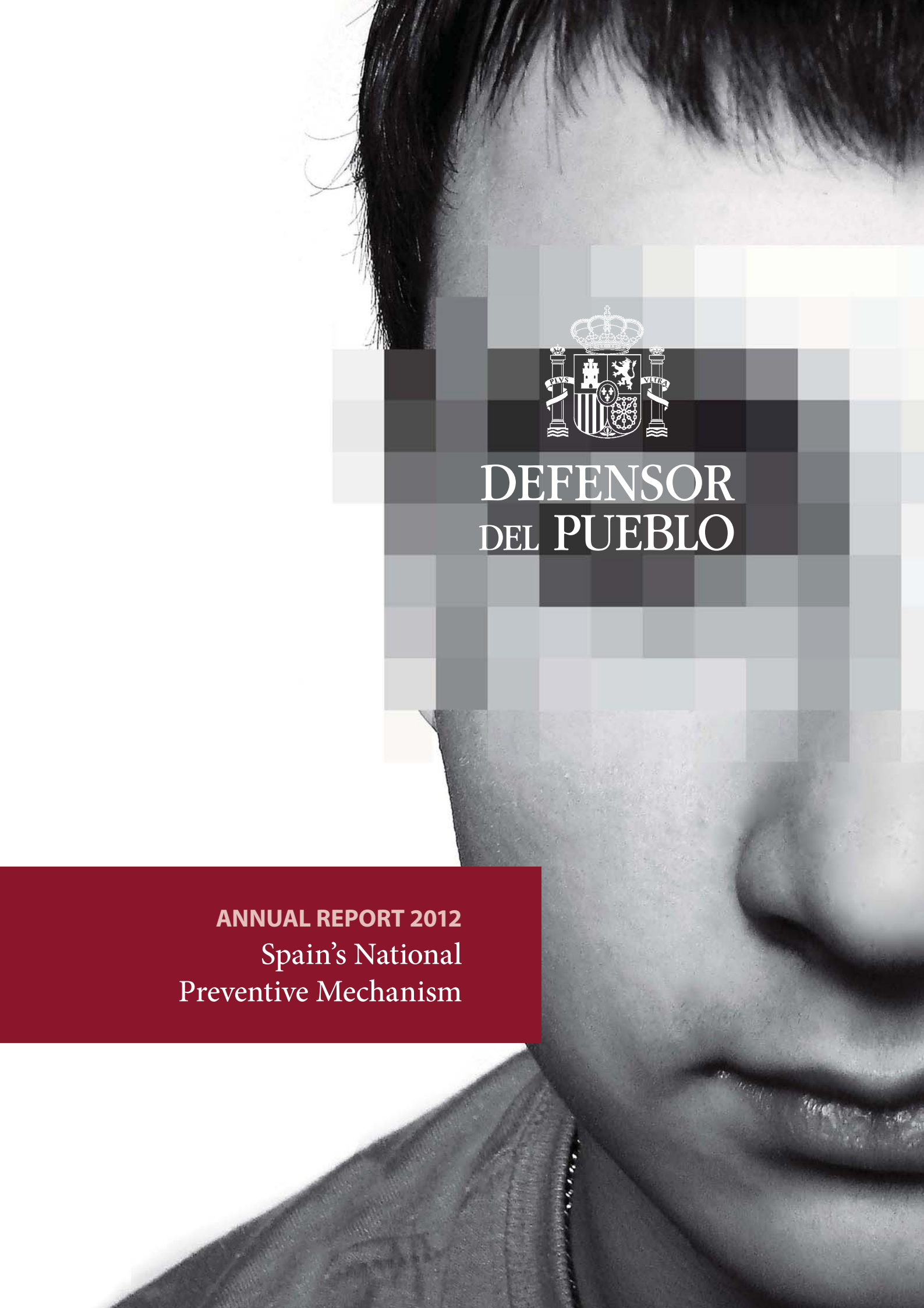
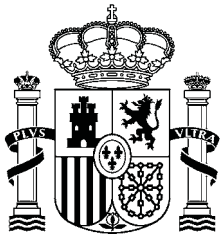


DEFENSOR DEL PUEBLO

ANNUAL REPORT 2012
Spain's National Preventive Mechanism



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Spain's National Preventive Mechanism

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Presentation

The Spanish Ombudsman Institution (*Defensor del Pueblo*), which at the same time is the National Mechanism for the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (NPM), reaches its third year in the exercise of this responsibility and hereby submits the annual report pertaining to the Spanish Parliament (*Cortes Generales*) and to the United Nations Subcommittee on the Prevention of Torture (SPT). In February 2012 the Spanish NPM appeared before said Subcommittee in order to submit the first annual report, and since then several contacts have been maintained.

This exercise shows continuity with the path undertaken and also the changes required to improve the performance of the assigned mandate; an effort has been made to carry out a relevant number of visits, and external technical experts in several scientific disciplines have been included in those visits which could be considered more complex; priority has been given to a better understanding of the situation of the persons deprived of liberty through interviews and questionnaires; while this Institution has continued our intense collaboration with other NPMs, sharing the experiences and methodologies used while carrying out the visits, with the preventive approach which is the trademark of all NPMs.

A relevant novelty has been the publication in the Spanish Official State Gazette (*BOE*) of 13 March 2013 of the Resolution of 27 February from the Ombudsman, opening the procedure for the appointment of members of the Advisory Council to the NPM. The imminent appointment and constitution of the Advisory Council (*Consejo Asesor*) shall complete the institutional design established by the legislator, and facilitate the legal and technical cooperation of such body with the tasks of the NPM.

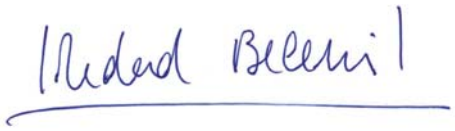
This year's report includes, for the first time, some annexes with the charts of the conclusions obtained after each visit, as well as the monitoring carried out after sending the conclusions of the previous years' visits, thus facilitating the consultation of each visited facility. Likewise, to answer the worries which have appeared in the sphere of civil society, and appendix has been included with the summary of the actions taken by the Ombudsman Institution in the matters where the NPM acts in a preventive way. This dimension is more extensively developed in the general annual report of the Institution.

Also as a novelty, a social health care center has been visited and a repatriation flight for foreigners, organized by FRONTEX (European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union), has been monitored.

The significant number of visits conducted over a three-year period and the depth of such visits has allowed us to carry out an analysis on the situation of the

deprivation of liberty in Spain and to establish our own doctrine on the conditions which should be applied to those situations by the different public administrations which have a responsibility therein.

Soledad Becerril
Spanish Ombudsman



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Acronyms and abbreviations used

AP	Provincial Court
APDHE	Spanish Association for Human Rights
ATS	Medical-technical assistant
BEDEX	Spanish National Police Force's Brigade for Deportation of Foreign Offenders
BOE	Spanish Official State Gazette
CCAA	Regional Autonomous Communities (Spanish regional government)
CERMI	Spanish Committee of Disabled People's Representatives
CETI	Temporary Accommodation Center for Immigrants
CGAE	General Council of Spanish Lawyers
CGPJ	General Council of the Spanish Judicial Authority
CIE	Immigrant Detention Center
CGC	Civil Guard Headquarters
CGEF	Central Department on Immigration and Borders
CGPC	Central Police of the Canary Islands
CNP	Spanish National Police Force
CP	Prison
CPT	European Committee for the Prevention of Torture (Council of Europe)
DGGC	Directorate General of the Civil Guard
DGP	Directorate General of the Police
DUE	University Diploma in Nursing
EDM	Military Disciplinary Establishment
FJ	Legal basis
FGE	Spanish Attorney General's Office
FRONTEX	European Agency for the Management of Operational Cooperation at the External Borders
FSC-CCOO	Federation of Citizens Services – trade union
GC	Civil Guard
GINSO	Association for the Management of Social Integration

INE	Spanish National Statistics Institute
LECrim	Spanish Code of Criminal Procedure
LODP	Organic Law on the Office of the Ombudsman Institution
LOEx	Organic Law on Foreign Nationals
LORPM	Organic Law regulating the criminal responsibility of minors
MER	Education and Respect Ward
NPM	National Preventive Mechanism for the Prevention of Torture and other cruel, inhuman or degrading treatment of punishment (National Mechanims for the Prevention of Torture)
OAR	Spanish Office of Refuge and Asylum
NGO	Non-governmental Organization
UN	Organization of the United Nations
OPCAT	Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted by the General Assembly of the United Nations in resolution 77/199, of 18 December 2002)
PAIEM	Framework program for the comprehensive care of the mentally ill
PPS	Suicide Prevention Program
RP	Prison Regulations
SAMUR	Local Emergency and Rescue Service
SES	Office of the Secretary of State for Security (Ministry of the Interior)
SGIP	Office of the Secretary General for Prisons (Ministry of the Interior)
SOAJP	Suspension of the Legal Guidance and Assistance Service for Prisoners
SPT	UN Subcommittee for the Prevention of Torture
STC	Decision of the Spanish Constitutional Court
STS	Decision of the Spanish Supreme Court
TAI	Technical Intervention Assistants
TAIEX	Project for Technical Assistance Information Exchange (European Commission)
TSJ	High Court of Justice
UCER	Central Unit for Deportation and Repatriation (Spanish National Police Force)
UCH	Prison Hospital Wards
UIP	Police Action Unit
VIH	Human Immunodeficiency Virus

Introduction
§1-§6

1. This report gives an account of the activity developed by the National Preventative Mechanism against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (hereinafter, NPM) throughout the year 2012, thus complying with the requirements established in the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), to prepare a specific report on an annual basis.

Obligation to prepare an annual report

In response to such obligation, the 2011 Annual Report of the NPM was submitted at the Official Records of the Spanish Parliament on the 6th of June 2012 and on the 3rd of July of the same year it was sent by post to the UN Subcommittee for the Prevention of Torture (SPT), with headquarters in Geneva (Switzerland). On the 21st of February 2012 the Subcommittee convened the Spanish Ombudsman Institution to such city in order to present the Annual Report pertaining to year 2010.

The 2010 Annual Report was presented before the SPT (UN) on 21 February 2012

2. As mentioned in paragraph 12 of the 2011 Annual Report, the visits have continued to be conducted by teams made up of persons with legal training, together with the assistance and cooperation of external technicians of well-established professional experience and knowledge, accredited in the matters referred to by the Optional Protocol, such as medicine, psychiatry or psychology. In this way, a contribution is made towards a comprehensive and multidisciplinary evaluation of the centers and places of deprivation of liberty, focusing on specific aspects of the visited facilities.

The NPM conducts a comprehensive and multidisciplinary evaluation of the visited places of deprivation of liberty

3. Since the beginning of its activity in March 2010, the Spanish NPM has conducted 363 visits to places of deprivation of liberty and has consolidated a broad doctrine which has an effective influence on the activity of all the public administrations concerned. As is already widely known, the NPM carries out visits to centers of deprivation of liberty in order to identify structural and procedural problems which may help prevent the practice of torture or ill-treatment and to avoid their eventual impunity. After the visits, following the methodology used in previous years, conclusions are drafted and sent to the administrations concerned, in relation to the shortcomings identified. As a novelty in this report and in response to the requests sent by some representatives of the civil society, the conclusions of each center are shown in the charts included in an annex at the end of this report. Likewise, for ease of consultation of the visited facilities, it was judged appropriate to include in this report some follow-up charts of the visits conducted in year 2011, individualizing each place of deprivation of liberty and showing the conclusions drawn after the visit, as well as the resolutions formulated during the investigation that was undertaken and the response of the relevant administration.

Since the beginning of the activity in March 2010, 363 places of deprivation of liberty have been visited

In those cases where the immediate measures proposed to improve the detention conditions are not adopted by the authorities, the NPM may formally make use of the relevant resolutions which the law recognizes to the Ombudsman Institution, such as Recommendations, Suggestions or Reminders of Legal Duties. Thus, in year 2012 a total of 118 Recommendations, 79 Suggestions and 8 Reminders of

In year 2012, a total of 118 recommendations, 79 suggestions and 8 reminders of Legal Duties have been carried out

Legal Duties have been carried out, the content of which is detailed throughout this report.

At the visited places, photos are taken and included in the appropriate records

4. The Institution has followed the criteria established in previous years about conducting unannounced visits (with the exception of three which were carried out together with foreign delegations) at any time of the day or night, as well as obtaining photos of the centers, which are integrated into the appropriate records and some of them are also included in this report.

The NPM has a preventive mission, and its goal is to promote changes of operational and regulatory nature, if necessary

5. It is necessary to remember that the action of the NPM is -as its very name implies-, of a preventive nature, and its goal is to promote the necessary changes, at both regulatory and operational level, in order to hinder and, ideally, prevent, the occurrence of cases of torture or ill-treatment. On becoming aware of the alleged commission of a fact which might be codified as torture, cruel, inhuman or degrading treatment, arising from a visit, through the mass media or by means of a document from the interested persons or third parties, it is then reported to the relevant area of the Ombudsman Institution to establish, as the case may be, if it is appropriate to open an investigation. Notwithstanding this, the NPM carries out a study of the complaints submitted and the investigations conducted at the Institution, in order to determine the visits which are to be implemented during the year. A record of the eventual handling of complaints or *ex officio* cases (*expedientes de oficio*) due to ill-treatment is made in the relevant sections of the Annual Report of the Ombudsman Institution. However, in order to better inform on the work carried out by the Ombudsman Institution regarding torture and ill-treatment within its reactive aspect, and likewise, so as to contextualize with specific cases the framework in which the action of the NPM takes place, it has been deemed appropriate to include in this Report, and in the successive ones, an Appendix containing a summarized version of the action taken by the Ombudsman Institution in this field.

The procedure to appoint members of the Advisory Council to the NPM went into effect in February 2013

6. On the other hand, as was already pointed out in paragraphs 10 of the 2010 Annual Report and 11 of the 2011 Annual Report, the complete design of the NPM established by means of Organic Law 1/2009, of 3 November, which introduced a single final provision in the Organic Law on the Spanish Ombudsman Institution, entailed setting up the Advisory Council. The reform of the Regulations governing the Ombudsman Institution where the creation of the Advisory Council was provided for, was approved in 2012 (Agreement of the Spanish Chamber of Congress and Senate Bureau of 25 January 2012, Official State Gazette no. 52, of 1 March). The procedure to appoint members to the Advisory Council of the National Mechanism for the Prevention of Torture went into effect by means of the Resolution of 27 February 2013 from the Spanish Ombudsman (Official State Gazette no. 62, of 13 March).

Visits undertaken §7-§9

7. In year 2012, a total of 52 visits have been carried out. Their distribution, taking into account the typology of the facilities, is shown in table below. Their geographical location and classification, according to the typology of the visited facilities, is shown in Figure 1.

In 2011 a total of 52 visits was carried out

Table 1. Typology of the places of deprivation of liberty visited

Places	Number of visits
Police stations and other places of short-term custody; Spanish National Police Force	18
Local Police	7
Prison facilities	6
Barracks and other places of short-term custody; Civil Guard	5
Autonomous police forces (Mossos d'Esquadra, Ertzaintza and Policia Foral)	4
Immigrant Detention Centers	4
Centers for juvenile offenders	3
Operations for the repatriation of foreigners	2
Prison cells in court buildings	1
Prison hospital wards	1
Social health care residences	1
Total	52

8. From the total of 52 visits carried out in 2012, 12 were of a multidisciplinary nature. Some of the visited facilities had been previously inspected, but a follow-up was considered appropriate in order to check compliance of the reported recommendations and to identify new eventual shortcomings. In the specific case of the Immigrant Detention Centers, these follow-up visits have been carried out together with external technicians, so as to pay special attention to the medical or psychological aspects.

Twelve of the visits were multidisciplinary

The collaboration of the external technicians, experts in legal and forensic medicine, in psychiatry and psychology, has contributed to provide –as also occurred in 2011–, a particularly qualified focus at the time of conducting the individual interviews with the persons deprived of liberty and this has allowed for a better analysis of the conditions of deprivation of liberty, as well as of the potential bad practices or risks of ill-treatment which may occur.

9. As novelties this year, the Ombudsman Institution highlights the visits carried out to the social health care center "*San Jose*" (Toledo), and the one conducted during the repatriation flight for foreigners organized by the European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union (FRONTEX).

In 2012 a visit was carried out to a social health care residence for the disabled and the elderly

The visit lasted for three days

The Assisted Living Residence "San José", located in Toledo, was inaugurated in 1977 as a psychiatric hospital, to cater to a population which was distributed in two focus areas: the disabled and the elderly. Said facility is the largest center with these characteristics in Spain. It has a staff of 413 professionals and a capacity for up to 400 people. With this first visit, the NPM starts a new working perspective. The visit, which lasted for three days, examined, on the one hand, the potential deprivation of liberty which some residents might be subject to if they were placed in the center without their consent; and, on the other hand, the living conditions and the care which was provided, on a general basis, to all residents of the center, as well as the use of physical and pharmacological restraints. For the social health aspects, it was considered necessary that the team of the visit include a psychiatrist, a psychologist and a general practitioner, as external technicians. The conclusions shall be analyzed in the relevant section of this report.

In addition, it has supervised a flight for the repatriation of foreigners, organized by the European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union (FRONTEX)

In addition, through FRONTEX, an agency which started operations in May 2005, joint flights of the Member State countries were organized for deportation of third-country nationals who are subjects of removal orders. Out of these flights, the NPM has had the opportunity to supervise, unannounced, a flight organized by the Netherlands. Such country, together with France, Germany, Norway and Sweden, was removing from the territory a total of 24 Nigerian citizens. At Madrid-Barajas airport 5 citizens who had been expelled from Spain were embarked, as well as 2 from Portugal and 3 from Greece. During the whole operation, each expelled person is under custody by the police force of the respective country which has ordered their deportation. The Spanish team for the repatriation of the 5 Nigerian citizens consisted of 11 people: the Head of the operation and the Head of the escort team, who was in charge of the team made up of another 9 officers from the Central Unit for Deportation and Repatriation (*UCER*). During the visit, the Central Unit for Deportation and Repatriation facilities at Madrid-Barajas airport were inspected, and the team watched the whole process, from the arrival up to the embarkation of the persons that were going to be expelled. This consisted of the supervision of the transfer vehicles, examination of the deportation and repatriation documents, personal search of the repatriated persons, stay at the waiting areas, escorting the repatriated persons in "approach vehicles" (*jardineras*) up to the parking place of the aircraft and, finally, embarkation thereon. In addition, while waiting, the team had the opportunity to conduct interviews with the five Nigerian citizens that were going to be deported by Spain.

Figure 1. Geographical location of the facilities visited in 2012

Places of deprivation of liberty visited in 2012	
Spanish National Police Force	18
Civil Guard	5
Basque autonomous police force (*Ertzaintza*)	1
Navarre Autonomous police force (*Policia Foral*)	1
Catalan Autonomous police force (*Mossos d'Esquadra*)	2
Municipal detention facilities	7
Prison cells in court buildings	1
Immigrant detention centers (CIE)	4
Prison facilities	6
Centers for juvenile offenders	3
Operations for repatriation of foreign nationals	2
Social health care centers	1
Prison hospital wards	1
TOTAL	52

Table 2. Spanish National Police Force departments and stations

SUPERIOR POLICE DEPARTMENTS		
Number	**Town/City**	**Province**
1	Logroño**	La Rioja
2	Seville**	Seville
3	Saragossa**	Saragossa
POLICE STATIONS		
Number	**Town/City**	**Province**
4	Algeciras	Cadiz
5	Algeciras-Port	Cadiz
6	Alicante**	Alicante
7	Leganes	Madrid
8	Madrid, Carabanchel distritc	Madrid
9	Madrid, Latina distritc	Madrid
10	Madrid, Moncloa-Aravaca distritc	Madrid
11	Madrid, Puente de Vallecas distritc	Madrid
12	Madrid, Usera-Villaverde distritc	Madrid
13	Malaga**	Malaga
14	Medina del Campo	Valladolid
15	Merida	Badajoz
16	Torremolinos	Malaga
17	Vigo-Redondela	Pontevedra
18	Saragossa, Actur Rey Fernando**	Saragossa

* Multidisciplinary visit.
** Follow-up visit.

Table 3. Civil Guard command headquarters and barracks

COMMAND HEADQUARTERS		
Number	**Town/City**	**Province**
1	Huesca	Huesca
BARRACKS		
Number	**Town/City**	**Province**
2	Algeciras-Port	Cadiz
3	Baracaldo	Biscay
4	Olite	Navarre
5	Vigo	Pontevedra

Tabla 4. Regional Autonomous Police Forces' stations

BASQUE AUTONOMOUS POLICE FORCE		
Number	**Town/City**	**Province**
1	Bilbao	Biscay
CATALAN AUTONOMOUS POLICE FORCE		
Number	**Town/City**	**Province**
1	L'Hospitalet de Llobregat	Barcelona
2	Sabadell	Barcelona
NAVARRE AUTONOMOUS POLICE FORCE		
Number	**Town/City**	**Province**
1	Estella	Navarre

Tabla 5. Local police stations

LOCAL POLICE		
Number	**Town/City**	**Province**
1	Bilbao	Biscay
2	Ejea de los Caballeros	Saragossa
3	Fuengirola	Malaga
4	Marbella	Malaga
5	Medina del Campo	Valladolid
6	Tafalla	Navarre
7	Zafra	Badajoz

Tabla 6. Prison cells in court buildings

PRISON CELLS IN COURT BUILDINGS		
Number	**Town/City**	**Buildings**
1	Merida (Badajoz)	*Ciudad de la Justicia*

Tabla 7. Immigrant Detention Centers

IMMIGRANT DETENTION CENTERS		
Number	**Town/City**	**Province**
1	Algeciras**	Cadiz
2	Barcelona*/**	Barcelona
3	Madrid*/**	Madrid
4	Valencia*/**	Valencia

* Multidisciplinary visit.
** Follow-up visit.

Tabla 8. Prison facilities

PRISON FACILITIES			
Number	**Center**	**Town/City**	**Province**
1	A Lama*	A Lama	Pontevedra
2	Alcala de Guadaira**	Alcala de Guadaira	Seville
3	Alava*	Nanclares de Oca	Alava
4	Barcelona (women)*	Barcelona	Barcelona
5	Murcia II*	Murcia	Murcia
6	Ocaña II*	Ocaña	Toledo

* Multidisciplinary visit.
** Follow-up visit.

Tabla 9. Centers for juvenile offenders

CENTERS FOR JUVENILE OFFENDERS			
Number	**Center**	**Town/City**	**Province**
1	Las Palmeras*	Madrid	Madrid
2	Teresa de Calcuta*	Brea de Tajo	Madrid
3	Zambrana*	Valladolid	Valladolid

* Multidisciplinary visit.
** Follow-up visit.

Tabla 10. Centers for the elderly and the disabled

CENTERS FOR THE ELDERLY AND THE DISABLED			
Number	**Center**	**Town/City**	**Province**
1	Assisted Living Residence «San José»*	Toledo	Toledo

* Multidisciplinary visit.

Tabla 11. Prison hospital wards

PRISON HOSPITAL WARDS			
Number	**Center**	**Town/City**	**Province**
1	Gregorio Marañón	Madrid	Madrid

Tabla 12. Operations for the repatriation of foreigners

OPERATIONS FOR THE REPATRIATION OF FOREIGNERS		
Number	**Operations**	**Province**
1	FRONTEX operation for a repatriation with destination Lagos (Nigeria)	Madrid
2	Spanish National Police Force operation for the repatriation with destination Guayaquil (Ecuador) and Bogota (Colombia)	Madrid

Situations of Deprivation of Liberty

I. Short-term Deprivation of Liberty §10-§39

Actions of the different police forces

10. In this section regarding short-term deprivation of liberty an analysis is carried out on the actions of the different police forces in Spain, as well as their protocols for procedure with detainees.

In 2012 there were a total of 381,965 detentions with confinement to prison cells

11. Throughout year 2012 and according to the information provided by the Spanish National Police Force, the Civil Guard and the regional autonomous police forces, the number of detentions with confinement to prison cells was 381,965, which represents a decrease from year 2011, where over 425,000 detentions were implemented.

The Spanish National Police Force has implemented a total of 238,610 detentions

The Spanish National Police Force has carried out a total of 238,610 detentions, of which 179,035 were due to the alleged commission of a criminal offense and 59,575 due to violation of the Spanish Law on Foreign Nationals.

Table 13. Detentions with confinement to prison cells implemented by the Spanish National Police Force in 2012, broken down by regional autonomous communities, cities and provinces

Autonomous Regional Communities	Province	Number of detentions with confinement to prison cells
Andalusia		**47,540**
	Almeria	4,173
	Cadiz	8,657
	Cordoba	2,171
	Granada	3,994
	Huelva	1,561
	Jaen	2,009
	Malaga	15,939
	Seville	9,036
Aragon		**7,282**
	Huesca	649
	Teruel	280
	Saragossa	6,353
Asturias		**4,668**
Balearic Islands		**7,273**
Canary Islands		**10,605**
	Las Palmas	5,947
	Santa Cruz de Tenerife	4,658
Cantabria		**2,326**
Castile-La Mancha		**7,831**
	Albacete	2,285
	Ciudad Real	2,173

Autonomous Regional Communities	Province	Number of detentions with confinement to prison cells
	Cuenca	455
	Guadalajara	574
	Toledo	2,344
Castile-Leon		**8,111**
	Avila	448
	Burgos	1,699
	Leon	1,587
	Palencia	647
	Salamanca	1,019
	Segovia	394
	Soria	294
	Valladolid	1,670
	Zamora	353
Catalonia		**9,589**
	Barcelona	6,756
	Gerona	1,528
	Lerida	409
	Tarragona	896
Ceuta		**5,104**
Community of Valencia		**32,999**
	Alicante	13,554
	Castellon	2,603
	Valencia	16,842
Extremadura		**3,179**
	Badajoz	2,397
	Caceres	782
Galicia		**6,907**
	La Coruña	2,810
	Lugo	846
	Orense	711
	Pontevedra	2,540
La Rioja		**1,506**
Community of Madrid		**64,133**
Melilla		**5,178**
Murcia		**9,480**

Autonomous Regional Communities	Province	Number of detentions with confinement to prison cells
Navarre		**1,267**
Basque Country		**2,801**
	Alava	434
	Guipuzcoa	1,708
	Biscay	659
Central bodies		**831**
Grand Total		**238,610**

Source: In-house compilation based on data supplied by the Directorate General of the Police (DGP).

A total of 57,719 transfers of prisoners have been implemented

On the other hand, the Directorate General of the Police has reported that in 2012 a total of 57,719 transfers of prisoners have been implemented between prison facilities or between those and judicial or healthcare facilities.

6 disciplinary proceedings were opened against members of the Spanish National Police Force

In relation to the disciplinary proceedings due to alleged bad practices or the alleged commission of tortures or ill-treatment by Spanish National Police Force officers against persons deprived of liberty, the Directorate General of the Police has reported that six administrative proceedings were opened in 2012, involving seven officers, none of whom showed repeated behavior. Four of these cases are pending the relevant legal procedure, three of them on alleged offenses of assault by three officers in Madrid, one from the Chamberi District police station, another one from the Mostoles police station and the third one from the Fuenlabrada police station. The fourth case refers to an alleged illegal detention carried out by an officer from the Central District police station in Palma de Mallorca (Balearic Islands). The other two proceedings have been closed. One of them referred to an officer from the Tudela police station (Navarre), on alleged insults to a prisoner who was under his/her custody in a hospital center. The last proceedings was closed due to the fact that in the ongoing legal case on alleged ill-treatment of a detainee at the Murcia Immigrant Detention Center (abbreviated as *CIE* in Spanish) the discontinuance and temporary closure thereof had been ordered.

The Civil Guard has made 80,466 detentions with confinement to prison cells

Throughout 2012, the Civil Guard (abbreviated *GC* in Spanish) has made a total of 80,466 detentions which implied confinement to prison cells.

Table 14. Detentions with confinement to prison cells made by the Civil Guard in 2012, broken down by regional autonomous communities, cities and command headquarters (HQ)

Regional Autonomous Community	Command HQ	Number of detentions with confinement to prison cells
Andalusia		**20,229**
	Algeciras	1,639
	Almeria	3,591
	Cadiz	2,694
	Cordoba	1,284
	Granada	2,962
	Huelva	2,034
	Jaen	1,610
	Malaga	2,095
	Seville	2,320
Aragon		**1,547**
	Huesca	455
	Teruel	210
	Saragossa	882
Asturias		**1,407**
	Gijon	845
	Oviedo	562
Balearic Islands		**4,693**
Canary Islands		**5,557**
	Las Palmas	3,668
	Santa Cruz de Tenerife	1,889
Cantabria		**1,239**
Castile-La Mancha		**5,511**
	Albacete	781
	Ciudad Real	1,168
	Cuenca	568
	Guadalajara	737
	Toledo	2,257
Castile-Leon		**3,990**
	Avila	323
	Burgos	497
	Leon	879
	Palencia	264

Regional Autonomous Community	Command HQ	Number of detentions with confinement to prison cells
	Salamanca	280
	Segovia	450
	Soria	260
	Valladolid	693
	Zamora	344
Catalonia		**488**
	Barcelona	208
	Gerona	94
	Lerida	79
	Tarragona	107
Ceuta		**1,358**
Community of Valencia		**15,809**
	Alicante/Alicant	7,861
	Castellon de la Plana /Castello	2,100
	Valencia	5,848
Extremadura		**1,314**
	Badajoz	603
	Caceres	711
Galicia		**3,884**
	La Coruña	1,628
	Lugo	532
	Orense	591
	Pontevedra	1,133
La Rioja		**742**
Community of Madrid		**7,318**
Melilla		**416**
Murcia		**4,035**
Navarre		**628**
Basque Country		**227**
	Alava/Araba	65
	Guipuzcoa	58
	Biscay	104
Civil Guard Information Department		**74**
Grand Total		**80,466**

Source: In-house compilation based on data supplied by the Directorate General of the Civil Guard (*DGGC*).

The Civil Guard has carried out 143,648 transfers of prisoners

On the other hand, the Directorate General of the Civil Guard (abbreviated as *DGGC* in Spanish) has reported that in 2012 a total of 143,648 transfers of prisoners were carried out between prison facilities or between those and judicial or healthcare facilities, with a total of 265,044 inmates being transferred at national level.

Nine judicial proceedings were initiated against members of the Civil Guard

As regards the total amount of complaints on bad practices or the alleged commission of torture or ill-treatment by officers of the Civil Guard against persons deprived of liberty, at Civil Guard facilities or during the transfers, the Directorate General of the Civil Guard has reported that 9 judicial proceedings were initiated in 2012. In one of them, referred to the post in Cabezon (Valladolid), the judicial body has decided to discontinue and close the procedure. The eight remaining ones are currently pending a final judicial decision, and for this reason, no administrative action has been taken up to date. The officers allegedly involved in those acts were stationed in the Fiscal Patrol of Sanlucar de Barrameda (Cadiz), the Reserve and Safety Group no. 3 in Valencia, the post of Puerto Serrano (Cadiz), the *UPROSE* Company of Transfers (Madrid), the main post of Collado Villalba (Madrid), the Core of Destinations in Badajoz, the post of Cofrentes (Valencia) and the Judicial Police team in Casetas (Saragossa).

The Basque autonomous police force made 8,157 detentions with confinement to prison cells

For its part, in 2012 the Basque autonomous police force *(Ertzaintza)* has implemented a total of 8,157 detentions which entailed confinement to prison cells.

Table 15. Detentions with confinement to prison cells made by the Basque autonomous police force in 2012, broken down by historic territories and police stations

Territory	Police stations	Number of detentions with confinement to prison cells
Alava		**1,020**
	Laguardia	91
	Llodio/Llodio	32
	Vitoria-Gasteiz	897
Biscay		**4,168**
	Valmaseda	85
	Basauri	98
	Bilbao	1,958
	Durango	292
	Erandio	140
	Galdakao	114
	Gernica/Lumo	268
	Gecho	241
	Muskiz	317

Territory	Police stations	Number of detentions with confinement to prison cells
	Ondarroa	72
	Sestao	583
Guipuzcoa		**2,846**
	Azcoitia	76
	Beasain	193
	Bergara	183
	San Sebastian/Donostia	711
	Eibar	178
	Renteria	448
	Hernani	405
	Irun	344
	Tolosa	119
	Zarauz	127
	Zumarraga	62
		123
	Traffic patrols	89
	Other units	34
Total detentions		**8,157**

Source: In-house compilation based on data supplied by the Department of the Interior of the Basque Government.

There have been no complaints on bad practices

The Department of the Interior of the Basque Regional Autonomous Government (hereinafter, Basque Government) has reported that in 2012 there are no complaints on record against members of the Basque autonomous police force *(Ertzaintza)* due to bad practices or alleged commission of tortures or ill-treatment.

The Catalan autonomous police force made 53,124 detentions with confinement to prison cells

As regards the Catalan autonomous police force *(Mossos d'Esquadra),* in 2012 it implemented a total of 53,124 detentions with confinement to prison cells.

Table 16. Detentions with confinement to prison cells made by the Catalan autonomous police force in 2012, broken down by police stations

Regional Autonomous Government of Catalonia *(Generalitat)* police force facilities	Number of detentions with confinement to prison cells
Central Police Region	**2,021**
ABP Anoia-Igualada	487
ABP Bages-Manresa	884
ABP Berguedà-Berga	129
ABP Osona-Vic	480
ABP Solsonès-Solsona	41

* *(Translator's note: police basic facilities)*

Regional Autonomous Government of Catalonia *(Generalitat)* police force facilities	Number of detentions with confinement to prison cells
Gerona Police Region	**5,372**
ABP Alt Empordà-Figueres-Figueres	735
ABP Alt Empordà-Figueres-La Jonquera	243
ABP Alt Empordà-Roses	405
ABP Baix Empordà-La Bisbal d'Empordá	521
ABP Baix Empordà-Sant Feliu de Guíxols	315
ABP Garrotxa-Olot	164
ABP Gironès-Pla de l'Estany-Banyoles	85
ABP Gironès-Pla de l'Estany-Gerona	996
ABP Gironès-Pla de l'Estany-Salt	363
ABP Ripollès-Ripoll	125
ABP Selva Interior-Santa Coloma de Farners	441
ABP Selva Litoral-Blanes	311
ABP-Selva Litoral-Lloret de Mar	668
Barcelona Metropolitan Police Region	**18,508**
ABP Barcelona	140
ABP Ciutat Vella	6.596
ABP Eixample	3.352
ABP Gracià	417
ABP Horta-Guinardó	730
ABP Les Corts	794
ABP Nou Barris	750
ABP Sant Andreu	676
ABP Sant Martí	2,536
ABP Sants-Montjuic	1,876
ABP Sarrià-Sant Gervasi	641
North Metropolitan Police Region	**10,918**
ABP Arenys de Mar-Arenys de Mar	179
ABP Arenys de Mar-Pineda de Mar	630
ABP Badalona-Badalona	1,789
ABP Badalona-Sant Adrià de Besòs	277
ABP Cerdanyola-Barberà del Vallès	208
ABP Cerdanyola-Cerdanyola del Vallès	367
ABP Cerdanyola-Montcada i Reixac	337
ABP Cerdanyola-Ripollet	233
ABP Granollers-Caldes de Montbuí	110

Regional Autonomous Government of Catalonia *(Generalitat)* police force facilities	Number of detentions with confinement to prison cells
ABP Granollers-Granollers	1,128
ABP Granollers-Sant Celoni	87
ABP Mataró-Mataró	918
ABP Mollet del Vallès-Mollet del Vallès	456
ABP Premià de Mar-Premià de Mar	311
ABP Rubí-Rubi	409
ABP Rubí-Sant Cugat del Vallès	215
ABP Sabadell-Sabadell	1,181
ABP Sabadell-Santa Perpetua Mogoda	116
ABP Santa Coloma de Gramenet-Santa Coloma de Gramenet	672
ABP Terrassa-Terrassa	1,295
Southern Metropolitan Police Region	**7,394**
ABP Alt Penedès-Sant Sadurni d'Anoia	61
ABP Alt Penedès-Villafranca del Penedès	428
ABP Cornellà de Llobregat	593
ABP El Prat de Llobregat	765
ABP Esplugues de Llobregat	216
ABP Gavà-Castelldefels	338
ABP Gavà-Gavà	264
ABP Gavà-Viladecans	260
ABP Garraf-Sitges	292
ABP Garraf-Vilanova i la Geltrú	634
ABP L'Hospitalet de Llobregat	1,901
ABP Martorell	757
ABP Sant Boi de Llobregat	404
ABP Sant Feliu de Llobregat-Sant Feliu de Llobregat	257
ABP Sant Feliu de Llobregat-Sant Vicenç dels Horts	224
Western Pyrinees Police Region	**314**
ABP Alt Urgell-La Seu d'Urgell	103
ABP Cerdanya-Puigcerdà	102
ABP Pallars Jussà-Pallars Sobirà-Sort	14
ABP Pallars Jussà-Pallars Sobirà-Tremp	53
ABP Vall d'Aran-Alta Ribagorça-El Pont de Suert	5
ABP Vall d'Aran-Alta Ribagorça-Vielha	37

Regional Autonomous Government of Catalonia *(Generalitat)* police force facilities	Number of detentions with confinement to prison cells
Eastern Police Region	**2,025**
ABP Noguera-Balaguer	163
ABP Noguera-Ponts	19
ABP Segarra-Urgell-Cervera	140
ABP Segarra-Urgell-Tàrrega	168
ABP Segrià-Garrigues-Pla d'Urgell-Les Borges Blanques	52
ABP Segrià-Garrigues-Pla d'Urgell-Lerida	1.352
ABP Segrià-Garriques-Pla d'Urgell-Mollerussa	131
Camp de Tarragona Police Region	**5,014**
ABP Alt Camp-C. de Barberà-Montblanc	59
ABP Alt Camp-C. De Barberà-Valls	225
ABP Baix Camp-Priorat-Cambrils	419
ABP Baix Camp-Priorat-Falset	27
ABP Baix Camp-Priorat-Reus	952
ABP Baix Penedès-Vendrell	700
ABP Tarragonès-Salou	772
ABP Tarragonès-Tarragona	1.860
Terres de L'Ebre Police Region	**1,558**
ABP Baix Ebre-Tortosa	979
ABP Montsià-Amposta	443
ABP Terra Alta-Ribera d'Ebre-Gandesa	27
ABP Terra Alta-Ribera d'Ebre-Mora d'ebre	109
TOTAL	**53,124**

Source: In-house compilation based on data supplied by the Department of the Interior of the Regional Autonomous Government of Catalonia.

There is no record of any alleged case of torture or ill-treatment

The Department of the Interior of the Regional Autonomous Government of Catalonia [(*Generalitat de Cataluña),* hereinafter, Government of Catalonia] has reported that there is no record of any alleged commission of torture or ill-treatment by officers of the Catalan autonomous police force.

The Navarre autonomous police force made 1,608 detentions with confinement to prison cells

In 2012, the Navarre autonomous police force (*Policía Foral*) made a total of 1,608 detentions with confinement to prison cells.

Table 17. Detentions with confinement to prison cells made in 2012 by the Navarre autonomous police force, broken down by police stations

Police stations	Number of detentions with confinement to prison cells
Alsasua	15
Elizondo	80
Estella	131
Pamplona	957
Sangüesa	20
Tafalla	146
Tudela	259
TOTAL	**1,608**

Source: In-house compilation based on data supplied by the Department of the Presidency, Justice and Interior of the Government of Navarre.

No complaints have been received on alleged ill-treatment

The Department of the Presidency, Justice and Interior of the Regional autonomous Government of Navarre (hereinafter, Government of Navarre) reported that no complaints were received in 2012 in relation to the treatment accorded to detainees by the Navarre autonomous police force.

The Canary Islands police force has not made any detention with confinement to prison cells

Finally, the Department of Economic Affairs, Finance and Safety of the Regional Autonomous Government of the Canary Islands (hereinafter, Government of the Canary Islands) has reported that in 2012 the Canary Islands Central Police Force has not made any detention with confinement to prison cells. Likewise, there is no record of any complaint filed against the actions taken by members of such police body during 2012.

Visits carried out to 35 places of short-term deprivation of liberty

12. As shown on Tables 2-6, in 2012 the Ombudsman Institution has visited 35 places of short-term deprivation of liberty.

Figure 2. Geographical location of the places of short-term deprivation of liberty visited in 2012

Legend	
Spanish National Police Force	18
Civil Guard	5
Basque autonomous police force *(Ertzaintza)*	1
Navarre autonomous police force *(Policía Foral)*	1
Catalan autonomous police force *(Mossos d'Esquadra)*	2
Municipal detention facilities	7
Prison cells in court buildings	1
TOTAL	35

13. The following paragraphs include a description of the shortcomings detected in the centers of short-term deprivation of liberty which were visited. The tables with the specific conclusions regarding each facility, which were sent to the different public institutions, are included at the end of this section.

The specific conclusions are included at the end of this section

14. The video-surveillance systems found in all facilities, with the exception of those at the Catalan autonomous police force stations, did not comply with the criteria established in paragraph 477 of the 2010 Annual Report, and in paragraphs 38, 39 and 40 of the 2011 Annual Report. However, the Directorate General of the Police, the Directorate General of the Civil Guard and the local police forces of Bilbao (Biscay) and Tafalla (Navarre) have reported that they accept the criterion of this Institution, and that their implementation is subject to availability of funding.

With the exception of the Catalan autonomous police force, the video-surveillance systems continue to fall short

Photograph 1

Video-surveillance monitors at the Catalan autonomous police force station in Sabadell (Barcelona)

15. In spite of the Spanish National Police Force having reported to this Institution that it was studying the possibility of installing sound calling systems so that detainees may communicate with the custody officers, this deficiency was found in a significant number of the visits conducted at facilities of said police force, as was already set forth in paragraphs 57 of the 2010 Annual Report and 41 of the 2011 Annual Report. Communication between detainees and officers is therefore still not guaranteed in such cases. The same deficiency was detected at some facilities of the local police forces.

Communication between detainees and officers is still not guaranteed

16. As was highlighted in paragraphs 104 of the 2010 Annual Report and 42 of the 2011 Annual Report, this Institution considers that there should be a constant presence of officers at the prison cell area when there are detainees therein. It has been noticed that in some facilities there were no sound calling systems or that, even if they existed, they were not heard in some areas which were far from the prison cells. Therefore, in case of an emergency, a quick reaction of such officers would be hindered.

Constant presence of officers in the prison cell area, when there are any detainees

There must be officers specifically in charge of the custody of detainees

17. At the Civil Guard command headquarters in Huesca it was noticed that there were no officers specifically in charge of the custody of detainees, and this task was being performed instead by the civil guards of the post where the detention took place. As regards certain aspects, there didn't seem to be any common guidelines for action with the detainees in all posts of the command headquarters, which is something that should be remedied. The Directorate General of the Civil Guard accepted the criterion of this Institution, and proceeded to send all units run by the command headquarters a document with explicit guidelines regarding this matter.

A recommendation has been formulated for the handouts informing detainees of their rights to include the term "lawyer" but not "legal counsel", in order to make it comprehensible to people not familiar with the legal language

18. As regards the reading of rights to detainees, as established in Article 520 of the Spanish Code of Criminal Procedure (abbreviated as *LECrim* in Spanish), at some facilities of the local police forces it has been noticed that this document does not exist in several languages.

On the other hand and on a general basis, it has continued to be observed that the terms "legal counsel" (*letrado*) and "lawyer" (*abogado*) are used in the handouts providing information on rights, contrary to the provisions set forth in paragraphs 476 of the 2010 Annual Report and 45 of the 2011 Annual Report, with the exception of the leaflets that are used in the Civil Guard barracks in the Algeciras Port (Cadiz) and Vigo (Pontevedra), the Spanish National Police Force station in the Algeciras Port (Cadiz) and the local police station in Zafra (Badajoz). In that regard a Recommendation has been sent to the National Judicial Police Coordinating Commission in order to amend the printed handouts and include only the term "lawyer". Finally, it should be noted as a good practice of the local police station in Tafalla (Navarre), that it includes the right of minors to conduct a private interview with their lawyer before giving evidence, in compliance with section b) of Article 22 of the Organic Law 5/2000, of 12 January, on the criminal responsibility of minors. In a similar vein, the inclusion on the reading of rights record at the local police station in Ejea de los Caballeros (Saragossa) of the mention that "no detainee may be subject to torture or ill-treatment by word or deed", should be positively noted.

The majority of the facilities visited still fail to notify detainees in writing of their right to habeas corpus

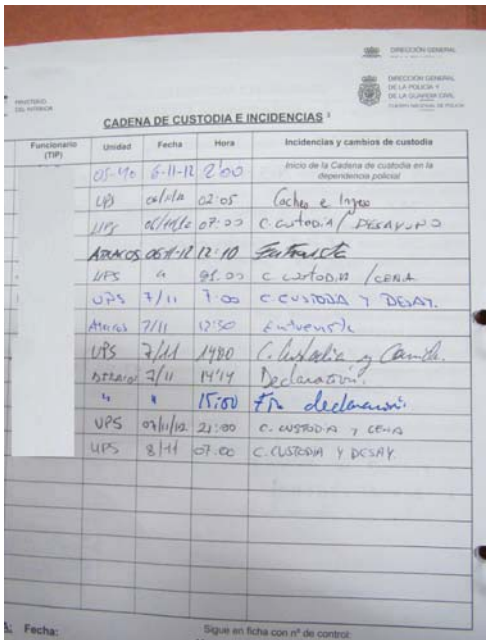
19. The criteria expressed by this Institution in paragraphs 476 of the 2010 Annual Report and 47 of the 2011 Annual Report, that detainees must be notified in writing of the possibility to lodge *habeas corpus* proceeding is still not complied with at the majority of the facilities visited, with the exception of the Superior Police Departments in Logroño (La Rioja) and Seville (Western Andalusia), and the police stations of Leganes and La Latina District in Madrid. On the other hand, in the vast majority of the interviews conducted with detainees, they declared not to have been informed in this respect, not even verbally. During the visit to the Spanish National Police Force station in Algeciras (Cadiz), it was verified that the official report sent to the Court included a formality declaring that the detainee had been notified of his/her right to apply for *habeas corpus* proceeding. Such formality already included, pre-printed and in block capitals, the sentence "he/she does not wish to benefit from said procedure", without giving the possibility, as other formalities of the same official report, to make any other note in that respect, which should be remedied.

20. As was highlighted in paragraphs 468 of the 2010 Annual Report and 44 of the 2011 Annual Report, this Institution considers that access to a lawyer in the period immediately after the beginning of the deprivation of liberty is essential for the prevention of torture and ill-treatment. However, in the majority of the facilities visited the Institution has continued to notice that the request for legal aid is made at the time when authorities will proceed to record the statements of the interested party, with the exception of the Superior Police Department of Western Andalusia (Seville), the Civil Guard barrack in the Algeciras Port (Cadiz), the Spanish National Police Force stations in the Carabanchel district (Madrid) and Medina del Campo (Valladolid), the Catalan autonomous police force station in Sabadell (Barcelona) and the Local Police of Fuengirola and Marbella, in Malaga.

Access to a lawyer immediately after being deprived of liberty is essential

In the Report of Custody and Registration of detainees at the Malaga provincial police headquarters it was noticed that some of the custody records included notes saying that the detainee had held an "interview" with police officers, before giving evidence and having the assistance of a lawyer. This Institution considers that, in such cases, the custody record such expressly mention the purpose or goal of such interview which, under no circumstances may entail a recording of statements, as well as the duration thereof. In this sense as well, one of the detainees interviewed at the police station of the Spanish National Police Force station in the Actur-Rey Fernando district (Saragossa), declared: "The officers tried to interrogate me but I demanded that my lawyer be present, and he arrived that night". This testimony matches the one made by a female legal counsel who was present at the time of the visit, about it "being current practice that the officers interrogate detainees before the recording of statements in the presence of their lawyer". In this regard, the Directorate General of the Police has reported to be unaware of this bad practice, as well as there being no complaints in relation to these facts and that, should it detect them, such complaints would be appropriately amended.

The custody records must include a note on the purpose and goal of the interviews held with police officers, before giving evidence or having the assistance of a lawyer


CADENA DE CUSTODIA E INCIDENCIAS

Funcionario (TIP)	Unidad	Fecha	Hora	Incidencias y cambios de custodia
				Inicio de la Cadena de custodia en la dependencia policial
				Cacheo e Ingreso
				C. custodia / DESAYUNO
				Entrevista
				C. custodia / CENA
				C. CUSTODIA Y DESAY.
				Entrevista
				C. custodia y Cambio
				Declaración
				Fin declaración
				C. CUSTODIA Y CENA
				C. CUSTODIA Y DESAY.

Fecha: Sigue en ficha con nº de control

Photograph 2

Custody record at the Spanish National Police Force station in Malaga, which shows that the detainee was interviewed twice before the recording of statements in the presence of a lawyer

During the visit to the Spanish National Police Force station of the Usera-Villaverde district in Madrid, it came to light that, after the recording of statements, lawyers and detainees held interviews in the area at the entrance of the prison cells, without minimum privacy, since the police officers were located nearby in order to visually control detainees, as the latter themselves declared. Given the fact that at such facilities there are two rooms for the recording of statements, with a small glass window in the door which would allow for visual control, a Suggestion has been sent to the Directorate General of the Police for those rooms to be used for interviews between detainees and their lawyers.

Due to the complexity of the crime, there have been detentions where the 72-hour- period has been used up or even exceeded

21. During the visits carried out in 2012 the Institution requested information and, while examining the Report of Custody and Registration of Detainees, were able to verify that the majority of said detainees were handed over to the judicial authorities within a maximum period of 24 hours. It is however true that there have been cases in which, due to the complexity of the crime under investigation, the detention has exceeded such time frame, nearly using up the 72 hours, and even more, at times, although always with the appropriate authorization from the courts. This latter scenario was detected at the Civil Guard post in the Algeciras Port (Cadiz), where the judicial authority was requested to authorize the detention for an additional period of 72 hours, so that detainees carrying drugs inside their bodies may expel them.

The Spanish Constitutional Court considers that the practice of taking detainees before a judicial authority in the early morning the day after completing the police action prolongs unnecessarily the detention, thus infringing Art. 17.2 of the Spanish Constitution

As regards the handing over of detainees to the judicial authorities, it should be recalled that it is reiterated case law of the Spanish Constitutional Court that infringement of Article 17.2 of the Spanish Constitution may take place not only on exceeding the maximum absolute period of 72 hours accorded from the time of the detention, but also when -within this maximum period- the temporary limit regarding detention is exceeded, since it is no longer necessary due to the fact that the investigation to clarify the occurrences had been carried out, and the detainee is however not released or taken before a judicial authority. In this sense, said high court of justice has considered that the practice of taking detainees before the judicial authorities in the early morning the day following the police action, thus unnecessarily prolonging the duration of the detention, infringes the aforementioned article. This does not imply that the existence of collaboration protocols between the courts and the State Security Forces, which try to regulate the transfer of detainees, is incompatible with the constitutional requirement of not unduly prolonging the detention time of a citizen, since both provisions may coexist reasonably, and the particular circumstances involved shall be pondered in each case.

Detainees get health assistance when they request it

22. At the interviews held with detainees, all of them declared that, when they requested the assistance of a physician, they were taken to a health center or the health services were called to the facilities, thus complying with this right established in Article 520 of the Spanish Code of Criminal Procedure (abbreviated as *LEcrim* in Spanish). On the other hand, during the visits to the Superior Police

Department of the Spanish National Police Force in Western Andalusia (Seville), the Spanish National Police Force stations of the Latina and Carabanchel districts in Madrid, the Civil Guard barrack in Olite (Navarre) and the Navarre autonomous police force station in Estella (Navarre), it was noticed that when detainees get medical assistance, a copy of the medical record with the assistance provided is included in the official police report. In the documentation examined it was verified that in some cases such medical reports included the medical history of detainees with personal data which affect their personal privacy. On the contrary, at the Local Police station in Bilbao (Biscay) it was verified that the copy of the medical report issued after the medical assistance provided due to common illness is delivered to the interested person, and the police proceedings do not keep a copy thereof.

State Security Forces are only authorized to obtain and process medical data of detainees when the need therefor is duly accredited

In the opinion of the Ombudsman Institution, the joint understanding of Articles 796.1.1 of the Spanish Code on Criminal Procedure, 22.2 of the Organic Law on the Protection of Personal Data (abbreviated as *LOPD* in Spanish), and 12.3 of Law 41/2002, of 14 November, on the Autonomy of the Patient and the Rights and Obligations Pertaining to Clinical Information and Documentation, entails that the State Security Forces are only authorized to obtain and process the medical data of detainees upon compliance of certain conditions, which have been reiterated by the Spanish Data Protection Agency in its legal reports: it must be duly accredited that the obtaining of such data is necessary for the prevention of a real and serious danger to public safety or for the prosecution of criminal offenses and, given that this is especially protected data, it should be absolutely necessary for the purposes of a specific investigation; it must be a specific and precise request, since the request for massive data is not compatible with all the foregoing; that the request be made with substantiated reasons, showing their relation with the described scenarios; and that, in compliance with Article 22.4 of the Organic Law on the Protection of Personal Data, such data is eliminated "when it is no longer necessary for the inquiries that motivated its storage". This criterion has been notified to the different Departments which are competent in this matter.

There must be general protocols for procedures in cases of detainees with contagious diseases and in gestation period

23. As regards the general protocols for procedures in cases of detainees with contagious diseases or female detainees in their gestation period, which were referred to in paragraph 49 of the 2011 Annual Report, at some of the visits undertaken it has been noticed that such protocols are non-existent, which is something that must be remedied. On the contrary, it was verified that such protocol existed during the visit carried out to the Spanish National Police Force station in Vigo (Pontevedra). It also had a book with the transfer of detainees who needed medical assistance, including the name of the detainee, the brigade that conducted the transfer, the date and time of departure and return to the police facilities.

Lack of prophylactic tools

24. Likewise, it has been detected that there is a lack of prophylactic tools, such as gloves or masks, at some of the facilities visited. Therefore, it has been requested that this shortcoming be remedied.

A Recommendation has been sent to provide a budget line for the medicine prescribed to detainees

25. The medication that detainees must take is supplied by the custody officers, provided that the relevant physician has prescribed it. In the case of the Spanish National Police Force station of La Latina district (Madrid), the custody officers declared that, sometimes and for humanitarian reasons, they themselves acquired the medicine, due to the fact that the health centers did not provide the prescribed drugs or they were supplied for an only a single intake. Therefore, in order to safeguard the detainees' right to health, a Recommendation has been sent to the Directorate General of the Police for a budget line to be provided so that the Spanish National Police Force officers do not have to acquire the medicine at their own expense. At the time of drafting this report, such recommendation is waiting to receive a response.

It has continued to be noticed that some officers are not duly identified

26. At the majority of the Spanish National Police Force stations, at the Local Police stations, with the exception of the one in Medina del Campo (Valladolid), and at the Civil Guard barrack in Olite (Navarre), it was detected that some of the officers were not duly identified, contrary to the criterion set forth in paragraph 52 of the 2011 Annual Report. In case of the Spanish National Police Force station in Algeciras (Cadiz), none of the officers had their identity badge on, with the exception of the Head of Service. On the other hand, this Institution already pointed out in paragraph 137 of the 2010 Annual Report that it was necessary, for an adequate balance between the safety of officers and to right of citizens to identify the persons acting as law enforcement officials, to make it compulsory for the officers of the Basque autonomous police force to be identified, since this was not expressly established in their regulations. Since the first visits undertaken to the facilities of such police force, this Institution has insisted before the Department of the Interior of the Basque Government that such compulsory identification is formally regulated, something which has finally been accepted.

Data in the identity badges must be perfectly visible

This Institution has also insisted with the different police forces so that the spelling in the identity badges is perfectly visible from a so-called "respectful distance". Up to now, such suggestion has not been accepted. On the contrary, it should be pointed out that the spelling of the identity numbers of the officers from the Navarre autonomous police force allows them to be read at a certain distance without difficulty.

Officers must access the custody area unarmed

27. At some of the facilities visited throughout 2012 the non-compliance of the criterion described in paragraph 53 of the 2011 Annual Report was noticed, about accessing custody areas without any weapons, for the sake of the safety of detainees and the officers themselves, and this is something that should be remedied. To this end, it is advisable to have weapons stands or safe deposit boxes at the entrance area to prison cells, as is done at the Spanish National Police Force station in Malaga, the Catalan autonomous police force station in Sabadell and L´Hospitalet de Llobregat (Barcelona), and at the Local Police station in Bilbao (Biscay). During the visit to the Spanish National Police Force station in the Moncloa district (Madrid), it was reported that officers used to enter into the area

of prison cells with their weapon without a charger, which did not prevent the weapon from keeping a bullet in its chamber. The Directorate General of the Police has reminded this facility of the existing service order in this respect, instructing that weapons should be left at the safety deposit box located in the office of the Security Service, and has encouraged its compliance by all the staff ascribed to the police station, and most especially by the Security Service.

Photograph 3

Weapon stands at the Local Police station in Bilbao (Biscay)

28. Instruction 12/2009 from the Office of the Secretary of State for Security, applicable to the Spanish National Police Force and to the Civil Guard, establishes that the Detainee Record of Custody and Registration should include all the difficulties pertaining to the latter, as well as any relevant incidents which may occur. Even though in previous reports it has been pointed out that in many of the visited facilities this Record was not properly completed and that the managing bodies of both police forces have reminded the compulsory compliance of said instruction, during the visits carried out in 2012 shortcomings have been again detected, with the exception of the Superior Police Department of the Spanish National Police Force in Logroño (La Rioja), and the Spanish National Police Force stations in Malaga, Medina del Campo (Valladolid) and Merida (Badajoz). However, good practices were detected at the Spanish National Police Force such as the aforementioned Superior Police Department in Logroño (La Rioja). There, the existence of individualized sheets for the control of minors in detention was observed, where all the incidents of the minor's chain of custody were noted down, recording also the belongings which had been taken away from them. At the Spanish National Police Force station of Vigo-Redondela (Pontevedra), apart from the mentioned book, a document prepared by the Head of Security is completed, including all the incidents taking place in the prison cells, taking note of the date, the number of the official report, the custody officers and the detainee that was involved.

The Detainee Record of Custody and Registration should include everything that may affect the detainee, as well as any relevant incidents

It is worth noting the good practice of the Catalan and Basque autonomous police forces which have computer systems for the information and monitoring of the detention

As regards the remaining Security Forces, the Local Police force in Bilbao (Biscay), even though it keeps a computerized individual registration sheet for each detainee, it does not include in detail all the difficulties which may occur in the chain of custody of detainees. On the contrary, at the Local Police in Marbella (Malaga), the Institution noted the existence of individualized sheets for each detainee in which all the difficulties, which may occur, are included. The Local Police of Tafalla (Navarre) uses a single record book of detainees, which does not describe in detail the chain of custody of detainees, according to the criteria described in paragraphs 223 of the 2010 Annual Report and 54 of the 2011 Annual Report, and it also does not have an independent record book to register the minors in detention, which should be remedied. The Navarre autonomous police force in Estella (Navarre) also does not have a record book of detainees who are minors. It is worth noting the good practice of the Catalan and Basque autonomous police forces which have their own computer systems for the information and monitoring of the detention, where all the difficulties that occur in relation to the detainee at hand are registered. Thus, both the chain of custody and the incidents are guaranteed. As it continues to be common usage in the prison cell area of the court buildings, the Court of Justice of Merida (Badajoz) did not have a registration book of detainees and prisoners which pass through the prison cells of such facilities daily. This is a shortcoming that was also detected in the case of the Navarre autonomous police force in Estella (Navarre), since it shares the prison cells of the court building of said town.

