MNP 2013

ANNUAL REPORT 2013
Spain's National Preventive Mechanism against Torture

DEFENSOR DEL PUEBLO
SPANISH OMBUDSMAN

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Annual Report 2013

Spain's National Preventive Mechanism against Torture

Madrid, 2014

Layout and printing: Editorial MIC

Legal Deposit: M-8641-2015

ISSN: 2254-3937

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www.defensordelpueblo.es

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Presentation

The Spanish Ombudsman (Defensor del Pueblo), as the "National Preventive Mechanism against Torture and other cruel, inhuman or degrading treatment or punishment" (Mecanismo Nacional de Prevención de la Tortura y otros tratos o penas crueles, inhumanos o degradantes –"NPM"), is entrusted with the supervision of centres for the deprivation of liberty, for human rights to be respected at all of them.

Throughout 2013, 60 centres were visited. Visits were intense and the Ombudsman technical experts were often accompanied by specialists in legal medicine, psychiatry and psychology.

In addition, it used the advice of the Advisory Council (Consejo Asesor), formed by jurists specialised in fields such as international law, prison law or law philosophy, and specialists in psychology or medicine. We should like to thank them all warmly for their contributions.

We must also point out that the visits undertaken, in their immense majority made without prior warning, were always well received.

This year, for the first time, a flight repatriating foreigners was supervised from the reception of the foreign nationals at the airport to their final destination.

Although this is not the purpose of the NPM strictly speaking, it is appropriate to mention the visits made to centres abroad with Spanish prisoners. At these visits, particular attention is given to prisoners with serious diseases who need special care and, where possible, their relocation to Spain to continue the prison sentence is requested. The cooperation of Spanish embassies has been particularly relevant for these purposes.

The report is intended to be as objective as possible. On the one hand, it mentions the improvements made at the centres, often, after the recommendations made and, on the other hand, it does not avoid describing the deficiencies still detected, since its purpose is to achieve, with the cooperation of many people, the demanding objective of having the conditions required by international treaties on human rights met everywhere.

Madrid, May 2014

Soledad Becerril
DEFENSORA DEL PUEBLO
[SPANISH OMBUDSMAN]

ACRONYMS AND ABBREVIATIONS USED

ABP	Basic Policing Area *(Área Básica Policial)*
AENA	Aeropuertos Españoles y Navegación Aérea
ATS	Medical-technical assistant *(Asistente Técnico Sanitario)*
BEDEX	Spanish National Police Force's Brigade for Deportation of Foreign Offenders *(Brigada de Expulsión de Delincuentes Extranjeros –"CNP")*
BOE	Spanish Official State Gazette *(Boletín Oficial del Estado)*
C	Community
CAI	Immediate Attention Centre *(Centro de Atención Inmediata)*
CAS	Centre for the Attention and Follow Up of Drug Addictions *(Centro de Atención y Seguimiento de Toxicomanías)*
CCAA	Regional Autonomous Communities *(Spanish regional government (Comunidades Autónomas)*
CEAR	Spanish Commission for Assistance to Refugees *(Comisión Española de Ayuda al Refugiado)*
CETI	Temporary Accommodation Centre for Immigrants *(Centro de Estancia Temporal de Inmigrantes)*
CGEF	Central Department on Immigration and Borders *(Comisaría General de Extranjería y Fronteras)*
CIE	Detention Centre for Foreign Nationals *(Centro de Internamiento de Extranjeros)*
CMI	Centre for Young Offenders *(Centro para Menores Infractores)*
CNP	Spanish National Police Force *(Cuerpo Nacional de Policía)*
CP	Prison *(Centro Penitenciario)*
CPT	European Committee for the Prevention of Torture *(Council of Europe)*
DGGC	Directorate General for the Civil Guard) *(Dirección General de la Civil Guard)*
DGP	Directorate General for the Police *(Dirección General de la Policía)*
DUE	Holder of a University Diploma in Nursing *(Diplomado Universitario en Enfermería)*
EDM	Military Disciplinary Establishment *(Establecimiento Disciplinario Militar)*
FAISEM	Public Foundation of Andalusia for the Social Integration of Persons with Mental Disease *(Fundación Pública Andaluza para la Integración Social de Personas con Enfermedad Mental)*
FEAPS	Spanish Confederation of Organisations for the Benefit of Persons with Intellectual or Development Disabilities *(Confederación Española de Organizaciones en favor de las Personas con Discapacidad Intelectual o del Desarrollo)*
FRONTEX	European Agency for the Management of Operational Cooperation at the External Borders
GC	Civil Guard *(Guardia Civil)*
HPP	Prison Psychiatric Hospital *(Hospital Psiquiátrico Penitenciario)*
IASS	Social Services Institute of ARAGON *(Instituto Aragonés de Servicios Sociales)*
IG	General Report of the CPT
ILMO.	Honourable
INE	National Statistics Institute *(Instituto Nacional de Estadística)*

INTERPOL	International Organisation of Criminal Police
LO	Basic Law *(Ley Orgánica)*
LOGP	General Penitentiary Basic Law *(Ley Orgánica General Penitenciaria)*
LOPD	Basic Data Protection Law *(Ley Orgánica de Protección de Datos)*
NPM	National Preventive Mechanism against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
OAR	Asylum and Refugees Office *(Oficina de Asilo y Refugio)*
OM	Ministerial Order *(Orden Ministerial)*
NGO	Non-Governmental Organisation
UN	Organisation of the United Nations
OPCAT	Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
PACEP	Plan for Amortisation and Creation of Penitentiary Establishments *(Plan de Amortización y Creación de Establecimientos Penitenciarios)*
PAIEM	Framework Program for the Comprehensive Care of the Mentally Ill *(Programa Marco para la atención integral a los enfermos mentales)*
PPS	Suicide Prevention Program *(Programa de Prevención de Suicidios)*
PRS	Suicide Risk Protocol *(Protocolo de Riesgo de Suicidio)*
RP	Prison Regulations *(Reglamento Penitenciario)*
RVR	Restricted Living Regime *(Régimen de Vida Restringido)*
RVSE	Living Regime with Separation of the Patient from the Surrounding *(Régimen de Vida con Separación del Paciente del Entorno)*
SGIP	Office of the Secretary General for Prisons *(Secretary General for Penitentiary Institutions)*
SME	Service for Materialisation of Foreign Nationals *(Servicio de Materialización de Extranjeros)*
SEDEX	Service of Expulsions of Foreign Offenders *(Servicio de Expulsiones de Delincuentes Extranjeros)*
SPE	Service for the Planning of Foreign Nationals *(Servicio de Planificación de Extranjeros)*
STC	Judgment of the Spanish Constitutional Court *(Sentencia Tribunal Constitucional)*
T1	Terminal 1 Airport Adolfo Suárez Madrid-Barajas
T4	Terminal 4 Airport Adolfo Suárez Madrid-Barajas
UCER	Central Unit for Deportation and Repatriation *(Unidad Central de Expulsiones y Repatriaciones) (CNP)*
UCH	Hospital Custody Units *(Unidades de Custodia Hospitalaria)*
EU	European Union
UHPP-C	Prison Psychiatric Hospital Unit of Catalonia *(Unidad de Hospitalización de Psiquiatría Penitenciaria de Catalonia)*
UIP	Police Action Unit *(Unidad de Intervención Policial)*
URPP	Prison Psychiatric Rehabilitation Unit *(Unidad de Rehabilitación Psiquiátrica Penitenciaria)*
UTE	Educational Therapeutic Unit *(Unidad Terapéutica Educativa)*
VER	Regimental Special Surveillance *(Vigilancia Especial Regimental)*

Introduction
§ 1 - § 8

Obligation to draw up an annual report

1. This report renders account of the activity performed by the National Preventive Mechanism against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (NPM) in 2013, taking into account the provision of the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), made in New York on 18 December 2002, for issue of an annual report.

Report 2012 NPM before the Spanish Parliament and the Subcommittee on Prevention of Torture

The previous report of the NPM, on the activity performed in 2012, was submitted to the Official Registry of the Spanish Parliament on 16 May 2013 and sent to the United Nations Subcommittee on Prevention of Torture.

Reports 2010, 2011 and 2012 NPM submitted to the Spanish Parliament

The Ombudsman appeared before the Mixed Committee for Relations with the Ombudsman of the Spanish Parliament to submit Annual Reports 2010, 2011 and 2012 NPM, on 28 May 2013. In addition, on 22 October 2013, the Ombudsman appeared before the Mixed Committee for Relations with the Ombudsman, of the Spanish Parliament, where she reported on the activity of the institution at 30 September 2013, and referred also to the activity performed by the Institution in its capacity as National Preventative Mechanism against Torture (NPM).

Multidisciplinary visits

2. As in previous years, in 2013, multidisciplinary visits were made at which, in addition to technical experts of the Ombudsman who had mainly legal training, external technical experts in various fields such as medicine, psychiatry or psychology also participated to carry out an integrated assessment of the places for deprivation of liberty that had been visited.

From March 2010 to 31 December 2013, a total 423 visits

3. From the commencement of the activity of the NPM, in March 2010, until 31 December 2013, a total 423 visits were made, 39 of which were multidisciplinary, in which external technical experts participated. As mentioned in the previous annual report, upon completion of the visits, the conclusions drawn are sent to the various responsible authorities for them to correct the detected deficiencies, to the extent possible.

The conclusions are recorded in the annexes to this report

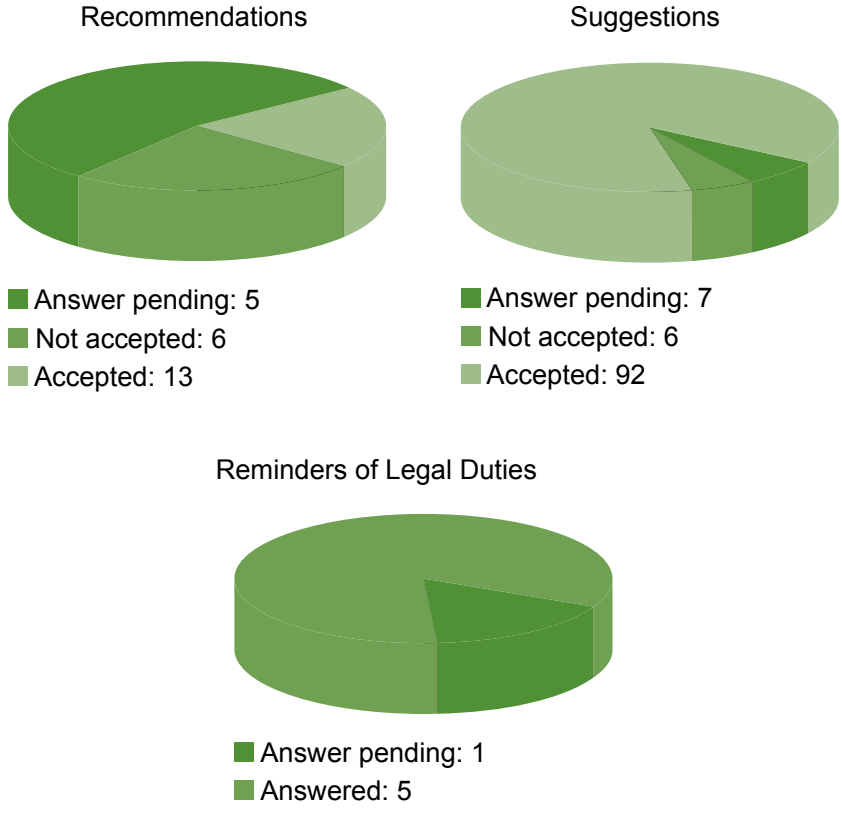
4. As was done in Annual Report 2012, the conclusions sent to the various authorities are recorded in the annexes to this report and are specified, centre by centre, taking into account each type of deprivation of liberty. Said annexes also include a follow up of the visits made

in previous years and of those in respect of which the answer of the responsible Authority was pending.

24 Recommendations, 105 Suggestions and 6 Reminders of Legal Duties

5. When the authorities fail to adopt corrective measures relating to the deficiencies recorded in the conclusions sent to them, the resolutions recognised to the Ombudsman, such as Recommendations, Suggestions or Reminders of Legal Duties, are used. Thus, in 2013 a total 24 Recommendations, 105 Suggestions and 6 Reminders of Legal Duties were issued, the state of acceptance or rejection of which is shown in the following graphics.

Graphic 1
Recommendations, Suggestions and Reminders of Legal Duties issued



Unannounced visits

6. All visits made in 2013, other than six, were unannounced. Some of them were made at night and following the criterion of making photographs of the visited facilities, attached to the relevant record, some of which are included in this report.

