutely non-existent.

Q. It goes on to say:

"The CPT considers that the Scottish authorities need to seek alternative solutions to break the cycle and reduce the number of prisoners held in prolonged segregation in the current SRU system. It recommends the development of step-down facilities and invites the

authorities to consider investing more in the establishment of small, therapeutic units that can provide a robust psychosocial support system for these prisoners to facilitate their reintegration process and provide a feasible alternative to prolonged segregation in SRUs. The regimes in the SRUs should enable all prisoners, no matter what their category, to be offered at least two hours of meaningful human contact every day, including being offered purposeful activities of a varied nature. Individual regime plans tailored specifically for persons held in segregation under rule 95 should be further developed with a view to assisting them to return to a normal regime."

The reference there is not simply just to an hour or two hours out of their cell for exercise. It's a reference to meaningful human contact?

A. Yes. Purposeful human contact. Human contact that goes beyond: here is your lunch.

Q. Given that they're being held in segregation and not in socialisation with other prisoners, that would mean that it would have to be staff resources that would be deployed?

A. Yes.

Q. Over to page 7, this is a section entitled:

"Prison establishments holding women and female

juvenile prisoners."

And the report states:

"The CPT was encouraged by the progressive policy changes under way, notably the plans for smaller, more individualised community-facing units for female offenders. Nevertheless, it found that the admissions process could be further developed to take into account the vulnerabilities of women prisoners, including screening for sexual abuse or other forms of gender-based violence inflicted prior to entry to prison and ensuring that such information is reflected in the drawing up of care plans."

Pausing there. You talked about ACT and the processes on admission in relation to the question of self-harming. However, this part of the report is obviously going much further and talking about -- in particular for women. You might say men also, but more often than not women being subject to sexual violence or gender-based violence prior to arriving at prison?

A. Mm hmm.

Q. It goes on to say:

"The CPT raises serious concerns about the treatment of women prisoners held in segregation at Cornton Vale prison, both within the SRU and Ross House. The CPT found women who clearly were in need of urgent care and

treatment in a psychiatric facility and should not have been in a prison environment, let alone segregated for extended periods in solitary confinement under rules 95 and 41 (accommodation in specified conditions for health or welfare reasons).

"Prison staff were not trained to manage the highly disturbed women: for example, one had bitten through the skin and muscle of her arm down to the bone; another woman sat in isolation surrounded by blood and faeces on the wall, and a third woman set fire to her own hair in her cell. At least five women with whom the CPT's delegation spoke had severe mental health issues requiring hospital treatment, care and support.

"The CPT noted that while male prisoners in a similar situation could be transferred to a high secure psychiatric facility, in Scotland there is still no such possibility for women prisoners (and the possibility of effecting a transfer to Rampton hospital in England rarely occurred in practice, due to jurisdictional complexities and distance). Also, it was not clear why the women could not be transferred to a Scottish medium secure psychiatric facility."

I think this echoes what you told us earlier and the difficulties with there not being a high secure facility for women in Scotland, but also your views of the

security at the medium secure psychiatric facility in any event?

A. Yes.

Q. It continues on:

"These severely mentally ill women required immediate enhanced care and support by mental health staff, with a focus on providing a more therapeutic environment and ensuring that they have more out of cell time and meaningful human contact. For female prisoners with personality/behavioural disorders, who are not eligible for transfer to a psychiatric hospital a multi-faceted approach should be adopted, involving clinical psychologists in the design of individual programmes, including psycho-social support and treatment. Further, clear protocols and operating procedures among the SPS, NHS, the judiciary, and social services should be developed to ensure that vulnerable women who cannot be treated under the Scottish Mental Health Act are afforded the necessary care in an appropriate environment."

If we pause there.

These women that are being referred to here are not ones that would fall within a category for which they could be treated in a mental health facility as defined under the Act. For example, these are people who

perhaps have personality and behavioural disorders who can't be treated, but yet the prison regime is not suitable for their needs?

A. Yes.

Q. It continues:

"The CPT requests to be informed about the treatment of the women held in Cornton Vale's SRU under rule 41 at the time of its delegation's visit. Overall, the CPT considered that neither the SRU nor Ross House was suitably equipped or staffed to provide proper care for the vulnerable women they held at the time of the visit."

