Scottish Child Abuse Inquiry

Witness Statement of

Alan MITCHELL

Support person present: No.

1. My name is Alan Mitchell. My date of birth is [redacted] 1967. My contact details are known to the Inquiry.

Background

2. I attended Glasgow University and graduated with a degree in medicine in 1991. I undertook GP training in Lanarkshire. In 1996, I started work as a GP at Shotts Prison. I remained in that position until 1998. During that period, in addition to covering Shotts during the day, I was one of three GPs who covered Low Moss Prison in Glasgow and Longriggend Remand Unit just outside Airdrie in North Lanarkshire in the evenings and at weekends.

3. From 1998 until 2002, I was Head of Healthcare within the Scottish Prison Service (SPS). At that point in time healthcare services for prisoners in Scotland were commissioned by and provided by SPS engaged staff. I was employed by SPS and had a senior civil servant contract. My role was to coordinate the provision of healthcare services, including nursing and pharmacy services, across each of Scotland's prisons; including Polmont Young Offenders Institution and Longriggend, which closed in 2000.

4. From 2002 until 2007, I was engaged as a GP in a practice providing services to homeless people in Glasgow. In 2006, I was appointed clinical director of the East Renfrewshire Community Health and Care Partnership. In 2007, I also took on the role

as clinical director of the Renfrewshire Health Partnership. I remained as a clinical director in NHS Greater Glasgow and Clyde until 2017, when I left NHS practice.

5. In 2010, I started work as a GP at Dungavel House Immigration Removal Centre near Strathaven in South Lanarkshire. I have been there for twelve years. My clinical work is now solely within the immigration removal centre and I work around eight clinical sessions each month. Essentially as GPs we provide primary healthcare services to foreign nationals whom the Home Office detains in an immigration facility. Individuals are often held there prior to removal from the UK. Not all persons held there would be immediately removed from the UK however; many being granted bail by an immigration judge. There is a mixture of people held there. Sometimes, people have been in the UK for a period of time regularly and then their stay becomes irregular, for example if they overstay on their visa. There are also people who arrive irregularly, for example on small boats crossing the English Channel. There is a third group of foreign national ex-offenders. Within the UK, if a foreign national is convicted of an offence and sentenced I believe to a period of imprisonment of one year or more, there is a presumption that he or she will be deported at the end of that sentence.

6. From 2016 until 2021, I was chair of the Independent Prison Monitoring Advisory Group in Scotland (IPMAG). I was a Commissioner at the Scottish Human Rights Commission (SHRC) at that time and it had been agreed that chair of IPMAG would be one of my roles.

7. In 2002, I was also appointed as an expert by the Council of Europe to the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT); this arising because I had been recommended by Professor Andrew Coyle, whom I understand has already given evidence to the Inquiry. Prior to that I wasn't too aware of the Council of Europe or that there was a committee established to visit places of deprivation of liberty remitted with the prevention of torture in member states. Between 2002 and 2017, I was an ad hoc expert to the Committee. I typically carried out about three visits a year across different member states within the Council of Europe.

8. In 2017, I was elected as the UK member of the CPT. The Committee comprises 47 seats. Each member state of the Council of Europe has one member elected in respect thereof. Russia is no longer a member state but is still a party to our Convention. As the member elected in respect of the UK, I don't represent the UK or its government's policies or positions on the Committee. I am elected in respect of the UK. As the UK member of the Committee, I do not visit the countries of the UK. In 2021, I was elected President of the CPT.

9. In addition to my work at Dungavel and my engagement with the CPT, I undertake a fair amount of court work in relation to extradition matters as these concern prison conditions in requesting foreign states. I am usually instructed by the defence but my duty as an expert is to the court. I have also been instructed by the prosecution, but more often it is by the defence. I've also recently been engaged by the Central Legal Office (CLO) of the NHS and one of the medical defence organisations to give an expert opinion in relation to potential issues arising about medical doctors working in secure settings.

Medical work at HMP Shotts and Longriggend Remand Unit, North Lanarkshire

10. Longriggend held young male remands. I recognised that many of the young men I met there and subsequently in Polmont had come up through the care system, but it wasn't something that was specifically discussed. Between 1996 and 1998, I covered one in three weekends there. I would be on call overnight and often attended there out of hours. I wasn't given any particular training or introduction when I commenced that role. I was given very little direction. I had to make up my own mind about things very quickly.

11. I remember starting work at Shotts in 1996. In the early to mid 1990s, Scottish prisons could be somewhat violent places. There were a lot of prisoner on prisoner assaults. There were a lot of prisoner on staff assaults There had been a number of well-publicised incidents of staff on prisoner assaults. At that time, I believe there had been some successful civil actions brought by prisoners against staff for assaults. Early on

in my time at Shotts, I remember the Governor taking me into his office. He set out very clearly that if I had any concerns that a prisoner might have been assaulted by a member of staff then I should go directly to him. He very much wanted a culture of openness that set out clearly that staff on prisoner violence was wrong and wouldn't be tolerated. He told the staff that he'd spoken to the new GP and asked him to come to him if he had the slightest concern that any prisoner had been ill-treated. He made it clear that nothing would be hidden.

12. I did see a stark difference between the culture at Longriggend and prisons for adults. Longriggend was an environment where relations between prisoners and staff were more distant than at Shotts . At the time, it held young people of twenty years or younger on remand. It also accommodated particular adult prisoners as workers. They would be prisoners that the SPS wanted to keep separate from other prisoners. They may have included police officers or prison officers who had been convicted of offences for fear that their safety might be at risk if they were held in other establishments. I had very little to do with the adult prisoners at Longriggend. They kept themselves to themselves. I had most contact with the young people themselves.

13. The geography was funny because Longriggend was only a few miles from Polmont. I never understood the raison d'etre of Longriggend. A young person remanded by the court would typically spend their first night in Barlinnie. They would then be taken to Longriggend. When they returned to court, the bus started at Polmont and collected the young men from Longriggend. After court, they were remanded back to Barlinnie rather than Longriggend. All admissions to Longriggend were via Barlinnie. If they were standing trial at Glasgow Sheriff Court or Glasgow High Court, my understanding was that the young people would travel to court from Barlinnie every day rather than Longriggend. If you were going to be in custody for more than one night and you didn't have a court appearance, you were held in Longriggend.

