



**REPORT ON  
A FULL ANNOUNCED  
INSPECTION  
OF  
THE MILITARY CORRECTIVE  
TRAINING CENTRE**

**14–18 JUNE 2004**

**BY  
HM CHIEF INSPECTOR OF PRISONS**

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## INTRODUCTION

This is the first independent inspection of the Military Corrective Training Centre (MCTC) at Colchester. An inspector from this Inspectorate had previously attended the Provost Marshal's own mandatory annual inspection of MCTC; and we have advised his office on improved suicide and self-harm procedures and helped develop criteria for assessment of the MCTC, based upon the healthy prison tests that we use for all places of custody. Last year, we were asked to undertake our own regular independent inspections of the establishment, under a Protocol agreed with the Provost Marshal.

This process has been a constructive one. It reflects the fact that the armed services are anxious to ensure that there is transparent and independent validation of the conditions and treatment of those they hold in detention at the MCTC. We were mindful in this inspection of the particularities of an establishment run as part of the armed services, to which many of those held will return. It is clearly important that, during detention, service discipline and procedures are maintained and not undermined. However, it is equally important to recognise the particular vulnerabilities of those held in custody and to ensure that the safeguards required in international and domestic law are in place. Independent inspection is part of those safeguards.

The MCTC holds three separate categories of detainee. First, there are those who have committed disciplinary offences, dealt with under courts martial or summarily, and who will be returning to their unit after sentence; among them some who are serving very short sentences for summary offences (A Company). The core of their sentence will be military training. Second, there are those whose offences are so significant, or so frequent, that they will be discharged from the services after sentence (D Company). They need to be prepared for resettlement in the community. In most cases, detainees have breached military rules, rather than criminal law; and

they are held in relatively open conditions. The third category consists of detainees who are under investigation, or awaiting trial or transfer to a civilian prison, for criminal offences. They are held in secure conditions (in C Block). MCTC staff come from all three services, though the majority are members of the Military Provost Staff in the Adjutant General's Corps.

Overall, the picture presented in this report is a positive one. It depicts an establishment that is essentially safe, well maintained and well supervised. Of necessity, discipline and good order are visible and pronounced. Detainees' accommodation, personal hygiene and outdoor exercise are well provided for. One of the strengths of such an environment is that there is a sense of community between staff and detainees, in particular the detainees who will return to their services: a recognition that they are all on the same side, and indeed that this may literally be the case on active service. The MCTC has a formidable reputation within the services, and 25% of the detainees in our survey said that they felt depressed or even suicidal on arrival. However, these feelings were clearly mitigated by reality: 81% in fact said that they felt safe on their first night, and over 80% of those surveyed said that they had never felt unsafe at MCTC, and never been victimised either by other detainees or staff.

Over the last few years, steps had also been taken to recognise the particular vulnerabilities of those in detention. In particular, following two suicides, suicide and self-harm prevention policies and procedures had been put in place, drawing on Prison Service practice, adapted for a service setting. The 'blue star' system was thorough and effective, with the personal involvement of the Commandant in relation to those at highest risk. Similarly, as the MCTC, like the services, dealt with under-18s, child protection policies were well-developed, as were relations with the local Area Child Protection Committee. These are developments that the services more widely may wish to examine, in light of current concerns.

We did, however, have some concerns, and recommend some changes to procedures. Those assessed as at risk of suicide were routinely placed in the secure accommodation of C Block, together with those under criminal charge or investigation, and with a very limited regime. During periods of lock-up, they were

placed in strip clothing. These measures were no doubt designed to be protective, but were in fact likely to heighten risk and depression. Other ways of managing those at risk of self-harm, and assessing risk to themselves and others, need to be developed. Similarly, as in all service settings, under-18s shared accommodation with adults. But there are particular risks associated with doing so in locked accommodation; and child protection has to be an overriding consideration. Again, we propose some amendments to practice.

The chain of command, in a service setting, plays a key role in dealing with problems, as well as enforcing discipline. It was therefore relied upon in the MCTC as a means of complaint-handling and preventing bullying; and in relation to the latter appeared to be largely successful. However, a significant link in the chain of command – the relationship with a section corporal – was missing. Detainees were out of their regular unit, and most were private soldiers, or the equivalent, while no staff were below the rank of sergeant. This, and the particularities of a custodial setting, demanded more formal and confidential procedures, particularly for the handling of complaints. There was no confidential complaints route to the Commandant or above, and the two independent complaints channels were ineffective. In spite of efforts by the Independent Board of Visitors, their complaints procedure was virtually moribund. There was a procedure for detainees to complain to the Army Visiting Officer from the neighbouring garrison, but this, uniquely to MCTC, required a detainee to ‘step out’ publicly in a formal parade of all detainees, staff and officers. This was both public and intimidating. The provision of confidential and individual complaints mechanisms is a necessary protection in a place of detention; and we urge that this be provided in a way that is appropriate for MCTC.

The MCTC holds a small number of women and detainees from minority ethnic communities, including service personnel from overseas. We examined their treatment in the light of the Army’s own directive on equal opportunities and diversity, as well as our own *Expectations*. We found significant deficits in relation to both. While the requirements for staff training, and for a Commandant’s action plan, were met, neither had resulted in practices and policies that were capable of recognising, or dealing with, discrimination. There were no effective monitoring arrangements, even where required under the action plan, and complaints procedures

relating to allegations of discriminatory treatment were unsatisfactory. Of even greater concern was that those responsible for implementing policy did not appear to understand, or accept, the Army's own commitment to fairness and respect for difference. We were told that the regular sexual harassment reported by a woman detainee was 'normal male-female rapport'; and that monitoring take-up by ethnicity would be divisive, as service personnel had 'only one skin'. We recommend urgent action to ensure that attitudes and practice at MCTC reflect best practice in the services, as well as its legal obligations.

One of the litmus tests of a secure environment is its most secure facility. In prisons, this is the segregation unit. At MCTC, it is C Block, the only cellular and locked facility. It contains some of the most damaged, as well as potentially damaging, detainees; many extremely anxious about their trial and sentence. It is clear from this inspection (and previous Provost Marshal inspections) that significant improvements in both culture and practice had taken place, following a thorough review of procedures. Staff had detailed knowledge of those in their care; all were trained in suicide prevention, and dealt with detainees in a relatively relaxed way. However, there was very limited activity available to detainees, and this impacted particularly on those who spent months there awaiting trial, adding to their anxiety and potential instability. Remedying this should be the next objective of managers.

Successful resettlement must be one of the key aims of any custodial setting. For those in A and D Companies, this means either return to the services, or to the community. It was clear to us that MCTC's role in relation to the former group was much clearer and better developed than that in relation to the latter. Those who were 'soldiering on' had a full programme of military training, designed to retain and improve their soldiering skills. We did not inspect the quality of the military training offered. However, though it was clearly primarily Army training, it nonetheless provided a full regime of activity, with a purpose and focus that related to the detainee's future. Moreover, those detainees were more likely to be amenable to a disciplined service environment, and to be regarded by staff as part of the services.

In the past, those returning to the services were the majority of Colchester detainees, and the establishment clearly understood, and was geared towards their needs – with

one exception. Levels of literacy and numeracy at MCTC were as low as at many prisons we inspect – around 70% of detainees were at or below level 1 basic skills, and therefore had the reading skills of a competent 11-year old. Yet there had been no basic skills teaching for several months, and even when a teacher was in place, provision would be insufficient to meet the need. This is clearly relevant for those who will immediately return to civilian life: but it is also important for other detainees, whose literacy deficits may have contributed to their disciplinary problems, and who will ultimately have to compete in the job market.

The MCTC offered much less to those who would be discharged from the services after sentence, and who now constitute around half the population. Though attempts had been made to provide employment-related training, there was little available at the time of the inspection. Most of these detainees were therefore marking time until their release. Even those who were engaged in activity were unable to obtain externally recognised qualifications; and, as already noted, there was no provision to meet the significant basic skills deficits of the majority of detainees.

The resettlement needs of these detainees are considerable – some will have debt and alcohol problems, and the great majority will need help in finding housing and employment. These are precisely the factors in any custodial environment that can inhibit successful resettlement and result in social exclusion and reoffending. The small welfare department was doing its best to meet those needs; but there was no coherent, corporate strategy to ensure that each detainee's resettlement needs, identified on reception, were followed through and dealt with adequately and in time.

There are issues here both of resources and attitude. Undoubtedly, more resources are needed; and, as prisons have found, some of those can be levered in from outside, by developing partnerships with agencies and businesses. But we also detected a resistance to devoting resources to 'bad' soldiers, which are not available to 'good' soldiers honourably discharged. In our view, this is mistaken. By definition, these are young men and women who have been problematic in the armed services; without positive help, they are likely to be even more so in society. We recommend that the armed services work closely with the Social Exclusion Unit and other government departments to develop a strategy for preventing this.

In conclusion, this inspection has highlighted a number of areas at MCTC which need further development: in particular, complaints, equal opportunities and resettlement. But it also records an environment that was overall safe and well-ordered, with a level of care and concern for the well-being of detainees, particularly those returning to active service. The authorities had been quick to implement improved procedures for vulnerable detainees, which were firmly embedded by the time of our inspection. The core task of the MCTC is to be found in its name – it is primarily a corrective and training, not a punitive, environment. The challenge for the Commandant and his superior officers will be to ensure that the establishment is fully equipped to carry out that task, for the benefit of the armed services and the wider community.

**Anne Owers**

**HM Chief Inspector of Prisons**

**August 2004**



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## **FACT PAGE**

### **Task of the establishment**

The Military Corrective Training Centre (MCTC) is the armed services' one remaining corrective training establishment and can hold up to 312 male and female detainees, although in practice the population has rarely exceeded 150. Although under Army command, it is a joint service establishment with both staff and detainees from the Army, Royal Navy, Royal Marines and Royal Air Force. The great majority of both staff and detainees are usually, however, from the Army.

All detainees are held in accordance with rules determining committal to custody for their particular service. The vast majority are serving periods of detention to which they have been sentenced by court martial or after summary hearing by their commanding officers. Most detainees are rule, rather than law, breakers and few are committed for offences that would have resulted in custody had they been in civilian life.

MCTC may also hold remanded detainees under investigation and who have been committed to MCTC because it was judged necessary to hold them in secure conditions. These could include civilian staff and dependants who had been based overseas and were thus subject to service law.

MCTC has a staff complement of 125 (115 at the time of the inspection) of whom most are sergeants and staff sergeants of the Military Provost Staff (MPS), a branch of the Adjutant General's Corps. They are normally in post for between two and three years. The Commandant has a reporting line to the Provost Marshal (Army), who in turn reports to the Adjutant General.

### **Area organisation**

Provost Marshall (Army) – Inspector of Military Establishments (Army) (I of ME)  
(A).

**Number held**

157.

**Certified normal accommodation**

312.

**Operational capacity**

312.

**Last inspection**

Inspector of Military Establishments (Army) last annual inspection – 8 April 2003.

Independent Board of Visitors official reportable visit – 16 January 2004.

This was the first independent inspection by HMCIP.

**Description of residential units**

The establishment is organised around three companies. A Company holds those returning to the services after their period of detention and D Company those being discharged from the services and returning to civilian life. C Block, the only secure facility within MCTC, has 17 cells and one unfurnished cell and holds: detainees in military custody prior to courts martial or summary dealing; detainees awarded sentences of imprisonment by courts martial in transit to HM prisons; and detainees segregated under rule 37 Imprisonment and Detention Rules (Army) 1979.

**Brief history**

The MCTC was established at Colchester shortly after the Second World War in a hutted camp that previously held German prisoners of war. In the 1980s this was replaced by new purpose-built buildings, which now provide high standard accommodation and facilities.

# HEALTHY ESTABLISHMENT SUMMARY

## Introduction

HE.01 This was the first independent inspection of the Military Corrective Training Centre (MCTC). It was carried out against agreed inspection criteria (set out in the document *Positive Attitudes*), and in line with Her Majesty's Inspectorate of Prisons' four tests of a healthy custodial environment as set out below:

- **Safety** – all detainees are held in safety.
- **Respect** – detainees are treated with respect for their human dignity.
- **Purposeful activity** – detainees are fully and purposefully occupied.
- **Resettlement** – detainees are prepared for their release and return, or resettlement into the community.

HE.02 The inspection covered all aspects of the regime and treatment of detainees but excluded any aspect of military training.

## Safety

HE.03 The MCTC provided a safe environment for detainees, and 82% of detainees surveyed said they had never felt unsafe. However, a quarter had had significant concerns on or before arrival, and procedures to mitigate these could be improved. There were robust procedures, and thorough risk assessment, in relation to suicide and self-harm and child protection, but those at risk of suicide were inappropriately routinely placed in secure accommodation. There were no procedures to identify and deal with current or past bullying, though staff dealt with incidents proactively.

HE.04 Detainees were transported to the Military Corrective Training Centre (MCTC) in a dignified and safe manner, accompanied by staff who were well informed about those in their care and able to pass on detailed information to reception staff on arrival.

HE.05 Some detainees arrived at MCTC in a state of heightened anxiety, due to its reputation. Twenty-five percent of those in our survey said that they felt depressed or suicidal on arrival. In the great majority of cases, those feelings were swiftly

dissipated; but it was important that reception procedures allowed initial concerns to be voiced.

HE.06 The large room used as a reception facility also doubled as a waiting area for detainees with medical or welfare appointments. Risk assessments were completed diligently by regular reception staff, but there was little privacy for sensitive discussions and, on occasions, a risk assessment was carried out in the property storeroom, the only facility available that offered any level of privacy.

HE.07 There was little to occupy new arrivals as they waited to be seen, and they were not permitted to talk to each other. There was only a limited amount of written information about the MCTC to allay initial anxieties. Neither was information provided to detainees following sentence and prior to arrival at MCTC.

HE.08 All new receptions received during working hours were seen by healthcare and welfare staff prior to location on their company lines, but they were not routinely seen by the padre. New arrivals were not offered the opportunity to make a phone call.

HE.09 A further risk assessment was completed for each new reception following location on their company line, and they were routinely placed on special 15-minute observations during their first night in custody. Befrienders were also available to help new arrivals to settle in, although they were not trained for this sensitive work.

HE.10 The induction process (or 'milk-run') was mainly a series of interviews with key staff in the establishment – such as healthcare, education and welfare staff as well as the CSM and Commandant. Many detainees complained that they were not given the information they needed to know during induction relevant to their individual circumstances, particularly in relation to financial advice. This was a major concern, and in some cases a contributory factor to detention. Much of the information was provided in a written format, notwithstanding data from the establishment indicating very low levels of literacy among over 70% of the detainee population. However, the process of induction was also used to motivate detainees to achieve during their stay at MCTC, and the Commandant saw each new arrival individually for that purpose.

HE.11 Detainees confirmed that bullying was not prevalent at MCTC, and when incidents of bullying were identified staff acted appropriately. There were good staffing levels on the company lines during the day, and night cover was also good. However, MCTC did not have its own anti-bullying policy or procedures though it followed the Army-wide policy. There was no anti-bullying committee and no specific interventions were available to bullies or their victims. Bullying surveys were not carried out regularly to supply confidential information about current or past bullying and, in the absence of policies and procedures to tackle the issue proactively, there may have been some under-reporting of incidents.

HE.12 In contrast, there was a policy on suicide and self-harm that had a very high profile at MCTC, and staff at all levels had a good understanding of procedures that underpinned the policy. The Commandant reviewed all open blue star (high risk) booklets each day. A multi-disciplinary risk assessment meeting took place weekly to review all cases of detainees subject to suicide and self-harm procedures.

HE.13 Detainees were actively encouraged to be aware of others who might be at risk of self-harm. Access to the Samaritans was freely available. Arrangements to monitor those assessed as at risk were efficient, demonstrated by high quality recordings in observation booklets. However, comprehensive support plans were not routinely produced. Detainees placed on the highest level of observation (blue star) were routinely located in the secure accommodation of C Block, where there were high staffing levels but a very limited regime. Additionally, they were placed in strip clothing (Kevlar suits) for lengthy periods when locked up. Neither the placement nor the clothing were appropriate as routine measures for detainees who were solely at risk of self-harm.

HE.14 Good links had been established with the Prison Service to develop best practice on the prevention of suicide and self-harm, and the chair of the suicide prevention awareness team (SPAT) attended Prison Service area meetings.

HE.15 We were impressed with the comprehensive child protection procedures that had been put in place to protect the small number of under-18 detainees sometimes held at MCTC. The establishment had also secured the support of agencies in the

Essex area child protection committee (ACPC) and the Commandant was a full member of the ACPC. Many staff had already undertaken child protection training and the remainder were due to be trained within the next few months.

HE.16 In accordance with policies operating in all service settings, service personnel under the age of 18 lived and mixed freely with adults. Although thorough individual risk assessments were carried out, specific assessments of risk associated with room sharing were not; nor was there dedicated accommodation for under-18s who wanted or need to be held separately.

HE.17 The rules of the establishment were made clear to detainees and enforced fairly. Detainees were managed within a highly disciplined environment, although there was an emphasis on supporting improvement and training rather than punishment. There was a low level of use of summary proceedings and the punishments were consistent and fair. Detainees were encouraged to take responsibility for themselves and those with whom they shared a room. Those detainees who were returning to service accepted the rules and discipline more readily than those who planned to leave the services when they completed their sentence.

HE.18 Although the recorded use of force was low, there was no system to monitor patterns or trends. There was an unfurnished cell in C Block that was used as part of the de-escalation process for refractory detainees following an incident involving the use of force. This cell was also used for overnight observation of detainees considered to be at risk of serious harm (see HE.13).

HE.19 Detainees held in secure conditions in C Block were cared for in a well ordered and safe environment, spending most of their time during the day out of their rooms but with little to occupy themselves. Those sentenced and awaiting transfer to a civilian prison or those held for discipline reasons stayed for only a few days, but there were others awaiting trial who stayed for several weeks, and sometimes months. There was insufficient activity for those held for longer periods, including those assessed as at risk of self-harm (see HE.13 ). Detainees who could have been vulnerable by virtue of their offence were occasionally held in C Block and their safety had not been compromised.



## **Respect**

**HE.20 The quality of accommodation and facilities on offer at MCTC were appropriate to the setting and generally of a good standard. However, some of the important practices and procedures that we use to measure respectful treatment, for example in relation to complaints and equal opportunities, caused concern.**

HE.21 The staging system, which offered incentives and privileges for good behaviour, required performance to be measured over a minimum of six weeks before a detainee's movement from level one to level two could be considered. This effectively excluded a very significant proportion of the population from the scheme, simply because of the length of their sentence, and made the incentive of progress meaningless.

HE.22 The company lines (living units) provided clean and well ordered accommodation equipped sufficiently to meet the reasonable needs of detainees. All rooms had en-suite facilities and all detainees could shower every day. Detainees were allocated to rooms according to their level on the staging system, with better furnished and equipped rooms available to those on the highest level. Improved recreational facilities, including the use of an association room were available to those on the highest level of the staging system.

HE.23 Detainees, including those in C Block, spent most of their day during weekdays unlocked, but the majority of detainees on D Company (those leaving the services) had little to occupy themselves usefully for most of the day. All detainees could go outside in the fresh air every day. There was a period of about an hour-and-a-half during the evening for association, but detainees were not permitted to mix with others on different levels of the staging system during this period and there was very little for them to do. There were three periods of lock up during the day at the weekend, and many detainees complained about the amount of time that they were locked in their rooms at the weekend.

HE.24 Access to the telephone was restricted to one 10-minute call per week, and the siting of the telephones in a busy reception area provided little privacy.

HE.25 Detainees dined communally in a relaxed but well supervised environment within their individual company lines. The quality and quantity of food were reasonable, although there were limited options for healthy eating, cultural choice and those on medical diets. There were a number of significant health and safety issues in the kitchen.

HE.26 All detainees were required to purchase essential toiletries from the shop, even if they had brought supplies with them, and there were limited skin and hair care items for minority ethnic detainees who required them.