Coordination with the relevant area of the Ombudsman's Office

7. If during the visits made by the NPM knowledge is obtained of the purported performance of an act that could be statutorily classified as torture, or cruel, inhuman or degrading treatment, the case is referred to the respective department of the Ombudsman's Office for it to assess, if appropriate, whether to take the respective action, which would be recorded in the relevant annual report of the Ombudsman. Nevertheless, as was done last year, to make the report more consist-

ent, an Appendix is included, recording the actions of the Ombudsman in this field.

Creation of the Advisory Council

8. Lastly, paragraph 6 of Annual Report 2012 mentioned that the full design of the NPM required the creation of the Advisory Council. The reform of the Ombudsman Regulation, which contemplated the creation of the Advisory Council, was approved in 2012 (Resolution of the Lower House and Higher House of Parliament of 25 January 2012, BOE, no. 52 of 1 March). Subsequently, the Decision of 27 February 2013 of the Ombudsman called the procedure for appointment of members of the Advisory Council of the National Preventive Mechanism against Torture (BOE no. 62, of 13 March). Lastly, the Decision of 20 May 2013, of the Ombudsman, resolved said proceeding (BOE no. 125, of 25 May), appointing the members of the Advisory Council.

Reunión constitutiva del Consejo Asesor, presidido por la Defensora del Pueblo

The meeting forming the Advisory Council was held at the seat of the Ombudsman on 26 June 2013. Said Council, presided over by the Ombudsman, consists of the Assistants to the Ombudsman and the following members: Milagros Fuentes, lawyer and President of the Bar Association of Santa Cruz de la Palma (designated at the proposal of the General Council of the Spanish Legal Profession); Berta M.ª Uriel, doctor and Deputy President of the Official Association of Medical Practitioners of Orense (designated by the General Council of Official Associations of Medical Practitioners of Spain); Vicenta Esteve, clinical psychologist and Deputy President of the Official Association of Psychologists of Valencia Autonomous Community (designated by the General Council of Official Associations of Psychologists of Spain); Emilio Ginés, member of the UN Subcommittee on the Prevention of Torture; Francisco Javier de Lucas, Professor of Philosophy of Law and former present of the Spanish Committee for Assistance to Refugees (Comisión Española de Ayuda al Refugiado –"CEAR"); Fernando M. Mariño, professor of International Public Law and former President and member of the United Nations Committee against Torture; Julián Carlos Ríos, lawyer specialised in Prison Law and lecturer of Criminal Law, and Yolanda Román, jurist specialised in Human Rights. The latter five members were elected from among the candidatures submitted in the public invitation before the Ombudsman, personally or representing organisations or associations representing civil society.

First ordinary meeting of the Advisory Council

The first ordinary meeting of the Advisory Council was held on 16 December 2013 and, among other matters, account was rendered of the activity performed by the NPM in 2013, the members were offered the possibility of accompanying the technical experts of the NPM in their inspections, promoting places for deprivation of liberty to be visited and matters to be examined at the visits to be made in 2014.

Visits made
§ 9 - § 11

9. In 2013, a total 60 visits were made to places of deprivation of liberty.

60 visits

Of the 60 visits, 5 of them were institutional, attended by the Ombudsman, and the responsible authorities were called to encourage dialogue pursuant to article 22 of the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, directly and personally. In addition to these visits, the Ombudsman also participated in a further 10 visits to places for deprivation of liberty in Spain.

Five visits were institutional

Of the total visits, 18 were multidisciplinary, with the cooperation of external technical experts, specialised in legal and forensic medicine, psychiatry and psychology, providing a particularly qualified point of view when assessing certain areas and protocols of the place visited and holding individual interviews with persons deprived of liberty.

Eighteen visits were multidisciplinary

In addition, 28 visits were made for follow-up purposes, to verify compliance with the conclusions drawn at previous visits and identify eventual new deficiencies.

Twenty-eight were follow-up visits

Members of the Advisory Council of the NPM participated in 4 of the visits made in 2013.

Participation of members of the Advisory Council

Lastly, one of the visits was made accompanied by a delegation of the Ombudsman of Ukraine.

10. As a novelty this year it must be pointed out that, in the supervision of an operation for repatriation of foreign nationals to Ecuador and Colombia, the team of the NPM, consisting of one technical expert and one forensic medical practitioner, travelled in the same aircraft together with the repatriated persons and police personnel to their final destination. Said visit is reviewed further in depth in paragraphs 227 to 244.

Supervisión de un operativo de repatriación de extranjeros

11. The distribution of visits is set out in the following table

Table 1
Types of places of deprivation of liberty

Places	Number of visits
District police stations and other places of short-term custody National Police Force	20
Barracks and other places of short-term custody of the Civil Guard	9
Prisons	8
Centres for young offenders	6
Centres for detention of foreign nationals	5
Social healthcare centres	2
Prison psychiatric hospitals	2
Rooms for persons refused entry and asylum seekers at border control posts	2
Military disciplinary establishments	1
Court holding cells	1
Prisoner transportation operations	1
Foreign national repatriation operations	1
Local Police stations	1
Hospital Custody Units	1
TOTAL	60

Chart 2
Geographical location of facilities visited in 2013

Places of deprivation of liberty visited in 2013

National Police Force (CNP)	20
Room for persons refused entry and asylum seekers at border control posts	2
Civil Guard	9
Municipal depots	1
Court holding cells	1
Centres for Detention of Foreign Nationals (CIE)	5
Prison psychiatric hospitals	2
Prisons	8
Centres for young offenders	6
Social healthcare centres	2
Military Disciplinary Establishments	1
Prisoner transportation operation	1
Foreign national repatriation operations	1
Hospital Custody Unit	1
TOTAL	60

Table 2
National Police Force Headquarters and District Stations

SUPERIOR POLICE HEADQUARTERS		
Number	Locality	Province
1	Toledo**	Toledo
2	Valencia/València*****	València/Valencia
POLICE STATIONS		
Number	Locality	Province
3	Córdoba, Este district**	Córdoba
4	Burgos	Burgos
5	Madrid, Arganzuela district	Madrid
6	Madrid, Centro district**	Madrid
7	Madrid, Chamartín district**/***	Madrid
8	Madrid, Ciudad Lineal district	Madrid
9	Madrid, Moratalaz district	Madrid
10	Madrid, Puente de Vallecas district**	Madrid
11	Madrid, San Blas district**	Madrid
12	Madrid, Tetuán district	Madrid
13	Madrid, Central Registry of Detainees**	Madrid
14	Palencia	Palencia
15	Pozuelo de Alarcón	Madrid
16	Salamanca	Salamanca
17	Torrejón de Ardoz	Madrid
18	Teruel	Teruel
19	Valencia, Central Inspectorate on Shift **/*****	València/Valencia
20	Zamora	Zamora

** Follow-up visit
*** Visit together with the Ombudsman of Ukraine
***** Participation of members of the Advisory Council

Table 3
Civil Guard Headquarters and Stations

HEADQUARTERS		
Number	Locality	Province
1	Córdoba**	Córdoba
2	Tres Cantos**	Madrid
3	Burgos	Burgos
4	Palencia	Palencia
5	Salamanca	Salamanca
6	Toledo**	Toledo
7	Valencia/València**/*****	València/Valencia
8	Zamora	Zamora
STATIONS		
Number	Locality	Province
9	Madrid**	Madrid

** Follow-up visit
***** Participation of members of the Advisory Council

Table 4
Local Police Stations

Number	Locality	Province
1	Peñaranda de Bracamonte	Salamanca

Table 5
Court holding cells

Number	Locality	Province
1	Madrid**	Madrid

** Follow-up visit

Table 6
Centres for detention of foreign nationals

Number	Locality	Province
1	Barcelona**	Barcelona
2	Madrid*/**	Madrid
3	Murcia*/**	Murcia
4	Tarifa**/****	Cádiz
5	Valencia/València**/****	València/Valencia

* Multidisciplinary visit
** Follow-up visit
**** Protocol visit

Table 7
Military disciplinary establishments

Number	Locality	Province
1	Colmenar Viejo**	Madrid

** Follow-up visit

Table 8
Prisons

Number	Name	Locality	Province
1	Barcelona (men)**	Barcelona	Barcelona
2	Córdoba	Córdoba	Córdoba
3	Puerto I*	El Puerto de Santa María	Cádiz
4	Puerto III*	El Puerto de Santa María	Cádiz
5	Segovia*	Torredondo	Segovia
6	Sevilla I****	Sevilla	Sevilla
7	Sevilla II**/****	Sevilla	Sevilla
8	Villabona*/**	Llanera	Asturias

* Multidisciplinary visit
** Follow-up visit
**** Protocol visit

Table 9
Prison psychiatric hospitals

Number	Name	Town/city	Province
1	Sevilla*	Alcalá de Guadaíra	Sevilla
2	UHPP de Brians*	Sant Esteve de Sesrovires	Barcelona

* Multidisciplinary visit

Table 10
Centres for young offenders

Number	Name	Town/city	Province
1	Albaidel**	Albacete	Albacete
2	Els Til·lers*/*****	Mollet del Vallès	Barcelona
3	Las Lagunillas*/**	Jaén	Jaén
4	Montefiz*	Ourense	Ourense
5	Monteledo*	Ourense	Ourense
6	Sograndio*	Sograndio	Asturias

* Multidisciplinary visit
** Follow-up visit
***** Participation of Advisory Council members

Table 11
Social healthcare centres

Number	Name	Town/city	Province
1	Mental health centre Casta Salud Arévalo*	Árevalo	Ávila
2	Healthcare centre El Pinar*	Teruel	Teruel

* Multidisciplinary visit

Table 12
Foreign national repatriation operation

Number	Town/city	Province
1	Madrid-Bogotá (Colombia) foreign national repatriation operation*	Madrid

* Multidisciplinary visit

Table 13
Prisoner transportation operation

Number	Operation	Province
1	Operativo de traslado de reclusos desde Canarias realizado por la Guardia Civil, en el aeropuerto de Jerez de la Frontera*	Cádiz

* Visita multidisciplinar

Table 14
Hospital Custody Units

Number	Town/city	Province
1	Hospital Reina Sofía**	Córdoba

* Multidisciplinary visit
** Follow-up visit

Table 15
Rooms for persons refused entry and asylum seekers at border control posts

Number	Operation	Province
1	Rooms for asylum and persons refused entry at terminals 1 and 4 satellite of the National Police Station at airport Adolfo Suárez Madrid-Barajas*/**	Madrid
2	Rooms for asylum seekers and persons refused entry at terminals 1 and 4 satellite of the National Police Station at airport Adolfo Suárez Madrid-Barajas**/****	Madrid

* Multidisciplinary visit
** Follow-up visit
**** Protocol visit

Situation of deprivation of liberty

I. Short-term deprivation of liberty
§ 12 - § 34

I. Short-term deprivation of liberty

Security Forces and Corps

12. This section reviews the action of the Security Corps and Forces, relating to the various protocols of each corps for treatment its detainees.

361,066 detentions in cells

13. Throughout 2013, the total number of detentions in cells made by the CNP, Civil Guard and autonomous community police was 361,066, thus lower than the number of detentions in 2012, when 381,965 persons were detained.

225,699 detentions by the CNP

In turn, the CNP detained a total 225,699 persons, 49,406 of whom were detained for infringement of the law on foreign nationals.

Table 16

Detentions in cells made by the CNP, in terms of autonomous communities and cities and provinces in 2013

OPERATIONAL TRANSFER OF PRISONERS		
AUTONOMOUS COMMUNITIES	PROVINCES	NUMBER OF DETAINEES
Andalusia		47,519
	Almería	3,936
	Cádiz	8,609
	Córdoba	2,484
	Granada	3,868
	Huelva	1,397
	Jaén	1,877
	Málaga	16,146
	Seville	9,202
Aragon		7,103
	Huesca	529
	Teruel	258
	Zaragoza	6,316
Principality of Asturias		4,427

Table 16

Detentions in cells made by the CNP, in terms of autonomous communities and cities and provinces in 2013

OPERATIONAL TRANSFER OF PRISONERS		
AUTONOMOUS COMMUNITIES	PROVINCES	NUMBER OF DETAINEES
Balearic Islands		7,549
Canary Islands		10,193
	Las Palmas	5,678
	Santa Cruz de Tenerife	4,515
Cantabria		2,123
Castile-La Mancha		7,126
	Albacete	2,290
	Ciudad Real	2,013
	Cuenca	442
	Guadalajara	467
	Toledo	1,914
Castile and Leon		7,427
	Ávila	407
	Burgos	1,426
	León	1,442
	Palencia	611
	Salamanca	1,027
	Segovia	342
	Soria	278
	Valladolid	1,578
	Zamora	316
Catalonia		9,291
	Barcelona	6,674
	Girona	1,167
	Lleida	518
	Tarragona	932
Ceuta		6,389
Autonomous Community of Valencia		31,974
	Alacant/Alicante	12,962
	Castelló/Castellón	2,650
	València/Valencia	16,362
Extremadura		3,170
	Badajoz	2,400
	Cáceres	770
Galicia		6,980
	A Coruña	2,517
	Lugo	884

Table 16

Detentions in cells made by the CNP, in terms of autonomous communities and cities and provinces in 2013

OPERATIONAL TRANSFER OF PRISONERS		
AUTONOMOUS COMMUNITIES	PROVINCES	NUMBER OF DETAINEES
	Ourense	720
	Pontevedra	2,859
La Rioja		1,532
Autonomous Community of Madrid		54,946
Melilla		4,591
Murcia		8,837
Navarre		1,417
Basque Country		2,694
	Araba/Álava	418
	Gipuzkoa	1,612
	Bizkaia	664
Central bodies		411
TOTAL GENERAL		**225,699**

Source: Own preparation based on data furnished by the DGP.