Healthcare needs of young people

14. Young people tend to be fit and healthy. For example, Polmont held about five hundred young men in the late 1990s. The GPs there would see some mental health issues but

other issues tended to be musculoskeletal injuries and acne. Young people don't have the pathology that requires them to access hospital services very often. At Longriggend, there was a fair bit of self-harm amongst young people and a fair bit of inter-youngster violence. If I felt that someone needed to be seen at hospital in an emergency situation it was never a problem. Prison officers didn't want to have someone in the prison if the GP felt that he shouldn't be there.

15. If a young person had a physical health problem then I could get them to hospital quickly. If they had a mental health problem that I thought 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. It required them to be seen by the prison psychiatrist and the necessary forms completed, enabling them to be 'sectioned' under the Mental Health Act and transferred to hospital. It is mandatory for prisoners to be 'sectioned' if they require mental health assessment even if they agree to be admitted to hospital voluntarily.

16. I remember one occasion at Longriggend when I took the view that a young person needed to be reviewed by a psychiatrist and a period of inpatient assessment. If I recall correctly it happened at the weekend. I decided to use the civil procedure. I took the view that as he was on remand and he had not been convicted. I could use the civil mental health law as applicable to the community at the time. I 'sectioned' the young man. I phoned the psychiatrist at Monklands, who accepted the patient. The following week, I was criticised. If I recall correctly, the Mental Welfare Commission were a bit unhappy that I had used the civil procedure. The Commission are notified every time someone is admitted to hospital on a compulsory basis. I don't think there had been a previous instance whereby the civil mental health legislation had been applied in such a circumstance.

Segregation

17. At that time, prisoners placed in segregation had to be reviewed by a doctor. Segregation is now called "care and separation". It is a matter for prison management

rather than the doctor, but the prisoner in segregation had to be seen by a member of the healthcare team every day. I think they had to be reviewed by the GP once a week.

18. The Prison Rules were the same for young people as for adult offenders. There may have been a couple of paragraphs about younger prisoners, but the rules were the rules. As far as I'm aware, rules relating to restraint were the same for young people as for adults. If physical restraint was used, the prisoner had to be reviewed by a doctor. If a prisoner was relocated from normal cellular accommodation to the segregation unit they might have to be restrained by what was called a three man team. That person would have to be examined by a doctor to ensure that he hadn't been physically injured during that process. I was given guidance about what a permissible level of restraint was. It was written within the Prison Rules at the time. I had a well-thumbed copy of the rules.

19. The Prison Rules were revised to include a provision that if the doctor has a concern that continued isolation in segregation will have a negative effect on the prisoner's health, the doctor can recommend to the governor that the person be removed from segregation. The governor has to give effect to that recommendation. I suspect a lot of doctors are unaware of the provision and I don't know how many times it has been invoked. I think that revision came into force around 2006. I was one of the consultees at the time and I thought it was a positive step. On first consideration it was. The challenge is that the UN's Standard Minimum Rules for the Treatment of Prisoners, which is soft law, set out clearly that healthcare staff should have no part in deciding whether a person is fit for punishment or fit for segregation. The rule in Scotland means that doctors are not asked to declare prisoners to be fit for segregation but they can declare them to be unfit. If you don't declare them to be unfit are you then declaring them to be fit for segregation?

Suicide Prevention Strategy

20. In 1996, SPS had a suicide prevention strategy. It was really a suicide supervision strategy which entailed seclusion. There were three levels of supervision: Strict Suicide Supervision (SSS), Intermediate Suicide Supervision (ISS) and Basic Suicide Supervision (BSS). 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. That initial decision was frequently to place the person on SSS. This entailed the prisoner being placed in a so-called "safe cell", which was essentially a bare cell. It was designed to be ligature free with no physical ligature points. It also involved all personal effects being removed, including clothing. Prisoners on SSS would be provided with a rip-proof poncho and probably paper underpants along with a blanket or two. They would be locked in that cell with an absolute lack of stimulation. I think the rules at the time were that prisoners on SSS had to be reviewed every fifteen minutes. That review was carried out through a spyhole on the door.

21. Within 24 hours of being placed on SSS, the person had to be reviewed by a GP. In that system at the time, the GP decided whether the person needed to continue on SSS or could be reduced to ISS, BSS or taken off supervision. ISS involved the GP setting out what articles the person could have in their cell. They were still kept in the safe cell, but they could be permitted to have books or to come out of the cell for a cigarette. It was a very medical model. The GP would have about ten minutes with the prisoner prior to making a decision about the level of supervision. You would see the prisoner in the cell rather than in a consulting room. There were no chairs to sit on so I would often sit on the mattress alongside the prisoner. The assessment was based on my own judgement.

22. I knew the men at Shotts well, but I didn't know the young men at Longriggend. I would be there in an emergency capacity. I only covered Longriggend at weekends and evenings. There was a regular GP from Airdrie who worked at Longriggend, Doctor John Llwanda. He would be responsible for any follow-up. Similarly, there was a regular GP for Low Moss, Doctor David Latta. Doctor Llwanda and Doctor Latta would cover Shotts at weekends and night time when they were on-call. If they had been out to Shotts when they were on-call, the responsibility for follow-up with the men at Shotts lay with me. That was how the system worked. I think there was a psychiatrist who visited Longriggend. I think it was Dr Maureen Sturrock. If I recall correctly, she was a forensic psychiatrist and later became the principal psychiatrist in the Scottish Government Health Department.

23. If someone was on SSS, he had to be reviewed daily by the doctor. If I saw someone on a Friday night and I was on duty for the weekend, I would have to see them on the Saturday and then the Sunday. I recognised that the very austere environment was likely to be harmful to them. I tended to bring them down as quickly as possible from SSS to ISS then to BSS then off suicide supervision altogether. It was an incredibly medical model.