HE.27 All detainees, including those held in C Block, were encouraged to attend weekly ecumenical Christian services in the large, modern, well appointed chapel. Although there were no alternative facilities for non-Christian faiths, the padre facilitated access to ministers of a wide range of faiths. However, this was not a service that was well publicised, and in our survey 35% of respondents said that they did not know if they were able to speak to a religious leader of their faith in private if they wanted to. The padre offered a high level of pastoral and personal support to detainees.

HE.28 The quality of healthcare was generally good, particularly that given by the medical officer. Healthcare was provided by a small staff group. While interactions with patients were appropriate and respectful, the majority of the medics' time was taken up with administration rather than direct patient care. Staff time to develop more patient-focused care was further eroded by the demands of the rotas and the provision of overnight cover. We were not convinced of the need for overnight cover and there were no systems to routinely collect and analyse morbidity data for the establishment to review the need this, nor indeed make an assessment of healthcare needs generally.

HE.29 Staff-detainee relationships were professionally sound, but some detainees complained about staff attitudes, and some said that they could not relate to their

company sergeants at MCTC in the same way as they were able to relate to their corporal (or equivalent) in the units in which they normally served. Consequently, many used the welfare service, rather than the usual chain of command, as a source of help and information. The Commandant routinely saw every detainee as they arrived as part of a process of motivating them to make the most of their time at MCTC, and also before they left MCTC as part of a process of affirmation.

HE.30 Detainees were broadly satisfied with the system for making applications and the speed with which their applications were dealt with. By contrast, almost half the population expressed a lack of confidence in the working of the complaints system, and more than a quarter of respondents to our survey reported that they had been discouraged from making a complaint.

HE.31 There were three avenues of complaint: the chain of command; the Independent Board of Visitors (IBOV); and the Army Visiting Officer (AVO). There was no system of written complaints and no confidential access to the Commandant, the IBOV or the Provost Marshal. It was difficult to see how the chain of command investigated complaints, as there was little written evidence and no analysis of trends. More than half of respondents to our survey said they did not know about the IBOV or their role. Detainees were asked to indicate the day before the weekly visit of the AVO that they wished to make a complaint. All detainees were required to parade in front of the AVO; those wishing to make a complaint were required to 'step out' from the parade before speaking privately to the AVO. We were not surprised that some detainees said they found this procedure intimidating. Detainees' ease of access to health and welfare staff, and the presence of the padre on company lines most evenings, provided a channel for ventilating grievances and seeking support and intervention for those who considered the formal channels of complaint ineffective.

HE.32 Many aspects of the establishment's own equal opportunities statement and action plan had not been implemented. There was no regime monitoring to assess equality of opportunity in any area of activity. Significantly, the establishment was unable to provide us with the standard population breakdown by ethnicity. There was no management committee to monitor or promote equality of opportunity. There was limited information concerning equality issues within the establishment, and that

which was available was located in the education and training block or headquarters area – there were none in the company lines. The few racial incident complaints that had been made had not in our view been investigated with sufficient rigour – nor had the victims been well supported. One woman reported continuous sexual harassment, for which she was receiving no support. The different and specific needs of detainees from the RAF and the navy and foreign national populations had not been considered. We were told that there was a reluctance to acknowledge difference as this was considered to be divisive. However, this was contrary to the Army directive underpinning equal opportunities, *Values and Standards in the British Army*.

### **Purposeful activity**

**HE.33 Some progress had been made to increase the range and quality of education and training, but delivery had been severely affected by staff shortages in all areas. Additionally, the provision available had not kept pace with the rise in numbers of detainees and the change in proportions of A and D Company. The amount and quality of activity was much greater for A than for D Company.**

HE.34 Despite the increase in the range of education and vocational training provision, there were too few places to meet the needs of the whole population at MCTC, and significant shortages of staff had exacerbated the situation.

HE.35 Detainees from A Company who were to return to their units were fully occupied throughout the day in ongoing military training, but many detainees from D Company waiting to be discharged into the community (almost half of the population) had little to occupy them usefully. There was adequate provision to provide ongoing military training for A Company detainees due to return to their units, but insufficient provision for those being discharged from D Company – in particular, those serving long sentences. There was a need to prioritise the limited provision, but there were instances when detainees from D Company on long-term sentences were removed from programmes or courses to allow in those with short-term sentences.

HE.36 There had been a significant rise in the numbers of detainees held in D Company. Historically the population split had been in the proportion of one-third D Company to two-thirds A Company, but this had gradually changed and, at the time

of the inspection, the two companies held almost equal numbers: we were told that this was becoming the norm. This had resulted in a significant rise in the demand for more education and training places for the growing D Company population.

HE.37 As a consequence, much of the time that detainees in D Company spent unlocked was on routine cleaning duties; this was not purposeful activity and did not assist them to prepare for release to the community. Many of these detainees complained that their status as people about to be discharged from the services was not acknowledged, and that all activity was military-focused and no longer applicable to them.

HE.38 There were very low levels of literacy and numeracy skills among approximately 70% of the detainee population, but there was no basic skills teacher in post at the time of the inspection. Moreover, the current and likely future provision to deliver basic skills was generally available only to D Company (see paragraph HE.36). Little basic skills support was offered to detainees in C Block, who had no other access to education due to the nature of the company and limited staffing in education.

HE.39 There were 22 places in total on the various vocational training courses available – brickwork, painting and decorating, and garage practices and welding skills – but serious staffing shortages in all of those areas had frequently reduced places at any one time to four. Some of the vocational training did not offer industry-recognised qualifications or skills.

HE.40 Short accredited courses had been introduced in subjects such as food handling and hygiene, manual lifting and first aid, and achievements for those able to access the courses had been high. However, due to budgetary constraints the courses were run infrequently and, consequently, accreditations overall were low.

HE.41 MCTC had recently become linked to the Army library service, and this had been a significant achievement. Detainees' access to the library was satisfactory, but its resources were inadequate and failed to provide sufficient material to support literacy, numeracy and language needs and the vocational training provision. There

were also insufficient careers information and resources in the library to support further and higher education study.

## **Resettlement**

**HE.42 Although provision to reintegrate detainees from A Company returning to their units was adequate, there were insufficient resources to meet the resettlement needs of D Company being discharged back to the community at the most appropriate time. The welfare department provided a good service on debt management and housing, and detainees with substance use problems had ready access to services.**

HE.43 The resettlement and reintegration process for those detainees in A Company on short sentences was well structured and well designed in modular format, with an emphasis on military training and support. The process for detainees on longer sentences was less well defined and often repetitive, with little access to education classes. Although a significant numbers of detainees from A Company had poor levels of literacy and numeracy, their reintegration needs were considered best met by equipping them with the military skills to enable them to manage more effectively within their units, rather than offering them basic skills education.

HE.44 For those in D Company, the process of resettlement and reintegration was less well structured and lacked a cohesive and integrated approach to education and vocational training and preparation for release. In our survey, 65% of respondents said that they had done nothing at MCTC that would help them in the future.

HE.45 A representative from the job centre attended for two half-days to help detainees with benefit enquiries and to make appointments at local job centres for those due to be released. There was an over-reliance on the job centre staff to arrange these appointments, which were restricted to the last weeks of sentence. There was no structured careers guidance prior to the job search programme and little information in the library about careers guidance.

HE.46 The welfare department provided an effective and easily accessible service, particularly on debt management and housing problems, and detainees valued its support and assistance.

HE.47 Detainees with substance use problems could access a discreet service from a local drug and alcohol counselling service, which worked jointly with community psychiatric nurses from the military department of community psychiatry in Colchester. From the referral data, the most problematic substance identified was alcohol (65%). Sessions on aggression management associated with excessive drinking were also available. The provision of follow-up care was difficult, given the high turnover of D Company and their potentially wide dispersal, but efforts were made to locate external services for those being discharged, and reports were sent back to units for those from A Company who were soldiering on.

HE.48 There was good use of release on temporary licence to enable detainees to undertake further education in the community or to take part in community projects. But there were missed opportunities to support accreditation for some of the skills that detainees were developing from the community project work.

HE.49 In our survey, 53% of respondents said they had home or relationship problems. However, arrangements for detainees to maintain contact with their families and friends by telephone and correspondence were limited for most of them due to their considerable distance from home. Although visitors were treated courteously by visits staff and procedures were efficient, the general facilities in the visits area were inadequate. Visits took place in the main reception area at times when routine reception activities also took place. This area was also used as a waiting area for detainees to see healthcare or welfare staff. There were no disabled toilets and no crèche facility. Refreshments, other than a drink, were not available, which was particularly unaccommodating for visitors who had travelled long distances.

### **Main recommendations**

**HE.50 Detainees at risk of suicide or self-harm should not be routinely located in C Block, nor should they be placed in strip clothing unless a risk assessment indicates that this is necessary.**

**HE.51 Procedures designed to tackle bullying should be reviewed. An anti-bullying strategy should be developed, based on an up-to-date survey of any past or current bullying. An anti-bullying committee should oversee the implementation of the strategy.**

**HE.52 The complaints system should be fundamentally overhauled so that detainees have more confidence in it.**

**HE.53 There should be sufficient purposeful activity – particularly education and vocational training – for all detainees.**

**HE.54 There should be a fundamental review of the equal opportunities action plan to ensure that it meets the requirements of the Army directive *Values and Standards in the British Army*. An equal opportunities committee should oversee the implementation of the action plan.**

**HE.55 There should be a resettlement strategy based on a needs analysis of the different and distinct needs of the diverse and changing population at MCTC.**



# CHAPTER ONE

## RECEPTION INTO DETENTION

### Courts, escorts and transfers

#### Expected outcomes

The expected outcomes for the movement of detainees to and from courts and between units are:

- **Safety:** detainees travel in safe conditions to and from court and between units
- **Safety:** detainees are held safely in licensed detention facilities and under the correct category of risk assessment
- **Respect:** detainees are held in decent conditions in escort vehicles and at court
- **Respect:** the individual needs of detainees during escort and while at court are given proper attention

1.01 The Military Corrective Training Centre (MCTC) received receptions from all over the UK and overseas, and it was not uncommon for escorts to arrive outside of normal, daytime hours. A booking form was sent out to the unit from which the detainee was being conveyed, which advised them of the documentation that detainees were required to have with them on arrival at MCTC. This included written authority to hold the detainee, a character reference, a pre-sentence report for those sentenced via a court martial, and a medical assessment.

1.02 Every attempt was made to receive new arrivals within normal reception hours although this was not always possible, particularly for those travelling from overseas. The vehicles used for the escorts varied considerably and included hire cars, Land Rovers and mini buses. All vehicles used which we examined during the inspection appeared clean and fit for purpose.

1.03 Prior to the transfer the escort staff were responsible for ensuring that they were given a full briefing on any risk posed by the detainee in their charge. The

advanced booking form also required the sending unit to assess whether the detainee was considered to be a suicide risk.

1.04 Detainees under escort were not normally handcuffed, but the escort did carry handcuffs and had the authority to apply them if they considered this necessary. Staff from one escort told us that they might consider applying handcuffs during a toilet or meal break, but this depended on the level of perceived risk posed by the detainee. New arrivals to whom we spoke during the inspection confirmed that they had been treated well by the escort staff and had received adequate breaks during the journey.

1.05 We were told that escort staff selected took account of issues such as the rank, gender and medical condition of the detainee involved.

## **Conclusion**

1.06 Escort staff were well briefed about detainees in their charge, and efficient procedures incorporated thorough risk assessments. Detainees were transported with an appropriate level of comfort and respectful treatment.

## **Arrival and first days in detention**

### **Expected outcomes**

The expected outcomes for the safe introduction of service personnel into detention are:

- **Safety:** everything reasonable is done to help detainees feel safe on their reception into detention; detainees are cared for and supported by competent staff
- **Respect:** the way in which entry procedures are conducted and the approach of the competent staff preserves the individual identity of detainees and is responsive to their needs
- **Respect:** detainees are made aware of the MCTC/unit detention room rules, how to access information and cope with detention
- **Purposeful activity:** detainees are constructively occupied during their first days in detention

## Reception and first night arrangements

1.07 The reception facility (which was also used for visits) consisted of a large room with a central workstation for staff. There was also an office, staff rest room, toilet facilities for both staff and detainees, and a property storeroom. A section of the large room was used as a waiting area for other detainees waiting for the healthcare and welfare departments, which were situated immediately adjacent to reception. No separate holding rooms or interview rooms were provided for these departments. All areas in reception were clean and tidy.

1.08 New receptions and those detainees waiting for appointments in other departments sometimes had to wait in this area for long periods – as long as four hours for new arrivals. Throughout this period they had to remain seated without talking. One detainee told us that he had been reprimanded for looking out of the window during a lengthy waiting period. The main waiting area had separate designated seating for A and D Companies and detainees were closely supervised. There was nothing to occupy the detainees and only limited reading material. Refreshments were provided during the morning and afternoon.

1.09 There were approximately 120 new receptions on average each month. All detainees had been passed as medically fit before leaving their unit and arrived with a completed booking form and a character report. For those who had been dealt with via a court martial, a pre-sentence report was also provided.

1.10 Many detainees told us that they were apprehensive about coming to the MCTC because of its reputation within the services for harsh treatment. Only 15% of respondents to our survey said they had received advance information about the establishment, which could have provided some reassurance prior to their transfer. The majority of detainees told us that, in reality, the reputation of harsh treatment was ill founded: 81% of the respondents to our survey said that they felt safe on their first night at MCTC.

1.11 On their arrival, reception staff checked all information and completed a risk assessment form. However, due to the limited facilities available, the initial interview, which entailed detailed questioning on personal details, had to be conducted in the

property storeroom, which was the only facility available to ensure some level of privacy. This was an inappropriate location for such an important interview, although from our observations and discussions with detainees it appeared that the interview itself was handled sensitively. Medical interviews were also occasionally conducted in the property store.

1.12 The next stage of the process was a property and kit check. All personal items, except a small, temporary supply of hygiene items, were removed and placed in detainees' stored property. Extra supplies of personal items, such as toiletries, were removed and detainees were not permitted to access them until their release from custody. Detainees were required to purchase replacement supplies from the shop with their reimbursement allowance gained in custody, and this was a cause for much complaint to us during the inspection. The allowance for cigarettes was two per day and any cigarettes brought in over this allowance were placed in stored property. Arrangements for holding personal property were accountable and secure. If a newly arrived detainee was in need of what were considered to be the basic minimum requirements, an 'emergency shop' was arranged.

1.13 Following completion of the reception procedures new arrivals received a rub down search. Thereafter they were required to wait for interviews with both the healthcare and welfare departments. They did not see the padre routinely within the first 24 hours, although he did make himself available regularly to detainees on their residential units (company lines) during most evenings.

1.14 The formal procedures in reception were conducted by regular members of reception staff: all of them were clearly familiar with the required routines. However, the often lengthy process in reception did not fully engage new arrivals personally. It was only during the risk assessment interview that staff appeared to have either the time or opportunity to listen to any concerns. More sensitivity was shown to female detainees, who were always escorted by at least one female member of staff who remained with them throughout the initial part of the reception process.

1.15 The receiving company was responsible for arranging a meal for new arrivals. This meant that it was usually only a sandwich meal if the arrival did not coincide

with standard mealtimes. Staff on the designated company carried out a further individual risk assessment, following up on any initial concerns raised as part of the reception interview. This considered risks arising in relation to detainees known to one another; but it did not assess the overall risk posed by or to detainees sharing rooms. New arrivals were routinely placed on special observations, with a 15-minute check during periods of lock up. If a risk assessment indicated that a detainee had a high level of anxiety, they were located in a single room adjacent to the night staff. This room was also used for late arrivals so as not to disturb detainees already settled in their dormitories. Detainees considered to be at risk of self-harm were located in C Block on their first night in custody, where they could be more closely monitored in a setting with a higher staffing ratio than the other company lines.

1.16 All new arrivals were able to shower on their units – all rooms had en-suite facilities.

1.17 In our survey, 53% of respondents said they had home or relationship problems. In addition 23% had problems contacting their families and 17% had problems ensuring dependants were looked after. However, new arrivals were not routinely allowed a reception telephone call, as the MCTC expected the sending unit to have allowed the detainee to communicate with their family about their movement to MCTC. Staff within company lines normally dealt with telephone enquiries from families about new arrivals. New arrivals were provided with a public expense letter on their first night.

1.18 Written information provided to detainees as they arrived in their company line included details of the daily routines, the complaints procedure and other general information about the MCTC. Detainees were encouraged by staff to seek additional clarification if required.

1.19 The establishment also provided Befrienders to help new arrivals settle in. Befrienders were trustees who had reached level three of the staging system (see also paragraphs 6.13-6.25). Befrienders were not trained to undertake this important role, although they were given a verbal briefing and provided with a briefing sheet setting out their responsibilities. This included instructions to enlist the help of the night staff

if necessary. In addition to patrol duties, Befrienders were required to assist new arrivals and advise them of matters such as the daily routines and the induction process.

1.20 When receptions arrived outside normal daytime hours, a shortened reception procedure was followed before they were locked up for the night: this always included the completion of a full risk assessment. Other aspects of the reception process were completed the following day.

### **Conclusion**

1.21 The reception area was clean and tidy and formalities were carried out efficiently, though detainees often had to wait in reception for long periods with only a limited selection of reading material and little activity to pass the time. They were however provided with refreshments while they waited and were closely supervised. Thorough risk assessments were carried out, though facilities for private interviews were inadequate. New arrivals always had access to showers, though not always to phones. Befrienders were available to assist new arrivals but they were not trained for their role. New arrivals did not receive advance information about the MCTC, despite expressing a high level of anxiety before arrival. However, in our survey 81% of detainees said that they felt safe on their first night at MCTC.

### **Recommendations**

1.22 **There should be separate holding areas for new arrivals and other detainees waiting for medical and welfare appointments.**

1.23 **There should be an appropriate facility for private interviews.**

1.24 **Detainees should be able to retain permitted items up to the accepted in-possession limits rather than have to place them in stored property and then be required to purchase further supplies.**

1.25 **The padre should see all new arrivals within the first 24 hours.**

1.26 **New arrivals should be allowed to make a reception telephone call.**

1.27 **Befrienders should receive advance training for their role.**

### **Housekeeping points**

1.28 New arrivals should be processed and moved through reception with minimum delay.

1.29 There should be a wider selection of reading material available for detainees waiting in reception.

1.30 Advance information about the MCTC should be provided to detainees prior to their transfer in.

### **Induction**

1.31 The induction programme was referred to locally as the 'milk run'. In our survey, 41% of respondents said the induction process did not provide them with all the information they needed to know about the MCTC, and they commented on the lack of information about the consequences of their detention for their individual circumstances. One detainee wrote: 'There is not enough advice given to you upon arrival about money and home problems by welfare.' Another commented: 'Being married my full entitlements for my wife and children for visits, financial support ... was not explained. It took five months to get support for travelling fares.' And another: 'I wasn't informed about what I was entitled to when I first arrived and I didn't receive a phone call for six days.'

1.32 During the inspection we received many complaints from detainees, already in debt, about the impact of losing their wage while in custody at MCTC. In some cases, financial worries had been one of the precipitating causes of the offence that led to detention. Levels of dissatisfaction were particularly high for detainees held in A Company who felt this was unfair because they were 'soldiering on' and returning to the units following completion of their sentence.

1.33 The induction process consisted of a series of interviews with welfare, healthcare, and education staff and the company sergeant major. Additional

information was generally issued to new arrivals only in written form (including important information such as complaints procedures), despite data collected by the MCTC that suggested up to 70% of detainees were below level one standard in literacy. There was evidence that some staff occasionally explained and reinforced written information verbally.

1.34 The information provided was not delivered in a stimulating format; important areas, such as bullying, were covered by a single paragraph in a document. This was a missed opportunity for staff to deliver a full presentation and engage meaningfully with the participants.

1.35 Detainees told us that they would have liked to have learned more about the opportunities available to them at MCTC during the induction process. One respondent to our survey wrote: 'A more comprehensive tour of the establishment is required, what potential benefits are available and the staging system.'