The Record of custody must include a note on the strip searches performed

29. It is still common not to record the practice of strip searches in the Record of Custody of each detainee. The justification provided by the custody officers is that if they are not recorded it is because this type of search does not occur, but this circumstance is not compatible with some statements taken at the interviews carried out during the visits in 2012. Thus, during the visit to the Spanish National Police Force station in the Vallecas district (Madrid), all the detainees, with the exception of a woman, declared that they had been ordered to remove their clothes piece by piece, taking their underwear down to their knees, and they were forced to do "sit-ups". As declared by all detainees that were at the Spanish National Police Force station in the Usera-Villaverde district (Madrid), all of them had been subject to this type of search, as well as nearly all those interviewed at the Superior Police Department of the Spanish National Police Force in Western Andalusia (Seville).

The specific reasons for the strip searches must be detailed

In the occasions where it was possible to check that the strip search practice was recorded, as are the cases of the computerized individual sheets of the Local Police in Bilbao (Biscay) or of the Basque autonomous police force in its computer software, it was observed that the specific reasons for such action were not expressly detailed, contrary to the criteria established in paragraphs 139 of the 2010 Annual Report and 55 of the 2011 Annual Report.

30. The belongings taken from detainees during the searches must be kept in heat-sealable bags so that they may only be opened by detainees themselves upon leaving the facilities. However, at some of the facilities visited it was continued to be noticed that such belongings are kept in plastic bags or even in envelopes, against the criteria explained in paragraphs 67 of the 2010 Annual Report and 71 of the 2011 Annual Report. On the other hand, in all the interviews held with detainees, they declared that the belongings which were taken from them were correctly recorded in the custody sheets.

The belongings taken from detainees should be kept in heat-sealable bags

Photograph 4

Closet for the storage of detainees' belongings at the Spanish National Police Force station in Torremolinos (Malaga)

31. At the majority of the facilities visited, detainees' access to the inside of the custody area is made through a direct entrance, avoiding contact with the public present in these facilities to carry out some procedure, in compliance with the provisions set forth in paragraphs 46 and 95 of the 2010 Annual Report and 56 of the 2011 Annual Report. There are some facilities that, even though they have an independent entrance into the area of prison cells, this does not preclude the public exposure of detainees. Such is the case of the Local Police station in Medina del Campo (Valladolid) where, as may be seen in the following photo, the normal entrance of detainees is carried out through a back door at the rear side of the building, which has direct access to the area of prison cells, but it opens onto an open space, adjacent to some gardens and a children's playground, without there being a fence or a wall which may prevent the vision of detainees and their public exposure.

Access to the inside of the custody area is made through a direct entrance in order to avoid contact of the detainee with the public

Entrance to the prison cells of the Local Police station in Medina del Campo (Valladolid)

Photograph 5

In a similar vein, the Local Police in Marbella (Malaga) has a building specifically for prison cells where detainees do not enter through the main door, although they are also subject to public and media exposure, because the transfer vehicles have to park on the pavement from where detainees have access to the building through a side door.

At the facilities there should be no elements which may allow self-harm attempts by detainees

32. One of the priorities of the NPM during its visits has been to verify that in the facilities for deprivation of liberty there are no shortcomings which may prevent them from ensuring the physical integrity of detainees, given the number of cases of self-harm attempts by detainees shown in Tables 18 and 19 which are included at the end of this paragraph. In this sense, the existence of horizontal bars in the cells' gate has been noticed at some of the facilities visited, as well as metal sheets or even unshielded locks, which may be used by detainees in an attempt for self-harm. This is something that should be avoided, in compliance with the criteria established in paragraphs 47 of the 2010 Annual Report and 62 of the 2011 Annual Report.

Metal sheet at one of the cells of the Spanish National Police Force station in Algeciras (Cadiz)

Photograph 6

Maximum attention should be paid to the safety guarantees

Likewise, the metal grids protecting lights inside the cells at the Local Police stations in Marbella and Fuengirola (Malaga) may facilitate the same suicide or self-harm attempts, and also the porcelain bathroom fittings of these facilities, as well as those existing in the holding cells of the Spanish National Police Force station in Malaga and in the bathrooms of the Spanish National Police Force station in Medina del Campo (Valladolid).

At said holding cells of the police station in Malaga, bed headboards have bars, as well as the steps of the built-in bunk beds at the Local Police station in Ejea de los Caballeros (Saragossa) that have two vertical bars and several horizontal ones, which may also lead to detainees trying to harm themselves.

In an effort to maximize the safety guarantees, the case of the cell doors at the Catalan autonomous police force station in Sabadell (Barcelona) should be highlighted as good practice. In such cell doors, in spite of having vertical bars, a stop has been installed in the top end of its hinges to prevent any hanging or knotting and, therefore avoiding any attempt of detainees for self-harm or suicide.

According to data from the Directorate General of the Police there has been a total of 386 self-harm attempts

According to information provided by the Directorate General of the Police, in 2012 a total of 386 self-harm attempts have taken place.

Table 18. Total number of self-harm attempts registered in 2012 by detainees in custody with the Spanish National Police Force

		Severe	Mild	Total
	Almeria		3	3
	Cadiz		28	28
	Cordoba		6	6
	Granada		8	8
	Huelva		7	7
	Jaen		4	4
	Malaga	1	22	23
	Seville	2	29	31
Andalusia		**3**	**107**	**110**
	Saragossa	1	7	8
Aragon		**1**	**7**	**8**
Asturias			**11**	**11**
Baleares		**1**	**15**	**16**
	Las Palmas		12	12
	Santa Cruz de Tenerife	1	18	19
Canary Islands		**1**	**30**	**31**

Police Department	Province	Injury result		
		Severe	Mild	Total
Cantabria			**7**	**7**
	Albacete		7	7
	Ciudad Real		5	5
	Cuenca		3	3
	Toledo		2	2
Castile-La Mancha			**17**	**17**
	Avila		2	2
	Burgos		2	2
	Leon		6	6
	Palencia		5	5
	Salamanca		5	5
	Segovia		1	1
	Valladolid		3	3
Castile-Leon			**24**	**24**
	Barcelona		2	2
Catalonia			**2**	**2**
Ceuta			4	4
	Alicante	1	15	16
	Castellon		5	5
	Valencia	1	26	27
Community of Valencia		**2**	**46**	**48**
	Badajoz		7	7
	Caceres		1	1
Extremadura			**8**	**8**
	La Coruña	1	15	16
	Lugo		3	3
	Pontevedra		4	4
Galicia		**1**	**22**	**23**
La Rioja			**6**	**6**
Madrid		**2**	**39**	**41**
Melilla			**5**	**5**
Murcia		**1**	**14**	**15**
Navarre		**1**	**9**	**10**
Total		**13**	**373**	**386**

Source: In-house compilation based on data supplied by the Directorate General of the Police.

For their part, the Directorate General of the Civil Guard has reported that in 2012 a total of 84 self-harm attempts have occurred.

The Civil Guard has reported 84 self-harm attempts

Table 19. Total number of self-harm attempts registered in 2012 by detainees in custody of the Civil Guard

Command HQ	Number of attempts
La Coruña	5
Albacete	1
Alicante	15
Asturias	1
Badajoz	1
Caceres	1
Cantabria	6
Castellon	5
Cuenca	1
Guipuzcoa	1
Huelva	1
Balearic Islands	1
Las Palmas	7
Leon	1
Lugo	2
Madrid	24
Murcia	4
Navarre	1
Palencia	1
Toledo	4
Saragossa	1

Source: In-house compilation based on data supplied by the Directorate General of the Civil Guard.

Finally, the Navarre autonomous police force has reported that at the police station in Elizondo there has been a case of attempted suicide. However, there has been no such case at the facilities of the Central Police of the Canary Islands, the Basque or the Catalan autonomous police forces.

The Navarre autonomous police force has reported a case of self-harm

33. It has been noticed that, inside the cells or in the shared bathrooms at some prison cells, there are squatting toilets, which is not adequate for those detainees who, due to their age or physical conditions or limitations, need to use these bathroom facilities. Likewise, it is not acceptable for cells to have a toilet bowl inside, both for the lack of privacy of detainees and for the bad smells to be endured, which was already expressed in paragraphs 241 of the 2010 Annual Report and 58 of the 2011 Annual Report.

The privacy of detainees should be guaranteed, without toilet bowls being installed inside the cells

Toilets inside a collective cell at a Spanish National Police Force station in Malaga

Photograph 7

This Institution insists on the need to improve ventilation, remove bad smells and ensure cleanliness in the area of prison cells

34. The Ombudsman Institution must repeat the criteria set forth in paragraphs 52, 53 and 54 of the 2010 Annual Report, and 65, 66 and 67 of the 2011 Annual Report, as regards the need to asses temperature, improve ventilation, remove bad smells and ensure cleanliness in the prison cell area, since the Institution has continued to detect shortcomings in relation to these aspects at those facilities for short-term deprivation of liberty visited during 2012. Shortcomings have also been detected in the lighting of some of the facilities visited. The Ombudsman Institution hereby demands the persons in charge of said places to have them remedied, in compliance with the criteria established in paragraphs 51 of the 2010 Annual Report and 64 of the 2011 Annual Report.

In general, the size of cells complies with the provisions set forth by the European Committee for the Prevention of Torture

35. On a general basis, the size of cells at the visited facilities complies with the criteria established in paragraphs 49 of the 2010 Annual Report (which –referring to the second General Report from the European Committee for the Prevention of Torture– considered as desirable dimensions for individual living spaces approximately 7 square meters) and 61 of the 2011 Annual Report, with the exception of 4 out of the 5 cells at the facilities of the Civil Guard in the Algeciras Port (Cadiz), that have a size of 4 square meters.

Photograph 8

Inside of one of the cells at the Civil Guard barrack in the Algeciras Port

Photograph 9

Inside of one of the cells at the police station in La Latina district (Madrid)

On the other hand, it is virtually impossible to find prison cells with a mechanical system installed to open the doors, which would facilitate their eviction in case of emergency, with the exception of the Local Police station in Fuengirola (Malaga), which does include such system.

No mechanical systems have been installed to open the cell doors

36. As was stated in paragraph 57 of the 2011 Annual Report, in reference to the general maintenance of the prison cell area, a request had to be sent to the Directorate General of the Police for an adequate maintenance of prison cells at the police stations in Alicante and the Moncloa-Aravaca district in Madrid, as well as the repair of the lavatories that were unusable at the Superior Police Departments of Western Andalusia (Seville) and Aragon. Also a request has been sent for the repair of the dampness existing in the prison cells at the Local Police station in Marbella (Malaga), in compliance with paragraphs 48 of the 2010 Annual Report and 57 of the 2011 Annual Report.

A request has been sent to the Directorate General of the Police for adequate general maintenance of several of the facilities visited

Dampness in the prison cells at the Local Police in Marbella (Malaga)

Photograph 10

Access to the prison cells at the police station in Moncloa-Aravaca (Madrid)

Photograph 11

The food supplied has been the subject of complaints

37. The food which is supplied to detainees has been the subject of complaints in the different interviews held with them, essentially at the facilities of the Spanish National Police Force, where prepared food kits are provided. During the visits this Institution was able to verify that many of such kits were untouched inside the cells. At two different facilities of the Spanish National Police Force, two Muslim detainees declared that they had been given food with pork, which after the appropriate follow up, proved to be untrue in both cases.

There is no uniform criteria regarding the clothes and utensils for relaxing that must be supplied to detainees

38. The different State Security Forces do not have a uniform criteria regarding the clothes and utensils for relaxing that must be supplied to detainees for their stay in prison cells, according to the provisions of paragraphs 61 and 133 of the 2010 Annual Report, and 71 of the 2011 Annual Report.

It is common for detainees to be provided with previously used blankets

Certainly, during the visits carried out in 2012 the Ombudsman Institution was able to verify that there are facilities, such as those of the Civil Guard in the Algeciras Port (Cadiz), where no blankets or mats were supplied to detainees, which was the reason for a complaint sent by two detainees that were held at the prison cells at the time of the visit. On the contrary, the Local Police in Zafra (Badajoz) provide mattresses and pillows to detainees. However, the most common action is to provide detainees with already used blankets, which has also been the subject of complaint at several of the facilities visited. At the Spanish National Police Force station in Merida (Badajoz) the Ombudsman Institution was able to verify that in the prison cell area there was a communication from the Directorate General of the Police mentioning the Recommendation sent by this Institution to proceed to clean the blankets after each use by detainees, which shows the interest of said governing body to homogenize the actions of the Spanish National Police Force in this respect, and the same was also verified at the police stations in Medina del Campo (Valladolid) and the Algeciras Port (Cadiz). The Catalan autonomous police force still fails to supply clean blankets, not previously used by other detainees, as was verified at the police stations in L'Hospitalet de Llobregat and Sabadell (Barcelona). The Local Police in Bilbao (Biscay) gives each detainee blankets that have been washed and disinfected, for a single use, as well as straw mats, but no mattresses or mats, against the criterion established in paragraphs 133 of the 2010 Annual Report and 71 of the 2011 Annual Report. The Basque autonomous police force also gives out straw mats to detainees, as was verified at their police station in Bilbao (Biscay). It has not accepted the recommendation to modify this procedure in view of the remarks made by this Institution, contrary to the Local Police in Bilbao (Biscay), which has accepted the criterion of the Ombudsman Institution, although it has made its implementation conditional upon having the necessary budgetary availability.

Blankets at the Spanish National Police Force station in Alicante

Photograph 12

Mattress in one of the cells at the Command HQ of the Civil Guard in Huesca

Photograph 13

The interviewed detainees did not have complaints regarding the treatment or attention received by the officers

39. In the interviews held with detainees, they generally did not express any complaint in relation to the treatment or attention that they had received from the officers at the facilities where they were under custody. However, there was a detainee interviewed at the Spanish National Police Force station in the Carabanchel district (Madrid), who declared having been subject to incorrect verbal treatment by the officers, without giving any more details. Another detainee in the same facility declared having been the subject of physical ill-treatment when he was taken to a cell. This Institution was able to check, through the images on one of the recordings, that the action of the officers could not be considered ill-treatment, but proportional to the resistant attitude shown by the detainee. Another detainee at the Spanish National Police Force station in Malaga declared that he had been hit in the abdomen and arms, when he was handcuffed upon arrival at said facility (he had been detained for more than two days), even though he had no sign whatsoever of such ill-treatment.

On the other hand, an overwhelming majority of the interviewed detainees declared that when they called the officers, they come promptly: "You have to shout at them, but they come. They take 10 minutes"; "you tell them and they open the cell"; "I didn't have to wait for long". However, some detainees complained, such as two who were at the Spanish National Police Force station in the Vallecas district (Madrid), stating that "they pay no attention to you"; "I was calling for half an hour and had to urinate in a corner of the cell. Then I cleaned it with a mop that they gave me".

Any intimidating and threatening object should be removed

During the visit to the Spanish National Police Force station in the Moncloa-Aravaca district (Madrid), it was detected that, at the entrance to the corridor of cells, there was an air extractor metal support where there was a drawing or engraving of a skull with two crossbones, with the inscription "RIP" (*rest in peace*) underneath and the inscription "IRON BARS" (*rejas*) to the right, which was deemed to be intimidating for the persons coming into those prison cells,

according to the criterion established in paragraph 51 of the 2011 Annual Report, where a reference was already included regarding the existence of intimidating and threatening objects at the police facilities.

Finally, during the visit to the Spanish National Police Force station in Algeciras (Cadiz), an officer was about to transfer a female minor to a shelter without notifying this circumstance to her mother, due to a simple problem of ignorance of her language by such officer and also those who were on duty at the time. The technical experts who were conducting this visit proceeded then to inform both women of this transfer and, the next day it was brought to the attention of the female head of the foreign nationals group that, in cases like this one, an interpreter should be contacted.

Situations of Deprivation of Liberty

II. Medium-term Deprivations of liberty §40-§71

II.1. Immigrant Detention Centers (CIEs) §40-§70

II.2. Military Disciplinary Establishments §71

II.1. Immigrant Detention Centers

The Immigrant Detention Centers are public establishments of a non-penitentiary nature

40. The Immigrant Detention Centers (abbreviated as *CIE* in Spanish, referred to as *CIE* in this section) are public establishments of a non-penitentiary nature where foreign citizens are taken while waiting for the procedure or implementation of their deportation or refoulement. Both the authorization for admission and for internment, with a maximum duration of 60 days, are subject to judicial control.

In 2012 there have been 6,645 illegal entries

According to data from the Spanish Ministry of the Interior, in 2012 a total of 6,645 illegal entries were registered, taking as such the entries by means of small boats *(pateras),* by swimming, hidden in vehicles or other transportation, or else crossing the border perimeter.

Table 20. Entry of immigrants in irregular situations through unauthorized border posts in 2011 and 2012

	2011	2012
Ceuta and Melilla	3,343	2,841
Canary Islands	340	173
Peninsula and Balearic Islands	5,101	3,631
Total	**8,784**	**6,645**

Source: In-house compilation based on data taken from the website of the Spanish Ministry of the Interior.

In 2012 there have been 5,575 detentions with confinement to prison cells due to infringement of the Foreign Nationals Law

41. As regards detentions of foreign citizens with confinement to prison cells due to the infringement of the Foreign Nationals Law, according to the information supplied by the Directorate General of the Police, a total of 59,575 detentions have been carried out in 2012, which represents a decrease of 34.11% as compared with those implemented in 2011, which totaled 90,424 detentions.

Table 21. Detentions with confinement to prison cells registered due to infringement of the Foreign Nationals Law, carried out by the Spanish National Police Force in 2012, broken down by Autonomous Communities, cities and provinces

Autonomous Community	Province	Number of detainees
Andalusia		**9,212**
	Almeria	1,862
	Cadiz	2,480
	Cordoba	311
	Granada	1,365
	Huelva	355
	Jaen	268
	Malaga	1,680
	Seville	891

Autonomous Community	Province	Number of detainees
Aragon		**856**
	Huesca	166
	Teruel	67
	Saragossa	623
Asturias		**423**
Balearic Islands		**520**
Canary Islands		**655**
	Las Palmas	382
	Santa Cruz de Tenerife	273
Cantabria		**353**
Castile-La Mancha		**1,808**
	Albacete	406
	Ciudad Real	451
	Cuenca	123
	Guadalajara	126
	Toledo	702
Castile-Leon		**1,710**
	Avila	140
	Burgos	263
	Leon	327
	Palencia	250
	Salamanca	282
	Segovia	85
	Soria	63
	Valladolid	241
	Zamora	59
Catalonia		**6,452**
	Barcelona	4,733
	Gerona	1,175
	Lerida	206
	Tarragona	338
Ceuta		**3,168**
Community of Valencia		**4,888**
	Alicante	2,262
	Castellon	527
	Valencia	2,099

Autonomous Community	Province	Number of detainees
Extremadura		**396**
	Badajoz	248
	Caceres	148
Galicia		**584**
	La Coruña	223
	Lugo	100
	Orense	73
	Pontevedra	188
La Rioja		**314**
Community of Madrid		**19,813**
Melilla		**3,330**
Murcia		**2,426**
Navarre		**371**
Basque Country		**2,296**
	Alava	341
	Guipuzcoa	1,509
	Biscay	446
Total general		**59,575**

Source: In-house compilation based on data supplied by the Directorate General of the Police.

42. Of the total 59,575 foreign citizens detained, 11,325 were held in the different *CIE*s.

11,325 foreign nationals were held in CIEs

Table 22. Foreign citizens held in CIEs in 2012

CIE	Number of inmates		
	Men	Women	Total
Algeciras	3,062	200	3,262
Barcelona	1,932	1	1,933
Las Palmas	251	21	272
Madrid	2,695	328	3,023
Malaga*	142	48	190
Murcia	1,258	42	1,300
Tenerife	120	20	140
Valencia	1,102	103	1.205
Grand Total	**10,562**	**763**	**11,325**

* Until 6/20/2012 when it is closed down.
Source: In-house compilation based on data supplied by the Directorate General of the Police.

In spite of the fact that this internment measure strives to ensure the effective repatriation of foreign citizens, of the total 11,325 foreign inmates, only 5,924 were able to be repatriated, as is shown in the following table. This means that in 2012 over 52% of the foreign inmates have not been deported, with a decrease of more than 7% in comparison to the figures in 2011. The case of the *CIE* in Las Palmas should be highlighted, with a decrease of over 47%.

Table 23. Expulsion of foreign inmates held in *CIE*s in 2012

CIE	Number of inmates	Number of deportations	Percentage
Algeciras	3,262	1,197	36,69
Barcelona	1,933	970	50,18
Las Palmas	272	32	11,76
Madrid	3,023	1,789	59,17
Malaga*	190	128	67,36
Murcia	1,300	808	62,15
Tenerife	140	28	20
Valencia	1,205	972	80,66
Total	**11,325**	**5,924**	**52,30**

* Until 6/20/2012 when it is closed down.
Source: In-house compilation based on data supplied by the Directorate General of the Police.

More than 52% of the inmates have not been removed

43. In 2012 a total of 16,401 repatriations of foreign citizens have been registered, according to data supplied by the Directorate General of the Police.

Table 24. Repatriations of irregular foreign nationals in 2011 and 2012

	2011	2012	Diferencia
Refoulements	7,064	6,271	-793
Unqualified deportations*	2,244	1,321	-923
Qualified deportations***	9,114	8,809	-305
Total	**18,422**	**16,401**	**-2,021**

Source: In-house compilation based on data obtained from the website of the Spanish Ministry of the Interior.
* Persons who attempted entry into Spain through posts not authorized as borders.
** Persons intercepted in a Spanish town without documentation.
*** "The Spanish Ministry of the Interior set up in 2009 the Spanish National Police Force's Brigade for Deportation of Foreign Offenders (BEDEX), whose mission is to repatriate foreign offenders with long criminal records and/or convictions (see paragraph 59) related to terrorism, organized gangs, gender-based violence or any other particularly serious criminal activity that pose a threat to public security". This distinction comes from the explanation of data supplied by the Spanish Ministry of the Interior itself (http://www.interior.gob.es/file/59/59299/59299.pdf).

A specific regulation to regulate the detention regime of foreign citizens has still not been published

44. A specific regulation in order to regulate the detention regime of foreign nationals has still not been published, in spite of the appearance of the Spanish Ministry of the Interior before the Spanish Parliament's Committee on Internal Affairs in January 2012, which was referred to in paragraphs 79 and 80 of the 2011 Annual Report. However, it has been reported that the plans for said regulation has been submitted at the Plenary Meeting of the General Council of the Judiciary, in compliance with the provisions of Article 108.1.e) of the Organic Law on the Judiciary. This Institution considers it necessary to speed up the procedures for the final publication of such regulation which, according to information provided by the Directorate General of the Police, shall take into account the recommendations made by the Ombudsman Institution and shown in the following table.

Table 25. Monitoring of the Reminder of Legal Duties* and Recommendations sent on a general basis to all *CIE*s

Resolutions	Paragraph number in Annual Reports	Reply from the Administration
Habeas corpus. Verbal and written information on this right.	476 (2010), 90 (2011)	Rejected.
Information on international protection and written recording that it was offered.	275 (2010), 90 (2011)	The request to prepare a protocol on this matter shall be sent to each *CIE.*
Establishment of a Suicide Prevention Protocol *(PPS).*	266 (2010), 94 (2011)	There is no protocol. This matter is included in the training programs for officers of *CIE*s.
Psychological and psychiatric assistance.	266 (2010), 94 (2011)	In case of need, assessed by the physician at the *CIE,* inmates are sent to the assigned hospital.
Limitation of legal rights.	275 (2010), 91 (2011)	It is up to the General Council of Spanish Lawyers to adopt criteria to optimize the free legal assistance service.
Protocol for evacuation.	262 (2010), 95 (2011)	All *CIE*s have a self-protection plan.
Extension of the duration of visits.	274 (2010), 98 (2011)	Duration depends on the number of inmates, on the facilities and activities. In justified cases, they are permitted outside the fixed opening hours.
Private visits.	274 (2010), 98 (2011)	Rejected.

Resolutions	Paragraph number in Annual Reports	Reply from the Administration
Facilities that allow physical contact.	274 (2010), 98 (2011)	Allowed if the personal and family circumstances of the inmate make it advisable, while ensuring safety.
Intercoms in dormitories.	262 (2010), 95 (2011)	Accepted. Pending budgetary availability.
Permanent access to dormitories and lavatories.	268 (2010), 96 (2011)	The general rule is to allow permanent access to dormitories and lavatories.
Dormitories for individual or double use.	256 (2010), 97 (2011)	Rejected for budgetary reasons.
Access to personal belongings.	278 (2010), 100 (2011)	Allowed except for safety reasons or at night times.
Access to mobile phones.	279 (2010), 100 (2011)	Allowed but must be returned after use.
* Provide *CIE*s with social workers.	282 (2010), 82 (2011)	Only present at the CIE in Madrid and its extension to other centers is under study.

The CIE *in Algeciras must be closed down*

45. As was set forth in paragraph 254 of the 2010 Annual Report, this Institution considered that at least two of the eight *CIE*s that were visited should be closed down; specifically those in Malaga and Algeciras. The first of them was provisionally closed on the 20th of June 2012 and definitely by means of the Order PRE/9/2013, of 8 January. However the *CIE* in Algeciras is still open, even though it doesn't comply with the appropriate conditions that a center of this nature must have, in spite of the reforms carried out therein. On the other hand, it has been reported that the *CIE* in Fuerteventura has been temporary closed due to the decreased arrival of immigrants.

In 2012 the CIEs *in Barcelona, Madrid, Valencia and Algeciras were visited*

46. In 2012 visits have been conducted to the *CIE*s in Barcelona, Madrid, Valencia and Algeciras. Although such centers had already been visited in 2010, and in the case of Valencia, also in 2011, a follow-up was deemed appropriate to check compliance of the recommendations sent and to identify eventual new shortcomings.

Figure 3. Geographical location of the *CIE*s visited in 2012

47. Three of the visits undertaken to *CIE*s, specifically to the ones in Barcelona, Madrid and Valencia, were multidisciplinary visits. All of them included participation of a technical expert in legal and forensic medicine, and the visit to Valencia also included a female graduate in psychology. The goal of these visits was to make an in-depth study and assessment of the medical assistance provided at these centers, besides detecting and checking, as has been previously referred, if the shortcomings identified in previous visits had been permanently remedied.

The goal of the multidisciplinary visits undertaken was to make an in-depth assessment of the medical assistance provided

The methodology applied during the visits, in order to make an in-depth analysis of such medical assistance, has been as follows: initial interview with the director of the *CIE;* interviews with all the healthcare personnel that was on duty at the center during the visit; attendance to some of the medical consultations that were scheduled to be carried out during the stay of the visit team at the center and implementation of an analysis of a significant number of clinical histories, as well as carrying out personal interviews with (and, as the case may be, medical check-up) of such inmates. The cases were chosen taking into account the following criteria: inmates who had needed medical assistance during the first day of the visit; inmates who, through questionnaires provided for this purpose, had reported to the members of the visit team that they had been victims of assault by members of the Spanish National Police Force on duty at the Center or else had witnessed some such case; inmates who, through questionnaires provided for this purpose, had expressed to the members of the visiting team, their discontent

Interviews have been held with the director, healthcare personnel and inmates of the CIE*, in addition to attending some medical consultations and studying a significant number of medical histories*

with the efficacy of the work performed by the health services, and finally, inmates whose medical checkup was expressly requested by the technicians from the Ombudsman Institution carrying out the visit.

An investigation has been carried out on the treatment provided to inmates who have denounced ill-treatment by police officers

48. During these multidisciplinary visits, an investigation was carried out on the treatment provided to those inmates who had been tried to be deported without success, taking into account the complaints received at this Institution denouncing that the interested persons had been the subject of alleged ill-treatment by the police. In the cases examined at the *CIE*s of Madrid and Valencia, interviews were held with inmates who were still interned and clinical histories were reviewed, but it was not possible to conclude, either because of the data included in those histories or due to the declarations of the interested persons themselves, that there had been any ill-treatment by police officers.

Those inmates who complained of ill-treatment were physically examined

At the Immigration Detention Centers visited, some inmates complained that they had been subject to ill-treatment. In those cases, in addition to viewing any recordings that may exist in this respect, physical exams of those involved were carried out by the external technical expert, subsequently reporting such actions to the relevant Department of the Ombudsman Institution so that it may assess the possibility of opening the appropriate investigation.

Individual and group interviews have been held with the inmates

49. During the visits to the *CIE*s, besides the personal interviews held with some inmates, group interviews were also held with some inmates, who were given questionnaires regarding the prison regime and the treatment they received. Many of them declared that the rules of the center were not clear and were not respected; some of them declared that they felt unsafe at the center, in case of risks of illness or fire, as well as due to the treatment by certain officers or other inmates; as regards the means of restraint, the majority declared that isolation (temporal separation) was used for almost any reason; many considered that strip searches were humiliating, although the vast majority declared that they were conducted in a private place and that room searches were frequent and without their presence, not knowing if the officers needed authorization to carry them out; they also complained of the food, as well as the water temperature and the furniture.

The existing recordings were viewed, in order to check if complaints sent by inmates were true

50. In relation to the personal or room searches, during the visit to the *CIE* in Valencia the existing recordings were viewed in order to assess if the complaints of inmates on personal searches -where they declared that they were told to undress upon being admitted at the center- and the complaints on room searches -where they said those were conducted every day-, were true or not. From the results of the investigation it may be concluded that the viewed searches were superficial, and only one case was detected where an inmate brought down his trousers a little bit. As regards the daily search of rooms, it was noticed that, indeed, when inmates left their rooms, the officers entered into them and remained inside only for a few seconds in order to check, as was reported, that all inmates had left.

Now it is appropriate to mention the recent Decision of the Spanish Constitutional Court (abbreviated as STC in Spanish) 17/2013, of 31 January, in which the high court considers, in it legal basis no. 14, that "as regards the purpose of the search itself, it is beyond question that a measure such as the one established in the contested precept may constitute, in certain situations, a means necessary for the protection of safety in a detention center, thus ensuring an orderly cohabitation therein. (...) upon adoption of such measure, it is necessary to weigh, in an adequate and balanced manner, on the one hand, the seriousness of the interference it entails for personal privacy, and on the other hand, if such measure is indispensable to ensure the defense of public interest, expressed in the maintenance of public order and safety of the center, which it strives to protect. It is naturally well understood that the respect of this requirement needs substantiation if the measure by the Administration, given that only such substantiation will allow it to be valued by the concerned person, in the first place, taking into account the right of inmates, according to Art. 62 quáter of the Organic Law on Foreign Nationals, to submit complaints and claims or to have the assistance of their lawyer [Art. 62 bis.f) of the Organic Law on Foreign Nationals] and, as the case may be, of the judicial body in charge of controlling the admission measure decided by such body, so that it may assess the reason which may justify, in view of the circumstances of the case, the sacrifice of the fundamental right (Art. 62.6 of the Organic Law on Foreign Nationals)".

In certain situations, the search is justified. It must be evaluated, in an adequate and balanced manner, on the one hand, the seriousness of the interference it entails for personal privacy, and on the other hand, if the measure is indispensable to ensure defense of public interest

51. As regards the means of restraint, either physical personal restraint or the measure for temporary separation (isolation), referred to in paragraph 49 and which was the subject of complaint by inmates, the aforementioned Decision of the Spanish Constitutional Court establishes, in its legal basis no. 15, the following: "Its adoption is only justified in specific scenarios, legally defined as regards certain behaviors of inmates which the Administration must prevent or avoid, since undoubtedly the safety and correct order of the establishment would be affected in case of there being an escape, violence towards persons, damages of things or disobedience towards the staff. (...) the adoption of these measures is both limited by its exclusive purpose, which is the reestablishment of normalcy at the center, and their limited duration, since they may only subsist for the time strictly necessary for the elimination of the circumstance that gave rise to it, which must be ultimately assessed by the judge".

The use of means of restraint is only justified in specific and legally defined scenarios

52. As was already referred to in paragraph 93 of the 2011 Annual Report, the medical assistance at the different *CIE*s was outsourced by means of a contract with the company *SERMEDES,* up to the 16th of August 2012 and, since that date, it had been awarded by public tender to the company *CLÍNICA MADRID.* The three multidisciplinary visits were conducted when the first of them was providing services therein. Therefore the Ombudsman Institution was able to assess if the protocols were the same at the three centers and if the shortcomings identified in the first and second visits were being remedied.

The medical assistance service is outsourced

53. At the *CIE*s visited there was no medical assistance in afternoon or evening hours. The same could be said of the absence of a University Registered Nurse (abbreviated as *DUE* in Spanish) in the evening. As was already referred to in paragraph 93 of the 2011 Annual Report, this absence may compromise the right of

It has been requested that medical assistance is provided on a permanent basis

inmates to health, since it forced important decisions in this field to be taken by staff that was not qualified for it. Therefore, it was requested that medical assistance was provided on a permanent basis. The Directorate General of the Police reported that the contract for the provision of services had been extended with the subcontracted company, so that the assistance of both a physician and a registered nurse would be implemented by means of a permanent location system outside of the hours when they should be physically present.

Although there is no specific program for the prevention of suicide, precise instructions are sent to the police officers in order to reduce such risk

54. As regards the psychological and psychiatric assistance of inmates referred to in paragraphs 266 of the 2010 Annual Report and 94 of the 2011 Annual Report, the Directorate General of the Police has reported, in the specific case of the *CIE* in Valencia, that members of the NGO "Psicólogos sin fronteras" ("Psychologists without borders"] pay daily visits to the center catering to an average of 8-10 inmates per day. As regards the establishment of a specific program for the prevention of suicide, the Directorate General of the Police has reported that it is not provided at *CIE*s, since they are not penitentiary units. However, this same authority informed that instructions are periodically sent to the police officers on duty, in order to reduce the risk of self-harm or suicide by inmates.

A new request has been made so that injuries may be photographed and sent to the judicial authority

55. When analyzing the clinical histories which included references to the injuries, it was noticed that there wasn't an adequate description of the type of injury, its shape, dimensions and exact location, nor the remaining characteristics included that may subsequently allow the determination of the causes. As was pointed out in paragraphs 357 of the 2010 Annual Report and 86 of the 2011 Annual Report, it was again requested that photographs of the injuries be taken for their subsequent remission to the judicial authority. The Directorate General of the Police has reported that, given the relevance of this matter, the new subcontracted company has been informed of this so that it may assess its implementation.

The format and content of the clinical histories must comply with the law

56. At the visited centers it was detected that, neither the format nor the content of the clinical histories complied with the provisions set forth in Law 41/2002, of 14 November, on the Autonomy of the Patient and the Rights and Obligations pertaining to Clinical Information and Documentation. The Directorate General of the Police has reported that the company *SERMEDES* had remedied this shortcoming and that the medical service from the Directorate General of the Police has also sent a request to the new company, *CLÍNICA MADRID,* to have them remedy this aspect as well.

At the CIEs in Valencia and Barcelona there was no record of any demand for medical assistance

57. At the *CIE*s in Valencia and Barcelona there was no record whatsoever stating explicitly any demands for medical assistance made by inmates or whether such demands had been subsequently provided. The Directorate General of the Police has reported that, in the case of Barcelona, a book with free access for inmates was established, with sealed and numbered pages, and in the case of Valencia, a daily list of medical consultations where inmates may sign up if they wish to have a physical exam that day.

Injury reports must be sent to the Local Criminal Court on duty

58. In relation to the injury reports which may be issued after a police operation, regarding both inmates and officers, during the visits undertaken to the *CIE*s in Barcelona, Madrid and Valencia it was noticed that those issued to inmates were sent to the overseeing court or to the court that authorized the internment, while the reports issued to the police officers were sent to the Local Criminal Court on duty. For this reason, it was requested from the Directorate General of the Police that all reports be jointly sent to the latter, which has been accepted by such governing body.

It has continued to be noticed that at CIEs *there are foreigners coming from prison who coexist with others who are interned due to an illegal stay*

59. During the visits carried out in 2012 it has continued to be noticed that at the *CIE*s there is a cohabitation of foreign citizens who are going to be removed from the national territory, some of them coming from prison while others held there just for a mere irregular stay in our country. The latter has complained of this fact. In the specific case of Valencia it was reported that 86% of the persons held there until May 2012 had a criminal or police record, although no details were given on what part of that percentage corresponded only to those with a criminal record. It is necessary to point out that the Spanish Ministry of the Interior usually provides data disaggregated by "qualified" and "unqualified" expulsion, and it is impossible to obtain data on those foreigners that are held and have a criminal record, as opposed to those with a police record. Due to the above, it is necessary to improve the quality of statistics in order to have a clear knowledge of the percentage of foreigners held and deported who have a criminal record, differentiating them from those who only have a police record.

Lack of social assistance services

60. The lack of social assistance services referred to in paragraph 82 of the 2011 Annual Report, which was detected in all the *CIE*s except for the one in Madrid, is pending the new regulation for the organization and operation of *CIE*s which, according to a report from the Directorate General of the Police, shall provide for such possibility.

The lack of notification regarding the time when they will be removed has been, again, a reason for complaint by inmates

61. The lack of notification to inmates regarding the time they will be deported, already pointed out in paragraph 84 of the 2011 Annual Report, has been the subject of complaint at the visits undertaken to the *CIE*s in Madrid and Valencia. In the latter, the director reported that he had submitted this matter to the Central Department so that the criteria applicable to all centers may be unified. In that regard, this Institution has been pleased to learn of the Ruling of 30 March, from the Local Criminal Court no. 8 of Las Palmas de Gran Canaria, acting as overseeing court of the Barranco Seco *CIE,* where it stated that the communication to inmates regarding their expulsion or release from the *CIE* must be made with a minimum of 12 hours prior to its implementation, in line with the trend followed by other courts, amongst them those overseeing stays at the *CIE* of Madrid.

The installation of cameras has been requested at those facilities which had none

62. As regards the video-surveillance of these centers, which was referred to in paragraphs 261 of the 2010 Annual Report and 87 of the 2011 Annual Report, after the visit carried out to the *CIE* of Barcelona some cameras have been installed in a space intended for a library and in another space used for the tempo-

ral separation of inmates. The installation of cameras has also been requested in the area intended for the temporary separation and the space between such area and the communal areas at the *CIE* of Algeciras and in the room where inmates are identified at the *CIE* of Madrid.

In spite of the instructions sent by the Directorate General of the Police, it has been noticed that some officers do not show their identity badge

63. In spite of the Directorate General of the Police having informed this Institution that instructions had been sent regarding the lack of identification of officers referred to in paragraph 88 of the 2011 Annual Report, it has been noticed again, during the visits to the *CIE*s, that some officers continued without showing their identity badge. A special mention should be made to the *CIE* in Algeciras where, with the exception of a female head of service who was present at the time of conducting the visit, none of the officers had their badges on, which was immediately notified to the director of such center.

Duty to inform and record in writing the fact that access to the information on international protection had been guaranteed

64. This Institution had requested to make sure that the brochures on international protection prepared in several languages by the Office of Refuge and Asylum (abbreviated as *OAR* in Spanish) were effectively distributed, as established in paragraphs 275 of the 2010 Annual Report and 90 of the 2011 Annual Report, as well as recording in writing that the possibility of the inmate to apply for asylum or refuge had been offered, and to include said circumstances in the inmate's record. During the visits to the *CIE* in Valencia and Madrid this shortcoming was detected and, specifically in Madrid, three inmates asked the members of the visit team to send this application for them. After these visits, the Directorate General of the Police reported it would consider drafting a protocol at each *CIE* in order to inform and leave a written record of the fact that access to the information on international protection had been guaranteed.

Night access to the lavatories must be guaranteed

65. During the visits carried out to the *CIE*s in Madrid and Valencia, complaints were received from inmates on the fact that night access to lavatories was not permanent, as it should be according to the criteria established in paragraphs 268 of the 2010 Annual Report and 96 of the 2011 Annual Report. During the visit to the *CIE* in Valencia it was verified in the early morning that plastic bottles, where inmates had urinated during the night, had been left in the rooms and in the lavatories. The Directorate General of the Police has reported that it has reiterated to all officers, by an order in writing, read and signed by all, that officers must pay attention and attend to any requests from inmates during the night. As regards the *CIE* of Madrid, such governing body has reported that, after the visit, all the necessary reforms had been carried out and that now all rooms had a hand basin and toilet bowl inside.

Complaints have been received on phone calls from the outside and their cost

66. A complaint has also been received from inmates of the *CIE*s in Madrid and Algeciras, as regards phone calls from the outside and, at the *CIE* in Valencia, the cost of the card to be able to make such calls. At the first of these centers the Ombudsman Institution was able to verify that, during the established times, the telephone in the control room was off the hook, and the Directorate General of

the Police declared it was working to set up a switchboard. At the *CIE* in Algeciras no calls were allowed from the outside, and the Directorate General of the Police reported in this regard that a specific and personal service would be additionally needed, both for safety and to receive calls. As regards the *CIE* of Valencia, inmates complained that, except the phone cards provided by family or friends, they had to buy them from the kitchen staff, which entailed an "extra charge", as they said, for these cards and, besides, if they didn't have the exact amount, they were told they had no change, which in some cases resulted in their paying a lot more for these cards. The Directorate General of the Police has reported that there is no record of the charge of commissions and that the supply of such cards would be solved with the arrival of the social workers included in the future regulation of the *CIE*s.

There is no budget for recreational material

67. As regards the lack of recreational material referred to in paragraphs 271 of the 2010 Annual Report and 103 of the 2011 Annual Report, the Directorate General of the Police has informed that the inmates themselves are the ones who sometimes spoil the material provided to them and that, given the lack of a budget for this concept, they depend on the material donated by NGOs, companies or even officers themselves. This shortage has been the subject of complaints from inmates of the *CIE*s in Algeciras and Valencia; specifically from the latter, regarding the lack of sports material, such as balls for play in the courtyard. Notwithstanding the reply sent by the Directorate General of the Police, during the visits undertaken to the *CIE*s in Tarifa (2010), Santa Cruz de Tenerife (2011) and Barcelona (2012), the Ombudsman Institution was able to verify that these centers had adequate material, and no inappropriate use thereof was referred to by the persons in charge of the centers.

In spite of the lack of a budget to carry out construction, the visitation room at the CIE *in Valencia has been reformed and the courtyard at the women's area of the* CIE *in Algeciras has been repaired*

68. In relation to other shortcomings identified at the visited centers, such as the lack of a washer and dryer, or of shower screens at the *CIE* in Valencia, the replacement of impaired mattresses at the *CIE* in Madrid or to partially cover the courtyards in Algeciras and Valencia, the Directorate General of the Police has adduced the lack of budget to carry out the necessary works or acquisitions. However, in the case of the courtyard at the women's area of the *CIE* in Algeciras, given the general disrepair thereof, the Directorate General of the Police has reported that it would proceed to adequately repair it. In a similar vein, in the specific case of the visitation room at the *CIE* in Valencia, it has been reformed after the visit of this Institution. It now has a parlor/independent room and another two separated by a partition, which offer more privacy while ensuring safety.

At the CIE *in Valencia, construction have started to remedy the shortcomings pointed out in 2010 and 2011*

69. The Directorate General of the Police has reported that in November 2012 it started the construction to repair the drainage collection systems located in the semibasement of the *CIE* in Valencia, in order to remove the bad smells which affected the office area, as was referred to in paragraphs 254 of the 2010 Annual Report and 105 of the 2011 Annual Report.

Courtyard of the women's area in Algeciras

Fotografía 14

70. Finally, during the visit to the *CIE* in Valencia, two shortcomings, which have already been remedied, were detected. The first one referred to the fact that, sometimes the inmates were not given food and water for the trips they took to the consulate or embassy, which was corroborated by the director, adducing that in some cases the Brigade notified the transfer when the kitchen was already closed and it was not possible to prepare food packages for the trip. The Directorate General of the Police has reported that this shortcoming has already been remedied. The second one, which has also been solved, referred to the empty suitcases of inmates that had been deported and did not want to take the suitcases along with them. They were kept in a warehouse, and the inmates were not asked to sign any document to record their renunciation to take such objects with them.

II.2. Military Disciplinary Establishments

Detentions at Military Disciplinary Establishments

71. According to the information supplied by the Office of the Secretary of State for Security, the following arrests took place in Spain in 2012 at the 8 Military Disciplinary Establishments (abbreviated as *EDM* in Spanish).

Table 26. Detentions at Military Disciplinary Establishments (abbreviated as *EDM* in Spanish) in 2012

EDM under the authority of the Spanish Army					EDM under the authority of the Spanish Air Force		*EDM* under the authority of the Spanish Navy	TOTAL
Center *EDM* (Colmenar Viejo, Madrid)	*EDM* Ceuta	*EDM* Melilla	*EDM* Tenerife (San Cristobal de la Laguna, Santa Cruz de Tenerife)	*EDM* Las Palmas (Las Palmas de Gran Canaria)	*EDM* Norte (Leon)	*EDM* Las Palmas (Las Palmas de Gran Canaria)	*EDM* Sur (San Fernando, Cadiz)	
77	37	31	26	13	41	0	37	262

Situations of Deprivation of Liberty

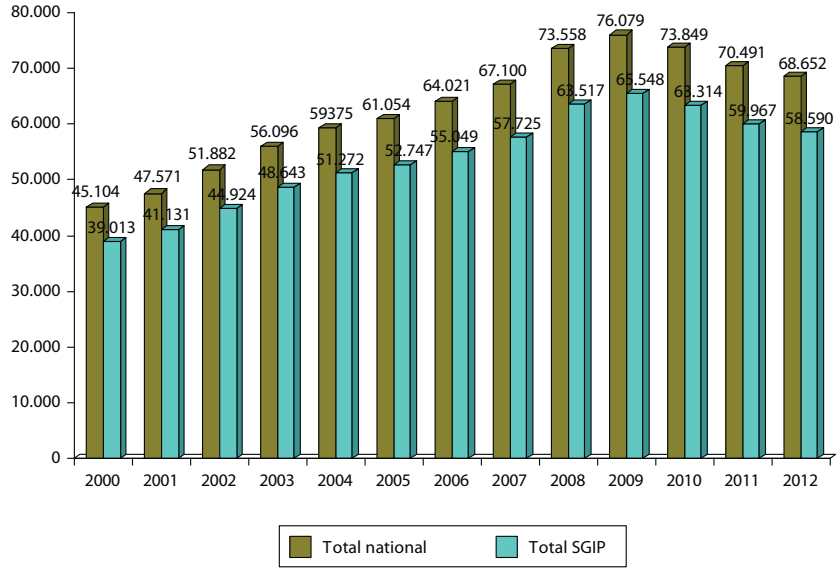
III. Long-term Deprivations of Liberty §72-§210

III.1. Prison facilities under the authority of the Office of the Secretary General for Prisons (abbreviated as *SGIP in Spanish,* hereinafter, *SGIP)* and the Department of Justice of the Government of Catalonia

The prison population continues to decrease

72. As was already declared in the reports from previous years, the Spanish prison population has shown a down ward trend in the last few years, in particular as regards remand prisoners. In 2012 the total number of inmates has been reduced by 1,839 inmates, which represents 10.3% accumulated in the last three years. The table hereinafter represents the evolution of the prison population since year 2000.

Table 27. Evolution of the prison population



Source: In-house compilation based on data supplied by the SGIP.

The number of remand prisoners has also decreased

For its part, the percentage of remand prisoners has gone from 20.88% at the beginning of 2010 to 18.98% at the end of 2010, then to 17.66% at the end of 2011, and finally down to 15.86% at the end of 2012.

Table 28. Distribution of the prison population at the*SGIP* and the Department of Justice of the Government of Catalonia, by gender and criminal-proceeding status, in 2011 and 2012

	SGIP			CATALONIA				
2011	Remand	Convicted	Total *SGIP*	Remand	Convicted	Total Catalonia	Total	%
Men	9,529	45,796	55,325	1,781	8,009	9,790	65,115	92.37
Women	958	3,684	4,642	177	557	734	5,376	7.63
Total	**10,487**	**49,480**	**59,967**	**1,958**	**8,566**	**10,524**	**79,491**	**100**
2012	**Remand**	**Convicted**	**Total *SGIP***	**Remand**	**Convicted**	**Total Catalonia**	**Total**	**%**
Men	8,270	45,754	54,024	1,611	7,786	9,397	63,421	92.39
Women	852	3,714	4,566	158	507	665	5,231	7.61
Total	**9,122**	**49,468**	**58,590**	**1,769**	**8,293**	**10,062**	**68,652**	**100**

The prison population of foreigners at the end of 2012 was composed of 22,907 persons, which represents 33.36% of the total prison population, i.e. one percent point below the previous year's figure. The percentage of men and women held in prison during 2012 are practically identical to those in 2011.

Finally, the distribution of the convicted prison population, according to the classification level, shows nearly identical percentages to those in 2011, as may be seen in the following table.

Table 29. Distribution of the prison population convicted by the*SGIP* and the Department of Justice of the Government of Catalonia, by gender, criminal-proceeding status and classification level, in 2011 and 2012

	SGIP			CATALONIA				
2012	MEN	WOMEN	TOTAL *SGIP*	MEN	WOMEN	TOTAL CATALONIA	TOTAL	%
UNCLASSIFIED	5,489	397	**5,886**	869	61	**930**	**6,816**	**11.80**
1.st DEGREE	854	79	**933**	153	8	**161**	**1,094**	**1.89**
2.nd DEGREE	32,932	2,321	**35,253**	5,223	262	**5,485**	**40,738**	**70.52**
3.rd DEGREE	6,479	917	**7,396**	1,541	176	**1,717**	**9,113**	**15.77**
TOTAL	**45,754**	**3,714**	**49,468**	**7,786**	**507**	**8,293**	**57,761**	**100**

Source: In-house compilation based on data supplied by the SGIP and the Department of Justice of the Government of Catalonia.

Tabla 30. Distribution of the prison population by Autonomous Regional Communities, gender and criminal-proceeding status

Autonomous Com.	Remand prisoners		Total remand p.	Convicted prisoners		Total convicted p.	Grand Total
	Men	Women		Men	Women		
Andalusia	2,080	165	2,245	12,560	1,005	13,565	15.810
Aragon	169	15	184	1,943	111	2,054	2.238
Asturias	118	6	124	1,208	112	1,320	1.444
Baleares	305	28	333	1,353	104	1,457	1.790
C. A. Ceuta	134	7	141	109	13	122	263
C. A. Melilla	83	2	85	220	14	234	319
Canary Islands	605	95	700	2,786	223	3,009	3.709
Cantabria	54	9	63	560	24	584	647
Castile-La Mancha	295	10	305	1,619	29	1,648	1.953
Castile-Leon	307	24	331	4,719	363	5,082	5.413

Autonomous Com.	Remand prisoners		Total remand p.	Convicted prisoners		Total convicted p.	Grand Total
	Men	Women		Men	Women		
Catalonia	1,611	158	1,769	7,786	507	8,293	10.062
Extremadura	178	17	195	1,032	50	1,082	1.277
Galicia	311	28	339	3,120	181	3,301	3.640
La Rioja	48	2	50	298	15	313	363
Madrid	2,114	322	2,436	5,967	734	6,701	9.137
Murcia	259	17	276	1,298	98	1,396	1.672
Navarre	68	6	74	223	22	245	319
Basque Country	170	10	180	1,115	124	1,239	1.419
C. Valencia	972	89	1,061	5,624	492	6,116	7.177
Total	9,881	1,010	10,891	53,540	4,221	57,761	68.652

Source: In-house compilation based on data supplied by the SGIP and the Department of Justice of the Government of Catalonia.

SGIP has carried out 73 inspection reports

73. According to the information provided by the *SGIP*, in 2012 a total of 73 inspection reports were carried out in relation to complaints for ill-treatment, 41 of which have been closed, 19 are currently in progress, 1 has been turned into classified information and 12 are pending resolution. In addition, 2 classified cases have been initiated, which gave rise to the opening of two disciplinary proceedings, which are still pending resolution.

The Government of Catalonia has initiated 31 information proceedings

The Government of Catalonia has reported that, in 2012 the Inspection Service from the General Directorate of Prison Services initiated 31 information proceedings derived from the relevant complaints for ill-treatment submitted by inmates or their families. With the exception of three cases, which were in the pre-trial phase, the remaining information proceedings were closed since no signs or evidence were found of the existence of ill-treatment. Likewise, a report was sent on the existence of a single legal proceeding in progress against officers of the Catalan penitentiary services for alleged ill-treatment against inmates of a prison. It is a court case opened against nine prison officers from the Quatre Camins prison (Barcelona), due to occurrences that took place in 2004 during a riot by a group of inmates.

In 2012 a total of 6 visits were carried out to prison facilities

74. In 2012 the NPM carried out six visits to prisons: five of them fell within the responsibility of the *SGIP* –the facilities in A Lama (Pontevedra), Alcala de Guadaira (Seville), Alava, Murcia II and Ocaña II (Toledo)– and one of them was within the responsibility of the Department of Justice of the Government of Catalonia: the women's prison of Barcelona.

Image 4. Geographical location of the prison facilities visited in 2012

Except for one, the rest of the monitoring visits were of a multidisciplinary nature, following the same methodology

75. All the visits had a duration of two days and were of a multidisciplinary nature –with experts in psychiatry and legal and forensic medicine–, except the one carried out to the prison of Alcala de Guadaira (Seville), which consisted of a monitoring visit similar to the one undertaken the previous year. The methodology applied at the multidisciplinary visits consisted of interviews with the staff (essentially the management and the healthcare personnel) and individual interviews to a selection of inmates chosen according to criteria based on age, nationality and module. Likewise, the criteria used for their selection was the fact of their having been recently subject to penalties or means of restraint, of being in a situation of isolation at the time (either due to a penalty or as a means of restraint), that Article 75.1 of the prison regulations was being applied to them, of them being interned at the infirmary, or of inmates being classified as first degree. On the other hand, during the visits an examination of the disciplinary proceedings was carried out, with a special interest to those resulting from incidents where means of restraint had been used or had resulted in injuries and cases of application of means of restraint (in particular in cases of physical restraint); in addition to assessing the systems for video-surveillance and record-

ing, and the living conditions and other aspects of the treatment of inmates. The external technicians, in addition to examining the quality of the medical assistance provided and other healthcare issues, performed an analysis of the clinical histories and of the medical and legal documentation generated by the medical professional provided to inmates (essentially the medical reports on injuries issued by the medical professional provided to inmates when they suffer injuries produced inside the prison).

The visited centers had different typology according to the gender of the prison population

76. As regards the characteristics of the prison population of each center, the prison of Alcala de Guadaira (Seville) and the women's prison of Barcelona are exclusively for women (except as regards the open section of the one in Barcelona), while the prison of Ocaña II (Toledo) is for men, and the other three –even though they are also for men– have at least one module for women. The two centers exclusively for women had a specific module for mothers with children under the age of three and pregnant women in the final months of gestation. As regards the legal proceedings status of the persons held at the centers, all penitentiary facilities had both convicted and remand prisoners, although the women's prison of Barcelona essentially held female remand prisoners and the prisons of A Lama (Pontevedra), Alava and Ocaña II (Toledo) held mainly convicts. Finally, the majority of prisons had open sections, where the inmates classified in third degree lived, although such facilities were not visited.

Very different as regards size and occupancy

77. As may be seen in the following table, within the different prison structures existing in our country, this Institution has visited very diverse centers as regards both size and occupancy: small centers –the prison of Ocaña II (Toledo) and, especially, the prisons of Alcala de Guadaira (Seville) and the women's prison of Barcelona–, medium-sized –the prisons of Alava and Murcia II–, and large centers –such as the prison of A Lama (Pontevedra).

Table 31. Occupancy of the visited prisons

Prison	Occupancy on day of visit (inmates)	Number of cells
Prison of A Lama (Pontevedra)	1.210*	1235 cells
Prison of Alcala de Guadaira (Seville)	162**	135 cells
Prison of Alava	632***	552 cells (modules in operation)
Women's prison of Barcelona	170****	51 cells
Prison of Murcia II	972	762 cells (modules in operation)
Prison of Ocaña II (Toledo)	419*****	424 cells

* Over 100 men and 4 women in the Social Integration Center «Carmen Avendaño».
** More than 7 women in the open section.
*** Over 85 inmates in an open regime, located in the former prison of Nanclares de la Oca.
**** Over 107 women and 217 men in the open section.
***** More than 2 inmates in the open section.

At the prisons of Alava and Murcia II some modules were closed due to lack of personnel

The cells were individual or for double occupancy in all centers. In the case of the prisons of Alava and Murcia II, several modules were closed due to lack of personnel, and therefore, in spite of there being empty cells, the majority of them were for double occupancy. The same use was noticed at the prison of Alcala de Guadaira (Seville), due to an increase of 25% in the occupancy of the center as compared with the previous visit. The three cases have been notified to the *SGIP* in order to have this situation remedied. At the women's prison of Barcelona, there was a situation of overcrowding, since six female inmates occupied the majority of cells and some of them had up to eight. One of the inmates from such center declared: «Living together is very hard. In my room there are seven of us, so we need to get on well, because otherwise there would be daily conflicts». These situations represent a breach of the legal mandate on cell principle, as described in paragraphs 318 of the 2010 Annual Report and 119 of the 2011 Annual Report. Therefore, adequate measures should be adopted in order to remedy this situation.

Cell with capacity for 7 inmates at the women's prison of Barcelona

Photograph 15

The occupancy at Ocaña II (Toledo) has decreased

On the contrary, the occupancy decrease at the prison of Ocaña II (Toledo) as compared to the one registered in previous years should be commended (599 inmates at the visit undertaken by the Ombudsman Institution in 2008, in comparison to 419 inmates during this visit).

The video-surveillance and recording systems are still not present in all facilities (except cells and bathrooms)

78. In general, the video-surveillance and recording systems at the prisons visited do not comply with the criteria described in paragraphs 334 and 477 of the 2010 Annual Report and 120 of the 2011 Annual Report, and therefore the opinion of this Institution in this respect had to be reiterated. As regards the prison of Alcala de Guadaira (Seville), in respect of which this shortcoming was already pointed out in the mentioned paragraph of the 2011 Annual Report, it was reported that a study of the current system and its possible upgrading was already under way.

There are no video-surveillance systems in the cells where physical restraint is applied

The majority of the visited centers do not have these systems installed in those cells where physical restraint is applied, which in the opinion of the Ombudsman Institution is not adequately in accordance with the provisions of paragraph 143 of the 2011 Annual Report.

In addition, whenever there are incidents with injuries, the images are generally extracted and kept apart, but are only sent to court if it is so requested. On the contrary, the criterion of the Ombudsman Institution is that, in case of this type of incident, the recordings should always be sent to court ex officio.