24. There is no period of enforced isolation which is emotionally safe. There is no period of isolation which doesn't have a negative impact. A lot of research has been done on this over the years. As GPs, we wanted people out of that austere environment as quickly as possible. The first time that I saw someone, I might reduce them to ISS. It was rare that I moved straight to BSS from SSS. I was relatively new and I didn't want to reduce the level of supervision prematurely. SSS usually lasted for a couple of days at most, but it depended on the GP and what risks the GP foresaw.

25. Young people wouldn't be on SSS for weeks but rather days. A few days was still harmful. If you're despairing enough that you try to hang yourself, to put you in a socially unstimulating environment could only cause you to be in further despair. There was no clock on the wall, you may struggle to discern daytime from night-time. There are staff peering through the hole in your door every fifteen minutes. If you're further despairing then you will tell the doctor what you think he wants to hear to take you out of that environment, which I became aware of.

Abuse at Longriggend

26. Longriggend was a very austere place. Relations between staff and prisoners were cold, but I never came across staff-prisoner violence at Longriggend. Safeguarding wasn't a word that was used in the 1990s. I did see prisoner on prisoner violence at Longriggend. I did not see prisoner on prisoner sexual violence in any of the prisons that I worked in. I never had a concern that someone had been a victim of sexual violence. If I came across something that I considered to be abuse, I was not given guidance on how to act other than that I would have gone to the Governor. I don't remember any such situations occurring at Longriggend.

27. I don't remember having any concerns that a young person had been the victim of violence at the hands of a prison officer. I do remember the harsh environment and the distant relationships between prisoners and officers. There was often disrespectful language used by prisoners and officers. Young people would swear at officers and officers would swear back at them. I felt a bit uncomfortable, but I suppose I accepted that was part of the culture at the time. Some of what was hurled by prisoners at officers was pretty awful. Often, the retorts from staff were also pretty awful. I didn't feel that there was a requirement to be challenging of that. There was no inspection or oversight of my work at Longriggend by any healthcare regulator.

Work as Head of Healthcare at SPS

Reform of Suicide Prevention Strategy

28. We changed the system of suicide prevention in 1999/2000 when I was at SPS headquarters. There had been a number of suicides in Scottish prisons in the late 1990s. Often, the suicides were of young people on remand or at the start of their sentence. There was a huge amount of political pressure in the late 1990s. Looking at the number of suicides in Scottish prisons over the years, I could understand the concern. I didn't know why so many people were taking their lives. If someone is determined to take their own life then they will, irrespective of how hard we try to prevent it.

29. Henry McLeish was the Minister at the time. I remember going to his office at St. Andrew's House with the then Chief Executive of SPS, Eddie Frizzell. We had to set out what we were going to do about the high number of suicides in Scottish prisons. We committed to a review of the system of managing those considered at risk of self-harm or suicide. There was a psychologist from Stirling called Kevin Power. He and I in particular felt that the system of identification and management of those at risk of self-harm needed to be more multi-disciplinary. The medical model was inappropriate. Our argument was that the staff working with prisoners during the day knew them best,

not the doctor coming in, even if it was the regular doctor. We felt that the staff should be much more involved.

30. We adopted a different approach called ACT. The acronym was Assessment, Care and Teamwork. We got the prison officers on board. There was some initial scepticism but we had a very open discussion. At that point in time, SPS had what was called a Suicide Risk Management Group. We held a number of events in prisons across Scotland to discuss our proposals with staff and set out our vision that we needed to move away from a purely medical model. The consideration and management of self-harm was everybody's job. There was some pushback from medical colleagues, some of whom quite liked the medical model. I however didn't agree with a mainly medical approach.

31. The revised strategy was very much that it was a team decision rather than the decision only of the doctor as to how a person should be managed. It shouldn't be a conversation carried out by staff in the absence of the prisoner. The person should be involved in the decision and be part of the conversation. There needed to be engagement between the staff as a group and the prisoner. The discussion should always include a member of the health care team, the prisoner's personal officer, if he or she were available, a representative from the mental health team and the chaplaincy services, if they were engaged. The safety net was that if one person's view was more cautious than the others, that view was determining. For example, if one person in the review team felt that the person still presented a high risk of self-harm and should be held in a safe cell then that was the default. The most cautious voice was listened to, which I think was appropriate.

32. In the course of an ordinary consultation with me, if a prisoner expressed suicidal thoughts then I could initiate the process for them to be placed in a safe cell. On most occasions when a concern was raised by a member of staff, the doctor wouldn't be present. It would be the prison officer who made the decision, often with input from one of the senior officers. They would typically be placed on SSS. They were not as far as I can recall placed on ISS or BSS. It was only the doctor who could reduce the supervision level. The new system was much more about having a team discussion

about it and importantly the prisoner should be involved in that. The system remains in use in Scottish prisons in modified form. A similar approach is also in use in England and Wales.

33. As soon as any member of staff expresses a concern that someone was at risk of self-harm, there has to be an assessment involving more than one member of staff. Typically, one of the nurses and the duty manager would be involved. They would have an initial case conference to decide the most appropriate environment that the person can be managed in. It's not always the case that they need to be placed in a bare cell. Previously, it was uni-directional and there was only one outcome if there was the slightest concern that someone was at risk of self-harm. It's now a much broader assessment. There are not nearly as many people placed initially in safe, bare cells as was previously the case. Safe cells are I believe now used less frequently. I think there is a much greater appreciation, not only amongst healthcare staff but also amongst custody staff, about the negative impact that placing an individual in isolation can have. The culture now is very much about working with the person to explore the reasons for their thoughts of self-harm and trying to find a way through it.

34. ACT was designed as a care-planning process. It set in place a number of aims by way of interventions that might be helpful and who should be involved. It's very much a care-planning process that can last for several weeks. It will include, importantly, engagement with mental health professionals. Prisons now have dedicated mental health teams. There is much more engagement with prisoners who are placed in bare cells nowadays. In the late 1990s, the door would be closed most of the time. There is now more engagement between staff and the person placed in the safe cell, albeit I don't work in Scottish prisons now so I may not be up to date operationally.