1.36 Towards the conclusion of the induction process, each detainee had an interview with the Commandant in his office. The process followed a format familiar to service personnel, with each member of that morning's office party being marched in turn. The interviews that we observed were relatively brief and fairly formal, but were affirming occasions, usually covering the reasons why the detainee had been sent to MCTC and a brief discussion of any individual problems. An important objective was for the Commandant to satisfy himself that the different aspects of the induction process had been satisfactorily completed, and that the detainee understood what was expected of them. The interview concluded with the Commandant outlining the targets that the detainee should meet before they were next paraded on the office party, which in most cases was immediately prior to release.

1.37 A number of detainees told us that they received additional information and support from their peers. Because of their low numbers at any one time, such peer support was not always available to women held at the MCTC.



## **Conclusion**

1.38 Induction information was not provided in a stimulating format and much of it was inaccessible to detainees with poor reading skills. It was not an interactive process. Many detainees reported that the induction process did not provide them with all the information they required about the MCTC. A lot of detainees received additional information and support from their peers, but women, who were a minority group at MCTC, gained little benefit from peer support.

## **Recommendation**

1.39 **The induction process and its content should be reviewed in consultation with detainees to ensure that it provides new detainees with all the information they need to know. Staff should deliver the revised programme through a range of participative modules, reinforced by written information or other media accessible to those with low literacy levels.**

## **Good practice**

1.40 *The Commandant saw all new arrivals on completion of the induction process.*



## CHAPTER TWO

### STRUCTURE OF THE FACILITY

#### Expected outcomes

The expected outcomes for the structure of the facility are:

- **Safety:** the detention facilities are physically safe and secure for detention
- **Respect:** detainees are held in accommodation suitable for their needs
- **Purposeful activity:** purposeful activity takes place in properly maintained accommodation

#### A and D Companies

2.01 One residential block accommodated two separate living units (company lines) for detainees from A Company (those who were 'soldiering on' and returning to their units following completion of their sentence) and D Company (detainees who had been dismissed from the services and would be discharged into the community following completion of their sentence). There were no shared facilities and detainees from different companies were not permitted to mix with each other at all. (See also section on C Block, paragraphs 6.42-6.48.)

2.02 Detainees were allocated to rooms according to their level on the staging system (see paragraphs 6.13-6.25) and so shared with others on the same level. Both units had a capacity of 76 and a mixture of eight and four-bed dormitories. There were also two single rooms on each unit that were used to accommodate single women detainees, new arrivals who arrived too late to be located in a dormitory, or detainees who needed special staff observation. The unit for A Company included discrete accommodation for detainees in Garsia platoon – those who were serving less than 42 days detention before returning to their units.

2.03 The dormitories allocated to stage one detainees provided a bed, chair and locker to each detainee. The dormitories for stage two detainees provided softer and more comfortable chairs and larger lockers. The four-bed dormitories accommodated

detainees on the highest level of the staging system and, in addition to the softer and more comfortable furniture, they offered more individual storage space for clothing and personal possessions. All rooms had a communal table and chairs for letter writing, reading etc. Detainees could choose to be located in a smoking or non-smoking room.

2.04 The detainees maintained the dormitories and the communal areas to a very high standard of cleanliness. Both units had a separate laundry and the designated unit laundry orderly washed detainees' kit. The laundry included dryers and there were also washing lines outside. We received very few complaints about lost or damaged kit. All units had irons and ironing boards and detainees were expected to attend to their kit during the period between the evening meal and evening lock up.

2.05 There was a separate dining room on each company line and everyone ate their meals communally. The atmosphere was quiet but relaxed at mealtimes, although detainees complained that they could only speak with others at the same table and were not allowed to talk with those at neighbouring tables.

2.06 There were outside areas designated for midday breaks – detainees were given two tea breaks each day. Many took the opportunity to play volleyball during their break-time.

2.07 All dormitories had an integral shower, two sinks and one toilet, which was sufficient for daily showers and to maintain a high standard of personal hygiene. A bath was also available on the unit for those who were given special dispensation by the doctor.

2.08 Each company line had an association room with a television and a separate games room, but use of this depended on the detainee's staging level. None of the dormitories had TVs. Detainees who could not use the association room were provided with a radio in their dormitory.

2.09 Several notice boards displayed information about unit rules and general information about internal procedures, such as applications. External information

leaflets, including advice about welfare benefits and self-help organisations, were neatly displayed on a rotunda.

2.10 Each unit had two telephones and detainees could make one free telephone call to anywhere in the world once a week. However, the telephones were situated in the reception area where applications were handed to staff during the evening at the same time as telephone calls were permitted. This was also the location for detainees to assemble for evening gym. The result was that there was little quiet and privacy for detainees making their telephone calls and we received many complaints from detainees about this. (See also paragraph 3.87.)

2.11 Staffing levels on the company lines were generous, with a staff sergeant and five platoon sergeants per unit during daytime shifts and one platoon sergeant each during a night shift. In addition, two sergeants were on duty in the main gate at night as well as one sleeping on call between the two units.

## **Conclusion**

2.12 The company lines offered an adequate, clean living environment with hygienic facilities in pleasant well maintained grounds. The provision of a free weekly telephone call was good practice, but detainees making telephone calls in the evening had very little privacy as the telephones were sited in an area of considerable evening activity.

## **Staff–detainee relationships**

2.13 Staff at MCTC told us that they placed much importance on positive working relationships with detainees. They explained that, while the service personnel in their care were serving custodial sentences for acts of indiscipline (and, in a minority of cases, for criminal offences) they were still 'on the same side', and so could maintain relationships on a similar level to that appropriate within normal units.

2.14 For many detainees, the perceptions of relationships were not as positive. In our survey, 49% of respondents said that most staff did not treat them with respect. One detainee wrote: 'I am only here for AWOL [absent without leave] and I get treated like a mass murderer and spoken to like crap.' In our own analysis of

complaints (see paragraph 3.116) the second highest topic for complaint over the 12-month period from January 2003-04 was staff attitudes.

2.15 Efforts were made at the most senior level to establish appropriate working relationships with all detainees. The Commandant had a meeting with detainees within two days of their arrival and immediately prior to their discharge. He also periodically met those serving longer periods, in particular on their movement from level two of the staging system to level three. We attended such meetings, which were tailored to the individual and affirmative.

2.16 Detainees spent most of their time at MCTC in their allotted companies – A, D or C Block. During the daytime, relationships mirrored those expected in a service training setting, although the minority of detainees from the Royal Navy (RN) or RAF found it initially harder to adapt to staff expectations that were modelled on an Army culture. Women faced particular difficulties because they were in the minority, and especially if they were also from RN or RAF. However, we found no evidence to suggest that there was a difference in relationships attributable to a particular service background.

2.17 At about 7.00pm on weekdays, most staff ceased to wear their berets or caps, signalling a more informal and relaxed relationship with their platoons.

2.18 The generous staffing levels meant that there was always a significant staff presence whenever large numbers of detainees were together. While this provided a safeguard against bullying, many detainees complained of superficial relationships with staff, in particular with the platoon sergeants who, as the first level in the command structure, should have been their first point of contact. Many detainees told us that they would be most likely to go to welfare staff for help rather than speak to their platoon sergeants.

2.19 Except for the Garsia platoon – holding those serving less than 42 days – where there appeared to be greater continuity of staff, detainees noted a lack of continuity in the sergeants supervising them. One group told us they did not feel ‘owned’ by anybody, and contrasted this with their experience in their own units or

ships where they felt a strong identity with the corporal (or equivalent) immediately responsible for them.

2.20 The Company Commanders were aware of this problem, which had been exacerbated by the recent deployment of many MCTC staff, in rotation, on overseas operations. Until a month prior to the inspection, A and D Companies had shared the same staff group, but now each company had its own complement of staff. It was too early to determine whether this had permitted greater continuity, and thus improvement, in staff-detainee relationships.

2.21 While it was difficult to replicate the unit command structure within MCTC, there was scope to designate one sergeant with the lead responsibility for a particular detainee, with an alternate or shadow from the other main shift to act for them when not on duty. Such an arrangement had the potential to encourage staff at sergeant level to be more proactive in their relationships.

2.22 We were struck by the confidence that detainees had in the ability and willingness of the padre, welfare and healthcare departments, who helped them with problems in a way that their chain of command would have done in their unit. In our survey, 68% of respondents said they knew a member of staff they could turn to for help, and many detainees told us that those staff were from welfare, healthcare or the padre.

## **Conclusion**

2.23 Relations between staff and detainees appeared to be professionally sound, although almost half of the respondents to our survey complained that staff did not treat them with respect. However, many detainees did not feel that the sergeants who had immediate command over them knew them, or identified with them. They tended therefore to approach welfare, healthcare staff or the padre. We appreciated the problems presented by the shift system and understood that recent operational demands upon MCTC had contributed to this. Officers commanding the companies were aware of the problem.

**Recommendation**

**2.24 There should be efforts to structure contacts between individual detainees and their platoon sergeants to allow greater continuity of relationships; staff should be more proactive in establishing relationships with individual detainees.**



## CHAPTER THREE

### DUTY OF CARE

#### Anti-bullying

##### Expected outcomes

The expected outcomes on anti-bullying measures are:

- **Safety:** detainees are as safe as possible from bullying behaviour
- **Respect:** bullies and victims are treated fairly within military standards and are aware of the systems that operate to prevent bullying behaviour
- **Purposeful activity:** activities take place to discourage bullying and assist victims and potential victims

3.01 The MCTC did not have a specific written policy or document outlining how bullying was dealt with at the Centre. We were told that it followed the general Army policy on anti-bullying. There was no committee overseeing practice in relation to this area. It was the view of staff at all ranks that incidents of bullying were extremely low. Detainees confirmed this with us; many said they felt much safer at MCTC than within their own Army units. In our survey, 14% of respondents said they had been victimised, verbally or physically, by another detainee or a group of detainees during their time at the MCTC, with the majority reporting that victimisation had been in the form of insulting remarks. This was the first confidential survey carried out at MCTC that specifically asked detainees about levels of bullying. Nor had any surveys been done to establish whether detainees had experienced bullying in the past, which might have, for example, preceded absence without leave.

3.02 On reception a comprehensive risk assessment was completed to identify, among other things, potentially vulnerable detainees and those who had a history of violent behaviour. The levels of staff were relatively high and supervision throughout the establishment was generally good. However, the design and layout of the establishment still provided ample opportunity for bullying to take place.

3.03 Detainees said that staff took incidents of bullying very seriously; potential bullies and victims were separated. We found evidence of staff awareness of potential bullying situations. One example related to a detainee who had suffered cuts and bruises to his face during the early evening lock up period in an eight-bed dormitory. He initially reported horseplay and that he had been the author of his own misfortune. Through determined and diligent questioning by staff, the detainee subsequently admitted that he had been involved in a fight with another detainee, and the incident was dealt with accordingly.

3.04 The staff sergeant on the company concerned normally conducted initial investigations into incidents of bullying and unexplained injuries or referred them immediately to senior management. The Commandant reviewed all cases at the weekly risk assessment meeting (see paragraph 3.19). Details of the incident, findings and outcome were recorded in the individual files of those concerned. No specific interventions were available for bullies or victims, where identified.

### **Conclusion**

3.05 The establishment did not have an anti-bullying policy or written strategy. Reported incidents of bullying were low, although 14% of respondents to our confidential survey reported that they had been victimised while at the MCTC, indicating that there might have been some under-reporting. Where incidents of bullying were identified staff acted appropriately. However, no specific interventions were available to bullies or their victims.

### **Recommendations**

3.06 **There should be an annual survey to monitor the levels of bullying within the establishment.**

3.07 **The anti-bullying policy and strategy should include the availability of interventions for bullies and their victims.**

## **Child protection**

3.08 Detainees aged 17, and even, on very rare occasions, 16, could be held at MCTC. Two 17-year-olds were held at the time of the inspection, which was a typical number. Civilian dependants of service personnel stationed in units overseas, who were subject to military law, could also be held, although in practice this had not happened for many years. The welfare department often dealt with issues in relation to the children of detainees, which could have implications for the child protection services. It was not unusual for detainees over 18 to disclose abuse in childhood. All these required investigation by the appropriate agencies. Consequently, it was critical that MCTC had clear child protection procedures in place.

3.09 We were very impressed with the comprehensive child protection procedures that had been put in place in a very short time, and with support from the agencies in the Essex area child protection committee (ACPC). The Commandant was now a full member of that committee and had recently attended his first meeting. The first meeting of the MCTC's own child protection committee had also taken place in May 2004, and the appropriate agencies were well represented. This committee was due to meet quarterly.

3.10 Twenty senior MCTC staff had undergone child protection training, in which ACPC staff had assisted. Military provost staff custodial specialists had also been brought from Germany, Northern Ireland, Catterick and Winchester to be aware of the implications for detainees held in service guardrooms. All staff in MCTC were due to complete child protection training by August 2004.

3.11 The welfare officer had held the position of MCTC child protection coordinator since May 2004 and had already made four referrals under the procedures for allegations of historic abuse.

3.12 In accordance with policies operating in all service settings, service personnel under the age of 18 lived and mixed freely with adults. This requires further consideration when applied in a custodial setting, where those who are legally children may be locked up with adults: for that reason, in other custodial settings, those under 18 must be held separately. Risk assessments did not include an

assessment of any risks associated with sharing a room with others. While it may not be necessary or appropriate to separate all those under 18 – in some cases, effectively isolating them from their peers – this should be subject to thorough assessments of risk; and with the option of separate rooms for under-18s if they need or wish for this. Effective anti-bullying and complaints procedures become particularly important in such circumstances.

### **Conclusion**

3.13 Child protection procedures were sound, and the efficiency with which they had been implemented was commendable.

### **Recommendations**

3.14 **Risk assessments should include assessing risk of room-sharing, with particular reference to situations where under-18s may be held with adults.**

3.15 **Separate accommodation should be available for under-18s who need to be held separately from adults.**

### **Preventing self-harm and suicide**

#### **Expected outcomes**

The expected outcomes for preventing self-harm and suicide are:

- **Safety:** detainees are held in an environment in which all reasonable steps are taken to identify vulnerability and prevent suicide and self-harm
- **Safety:** relevant information about individual detainees judged to be vulnerable and at risk of suicide or self-harm is communicated effectively and appropriate action taken
- **Respect:** detainees at risk of suicide or self-harm know where to find help and access it in times of crisis or need
- **Purposeful activity:** Those detainees at risk of suicide or self-harm are encouraged to participate in appropriate purposeful activities, including coping skills programmes

3.16 A suicide awareness and self-harm prevention policy had been published in June 2004 just prior to the inspection. This document explained that the suicide prevention awareness team (SPAT) was scheduled to meet quarterly, in place of its previous infrequent meetings. The SPAT had met once to date in 2004, and only once during the previous year.

3.17 The SPAT was chaired by the commanding officer on D Company who had established good links with the Prison Service and attended the Eastern area suicide awareness meeting. The SPAT also had liaison officers working in all areas of the establishment.

3.18 Over the past few years the MCTC had introduced a system based on the Prison Service F2052SH booklets, routinely used to monitor prisoners considered at risk of self-harm or suicide. The system used at the MCTC was known as the 'blue star' booklet. Instructions relating to the raising and completion of this booklet were covered in a local standing order. The move to adopt best practice from the Prison Service followed two self-inflicted deaths in custody at the MCTC, the last in May 2000.

3.19 In addition to the blue star booklet there was a comprehensive system of risk assessments, coded to highlight to staff the particular risk an individual might pose (the coding identified the nature of the risk assessment, such as age, previous use of drugs or alcohol, history of violent behaviour, history of escape). All new arrivals were initially placed on special observations; there was another category for very special observations. Both these categories resulted in 15-minute monitoring checks during lock up periods until these were reviewed by the risk assessment committee, which met weekly.

3.20 Membership of the risk assessment committee included the Commandant, commanding officers from A and D Companies (the commanding officer for D Company also had responsibility for C Block), padre, welfare and the medical officer. They met each Monday and reviewed all detainees subject to special or very special observations, as well as those on open blue star booklets. The numbers of detainees under observation at any one time varied but had recently exceeded 60 on several

occasions, which appeared unwieldy. However the risk assessment meeting we observed demonstrated a high level of detailed knowledge of individual detainees by all members of the team. A list of those detainees on observations was available to all staff via the IT database.

3.21 The use of blue star booklets was low; just three had been opened in 2004 up to the time of the inspection and 14 had been opened the previous year. There were no open booklets at the time of inspection. Detainees who threatened self-harm remained under supervision until there had been a proper assessment of risk. We reviewed some of the closed booklets: daily monitoring entries were generally completed to a good standard, demonstrating a high level of interaction with the individual concerned. The space provided for daily entries was, however, limited and may have not been sufficient to record an important entry.

3.22 The blue star booklet was designed with sections to be completed by the officer in command/company sergeant major from the company concerned, medical officer, welfare officer and padre. On completion the booklet went to the Commandant for a final decision on whether blue star procedures should continue. In some of the closed blue star booklets we examined some sections had not always been completed. We found no evidence that written support plans were formulated in line with local procedures. Once a blue star booklet had been opened the Commandant reviewed it each day, which demonstrated his personal commitment to this important area.

3.23 Individuals subject to open blue star booklets were routinely moved to C Block for closer supervision (see paragraphs 6.34, 6.35). During periods of lock up, those on open booklets were located in the unfurnished cell in C Block and had to wear a Kevlar suit (made of material which could not be torn and intended as a safety protection) and had their possessions removed. During the night they were also issued with a Kevlar blanket. The cell was completely unfurnished, without fixed furniture or toilet or sink. This amounted to virtual strip conditions during periods of lock up for detainees who had been assessed as at risk of suicide or self-harm. In 2003 one detainee was subject to these restrictions for two-and-a-half months. (See main recommendation HE.50.) During the day, detainees on blue star booklets located in C

Block were encouraged to participate in activities, subject to risk assessment. However, the level of regime offered there was still far short of that available to detainees on the other companies.

3.24 Where a particular individual was considered to be at immediate risk of suicide, an ‘open door’ policy was instigated. This involved the deployment of an additional member of staff to C Block and a constant watch maintained at the open cell door.

3.25 If an individual who had been on a blue star booklet returned at any stage to their unit or was transferred into the prison system, a copy of their closed booklet was routinely sent with the escort.

3.26 There were very high levels of training for staff, including refresher training, in first aid and suicide and self-harm; most attended these courses annually. Procedures for immediate response to suicide attempts were also good; a designated member of staff on each company carried a ligature knife at all times. Sealed emergency response kits were also available in residential areas. Staff at all levels demonstrated a good knowledge of procedures and a personal commitment to preventing acts of self-harm. Food refusals were closely monitored and recorded in the company observation book.

3.27 Clearly displayed notices provided details to detainees on how to contact the Samaritans, and pre-set mobile telephones with links to the Samaritans were available in the main gate and in C Block. A and D Company detainees were also allowed to use the staff telephone to contact the Samaritans. Written advice had been issued to detainees in all dormitories about indicators that one of their peers was at risk of self-harm – they were urged to alert staff immediately about any such concerns. Detainees said that staff took such information offered seriously and acted sensitively.

## **Conclusion**

3.28 The MCTC had implemented a number of good systems designed to prevent incidents of self-harm and suicide. The introduction of the blue star system was complemented by excellent arrangements for completing and reviewing risk

assessments. The Commandant reviewed all open blue star booklets each day. The suicide prevention awareness team had not met frequently, but a revised policy had been put in place just prior to the inspection to remedy this. The team had also established positive links with the Prison Service to keep abreast of good practice. Monitoring entries in blue star booklets were generally good, although space for detailed daily entries was restricted and detailed support plans were not routinely included. We were concerned that detainees on open blue star booklets were routinely located in the secure conditions of C Block with limited access to regime in virtual strip conditions during lock up periods. (See also main recommendation HE.50.)