In case of incidents with injuries the recordings must be sent to court ex officio

79. Module 3 of the prison of Ocaña II (Toledo) did not have intercoms or sound systems for calling inside the cells, contrary to the provisions of paragraphs 336 of the 2010 Annual Report and 121 of the 2011 Annual Report, and such change is pending implementation, which should be carried out as soon as possible. As regards the prison of Alcala de Guadaira (Seville), it was reported that the installation of the sound systems for calling from the cells would be executed when budget availability permits.

Sound systems for calling should be installed

80. As regards the information on rights and duties which are provided to inmates upon admission, during the visit to the women's prison of Barcelona it was detected that informative sheets were available on basic issues regarding the stay at such center, in Spanish, Catalan, English and French, but not in other languages which are common among female inmates, which should be remedied. On the other hand, although other inmates normally act as interpreters and there is usually no problem with communication, prisons should have a system for simultaneous interpretation for those cases when it is necessary.

There should be a system for simultaneous interpretation

81. As regards medical assistance, the external experts that were part of the visit teams were able to check that, in general and from a technical point of view, its quality was correct. A positive mention should be made of the high degree of satisfaction of the inmates –both male and female– interviewed at the prison of Alava and the women's prison of Barcelona with the professional work carried out by the healthcare team in general and, particularly, as referred to the latter, a very favorable opinion of the mothers regarding the pediatrician. There was only one complaint from a female inmate, in relation to the medical assistance received on the previous night. However, once the medical-forensic expert, who was part of the visit team, had examined said inmate and her medical history, the action taken by the healthcare team was deemed correct.

Adequate medical assistance

82. In the Moscow Declaration of 2003, the World Health Organization recommended for public health services to establish close links with the prison health services, or to be directly integrated with them. Along the same lines, Law 16/2003, of 28 May, on the cohesion and quality of the Spanish National Health Service, provided for the prison health services to be transferred to the Autonomous Regional Communities for their full inclusion in public health services. However, up to this day, the health services of the Basque Country prisons are the only ones in Spain where a transfer of the functions and services has been implemented from the State authorities in healthcare matters to an autonomous regional community, which this Institution was able to verify during the visit to the prison of Alava.

Although the prison health services have been transferred to the Autonomous Communities, only the Basque Country has implemented the transfer of competencies

Those prisons which are far from urban areas or have large occupancy rates should have 24 hours medical assistance at the center

83. The prisons of A Lama (Pontevedra), Alava and Murcia II –the visited prisons with the largest prison population– have a 24 hours on-site medical service. At the other centers visited, outside opening hours of the medical surgery it is necessary to call the physicians or registered nurses who are on-call and may be reached. In addition, these are centers are located in urban areas (the women's prison of Barcelona and the prison of Ocaña II (Toledo)] or very near to them (the prison of Alcala de Guadaira (Seville)]. This situation is deemed correct, as the criterion of this Institution is that those prisons with largest occupancy rates or which are far from urban areas with emergency medical services should have 24 hours on-site medical assistance at the center.

A specific protocol should be established for an initial medical check-up

84. At the time when an admission is carried out at a prison, a full medical examination should be carried out by the medical team of the center. However, at the women's prison of Barcelona there is no protocol for such initial exam. It has therefore been reported to the Department of Justice of the Government of Catalonia that it is convenient, for a better uniformity of criteria among physicians, to establish a specific protocol for an initial medical check-up of inmates, including analysis to detect consumption of intoxicating substances or the existence of contagious diseases and an evaluation scale for the risk of suicide.

The planned medical consultations should not be delayed over time, in order to satisfy inmates' demands

85. The frequency of the medical consultations planned for the different modules of the prison should be adequate to meet the demands of inmates. During the visit to the prison of Murcia II it was detected that, although theoretically weekly consultations on demand were established, while reviewing the records it was noticed that the frequency was generally lower, since it was normally delayed for two or, even, in some cases, more weeks. For its part, on the basis of what was observed at the prison of Alava, it was concluded that it would be advisable to alternatively organize the medical consultations on demand so that they would be more frequent, thus avoiding an excessive request for urgent consultations.

Specialized assistance is also provided

86. As regards specialized assistance at the center, it should be positively pointed out that there is a large number of specialists going to the women's prison of Barcelona to cater to the demands of this kind of medical assistance, with a frequency which avoids the existence of a waiting list as well as facilitates that adequate promptness in handling the needs of the prison population. At the prison of Murcia II a collaborative agreement has been signed with the Health Department from the Murcia Autonomous Government for the provision of specialized support in psychiatry, internal medicine and gynecology. Nonetheless, it would be advisable to extend this agreement to include the assistance of an internal medicine specialist, in order to conduct a better control of diseases, which play a major role at the center.

There should be a register of requests for medical assistance

87. In the opinion of this Institution, prisons should have a register of requests for medical assistance and of the programmed appointments with the health services, in order to know exactly who demands medical assistance, how many consultations are provided every day and which periodical appointments are made

by health services due to the pathology of inmates, which would be of particular interest as regards complaints for delays in the medical assistance. The women's prison of Barcelona and the prison of Murcia II did not have such a register, and the prison of Alava also did not have a protocol for those cases of requests for urgent assistance. Therefore, it has been requested that these shortcomings be remedied.

Telemedicine systems should be used

88. As was already expressed in paragraphs 339 of the 2010 Annual Report and 130 of the 2011 Annual Report, it would be convenient to conduct certain medical consultations through a telemedicine system. Of the facilities visited, the prison of Alava stands out as a pioneer in the use of this system, which has allowed for access to specialized assistance, thus reducing delays and avoiding transportation of the inmate and the possibility of cancellation of these consultations.

At Ocaña II (Toledo) a waiting list of nearly one year has been detected for surgical interventions

89. During the visit to the prison of Ocaña II (Toledo), the Institution was informed that inmates needing surgery were on a waiting list of nearly one year, with the only exception of the specialty of maxillofacial surgery. In that regard, more detailed information has been requested from the *SGIP* on those inmates who may be affected by such delay, in order to assess the possible opening of an investigation in this respect by the Health and Social Policy Department of the Ombudsman Institution.

When the patient requires close monitoring, the administration of medication should be done under the direct observation of the healthcare personnel

90. As regards the dispensing of medication, doctor's prescriptions are included in the medical history and the dosage of the medication being administered to each inmate is prepared in individualized bags, which are duly labeled. The criterion of the Ombudsman Institution is that, when medication requires a closer monitoring (such as the case of psychotropic drugs), this should be administered under the direct observation of the healthcare personnel, and it was thus recommended particularly with regard to the prison of Alava. At the prison of A Lama (Pontevedra), the insufficient number of clinical assistants, who are in charge of administering the medication, makes it impossible to guarantee the distribution thereof on the weekends (with the exception of the infirmary pavilion, where it is carried out by registered nurses). Therefore, it would be necessary to implement the appropriate procedures to increase the size of the staff in that regard.

An effort should be made to computerize the medical histories, as well as to coordinate with the public healthcare system

91. Prisons should begin to computerize medical histories and to coordinate with public health services, both primary and specialized care, as tools to improve the medical assistance provided to inmates. At the prison of Alava it was noticed that several ways to manage the medical history coexisted at the center, and this Institution considers that the integration of all systems would be advisable. At the prison of A Lama (Pontevedra), a lack of coordination was detected between the general assistance network and the prison physicians, which sometimes provoked duplications when requesting diagnostic and analytic tests, and delays in the reading of their results. It would therefore be advisable to implement

the electronic medical history at the center and its connection with the public network of healthcare services.

Infirmaries are adequately equipped

92. On a general basis, the facilities and equipment of the visited infirmaries were adequate. However, at the prison of Alava it was noticed that the X-ray machine was not used due to lack of the appropriate technician, which is something that should be remedied.

Measures should be taken in order to avoid missed medical appointments due to lack of police staff for the custody and transfer of inmates

93. Regarding missed medical appointments due to lack of police staff for the custody and transfer of inmates –which is a problem that was already referred to in paragraph 129 of the 2011 Annual Report–, the *SGIP* has reported to this Institution the relevant number and percentages for each prison in 2012. Although in the vast majority of centers the number of missed appointments for such reason is non-existent or lower than 10%, some cases stand out negatively, such as the prison of Madrid II (11.60%), the Prison Psychiatric Hospital of Seville (22.11%), the prison of Seville (26.04%) and the prison of Jaen (29.01%). At the investigation which this Institution is carrying out in that regard together with the *SGIP*, the Directorate General of the Police and the General Directorate of the Civil Guard, it has been reported that there are regular meetings among those governing bodies and the relevant healthcare authorities from the Autonomous Regional Communities, in order to solve the problems which may derive from the transfer of inmates to healthcare centers. Likewise, the *SGIP* has reported the existence of a protocol for procedures in cases of hospital referrals due to medical emergencies, and the Directorate General of the Police has reported that, when the responsible police officers detect that difficulties to comply with the transfers are due to reasons of a structural nature, it studies the possibility of increasing the number of the staff affected by those tasks. Specifically, as a consequence of the arrangements carried out by the *SGIP* with the responsible persons at provincial level from the Andalusian Health Services in Seville, the Directorate General of the Police and the Directorate General of the Civil Guard, a decrease has been achieved in the number of missed consultations due to lack of custody at prisons in Seville, which have gone from 35% in 2011 to 26% in 2012. For its part, the Department of Justice of the Government of Catalonia has reported a total of 28 occurrences of missed medical appointments in 2012 due to the non-appearance of the officers in charge of the custody and transfer of inmates.

The PAIEM *(Framework Program for the Comprehensive c Care of the Mentally Ill) is being progressively implemented*

94. Treatment of mental illnesses in prison should not be limited to diagnosis of the suffered pathology and prescription of the adequate pharmacological therapy. It is additionally necessary to improve the quality of life for patients, increasing their personal autonomy and adaptation to the environment. In this sense, there is reason to commend the progressive implementation of the *PAIEM* (Framework Program for the Comprehensive Care of the Mentally Ill) in the prisons run by the *SGIP* –which was already referred to in paragraphs 341 of the 2010 Annual Report and 132 of the 2011 Annual Report–. It is however necessary to implement this program in all centers which still do not implemented it, such as the prison

of Murcia II, and its full implementation in those centers where it is still at a very early stage, such as the prison of Alava, where the PAIEM does not yet include all inmates with psychiatric pathologies. At the prisons of A Lama (Pontevedra) and Ocaña II (Toledo), a satisfactory operation of this program was observed, which was confirmed by inmates.

On the contrary, at the women's prison of Barcelona, run by the Government of Catalonia, the treatment of mental illness at the center is essentially limited to diagnosis of the suffered pathology and prescription of the adequate pharmacological therapy. Therefore, a program should be established for the comprehensive care of the mentally ill, to include measures for rehabilitation and social reintegration.

Admission should be provided for those inmates with acute mental disorders who are held in prison and need specialized monitoring

95. At the visit to the prison of Ocaña II (Toledo) it was reported that there had sometimes been conflictive situations when applying for hospitalization of patients with a psychiatric pathology, since the assigned hospital did not have any beds with restricted access and police surveillance for this medical specialty. As a consequence, the Ombudsman Institution has reported to the *SGIP* that the necessary arrangements should be carried out with the healthcare authorities in order to allow for admission of those prisoners with acute mental disorders who are held in prison and need specialized monitoring.

Inmates with psychiatric pathologies should be placed in individual cells

96. At the visit to the women's prison of Barcelona it was detected that inmates with diverse psychiatric pathology lived together in the same cell in the infirmary, which caused cohabitation conflicts. Therefore, the necessary measures should be adopted so that in similar situations inmates are placed in individual cells.

Psychology consultation services are needed

97. On the other hand, given the high rate of psychiatric disorders in prisons, it would be convenient to establish psychology consultation services, which already became clear at the women's prison of Barcelona and the prison of Alava.

In 2012 a total of 202 deaths took place in prison

98. The information provided by the *SGIP* and the Department of Justice of the Government of Catalonia, reports that in 2012 a total of 202 deaths took place in prison: 167 in prisons run by the *SGIP* and 35 in prisons run by the Catalan authorities. In the case of Catalonia, this figure has decreased by 36% as compared to deaths registered in 2011. On the contrary, the *SGIP* reports an increase in comparison to data from 2011. The data on deaths by suicide in 2012 show an increase in both administrations: 25 in the *SGIP* compared to 15 in 2011, and 6 in Catalonia compared to 2 in year 2011.

Table 32. Deaths of inmates in prisons run by the *SGIP* in year 2012

Typology	Prison	Hospital	Total
Drugs	34	0	34
Suicide	25	0	25
HIV/AIDS	1	8	9
Assault	0	0	0

Typology	Prison	Hospital	Total
Accidents	4	1	5
Other illnesses	34	60	94
TOTAL	98	69	167

Source: In-house compilation based on data supplied by the *SGIP*.

Table 33. Deaths of inmates at prisons under the authority of the Government of Catalonia in 2012

Typology	Total
Drugs	1
Suicide	6
Other causes	15
Natural causes	13
TOTAL	35

Source: In-house compilation based on data provided by the Justice Department of the Government of Catalonia.

Whenever the Ombudsman Institution learns of a death, it carries out an ex officio investigation

Note should be taken that whenever there is knowledge of a death in such circumstances, the Security and Justice Department of the Ombudsman Institution files an *ex officio* complaint, as explained in the appendix of this report. Furthermore, in the course of the NPM inspection visits, the files of cases of deaths in the prison during the year are reviewed. Said review was performed at the prison of Araba/Alava, where there were two deaths in 2012. The first one occurred following hospitalization of the inmate, so that the hospital's medical records were consulted, but not the death certificate. In the second case, the inmate was found dead in his cell. Given the characteristics of the incident, it was reported to the courts. A Magistrates' Court intervened and ordered that a judicial autopsy be performed, the report of which was not consulted at the time of the inspection.

During the inspection visits the monitoring of implementation of the Suicide Prevention Program was examined

99. The World Health Organization considers persons deprived of liberty as a group at high risk for committing suicide. This implies that the Penitentiary Administration must take all possible measures to avoid suicidal conduct and regularly assess their effectiveness to improve the quality of said measures. For this purpose, during the inspection visits the monitoring of implementation of the Office of the Secretary General for Prisons' Suicide Prevention Program (abbreviated as *PPS* in Spanish) is examined. At the Murcia II prison, for example, it was noted that the program was being applied with good results, but that specific scales should be used as part of the routine to assess the risk of suicide during the medical examination upon an inmate's admission to the prison. In turn, at the A Lama prison (Pontevedra), it was noted that the risk assessment instrument was only applied in cases in which there was a previous history or the physician suspected that there could be psychiatric symptoms. A more rigorous system of observation of the mental state of inmates should thus be implemented, in particu-

lar in respect to the possible appearance of emotional or depressive symptoms, by means of training courses or practice in the use of screening instruments. In addition, the prison should provide inmates with training to support the Suicide Prevention Program, as is done at the Murcia II prison. This deficiency has been detected in particular at the Araba/Alava prison.

It was noted that at the women's prison in Barcelona it is not applied systematically

At the women's prison of Barcelona, which is under the authority of the Government of Catalonia, it was noted that there is no systematic application of a program to detect the risk of suicide, and that there is no specific protocol for the prevention of suicides, something which should be corrected.

During the inspection visit to the prison of A Lama (Pontevedra) a considerable increase in the practice of strip searches was noted

100. The majority of the inmates interviewed did not express any objection to body searches and searches in their cells, full body searches not being frequent. However, during the inspection of the prison of A Lama (Pontevedra), a considerable increase in recent years of the practice of strip searches was noted (15 in 2010, 27 in 2011 and 45 in 2012). Its use was motivated, amongst other circumstances, by suspicions of possession or introduction by inmates of forbidden substances, following communications with relatives or reentry following a period of leave. For the purpose of assessing whether the practice was justified or not, the Office of the *SGIP* has been requested to inform the Ombudsman Institution of the result obtained in each one of these strip searches, indicating the date, inmate, module, motives and whether any forbidden or toxic substance was found.

In the disciplinary proceedings examined, it was verified that the Parole Judge had been properly informed

101. During the inspection visits, a sample of the disciplinary proceedings processed at each prison was examined. The criterion used in selecting the files was the application of restraining measures to the inmates and /or processing of several disciplinary proceedings against the same inmate. In all of them, it was verified that they had been processed correctly and that the Parole Judge had been properly notified. The sanction that is most often imposed is depriving an inmate of group strolls and recreational activities, followed by solitary confinement, either in the inmate's own cell –if it is single– or in the special secure detention department or module.

Provisional solitary confinement is the restraining measure used most often

102. Likewise, as indicated in paragraph 140 of the 2011 Annual Report, the use of restraining measures is analyzed in the course of the inspection visits: review of records, review of individual cases and verification of the circumstances, duration of the measure, verification of supervision and control during the application of the measure, and verification that the Parole Judge was informed of application of the restraining measure. Provisional solitary confinement is the restraining measure most commonly employed; physical restraints are rarely used, and physical force, handcuffs and aerosol sprays are even more rare (there was only one case in which the latter was used at the prison of A Lama, Pontevedra).

A recommendation was made to the Office of the (SGIP) to review the use of provisional solitary confinement at the II prison (Toledo)

During the inspection visit to the Ocaña II prison (Toledo), the team examined the file of an inmate on whom the restraining measures of personal physical force, 28 hours of provisional solitary confinement and 4 hours of physical restraint with straps had been applied as a result of an aggression against a fellow inmate. In the notification to the Parole Judge, no mention was made of the physical force; there was only reference to the provisional solitary confinement and physical restraint with the straps, and the *SGIP* was thus duly informed. In respect to the duration of the measures, article 72 of Prison Regulations states that restraining measures shall only be applied «for the amount of time that is strictly necessary». However, at that prison, it was noted that in 10 cases provisional solitary confinement lasted about 48 hours and in one case lasted for more than two and half days. In consequence, the *SGIP* has been urged to review the use of provisional solitary confinement at the prison.

The use of physical restraints is examined to verify that application and supervision thereof is properly recorded

103. In respect to the use of physical restraints, the application and supervision procedure is checked to make sure that it is properly recorded. In this sense, the examination of the documents carried out during the inspection of the Ocaña II prison (Toledo) revealed that in the files of application of physical restraint, there was no record of the exact moment at which the medical control was performed. It was also noted that this was not recorded or documented in a detailed manner at the prison of A Lama (Pontevedra). These are deficiencies that must be corrected.

Physical restraint cell at the Ocaña II prison (Toledo)

Photograph 16

The SGIP was reminded that inmates who are physically immobilized must be permanently supervised

In connection with the foregoing, the *SGIP* has had to be reminded of the Ombudsman Institution's criterion, stated in paragraph 143 of the 2011 Annual Report, whereby persons who are physically restrained must be permanently supervised, preferably by health-care personnel, to avoid possible complications that might arise while the inmate is completely immobilized and thus unable to react adequately to any possible complications.

This criterion is applied at the women's prison of Barcelona

On the other hand, said criterion is satisfied at the women's prison of Barcelona. At that prison, two of the special department cells are equipped with video surveillance systems to tape application of the physical restraint. In the course of the inspection visits the tapes of two restraints performed on inmates were viewed.

In both cases, it was verified that the prison staff as well as management personnel accompanied the inmates during the entire period of restraint.

The SGIP has been informed of the treatment in a case detected at Ocaña II (Toledo)

In respect to the physical restraint carried out on an inmate at the Ocaña II prison (Toledo), to whom several restraining measures were applied as a result of an aggression against another inmate, as mentioned in paragraph 104, said inmate's medical records indicated that during the examination performed by the doctor the former did not show the aggressiveness and agitation which had led, according to the prison staff, to the intervention, in spite of which the doctor gave the inmate injections of tranquilizers and neuroleptics. In this respect, the Ombudsman Institution has drawn the *SGIP*'s attention to the discrepancy detected between the physician's report and the adoption of a measure, which is intended to be exceptional, namely injecting medication without the inmate's consent.

104. The following general principle is established in Article 75.1 of Prison Regulations: «Persons arrested, sentenced and inmates shall not be subject to any regimental limitations other than those required to ensure their personal integrity or for the security and good order of the establishments, as well as those deemed appropriate for their treatment or that stem from their classification level». In addition, Article 75.2 of the Prison Regulations provides for the adoption of measures that entail regimental limitations, at the inmate's request, informing the Parole Judge thereof, where necessary to safeguard the inmate's life or physical integrity. However, the criterion adopted by the *SGIP* in respect to the application of Article 75 of Prison Regulations does not correspond to the Ombudsman Institution's stance as expressed a few years ago and reiterated to the *SGIP* on occasion of these inspection visits. In this Institution's opinion, the literal wording of said article must be respected, so that in all cases of regimental limitations adopted by virtue of said rule the sole motive should be ensuring the inmate's physical integrity, and in the case of other objectives, the possibilities offered by regulations in force should be applied, including the application of a disciplinary regime, the use of restraining measures, a proposed classification level demotion, a change of module or department, or any other measure provided in penitentiary legislation. Otherwise, the protection mechanisms granted to inmates by penitentiary legislation would be seriously undermined.

The sole motive of inmate regimental limitations must be to ensure their physical integrity

In any case, the *SGIP* must comply with its Instruction 3/2010, of 6th March, on the protocol for action in security matters, whereby this article should only be applied in the case of serious incidents which entail a risk for the prison's security and order, and the motives for said application must be clearly substantiated in the resolution for its application, with the affected inmate having the possibility to contest said application by means of an appeal.

This measure must only be applied in case of serious incidents, which affect the prison's security and order

The use of Article 75 of Prison Regulations was studied in depth at the prisons of Araba/Alava and Ocaña II (Toledo), including inmates to whom regimental limitations were being applied on the basis of Article 75 and examination of the

books in which these measures are recorded and some of the files of inmates to whom they had been applied.

The notifications to the Parole Judge do not specify the causes that give rise to the adoption of these measures

105. First of all, during the inspection visit to the Ocaña II prison (Toledo), it was noted that the notifications to the Parole Judge regarding application of Article 75.1 of Prison Regulations did not specify the exact causes that gave rise to adopting the measures. Instead, standard forms were used which only indicated that the measure had been taken for «the security and good order of the establishment». According to information provided by inmates and confirmed by the Director, when an inmate's mobile phone is seized, Article 75.1 of Prison Regulations is systematically applied for about one month, after which a disciplinary proceeding is opened for possession of forbidden objects. In these cases application of the article does not seem justified, bearing in mind that the rapid processing of the disciplinary proceeding or the adoption of other less harmful measures could satisfy the intended objectives with greater guarantees for the inmate, and that the current systematic application turns out to be a double punishment for the same incidents, given that the time spent by inmates in solitary confinement is not even discounted.

The frequency of their application does not correspond to what should be exceptional

106. In respect to the frequency with which Article 75.1 of Prison Regulations is applied, during the inspection visit to the Ocaña II prison (Toledo), it was noted that in 2012 and up to the date of the inspection (in the month of December), the said article was applied on 37 occasions to 33 inmates, which entails approximately 8% of inmates, taking into account occupancy at the prison on the day of the inspection visit. This figure does not seem to correspond to the exceptional nature of application, which must govern the use to this measure. In consequence, the *SGIP* has been told that it would be appropriate to review the circumstances in which the said article of Prison Regulations is applied.

The period of time during which the limitations are applied is excessive

107. In respect to the duration of this measure, in 2012 most of the cases in which it was used at the Ocaña II prison (Toledo) lasted about one month. Furthermore, although the Director of the prison stated that these regimental limitations are applied for a maximum period of one month, in six cases they lasted to six days more than one month. The limitations were even applied three successive times to one inmate, making a total of 3 months with only two days of respite. This period of time is much too long; in consequence application of Article 75.1 of Prison Regulations should also be reviewed in this matter. On the other hand, in 11 cases the regimental limitations only lasted one day, and even just a few hours. In these cases, there do not seem to be sufficient reasons to justify adopting such exceptional measures, for situations which, apparently, were quickly resolved, instead of recurring to other measures, such as provisional solitary confinement. At the Araba/Alava prison, the Director stated that normally this article is not applied for more than three days, although all of the inmates to whom the article was being applied at the time of the inspection had been in that situation for at least 9 days, with one that had even been subject to limitations for two and half months.

108. In connection with the prison regimes resulting from application of Article 75.1 of Prison Regulations, in the course of the inspection visits to the prisons of Araba/Alava and Ocaña II (Toledo) it was verified that contrary to the provisions of the aforementioned Instruction 3/2010, said application entailed a regime similar to that of solitary confinement sanctions or the secure detention regime, however without the same procedural guarantees offered by the latter. At the Ocaña II prison (Toledo) the measure was applied in the module for new inmates and solitary confinement and at the Araba/Alava prison it was normally carried out in the inmate admissions, release and transit modules –except for women, who stayed in their modules, but in specific cells–, and exceptionally in observation cells that will be described later on. In consequence, in both prisons inmates changed module and moved to cells with more security than ordinary cells (double doors with security locks, bookcase with no shelves), where they could only keep a limited number of belongings because the cells were searched frequently. Inmates had three, four or five hours in the courtyard, and spent the rest of their time in their cells, since they were not allowed to attend classes, workshops or engage in any other activity. In the case of the women at the Araba/Alava prison, they were only allowed to go out to the courtyard for 3 hours, since they could not be there at the same time as the other inmates. In addition, one of the inmates interviewed at the Araba/Alava prison to whom Article 75 of Prison Regulations was being applied in a secure detention module observation cell stated that she had not been allowed to go out to the courtyard, which was confirmed by the inmate assistant guard. If that is correct, the «minimum of three hours daily in the courtyard» established in her notification of application of Article 75 of Prison Regulations was not complied with. Furthermore, at that prison –in contrast with the Ocaña II prison (Toledo)– inmates were not allowed to have television sets in their cells, which cannot be justified other than as an additional sanction to their situation.

It was noted that the prison regime resulting from the application of limitations varies from one prison to another, and that in one case it was similar to the solitary confinement or secure detention regimes, but without the same procedural guarantees

Photograph 17

Courtyard of the inmate admissions module at the Araba/ Alava prison, where article 75 of Prison Regulations is applied

Regimental limitations that are applied must be specified in the notification to the interested party and in the communication to the Parole Judge

109. The specific regimental limitations applied by virtue of Article 75 of Prison Regulations must be indicated in the notification to the interested party and in the communication to the Parole Judge. Nonetheless, deficiencies in this respect were detected at both the Ocaña II (Toledo) and Araba/Alava prisons. Said limitations were not specified in the communication to the Parole Judge or in the notifications to the interested parties. Furthermore, at the Araba/ Alava prison it was noted that both communications only referred to the time spent in the courtyard or to the restriction applied to oral communications, but that other regimental limitations were not specified, not even cases in which inmates were transferred to the secure detention department, not being allowed to have the same belongings as in a normal cell –not even a book or other pastimes– or carry out activities, and having their right of privacy limited by the permanent observation of an inmate assistant guard.

Approval by medical services must be included

110. The forms regarding the application of Article 75 of Prison Regulations that were examined in the course of the inspection visit to the Araba/Alava prison did not include approval by medical services. The prison staff declared that the original document was probably in the infirmary. In consequence, the Office of the SGIP has been told that express instructions should be given to have said document be noted on inmates' files.

The increase in the number of inmates who require regimental limitations is an indication of the anomalous operation of the system of separation

111. Even though the measure provided in Article 75.2 of Prison Regulations is geared at protecting inmates, it is nonetheless meant to be an exception and entails regimental limitations. For this reason, the increase of the number of inmates in a prison requiring the protection provided in said article can be considered as an indication of the anomalous functioning of the internal separation system. Such an anomalous operation was observed at the Ocaña II prison (Toledo) where in 2012 the said article was applied on 31 occasions, perhaps due to limited means for internal separation (only three modules, one of which is a respect module), involving 7.43% of all inmates at the prison.

Prolonged duration of separation may entail that other measures are not taken to solve the problem

Furthermore, at the Ocaña II prison (Toledo), some cases of prolonged duration (up to 4 months) in the application of Article 75.2 of Prison Regulations could indicate that other measures were not taken to solve the problem, such as, for example, a transfer to another prison. In consequence, whenever possible, other measures should be resorted to in order to reduce the number of occasions in which it is necessary to adopt the measure provided in Article 75.2 of Prison Regulations.

The facilities where these kinds of measures are applied must be appropriate

112. The facilities used to implement a sanction of solitary confinement, precautionary measures, provisional solitary confinement or regimental limitations and personal protection measures pursuant to Article 75 of Prison Regulations must be appropriate and have characteristics similar to those of ordinary cells, especially in cases in which the stay of inmates is prolonged.

At the Araba/Alava prison the observation cells are used in exceptional cases

The Araba/Alava prison has 5 observation cells which, according to the information given, are used in exceptional cases for inmates with regimental limitations pursuant to Article 75.1 of Prison Regulations and personal protection measures in accordance with article 75.2, and also for exceptional cases of solitary confinement and precautionary measures. These cells are located in the secure detention module, which was not fully operational due to lack of personnel. Two of the four buildings that comprise the module consist of three adjacent cells. The interior of the cells on either side of the middle cell can be viewed through the windows of the latter, which is occupied by an inmate assistant guard. A third building consists of one observation cell plus the inmate assistant guard's cell. The observation cells do not have any furniture or space for belongings. Inmates are not allowed to have any personal belongings in these cells, not even basic personal hygiene products, and sometimes not even sheets. In one corner, without any type of privacy, there is a toilet consisting of a metal plate on the floor and an opening in the wall from which water flows. The observation cell is for an inmate in charge of watching over the inmates residing in the observation cells and using the intercom to call the staff member in the cabin in case of need.

Two pictures of one of the observation cells at the Araba/Alava prison

Photograph 18

Photograph 19

The SGIP has been informed that the living conditions applied at the Araba/Alava prison for a period of several days are not appropriate

At the time of the inspection visit, two women and one man occupied the observation cells. One of the women had been there for three days in solitary confinement, the other for ten days as a result of application of Article 75.1 of Prison Regulations, and the man for nearly one month for the same reason. These inmates were interviewed individually, together with the women and man «guard assistant» inmates, who declared that they had not received any training for their activity, which must be corrected. One of the women inmates complained that she had not been able to shower for four days, despite having requested to do so. In addition, the two women inmates declared that they had not gone out to the courtyard since they had entered the observation cells. These living conditions for stays that last several days are not acceptable, and the *SGIP* has been informed that immediate measures should be adopted to correct this situation.

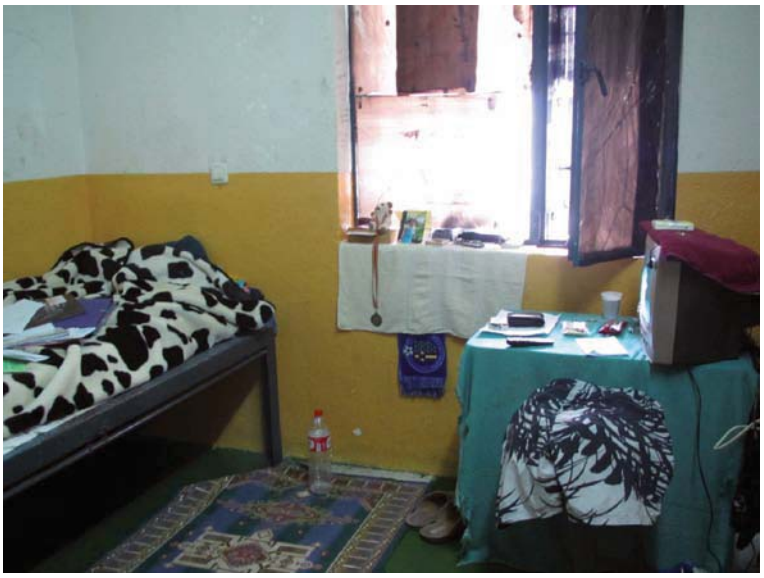
The state of one of the women inmates seems to obey to the excessive predominance of regimental aspects over strictly medical ones

Furthermore, given the state of the inmate who had been in one of the observation cells for ten days, who was «delirious» according to the forensic doctor on the inspection team, it was difficult to accept that medical approval had been given for her to remain in that situation. In the opinion of the aforementioned forensic doctor, it is counterproductive for a mentally ill person to be in such a situation, and the fact that the medical reports did not object to the application of said measure seems to obey to a lack of thoroughness or to excessive predominance of regimental aspects over strictly medical ones.

The facilities of the solitary confinement and admissions module at the Ocaña II prison (Toledo) are insufficient for long stays

At the Ocaña II prison (Toledo), the solitary confinement and admissions module facilities are insufficient for long stays, including fulfillment of a solitary confinement sanction or regimental limitations of Article 75 of Prison Regulations, and appropriate measures should be taken to make those facilities similar to cells in ordinary modules.

A cell in the solitary confinement module at the Ocaña II prison (Toledo)



Photograph 20

At the A Lama Prison (Pontevedra), a swastika painted on a piece of paper was found stuck on the wall of one of the cells of the solitary confinement module. It was removed following instructions given by the Ombudsman Institution's staff, as this type of situation is unacceptable. The presence of this kind of sign should be avoided by means of appropriate inspections of cells.

A protocol must be drawn up for the appropriate medical examination in these cases, including supervision of the conditions of the cell

113. At the prisons of Araba/Alava and A Lama (Pontevedra) there were no guidelines in respect to the obligatory medical examination, or regarding the content of the reports, in situations of solitary confinement or regimental limitations and personal protection measures of Article 75 of Prison Regulations. In consequence, an appropriate protocol should be established for the medical examination to be performed in these cases, including supervision of cell conditions.

The report of injuries must be filled out systematically and forwarded to the competent judicial authority

114. In respect to obligatory collaboration with the Justice Department in the event of acts which could be considered an offense, it was noted that at the women's prison of Barcelona, when an injured inmate was treated by the medical services for injuries due to a fight with other inmates, said services only inform the prison Director, who depending on the severity of the injuries decides whether or not to inform the judicial authorities. Moreover, at the Araba/Alava prison, the medical services only issue the corresponding report of injuries when the patient informs them that they were caused in a fight with other inmates or in an altercation with prison staff. An examination of the reports of injuries at the Murcia II prison revealed that medical service doctors did not always fill out the obligatory report of injuries in all cases treated, which should be done irrespective of the etiology and even in the absence of objective injuries. In consequence, the competent administrations have been reminded that when an inmate is treated by the medical services for injuries the origin of which could be an offense, they must systematically fill out the corresponding report of injuries and forward it to the competent judicial authority, in accordance with the provisions of Section 262 of the Criminal Procedure Law.

The report of injuries must be forwarded immediately to the corresponding Duty Court

Moreover, it should be stressed that the speed with which the corresponding report of injuries is forwarded to the Duty Court is essential. Although the Criminal Procedure Law does not specify a deadline, it does state that the report must be forwarded «immediately». This is to enable the Judge to adopt a decision pursuant to his/her criterion and the contents of the report and order that the inmate be examined by the forensic doctor as soon as possible in order to thoroughly document and analyze the injuries, because if the forensic doctor does not have immediate access to the injuries, these could undergo modifications making it more difficult to interpret the injury mechanism or other aspects of major medical-legal importance.

The reports of injuries must include photographs

115. As regards the content of injury reports, in the inspection visits to the prison it was noted, like in previous inspections, that photographs are not included in the reports and that in many cases the reports do not comply with the criteria specified in Paragraphs 357 of the 2010 Annual Report and 144 of the 2011 Annual Report. At the Araba/Alava prison and the women's prison of Barcelona,

following analysis of the descriptions of the injuries recorded in the medical records, it was concluded that the type, form, size, exact locations and other features of the injuries should be described more accurately in order to allow the cause to be determined. Furthermore, in the majority of the prisons inspected it was noted that the reports of injuries do not describe how the inmate explained the manner in which the injuries were caused, making it impossible to compare the inmate's statements with the doctor's observations. The Ombudsman Institution has informed the *SGIP* and the Department of Justice of the Government of Catalonia that these deficiencies must be corrected.

No specific testimony of mistreatment was recorded in the interviews of inmates

116. During the interviews of inmates at the prisons inspected, no specific testimony of mistreatment by prison staff was recorded, which could have led to taking actions with the European Gendarmerie Force (EGF) and the Public Administration. Moreover, in the course of the interviews inmates were asked about the way the prison staff treated them. The answers varied and did not allow inferring certain patterns of behavior in the prisons, although in general terms the technical team (psychologists, social workers, etc.) is the one that is best valued. Even though the majority of the inmates interviewed did not express major complaints, some made the following comments:

Inmates declared that some members of the prison staff are less respectful than others

An inmate at the prison of A Lama (Pontevedra) stated that he had not felt verbally or physically abused by anyone at the prison, although he declared that some of the staff was less respectful regarding inmates' rights, adding that: «I have never complained because I couldn't be bothered». Another inmate stated he had felt verbally abused on some occasions by members of the prison staff, but that «I've never complained because I'm afraid of the consequences because I'm classified as first degree».

At the Araba/Alava prison, an inmate declared that there were some staff members who were not respectful of inmates' rights: «Some staff members go too far and the head of service has to tell them to stop», and that the inmates had very little relations with the staff: «Here we don't have any contact with the staff, they stay in the bunker». He also declared that «for the sake of filling out reports, it's normal for the prison staff to claim that inmates do not speak to them properly». Two first degree inmates interviewed at that prison, who had been transferred there from their prisons of origin due to extraordinary leave, complained of rub-down searches performed on their relatives when the latter came to visit («these are additional measures of punishment for the family»»), although they acknowledged that the situation had improved in the last few years.

At the Murcia II prison, an inmate in the respect module stated the following: «The only problem is that they give you negative points for something that happens in the court yard, issues regarding cleanliness or something like that» and they are not informed, so that when they accumulate a specific number of negative points they are punished. She pointed out that inmates had informed the educator so the latter could take some action in that respect.

At the Ocaña II prison (Toledo), an inmate declared that «The majority of the staff members are fine. It's not that the minority is bad, but the criterion to hire personnel is not very good, so there are staff members who do not treat you the way they should, they don't know inmates' rights»; «Another issue is fear of repercussions if you file a claim or report something. People don't complain about the treatment by staff members. There is generalized fear of the consequences of reporting something...after they can initiate a proceedings against you». Another inmate stated: «Many staff members are racists, they search foreigners more, and others could care less... I don't go near the cabin».

At the women's prison of Barcelona and the prison of Alcala de Guadaira the friendly relationship between prison staff and inmates is noteworthy

Lastly, at the women's prison of Barcelona and the Alcala de Guadaira prison (Seville), the friendliness and close relationship observed between the prison staff and inmates is noteworthy, together with the positive assessment of the two prisons by the inmates.

A large variety of treatment programs has been noted

117. The number and variety of treatment programs observed at the prisons inspected varies a lot. At the Araba/Alava prison there were only three programs: drug addictions, gender violence and control of sexual aggression, the last two with very few participants, and the animal-assisted therapy program (abbreviated as *TACA* in Spanish), that was implemented at the Nanclares de Oca prison (Araba/Alava) but had been discontinued. The *SGIP* was informed that measures should be taken to increase treatment programs and re-establish animal-assisted therapy. Moreover, during the inspection visit at the Alcala de Guadaira prison (Seville) it was noted that the family mediation program for inmates and their families, which initially was carried out by the *SGIP* together with the Regional Autonomous Government of Andalusia (*[Junta de Andalucia]*, hereinafter, Government of Andalusia) and the Official Association of Psychologists, was not being implemented. In respect to the Murcia II prison, the *SGIP* has been asked for information regarding steps taken with the Official Association of Psychologists to provide specific training to three psychologists in the treatment of sexual aggressors. Lastly, the large number of treatment programs at the prison of A Lama (Pontevedra) should be highlighted.

Education and Respect Wards continue to be set up in prisons under the authority of the SGIP

118. The implementation of the Education and Respect Wards (abbreviated as *MER* in Spanish), which are referred to in paragraphs 346 of the 2010 Annual Report and 146 of the 2011 Annual Report, has continued with the implementation of programs in prisons under the authority of the *SGIP*. The most recent information that the Ombudsman's Institution has is that at 31 December 2012 the program was underway at 72 prisons (not including Social Insertion Centers), with a total of 246 respect modules and the participation of 18,799 inmates. In fact, all of the prisons inspected had at least one Education and Respect Ward and the entire Alcala de Guadaira prison (Seville) operates as such a ward, except for a few inmates who do no want to voluntarily form part of the system, who have been expelled from the module because they are in the infirmary or due to indefinite sick leave.

The Alcala de Guadaira prison (Seville) and the women's prison of Barcelona have a specific ward for mothers that is specially adapted for children

119. The Alcala de Guadaira prison (Seville) and the women's prison of Barcelona have a specific ward for mothers with children under the age of three and pregnant inmates in the last stage of gestation. In the first one, during the last inspection visit carried out in 2011 this module was closed when the Incarcerated Mothers' Unit was opened. However, in August 2012 the ward was opened again to house mothers for the purpose of properly classifying these inmates for the Mothers' Unit or this prison. In both cases, the inmates expressed their satisfaction with the treatment received in the respective centers, in particular as regards their children. Indeed, the specific feature of these modules in comparison with the other parts of both prisons is that they are appropriate for children. The rooms are decorated much like those of a normal home and are equipped with all the necessary material: cribs, furniture, curtains toys, etc. Children aged 4 to 12 months are taken care in the prisons' day care centers and those aged 1 to 3 go to outside day care centers. After the age of three, and depending on the mother's sentence, they can be transferred with their mother to a dependent unit.

A bedroom in the mothers' ward at the Alcala de Guadaira prison (Seville)

Photograph 21

Courtyard of the mothers' ward at the women's prison of Barcelona

Photograph 22

There have been complaints regarding training, sociocultural and sports activities at the prisons inspected

120. Regarding training, social, cultural and sports activities, at the Ocaña II prison (Toledo) some inmates complained that they spent a lot of time «locked up», «only six or seven hours in the courtyard (at others, ten hours), and few activities». On the other hand, the Murcia II prison stands out for the large number of activities it has. In respect to the program of activities at the Alcala de Guadaira prison (Seville), lack of which had been cause of complaint by some inmates during the 2011 inspection visit, it was noted that there were many activities and were offered all day long, although there was no sports coach, like at the women's prison of Barcelona, which should be corrected. As regards the complaint received by the Security and Justice Department of the Ombudsman Institution in connection with the alleged non-existence of a library in the women's modules of the Araba/Alava prison, the prison informed that both modules had a room that was used as a library, although some books had to be requested from the library at the multipurpose module, and that some inmates were allowed to go to said library every day.

Library at the multipurpose module of the Araba/Alava prison

Photograph 23

Measures should be taken to increase the offer of paid duties and jobs in manufacturing workshops

121. In respect to the paid activities that inmates can perform, they are given the possibility of performing paid «duties» and jobs in the manufacturing workshops. It is noteworthy that at the women's prison of Barcelona nearly half of the inmates were involved in paid activities. On the other hand, at the prisons of Araba/Alava and A Lama (Pontevedra) the total number of paid duties and jobs in manufacturing workshops, which are intended to keep inmates occupied, is limited. In consequence the *SGIP* has been informed that appropri ate measures should be adopted to increase the offer of paid duties and jobs in manufacturing workshops.

Manufacturing workshop at the Araba/Alava prison

Photograph 24

Inmates' telephone communications must be facilitated, and their privacy must be guaranteed

122. In respect to the means available to inmates to facilitate their telephone communications, at the Araba/Alava prison it was noted that some telephones in the modules did not have elements to ensure the privacy of an inmate making a phone call, which should be corrected, in line with what was pointed out in paragraph 150 of the 2011 Annual Report. Said paragraph mentioned this same deficiency in respect to the Alcala de Guadaira prison (Seville). In the course of the follow-up inspection made in 2012, it was noted that partitions had been installed in order to preserve the privacy of telephone conversations. Moreover, at the women's prison of Barcelona inmates stated that there existed a problem of compatibility between the Spanish telephone company *Telefonica* and the telephone companies of the Dominican Republic and Nigeria, which was confirmed by the Director. Due to said incompatibility, the inmates from these countries were unable to communicate with their families with the prison's telephones. This Institution has addressed the Department of Justice of the Government of Catalonia expressing the need to resolve this situation as soon as possible.

The Prison Orientation and Legal Aid Service has been suspended in Andalusia

123. During the inspection visit to the Alcala de Guadaira prison (Seville), information was provided regarding suspension in Andalusia of the Prison Orientation and Legal Aid Service (abbreviated as *SOAJP* in Spanish), which existed pursuant to a three party agreement between the Ministry of the Interior, the Department of Justice of the Government of Andalusia and the Andalusian Council of Bar Associations *(Consejo Andaluz de Colegios de Abogados),* matter which is currently being investigated by the Security and Justice Department of the Ombudsman Institution.

Training for prison staff has to be broadened

124. In reference to prison staff, it is necessary to highlight the need to extend their training to the different areas that could affect their work, and in general regarding the guarantees for the protection of human rights in carrying out their functions. Likewise, it is recommended that all personnel receive training in ba-

sic life support measures and regular training courses in the correct application of security and restraint measures. Likewise, given that mental disorders are the most prevalent health problems of prison populations, the possibility of implementing a training program for prison staff in mental health and drug addiction should be considered. Lastly, appropriate prison staff should be trained in the detection and documentation of cases of physical abuse, and specifically trained in the Istanbul Protocol.

Prison staff members must wear their obligatory identification

125. At the Alcala de Guadaira (Seville) and Murcia II prisons it was noted that some staff members were not wearing obligatory identification specifying their job and professional ID number, which has been reported to the *SGIP*.

It has been detected that prices in prison commissaries are 20% to 30% higher than on the outside

126. During the inspection visit to the Ocaña II prison (Toledo) some inmates complained about the prices at the prison commissary. After comparing the list of prices provided by the prison management with those of some national supermarket chains, it was confirmed that in many cases commissary prices were in fact 20% to 30% higher than outside prices. This entails an additional burden for inmates, many of whom lack economic resources. This concern has been forwarded to the *SGIP* for assessment.

During transfers, inmates must be allowed to carry sufficient belongings and access to proper lavatory facilities to clean themselves

127. During one of the interviews held at the Araba/Alava prison, an inmate declared that he had travelled for 11 days from the Albolote prison (Granada) for a family visit, with very few belongings, and that during the overnight stays at different prisons he was not allowed access to his clothes or to have a shower. In this respect, the *SGIP* has been informed that the necessary measures must be adopted to enable inmates to travel with enough belongings depending on the length of the transfer, and if fitting, until their return to the prison of origin and to allow them to access said belongings and proper lavatory facilities.

The Government of Catalonia has computerized personal files

128. The good practices that should be highlighted include the computerization of personal files by the Directorate General for Penitentiary Services *(Dirección General de Servicios Penitenciarios)* of the Government of Catalonia, as noted at the women's prison of Barcelona, and the Intranet at the Araba/Alava prison, where updated information regarding the prison's most important matters is available (occupancy, register of disciplinary proceedings, register of application of restraining measures, incidents, etc.).

Public transport must be provided to travel to prisons

129. The issue of transport facilities to the prisons was highlighted in paragraph 153 of the 2011 Annual Report. In respect to the Murcia II prison, the SGIP has been asked for information regarding steps taken by the Murcia Region Transportation Agency to provide public transport to the prison, given that at the time of the inspection visit relatives had to drive by car or by taxi from Alcantarilla or the city of Murcia, entailing a cost of about 20€ or 25€ respectively.

In respect to the Araba/Alava prison, the Alava Provincial Council has tried to mitigate the lack of public transport to the prison by hiring a taxi whenever necessary to drive an inmate or relative to the prison for a cost of 1.75 €.

The conditions of the different types of rooms at new prisons have improved

130. Improvement of the architecture of recently built prisons, such as the prisons of Araba/Alava and Murcia II, is evidenced in numerous details, in particular enlarging cells from 10 to 13 m^2, resizing the common areas of the modules (dining room, TV room, etc.), new productive cooking and gardening workshops, a canopy to facilitate internal circulation and to allow inmates to be covered when going from one building to another, and elimination of the surveillance tower.

Cell at the Murcia II prison

Photograph 25

Canopy at the Araba/Alava prison

Photograph 26

In general the state of conservation of the facilities at the prisons inspected is acceptable

131. In general, the conditions of the facilities at the prisons inspected are acceptable. However, at the prison of A Lama (Pontevedra), the women's prison of Barcelona and the prison of Ocaña II (Toledo), inmates complained about room temperatures and of the water in the showers, complaint which has been referred to the *SGIP* and the Department of Justice of the Government of Catalonia, for assessment and subsequent adoption of appropriate measures, in accordance with the content of paragraphs 328 of the 2010 Annual Report and 157 of the 2011 Annual Report. Furthermore, at the Ocaña II prison (Toledo) some of the inmates interviewed complained that since the showers of the modules were located in the courtyard, in the winter they had to shower out in the cold, where there was a lack of security and it was difficult to warn prison staff in case of fights. They also complained that the water of the showers in module 7 was cold. The complaints were forwarded to the *SGIP* for verification and if fitting, to have measures adopted to correct the deficiencies.

The Araba/Alava prison had cracks due to subsidence of the terrain

At the Araba/Alava prison, inspectors were informed that even though it had been opened recently, subsidence of the terrain had caused cracks, disadjustments of doors, etc. Furthermore, other aspects of infrastructures that had been cause of complaints to this Institution's Security and Justice Department were noted, although the natural light was not deemed insufficient and the courtyards of the infirmary and women's modules were not considered to be small.

Courtyard of one of the women's modules at the Araba/Alava prison

Photograph 27

Lastly, at the Ocaña II prison no hoses, alarm switches, standalone fire-fighting equipment, smoke alarms, door signs or automatic door opening system were seen, which must be corrected.

III.2. Centers for Juvenile Offenders

In 2011 17,039 final judgments were entered in the Central Registry of Criminal Liability Judgments against Minors

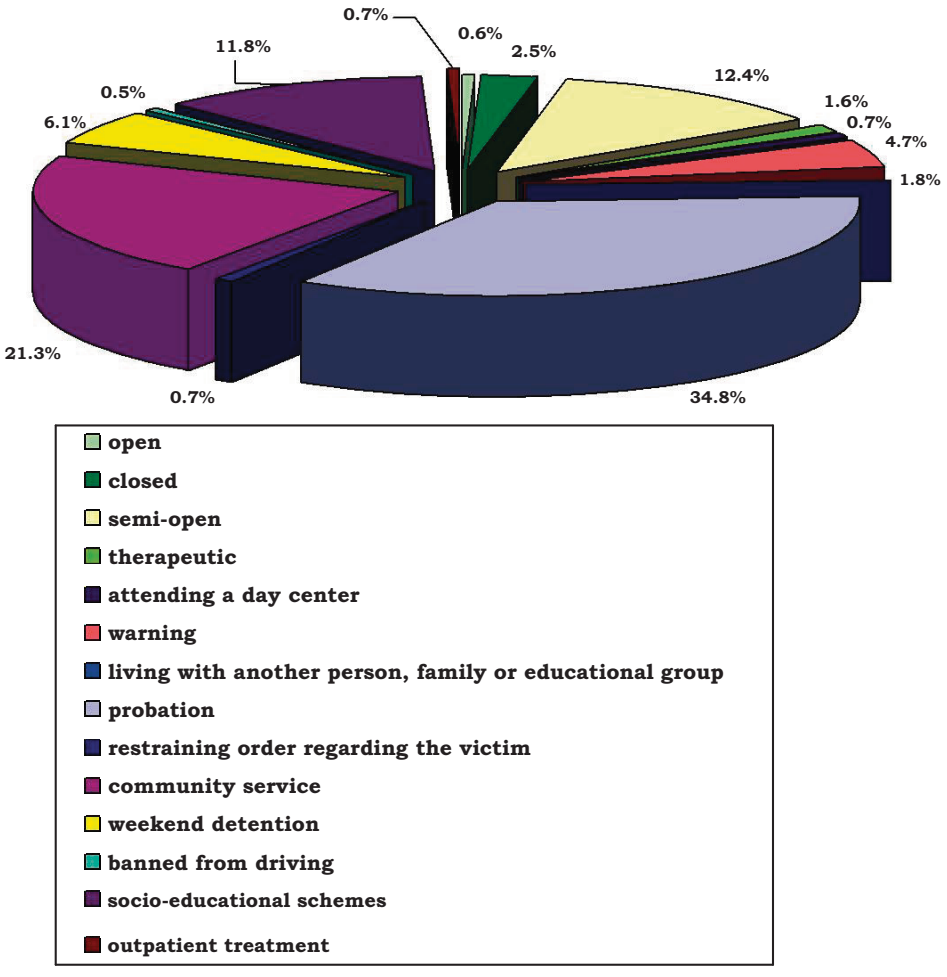
132. According to a study carried out by Spain's National Statistics Institute (abbreviated as INE in Spanish) published in September 2012, in 2011 a total of 17,039 final judgments were entered in the Central Registry of Criminal Liability Judgments against Minors *(Registro de Sentencias de Responsabilidad Penal de los Menores)*, entailing a 6.6% decrease in respect to 2010. The number of minors between the ages of 14 and 17 per 1,000 inhabitants in the same age range that were convicted was 9.72, compared to 10.22 in 2010. By sex male minors committed 85.1% of the infractions and females 14.9%.

In 2011 judges adopted 23,718 legal measures, which entailed a decrease of 5.4% in respect to the previous year.

Legal measures imposed on minors in 2011

133. The tables which appear below refer to the measures imposed by the courts on juvenile offenders on the basis of national and regional data for 2011 contained in the last statistics published by the Spanish National Statistics Institute. The following graph presents in greater detail the different regimes of custodial measures that affect the right to liberty.

Figure 5. Type of legal measures imposed on minors in 2011



Source: In-house compilation based on data taken by the National Statistics Institute from the Central Registry of Criminal Liability Judgments against Minors.

Table 34. Legal measures adopted in regional autonomous communities and cities in 2011, according to the type of custody

Regional Autonomous Communities	Open custody	Semi-open custody	Closed custody	Therapeutic custody in closed, semi-open and open regime
Andalusia	26	542	35	92
Aragon	0	69	8	15
Principality of Asturias	0	90	3	1
Balearic Islands	3	139	16	3
Canary Islands	4	66	5	49
Cantabria	0	18	4	7
Castile-La Mancha	27	113	24	21
Castile y León	14	92	9	9
Catalonia	10	349	304	24
Ceuta	0	28	10	3
Community of Valenciana	7	634	57	49
Extremadura	0	41	2	2
Galicia	10	159	28	25
La Rioja	0	23	1	1
Community of Madrid	8	250	43	45
Melilla	1	26	4	9
Murcia	24	171	26	2
Navarre	0	20	0	3
Basque Country	5	107	8	8
TOTAL	**139**	**2,937**	**587**	**368**

Source: In-house compilation based on data taken by the National Statistics Institute from the Central Registry of Criminal Liability Judgments against Minors.

Table 35. Measures adopted in 2011, according to the type of custody and sex

	Open custody	Semi-open custody	Closed custody	Therapeutic custody in closed, semi-open or open regime
Males	122	2.705	564	314
Females	17	232	23	54
TOTAL	**139**	**2,937**	**587**	**368**

Source: In-house compilation based on data taken by the National Statistics Institute from the Central Registry of Criminal Liability Judgments against Minors.

Table 36. Measures adopted in 2011, according to the type of custody and nationality

	Open custody	Semi-open custody	Closed custody	Therapeutic custody in closed, semi-open and open regime
Spaniards	118	2,045	287	298
Foreigners	21	892	300	70
TOTAL	**139**	**2,937**	**587**	**368**

Accusations and complaints regarding alleged mistreatment in centers for juvenile offenders

134. The next table shows the information provided by Regional Autonomous Communities and Cities regarding accusations or complaints they received in 2012 for alleged cases of torture, mistreatment or cruel and humiliating treatment suffered by minors in custody in detention centers for juvenile offenders.

Table 37. Accusations and complaints in 2012 for mistreatment in centers for juvenile offenders

JUVENILE CENTERS		
Regional Autonomous Community or City	**Information**	**Accusations/ Complaints**
Andalusia	«Tierras de Oria» Center. One accusation: by an adolescent and his mother against a female worker for coercion. The judgment dismissing the accusation was appealed and ratified by the Provincial High Court. «Bahía de Cadiz» Center. One accusation: by an adolescent against a worker for taking advantage of his position as counselor to obtain sexual favors. The case was resolved by dismissing the worker. Court proceedings are currently underway. «Cantalgallo» Center. One accusation: by a female adolescent due to actions by staff. Referred to the Juvenile Court and stay of proceedings. «El Molino» Center. 2 accusations: by two minors against two security guards for aggression. The internal investigation did not find indications to confirm veracity, but a disciplinary file was opened against the workers due to deficiencies in communicating the incident. The incident is being investigated by the court. «El Molino» Center. 1 complaint: by the mother of a minor for inadequate medical care. Reports were requested and the diagnosis was verified, with no evidence of lack of care.	5
Aragon	No accusations.	0
Principality of Asturias	No accusations.	0
Canary Islands	3 complaints/accusations that could be considered to be humiliating treatment, insults and/or rudeness.	3
Cantabria	No accusations.	0

JUVENILE CENTERS		
Regional Autonomous Community or City	**Information**	**Accusations/ Complaints**
Castile-La Mancha	No accusations.	0
Castile y Leon	No accusations.	0
Catalonia	No accusations of mistreatment. 2 disciplinary proceeding opened against employees: «Els Tillers» Center for aggression against a minor in custody. A resolution was issued rescinding appointment of the temporary employee and the sanction is pending execution. «L'Alzina» Center for allegedly allowing and encouraging that a minor in custody hit others in the context of an organized activity as an alleged form of motivation. The proceeding is in the investigation phase.	0
Extremadura	3 accusations. «Vicente Marcelo Ness» Center (Badajoz). The corresponding judicial proceedings have been initiated (two are in the investigation phase); in one of the administrative actions consisted of temporary suspension of the staff member's job and salary.	3
Galicia	No accusations.	0
Balearic Islands	1 accusation against a security guard reported to the Civil Guard, Public Prosecution and Juvenile Court. No information has yet been obtained regarding the outcome.	1
Community of Madrid	2 accusations: One against an educator for insults and rudeness, filed away by a ruling of the Court. An accusation by a father on behalf of his underage son in custody in a center, pending judicial resolution.	2
Region of Murcia	No accusations	0
Chartered Community of Navarre	No accusations.	0
Basque Country	No accusations.	0
La Rioja	No accusations.	0
Community of Valencia	No accusations.	0
Aut. City of Ceuta	5 accusations reported to the Juvenile Court.	5
Aut. City of Melilla	No accusations.	0

In 2012 three centers for juvenile offenders were inspected

135. In 2012 three centers for juvenile offenders were inspected. The center «Teresa de Calcuta» in Brea de Tajo (Madrid) is the center in Spain with the largest capacity. The «Zambrana» center in Valladolid is the only one for juvenile offenders in the Community of Castile y Leon for serving closed regime custodial measures. These two centers are equipped with specific units for the therapeutic custody of minors. Lastly, an inspection visit was made to the «Las Palmeras» center in Madrid, which is for minors serving custodial measures in semi-open

and open regimes imposed on pregnant minors or who have children under the age of 3 in their care.