Observations on current healthcare provision in Scottish prisons

35. Unlike England and Wales, if you visit any Scottish prison today, it's unlikely that you'll find someone in prison whom a psychiatrist has assessed as requiring hospital treatment who has been waiting any significant period of time for an inpatient

psychiatric bed. That is perhaps with the exception of Cornton Vale. The psychiatrists at the State Hospital at Carstairs have an excellent relationship with the prisons. Many of them will have allocated prisons where they undertake regular sessions. The treating psychiatrist in the prison may well be the psychiatrist who has an available bed either in the State Hospital or in one of the intensive psychiatric care units in a community mental health facility. Cornton Vale is a bit different because Carstairs does not take women. The last two published CPT reports in relation to Scotland set out the Committee's concerns in relation to Cornton Vale. There can be women in Cornton Vale who have been assessed as requiring a high secure hospital bed. The only high secure facility for women in the UK is in Rampton in England. That's challenging because of different mental health legislation in England. Fortunately, there are medium-secure facilities at Perth and Rowanbank Clinic in Glasgow.

36. I think there have been big challenges since the NHS took over responsibility for healthcare in Scottish prisons in 2011. There are significant staffing challenges. There is a huge organisational difference between the healthcare providers and prison staff. There are often tensions between healthcare staff and prison staff. That's one of the reasons why I no longer do locums in Scottish prisons. Laterally, I didn't enjoy it. When I worked in prisons, there was a whole team approach. Healthcare staff relied on custody staff and custody staff relied on healthcare staff. Now, because they are engaged differently, there can often be tensions. The healthcare staff have an NHS way of doing things and the custody staff have an SPS way of doing things. There was a report by the Scottish Parliament's Health and Sports Committee, which I think was published in 2017. It was actually quite a damning indictment of healthcare in Scotland's prisons.

37. I think little has changed since the publication of that report. In my experience, the flexibility isn't there anymore. Previously, there was one world and now there are two worlds, the NHS world and the SPS world. There are big issues around access, care planning, staffing and prisoners as patients having difficulty accessing hospital services. In some prisons, there will be a quota on the number of prisoners that can be taken to hospital in any one day. There can be a quota for outpatient appointments and a quota for inpatient bed watches. It's not needs-based at all. It's all about staffing.

When I worked in Shotts as a GP, if we had two patients already within the local hospital and I had a third emergency who needed to go, the officer in charge of prisoner escorts would come and ask me if that prisoner really needed to go to hospital. If I said that the man needed to go then the officer would find the staff. There was never an occasion whereby I could not ensure that someone whom I felt I was no longer able to care for, was not transferred to hospital.

38. Nowadays, prison managers might say they only have enough staff such that we can have two patients attending outpatient appointments in the morning and two in the afternoon. When the pattern of outpatient attendances for the next week becomes evident, doctors and nurses are often asked to prioritise. Prison managers will tell them that only two prisoners can attend appointments and the healthcare staff have to choose which two go out to that day. It can be similar in relation to emergency or urgent care.

Monitoring of Scotland's prisons

39. From 2016 until 2021, I was chair of the Independent Prison Monitoring Advisory Group in Scotland. The responsibility for prison monitoring in Scotland now sits within the office of the Chief Inspector of Prisons. When prison monitoring was introduced in Scotland, there was established an independent prison monitoring advisory group who would advise the Chief Inspector on the monitoring of prisons. As a Commissioner within the SHRC, it was decided that I would be chair of that advisory group. Independent prison monitors are lay people. The legislation requires that there is a weekly visit by a monitor to each prison in Scotland. Inspections happen every four or five years. They can be announced and unannounced.

40. There used to be something called the Visiting Committees (VCs) in Scottish prisons. They were not independently appointed. They typically comprised local councillors and others appointed by the Secretary of State. Some were considered to be more effective than others. The VC at Polmont was chaired by the wife of Lord Cullen. It

was felt to be a VC that actually looked and engaged and sought to have a real understanding of what was happening in the prison.

41. Independent prison monitors have replaced VCs. They are lay people who volunteer their time by going into prisons. They monitor what is happening there. For example, they can talk to prisoners in private. They can choose which prisoners to talk with or any prisoner can make a request to see an independent prison monitor. They will look at the regime and what's happening in the prison. If there are any incidents within the prison then they should be informed. If there is a death in custody, they are informed of that. They don't investigate complaints as such, but if a prisoner has a complaint then they can approach a prison monitor who can assist in advising as to how the prisoner should progress their complaint. The monitor can speak to the prison staff on behalf of that prisoner. They therefore have a liaison role between prisoners and staff.

42. The Independent Prison Monitoring Advisory Group was charged with advising the Chief Inspector of Prisons on the monitoring process. It included representation from ex-governors. We also had academics, the former chair of the parole board and my predecessor as UK CPT member. Our role was to advise the Chief Inspector of Prisons on what we felt that effective monitoring should look like in Scotland's prisons.

43. There are four monitoring coordinators across Scotland, who are civil servants. Their job is to coordinate the activities of the volunteers. There are monitoring frameworks including in relation to decency, activities and access to healthcare. When I was chair, the advisory group felt that the independent prison monitors needed to pay more attention to those held in segregation units.

44. Things were difficult during the COVID-19 pandemic. The CPT suspended its in-person, on-site monitoring between March 2020 and July 2020. We restarted our on-site monitoring in July 2020. I remain quite firmly of the view 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. COVID was a very unhealthy period for Scottish prisons and SPS is still struggling to get out of it. Lockdowns were severe. In March

2020, the CPT issued a statement of principles in relation to the care of those in custody in the context of the pandemic. It included some fundamental rights that should always be respected. These fundamental rights included access to hot water and soap every day, the ability to take an hour of outdoor exercise every day and the ability to remain in contact with your family and your lawyer.