### **Recommendations**

3.29 **The suicide prevention awareness team should meet at least quarterly.**

3.30 **When a blue star booklet is opened a written support plan should be formulated, taking account of the views of the individual concerned. A copy of the completed support plan should remain with the booklet.**

### **Housekeeping points**

3.31 There should be more space in blue star booklets for daily monitoring entries.

3.32 All sections of the blue star booklet should be fully completed.

### **Good practice**

3.33 *The chair of the suicide prevention awareness team had established good links with the Prison Service and regularly attended Eastern area suicide awareness meetings. This assisted the Military Corrective Training Centre to keep abreast of new initiatives in the prison service.*

3.34 *The Commandant reviewed all open blue star booklets on a daily basis.*



## Substance use

### Expected outcomes

The expected outcomes on substance use are:

- **Safety:** all detainees are as safe as possible from exposure to and the effects of substance use while in custody
- **Respect:** detainees with substance related needs are identified at reception and can access appropriate interventions
- **Purposeful activity:** detainees receive effective drug and alcohol education programmes to meet their needs
- **Resettlement and reducing re-offending:** detainees, according to their individually assessed needs, are provided with the necessary support and treatment in detention and planned for release to help reduce re-offending

3.35 The two main aspects of the management of substance use at MCTC – supply identification and control, and harm minimisation and care – were largely separate activities. The former was implemented via the discipline route of compulsory drugs testing; the latter was mainly carried out through an external provider who worked closely with the welfare department and healthcare. This was a deliberate separation to provide detainees with an alternative means of assessment away from the military system.

3.36 Although only very rarely cited as the main offence, substance use – in particular alcohol – was recognised as a problem by several of the detainees on admission to MCTC. Although our survey showed that drunkenness was the main offence for only 0.63% of respondents, 16% considered their drinking to be a problem. In contrast, whereas 3.18% of main offences were related to drugs, only 10% of new detainees reported this as a problem. Although staff recognised that substance use was an issue for detainees, substance use awareness was not included in any aspect of the detainees' programme.

3.37 New detainees often disclosed these problems to healthcare staff during the initial health screening in reception, which allowed for early intervention. The doctor saw all new receptions and explained the range of services available. He also advised

them of the risk of blood-borne viruses and other infectious diseases associated with substance use.

3.38 During 2002 the doctor had initiated a protocol for the care of detainees identified as having an alcohol problem. This was subsequently evaluated by an audit of the notes of all detainees leaving MCTC during the first three months of 2003. This was a manual audit with inconclusive results and the protocol was not developed further.

3.39 The welfare officer saw detainees who volunteered that they had a substance use problem and referred them on to the drugs and alcohol counselling service. This service was well established; the provider, Cranstoun Drug Services, had worked in MCTC since May 1999. Detainees received their counselling in the welfare department and did not have to specify why they were visiting welfare when making their application.

3.40 Two counsellors were the main providers of care. They were contracted to provide six sessions per day on 48 days of the year, which was approximately once a week. There was the potential in the contract for extra sessions, if needed. As well as substance use counselling, they also provided generic counselling, working jointly with community psychiatric nurses (CPNs) from the military department of community psychiatry in Colchester.

3.41 During the past year 148 referrals had been made to the service, nearly 12% of the total MCTC population. This was an increase of 13% over the previous year's activity. By far the majority (61%) were from A Company, with 35% from D Company. The greatest number, 71%, were aged 17-22. Although only a small proportion of the total number of detainees, eight were Fijians (known to have a low tolerance for alcohol), an increase from only one the previous year.

3.42 From the referral data, by far the most prevalent substance identified as 'problematic' by clients was alcohol (65%). A further 25% considered both drugs and alcohol to be a problem, and 10% drugs only. The figure for drugs only had nearly doubled in the past year, with cocaine and crack now taking over from ecstasy. It was

unclear whether this was a real change or a greater willingness by detainees to be open about their substance use.

3.43 Detainees could access a range of interventions dependent upon their need and length of stay. A total of 302 one-to-one counselling sessions had been provided, including 67 one-off sessions, and 76 clients receiving multiple sessions. All received an assessment and care plan, aimed at helping the client identify the root cause of their problem. Some also attended sessions on harm reduction and aggression management, the latter frequently associated with heavy drinking.

3.44 The drugs and alcohol service tried to ensure throughcare, but follow-up was difficult given the turnover of clients and their potentially wide dispersal. For those in A Company returning to their unit, the service sent a written report to the unit's medical officer. D Company clients who required it were given practical help in identifying external drugs services, such as drop-in counselling services. The number of detainees who accessed or benefited from such referrals was not known.

3.45 The MCTC anti-drugs strategy was twofold: the physical searches of detainees (usually stage three) leaving or entering the camp after town visits, as well as perimeter searches; and participation in the Army-wide compulsory drug testing (CDT) initiative.

3.46 CDT was the responsibility of the director of personnel services (Army) based at Upavon in Wiltshire. The national teams were responsible for the regular testing of all unit personnel on a rolling programme. MCTC had last been tested by the national team over two years previously.

3.47 To enable interim testing, most training units such as MCTC had been given devolved CDT status and staff trained to undertake the testing.

3.48 MCTC had met its target of testing approximately 40 personnel per month, selected at random from both A and D Companies and including some staff members. Testing usually took place in F Block under strictly controlled conditions. There were specific testing kits and a rigid protocol to be followed. Staff members were trained

(and regularly updated) as monitors. Their role was to observe the urine sampling to ensure there could be no tampering. Additionally, the sample bottles were temperature-sensitive so water could not be substituted.

3.49 Samples were then labelled and sealed in specially designed plastic bags for despatch to the CDT unit at Upavon for testing. Results were monitored centrally at Upavon and kept anonymous unless positive. Positive or borderline results were notified to the Commandant. In the last month there had been just one positive (cannabis) in the MCTC and the timing indicated that the detainee had used the substance prior to admission there. While the numbers of positive or borderline results were small, there was no evidence of monitoring by the unit to look for any trends over time.

3.50 There was no random testing or testing on suspicion. If a detainee was suspected of misusing drugs, he or she would be referred to the doctor for a test. The devolved system of CDT was efficient and seemed to work very well.

### **Conclusion**

3.51 The level of detainees' substance use on admission, especially alcohol, was of concern. Detainees had good access to drug and alcohol services, which worked well with other departments within MCTC, notably welfare and healthcare, to provide client-focused care. Substance awareness was not formally included in the education and training programme. The systems for supply reduction appeared to work well.

### **Recommendations**

3.52 **Substance use awareness, and in particular alcohol awareness, should be introduced into the detainees' education and training programme.**

3.53 **There should be more formal and regular health promotion of substance use issues.**

3.54 **The draft alcohol protocol should be updated and reintroduced.**

3.55 There should be a system for identifying any trends in positive compulsory drug testing.

### Equal opportunities and diversity

#### Expected outcomes

The expected outcomes for race and ethnicity are:

- **Safety:** detainees live in an environment in which they are safe from physical, verbal or emotional abuse, intimidation or victimisation or any discrimination on the grounds of race or culture
- **Respect:** detainees experience a culture that values diversity and actively promotes, maintains and monitors good practice in race relations

3.56 In our survey, one of the 88 detainees who responded was a woman, 8% were from black or minority ethnic communities and 12% were foreign nationals. The MCTC held data on only the religion and gender of detainees; they could not provide us with details of the ethnic breakdown of the population.

#### Policy and practice

3.57 At least four of the senior officers had attended the Army's national three-day course to be recognised as equal opportunity advisers. All staff had received the mandatory annual equal opportunity training, and this was also delivered to all detainees of A Company who stayed at the establishment for at least four weeks. Because the training was delivered in accordance with a standard package, many staff and detainees had received exactly the same message on numerous occasions over the years. Although many officers thought D Company received equal opportunity training from the education department, this was not the case and they received no input.

3.58 In accordance with the Army directive *Values and Standards of the British Army*, there was a Commandant's equal opportunities statement and action plan. The statement was on display to staff and detainees in residential areas. The action plan did not describe specific measurable action points in all areas, and some action points offered scope for subjective judgements and/or were difficult to assess – for example,

the action required 'check performance appraisal to ensure no discrimination' and to eradicate unacceptable behaviour by everyone 'challenging any form of unacceptable behaviour'.

3.59 The stated objective of the Army directive was to ensure fairness and to respect difference to ensure operational effectiveness. The absence of an effective regime monitoring system in relation to equality of opportunity prevented the Commandant from being able to demonstrate that his plan delivered these outcomes. For instance, there was no way of knowing what proportion of women or black and minority ethnic detainees achieved level three of the staging system, applied for and got places on community projects, got access to recreational gym, or were subject to summary proceedings. Although we found no evidence of disproportionate levels in any areas, there was also no evidence to demonstrate that the objective of fairness had been achieved.

3.60 Monitoring arrangements described in the Commandant's action plan to hold 'focus groups, record the number and type of complaints' and 'observe and gain feedback on behaviour' had not been implemented.

3.61 Many staff at different levels of seniority at MCTC told us that their approach to ensuring equality for all was to 'treat everybody the same' and that recognition of difference within the services was contrary to their general aim of unity and comradeship. Furthermore, it was asserted at a senior level that recognition of difference was potentially divisive and alien to the values and standards of the British Army, which promulgated, 'a close-knit and mutually supporting military community' and required the sharing of 'a common bond of identity' and valued the collective above the individual. We were told: 'In the Army we all wear the same skin.' However, this approach was not consistent with the Army directive to respect difference.

3.62 Two of the equal opportunities advisers said it would be inappropriate to monitor outcomes because it would identify differences between individuals. Another was dismissive of sexual harassment reported by a female detainee (see para 3.70). This indicated a lack of understanding of the Army's own directive on equality and

diversity, to say nothing of wider concepts of equal treatment on the part of those charged with delivering and supporting the diversity agenda.

3.63 A few posters explaining how to complain and identifying the equal opportunities adviser were displayed in the education, training and headquarters buildings, but there were none in any of the detainees' company lines. There were no posters explaining the equal opportunities policy or complaints procedure for visitors, or posters promoting cultural diversity. There had been one example of support for a Muslim detainee, but few other arrangements to support cultural diversity. The detainees' menu did not indicate which options were suitable for those on restricted or special diets, and did not reflect the dietary preferences of the foreign national detainees.

3.64 Part one orders issued during the inspection included descriptions of sexual and racial harassment and instructions on how to report this confidentially. However, there was no information about the sanctions for those found guilty and no staff/detainee equal opportunities management committee to review and promote the equal opportunities agenda. Part one orders were on display on each residential area and read to detainees each week.

### Complaints

3.65 In our survey, 4% of respondents reported victimisation from detainees and 2% from staff due to race. However, some detainees told us they would be reluctant to complain, especially if they thought it might affect their discharge back to their active unit.

3.66 An equal opportunities adviser investigated complaints about diversity. There had been eight complaints in the previous 10 months, but there was no ongoing monitoring or evaluation of the key intelligence, such as the nature of the complaint, location, people involved or the outcome. The following information was evident from our examination of the complaints. Three reported sexual harassment – all were women, two were detainees, one a member of staff. Two complaints were from detainees about bullying and two about racism. Three complaints involved the same

detainees over an extended period. The eighth complaint was in fact a statement of denial in relation to one of the previous complaints.

3.67 These complaints were recorded with statements from victims and records of interviews with alleged perpetrators. Five complaints were found to be proven; in all cases the perpetrator was warned, one person was instructed to complete the equal opportunities course and none were subject to summary proceedings. Instructions encouraged swift resolution where possible by informal means. We found a number of cases where it was reported that the victim ‘did not wish to complain [formally]’ even where the investigation had found in favour of the complainant. While we support early and informal resolution, too great a reliance on this can discourage victims from pursuing serious issues and mask the extent or nature of generic problems. It is therefore essential to monitor complaints, both formal and informal, and for senior officers to satisfy themselves that informal resolution is both appropriate and in the interests of the complainant.

3.68 Detainees to whom we spoke were not aware that there was a separate equal opportunities complaints system. Despite the small number of information posters in the education and training centres, detainees consistently told us that all complaints should be made through the line of command or by reporting to the visiting officer. There had been no complaints or observations from visitors about equal opportunities issues.

3.69 One detainee reported witnessing a prolonged barrage of untargeted homophobic abuse when a group of detainees were watching television with staff, and feeling vulnerable when the staff took no action to challenge the behaviour. Another detainee reported concerns that black and minority ethnic detainees were given few opportunities to progress, but did not feel his concerns would be taken seriously if he complained.

### Women detainees

3.70 Women were generally expected to contribute to, and participate in, all the activities of the training regime. When an appointed equal opportunities adviser was asked to comment on a female detainee’s report to us of daily harassment, sexual



innuendo and abuse from male detainees, he responded that this was ‘normal male-female rapport, and women detainees accept it as their lot’.

3.71 Women detainees were given separate accommodation and support from female staff and were always received under escort by women staff; to this extent they were able to report receiving ‘positive action’ to ensure that they were treated fairly. Like their male counterparts, their primary source of support came from their roommates, if they had one. The number of women received and held at any one time was always small, and it was not uncommon for only one woman to be held at any time. Approximately 30 women had served sentences at MCTC over the previous 12 months.

#### **Foreign national detainees**

3.72 Many staff expressed views to us during the inspection that indicated that they saw foreign national detainees as less able than British detainees. Many foreign national detainees had English as their second or third language. There were no services to support the learning of English as a second language. Although foreign national detainees were unlikely to get visits at the establishment, there were no arrangements to provide them with additional telephone calls or calls at times to accommodate time differences.

#### **Conclusion**

3.73 No empirical evidence was available to measure the outcomes of the Army equal opportunities and diversity directive. MCTC’s equal opportunities action plan and monitoring was insufficiently robust to provide this information. The plan was not implemented in key areas by the trained advisers, some of whom demonstrated little understanding of or commitment to their responsibilities. There was a low level of formal complaints about equal opportunities – it was unclear whether this was because of the absence of problems or low levels of expectation. There were few women detainees at any time (often only one). Although some support arrangements were in place, it appeared that sexual harassment was not being recognised or effectively tackled. The different and specific needs of detainees from RAF and the

navy, and foreign national populations, had not been fully considered. (See also main recommendation HE.54.)

### **Recommendations**

**3.74 Equal opportunities advisers should be proactive in promoting and enforcing an attitude of equality by their actions and attitudes, and by providing information and advice to increase detainee and staff confidence in the Army's equal opportunity directive.**

**3.75 All detainees should receive effective equal opportunities training in accordance with the Commandant's equal opportunities action plan.**

**3.76 The Commandant's action plan should describe systems that provide clear data or comprehensive anonymous feedback; these should be used to monitor outcomes for minority populations and to provide management information about the effectiveness of the plan.**

**3.77 Complaints should be monitored to inform senior officers of areas where action is required.**

**3.78 Investigators should always record proven complaints as formal complaints.**

**3.79 There should be a needs analysis of foreign national detainees to identify any particular training, education or resettlement needs that should be met to ensure their fair access to all aspects of the regime.**

**3.80 Military training should include some acknowledgement of and respect for the specialist skills required for Royal Navy and RAF detainees.**

**3.81 The establishment should set up an equal opportunities committee; this should involve staff and detainees, review outcomes and promote the policy.**

### Housekeeping point

3.82 The practice of repeating the same equal opportunities training each year should be reviewed to evaluate whether this should be enhanced by a local element specific to the establishment.

### Maintaining contact with family and unit

#### Expected outcomes

The expected outcomes on detainees' contact with family and unit are:

- **Safety:** detainees and visitors feel safe in their contact with each other and visitors feel safe within the establishment
- **Respect:** The rights of detainees to maintain contact with family and friends are upheld and practical arrangements are in place to provide for them
- **Respect:** visitors are welcomed and recognised as free members of society in order that they may contribute positively to the detainees' progress

3.83 Eighty-three per cent of the detainees at MCTC were over 100 miles from their home. Detainees were informed of their entitlement to letters, telephone calls and visits as part of the initial induction process, which invariably took place within the first 24 hours following their arrival at MCTC.

3.84 Detainees were not permitted to receive stamps or stamped addressed envelopes through the post. New arrivals received a public expense letter on arrival, after which all postage and stationery had to be purchased from their own money. There was no restriction on the number of self-purchased letters that detainees could send. Outgoing mail was either handed to staff or slid under the door of rooms after evening lock up for staff to collect and process. This system was not secure as detainees on stage three were often unlocked later and potentially had access to outgoing letters from those on stages one and two. Staff did not routinely read mail. Both outgoing and incoming mail was processed without any undue delay. Incoming mail was opened in front of the detainee and checked for enclosures.

3.85 Detainees on stages one and two were allowed a weekly 10-minute public expense telephone call, including outside the UK. These calls had to be booked in

advance with staff, who allowed a 15-minute slot for each call. Incoming telephone calls could only be taken if authorised.

3.86 Two telephones each were provided on A and D Companies. While protected by privacy hoods, these were very close together and not in suitably private areas of the units (see also paragraph 2.50). The telephones were programmed to cut off after 10 minutes. The 10-minute restriction was a particular source of complaint by detainees. Those on stage three could purchase telephone cards from the shop and use a telephone kiosk situated near the main gate – this was in addition to the free 10-minute weekly telephone call.

3.87 Many visitors travelled a considerable distance to MCTC and public transport facilities were very poor. Those travelling from the railway station in Colchester had to take an expensive taxi ride or walk approximately a third of a mile from the nearest bus stop. However, visitors could apply to MCTC for assistance with transport costs. Visitors were informed that they should arrive for their visit no more than 15 minutes in advance. They were then required to wait at the main barrier until the detainee was in place in the visits area before being called through the main gate and into the visits hall. There were no facilities for visitors to wait at the barrier, which was particularly problematic in inclement weather.

3.88 The visits facility also doubled as the main reception area, and was also a waiting area for healthcare and welfare services; this was far from ideal as it was still used as a work area while visits took place. There were no disabled toilet facilities and no children's play area. Staff did, however, hold a supply of videos to occupy small children. Refreshments were provided by the catering department but were normally limited to a cup of tea or orange squash. Tables were set out for acceptable levels of privacy and staff were observant but maintained a respectful distance. Visits to detainees who were vulnerable were risk assessed and took place either in the main visits room or on C Block.

3.89 Visits were held at the weekends when a two-hour period was available both mornings and afternoons. Visits were also available on Wednesday afternoons, but

this was not publicised to detainees or their visitors as this was normally kept for visits from staff from detainees' units.

3.90 The visits entitlement was two hours each week. The establishment tried to accommodate those travelling long distances by allowing more than one visit over a weekend, providing this did not exceed overall entitlement. Detainees were not deprived of visits as an award following summary proceedings.

3.91 Details of potential visitors were taken when detainees first arrived at MCTC and an information pack was sent to the visitors listed, which included directions, visit times and details of visit procedures. It also explained that visitors were required to make a written application. Visits were booked by clerks in the welfare department; up to 14 visits were booked for each session. There was normally a restriction of two visitors to each table, with visitors having to swap over if necessary – although staff had discretion on this. Visitors could apply for their next visit while they were at the establishment and staff confirmed the appointment by telephone the next day. There was also an excellent arrangement for staff to contact visitors who were late for their visits, if possible, to reassure detainees who were concerned about their late arrival.

3.92 We observed two social visits on the Wednesday of the inspection. Visitors were received by respectful and friendly staff. They were required to produce ID to the staff at the gate and they were called through to the main gate when the detainee had been brought across to the visits hall. There was some waiting time while getting the detainee across, but this time was made up at the end of the visit. Following the visit, detainees and visitors were processed speedily to avoid undue delays.

3.93 Visitors were not searched but detainees were. A passive drug dog had been used in the past, but this deterrent was not available at the time of the inspection due to staffing shortages. The establishment had never conducted a survey of visitors to find out their views of visit arrangements and there was no other formal means for them to comment on visiting arrangements.

## Conclusion

3.94 Many visitors travelled considerable distances to MCTC. They were treated courteously by staff and procedures were efficient, although the general facilities in the visits area were inadequate. Arrangements for detainees to maintain contact with their families and friends by telephone and correspondence were limited.

## Recommendations

3.95 **Detainees should receive a public expense letter each week.**

3.96 **A secure post box should be provided in each company for detainees to post their letters.**

3.97 **Facilities for visits should be improved, including appropriate disabled access, supervised child play facilities, and vending machines to provide a wider range of refreshments.**

3.98 **Facilities for visitors to wait outside the establishment should be improved.**

3.99 **There should be regular surveys of visitors to take account of their views.**

## Good practice

3.100 *Visitors arriving late were contacted by staff via their mobile telephones, where possible, to ease any concern on behalf of the detainee awaiting the visit.*

## Requests and complaints

### Expected outcomes

The expected outcomes for detainees' requests and complaints are:

- **Safety:** detainees are safe from recrimination in making requests and complaints
- **Respect:** detainees know and can exercise their right of access to requests and complaints; they receive a prompt, courteous and fair response from staff

3.101 In our survey, 72% of respondents said that applications were dealt with fairly; only 11% said they were not. Additionally every evening, from 6.00pm, detainees could ask a designated staff member on their company to put them on the list to see the doctor or welfare department. These requests were then incorporated in the following day's movement sheets, to secure the appointment that they sought.