Figure 6. Geographic location of centers for juvenile offenders inspected in 2012

All of the inspection visits were multidisciplinar

136. All of the inspection visits were carried out by multidisciplinary teams comprising external specialists, experts in psychiatry and psychology, some of them specialized in child psychiatry. The inspection visits to the «Teresa de Calcuta» and «Zambrana» centers, which have the biggest occupancy, were carried out over a period of two days. During the inspection visits interviews were held with the management teams and staff members. Private interviews were also held with minors on a voluntary basis. In addition, at the «Teresa de Calcuta» center self-administered questionnaire-interviews were handed out to the minors and to the psychologists, educators, social workers and technical intervention assistants (abbreviated as *TAI* in Spanish). Moreover, the documents regarding minors at the centers were reviewed, including procedures used in handling the minors and legal and administrative measures established and applied at the centers, log books, personal, disciplinary and medical files, internal rules and regulations, etc. The «Teresa de Calcuta» and «Zambrana» centers were inspected without prior notice. The «Las Palmeras» center, however, was informed in advance of the inspection given that in this case the NPM was accompanied by a delegation from the Armenian Ombudsman Institution, which is participating in the TAIEX (JHA IND/STUD 50469) project organized by the European Commission.

Private organizations intervene in the management of the three centers inspected

137. The «Teresa de Calcuta» center was created as a result of a collaboration agreement entered into in 2005 by the Agency of the Community of Madrid for the Re-education and Reinsertion of Juvenile Offenders *(Agencia de la Comunidad de Madrid para la Reeducación y Reinserción del Menor Infractor)* and the Association for Social Integration Management (abbreviated as GINSO in Spanish) for the construction and subsequent management of a Center for the Enforcement of Judicial Measures *(Centro de Ejecución de Medidas Judiciales)*. The «Zambrana» center is publicly owned and managed, although not all personnel are civil servants or employees of the Regional Autonomous Government of Castile y Leon (hereinafter, Government of Castile y Leon). Staff members of the *Fundación Grupo Norte, Prosintel* and *Grupo Lince* also work at the center. The «Las Palmeras» center is publicly owned and is managed by the foundation Padre *Garralda-Horizontes Abiertos*.

Occupancy of the centers inspected

138. The following table shows the capacity of each center inspected and the number of places that were occupied on the days of the inspection:

Table 38. Places and occupancy of the centers for juvenile offenders inspected

Centers inspected	Number of places	Occupancy
«Las Palmeras» Center for Incarcerated Minors (Madrid)	14	11
«Teresa de Calcuta» Center for Incarcerated Minors (Brea de Tajo, Madrid)	182*	97**
«Zambrana» Center for Incarcerated Minors (Valladolid)	69	66***

* The Autonomous Community subsidizes 140 places.
** 5 were female.
*** 7 were male.

Distribution according to the custodial regime ordered

139. The distribution of minors in custody in the different centers according to the type of custody ordered and the type of judicial resolution was the following:

Tables 39-41. Custodial regimes and type of judicial resolution of minors in custody in centers for juvenile offenders inspected

«Las Palmeras» Center for Incarcerated Minors	
Custodial regime	**N.º minors**
Mental health therapeutic regime	2
Open regime	1
Semi-open regime	8
Judicial resolution	**N.º minors**
Final	8
Preventive	3

«Teresa de Calcuta» Center for Incarcerated Minors	
Custodial regime	**N.º minors**
Therapeutic regime	24
Semi-open regime	21
Closed regime	52
Judicial resolution	**N.º minors**
Final	75
Preventive	22

«Zambrana» Center for Incarcerated Minors	
Custodial regime	**N.º minors**
Therapeutic regime	4
Open regime	3
Semi-open regime	45
Closed regime	12
Weekend regime	2
Judicial resolution	**N.º minors**
Final	55
Preventive	11

Sociodemographic profile

140. The sociodemographic profile of the minors in custody in the three centers inspected was the following:

Tables 42-44. Sociodemographic profile of the minors in custody in the centers for juvenile offenders inspected

«Las Palmeras» Center for Incarcerated Minors	
Gender	
Females	11 (100%)
Nationality	
Spaniards	6 (55%)
Foreigners	5 (45%)

«Las Palmeras» Center for Incarcerated Minors	
Age	
Under 18	9 (82%)
Over 18	2 (18%)

«Teresa de Calcuta» Center for Incarcerated Minors	
Gender	
Male	92 (94%)
Female	5 (6%)
Nationality	
Spaniards	32 (33%)
Foreigners	65 (67%)
Age	
Under 18	62 (64%)
Over 18	35 (36%)

«Zambrana» Center for Incarcerated Minors	
Gender	
Male	59 (89%)
Female	7 (11%)
Nationality	
Spaniards	53 (80%)
Foreigners	13 (20%)
Age	
Under 18	36 (54%)
Over 18	30 (46%)

141. With the exception of two cases, all of the minors in custody were wards of the juvenile courts located in the same autonomous community as the center in which they resided and region in which their families lived. Of the two exceptions mentioned, one involved a female minor in custody at the «Las Palmeras» center in Madrid, whose transfer to the center had been authorized to serve a sentence issued by the Juvenile Court of Guadalajara because her mother had moved to Parla (Madrid). The other case involved a male at the «Zambrana»

Except for two cases, all of the minors in custody were wards of the Juvenile Courts located in the same autonomous region as the center and as the minor's family residence

center in Valladolid who was serving a custodial measure in the semi-open regime imposed by the Juvenile Court of Tarragona but whose family lived in Castile y Leon. At the «Teresa de Calcuta» center there was a female minor whose family lived in the Canary Islands but who was in custody at that center because the offense had been committed in Madrid and she was a ward of a Juvenile Court in Madrid. Although almost all minors in custody were serving measures in centers located in the same autonomous community where their families lived, note must be taken that the «Zambrana» center is the only one where minors can serve custody measures in a closed regime in an Autonomous Community consisting of 9 provinces. It is thus difficult to avoid having minors with ties to a city having to serve their custodial measures far away from it, contrary to the reiterated proposal made by the Ombudsman Institution since September 2002 and recently in paragraph 169 of the 2011 Annual Report.

Deficiencies in the video surveillance systems were detected in respect to coverage of the cameras, recordings, conservation and access, and also the locations for viewing monitors

142. None of the centers inspected were fitted with video surveillance systems that fully complied with all the characteristics that this Institution has repeatedly considered necessary, as mentioned in paragraphs 236, 395 and 477 of the 2010 Annual Report and paragraphs 171 of 172 of the 2011 Annual Report, in respect to field of coverage of the cameras, image and audio recordings and their activation, conservation and access protocol, or the locations for installing viewing monitors. In effect, at the «Teresa de Calcuta» center the video surveillance system did not cover all common areas and there was no protocol for the recording, custody and extraction of incidents. The field of coverage of the video surveillance system at the «Zambrana» center did not include all common areas either, and there were no recordings. Lastly, the «Las Palmeras» center did not have any type of video surveillance at all.

Video surveillance monitors at the «Zambrana» center

Photograph 28

143. The admissions or reception procedure is sufficiently documented, all centers having a log book to note the identity, date and time of admissions, judicial authority ordering the measure, reasons for the admission, personal data of the minor's lawyer, and subsequently, transfers and release, with a personal file opened for each minor. As indicated in paragraph 177 of the 2011 Annual Report, once minors have served their custodial measure, no record of the file is to be kept at the center. This, however, is not the case at the «Zambrana» center, where the personal files are stored when minors are released, the reason given being that since it is publicly owned its facilities can be used to store said files.

It was noted that the admissions or reception procedure is sufficiently documented

144. At the three centers inspected, when a minor is admitted, a thorough assessment of his/her medical and psychological aspects is performed. When minors are admitted to the «Teresa de Calcuta» center they are kept two to seven days in the admissions and classification phase. During this time they are in a situation comparable to that of separation from the group. Even though they are not taken to a specific unit, they have to stay in their room within the unit corresponding to their regime and can only go outdoors when the other juveniles in custody are not there, having to take part in the assessments required by the center's different professionals. During this period of time they do not participate in activities.

On admission, the minor's medical and psychological aspects are fully assessed

Interior of a room at the «Teresa de Calcuta» center

Photograph 29

Photograph 30

At the «Zambrana» center, the stay in the admissions unit can last a maximum of three days

At the «Zambrana» center, the stay in the Admissions Unit can last a maximum of three days, although normally it is shorter. Of the files examined at random, in approximately 25% it was noted that most minors were assigned to a specific unit the same day they were admitted or the day after, with only 4.5% of minors having spent three days in the said Admissions Unit.

Interior of a room at the «Zambrana» center

Photograph 31

Photograph 32

Interior of a room at the «Las Palmeras» center

Photograph 33

Photograph 34

The criteria for the distribution of minors vary from one center to another

145. Given the structure and layout of the building at the «Las Palmeras» center, there are no physically separated units or groups, and the 12 bedrooms for minors are located along two parallel hallways on the first floor of the building, which is used exclusively to house these bedrooms. Despite the fact that it is impossible to physically separate minors in different units, they are separated according to the educational group to which they are assigned. These educational groups include the following: the reception group, the educational development groups from one to four and the final group. The distribution of units or groups at the «Teresa de Calcuta» center and the accommodation of minors in each one correspond to the Internal Stage Classification Program followed. These stages consist of an initial stage, observation stage, development stage and final stage. Each one of them has specific guidelines or requirements to advance to the next stage or to be demoted, depending on the regime in which minors are in custody, in other words a closed, semi-open or open regime. This system of promotion and incentives allows minors with the greatest problems of self-control to have a more adapted observation area that is better suited to their real capacities and needs. At the «Zambrana» center, the fundamental criteria for the distribution and placement of minors in units with other minors is age and their cognitive and personality development. The center has nine units, which are either residential or coexistence units and non-residential units. There are eight residential units, consisting of four units for boys, one unit for girls, one therapeutic unit and one admissions unit.

When they are admitted, minors are given information on their rights and obligations, general organization matters and operating and disciplinary rules

146. On being admitted to a center, all minors are given written information regarding their rights and obligations, general organization matters, operational rules, disciplinary regulations and means for lodging requests, complaints or appeals. These informative booklets are available in several languages in the two centers of the Community of Madrid, but not at the «Zambrana» center in Valladolid, contrary to the content of paragraph 176 of the 2011 Annual Report. In the course of an interview of a minor in the center's Admissions Unit, who had been admitted three days before, the minor stated that he had been properly treated at all times but it was noted that he had not been given the Information

Booklet with the center's regulations, and he said that he was not aware of said booklet. The educator on duty in said unit was asked about this matter, but was unable to satisfactorily explain why this minor did not have a copy of said booklet in his room, even though there was a copy in the educator's office.

The only center that informs minors of the habeas corpus procedure is «Zambrana»

147. The «Zambrana» center is the only one that gives minors, when they are admitted, verbal information of the possibility of filing proceedings of *habeas corpus,* but none of the three centers provides information of this right in writing, contrary to the proposal made in paragraphs 476 of the 2010 Annual Report and 176 of the 2011 Annual Report.

The lack of documents of some foreigners, or the difficulties encountered to provide them with documents, is a source of concern

148. Once minors have been formally admitted, the admission is reported to the juvenile courts, the Spanish Public Prosecutor's Office, the minor's legal guardians, the corresponding department of the regional autonomous community and the consular authorities in the case of minors who are foreigners. However this last notification is not performed at the «Zambrana» center, contrary to the statement expressed in paragraph 178 of the 2011 Annual Report. In respect to minors and adolescents of foreign origin the lack of documents for some of them is a source of concern, together with the difficulties centers have to obtain said documents. As pointed out at the «Teresa de Calcuta» center, this has led to a paradoxical situation whereby some minors, whether wards of the autonomous region or not, remain undocumented during their stay at the center and even lack any documentation when they are released after serving the custodial measure imposed, impeding their integration in society, as highlighted in paragraph 193 of the 2011 Annual Report.

Filling out the Logs or Registries correctly is essential

149. Centers must have Registries or Logs in which to record specific actions or incidents, and must register the latter properly, in order to control and assess the center's day-to-day operations.

The «Teresa de Calcuta» center does not have a Record of complaints

150. The «Teresa de Calcuta» center provides minors in custody with information on their right to lodge complaints with the center's director or the competent authorities outside the center. However, the center does not have a Record of Complaints in which minors can address their requests or complaints to the center's director, to judicial authorities, to the Ombudsman Institution or to other similar institutions in the Community of Madrid, as stated in paragraph 204 of the 2011 Annual Report. Even though the center has a system for the participation of minors in internal group and module meetings, the system is not meant to replace the possibility of having properly established channels for individual complaints (suggestion boxes, official forms to file complaints or suggestions). During the interviews several minors in custody mentioned that they had tried to process complaints in writing and they had been discouraged from doing so and encouraged to communicate the complaints verbally. The «Las Palmeras» center does not have a Record of Complaints, although it does have standard forms for making allegations, petitions and complaints that are kept in the records, in which there was evidence of the director's refusal or authorization. This center

also lacks computer records of disciplinary proceedings and application of restraint methods and personal searches, making it impossible to store, process, and sporadically consult data and to prepare reports and statistics regarding these matters. A recommendation was made to have these deficiencies corrected. The «Zambrana» center has a computerized Record of requests, complaints and appeals where the ones made in writing and presented in open or closed envelopes are recorded, but not the ones submitted verbally. On consultation of this Record, it was noted that 210 requests, complaints or appeals had been made since 1st of January 2012 until the day prior to the inspection visit, of which 45 were submitted in closed envelopes, and that when they were submitted in open envelopes the content appeared in the section of the form labeled as «Matter».

The «Zambrana» center has a Record of means of restraint

151. The «Zambrana» center also has Record of means of restraint, in which it was noted that from the 1st of January 2012 until the day of the inspection visit, only personal restraint (on 91 occasions) and physical restraint (on 56 occasions) were recorded. The Record does not indicate, in any of the interventions except one, that temporary separation had to be employed, even though the computer program used to record the interventions does have that option. Several reports of incidents were randomly examined and it was noted that temporary separation in the area of the center specifically intended for that purpose was not infrequent, as confirmed by the minors interviewed, some security guards and members of the management team. The latter justified the fact that it did not appear in the Record of means of restraint because it was considered an «educational measure» or «a measure to distance the minor from the others until he/she calmed down following an incident», not comparable to a real separation.

According to the annual report of the «Teresa de Calcuta» center, in 2011 90 physical restraints were performed

The 2011 Annual Report of the «Teresa de Calcuta» center contains references to 90 physical restraints (64 in units where minors live together and 26 in the therapeutic unit), as well as 317 separations from the group. According to these figures, approximately one out of three minors in custody in units where minors live together and one out of two in therapeutic units have been restrained. The structured interviews carried out by the external specialists with the minors revealed considerably higher figures of minors who said they had been restrained in the course of the past month, indicating either that not all restraints are recorded by the center, or discrepancies regarding what is considered to be a restraint, with the ones not considered as such recorded administratively, and what the minors declare in the interviews as a restraint. However, it was not possible to establish the exact manner in which restraint statistics are determined in order to verify their reliability.

At the «Las Palmeras» center there is no Registry to record the application of restraint measures, although a report is drafted and attached to the minor's personal file

At the «Las Palmeras» center there is no Registry of application of means of restraint, although a report is drafted and included in the minor's personal file, as verified. The director informed the inspection team that since the center was opened, restraint had only been applied on five occasions, two years ago, to two female minors (three times on one and twice on the other). Personal restraint is always applied by an intervention assistant technician and if necessary the assis-

tance of external security personnel is requested. When preventive separation from the group is applied an educator is always with the minor. In the 2011 Annual Report it states that no means of restraint were used that year (personal physical fixation, rubber baton, physical fixation or temporary separation from the group) and in 2012 preventive separation was used as a means of restraint on two occasions, namely on the 7th of June and the 25th of November. This information in respect to 2011 and 2012 was confirmed by the female minors interviewed.

During the inspection visit of the facilities at the «Teresa de Calcuta» center, the file of an adolescent who died at the center was examined

152. As mentioned, according to the 2011 Annual Report of the «Teresa de Calcuta» center, separation from the group was used 317 times, of which 105 was as a preventive solitary confinement measure. During the inspection visit to that center, the file of a minor who died there of sudden cardiac arrest at dawn on Saturday, July 9th 2011, while serving a weekend custodial measure, was examined. At the time he was admitted to the center he suffered several episodes of «anxiety attacks» and a situation of conflict with the security personnel, as a result of which he had to be overpowered twice by applying means of physical and mechanical restraint and provisional solitary confinement in a room, where he apparently remained alone and shackled for an indeterminate period of time, without surveillance or the presence of educational or security personnel, passing away in said room. In the file there is no evidence that a physician, psychologist or psychiatrist examined the minor at the time of admission or when it was resolved to apply the restraint and provisional solitary confinement. There are no clinical notes by a professional who may have examined the adolescent at that moment or that certify that the symptoms he had corresponded to anxiety. No request was made for a medical assessment of the symptoms, in accordance with appropriate medical practice. As a result of the death preliminary proceedings were initiated by a Court of First Instance and Magistrates' Court of Arganda del Rey, in which it was resolved to provisionally stay and shelve the proceedings, due to lack of evidence that the actions taken by staff of the center could be the cause of the death. At present, the center has a daily observation Record in each module where it was confirmed that a psychologist or educator passes by to speak to a minor in separation at least once every three hours and the doctor visits the minor every day. In the interviews with educators, it was noted that they do not have formal training in crisis intervention and that the psychologists do not intervene unless the educator wishes *a posteriori* to consult them regarding an incident and receive feedback, or if it is discussed at a coordination session.

A suggestion was made to the Community of Madrid to have protocols drafted regarding the simultaneous use of means of restraint and provisional solitary confinement

In order to prevent that an incident similar to the one described occur again in the future, the Ombudsman Institution has suggested to the Ministry for the Presidency, Justice and Spokesperson of the Community of Madrid *(Consejería de Presidencia, Justicia y Portavocía del Gobierno)* that protocols be drafted regarding the simultaneous use of means of restraint, such as physical restraint, mechanical fixation and provisional solitary confinement on minors in custody in centers for juvenile offenders. These protocols must carefully determine the manner in which staff members should act in these cases, and if necessary, re-

quire great care with the surveillance and control of minors in solitary confinement, including examination by a physician and that they be accompanied during the period of solitary confinement and as long as their state of anxiety persists, in particular in the case of minors who are physically immobilized, situation which must be permanently supervised, preferably by health care personnel.

Rooms for solitary confinement at the «Teresa de Calcuta» center are similar to those in other centers

The rooms for provisional solitary confinement and separation from the group at the «Teresa de Calcuta» center are similar to the other rooms. The main differences are that they do not have shelves, a partition wall separating the lavatory, curtains or night table. The beds in these rooms are dangerous because the mattresses are loose, exposing the bed's metallic corners, with which adolescents seeking to hurt themselves could cause serious injuries. This should be avoided, in accordance with the criteria upheld in paragraphs 47 and 208 of the 2010 Annual Report and 189 and 202 of the 2011 Annual Report.

Special room for solitary confinement or separation from the groups at the «Teresa de Calcuta» center

Photograph 35

At the «Zambrana» center, the punishment of separation from the group is enforced in special rooms

At the «Zambrana» center, the punishment of separation from the group is enforced in one of the two specific rooms existing for that purpose in the center. These rooms have the same features as the minor's own bedroom and are located in an area which also has its own courtyard where the punished minor can spend two hours a day outdoors, a dining room and a living room. In the disciplinary files with a punishment of separation from the group that were examined, it was noted that all of them contained a medical report issued prior to fulfillment of the punishment, regarding whether or not there existed drawbacks to have the minor remain separated from the group. Likewise, it was observed that the psychologist monitors the separation daily, noting in writing the day and time of the visit and the minor's state of health. In addition to the psychologist's follow-up, the education team drafts a report containing daily morning and afternoon notes regarding fulfillment of the sanction, which are also included in the file.

The «Las Palmeras» center has special rooms for separation from the group punishments

At the «Las Palmeras» center there is a special room, namely individual room n.º 2, for separations from the group, located along the same hallway as the other rooms. This special room has features that are identical to the others, except that it does not have a folding table or night table, and the closet has no door. The room has a lot of natural and artificial light and a bell to call for help if necessary.

The «Teresa de Calcuta» center does not have a specific record book for personal searches

153. In respect to personal searches, at the «Teresa de Calcuta» center inspectors were informed that whenever a minor returns from an outing or on admission to the center, a superficial search is performed. It is not considered a full-body strip search because the minor remains covered with a towel. Different testimony given by minors in custody indicated that on occasions they are left totally nude with exploration of body cavities (mouth and rectal area) being conducted by the technical intervention assistants without the presence of medical personnel. This was confirmed by staff members, who acknowledged that sometimes body cavities were examined because on at least one occasion they discovered that an adolescent was trying to introduce a non-authorized substance in that manner, which was reported to the Judge. Even though personal searches are common, the center does not have a specific log in which to note when these searches are performed, the cause, person in charge, director's authorization and intervention of medical personnel, if fitting, notification to the Judge if appropriate, as well as notification of incidents, as indicated in paragraphs 407 of the 2010 Annual Report and 183 and 184 of the 2011 Annual Report, and article 54.6 of the Regulations of Juvenile Criminal Liability Organic Law 5/2000, of 12th January. It was noted that on occasions the personal search is performed by a technical intervention assistant without any other staff member present. The intervention is not recorded and there is no external monitoring to prevent potential abuses of authority or situations of conflict. In consequence, it is essential to ensure that personal and property searches are always performed in the presence of an educator or of the coordinator, as provided in the aforementioned paragraphs.

Due processing of disciplinary proceedings

154. On examining the disciplinary proceedings at the three centers it was noted that they are properly processed and that only three to four days go by from the time the procedure is initiated until it is resolved. In general terms, the policy regarding application of the disciplinary regime at «Teresa de Calcuta» offers full guarantees. An example of said policy is that minors are informed of their right to appeal punishments imposed on them to the Judge. Analysis of the documentation revealed that about 15% of minor sanctions, 23% of serious sanctions and 40% of very serious sanctions are appealed, with the Judge partially allowing 9% of the serious sanctions and 36% of the very serious sanctions.

Delays in responding to reprehensible behavior are detrimental for the pedagogical value of the sanction imposed

In contrast to what happens in other centers, where filing an appeal does not stop fulfillment of the sanction, at «Teresa de Calcuta» application of the punishment is suspended until the resolution is received, which takes from one to three weeks. This period of time is detrimental for the pedagogical value of the measures, given that sanctions are effective in accordance with the immediacy between the act and its consequence, which helps the minor associate both and not simply consider the sanction as punishment. Given that legal criteria with due guarantees must prevail over educational criteria, it is advisable in this sense that the judicial proceedings be speeded up to allow for a faster response and thus maximize the educational value of the sanctions. In this sense, in reviewing the disciplinary proceedings at the «Zambrana» center, it was noted that in some cases more than 30 or 40 days

had passed from the day on which the infraction was committed until the resolution was adopted to initiate the procedure. In such cases there is failure to comply with the immediacy that should exist between the time the infraction is committed and the disciplinary reaction with the corresponding sanction.

The «Las Palmeras» center does not have a computerized registry of the application disciplinary regimes

As mentioned, the «Las Palmeras» center does not have a computerized registry of the application of the disciplinary regime. In consequence, during the inspection the Deputy Director drafted a list of the 21 disciplinary procedures initiated in 2011 from the January 1st to December 18th. On examining said list, it was noted that all procedures had been initiated as a result of infractions classified in Article 63 of the Regulations (serious infractions). Moreover, it was noted that the 2011 Report contained information on the following disciplinary procedures: 1 due to a very serious infraction, 16 for serious infractions and 163 for minor infractions. According to the Deputy Director, this difference in the figures between the two consecutive years was due to the fact that the data used to draft the 2012 list were obtained from information in the procedures initiated for very serious and serious infractions, which are notified to the Judge, Public Prosecutor and the Agency. This information is easy to obtain, which is not the case in respect to minor infractions.

The balanced application of a disciplinary regime and of educational corrections is advisable

155. Paragraph 188 of the 2011 Annual Report already expressed concern regarding the large number of disciplinary procedures applied in some centers, to the detriment of the application of educational corrections. However, on examining the documents during the inspection visit at the «Teresa de Calcuta» center, an increase in the application of educational corrections at that center was noted, leading to the assessment that any excess, either in the application of one type of procedure or the other (educational or disciplinary) is not advisable. Educational corrections, without prejudice to their pedagogical value, have some drawbacks: they are not contemplated in the regulations; they are inevitably subject to the arbitrariness of the educator; and they are beyond the scope of the system of legal guarantees provided in the regulations for sanctions, and thus are not registered, for example, in the statistical information submitted by this center. In consequence, the balanced application of the disciplinary regime and educational corrections would be advisable, obviously in accordance with the circumstances.

A recommendation has been made to ensure that minors' lawyers are informed of the disciplinary sanctions imposed on minors

156. At the three centers inspected it was noted that the lawyers of minors in custody are not informed of the resolutions adopted in respect to disciplinary procedures initiated against minors which give rise to sanctions, contrary to the contents of paragraphs 409 of the 2010 Annual Report and 175 of the 2011 Annual Report. In this respect and following an analysis of the matter, a Recommendation has been made to the Ministry of Justice to modify section two of Article 76 of Royal Decree 1774/2004, of 30th July, in order to impose on centers for juvenile offenders the obligation of communicating to the minor's lawyer all of the disciplinary sanctions imposed on the minor and to clarify in which cases

said notification is obligatory, at least when the punishment entails separation from the group imposed due to a serious or very serious infraction.

Greater pedagogical participation of educators in conversations between the adolescents regarding reprehensible behavior

157. The minors interviewed and the Director of «Las Palmeras» stated that minors are forbidden to talk to each other about certain topics and that educators control all their conservations in order to monitor the prohibition. After having detected the same prohibition and control at the center for juvenile offenders «*Pi Gros*» in Albacete, the NPM expressed its criterion in paragraph 182 of its 2011 Annual Report, considering that said prohibition and constant supervision constitutes arbitrary and undue rigor in the application of rules and an unnecessary interference in the right of minors to communicate freely. The reeducational purpose of centers for juvenile offenders is not achieved by forbidding that they discuss certain topics, such as extolling criminal pursuits, techniques for committing offenses, defending drug consumption, etc. In consequence, more than prohibiting this type of conservation, educators should intervene with a negative assessment of this kind of behavior so that the juveniles can understand their arguments.

The rooms for visits at the «Teresa de Calcuta» center infringe on the right to personal and family privacy

158. The entrance doors to the visit rooms at «Teresa de Calcuta» center are one way mirrors through which the inside of the room can be seen at all times. During family visits, the technical intervention assistants can observe and listen to what is going on inside without being seen. These security and surveillance conditions in the visit rooms are measures that invade the right of personal and family privacy, provided there are not suspicions of a relationship of verbal or physical abuse between parents and child or vice-versa. Many of the minors interviewed declared that this control caused them great anxiety. «I don't think it's right that the security guards are in back of the mirror.» «Not enough time and with an intervention assistant technician watching you, even if the visits are not supervised.» «Because I need privacy to express myself to my family, without having supervisors speculate on what I'm talking about.» «Because there's a supervisor watching you through a tinted window.» «Because they have windows and they invade my privacy.»

Photograph 36

Rooms for visits at the «Teresa de Calcuta» center

Photograph 37

Glass panel in the room for visits

159. In respect to health care, the «Teresa de Calcuta» center has a doctor and a nurse that do not belong to the public health system. From the point of view of health care, this means that the center is under the authority of Brea de Tajo. The Primary Care physician there, who has medical records for all of the juveniles in custody, is consulted and orders the tests and examinations to be performed and prescribes required medication. Despite the high occupancy at this center, it lacks basic life support and reanimation equipment. At the time of the inspection visit, it was noted that one of the minors in custody had a myocardiopathy and tuberculosis, with a high risk of having a heart attack if he did sports or in the case of physical effort. At the «Zambrana» center, the health care professionals are located in the center itself and available to attend minors directly. At the «Las Palmeras» center, the health care services are provided under an agreement with the *Clínica Madrid,* whereby a doctor visits the center two days a week, a psychiatrist is available whenever needed, usually once a week, and a registered nurse goes to the center the day after the psychiatrist's visit.

The health care provided in the centers inspected varies

The medical or psychiatric criteria to justify the reasons for therapeutic custody are not clear

160. Two of the centers visited, namely «Teresa de Calcuta» and «Zambrana», have specific units for serving therapeutic custody measures. On the day of the inspection visits, «Teresa de Calcuta» had 24 juveniles in the therapeutic regime (19 for mental health and 5 for drug addictions) and «Zambrana» had 4 (2 for mental health and 2 for drug addictions). Although the «Las Palmeras» center does not have a therapeutic unit, an ad hoc treatment had been established for a female juvenile in therapeutic custody. According to the reports of the external experts, the files of minors in custody with therapeutic regimes at those centers did not clearly reflect the medical or psychiatric criteria to justify sending these adolescents to this type of unit, given that «therapeutic custody» is ordered in a judgment, with prior diagnosis and assessment of the juvenile by social services, but not by mental health professionals. In the opinion of the psychiatrists on the inspection teams, given that there was no prior medical or psychiatric diagnosis, it was not clear what condition was to be treated, and it seemed that the custody regime was applied to formally comply with the provisions of the court judgment.

The «Teresa de Calcuta» center is the only one in the Community of Madrid that has a therapeutic or mental health module

The «Teresa de Calcuta» center is the only center in the Community of Madrid that has a therapeutic or mental health module. Given that it only has 24 places, this means that less than 1% of juvenile court sentences in semi-open or closed custody include admissions to a therapeutic unit. The criteria that justify sending an adolescent to this type of unit are not clear. In all the medical records consulted at the «Teresa de Calcuta» center, the external experts noted that they contained appropriate psychiatric diagnosis and considered that overall minors in custody are medicated little, especially in comparison with the treatments they had prior to entering the center. All of these points highlight a notable therapeutic policy on the part of the professionals and the obvious fact that the institution itself serves to contain the minors, as it offers an environment in which higher dosages of medication are not necessary. In respect to psychiatric diagnoses, all of the medical records consulted contained appropriate diagnosis prescriptions.

At the «Zambrana» center lack of a clear distinction between the therapeutic custody unit and the others was noted

At the «Zambrana» center lack of some differentiation of the therapeutic custody unit from the others was noted. The minors and professionals interviewed at the center did not have a clear idea of the differences involved in being assigned to the therapeutic unit, and did not see it as a unit having a specialized or therapeutic mental health program. In fact there are no differences between the intervention with a minor in therapeutic custody and the intervention with any other minor at the center in need of psychiatric attention. The professionals interviewed pointed out that due to the personalized attention provided, the therapeutic unit was for all minors who needed it. This was verified during the inspection visit, since of the total of 66 minors in custody, there were only 4 places in the therapeutic custody unit, and about 30 minors were being monitored and the psychiatrist saw them as a minimum once a month.

Even though there is no therapeutic unit at the «Las Palmeras» center, on the day of the inspection visit there were two adolescents in therapeutic regime custody for mental health, and there were two other minors in custody undergoing psychiatric treatment. The two in therapeutic custody were from «Teresa de Calcuta» center, and thus had been referred with prior psychiatric assessment and pharmacological treatments. Even though no one explained to the center's psychologist the reason for the transfers to «Las Palmeras», she thought that it was due to its proximity to their school and workplace respectively. Moreover, the psychiatrist on the inspection team noted that in the files that were reviewed, the reports submitted on admissions of a minor were the ones drafted by the public prosecutor's office for juveniles, but that the contents thereof were not sufficient to establish a clinical diagnosis. On many occasions the information provided verbally by the families is the only source of knowledge regarding pharmacological treatments. In consequence, it would be advisable to have access to more detailed prior information regarding the minors in custody, in particular in connection to reports from the mental health team that treated them.

At the "Las Palmeras" center, even though there is no therapeutic unit, there were two adolescents in therapeutic custody for mental health problems

161. Without prejudice to the aspects that are the subject of criticism and which are highlighted to the centers for juvenile offenders for the purpose of correcting deficiencies, the work they perform during the custody of these minors is noteworthy. However, this work is not continued after the minors are released, making their reinsertion much more difficult. In this respect, it would be beneficial to have some type of residential resource (like the supervised apartments) for those who leave the center, turn18 and cannot go back home, as noted at the «Las Palmeras» center.

There should be residential resources to facilitate the reinsertion of minors once they leave the centers and turn 18

162. Moreover, in addition to minors with mental health or drug addiction problems the situation of minors with intellectual disabilities is delicate, given that they cannot integrate in the center's activity or in the psychological and educational support programs with the same capacity that the other minors in custody have, as noted at the «Teresa de Calcuta» center. It is thus necessary to look into the need of having centers with a specific unit for juvenile offenders with mild-moderate intellectual disability geared at attending to the specific needs of this group of offenders in custody.

There should be specific units for juvenile offenders with mild-moderate intellectual disabilities

163. All the centers for juvenile offenders guarantee the right to receive obligatory education and for this purpose have state-approved schooling and training programs, as well as academic support. At the «Zambrana» center, training for minors in custody is supplemented with pre-employment and occupational training workshops in carpentry, autos and mechanics, gardening, computing, woodwork and masonry, and at the «Teresa de Calcuta» center, in bread making, automobiles, outdoor cleaning, woodturning, graphic design, printing and book binding, industrial mechanics, gardening and masonry.

At the "Zambrana" center obligatory schooling is supplemented with pre-employment and occupational workshops

Carpentry workshop at the «Zambrana» center

Photograph 38

View of the automotive and mechanics workshop at the «Zambrana» center

Photograph 39

View of the automotive and mechanics workshop at the «Zambrana» center

Photograph 40

It also has sports facilities

164. Given the size of these two centers and their ample facilities, in addition to the training workshops mentioned above, they also have gardens, a swimming pool, sport grounds and a gymnasium.

Photograph 41

Gymnasium at the «Zambrana» center

Photograph 42

Swimming pool at the «Teresa de Calcuta» center

Photograph 43

Sports ground at the «Teresa de Calcuta» center

III.3. Social Health Care Centers

The Ombudsman Institution has inspected many centers of this kind. In turn, inspections of these facilities were initiated as a new line of work for the NPM

165. In 2012 the NPM initiated a new line of work with an inspection visit to a health care residence for the elderly and handicapped persons. The Ombudsman Institution wishes to continue and extend this line of work over the next few years. This was the first inspection visit carried out by the Ombudsman Institution as NPM, although since its foundation it has performed many inspection visits to this type of center, resulting in the following reports: «Public and Private Residences for Senior Citizens» *(Residencias publicas y privadas de la tercera edad)* (1990), «Legal and Healthcare Situation of the Mentally Ill in Spain» *(Situacion jurídica y asistencial del enfermo mental en España)* (1991), «Residential Care for Persons with Disabilities and Other Related Aspects» *(Atencion residencial a personas con discapacidad y otros aspectos conexos)* (1996) and «Social Welfare Health Care in Spain: Gerontological Perspective and Other Related Aspects» *(La atención sociosanitaria en España: perspectiva gerontologica y otros aspectos conexos)* (2000).

This type of center requires special protection and the work of the NPM is particularly important

166. Public residential healthcare centers provide healthcare, social and rehabilitation services, amongst others, to senior citizens, chronically ill patients and persons with physical, psychological, sensorial or intellectual disability who are in a situation of dependency and require supplementary support in order to ultimately improve their quality of life. Given the situations in which the residents of these centers find themselves, they are more vulnerable, at times due to a situation of defenselessness or to their own incapacity to report situations of abuse. For this reason they require special protection and in this sense the work of the NPM is particularly important.

In 2011 55.288 involuntary admission proceedings were initiated

According to the «Survey on Disabilities, Personal Autonomy and Situations of Dependency» *(Encuesta sobre Discapacidades, Autonomia Personal y Situaciones de Dependencia)* carried out in 2008 by the National Statistics Institute, 269,400 persons who declared they had some type of disability were in public or private institutions: health care residences (216,400 persons), centers for persons with a disability (36,000 persons) and long-term care hospitals (17,100 persons). Furthermore, according to the information provided by the Spanish Office of the Attorney General, in 2011 a total of 55,288 involuntary admission proceedings were initiated, as shown in the following table.

Table 45. Involuntary admission proceedings initiated in 2011

Regional Autonomous Communities	N.º of proceedings
Andalusia	8,039
Aragon	501
Principality of Asturias	756

Regional Autonomous Communities	N.º of proceedings
Balearic Islands	535
Canary Islands	1,109
Cantabria	268
Castile-La Mancha	1,108
Castile y Leon	1,257
Catalonia	7,709
Comunitat Valenciana	4,774
Extremadura	490
Galicia	2,641
La Rioja	291
Community of Madrid	21,826
Murcia	671
Navarre	316
Basque Country	2,997
Total	**55,288**

Source: In-house compilation based on data provided by the Spanish Office of the Attorney General.

The need to regulate by means of an organic law the involuntary admission of persons due to severe psychological pathologies has been reiterated

167. As pointed out in paragraph 470 of the 2010 Annual Report, Decision of the Constitutional Court 132/2010, of 2 December, declared unconstitutional two sub-sections of the first paragraph of Article 763 of the Civil Procedure Law, which provides for involuntary admission due to psychic disorders, considering that said measure, which entails deprivation of personal liberty, cannot be adopted pursuant to an ordinary law, but rather an organic law. The NPM has reminded the Secretary of State for Justice of the need to draft, as rapidly as possible, an organic law bill to regulate involuntary admission of persons who due to a serious psychopathology do not have the capacity to decide at a given time regarding the treatment of their mental health, and after having tried less restrictive alternative measures, need to be hospitalized to receive appropriate psychiatric treatment, thus depriving them of their personal liberty. This is in accordance with the UN International Convention on the Rights of Persons with Disabilities, which came into force on 3 May 2008, and with the Observations of the UN Committee on the Rights of Persons with Disabilities in its initial report on Spain (CRPD/C/ESP/1).

The Secretary of State for Justice reported that work on the first copy of the draft bill to modify the Civil Code and the Civil Procedure Law would finalize at the beginning of 2013, after which the draft would be forwarded to the different Min-

istries, associations and groups that were affected to enable them to give their opinion regarding the draft.

There are numerous legal gaps in the forced committal of elderly persons to residential care centers

168. In respect to forced committal to residential care centers for the elderly and the disabled, Law 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care of persons in a situation of dependency includes, in the rights of persons in a situation of dependency, the right «to freely decide regarding entering a living residence, and to the full exercise of their jurisdictional rights in the case of involuntary committal, with the guarantee of contradictory proceedings». Notwithstanding the foregoing, the important legal gaps that exist in this respect have given rise to the application by public administrations as well as judges and public prosecutors of criteria that is contradictory and has very different implications. Given the disparity of figures regarding proceedings initiated in the different regional autonomous communities shown in Table 172, the difference of criteria that exists in each judicial district in respect to the requirement of having or not judicial authorization for committing persons to certain centers can be inferred.

The non-voluntary committal of elderly persons to residential care centers must also be regulated

In consequence, the NPM has asked the Office of the Secretary of State that the aforementioned organic draft bill also regulate the non-voluntary committal of elderly persons to residential care centers when they are not in condition to provide valid consent, establishing necessary legal guarantees for the full respect of the rights of citizens, both fundamental rights and specific rights in the field of health.

Maximum specialization of judicial bodies should be achieved

169. In order to guarantee the respect and protection of the rights of persons for whom forced committal or a declaration of incapacity is requested, the NPM has informed the General Council of the Spanish Judicial Authority (abbreviated as *CGPJ* in Spanish) that judicial bodies must acquire maximum specialization and that matters of forced committal and incapacitation in major cities should correspond to a single judge, where this has not yet occurred and where there are several judges. In this respect, the General Council of the Spanish Judicial Authority has pointed out that when specialization is not possible in a judicial district due to the workload, incapacity, committal and guardianship proceedings are sent to a sole court, making it easier to adopt uniform criteria and speeding up the resolution of conflicts.

The creation of a Public Prosecutor's Office specialized in the protection of persons with disabilities is recommended

Likewise, information has been requested from the Spanish Attorney General's Office (abbreviated as *FGE* in Spanish) regarding the current level of specialization in the Provincial Public Prosecutor's Office in respect to the protection of persons with disabilities, and regarding the existence in different Public Prosecutor Offices of guidelines for public prosecutors in charge of the protection of persons with disabilities to regularly inspect centers, residential care centers and supervised apartments, pursuant to the faculty-duty assigned to the Public Prosecutor's Office in Article 4.2 of its Organic Statute. In any case, the creation of a Public Prosecutor's Office specialized in the protection of persons with disabili-

ties is advisable, similar to the ones that already exist for relevant matters, in accordance with the mission entrusted in the Spanish Constitution and the Public Prosecutor's Office Organic Statute.

A recommendation has been made to establish legal guidance services for persons with disabilities

Moreover, the General Council of Spanish Lawyers *[Consejo General de la Abogacia Española (CGAE)]* was informed that it would be advisable to establish legal guidance services for persons with disabilities at the Bar Associations that did not yet have them, in order to provide the defendants in incapacity or committal proceedings with an adequate technical defense. In this respect, the General Council of Spanish Lawyers reported that the program to provide said services was launched within the framework of the collaboration agreement signed in 2004 by the *ONCE* Foundation and the Spanish Committee of representatives of persons with disabilities (abbreviated as *CERMI* in Spanish) with five «Bar Associations» *(Colegios de Abogados)* with the objective of establishing within the legal aid structure a group of lawyers specialized in all topics that could affect the rights of persons with disabilities. Nonetheless, given the uneven development of the program in different Bar Associations and the lack of collaboration of the public administrations, at present the service is being fomented through training and awareness-raising actions for the members of the different Bar Associations. In turn, the Bar Association of Toledo has informed this Institution that it does not have resources to create a specific legal guidance service for persons with disabilities.

A psychiatrist, a psychologist and a physician participated in the inspection visit as external experts

170. The inspection visit to the Assisted Living Residence *(Residencia Social Asistida)* «San José» (Toledo) was carried out over a period of three days. In addition to having experts from the Ombudsman Institution, it was deemed necessary to have a psychiatrist, a psychologist and a general practitioner as external experts. During the inspection, the different aspects examined were, amongst others that are mentioned in this section, the admissions procedure, the center's internal operations, the living conditions of the residents, the medical and psychosocial care provided, the use of physical and pharmacological restraints, and the suitability of the staff in quantitative and qualitative terms. Likewise, interviews were held with the center's management, staff, residents and relatives, and some of the center's activities were viewed, such as meals, distribution of medication and «bedtime». The twenty residents who were individually interviewed were chosen on the basis of the following criteria: sex, age, diagnosis, cognitive impairment and the amount of time they had been there, together with certain behavior that was observed during the inspection.

The residence attends to elderly persons and persons with disabilities with many different profiles

171. The «San José» Assisted Living Residence, which belongs to the Toledo Provincial Council, attends to persons with very different profiles who are distributed amongst 4 buildings: the first one is for persons with mild to severe mental disabilities; the second is for psychogeriatrics and assisted psychogeriatrics; the third is for persons with moderate to severe mental health problems; and the fourth is for assisted geriatrics and persons able to manage on their own. In addi-

tion to these four residential buildings, the complex has a day center for psychogeriatrics and persons with Alzheimer's, and a supervised dwelling for mentally handicapped persons (located outside the center's premises but under its authority).

Residential center with a large percentage of long term admissions (21 years)

The center has evolved since it was opened in 1977 as a psychiatric hospital. The transformation into a residential center began at the end of the 1980's, pursuant to the reforms established by the General Health Law 14/1986 of 25 April, according to which care for mental health problems was to be provided by boosting the resources available at an ambulatory level and the partial hospitalization and home care systems, reducing as much as possible the need for hospitalization. The user profile of a high percentage of residents consists of a long period of institutionalization. The average stay in the center is 21 years. For example, there is the case of a 69 year-old patient with a diagnosis of mild mental disability and bipolar disorder who has been living in the center for 42 years.

One of the buildings of the «San José» assisted living residence

Photograph 44

Psychogeriatrics and Alzheimer patient day center at the «San José» assisted living residence

Photograph 45

This center is the biggest of its kind in Spain

172. According to the information provided, the «San José» Assisted Living Residence is the largest of its kind in Spain, with a staff of 413 professionals, including external services, 406 places, of which 353 were filled at the time of the inspection visit (320 in the residence, 25 in the day center and 8 in the supervised dwelling). These are public places of the Toledo Provincial Council or places sub-

sidized by the Government of Castile-La Mancha (43 places in the residence, 10 in the day center and 7 in the supervised dwelling). However, the fact that there are vacant places is not due to lack of demand, but rather to the order issued by both administrations to suspend admissions, and even assessment of applications, due to budget cuts. So even though demand for the service is considerable, the official waiting list is not that long. In this respect, the aforementioned Regional Ministry and Provincial Council have been asked to submit reports on the measures that must be adopted to deal with the waiting list they will eventually have with persons waiting to obtain a place in the center.

The 2012 budget has been reduced by 18%

Moreover, in 2012 the center's management became aware of the difficulties it faced following a reduction of 18% of its budget in respect to 2011.

Judicial authorization must be obtained for non-voluntary committals

173. During the interviews, some of the men and women in residence declared that they had entered the center «against their will», adding that they were sent there to relieve their families of the obligation to care for them, due to their social situation or for other reasons. One resident declared the following: «I am not able to adapt. I know I have to be brave and that I have to think of my children and accept that it has to be this way. They work and cannot take care of me, but I just can't accept that and adapt.» Following a review of the documentation, it was concluded that neither the Toledo Provincial Council nor the Regional Ministry of Health and Social Affairs of the Community of Castile-La Mancha require express judicial authorization to commit elderly persons or persons with disabilities who do not have the capacity to consent freely, whether or not they are judicially incapacitated, to the center. In consequence, the two administrations have been informed that in such cases judicial authorization for non-voluntary committal should be required, pursuant to Article 763 of the Civil Procedure Law.

Periodic control must entail greater involvement on the part of the Attorney General's Office

174. In respect to the periodic control of non-voluntary committal, the «Manual of good practices of the service of the Attorney General's Office specialized in the protection and support of persons with disability» *(Manual de buenas practicas de los servicios especializados del Ministerio Fiscal en la proteccion a las personas con discapacidad y apoyos)* states that in addition to examining the report drafted by the center, the Office also takes into consideration, whenever possible, the report of the forensic doctor or of an independent physician appointed by the judge, different from the center's physician, and shall give the person affected by the measure a hearing. However, on reviewing the files at the center in which judicial authorization of committal appeared, there was no reference to those actions during the periodic control, which has been brought to the attention of the Office of the Attorney General.

Periodic medical reports should be more thorough and be updated

Likewise, in cases in which committal was authorized by the court, it was noted that the medical reports submitted every six months to the judge in order to substantiate the need to maintain committal measures, in accordance with Article 763.4 of the Civil Procedure Law, are in many cases identical copies in which

the only changes every six months are the dates, which was also brought to the attention of the Office of the Attorney General. In order to ensure full respect of the safeguards of the persons committed to a center, the medical reports submitted by the latter must be thorough and updated.

The effects of judicial incapacitation should be limited to the exact terms and conditions required by the residential care measure

175. About 60% of the residents in the center at the time of the inspection visit were totally judicially incapacitated. For another 10% the incapacitation proceedings were underway, and only 6 persons were only partially incapacitated. In the NPM's opinion, both the centers and the Public Prosecutor's Office should devote great efforts to promoting a balanced use of the legal figure of incapacitation, carrying out a thorough assessment of the affected party's capacities and his/her real level of functionality and capacity of judgment, volition and free choice, respecting as much as possible his/her capacities and autonomy. Likewise, in cases in which it is deemed appropriate to seek judicial incapacitation and given the possibility of establishing levels of incapacity, it would be advisable to limit its effects to the exact terms and conditions required by the residential care measure, duly justifying the reasons for and objective of requesting a ruling of incapacity; in other words, what benefits is the person with disabilities going to obtain once the judgment of incapacity is issued.

A thorough neuropsychological examination and psychological assessment should be performed

176. On the other hand, it was noted that when the center applies for incapacitation, it prepares a social and medical report, but does not perform a neuropsychological examination or psychopathological assessment as thorough as if they were performed by an external neurology or mental health service. This is something which should be corrected.

Having the center and relatives make decisions without consulting residents who are not incapacitated should be avoided

177. The common practice observed during the inspection visit, whereby residents who are not incapacitated are nonetheless subject, in respect to some decisions, to the agreement reached between their relatives and the center, should be avoided. These agreements contain covenants regarding matters such as management of a resident's pocket money, outings and the activities he/she can perform, which could violate the personal freedom of citizens whose lives are already limited and for whom these aspects are very important.

The admissions process must respond to patients' functionality and possibilities of rehabilitation

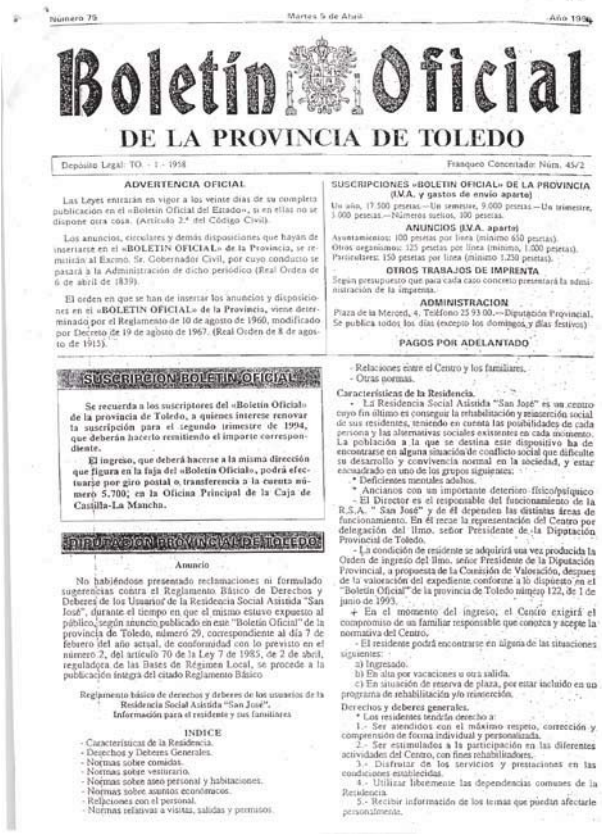
178. The procedure of admissions to a residential center of this sort normally consists of keeping the person in observation for a certain period of time, during which neuropsychological tests are carried out and his/her level of autonomy and relationships established with other residents is assessed in order to determine the most suitable module for his/her rehabilitation and stay. However, at «San José» Residence, classification of the residents in the different buildings is done prior to admissions, on the basis of the reports issued by the general practitioners (whose assessments on occasions are too high in respect to disabilities, as noted), so that they arrive in preassigned buildings which may not correspond to their real needs. In order to avoid these situations, the procedure described at the beginning of this paragraph should be generally adopted. In consequence, assignment to buildings should be decided on the basis of functionality and the possi-

bility of rehabilitating patients with programs geared at cognitive rehabilitation, rather than simply leisure activities, and dealing with the strong institutionalization of residents.

Residents and their relatives must be properly informed on admissions, and the wording and format of information sheets must be comprehensible

179. According to the information provided during the inspection visit at the «San José» Residence, residents and their families are given the regulations of residences published in 1994 in the Official Provincial Gazette, and an information sheet regarding visiting hours and meal schedules, outings with the family, clothes and pocket money expenses. However, none of the residents interviewed knew of these documents, which in addition were not posted in visible places or where they could be consulted, which must be corrected. In this type of center it is essential that new residents and their families be appropriately informed of the internal operating rules and regulations. Furthermore, this information must be written bearing in mind the characteristics of the residential population in each center, ensuring that its wording and format enables the majority of residents to understand it.

Information regarding rights and obligations given to new residents



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DE LA PROVINCIA DE TOLEDO

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Las Leyes entrarán en vigor a los veinte días de su completa publicación en el «Boletín Oficial del Estado», si en ellas no se dispone otra cosa. (Artículo 2.º del Código Civil).

Los anuncios, circulares y demás disposiciones que hayan de insertarse en el «BOLETIN OFICIAL» de la Provincia, se remitirán al Excmo. Sr. Gobernador Civil, por cuyo conducto se pasará a la Administración de dicho periódico (Real Orden de 6 de abril de 1839).

El orden en que se han de insertar los anuncios y disposiciones en el «BOLETIN OFICIAL» de la Provincia, viene determinado por el Reglamento de 10 de agosto de 1960, modificado por Decreto de 19 de agosto de 1967. (Real Orden de 8 de agosto de 1915).

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El ingreso, que deberá hacerse a la misma dirección que figura en la faja del «Boletín Oficial», podrá efectuarse por giro postal o transferencia a la cuenta número 5.700, en la Oficina Principal de la Caja de Castilla-La Mancha.

DIPUTACION PROVINCIAL DE TOLEDO

Anuncio

No habiéndose presentado reclamaciones ni formulado sugerencias contra el Reglamento Básico de Derechos y Deberes de los Usuarios de la Residencia Social Asistida "San José", durante el tiempo en que el mismo estuvo expuesto al público, según anuncio publicado en este "Boletín Oficial" de la provincia de Toledo, número 29, correspondiente al día 7 de febrero del año actual, de conformidad con lo previsto en el número 2, del artículo 70 de la Ley 7 de 1985, de 2 de abril, reguladora de las Bases de Régimen Local, se procede a la publicación íntegra del citado Reglamento Básico

Reglamento básico de derechos y deberes de los usuarios de la Residencia Social Asistida "San José".
Información para el residente y sus familiares

INDICE

- Características de la Residencia.
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Características de la Residencia.

• La Residencia Social Asistida "San José" es un centro cuyo fin último es conseguir la rehabilitación y reinserción social de sus residentes, teniendo en cuenta las posibilidades de cada persona y las alternativas sociales existentes en cada momento. La población a la que se destina este dispositivo ha de encontrarse en alguna situación de conflicto social que dificulte su desarrollo y convivencia normal en la sociedad, y estar encuadrado en uno de los grupos siguientes:

* Deficientes mentales adultos.
* Ancianos con un importante deterioro físico/psíquico

- El Director es el responsable del funcionamiento de la R.S.A. " San José" y de él dependen las distintas áreas de funcionamiento. En él recae la representación del Centro por delegación del Ilmo. señor Presidente de la Diputación Provincial de Toledo.

- La condición de residente se adquirirá una vez producida la Orden de ingreso del Ilmo. señor Presidente de la Diputación Provincial, a propuesta de la Comisión de Valoración, después de la valoración del expediente conforme a lo dispuesto en el "Boletín Oficial" de la provincia de Toledo número 122, de 1 de junio de 1993.

+ En el momento del ingreso; el Centro exigirá el compromiso de un familiar responsable que conozca y acepte la normativa del Centro.

- El residente podrá encontrarse en alguna de las situaciones siguientes:

a) Ingresado.
b) En alta por vacaciones u otra salida.
c) En situación de reserva de plaza, por estar incluido en un programa de rehabilitación y/o reinserción.

Derechos y deberes generales.

* Los residentes tendrán derecho a:

1.- Ser atendidos con el máximo respeto, corrección y comprensión de forma individual y personalizada.

2.- Ser estimulados a la participación en las diferentes actividades del Centro, con fines rehabilitadores.

3.- Disfrutar de los servicios y prestaciones en las condiciones establecidas.

4.- Utilizar libremente las dependencias comunes de la Residencia.

5.- Recibir información de los temas que puedan afectarle personalmente.

Photograph 46

180. The «San José» Residence does not have Internal Rules and Regulations, or any other document specifying the center's objectives and programs, analyzing the procedures and professional profiles needed to implement the programs, and indicators to assess rehabilitation and social reinsertion of residents, which is essential in this type of center.

It is essential to have internal Rules and Regulations

An interdisciplinary assessment and individualized treatment plans are necessary

181. The interdisciplinary assessment of cases is essential, which must be included in the Departments of Psychology, Medicine and Nursing, as well as Individualized Treatment Plans, aspects of which must be discussed with the interested parties, in line with the content of paragraph 37 of the CPT 8th General Report [CPT/Inf (98) 12]. In contrast, in the case of the «San José» Residence, the intervention plan and progress reports for residents are drawn up by each department separately, which should be corrected with the individualized and interdisciplinary assessment of residents.

Psychological services must be reinforced with a psychiatrist

182. Psychological and psychiatric services perform important therapeutically and rehabilitative work, which is essential for these centers. This is why the standardized minimum personnel ratios established for this purpose must be satisfied. However, the «San José» Residence only has one psychologist, who works mainly at the day center. In respect to the residence, the psychologist only performs psychological assessments for judicial incapacitations. In consequence, there are no psychological therapies for patients, no protocols for the psychological management of patients with behavior disorders, neuropsychological diagnoses are not performed and cognitive/neuropsychological rehabilitation programs are not established. Moreover, it was noted that many residents are not periodically reassessed from a psychological or psychiatric point of view, with diagnoses and treatments going unchanged, contrary to the provisions of paragraph 40 of the CPT 8th General Report [CPT/Inf (98) 12]. In consequence, it is essential to correct these major deficiencies, enhancing the psychological service, including a psychiatrist to review the files and update diagnoses and treatments of psychiatric patients at least twice a year.

The occupational therapy services must be enhanced

183. Occupational therapy is a social and health care discipline that evaluates a person's capacity to carry out standard daily activities and aims at enhancing said capacity, by means of appropriate treatment, to reach the highest possible level of independence in his/her daily life. The Occupational Therapy Department at «San José» Residence evaluates patients and draws up rehabilitation and physiotherapy actions in conjunction with the Medical Department. However, seven occupational therapists, who do not have the support of assistants and only work mornings, are not sufficient for the current population of 320 residents, most of whom are dependents. Moreover, most of their work is carried out without any kind of external supervision or coordination, and lacks an interdisciplinary approach. All of this explains why the results of the program are scarce in respect to the center's size. In consequence, necessary measures should be adopted to enhance this area of work, which would have a considerable impact on the quality of the care, in accordance with paragraph 43 of the aforementioned CPT 8th General Report [CPT/Inf (98) 12].

Photograph 47

Occupational therapy room in one of the buildings

Photograph 48

Physiotherapy room in one of the buildings

184. During the inspection visit the team was able to see different activities carried out at the «*San José*» Residence as part of the daily routine and to verify that the center has a policy of treating residents in a dignified and respectful manner. The personnel's kind, close relationship with patients, confirmed by the latter, was particularly evident. Likewise, relatives that were interviewed expressed their satisfaction for the good care and treatment their loved ones received in the residence. As evidence of the good practices at the center in respect to the way in which patients are treated, the case of a patient suffering from organic brain disorder, which caused him to try to destroy everything in his room, to fill it with excrement, etc., is noteworthy. Following several attempts to control him without having to use physical restraints not based on medical prescription, the center invested a significant amount of money to adapt a room to the resident's needs, with elements that withstand better the destructive action and are easier to clean.

Door with camera and interior of the bedroom with waterproof walls, flooring and ceiling, water faucet to be able to clean it, high windows and ceilings

Photograph 49

Photograph 50

The staff treats residents in a dignified and friendly manner

185. The residents who can manage on their own go out alone to the center's outdoor areas. The nursing assistants in each building take dependent residents outside every morning, except when the weather is bad. They are not taken outside in the afternoon, when they only go out on certain exceptional occasions or when they have visits and are taken out to have some fresh air or go for a walk. Furthermore, in the summer the entrance doors to the buildings are closed from 1:00 pm to 5:00 pm to avoid the risk of sunburns. In order to avoid such a drastic measure, it would be more logical to have a routine control system at the door of each module to prevent residents with serious cognitive impairment to go outdoors without being accompanied by a nursing assistant.