45. In Scotland's prisons, little regard was given to ensuring that those principles were fully respected. You monitor the principles by going into prisons and seeing things in person, taking appropriate precautions such as COVID tests and wearing personal protective equipment as required. During the height of the Covid pandemic monitoring was frequently done remotely. There would be a liaison person, a member of prison staff who was appointed to talk to the monitoring coordinators. While many prisoners would be locked in their cells and not be given an hour of outdoor exercise, some prisoners with work privileges, called "pass-men", would be outside their cells cleaning. The telephone calls between monitors and prisoners were typically between monitors and pass-men because the pass-men were on the landings. They were happy to be out of their cells. I was of the view that we wanted to be talking to the people who were locked in their cells.

46. There was one instance at Greenock Prison whereby, if I recall correctly, a prisoner was confined to his cell for over three weeks. It was all in the context of being a close-contact with a COVID positive person and then developing COVID. For three weeks, the man didn't get out of his cell at all. He had no access to a shower, no access to outdoor exercise and no access to a telephone. You cannot deny someone access to their lawyer. As chair of the Advisory Group, I had a number of meetings with the then Cabinet Secretary for Justice in relation to my concerns from a human rights perspective as to what was or was not happening in Scotland's prisons.

Work of the Committee for the Prevention of Torture

47. The CPT is a treaty monitoring body. The UK is party to the European Convention on Human Rights (ECHR) and also party to the European Convention for the Prevention

of Torture and Inhuman or Degrading Treatment or Punishment. The word "prevention" is key. If you look at reports for inspectorates of prisons, you find very little if any reference to ill treatment. Ill treatment and the prevention of ill treatment is the key to the mandate of the CPT. In all the reports of our committee, one of the first things we reference is in relation to any allegations of deliberate ill treatment of prisoners by staff. We then discuss any allegations of inter-prisoner violence. We are not a judicial body nor are we an investigative body, but of necessity we interview staff and prisoners when we visit places of detention and try to ascertain the situation vis-a-vis safeguards for the prevention of ill treatment.

48. There is no single internationally agreed definition of torture. When visiting prisons, I will often introduce myself as being a member of a committee for the prevention of ill treatment. If you use the word "torture", staff will respond by saying that they don't torture prisoners. The Committee is for the prevention of torture and inhuman or degrading ill treatment or punishment. Denying someone access to a shower for a significant period of time could be described as inhuman or degrading. Our reports also consider access to work opportunities, vocational training and education.

49. The CPT is not a prisons inspectorate.. The core of our mandate is Article 3 of the European Convention on Human Rights- the prohibition of torture and inhuman or degrading treatment of punishment.

50. The Committee undertakes periodic and ad hoc visits. In July of each year, the Committee will advise which countries are intended to receive a periodic visit the following year.. Larger countries typically receive periodic visits every four years; smaller countries a periodic visit every six to seven years or so..

Selection of Committee members

When Committee members are being selected, the process in the UK is such that there is an open competition. Anybody who meets the person specification in relation to experience, typically experience of the criminal justice system or the healthcare system particularly as it relates to persons deprived of their liberty, can apply. 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 coordinating body. Thereafter, UK ministers will propose a list of three candidates to the Parliamentary Assembly of the Council of Europe for their consideration. The Parliamentary Assembly will then approve or otherwise the list of three candidates.

51. The three candidates proposed by the member state all have to be appointable. States cannot seek to have their preferred candidate elected. There has to be at least one man and one woman on each of the country lists. The Parliamentary Assembly must be content that the three names suggested by the state part have the competence that they can serve as independent experts. A vote is then held at the Committee of Ministers who elect the members of the CPT.

52. The President of the CPT 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. At present, the first Vice-President is Hans Wolff, who is a medical doctor from Switzerland and the second Vice-President is Therese Rytter, who is a lawyer working for a Danish human rights NGO, Dignity. Each of the Bureau members serves two years but they can be re-elected. Members elected in respect of each state are typically elected for a four year term and can be re-elected only twice.

53. Judges to the European Court of Human Rights are elected by the Parliamentary Assembly rather than the Committee of Ministers for a tenure of office of nine years.. They may remain as judges until such time as a successor has been identified and is ready to take office. The CPT is different in that a member must leave at the end of his or her term, irrespective as to whether a successor member has been identified or otherwise. There will therefore be periods when, for various reasons, we may have as few as 39 members rather than 47 as happened recently.

54. I was first appointed as a member of the Committee in 2017. This is my sixth year and my second mandate as a member. My predecessor was also a Scot, Jim McManus. He is an academic lawyer and a previous chair of the Parole Board for Scotland. He was also the Scottish Prison Complaints Commissioner when I first started working in

Scottish prisons in 1996. My predecessor as President of the CPT was Mykola Gnatovskyy from Ukraine, who is now a judge at the European Court of Human Rights. His predecessor was Latif Huseynov of Azerbaijan, who is also a judge at the European Court of Human Rights.

Training

55. Many of the members of the Committee have quite a close working knowledge of the criminal justice system, social care system or psychiatric healthcare system in their own country. They may have had a role in inspecting or working directly in places of deprivation of liberty in their own country. As a Committee, whenever we meet in plenary we dedicate time to training activities as suggested and recognised by Committee members.

56. As members, we all have expertise in our individual fields. The plenary meeting allows us to share our expertise with our fellow Committee members and the staff group and also often involves external experts in our training activities in monitoring places of deprivation of liberty .

Process of Committee visits

57. When the Committee visits any country, it familiarises itself with the national legislation and also the local prison regulations. Typically, there will be around seven Committee members on a visiting delegation, but it also depends on the size of the country being visited. We also take with us ad hoc experts and interpreter colleagues. Additionally, we are assisted in our visits by Secretariat colleagues, many of whom have been at the CPT for many years. Some visiting delegations can therefore be quite large, but we split into groups. If we're doing a periodic visit, we might have one group that looks at prisons and police and another group that looks at psychiatry and social care homes. When we undertake our monitoring work, we'll form an assessment as to how well or otherwise the safeguards within either the national legislation or local regulations are being applied in practice.