3.102 This satisfaction did not extend to the complaints system. Only 18% of respondents felt that complaints were dealt with fairly, whereas 47% did not. Although 55% had never tried to make a complaint, of those who had 26% said they had tried to complain and had been encouraged to withdraw it. There were no accessible procedures for making written complaints, no guidance for detainees who were dissatisfied with the response to a complaint, and no formal appeals system.

3.103 The limited information that was given to detainees about how to complain was set out in the general information book provided by each company and located in each dormitory. The tone of the information book was discouraging, and the section on complaints was prefaced by: 'In the unlikely event of having a complaint ...'. The advice that followed required the complaint to be progressed through the section (platoon) commander and thence up four levels to the Commandant and thereafter to the Army Visiting Officer (AVO) and the Independent Board of Visitors (IBOV). This advice was confusing: detainees either did not have an identified section/platoon commander or did not know them; the specific and separate roles of the AVO and the IBOV were not explained, and indeed were presented as if they were an extension of the chain of command; and there was no information on how to access them as entities independent of the chain of command.

3.104 There were, in fact, three separate formal channels in MCTC through which complaints could be raised: the chain of command, the Independent Board of Visitors, and the Army Visiting Officer.

3.105 In the absence of any recorded system, we could find out little about how the chain of command handled complaints. It appeared to happen informally, and it was evident from detainee responses to our survey, as well as comments made to us during

the inspection, that they had little confidence in it as a system. There was no system of confidential access to the Commandant, the IBOV or the Provost Marshal.

3.106 Attempts by the IBOV to establish a channel by which detainees could access them directly had failed. Currently, there was a book in each company office in which detainees could communicate an issue to the IBOV or seek a meeting. Detainees were required to ask their company sergeants for the IBOV book. Detainees told us that, in most cases, they were asked why they wished to see the IBOV. The reason that staff asked why detainees wished to see the IBOV might have been to ascertain whether they could deal with potential complaints. However, many detainees interpreted this as attempts to dissuade them from making a complaint.

3.107 We examined the IBOV books in A and D Companies. In one of them two entries had been made at the time the arrangement was first introduced in January 2004; thereafter none at all. Notwithstanding this, IBOV members had continued to check and sign the books on their monthly visits. The chair of the IBOV expressed to us his frustration at how poorly the arrangement had been working.

3.108 The ineffectiveness of the role of the IBOV in relation to complaints, despite its members' own efforts, seemed to be rooted in its low profile within MCTC. In our survey, 55% of respondents said they did not know what the IBOV was or did and, of those who did, 15% said it was difficult or very difficult to access.

3.109 The Army Visiting Officer (AVO) for each week was a captain or major required to be detailed from the Army units that formed the Colchester Garrison in rotation. The formal position appeared to be that AVO reports were to be submitted to the garrison commander, with copies to the Provost Marshal (Army) and to the Commandant MCTC. The routing to the garrison commander and the Provost Marshal was intended to demonstrate the independence of the AVO role, but we found no evidence that either had raised issues arising from the investigations or conclusions of an AVO on any individual complaint.

3.110 Detainees were required to register the evening before the Army Visiting Officer's visit if they intended to make a complaint to the AVO. Each Thursday,



detainees were marched on to the MCTC parade ground where, after they were called to attention by the sergeant major, the AVO marched on. After the appropriate military courtesies, the AVO announced who they were and invited any detainee with a complaint to 'step out'. Anyone doing so was marched off to a room in the company lines where the AVO could later interview them. We initially assumed that this very public complaints procedure was one that operated generally within the armed services; subsequent inquiries indicated that this arrangement existed only at MCTC and was thus specific to those in service custody.

3.111 The AVO was normally escorted to any area where detainees who had not been paraded were located, such as C Block.

3.112 In many weeks no complaints were made. However, in one exceptional week at the end of March 2004, 16 complainants had stepped out. We observed the weekly 'stepping out' parade during the inspection. Only one detainee 'stepped out'. We felt that the whole 'stepping out' procedure, and the highly public way in which this had to be done, was potentially intimidating to detainees who would otherwise wish to complain.

3.113 MCTC held relatively detailed records of the complaints that had been made, copies of which were laid on the table (but not circulated in advance) at six-monthly formal meetings of the IBOV (though the IBOV had right of access to complaint documentation at any time). By this time the complaint and its subsequent investigation were usually distant, and in many cases the complainant long departed.

3.114 There appeared to be no systematic review by MCTC of the source, nature and patterns of the complaints. However, our analysis suggested that in the year ending 15 January 2004 a total of 61 detainees had complained – 33 from A Company, 25 from D Company and three from C Block. Between them they raised a total of 76 issues, 28 relating to food and kitchen hygiene, seven to training, 23 to staff attitudes and 18 to discipline. All bar three were reported as having been resolved by the AVO. However, the summaries of the investigations in many of the AVO reports were so brief, and the quality so variable, as to make it unclear on what evidence the AVO had based the decision and what, if any, action had been taken by MCTC as a

consequence – although in fact very few complaints appeared to have been even partially upheld by the AVO.

3.115 We identified serious weakness in each of the three formal channels of complaint that existed within MCTC. We would have had considerably greater concerns about our findings were it not for the very effective work of a fourth, more informal channel of complaint – provided by the welfare department, the padre and, to a lesser extent, by the healthcare department.

### **Conclusion**

3.116 Detainees were broadly satisfied with the system for making applications and the speed with which their appointments were made. By contrast, almost half the population expressed a lack of confidence in the working of the complaints system, and more than a quarter of respondents to our survey reported that they had been discouraged from making a complaint. There were three avenues for formal complaints, but none provided confidential access or evidence of effective complaints resolution. Detainees used informal alternative mechanisms, through the padre and welfare and health departments. There was a need to review, and overhaul, the whole working of the complaints system within MCTC. (See also main recommendation HE.52.)

### **Recommendations**

**3.117 Arrangements to enable detainees to make written complaints, with an appropriate appeal system, should be instituted without delay.**

**3.118 A box permitting detainees to make confidential access to the Commandant and the Provost Marshal should be available on each company, and a similar box should be provided for confidential access to the Independent Board of Visitors.**

**3.119 The Commandant's management team and the Independent Board of Visitors should regularly review all the complaints and outcomes of investigations, and monitor patterns and trends.**

3.120 **The different avenues to raise complaints should be explained to detainees, both verbally and in a clear and simple written document.**

### **Legal rights**

#### **Expected outcomes**

The expected outcomes for legal rights procedures are:

- **Safety** detainees are safe from recrimination in exercising their legal rights
- **Respect:** detainees know their rights of access to legal representation and appeals and can exercise those rights while in detention
- **Purposeful activity:** the regime allows reasonable opportunity to pursue legal representation and right to appeal

3.121 Most detainees arrived at MCTC after sentence at court martial or a summary hearing before their commanding officer. Those undergoing court martial were provided with legal representation as of right through the Army legal aid service. After a court martial or summary hearing the detainees were advised of their right of appeal.

3.122 The small number of unsentenced detainees under investigation held in C Block normally had their legal representation in place before arrival at MCTC.

3.123 In detainees' initial interviews, the welfare department always checked on their situation in relation to legal representation and, where necessary, undertook their own liaison with the legal aid authorities. Detainees had easy access to the welfare department, and often sought its help when faced with further charges during their detention.

3.124 Detainees appeared to have easy access to their legal representatives; we observed some visiting MCTC during the inspection.

3.125 Staff opened correspondence from their solicitor in front of the detainee to check for enclosures; the contents were never read.

## **Conclusion**

3.126 There were sound arrangements within MCTC for securing and protecting legal rights.

## CHAPTER FOUR

### HEALTHCARE

#### **Expected outcomes**

Inspectors will make judgements about primary medical care against the following outcomes:

- detainees experience a full range of primary medical care, health promotion and disease prevention services in an environment that is clean, safe and conforms with the standards that operate in the NHS
- detainee medical records are available to those responsible for the care of the patient
- detainees receive medical attention from appropriately trained staff and support and care in meeting their health needs from all staff. Their right to refuse treatment is recognised
- detainees with mental health problems are identified quickly, receive rapid and reliable primary assessment, treatment and care and, where appropriate, are referred and transferred without delay to appropriate specialist care
- routines, regimes and training programmes are designed and delivered to support and promote detainees' health
- detainees' access to primary medical care is equivalent to that of normal service personnel
- detainees are encouraged to maintain healthy lifestyles while in detention
- detainees receive inpatient primary medical care that meets NHS standards in an environment that is clean, safe and meets NHS standards
- medical staff are to have unrestricted access to the patients for their care at all times
- patients requiring specialist healthcare are identified promptly and referred to service specialists or the NHS
- specialists assess patients promptly and specialist care may be delivered in detention as in normal service life or, if necessary, transferred to the NHS

- continuity of treatment and care is not impeded by the transfer between units and the NHS nor by inappropriate security precautions

## **Introduction**

4.01 The medical centre provided primary healthcare for up to 220 soldiers under sentence and 156 military and civilian staff. Although the MCTC catered for all three services, the majority of detainees and staff were from the Army. It was unique as a military medical centre. As well as observing best clinical practice and adhering to medical directives, policies and procedures, it also had to act within the rules of Imprisonment and Detention (Army) 1979. This was against a background of no legal definition of ‘fit for detention’. Nor was there a protocol that took into consideration the variability in the standards of health and documentation between the sending units of the three services.

4.02 The health needs of the population had also changed with the introduction of the MCTC as a facility catering for all three services. In the past, only fully fit soldiers were accepted. Now, although relatively few, soldiers did arrive with pre-existing injuries or illnesses. In our survey, 6% of respondents said they had a health problem on arrival.

4.03 Since April 2004, there had also been changes to the organisation of Army primary care services in the UK. Instead of being geographically based by individual commands, primary care was centralised into a single primary care directorate in Camberley, Surrey, with day-to-day operational command through regional clinical directors, each of whom had a small HQ staff. Consequently, healthcare staff in the MCTC were now professionally accountable to the Eastern region Army primary healthcare service (APHCS) located in the nearby garrison.

4.04 A specialist medical staff inspection, completed in July 2003 by a staff officer from HQ 4 division, rated the medical centre at MCTC as amber.

## **Environment**

4.05 The medical centre was a single-storey, purpose-built building near the entrance to the camp. To maintain security, the doors to the main entrance were kept

locked during working hours. It was linked with reception and the welfare department via a shared waiting room. The waiting room was large and bare, with only limited information leaflets and no health promotion material (see also paragraph 1.07).

4.06 Although purpose-built and spacious, the medical centre was cluttered and some areas were not fully functional or were redundant, for example, the bath located in the treatment room. The treatment room was otherwise well equipped.

4.07 The pharmacy was a tiny room accessed through the treatment room. It had no ventilation or air conditioning and was consequently very hot. It did not consistently comply with the requirement to store pharmaceutical supplies at less than 15°C. There was a maximum/minimum thermometer to measure the fridge temperatures, which were maintained at the appropriate levels and properly recorded, as was ambient temperature.

4.08 There was a large and well equipped physiotherapy suite, a small medical supplies store, the practice manager's office and the duty room for use by the night staff. Both the X-ray room and dental surgery were no longer used for their intended purposes. The former contained the audio booth and was used as a staff locker room. There were proposals to convert the latter into a purpose-built pharmacy.

4.09 The original administrative/documentation office had proved to be too small and staff had improvised and created a larger working area by placing two desks opposite the patient seating area. There was little privacy as conversations on the telephone could be overheard by waiting patients, as could conversations between waiting patients and the medical staff. Although the patient information boards on the wall were not directly visible to waiting patients, they could be clearly seen by anyone approaching the desk.

4.10 The whole administrative area was generally untidy, with sets of notes and referral letters in trays pending action. Unit manuals and publications were available for reference.

## **Records**

4.11 Individual detainee and staff medical records were kept in locked cabinets in the small administrative office between the doctor's surgery and the waiting area. Detainees' medical records were stored alphabetically by company in a lockable filing cabinet. Staff records were kept in a separate filing cabinet. We reviewed several sets of notes, which were of variable quality and completeness. This was largely a reflection of the quality of documentation of the sending units.

## **Staffing**

4.12 The staff cadre was small; only 6.42 whole time equivalents (WTE). Medical cover was provided by a full-time civilian medical practitioner, who had worked at MCTC for the past 15 years. He had previous experience as a prison medical officer. He was invited to attend the commanding officer's weekly 'O group' meeting of senior staff but did not attend frequently. He provided out of hours medical cover on a rota with general practitioners from Colchester garrison medical centre.

4.13 There were no nursing or pharmacy staff. All medical centre staff were fully trained to the equivalent of a combat medical technician class 1 (CMT 1). The practice manager was a Royal Army Medical Corps (RAMC) sergeant. There were a further two CMT corporals (Army), a female CMT lance corporal and a leading medical assistant from the Royal Navy. A part-time civilian physiotherapist provided care on Mondays and Thursday (16 hours per week).

4.14 An RAMC community psychiatric nurse (CPN) from the military department of community mental health team in Colchester visited weekly.

4.15 Dental, X-ray and chiropody services were available at the garrison medical reception station.



## **Delivery of care**

### **Primary care**

4.16 Despite being a primary care facility with only five full-time medics, the medical centre provided 24-hour cover, 365 days a year – although the overnight cover was a ‘sleeping duty’. There was no comprehensive record of the number of times or the problems for which the medics had been called to attend company lines or answer queries out of hours. Other than shift handover details, only significant incidents were entered in the daily occurrence book.

4.17 The medics worked on a rota, with at least one on duty at all times and up to three during the overlap of shifts.

4.18 A member of the healthcare team saw all new detainees who arrived during working hours in the shared waiting room, and asked them to complete a basic medical questionnaire (BMQ). The medic completed it on behalf of any detainee who had difficulty with reading. Particular attention was paid if there was evidence that the detainee was medically downgraded, there were restriction of duties certificates, any psychiatric conditions or if the detainee was on medication.

4.19 Detainees were not physically examined at the initial interview and there was little or no privacy as they were seated at a table in full view and, potentially, earshot of other people in the room. If the detainee indicated that they wanted to speak in confidence, or had had a positive response to one of the BMQ questions, they were taken aside for a private discussion. However, this was in the property storeroom, which was wholly unsuitable. Detainees arriving out of hours were seen in a small room in the main guardroom at the camp gate.

4.20 While ensuring medical confidentiality, healthcare staff liaised with reception staff if detainees raised issues that indicated particular areas of risk or vulnerability. Although most new detainees arrived with their medical records (F Med 4), some did not. The quality of information from sending units’ medical officers was also very variable.

4.21 Female detainees followed the same procedure on arrival if the female medic was on duty. Otherwise, they were taken to the garrison medical reception station to be seen by the duty nurse prior to admission to MCTC.

4.22 The following day the doctor saw and examined the detainee in the medical centre after the medics had taken basic observations, such as weight and blood pressure. Every detainee had their weight recorded in a book on arrival and again on transfer or release. Particular attention was paid to the occupational capabilities or limitations of new detainees as well as identifying healthcare needs. There had been 251 new admissions since 1 April 2004.

4.23 In recognition of the differing training requirements between the three services, and to prevent injury, the doctor routinely issued RAF and RN detainees with insoles for their boots and a 'light duties' chit to restrict the amount and duration of physical training for their first month at the MCTC.

4.24 The doctor also initiated any investigations or referrals to other health services as required. A review of outside referrals for the past year showed that the vast majority (80%) were for psychiatric opinion (mainly for alcohol-related problems or forms of post-traumatic stress disorder). The few referrals for other secondary care did not experience undue delay.

4.25 Detainees were given a copy of the practice leaflet and informed of how to access healthcare, the medical centre procedures, and the availability of external services.

4.26 Detainees were very positive about the access to and the overall quality of healthcare they received while in MCTC, particularly from the doctor. In our survey, 77% reported that it was easy or very easy to see the doctor, and 82% rated the quality of care as good or very good. While the survey specified nurse rather than medic, the response for ease of access to be seen was 47% easy or very easy, with 40% considering the quality of care received to be good or very good. However, 40% of respondents had not tried to access nurse care, whereas the corresponding figure for the doctor was only 15%.

4.27 There was no appointments or triage system and attendance time was determined by the company. Staff wishing to see the doctor were seen between 8.30am and 9.00am on weekdays. A Company patients were seen between 9.00am and 10.00am, D Company from 10.30 to 11.30am, and C Block from 11.30am.

4.28 Detainees who wished to see the doctor or medical centre staff made an application during the general applications session at their company office in the previous evening before lock up. Staff did not routinely ask detainees the reason for reporting sick.

4.29 Early each day the company clerks produced a distribution sheet, which specified all the appointments for detainees that day, and a copy was distributed to relevant departments, including the medical centre. This included both internal appointments and those for detainees accessing services at the garrison medical reception station, such as ante-natal, dental care or radiological investigations. The company clerks, rather than medical centre staff, made all the external appointments as they also coordinated the escorts and transport.

4.30 Detainees attending the medical centre were escorted from company lines to the reception waiting room where they were supervised by company staff. They reported to medical centre staff and then went back to reception to wait to be seen. After they were seen by the doctor, they usually had to wait until all the company sick had been seen before returning to company lines or training.

4.31 There was good access for detainees requiring X-rays. Transport and escort availability permitting, they could be seen by the radiographer on three mornings a week. The X-rays were returned to the medical centre for the doctor to review them the same day. Formal reporting of the X-ray by a radiologist from HMS Hasler took two to three weeks.

4.32 Detainees who were concerned about sexually transmitted diseases could access the civilian STI clinic in Colchester. There was a two-week waiting time, but two or three detainees attended each week and were escorted in civilian clothes.

4.33 Chiropody was available for detainees at the garrison medical reception station on Thursday mornings but, as for most care, data was not collected in the medical centre to determine the level of usage or need. Short of going through each detainee's medical record, there was no means to establish how many detainees had tried to access which services or when. There were very few systems to collect or analyse activity data to inform service development, nor was data collected routinely to indicate the impact of MCTC staff shortages on the non-attendance rates at outside appointments.

4.34 Prescriptions were handwritten by the doctor and also entered electronically by medics on to the primary care information system (EMIS). There was no medicines management as such, although the newly established pharmacy adviser had started to review prescribing patterns. The doctor had not yet received training in the use of EMIS, nor was there a printer in his surgery.

4.35 Medics transcribed prescriptions on to drug administration charts (as used in the inpatient unit of the garrison medical reception station) and kept them alphabetically by company in a ring binder. To ensure some confidentiality during administration, the medics folded the forms in half so that the only form visible was that of the patient being treated. A review of the charts showed that not all had been signed.

4.36 Medications were distributed by the duty medic in the company dining halls from a trolley during meal times. Medics had had only minimal training in drugs dispensing and administration and only two had been through the Buttercups pharmacy assistants course organised by Boots the Chemist. We were concerned that, in the absence of adequate training, prescriptions were not checked by a second person prior to issue to the patient.

4.37 There was a practice formulary but no in-possession or special sick policies. Consequently, all medications were administered by observed consumption, and even skin creams were not allowed to be kept in-possession by the detainee. Patient

information leaflets were not routinely available, nor was relevant information displayed.

4.38 The doctor provided smoking cessation advice, usually on a Thursday; however, this was not in the context of a formal smoking cessation clinic. Detainees had access to nicotine replacement therapy, but they appeared to use the patches to cope with delays in the availability of cigarettes rather than to give up smoking. There was no carbon monoxide monitor to test whether detainees were using the patches appropriately.

4.39 Only two controlled drugs were kept in the medical centre and neither had been issued since the beginning of 2004. The register was correctly maintained and up to date.