The team at the building where the resident lives makes the decisions regarding outings

186. Outings for residents at the center are authorized by the team in the building where they live, on the basis of their capacity to go on an outing. If they are able to go, they are given an outing «pass» with the days and times authorized by the clinical staff, which they have to show on their way out. Likewise, residents can spend a few days outside the center with their families, and if they are not incapacitated, alone. There is no time limit for outings, unless a resident is away for long periods of times, in which case he/she could risk losing the place in the center.

The center also organizes outings

The center's Recreational Activities Commission can also organize outings. During the inspection visit, a group of 30 residents who could manage on their own was spending a week at a beach in Murcia.

The residents' daily routine is rigid and monotonous, and more activities should be organized

187. The residents' daily routine is rigid and monotonous. The most common feeling amongst residents who have been in the center for less than a year is that «time does not pass» or that it passes «exasperatingly slowly». There are only activities from 10:00 am to 1:00 pm in the occupational therapy area and in the so-called School (rug-making, drawing, cognitive exercises, psycho-educational talks, etc.). These activities are for persons better able to manage on their own, and most residents just stay in the hallways or in the television room and do not participate. The lack of activities leads residents to live in a state of lethargy and lack of response to the surroundings to which they initially resist. For residents who are not authorized to leave the center, television is nearly the only activity they have. Furthermore, at night the majority of residents have to spend about 11 hours in their rooms, where they usually do not have a television or anything else that can serve as a stimulus or entertainment. For example, one resident who was interviewed described a routine in which the only activities were meals and buying two *cans* of Coke at the bar in the square, and when asked what he did after breakfast simply answered «I wait for lunchtime». Another resident said: «I am fed up with television and of being here. There are times when even if you don't want to you fall asleep watching television because you are so bored. And then at night you spend hours tossing and turning in bed (...)». One resident said: «What I like best in the center is the can of Coke they give us.» In consequence, necessary measures must be adopted to lessen the current shortage of activities and stimulus for residents, especially in the afternoon.

Living room in one of the buildings

Photograph 51

The center's school

Photograph 52

The institutionalization syndrome was detected in many of the residents

188. A stay in these centers can give rise to the so-called «institutionalization syndrome», consisting of a series of symptoms provoked by the institution itself which little by little become ingrained in the resident's identity and subsequently are indistinguishable from a mental disorder and difficult to revert without a change of environment. Some of the characteristic symptoms of the disorder include a low capacity to make decisions, lack of initiative, difficulty to plan time, lack of creativity and regression of inductive logical thinking, incapacity to deal with new situations, isolation and difficulties to relate to other persons.

More work should be done to rehabilitate residents

During the inspection visit, the experts detected the said symptoms in many of the residents. In order to rehabilitate patients an appropriate diagnosis is needed, together with individualized treatment plans, a re-diagnosis by an external professional and the possibility of a progressive change of environment to units that enable them to assume some degree of autonomy and control over their own lives (supervised apartments, open door mini-residences, day centers, etc.). However, in the case of residents who have spent decades in a residential center this process is very difficult and can generate in the affected parties more anguish than benefits.

The possibility of community reinsertion should be reassessed periodically

189. In some persons under the age of 60 one could sense their despair at being in an institution where they felt they could spend the rest of their lives, without any alternative options of care in an open setting. In consequence, the Toledo Provincial Council has been urged to regularly reassess the possibility of community reinsertion in an open setting for some of these persons, in particular the ones who do not have a geriatric profile. In this sense, in paragraph 57 of the 8th General Report the CPT highlights that patients whose mental state no longer requires committal to a care residence should not continue to live in one due to lack of appropriate care or accommodation in the community.

190. Although the center informed the inspection team that on occasions couples or spouses had been admitted, there were never able to share a room because the center does not have facilities prepared for couples to share living quarters, whether they were admitted as a couple or met each other in the center. This state of affairs should be corrected.

Areas to allow couples to live together should be available

The center also lacks a specific policy in respect to patients' right to privacy and sexual life. Thought must given to this issue, followed by technical decisions that will enable taking into consideration and respecting the possibility of allowing emotional relationships in the center, with appropriate protection of residents who due to their disabilities may not be in conditions to have sexual relations in the full exercise of their capacity of volition and judgment.

A clear policy in respect to patients' right to privacy and a sexual life must be established

In addition, residents have to accept being nude in front of health care personnel and even of other residents, since doors to the lavatories and bedrooms are not closed: «You're nude and the nursing assistants come and go without paying attention. It is a little humiliating, but you get used to it.»

191. The autonomy and positive participation of residents must be encouraged, both from a therapeutic point of view and in respect to their fundamental rights. Furthermore, since the role of the family is essential in the process of psychological and social rehabilitation of persons suffering from mental illnesses, the active participation of family members in the life of the center and in the matters that affect residents should be encouraged. This participation could be channeled through the Participation Council, the Menu Commission, the Commission for Social and Cultural Activities, etc., or by means of satisfaction surveys amongst residents and their families.

Patient autonomy and the active participation of their families must be encouraged

In this sense, the center that was inspected does not have systems for the participation of residents and their families in the life of the center, whether it be in day to day matters –menus, outings, program of activities, etc.– or in aspects that affect their basic rights more directly, which should be corrected. However, the Project «Meeting Point», consisting of specific meetings with families to discuss matters of interest for the latter should be highlighted as a positive element.

192. An effective procedure to submit and resolve complaints is a basic guarantee against mistreatment. However, the «*San José*» Residence does not have a mechanism for submitting complaints and/or suggestions, lacking official forms and boxes for that purpose, nor does it have a unified procedure for processing complaints. This procedure must be established as soon as possible.

A system for making complaints/suggestions must be established as soon as possible

193. The visiting times for relatives are ample, and are given on admissions. Families can walk around the gardens or visit with their relative in areas prepared for that purpose in the buildings. The majority of residents who were interviewed declared that they would like to have more contact with their relatives, although they argue that in many cases it is not possible since they come from villages that are not close to the center. Several persons interviewed from

The feeling of being uprooted must be avoided

small villages of the Toledo province hinterland expressed with great sorrow the feeling of being uprooted as a result of their placement in the residence. These are persons who were well integrated with their neighbors, who lose their social network and their contacts, and live far from their family surroundings and their village. Small residences located in these villages would be a better solution for these persons, who could thus conserve a greater degree of autonomy, maintain their social support network and avoid the impairment caused by institutionalization.

The visits of persons that belong to guardianship foundations, which represent the sole contact with the exterior for some residents, are a positive note worthy of mention.

A Record of official visits is required

194. The center does not have a Record of official inspection visits in which to record those made by the Ombudsman Institution, the Public Prosecutor's Office, the Government of Castile-La Mancha or the Provincial Council itself, which must be corrected.

Disciplinary measures imposed must be discussed or explained to the affected residents

195. Even though the center does not have any regulations or system of rules *per se,* some «punishments», which vary from one building to another, are imposed on residents. Some of the punishments mentioned during the inspection were having to watch television in the room with persons with severe mental disabilities, having the resident wear a pajama or nightgown (which means he/she cannot leave the unit), or restricting visits. For example, notes made by nurses in a patient's file stated the following: «She was dressed with a pajama because last night she did not want to get in bed, and she was finally found with a lighter. She'll have to wear pajamas until the 12th, but she won't be told.» (2010). «Altercation with another resident. She is dressed in pajamas and will not leave the unit until the 3rd of November (one week)» (2011). These punishments are generally applied for minor infringements (altercations with other residents, showing lack of respect for staff, not respecting timetables) and constitute alternatives to the use of physical restraints. In this sense, the external experts considered them positive, because an incident that is of minor importance in terms of aggressiveness towards the resident («wearing pajamas») is in itself a deterrent, as noted during the inspection visit, thus avoiding more aggressive actions. However, it seems that in most cases these measures are not discussed or explained to the residents, which should be corrected.

Appropriate health care

196. From a healthcare point of view, residents were well taken care of, with magnificent results in respect to the pathologies common to severely dependent persons. Likewise, the treatments seemed to correspond to the pathologies, and note was made of the effort to develop written protocols for the most common health care procedures.

Photograph 53

Doctor's office in one of the buildings

197. Notwithstanding the foregoing, a review of the current allocation of physicians to the different buildings is considered necessary, given that said allocation does not always correspond to the characteristics of the people in need of medical attention. For example, there was a general practitioner in the geriatrics building, where the average age is 78, and a geriatrician in the building devoted to mild to moderate mental disabilities, where the average age is 63.

The current allocation of physicians to the buildings must be reviewed

198. Physical and pharmacological restraints are used relatively often in psychiatric hospital and health care residences to prevent falls or injuries to residents or third parties, to avoid alterations of the therapeutic program (removal of intravenous needles, nasogastric tubes, etc.), or to manage violent or aggressive behavior. Negative effects have been documented in the continued use of both types of restraints (in the case of physical restraints: pressure ulcers, infections, incontinence or loss of appetite, amongst others, and psychological effects such as shame, aggressiveness, depression, apathy or social isolation; in the case of tranquilizing psychotropic drugs: delirium, impairment of cognitive functions and of communication, depression, dehydration, unstable gait with the risk of falling, etc.). From the foregoing it can be concluded that the unnecessary and/or excessive use of these measures could entail a violation of a person's right to dignity and free development of his/her personality (Article 10 Spanish Constitution), to liberty (Article 17 Spanish Constitution), to physical and moral integrity and not to be subjected to inhuman or degrading treatment (Article 15 Spanish Constitution).

The unnecessary or excessive use of physical or pharmacological restraints could entail a violation of fundamental rights

But despite Constitutional protection, the use of these restraints is not regulated at the national level. Indeed, Basic Law 41/2002, of 14 November, regulating the autonomy of patients and the rights and obligations in respect to clinical information and documentation, contains the principle of a patient's prior consent (the so-called «informed consent»), the right to refuse treatment (except in cases provided by law), and the physician's right to intervene, even without the patient's

The use of physical and pharmacological restraints is not regulated at a national level

consent, when there exists «a serious immediate risk for the patient's physical or psychological integrity and his/her consent cannot be obtained»; however, there is no specific mention or reference to physical or pharmacological restraints. Nonetheless, the Social Services laws of some autonomous regions do establish the right of users of Social Services to not be subjected to any kind of immobilization or physical and pharmacological restraint without a medical prescription and supervision, unless there exists imminent danger for the user's physical safety and that of third parties. As a safeguard for users, these laws require documented justification for said actions, that they be recorded in the user's file and that the Public Prosecutor's Office be notified.

The use of physical and pharmacological restraints must be regulated in a clear and precise manner

In consequence, it is essential to clearly and concisely regulate the concept of restraint at a national level, together with the cases in which restraint can be applied, proportionality and suitability of the means used, the time the measure is to last, authorization for application of the measure, documentation of measures taken, assessment of the effects and results, and all necessary guarantees.

Residential centers must aim at reducing the use of restraints

199. Moreover, centers should aim at reducing the use of restraints. This could be achieved, for example, by encouraging residents to move around with mobilization and «fitness walking» programs to prevent loss of mobility, or by means of greater control by the assistant nursing staff to prevent falls. Likewise, the use of restraints that only limit a patient's mobility to the extent required should be given priority (for example, non-skid harnesses instead of belts).

The Protocol on the use of restraints must be updated to unify guidelines and ensure that the rights of individual residents are guaranteed at all times

During the inspection visit it was noted that in general terms the «San José» Residence tried to minimize the use of restraint and to use them in any case following medical criteria, and not as punishment. The physician asks the relatives to authorize the measure in writing and fills out the form prescribing restraint, which is not subsequently modified or updated if the conditions that motivated immobilization do not change. The physician prescribes physical restraint and day to day application is carried out by the nursing staff following the medical order. Even though use of restraints is and subject to strict medical criteria of the physician in charge in each building, the medical personnel interviewed acknowledged that some of the restraints could be avoided by having more assistant nursing staff and with mobilization and walking programs. The center's management should update the «Protocol on the Use of Restraints» in order to unify guidelines in this matter, subject at all times to guarantees for the rights of individual residents.

Photograph 54

Armchairs with restraints

Photograph 55

Information posters prepared by the Toledo Provincial Council on the use of restraints in one of the buildings

200. Even though it should be obligatory in this type of institution, the center does not have a policy in respect to «palliative care», and some differences of criteria were observed during the interviews of the medical staff. In consequence, guidelines should be adopted in this respect.

A policy for palliative care must be adopted

201. A living will is a document in which a person expresses in advance his/her wishes or instructions regarding medical care which are to be taken into account in the event he/she is in a situation in which said wishes cannot be freely expressed. However, the «*San José*» Residence does not have any living will forms and does not inform residents regarding this matter. Given the type of residents it has, it would be advisable to inform them to this possibility. A protocol should thus be drafted for this matter.

A protocol for living wills must be established

Clinical records must be computerized and connected with the general healthcare network, and guarantee the confidentiality of the information

202. The center that was inspected does not have computerized clinical records or connection to the general healthcare network. In consequence, information regarding health care issues of some patients or their current diagnosis and treatment has to be found by searching through paper files, some of which are very old. The center also lacks a common database and systems to guarantee the confidentiality of the data. Each building operates with its own data processing system, and some discrepancies were observed between these data and the ones provided by the Department of Social Work. In consequence, appropriate measures must be adopted to mitigate these deficiencies.

The functions of the professionals rendering services in the center must be defined

203. The workers at «*San José*» Residence are subject to the «Framework Agreement for Clinical Personnel» (*acuerdo marco de personal clínico),* also applicable to the Toledo Provincial Hospital, which refers mainly to hospital functions and is thus not suitable for the center, where many tasks that are essential in caring for the residents are not included. The center needs to establish an internal organizational system with the job descriptions of the professionals who work there.

Excess rotation of personnel must be avoided

204. Staff substitutions are handled by means of the so-called one-day «urgent substitution contract» that are managed by the center itself of which there were about 400 every month. Even though the number of these contracts is diminishing, as noted, it is necessary to adopt necessary measures to avoid an excessive level of staff rotation and its repercussion on care of the residents.

The center's layout is reminiscent of a small village

205. The «*San José*» Residence was built in the decade of the sixties, with a structure that is reminiscent of a small village. In the middle of the complex there is a square with a kiosk, reading room, hairdressers, cafeteria and game room, although during the inspection visit the team only saw the cafeteria in operation. The game room is closed, and has dampness and paint peeling from the ceiling. There is also a church, with daily mass, a swimming pool and outdoor area with some fitness equipment for elderly persons. This equipment is not properly secured to the ground, and is thus not used.

«Square» with the center's facilities and services

Photograph 56

206. The Residence consists of four buildings, one of which was recently built. They all have an infirmary and common areas (dining rooms, rooms/ area for visits, rooms for occupational therapy and physiotherapy, etc.). The residential units are assigned depending on sex and the level of mobility. Persons with less amount of autonomy are on the ground floor, and those with more autonomy are on the upper floor.

Residents are distributed amongst several buildings

Pictures of two of the center's bedrooms

Photograph 57

Photograph 58

Living room in one of the buildings

Photograph 59

The facilities that have not been adapted or that are inappropriate must be improved

207. Renovation work must be carried out to improve certain structures that are not appropriate, such as the hallway windows of the three buildings, which open inwards, thus entailing a risk for residents as they go past a window, and the interior windows which are not protected, although nets have been put up in the interior courtyards to prevent the risk of falls.

The maximum number of persons per bedroom should be two

208. The vast majority of bedrooms in the center are single or double, although it was noted that one of the buildings has a few triple bedrooms. Given the center's current level of occupancy, which is below its total capacity, necessary measures should be adopted so that the maximum number of persons per bedroom be two.

A call bell system must be installed

209. The bedrooms for patients do not have an alarm or call bell system, and this should be corrected.

The emergency and evacuation plans should be complied with

210. Although all the buildings have emergency and evacuation plans, the main doors of these buildings are locked at night to prevent residents from exiting. In this respect, a solution must be adopted in accordance with the emergency and evacuation plans.

Situations of Deprivation of Liberty

IV. Special Interest Sites in Deprivation of Liberty §211-§246

IV.1. Prison Hospital Wards §211-§220

IV.2. Operations for the repatriation of foreign nationals §221-§246

IV.1. Prison Hospital Wards

They are under the authority of the SGIP

211. Prison Hospital Wards (abbreviated as *UCH* in Spanish) are facilities in hospitals of the public health network that accommodate inmates who require hospital treatment. Even though the hospital buildings are subject to the authority of the corresponding Ministry of the Regional Autonomous Community, secure hospitals units are under the authority of the *SGIP* and the custody of hospitalized inmates corresponds exclusively to the National Police Force (abbreviated as *CNP* in Spanish).

In 2012 the Prison Hospital Ward of the University General Hospital Gregorio Marañón in Madrid was inspected

212. In 2012 the Prison Hospital Ward of the University General Hospital *Gregorio Marañón* of Madrid was inspected. The corresponding authorities were informed in advance of the inspection visit, bearing in mind it was going to include a delegation from the Armenian Ombudsman Institution as participant in the TAIEX (JHA IND/STUD 50469) project organized by the European Commission.

It has 12 rooms, of which four are single and the rest double. It has a total of 18 beds available

213. The Prison Hospital Ward of the University General Hospital *Gregorio Marañón* has twelve rooms, four of which are for individual use and the others are for double occupancy, with a total of 18 beds. The rooms have the same features as any others in the hospital, with the logical exception of elements needed to guarantee custody and prevent inmates from escaping. Likewise, there are three with special characteristics: one is for solitary confinement, and the other two are used for hospitalized inmates who might be carrying narcotics inside their bodies. The beds, mattresses and linen used by the inmates are the same as the ones used for other hospitalized patients.

The deficiencies of the solitary confinement room must be corrected

214. The solitary confinement room had two doors. The inside door, shown in the picture below, opens inwards, which was the cause of some security incidents in the past, including one in which an inmate blocked the door with a bed, impeding the entrance of the police agents. This deficiency should be corrected to avoid further incidents of this type.

Door of the solitary confinement room opening inwards

Photograph 60

A record is kept of what happens in the rooms to control narcotics

215. When persons carrying pellets of narcotics in their bodies are admitted to the rooms for the control of narcotics, expulsion of the drugs is controlled and recorded on a sheet that includes, amongst other information, the name, surnames and court handling the corresponding proceedings.

There are about 1,400 admissions per year

216. On the day of the inspection visit 15 patients were hospitalized, of which 7 voluntarily accepted to have a confidential interview. They all declared that they had been properly treated by the healthcare personnel and by the police agents in charge of their custody. In the Record of Admissions, opened at the page for the 5th of October 2012, it was noted that from that date up to the 18th of December 2012, 273 persons had been admitted to the Prison Hospital Ward. According to information provided by the physician in charge of coordinating penitentiary healthcare, there were 1,400 admissions every year, with inmates being distributed to different rooms in accordance with medical instructions.

A specific information protocol regarding prophylactic measures should be adopted

217. The police agents that were interviewed declared that they did not know of the existence of a specific information protocol regarding prophylactic measures for agents in charge of the custody and transfer of prisoners. In consequence, an information protocol of this sort should be adopted.

Deficient video surveillance system

218. The video surveillance system is a color system, and only permits viewing, but not recording. The cameras cover the entrance door to the Prison Hospital Ward and the exterior side of the windows. Like the other Prison Hospital Wards inspected, it does not comply with features considered necessary, in accordance with the criteria expressed in 477 of the 2010 Annual Report and 209 of the 2011 Annual Report.

Agents must be identified when they are in the Prison Hospital Wards

219. It was noted that the police agents in charge of the custody in these facilities were dressed as ordinary citizens and were not wearing an identification badge or regulation weapon, which they left in a locker. The explanation given to inspectors, which seemed reasonable, was that agents wore plainclothes for purposes of discretion when hospitalized prisoners had to be transferred to other parts of the hospital for medical tests. However, in accordance with Instruction 13/2007 of the Office of the Secretary of State for Security and the criterion stated in paragraphs 66 and 113 of the 2010 Annual Report and 52 of the 2011 Annual Report, it would be advisable that agents wear at least their identification when they are in the Prison Hospital Ward.

A terminally ill prisoner tried to commit suicide

220. Inspectors were informed that in the last two years one accusation had been filed for alleged mistreatment in said unit, and that it had been filed away. Moreover, the inspection team was told that there had been a case of self-inflicted injuries at that Prison Hospital Ward and that a prisoner who had been diagnosed a tumor and was in the terminal phase tried to commit suicide, although the hospital staff realized what was happening on time and impeded the suicide.

IV.2. Operations for the repatriation of foreign nationals

Expulsion or repatriation occurs following the resolution by the competent authority

221. As indicated in the 2010 Annual Report, the Central Unit for Deportation and Repatriation (abbreviated *UCER* in Spanish), under the authority of the Central Department of Immigration and Border Police (abbreviated as *CGEF* in Spanish), is in charge of executing the repatriation of foreigners whose expulsion or repatriation has been ordered by the competent authority. Likewise, amongst other matters the European Agency FRONTEX is in charge of managing and coordinating necessary support to the member states to organize joint operations of repatriation of citizens that are not nationals of a member state of the European Union.

Personnel of the Ombudsman Institution supervised two repatriation flights

222. In 2012, personnel of the Ombudsman Institution supervised two flights repatriating foreigners. The first one, operated by the European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the Union (FRONTEX) and organized by Holland, was to Nigeria. The second flight, organized and exclusively operated by the Spanish authorities, was to Ecuador and Colombia.

The Ombudsman Institution supervised the Madrid-Barajas phase of the first joint FRONTEX flight, in which seven countries participated

223. The joint FRONTEX flight was the first of its kind, with operations of the phase carried out at the Madrid-Barajas airport being supervised by experts of the Ombudsman Institution in its capacity as NPM. The objective was to check the degree of coordination of the different countries participating in these flights, and whether the practices of FRONTEX complied with Spanish regulations. Furthermore, the supervisors wanted to examine the state of the facilities and the conditions in which foreigners are transferred from police premises until they are boarded on the airplane for repatriation; and also the protocols and procedures followed by the national police in the custody, identification and registration of persons repatriated, and the medical care they are given. The flight to Lagos, in which 34 Nigerian citizens were repatriated, had been organized by Holland, and operations had begun in Rotterdam (Holland), where 24 of those citizens boarded the plane, 14 being repatriated by Holland and the other 10 by France, Germany, Norway and Sweden. On arrival of the flight in Madrid, 10 other citizens boarded the plane, 5 being repatriated by Spain, 3 by Greece and 2 by Portugal.

The facilities at Barajas are in a good state of conservation, but the video surveillance is insufficient

224. The Central Unit for Deportation and Repatriation facilities described in paragraph 446 of the 2010 Annual Report continued to be in a good state of upkeep, and the office area had been enlarged. The video surveillance system, as previously indicated in the said paragraph, does not include recordings and is limited to the area of custody of persons being repatriated, contrary to what should exist in accordance with the general comments of paragraph 477 of the 2010 Annual Report. These deficiencies should be corrected.

The persons in charge of the operation receive training. The returnees do not have forms to lodge written complaints

225. During the interviews of the persons in charge of the operations, they stated that all members of the Central Unit for Deportation and Repatriation are trained in expulsions, suicide prevention and self-inflicted injuries, detection of possible situations of abuse, harassment or mistreatment by other detainees, and that in this sense its personnel takes a one-week course on deportations, regulations and intervention techniques. Every three months the Madrid Municipal

Emergency and Rescue Service (abbreviated as *SAMUR* in Spanish) organizes a course in first aid, which 25% of the personnel had already taken. In this current operation, only one of the five persons to be repatriated had a passport, which is why the Nigerian Embassy in Madrid issued four emergency travel certificates.

Lastly, the inspection team was informed that there is no officially established form which persons being repatriated could use to submit written complaints in respect to the deportation operations.

The police forces consisted of agents from the different participating countries. Spanish police were not wearing uniforms or identification badges

226. The police forces, consisting of police agents from the countries who were repatriating in this case Nigerian citizens, were joined by 11 national police agents members of the Central Unit for Deportation and Repatriation, two of whom were women, given that one of the persons expelled by Spain was a woman. The personnel of the Central Unit for Deportation and Repatriation participating in these operations do not wear their uniform and are not identified with their badge numbers. However, they wear at all times reflecting vests which identify them as police agents, similar to the ones used by the police agents of other countries in FRONTEX repatriation operations, as was noted with the police agents guarding the persons repatriated on this flight by Greece, Portugal, Holland, France, Germany, Sweden and Norway. This Institution believes that this deficiency must be corrected, so that the returnees can know the identification of the police agents guarding them, without having to ask for that information.

Persons being repatriated by Spain came from the Immigrant Detention Centers of Valencia, Saragossa and Madrid

227. The five persons repatriated by Spain arrived at the Central Unit for Deportation and Repatriation facilities in two partitioned police vehicles transporting, respectively, a woman from the Immigrant Detention Center (abbreviated as *CIE* in Spanish) of Valencia and a man from a prison in Saragossa. In addition, three men were transferred from the Madrid Immigrant Detention Center in a van. As can be seen in the following pictures, the van has a closed compartment for the persons being transferred, consisting of a metal bench for two persons but no seat belts, which should be corrected as the absence of this passive security element for detainees could jeopardize their physical integrity, in accordance with what was stated in paragraph 214 of the 2011 Annual Report.

Inside the van

Photograph 61

Individual custody forms are not available

228. There are no individual custody forms to be used for deportees from the time they leave their place of origin (Immigrant Detention Center, prison, police stations, Central Registry of Detainees...), which means that the chain of custody cannot be properly controlled from that moment until they are handed over in the country of destination. This must be corrected.

After the documentation had been checked, a thorough search was carried out

229. After the documentation had been checked, the escorts of the repatriation operation carried out a very thorough body search on the men, one at a time, examining their clothes, their mouth and their feet, which obliged detainees to take off their socks and shoes. They carefully removed all objects that could entail a threat for the security of persons, and objects that could be used by detainees to cause self-inflicted injuries and thus try to make their expulsion very difficult or to impede it. The woman was also searched like the men, except that women agents of the Central Unit for Deportation and Repatriation performed it in the women's lavatory. A female expert of the inspection team observed this search. According to the information provided, strip searches are only performed when a detainee looks suspicious. In respect to money and valuables carried by detainees, they are deposited in transparent plastic bags labeled with the owner's name and sealed in his/her presence, which are in the custody of the head of the operation or whoever the latter appoints.

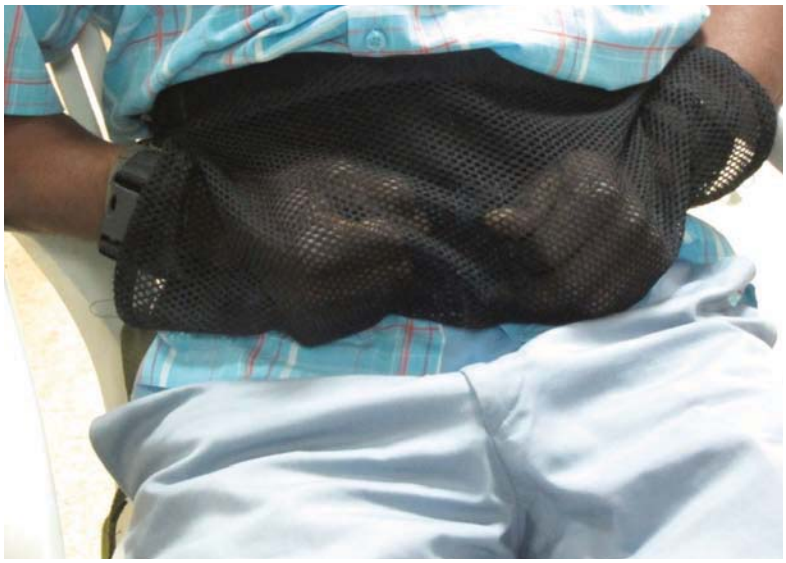
The police agents are not armed, and have means of restraint to use in situations of risk

230. It was noted that the police agents were not wearing, at any time, their regulation weapon, defenses or shields. The police commanders stated that in cases of resistance or violent behavior during an operation, restraint and restraining measures would be used proportional to the situation. For this purpose the Central Unit for Deportation and Repatriation has cords, immobilization belts and shackles, although it was pointed out that the latter are hardly ever used. The police escorts also have utensils to cut cords, anti-cut gloves and overalls for deportees who need them. Likewise, they have two mats in which they can immobilize deportees in cases of great resistance.

To avoid incidents, aggressions and self-inflicted injuries, after the searches five deportees had their wrists tied with immobilization belts, as shown in the following pictures, which they wore during the time they waited, when they were transferred by bus on the runway and during boarding. These belts allow eating and drinking, since they are equipped with a device on the right hand strap consisting of an extendable cord.

Immobilization belt

Photograph 62



Photograph 63

Finally, it was noted that the persons being repatriated by Portugal were not wearing any means of restraint and walked on their own at all times, and that those repatriated by Greece were wearing handcuffs.

The Ombudsman Institution criteria is that returnees must be informed of the details of the repatriation

231. Following the searches, the returnees were told to sit in a waiting room until the time came to transfer them for boarding. The five Nigerian citizens interviewed in that room declared that they had been properly treated during the transfer to the airport. Only one of them had been informed in advance of the manner in which he was going to be repatriated. The Ombudsman Institution's criterion is that the administrative authorities must inform inmates sufficiently in advance of when they are going to be repatriated and of the details of the procedure, in accordance with the content of paragraph 84 of the 2011 Annual Report. Moreover, the persons who are going to be repatriated are not informed of the duration of the flight, possible stopovers and other information regarding the operation, which must be corrected.

During the flight returnees keep their seat belts buckled

232. The deportees boarded the plane with the custody agents forming a security corridor from the vehicle that had brought them from the terminal to the aircraft. Each detainee was guarded by four agents: one in front, another in back and one on each side. The Nigerian woman who was being repatriated by Spain had to have her legs immobilized with restraint belts when she tried to resist boarding the aircraft. Once they were inside the airplane, the agents accompanied detainees to the seat that had been assigned by the Dutch agents in charge, since Holland had organized this FRONTEX flight. The head of the Spanish operation informed the inspection team that after the plane had taken off, immobilization belts would be removed if the returnees were calm. It was noted that the detainees repatriated from Holland were not wearing any kind of physical restraint. The aircraft had two rows of seats, with three seats on each side. A detainee sat in each row (in the middle or window seat), with two police escorts in charge of his/her custody. According to what the inspection team was told, the deportees kept their seat belts on for the whole flight.

As the operation was organized by Holland, this country was responsible for the medical care

233. This operation did not have any Spanish physician or nurses, since it was up to the authorities of Holland, who had organized the flight, to appoint the healthcare service for the operation, which in this case was a Dutch physician without the assistance of a nurse. In respect to detainees repatriated by Spain, there was a list with their particulars in which it was noted that they were all in good health to travel. In this regard, the persons in charge of the operation informed the inspection team that no systematic medical check-ups are performed. Instead only foreigners being repatriated undergoing medical treatment or who have some symptoms or ailment are examined by a physician, who decides if they are in condition to travel and prepares a report that is given to the head of the operation. Otherwise, it is noted by default that the deportees are healthy and fit to travel. One of the persons who was going to be repatriated, and who did not have a medical report, told the inspection team that he suffered from a heart ailment and was undergoing treatment with a medication he had not taken. On confirmation of this fact by the medical service of the Immigrant Detention Center, the Directorate General of the Police was informed that said circumstances should have appeared in the Immigrant Detention Center medical report, with express mention of whether the citizen was fit to travel, even though he had not taken his medication, and informing the physician on board the airplane of the situation.

Multilanguage versions of the medical reports should be provided

234. In case the persons who are going to be repatriated have a medical report, the head of the operation informed the inspection team that it would be given to the physician intervening in the operation, and that if the latter did not speak Spanish the report would be translated orally. This Institution believes that in these cases multilingual versions of said documents should be issued, in accordance with Directive 1.1.2 on Security Rules in Joint Expulsions by Air, of the Council Decision of 29th April 2004.

Whenever medical care is given for injuries, it must communicated to the judicial authorities

235. In respect to failed repatriations, a medical examination of returnees is only carried out if they have injuries, and the judicial authorities are only informed in case of severe injuries. This should be corrected, so that whenever medical care is provided due to injuries and irrespective of the scope of the injuries, the report of injuries must be forwarded to the judicial authorities.

Experts of the Ombudsman Institution inspected an operation organized by the Spanish Central Department of Immigration and Borders

236. In the inspection of the operation of repatriation of foreign nationals organized by the Spanish Central Department of Immigration and Borders, performed the day after the one described above, the same methodology employed in the FRONTEX repatriation operation was used, although this time the inspection began at the Aluche police station and included the transfer to the airport. On the flight with destination to Guayaquil and Bogota 47 citizens from Ecuador and 59 from Colombia were repatriated, including a minor and his father. Furthermore, a Colombian citizen who had been expelled from Holland and was accompanied by three police agents from that country was also being repatriated on that flight.

The transfer from the Immigrant Detention Center of Aluche to the airport was carried out without any problem

237. Six vehicles were used for the transfer of the deportees at the Aluche police station to the Central Unit for Deportation and Repatriation airport facilities: a bus, four vans, and a police vehicle. The process began in the hall of the Immigrant Detention Center in Madrid, when detainees left the Immigrant Detention Center and were distributed to the different vehicles mentioned, together with their belongings. Two of the experts of the NPM team who took part in this inspection travelled on the bus together with 20 deportees, to check on site how the transfer was carried out. The transfer took 25 minutes, during which one of the police agents entered the area where the detainees were seated five times to see how they were, interacting with them to keep them calm and thus avoid any incident, and informing them ten minutes before reaching the airport where the trip was going to end.

The head of the operation briefed the police agents on how the operation would unfold

238. In the airport at the Central Unit for Deportation and Repatriation facilities, the team members attended a meeting at which the head of operations briefed the police agents on how the operation was going to unfold, and specifically informed that there were three detainees who required special surveillance given their police or criminal records and prior personal behavior. He informed the police agents of the seating distribution, for both the deportees and the escorts, and that the Consul of Columbia would also be on the flight, together with five other employees of the Embassy and Consulate and two Colombian police agents. Finally he explained that the escort service in charge of the custody of the deportees consisted of 30 agents from the Spanish National Police Force's Brigade for Deportation of Foreign Offenders (abbreviated as *BEDEX* in Spanish), 44 from the Police Action Unit (abbreviated as *UIP* in Spanish), 33 from the Central Department of Immigration and Border Police, 2 INTERPOL agents and 3 escorts from Holland, who were accompanying a Colombian citizen being repatriated by that country. Of the total number of escorts, 11 were women.

The documentation and identity of the returnees was checked

239. Subsequently, the documentation was checked, specifically the existence of a passport or travel document and administrative or judicial resolution of expulsion or repatriation. All of the deportees had passports except one, who had been issued a travel document or safe-conduct. If the lack of obligatory documentation had been detected, the repatriation would have been suspended. Once these formalities had terminated, the order was given to start taking the deportees out of the vehicles. From that point on the procedure consisted of taking out the luggage from one of the vehicles, after which the foreign nationals came out one by one in order to be identified. A police agent asked each one his/her name and nationality and checked it on a list, telling another agent out loud the number that had been previously assigned to that person. The second agent checked the photographs he had of the person named in order to make a visual verification. Once this had been checked, a label was stuck onto the deportee's clothes with his/her name and assigned number. Subsequently the deportee was asked to identify his/her luggage, which was labeled with the assigned number and nationality and then stored in the plane's hold.

Regulated searches were performed

240. With respect to body and clothing searches, they were of the same intensity and characteristics as the ones described in paragraph 224, the returnees being informed of the objects and clothes they could not take with them, which were placed in bags identified in their presence with the owner's names.

On boarding the restraints were removed

241. In contrast with the means of restraint referred to earlier in the description of the FRONTEX operation, in this case all of the deportees, with the exception of the minor and his father, had their wrists tied with pieces of fabric. These ties were removed for the body searches and then used again when the searches finished, with deportees keeping them on until they boarded the plane.

Medical personnel should be aware of medical circumstances in advance

242. A physician and a registered nurse from the Regional Healthcare Unit of the Superior Police Department of Castile y Leon-Valladolid were in charge of medical care during this operation. They declared that they participated in two flights of this kind every year. On arrival at the Central Unit for Deportation and Repatriation premises they examined some of the deportees from the Madrid Immigrant Detention Center who were diabetic, as well as the medical documentation that had been prepared in that respect by the Immigrant Detention Center's medical staff. After checking that a specific medication for a type of diabetes was missing, the physician wrote out a prescription and handed it to a police agent asking that he go buy it. The inspection team was told that medical personnel is not informed sufficiently in advance of the type of medical circumstances they are going to be dealing with, which should be corrected to prevent any incident that could occur during the flight and to ensure that all necessary medical and pharmacological material is available. Moreover, and without questioning the professionalism and experience of the medical team, the criteria that should be followed is to guarantee the independence and impartiality of the medical personnel that intervene in repatriation operations by incorporating medical personnel that does not belong to the Directorate General of the Police.

Some returnees were able to communicate with their families to inform them of the transfer

243. In the different interviews of returnees, the latter reported that both the conditions of transfer to the Central Unit for Deportation and Repatriation facilities and the stay at the Immigrant Detention Center in Madrid had been correct. In respect to notification of the expulsion, a Colombian citizen stated that she had been informed the previous afternoon. A fellow countryman, on the other hand, stated that he had been informed at 7 a.m. that same day, whilst other inmates in his room were sleeping, and that he had not been allowed to call his wife, who was pregnant, to inform her that he was being repatriated. During the interview he asked the NPM expert to contact her to inform her of the situation, which was successfully done when the inspection finished. A citizen of Ecuador also said that he had not been allowed to communicate with his family, a complaint that was reiterated by another Colombian deportee. The latter had presented himself voluntarily at the National Police Station in Aranjuez, but had not been able to inform his family of his return to his country. Lastly, the inspection team interviewed the citizen from Ecuador who had not been handcuffed and was accompanied by his six-year old son in a room near the exit to the runway, accompanied by two agents who later travelled on the flight as escorts. The conversation focused on very superficial aspects, due to the child's presence. The interviewee stated that they had travelled in an undercover vehicle from Elda (Alicante) and that they had slept most of the way. Note was made that the child was calm and that actions of the two police agents guarding them were appropriate at all times in view of the child's presence, with an effort on their part to create a relaxed and pleasant atmosphere for the child.

A court suspended the expulsion of two citizens. The others, including a minor with his father, boarded the aircraft

244. Before the transfer to the aircraft, the last roll call was done (47 Ecuadorian citizens and 61 Colombian citizens). However, ten minutes afar the roll call a fax was received from a court suspending the expulsion of two Columbian citizens, who were separated from the group and led to another room while the others were transferred in buses to board the plane. The first bus was for the Ecuadorian child and his father and the diplomatic representatives of Colombia. According to the information provided, the reason for having the child in the first bus was to avoid "having him see the atmosphere and how the other deportees were boarded". Once the said vehicle had parked next to the aircraft, the child and his father descended, together with the diplomatic representatives, and boarded the airplane through the front door, since they were going to be seated in the first rows of the passenger cabin. The other deportees boarded through the rear door, after passing through a corridor formed by the police agents. Once onboard, the escorts and the deportees sat together. On the side rows, consisting of two seats, the escorts sat in the aisle seats, and in the center rows, consisting of four seats, the escorts also sat in the aisle seats.

Boarding of returnees

Photograph 64

During boarding, one of the returnees made an attempt to escape on reaching the stairway leading to the plane. He was restrained and overpowered by the escort accompanying him and the agents who formed the security corridor. After securing his hands with metal handcuffs behind his back, he boarded the plane surrounded by four agents, two holding his arms and two others holding his legs. Two NPM experts observed that the restraint was necessary given the returnee attitude and was proportional to the situation, and that the agents avoided at all times being violent, trying to make sure not to injure the returnee in any way. After being seated on the plane, the inspection team noted how this deportee was examined by the physician, who informed the head of the operation that he was in a perfect state of health and had no injury.

A returnee tried to escape and was subdued and led to the aircraft, where the physician checked that he did not have any injuries

245. According to information provided by the Directorate General of the Police, on the repatriation flights carried out in 2012 there were a total of nine incidents, shown in the following table.

In 2012 there were nine incidents

Table 46. Incidents during flights

Flights			
Incident	**Date**	**Destination**	**Organizer**
Before the transfer a returnee injured himself in the cell at the Algeciras police station.	1-5-2012	Morocco	Central Dept. of Immigration and Borders
A deportee attacked an Irish escort with a razor blade.	3-7-2012	Nigeria	FRONTEX
Several deportees took off their clothes in the bus, and one tried to hurt himself with a piece of the partition.	3-9-2012	D. R. Congo	Central Dept. of Immigration and Borders
A deportee verbally confronted one of the escorts, stealing his glasses and spitting in his face.	3-21-2012	Morocco	Central Dept. of Immigration and Borders
Several deportees cut themselves during the transfer to the airport.	5-7-2012	Georgia	Central Dept. of Immigration and Borders
One of the deportees hurt himself on the head by banging it against the stairs and the ground.	5-21-2012	Nigeria	FRONTEX
A deportee was overpowered when he caused injuries to a police agent's hand and wrist and biting his forearm.	8-22-2012	Morocco	Central Dept. of Immigration and Borders
A deportee threw himself on a crew member and had to be subdued, when he hit his face against the seat in front of him.	10-23-2012	Morocco	Central Dept. of Immigration and Borders
A returnee tried to escape when he was being boarded.	10-31-2012	Morocco	Central Dept. of Immigration and Borders

Likewise, the Directorate General of the Police reported four incidents that occurred with deportees who were going to be taken to Algeria by boat.

Table 47. Incidents during trips by boat

Boat			
Incident	**Date**	**Destination**	**Organizer**
A returnee hit himself during the transfer to the port in a police van.	2-21-2012	Algeria	Central Dept. of Immigration and Borders
Failed repatriation of three citizens who cut themselves at the police station of Alicante.	3-14-2012	Algeria	Central Dept. of Immigration and Borders
Struggle with a deportee on refusing to be boarded.	3-20-2012	Algeria	Central Dept. of Immigration and Borders
Failed repatriation when an Algerian citizen suffering from diabetes was disembarked.	7-4-2012	Algeria	Central Dept. of Immigration and Borders

Repatriation operations in 2012

246. The tables below show the repatriation operations of foreign nationals organized by FRONTEX and by the Central Department of Immigration and Borders in 2012, according to the data provided by the Directorate General of the Police.

Table 48. Joint flights programmed by FRONTEX in 2012

Joint FRONTEX International Flights						
Flight date	**Departure**	**Nationality**	**Stopover**	**Destination**	**Returnees**	**Organizer**
12/8	Madrid	Ecuador	No	Quito	43	Spain
		Columbia		Bogota	52	
12/9	Madrid	Nigeria	Rome	Lagos	2	Italy
02/23	Madrid	Ukraine	Vienna	Kiev	15	Spain
		Georgia		Tbilisi	13	
03/7	Vienna	Nigeria	Madrid	Lagos	8	Austria
04/18		Nigeria	Madrid	Lagos	8	Holland
04/27	Madrid	Ukraine	Viena	Kiev	10	Spain
		Georgia		Tbilisi	10	
05/31	Oslo	Nigeria	Madrid	Lagos	11	Norway
06/29	Madrid	Ukraine	Vienna	Kiev	7	Spain
		Georgia		Tbilisi	12	
09/12	Vienna	Nigeria	Madrid	Lagos	8	Austria
10/11	Madrid	Georgia	Vienna	Tbilisi	5	Austria
10/17	Rotterdam	Nigeria	Madrid	Lagos	5	Holland
10/25	Madrid	Pakistan	No	Islamabad	26	Spain
12/12	Madrid	Armenia	Vienna	Tbilisi	8	Austria
		Georgia			9	
Total					**252**	

Source: In-house compilation based on information provided by the Directorate General of the Police.

Table 49. International flights carried out in 2012 by the Central Department of Immigration and Borders

International Flights					
Flight date	**Departure**	**Nationality**	**Stopover**	**Destination**	**Returnees**
02/14	Madrid	Nigeria	No	Lagos	39
		Cameroon		Douala	4
02/16	Madrid	Mali	No	Bamako	29
		Cameroon		Douala	5
03/09	Madrid	Congo	Malaga	Kinshasa	53

International Flights					
Flight date	**Departure**	**Nationality**	**Stopover**	**Destination**	**Returnees**
03/23	Madrid	Nigeria	No	Lagos	27
		Cameroon		Douala	5
04/13	Madrid	Ivory Coast	No	Abidjan	19
		Guinea		Conakry	10
05/07	Madrid	Georgia	Barcelona	Tbilisi	15
05/10	Madrid	Senegal	No	Dakar	31
		Cameroon		Douala	5
06/14	Madrid	Gambia	No	Banjul	19
		Nigeria		Lagos	34
06/20	Madrid	Ecuador	No	Guayaquil	43
		Colombia			59
07/05	Madrid	Congo	Malaga	Kinshasa	13
		Senegal		Dakar	19
08/09	Madrid	Senegal	Malaga	Dakar	25
		Nigeria		Lagos	27
09/27	Madrid	Senegal	Malaga	Dakar	52
10/18	Madrid	Ecuador	No	Guayaquil	47
		Columbia		Bogota	59
11/15	Madrid	Nigeria	No	Lagos	47
11/29	Madrid	Senegal	Malaga	Dakar	39
12/18	Madrid	Senegal	No	Dakar	34
Total					**759**

Source: In-house compilation based on information provided by the General Directorate of the Police.

Table 50. Repatriations to Morocco via Ceuta carried out in 2012 by the Central Department of Immigration and Borders

Repatriations to Morocco via Ceuta				
Flight Date	**Departure**	**Stopover**	**Destination**	**Returnees**
01/05/2012	Madrid	Jerez Frta.	Ceuta	29
		Algeciras		
01/10/2012	Madrid	Barcelona	Ceuta	23
		Algeciras		
01/12/2012	Madrid	Algeciras	Ceuta	20
01/17/2012	Madrid	Jerez Frta.	Ceuta	22
		Algeciras		

Repatriations to Morocco via Ceuta				
Flight Date	**Departure**	**Stopover**	**Destination**	**Returnees**
01/19/2012	Madrid	Algeciras	Ceuta	22
01/24/2012	Madrid	Algeciras	Ceuta	17
01/26/2012	Madrid	Jerez Frta. Algeciras	Ceuta	21
01/01/2012	Madrid	Barcelona Jerez Frta.	Ceuta	18
02/02/2012	Madrid	Jerez Frta. Algeciras	Ceuta	23
02/07/2012	Madrid	Algeciras	Ceuta	24
02/09/2012	Madrid	Algeciras	Ceuta	20
02/14/2012	Madrid	Jerez Frta. Algeciras	Ceuta	24
02/16/2012	Madrid	Algeciras	Ceuta	21
02/21/2012	Madrid	Barcelona Jerez Frta.	Ceuta	23
02/23/2012	Madrid	Algeciras	Ceuta	18
02/28/2012	Madrid	Jerez Frta. Algeciras	Ceuta	25
03/01/2012	Madrid	Jerez Frta. Algeciras	Ceuta	21
03/06/2012	Madrid	Barcelona Jerez Frta. Algeciras	Ceuta	19
03/08/2012	Madrid	Jerez Frta. Algeciras	Ceuta	23
03/13/2012	Madrid	Algeciras	Ceuta	21
03/15/2012	Madrid	Algeciras	Ceuta	22
03/21/2012	Madrid	Algeciras	Ceuta	23
03/23/2012	Madrid	Barcelona Algeciras	Ceuta	21
03/27/2012	Madrid	Algeciras	Ceuta	22
03/30/2012	Madrid	Algeciras	Ceuta	24
04/02/2012	Madrid	Barcelona	Ceuta	23
04/04/2012	Madrid	Jerez Frta. Algeciras	Ceuta	24

Repatriations to Morocco via Ceuta				
Flight Date	**Departure**	**Stopover**	**Destination**	**Returnees**
04/12/2012	Madrid	Jerez Frta. Algeciras	Ceuta	18
04/17/2012	Madrid	Barcelona	Ceuta	19
04/19/2012	Madrid	Algeciras	Ceuta	23
04/24/2012	Madrid	Jerez Frta. Algeciras	Ceuta	21 1
04/26/2012	Madrid	Algeciras	Ceuta	20
05/03/2012	Madrid	Barcelona Algeciras	Ceuta	24
05/04/2012	Madrid	Jerez Frta. Algeciras	Ceuta	24
05/08/2012	Madrid	Algeciras	Ceuta	23
05/10/2012	Madrid	Algeciras	Ceuta	22
05/16/2012	Madrid	Barcelona Algeciras	Ceuta	18
05/18/2012	Madrid	Algeciras	Ceuta	26
05/22/2012	Madrid	Algeciras	Ceuta	25
05/25/2012	Madrid	Jerez Frta. Algeciras	Ceuta	22
05/29/2012	Madrid	Algeciras	Ceuta	23
06/01/2012	Madrid	Jerez Frta. Algeciras	Ceuta	23
06/05/2012	Madrid	Barcelona Algeciras	Ceuta	22
06/07/2012	Madrid	Algeciras	Ceuta	22
06/12/2012	Madrid	Jerez Frta. Algeciras	Ceuta	16
06/14/2012	Madrid	Jerez Frta. Algeciras	Ceuta	21
06/19/2012	Madrid	Barcelona Algeciras	Ceuta	23
06/21/2012	Madrid	Jerez Frta. Algeciras	Ceuta	19
06/26/2012	Madrid	Jerez Frta. Algeciras	Ceuta	24

Repatriations to Morocco via Ceuta				
Flight Date	**Departure**	**Stopover**	**Destination**	**Returnees**
06/28/2012	Madrid	Jerez Frta. Algeciras	Ceuta	20
07/03/2012	Madrid	Barcelona	Ceuta	22
07/05/2012	Madrid	Algeciras	Ceuta	19
07/11/2012	Madrid	Algeciras	Ceuta	21
07/17/2012	Madrid	Barcelona Algeciras	Ceuta	19
07/19/2012	Madrid	Algeciras	Ceuta	21
07/24/2012	Madrid	Algeciras	Ceuta	18
07/26/2012	Madrid	Algeciras	Ceuta	23
07/31/2012	Madrid	Barcelona Algeciras Jerez Frta.	Ceuta	22
08/02/2012	Madrid	Algeciras	Ceuta	22
08/07/2012	Madrid	Barcelona	Ceuta	23
08/14/2012	Madrid	Algeciras	Ceuta	21
08/17/2012	Madrid	Algeciras	Ceuta	25
08/22/2012	Madrid	Barcelona Algeciras	Ceuta	23
08/24/2012	Madrid	Jerez Frta. Algeciras	Ceuta	22
08/28/2012	Madrid	Algeciras	Ceuta	23
08/30/2012	Madrid	Algeciras	Ceuta	15
09/06/2012	Madrid	Jerez Frta.	Ceuta	21
09/10/2012	Madrid	Barcelona Algeciras	Ceuta	22
09/13/2012	Madrid	Algeciras	Ceuta	24
09/18/2012	Madrid	Jerez Frta. Algeciras	Ceuta	23
09/20/2012	Madrid	Algeciras	Ceuta	23
09/25/2012	Madrid	Barcelona	Ceuta	20
09/27/2012	Madrid	Algeciras	Ceuta	20
10/02/2012	Madrid	Algeciras	Ceuta	21
10/05/2012	Madrid	Jerez Frta. Algeciras	Ceuta	25

Repatriations to Morocco via Ceuta				
Flight Date	**Departure**	**Stopover**	**Destination**	**Returnees**
10/09/2012	Madrid	Barcelona	Ceuta	21
10/11/2012	Madrid	Jerez Frta. / Algeciras	Ceuta	17
10/16/2012	Madrid	Algeciras	Ceuta	18
10/18/2012	Madrid	Algeciras	Ceuta	20
10/23/2012	Madrid	Barcelona	Ceuta	23
10/30/2012	Madrid	Algeciras	Ceuta	22
10/31/2012	Madrid	Jerez Frta. / Algeciras	Ceuta	23
11/06/2012	Madrid	Barcelona / Jerez Frta.	Ceuta	18
11/08/2012	Madrid	Jerez Frta. / Algeciras	Ceuta	19
11/13/2012	Madrid	Jerez Frta. / Algeciras	Ceuta	13
11/20/2012	Madrid	Barcelona	Ceuta	20
11/22/2012	Madrid	Jerez Frta. / Algeciras	Ceuta	21
11/27/2012	Madrid	Jerez Frta. / Algeciras	Ceuta	16
12/04/2012	Madrid	Barcelona	Ceuta	24
12/11/2012	Madrid	Algeciras	Ceuta	25
12/13/2012	Madrid	Algeciras	Ceuta	20
12/18/2012	Madrid	Barcelona	Ceuta	19
12/20/2012	Madrid	Jerez Frta. / Algeciras	Ceuta	20
12/27/2012	Madrid	Algeciras	Ceuta	19
12/28/2012	Madrid	Barcelona	Ceuta	20
Total				**2,028**

Source: In-house compilation based on information provided by the Directorate General of the Police.

Table 51. Repatriations to Morocco via Melilla carried out in 2012 by the Central Department of Immigration and Borders

Repatriations to Morocco via Melilla				
Flight date	**Departure**	**Stopover**	**Destination**	**Returnees**
01/12/2012	Madrid	No	Melilla	4
01/19/2012	Madrid	No	Melilla	5
01/26/2012	Madrid	No	Melilla	3
02/02/2012	Madrid	No	Melilla	6
02/09/2012	Madrid	No	Melilla	3
02/23/2012	Madrid	No	Melilla	4
03/01/2012	Madrid	No	Melilla	3
03/08/2012	Madrid	No	Melilla	5
03/15/2012	Madrid	No	Melilla	4
03/23/2012	Madrid	No	Melilla	2
04/12/2012	Madrid	No	Melilla	5
04/19/2012	Madrid	No	Melilla	5
04/26/2012	Madrid	Jerez Frta.	Melilla	4
05/04/2012	Madrid	No	Melilla	3
05/10/2012	Madrid	No	Melilla	5
05/18/2012	Madrid	No	Melilla	4
06/01/2012	Madrid	Jerez Frta.	Melilla	4
06/07/2012	Madrid	No	Melilla	4
06/14/2012	Madrid	No	Melilla	3
06/21/2012	Madrid	No	Melilla	5
06/28/2012	Madrid	No	Melilla	5
07/05/2012	Madrid	No	Melilla	5
07/11/2012	Madrid	No	Melilla	3
07/19/2012	Madrid	Jerez Frta.	Melilla	4
07/26/2012	Madrid	No	Melilla	3
08/02/2012	Madrid	No	Melilla	2
08/24/2012	Madrid	No	Melilla	5
08/30/2012	Madrid	No	Melilla	2
09/14/2012	Madrid	Barcelona	Melilla	19
09/20/2012	Madrid	No	Melilla	5
09/27/2012	Madrid	No	Melilla	6
10/05/2012	Madrid	No	Melilla	5
10/11/2012	Madrid	No	Melilla	2
10/31/2012	Madrid	No	Melilla	4

Repatriations to Morocco via Melilla				
Flight date	**Departure**	**Stopover**	**Destination**	**Returnees**
11/08/2012	Madrid	No	Melilla	2
11/16/2012	Madrid	No	Melilla	2
11/22/2012	Madrid	No	Melilla	4
11/27/2012	Madrid	Almeria	Melilla	30
11/30/2012	Madrid	No	Melilla	5
12/05/2012	Madrid	No	Melilla	9
12/13/2012	Madrid	Barcelona	Melilla	5
12/20/2012	Madrid	No	Melilla	4
Total				**212**

Source: In-house compilation based on information provided by the Directorate General of the Police.

Table 52. Repatriations of Algerian citizens by boat carried out in 2012 by the Central Department of Immigration and Borders

International Boats		
Routes	**Boats**	**Algerians**
Alicante/Oran	55	613
Almeria/Ghazaouet	74	740
Almeria/Oran	12	86
Total	**141**	**1,439**

Source: In-house compilation based on information provided by the Directorate General of the Police.

Institutional activities for training and dissemination

§247-§253

247. Once again, and in accordance with article 23 of the OPCAT (Optional Protocol to the Convention against Torture), the Annual Report corresponding to 2011 was presented to the Spanish Parliament (*Congreso de Diputados*) (6th June 2012). 1,370 copies of the Report were handed out for distribution to the authorities and representatives of civil society. In addition, on the 13th and 14th of September 2012, interviews were held with representatives of the Coordination Committee for the Prevention of Torture (*Coordinadora para la Prevencion de la Tortura*), the Federation of Associations for the Defense and Promotion of Human Rights in Spain (*La Federación de Asociaciones de Defensa y Promoción de los Derechos Humanos de España*), the Spanish Society for International Human Rights Law *(la Asociación Española para el Derecho Internacional de los Derechos Humanos*), the Association for Human Rights (*Asociación pro Derechos Humanos [APDHE*]), Red Cross and *Red Acoge*, and labor unions such as the Federal Police Union (*Union Federal de Policía),* Union of Civil Guard Officers (*Unión de Oficiales de la Guardia Civil*), the Unified Association of Civil Guards (*Asociación Unificada de la Guardia Civi*l), and the Federation of Citizen Services-trade union (*FSC-CCOO)*, with the objective to explain the contents of the 2011 Report and offer a preview of the NPM's general lines of action in 2012.

On the 6th of June 2012 the report of the previous year was presented to the Chamber of Deputies

248. On the 21st of February the acting Ombudsman appeared before the SPT (UN Subcommittee for the Prevention of Torture) and the High Commissioner for Human Rights within the context of the Subcommittee's 16th session at its headquarters in the Palace of the United Nations in Geneva (Switzerland). The meeting took place within the framework of the relations of dialogue and cooperation established between the NPM and the SPT, for the purpose of exchanging information and experiences regarding the activities carried out by Spain's Ombudsman Institution in its capacity as NPM. In the course of the hearing the main conclusions of the NPM's first Annual Report were highlighted, with a preview of the basic lines of action for the future 2011 Report.

The acting Ombudsman appeared before the UN Subcommittee for the Prevention of Torture

249. With respect to the work of dissemination of competencies, operations and actions carried out by the NPM in 2012, experts from the Mechanism participated in different forums, including the 14th National Gathering of Penitentiary Legal Guidance and Aid Services (*XIV Encuentro Estatal de Servicios de Orientación y Asistencia Jurídica Penitenciaria)*, the Seminar of the Training and Improvement Division of the Police Training Center on Human Rights and Police Legitimacy (*Seminario de la División de Formación y Perfeccionamiento del Centro de Formación de la Policía de derechos humanos y legitimidad policíal)*; and the Master's in International Protection of Human Rights (Máster en Proteción Internacional de los Derechos Humanos) at the University of Alcala de Henares Law School (Madrid).

NPM experts have participated in different forums

250. In addition, communication with the SPT, the Association for the Prevention of Torture and other NPMs was constant, with the aim of exchanging experiences and reinforcing the prevention work of these institutions.