From what I've read out, there in that whole paragraph, it's quite a damning indictment of the situation at Cornton Vale at the time?

A. While, as a national member, I was present during the adoption of the court, I'm unable to comment on the report. As I sat during the adoption of that report, I was ashamed.

Q. It continues just on this last part here:

"As regards to provision of healthcare, a number of systemic issues are raised, such as the incompatibility of the electronic systems used in the prisons and in the community."

Does that relate to the sharing of medical

information, medical records?

A. Yes.

Q. "... difficult access to addiction services, files, and the absence of an electronic prescribing system all leading to possible discontinuity of care when prisoners arrive or leave the prison system."

If I stop there. In relation to those who are dependent on prescription medication or, for example, medication for some types of disorders, if there is a break in that, that can have quite serious implications for their mental health --

A. It can.

Q. -- after arriving in prison?

A. Yes.

Q. "Further, with regard to healthcare staffing levels there is a need to increase the presence of general practitioners in all the prisons visited and more generally to strengthen the addictions and mental health nursing teams. Also the CPT recommends further investment be put into developing an effective and wider anti-drug strategy and a peer-led programme of substance misuse eduction in each prison to educate prisoners, particularly new arrivals, about the dangers of drug misuse. The CPT also found instances of inter-prisoner bullying for prescribed medication at every prison

visited and recommends that the way in which prescription drugs are distributed and their intake supervised be reviewed."

A. Yes.

Q. This Inquiry has heard some evidence from a mother about her daughter who was in prison and sadly took her own life, who was able to obtain prescription drugs that weren't prescribed to her, but also talked about other prisoners bullying prisoners for drugs and the like.

A. Yes.

Q. Go to page 55, I just want to look at one part of the detail of the report. I'm not going to go to any other parts --

LADY SMITH: Page 55?

MS FORBES: Sorry, page 55 of this document and --

LADY SMITH: It's of the report. It's much further on.

MS FORBES: Sorry, my Lady.

LADY SMITH: These are the numbers at the top.

MS FORBES: Is it the same number on Nuix?

LADY SMITH: Yes, it is. Thank you.

MS FORBES: Section 104, just further down the page; I just want to refer to this part of the report because it specifically deals with juveniles:

"There were three 17-year-old female juvenile inmates held at Grampian prison. These juveniles were

held in a small separate section of the main women's hall, with a distinct common area adjacent to their individual cells. The juvenile cells and common area were identical to the rest of the female unit, but were sparsely furnished, undecorated and entirely carceral. Adult women offenders were not permitted into the section, but the juveniles were permitted out to attend the servery and collect medication."

Page 56 of that report, that continues:

"The juvenile inmates between the delegations complained about complete boredom. While they benefited from some six hours unlocked from their cells, their days were empty and unstructured. No regular juvenile-centric programmes or activities tailored to their specific needs were offered to them. These juveniles were also in need of more psychological and social welfare support; several said that they had been abused and/or had recently lost parents or relatives. They lived alone in their section and were solely reliant on each other for company. The potential for inter-juvenile bullying or intimidation was high and it was clear that one of the three juveniles was too fearful to speak to the delegation openly in front of the other juveniles. When speaking to the delegation, the juveniles proactively asked for more activities to

structure their day and more support from the prison authorities, who allegedly treated them in much the same way as the adult females.

"The CPT has long advocated that all detained juveniles who are suspected or convicted of a criminal offence should be held in detention centres specifically designed for persons of this age, offering a non-prison-like environment and regimes tailored to their specific needs and staffed by persons trained in dealing with the young.

"In light of this, CPT recommends that the Scottish authorities revise the way in which they are holding female juvenile inmates at Grampian prison and young offenders institution and take concrete measures to turn the juvenile section into a truly juvenile-centred unit. This should be composed of a small well-staffed unit, with regular attendance by personal officers and staff with specific juvenile-centric training, and should offer psychological, post-trauma and social welfare support. Juveniles should be unlocked for the majority of the day and provided with a range of purposeful activities throughout the day, and staff should promote a sense of community within the unit. Staff should also be constantly vigilant for signs of possible inter-juvenile bullying."