58. The CPT is not an inspectorate body. It is a treaty monitoring mechanism. For example, in the UK context there are inspectorates of prisons. The core of our mandate is the prevention of ill treatment. In exercising our mandate, when we enter prisons we ask ourselves what are the safeguards to prevent ill treatment within this prison? What are the conditions within this prison which may lend themselves to a culture whereby there may be ill treatment? These are issues such as overcrowding and lack of staffing. In relation to accommodation, we consider whether prisoners have their own cells or whether there is sharing of cells? Is there a risk assessment before prisoners are required to share cells with one another? In some countries, the norm would be for persons to share large dormitories. As a Committee, we recognise that large dormitories can be an environment where inter-prisoner violence flourishes. We would consider that. We look at issues such as the role of healthcare staff in the documenting of injuries and the reporting of injuries where such are found. Access to healthcare staff, accurate recording of injuries and reporting of injuries as appropriate add to the safeguards that prevent ill treatment.

59. There are of course instances where we come across deliberate ill treatment of prisoners by prison staff. Deliberate ill treatment happens for a number of reasons. Factors include overcrowding in prisons and low staff to prisoner ratios. Staff numbers in prisons tend to be set according to what the designed operational capacity is, rather than the actual number of persons held there at any one time. Prison overcrowding is a blight in many countries across Europe. Many of the prisons in the UK are overcrowded and understaffed, which is a situation that very much lends itself to increased physical violence between prisoners and prison staff.

60. Our mandate is a significant one when we visit a country. We often start a visit by talking to Non-Governmental Organisations (NGOs). They will give us very helpful information because they often visit places of deprivation of liberty. At the end of a visit, we would routinely have final talks with government ministers.

61. During our visits we have access to all documentation, both hard copy and electronic, that we think might be helpful to us. That can include disciplinary registers and access to CCTV recordings that may be held by the prison. We are able to interview prisoners

in private. We are able to talk to members of staff or any such person whom we think could be helpful to us in our evaluation of the situation in relation to any ill treatment that does prevail or more so the safeguards for the prevention of ill treatment. We always have professional interpretation services to hand as is required.

62. We speak to management of an establishment. On occasion we may speak with a prisoner's lawyer, with the prisoner's permission, if the prisoner has a particular issue and their lawyer is handling that issue for them. As a Committee, we do not consider individual complaints. We do however when we visit prisons look at the complaints register. We take a view on the complaints handling process. An effective complaints system is a good safeguard in the prevention of ill treatment.

63. We speak to staff and it's important we do that, but we spend most of our time engaging with prisoners. They are key to our work. The length of time we spend at an institution is at our discretion. Typically, we start early in the morning and finish late in the evening. We need to interview a representative sample, depending on what the issues are. We seek to interview all groups of prisoners. We are aware that certain groups of prisoners are more vulnerable. If there is any ill treatment, certain groups are more likely to be ill-treated than others. We will have a particular focus on those groups of prisoners, who we believe to be at greatest risk of ill treatment.

64. Those vulnerable groups include prisoners secluded in segregation units for punishment reasons or administrative segregation purposes, which 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. There will be people who are held in isolation for medical purposes, for example they may have a communicable disease such as tuberculosis. Juveniles are a group who are identified as being at increased risk, as well as people who have committed sexual offences, particularly sexual offences against children. Transgender people are also often at greater risk.

Juveniles

65. We do consider the conditions of detention and treatment of juveniles as a Committee. Some of our visits will include to juvenile institutions. In respect of a regime of purposeful activities, one of the things that I'm keen to talk to young men in custody about is parenting issues and how imprisonment might better prepare them for returning to their families when they're liberated. Many young people in prison have very young children and miss out on their children's formative years in many respects.

66. Prisons should in part be preparing people for reintegration. Most people are in prison for a short period of time and they will then return to society. In relation to preparation for release, I believe that these kind of health issues are important to discuss with young people. Bullying is common among juveniles so we do talk to them about that.

Safeguarding concerns

67. If a visiting delegation had a safeguarding concern, they would discuss such with the relevant person on site, at the time such as the prison governor. Within our Convention, there is the provision within Article 8, paragraph 5 which enables the Committee to make an immediate observation to the authorities. We can make an immediate observation with a request that action be taken immediately and that we be informed as to the outcome. We see that very much as an example of cooperation between ourselves as the Committee, the staff at the establishment we visit and the member state.

68. The immediate observation, as well as being made orally, would also be made in writing to the state party. It would be reflected in the Committee's report to that country. There may be visits whereby there are no immediate observations. There may be visits whereby there are a number of immediate observations. Follow-up depends on what the immediate concern is. The member state is often asked to confirm, typically within one month, that the action requested by the Committee has been effected. If the authorities of a country tells us that they have acted then we take that on trust. As well

as periodic visits we have a system of ad hoc visits. When we go back to a country, we will check that action has been taken when we return to an establishment.

69. There have been occasions when the Committee's visiting delegation has come across a young person for whom they have made an immediate observation. On occasion, members of the Committee have been concerned about a particular detainee and have engaged with the management of the establishment and recommended the transfer of that person to another cell or another prison.

70. I would 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. I am paraphrasing from the work that I do with the Home Office in relation to those who believe themselves to have been victims of torture. One of the roles a GP has within an immigration removal centre is to report to the Home Office any concerns they have that an individual may have been a victim of torture. There is a Home Office definition of torture, but there are a number of other definitions of what constitutes torture. There is not a single definition used by the CPT. The CPT is not a judicial body. In our reports, we use the phraseology that an act(s) could be described as amounting to torture or inhuman or degrading treatment.

71. In some countries, mothers can have their children stay with them in prison for quite some time. I think there are a number of issues in respect of very young people being in prison with their mum. In relation to the conditions in which both child and mother are detained for example, the child may be held in a regime as restrictive as the mother is held and may not enjoy as much time outdoors as other children held with their mothers who may have a more open regime, although in the same prison. These are children in custody who are often not afforded the full range of activities afforded to children in the community and it's important that for children who are in prison with their mothers that they have as full access to play and education as possible .