The DGP carried out 43,773 identifications

The DGP reported that, in 2013, it carried out a total 43,773 identifications, pursuant to Basic Law 1/1992, of 21 February, on the Protection of Citizen Security, 23,129 of which were identifications of foreign nationals.

In 2013, only one disciplinary proceeding was instituted against an officer of the CNP

In respect of disciplinary proceedings instituted for purported malpractice or purported torture, ill-treatment, cruel or inhuman treatment inflicted by officers of the CNP on persons deprived of liberty, at official facilities and during the proceedings, the DGP reported that, in 2013, only one disciplinary proceeding was instituted against an officer of the CNP, posted at the Police Station of Tenerife Sur, who appeared to provide services in a riot at a bar and, after hitting a youth over the head several times, is accused of a purported crime of injuries and tortures, waiting for a judgment, so that the disciplinary proceeding is stayed. In addition, it is reported that there is no record of officers against whom repeated complaints have been filed, in the last three years, for crimes of this type.

The GC carried out 75,810 detentions

The GC, in 2013, carried out a total 75,810 detentions in cells.

Table 17

Detentions in cells by the Civil Guard in terms of autonomous communities and cities and headquarters

AUTONOMOUS COMMUNITY OR CITY	HEADQUARTERS	NO. OF DETAINED IN CELLS
Andalusia		18,390
	Algeciras	1,977
	Almería	3,273
	Cádiz	2,350
	Córdoba	1,251
	Granada	2,585
	Huelva	1,770
	Jaén	1,397
	Málaga	1,997
	Seville	1,790
Aragon		1,452
	Huesca	556
	Teruel	183
	Zaragoza	713
Asturias		1,149
	Gijón	604
	Oviedo	545
Balearic Islands		3,973
Canary Islands		5,365
	Las Palmas	3,549
	Santa Cruz de Tenerife	1,816
Cantabria		1,467
Castile-La Mancha		5,639
	Albacete	841
	Ciudad Real	1,269
	Cuenca	493
	Guadalajara	776
	Toledo	2,260
Castile and Leon		3,398
	Ávila	245
	Burgos	422
	León	584
	Palencia	289
	Salamanca	390
	Segovia	417
	Soria	165
	Valladolid	522
	Zamora	364

Table 17

Detentions in cells by the Civil Guard in terms of autonomous communities and cities and headquarters

AUTONOMOUS COMMUNITY OR CITY	HEADQUARTERS	NO. OF DETAINED IN CELLS
Catalonia		846
	Barcelona	465
	Girona	190
	Lleida	60
	Tarragona	131
Ceuta		2,250
Autonomous Community of Valencia		14,605
	Alacant/Alicante	6,688
	Castelló/Castellón	2,167
	València/Valencia	5,750
Extremadura		1,203
	Badajoz	546
	Cáceres	657
Galicia		3,663
	A Coruña	1,750
	Lugo	292
	Ourense	545
	Pontevedra	1,076
La Rioja		767
Autonomous Community of Madrid		6,858
Melilla		121
Murcia		4,067
Navarre		443
Basque Country		154
	Araba/Álava	47
	Gipuzkoa	55
	Bizkaia	52
TOTAL GENERAL		**75,810**

Source: Own preparation based on data furnished by the DGGC.

Five court proceedings in progress

In respect of charges brought for purported malpractice or purported tortures, ill-treatment, cruel or inhuman treatment inflicted by officers of the GC on persons deprived of liberty, at official facilities, the DGGC reported that, for facts occurred in 2013, five court proceedings are in progress and, accordingly, no administrative penalty has been imposed on any officer. One of these charges is for purported ill-treatment of a detainee within the cells. Charges were brought against three officers of the Principal Post Rivas Vaciamadrid (Madrid). The other four charges refer to purported injuries caused to detained persons while remanded in custody. In the first case, charges were brought against

three officers of the Principal Post of Tarifa (Cádiz); in the second, charges were brought against one officer of the Principal Post of Los Barrios (Cádiz); in the third case, charges were brought against two officers of the Principal Post of Majadahonda (Madrid) and, in the fourth, charges were brought against one officer of the Principal Post of San Juan (Alicante). In the latter case, charges were brought against the officer for purported abuse of authority.

The Ertzaintza carried out 7,554 detentions

The Ertzaintza carried out, in 2013, a total 7,554 detentions with confinement in cells.

Table 18

Detentions with confinement in cells made by the Ertzaintza in terms of historical territories and headquarters

TERRITORY	HEADQUARTERS	DETENTIONS
Araba/Álava		875
	Laguardia	29
	Laudio	97
	Vitoria-Gasteiz	749
Bizkaia		4,121
	Balmaseda	84
	Basauri	97
	Bilbao	1,875
	Durango	306
	Erandio	161
	Galdakao	100
	Gernika	238
	Getxo	232
	Muskiz	301
	Ondarroa	89
	Sestao	638
Gipuzkoa		2,486
	Azkoitia	33
	Beasain	119
	Bergara	170
	Donostia-San Sebastián	737
	Eibar	186
	Errenteria	257
	Hernani	265
	Irun	391
	Tolosa	121
	Zarautz	137
	Zumarraga	70
		72
	Unidades de Tráfico	31
	Otras Unidades	41
TOTAL DETENCIONES		**7,554**

Source: Own preparation based on data furnished by the Department of the Interior of the Basque Government

No criminal charges

In respect of the charges received for purported malpractice or purported tortures, ill-treatment, cruel or inhuman treatment inflicted by officers of the Ertzaintza on persons deprived of liberty, at official facilities, the Department of the Interior of the Basque Government reported that, in 2013, no criminal charges were received for facts of this kind.

50,943 detentions by the Mossos d'Esquadra

In turn, the Mossos d'Esquadra carried out a total 50,943 detentions with confinement in cells.

Table 19

Detentions with confinement in cells made by the Mossos d'Esquadra in 2013, and distribution by headquarters

FACILITIES OF THE POLICE OF THE GOVERNMENT OF CATALONIA	NUMBER OF DETAINEES
CENTRAL POLICE REGION	1.930
ABP Osona – Vic	536
ABP Anoia – Igualada	463
ABP Bages – Manresa	783
ABP Solsonès – Solsona	31
ABP Berguedà – Berga	117
POLICE REGION OF GIRONA	5.116
ABP Gironès-Pla de l'Estany – Banyoles	85
ABP Gironès-Pla de l'Estany – Girona	991
ABP Gironès-Pla de l'Estany – Salt	423
ABP Alt Empordà-Figueres – Figueres	562
ABP Alt Empordà-Figueres - La Jonquera	230
ABP Alt Empordà - Roses	410
ABP Baix Empordà - La Bisbal d'Empordà	563
ABP Baix Empordà – Sant Feliu de Guíxols	219
ABP Garrotxa – Olot	163
ABP Ripollès – Ripoll	83
ABP Selva Litoral – Blanes	326
ABP-Selva Litoral – Lloret de Mar	662
ABP Selva Interior – Santa Coloma de Farners	399
POLICE REGION OF METROPOLITANA BARCELONA	17.554
ABP Sant Martí	8.362
ABP Ciutat Vella	3
ABP Eixample	3.250
ABP Sants-Montjuic	2.166
ABP Les Corts	707
ABP Sarrià-Sant Gervasi	695
ABP Gràcia	360
ABP Horta-Guinardó	560
ABP Nou Barris	759
ABP Sant Andreu	585
ABP Barcelona	107

Table 19

Detentions with confinement in cells made by the Mossos d'Esquadra in 2013, and distribution by headquarters

FACILITIES OF THE POLICE OF THE GOVERNMENT OF CATALONIA	NUMBER OF DETAINEES
POLICE REGION METROPOLITANA NORD	10.367
ABP Arenys de Mar – Arenys de Mar	162
ABP Arenys de Mar – Pineda de Mar	641
ABP Mataró – Mataró	940
ABP Premià de Mar – Premià de Mar	309
ABP Granollers – Caldes de Montbuí	86
ABP Granollers – Sant Celoni	99
ABP Granollers – Granollers	1.125
ABP Mollet del Vallès – Mollet del Vallès	440
ABP Badalona – Sant Adrià de Besòs	296
ABP Badalona - Badalona	1.659
ABP Cerdanyola – Barberà del Vallès	203
ABP Cerdanyola – Cerdanyola del Vallès	361
ABP Cerdanyola – Montcada i Reixac	291
ABP Cerdanyola – Ripollet	187
ABP Rubí – Sant Cugat del Vallès	169
ABP Rubí – Rubi	435
ABP Sabadell – Sabadell	1.123
ABP Sabadell – Santa Perpetua Mogoda	146
ABP Terrassa - Terrassa	1.141
ABP Santa Coloma de Gramenet – Santa Coloma de Gramenet	554
POLICE REGION METROPOLITANA SUD	7.397
ABP Alt Penedès – Sant Sadurní d'Anoia	58
ABP Alt Penedès – Villafranca del Penedès	460
ABP Martorell - Martorell	755
ABP Gavà – Castelldefels	291
ABP Gavà – Gavà	332
ABP Gavà – Viladecans	254
ABP Sant Feliu de Llobregat – Sant Feliu de Llobregat	249
ABP Santa Feliu de Llobregat – Sant Vicenç dels Horts	220
ABP Garraf – Sitges	315
ABP Garraf – Vilanova i la Geltrú	595
ABP L'Hospitalet de Llobregat – L'Hospitalet de Llobregat	1.907
ABP El Prat de Llobregat- Aeropuerto del Prat	229
ABP El Prat de Llobregat- El Prat de Llobregat	491
ABP Sant Boi de Llobregat – Sant Boi de Llobregat	420
ABP Cornellà de Llobregat – Cornellà de Llobregat	647
ABP Esplugues de Llobregat – Espluges de Llobregat	174

Table 19

Detentions with confinement in cells made by the Mossos d'Esquadra in 2013, and distribution by headquarters

FACILITIES OF THE POLICE OF THE GOVERNMENT OF CATALONIA	NUMBER OF DETAINEES
POLICE REGION PIRINEU OCCIDENTAL	305
ABP Alt Urgell – La Seu d'Urgell	89
ABP Cerdanya – Puigcerdà	115
ABP Pallars Jussà-Pallars Sobirà – Sort	13
ABP Pallars Jussà-Pallars Sobirà – Tremp	53
ABP Vall d'Aran-Alta Ribagorça – El Pont de Suert	7
ABP Vall d'Aran-Alta Ribagorça – VIELHA	28
POLICE REGION PONENT	1.957
ABP Segrià-Garrigues-Pla d'Urgell – Les Borges Blanques	44
ABP Segrià-Garrigues-Pla d'Urgell – Lleida	1.330
ABP Segrià-Garriques-Pla d'Urgell – Mollerussa	134
ABP Segarra-Urgell – Cervera	138
ABP Segarra-Urgell – Tàrrega	150
ABP Noguera – Balaguer	138
ABP Noguera – Ponts	23
POLICE REGION CAMP DE TARRAGONA	4.989
ABP Alt Camp-C. de Barberà – Montblanc	54
ABP Alt Camp-C. De Barberà – Valls	223
ABP Baix Camp-Priorat – Cambrils	371
ABP Baix Camp-Priorat – Falset	34
ABP Baix Camp-Priorat – REUS	1.058
ABP Baix Penedès – VENDRELL	744
ABP Tarragonès – SALOU	754
ABP Tarragonès – TARRAGONA	1.751
POLICE REGION TERRES DE L'EBRE	1.328
ABP Baix Ebre – Tortosa	811
ABP Terra Alta- Ribera d'Ebre – Gandesa	36
ABP Terra Alta-Ribera d'Ebre – Mora d'Ebre	104
ABP Montsià – Amposta	377
TOTAL	**50.943**

Source: Own preparation based on data furnished by the Departament d'Interior of the Government of Catalonia.