4.40 Pharmaceutical services at MCTC had undergone a thorough audit by the SO2 pharmacist from Army primary healthcare service in March 2004, and many of the discrepancies we noted would be rectified if his recommendations were implemented.

4.41 The pressure on the medics to complete the necessary administrative tasks and the lack of a nurse meant that there were no well man or chronic disease clinics. The former could be accessed through the garrison medical reception station. Given the relatively young population, the latter was less relevant, although the establishment of a chronic disease register would help to inform service developments.

4.42 The physiotherapist was very experienced and provided a flexible and comprehensive service for detainees, seeing at least 16 patients on each of her two days at MCTC. These were a mixture of initial assessments, treatment programmes and self-help advice sessions. She was working with the doctor and the gym-based remedial instructor to define which patients would benefit from the different approaches to care. Patients were very positive about the quality of her treatment.

4.43 All detainees were given a full medical examination on their release or discharge, and given summary letters with a copy sent to their GP, if known.

4.44 The only method of morbidity surveillance was via the centrally collected monthly J97 morbidity surveillance forms. Although submitted monthly, the medical centre received analysis of the results in an annual health report. Scrutiny of J97 forms submitted since January 2004 showed a significant monthly variability, with skin conditions, knee disorders and other musculo-skeletal conditions the most frequently reported.

4.45 Medical centre staff did collect weekly statistics on the number of detainees placed on light duties by company. These were totals and not broken down by service. It was also not possible to establish the length of time individuals were on light duties. By far the majority each week were detainees from A Company.

4.46 The lack of dedicated administrative support was problematic. The volume of paperwork was greater than at most regular Army units because of the extra requirements of detention and the rapid turnover of detainees. Standing orders for the medical centre had been revised as had some policies and protocols, which was much to the credit of the practice manager given the healthcare team's size and limited capacity. If any member were ill or on leave the practice manager had to fill in on the duty rota. For similar reasons there was only limited continuing professional development for staff, minimal clinical supervision, and clinical governance was only slowly being introduced. The fact that the medics did not provide regular direct patient care meant that they were also at risk of losing their clinical skills.

4.47 Most permanent staff at MCTC were higher in rank than those employed in the medical centre, which had raised difficulties when their medical advice was questioned. Given the breadth and degree of his responsibility and the rank structure of the rest of the unit, we were surprised that the rank of practice manager post was a sergeant.

### **Mental healthcare**

4.48 Detainees who were known to psychiatric services or identified as having problems on reception were referred to the garrison community mental health department based in Colchester. The team included a consultant psychiatrist (retired

RAMC), a clinical psychologist and four CPNs, two of whom were dually qualified (registered mental nurse/registered general nurse).

4.49 All referrals were reviewed at a weekly allocation meeting and allocated to the most appropriate member of the team. Routine referrals were seen within 20 days, although urgent cases were seen sooner.

4.50 One of the CPNs was the main link between the team and MCTC. He held a weekly clinic, in the welfare office, seeing three to four patients per session, and carried a caseload of between 12 to 15 detainees at any one time. For some detainees the consultation was a one-off, for others it could be ongoing over a few weeks. Detainees referred to other members of the mental health team were seen at the team's base in Colchester. The CPN maintained his own case notes but sent a detailed report to the doctor for inclusion in the detainee's medical records.

4.51 Most of the detainees seen by the team were not mentally ill but had difficulty coping with situational factors, the vast majority of which were related to alcohol and relationship problems. These detainees benefited from the close working between the mental health team, the doctor, the welfare officer and the substance use services in providing an holistic approach to their care.

## **Conclusion**

4.52 The medical centre staff were well motivated and professional and treated patients with respect in a caring manner. They were very stretched and their small numbers and skill mix did not reflect the population or workload changes. Nor did the staffing rank reflect the unique demands of providing healthcare in a custodial setting. The establishment of the Eastern region Army primary healthcare service was very recent and the working relationship with medical centre staff was being developed.

## **Recommendations**

4.53 **The Commandant and medical centre staff should work closely with Army primary healthcare service staff to determine the strategic role of the medical centre.**

**4.54 There should be a healthcare needs analysis that identifies the needs of the population and reflects the increases in the numbers of detainees arriving at the MCTC with existing health problems and the increasing proportion in D Company awaiting discharge.**

**4.55 The doctor should regularly attend the Commandant's weekly senior management meeting to ensure a senior healthcare input to decisions which may impact on the health or healthcare of detainees.**

**4.56 The medical centre staff skill mix and rank structure should be reviewed and action taken on the recommendations in the July 2003 Specialist Staff Inspection, including the appointment of a practice nurse, part-time pharmacy technician, the regrading of the practice manager's post and employment of administrative staff.**

**4.57 There should be a training needs analysis; training plans should be developed for all medical centre staff and steps taken to ensure they maintain their clinical competency.**

**4.58 The need for overnight cover at the MCTC should be reviewed and alternative policies and procedures for out of hours cover developed in consultation with the senior medical officer at Colchester garrison.**

**4.59 A medicines and therapeutics committee should be established, with input from the garrison pharmacist and the Army primary healthcare service pharmacy adviser, to introduce medicines management, in-possession and special sick policies and update the prescribing formulary.**

**4.60 All medics should be Buttercup-trained; alternative arrangements should be made for medication distribution.**



**4.61 The pharmacy should be relocated to the ex-dental surgery, as planned, and the current use of medical centre space reviewed to provide a further consultation room.**

**4.62 There should be an alternative site for confidential medical interviews with new arrivals in reception.**

**4.63 Regular primary care clinics should be developed, including well man and smoking cessation. Nicotine patches should be prescribed as part of a smoking cessation programme, which includes carbon monoxide monitoring.**

**4.64 Clinical supervision for all medical centre staff should be introduced.**

**Housekeeping point**

**4.65 There should be monitoring systems for the audit of care and service planning.**



## CHAPTER FIVE

### ACTIVITIES

#### **Expected outcomes**

The expected outcomes for education and skills training are:

- **Safety:** detainees receive education and skills training in a safe, suitable environment in which they feel able to participate fully
- **Respect:** where practical, detainees are offered opportunities in education and work skills programmes which meet their identified needs, promote and respect personal responsibility and different levels of ability
- **Purposeful activity:** detainees have the opportunity to engage in a range of educational programmes which provide constructive and meaningful activity and opportunity for self-expression
- **Resettlement:** detainees in D Company MCTC experience education and skills opportunities and work training specifically to assist them in reintegrating into civilian life

#### **Education and training**

5.01 Most detainees at MCTC were occupied in some form of activity during the day, but the extent to which this was truly purposeful for all varied a great deal.

5.02 There had been a significant change in the numbers of detainees held in D Company. Historically the population split had been one-third D Company to two-thirds A Company, but this had gradually changed and, at the time of the inspection, the two companies held almost equal numbers: we were told that this was becoming the norm. This had resulted in a significant rise in the demand for education and training places for the growing D Company population. (See also paragraph 7.02.)

5.03 Good progress had been made recently to increase the range and quality of education and training, but delivery had been severely affected by staff shortages in

all areas. Additionally the provision available had not kept pace with the general rise in numbers of detainees and, in particular, the change in proportions of A Company and D Company.

5.04 For detainees in A Company daytime activity was connected with military training, irrespective of their length of sentence. In D Company activities included education and vocational training, a preparation for release course and a range of other tasks including, for example, cleaning and estate maintenance on the pig farm. However, there were insufficient places to accommodate the level of demand. Due to staff shortages at the time of inspection, many detainees from D Company were spending most of their days in their rooms cleaning kit and carrying out routine cleaning tasks within company lines.

5.05 The education and training provision was managed by a senior officer. The provision had improved in the last year and now included a variety of short accredited courses – for example, basic health and safety, manual handling, basic food hygiene, first aid, fork lift truck operations. Achievement of these programmes for the learners who were able to access them was good; however they were run infrequently due to budgetary restrictions and so the accreditation overall was low.

5.06 Education and training courses were primarily available to D Company. There were 45 education places available at any one time, but at the time of the inspection places had been reduced to 35 due to staff shortages. All detainees were given a basic skills screening assessment during induction and then a personal timetable was drawn up in consultation with a member of D Company staff. An action planning pro forma had been developed for learners to self-assess their personal needs and translate them into actions and targets, but this had yet to be fully implemented. (See also paragraph 7.05.) A member of the administrative staff, who was also the librarian, carried out the screening assessment. Although she was not qualified to deliver or assess outcomes, no other member of staff was available to deliver the screening assessment.

5.07 The company staff allocated detainees to education or training and worked out a timetable for them according to the places available. However, priority was often given to those with short sentences, who sometimes took over places from those on

longer sentences. Detainees on longer sentences were often demotivated and gained places only towards the end of their sentence.

5.08 Many detainees had a low level of literacy, with some 70% at level one or below. This reflected the national picture for the services generally. While MCTC recognised this was a significant issue, there was no structured provision to support the basic skills needs of the detainees. There were no teachers appointed for literacy or numeracy support, and this had been the case for several months. Although a post had been advertised and was being filled, provision would still be insufficient to meet the needs of the whole population. Moreover, current and likely future provision to deliver basic skills was generally available only to D Company detainees, although many detainees from A Company had also been assessed at level one or below. We were told that, in terms of priority, detainees from A needed military training to enable them to return to their units better equipped as soldiers rather than with improved levels of basic skills. Little basic skills support was offered to detainees in C Block, who had no other access to education due to the nature of the company and limited staffing in education.

5.09 Due to the absence of a basic skills teacher, the outcome of the basic skills screening assessment was not used. If detainees were enrolled on LearnDirect courses a basic skills screening assessment was carried out again and there were further diagnostic assessments to identify the level of support required through the LearnDirect online courses.

5.10 There were a number of classrooms for literacy and numeracy sessions, preparation for release and LearnDirect courses. Six networked computers were connected to the internet for LearnDirect courses, with plans to bring the total to 16. The centre offered a wide range of LearnDirect information technology courses and achievements were high. Two staff had a high level of experience in IT courses. Learners were enthusiastic and valued the qualifications, which ranged from the ECDL (European computer driving licence) to web design. Computers were industry-standard and provided internet access. Learners could drop in to use the resources when classes were not timetabled. The education department was investigating

possible additional courses, such as CLAIT (computer literacy and information technology) Plus.

5.11 The range of vocational training courses provided approximately 22 places, although due to staff shortages at the time of inspection only the garage welding and Kwik-Fit courses were running, and this had reduced the actual number of places to four. Courses included accredited programmes and taster weeks. Pig farming was no longer carried out, although the establishment planned to use the resources to extend its vocational training facilities. Vocational training staff were not routinely involved in the action planning/individual timetabling process described above and did not receive information about detainees' literacy, numeracy or language skills.

5.12 The plumbing course offered a basic accredited short course of two weeks for up to four learners. The plumbing tutor was also the painting and decorating tutor, and he ran both courses at the same time in different locations. No learners were training in this area at the time of inspection because the instructor was on four weeks leave. The workshop was generally untidy and tools were poorly stored. Workshop bays were run down and there was evidence of poor quality work by trainees, such as badly burnt skirting caused while soldering joints. The standard of plumbing work inspected was very poor.

5.13 A brickwork course was available for up to seven learners. No learners were training in this area because there was no instructor at the time of inspection, and there had been no instructor since January 2004. The resources of bricks and thermal blocks for this area were completely unsuitable for training purposes. The accredited course offered covered block work only and was therefore limited in scope.

5.14 The painting and decorating course offered a basic in-house training programme and a short course of four weeks which had in practice only been able to accommodate four learners at a time. No learners were training in this area because there was no instructor at the time of inspection. No accredited qualifications were offered.

5.15 Short accredited modules were offered in both garage practices and welding skills. Both courses were taught by a very experienced instructor qualified as an assessor. The garage courses were aimed at Kwik-Fit skills in, for example, exhaust, tyre and shock absorbers fitting. Welding courses were aimed at gas and electric welding. The standard of assessed work was good and there was regular assessment by an external assessor for the welding course. The workshop was equipped to a satisfactory standard with appropriate vehicles and tools and equipment. However, the workshops were small and cluttered with engine rigs, for example, which were no longer used.

5.16 The officer in charge of education had arranged a lift truck operations course, which offered a recognised qualification for counter balance lift trucks. This was provided by an external agency to those detainees in D company nearing the end of their sentence and about to be released into the community, and the qualification was designed to improve their employment prospects. The availability of the course, which was free to detainees, depended on available funding.

5.17 There was good use of release on temporary licence to allow detainees to attend day release courses, and detainees were encouraged to pursue higher education courses through day release. MCTC had good involvement in a wide range of projects in the local community and further afield. These included charity and local community projects such as painting and decorating and garden work; there were also Outward Bound-type courses. While records were kept of these events as promotional material, little use was made of skills developed – such as working with others, improving learning, and problem solving – to support portfolios of evidence towards accreditation for key or basic skills.

5.18 The preparation for release programme was available for detainees in their last week of sentence. This focused mainly on the preparation of a CV and interviews with job centre staff. IT resources for the preparation for release courses were poor and lacked basic software, such as spell checkers. The scheduled five-day course was often curtailed and was provided at a late stage in a detainee's sentence.

## **Conclusion**

5.19 There were too few education and training places available to meet the needs of all detainees, and staffing shortages exacerbated the problem. (See also main recommendation HE.53.) Those vocational training courses offered did not provide industry-recognised qualifications or skills in some cases. Many detainees needed help to improve their literacy and numeracy skills, but there was insufficient provision, also compounded by staff shortages to meet the demand. Some detainees were able to engage in useful outside work, but the skills gained were not recorded or accredited.

## **Recommendations**

5.20 **The range of industry-relevant vocational training courses should be increased.**

5.21 **Literacy, numeracy and language training should be provided for all detainees who need this.**

5.22 **Vocational training staff should receive information about detainees' initial assessment.**

5.23 **A Company should have better access to education provision.**

5.24 **MCTC should provide a programme of evening education classes.**

## **Housekeeping point**

5.25 The housekeeping in all of the workshops should be improved.

## **Library**

5.26 Library facilities were available in the education centre. Most detainees could access the library at least once per week. This was often on an afternoon when staff training took place. The library was run by a member of the administrative staff who had other duties (PA to the officer in charge of education and training). In the absence of a basic skills teacher, she also supervised and marked the Basic Skills Agency (BSA) screening assessment during detainees' induction.



5.27 The stock of books was mainly recreational, with many that had been donated. There were few books or resources to support literacy, numeracy or language needs. There were no books or other resources to support vocational courses. The library was not linked to the county council library service, although attempts were made to secure loan books from other sources. MCTC had recently become linked to the Army library service, which had been a significant achievement.

### **Conclusion**

5.28 Detainees' access to the library was satisfactory. Its resources were inadequate and failed to provide sufficient material to support literacy, numeracy and language needs and the vocational training provision. There was also insufficient careers information and resources to support further and higher education study.

### **Recommendations**

**5.29 The current library stock should be reviewed and evaluated to establish and rectify deficiencies.**

**5.30 There should be more library resources to support detainees' literacy, numeracy and language needs.**

**5.31 Staff levels should be improved to increase detainees' access to the library facilities.**

### **Time out of room**

5.32 There was a published daily routine for weekdays and weekends and there was virtually no deviation from the published times. On weekdays, detainees were unlocked at 7.00am and were not locked in their rooms again until 5.15pm. They remained locked up for an hour. While the periods of unlock were generous, there was little for the great majority of the population of D Company, who were not engaged in education or training, to do during the day. We did not find that staff engaged with them proactively, or promoted positive activity, except for repetitive kit cleaning.

5.33 At 6.15pm detainees were unlocked and allowed free time until final lock up at 8.00pm. There were no evening education or training courses. Access to the games and TV room was a privilege for detainees on levels two and three. Detainees from different levels of the staging system were not permitted to mix with each other. Evening unlock time was used for detainees to make their applications to staff and this was an orderly procedure managed from the company office.

5.34 Detainees could not make daily telephone calls: they were entitled to one 10-minute call in the evening once a week. There was ample time to shower using the ensuite facilities after they were locked in their rooms for the evening. In reality there was very little to occupy detainees on level one of the staging system, which was the majority of the population (68% at the time of the inspection).

5.35 All detainees had daily access to fresh air as each company had a small outside area, which they used for ball games such as volleyball, both during the evening and during the day. Many detainees took the opportunity to spend some time in the fresh air to socialise and the area was pleasant enough for this, although there was no seating.

5.36 The facilities in the gym and weights room were excellent and there was a comprehensive programme of physical training, which was linked to the programme of military training<sup>1</sup> for detainees from A Company. Detainees from D Company could use the recreational facilities in the gym and weights room during the evening and weekends only, and access was dependent on their level of the staging system. Detainees had to make an application to use the recreational gym facilities. Due to staff shortages there had been occasions when it had not been possible to meet the demand for recreational gym in the evening and at weekends.

5.37 At the weekend there was an additional period of lock up for an hour and a half mid-morning and again after lunch. Evening lock up was at 5.30pm at weekends. Many detainees complained about the lack of activity at the weekend, and that they spent considerably more time locked in their rooms than during weekdays, with

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<sup>1</sup> This inspection did not include any aspects of military training.

very little other than radios to keep them occupied. Physical training staff occasionally organised weekend runs around the centre, but this activity was inconsistent and depended on the availability of staff. Staffing constraints within the MCTC and operational deployments had significantly affected weekend PE activity.

## **Conclusion**

5.38 Detainees were unlocked for a reasonable period of the day during weekdays but spent more time locked up at the weekend. There was insufficient activity during the daytime periods of unlock for the majority of the population on D Company. For most detainees there was insufficient activity generally, including opportunities to socialise or take part in recreational facilities during the evenings or at weekends.

## **Recommendation**

5.39 **There should be better recreational and social facilities for detainees during periods of evening unlock, and a programme of organised activity at the weekend, including outdoor activity.**

## **Faith and religious activity**

### **Expected outcomes**

The expected outcomes for religious practice, pastoral care and spiritual activities are:

**Safety:** detainees can safely take part in spiritual activities

**Respect:** detainees of all permitted religions are able to practise their faith in suitable accommodation

**Purposeful activity:** detainees have ready access to a range of appropriate spiritual activities

5.40 At the time of the inspection, 60% of the detainees had registered as Church of England, 32% were other Christian denominations and 8% had no religion; none were registered as non-Christian faiths.

5.41 There was a full-time Catholic padre, and a Church of England assistant padre who attended once a week. The padre had access to an extensive list of ministers of other Christian and non-Christian denominations who attended to minister to

detainees on request. However, there was no information for detainees about the provision for observance of minority religions or how to request a meeting with a minister of a specific faith.

5.42 In our survey, 17% of respondents said they did not feel that their religious beliefs were respected; 12% did not think that they could speak to a religious leader of their faith in private if they wanted to; and 35% said that they did not know whether they could.

5.43 The padre did not undertake a formal private interview with the detainees when they arrived, although he made a point of meeting them informally in their rooms or the dining room during their recreational periods.

5.44 Ecumenical Christian services were held every Sunday and all detainees were encouraged to attend; no other key events clashed with the time of the service. All detainees knew the time of the services; they were not required to apply in advance to attend, and no detainees were excluded by the padre, the medical officer or the Commandant. Detainees held in the secure accommodation of C Block were also allowed to attend. Between a third and a half of the detainees voluntarily attended services each week. Occasionally visiting ministers or preachers contributed or foreign national detainees were encouraged to share their own choral tradition. There were no discipline or order problems during services.

5.45 Services were held in a large, modern well appointed chapel that was also used for some meetings and classes.

5.46 There was no alternative facility for non-Christians to complete their observances, although there were examples of individual Muslim detainees being woken and supported to complete their daily prayers in a recreation room in the accommodation block. There was also an example of a Muslim detainee given escorted visits to a local mosque for Friday prayers. Army regulations that permit detainees to possess religious artefacts were observed, and there were no reports of problems with this in our survey or the establishment complaint process.

5.47 The padre was known personally to all detainees and staff, and generally held in high regard. He contributed to the weekly risk assessment meeting (see paragraph 3.19) and used this to ensure that he was aware of any detainees who needed extra support. He made himself available to detainees through informal rounds five days a week; these were timed to coincide with detainees' meal or recreational periods so that they could have time to talk. The padre could arrange to see any detainee in private and frequently referred problems to other officers, or mediated low level concerns to avoid future problems. He was also on call to respond to concerns about the welfare of a detainee or their family.