Reports of the Committee and member state responses

72. A draft report which is compiled by the visiting delegation is presented to the plenary for consideration and adoption by the whole Committee. Reports of the Committee are reports of the Committee, not reports of the delegation. Immediate observations are formulated by the delegation and conveyed to the relevant parties. The national member has no role in commenting on a report for their own country.

73. Reports of the Committee are submitted to the government of the state party. It is the state that is the party to our Convention. The UK is rather more complex legislatively because there are three devolved nations therein. Any report of the CPT in respect of a visit to any part of the UK is addressed to the UK Government. A report in respect of Scotland is transmitted to the UK Government rather than the Scottish Government directly. My understanding is that UK Government will liaise with Scottish Government which would compile their response, which is then forwarded to the UK Government for onward transmission to the CPT.

74. As the national member, I am not involved in visits to the UK, nor would I take a view on whether a visit to the UK is required or otherwise. The national member is precluded from having any discussion in relation to the substance of reports concerning their own country and don't have any influence as to when a visit should take place and what should be looked at. Those matters are for the wider Committee and the visiting delegation.

75. The CPT visited Scottish prisons in 2018 and made various observations. Reference was made to the "dog boxes" (holding cubicles in the reception area) at HMP Barlinnie. They've been there for far too long. I worked at Barlinnie for a short period of time, most recently about ten years ago. The "dog boxes" have been criticised by the CPT since 1994 but they were still there in 2018. The publication of CPT reports and government responses send a strong message. 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.

76. The CPT's work is based on the twin pillars of cooperation and confidentiality. Reports are not published without the state party's invitation to publish. As we often set out in our reports, cooperation extends to more than facilitating visits. It also extends to taking the recommendations seriously and implementing them. In circumstances whereby the Committee feels that no discernible progress has been made in relation to particular issues, then the Committee may take the decision to make a public statement in respect thereof. However, in the history of the Committee there have only been ten public statements made. A public statement is a sign of a failure of cooperation.

77. Transmission of the report is to the government of the member state rather than to the establishments that have been visited. At the end of a visit, I encourage Ministers to transmit the report to the governors of the establishments when they receive it. However, our interlocutor is the state party.

78. Some countries may choose not to make their reports public. They're allowed to do so in the terms of the Convention. If the Committee feels that continued recommendations are being ignored, then the Committee can make a public statement. The public statement will be discussed at the Committee of Ministers of the Council of Europe in Strasbourg. The Committee of Ministers comprises the ambassadors of each of the member states.. Reports of the CPT and public statements of the CPT can have a considerable political influence on member states to bring about the improvements that the Committee has sought.

79. The last time the Committee visited Scotland was in 2019. That 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. Reading these reports together enables you to take a view as to what extent the Committee has followed up on recommendations previously made. For example, the 2018 report references the "dog boxes" at Barlinnie and refers to previous recommendations of the Committee from 1994, 2003 and 2012 in that regard.

80. We are in regular dialogue with a number of NGOs within countries. Prisoners lawyers may write to us if they have a particular concern in relation to their client or a broader concern in relation to the prison system. Such information can be very helpful in informing the Committee's thinking as to whether there is a need to return to a country and whether effect has been given to previous recommendations and immediate observations. If the Committee has a concern that effect hasn't been given to an immediate observation, we can return to that country to check for ourselves. The CPT's powers are the powers of political persuasion. Its role is to encourage state parties to fully implement the recommendations of the Committee.

Concerns about abuse or ill treatment of young people in Scottish institutions

81. When I worked in Scottish prisons, my experience of young people was limited to Longriggend in the late 1990s and Polmont in my role as head of prison healthcare services from 1998 to 2002. I can't recall any specific example where I had a concern about abuse in relation to a young person. However, I did admit the young man at Longriggend for psychiatric assessment compulsorily, using civil mental health legislation rather than criminal procedure mental health legislation. My concern was that his mental health needs could not be appropriately managed within Longriggend. It was not possible to get a psychiatrist to come and see him at the weekend. My concern for his welfare was such that I used the civil mental health processes to have him psychiatrically reviewed. If he had had a somatic complaint, it would have been really easy for me to get him seen at hospital. Because he had a mental health problem, it wasn't. He was psychiatrically unwell and was being held in a remand unit where he couldn't get appropriate care. I think the legislative provisions may still be the same today.

82. The impact on families should not be under-estimated in respect when a father, mother or other carer is imprisoned. It's difficult to see a situation whereby imprisonment is not often harmful and does not have a negative effect, on the prisoner's family. When a family member is committed to prison, the work that prisons can do by and large is

limited to the family member who is in the prison. It's much more difficult to work with the whole family.

83. The SPS does give consideration to the distinct needs of young people. For instance when I was with SPS, I know that there were parenting classes at Polmont. In Shotts, many of the men would have had older children while some still had young families t. Classes on looking after a new-born or a one year old infant can be very helpful for new dads . Parenting classes are I understand also offered to young women in custody. I think the SPS has got much better at working with those who are in custody to identify what learning and activity opportunities might help them whilst in prison and beyond. Examples could be, courses in anger management and help with drug and alcohol abuse.

84. I have never given a statement to the police or the Crown over concerns about a child or young person in Scotland. I have never had any concerns about an alleged abuser working with children or young people.

Use of restraint

85. I have been asked to comment on the use of restraint in residential care settings for children and young people in Scotland. I am 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. The CPT's standard is that when restrained, all persons should be under the direct constant supervision of a member of staff. It's been so long since I worked with young people in custody in Scotland that I don't know what current supervision practice is when persons are restrained. I'm not aware of the CPT having visited any residential care settings in Scotland.