Some of that reflects some of the issues that you talked about earlier in your experience of working at the CPT?

A. Yes.

Q. And no doubt you would -- I know you weren't involved in these recommendations, but you would agree with those recommendations, given what was found on that visit?

A. I would.

Q. If we can go to page 9 of this report, there is a section C:

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

So you told us earlier that the CPT doesn't have to make immediate observations. Sometimes there would be none; sometimes there would be many. On this occasion, on this visit they've decided to make immediate observations and they do so at section 6. If we can just read out that part:

"At its meetings with the Scottish authorities on the 24th and 25 October 2018, the CPT's delegation made three immediate observations under Article 8, paragraph 5 of the Convention. The first observation concerned the continued placing of prisoners in the very small cubicles in the reception area of Barlinnie prison for two hours or more. It requested that the Scottish

authorities take urgent action to end the use of these cubicles and develop larger reception waiting areas."

This is something that would have been communicated orally at the time, and did you also see in writing quite shortly after, in advance of this report being published?

A. Indeed.

Q. However, I think we have heard that these dog boxes at Barlinnie -- this visit was in October 2018, and the dog boxes at Barlinnie were not removed until at least 2020, so far as I understand it. That would be 18 months to two years after the visit.

I'll continue on:

"The second observation regarded inmates on non-offence protection and extended rule 95(11) segregation (within and outside of the separation and reintegration units) at Grampian, Edinburgh and Shotts prisons, who were locked in their cells for 23 to 24 hours per day for several weeks, if not months, at a time. The delegation requested that the Scottish authorities ensure that all segregated inmates and particularly those inmates who are held outside of the SRUs under rule 95 orders are offered at least one hour of outdoor exercise every day."

So that's an example of something that in your view

would be able to be given effect to without necessarily incurring additional building costs or something of that nature?

A. It's something that could be given immediate effect to.

Q. "The third observation concerned treatment of women prisoners held in segregation at Cornton Vale prison, both within the separation and reintegration units and Ross House. The delegation met several women who clearly were in need of urgent care and treatment in a psychiatric facility and should not have been in a prison environment, let alone segregated for extended periods in solitary confinement. The delegation requested that the Scottish authorities provide immediate enhanced care and support by mental healthcare staff for these severely mentally ill women with a focus on providing a more therapeutic environment and ensuring they have more out of cell time and meaningful human contact."

So that's perhaps something that is not quite so easy to fix in the short term; would you agree? That is something that needs resources.

A. I think it's reasonably easy to fix in the short term if there's the will to do it. If it is seen as a priority, it doesn't -- that requires personnel. It requires engagement of prison staff with these women. It

requires prison management to look at the existing resource and how the existing resources are being applied, and whether more meaningful contact could be made from within the staff pool that already existed, albeit enhanced specialist services are also part of this.

LADY SMITH: Alan, are you telling me the oft repeated mantra "that's all very interesting, but there's no money for this" won't do because there are alternatives?

A. I think, my Lady, that in some respects these -- and I'm unfamiliar as to how the units in question were staffed at the time. But my reading of this is there would have been staff who would have been sitting the opposite side of locked doors, and these staff could be -- their skills could be better utilised by direct engagement with the women at the time.

LADY SMITH: Is that also a matter of tapping the ideas that the staff themselves may have if they're invited to contribute?

A. Absolutely. It's very boring for staff to be sitting the opposite side of locked doors.

LADY SMITH: Thank you.

MS FORBES: I think after this visit and report, the CPT carried out a follow-up in 2019 and that, again, was in October 2019. They published their report in

October 2020.

I'm not going to go to it, but it was apparent, I think, from that report that many of the recommendations that were made in the report had not been implemented, particularly around high secure mental health accommodation for women, for which there is still no facility in Scotland.

I think they also commented that the use of long-term segregation remained worrying, given the length of time for which certain prisoners are held in such conditions and there was also the issue of the body worn video cameras that were recommended and they invited the Scottish authorities to consider rolling that out?

A. It's very, very unusual for the CPT to carry out a second ad hoc visit a year later than the previous ad hoc visit to the same establishments in any Council of Europe Member State.