5.48 The padre facilitated A Company detainees to learn about the core values of the armed services. We observed one session, where he demonstrated a relevant and direct approach to these important issues and fully involved detainees in discussion.

### **Conclusion**

5.49 The padre was fully involved in the daily life of the detainees, who reported a high level of pastoral and personal support from him. However, some detainees were not aware of the range of faith ministers who were available or how to arrange to see a non-Christian minister.

### **Recommendations**

5.50 **Detainees should be told, verbally and in writing, how to access ministers of their own faith during their induction; notices with this information, and celebrating religious diversity, should be displayed.**

5.51 **A dedicated space should be made available for attending non-Christian ministers and for the religious observance of non-Christian detainees.**



## CHAPTER SIX

### GOOD ORDER AND DISCIPLINE

#### Expected outcomes

The expected outcomes for good order and discipline are:

- **Safety:** detainees' safety is protected by clear rules appropriate for the maintenance of good order and discipline and enforced by the authority of staff which is properly exercised
- **Respect:** detainees understand the rules of the establishment and are treated fairly
- **Respect:** detainees improve their behaviour through encouragement
- **Purposeful activity:** good order is supported through activities for detainees which are challenging and well organised

#### Rules of the establishment

6.01 Detainees were read instructions and rules of the establishment during their induction process; the rules were also displayed in their rooms or on notice boards in the company lines. Detainees said that the other detainees were the most useful source of practical information when they arrived. They told us that staff were strict and demanded high standards of compliance, but that they were fair in enforcing the rules. Detainees also said that the staff were vigilant to maintain a stable environment.

6.02 When detainees did breach rules or instructions they were usually dealt with immediately by officers who reiterated and reinforced what was expected – the officers' primary aim was to retrain detainees rather than punish them. Significant emphasis was placed on punctuality, reliability and responsibility, and detainees were aware of the high standard of obedience expected of them. Detainees in A Company generally saw this as consistent with their status as soldiers.

6.03 There were few complaints from detainees about the fairness of staff in enforcing the rules, although some said that they would be reluctant to complain about

unfairness because they did not want to draw attention to themselves (see paragraph 3.117).

6.04 Detainees were entitled to additional privileges at weekends if all detainees in their room had performed to a high standard; in some cases the group lost the privilege because of the failing of just one person. A Company detainees found this acceptable because they recognised the importance of teamwork and joint responsibility as consistent with their experience in their service units. D Company detainees were generally less accepting of the standards of discipline and the group responsibility because many no longer saw themselves as soldiers or saw the relevance of military discipline in their future outside the services.

6.05 Routines allowed sufficient time for detainees to organise their personal time and kit to be ready for the activities and inspections. They were encouraged to take personal responsibility and to support each other in their activities and in their shared accommodation.

### **Conclusion**

6.06 Detainees were managed within a highly disciplined environment, which they recognised as consistent with their training and active units. There was an emphasis on supporting improvement and training rather than punishment. Detainees were encouraged to take responsibility for themselves and those with whom they shared a room. Those detainees who intended to return to service accepted the rules and discipline more readily than those who would leave the services when they completed their sentence.

### **Security**

6.07 The perimeter of the establishment was fenced to prevent absconds and to provide a defensive boundary consistent with its military role. There was little history of detainees absconding, and the fences were adequate to ensure that they remained in the establishment without being excessively oppressive. The perimeter was checked daily and patrolled at night by an armed officer and stage three A Company detainees. It was physically assessed every two years, in accordance with Ministry of Defence



regulations. There were some remedial points that required attention to prevent unlawful entry into the establishment.

6.08 The gate was controlled by a vehicle barrier and all vehicles and visitors entering were registered and controlled. All military equipment and arms were secured and audited in accordance with standard Army protocols. Shadow boards were used to track the location of tools and equipment in the workshops and training areas. There was a protocol to test contingency plans; senior officers knew where the contingency plans were stored.

6.09 There was no strip searching at the establishment. Detainees were subject to a rub down search on reception and when entering and leaving their visits. Protocols required same-gender staff to search detainees, and this was complied with. Visits were supervised to prevent the passing of illegal items; there had been no such recorded incident in the previous year.

6.10 There was a system to identify those detainees who posed a high risk of abscond; they were placed on 'red star' procedures, which involved frequent checks at night. Red star detainees were not routinely placed in the more secure accommodation of C Block. No red star detainees had absconded in the previous year.

6.11 Physical security was unobtrusive and appropriate to the risk of absconding. Staff demonstrated detailed knowledge of the circumstances, problems and progress of the detainees in their care. There was no formal intelligence reporting system, although staff were aware of how to report concerns up the command chain. One officer was responsible for collating intelligence, and any concerns were discussed at the routine weekly senior officers' meeting.

## **Conclusion**

6.12 The security systems were adequate to ensure the safety of the detainees, and appropriate to manage the low risk of abscond.

## **The staging system**

6.13 The progressive staging system that operated in the MCTC was prescribed in the Imprisonment and Detention Rules (Army) 1979 and appeared not to have been revised since that date, although the privileges associated with each stage had been revised. These arrangements predated the incentive and earned privileges schemes subsequently introduced by HM Prison Service. It differed from these in that all detainees started at stage one, whereas in civilian prisons entry is at the midpoint with the possibility of progress either upwards or downwards.

6.14 Under the MCTC scheme, all detainees were required to secure at least six weekly 'recommends' before they could move to stage two. 'Recommends' were determined by performance and behaviour within the companies, and by personal application and progress in training – military for those in A Company, vocational training and other preparation for resettlement for those in D Company. In the case of A Company, both elements were scored daily and closely calibrated, but for D Company the evaluation of progress on training depended on written weekly reports from instructors rather than scores. Detainees wore different coloured tabs attached to their uniform to signify their level on the staging system.

6.15 Factors scored in both the company and training components included motivation, effort, demeanour, hygiene and cleanliness, attitudes to both staff and other detainees, and personal bearing. In each area there was a possible score of 25 points per week, although in practice this was rarely achieved. A 'recommend' could be gained normally if a score of at least 17 or 18 was gained in each component – staff looked for balanced performance in the 'social' areas of the companies as well as military activity. This was regarded as particularly important because some detainees had been very effective while on operations, but their difficulties arose in the more routine areas of barrack or garrison life.

6.16 Stage one effectively gave no privileges beyond access to a newspaper and radio in the group dormitory, and a 10-minute weekly telephone call. After a minimum of six weeks it was possible to move to stage two, although in practice this took eight or more weeks for many detainees. This effectively excluded a very

significant proportion of the population from the scheme simply because of the length of their sentence, and made the incentive of progress meaningless.

6.17 Within Garsia platoon, where the short periods of detention made it effectively impossible to move beyond stage one, there was a phasing system that allowed some easing of the general austerity to provide an incentive for individual progress.

6.18 Privileges at level two of the staging system included access to a games room, colour television and more freedom of movement within the company lines, including doors unlocked at night. Greater benefits accrued with movement to stage three, which could be achieved after a further six weeks. These included: a significantly higher allowance; the option of purchasing telephone cards from the shop and using a telephone kiosk situated near to the main gate (in addition to the free 10-minute weekly telephone call given to detainees at all levels of the staging system); parole in the town for half-a-day per week; and freedom to move unescorted within the whole of MCTC.

6.19 Movement from stage one to stage two was agreed by the Company Commander on the recommendation of the company sergeant major. The approval of the Commandant was necessary for a move to stage three. On such approval, and as affirmation of progress to the top level of the staging system, detainees were paraded in front of the Commandant as part of the morning office party to receive their stage three coloured tab directly from him.

6.20 A large majority of detainees never moved beyond stage one – in our survey, 68% said they were on stage one, 17% on stage two and only 8% on stage three. While 55% felt that they had been treated fairly by the system, a significant minority – 38% – felt that they had not. Detainees complained that the sergeants who wrote reports on them did not know them, a concern linked with their feeling that there was no particular member of staff who ‘owned’ them. They were also concerned that there was no appeal system against unjust decisions or judgements by staff.

6.21 There was, however, scope to make the operation of the scheme more transparent to the detainees, so that they felt this was something that was done with them rather than to them.

6.22 We were told that the scheme was being reviewed with a view to creating two additional stages – a stage four, which would permit longer serving detainees to attend courses in outside colleges, and a stage five, which might permit those in A Company to be ‘paroled’ back to their units and resume their work while still technically serving a sentence.

### **Conclusion**

6.23 The working of the staging system was both transparent, particularly in A Company, and closely monitored by the chain of command – and in the case of a move to stage three, involving the Commandant himself. The majority of the population did not stay at MCTC long enough to progress under the scheme. Some also felt aggrieved at the lack of an appeal system. There was scope for reviewing the privileges accorded on stage one, and the time that it took detainees to move from stage one to stage two.

### **Recommendations**

6.24 **The staging system should be reviewed to ensure that the level of privileges and the time taken for detainees to move from stages one to two provide an incentive.**

6.25 **An easily accessible appeal system should be set up.**

### **Detainee disciplinary procedures**

6.26 Minor errors or rule infringements by detainees were generally dealt with immediately by staff, who corrected and reiterated instructions. When detainees committed a more serious offence they could be charged with breaking rules and made subject to dealings under the Imprisonment and Detention (Army) Rules 1979, conducted by their Company Commander or the Commandant. The punishments allowed were admonishment, extra military training, or down staging.

6.27 Company Commanders had dealt with approximately 40 minor charges in the previous two years. One charge was found unproven and the remainder were dealt with by admonishment or extra training. The offences included disrespect for staff, fighting and smoking in bed.

6.28 The Commandant had dealt with 20 charges in the previous two years: these included nine for returning from parole under the influence of alcohol, five for disrespect to staff, three for sleeping during the day and three for failure to attend work. Eighteen of the 20 detainees had their stage downgraded.

6.29 Records indicated that detainees could put their case at summary proceedings. The majority pleaded guilty and none had appealed against the punishment they received. There had been 10 examples of detainees being admonished, which indicated that their mitigation had been considered and accepted. There were no recorded complaints about the application of summary proceedings, and no detainees raised this with us during the inspection. There had been no examples of detainees charged with serious offences. There were no summary proceedings to observe during the inspection.

## **Conclusion**

6.30 There was a low level of use of disciplinary hearings and the punishments were consistent and fair. The use of extra military training was a constructive response to disciplinary problems.

## **Use of force**

6.31 All of the custodial staff and officers were up-to-date in their control and restraint training, which was incorporated into their compulsory annual individual training directives. There were four control and restraint instructors who trained all other staff. There had been four recorded incidents of the use of force in the previous year, involving three detainees. Three of these records were complete, with comprehensive witness statements and records of de-escalation. Handcuffs were used during two of the incidents, in both cases to assist in relocating the detainee, and were removed as soon as he was located in the unfurnished cell in C Block. One record,

dated April 2004, had only one officer's statement and did not describe what force was used.

6.32 Although there was a procedure to record injury after the use of force, this record was kept in the confidential medical record without cross-reference to the use of force documentation. Despite the low levels of the use of force, there was no system to monitor or track the patterns of when or where force was used, or to identify any other significant patterns. Although no detainees complained to us about violence from staff, in our survey 7% of respondents said they had been physically restrained by staff in the previous six months. This figure was higher than that represented by the three detainees recorded (2%).

6.33 There was an adequate set of control and restraint protective equipment for planned interventions, although this had not been required in recent years. Two pairs of handcuffs were available in a locked cabinet in each accommodation block. No injuries to staff had been recorded during the use of force.

6.34 There was one unfurnished gated room located in C Block. A body belt was displayed in this room with a Kevlar suit (strip clothing) and bedding. We were told that the body belt had not been used for many years. However, it was kept in sight of detainees and visitors and this was potentially intimidating, and left C Block staff open to allegations of its use.

6.35 No record was maintained of the authority or reasons for the use of the unfurnished cell, except that recorded in each detainee's individual record. Consequently, although its use was generally reported by staff to be 'quite low' there was no way to aggregate the incidents and monitor trends in its use. The unfurnished cell was reportedly used both as a location for refractory detainees after the use of force and routinely for the overnight observation of detainees at risk of self-harm (see paragraph 3.23). There was no system to identify the frequency of each use or the time spent in the cell. On average, detainees placed in C Block because of violence were returned to their own company within two days.

## **Conclusion**

6.36 The recorded use of force was low, although recordings were lower than that reported by detainees in our survey. We were concerned that there were no systems to monitor frequency or trends in the use of force or the use of the unfurnished cell. Moreover, authorisation and records of the use of the unfurnished cell were not kept separately from detainees' records. The display in the unfurnished cell of a body belt (which had apparently not been used for many years) was unnecessary and potentially intimidating.

## **Recommendations**

6.37 **The authority of the duty officer should be obtained and recorded, specifying reasons, when detainees are located in the unfurnished cell. There should be a log of observations and incidents until the detainee is removed.**

6.38 **There should be a system to monitor trends in the use of force and use of the unfurnished cell to identify and address patterns and trends in location, activity, authorising officer, time or people involved.**

6.39 **All events that result in any force being used on detainees should be fully recorded on the correct forms.**

6.40 **The record of a detainee's injury should be copied on to the use of force record so that the senior officer managing this can be aware of patterns of injury and possible training issues.**

6.41 **The body belt should be held out of sight and secured with restricted access.**

## **C Block**

6.42 C Block was a secure, locked single-storey accommodation block of individual cells with integral sanitation and one unfurnished cell. It had its own secure exercise area, association/classroom and bathing facilities.

6.43 Ninety-five detainees had been held in C Block in the year prior to the inspection, for one of three reasons: post-sentence awaiting transfer to prison (18); under investigation (40); or held in segregation (37). C Block also held detainees vulnerable to self-harm (14 in 2003-4), (see paragraph 3.21).

6.44 There were three staff on duty during the day – one staff sergeant and two sergeants – and two sergeants at night (one sleeping). All staff were trained in first aid, suicide and self-harm prevention and control and restraint. The staff in C Block had a detailed knowledge of the detainees in their care and managed them in a relaxed and relatively approachable manner. Detainees had a similar regime to those in A and D companies and were allowed out of their cells all day, although activity was limited. There was a television room and some books available from the library. Unless prohibited by a risk assessment, detainees were allowed to take their meals in a dining area on D Company.

6.45 Detainees held prior to transfer to prison spent an average of three days in C Block and were provided with information about prison before they left. Those held for discipline or safety reasons – coming equally from A and D Company – spent on average approximately two days there, indicating a positive attitude by staff to de-escalating incidents and moving detainees on. However, those awaiting trial spent an average of five weeks in C Block and some spent many months there. For these detainees the regime was insufficiently varied, and there was inadequate access to continued learning or training support from the education department. These detainees had the advantage of maintaining their full allowance prior to sentence, although restrictions on purchases were the same as other detainees.

6.46 MCTC did not have a unit specifically for vulnerable detainees or a separate policy for managing detainees considered potentially vulnerable by virtue of the nature of their offence. We were told that such detainees had been on occasions located on F Block (the administration block) and C Block had managed a few individual cases awaiting trial for serious sex or violence offences, creating individual risk assessments and separating detainees when necessary. There had been an incident of inappropriate contact between a sex offender wanting to see photographs of other detainees' children, which indicated a lack of appropriate supervision of that



particular detainee's activities. However, there had been no incidents of violence or attack on such detainees.

### **Conclusion**

6.47 C Block was well ordered and a safe and appropriate facility for those spending short periods there. However, there was inadequate activity, training or education for those spending extended periods there.

### **Recommendation**

6.48 **A positive regime of activity, education and training should be offered to detainees spending more than one week in C Block.**



# CHAPTER SEVEN

## RESETTLEMENT

### Expected outcomes

The expected outcomes for resettlement training are:

- **Safety:** detainees work in a safe, suitable environment
- **Respect:** the range, type and availability of activity meets the needs of the detainee population and detainees are treated fairly in all aspects of their work
- **Purposeful activity:** detainees are engaged in well organised resettlement activities
- **Resettlement:** detainees are occupied in realistic training that prepares them for employment on release

### Management of resettlement

7.01 The reintegration needs of detainees from A Company (those who were soldiering on) were catered for in the main through continued military training to enable them to return to their units having maintained their standard of training (despite an acknowledgment that many had basic skills needs – see paragraph 5.08). This inspection did not cover any aspect of military training (including non-recreational physical education). The resettlement needs of those being discharged from the Army in D Company centred on a five-day preparation for release programme.

7.02 At the time of the inspection, the proportions of the two main populations, A Company and D Company, were almost equally split, with 52% A Company detainees and 46% D Company. This represented a significant change in the population over recent years, when D Company had previously represented about a third of the population. This clearly had significant implications for resettlement services and programme planning at MCTC.

7.03 There was a standing committee on resettlement attended by all companies, and departments such as education and training and welfare services. Although the representation was appropriate to the task of the group, there was not a clearly defined resettlement policy or strategy to set a framework within which the work of this group should be carried out and, consequently, there was a lack of coordination of the various departments carrying out various resettlement functions. At the time of the inspection the sergeant major in D Company was developing a sentence planning system, but this appeared to be in isolation from the work of the resettlement committee.

### **Sentence and custody planning**

7.04 MCTC recognised the importance of beginning the process of reintegration and resettlement at the earliest possible stage. This began for all detainees during induction, when they were required to parade in front of the Commandant individually as part of the morning office party. This process was intended to be motivational, and the Commandant encouraged detainees to make the most of the opportunities available to them while serving their sentence at MCTC.

7.05 In D Company a member of staff allocated activity to individual detainees from the timetable. He had also developed an action planning pro forma for detainees to self-assess their personal needs and translate them into actions and targets, but this had yet to be fully implemented. The action plans that we saw did not set personal goals and were not linked to individual assessed need. They were best described as individual timetables derived from the pre-set core education and training timetable.

7.06 Other departments offering courses and delivering courses and resettlement programmes were not linked into the action planning process. As a result, those on longer term sentences were often removed from courses to allow those on shorter sentences to benefit prior to their release. While the intention was to ensure that detainees on short sentences also had the opportunity to gain some skills and qualifications before they were released, the disruption and lack of continuity experienced by detainees serving longer sentences was a major cause of dissatisfaction expressed to us.

7.07 The process of action planning was a long way short of a formal sentence planning process which agrees on personal goals and targets to address individual need, identified through a thorough assessment process.

### **A Company**

7.08 Reintegration planning was adequate to meet the needs of the short-term detainees in A Company where the emphasis was on military retraining. Modular training was well developed and those from the Royal Airforce and Royal Navy gained many additional skills, for example reconnaissance and surveillance techniques. Those on longer sentences were often required to repeat training. There was no structured planning to integrate education with the military training for those on longer sentences needing to improve their literacy and numeracy skills. At the time of the inspection no basic skills tutoring took place due to staff shortages. A member of staff provided classes in literacy and numeracy on a voluntary basis. When detainees returned to their units after serving their sentence their commanding officers were routinely provided with reports on their literacy/numeracy needs and progress with military training and interpersonal skills.

### **D Company**

7.09 The pre-release programme for detainees from D Company took place towards the end of their sentence and lasted for one week. It formed a major part of the resettlement programme.

7.10 The room used for the course was poorly resourced. There were eight personal computers and one printer. The computers were not linked to the internet and therefore were of limited effectiveness in supporting job search. Although many of the detainees had poor literacy skills, the Word packages used to develop CVs and write letters did not have a spell check function. The desks used in the classroom were unsuitable for computer work.

7.11 The start of the course focused on job goals. Other information from the personal action planning process (such as results of diagnostic assessment of literacy and numeracy skills to supplement screening test results) was not utilised. As previously indicated, there was no access to literacy support at the time of inspection

due to staff shortages. We observed one group lesson where some detainees required literacy support to complete exercises, but the tutor was not qualified or experienced to support their learning needs.

7.12 A representative from the job centre attended for two half-days to help with benefit enquiries and to make appointments for detainees at job centres in the areas where they were to be released. There was an over-reliance on the job centre staff to arrange these appointments, which were restricted to the last weeks of sentence. There was no structured careers guidance prior to the job search programme and little information in the library about careers guidance.