Two charges against officers of the Mossos d'Esquadra

In respect of the charges received for purported malpractice or purported tortures, ill-treatment, cruel or inhuman treatment inflicted by officers of the Mossos d'Esquadra on persons deprived of liberty, the Department of the Interior of the Government of Catalonia reported that, in 2013, two charges were received. In the first case, for the detention and remand in custody of one person, for a purported crime of

resistance and disobedience to police officers. Charges were brought before the court against three officers, and the proceeding is at the stage of investigation. The internal proceeding arising from this complaint does not contemplate precautionary measures. The second complaint refers to the death of one person after a police action, involving nine officers. As a precautionary measure they were relocated and the instituted disciplinary proceedings are stayed until a judgment is rendered in the court proceeding.

11,060 detentions by the Foral Police of Navarre

The Foral Police of Navarre carried out a total 1,060 detentions with confinement in cells.

Table 20

Detentions with confinement in cells made in 2013 by the Foral Police and distribution by headquarters

HEADQUARTERS	DETENTIONS
Alsasua	13
Elizondo	43
Estella	81
Pamplona	620
Sangüesa	3
Tafalla	94
Tudela	206
TOTAL	**1,060**

Source: Own preparation on data furnished by the Department of Presidency, Justice and the Interior of the Government of Navarre.

Three charges against officers of the Foral Police of Navarre

In respect of the number of charges received for purported malpractice or purported tortures, cruel or inhuman treatment inflicted by officers of the Foral Police of Navarre on persons deprived of liberty, the Department of Presidency, Justice and the Interior of the Government of Navarre reported that, in 2013, three complaints were received in which five officers are involved. Two of the three criminal complaints brought were resolved by the court, dismissing action against the officers, so that a judgment of provisional dismissal was rendered. The third action is pending a court decision.

The Police of the Canary Islands carried out 21 detentions

Lastly, the Department of Economy, Finance and Security of the Government of the Canary Islands reported that in 2013 the Police of the Canary Islands carried out 21 detentions with confinement in cells, no charges having been brought against the officers of this corps for purported malpractice or purported tortures, ill-treatment, cruel or inhuman treatment inflicted on persons deprived of liberty.

Table 21

Detentions with confinement in cells made in 2013 by the Police of the Canary Islands and distribution by headquarters

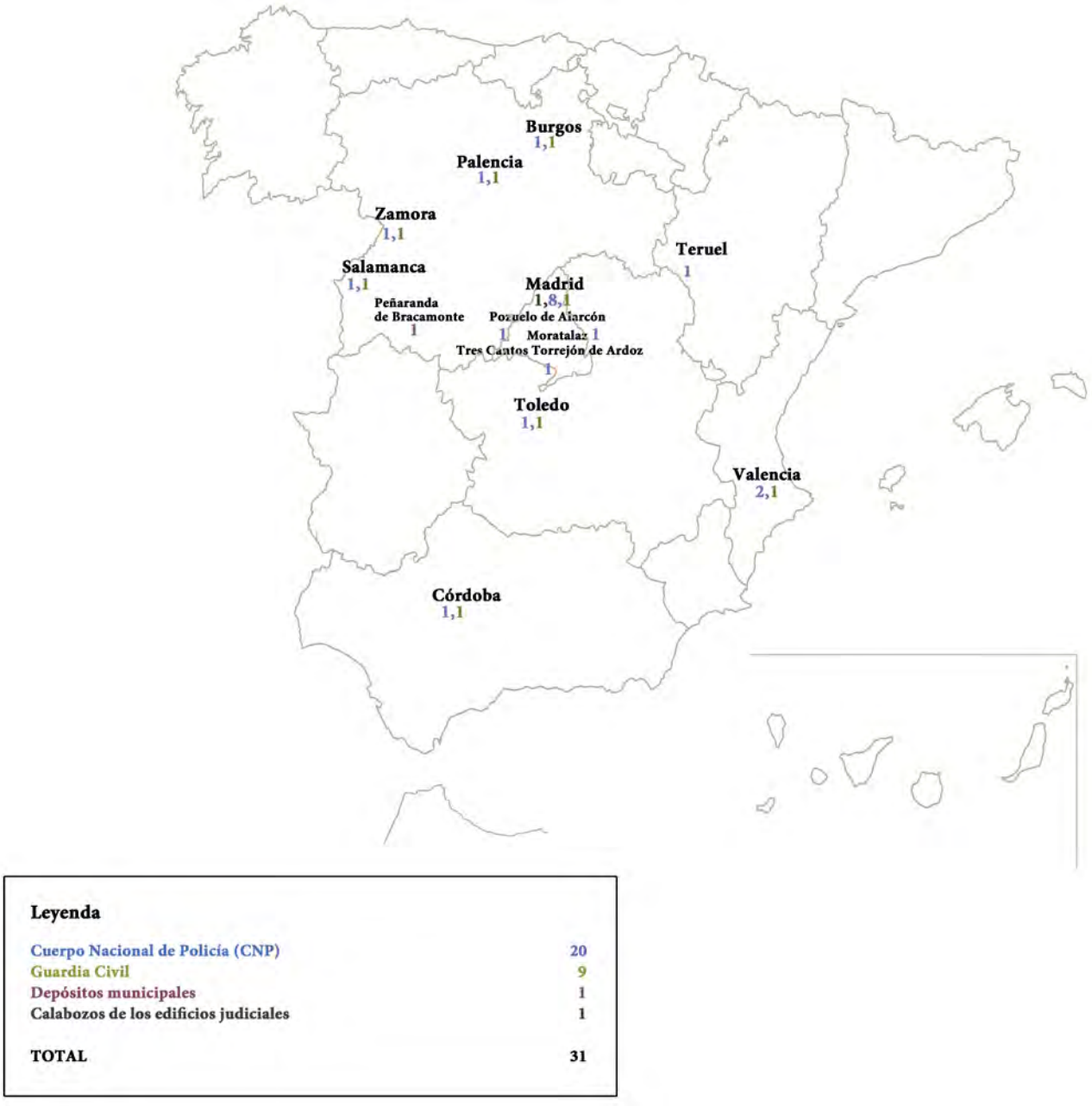
HEADQUARTERS	DETENTIONS
Las Palmas de Gran Canaria	21
Santa Cruz de Tenerife	0
TOTAL	**21**

Source: Own preparation based on data furnished by the Department of Economy, Finance and Security of the Government of the Canary Islands.

31 places of short-term deprivation of liberty visited

14. In 2013, 31 places of short-term deprivation of liberty were visited, as shown in tables 2-5. Some of these visits were for follow-up, in other words, made at places that had been visited in previous years in which it was intended to verify whether the deficiencies that had been observed at that time had been corrected.

Chart 3
Geographical location of places of short-term deprivation of liberty visited in 2013



Same methodology as in previous years

15. The visits made in 2013 were carried out using the same methodology as in previous years: confidential interviews were held with detainees who raised no objection, the documentation relating to them was reviewed and the general conditions in which they were found were examined, in addition to the safeguard of their fundamental rights. In addition, during the visits, both the location and structure of the facility, the living system, the detention system and the access to medical attention of the persons deprived of liberty, procedures used

to handle the detainees and legal and administrative measures applied at the examined facility were reviewed.

Deficiencies and good practices

16. The annexes to this report set out in detail the conclusions sent to the various authorities, relating to each particular facility. The deficiencies and, where appropriate, good practices, observed during these visits, are set out below.

Poor coverage of video-surveillance system

17. The poor coverage of the video-surveillance system persists in most of the places visited. As mentioned in paragraph 14 of Annual Report 2012, both the DGP and the DGGC reported that the setting up of a system conforming to the criteria of this Institution is subject to the budgetary availability for this item. Notwithstanding the differences of criteria between both bodies, in respect of the installation or otherwise of cameras within the cells, at the visits made to the facilities of the GC it was reported that the recording of pictures was inappropriate, considering that this would violate the privacy of the detainees. This practice prevents viewing and subsequently submitting any incidents that may have occurred, which should be corrected.

The presence of custody officers in the cell area is essential

18. The presence of custody officers in the cell area, when detainees are present, is essential, to avoid situations of risk in those cases in which the immediate presence of offices may be necessary. In this respect, a recommendation has been made to the DGP to correct, provided that sufficient personnel is available at the facility, this deficiency, recorded in paragraph 16 of Annual Report 2012. Said body reported that the Recommendation was referred to the Attached Operating Directorate for it to proceed to change the previous instructions.

Information on the possibility of instituting habeas corpus proceedings

19. Only at two of the visited facilities, the CNP district stations of Córdoba and of Madrid-Vallecas, was it observed that detainees were informed in writing, in the printed form for the reading of rights, of the possibility of instituting habeas corpus proceedings, which should be corrected according to the criterion of this Institution, recorded in paragraphs 476 of Annual Report 2010 and 19 of Annual Report 2012.

Cases of “interviews” with police officers without presence of a lawyer

20. The deficiency mentioned in paragraph 20 of Annual Report 2012, relating to the fact that certain detainees had held an “interview” with police officers, before making a statement and being assisted by a lawyer, was observed also at the visits made to the superior headquarters of the CNP in Toledo and Valencia and at the police stations of this corps in Burgos, Palencia and Zamora. The DGP, in all the aforementioned cases, reported that instructions had been given for the subject matter, purpose and duration of the interview or arrangement to be recorded in the custody form and for the investigation dossier to be sent to the court to report it.

Average stay of detainees at police facilities of 24 hours

21. It was verified that the average stay of detainees at police facilities continues to be 24 hours, before they are referred to the responsible court authority. At the police station of the CNP of Pozuelo de Alarcón (Madrid), it was verified that detainees were referred to the court authority even on weekends. Such good practice should extend to other facilities, establishing the protocols considered necessary with the courts, for due compliance with the constitutional theory mentioned in paragraph 21 of Annual Report 2012.

No copy should be kept in the police record of charges of medical assistance reports with the medical record of the interested parties

22. The deficiency pointed out in paragraph 22 of Annual Report 2012, in respect of the fact that a copy was kept in the police record of charges of the reports of medical assistance received by detainees, in which, in many cases, the clinical record of the detainees was included, continued to be observed in some of the places visited. This Institution considers, as it pointed out to the responsible authorities, that, in those cases in which medical attention is provided to a detainee and such person has not given his/her consent to the transfer of data, no copy of the issued medical assistance report should be kept in the record of charges, unless the requirements established in articles 11.2.d) or 22.2 of the LOPD are met. If the detainee gives his/her consent, such consent should be recorded in writing and attached to the medical report, expressly mentioning that he/she was informed of the possibility of rejecting such transfer.

Acceptance of the recommendation for purchase of medicines for detainees

23. The recommendation mentioned in paragraph 25 of Annual Report 2012, relating to enabling a budgetary item for purchase of medicines for detainees, to safeguard their right to health, was accepted by the DGP, which reported that it had been enabled and awarded directly to the healthcare area of the Personnel Division, for its distribution to the various Superior Headquarters.

Falta de identificación de los agentes

24. The deficiency pointed out in the annual reports for previous years, on the lack of identification of the officers, was not observed in most of the visits made in 2013. At the facilities of the GC, due to the new uniform, officers were duly identified and only in certain specific cases, at the visits made to facilities of the CNP, was it necessary to report such infringement to the DGP.

Lack of identification of officers

25. It is necessary to insist on the need for all facilities for custody of detainees to have a gun rack to deposit the statutory weapon and thus avoid carrying it when in contact with detainees in the cell area, to preserve the safety both of the detainees and of the officers themselves.

Deficiencias en la cumplimentación del Libro de Registro y Custodia de Detenidos

26. It was observed that compliance with the Detainees Registration and Custody Book, applicable to the CNP and to the GC, continues to show deficiencies that, due to the time elapsed since the book was implemented, should have been finally corrected. In the custody forms it has been observed that incidents with detainees, such as food supplied, body searches, taking of statements, etc., are not always recorded. At the visit made to the Civil Guard Headquarters in Valencia it

was observed that one custody form was left blank, without any entry, apparently because the detainee was not confined in cells. This is not considered adequate, since the place where he remained and the officer with whom he stayed, in addition to the formalities (information of rights, summary, etc.) carried out and his release should have been entered, pursuant to Instruction 19/2005 of the Secretary of State for Security. For this reason, it appears necessary for the instructions for correct completion of the registration book to be expressly repeated.