Such visits -- and I speak generally here -- would be considered whereby the committee had real concerns that the recommendations following the previous visit had not been given due regard.

MS FORBES: Thinking about the Council of Europe and the member states; would it be fair to say, from this, it doesn't look like Scotland are performing particularly

well in comparison to other places?
A. There is no league table. However, when one looks at ad hoc visits that have taken place in quick succession these are very unusual.
Q. I think the changes from that, we have already talked about, which was the dog boxes at reception being removed. But also Cornton Vale has closed and Stirling opened?
A. Yes.
Q. Although we don't know what the situation may well be in respect of the women who have been transferred there. Two community custody units in Dundee and Glasgow, for women, have opened in 2022, which I think gave effect to some part of the recommendations that were talked about.
I don't know if that --
LADY SMITH: Would that be a good place to pause?
I normally take a short break now, if that would work for you, Alan, and I'll sit again in another ten minutes or so. Thank you.
(3.03 pm)
(A short break)
(3.15 pm)
LADY SMITH: Alan, are you ready for us to resume?
A. I am.
LADY SMITH: Thank you.

Ms Forbes.

MS FORBES: My Lady.

Dr Mitchell, just thinking about the CPT report that we've just looked at, the recommendations and the follow-up that was carried out, in your capacity in the CPT; have you been aware of any concerns that there could be a situation whereby a Member State refuses to extradite someone to the UK because of convention concern or violations in prisons?

A. As you referenced before, I do quite a lot of work for the extradition court, which sits at Westminster Magistrates', and I'm aware of two recent cases. There was a case where a court, I believe, in Karlsruhe, in Germany, refused extradition very recently to the United Kingdom. It was to Wandsworth Prison and, in fact, that case was highlight -- brought to my attention by the current UK judge at the court.

There was also a case very recently whereby a High Court judge in Dublin refused extradition from Ireland to Scotland on account of his concerns that the conditions of detention -- I believe it was at Low Moss -- and the treatment to be afforded to the requested person. If he were to extradited, that there was a real risk that his Article 3 rights would not be respected.

Q. As you pointed out earlier, there has also been a decision previously about the size of accommodation in which prisoners are being kept, in a decision by a judge that that was a breach of Article 3?
A. Yes. The Muršic v Croatia case is a well-cited jurisprudence of the European Court of Human Rights, and indeed is the benchmark against which all cases in relation to prisoners' living space, I understand, is referenced when such cases are brought.
Q. So if you are looking at it through the context of a situation whereby member states are potentially going to refuse to extradite individuals to the UK because of concerns about the conditions they're being held in in prisons, that's quite a sad state of affairs to be in?
A. I think it's an extremely sad state of affairs. But I would hope that such refusals of extradition requests would only serve but to increase the stimulus to improve conditions within prisons in the United Kingdom.
Q. If I can go back to your statement now, which is the WIT-1-000001201, and we were on page 25 before we went to the CPT report. There is a section just after paragraph 80, "Concerns about abuse or ill-treatment of young people in Scottish institutions".
I think this section of your statement, you are talking about whether or not you had any concerns when

you worked in Scottish prisons, and you comment that your experience of young people at that time was limited to Longriggend in the late 1990s and Polmont, as head of the prison healthcare services from 1998 to 2003.

You can't recall any specific example where you had a concern about abuse in relation to a young person. However, you do refer again to the committal of a young man at Longriggend under the civil mental health legislation?

A. Yes.

Q. We have gone through that and you've told us your reasons behind that, and the fact there wasn't a psychiatrist available at that time to come and see him at the weekend.

The concern later on in that paragraph is the legislative provisions may still be the same today and perhaps there's a lacuna in the law in that respect.

Continuing on to paragraph 82, you talk about the impact on families and that that shouldn't be underestimated in respect -- when a father or mother or another carer is imprisoned and it's difficult to see a situation whereby imprisonment is not harmful and does not have a negative effect on the prisoner's family, and when a family member is committed to prison the work that prisons can do by and large is limited to that

family member who is in the prison?