86. If applied without appropriate oversight and safeguards, for example applied longer than necessary or if the person were not released in order to use the toilet because they were not under the direct supervision of staff, then restraint could be described as inhuman or degrading treatment contrary to Article 3 of ECHR. It could be a

justifiable interference in respect of Article 8 if the young person is in prison for example with restraint being applied proportionately and safely. Having regard to that consideration, I think that it is all the more important that there is a clear and precise legal basis and authority for the use of restraint in respect of a child or young person in care and that the law on restraint of children and young people in care should be freely accessible to those who may be affected by it.

Lessons to be learned

87. I deliberately avoid the word rehabilitation in the prison context. I think it's a word that is overused and misunderstood. It suggests that prior to imprisonment someone was 'habilitated'. I don't know how prisons can rehabilitate. At best, prisons can work with people to prepare for that person's reintegration into society. Social skills are important.

88. Most patients that paediatricians see will be at primary school, nursery or pre-nursery. They see very few children of secondary school age. Children have a whole lot of hormonal and emotional things going on at that age, but are pretty unlikely to be in touch with health services. When they are in contact, it's sometimes because things have gone wrong very quickly. Culturally, I think that our health systems could do far better by thinking about what the health needs of secondary school age children and young people might be. I think young people are more open to talking about how they feel than when I was at secondary school. I think that social media space has probably given them the permission, in part, to do that.

89. I think legislation is an important safeguard. When it is inappropriately applied, it becomes a non-safeguard. I think there are lacunae in the current legislation when it comes to mental health care provision for young people in custody. If people other than me have identified these gaps, they may not have considered that they are big enough or important enough for anything to be done about them. I think the legislative safeguards should be even stronger for a seventeen year in prison than a seventeen year old in the community. The legislation should have an even greater protective

effect. Someone in custody should not be disadvantaged or forgotten about in legislative terms. If a seventeen year old in Airdrie had a mental health crisis and a seventeen year old in Longriggend had a mental health crisis, they should both have access to the same range of services. The fact that one person is in custody while the other is not, shouldn't make a difference as to how they might each access appropriate specialist mental health assessment and care.

90. I think legislative change is required in relation to persons who are remanded and need urgent hospital admission, in order that there is a process whereby that can be achieved timeously. I'm not as up to date in processes in Scotland as I was at that time and there may have been developments that I'm unaware of. A young person in custody should have the same access to mental health services as a young person in the community and that wasn't the case previously.

91. In the course of my work with people in prison, I have observed some themes that concern young people. One thing that is often overlooked is communication and the ability for staff and a detained person to communicate freely at all times. For example, in Scottish prisons at present, my understanding is that the only interpretation services available are telephone interpretation services. If you have a non-English speaker who is remanded, it can be incredibly difficult for that person to communicate with other prisoners, staff and even to access telephone interpretation services. It's an area that I'm very conscious of when I come across people who do not speak the language or have other forms of communication difficulties with those who are charged with their care. It's not sufficient to say that there are interpreters at court or when people are being interviewed by the police. The staff charged with looking after them need to be able to communicate with them 24/7.

92. When does neglect of a person's needs become the equivalent to deliberate ill treatment? It's hard being a teenager and it must be really hard being a teenager in detention. My concerns have mainly been related to insufficient attention being given to what the real needs of a fifteen, sixteen or seventeen year old are. In law there are provisions relating to keeping separate in detention juveniles and adults. I think that sometimes young people are simply seen as shorter, less mature versions of taller

and biologically older people. That's not the case. Their needs are different. Staff need to have the appropriate training and awareness to deal with that. I often visit prisons in Europe and beyond. At times, it's quite obvious that staff who are working with young people have not been the subject of any particular selection process. I think staff need to be specifically trained and recruited for looking after children, but that's not always the case in every country.

93. In the Scottish context, persons will be held in Polmont until they're 21. They will then be transferred to an adult prison. I think that one of the challenges is that various international and national covenants assume that 18 or 21 represent an arbitrary level of development and maturity. There can be incredibly mature 15 years olds and incredibly immature 25 year olds. It's a bit unhelpful to reference age in the whole debate but we reference age all the time. It should be about trying to identity what the needs of each young person are and how that young person can best be supported and have their needs met. I struggle with 16, 18, 21. Why 21 and not 25? I understand that people leaving the care system can now access support until they turn 25. Within each country's legislation, they will define young offenders slightly differently. There will be countries where 14 and 15 year old children are held in what is essentially prison custody. In other countries, they will be held in secure accommodation for children. Legislation about the age of criminal responsibility is important. Courts can only have regard to legislation.

94. We need to actively seek the views of young people and listen to them. I don't think we've been very good at that in the past. We need to recognise that some 16 year olds will actually be pretty mature in their approach. Our assessment of the needs of young people shouldn't be overly focused on their biological age. Ideally, everyone should be assessed individually according to their needs. It comes back to asking children and young people what would be helpful for them in aiding their protection and assisting their development and maturity. I think that a template for inspection of secure establishments could be agreed collaboratively. The body charged with completing the template is a secondary issue, but it's about getting the template right in the first instance and being informed by the needs and experiences of young people.

95. I wonder to what extent organisations or individuals are encouraged to share intelligence or useful information with the bodies that are responsible for protection and review of the safeguards in Scotland? . I think it could be useful to engage with young people after they have left the care system or after they have spent a period of time in custody. That could tell us so much more about their experiences and inform our thinking about how we could make it better for them. I think it would be helpful if it became the norm for people to have a conversation six months or so after they've left care or prison. In that way, people's experiences could be effectively learned from after they've had a chance to reflect on them.

96. Sadly, a lot of people will end up returning to prison. We need to try and engage with them about what has caused their return and what might the prison have done better to prepare them for release and reintegration. One of the most progressive criminal justice systems is in Norway. There is a maximum security prison there called Halden. I don't know whether it houses juveniles, but its figures in relation to recidivism are very good. What is it that they're doing that make their figures so good?

97. I have no objection to my witness statement being published as part of the evidence to the Inquiry. I believe the facts stated in this witness statement are true.

Signed…… [redacted] ……..

16 February 2023

Dated……