Failure to enter full body search of detainee

Likewise, in the light of the exhaustive review of the custody forms, only on few occasions is it recorded that the detainee is body searched on entering the facilities, even if only superficially and only one form was found recording that a full body search had been carried out, despite the fact that, in the interviews held with the detainees, most of them stated that their clothes had been removed. At the Superior Headquarters of the CNP in Valencia it was verified that one custody form recorded as its first entry the “body search and confinement in cells”, the custody officer being requested for information on the registration that was usually carried out (superficial or full), since both detainees confined at the time of the visit had stated that their clothes were removed and they were obliged to do sit-ups. The officer stated: “All detainees have their clothes removed, for their inspection, but they are not touched, although it was not considered that this was a full body search and was done for security reasons”. He did report: “What he considered to be full body searches, were ordered by the examiner and were made feeling the detainee and were recorded in the dossier of the investigations remitted to the judge but not in the custody form”.

Absence of self-closing bags for belongings

27. No irregularity was observed in the entry of the belongings removed from the detainees, upon their confinement in cells and no complaint was received from them in such respect. Nevertheless, at certain facilities visited in 2103 the lack of self-closing bags to keep such belongings continued to be observed since these are placed in envelopes or plastic bags which are then knotted, in addition to the lack of lockers or cupboards to keep such bags.

Absence of independent entrances to the custody area

28. Some of the visited facilities continue without independent entrances to the custody area, causing public exposure of the detainees, contravening the criterion established in paragraph 31 of Annual Report 2012. In the specific case of the station of the CNP of the San Blas District (Madrid), a suggestion had to be made to correct such deficiency, which was accepted by the DGP, which reported that the detainees entered the facilities through a door at the side of the building.

Deficiencies at various facilities that could cause self-injuries or suicide attempts

29. Deficiencies continued to be detected at various facilities that could cause the detainees to attempt to injure themselves or commit suicide. Items such as door hinges, unprotected locks or metal plates may be used by the detainees to cause themselves injuries. The presence, on the cell doors, of horizontal bars or small windows with bars should be suppressed.

Door of one of the cells of the station of the CNP in the San Blas District in Madrid

Suggestion accepted

At this facility, a suggestion had to be made, which was accepted by the DGP, for such deficiency to be corrected, particularly since, days before the visit, a detainee committed suicide using the small window.

Request for change of type of toilets

Likewise, the replacement of ceramic toilets, at those facilities where they existed, by other anti-vandal ones was also requested, to prevent the detainees, on breaking them, to cause themselves injuries or attempt to attack the officers.

Attempts of self-injury and deaths

The attempts of self-injury and deaths of person under custody of the various police corps are set out below. In respect of the police facilities of the Directorate General for the Police and the Ertzaintza there is no knowledge of deaths occurred in 2013.

Table 22

Total number of attempts at self-injury of detainees in custody of the CNP recorded in 2013

HEADQUARTERS	PROVINCE	INJURY RESULT		
		GRAVE	MINOR	TOTAL
	Almería		3	3
	Cádiz	1	27	28
	Córdoba		6	6

Table 22

Total number of attempts at self-injury of detainees in custody of the CNP recorded in 2013

HEADQUARTERS	PROVINCE	INJURY RESULT		
		GRAVE	MINOR	TOTAL
	Granada		5	5
	Huelva		3	3
	Jaén			0
	Málaga	1	27	28
	Seville		26	26
ANDALUSIA		**2**	**97**	**99**
	Huesca		2	2
	Zaragoza	1	3	4
ARAGON		**1**	**5**	**6**
ASTURIAS			**16**	**16**
BALEARIC ISLANDS		**1**	**12**	**13**
	Las Palmas		5	5
	Santa Cruz de Tenerife	1	9	10
CANARY ISLANDS		**1**	**14**	**15**
CANTABRIA			**7**	**7**
	Albacete		6	6
	Ciudad Real		3	3
	Cuenca		2	2
	Toledo	1	4	5
CASTILE-LA MANCHA		**1**	**15**	**16**
	Ávila		2	2
	Burgos		1	1
	León		2	2
	Palencia		4	4
	Salamanca		1	1
	Segovia		3	3
	Soria		2	2
	Valladolid		1	1
CASTILE AND LEON			**16**	**16**
	Barcelona		4	4
	Girona			
	Lleida			
	Tarragona			
CATALONIA			**4**	**4**

Table 22

Total number of attempts at self-injury of detainees in custody of the CNP recorded in 2013

HEADQUARTERS	PROVINCE	INJURY RESULT		
		GRAVE	MINOR	TOTAL
CEUTA			**2**	**2**
	Alacant/Alicante	1	16	17
	Castelló/Castellón		5	5
	València/Valencia	1	30	31
AUTONOMOUS COMMUNITY OF VALENCIA		**2**	**51**	**53**
	Badajoz		6	6
	Cáceres		1	1
EXTREMADURA			**7**	**7**
	A Coruña	2	29	31
	Lugo	1	8	9
	Orense	1		1
	Pontevedra		5	5
GALICIA		**4**	**42**	**46**
LA RIOJA		**1**	**6**	**7**
MADRID		**1**	**50**	**51**
MELILLA			**1**	**1**
MURCIA			**14**	**14**
NAVARRE			**12**	**12**
BASQUE COUNTRY			**2**	**2**
TOTAL		**14**	**373**	**387**

Source: Own preparation based on data furnished by the DGP.

Table 23

Total number of attempts at self-injury of detainees in custody of the Civil Guard recorded in 2013

HEADQUARTERS	NO. OF ATTEMPTS
A Coruña	8
Albacete	2
Alacant / Alicante	3
Badajoz	1
Burgos	2
Cádiz	4
Castelló / Castellón	4
Ceuta	1
Ciudad Real	3
Córdoba	4

Table 23

Total number of attempts at self-injury of detainees in custody of the Civil Guard recorded in 2013

HEADQUARTERS	NO. OF ATTEMPTS
Granada	2
Huelva	1
Huesca	3
Illes Balears	14
Jaén	1
Las Palmas	12
Lugo	1
Madrid	16
Málaga	1
Oviedo	1
S. C. de Tenerife	2
Segovia	1
Sevilla	2
Toledo	3
Valencia	4
Zamora	1
Zaragoza	2
TOTAL	**99**

Source: Own preparation based on data furnished by the DGGC.

Table 24

Total number of attempts at self-injury of detainees in custody of the Ertzaintza recorded in 2013

	N.º OF ATTEMPS
TOTAL	**2**

Source: Own preparation based on data furnished by the Department of the Interior of the Basque Government.

Table 25

Total number of attempts at self-injury of detainees in custody of the Mossos d'Esquadra recorded in 2013

	N.º OF ATTEMPS
TOTAL	**240**

Source: Own preparation based on data furnished by the Departament d'Interior of the Government of Catalonia.

Table 26

Total number of deaths of detainees in custody of the Civil Guard recorded in 2013

HEADQUARTERS	NO. OF DEATHS
Cantabria	1
TOTAL	**1**

Source: Own preparation based on data furnished by the DGGC.

Table 27

Total number of deaths of detainees in custody of the Mossos d'Esquadra recorded in 2013

HEADQUARTERS	NO. OF DEATHS
Vendrell	1
Les Corts	1
TOTAL	**2**

Source: Own preparation based on data furnished by the Departament d'Interior of the Government of Catalonia.

Attempts of self-injury

Lastly, the Department of Presidency, Justice and the Interior of the Government of Navarre reported that at the Headquarters of Tudela five attempts of self-injury were made by persons in cells and one at the Headquarters of Estella, no case existing at the facilities of the General Corps of the Police of the Canary Islands, as reported by the Department of Economy, Finance and Security of the Government of the Canary Islands.

Request for replacement of squat toilets

30. Both at the facilities of the GC and at those of the CNP it had to be requested that the squat toilets observed in the bathrooms be replaced, since it was considered that they were not adequate for those detainees that, given their age or physical condition, had to use seat toilets. In addition, the Department of Presidency, Justice and Spokesman of Government of Madrid Autonomous Community was requested that the access to the toilets within the cells of the Courts of Plaza de Castilla, in Madrid should not affect the privacy of persons deprived of liberty who must use them and should not cause bad odour to the rest of the colleagues of the cell, pursuant to paragraph 33 of Annual Report 2012. Said Department reported that a door would be installed at those toilets and that the air extraction system had been reviewed to avoid bad odour.

Toilet inside one of the cells of the Courts of Plaza de Castilla in Madrid

31. The deficiencies with regard to temperature, ventilation, cleanliness, lighting and general maintenance of the cell area continued to be detected in most of the visited facilities. After the follow-up visit made this year to the station of the CNP in Centro District Madrid, the need to carry out an entire renovation or, preferably, to move the facilities elsewhere was conveyed to the DGP given the state of repair and maintenance of these facilities. Said executive centre declared that the actions contemplated by the 2014-2023 Director Plan for Real Estate Infrastructures include: “In view of the difficulties that may be encountered to renovate the property, the proposal for action would be its alienation and renovation or construction of a new building...”, for which purposes the Sub-Directorate for Logistics has commenced the appropriate arrangements.

Deficiencies in the cell area

Cell area of CNM Madrid Centro district station

Correction of deficiencies

On the other hand, at the follow-up visits made to the Headquarters of the GC of Cordoba and Toledo it was verified that the custody area had been fully renovated, correcting the deficiencies observed at the previous visits that had been pointed out in Annual Report 2010.

Cells of the Headquarters of the GC in Cordoba

Complaints received from detainees relating to provision of inadequate or cold food

32. At the interviews held with the detainees, they continued to have complaints as to the food kits provided by the CNP, which does not occur in the case of the detainees at the facilities of the GC, where food is provided from close by restaurant establishments. At the visit made to the Superior Headquarters of the CNP in Toledo, one detainee stated that he was diabetic and the packed food he had been provided with was inadequate for him. This was confirmed by the custody officers who even stated that they had given the detainee a piece of fruit that he had rejected. His custody form recorded that, at 8:40 h., on 29 October, this person had refused his breakfast ("he does not wish to have breakfast"). Nevertheless, the form did not record either the lunch or dinner of the 28th or that the detainee had refused to eat these two times. The DGP reported that no diet for diabetics is contracted with the company that supplies the catering service, but that adequate food is supplied from close by hospitality establishments, as is also done for persons with allergies.

Rejection of dinner for not being heated

At the visit made to the station of the CNP of the Ciudad Lineal District of Madrid, the three detainees who had spent the night at these facilities stated that they had refused dinner because it had not been heated. The DGP reported that due instructions had been given to correct this deficiency.

At the visit made to the station of the CNP of the Tetuán District of Madrid, packed food past its consume by date was found, so that the DGP had to remind the persons responsible for these facilities to extreme their inspections in this respect.

Packed food at the CNP District Station of Ciudad Lineal of Madrid

33. Despite the instructions given by the DGP relating to the supply to detainees of blankets not previously used by other detainees, this deficiency continues in many of the facilities of this police corps. On the other hand, at the visit made to the Headquarters of the GC of Salamanca a suggestion was made for this deficiency to be corrected, which was accepted by the DGGC.

Blankets at the CNP Córdoba Este District Station

Complaints of detainees for provision of expired packed food, lack of plastic glasses to drink and bad odour in toilets

34. At the interviews held with detainees, no complaints were made about the reading of rights and this obligation was performed at the facilities visited in 2013. Complaints were made as to the food ("I was given cold paella"; "the food is bad"; "the packed food was past its eat before date"; "the food is disgusting") and, in certain cases, because they were not provided with plastic glasses to drink and had to drink water directly from the tap, as stated by the detainees interviewed at the station of the CNP of the Tetuán District of Madrid. In general, detainees did not complain about having to wait to go to the toilet ("I called the agent and he came in a few minutes"; "when I informed them through the interphone that I wanted to go to the toilet, they came down immediately"; "I had no problems because there are always people in the cells"), or of the attention received when they requested medical attention. Some people did complain of the bad odour in the cells ("although the cleaners mopped the floor in the morning it continued to smell bad") and of the lack of hygiene of the blankets provided ("I was given a dirty blanket"; "the blankets smell of cell").

Full body search

Almost all the detainees stated that they had been given a full body search before entering the cells, although they raised no complaint as to having felt uncomfortable or been humiliated by this practice ("I was searched in the toilets and it was a full body search so that I had to take off all my clothes by parts"; "I was given a full body search, had to pull down my boxers and do sit ups"; "a woman searched me and made me take off my jacket, T-shirt, trousers and panties and I had to do sit ups").