A. Mm hmm.

Q. Going over to page 26, you comment it's much more difficult to work with the whole family as a unit.

At paragraph 83, you say that the Scottish Prison Service does give consideration to the distinct needs of young people, and you give an example that when you were with the Scottish Prison Service you know that there are parenting classes at Polmont and, at Shotts, many of the men would have had older children while some still had young families. Classes about looking after a newborn or one-year-old infant can be very helpful for new dads, and you were aware that parenting classes were also offered to young women in custody.

Is that --

A. Yes, yes.

Q. You think that the Prison Service became much better at working with those who were in custody to identify what learning and activity opportunities might help them whilst in prison and beyond.

A. I think we have.

Q. The examples you give are anger management, which of course would be relevant in many cases and help with the drug and alcohol abuse?

A. Yes.

Q. I think you were asked, at paragraph 84, about whether you have been involved in any police statement or given information to the Crown about concerns about a child or young person in Scotland or alleged abuser and you haven't?

A. That's correct.

Q. Looking at the use of restraint then. Paragraph 85, you've been asked to comment on the use of restraint in residential care settings for children and young people in Scotland.

You say that you are not sure whether the Care Inspectorate are currently responsible for monitoring the use of physical restraint in residential care settings for children and young people in Scotland. I think we have heard evidence in this Inquiry that they are.

You say that the CPT's standard is, when restrained, all persons should be under the direct, constant supervision of a member of staff?

A. Yes.

Q. Just talking about that, do you mean -- is that the mechanical restraint?

A. Yes.

Q. In the circumstances, we talked about the belt.

A. Yes.

Q. Your view as the CPT, throughout the whole course of that restraint, whether that be for a couple of hours, if that was still ongoing, they should be under constant supervision?
A. Indeed.
Q. You say, as well, it's been a long time since you've worked with young people in custody, and supervision practice and restraint may well have changed, and the CPT are not involved in visiting residential care settings in Scotland?
A. They haven't visited any to date, as far as I'm aware.
Q. Do you think that's because there is another organisation carrying out that type of oversight and function, or is it just something that they haven't decided to undertake as yet, but could in the future?
A. It's something that the committee may decide to undertake in the future. It's -- the work of the committee has been going on now for several years. The focus of the committee's work necessarily does change, as I've said. We are not a prisons inspectorate, though most people who are deprived of their liberty are in prison, so we always have a focus on prisons.

In advance of country visits, we're very dependent on what non-governmental organisations tell us, what the regulators in that country tell us, and the information

they give is -- very much informs our thinking as to where -- where can we add value?

Because if we can't -- don't add value, then we're not utilising the skill set that we can as best we might be able to.

If, for example, in any country there was information provided, contact from organisations involved in residential care settings for children, then the CPT would look at that, would consider that as part of a future visit.

Q. Are you aware of a recent report in relation to Edinburgh Secure Services that was made available?

A. I'm not, no.

Q. In fact, that service had been shut down thereafter, but it was result of a whistleblower coming forward.

A. No.

Q. In a situation like that, a residential care setting, where perhaps it hasn't been uncovered by, for example, the Care Inspectorate or another organisation, is something that -- if you thought the CPT could add value; it would be something that would be considered?

A. Yes.

Q. Albeit you, as the UK member, would not be the person involved in making that decision?

A. No, that's right. But the national member -- once

a country visit -- once a periodic country visit has been decided upon, the national member will provide a briefing to the members of the visiting delegation as to her or his understanding of the current situation, any hot topics, as it were, within their country.

Thereafter, it's entirely up to the delegation to decide which places they'll visit. The national member may simply provide that information, that intelligence.

Q. Because the information that the Inquiry has heard is, at the moment, there are only five young persons under the age of 18 being held in the Scottish Prison Service estate and that the goal seems to be to move any under 18s out of that system entirely and into some form of secure setting.

It may be that in the future young persons under the age of 18 who are held -- who have their liberty deprived, are invariably being held in secure settings. So if you wanted to look at those conditions, you would have to go to those types of settings.

Were you aware of the fact that was the goal in Scotland, to move those people of those ages out of the prison estate?

A. Yes. I was aware of the fact. I was unaware there are currently only five people -- there are only five children in prison in Scotland, in prisons or young

offenders institutions in Scotland at the moment. That is quite a shift as compared to what was the case in previous years, and a welcome shift.