Communications with other institutions

Participation in the "European NPM Project"

251. In respect to training activities, the Ombudsman Institution continued to participate in the "European NPM Project", organized and financed by the Council of Europe in collaboration with the European Commission, attending the workshop on "Monitoring the risks of ill-treatment or torture during immigrant repatriation procedures: consultations regarding deportation, monitoring joint repatriations and border security", held in Belgrade (Serbia) on the 12th and 13th of June 2012. Likewise, the Institution attended the "Workshop on the deportation of foreign nationals and the National Prevention Mechanism Mandate", held on the 20th and 21st of March in Geneva (Switzerland).

Symposiums with the NPMs of Macedonia, Serbia and Armenia

252. Furthermore, symposiums were organized in collaboration with the NPMs of other countries to discuss the Spanish NPM's mandate and the activities it had carried out. Specifically, in 2012 symposiums were held with the NPMs of Macedonia, Serbia and Armenia.

The Ombudsmen of Bolivia and Ecuador visited the Institution in Spain to learn about the NPM

253. Lastly, the Institution was visited by the Ombudsmen of Bolivia and Ecuador, who were personally interested in learning about the operations of their Spanish counterpart, including its activities as NPM.

General Conclusions

§254-§264

Recommendations made by the NPM in 2010 and 2011 remain outstanding

254. Despite the recommendations of the National Mechanism for the Prevention of Torture (abbreviated as NPM, or *MNP* in Spanish) in its 2010 and 2011 Annual Reports, among other things, the following remain to be carried out: amendment of Article 174 of the Criminal Code, which includes the definition of the crime of torture; amendment of Article 520 of the Spanish Code of Criminal Procedure (abbreviated as LECrim in Spanish), in order to reduce the maximum period of eight hours within which the right to legal assistance must be made effective, and the inclusion of the right to apply for *habeas corpus;* the reform of the *incommunicado* detention in the manner indicated by the NPM in paragraphs 480 and 481 of the 2010 Annual Report, the most comprehensive regulation of involuntary civil detention; the adoption of unified systems of inspection of all local police forces.

It is necessary to computerize the data collection of complaints regarding police behavior

255. It is also necessary to design a computer application to collect information statistics on complaints regarding police behavior that may constitute torture, ill-treatment or denial of assurance of the detained as well as statistical information on the number of police officers with criminal or disciplinary lawsuits open for such acts, their processing status, the penalties imposed and the type of sanction in question.

The Spanish Public Prosecutor's Office has played a more active role in controlling crimes of torture and abuse

256. The interest of the Spanish Public Prosecutor's Office to play a more active role against such crimes is referenced in the 2012 Report, which advocates for individualized treatment for crimes of torture and abuse in their record systems, thus facilitating the impetus and control of actions brought about for such offenses. As stated in this Report, which references activities during the year 2011, the number of criminal proceedings for torture and other crimes against moral integrity committed by a civil servant in this capacity as such provides a useful tool for assessing the degree to which the rights of detainees and prisoners was complied with, as well as judicial investigation mechanisms for dealing with complaints. To this end are the following data, provided by the Public Prosecutor's Office:

Table 53. Preliminary proceedings initiated by the Spanish Public Prosecutor's Office in 2011

Public Prosecutor's Office	Torture	Degrading treatment	Against moral integrity by authority or civil servants	Total
A Coruña Prov. High Court	0	2	4	**6**
Albacete Prov. High Court	1	2	0	**3**
Alicante Prov. High Court	1	0	0	**1**
Almeria Prov. High Court	0	0	0	**0**
Araba/Alava Prov. High Court	0	8	1	**9**
Asturias Prov. High Court	0	1	5	**6**
Ávila Prov. High Court	0	1	0	**1**
Badajoz Prov. High Court	0	6	0	**6**

Public Prosecutor's Office	Torture	Degrading treatment	Against moral integrity by authority or civil servants	Total
Barcelona Prov. High Court	1	4	3	**8**
Bizkaia Prov. High Court	4	6	1	**11**
Burgos Prov. High Court	0	0	0	**0**
Caceres Prov. High Court	0	1	1	**2**
Cadiz Prov. High Court	1	3	0	**4**
Cantabria Prov. High Court	0	0	1	**1**
Castello/Castellon Prov. High Court	0	0	0	**0**
Ciudad Real Prov. High Court	0	0	4	**4**
Cordoba Prov. High Court	0	45	0	**45**
Cuenca Prov. High Court	0	1	4	**5**
Gipuzkoa Prov. High Court	5	6	6	**17**
Gerona Prov. High Court	0	0	0	**0**
Granada Prov. High Court	0	0	0	**0**
Guadalajara Prov. High Court	1	1	2	**4**
Huelva Prov. High Court	0	73	0	**73**
Huesca Prov. High Court	0	1	0	**1**
Balearic Islands Prov. High Court	0	2	2	**4**
Jaen Prov. High Court	0	0	0	**0**
La Rioja Prov. High Court	0	2	0	**2**
Las Palmas Prov. High Court	8	6	4	**18**
Leon Prov. High Court	0	2	1	**3**
Lerida Prov. High Court	0	0	0	**0**
Lugo Prov. High Court	0	2	1	**3**
Madrid Prov. High Court	11	6	7	**24**
Malaga Prov. High Court	0	2	0	**2**
Murcia Prov. High Court	0	18	5	**23**
Navarre Prov. High Court	4	1	1	**6**
Orense Prov. High Court	0	5	0	**5**
Palencia Prov. High Court	0	1	1	**2**
Pontevedra Prov. High Court	1	6	3	**10**
Salamanca Prov. High Court	0	1	0	**1**
S.Cruz Prov. High Court	3	4	1	**8**
Segovia Prov. High Court	0	1	1	**2**
Seville Prov. High Court	2	2	1	**5**

Public Prosecutor's Office	Torture	Degrading treatment	Against moral integrity by authority or civil servants	Total
Soria Prov. High Court	0	1	0	**1**
Tarragona Prov. High Court	0	1	0	**1**
Teruel Prov. High Court	0	3	0	**3**
Toledo Prov. High Court	0	0	3	**3**
Valencia Prov. High Court	0	1	0	**1**
Valladolid Prov. High Court	1	3	2	**6**
Zamora Prov. High Court	0	0	1	**1**
Saragossa Prov. High Court	0	0	0	**0**
High Court of Justice Andalusia	0	0	0	**0**
High Court of Justice Aragon	0	0	0	**0**
High Court of Justice Canary Islands	0	0	0	**0**
High Court of Justice Castilla y Leon	0	0	0	**0**
High Court of Justice Castilla-La Mancha	0	0	0	**0**
High Court of Justice Catalonia	2	0	0	**2**
High Court of Justice Extremadura	0	0	0	**0**
High Court of Justice Galicia	0	0	0	**0**
High Court of Justice Madrid (Auto. Community)	0	0	0	**0**
High Court of Justice Basque Country	0	0	0	**0**
High Court of Justice Valencia (Aut. Comm.)	0	0	0	**0**
Total	**46**	**231**	**66**	**343**

Source: In- house compilation based on information provided by the Attorney General's Office (2012 Report).

One should recall the role of the Spanish Public Prosecutor's Office in the prosecution of these crimes and the importance of an immediate forensic medical examination, issued pursuant to the requirements of the Istanbul Protocol.

Granting pardons to enforcement officers convicted of abuse should be avoided

257. A pardon is a measure of grace that may correct an injustice caused by the strict application of the law, but granting pardons to law enforcement officers who have been convicted of crimes involving the mistreatment of individuals deprived of freedom should be avoided. The execution of a judgment in its entirety acts as a deterrent to the commission of similar acts in the future. Logi-

cally, this result does not hold if a pardon is granted, giving rise to certain expectations of impunity. This also negatively impacts the commendable performance of the State Security Forces as a whole, in terms of the efficiency of the judicial function and preventive agenda of the NPM.

The general conclusions presented are grouped by length of deprivation of liberty

258. Notwithstanding the considerations and conclusions concerning the facilities of special interest regarding deprivation of liberty visited in 2012 that were developed throughout this report, a general summary follows that would apply to the type of facilities referenced here.

259. General conclusions regarding short-term depravation of liberty.

Poor video surveillance systems

- In most facilities, video surveillance systems do not meet the criteria established by the Ombudsman Institution in previous reports.

The lack of call sound systems

- Many facilities do not have officers in the cells at all times when detainees are present, and / or have cells that lack call sound systems, which can pose a risk in situations that require the immediate presence of officers.

No information in writing about habeas corpus

- In most facilities that were visited, prisoners are not informed in writing of the possibility of filing a writ of *habeas corpus*.

Immediate access to a lawyer

- Although access to a lawyer in the period immediately following the start of the deprivation of liberty is essential for the prevention of torture and abuse, in most of facilities visited the request for legal aid is made at the time when authorities will proceed to take the statements of the interested party.

The time of detention is longer than necessary

- With regards to bringing justice to those detained, the Constitutional Court has held that the practice of having detainees appear before the court first thing in the morning following the completion of police inspections extends detention longer than necessary, violating Article 17.2 of the Spanish Constitution.

Reports contain personal data of privacy concern

- In some facilities, it was observed that when detainees receive medical care, information about the assistance they receive is included in a copy of the police report. Sometimes this includes the medical history of the detainees, which in the opinion of this Institution is inappropriate, being that this relates to personal / private information.

Often, agents are not properly identified

- In many units it was found that the officers were not properly identified. The Basque autonomous police force (*Ertzaintza*) accepted the recommendation made by this Institution to establish the requirement that officers be identified. Nonetheless, recommendations made to various other Police Forces have not been accepted, which call for the writing on their name badges to be clearly visible from what is deemed a "respectful distance" (*distancia de respeto*).

- It continues to be observed in some units that the criteria of the Ombudsman Institution has not been complied with regarding weapons not being present when access to the custody area is granted, in the interest of safety of detainees and the agents themselves.

Agents must go unarmed to the custody area

- Although the governing bodies of the Spanish National Police Force (abbreviated as *CNP* in Spanish) and Civil Guard (abbreviated as GC in Spanish) have completed their compulsory Detainee Record of Custody, deficiencies been identified, particularly with regard to the practice of strip searches.

Poorly complying with the Detainee Record of Custody

- Some facilities have deficiencies that impede guaranteeing the physical integrity of detainees, such as horizontal bars on cell doors, sheet metal or exposed bolts, which can be utilized by the detainees to attempt to cause self-harm.

Facilities with potentially dangerous elements

260. General conclusions regarding Immigrant Detention Centers.

- Although the detention order should ensure effective repatriation of immigrants, 52% of immigrants held in 2012 have not been removed.

52% of immigrants have not been removed

- A regulation has yet to be published regulating the detention conditions of foreign nationals, and thus it is necessary to streamline procedures for the final publication of this regulation.

Regulations governing detention have not been published

- The Directorate General of the Police (abbreviated as *DGP* in Spanish) has rejected the formulated Recommendation that inmates be informed verbally and in writing of the possibility of filing a writ of *habeas corpus*.

Habeas corpus *recommendations rejected*

- The Recommendation facilitating information on international protection was accepted, with written evidence that such was carried out.

International protection is accepted

- The Public Administration proceeded in accordance with the criteria of the Ombudsman Institution regarding the closure of the Immigrant Detention Center (abbreviated as *CIE* in Spanish) in Malaga, but not that of Algeciras, which remains open despite a request for its closure as well.

Immigrant Detention Center in Malaga closed

- In the recent Decision of the Spanish Court (abbreviated as *STC* in Spanish) 17/2013, of 31 January, the high court considers that, in order for the practice of personal searches of detained immigrants to be admissible, the Public Administration must find such action necessary to ensure the safety of the establishment. Similarly, advance notice, or depending on the circumstances of the case, simultaneous or subsequent notice will be necessary regarding the dimension and degree of the search, as well as the items seized as a result.

Personal searches upon confirmation of the need

- Regarding means of restraint, the said Decision considers that its adoption is bound by both its aim (the restoration of normalcy in the center) as well as its limited duration, and as such most only occur for as long as is necessary to dispel the circumstances that necessitated the restraint.

The adoption of means of restraint is determined by their purpose and duration

No medical assistance in the afternoon and evening

- In the Immigrant Detention Centers visited, medical attention has not been present during the afternoon or evening, nor has a University Registered Nurse (abbreviated as *DUE* in Spanish) in the evening, which could compromise the right to health of the inmates. The Directorate General of the Police reported that the contract for the provision of service had been extended with the contractor.

The Recommendation for psychological assistance was rejected

- The Directorate General of the Police **rejected the formulated Recommendation** to provide **psychological and psychiatric care** to inmates, claiming that if necessary, inmates could be referred to the hospital.

The Recommendation for a suicide prevention program was rejected

- The **Recommendation to develop a program for the prevention of suicides was rejected** as well, although the Directorate General of the Police has reported periodically giving instructions to prison staff to reduce the risk of self-harm or suicide.

Medical records do not comply with the legislation

- During the visits it was observed that the format and content of **medical records did not comply with the existing legislation** in matters of clinical information and documentation. The Directorate General of the Police reported that the new contractor has been called on to remedy this deficiency.

Insufficient medical assistance in the Immigrant Detention Centers in Valencia and Barcelona

- In Immigrant Detention Centers in Valencia and Barcelona, there were no reliable **records** showing **requests for medical care** and if such was in fact subsequently carried out, deficiencies have been corrected.

Incomplete injury reports, missing photos

- **In the injury reports that were examined**, the type, form, size, exact location, etc. of the injuries **were not adequately described**, nor were photographs included, which must be corrected. The Directorate General of the Police reported that it has called on the contractor to assess the correction.

Injury reports were not sent to the Duty Court

- In the Immigrant Detention Centers that were visited, **injury reports** issued to the inmates were sent to the overseeing court or to that which authorized the internment, and those of the police officers to the Local Criminal Court on duty, which was corrected by the Directorate General of the Police, having directed them jointly to the latter.

Living with citizens from prison

- **Foreign nationals** who come from prison **coexist with other foreign nations who are detained** merely because of their unauthorized stay in our country

There are no social services

- **The absence of social assistance services,** provided for in the Organic Law 4/2000, is still awaiting regulatory development.

Notification is not made regarding the time of release

- The lack of notification to inmates regarding when they will be released has been a source of complaints. Some of the courts which oversee the Immigrant Detention Centers deem that **the release notice must be made with a minimum of 12 hours in advance.**

Deficiencies of video surveillance systems in the Immigrant Detention Centers

- Deficiencies have been observed in terms of the video surveillance systems in the Immigrant Detention Centers that were visited.

- Although the Directorate General of Police had informed this Institution that it had followed instructions regarding officers' lack of identification, noncompliance has been observed in some of the centers that were visited.

Officers are not identified

- In some of the Immigrant Detention Centers, complaints were received with regards to there not being permanent lavatory access at night. The Directorate General of Police has reported that it has reiterated to all prison staff to attend to the requests of inmates during the night.

Difficulties regarding lavatory access at night

- The Recommendation that inmates should have cell phone access was accepted, as long as they return them after use.

Recommendation regarding cell phone access accepted

- The Recommendation to install intercoms was also accepted, with its execution pending budget availability.

Recommendation regarding intercoms accepted

- The lack of recreational material and sports equipment was the source of complaints in some of the Immigrant Detention Centers.

Lack of recreational material and sports equipment

261. General conclusions regarding the prisons.

- Many prisons fail to comply with the legal mandate of the cell principle (one prisoner per cell), and thus necessary measures should be taken to avoid this.

Noncompliance with one prisoner per cell

- The video surveillance systems do not generally comply with the criteria stated by the Ombudsman Institution, which is particularly serious in cells in which restraining measures of physical restraint are used. In addition, in case of incidents involving injury, the recordings are not generally sent to the court unless at the court's request.

Insufficient video surveillance

- All prisons should have sound systems in the interior of the cells, which is not always complied with.

There are not always call sound systems

- Information regarding rights and responsibilities should be available in the different languages common in that prison, with a simultaneous translation system available when necessary.

Rights and responsibilities should be in different languages

- Prisons with higher occupancy or that are located away from populated areas with emergency medical services should have 24-hour in-person health care available at the site. The frequency of visits should be required to meet the demands of the inmates.

Isolated prisons should provide 24-hour health support

- The Government of Catalonia *(Generalitat de Cataluña)* should establish a specific protocol for the medical examination of inmates upon admission.

Specific protocol for medical examinations upon admission

- Prisons should provide records of medical care requests and appointments.

Records for requests for medical care

Promoting telemedicine

- Certain medical consultations should be further carried out through telemedicine systems.

Medicine should be dispensed under the immediate observation of healthcare workers

- When taking medication that requires closer monitoring (as is the case with psychotropic drugs), it must be dispensed under the immediate observation of health workers.

Coordination with public health services

- Prisons should set up the computerization of medical records and coordination with the public health services as a tool to improve the medical care provided to inmates.

Missed medical appointments due to lack of guards

- Although in the majority of prisons, the number of medical appointments missed due to the lack of guards available to watch over and transfer inmates is nonexistent or lower than 10%, the following cases should be negatively highlighted: Psychiatric Penitentiary Hospital in Seville (22.11%), the Seville Prison (26.04%) and the Jaen Prison (29.01%).

A rehabilitation and reintegration program for the mentally ill is needed

- The progressive implementation of the Framework program for comprehensive care for the mentally ill (abbreviated as *PAIEM* in Spanish) by the *SGIP (*Office of the Secretary General for Prisons) must be commended. It has been expressed to the Government of Catalonia that a similar program with rehabilitation measures and social reintegration should be established.

The establishment of psychology consultation service is advisable

- Given the high rate of mental disorders in prison, the establishment of psychology consultation services is advisable.

Measures to prevent suicide should be improved

- Measures should be further improved to prevent inmates' suicidal behavior and to periodically evaluate their effectiveness in order to improve their quality. The prison facilities in the Government of Catalonia do not have a specific protocol for suicide prevention, which should be corrected.

The use of coercive measures should be correctly documented

- Proper documentation regarding the use of restraining means (the circumstances, duration, monitoring and control, communication with the parole judge, etc.) is essential.

Permanent supervision of immobile persons

- The *SGIP* must be reminded of the Ombudsman Institution criteria that immobile persons must be permanently monitored, preferably by medical personnel.

Regimental limitation should only be applied to guarantee the security of the inmate and should be communicated to the affected inmate and the parole judge

- The approach taken by the *SGIP* regarding the application of Article 75 of the Prison Regulations is not consistent with the Ombudsman Institution in that the regimental limitations that may be agreed upon under this rule must be for the sole purpose of securing the inmate; if other objectives are pursued, then possibilities granted by the penitentiary legislation must be resorted to. In any case, the *SGIP* should fulfill its Instruction 3/2010, of 6 March, such that the application of Article 75.1 of the Prison Regulations only applies to acts which, by their gravity, would endanger the security

and order of the prison, and the reasons must be specifically accredited in the resolution, with the affected inmate having the option to contradict them through appeal. The prison regime should not in any case be one with sanctions like isolation or secure detention, and concrete regimental limitations should be specified in the notification to the affected person as well as in the communication with the parole judge. Moreover, the increase of inmates in a prison that require protection under Article 75.2 of the Prison Regulations can be considered an indication of abnormal functioning of the prison's internal separation system.

- Facilities which carry out compliance with the sanction of isolation, precautionary measures, provisional isolation, or Article 75 of the Prison Regulations, must be adequate and have conditions similar to those of ordinary cells.

Isolation facilities must be adequate

- Medical examinations must follow proper protocol in situations of isolation or regimental limitations and the personal protective measures in Article 75 of the Prison Regulations.

Medical examinations must follow protocol

- It should be recalled that when medical services address an inmate with injuries that may be of criminal nature, the corresponding injury report should be systematically processed and directed to the competent judicial authority as soon as possible.

Injury reports of criminal nature should be processed as swiftly as possible

- Injury reports do not include photographs and in many cases do not adequately describe the type of injury sustained, nor the form, size, exact location and other characteristics that would subsequently permit the determination of the mechanism of production, nor do they describe how the injured person referenced the injuries that occurred.

Injury reports incomplete and missing photos

- Prisons must have treatment, educational, socio-cultural, and recreational and sports programs necessary for the inmates' personal development and labor and social skills, thus facilitating their reintegration. It should also offer the possibility of paid and productive work to the largest number of inmates possible.

Treatment, cultural, and sports programs should be established.
Productive and paid work

- The training of prison staff should be expanded in the various areas that may affect their work, especially regarding guarantees of human rights protections. It should be reiterated that carrying identification is mandatory.

Prison staff should expand their training and should be identified

- In the internal transfers between prisons, necessary steps should be adopted so that inmates can arrange for enough belongings depending on the estimated duration of the transfer, and so that they can access them and wash properly.

Inmates should arrange their belongings during transfers

262. General conclusions regarding centers for minor offenders.

There should be maximum surveillance of minors who are isolated or under physical restraint

- In the case of having to jointly resort to provisional isolation and physical restraint as a means of containing a violent or aggressive situation, there should be increased surveillance and control of the isolated individual, as well as a medical examination and accompaniment for the minor, preferably by health personnel.

The use of restraint or separation must be recorded

- The use of any measure equivalent to a means of restraint, such as temporary separation, regardless of whether it may be considered as an educational measure, must be recorded in the Records of means of restraint.

Strip searches must be made in the presence of an educator or health personnel, and should be communicated

- Personal strip searches should always be performed in the presence of an educator or a coordinator, in order to prevent potential abuses of power or conflictive situations, as well as with the intervention of health personnel if a body cavity search (of the mouth and rectal area) is preformed. These searches, in spite of being communicated to the judge and the relevant regional autonomous Public Administration, should be recorded in a specific book that lists the date and time they were carried out, the reason, person in charge, authorization of the director and the involvement of health personnel, as well as the outcome.

Disciplinary action as swift as possible once an offence is committed

- After an offence is committed, the disciplinary action and initiation of the corresponding proceedings, the imposition of the sanction, and enforcement should ensue as swiftly as possible.

Sanctions should be communicated to the lawyers of minors

- Sanction resolutions of disciplinary proceedings for a serious or very serious office must be communicated to inmates' lawyers, in order to guarantee their right to defense.

The circumstances of each case should be assessed

- It is advisable, when dealing with the circumstances of each case, to evaluate in a prudent manner the application of the penalty system or educational corrections in the face of situations that could be susceptible to one response or another.

Educators should guide rather than ban conversations about contentious issues

- Instead of prohibiting minor inmates from speaking amongst themselves about certain issues, such as the glorification of criminal histories, techniques for committing crimes or justifications for using drugs, educators should be involved in these conversations in order to make minors understand the negative outcome of such behavior.

Therapeutic placements must include clinical diagnosis

- Documentation and reports should be provided when a minor is subject to therapeutic placement, which should include a clinical diagnosis, previously evaluated by mental health professionals, as well as detailed background information, such as reports from the mental health teams that had previously treated the minor. This is so that professionals in the center may have a clear sense of the medical or psychiatric criteria by which it was decided that therapeutic internment was advised, as well as the type of intervention there should be.

- The need for a specific unit for young offenders with mild to moderate intellectual disabilities that is designed for the particular needs of this group should be evaluated, since they find it very difficult to integrate into the dynamics of centers with other minor inmates.

The need for specific units for mild to moderate intellectual disability

263. General conclusions regarding health care centers.

- The Office of the Secretary of State for Justice should proceed as quickly as possible to draft a bill that would regulate involuntary admission in these cases, as well as in residential centers for the elderly, in accordance with the Decision of the Constitutional Court 132/2010, of 2 December.

Drafting a bill to regulate involuntary admission

- To ensure the respect and protection of the rights of individuals facing forced admission or a declaration of incapacity, maximum judicial specialization should be enforced; for people with disabilities, legal counseling should be established in the Bar Associations that do not have it.

Maximum specialization of judicial bodies and legal counseling services

- For admission in centers of this nature, judicial authorization should be required for involuntary admission of Article 763 of the Civil Procedure Act, and the medical reports that the center periodically sends to the judge regarding the need to prolong admission should be comprehensive and up-to-date.

Judicial authorization and current medical forms should be required

- The limitation of rights of incapacitation implied by the legal institution requires that both the centers and the Spanish Public Prosecutor's Office operate with prudence, making a comprehensive assessment of the capabilities of the subject and their actual level of functionality and judgment, volition and free choice, while preserving the person's capabilities and autonomy.

Operating with prudence regarding incapacitation

- The practice of non-disabled residents being subject to decisions made between the center and their families should be avoided.

Deciding on behalf of the non-disabled should be avoided

- In centers of this type, Internal Rules and Regulations are essential, as are documents in which the objectives and programming of the center are detailed, an analysis of the processes is conducted, the required professionals are profiled, and indicators are established to assess the rehabilitation and social reintegration of residents. Also, new residents and their families should be suitably informed of the internal regulations.

Centers should have Internal Rules and Regulations

- It is crucial to conduct an interdisciplinary assessment of cases that includes the fields of psychology, medicine and nursing in the centers, and that establishes individualized treatment plans.

Interdisciplinary assessments and individualized treatment plans should be done

- Psychology and psychiatry services, which carry out a significant therapeutic and rehabilitative function, should be enhanced, as should the field of occupational therapy.

Occupational therapy should be strengthened

Rehabilitation should be promoted

- It is necessary to enhance the rehabilitation of patients and prevent the so-called "institutionalization syndrome" (*síndrome de institucionalización*). From time to time, the possibility of community reintegration in an open environment must be evaluated.

Activities and stimuli should be provided

- Activities and stimuli for residents should be scheduled. At the same time, their autonomy and positive participation should be fostered in the life of the center, as should that of their families. There should also be a mechanism for complaints and / or suggestions.

The use of physical and pharmacological restraints must follow protocol

- The use of physical and pharmacological restraints must follow protocol and must be reduced when possible, since unnecessary and / or excessive use may involve a violation of the rights of residents. In any case, at the national level, the following should be regulated in a clear and precise manner: the concept of restraint, assumptions regarding the application of restraint, the proportionality and appropriateness of the method used, the duration of the measure, the authorization for use, the staff permitted to implement it, documentation of performances, the evaluation of the effects and results, and all the necessary guarantees.

A model of preparing wills in advance is needed

- These kinds of centers should have a policy of "palliative care" (*cuidados paliativos*) and a model of preparing wills in advance.

264. General conclusions regarding repatriation of immigrants.

A video surveillance system should be installed in Barajas

- A video surveillance system must be installed in the areas of custody for deportees from the offices of the Central Unit for Deportation and Repatriation (National Police Force) (abbreviated as *UCER* in Spanish) of the Madrid-Barajas airport, according to the criteria of the Ombudsman Institution.

Staff should be identified

- Staff of the Central Unit for Deportation and Repatriation involved in the repatriation operations should visibly wear their identification number during the entire operation.

The chain of guards must be listed on individual sheets

- Individual custodial sheets must be established for deportees from when they leave their place of origin (be it an Immigrant Detention Center, prison, police station, Central Registry of Detainees...) so that the chain of custody may be properly controlled from that point until they are delivered to the destination country.

Vehicles should have seat belts

- Vehicles that shuttle deportees should have seat belts.

Early communication of repatriation

- At the moment in which repatriation is to be carried out, it should be communicated with sufficient notice to the individuals involved, along with information about the details of the repatriation, such as the duration of the flight or possible stopovers.

- A systematic medical examination should be conducted on individuals who are to be repatriated, in order to certify that they are fit to travel and to prescribe, where appropriate, health guidelines to follow for the deportee during the operation. These documents should be made available in multiple languages.

A systematic medical examination should be conducted

- Whenever a returnee is treated for injuries during repatriation, an injury report should be provided to the judicial authority, regardless of the magnitude.

Injury reports should be brought to the judicial authority

- To ensure the independence and impartiality of medical personnel involved in repatriation operations, the teams should include medical staff from outside of the Directorate General of Police.

The medical staff handling the repatriation should be outsourced

Appendix

Processing of complaints of ill-treatment by the Ombudsman Institution

§265-§275

265. Notwithstanding the information developed in the Ombudsman Institution's annual report, it has been considered opportune to include in this report the reactionary activity that is carried out in the Institution in response to the alleged commission of acts that can be described as torture, cruel treatment, inhumane, or degrading, through the opening of the appropriate investigation. However, the latter must be suspended if, once it has been begun, a lawsuit or appeal is interposed before the normal courts or the Constitutional Court. Practically all investigations into ill-treatment, injury, or death run into this obstacle, since the acts they aim to investigate are subject to judicial examination. That said, this limitation does not impede investigations into the general problems that can arise from that individual investigation nor does it impede using monitoring, via the Public Prosecutor's Office, so that jurisdictional proceedings are resolved in due time and the judicial decision that ends said proceedings is made know. The subjective element of these investigations is identified in the citizen who has been deprived of freedom, whether for a short or long period of time, and the act or objective element to investigate comes from an interpretation in a broad sense of the term "ill-treatment".

Investigations of ill-treatment or death by the Ombudsman Institution are subject to judicial examination, thus monitoring is done via the Public Prosecutor's Office

266. The right of life and the right of freedom are basic precepts for the exercise of the rest of a person's recognized rights. Consequently, any information that the Ombudsman Institution receives relative to the death of a person who had been deprived of freedom, regardless of the way in which its reception is made, requires the opening of a case destined to verify the truth of the act, the circumstances in which it has taken place, and the actions of the Public Administration, the party responsible for guaranteeing the life and safety of persons deprived of freedom in its facilities.

The death of a person deprived of freedom requires the opening of a case

267. In the specific case of the Penitentiary Administration, in accordance with the information provided by the *SGIP*, in 2012, 167 inmates died, 98 of which were in prisons, and 69 in hospitals. In the prisons managed by the Government of Catalonia, 35 inmates died in 2012. Of the total number of inmate deaths, 31 were suicides, of which 6 took place in Catalonia and 25 in the rest of Spain. On behalf of the Ombudsman Institution, in the year 2012, upon being informed of the events, 27 cases were opened to investigate the death of inmates, 19 of which were *ex officio* and 8 were *ex parte*. In order to attempt to prevent or reduce inmate deaths by suicide, the Ombudsman Institution has urged the Penitentiary Administration to persevere in the creation and use of scientific instruments that might help professionals in the task of preventing vulnerable inmates from being exposed to high-risk situations that can lead to episodes of self-inflicted harm having serious consequences.

The Ombudsman Institution has asked for perseverance in the task of preventing high-risk situations

When the Ombudsman Institution is informed of an alleged act of ill-treatment, it opens a case. In 2012 55 ex officio cases were opened

268. In the same way that upon the death of a detainee, when the Ombudsman Institution becomes aware of actions within the prisons that could show evidence of ill-treatment, a case is opened in which information is requested of the Public Administration related to the alleged irregular events, the aim being to verify that the administrative instruments for complaints which are available to detainees, as well as the internal control instruments that the Public Administration has provided to verify its appropriate operation and respect for the rights of detainees, function normally and in accordance with stable protocol and actions. In 2012 55 cases of complaints of alleged ill-treatment in prisons were opened, 54 of which were *ex parte* and 1 *ex officio*. The adoption of control measures by prison staff has given rise, in a significant number of complaints, to detainees denouncing that they have been victims of unjustified use of force. These are cases in which the detainees denounce excess in the use of physical force or other coercive measures, whose origins lie in a previous incident that would justify the adoption of such measures, which deals with the possible dispute of proportionality or need for the measure taken. It usually occurs that detainees present their complaint simultaneously with their police report to the judicial authority, a circumstance that, as it has been pointed out, impedes dealing with the concerned matter in depth. In examining cases on its visit to the Araba/Alava prison, the NPM observed that in one case their was a note related to the sending of a report to the overseeing Court that communicated to the latter that the inmate had injuries upon his return from proceedings at a court, including an injury report. Since at the prison no one had information regarding the actions that might have occurred as a result of these injuries, following the visit the facts were transferred to the Security and Justice Department of the Ombudsman Institution. On behalf of said department, the appropriate *ex officio* investigations with the Spanish Attorney General's Office and *SGIP,* in order to obtain information about the judicial actions arising from the communication of the referenced injury report.

106 cases involving actions by the State Security Forces were opened

269. Complaints related to actions by the State Security Forces (the National Police Force, the Civil Guard, regional and local police) that directly affect a citizen require that police actions be evaluated and deemed correct or incorrect. In 2012 106 cases involving these actions were opened (11 *ex officio* and 95 *ex parte*). Of them, 5 were for deaths, 2 for injuries, and 99 for ill-treatment or improper treatment.

There were 5 deaths, 3 within police facilities and 2 in hospitals

Of the five deaths that gave rise to the appropriate *ex officio* cases opened, three had been produced within police facilities or after passing through them, and two in hospitals as a consequence of injuries that, in one case, a young man received in a police charge, and in another, a man received during his detainment. The Ombudsman Institution has investigated them all in 2012, logically with the limitations that are imposed upon it by the corresponding beginning of jurisdictional investigation of these actions.

2 in National Police Station and 1 in local police facilities

The three deaths in police facilities are described below. In the National Police Station in Merida (Badajoz), a 42-year-old man died due to acute pulmonary edema in the early morning on the 6th of April. A 55-year-old French citizen allegedly committed suicide on the 3rd May in the jail at the National Police Station in Torremolinos, Malaga, following his arrest after an altercation in a bar. On the 14th of July, at the Hospital Trueta in Gerona, a man died who had been arrested 3 days earlier by local police officers from Gerona, in whose facilities he made a suicide attempt.

One death in a hospital at Manresa and another in Basque Country

The two deaths in hospitals were that of a man, on the 1st of January 2012, arrested by the Catalan Autonomous Police Force in Manresa (Barcelona). During his arrest he fought with the officers, causing injuries to five of them. After being handcuffed, he began to breathe with difficulty and was transferred to the *Sant Joan de Deu* Hospital in Manresa, where he was admitted to the intensive care unit and died after remaining for hours in a state of induced coma. The other case investigated was that of the death of a young man after being hospitalized for several days as a consequence of a fractured skull, which he received when he was hit by a rubber bullet fired by an officer of the Basque Autonomous Police Force on the 5th of April 2012.

The Ombudsman Institution has opened 35 cases of ill-treatment and 66 cases of improper treatment by the State Police Forces

270. It is of great interest to the Ombudsman Institution to ensure the appropriate actions by the State Security Forces. In this respect, 35 cases of ill-treatment have been opened in 2012 (5 *ex officio* and 20 *ex parte*), and 66 cases for improper treatment. Within this context, even in the absence of deprivation of freedom, police actions from which an alleged disproportionate use of force can be deduced are subject to investigation by this Institution, as well as some police actions, leading to injuries, carried out during civic protests. Due to these actions, *ex officio* complaints have been opened, such as the complaint related to the actions of the Catalan Autonomous Police Force on the 29th of March 2012 in Barcelona, the one related to the injuries suffered by a female protester from the impact of a rubber bullet on the 11th of July 2012 in Madrid, the investigation into police actions that took place on the 17th and 18th of August 2011 in the city center of Madrid, especially in the case of the attack made by an officer on a young woman on "Atocha Street" (*Calle Atocha)* and the subsequent attacks on two other citizens; and the investigation began following numerous complaints regarding police action on the 25 of September 2012 during the protests that took place in the area surrounding the "*Parliament*" (*Congreso de los Diputados*) building.

A Recommendation that citizens be able to easily identify officers has been made

271. In all police actions it is essential for citizens to have ease of access to police identification. The Ombudsman Institution considers that the numerical identification of officers and facilitating it is a citizen's right. To this effect a Recommendation has been made demanding compliance with the obligation to wear an identification badge on uniforms, and additionally requiring badges with a larger

size be designed, all of which would have positive effects for the prevention of incidents and, if the need presented itself, to determine responsibility.

In this respect, an investigation was begun in 2012 following a complaint by an association of lawyers who came to the aid of some citizens who has been arrested, some *ex officio* and others direct designation by the interested parties, because these lawyers corroborated that in the police facilities they were greeted by persons in street clothes covered by hoods. This practice, in addition to improper treatment in respect to the lawyers, violates the right to a defense and creates total defenselessness, inasmuch as it made it impossible to determine whether the persons taking statements are truly the police-proceedings investigating officer and secretary.

Arrests of minors are subject to precautions that must be especially respected

272. Police treatment during arrests of minors has special gravity, since this action is governed by a number of precautions that must be especially respected by the State Security Forces, including those related to ways to perform the arrest, its communication to the minor's legal representatives, exceptions for handcuffing, transfers, and guarding in police facilities, all of which must be followed with the most possible rigor, as this Institution had the chance to highlight in the *ex officio* investigation that arose from the events occurring on the 20th of February 2012, when the National Police Force broke up an unauthorized protest in the city center of Valencia in which protesters, some minors and others adults, protested against budget cuts in education, with fights with the police and arrests with transfer to police station.

A complaint was opened due to alleged homophobic treatment at a Juvenile Detention Center

273. Regarding centers for juvenile offenders, a complaint was opened as a consequence of the police report made by a minor admitted to the Juvenile Detention Center *El Moline*, in Almeria, who, it appears, said he was suffering homophobic and discriminatory treatment, compared to the rest of his peers, by an educator at the center.

The reports received related to centers for protection of minors that are in judicial processing have been confirmed

274. Among the police reports related to centers for the protection of minors, while at the Ombudsman Institution investigations into supposed ill-treatment were opened, the truthfulness of the acts denounced in the investigations carried out by the Public Administration has not been able to be confirmed, nor has this Institution been offered elements that would allow it to question these official investigations, noting, as well, the processing of the appropriate judicial proceeding, such is the case, for example, of the police report made by a mother for possible ill-treatment of her daughter at a Valladolid center for protection of minors, or the report of the alleged attempted rape of a female minor in a residence center in Palencia.

The Ombudsman Institution has information regarding possible irregular actions at Immigrant Detention Centers

275. The Ombudsman Institution has information regarding possible irregular actions at Immigrant Detention Centers stemming from the complaints that are received and investigated, from those ones that are opened as *ex officio* cases, and from the visits that are made every year by Institution personnel.

Some of them have problems in the investigation, such as those that refer to verbal ill-treatment, due to the difficulties that proof and verification of these actions face, or those in which the investigation becomes impossible because, even before beginning the investigation, the interested party has been deported to his/her own country. In others specific actions are carried out that tend to revise existing police actions and/or action protocol for each situation. Such is the case of the death of a citizen from Conakry, Guinea, on the 6th of January 2012, at the Immigrant Detention Center of the *Zona Franca* area of Barcelona, in which there are suspicions regarding possible delays in medical attention required by the deceased and the inmate's difficulties in communicating, due to the absence of interpreters. He had also resided at the Temporary Accommodation Center for Immigrants in Melilla, though his clinical record did not reflect any information regarding the medical examinations given to him during his time at the that Center. The open investigation had to be suspended once the corresponding judicial proceedings were begun. This suspension was also recalled in the case of the complaint of injuries made by an inmate at the Immigrant Detention Center in Valencia in the complaint by a foreign national that, in the visit made to the Immigrant Detention Headquarters in Madrid, claimed to have just been beaten by two of the police officers who were guarding him.

Tables 54-58. Cases opened in 2012 by the Ombudsman Institution into deaths, ill-treatment, and improper treatment

Prisons			
	Ex officio	*Ex parte*	Total
Deaths	19	8	27
Ill-treatment	1	54	55
Total	**20**	**62**	**82**

State Security Forces			
	Ex officio	*Ex parte*	Total
Deaths	5	0	5
Ill-treatment	5	30	35
Improper Treatment	1	65	66
Total	**11**	**95**	**106**

Centers for Juvenile Offenders			
	Ex officio	*Ex parte*	Total
Ill-treatment	0	1	1
Total	**0**	**1**	**1**

Centers for Protection of Minors			
	Ex officio	*Ex parte*	Total
Ill-treatment	0	3	3
Total	**0**	**3**	**3**

Immigrant Detention Centers			
	Ex officio	*Ex parte*	Total
Deaths	0	1	1
Ill-treatment	0	3	3
Total	**0**	**4**	**4**

Annexes

1. Short-term Deprivation of Liberty
2. Medium-term Deprivation of Liberty
3. Long-term Deprivation of Liberty
4. Special Interest Sites in Deprivation of Liberty

1. Short-term Deprivation of Liberty

Tables 59-77. Conclusions on Spanish National Police Force facilities visited in 2012

WESTERN ANDALUSIA SUPERIOR POLICE DEPARTMENT (SEVILLE)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Awaiting response. *
Lacking call systems within cells.	16 (2012)	Awaiting response. *
Some officers did not wear identification badge.	26 (2012)	Awaiting response. *
Lacking heat-sealed plastic bags to store possessions taken away from detainees.	30 (2012)	Awaiting response. *
Cleanliness of blankets.	38 (2012)	Awaiting response. *
Evaluate temperature of jail.	34 (2012)	Awaiting response. *
Unpleasant odors in toilets.	34 (2012)	Awaiting response. *
Broken and unusable urinals.	36 (2012)	Awaiting response. *
Evaluation of lighting conditions of jail.	34 (2012)	Awaiting response. *
Inadequate completion of Detainee Record of Custody.	28 (2012)	Awaiting response. *
No records for full body searches.	29 (2012)	Awaiting response. *
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Health and Social Welfare Council, Government of Andalusia)**
In one of the police reports, a medical report appeared where personal information was recorded including clinical history and information from the medical examination the detainee was given.	22 (2012)	Awaiting response.
GOOD PRACTICES		
In standard forms informing detainees of their rights, the right to request a writ of *habeas corpus* is expressly stated, in order to create a reliable record of this request.		
The immediate communication of the arrest of the detainee to the family member or person designated by the former, as was corroborated by the Record of Telephone Calls.		
It was found in the Record of Telephone Calls that fulfilling the detainee's right to legal assistance is made in a short period of time following arrest.		

* The Administration's responses to Recommendations made in 2012 will be included in the 2013 report.

ARAGON SUPERIOR POLICE DEPARTMENT (SARAGOSSA)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Awaiting response.
Cell doors have grating that can facilitate self-inflicted injury by detainees.	32 (2012)	Awaiting response.
Inadequate completion of Detainee Record of Custody.	28 (2012)	Awaiting response.
Maintenance and repair of toilets.	36 (2012)	Awaiting response.
Unpleasant odors due to low ventilation.	34 (2012)	Awaiting response.
It was noted that facilities do not have an evacuation plan.	212 (2010) 63 (2011)	Awaiting response.

LA RIOJA (LOGROÑO) SUPERIOR POLICE DEPARTMENT		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Accepted. Awaiting budget availability.
No constant presence of officers in prison cell area when there are detainees.	17 (2012)	It depends upon the number of detainees and danger, given low provision of personnel.
Some officers did not wear identification badge.	26 (2012)	Ruling making this mandatory is periodically withdrawn.
Cleanliness of blankets.	38 (2012)	Accepted.
GOOD PRACTICES		
Inclusion in the record of reading of rights including the possibility of requesting *habeas corpus,* in compliance with the criterion set forth in paragraphs 476 of the 2010 Annual Report and 47 of the 2011 Annual Report and in the Recommendation made in record 11007407.		
The existence of individual juvenile detainee control sheets, on which all incidents in the minor's chain of custody are recorded, additionally specifying possessions that have been withheld from detainee.		

ALGECIRAS (CADIZ) POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Awaiting response.
Cell doors have elements that can facilitate self-inflicted injury by detainees.	32 (2012)	Awaiting response.
No record for full body searches.	29 (2012)	Awaiting response.

ALGECIRAS (CADIZ) POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Habeas corpus. In the report there is a section in which the following pre-printed text appears: "not willing to adhere to said proceedings".	19 (2012)	Awaiting response.
In printed materials used to inform detainees of their rights, the terms «lawyer» (*abogado*) and «legal council» (*letrado*) still appear.	476 (2010) 18 (2012)	Awaiting response.
No agent, except the chief of service, wore an identification badge.	26 (2012)	Awaiting response.
Cleanliness of blankets.	38 (2012)	Awaiting response.
Detainee belongings were not stored in the heat-sealed bags available.	30 (2012)	Awaiting response.
An officer was going to drive a female minor to a shelter without informing her mother.	39 (2012)	Awaiting response.

ALGECIRAS-PUERTO POLICE STATION (CADIZ)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
There is no video surveillance system in these facilities.	55, 477 (2010) 14 (2012)	Awaiting response.
No written records of full body searches.	29 (2012)	Awaiting response.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 19 (2012)	Awaiting response.
Cell doors have horizontal bars that can facilitate self-inflicted injury by detainees.	32 (2012)	Awaiting response.
The existing squat toilet is not adequate for those detainees that, due to their age or physical conditions, need to sit down to use the toilet.	33 (2012)	Awaiting response.
GOOD PRACTICES		
In written materials used to inform detainees of their rights, only the term "lawyer" *(abogado)* is used, in accordance with the criterion set forth in paragraph 476 of the 2010 Annual Report.		
Offering detainees unused blankets, in accordance with the criterion set forth in paragraph 38.		

ALICANTE/ALACANT POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
No call systems within cells.	16 (2012)	Awaiting response.
Some officers did not wear identification badge.	26 (2012)	Awaiting response.

ALICANTE/ALACANT POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Cleanliness within cells was inadequate.	34 (2012)	Awaiting response.
Cleanliness of blankets.	38 (2012)	Awaiting response.

MADRID-DISTRICT OF CARABANCHEL POLICE STATION		
CONCLUSIONS	**PARAGRAPHS No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Accepted. Awaiting budget availability.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 19 (2012)	Not accepted.
No constant presence of officers in jail area when there are detainees.	17 (2012)	At least one of the three agents.
Some officers did not wear identification badge.	26 (2012)	These are considered specific cases.
Cell doors have metal sheeting that can facilitate self-inflicted injury by detainees.	32 (2012)	Instructions given to rectify issue.
Evaluate temperature of jail.	34 (2012)	Instructions given to rectify issue.
Cleanliness within cells was inadequate.	34 (2012)	They are cleaned on a daily basis.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Community of Madrid Health Council)**
In one of the police reports, a medical report appeared where personal information was recorded including clinical history and information from the medical examination the detainee was given.	22 (2012)	Awaiting response.
GOOD PRACTICES		
Immediacy in calls made to an attorney, which benefits the detainees since proceedings are finished sooner, allowing him or her to spend less time detained in police station.		

MADRID- DISTRICT OF LA LATINA POLICE STATION		
CONCLUSIONS	**PARAGRAPHS No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Accepted. Awaiting budget availability.
No proof of practice for full body searches.	29 (2012)	Accepted.
At times medication for the detainees is obtained by officers from police station without the existence of a budget allotment for this purpose	25 (2012)	Not accepted. Recommendation made.

MADRID- DISTRICT OF LA LATINA POLICE STATION		
CONCLUSIONS	**PARAGRAPHS No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
Cell doors have metal sheeting that can facilitate self-inflicted injury by detainees.	32 (2012)	Instructions given to rectify issue.
Women's cell does not have adequate lighting.	34 (2012)	Instructions given to rectify issue.
In one of the police reports, a medical report appeared where personal information was recorded including clinical history and information from the medical examination the detainee was given.	22 (2012)	Awaiting response.
GOOD PRACTICES		
Inclusion in the record of reading of rights including the possibility of requesting *habeas corpus,* in compliance with the criterion set forth in paragraphs 476 of the 2010 Annual Report and in the Recommendation made in record 11007407.		

MADRID-DISTRICT OF LEGANES POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Accepted. Awaiting budget availability.
Cleanliness of blankets.	38 (2012)	Accepted.
Lacking heat-sealed plastic bags to store possessions taken away from detainees.	30 (2012)	Accepted.
Inadequate completion of Detainee Record of Custody.	28 (2012)	Accepted.
Evaluate temperature of jail.	34 (2012)	Not accepted. Suggestion made.
Unpleasant odors were noted in the jail due to lack of ventilation.	34 (2012)	Not accepted. Suggestion made.
The building's architecture does not allow for the needs of people with reduced mobility, locomotive disability, or for mothers with a baby carriage.	44 (2010)	Not accepted. Suggestion made.
Lack of privacy and confidentiality when filing police reports.		No space available. The availability of more service points takes priority.
Maintenance and upkeep work needs to be carried out.	36 (2012)	Instructions given to rectify.
GOOD PRACTICES		
Inclusion in the record of reading of rights including the possibility of requesting *habeas corpus*, in compliance with the criterion set forth in paragraphs 476 of the 2010 Annual Report and in the Recommendation made in record 11007407.		

MADRID- MONCLOA-ARAVACA DISTRICT POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Detainees enter the jail through the station's only entry door.	31 (2012)	An effort must be made so that they have no contact with citizens.
At the entrance to cells, there is a depiction of a skull featuring the inscription «RIP», which is considered an intimidation for detainees.	39 (2012)	It has been rectified.
Inadequacies in the state of upkeep and maintenance of the jail.	36 (2012)	Instructions given to rectify issue.
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Accepted. Awaiting budget availability.
When officers are inside prison cells, they carry their weapons unloaded.	27 (2012)	Instructions given to rectify issue.
Cleanliness of blankets.	38 (2012)	Instructions given to rectify issue.
Cell doors have a plaque around the lock, which can facilitate self-inflicted injury by detainees.	32 (2012)	Accepted. Awaiting budget availability.
Inadequate completion of Detainee Record of Custody.	28 (2012)	Instructions given to rectify issue.
Evaluate temperature of jail.	34 (2012)	Accepted. Awaiting budget availability.

MADRID- USERA-VILLAVERDE DISTRICT POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Accepted. Awaiting budget availability.
No written records of full body searches.	29 (2012)	Accepted.
Three officers were not wearing identification badges. One of them later rectified this.	26 (2012)	Not accepted. Suggestion made.
Detainees are interviewed by attorneys in a corner next to the entrance to jail cells, where no conversation can be held with any amount of privacy.	20 (2012)	Not accepted. Suggestion made.
The glass in a window in a door in one of the cells was broken.		Not accepted. Suggestion made.

MADRID-DISTRICT OF VALLECAS-PUENTE POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Accepted. Awaiting budget availability.

MADRID-DISTRICT OF VALLECAS-PUENTE POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
No constant presence of officers in prison cell area when there are detainees present.	17 (2012)	No response. Suggestion made.
Lacking call systems inside cells.	16 (2012)	Accepted. Awaiting budget availability.
Several detainees complained about the excessive amount of time officers took to respond to their calls.		Instructions given to rectify issue.
No proof of practice for full body searches.	29 (2012)	Instructions given to rectify issue.
The jail facilities do not have an area specifically reserved for searches that might preserve detainees' privacy.	29 (2012)	No space exists due to structural problems. Suggestion made.
Inadequate completion of Detainee Record of Custody.	28 (2012)	Instructions given to rectify issue.
Some officers did not wear identification badge.	26 (2012)	Instructions given to rectify issue.
A heat-sealed bag of possessions was opened without the detainee being present.	30 (2012)	Instructions given to rectify issue.
Possible overcrowding of jail.		Referrals to other police station.
Evaluate temperature of jail.	34 (2012)	Accepted. Awaiting budget availability.
Unpleasant odors were noted in the jail due to lack of ventilation.	34 (2012)	Accepted. Awaiting budget availability.
Cells do not have adequate lighting.	34 (2012)	No response. Suggestion made.
Unclean cells.	34 (2012)	Instructions given to rectify issue.
Cleanliness of blankets.	38 (2012)	Instructions given to rectify issue.

MALAGA POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Awaiting response.
Lacking video intercom at entrance door to jail from within the building, which affects the prevention, detection, reaction, and response in the event of an intrusion.		Awaiting response.
The headboards in temporary holding cells and the porcelain bathroom fittings can be used by detainees in attempts at self-inflicted injury.	32 (2012)	Awaiting response.

MALAGA POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
No proof of practice for full body searches.	29 (2012)	Awaiting response.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 19 (2012)	Awaiting response.
In models used to inform detainees of their rights, the terms "lawyer" (*abogado*) and "legal council" (*letrado*) still appear.	476 (2010) 18 (2012)	Awaiting response.
"Interviews" with detainees before taking statements without the presence of the attorney.	20 (2012)	Awaiting response.
Some shared cells have a toilet within.	33 (2012)	Awaiting response.
The squat toilets in lavatories are not adequate for those detainees that, due to their age and physical condition, need to sit down to use the toilet.	33 (2012)	Awaiting response.
Some officers did not wear identification badge.	26 (2012)	Awaiting response.
Evaluate temperature of jail.	34 (2012)	Awaiting response.
Cleanliness of blankets.	38 (2012)	Awaiting response.
It was reported that the blankets, after three washes, lose their fire-resistant properties.		Awaiting response.
Lacking masks and gloves to prevent the spread of infectious and contagious diseases.	24 (2012)	Awaiting response.
Lacking cut-proof gloves for performing personal searches on detainees.		Awaiting response.
GOOD PRACTICES		
The internal audits that, on a nearly monthly basis, are made regarding the prison cell area.		
Officers deposit their weapons in metal boxes kept under lock and key, in the interest of the safety of the detainees and the officers themselves, as is set forth in paragraph 27.		

MARBELLA POLICE STATION (MALAGA)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The exhaust fan in the prison cell area creates unpleasant odors in the local police facilities.		Awaiting response.

MEDINA DEL CAMPO POLICE STATION (VALLADOLID)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Awaiting response.

MEDINA DEL CAMPO POLICE STATION (VALLADOLID)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 19 (2012)	Awaiting response.
No written record of full body searches.	29 (2012)	Awaiting response.
In printed materials used to inform detainees of their rights, the terms "legal council" (*letrado*) and "lawyer" (*abogado*) still appear.	476 (2010) 18 (2012)	Awaiting response.
The porcelain bathroom fittings can be used by detainees in attempts at self-inflicted injury	32 (2012)	Awaiting response.
The furniture in the officers' work space is damaged.	48 (2010)	Awaiting response.
Lacking call systems inside cells.	16 (2012)	Awaiting response.
GOOD PRACTICES		
Immediacy in calls made to an attorney, which benefits the detainee since proceedings are finished sooner, allowing him or her to spend less time detained in police station.		
The correct completion of the Detainee Record of Custody, in accordance with that set forth in Instruction 12/2009 by the Office of the Secretary of State for Security and in the criterion set forth in paragraph 28.		
Offering detainees unused blankets, in accordance with the criterion set forth in paragraph 38.		

MERIDA POLICE STATION (BADAJOZ)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Awaiting response.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 19 (2012)	Awaiting response.
No written record of full body searches carried out.	29 (2012)	Awaiting response.
Some officers did not wear identification badge.	26 (2012)	Awaiting response.
In printed materials used to inform detainees of their rights, the terms "legal council" (*letrado*) and "lawyer" (*abogado*) still appear.	476 (2010) 18 (2012)	Awaiting response.
Evaluate temperature of jail.	34 (2012)	Awaiting response.
Cleaning services in prison cell area should be expanded to include weekends.	34 (2012)	Awaiting response.
GOOD PRACTICES		
The correct completion of the Detainee Record of Custody, in accordance with that set forth in Instruction 12/2009 by the Office of the Secretary of State for Security and in the criterion set forth in paragraph 28.		
Offering detainees unused blankets, in accordance with the criterion set forth in paragraph 38.		

TORREMOLINOS (MALAGA) POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Awaiting response.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 19 (2012)	Awaiting response.
No written record of full body searches carried out.	29 (2012)	Awaiting response.
Cell maintenance and upkeep.	36 (2012)	Awaiting response.
Some officers did not wear identification badge.	26 (2012)	Awaiting response.
In printed materials used to inform detainees of their rights, the terms "legal council" (*letrado*) and "lawyer" (*abogado*) still appear.	476 (2010) 18 (2012)	Awaiting response.
Calls made to attorneys not recorded, in most cases, in the Record of Telephone Calls.		Awaiting response.
Lacking heat-sealed plastic bags to store possessions taken away from detainees.	30 (2012)	Awaiting response.
Inadequate completion of Detainee Record of Custody.	28 (2012)	Awaiting response.
Cleanliness of blankets.	38 (2012)	Awaiting response.
Lacking masks and gloves to prevent the spread of infectious and contagious diseases.	24 (2012)	Awaiting response.

VIGO-REDONDELA (PONTEVEDRA) POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Awaiting response.
Unpleasant odors were noted in the jail due to lack of ventilation.	34 (2012)	Awaiting response.
GOOD PRACTICES		
The existence of a Record book in which transfers of detainees requiring medical attention are recorded.		
The existence of action protocol in the event of a pregnant detainee, or one suspected of possibly being pregnant, being admitted.		
The existence of an original document from the Chief of Security that records the incidents occurring in the jail, recording the date, report, police guards, and detainee implicated.		

ZARAGOZA- DISTRICT OF ACTUR-REY FERNANDO POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Accepted. Awaiting budget availability.

ZARAGOZA- DISTRICT OF ACTUR-REY FERNANDO POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Lacking call systems inside cells.	16 (2012)	There are always officers present in prison cell area.
No information regarding the number of detainees that have been in the prison cell area of each police station in Saragossa.	28 (2012)	Difference of criteria. Recommendation made.
Inadequate completion of Detainee Record of Custody.	28 (2012)	Difference of criteria. Suggestion made.
"Interviews" with detainees before recording statement without the presence of the attorney.	20 (2012)	No police reports exist in that regard. If detected, sanctions would follow.
Cell doors have sheeting that can facilitate self-inflicted injury by detainees.	32 (2012)	Not accepted. Suggestion made.
Cleanliness of blankets.	38 (2012)	Accepted.
GOOD PRACTICES		
A written protocol exists for action in cases involving pregnant detainees and another for cases involving detainees with infectious and contagious diseases.		

Tables 78-82. Conclusions regarding the Civil Guard facilities visited in 2012

HUESCA COMMAND HEADQUARTERS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
(S) The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Suggestion accepted. Awaiting budget availability.
(S) Detainees' possessions are stored in envelopes.	30 (2012)	Suggestion accepted. Awaiting budget availability.
(S) One of the cloth mattresses was dirty.	38 (2012)	Suggestion accepted. Awaiting budget availability.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
There are no common guidelines for action with detainees for all the Command Headquarters' posts.		Instructions given to rectify issue.
Inadequate completion of Detainee Record of Custody.	28 (2012)	Instructions given to rectify issue.
Lacking masks and gloves to prevent the spread of infectious and contagious diseases.	24 (2012)	Instructions given to rectify issue.
No written records of full body searches carried out.	29 (2012)	Instructions given to rectify issue.
Cleanliness of blankets.	38 (2012)	Instructions given to rectify issue.

* Recommendations (RE); Suggestions (S); Reminder of Legal Responsibilities (RLR).