Treatment given to detainees

Although most interviewed persons stated that the treatment received from the officers, both at the time of their detention and during their stay in the cells, had been correct, some of them raised complaints for purported ill-treatment or mistreatment. Thus, one detainee interviewed at the CNP Ciudad Lineal District Station (Madrid), stated that his treatment had been correct, except from two women officers who insulted him at the station, saying: "If this one were not here (referring to another detainee who was present), you would have it from me". Another detainee, interviewed at the CNP Madrid Centro District station, stated that he had been a victim of purported ill-treatment, at the time of his detention and subsequently at the police station. This person's lawyer filed a complaint before this Institution which is stayed, pursuant to article 17.2 of Basic Law 3/1981, of 6 April, regulating this Institution, since a court proceeding is being conducted for the same facts. One woman detainee interviewed at the Central Registry of Detainees of Madrid, stated that she had been the victim of purported ill-treatment during her detention, showed the marks left where she had been hit and permitted them to be photographed. This was subsequently conveyed to the Security and Justice Area of this Institution, and the relevant action was taken ex officio. The Directorate General for the Police reported that the detainee had refused a medical check-up as recorded in the medical certificate issued by the practitioner himself.

Subsequently, when statement was taken from her in the presence of her lawyer, she expressed her wish to receive medical assistance, although she finally rejected her transfer to the medical centre. The relevant police investigation of the facts was conducted and referred to the Duty Court of Investigation of Madrid. Accordingly, the action was deemed concluded, pursuant to article 17 of Basic Law 3/1981, of 6 April, Ombudsman Law.

Situation of deprivation of liberty

II. Mean-term deprivation of liberty
§ 35 - § 79

II.1. Detention centres for foreign nationals

35. Detention centres for foreign nationals (*centros de internamiento de extranjeros* – "CIE") are non-penitentiary public establishments, where foreign nationals pending processing or execution of their expulsion or repatriation are admitted. They are not of a penitentiary nature and both authorisation for admission and detention, for a maximum duration of 60 days, are subject to court control.

CIEs are not of a penitentiary nature

According to the Ministry of Interior, in 2013, a total 3,237 irregular entries took place.

3,237 irregular entries

Tabla 28
Irregulars entries through non-enabled border posts in 2013

POSTS	2013
Ceuta	351
Melilla	257
Islas Canarias	196
Península	2.433
Illes Balears	0
TOTAL	3.237

Source: Own preparation based on data taken from the website of the Ministry of Interior.

36. In respect of detentions with confinement in cells of foreign nationals for infringement of the Foreign Nationals Law, according to the information made available by the Directorate General for the Police, in 2013, 49,406 detentions were made, 17.07% less than those made in 2012, i.e., 59,575.

49,406 detentions with confinement in cells

Table 29

Detentions with confinement in cells for infringement of the Foreign Nationals Law made by the CNP in terms of autonomous communities and cities and provinces in 2013

AUTONOMOUS COMMUNITIES AND CITIES	PROVINCES	NO. OF DETAINEES
Andalusia		8,061
	Almería	1,472
	Cádiz	2,245
	Córdoba	256
	Granada	1,182
	Huelva	213
	Jaén	183
	Málaga	1,801
	Seville	709
Aragon		702
	Huesca	99
	Teruel	58
	Zaragoza	545
Principality of Asturias		349
Balearic Islands		514
Canary Islands		476
	Las Palmas	309
	Santa Cruz de Tenerife	167
Cantabria		396
Castile-La Mancha		1,138
	Albacete	249
	Ciudad Real	323
	Cuenca	129
	Guadalajara	48
	Toledo	389
Castile and Leon		1,264
	Ávila	105
	Burgos	200
	León	229
	Palencia	230
	Salamanca	235
	Segovia	56
	Soria	50
	Valladolid	117
	Zamora	42
Catalonia		5,975
	Barcelona	4,571
	Girona	743
	Lleida	252
	Tarragona	409
Ceuta		4,836

Table 29

Detentions with confinement in cells for infringement of the Foreign Nationals Law made by the CNP in terms of autonomous communities and cities and provinces in 2013

AUTONOMOUS COMMUNITIES AND CITIES	PROVINCES	NO. OF DETAINEES
Autonomous Community of Valencia		3,882
	Alacant / Alicante	1,885
	Castelló / Castellón	495
	València / Valencia	1,502
Extremadura		265
	Badajoz	182
	Cáceres	83
Galicia		640
	A Coruña	205
	Lugo	119
	Ourense	97
	Pontevedra	219
La Rioja		334
Autonomous Community of Madrid		13,607
Melilla		2,653
Murcia		1,943
Navarre		233
Basque Country		2,138
	Araba/Álava	260
	Gipuzkoa	1,428
	Bizkaia	450
TOTAL GENERAL		**49,406**

Source: Own preparation based on data furnished by the DGP.

9,002 foreign nationals detained in various CIEs, 4,726 of them expelled

37. Of the total 49,406 foreign nationals detained, 9,002 were held in the various CIEs, as shown in tables 29 and 30. Of the total 9,002 interned foreign nationals, 4,726 were expelled, although their holding is intended to ensure the effective repatriation of foreign nationals, as shown in the following table. This means that 47.51% of the foreign nationals detained in 2013 were not expelled, a figure similar to that for 2012. The cases of the CIE of Tenerife, with an increase of more than 67%, and of the CIE of Valencia, with a 17% reduction are to be pointed out.

Table 30
Expulsion of foreign nationals detained in CIEs in 2013

CIE	NUMBER DETAINED	NUMBER EXPELLED	PERCENTAGE
Algeciras	2,484	983	39.57
Barcelona	1,584	744	46.96
Las Palmas	212	56	26.41
Madrid	2,694	1,599	59.35
Murcia	1,013	674	66.53
Tenerife	99	87	87.87
Valencia	916	583	63.64
TOTAL	**9,002**	**4,726**	**52.49**

Source: Own preparation based on data furnished by the DGP.

Table 31
Foreign nationals detained in CIEs in 2013

CIE ALGECIRAS			
NATIONALITY	TOTAL	MEN	WOMEN
ALBANIA	9	7	2
ANGOLA	1	0	1
ALGERIA	72	69	3
ARGENTINA	6	4	2
ARMENIA	2	2	0
AUSTRALIA	2	1	1
BANGLADESH	3	3	0
BELARUS	1	1	0
BOLIVIA	22	16	6
BOSNIA-HERZEGOVINA	3	3	0
BRAZIL	16	7	9
BURKINA FASO	43	43	0
BURUNDI	3	3	0
CAMEROON	225	199	26
CHAD	249	241	8
CHILE	3	2	1
CHINA	9	6	3
COLOMBIA	20	17	3
IVORY COAST	31	28	3
CROATIA	1	0	1
CUBA	2	2	0
ECUADOR	6	6	0

NATIONALITY	TOTAL	MEN	WOMEN
EGYPT	1	1	0
ERITREA	3	2	1
U.S.A.	2	2	0
ETHIOPIA	3	3	0
GABON	6	6	0
GAMBIA	23	22	1
GEORGIA	8	8	0
GHANA	37	33	4
GUINEA	114	110	4
GUINEA BISSAU	54	54	0
EQUATORIAL GUINEA	1	0	1
HONDURAS	2	2	0
INDIA	5	5	0
IRAN	8	3	5
KAZAKHSTAN	2	2	0
KENYA	7	4	3
LIBERIA	16	16	0
LIBYA	3	3	0
LITHUANIA	1	1	0
MALAWI	4	4	0
MALI	294	290	4
MOROCCO	778	756	22
MAURITANIA	8	8	0
MOLDAVIA	4	4	0
NICARAGUA	1	1	0
NIGER	18	18	0
NIGERIA	49	36	13
COUNTRY UNKNOWN	2	1	1
PAKISTAN	7	7	0
PARAGUAY	20	13	7
PERU	5	4	1
CENTRAL AFRICAN REPUBLIC	18	14	4
BENIN REPUBLIC	5	4	1
CONGO REPUBLIC	24	20	4
DEMOCRATIC CONGO REPUBLIC	24	20	4
DOMINICAN REPUBLIC	6	2	4
RWANDA	4	4	0
RUSSIA	7	3	4
SENEGAL	66	63	3
SERBIA	2	2	0
SIERRA LEONE	17	17	0
SYRIA	1	1	0

NATIONALITY	TOTAL	MEN	WOMEN
SOMALIA	19	19	0
SRI LANKA	1	1	0
SOUTH AFRICA	2	2	0
SUDAN	32	31	1
TANZANIA	1	1	0
TOGO	20	19	1
TUNISIA	2	2	0
TURKEY	1	1	0
UKRAINE	16	16	0
UGANDA	8	8	0
URUGUAY	1	0	1
VENEZUELA	2	1	1
VIETNAM	1	1	0
YEMEN	1	1	0
YUGOSLAVIA	1	1	0
ZAMBIA	2	2	0
ZIMBABWE	4	4	0
TOTAL	**2,484**	**2,324**	**160**
CIE BARCELONA			
ALBANIA	19	19	0
ANGOLA	7	7	0
ALGERIA	287	287	0
ARGENTINA	8	8	0
ARMENIA	4	4	0
BANGLADESH	4	4	0
BOLIVIA	35	35	0
BOSNIA-HERZEGOVINA	8	8	0
BRAZIL	11	11	0
BURKINA FASO	9	9	0
BURUNDI	1	1	0
CAMEROON	30	30	0
CHAD	17	17	0
CHILE	14	14	0
CHINA	12	12	0
COLOMBIA	20	20	0
COMOROS	4	4	0
IVORY COAST	12	12	0
CROATIA	2	2	0
CUBA	1	1	0
ECUADOR	35	35	0
EL SALVADOR	2	2	0

NATIONALITY	TOTAL	MEN	WOMEN
PHILIPPINES	2	2	0
GABON	13	13	0
GAMBIA	20	20	0
GEORGIA	22	22	0
GHANA	13	13	0
GUATEMALA	1	1	0
GUINEA	86	86	0
GUINEA BISSAU	25	25	0
EQUATORIAL GUINEA	1	1	0
HONDURAS	14	14	0
INDIA	14	14	0
IRAQ	1	1	0
JORDAN	1	1	0
KUWAIT	1	1	0
LEBANON	1	1	0
LIBERIA	2	2	0
LIBYA	2	2	0
MACEDONIA	6	6	0
MALI	132	132	0
MOROCCO	441	441	0
MAURITANIA	1	1	0
MEXICO	7	7	0
MOLDAVIA	3	3	0
MONTENEGRO	1	1	0
NEPAL	2	2	0
NICARAGUA	1	1	0
NIGER	7	7	0
NIGERIA	18	18	0
NETHERLANDS	1	1	0
PAKISTAN	36	36	0
PALESTINE	4	4	0
PARAGUAY	10	10	0
PERU	13	13	0
CENTRAL AFRICAN REPUBLIC	18	18	0
CONGO REPUBLIC	3	3	0
DOMINICAN REPUBLIC	23	23	0
RWANDA	2	2	0
RUMANIA	1	1	0
RUSSIA	2	2	0
SAHARA	1	1	0
SENEGAL	44	44	0
SERBIA	10	10	0

NATIONALITY	TOTAL	MEN	WOMEN
SIERRA LEONE	3	3	0
SOMALIA	6	6	0
TANZANIA	1	1	0
TOGO	5	5	0
TUNISIA	2	2	0
UKRAINE	7	7	0
UGANDA	1	1	0
URUGUAY	1	1	0
VENEZUELA	10	10	0
TOTAL	**1,584**	**1,584**	**0**
CIE LAS PALMAS			
ALGERIA	3	3	0
ARGENTINA	1	1	0
BRAZIL	1	1	0
CABO VERDE	1	1	0
CAMEROON	1	1	0
CHAD	3	3	0
CHILE	2	1	1
CHINA	4	4	0
COLOMBIA	8	7	1
IVORY COAST	3	3	0
GAMBIA	2	2	0
GHANA	11	11	0
GUATEMALA	1	1	0
GUINEA	4	4	0
GUINEA BISSAU	1	1	0
HONDURAS	1	1	0
KENYA	1	1	0
LIBERIA	3	2	1
MALI	36	35	1
MOROCCO	98	93	5
MAURITANIA	1	1	0
NIGERIA	4	2	2
PAKISTAN	1	1	0
SENEGAL	6	6	0
SERBIA	4	4	0
SYRIA	8	6	2
VENEZUELA	3	2	1
TOTAL	**212**	**198**	**14**