Q. If you go to paragraph 86, again, you are going on to continue talking about restraint and you say that if applied without appropriate oversight and safeguards, for example applied longer than necessary or if the person were not released in order to use, for example, toilet facilities because they weren't under the direct supervision of staff, then restraint could be described as inhuman or degrading treatment contrary to Article 3?

A. Yes.

Q. Going over to page 27, it continues on that paragraph. It could be, you say, a justifiable interference in respect of Article 8 if a young person is in prison, for example, with restraint being applied proportionately and safely. Having regard to that consideration, you say that it's all the more important that there is clearly a precise legal basis for doing so, and that the law and restraint of children and young people in care should be freely accessible to those who may be affected by it?

A. Yes.

Q. Is the lack of any guidance or law in relation to restraint of children and young people; is that

something that you're aware of in Scotland?
A. I am unaware of any guidance in relation to the use of restraint in young people in Scotland.
Q. Looking forward then, lessons to be learned. At paragraph 87, you say that you deliberately avoid using the word "rehabilitation" in the prison text because it's overused and misunderstood. You question how prisons can rehabilitate because at best, you say, the prisons can work with people to prepare for that person's reintegration into society and in that regard social skills are extremely important?
A. Yes.
Q. Paragraph 88, you make the comment that paediatricians and doctors dealing with children will see them at a young age, primary school age, nursery or pre-nursery. But by the time they get to secondary school age, at which time they have a lot of hormonal and emotional issues going on perhaps, they are unlikely to be in touch with Health Services and that culturally our health systems could do far better by thinking about what the health needs of secondary school aged children and young people might be?
A. Yes, absolutely.
Q. Young people, in your view, are more open now to talking about how they feel than perhaps when you were at

school, and perhaps social media and the fact that people are able to share that information has given them permission to do that in part?

A. Yes.

Q. You talk about a legislation being an important safeguard, but when it is inappropriately applied it becomes a non-safeguard. I think we have already touched upon the fact that there may well be a look-in in the current legislation when it comes to mental health provision for young people in custody?

A. Yes.

Q. You make the point that legislative safeguards should be, perhaps, even stronger for a 17-year-old in prison than a 17-year-old in community -- in the community, that it should have even greater protective effect. But, at the very least, you say that someone who is 17-years-old and living in Airdrie and has a mental health crisis should be given the same -- sorry, a 17-year-old in Longriggend, if it still existed, and having a mental health crisis should be given access to the same services if they were 17-year-old and in Airdrie and in the community?

A. Yes.

Q. The fact that a person's in custody shouldn't make a difference as to how they might access specialist

mental health assessment and care.

I think you go on to say that in the course of your work with people in prison you have observed some themes that concern young people. I'll just go through that.

The communication and ability for staff and a detained person to communicate freely at all times; interpretation services, which you will have come across at Dungavel, for non-English speaking individuals who are remanded; to be able to communicate with other prisoners, staff and access to telephone interpretation services.

You make the point that you are provided with an interpreter when interviewed by the police or while you are at court, but when you are then in a secure setting you need to be able to try to communicate with people on a daily basis and it's very difficult to do that if you can't speak the language or don't have access to interpreter facilities?

A. Indeed. When I was chair of the prison monitoring advisory group, I asked a question as to how frequently recourse is made to the use of telephone interpreting in Scotland's prisons and the answer was: we don't know, but we don't think it's very often.

Which I think is self-explanatory.

Q. If the demographic of the country means that there are

more people in the population who are unable to speak English or fully understand what is being said because they speak a different language that becomes all the more important?

A. Of course it is.

Q. We are thinking recently, with events in Ukraine, there will be a lot of young people who have come to the UK and Scotland who may well be young and unable to speak the language fluently?

A. Yes.

Q. You talk about: when does neglect of a person's need become the equivalent to deliberate ill-treatment?

I think Her Ladyship touched on that earlier. It's the recklessness or neglect that can also amount to deliberate ill-treatment and effect.

You make the point that sometimes young people are simply seen as shorter, less mature versions of taller and biologically older people. But, in reality, their needs are extremely different. We have heard in the course of this Inquiry about the medical evidence that young persons and the development of their brain isn't really complete until the age of 25.