ALGECIRAS-PUERTO HEADQUARTERS (CADIZ)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
(S) No blankets are offered.	38 (2012)	Awaiting response.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Awaiting response.
The room used to store confiscated drugs does not meet the necessary security and sanitary conditions.		Awaiting response.
No written record of full body searches carried out.	29 (2012)	Awaiting response.
Inadequate completion of Detainee Record of Custody.	28 (2012)	Awaiting response.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 19 (2012)	Awaiting response.
One cell's broken floor tile can facilitate self-inflicted injury by detainees.	32 (2012)	Awaiting response.
The size of the five cells is inadequate.	35 (2012)	Awaiting response.
Officers carry their regulation weapon loaded in the prison cell area.	27 (2012)	Awaiting response.
The squat toilets in lavatories are not adequate for those detainees that, due to their age of physical condition, need to sit down to use the toilet.	33 (2012)	Awaiting response.
Detainees' possessions are stored in bags.	30 (2012)	Awaiting response.
Evaluate temperature of jail.	34 (2012)	Awaiting response.
In one of the cells unpleasant odors were noted due to lack of ventilation.	34 (2012)	Awaiting response.
GOOD PRACTICES		
In printed material used to inform detainees of their rights, only the term "lawyer" (*abogado*) is used, in accordance with the criterion set forth in paragraph 476 of the 2012 Annual Report.		
Immediacy in calls made to an attorney, which benefits the detainee since proceedings are finished sooner, allowing him or her to spend less time detained in police station.		

* Recommendations (RE); Suggestions (S); Reminder of Legal Responsibilities (RLR).

BARAKALDO (BISCAY) HEADQUARTERS		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
During the visit it was reported that the jail was no longer in use.		

OLITE (NAVARRE) HEADQUARTERS		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
Several deficiencies detected.		Following the inspection this detention center has been closed.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Health Department, Government of Navarre)**
In one of the police reports, a medical report appeared where personal information was recorded including clinical history and information from the medical examination the detainee was given.	22 (2012)	Awaiting response.

VIGO (PONTEVEDRA) HEADQUARTERS		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Awaiting response.
No constant presence of officers in prison cell area when there are detainees present.	17 (2012)	Awaiting response.
One cell's broken tiles can facilitate self-inflicted injury by detainees.	32 (2012)	Awaiting response.
Evaluate temperature of jail.	34 (2012)	Awaiting response.
GOOD PRACTICES		
In printed materials used to inform detainees of their rights, only the term "lawyer" (abogado) is used, in accordance with the criterion set forth in paragraph 476 of the 2012 Annual Report.		

Tables 83-86. Conclusions regarding the autonomous police facilities visited in 2012

BASQUE AUTONOMOUS POLICE FORCE BILBAO (BISCAY) POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE Department of the Interior, Justice, and Public Administration of the Basque Government**
The video surveillance system does not conform to this Institution's criteria.	55, 477 (2010) 14 (2012)	Not accepted.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 19 (2012)	Not accepted.
No record within the computer application of the practice of full body searches.	29 (2012)	A report is made in this regard.
In printed materials used to inform detainees of their rights, the terms "legal council" (*letrado*) and "lawyer" (*abogado*) still appear.	476 (2010) 18 (2012)	Accepted.

BASQUE AUTONOMOUS POLICE FORCE BILBAO (BISCAY) POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE Department of the Interior, Justice, and Public Administration of the Basque Government**
Detainees are given mats, but not mattresses.	38 (2012)	Not accepted.
GOOD PRACTICES		
Detainee chain of custody within the computer program known as *"Atxilo"*.		

L'HOSPITALET DE LLOBREGAT (BARCELONA) CATALAN AUTONOMOUS POLICE FORCE POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Department of the Interior of the Catalan Government)**
The vans used to for driving do not have seat belts for detainees.	214 (2011)	Awaiting response.
Cleanliness of blankets.	38 (2012)	Awaiting response.
Third parties are allowed to provide outside food to detainees.	162 (2010) 69 (2011)	Awaiting response.
GOOD PRACTICES		
Officers store their weapon in a rack before entering the prison cell area.		
Detainee chain of custody within the computer program known as "*SISDE*".		

SABADELL (BARCELONA) CATALAN AUTONOMOUS POLICE FORCE POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Department of the Interior of the Catalan Government)**
There is a 12-hour period in which Bar Associations are not contacted.	468 (2010) 20 (2012)	Lawyers are contacted via a list of lawyers on-call.
Cleanliness of blankets.	38 (2012)	Not accepted.
GOOD PRACTICES		
Officers store their weapon in a rack before entering the prison cell area.		
Detainee chain of custody within the computer program known as "*SISDE*".		
The censure, on the monitor screens, of the inner toilet area of the cells to block viewing and maintain detainees' privacy.		
The hinges on the vertical bars in cells have a cap on top to prevent hanging or tying anything.		

NAVARRE AUTONOMOUS POLICE FORCE OF ESTELLA POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Department of Presidency, Justice, and the Interior of the Government of Navarre)**
The video surveillance system does not conform to this Institution's criteria.	55 and 477 (2010) 14 (2012)	Accepted. Executed in fiscal year 2013.
Non-existence of any type of registry of the number of people who are admitted to the jail on a daily basis.	28 (2012)	Accepted. Instructions given to rectify issue.
Lacking Minor Detainee Record of Custody.	28 (2012)	One does exist but was not displayed during visit.
Detainee guard protocol must be changed so that searches and frisking be carried out «by an officer of the same sex as the detainee».	29 (2012)	Accepted. Instructions given to rectify issue.
Detainees' possessions are stored in bags.	30 (2012)	Accepted. Instructions given to rectify issue.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Departamento de Salud del Gobierno de Navarra)**
In one of the police reports, a medical report appeared where personal information was recorded including clinical history and information from the medical examination the detainee was given.	22 (2012)	Awaiting response.
GOOD PRACTICES		
The design of officers' identification numbers, which allows them to be read without problems from a distance.		
The "Reading of rights to minor detainees agreement", where the specific ability to reserve an interview with one's attorney before making a declaration is set forth, recognized for minor detainees in section b) of Article 22 of Organic Law 5/2000, of 12 January, of Minor Penal Responsibility.		

Tables 87-93. Conclusions regarding local police facilities visited in 2012

BILBAO LOCAL POLICE (BISCAY)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Officer identification.	26 (2012)	Instructions given to rectify issue.
Seat belts in the vehicles driven.	214 (2011)	Instructions given to rectify issue.
Inadequate completion of individual detainee custody file.	28 (2012)	Instructions given to rectify issue.
The video surveillance system does not conform to criteria of this Institution.	55, 477 (2010) 14 (2012)	Accepted. Awaiting budget availability.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 19 (2012)	Instructions given to rectify issue.
No written record of full body searches carried out.	29 (2012)	Instructions given to rectify issue.

BILBAO LOCAL POLICE (BISCAY)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
In printed materials used to inform detainees of their rights, the terms "legal council" (*letrado*) and "lawyer" (*abogado*) still appear.	476 (2010) 18 (2012)	Instructions given to rectify issue.
Detainees are given mats, but not mattresses.	38 (2012)	Accepted. Awaiting budget availability.
GOOD PRACTICES		
Officers store their weapon in a rack before entering the prison cell area.		
Offering detainees unused blankets, in accordance with the criterion set forth in paragraph 38.		
Copies of medical reports, written after detainee health assistance for common disease, are given to the interested party and no copy is stored at police facility.		

EJEA DE LOS CABALLEROS (SARAGOSSA) LOCAL POLICE		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Ejea de los Caballeros City Hall)**
The video surveillance system does not conform to this Institution's criteria.	477 (2010) 14 (2012)	Awaiting response.
Protocol for infectious and contagious diseases and for pregnant detainees.	23 (2012)	Awaiting response.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 19 (2012)	Awaiting response.
Lacking call systems inside cells.	16 (2012)	Awaiting response.
Cleanliness of blankets.	38 (2012)	Awaiting response.
Damaged mattresses.	38 (2012)	Awaiting response.
Horizontal bars on cell doors.	32 (2012)	Awaiting response.
Lacking printed material on information of rights in different languages.	18 (2012)	Awaiting response.
Officer identification.	26 (2012)	Awaiting response.
Food provided from outside.	69 (2011)	Awaiting response.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Department of Health, Social Welfare, and Family of the Aragon Government)**
In one of the police reports, a medical report appeared where personal information was recorded including clinical history and information from the medical examination the detainee was given.	22 (2012)	Awaiting response.
GOOD PRACTICES		
The existence of specific Regulations within Local Police.		
The inclusion in the text of the detainee's rights and responsibilities sheet of the following text: "No detainee can be subjected to torture nor verbal nor physical ill-treatment" (*Ningún detenido podrá ser sometido a torturas ni malos tratos de palabra u obra.*)		

FUENGIROLA LOCAL POLICE (MALAGA)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	477 (2010) 14 (2012)	Awaiting response.
No written information provided about possibility of filing habeas corpus proceedings.	476 (2010) 19 (2012)	Awaiting response.
Officer identification.	26 (2012)	Awaiting response.
Horizontal bars on cell door.	32 (2012)	Awaiting response.
No written record of full body searches recorded.	29 (2012)	Awaiting response.
The squat toilets in lavatories are not adequate for those detainees that, due to their age of physical condition, need to sit down to use the toilet.	33 (2012)	Awaiting response.
In written materials used to inform detainees of their rights, the terms "legal council" (*letrado*) and "lawyer" (*abogado*) still appear.	476 (2010) 18 (2012)	Awaiting response.
Detainees' possessions are stored in bags.	30 (2012)	Awaiting response.
GOOD PRACTICES		
Immediacy in calls made to an attorney, which benefits the detainee since proceedings are finished sooner, allowing him or her to spend less time detained in police station.		
The mechanical opening system of doors on all cells, which facilitates evacuation in case of an emergency.		
Offering detainees unused blankets, in accordance with the criterion set forth in paragraph 38.		

MARBELLA (MALAGA) LOCAL POLICE		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	477 (2010) 14 (2012)	Awaiting response.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 19 (2012)	Awaiting response.
No constant presence of officers in prison cell area when there are detainees present.	17 (2012)	Awaiting response.
Horizontal bars on cell door.	32 (2012)	Awaiting response.
No written record of full body searches recorded.	29 (2012)	Awaiting response.
Detainees' entrance to the facilities.	466 (2010) 31 (2012)	Awaiting response.
Evaluate the temperature of the jail area.	34 (2012)	Awaiting response.

MARBELLA (MALAGA) LOCAL POLICE		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Moisture stains on walls.	36 (2012)	Awaiting response.
Officer identification.	26 (2012)	Awaiting response.
The squat toilets in lavatories are not adequate for those detainees that, due to their age of physical condition, need to sit down to use the toilet.	33 (2012)	Awaiting response.
In printed materials used to inform detainees of their rights, the terms "legal council" (*letrado*) and "lawyer" (*abogado*) still appear.	476 (2010) 18 (2012)	Awaiting response.
Detainees' possessions are stored in bags.	30 (2012)	Awaiting response.
Mattresses bigger than the beds.	38 (2012)	Awaiting response.
GOOD PRACTICES		
Immediacy in calls made to an attorney, which benefits the detainee since proceedings are finished sooner, allowing him or her to spend less time detained in police station.		
In each detainee's individual file, any difficulties he/she might have are stated.		

MEDINA DEL CAMPO LOCAL POLICE (VALLADOLID)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	477 (2010) 14 (2012)	Awaiting response.
Horizontal bars on cell door.	32 (2012)	Awaiting response.
No written record of full body searches recorded.	29 (2012)	Awaiting response.
Detainee entrance to the facilities.	466 (2010) 31 (2012)	Awaiting response.
Location of cells.		Awaiting response.
In printed materials used to inform detainees of their rights, the terms "legal council" (*letrado*) and "lawyer" (*abogado*) still appear.	476 (2010) 18 (2012)	Awaiting response.
Lacking closet to store detainee's personal possessions.	30 (2012)	Awaiting response.
Blanket cleanliness.	38 (2012)	Awaiting response.
Detainees are not given mattresses.	38 (2012)	Awaiting response.
Toilet inside cells.	33 (2012)	Awaiting response.
Evaluate the temperature of the jail area.	34 (2012)	Awaiting response.

MEDINA DEL CAMPO LOCAL POLICE (VALLADOLID)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Unpleasant odors in cells.	34 (2012)	Awaiting response.
Cleanliness of jail.	34 (2012)	Awaiting response.

TAFALLA LOCAL POLICE (NAVARRE)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	477 (2010) 14 (2012)	Awaiting response.
No constant presence of officers in prison cell area when there are detainees present.	17 (2012)	Awaiting response.
Protocol for infectious and contagious diseases and for pregnant detainees.	23 (2012)	Awaiting response.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 19 (2012)	Awaiting response.
No proof of practice for full body searches.	29 (2012)	Awaiting response.
Inadequate completion of Detainee Record of Custody.	28 (2012)	Awaiting response.
There is no record book for juvenile detainees.	28 (2012)	Awaiting response.
Lacking printed materials with information on rights in different languages.	18 (2012)	Awaiting response.
Officer identification.	26 (2012)	Awaiting response.
Officers carry their weapon loaded in the prison cell area.	27 (2012)	Awaiting response.
Detainee entrance to the facilities.	466 (2010) 31 (2012)	Awaiting response.
Windows in the cell doors have vertical bars.	32 (2012)	Awaiting response.
The beds in the cells have sharp edges.	32 (2012)	Awaiting response.
In the prison cell area there is no fire prevention system.	212 (2010) 63 (2011)	Awaiting response.
Evaluate the temperature of the jail area.	34 (2012)	Awaiting response.
Detainees' possessions are stored in bags.	30 (2012)	Awaiting response.
Detainees are not given mattresses.	38 (2012)	Awaiting response.

ZAFRA LOCAL POLICE (BADAJOZ)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	477 (2010) 14 (2012)	Awaiting response.
Horizontal bars on cell door.	32 (2012)	Awaiting response.
No written record of full body searches recorded.	29 (2012)	Awaiting response.
Detainee entrance to the facilities.	466 (2010) 31 (2012)	Awaiting response.
No written information provided about possibility of filing habeas corpus proceedings.	476 (2010) 19 (2012)	Awaiting response.
Officers carry their weapon loaded in the Prison cell area.	27 (2012)	Awaiting response.
There are no weapon racks.	27 (2012)	Awaiting response.
Officer identification.	26 (2012)	Awaiting response.
Detainees' possessions are stored in bags and there is no locker.	30 (2012)	Awaiting response.
Toilet inside cells.	33 (2012)	Awaiting response.
Evaluate the temperature of the jail area.	34 (2012)	Awaiting response.
Cleanliness of jail.	34 (2012)	Awaiting response.
The squat toilets in lavatories are not adequate for those detainees that, due to their age of physical condition, need to sit down to use the toilet.	33 (2012)	Awaiting response.
GOOD PRACTICES		
Offering detainees unused blankets, in accordance with the criterion set forth in paragraph 38.		
In written materials used to inform detainees of their rights, only the term "lawyer" (*abogado*) is used, in accordance with the criterion set forth in paragraph 476 of the 2012 Annual Report.		

Table 94. Conclusions regarding courts visited in 2012

MERIDA CITY OF JUSTICE (CIUDAD DE LA JUSTICIA) (BADAJOZ)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
Officer identification.	26 (2012)	Awaiting response.
The phone booths in the prison cell area are not used.	20 (2012)	Awaiting response.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary of State for Justice)**
The video surveillance system does not conform to this Institution's criteria.	477 (2010) 14 (2012)	Awaiting response.
Registry book of detainee arrival and departure.	28 (2012)	Awaiting response.
Weapon rack in the jail area.	27 (2012)	Awaiting response.
Office material.		Awaiting response.
Furniture in guards' work area.		Awaiting response.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary General for Prisons)**
Information regarding infectious and contagious diseases.	23 (2012)	Awaiting response.
If a transfer is made first thing in the morning, inmates arrive without having had breakfast at the prison or without having taken medicine.		Awaiting response.

Table 95. Follow-up on the general recommendations made in previous years for all Spanish National Police Force facilities

GENERAL RECOMMENDATIONS TO SPANISH NATIONAL POLICE FORCE	PARAGRAPH No. ANNUAL REPORTS	ADMINISTRATIVE RESPONSE (Directorate General of the Police)
Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted. Its possible inclusion in *SIDENPOL* system will be examined.
Use of the term " lawyer" (*abogado*) in printed materials used to inform detainees of their rights.	476 (2010) 45 (2011)	Not accepted.
Keep records of the practice of full body searches in the Detainee Record of Custody.	68 (2010) 55 (2011)	Accepted. The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
Detainees must not enter the jail through the front door.	46 (2010) 56 (2011)	Accepted for newly built facilities.

GENERAL RECOMMENDATIONS TO SPANISH NATIONAL POLICE FORCE	PARAGRAPH No. ANNUAL REPORTS	ADMINISTRATIVE RESPONSE (Directorate General of the Police)
Offering clean blankets.	61 (2010) 71 (2011)	Accepted.
The detainee's right to legal aid must be fulfilled at the very beginning of arrest.	468 (2010) 44 (2011)	Not accepted.
Keep records in the Record of Telephone Calls of the time of phone call to lawyer.		Records kept except for occasional errors.
Officer identification.	66 (2010) 52 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
Correct completion of Detainee Record of Custody.	71 (2010) 54 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.

Tables 96-106. Follow-up on visits made to SPANISH NATIONAL POLICE FORCE facilities in previous years

WESTERN ANDALUSIA SUPERIOR POLICE DEPARTMENT (GRANADA)		
RESOLUTIONS*	PARAGRAPH No. ANNUAL REPORTS	ADMINISTRATIVE RESPONSE (Directorate General of the Police)
(S) Lacking heat-sealed bags for storing detainees' possessions.	72 (2011)	Rectified.
(R) The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	Accepted, awaiting budget availability.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted. Its possible inclusion in *SIDENPOL* system will be examined.
(R) Keep records in the Detainee Record of Custody of the practice of full body searches.	68 (2010) 55 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
(R) Correct completion of Detainee Record of Custody.	71 (2010) 54 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
(R) Use of the term "lawyer" (*abogado*) in written material used to inform detainees of their rights.	476 (2010) 45 (2011)	Not accepted.
(R) Officer identification.	66 (2010) 52 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.

WESTERN ANDALUSIA SUPERIOR POLICE DEPARTMENT (GRANADA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(R) Offering clean blankets.	61 (2010) 71 (2011)	Accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
No call system from within cells.	41 (2011)	Accepted, awaiting budget availability.
Malfunction of fire suppression systems in jail.	63 (2011)	Rectified.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

ALBACETE POLICE STATION		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(R) The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	Accepted, awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted. Its possible inclusion in *SIDENPOL* system will be examined.
(R) Keep records in the Detainee Record of Custody of the practice of full body searches.	68 (2010) 55 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
(R) Correct completion of Detainee Record of Custody.	71 (2010) 54 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
(R) Use of the term "lawyer" (*abogado*) in printed materials used to inform detainees of their rights.	476 (2010) 45 (2011)	Not accepted.
(R) Officer identification.	66 (2010) 52 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
(R) Offering clean blankets.	61 (2010) 71 (2011)	Accepted.

ALBACETE POLICE STATION		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(R) The detainee's right to legal aid must be fulfilled at the very beginning of arrest.	468 (2010) 44 (2011)	Not accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Do not allow third parties to provide detainees with outside food.	69 (2011)	Accepted.
Lacking display monitors in jail area.	40 (2011)	Accepted, awaiting budget availability.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

ALMERIA POLICE STATION		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(R) The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	Accepted, awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted. Its possible inclusion in *SIDENPOL* system will be examined.
(R) Use of the term "lawyer" (*abogado*) in printed materials used to inform detainees of their rights.	476 (2010) 45 (2011)	Not accepted.
(R) Offering clean blankets.	61 (2010) 71 (2011)	Accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Lacking glass in cell windows.	65 (2011)	Accepted.
Lacking display monitors in prison cell area.	40 (2011)	Accepted, awaiting budget availability.
Do not allow third parties to provide detainees with outside food.	69 (2011)	Accepted.
No bench in cells for detainee rest.	70 (2011)	Accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

ALMERIA-PUERTO POLICE STATION		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(R) The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	Accepted, awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted. Its possible inclusion in *SIDENPOL* system will be examined.
(R) Offering clean blankets.	61 (2010) 71 (2011)	Accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Unpleasant odors in officers' locker rooms.	66 (2011)	Rectified.
Dangerous surveillance monitor wiring installation.	40 (2011)	Rectified.
Inadequate state of jail cell upkeep and maintenance.	57 (2011)	Rectified.
Lacking Detainee Record of Custody at those facilities.	54 (2011)	Rectified.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

AYAMONTE POLICE STATION (HUELVA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(R) The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	Accepted, awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted. Its possible inclusion in *SIDENPOL* system will be examined.

AYAMONTE POLICE STATION (HUELVA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(R) Use of the term "lawyer" (*abogado*) in printed material used to inform detainees of their rights.	476 (2010) 45 (2011)	Not accepted.
(R) Officer identification.	66 (2010) 52 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
(R) Offering clean blankets.	61 (2010) 71 (2011)	Accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Lacking display monitors in prison cell area.	40 (2011)	Accepted, awaiting budget availability.
Lacking heating and air conditioning.	65 (2011)	Accepted, awaiting budget availability.
Vertical and horizontal bars in shared cell.	62 (2011)	Rectified.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

CASTELLO/CASTELLON POLICE STATION		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(R) The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	Accepted, awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Use of the term "lawyer" *(abogado)* in printed materials used to inform detainees of their rights.	476 (2010) 45 (2011)	Not accepted.
(R) Offering clean blankets.	61 (2010) 71 (2011)	Accepted.
(R) The detainee's right to legal aid must be fulfilled at the very beginning of arrest.	468 (2010) 44 (2011)	Not accepted.
(R) Keep records in the Record of Telephone Calls of the time of phone call to attorney.		Records kept except for occasional errors.

CASTELLO/CASTELLON POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Lacking heat-sealed bags for detainees' possessions.	72 (2011)	Rectified.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

CUENCA POLICE STATION		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(R) The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	Accepted, awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Use of the term "lawyer" (*abogado*) in forms used to inform detainees of their rights.	476 (2010) 45 (2011)	Not accepted.
(R) Offering clean blankets.	61 (2010) 71 (2011)	Accepted.
(R) The detainee's right to legal aid must be fulfilled at the very beginning of arrest.	468 (2010) 44 (2011)	Not accepted.
(R) Keep records in the Detainee Record of Custody of the practice of full body searches.	68 (2010) 55 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
(R) Detainees must not enter the jail through the front door.	46 (2010) 56 (2011)	Accepted for newly built facilities.
(R) Officer identification.	66 (2010) 52 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
(R) Correct completion of Detainee Record of Custody.	71 (2010) 54 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.

CUENCA POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Lack of display monitors in prison cell area.	40 (2011)	Accepted, awaiting budget availability.
Lack of preventive measures (masks).	50 (2011)	Rectified.
Lack of hygiene products for detainees.	68 (2011)	Rectified.
State of maintenance of prison cell lavatories.	57 (2011)	Rectified.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

EL EJIDO POLICE STATION (ALMERIA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(R) The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	Accepted, awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted. Its possible inclusion in *SIDENPOL* system will be examined.
(R) Use of the term "lawyer" (*abogado*) in printed materials used to inform detainees of their rights.	476 (2010) 45 (2011)	Not accepted.
(R) Offering clean blankets.	61 (2010) 71 (2011)	Accepted.
(R) Keep records in the Detainee Record of Custody of the practice of full body searches.	68 (2010) 55 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Lack of heating and air conditioning.	65 (2011)	Accepted, awaiting budget availability.
Lack of emergency evacuation plan, marked emergency exits, and fire suppression systems.	63 (2011)	Rectified.
Do not allow third parties to provide detainees with outside food.	69 (2011)	Accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

HUELVA POLICE STATION		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(R) The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	Accepted, awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted. Its possible inclusion in *SIDENPOL* system will be examined.
(R) Use of the term "lawyer" (*abogado*) in written materials used to inform detainees of their rights.	476 (2010) 45 (2011)	Not accepted.
(R) The detainee's right to legal aid must be fulfilled at the very beginning of arrest.	468 (2010) 44 (2011)	Not accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Do not allow third parties to provide detainees with outside food.	69 (2011)	Accepted.
Lacking display monitors in jail area.	40 (2011)	Accepted, awaiting budget availability.
Intercom in prison cell area not in working order.	41 (2011)	Rectified.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

MADRID-DISTRICT OF CHAMBERI POLICE STATION		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(R) The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	Accepted, awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted. Its possible inclusion in *SIDENPOL* system will be examined.

MADRID-DISTRICT OF CHAMBERI POLICE STATION		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(R) Offering clean blankets.	61 (2010) 71 (2011)	Accepted.
(R) Keep records in the Detainee Record of Custody of the practice of full body searches.	68 (2010) 55 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
(R) Detainees must not enter the jail through the front door.	46 (2010) 56 (2011)	Accepted for newly built facilities.
(R) Use of the term "lawyer" (*abogado*) in printed materials used to inform detainees of their rights.	476 (2010) 45 (2011)	Not accepted.
(R) The detainee's right to legal aid must be fulfilled at the very beginning of arrest.	468 (2010) 44 (2011)	Not accepted.
(R) Keep records in the Record of Telephone Calls of the time of phone call to attorney.		Records kept except for occasional errors.
(R) Officer identification.	66 (2010) 52 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
(R) Correct completion of Detainee Record of Custody.	71 (2010) 54 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Inadequate functioning of air conditioning in cells.	65 (2011)	Se subsana.
Cleanliness of cells on weekends.	67 (2011)	Rectified.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

CENTRAL REGISTRY OF DETAINEES (MADRID)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(S) Correct completion of Detainee Record of Custody.	71 (2010) 54 (2011)	The compliance with recommendation or the adoption of appropriate disciplinary measures is noted.
(S) No protocol for recording, nor for access to and procurement of video surveillance system recordings, nor systems to ensure they are not tampered with.	477 (2010) 38, 39 and 40 (2011)	Accepted. Instructions given to comply. Access to recordings is through telecommunication technicians.

CENTRAL REGISTRY OF DETAINEES (MADRID)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
(S) Install seatbelts in all Central Registry vehicles driven.	214 (2011)	Accepted for newly acquired vehicles.
(S) Avoid crowding of detainees in the fewest number of cells possible.	60 (2011)	Accepted, provided that conditions require it.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Installation of cameras in the inspection, body search, and statement taking rooms.	38 (2011)	Accepted, subject to its feasibility and to budget allowance.
Monitors for several video surveillance cameras in prison cells were turned off.	38, 39 and 40 (2011)	Cameras only work if someone is present and are motion-activated.
Equip facilities with a document shredder.		Rectified.
Computerization of Detainee Record of Custody.	54 (2011)	The possibility will be examined.
Inadequate completion of Record of Telephone Calls.	54 (2011)	Rectified.
Interruption of detainees' sleep to carry out inspections.		Only detainees arriving from other police stations are inspected.
No separation of criminal detainees and Foreign Nationals Law detainees.	60 (2011)	Accepted.
Air conditioning system did not work correctly.	65 (2011)	The temperature of the jail will be evaluated.
Unpleasant odors, poor ventilation and air removal.	66 (2011)	Accepted and maintenance company contacted regarding this issue.
Lighting broken in one of the cells.	64 (2011)	Rectified.
Call systems in cells.	41 (2011)	Not accepted.
Provide blankets and mattresses.	71 (2011)	Accepted.
Detainees are not provided with minimal provisions for hygiene.	68 (2011)	Soap is provided upon request and not permanently placed in lavatories to prevent self-inflicted injury.
Disorientation regarding time. Detainee's watches are taken away and facilities lack a visible clock.		Facility will be examined.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

Table 107. Follow-up on the general recommendations made in previous years for all Civil Guard facilities

RECOMMENDATIONS GENERAL A LA GC	PARAGRAPH No. ANNUAL REPORTS	RESPONSE (Directorate General of the Civil) Guard)
Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Accepted. Awaiting budget availability.
Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted.
Use of the term "lawyer" (*abogado*) in printed materials used to inform detainees of their rights.	476 (2010) 45 (2011)	The forms must be modified by the National Coordination Commission of the Judicial Police.
Keep records in the Detainee Record of Custody of the practice of full body searches.	68 (2010) 55 (2011)	If a search is made, a record is kept.
Detainees must not enter the jail through the front door.	95 (2010) 56 (2011)	Accepted for newly built facilities.
Offering clean blankets.	1,081 (2010) 71 (2011)	Accepted.
The detainee's right to legal aid must be fulfilled at the very beginning of arrest.	468 (2010) 44 (2011)	Not accepted.
Firearms are not to be carried in the jail.	112 (2010) 53 (2011)	Not accepted.
Officer identification.	113 (2010) 52 (2011)	Not accepted. They are considered to be identified at all times.
Correct completion of Detainee Record of Custody.	71 (2010) 54 (2011)	Not accepted. It is considered to be correctly completed.
Detainee guard officers carry out other functions simultaneously.	104 (2010)	Not accepted.

Tables 108-119. Follow-up on visits made to facilities of the Civil Guard in previous years

ALBACETE COMMAND HEADQUARTERS		
RESOLUTIONS*	PARAGRAPH No. ANNUAL REPORTS	ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)
(R) Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Accepted. Awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.

ALBACETE COMMAND HEADQUARTERS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted.
(R) Offering clean blankets.	1,081 (2010) 71 (2011)	Accepted.
(R) Officers on detainee guard are not to carry out other functions simultaneously.	68 (2010) 55 (2011)	If a search is made, a record is kept.
(R) Officers on detainee guard are not to carry out other functions simultaneously.	104 (2010)	Not accepted.
(R) Firearms are not to be carried in the jail.	112 (2010) 53 (2011)	Not accepted.
(R) The detainee's right to legal aid must be fulfilled at the very beginning of arrest.	468 (2010) 44 (2011)	Not accepted.
(R) Correct completion of Detainee Record of Custody.	71 (2010) 54 (2011)	Not accepted. It is considered to be correctly completed.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Close down cells for not meeting minimum recommended size.	61 (2011)	Accepted, prison cells are to be demolished and built according to regulations.
Lacking heat-sealed bags for detainees' possessions.	72 (2011)	Not accepted.
Lacking preventive measures (masks).	50 (2011)	Accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

ALMERIA COMMAND HEADQUARTERS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(R) Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Accepted. Awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.

ALMERIA COMMAND HEADQUARTERS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted.
(R) Offering clean blankets.	1,081 (2010) 71 (2011)	Accepted.
(R) Keep records in the Detainee Record of Custody of the practice of full body searches.	68 (2010) 55 (2011)	If a search is made, a record is kept.
(R) Correct completion of Detainee Record of Custody.	71 (2010) 54 (2011)	Not accepted. It is considered to be correctly completed.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

CASTELLO/CASTELLON COMMAND HEADQUARTERS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(R) Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Accepted. Awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted.
(R) Offering clean blankets.	1,081 (2010) 71 (2011)	Accepted.
(R) Keep records in the Detainee Record of Custody of the practice of full body searches.	68 (2010) 55 (2011)	If a search is made, a record is kept.
(R) Officers on detainee guard are not to carry out other functions simultaneously.	104 (2010)	Not accepted.
(R) Detainees must not enter the jail through the front door.	95 (2010) 56 (2011)	Accepted for newly built facilities.
(R) Use of the term "lawyer" (*abogado*) in printed materials used to inform detainees of their rights.	476 (2010) 45 (2011)	The National Coordination Commission of the Judicial Police must modify the printed material.

CASTELLO/CASTELLON COMMAND HEADQUARTERS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(R) The detainee's right to legal aid must be fulfilled at the very beginning of arrest.	468 (2010) 44 (2011)	Not accepted.
(R) Officer identification.	113 (2010) 52 (2011)	Not accepted. They are considered to be identified at all times.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Neither heating nor air conditioning.	65 (2011)	Rectified.
Lack of fire suppression systems.	63 (2011)	Rectified.
Lack of heat-sealed bags for detainees' possessions.	72 (2011)	Not accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

CUENCA COMMAND HEADQUARTERS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(R) Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Accepted. Awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted.
(R) Use of the term "lawyer" (*abogado*) in printed materials used to inform detainees of their rights.	476 (2010) 45 (2011)	The printed materials must be modified by the National Coordination Commission of the Judicial Police.
(R) The detainee's right to legal aid must be fulfilled at the very beginning of arrest.	468 (2010) 44 (2011)	Not accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Difficulties for emergency evacuation due to narrowness of hallway, which is blocked by cell doors.	62 (2011)	Accepted, subject to budget availability.

CUENCA COMMAND HEADQUARTERS		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Lacking heat-sealed bags for detainees' possessions.	72 (2011)	Not accepted.
Do not allow third parties to provide detainees with outside food.	69 (2011)	Not accepted, food inspected beforehand.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

GUADALAJARA COMMAND HEADQUARTERS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(R) Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Accepted. Awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted.
(R) Officers on detainee guard are not to carry out other functions simultaneously.	104 (2010)	Not accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
No heating or air conditioning.	65 (2011)	Rectified.
Detainees are not provided with minimal provisions for hygiene.	68 (2011)	Rectified.
Unsatisfactory state of cleanliness of mattresses and cells.	68 (2011)	Rectified.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

GIPUZKOA COMMAND HEADQUARTERS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(S) Installation of cameras in garage entrance and in inspection and identification rooms; incorporation of audio recording; and protocol for recording security, access and upkeep.	477 (2010) 226 (2011)	Accepted, subject to budget availability.

GIPUZKOA COMMAND HEADQUARTERS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(R) Officer identification.	113 (2010) 52 (2011)	Not accepted. They are considered to be identified at all times.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Lacking heat-sealed bags for detainees' possessions.	72 (2011)	Not accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

HUELVA COMMAND HEADQUARTERS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(R) Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Accepted. Awaiting budget availability.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted.
(R) Use of the term "lawyer" (*abogado*) in printed materials used to inform detainees of their rights.	476 (2010) 45 (2011)	The printed materials must be modified by the National Coordination Commission of the Judicial Police.
(R) Keep records in the Detainee Record of Custody of the practice of full body searches.	68 (2010) 55 (2011)	If a search is made, a record is kept.
(R) Officer identification.	113 (2010) 52 (2011)	Not accepted. They are considered to be identified at all times.
(S) Lack of heat-sealed bags for detainees' possessions.	72 (2011)	Accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

ALJARAQUE HEADQUARTERS (HUELVA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(R) Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Accepted. Awaiting budget availability.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.

ALJARAQUE HEADQUARTERS (HUELVA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted.
(R) Offering clean blankets.	1,081 (2010) 71 (2011)	Accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Unsatisfactory state de maintenance, hygiene and ventilation.	57, 66 and 67 (2011)	Rectified.
Neither heating nor air conditioning.	65 (2011)	Accepted, subject to budget availability.
Do not allow third parties to provide detainees with outside food.	69 (2011)	Not accepted, food inspected beforehand.
Lacking heat-sealed bags for detainees' possessions.	72 (2011)	Not accepted.
Detainees are not provided with minimal provisions for hygiene.	68 (2011)	Rectified.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

ARGUINEGUIN HEADQUARTERS (LAS PALMAS)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(S) Install a video surveillance system to conform to this Institution's criteria.	38 and 39 (2011)	Awaiting response.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted.
(R) Offering clean blankets.	1,081 (2010) 71 (2011)	Accepted.
(R) Officer identification.	113 (2010) 52 (2011)	Not accepted. They are considered to be identified at all times.
(R) Keep records in the Detainee Record of Custody of the practice of full body searches.	68 (2010) 55 (2011)	If a search is made, a record is kept.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

BOLLULLOS PAR DEL CONDADO HEADQUARTERS (HUELVA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(R) Install a video surveillance system to conform to this Institution's criteria.	38 and 39 (2011)	Awaiting response.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted.
(R) Offering clean blankets.	1,081 (2010) 71 (2011)	Accepted.
(R) Officer identification.	113 (2010) 52 (2011)	Not accepted. They are considered to be identified at all times.
(R) Use of the term "lawyer" (*abogado*) in Printed materials used to inform detainees of their rights.	476 (2010) 45 (2011)	The printed materials must be modified by the National Coordination Commission of the Judicial Police.
(R) The detainee's right to legal aid must be fulfilled at the very beginning of arrest.	468 (2010) 44 (2011)	Not accepted.
(R) Firearms are not to be carried in jail.	112 (2010) 53 (2011)	Not accepted.
(R) Correct completion of Detainee Record of Custody.	71 (2010) 54 (2011)	Not accepted. It is considered to be correctly completed.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Lacking heat-sealed bags for detainees' possessions.	72 (2011)	Not accepted.
Do not allow third parties to provide detainees with outside food.	69 (2011)	Not accepted, food inspected beforehand.
Poor state of cleanliness of jail.	67 (2011)	Rectified.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

EL EJIDO HEADQUARTERS (ALMERIA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(R) Install a video surveillance system to conform to this Institution's criteria.	38 and 39 (2011)	Awaiting response.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted.
(R) Offering clean blankets.	1081 (2010) 71 (2011)	Accepted.
(R) Firearms are not to be carried in jail.	112 (2010) 53 (2011)	Not accepted.
(R) Keep records in the Detainee Record of Custody of the practice of full body searches.	68 (2010) 55 (2011)	If a search is made, a record is kept.
(R) Officers on detainee guard are not to carry out other functions simultaneously.	104 (2010)	Not accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Poor lighting conditions in jail.	64 (2011)	Rectified.
Poor state of cleanliness of jail.	67 (2011)	Rectified.
Poor ventilation and unpleasant odo rs in cells.	66 2011)	Rectified.
No emergency evacuation plan, marked emergency exits, or fire suppression systems.	63 (2011)	Rectified.
Evaluate temperature of jail, not satisfactory on day of visit.	65 (2011)	Rectified, hot and cold water pump installed.
Spiral staircase endangers detainees and officers.	62 (2011)	Accepted and viability of alternative will be examined.
Do not allow third parties to provide detainees with outside food.	69 (2011)	Not accepted, food inspected beforehand.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

LAS ROZAS HEADQUARTERS (MADRID)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
(S) Renovate jail cell area to adapt cell dimensions to minimum recommended size.	61 (2011)	Not accepted.
(R) Install a video surveillance system to conform to this Institution's criteria.	38 and 39 (2011)	Awaiting response.
(R) Protocol for treating detainees with infectious and contagious diseases.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Protocol for treating pregnant detainees.	58 (2010) 49 (2011)	Not accepted. Actions adhere to guidelines provided by doctor and judicial authority.
(R) Information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 226 (2011)	Not accepted.
(R) Officer identification.	113 (2010) 52 (2011)	Not accepted. Se considera que siempre van identificados.
(R) Firearms are not to be carried in prison.	112 (2010) 53 (2011)	Not accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Non-existence of smoke detectors.	63 (2011)	Rectified.
Poor ventilation of jail.	66 (2011)	Rectified.
One of the two lavatories in the jail was out of order.	67 (2011)	Rectified.
Unsatisfactory storage for blankets in evacuation area.	62 (2011)	Rectified.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

Table 120. Follow-up on the general recommendations made in previous years for all of Basque Autonomous Police Force facilities

GENERAL RECOMMENDATIONS	PARAGRAPH No. ANNUAL REPORTS	RESPONSE (Security Council of the Basque Government)
The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	Not accepted.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 47 (2011)	Not accepted.
No record of full body searches performed and the causes justifying their performance.	55 (2011)	Records kept in computer application (*Atxilo*) and in a written report by officers performing search.
Officer identification.	52 (2011)	Accepted.

Tables 121-123. Follow-up on visits made to autonomous police in previous years

IRUN BASQUE AUTONOMOUS POLICE FORCE POLICE STATION (GIPUZKOA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Department of the Interior, Justice, and Public Administration)**
(S) Equip jail with mattresses.	71 (2011)	Not accepted.
(S) Lacking heat-sealed bags for storing detainees' possessions.	72 (2011)	Not accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	Not accepted.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 47 (2011)	Not accepted.
Officer identification.	52 (2011)	Not accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

GERONA CATALAN AUTONOMOUS POLICE FORCE POLICE STATION		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Councilor of the Interior)**
(R) Modification of Article 5 of Decree 78/2010 to incorporate audio in video surveillance devices.	38 (2011)	It will be taken into consideration in the improvement process for Catalan Autonomous Police Force services.
(S) Lacking heat-sealed bags for storing detainees' possessions.	72 (2011)	It will be considered in the next revision of Catalan Autonomous Police Force arrest procedures.

GERONA CATALAN AUTONOMOUS POLICE FORCE POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Protocol for detainees with infectious and contagious diseases and for pregnant detainees.	49 (2011)	There are «standardized work procedures» (*procedimientos normalizados de trabajo*) in which these situations are foreseen.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 47 (2011)	Not accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

SANTA CRUZ DE TENERIFE CANARY ISLANDS REGIONAL CENTRAL POLICE FORCE POLICE STATION		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Economy, Treasury, and Security Councilor)**
The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	It will be considered for inclusion in facility operation.
Proceed to remodel cell doors to prevent self-inflicted injury in detainees.	62 (2011)	It will be considered for inclusion in facility operation.
Toilet inside cells.	58 (2011)	It will be considered for inclusion in facility operation.

NOTE: The Ministry has reported that these jails were not operational, since persons who are arrested by the Canary Islands Police Force are placed under the authority of the Civil Guard or the Spanish National Police Force.

Tables 124-129. Follow-up on visits made to local police in previous years

ALGETE LOCAL POLICE (MADRID)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (City Hall)**
(S) Install a video surveillance system.	477 (2010) 38, 39 and 40 (2011)	Accepted.
(S) Written information about possibility of filing *habeas corpus* proceedings.	476 (2010) 47 (2011)	Accepted.
(S) Protocol for detainees with infectious and contagious diseases and for pregnant detainees.	49 (2011)	Accepted.
(S) Carrying weapons in jail area.	53 (2011)	Accepted.
(S) Do not offer blankets already used by another detainee.	71 (2011)	Accepted.
(S) Lack of heat-sealed bags for storing detainees' possessions.	72 (2011)	Accepted.

ALGETE LOCAL POLICE (MADRID)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
No call system from within cells.	41 (2011)	Detainees stay while preliminary criminal proceedings are carried out, and are transferred afterwards to the Civil Guard headquarters for custody.
In Detainee Record of Custody the detainee chain of custody is not specified.	54 (2011)	A computerized format has been incorporated for detainee chain of custody.
Lacking food, jail clothes, and hygiene products for detainees.	69, 71 and 68 (2011)	Detainees stay while preliminary criminal proceedings are carried out, and are transferred afterwards to the Civil Guard headquarters for custody.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

BERJA LOCAL POLICE (ALMERIA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (City Hall)**
(S) Install a video surveillance system.	477 (2010) 38, 39 and 40 (2011)	Awaiting response.
(S) Written information about possibility of filing *habeas corpus* proceedings.	476 (2010) 47 (2011)	Awaiting response.
(S) Carrying weapons in jail area.	53 (2011)	Awaiting response.
(S) Do not offer blankets already used by another detainee.	71 (2011)	Awaiting response.
(S) Evaluate temperature of jail throughout the year.	65 (2011)	Awaiting response.
(S) Lack of heat-sealed bags for storing detainees' possessions.	72 (2011)	Awaiting response.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Moisture stains in one of the cells.	57 (2011)	Rectified.
Protocol for detainees with infectious and contagious diseases and for pregnant detainees.	49 (2011)	Infectious and contagious detainees are transferred to the hospital and in recent years there have been no pregnant detainees.
Lacking fire suppression systems in jail.	63 (2011)	There is a hose in the jail.
No call system from within cells.	41 (2011)	Given the size of the jail, detainees call out requests.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

LA CAROLINA LOCAL POLICE (JAEN)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (City Hall)**
(S) Protocol for detainees with infectious and contagious diseases and for pregnant detainees.	49 (2011)	Awaiting response.
(S) Do not offer blankets already used by another detainee.	71 (2011)	Awaiting response.
(S) Proceed to remodel cells doors to prevent self-inflicted injury in detainees.	62 (2011)	Awaiting response.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Installation of a video surveillance system.	477 (2010) 38, 39 and 40 (2011)	Accepted, awaiting budget availability.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 47 (2011)	Rectified.
Use only the term "lawyer" (*abogado*) in printed materials used to de inform detainees of their rights.	476 (2010) 45 (2011)	Rectified.
Save a copy of detainees' custody sheet from Civil Guard.	54 (2011)	Rectified.
Carrying loaded weapons in jail area.	53 (2011)	Rectified.
No call system from within cells.	41 (2011)	It will be installed if the need for it is not covered by video surveillance.
Lacking fire suppression systems in jail.	63 (2011)	Rectified.
Lacking masks as preventive measure.	50 (2011)	Rectified.
Lacking heat-sealed bags for storing detainees' possessions.	72 (2011)	Rectified.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

DONOSTIA/SAN SEBASTIAN MUNICIPAL GUARD (GIPUZKOA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Town council)**
(R) Keep records in the "Detainee Record of Custody" (*Libro Registro de Personas Detenidas*) of the practice of full body searches and the causes justifying their use, and the information given to the judicial authority regarding the application of these measures in proceedings details.	222 (2010)	Accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

SUECA LOCAL POLICE (VALENCIA)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (City Hall)**
The video surveillance system does not conform to this Institution's criteria.	477 (2010) 38, 39 and 40 (2011)	Study of its viability.
Protocol for detainees with infectious and contagious diseases and for pregnant detainees.	49 (2011)	There are instructions in the Manual regarding operational regulations for the center.
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 47 (2011)	Not accepted.
There is no constant presence in the jail area when there are detainees nor are there call systems within cells.	42 and 41 (2011)	There are always officers present.
Lack of fire suppression systems in jail.	63 (2011)	Accepted.
Lack of heat-sealed bags for storing detainees' possessions.	72 (2011)	Accepted.
Poor ventilation in jail.	66 (2011)	Accepted.

NOTE: The City Hall of Sueca has reported that the conclusions made will be considered for application in the locality's new detainee center.

VALVERDE DEL CAMINO LOCAL POLICE (HUELVA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (City Hall)**
(S) Installation of a video surveillance system.	477 (2010) 38, 39 and 40 (2011)	Awaiting response.
(S) Protocol for detainees with infectious and contagious diseases and for pregnant detainees.	49 (2011)	Awaiting response.
(S) Do not offer blankets already used by another detainee.	71 (2011)	Awaiting response.
(S) Use only the term "lawyer" (*abogado*) in printed materials used to inform detainees of their rights.	476 (2010) 45 (2011)	Awaiting response.
(S) Lacking heat-sealed bags for storing detainees' possessions.	72 (2011)	Awaiting response.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
No written information provided about possibility of filing *habeas corpus* proceedings.	476 (2010) 47 (2011)	Rectified.
No record of full body searches performed.	55 (2011)	Rectified.

VALVERDE DEL CAMINO LOCAL POLICE (HUELVA)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Do not carry loaded weapons in jail area.	53 (2011)	Accepted.
Officer identification.	52 (2011)	Rectified.
Lacking fire suppression systems in jail.	63 (2011)	Rectified.
Cleanliness of jail.	67 (2011)	Rectified.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

NOTE: The City Hall of Valverde del Camino has reported that, after the visit made by NPM, a new center for detainees has been opened in the locality.

Table 130. Follow-up on the general recommendations made in previous years for all judicial buildings belonging to the Spanish Ministry of Justice

GENERAL RECOMMENDATIONS	PARAGRAPH No. ANNUAL REPORTS	ADMINISTRATIVE RESPONSE (Office of the Secretary of State for Justice)
Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Accepted partially.
Detainee Record of Custody.	247 (2010) 54 (2011)	Accepted.

Table 131. Follow-up on the general recommendations made in previous years for all judicial buildings belonging to the Regional Autonomous Community of the Canary Islands

GENERAL RECOMMENDATIONS	PARAGRAPH No. ANNUAL REPORTS	ADMINISTRATIVE RESPONSE (Ministry of the Presidency, Justice, and Equality)
Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Accepted. Awaiting budget availability.
Evaluate temperature of jail.	234 (2010) 65 (2011)	Accepted.

Tables 132-135. Follow-up on visits made in previous years to judicial buildings belonging to the Spanish Ministry of Justice

ALBACETE LAW COURTS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary of State for Justice)**
(S) Stop use of toilets in cells.	58 (2011)	Accepted. Awaiting budget availability.
(S) Provide weapon rack.		Accepted.
(R) Detainee Record of Custody.	54 (2011)	Accepted.

ALBACETE LAW COURTS		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary of State for Justice)**
The video surveillance system does not conform to this Institution's criteria.	226 (2011)	Accepted. Awaiting budget availability.
Lacking masks as preventive measure.	50 (2011)	Rectified.
Lack of closet or locker to store detainees' or inmates' possessions.	72 (2011)	Rectified.
Poor lighting conditions in guard room.	64 (2011)	Accepted.
Detainees and inmates' diet.	69 (2011)	Accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Civil Guard)**
Inmates and detainees enter through main door.	56 (2011)	Accepted. Entrance will now be through garage.
Firearms are not to be carried in jail area.	53 (2011)	Accepted. The appropriate instructions are being given.
Officer identification.	52 (2011)	Accepted. Adherence is affirmed.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

GUADALAJARA PROVINCIAL HIGH COURT		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary of State for Justice)**
(R) Detainee Record of Custody.	54 (2011)	Accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary of State for Justice)**
The video surveillance system does not conform to this Institution's criteria.	226 (2011)	Accepted. Awaiting budget availability.
Detainees and inmates' diet.	69 (2011)	Accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

GUADALAJARA CRIMINAL, FIRST INSTANCE, AND EXAMINING COURTS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary of State for Justice)**
(R) Detainee Record of Custody.	54 (2011)	Accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary of State for Justice)**
The video surveillance system does not conform to this Institution's criteria.	226 (2011)	Accepted. Awaiting budget availability.
Detainees and inmates' diet.	69 (2011)	Accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

MELILLA COURTS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary of State for Justice)**
(S) Horizontal bars on cell doors.	231 (2010) 62 (2011)	Awaiting response.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

Tables 136-137. Follow-up on visits made in previous years to judicial buildings belonging to the Regional Autonomous Community of the Canary Islands

EXAMINING AND FIRST INSTANCE COURT, CRIMINAL COURT, AND GENDER VIOLENCE COURT OF THE JUDICIAL DISTRICT OF LAS PALMAS OF GRAND CANARY (LAS PALMAS)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Ministry of the Presidency, Justice, and Equality)**
(R) Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	This recommendation is planned to be followed in the new judicial building.
(R) Evaluate temperature of jail.	234 (2010) 65 (2011)	Accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Detainees and inmates' diet.	239 (2010) 69 (2011)	Awaiting response.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

JUDICIAL DISTRICT OF SAN BARTOLOME DE TIRAJANA (LAS PALMAS) EXAMINING AND FIRST INSTANCE COURT AND GENDER VIOLENCE COURT		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Ministry of the Presidency, Justice and Equality)**
(S) Horizontal bars on cell doors	231 (2010) 62 (2011)	Accepted. Awaiting budget availability.
(R) Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Not possible at this center due to budgetary restrictions.
(R) Evaluate temperature of jail.	234 (2010) 65 (2011)	Accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Detainees and inmates' diet.	239 (2010) 69 (2011)	Awaiting response.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

Tables 138-139. Follow-up on visits made in previous years to judicial buildings under the authority of the Regional Autonomous Community of Cantabria

SANTANDER EXAMINING COURTS		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Ministry of the Presidency and Justice)**
Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Accepted. Awaiting budget availability.
Access to hygiene for inmates and detainees.	68 (2011)	Rectified.
Improve hygiene of officer work spaces to make them livable.	229 (2010)	Accepted. Instructions being given for improvement.
Inmate and detainee access and transfer to court rooms in conditions with improved privacy.	243 (2010 56 (2011))	Accepted. Awaiting future redistribution of rooms.
Horizontal bars on cell doors.	231 (2010) 62 (2011)	Rectified.
Lack of cleanliness in jail.	235 (2010)	Rectified.

SANTANDER CRIMINAL COURTS AND JUVENILE COURTS		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Ministry of the Presidency and Justice)**
Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Accepted. Awaiting budget availability.
Access to hygiene for inmates and detainees.	68 (2011)	Rectified.
Horizontal bars on cell doors.	231 (2010) 62 (2011)	Rectified.

Table 140. Follow-up on visits made in previous years to judicial buildings under the authority of the Regional Autonomous Community of La Rioja

LOGROÑO LAW COURTS		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Ministry of the Presidency and Justice)**
Video surveillance systems adapted to the criteria of this Institution.	477 (2010) 226 (2011)	Accepted. Coverage improved.

Table 141. Follow-up on visits made in previous years to judicial buildings under the authority of the Regional Autonomous Community of Valencia

CASTELLO/CASTELLON "CITY OF JUSTICE" (CIUDAD DE LA JUSTICIA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Ministry of Justice and Social Welfare)**
(S) The video surveillance system does not conform to this Institution's criteria.	38, 39 and 40 (2011)	Not accepted.
(S) Call systems in cells.	41 (2011)	Not accepted.

CASTELLO/CASTELLON "CITY OF JUSTICE" (CIUDAD DE LA JUSTICIA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Ministry of Justice and Social Welfare)**
(S) Lacking Detainee Record of arrival and departure.	54 (2011)	Not accepted.
(S) Individually and securely deposit detainee or inmate possessions in closet or locker.	67 and 71 (2010) 72 (2011)	Accepted.
(S) Detainees' and inmates' diet.	69 (2011)	Not accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

2. Medium-term Deprivation of Liberty

2.1. Immigrant Detention Centers

Tables 142-145. Conclusions regarding the Immigrant Detention Centers visited in 2012

ALGECIRAS IMMIGRANT DETENTION CENTER (CADIZ)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Facilities do not possess appropriate conditions.	45 (2012)	Remodeling work done to improve them.
Video surveillance cameras in the area with the the temporary separation cell.	477 (2010) 62 (2012)	Installation requested.
Officer identification.	63 (2012)	Requirement to fulfill this obligation reiterated.
There is no record of motives for full body searches.	50 (2012)	Records kept in personal files and in officer's log.
Water temperature.	268 (2010)	Water heater capacity and problems with thermostats.
Women's courtyard covered area.	68 (2012)	Remodeling has been requested.
Visit lengths.	98 (2011)	Not lengthened for space reasons and for lack of officers.
Leisure material.	67 (2012)	No budget allowance.
Not permitted to receive calls from outside.	66 (2012)	Not accepted. Security and organization problems.

BARCELONA IMMIGRANT DETENTION CENTER		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
(R) Installation of cameras in library and in the space used for inmate temporary separation.	477 (2010) 62 (2012)	Installation begun.

BARCELONA IMMIGRANT DETENTION CENTER		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
(R) Set up a record system for requests for medical assistance.	57 (2012)	A stamped and numbered record has been created.
(R) Provide Immigrant Detention Center with permanent health assistance.	53 (2012))	Services contract expanded.
(R) Improve injury descriptions.	55 (2012)	Accepted and forwarded to *SERMEDES.*
(R) Injury reports of officers as well as those of inmates must be sent together to the court on duty.	58 (2012)	Accepted.
(RLR) Remember legal obligation to comply with provisions of Article 262 of Criminal Procedure Law.	85 (2011)	Both security personnel and medical personnel must understand said obligation.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Lacking officer identification.	63 (2012)	Requirement to fulfill this obligation reiterated.
Water temperature of showers.	268 (2010)	Instructions given to rectify issue.
No social workers at Center.	60 (2012)	Accepted. Awaiting new organizational and operational regulations for Immigrant Detention Centers.
Content and format of clinical records do not adhere to Law 41/2002.	56 (2012)	Instructions given to rectify issue.
Language can pose a problem for for carrying out appropriate medical attention.	92 (2011)	Instructions given to rectify issue.

* Recommendations, Suggestions and Reminder of Legal Responsibilities.

MADRID IMMIGRANT DETENTION CENTER		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Installation of video surveillance cameras in the space designated for identifying inmates.	477 (2010) 62 (2012)	Not accepted.
Injury reports for inmates and those for officers are not sent together to the assigned court.	58 (2012)	Instructions given to rectify issue.
Officer identification.	63 (2012)	Requirement to fulfill this obligation reiterated.
Unrestricted bathroom access throughout the night.	65 (2012)	Sinks and toilets have been installed within all the rooms.
Telephone in security area off the hook during permitted calling hours.	66 (2012)	Considering installing a switchboard.
Poor state of mattresses.	68 82012)	Inmates damage material.

MADRID IMMIGRANT DETENTION CENTER		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Permanent medical assistance.	53 (2012)	Service contract expanded.
Specialized medical assistance.	54 (2012)	Inmates are transferred to *12 de Octubre* University Hospital and to *San Carlos* Clinical Hospital.
Medical appointments are carried out with the door open.		Medical personnel decide if the door stays open or is closed, for security reasons.
Injury descriptions.	55 (2012)	Instructions given to rectify issue.
Content and format of clinical records do not adhere to Law 41/2002.	56 (2012)	Instructions given to rectify issue.
Language can pose a problem for carrying out appropriate medical attention.	92 (2011)	Instructions given to rectify issue.

IMMIGRANT DETENTION CENTER VALENCIA		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
(R) Set up a record system for requests for medical assistance.	57 (2012)	A daily list has been created.
(R) Provide Immigrant Detention Center with permanent health assistance.	53 (2012)	Service contract expanded.
(R) Language should not be a problem for carrying out appropriate medical attention.	92 (2011)	Instructions given to rectify issue.
(R) Unrestricted toilet access throughout the night.	65 (2012)	Existing instructions have been reiterated.
(R) Control shower temperature.	268 (2010)	Thermostats have been installed.
(R) A basic hygiene kit should be provided.	268 (2010) 102 (2011)	One is given to them.
(RLR) Remember legal obligation to comply with provisions of Article 262 of Criminal Procedure Law.	85 (2011)	Both the security personnel and medical personnel understand said obligation.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Ex officio lawyer visits.	91 (2011)	The solution depends upon different Bar Associations
Unpleasant odors in offices.	69 (2012)	Instructions given to rectify issue.
Irregular distribution of telephone cards by kitchen staff.	66 (2012)	There is no record of demanding overpayment.
Visiting hours.	98 (2011)	Expanded.
Partitions in visitor room.	98 (2011)	They have been installed.

VALENCIA IMMIGRANT DETENTION CENTER		
CONCLUSIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Food given during trips to consulates or embassies.	70 (2012)	It has been rectified.
A receipt must be signed when depositing suitcases.	70 (2012)	Instructions given to rectify issue.
Courtyard covered area.	68 (2012)	Accepted. Awaiting budget availability.
Installation of washing machine and dryer.	68 (2012)	Being studied. Awaiting budget, space, and security clearance.
Leisure material.	67 (2012)	The center provides recreational material.
Repair of one of the separation cells.		It has been repaired.
Partitions in showers.	68 (2012)	Accepted. Awaiting budget availability.
Specialized medical assistance.	54 (2012)	Access is fully guaranteed under public health system.
No kind of psychological assistance is available to inmates.	54 (2012)	The NGO «Psychologists Without Borders» comes to the Center on a daily basis.
Medical appointments are carried out with the door open.		Medical personnel decide based on security reasons.
Injury descriptions and photographs of them.	55 (2012)	The contractor has been contacted about its rectification.
Content and format of clinical records do not adhere to Law 41/2002.	56 (2012)	Instructions given to rectify issue.

* Recommendations, Suggestions and Reminder of Legal Responsibilities.