NATIONALITY	TOTAL	MEN	WOMEN
CIE MADRID			
AFGHANISTAN	2	2	0
ALBANIA	22	22	0
ANGOLA	12	7	5
STATELESS	1	1	0
ALGERIA	76	75	1
ARGENTINA	14	10	4
ARMENIA	4	4	0
BANGLADESH	38	38	0
BENIN	1	1	0
BYELORUSSIA	1	1	0
BOLIVIA	70	65	5
BOSNIA-HERZEGOVINA	13	6	7
BOTSWANA	1	1	0
BRAZIL	41	24	17
BULGARIA	1	1	0
BURKINA FASO	11	11	0
CABO VERDE	3	3	0
CAMEROON	47	42	5
CANADA	1	1	0
CHAD	31	31	0
CHILE	17	14	3
CHINA	66	59	7
COLOMBIA	151	140	11
COMOROS	4	1	3
IVORY COAST	15	14	1
COSTA RICA	4	1	3
CROATIA	6	0	6
CUBA	10	6	4
ECUADOR	88	84	4
EGYPT	1	1	0
EL SALVADOR	9	8	1
ERITREA	1	0	1
SLOVAKIA	1	1	0
U.S.A.	5	5	0
ETHIOPIA	2	2	0
PHILIPPINES	4	4	0
GABON	10	10	0
GAMBIA	30	30	0
GEORGIA	25	24	1
GHANA	48	43	5
GUATEMALA	4	3	1

NATIONALITY	TOTAL	MEN	WOMEN
GUINEA	70	69	1
GUINEA BISSAU	41	41	0
EQUATORIAL GUINEA	22	14	8
HONDURAS	11	9	2
HUNGARY	1	1	0
INDIA	13	13	0
IRAQ	3	3	0
IRAN	4	3	1
ISRAEL	1	0	1
ITALY	4	4	0
JAMAICA	2	2	0
KENYA	4	3	1
LEBANON	3	3	0
LIBERIA	16	16	0
LITHUANIA	2	2	0
MALI	115	115	0
MOROCCO	533	528	5
MAURITANIA	9	9	0
MEXICO	15	14	1
MOLDAVIA	8	6	2
MOZAMBIQUE	1	1	0
MYANMAR	1	1	0
NEPAL	1	1	0
NICARAGUA	10	8	2
NIGER	19	16	3
NIGERIA	197	155	42
COUNTRY UNKNOWN	7	5	2
PAKISTAN	60	60	0
PALESTINE	4	4	0
PANAMA	1	1	0
PARAGUAY	48	29	19
PERU	28	26	2
POLAND	3	3	0
PORTUGAL	1	1	0
UNITED KINGDOM	2	2	0
CENTRAL AFRICAN REPUBLIC	9	6	3
CZECH REPUBLIC	2	2	0
BENIN REPUBLIC	1	0	1
CONGO REPUBLIC	9	7	2
CONGO DEMOCRATIC REPUBLIC	5	5	0
DOMINICAN REPUBLIC	80	67	13
RWANDA	2	2	0

NATIONALITY	TOTAL	MEN	WOMEN
RUMANIA	66	62	4
RUSSIA	19	11	8
SAHARA	1	1	0
SENEGAL	212	211	1
SERBIA	20	19	1
SIERRA LEONE	12	9	3
SOMALIA	3	3	0
SRI LANKA	2	2	0
SOUTH AFRICA	1	1	0
SUDAN	10	8	2
SURINAM	1	1	0
TOGO	2	2	0
TUNISIA	11	10	1
TURKEY	1	1	0
UKRAINE	32	30	2
UGANDA	3	3	0
URUGUAY	5	4	1
VENEZUELA	28	20	8
VIETNAM	2	2	0
YUGOSLAVIA	1	1	0
ZAMBIA	1	1	0
ZIMBABWE	2	1	1
TOTAL	**2,694**	**2,456**	**238**
CIE MURCIA			
ALBANIA	2	2	0
ALGERIA	493	493	0
ARGENTINA	2	2	0
BANGLADESH	1	1	0
BENIN	1	1	0
BOLIVIA	15	15	0
BRAZIL	1	1	0
BULGARIA	1	1	0
BURKINA FASO	5	5	0
CAMEROON	6	6	0
CHAD	5	5	0
CHINA	3	3	0
COLOMBIA	12	12	0
IVORY COAST	8	8	0
COSTA RICA	1	1	0
ECUADOR	20	20	0
EGYPT	2	2	0

NATIONALITY	TOTAL	MEN	WOMEN
GABON	6	6	0
GAMBIA	9	9	0
GEORGIA	1	1	0
GHANA	6	6	0
GUATEMALA	1	1	0
GUINEA	6	6	0
GUINEA BISSAU	6	6	0
EQUATORIAL GUINEA	1	1	0
INDIA	4	4	0
LIBERIA	3	3	0
MACEDONIA	3	3	0
MALAYSIA	1	1	0
MALAWI	2	2	0
MALI	10	10	0
MOROCCO	274	274	0
MAURITANIA	3	3	0
MEXICO	1	1	0
NICARAGUA	1	1	0
NIGER	4	4	0
NIGERIA	4	4	0
PAKISTAN	3	3	0
PALESTINE	1	1	0
PARAGUAY	2	2	0
CONGO REPUBLIC	1	1	0
DOMINICAN REPUBLIC	4	4	0
RUMANIA	5	5	0
RUSSIA	3	3	0
SENEGAL	34	34	0
SERBIA	1	1	0
SIERRA LEONE	5	5	0
SOMALIA	10	10	0
SUDAN	7	7	0
TUNISIA	3	3	0
UKRAINE	4	4	0
UGANDA	1	1	0
URUGUAY	2	2	0
YUGOSLAVIA	2	2	0
ZIMBABWE	1	1	0
TOTAL	**1,013**	**1,013**	**0**
CIE TENERIFE			
ALBANIA	2	2	0

NATIONALITY	TOTAL	MEN	WOMEN
ALGERIA	2	2	0
ARGENTINA	1	1	0
AFGHANISTAN	1	1	0
BANGLADESH	1	1	0
BENIN	1	0	1
BOLIVIA	1	1	0
BRAZIL	4	4	0
BURKINA FASO	5	5	0
COLOMBIA	2	1	1
IVORY COAST	2	2	0
GAMBIA	3	3	0
GUINEA	12	12	0
GUINEA BISSAU	1	1	0
EQUATORIAL GUINEA	1	0	1
MALI	15	15	0
MOROCCO	10	10	0
MAURITANIA	2	2	0
MEXICO	1	1	0
MONTENEGRO	1	1	0
NICARAGUA	1	0	1
NIGERIA	11	7	4
COUNTRY UNKNOWN	1	0	1
PARAGUAY	1	1	0
SENEGAL	12	12	0
UKRAINE	1	1	0
UGANDA	1	0	1
URUGUAY	1	1	0
VENEZUELA	2	1	1
TOTAL	**99**	**88**	**11**
CIE VALENCIA			
ALBANIA	10	8	2
ANGOLA	1	1	0
ALGERIA	221	215	6
ARGENTINA	7	6	1
ARMENIA	5	4	1
AZERBAIJAN	1	1	0
BANGLADESH	2	2	0
BELGIUM	1	1	0
BENIN	1	1	0
BOLIVIA	36	29	7
BOSNIA-HERZEGOVINA	5	1	4

NATIONALITY	TOTAL	MEN	WOMEN
BRAZIL	18	8	10
BULGARIA	4	3	1
BURKINA FASO	2	2	0
CABO VERDE	1	1	0
CAMEROON	11	9	2
CHAD	9	9	0
CHILE	8	6	2
CHINA	20	11	9
COLOMBIA	47	42	5
COMOROS	1	0	1
IVORY COAST	6	6	0
CROATIA	5	4	1
CUBA	2	1	1
ECUADOR	34	31	3
GABON	2	2	0
GAMBIA	4	4	0
GEORGIA	6	6	0
GHANA	11	10	1
GUATEMALA	1	0	1
GUINEA	5	5	0
GUINEA BISSAU	3	2	1
EQUATORIAL GUINEA	9	8	1
HONDURAS	4	2	2
INDIA	12	12	0
IRAN	1	1	0
ITALY	2	2	0
KAZAKHSTAN	1	0	1
LEBANON	1	1	0
LIBERIA	4	4	0
MACEDONIA	1	1	0
MALI	12	11	1
MOROCCO	159	148	11
MAURITANIA	2	2	0
MOLDAVIA	4	4	0
NEPAL	4	4	0
NIGER	1	1	0
NIGERIA	33	18	15
NEW ZEALAND	1	1	0
COUNTRY UNKNOWN	1	1	0
PAKISTAN	42	42	0
PARAGUAY	5	2	3
PERU	2	2	0

POLAND	1	1	0
PORTUGAL	1	1	0
CENTRAL AFRICAN REPUBLIC	6	5	1
CONGO DEMOCRATIC REPUBLIC	1	1	0
DOMINICAN REPUBLIC	4	3	1
RWANDA	1	1	0
RUMANIA	22	20	2
RUSSIA	11	10	1
SENEGAL	30	30	0
SERBIA	13	11	2
SIERRA LEONE	2	2	0
SOMALIA	4	2	2
SOUTH AFRICA	1	1	0
SUDAN	3	3	0
TUNISIA	1	1	0
TURKEY	2	2	0
UKRAINE	15	12	3
URUGUAY	4	3	1
VENEZUELA	2	2	0
YUGOSLAVIA	1	1	0
TOTAL	**916**	**810**	**106**

Source: Own preparation based on data furnished by the DGP.

Regulation on the operation and internal regime of CIEs

38. The Regulation on the operation and internal regime of centres for detention of foreign nationals (Reglamento de funcionamiento y régimen interior de los centros de internamiento de extranjeros), passed by Royal Decree 162/2014, of 14 March, was published in the BOE of 15 March 2014, so that it will be necessary to wait for the Directorate General for the Police to adopt the appropriate measures and provide the material and human means necessary to comply with the provisions of this Regulation, within one year after it enters into force, pursuant to its Single Interim Provision.

Increase of economic resources

In this respect, the Ministry of the Interior reports in its website that it increased the economic resources allocated to centres of this kind, to improve both their facilities and the services for their operation. To the 8.8 million euros per year for operating expenses of the current centres for the detention of foreign nationals (not including personnel remuneration expenses), a further three million euros will be added to reinforce the services of interpreters, healthcare and social services and miscellaneous supplies: personal care kits, pharmaceutical products, etc. It is also intended to make in the short term an investment of 2.56 million euros to improve and adapt the units, leisure areas and equipment of CIEs.

Possibility of Community financing

Lastly, it is reported that the policy dialogue between Spain and European Commission, within the Multi-annual Financial Framework of

the European Union for Internal Affairs for the 2014-2020 period, also contemplates the possibility of community financing to improve and modernise Centres for Detention of Foreign Nationals, and to sustain their operation.

CIE visited

39. In 2013 the CIEs of Barcelona, Madrid, Murcia, Tarifa (Cádiz) and Valencia were visited. These CIEs were visited in previous years, but it was considered necessary to follow up those visits to verify compliance with the recommendations made and identify eventual new deficiencies.

Chart 4
Geographical location of CIEs visited in 2013

Participation of the Ombudsman in the visits

40. The Ombudsman participated personally in two of the visits made to CIE, specifically those of Tarifa (Cádiz) and Valencia. These were follow-up visits the purpose of which was to convey, on site, to the responsible authorities, the conclusions drawn at the last inspection visits. The visit to the CIE of Barcelona was made after the death of one detainee. Another two visits, those made to Madrid and Murcia, were multidisciplinary, at which one external technical expert, specialised in legal and forensic medicine participated, since one of the objectives of these visits was to study and assess in depth the healthcare services provided at these centres.

Same methodology

The methodology followed during the visits, to analyse in depth such healthcare services, is the same as that used in the visits made in previous years to other CIEs, explained in paragraph 47 of Annual Report 2012.

Cases of unsuccessful expulsion

41. At the visits made, cases of detainees that it had been attempted to expel unsuccessfully were analysed, either holding interviews with the interested parties themselves, or reviewing their clinical records. At the CIE of Madrid, one of these cases had to be investigated during the visit made to it and, although the detainee had already been expelled, his clinical record was examined in which various medical reports were observed. The first of them recorded: “He is returned since he did not fly. He denies any aggression. He is on good state”. A second report, issued by the medical service of the CIE and addressed to the director of the centre, after a new failed attempt of expulsion, records: “Detainee (...) with number (...) returns from the airport stating that he was hit by various officers. Lacerations, erosions, all of them on his left ankle, knuckles and food and another bump on his left cheek are observed”. Subsequently, the detainee was referred to Hospital 12 de Octubre for a check-up. The report sent to said Hospital records: “Patient..., who says he was hit by various police officers to put him in the aircraft in which he should fly to his country the day before yesterday and has a bruise that we verified today. We thus request you to consider making an echography to search for a kidney hematoma”. The relevant action was instituted by the Migrations and Equal Treatment Department of the Ombudsman’s Office was instituted for these facts and the proceeding is currently in progress.