A. 25.

Q. I think, given your views, you would agree with that?

A. I would.

Q. You talk about staff needing to have appropriate training and awareness to deal with the differences, and you say that you often visit prisons in Europe and beyond and it's quite obvious sometimes that staff working with young people have not been the subject of any particular selection process, and that staff need to be specifically trained and recruited for looking after children, but that's not your experience at the CPT and every country?

A. No.

Q. You also talk about the fact that maturity levels can vary massively between even someone who is 15 and someone who is 25. It's perhaps unhelpful to reference age in the whole debate, but there's a need to try to identify specific individual needs for each young person and find out how they can be best supported and have their needs met.

You comment that people leaving the care system can access support until they turn 25.

A. Yes.

Q. And that each country in their legislation define young offenders slightly differently. There's countries where 14 and 15-year-old children are held in what is essentially prison custody. In other countries, they're held in secure accommodation for children.

You comment, I think, that we need to actively seek the views of young people and listen to them and, ideally, everyone needs to be assessed according to their needs.

You talk about a template for inspection of secure establishments and say that is something that could be agreed collaboratively.

Do you envisage that as a number of groups who have the appropriate interest and skills coming together to try to formulate that?

A. Yes. I think it's groups like the various Inspectorates that we have. It's the Children's Commissioner for Scotland. It's young people themselves. What is important to you? And how can we as the adults in the room best help ensure that your interests are protected as children? As adults, we've all been children.

Q. You say that it would be useful to engage with young people after they've left the care system or after they've spent a period of time in custody, and that perhaps could tell us much more about their experiences and inform the thinking of how we can make it better for them, because sadly a lot of people may end up returning to prison or deprivation of liberty situations.

You say that you need to try to engage with them about what has caused their return and what might the

prison have done better to prepare them for release and reintegration?

A. Yes.

Q. You then talk about Norway, and you say that in your view that's one of the most progressive criminal justice systems. You talk about a maximum secure prison there called Halden and the fact that the figures for recidivism are very good.

A. Indeed.

Q. Is there anything more you want to tell us about that, expand upon that?

A. I've been lucky enough to have been party to a number of conversations about Halden Prison. The recidivism rate is much lower as compared to other prisons in Norway.

Halden is a prison -- it's a modern prison, that's built without bars, and the Norwegian Prison Service is staffed by personnel who have, I think, a two-year training course as compared to the training for prison officers in the United Kingdom, which at the outset is limited to a few weeks and then there are updates.

Investment in the right people and in the right type of facility will pay dividends in relation to the societal benefits thereafter and certainly reduce recidivism.

Q. If we continue down in your statement to page 30, if we

go to paragraph 97, you say there that you have no objection to the witness statement that we've gone through being published as part of the evidence to the Inquiry and you believe the facts stated in the witness statement to be true.

That remains your position today?

A. It does.

Q. Is there anything else that you wanted to add? I think that's all the questions I have for you.

A. No, I think you've very thoroughly taken me through my witness statement, and so no further comment in relation to those areas that I could usefully provide further comment on, I think.

MS FORBES: I don't have any further questions, my Lady.

LADY SMITH: Alan, thank you so much for coming today to talk about what you've outlined in -- well, more than outlined in your written statement. It's been really helpful to me and I know you've not come to offer many instances of witnessing direct abuse, but what you've focused on, in relation to the various systems for various purposes that you've been involved in, seems quite unique to me. I'm really grateful to you for sharing your learning and experience with us in the way you have done.

You must be exhausted after everything we've

squeezed out of you today. I'm delighted to say you're now free to go, but with my thanks.

A. Thank you very much.

(The witness withdrew).

MS FORBES: My Lady, that is the evidence for today and, tomorrow, we resume with Teresa Medhurst and Neil Rennick from the Scottish Prison Service.

LADY SMITH: They are going to give evidence as a panel of two, both tomorrow and spilling into Thursday.

MS FORBES: That is my understanding, my Lady.

LADY SMITH: I'll rise now until tomorrow morning, starting at 10 o'clock. Thank you.

(3.41 pm)

(The Inquiry adjourned until 10.00 am on Wednesday, 1 November 2023)

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