7.13 There was no internal evaluation of the quality of the pre-release programme. In our survey, 65% of respondents said they had not done anything at MCTC that would help them in the future.

### **Programmes**

7.14 Almost half of the population at MCTC, 48%, had been sentenced for being absent without leave. The second highest category of offence, for 25% of those convicted, was violence against the person. Anecdotally we were told that many offences of violence had been committed while detainees had been under the influence of alcohol while on leave. Cranstoun, which provided the substance misuse services, delivered an anger management programme appropriate to address this behaviour. No other specific behaviour programmes or life skills programmes were offered, except for some budgeting work delivered by the welfare department (see below).

### **The welfare department**

7.15 The welfare department consisted of a hard working and committed group of four staff, assisted by a seconded full-time housing advice worker from Shelter.

7.16 All detainees were interviewed on arrival – over 1,200 in the previous 12 months. In addition, there had been nearly 2,800 ‘repeat’ interviews in which staff continued to progress issues with those detainees in their personal caseloads.

7.17 Without exception, detainees praised the accessibility of the welfare department and the help it gave them. It provided a vital role for allowing detainees to air the anxieties and concerns they found difficult to raise within their companies.

7.18 The welfare department concentrated on providing practical assistance and did not regard itself as a counselling service. The principal problems it dealt with related to debts and housing. In our survey, 48% of respondents said that they had 'money worries' when they first arrived at MCTC. Such anxieties were merely added to in MCTC as they received no military pay while serving their sentences. The welfare department attempted to give detainees some confidence in the future management of their debt problems.

7.19 The welfare department had established strong working relationships with SPACE, the single person's housing agency for those leaving the services, and with the Joint Services Housing Advice Organisation, for those requiring family accommodation. While no detainee left MCTC on discharge from the services without at least a bed and breakfast voucher for 48 hours accommodation, the welfare department continued to have many concerns about the problems confronting single detainees on their departure. There was no post-release support for detainees who were being discharged from the services.

7.20 Detainees also presented a significant number of domestic and personal problems, and this involved much work with other social and welfare agencies as well as unit welfare officers. For those being discharged from the services, these were mainly local authority or other civilian agencies in the areas to which detainees were likely to return. Many problems related to future housing, and the welfare department staff included a full-time worker seconded from the Colchester Shelter office who spent her time liaising with Shelter teams and other housing agencies in detainees' home areas. For those remaining in the services, links were primarily with unit welfare officers, the Soldiers, Sailors and Airmen's Family Association (SSAFFA), and specialist social workers based in overseas garrisons.

7.21 While the welfare department collaborated closely with their health colleagues and the padre, there was scope for more proactive work with both D Company staff and the education and training department.

### **Conclusion**

7.22 Detainees from A Company who were returning to their units were well prepared to do so (though it was primarily Army training), but many had other needs to be addressed, such as basic skills, that were not considered a priority. By contrast, there was no corporate strategy, and insufficient resources to assist the resettlement of those being discharged from D Company. The excellent work of the welfare department needed to be part of an overall resettlement framework, operating throughout the sentence.

### **Recommendations**

7.23 **There should be a resettlement group, chaired by the Commandant, on which all departments and companies are represented. This should meet regularly and review the corporate MCTC strategy for preparing all detainees for discharge, particularly those leaving the services.**

7.24 **There should be a structured sentence planning process for all detainees to ensure a coordinated approach to resettlement.**

7.25 **Resettlement planning should be a continuous process after initial assessment at induction, and properly resourced programmes preparing detainees for release should take place well before the end of a sentence.**

7.26 **The range of education courses should be extended to include personal development programmes, such as debt management and relationship counselling.**



# CHAPTER EIGHT

## SERVICES

### Catering

#### Expected outcomes

The expected outcomes for catering are:

- **Safety:** detainees are able to queue at the servery and eat their meals in safety
- **Safety:** detainees' food is prepared and served safely in accordance with environmental health regulations
- **Respect:** detainees receive a fair portion of healthy, balanced, nutritious and varied meals to meet their gender, dietary, religious, ethnic and medical needs
- **Respect:** detainees are encouraged to eat healthily

8.01 The catering provision was sub-contracted to a private contractor. There was a central kitchen with two adjacent serveries providing meals and dining facilities for A and D Companies. Detainees from C Block were served 30 minutes before the other two companies. Communal dining in C Block was risk assessed. Unless the Commandant directed that a detainee should eat in cell, detainees in C Block ate in the recreation room.

8.02 A member of the military staff and one member of the catering contractor supervised each servery. Detainees were allowed to serve themselves and we observed some examples of poor practice in basic food hygiene. Detainees dined in association, with military staff strategically placed for supervision. At the end of the dining out period mail and medicines were distributed.

8.03 Although there was no arrangement for detainees to select meals, there was an adequate choice of hot and cold meals. As an incentive, those on stage three were served first, followed by those at stage two and stage one. As a result, detainees on stage one often had no choice of meal. A full English breakfast was served every day with no other choice. Healthy options were limited, and arrangements were made for

vegetarian, cultural and medical diets when required. Portions were good and we considered the quality of food adequate, although our survey showed a high level of dissatisfaction with the food offered. Mealtimes were reasonably spaced and snacks were provided for supper.

8.04 While the kitchen was generally clean and facilities for food preparation were adequate, storage facilities were limited, resulting in frequent deliveries during the week. One boiler was out of service awaiting repairs and the second one required descaling. A sink unit in the kitchen area was covered in cling film and out of use due to waste blockage and drainage problems during the inspection. Tiles around the lower walls were missing and the areas were dirty and harboured grease and food particles. Plaster and paint was peeling off several walls.

8.05 Changing and sanitary conditions for contractor staff were in a particularly poor condition. The toilets were available for both men and women. However, the changing rooms did not have locks on the door and the shower worked intermittently. There was plaster and paint peeling off walls around the urinal, and the single cubicle toilet had not worked for some 18 months. These important health and safety issues were brought to the attention of the establishment during the inspection and remedial action was taken without delay.

## **Conclusion**

8.06 The catering provision was generally satisfactory, with detainees dining in association in a relaxed but well supervised environment. The quality and quantity of food were reasonable, although there were limited options for healthy eating, cultural choice and those on medical diets. There were a number of significant health and safety issues in the kitchen and staff toilet facilities.

## **Recommendations**

8.07 **There should be a greater range of healthy option and cultural choice meals.**

8.08 **There should be a confidential area for mail and medicine distribution during meal times.**

8.09 **There should be a rotation system in serving meals to ensure that all detainees have access to the full choice of meals, irrespective of their position on the staging system.**

8.10 **Health and safety issues in the kitchen and staff toilets should be monitored regularly.**

### **Detainees' shop**

#### **Expected outcomes**

The expected outcomes for the detainees' shop are:

- **Safety:** arrangements to enable detainees to purchase items minimise opportunities for bullying
- **Safety:** items held in the shop and store are stored and served according to the requirements of food safety, hygiene and security
- **Respect:** detainees have a suitable range of affordable goods available for purchase at reasonable prices to meet their ethnic, cultural and gender needs

8.11 The shop facility was managed by the reception staff. The main shop area was based in D Company, with a limited store kept in A Company. There was an insufficient range of products, particularly hair and skin care products, for minority ethnic detainees. In our survey 50% of respondents said that the shop did not sell a wide enough range of goods to meet their needs.

8.12 All detainees were required to pay for essential toiletries from their weekly allowance.

8.13 Detainees could make purchases from the shop once a week on a Wednesday afternoon. A shopping list system had been developed to help them select items prior to visiting the shop and to reduce delays in being served. The shop session was supervised to reduce the risk of bullying or intimidation. New admissions could make purchases within one day of admission.

## **Conclusion**

8.14 The shop facility was effectively managed and was accessible to all detainees. The range and quality of products was limited, however, with emphasis often on cheapest products. Detainees had to purchase basic essential toiletries, and the requirement for women to purchase sanitary protection products was discriminatory.

## **Recommendations**

8.15 **Detainees should be issued with essential toiletries free of charge.**

8.16 **The range of products in the shop should be extended to meet cultural needs.**

## CHAPTER NINE

### RECOMMENDATIONS, HOUSEKEEPING AND GOOD PRACTICE

*(Numbers in brackets refer to paragraph in main report)*

#### **Main recommendations**

**9.01 Detainees at risk of suicide or self-harm should not be routinely located in C Block, nor should they be placed in strip clothing unless a risk assessment indicates that this is necessary. (HE.50)**

**9.02 Procedures designed to tackle bullying should be reviewed. An anti-bullying strategy should be developed, based on an up-to-date survey of any past or current bullying. An anti-bullying committee should oversee the implementation of the strategy. (HE.51)**

**9.03 The complaints system should be fundamentally overhauled so that detainees have more confidence in it. (HE.52)**

**9.04 There should be sufficient purposeful activity – particularly education and vocational training – for all detainees. (HE.53)**

**9.05 There should be a fundamental review of the equal opportunities action plan to ensure that it meets the requirements of the Army directive *Values and Standards in the British Army*. An equal opportunities committee should oversee the implementation of the action plan. (HE.54)**

**9.06 There should be a resettlement strategy based on a needs analysis of the different and distinct needs of the diverse and changing population at MCTC. (HE.55)**

### ***Reception into detention***

- 9.07 There should be separate holding areas for new arrivals and other detainees waiting for medical and welfare appointments. (1.22)
- 9.08 There should be an appropriate facility for private interviews. (1.23)
- 9.09 Detainees should be able to retain permitted items up to the accepted in-possession limits rather than have to place them in stored property and then be required to purchase further supplies. (1.24)
- 9.10 The padre should see all new arrivals within the first 24 hours. (1.25)
- 9.11 New arrivals should be allowed to make a reception telephone call. (1.26)
- 9.12 Befrienders should receive advance training for their role. (1.27)
- 9.13 The induction process and its content should be reviewed in consultation with detainees to ensure that it provides new detainees with all the information they need to know. Staff should deliver the revised programme through a range of participative modules, reinforced by written information or other media accessible to those with low literacy levels. (1.39)

### ***Structure of the facility***

- 9.14 There should be efforts to structure contacts between individual detainees and their platoon sergeants to allow greater continuity of relationships; staff should be more proactive in establishing relationships with individual detainees. (2.24)

### ***Duty of care***

- 9.15 There should be an annual survey to monitor the levels of bullying within the establishment. (3.06)

- 9.16 An anti-bullying policy and strategy should include the availability of interventions for bullies and their victims. (3.07)**
- 9.17 Risk assessments should include assessing risk of room-sharing, with particular reference to situations where under-18s may be held with adults. (3.14)**
- 9.18 Separate accommodation should be available for under-18s who need to be held separately from adults. (3.15)**
- 9.19 The suicide prevention awareness team should meet at least quarterly. (3.29)**
- 9.20 When a blue star booklet is opened a written support plan should be formulated, taking account of the views of the individual concerned. A copy of the completed support plan should remain with the booklet. (3.30)**
- 9.21 Substance use awareness, and in particular alcohol awareness, should be introduced into the detainees' education and training programme. (3.52)**
- 9.22 There should be more formal and regular health promotion of substance use issues. (3.53)**
- 9.23 The draft alcohol protocol should be updated and reintroduced. (3.54)**
- 9.24 There should be a system for identifying any trends in positive compulsory drug testing. (3.55)**
- 9.25 Equal opportunities advisers should be proactive in promoting and enforcing an attitude of equality by their actions and attitudes, and by providing information and advice to increase detainees' and staff confidence in the Army's equal opportunity directive. (3.74)**

- 9.26 All detainees should receive effective equal opportunities training in accordance with the Commandant's equal opportunities action plan. (3.75)
- 9.27 The Commandant's action plan should describe systems that provide clear data or comprehensive anonymous feedback; these should be used to monitor outcomes for minority populations and to provide management information about the effectiveness of the plan. (3.76)
- 9.28 Complaints should be monitored to inform senior officers of areas where action is required. (3.77)
- 9.29 Investigators should always record proven complaints as formal complaints. (3.78)
- 9.30 There should be a needs analysis of foreign national detainees to identify any particular training, education or resettlement needs that should be met to ensure their fair access to all aspects of the regime. (3.79)
- 9.31 Military training should include some acknowledgement of and respect for the specialist skills required for Royal Navy and RAF detainees. (3.80)
- 9.32 The establishment should set up an equal opportunities committee; this should involve staff and detainees and review outcomes and promote the policy. (3.81)
- 9.33 Detainees should receive a public expense letter each week. (3.95)
- 9.34 A secure post box should be provided in each company for detainees to post their letters. (3.96)
- 9.35 Facilities for visits should be improved, including appropriate disabled access, supervised child play facilities, and vending machines to provide a wider range of refreshments. (3.97)



- 9.36 **Facilities for visitors to wait outside the establishment should be improved. (3.98)**
- 9.37 **There should be regular surveys of visitors to take account of their views. (3.99)**
- 9.38 **Arrangements to enable detainees to make written complaints, with an appropriate appeal system, should be instituted without delay. (3.117)**
- 9.39 **A box permitting detainees to make confidential access to the Commandant and the Provost Marshal should be available on each company, and a similar box should be provided for confidential access to the Independent Board of Visitors. (3.118)**
- 9.40 **The Commandant's management team and the Independent Board of Visitors should regularly review all the complaints and outcomes of investigations, and monitor patterns and trends. (3.119)**
- 9.41 **The different avenues to raise complaints should be explained to detainees, both verbally and in a clear and simple written document. (3.120)**

### ***Healthcare***

- 9.42 **The Commandant and medical centre staff should work closely with Army primary healthcare service staff to determine the strategic role of the medical centre. (4.53)**
- 9.43 **There should be a healthcare needs analysis that identifies the needs of the population and reflects the increases in the numbers of detainees arriving at the MCTC with existing health problems and the increasing proportion in D Company awaiting discharge. (4.54)**
- 9.44 **The doctor should regularly attend the Commandant's weekly senior management meeting to ensure a senior healthcare input to decisions which may impact on the health or healthcare of detainees. (4.55)**

**9.45 The medical centre staff skill mix and rank structure should be reviewed and action taken on the recommendations in the July 2003 Specialist Staff Inspection, including the appointment of a practice nurse, part-time pharmacy technician, the regrading of the practice manager's post and employment of administrative staff. (4.56)**

**9.46 There should be a training needs analysis; training plans should be developed for all medical centre staff and steps taken to ensure they maintain their clinical competency. (4.57)**

**9.47 The need for overnight cover at MCTC should be reviewed and alternative policies and procedures for out of hours cover developed in consultation with the senior medical officer at Colchester garrison. (4.58)**

**9.48 A medicines and therapeutics committee should be established, with input from the garrison pharmacist and the Army primary healthcare service pharmacy adviser, to introduce medicines management, in-possession and special sick policies and update the prescribing formulary. (4.59)**

**9.49 All medics should be Buttercup-trained; alternative arrangements should be made for medication distribution. (4.60)**

**9.50 The pharmacy should be relocated to the ex-dental surgery, as planned, and the current use of medical centre space reviewed to provide a further consultation room. (4.61)**

**9.51 There should be an alternative site for confidential medical interviews with new arrivals in reception. (4.62)**

**9.52 Regular primary care clinics should be developed, including well man and smoking cessation. Nicotine patches should be prescribed as part of a smoking cessation programme, which includes carbon monoxide monitoring. (4.63)**

9.53 **Clinical supervision for all medical centre staff should be introduced.**  
(4.64)

***Activities***

9.54 **The range of industry-relevant vocational training courses should be increased.** (5.20)

9.55 **Literacy, numeracy and language training should be provided for all detainees who need this.** (5.21)

9.56 **Vocational training staff should receive information about detainees' initial assessment.** (5.22)

9.57 **A Company should have better access to education provision.** (5.23)

9.58 **MCTC should provide a programme of evening education classes.** (5.24)

9.59 **The current library stock should be reviewed and evaluated to establish and rectify deficiencies.** (5.29)

9.60 **There should be more library resources to support detainees' literacy, numeracy and language needs.** (5.30)

9.61 **Staff levels should be improved to increase detainees' access to the library facilities.** (5.31)

9.62 **There should be better recreational and social facilities for detainees during periods of evening unlock, and a programme of organised activity at the weekend, including outdoor activity.** (5.39)

9.63 **Detainees should be told, verbally and in writing, how to access ministers of their own faith during their induction; notices with this information, and celebrating religious diversity, should be displayed.** (5.50)

9.64 A dedicated space should be made available for attending non-Christian ministers and for the religious observance of non-Christian detainees. (5.51)

***Good order and discipline***

9.65 The staging system should be reviewed to ensure that the level of privileges and the time taken for detainees to move from stages one to two provide an incentive. (6.24)

9.66 An easily accessible appeal system should be set up. (6.25)

9.67 The authority of the duty officer should be obtained and recorded, specifying reasons, when detainees are located in the unfurnished cell. There should be a log of observations and incidents until the detainee is removed. (6.37)

9.68 There should be a system to monitor trends in the use of force and use of the unfurnished cell to identify and address patterns and trends in location, activity, authorising officer, time or people involved. (6.38)

9.69 All events that result in any force being used on detainees should be fully recorded on the correct forms. (6.39)

9.70 The record of detainee's injury should be copied on to the use of force record so that the senior officer managing this can be aware of patterns of injury and possible training issues. (6.40)

9.71 The body belt should be held out of sight and secured with restricted access. (6.41)

9.72 A positive regime of activity, education and training should be offered to detainees spending more than one week in C Block. (6.48)

### ***Resettlement***

9.73 **There should be a resettlement group, chaired by the Commandant, on which all departments and companies are represented. This should meet regularly and review the corporate MCTC strategy to prepare all detainees for discharge, particularly those leaving the services. (7.23)**

9.74 **There should be structured sentence planning process for all detainees to ensure a coordinated approach to resettlement. (7.24)**

9.75 **Resettlement planning should be a continuous process after initial assessment at induction, and properly resources programmes preparing detainees for release should take place well before the end of a sentence. (7.25)**

9.76 **The range of education courses should be extended to include personal development programmes, such as debt management and relationship counselling. (7.26)**

### ***Services***

9.77 **There should be a greater range of healthy option and cultural choice meals. (8.07)**

9.78 **There should be a confidential area for mail and medicine distribution during meal times. (8.08)**

9.79 **There should be a rotation system in serving meals to ensure that all detainees have access to the full choice of meals, irrespective of their position on the staging system. (8.09)**

9.80 **Health and safety issues in the kitchen and staff toilets should be monitored more regularly. (8.10)**

9.81 **Detainees should be issued with essential toiletries free of charge. (8.15)**

9.82 **The range of products in the shop should be extended to meet cultural needs.** (8.16)

## **Housekeeping points**

### ***Reception into detention***

9.83 New arrivals should be processed and moved through reception with minimum delay. (1.28)

9.84 There should be a wider selection of reading material available for detainees waiting in reception. (1.29)

9.85 Advance information about MCTC should be provided to detainees prior to their transfer in. (1.30)

### ***Duty of care***

9.86 There should be more space in blue star booklets for daily monitoring entries. (3.31)

9.87 All sections of the blue star booklet should be fully completed. (3.32)

9.88 The practice of repeating the same equal opportunities training each year should be reviewed to evaluate whether this should be enhanced by a local element specific to the establishment. (3.82)

### ***Healthcare***

9.89 There should be monitoring systems for the audit of care and service planning. (4.65)

### ***Activities***

9.90 The housekeeping in all of the workshops should be improved. (5.25)

## **Examples of good practice**

9.91 *The Commandant saw all new arrivals on completion of the induction process.*  
(1.40)

9.92 *The chair of the suicide prevention awareness team had established good links with the prison service and regularly attended Eastern area suicide awareness meetings. This assisted the Military Corrective Training Centre to keep abreast of new initiatives in the prison service.* (3.33)

9.93 *The Commandant reviewed all open blue star booklets on a daily basis.* (3.34)

9.94 *Visitors arriving late were contacted by staff via their mobile telephones, where possible, to ease any concern on behalf of the detainee awaiting the visit.*  
(3.100)