Tables 146-152. Follow-up on visits to Immigrant Detention Centers made in previous years

ALGECIRAS (CADIZ)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
System for complaints and requests.	250 (2010)	There are complaint and request forms but copies are not given to the interested party nor are there a record kept of them.
Medical assistance in case of mass arrival of immigrants	263 (2010)	Red Cross provides initial assistance. If necessary, they are transferred to hospitals.
Telephone booths and vending machines.	279 (2010)	Correct maintenance (2012 visit).
Cleaning	260 (2010)	From Monday to Sunday. Three persons per module.

ALGECIRAS (CADIZ)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Laundry	270 (2010)	This service is lacking (2012 visit).
Manual cell door opening.	262 (2010)	Has not been installed (2012 visit).

ALGECIRAS (Tarifa Facilities) (CADIZ)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Sports material.	272 (2010)	It has been made available.
Remodeling and use of other buildings.	254 (2010)	If it were necessary, after remodeling two buildings could take in inmates from other Immigrant Detention Centers.
Lighting conditions.	258 (2010)	It is considered adequate given that inmates only enter module to sleep.

MADRID		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Methadone must not be taken to centers by officers.	264 (2010)	Those responsible for its delivery give it directly to the medical services at Immigrant Detention Centers.
Recreational material.	271 (2010)	Instructions have been given for its issue.
Courtyard coverings.	272 (2010)	Not carried out (2012 visit).
Manual cell door opening.	262 (2010)	Not installed (2012 visit).

MURCIA		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Medical assistance in case of a mass arrival of immigrants.	263 (2010)	Red Cross provides initial assistance. If necessary, they are transferred to hospitals.
The library and worship space are used to store luggage.	273 (2010)	It has been rectified, with luggage kept in a specific storage space.
Inmates stay in courtyard in afternoon.	272 (2010)	Recommendation accepted.
Manual cell door opening.	262 (2010)	Accepted. Awaiting budget availability.

LAS PALMAS OF GRAND CANARY (LAS PALMAS)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Emergency exit routes.	262 (2010) 95 (2011)	The Plan of self-protection has been modified to adapt it to the center.
Lacking female personnel.	89 (2011)	If necessary, some would come from immigration brigades or citizen security.
Relocation of the Canine Unit or its acoustic isolation.	105 (2011)	Not possible for structural reasons.
Provide a space for attorney visits.	98 (2011)	One has been provided.
Provide a space for family and friend visits.	98 (2011)	Not possible for structural reasons.
Avoid making inmates wash and dry their clothes in bedrooms and lavatories.	105 (2011)	Not possible for structural reasons.
Equip women's bedrooms with lockers.	105 (2011)	Not possible for budgetary reasons.
Outside provision of hygiene products is prohibited.	102 (2011)	Security protocol makes it impossible for liquid products in containers to be brought inside.
Recreational material.	103 (2011)	The center has been equipped.

SANTA CRUZ DE TENERIFE		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Emergency exit routes.	262 (2010) 95 (2011)	Currently in final phase of creation.

VALENCIA		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Manual cell door opening.	262 (2010)	Suggestion rejected for budgetary reasons.

2.2. Military Disciplinary Establishments

Tables 153-160. Follow-up on visits made to Military Disciplinary Establishments in previous years

GENERAL RESOLUTIONS REGARDING MILITARY DISCIPLINARY ESTABLISHMENTS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Undersecretary of the Ministry of Defense)**
(RE) The creation of an organism that would coordinate Military Disciplinary Establishments in such a way as to produce common regulations and procedures for action.	108 (2010)	Not accepted, without prejudice to recommendations that can be made so that conditions of compliance in arrests be uniform.

GENERAL RESOLUTIONS REGARDING MILITARY DISCIPLINARY ESTABLISHMENTS		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Undersecretary of the Ministry of Defense)**
(RE) Modification of Ministry Order 97/1993, of 30 September, regarding intimate communication, searches and body searches, and telephone communications.	300, 301 and 305 (2010) 108 (2011)	Not accepted. Deemed unnecessary.
(RE) Extension of video surveillance systems, in line with the criterion made manifest in paragraphs 293 and 477 of 2010 Annual Report.	293 and 477 (2010)	Accepted. Awaiting budget availability.
(RE) Examine conditions in which recordings are activated and other criteria reflected in paragraph 477 of 2010 Annual Report.	477 (2010)	Accepted. Awaiting budget availability.
(RE) Obtainment and preservation of those images that might reflect any incident that could occur involving an individual deprived of liberty.	477 (2010)	Accepted. Awaiting budget availability.
(RE) Authorize the loans required to provide arrested individuals with free hygiene products at the cost of the Administration.	297 (2010)	Not accepted.
GENERAL CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Undersecretary of the Ministry of Defense)**
Examine the possibility of opening a psychological office in Military Disciplinary Establishments lacking one.	111 (2011)	Accepted.

* Recommendations (RE); Suggestions (SU); Reminder of Legal Responsibilities (RLR).

CONCLUSIONS REGARDING COLMENAR VIEJO (MADRID) MILITARY DISCIPLINARY ESTABLISHMENT		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Undersecretary of the Ministry of Defense)**
Written record full body searches performed.	305 (2010)	Not accepted.
Provide locker rooms and lavatories for personnel assigned to establishment.		Accepted.

CONCLUSIONS NORTHERN MILITARY DISCIPLINARY ESTABLISHMENT, IN LEON		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Undersecretary of the Ministry of Defense)**
Written record of full body searches performed.	305 (2010)	Not accepted.
Provide locker rooms and lavatories for personnel assigned to establishment.		Accepted.
Examine possibility of establishing a regime of *vis-à-vis* conjugal visits for arrested individuals.	301 (2011)	Not accepted.

CONCLUSIONS REGARDING SAN FERNANDO (CADIZ) SOUTHERN MILITARY DISCIPLINARY ESTABLISHMENT		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Undersecretary of the Ministry of Defense)**
Provide a locker room for personnel.		Accepted.

CONCLUSIONS REGARDING CEUTA MILITARY DISCIPLINARY ESTABLISHMENT		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Undersecretary of the Ministry of Defense)**
No heating nor air conditioning, so in some periods of the year the temperature might not be appropriate.	292 (2010)	Accepted.
Examine the possibility of providing an area for sports activities in the center itself or allow the use of sports facilities at nearby quarters.	290 (2010)	Accepted. Awaiting budget availability.

CONCLUSIONS REGARDING MILITARY DISCIPLINARY ESTABLISHMENT MELILLA		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Undersecretary of the Ministry of Defense)**
Temperature was inappropriate, without heating or air conditioning.	292 (2010)	Accepted. Awaiting budget availability.

CONCLUSIONS REGARDING LAS PALMAS, OF LAS PALMAS OF GRAND CANARY MILITARY DISCIPLINARY ESTABLISHMENT		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Undersecretary of the Ministry of Defense)**
No heating nor air conditioning, so in some periods of the year the temperature might not be appropriate.	113 (2011)	Having evaluated the temperature year-round, it is deemed unnecessary.

CONCLUSIONS REGARDING TENERIFE MILITARY DISCIPLINARY ESTABLISHMENT, IN SANTA CRUZ DE TENERIFE		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Undersecretary of the Ministry of Defense)**
No heating nor air conditioning, so in some periods of the year the temperature might not be appropriate.	113 (2011)	Having evaluated the temperature year-round, it is deemed unnecessary.

3. Long-term Deprivation of Liberty

3.1. Prisons

Tables 161-166. Conclusions from visits made in 2012

ALCALA DE GUADAIRA (SEVILLE) PRISON		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Substantial increase in center occupancy.	79 (2012)	Awaiting response from Administration.
Elimination of family mediation program.	112 (2012)	Awaiting response from Administration.
Lack of sports monitors.	115 (2012)	Awaiting response from Administration.
Elimination of Suspension of the Legal Guidance and Assistance Service for Prisoners (*SOAJP*).	118 (2012)	Awaiting response from Administration.
Officer identification.	120 (2012)	Awaiting response from Administration.
GOOD PRACTICES		
Installation of partitions in telephone booths, in order to improve privacy in telephone conversations, in accordance with the criterion made manifest by this Institution.		

A LAMA PRISON (PONTEVEDRA)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
A notable increase in recent years in practice of strip searches.	102 (2012)	Awaiting response from Administration.
Review facility temperature.	126 (2012)	Awaiting response from Administration.
Create protocol for documenting the use of physical restraint.	105 (2012)	Awaiting response from Administration.
Creation of protocol regarding medical examinations in cases of isolation.	108 (2012)	Awaiting response from Administration.
Increase clinical aids on staff.	92 (2012)	Awaiting response from Administration.
Establish electronic clinical records and connection with health services network.	93 (2012)	Awaiting response from Administration.
Include photographs in injury reports.	110 (2012)	Awaiting response from Administration.
More rigorous observation of mental state of inmates in the Suicide Prevention Program.	96 (2012)	Awaiting response from Administration.
Training in security measures, restraint, and basic life support maneuvers.	119 (2012)	Awaiting response from Administration.

A LAMA PRISON (PONTEVEDRA)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Training program in mental health and drug addiction for personnel.	119 (2012)	Awaiting response from Administration.
Review cells.	107 (2012)	Awaiting response from Administration.
GOOD PRACTICES		
Success of the installation of the Framework Program for the Comprehensive Care of the Mentally Ill during the year it has been running.		

ARABA/ALAVA PRISON, IN NANCLARES DE LA OCA		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Living conditions in observation cells in closed department are not acceptable.	107 (2012)	Awaiting response from Administration.
The state of one inmate in one of the observation cells seems to be the result of a lack of rigorousness or an excessive predominance of aspects of the regime over health aspects.	107 (2012)	Awaiting response from Administration.
There are no steps for medical examinations in isolation cases or supervision of isolation cell conditions.	108 (2012)	Awaiting response from Administration.
The specific regime limitations of Article 75 of Prison Regulations are not specified in reports	106 (2012)	Awaiting response from Administration.
An inmate, to whom Article 75 of Prison Regulations was applied, declared that he had not been able to go to the courtyard.	106 (2012)	Awaiting response from Administration.
Length of application of Article 75 of Prison Regulations.	106 (2012)	Awaiting response from Administration.
Instructions should be made so that records be kept of approval by medical services in files that record the use of Article 75 of Prison Regulations.	106 (2012)	Awaiting response from Administration.
The video surveillance system does not conform with the criteria of the Ombudsman Institution.	80 (2012)	Awaiting response from Administration.
Observation cells in the special department do not have video surveillance.	80 (2012)	Awaiting response from Administration.
When there are fights resulting in injury, the recordings from the video surveillance system must be sent *ex officio* to the court.	80 (2012)	Awaiting response from Administration.
Several modules are closed for lack of personnel.	79 (2012)	Awaiting response from Administration.
Make sufficient possessions available during center-to-center transfers.	122 (2012)	Awaiting response from Administration.

ARABA/ALAVA PRISON, IN NANCLARES DE LA OCA		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Extension of treatment programs, offers of paid work, and spots in productive workshops.	112 (2012)	Awaiting response from Administration.
Television in cell during use of Article 75 of Prison Regulations.	106 (2012)	Awaiting response from Administration.
Create adequate protocol for system of emergency health assistance requests.	89 (2012)	Awaiting response from Administration.
Increase frequency of doctor appointments upon request.	87 (2012)	Awaiting response from Administration.
Systematic completion of injury reports.	109 (2012)	Awaiting response from Administration.
Detailed description of type of injury in injury reports. Photograph of injuries.	110 (2012)	Awaiting response from Administration.
Specific training for inmates providing support within the Suicide Prevention Program.	101 (2012)	Awaiting response from Administration.
Establishment of a psychological center.	99 (2012)	Awaiting response from Administration.
Direct supervision of dosage of psychotropic drugs.	92 (2012)	Awaiting response from Administration.
The Framework Program for the comprehensive Care of the Mentally Ill (*PAIEM*) must keep operating.	96 (2012)	Awaiting response from Administration.
Clinical record management.	93 (2012)	Awaiting response from Administration.
X-ray equipment non-operational.	94 (2012)	Awaiting response from Administration.
Animal therapy put into operation.	112 (2012)	Awaiting response from Administration.
Privacy of telephones in some modules.	117 (2012)	Awaiting response from Administration.
GOOD PRACTICES		
Intranet which provides up-to-date information regarding important matters at the center.		
Inmate satisfaction with professional work by health team in general.		
A pioneer prison in use of telemedicine.		

BARCELONA WOMEN'S PRISON		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform with the criteria of the Ombudsman Institution.	80 (2012)	Awaiting response from Administration.
Overcrowding in prison.	79 (2012)	Awaiting response from Administration.

BARCELONA WOMEN'S PRISON		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Injury reports sent to On-Duty Court (Article 262 Spanish Code of Criminal Procedure).	109 (2012)	Awaiting response from Administration.
More detailed description of injuries in clinical records. Accompany reports sent with photographs.	110 (2012)	Awaiting response from Administration.
In infirmary, inmates with different psychiatric pathologies live together.	98 (2012)	Awaiting response from Administration.
Record of requests for health care.	89 (2012)	Awaiting response from Administration.
Specific protocol for initial medical examination.	86 (2012)	Awaiting response from Administration.
Program for suicide risk detection.	101 (2012)	Awaiting response from Administration.
Set up a program for comprehensive attention for the mentally ill.	96 (2012)	Awaiting response from Administration.
Establishment of a psychological center.	99 (2012)	Awaiting response from Administration.
Information sheets covering basic matters regarding prison in different languages.	82 (2012)	Awaiting response from Administration.
Simultaneous interpretation system.	82 (2012)	Awaiting response from Administration.
Lacking sports monitor.	115 (2012)	Awaiting response from Administration.
Problems in telephone communication with Dominican Republic and Nigeria.	117 (2012)	Awaiting response from Administration.
Construction work needed for maintenance of center awaiting budget availability.	126 (2012)	Awaiting response from Administration.
Temperature should be evaluated.	126 (2012)	Awaiting response from Administration.
Measures should be taken for water temperature in showers to be appropriate.	126 (2012)	Awaiting response from Administration.
GOOD PRACTICES		
Cordiality and close relationship between center personnel and inmates.		
Good evaluation of center and center professionals given by all inmates interviewed.		
The great level of activities and the percentage of inmates who receive some type of remuneration for work.		
Computerization of personal records made by the Directorate General for Penitentiary Services.		
Center location in very center of Barcelona, which facilitates communication between inmates and their friends and family.		
The great number of specialists who come to the center to respond to requests of this type of medical assistance, with a frequency that means there is not waiting list.		

BARCELONA WOMEN'S PRISON		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The way in which doctor appointments outside of the prison are arranged, which allows for appropriate and correct assistance.		
Inmate satisfaction with the professional work done by the health team.		

MURCIA II CAMPOS DEL RIO PRISON (MURCIA)		
CONCLUSIONS (Spanish Office of the Secretary General for Prisons)	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system does not conform with the criteria of the Ombudsman Institution.	80 (2012)	Awaiting response from Administration.
Several officers did not wear identification.	120 (2012)	Awaiting response from Administration.
Lack of personnel has led to the closure of four modules.	79 (2012)	Awaiting response from Administration.
Injury reports must describe injuries more appropriately and include photographs.	110 (2012)	Awaiting response from Administration.
Framework program for the comprehensive care of the mentally ill not implemented.	96 (2012)	Awaiting response from Administration.
Specific scales for evaluating suicide risk must be employed in the examination made upon inmate's entry to center.	101 (2012)	Awaiting response from Administration.
The use of telemedicine would be appropriate.	90 (2012)	Awaiting response from Administration.
Establishment of a record of requests for medical care.	89 (2012)	Awaiting response from Administration.
Extension of agreement for assistance by a internal medicine specialist.	88 (2012)	Awaiting response from Administration.
CONCLUSIONS (Directorate General of the Civil Guard)	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
During the visit, the opportunity presented itself to observe how inmates were taken to be driven, at which time it was noted that two of the Civil Guards were not wearing identification.	26 (2012)	Awaiting response from Administration.
GOOD PRACTICES		
Training courses in accompanying inmates participating in the Suicide Prevention Program have been held.		

OCAÑA II PRISON (TOLEDO)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The general criterion adopted by the Spanish Office of the *SGIP* regarding the use of Article 75 of Prison Regulations does not adhere to the criterion made manifest by the Ombudsman Institution beginning two years ago.	106 (2012)	Awaiting response from Administration.

OCAÑA II PRISON (TOLEDO)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The use of Article 75.1 of Prison Regulations in this prison does not seem to correspond to the exceptional use that should preside over recurring to this measure.	106 (2012)	Awaiting response from Administration.
The length of use of Article 75.1 of Prison Regulations should be reviewed.	106 (2012)	Awaiting response from Administration.
In cases in which regimental limitations lasted a day or several hours, their justification is not understood.	106 (2012)	Awaiting response from Administration.
Use of Article 75.1 of Prison Regulations allows for a prison regime similar to sanctions involving isolation or secure detention.	106 (2012)	Awaiting response from Administration.
The specific regimental limitations are not specified to the judge in communications nor in any of the notifications to the interested party.	106 (2012)	Awaiting response from Administration.
The specific causes that brought about this measure being taken are not described either.	106 (2012)	Awaiting response from Administration.
The use of Article 75.1 of Prison Regulations when a mobile telephone is confiscated from an inmate, does not seem justified.	106 (2012)	Awaiting response from Administration.
The necessary measures should be taken to decrease the number of occasions in which it is necessary to employ Article 75. 2 of Prison Regulations.	106 (2012)	Awaiting response from Administration.
Prolonged use of Article 75.2 of Prison Regulations could mean that the necessary measures have not been taken with due diligence.	106 (2012)	Awaiting response from Administration.
The use of provisional isolation that is carried out in the center should be reviewed.	104 (2012)	Awaiting response from Administration.
In records there is no reflection of the exact time in which a medical examination is performed in cases of physical restraint.	105 (2012)	Awaiting response from Administration.
In one case it was detected that in communications to the parole judge only provisional isolation and physical restraint with straps appear, but not physical force.	104 (2012)	Awaiting response from Administration.
There is a discrepancy between the doctor's report and the injection of medication given to an inmate.	105 (2012)	Awaiting response from Administration.
The assigned hospital does not have beds with restricted access and police surveillance for patients with psychiatric pathology.	97 (2012)	Awaiting response from Administration.
The video surveillance system does not conform with the criteria of the Ombudsman Institution.	80 (2012)	Awaiting response from Administration.

OCAÑA II PRISON (TOLEDO)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Instructions must be made regarding obtainment and preservation of images of incidents.	80 (2012)	Awaiting response from Administration.
The physical restraint cell does not have a video surveillance system.	80 (2012)	Awaiting response from Administration.
The cells in module 3 do not have intercoms.	81 (2012)	Awaiting response from Administration.
The existence of hoses, alarm buttons, free-standing extinguishers, smoke detectors, indications, or automatic opening of doors was not observed.	126 (2012)	Awaiting response from Administration.
The cells in module 7 are too precarious for long stays such as cases of use of Article 75 of Prison Regulations.	107 (2012)	Awaiting response from Administration.
The water in the showers in module 7 is cold.	126 (2012)	Awaiting response from Administration.
Complaints about showers due to their location, the low temperature, and the feeling of lack of safety.	126 (2012)	Awaiting response from Administration.
The prices of the prison shop are 20% and 30% higher than those on the outside.	121 (2012)	Awaiting response from Administration.
GOOD PRACTICES		
A decrease in occupancy in center compared to that which was registered in previous years.		
The recent remodeling of several showers in modules.		

Tables 167-177. Follow-up on visits made in previous years

PRISON GENERAL RESOLUTIONS		
GENERAL CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
(RE) Installation of a manual opening system for cell doors in prisons, in order to facilitate inmate evacuation in the event of an emergency.	326 (2010) 159 (2011)	Accepted. Awaiting budget availability.

ALBOLOTE PRISON (GRANADA)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
Inadequacy of video surveillance system according to the criteria of the Ombudsman Institution.	477 (2010) 120 (2011)	Accepted. A study is being made of the current system and the possibility of modernizing it.
The staff of officers in charge of completing disciplinary proceedings is insufficient.	139 (2011)	It has been rectified, with an additional officer being added.

ALBOLOTE PRISON (GRANADA)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
The report made by the fire brigade as a result of the fire has recorded numerous inadequacies that must by corrected.	159 (2011)	Inadequacies are being rectified.
The control tower does not have the possibility to communicate with the exterior.	149 (2011)	It has been rectified.
In records of provisional isolation, there are references made to periodical eventual follow-ups made regarding the inmate's state.	141 (2011)	Accepted and instructions have been made for its rectification.
In regulation forms regarding the use of coercive measures, the term «physical restraint» is not used.	141 (2011)	Accepted and instructions have been made for its rectification.
Inadequacies in electronic security facilities and communications.		Inadequacies are being rectified.
Lacking productive workshops, occupational workshops, courses, etc.	147 and 148 (2011)	The center features an adequate number of productive workshops, occupational workshops, and treatment programs.
Poorly connected via public transportation.	(2011)	There are two public transportation lines.
Lacking specific protocol to notify family members when an inmate cannot receive a previously arranged visit.	(2011)	Authorization is given so that the inmate may call his family members.

* Recommendations (RE); Suggestions (S); Reminder of Legal Responsibilities (RLR).

ALCALA DE GUADAIRA PRISON (SEVILLE)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
Inadequacy of video surveillance system according to the criteria of the Ombudsman Institution.	477 (2010) 120 (2011)	An examination of the current system is being carried out and the possibility of modernizing it is being considered.
Removal of interior doors in cells due to risk of self-inflicted injury.	156 (2011)	A study of the viability of said removal will be carried out.
Lacking intercoms or call systems within cells.	121 (2011)	Accepted, awaiting budget availability. In any case, the immediate location of the officers' posts make it impossible for an incident to go unnoticed.
Lacking cell doors that open automatically.	159 (2011)	Its installation is not possible, due to the center's age.
Lacking smoke detectors in cells.	159 (2011)	Accepted, awaiting budget availability.
Lacking privacy in telephone communications.	150 (2011)	Accepted. In the follow-up visit made in 2012 it was noted that partitions had been installed in the telephone booths.

ALCALA DE GUADAIRA PRISON (SEVILLE)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
Scarcity of humane resources in school and sports areas.	147 (2011)	There are two teachers to cover the different levels.
Offering of training, educational, or occupational activities for inmates.	147 (2011)	The activities offered to inmates are deemed sufficient considering the center's occupancy, which could be noted in the visit made in 2012.

CASTELLO/CASTELLON PRISON		
RESOLUTIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
(RE) Permanent supervision by health personnel for physically restrained individuals, and video surveillance during use of the measure.	142 (2011)	Not accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
Inadequacy of video surveillance system according to the criteria of the Ombudsman Institution.	477 (2010) 120 (2011)	Accepted, a study is being made of the current system and the possibility of modernizing it.
Intercoms or call systems within cells.	121 (2011)	Accepted, awaiting budget availability.
To appropriately classify the inmates, it would be necessary to have another women's module.		Accepted, a new women's module has been provided.
Over-occupancy of women's module.	119 (2011)	Accepted, a new women's module has been provided.
The possibility of first degree inmates to participate in activities is scarce.	147 (2011)	There are sufficient offerings of activities.
Upon entry, information for inmates regarding their rights and obligations.	122 (2011)	Said information is given upon entry via an informational video and a discussion with a social worker and with «entry companion» inmates.
It is necessary to review protocol for searches.	136 (2011)	It has been proven that legal requirements are met.
Review of action protocol for isolation, since several inmates declared that the doctor did not visit them every day.	139 (2011)	Accepted and the doctor's daily visit to inmates in isolation will be supervised.
Many inmates declared they did not know what means were at their disposal to address the center's management, their parole judge, or the Ombudsman Institution.	151 (2011)	On bulletin boards and in the magazine published by Modules on Education and Respect there is information about processing requests and letters.

CASTELLO/CASTELLON PRISON		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
Inmate evaluations of module 1 of this facility is very negative.		Maintenance work has been carried out on the module and no deficiencies have been detected.
Evaluations of different workers from the center, and in particular of the technical team, by the inmates from module 1 is negative.		Evaluations of professionals by the inmates from this module is influenced by denied requests for permission.
Decrease in inmates working in productive workshops at center.	148 (2011)	Since the center's occupancy has decreased compared to previous years, in recent years the percentage of working inmates has remained steady.
Scarcity of telephones in the women's module and lack of intimacy.	150 (2011)	Accepted regarding privacy and remodeling project is being considered.
Difficulties faced by family members of inmates in being given appointments to communicate.		Deficiency rectified.
Less than one-third of the inmates has a paid job or work detail.	148 (2011)	The percentage of working female inmates at the center is higher than that of male inmates.
Temperature in module 1.	157 (2011)	Deficiency rectified.
The need to present a telephone contract to receive authorization for communication is an insurmountable obstacle for some inmates.	150 (2011)	When an inmate cannot provide proof of a telephone number, an attempt is made via the social worker, evaluating the inmate's situation, to solve the problem.
Nearly half of the inmates declared they did not know the contents of their treatment program.	(2011)	It has been demonstrated that treatment program information has been given to all inmates.
The Framework program for the Comprehensive Care of the Mentally Ill must be implanted to its full extent.	132 (2011)	Accepted, a doctor and two psychologists have been added.
These measures must be accompanied by a personalized evaluation of the awareness the patient has about his/her illness, and of their adherence to treatment.	132 (2011)	Accepted.
Several inmates expressed difficulty in requesting medical attention, especially nights, on weekends, and on holidays.	127 (2011)	It has been demonstrated that requests for medical attention had been tended to.
Staff of nurse's aid personnel is insufficient.	126 (2011)	Accepted and coverage of positions for nurse's aids is being evaluated.
Measures taken for supervised administration of medication for inmates in treatment involving psychotropic drugs.	133 (2011)	Medical services decide when «directly observed treatment» is Needed
Coordination of medical services with rest of the service components of the multidisciplinary team.		Said coordination is already carried out.

CASTELLO/CASTELLON PRISON		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
Exhaustive description of injury reports.	144 (2011)	A letter has been sent to all the prisons regarding the obligation of medical services to rigorously complete injury reports.
Increase in number of computers in medical service facilities.	131 (2011)	Means are sufficient.
Reactivation of treatment program for inmates sentenced for sexual assault.	135 (2011)	The program is arranged when there is a group of inmates susceptible to do the treatment.

* Recommendations (RE); Suggestions (S); Reminder of Legal Responsibilities (RLR).

FIGUERES PRISON (GERONA)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Justice Department of the Government of Catalonia)**
Although the Order JUS/330/2010, of 2 June, by the Justice Department of the Government of Catalonia ordered the creation of *Puig de les Basses* prison and the shutting down of the Figueres prison, the transfer is pending.		Planning for the opening of the *Puig de les Basses* prison is being worked on.
The architectural conditions and facilities of the prison are not appropriate for the needs of the penitentiary systems, therefore the opening of the *Puig de les Basses* prison must not be further delayed.		Planning for the opening of the *Puig de les Basses* prison is being worked on.
Over-occupancy.	119 (2011)	The center's occupancy remains between 160 and 170 inmates, with the commitment of central services to not surpass 180 inmates.
Inadequacy of video surveillance system according to the criterion of the Ombudsman Institution.	477 (2010) 120 (2011)	Considering the imminent opening of *Puig de les Basses* prison, it has been deemed unnecessary to intervene in this matter. However, in regard to protocols, they are accepted and instructions are given for rectification.
Poor ventilation and cleanliness of isolation cells.		Accepted and instructions have been made para its rectification.

FONTCALENT PSYCHIATRIC PENITENTIARY HOSPITAL (ALACANT/ALICANTE)		
RESOLUTIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
(S) Take necessary measures to solve security problems with access to acute cases department and the narrow hallway of the first floor gallery.	154 (2011)	The existing structure does not allow for remodeling of said facilities.

FONTCALENT PSYCHIATRIC PENITENTIARY HOSPITAL (ALACANT/ALICANTE)		
RESOLUTIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
(S) Equip the acute cases department with appropriate furniture.	154 (2011)	Accepted. Awaiting budget availability.
(S) Relocate the tray rack in cells in the acute cases department	154 (2011)	Accepted. Awaiting budget availability.
(S) Provide intercoms to all cells in the center and set up protocol for recordings.	121 (2011)	Accepted, installation of intercoms awaiting budget availability. The matter concerning recordings is awaiting response from Administration.
(S) Equip women's module with electric water heaters with sufficient capacity.	158 (2011)	Awaiting response from Administration.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
Need to proceed to regulate the appropriate reaction to conduct that disturbs normal operation of the center, to avoid situations of arbitrarity and defenselessness.	138 (2011)	Accepted and approved a «protocol for individualized program of intervention for behavioral alterations not caused by medical-psychiatric reasons».
Deficiencies in the acute cases department.	154 (2011)	Accepted and instructions have been made for its rectification.
Inadequacy of the women's department and impossibility of classification and separation.		Accepted and instructions have been made for its rectification.
Upon arrival inmates are not provided with written information of the center's features and their rights and obligations there.	122 (2011)	Accepted and a pamphlet is being created to be given out upon arrival.
Inadequacy of video surveillance system according to the criterion of the Ombudsman Institution.	477 (2010) 120 (2011)	Accepted and instructions have been made for its rectification.
Injuries inmates might suffer are documented using a medical report from the doctor but without photographs.	357 (2010) 144 (2011)	Not accepted.
Creation of an internal commission after a suicide is committed.	134 (2011)	The Ombudsman Institution's criterion is accepted.
Review availability of fire suppression systems.	159 (2011)	Accepted and instructions have been made for its rectification.
The hose in men's Module 1 does not have protection.	159 (2011)	Accepted and instructions have been made for its rectification.
Heating in cells.	157 (2011)	Accepted, awaiting budget availability.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary of State for Justice)**
Legal aspects of the condition of being unfit for trial.	124 (2011)	Review of Criminal Code is being studied, which all suggestions made by the Ombudsman Institution regarding the legal-criminal treatment of the mentally ill will be considered.

* Recommendations (RE); Suggestions (S); Reminder of Legal Responsibilities (RLR).

LAS PALMAS I PRISON, IN LAS PALMAS OF GRAND CANARY		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
The center does not have a video surveillance system inside, thus one must be installed to comply with the criterion of the Ombudsman Institution.	477 (2010) 120 (2011)	Accepted. Awaiting budget availability.
There is no centralized system for automatic doors in cells to make possible an urgent and quick evacuation in emergency situations.	159 (2011)	Not accepted. The evacuation plan is included in the Emergency Plan. There is no budget availability to affront this demand.
Non-existence of intercoms or call systems from inside cells.	121 (2011)	Accepted and the necessary work for installation is going to be done.
The lavatories of several facilities lack hot water.	158 (2011)	There is a project awaiting scheduling, according to budget availability.
Insufficiency of personnel in the communication area.		The decrease in the number of inmates by more than 400 since the opening of the new Las Palmas II prison has freed up space in the communication area.
There is no heating or air conditioning in the communication area.	157 (2011)	Not accepted. Its installation does not seem necessary given the area's climate conditions.
There is no heating or air conditioning in the cells, thus the temperature might not be appropriate in some times throughout the year.	157 (2011)	Not accepted. Its installation does not seem necessary given the area's climate conditions.

MADRID PRISON V		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
Cells do not have an automatic opening system.	326 (2010)	Accepted. Awaiting budget availability.
Stipend for minimum expenses for inmates without economic resources.		The prison already has a protocol for evaluating the concession of this type of aid.
The transformation of one of the two women's modules into a men's module would make it difficult to adequately separate female inmates.		The provision to reorder modules follows a reordering of the prison.
Provision of a stationary bike to the gym of women's Module 12.		Accepted and instructions have been given.
Some female inmates decried the excessive delay in receiving mail.		It was due to the interception of some of the female inmates' communications, notified to them and the parole judge.
The female inmates stated that there was Neither literacy nor Spanish as a second language class.	347 (2010)	The anomalies have been rectified.

MADRID PRISON V		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
Provide upon arrival at prison written information about health care services and basic hygienic measures.		Said information is provided in a pamphlet by the *SGIP* and is verbally communicated in the first medical examination.
Creation of a Protocol between the *SGIP* and the Community of Madrid for carrying out certain medical appointments via videoconferencing systems, and improvement of coordination.	339 (2010)	There is a collaboration agreement regarding medical assistance between the Ministry of the Interior and the Community of Madrid.
The restraints were in an unsatisfactory hygienic state. They must be cleaned or replaced immediately.		The state in which the straps were found was due to recent use.
In some modules it was observed that there were no sheets or bed linens provided in the cells.	332 (2010)	From time to time in some cases an inmate might not be transferred to a new module with his/her sheets, which is rectified as soon as possible.
Cleanliness of lights in some modules.	330 (2010)	The existing dirtiness of lights was due to insect extermination that was being carried out.
Coordination between different facilities must be maximized so that situations, like the one observed, of a delay in dispensing methadone to an inmate, do not occur.		It was a one-time situation- an exception.

* Recommendations (RE); Suggestions (SU); Reminder of Legal Responsibilities (RLR).

MELILLA PRISON		
RESOLUTIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
(S) The appropriate measures must be taken so that the video surveillance system remains operational at all times, with one or more officers in charge of its supervision and image viewing.		The system is operational at all times, though, due to its obsolescence, it is not functionally operative to assign officers for supervision and viewing.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
The video surveillance system is obsolete, therefore one must be installed that complies with the criterion of the Ombudsman Institution.	477 (2010) 120 (2011)	Accepted, a study is being made of the current system and of its possible modernization, depending on budget availability.
Little development in the way of specialized treatment programs.		Specialized treatment programs have been increased.
Lacking productive workshops.		The prison lacks workshops using outside business collaboration, though its own production workshops remain.

MELILLA PRISON		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
Female inmates do not participate in a single activity outside of their module.		Currently there are activities undertaken outside the module.
Emergency plan drills do not involve the collaboration of outside teams, firefighters, healthcare teams, civil protection, etc.	159 (2011)	A plan of action for emergencies is being instated.
The presence of traces of rust in windows and doors.	154 (2011)	The areas most affected are painted continuously.
Problems involving objects being thrown from outside.	154 (2011)	Measures have been taken and the rest are awaiting budget availability.
Remodeling of communication area.		It is in a good state of upkeep and maintenance.

* Recommendations (RE); Suggestions (S); Reminder of Legal Responsibilities (RLR).

TENERIFE II PRISON (SANTA CRUZ DE TENERIFE)		
RESOLUTIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
(S) Take the necessary measures so that the cells comply with or are made appropriate for the criterion of the Ombudsman Institution, however possible.	155 (2011)	Partially accepted. Current economic circumstances do not allow for construction to be done to increase the size of the cells. Despite this, an attempt will be made to comply with the legal mandate regarding the cell principle at the center, avoiding its over-occupancy in all cases.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
The center does not have a video surveillance system, therefore one must be installed that complies with the criterion of the Ombudsman Institution.	477 (2010)120 (2011)	Accepted and a study is being made of the current system and of its possible modernization.
Injuries incurred by inmates are documented using a medical report by the doctor, but not using photographs.	357 (2010)144 (2011)	Not accepted. The Recommendation made previously by the Ombudsman Institution is reiterated.
There is no heating nor air conditioning in the cells, therefore the temperature might not be appropriate in some times throughout the year.	157 (2011)	Accepted and installation of heating in all cells is pending.
Written information regarding *habeas corpus*.	476 (2010)123 (2011)	Accepted and instructions have been made for its rectification.
Unsatisfactory state of maintenance and upkeep of the different modules.	154 (2011)	Accepted and remodeling work has already been done.

* Recommendations (RE); Suggestions (S); Reminder of Legal Responsibilities (RLR).

SEVILLE INCARCERATED MOTHERS UNIT		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (SGIP)**
The written information provided upon arrival is only in Spanish, untranslated to other languages.	122 (2011)	Whenever there have been problems with language, female inmates are recurred to who offer the necessary guarantee that they will provide truthful information. If this is not possible, consular services arerecurred to.
Female inmates complained about little privacy when using the telephone.	150 (2011)	Accepted. Work has been done with the telephone company and a change of location has been made for the booths and partitions have been installed.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Seville City Hall)**
Lack of public transportation to the Seville Incarcerated Mothers Unit and *Luis Jiménez de Asúa* Center for Social Inclusion.	153 (2011)	Accepted and conversations with the Metropolitan Transportation Consortium have been initiated in order to find solutions to the aforementioned problem.

3.2. Correctional Centers for Juvenile Offenders

Tables 178-181. Conclusions regarding Centers for Minors visited in 2012

"LAS PALMERAS" CENTER FOR JUVENILE OFFENDERS (MADRID)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Ministry of the Presidency, Justice, and Spokespersons of the Government of the Community of Madrid)**
Female minors are prohibited to talk amongst themselves about certain topics.	152 (2012)	Awaiting response from Administration.
Minors' rights to communicate freely.	152 (2012)	Awaiting response from Administration.
The center lacks a computerized record of disciplinary proceedings, of the use of means of restraint, and of personal searches.	145 (2012)	Awaiting response from Administration.
Previous information regarding mental health.	155 (2012)	Awaiting response from Administration.
Residential resources for female minors leaving the center at any age over 18.	156 (2012)	Awaiting response from Administration.
GOOD PRACTICES		
Residents declared, in general, that they felt quite pleased with the personnel, especially with their respective tutors and with the center's operations. Likewise, most of them stated that this resource was appropriate for them and that they were learning a lot of favorable things applicable to their daily lives.		

CENTER FOR JUVENILE OFFENDERS «TERESA DE CALCUTA» (MADRID)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Ministry of the Presidency, Justice, and Spokespersons of the Government of the Community of Madrid)**
Habeas corpus.	142 (2012)	Awaiting response from Administration.
Video surveillance systems.	137 (2012)	Awaiting response from Administration.
In the separation from group rooms, the bed has metallic corners which can be used to inflict serious self-injury.	147 (2012)	Awaiting response from Administration.
Personal searches and searches of possessions.	148 (2012)	Awaiting response from Administration.
Lacking documentation of minors and youth of foreign origin.	143 (2012)	Awaiting response from Administration.
Complaint Record.	145 (2012)	Awaiting response from Administration.
Record of body searches.	148 (2012)	Awaiting response from Administration.
Educational corrections.	150 (2012)	Awaiting response from Administration.
The center is assisted by a doctor who forms part of the general health network of the Community of Madrid.	154 (2012)	Awaiting response from Administration.
The center lacks means of life support and of resuscitation.	154 (2012)	Awaiting response from Administration.
The psychiatrist is not actively and frequently included as a reference in therapeutic treatments with minors.	155 (2012)	Awaiting response from Administration.
Therapeutic detention.	155 (2012)	Awaiting response from Administration.
A specific module for juvenile offenders with low-moderate intellectual disability.	157 (2012)	Awaiting response from Administration.
Two-way mirrors in the visitation room.	153 (2012)	Awaiting response from Administration.
GOOD PRACTICES		
The generous size and quality of the facilities, the development and maintenance of gardens and sports grounds, and the existence of different buildings for each module reduce the feeling of overcrowding that is persistent in other centers.		
In examining the disciplinary proceedings, it was observed that the process is diligent and that, from the beginning until the resolution there was no more than three days.		
In all the medical records consulted, outside technicians confirmed that there were appropriate diagnostic psychiatric formulations.		
The center offers a large Training Program. The effort made by educators and psychologists to adapt the contents and the methodology for applying these programs to the particular characteristics of the minors, as well as to the requirements of the center's internal dynamics, was observed.		

«ZAMBRANA» CENTER FOR JUVENILE OFFENDERS (VALLADOLID)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Council for the Family and for Equal Opportunities of the Government of Castile and Leon)**
Habeas corpus.	142 (2012)	Awaiting response from Administration.
Personal files.	138 (2012)	Awaiting response from Administration.
Informative guide on rules at the center.	141 (2012)	Awaiting response from Administration.
Information regarding rights and obligations in different languages.	141 (2012)	Awaiting response from Administration.
Communication of arrival in the case of foreign minors.	143 (2012)	Awaiting response from Administration.
Record of means of temporary restraint and separation.	146 (2012)	Awaiting response from Administration.
Excessively long opening period for disciplinary proceedings from the day the offense was carried out.	149 (2012)	Awaiting response from Administration.
Communication to attorney of disciplinary punishment.	151 (2012)	Awaiting response from Administration.
Video surveillance systems.	137 (2012)	Awaiting response from Administration.
Anxiety attacks treated as violation.	147 (2012)	Awaiting response from Administration.
Differentiation of Therapeutic Detention Unit.	156 (2012)	Awaiting response from Administration.
Therapeutic detention via sentencing.	155 and 156 (2012)	Awaiting response from Administration.
There is no difference in treatment of a minor in therapeutic detention from any other.	155 and 156 (2012)	Awaiting response from Administration.
GOOD PRACTICES		
The healthcare assistance that minors receive at the center is correct, complete, and appropriate in general. It does not appear that psychotropic drugs are used in an abusive or aggressive way, nor is the assistance excessively medicalized nor psychiatrized.		
Inmates' clinical records stating they received medication were complete and with clear, up-to-date information, making it easy for healthcare professionals to consult them.		

Tables 182-188. Follow-up on visits made in previous years

«ALBAIDEL» CENTER FOR JUVENILE OFFENDERS (ALBACETE)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Family, Minors, Social Advancement, and Volunteership of the Government of Castile-La Mancha)**
(RLR) Written information regarding rights and obligations in different languages.	176 (2011)	Accepted.
(RLR) Class attendance during separation from group.	193 and 230 (2011)	Accepted.
(RLR) Close down the isolation room.	189 (2011)	Accepted.
(RLR) Remove cameras from visitation rooms.	171 (2011)	Accepted.
(S) Incorporate audio recording and protocol for obtainment of images for video surveillance system.	171 and 172 (2011)	Not accepted.
(S) Videoconferencing.	173 (2011)	Not accepted.
(S) Written information regarding *habeas corpus*.	176 (2011)	Not accepted.
(S) Record of complaints, requests, and suggestions.	204 (2011)	Not accepted.
(S) Pedagogical value of arrival protocol.	179 and 180 (2011)	Not accepted.
(S) Medical examination in the first 24 hours after arrival and interview with psychologist.	179 (2011)	Accepted.
(S) Disciplinary detention and educational corrections.	187 (2011)	Not accepted.
(S) Psychologists' reports included in disciplinary proceedings.	191 (2011)	Not accepted.
(S) Communication of punishment to minor's attorney.	175 (2011)	Not accepted.
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary of State for Justice)**
(R) Reform of second paragraph of Article 76 of Royal Decree 1774/2004, of 30 July.	175 (2011)	Awaiting response.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Family, Minors, Social Advancement, and Volunteership of the Government of Castile-La Mancha)**
Telephone in Observation Home.	202 (2011)	Accepted.
Practice of personal searches.	183 and 184 (2011)	Accepted.
Doctor is not familiar with center facilities.	195 (2011)	Accepted.
Problems with co-existence caused by withdrawal symptoms in some minors.	195 (2011)	Accepted.
Lacking security as declared by some teachers.		Accepted.

* Recommendations (R), Suggestions (S) and Reminder of Legal Responsibilities (RLR).

«BALUARTE SAN PEDRO ALTO» CENTER FOR JUVENILE OFFENDERS (MELILLA)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Council for Social Welfare and Health of Melilla)**
Facilities found to be lacking.	201 (2011)	A new center was opened 27 July 2012.

«EL MOLINO» CENTER FOR JUVENILE OFFENDERS (ALMERIA)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Council of Justice and the Interior of the Government of Andalusia)**
(R) Distribution of positions so that minors comply with measure in the province where there family lives.	169 (2011)	Accepted, subject to budget allowance.
(S) State informs the practice of full body searches.	183 (2011)	Accepted.
(S) Differentiation of where and how punishments and psychological or educational measures are fulfilled.	192 (2011)	Accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Council of Justice and the Interior of the Government of Andalusia)**
Errors in minors' first and last names.	177 (2011)	Accepted.
Information regarding rights and obligations only in Spanish.	180 (2011)	Accepted.
Text regarding this information difficult to understand.	226 (2011)	Accepted.
Written information regarding *habeas corpus*.	226 (2011)	Accepted.
Transfer of minors by uniformed agents in marked vehicles.	203 (2011)	Accepted.
Record in minor's record medical examinations and interviews with psychologist.	179 (2011)	Accepted.
Progress and methodology systems for individualized intervention programs.	181 (2011)	Accepted.
Right to leave for minors in open and semi-open detention.	193 (2011)	Accepted.
Classes for minors in the Observation Home.	193 (2011)	Accepted.
No communication regarding denied permission or leave to juvenile judge.	197 (2011)	Accepted.
Video surveillance, recording, and protocols for obtainment and preservation.	171 and 172 (2011)	Accepted.
Automatic doors in rooms.	202 (2011)	Accepted.
Call systems within rooms	202 (2011)	Accepted.
Disciplinary detention.	186, 187 and 188 (2011)	Accepted.

«EL MOLINO» CENTER FOR JUVENILE OFFENDERS (ALMERIA)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Council of Justice and the Interior of the Government of Andalusia)**
Specification of place where isolation punishment is carried out.	189 (2011)	Accepted.
Mandatory education continued during isolation from group.	193 (2011)	Accepted.
Heterogeneous training of educational staff.	198 (2011)	Accepted.
Difficulty for minors in getting attention of adults caring for them.	199 (2011)	Accepted.
Revision of admission protocol.	176 and 178 (2011)	Accepted.
Observation homes have prison aesthetic and very limited compatibility.	201 (2011)	Accepted.

* Recommendations (R), Suggestions (S) and Reminder of Legal Responsibilities (RLR).

«ELS REIETS» CENTER FOR PROTECTION OF MINOR DELINQUENTS (ALACANT/ALICANTE)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Council of Justice and Social Welfare of the Government of Valencia)**
(S) Range improvement of video surveillance systems.	477 (2010)	Not accepted, but in case the system range were broadened, the suggestions made by the Ombudsman Institution would be taken into consideration.
(S) Study of the recording conditions, the preservation and access for recordings; and communication to inmates that such recordings are being made.	477 (2010)	Not accepted.
(S) Preservation of images of incidents.	477 (2010)	Not accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

"ES PINARET" CENTER FOR PROTECTION OF JUVENILE OFFENDERS (BALEARIC ISLANDS)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Council of Health, Family, and Social Welfare of the Government of Balearic Islands)**
(S) Range improvement of video surveillance systems.	477 (2010)	Accepted and a study will be made for this purpose.
(S) Study of the recording conditions, the preservation and access for recordings; and communication to inmates that such recordings are being made.	477 (2010)	Accepted and necessary measures taken.
(S) Preservation of images of incidents.	477 (2010)	Accepted and necessary measures taken.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

"MALIAÑO" CENTERS FOR JUVENILE OFFENDERS (CANTABRIA)		
RESOLUTIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Ministry of the Presidency and Justice)**
(S) Video surveillance, range, and protocols for recordings, obtainment and preservation.	477 (2010)	Accepted.
(S) Preservation of images of incidents.	477 (2010)	Accepted.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Video surveillance, range, and protocols for recordings, obtainment and preservation.	477 (2010)	Accepted.
Installation of a system of automatically opening doors.	397 (2010)	Accepted.

* Recommendations (R); Suggestions (S); Reminder of Legal Responsibilities (RLR).

«MONTILIVI» CENTER FOR JUVENILE OFFENDERS (GERONA)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Justice Department of the Government of Catalonia)**
Video surveillance, range and protocols for recordings, obtainment and preservation.	171 and 172 (2011)	Accepted, subject to budget allowance.
Building not functional and space very limited.	201 (2011)	Accepted, reducing its capacity from 30 to 12 spaces.
Poor upkeep of homes and furniture.	202 (2011)	Accepted.
Temperature of rooms and common areas.	201 (2011)	Accepted.
Scarcity of material in occupational workshops.	194 (2011)	Accepted.
Lacking educators with specialized training.	198 (2011)	Accepted.
Increase psychiatric workday schedule.		Accepted.
Personal searches, searches of clothing and belongings of minors.	183, 184 (2011)	Accepted.

«PI GROS» CENTER FOR JUVENILE OFFENDERS (CASTELLO/CASTELLON)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Council of Justice and Social Welfare of the Government of Valencia)**
(RLR) Prohibition of speaking of certain topics and constant and permanent supervision of minors' conversations.	182 (2011)	Accepted.
(S) Diligence by director in disciplinary proceedings granting the lifting of punishment.	190 (2011)	Not accepted.
(S) Written information regarding *habeas corpus* proceedings.	176 (2011)	Not accepted.
(S) Video surveillance systems.	171 and 172 (2011)	Accepted, subject to budget availability.
(S) Inform minors' attorney regarding disciplinary punishment.	175 (2011)	Not accepted.

«PI GROS» CENTER FOR MINOR DELINQUENTS (CASTELLO/CASTELLON)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary of State for Justice)**
(R) Modification of second paragraph of Article 76 of Royal Decree 1774/2004, of 30 July.	175 (2011)	Awaiting response.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Council of Justice and Social Welfare of the Government of Valencia)**
Minors' personal record file when they are given their freedom.	177 (2011)	Accepted.
Air conditioning in the rooms.	201 (2011)	Accepted, subject to budget availability.
Reserved custody of minors' medical records.	195 (2011)	Accepted.
Automatically opening doors in rooms.	202 (2011)	Taken into consideration.

* Recommendations (R), Suggestions (S) and Reminder of Legal Responsibilities (RLR).

3.3. Social Health care centers

Table 189. Conclusions about the visit to *"San Jose"* Residential Center

"SAN JOSE" ASSISTED LIVING SOCIAL RESIDENCE, TOLEDO		
Office of the Secretary of State for Justice	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Organic law project that would regulate civil involuntary detention.	162 and 163 (2012)	Work is being finished on a preliminary draft for modification of the Civil Code and Criminal Procedure Law.
Spanish Attorney General's Office	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Encourage judicial use of legal institution of incapacitation	170 (2012)	Awaiting response from Administration.
Periodic control of involuntary arrivals.	164 (2012)	Awaiting response from Administration.
General Council of the Judiciary	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Specialization of judicial organisms.	164 (2012)	When specialization is not possible, exclusive delivery of proceedings for incapacity, detention, and custody are carried out in a single court.

"SAN JOSE" ASSISTED LIVING SOCIAL RESIDENCE, TOLEDO		
General Council of Spanish Legal Profession	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Public defender for disabled persons.	164 (2012)	Currently it has been decided to strengthen the service with training and awareness raising.
Toledo Bar Association	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Public defender for disabled persons.	164 (2012)	No resources available for the creation of a specific legal training service for disabled persons.
Toledo Provincial Council	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Measures taken to deal with waiting lists for admissions.	167 (2012)	Awaiting response from Administration.
Judicial authorization for involuntary detention.	168 (2012)	Awaiting response from Administration.
Exhaustive and up-to-date periodic medical reports.	169 (2012)	Awaiting response from Administration.
Judicial use of legal institution of incapacitation.	170 (2012)	Awaiting response from Administration.
Residents who are not deemed incapacitated see certain decisions subject to an agreement made at the center with their family members.	172 (2012)	Awaiting response from Administration.
Adopt standard admission procedure for a residential center.	173 (2012)	Awaiting response from Administration.
Ascription to wards with special attention paid to the functionality and possibilities for rehabilitation.	173 (2012)	Awaiting response from Administration.
Information for residents in a visible place or where it can be viewed.	174 (2012)	Awaiting response from Administration.
Writing and format of informational documents.	174 (2012)	Awaiting response from Administration.
Interior Detention Regulation.	175 (2012)	Awaiting response from Administration.
Clear definition of objectives and functions.	175 (2012)	Awaiting response from Administration.
Individualized and interdisciplinary evaluations of residents.	176 (2012)	Awaiting response from Administration.
Strengthen psychology service.	177 (2012)	Awaiting response from Administration.
Strengthen psychiatry service.	177 (2012)	Awaiting response from Administration.

"SAN JOSE" ASSISTED LIVING SOCIAL RESIDENCE, TOLEDO		
Toledo Provincial Council	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Strengthen occupational therapy department.	178 (2012)	Awaiting response from Administration.
Interdisciplinary focus lacking in occupational therapists.	178 (2012)	Awaiting response from Administration.
Scarcity of activities.	182 (2012)	Awaiting response from Administration.
Re-evaluation of community inclusion in follow-up services for persons who do not have a geriatric profile.	184 (2012)	Awaiting response from Administration.
Cohabitation of couples.	185 (2012)	Awaiting response from Administration.
Privacy and sexual life of patients.	185 (2012)	Awaiting response from Administration.
Encouragement of resident participation.	186 (2012)	Awaiting response from Administration.
Encouragement of family participation.	186 (2012)	Awaiting response from Administration.
Presentation of complains and/or suggestions.	187 (2012)	Awaiting response from Administration.
Record of official visits.	189 (2012)	Awaiting response from Administration.
Assignment of medical professionals to different wards.	192 (2012)	Awaiting response from Administration.
Bringing up to date the «Protocol for Use of Restraint».	193 (2012)	Awaiting response from Administration.
Policy for «palliative care».	195 (2012)	Awaiting response from Administration.
Protocol for living will.	196 (2012)	Awaiting response from Administration.
Computerized clinical records, common database, and personal information confidentiality.	197 (2012)	Awaiting response from Administration.
Definition of functions of different professionals working at the center.	198 (2012)	Awaiting response from Administration.
Excessive rotation of personnel.	199 (2012)	Awaiting response from Administration.
Remodeling needed to improve certain structures.	202 (2012)	Awaiting response from Administration.
Rooms with maximum capacity of two people.	203 (2012)	Awaiting response from Administration.
Call or alarm system in rooms.	204 (2012)	Awaiting response from Administration.
Emergency and evacuation plan.	205 (2012)	Awaiting response from Administration.

"SAN JOSE" ASSISTED LIVING SOCIAL RESIDENCE, TOLEDO		
Council of Health and Social Matters of the Government of Castile-La Mancha	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Measures taken to deal with waiting lists for admissions.	167 (2012)	Awaiting response from Administration.
Judicial authorization for involuntary detention.	168 (2012)	Awaiting response from Administration.
GOOD PRACTICES		
In general, the "*San Jose*" Residential Assisted Living Social Residence uses policies of respectful and dignified treatment with residents, trying to minimize the use of restraint and, of course, employ it using medical criteria and not as a means of punishment or penalty.		
The family members interviewed expressed their satisfaction with the attention and treatment that their loved ones receive at the residence.		
The project "Meeting place" that the center has undertaken with families must be completed. At this time, three meetings have been held, each one about a topic of interest for the families, related to the residents' situation.		

4. Special Interest Sites in Deprivation of Liberty

4.1. Prison hospital wards

Table 190. Conclusions from the visit made in 2012

"GREGORIO MARAÑON" HOSPITAL CUSTODY UNIT (MADRID)		
CONCLUSIONS (Directorate General of the Police)	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
Officer identification.	214 (2012)	Awaiting response.
CONCLUSIONS (Spanish Office of the Secretary General for Prisons)	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary General for Prisons)**
The video surveillance system does not conform to this Institution's criteria.	477 (2010) 213 (2012)	Awaiting response.
Automatically opening door system for isolation room.	209 (2012)	Awaiting response.
Informative protocol regarding precautionary measures.	212 (2012)	Awaiting response.

Tables 191-193. Follow-up on visits made in previous years

GENERAL CONCLUSIONS MADE REGARDING THE ALBACETE, CUENCA, CASTELLON, AND HUELVA PRISON HOSPITAL WARDS		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary General for Prisons)**
The video surveillance system does not conform to this Institution's criteria.	477 (2010) 209 (2011)	Accepted. Awaiting budget availability.

GENERAL CONCLUSIONS MADE REGARDING THE ALBACETE, CUENCA, CASTELLON,AND HUELVA HOSPITAL CUSTODY UNITS		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
Guard services by agents of both sexes.	210 (2011)	Accepted.
Officer identification.	211 (2011)	Accepted.
Check that utensils have been taken away from detainees.	212 (2011)	Accepted.

ALBACETE PRISON HOSPITAL WARD (UNIVERSITY HOSPITAL COMPLEX)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary General for Prisons)**
(S) Closets or lockers to store detainees' belongings.	208 (2011)	Accepted, subject to budget availability.
(S) Hot water in showers and sinks in rooms.	208 (2011)	It has been resolved.

* Recommendations (R), Suggestions (S) and Reminder of Legal Responsibilities (RLR).

CUENCA PRISON HOSPITAL WARD (VIRGEN DE LA LUZ HOSPITAL)		
RESOLUTIONS*	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Office of the Secretary General for Prisons)**
(S) Closets or lockers to store detainees' belongings.	208 (2011)	Accepted, subject to budget availability.
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE (Directorate General of the Police)**
No record of detainee arrivals and departures.		The record is kept at the Provincial Police Station.

* Recommendations (R), Suggestions (S) and Reminder of Legal Responsibilities (RLR).

4.2. Operations for the Repatriation of Foreign Nationals

Tables 194-195. Conclusions from visits made in 2012

OPERATION FOR THE REPATRIATION OF FOREIGN NATIONALS TO NIGERIA (FRONTEX), BARAJAS AIRPORT (MADRID)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
The video surveillance system in the Central Unit for Deportation and Repatriation facilities does not include recordings and is very limited in the waiting area for repatriated foreigners.	219 (2012)	Awaiting response.
No individual custody sheets available for repatriated foreigners from when they depart original location.	223 (2012)	Awaiting response.

OPERATION FOR THE REPATRIATION OF FOREIGN NATIONALS TO NIGERIA (FRONTEX), BARAJAS AIRPORT (MADRID)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Central Unit for Deportation and Repatriation personnel not identified with their badge number.	221 (2012)	Awaiting response.
Inform inmates with sufficient notice of the moment in which their deportation will take place and the details of this process.	226 (2012)	Awaiting response.
Information about the length of flight, possible stops and other information about operation.	226 (2012)	Awaiting response.
There are no official established means so that repatriated foreigners can file complaints regarding the deportation operation.	220 (2012)	Awaiting response.
Whenever medical assistance is given for injury, the injury reports must be sent to the judicial authority.	230 (2012)	Awaiting response.
The existence of a form was observed that participating countries must complete with the list of people being repatriated, which contained a box related to whether or not the person was in good health and could travel and if medical reports were attached. Regarding this, the responsible parties declared that systematic medical examinations were not carried out. These circumstances should have been reflected in a medical report from the Immigrant Detention Centers.	228 (2012)	Awaiting response.
Medical reports, when the doctor does not understand Spanish, must be made available in multi-lingual versions.	229 (2012)	Awaiting response.
The vans and buses in which repatriated foreigners are transported are not equipped with seatbelts.	232 (2012)	Awaiting response.

OPERATION FOR THE REPATRIATION OF FOREIGN NATIONALS TO COLOMBIA AND ECUADOR (CGEF), BARAJAS AIRPORT (MADRID)		
CONCLUSIONS	**PARAGRAPH No. ANNUAL REPORTS**	**ADMINISTRATIVE RESPONSE**
Independence and impartiality of medical personnel intervening in the repatriation operation.	237 (2012)	Awaiting response.
Medical personnel does not know with sufficient notice the type of medical circumstances.	237 (2012)	Awaiting response.
Persons being repatriated must know with sufficient notice the moment in which their flight is going to take place in order to advise their family members of these circumstances.	226 (2012)	Awaiting response.

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