Lack of leisure or sports material, lack of communication with lawyers, little time for visits

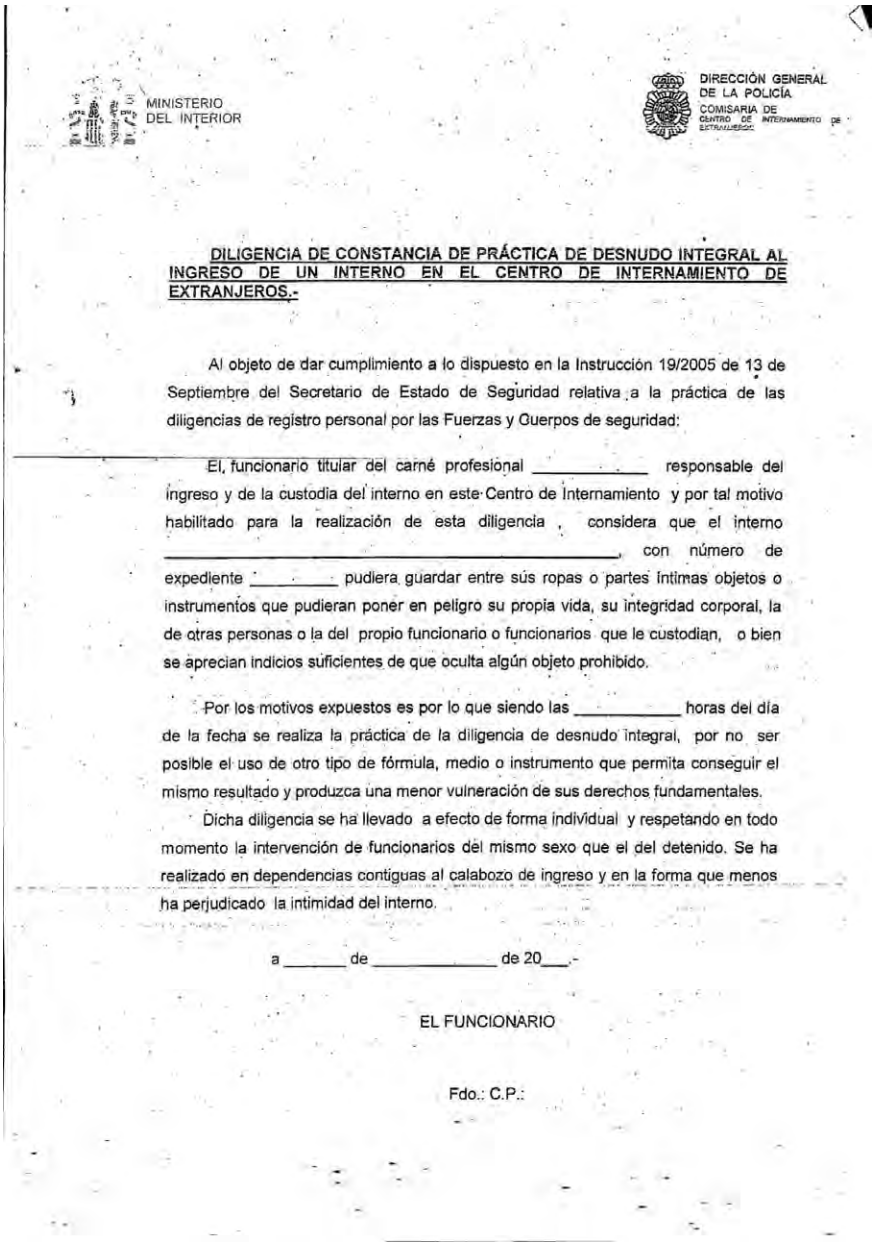
42. At the personal interviews held with detainees during the visits, the most widespread complaints referred to the lack of leisure or sports material; lack of communication with their lawyers; food; the little time they had for visits and the fact that they were not permitted to make physical contact with family relatives, particularly in cases in which children were involved. In respect of the treatment received from officers, most of them had no complaints for physical ill-treatment although they did mention incorrect oral treatment from certain officers. At the CIE of Murcia, one of the general complaints was the difficulty encountered by detainees to file complaints, since they were lacking paper or pen and some of them even mentioned that they were not allowed to deposit their complaints in a box enabled for the purpose and were instead obliged to deliver their complaints to the officer, and the difficulty to access the medical surgery, so that it would be necessary to report more exhaustively the manner in which to access medical consultation, either through the medical practitioner at the initial check-up, or, through the police authorities, in the general information provided to them on arrival at the CIE.

Complaints for body searchers

43. In respect of body searches, complaints continued to be received on the matter, such as those of the CIE of Murcia, since certain detainees considered them to be humiliating. In the personal records of the internees of any CIE, a form exists, which is the same for all detainees, both men and women, and in which only the sections related to the officer completing it, in the name of the detainee, the name of the detainee, his record number and the time and date on which it is issued, are completed. The specific

grounds required for the purpose, established by STC 17/2013, of 31 January, mentioned in paragraph 50 of Annual Report 2012, are not observed in these documents, since they are printed: “He considers that the detainee may keep in his clothes or intimate garments objects or instruments that could jeopardise his own life or physical safety or that of other persons or of the officer(s) keeping him in custody, or sufficient indications are observed that he conceals some prohibited object”.

Previously printed form for nude searches



MINISTERIO DEL INTERIOR

DIRECCIÓN GENERAL DE LA POLICÍA
COMISARIA DE
CENTRO DE INTERNAMIENTO DE EXTRANJEROS

DILIGENCIA DE CONSTANCIA DE PRÁCTICA DE DESNUDO INTEGRAL AL INGRESO DE UN INTERNO EN EL CENTRO DE INTERNAMIENTO DE EXTRANJEROS.-

Al objeto de dar cumplimiento a lo dispuesto en la Instrucción 19/2005 de 13 de Septiembre del Secretario de Estado de Seguridad relativa a la práctica de las diligencias de registro personal por las Fuerzas y Cuerpos de seguridad:

El, funcionario titular del carné profesional _____ responsable del ingreso y de la custodia del interno en este Centro de Internamiento y por tal motivo habilitado para la realización de esta diligencia, considera que el interno _____, con número de expediente _____ pudiera guardar entre sus ropas o partes íntimas objetos o instrumentos que pudieran poner en peligro su propia vida, su integridad corporal, la de otras personas o la del propio funcionario o funcionarios que le custodian, o bien se aprecian indicios suficientes de que oculta algún objeto prohibido.

Por los motivos expuestos es por lo que siendo las _____ horas del día de la fecha se realiza la práctica de la diligencia de desnudo integral, por no ser posible el uso de otro tipo de fórmula, medio o instrumento que permita conseguir el mismo resultado y produzca una menor vulneración de sus derechos fundamentales.

Dicha diligencia se ha llevado a efecto de forma individual y respetando en todo momento la intervención de funcionarios del mismo sexo que el del detenido. Se ha realizado en dependencias contiguas al calabozo de ingreso y en la forma que menos ha perjudicado la intimidad del interno.

a _____ de _____ de 20___.-

EL FUNCIONARIO

Fdo.: C.P.:

Compliance with recommendations

44. Since August 2012, the medical assistance of the various CIEs is provided by CLÍNICA MADRID. The two multidisciplinary visits had the purpose of verifying whether said company had established clear protocols of action in accordance with the recommendations made by this Institution at previous visits to other CIEs.

No permanent healthcare service

45. It has been verified that no permanent healthcare service is organised, to ensure medical and DUE attention in an ongoing manner,

according to the criterion established in paragraph 53 of Annual Report 2012. Thus, at the CIE of Murcia, the medical practitioner's timetable is from 8:30 to 14:30 h., from Monday to Friday, and he is on call the rest of the time, including Saturdays, Sundays and public holidays. The time during which a DUE remains at the centre is from 8:00h. to 22:00h. from Monday to Friday, and these professionals do not remain on call. At the CIE of Madrid, the timetable of the two medical practitioners is from 8:00. to 22:00h. from Monday to Friday on two shifts: one morning shift from 8:00h. to 15:00h., and another afternoon shift from 15:00h. to 22:00h.. On Saturdays, Sundays and public holidays their timetable is from 10:00. to 13:00h. DUEs cover a timetable from 8:00h. to 22:00h. every day of the week, including public holidays.

Lack of safeguard of adequate specialised assistance

46. Neither have the necessary arrangements been agreed to ensure adequate specialised assistance, including psychological, psychiatric and dental healthcare, according to paragraph 54 of Annual Report 2012.

Absence of record of requests for healthcare

47. There is no record of requests for healthcare or of the appointments scheduled by the healthcare services, according to the criterion established in paragraph 57 of Annual Report 2012.

Right to privacy in medical consultations

48. The necessary measures have not been adopted at the medical surgeries to ensure the right to privacy of the detainee, permitting the door of access to the surgery to remain closed.

Clinical record

49. The clinical record of the detainees is not adapted to the model contemplated by Law 41/2002, in accordance with the criterion established in paragraph 56 of Annual Report 2012.

Suggestion for performance of tests

50. In addition, since no tests are made to detect the consumption of toxic substances or the existence of infectious diseases, as soon as possible after the visit to the CIE of Madrid, a Suggestion was remitted for such tests to be made. The DGP reported that whether such tests should be made is left at the discretion of the medical practitioner, after the check-up made upon the first admission of a detainee.

Communication difficulties due to language

51. Language continues to be an obstacle to the fluid communication between the healthcare services and the detainees demanding medical attention, according to the criterion established in paragraph 92 of Annual Report 2011.

Recommendation for specific suicide prevention program

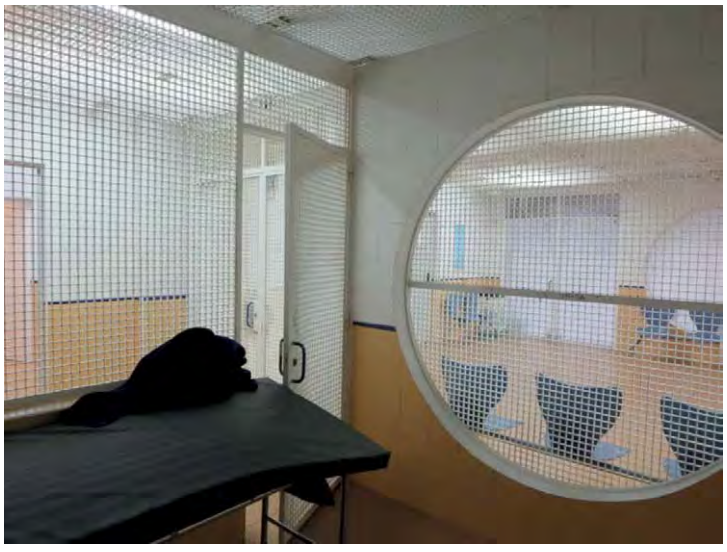
52. In respect of the establishment of a specific program for the prevention of suicides, mentioned in paragraph 54 of Annual Report 2012, a Recommendation was made, due to the visit to the CIE of Barcelona, after the death of one detainee. The DGP reported that an Instruction had been issued to the General Headquarters for Foreign Nationals and Borders, related to the measures of action for the prevention of suicides at these centres.

Institution of a proceeding due to death of a detainee

During the visit the administrative record of the deceased detainee was consulted in addition to his medical record, information was obtained from the officers, various detainees were interviewed, among them those who spent the night in the same cell as the deceased and the recordings of the room where he was provisionally separated and where the fact causing the death took place were requested.

All the above caused the institution of a proceeding at the Migrations and Equal Treatment Department of this Institution, which is currently in progress.

Room for temporary separation at the CIE of Barcelona



Picture of the room on the video-surveillance screen

Injuries are not photographed

53. As regards the description of the injuries, the same deficiencies recorded in paragraph 55 of Annual Report 2012 were verified, without the decision having been made to photograph the injuries and attach the photographs to the court record.

Remittance of injury reports to the duty court

54. We have knowledge, in view of the answer given by the Government to a written question of two members of the Higher House, that professional records issued to the detainees, at the CIE of Barcelona, recording any injury, of any kind, are sent to the duty court of Barcelona, as was pointed out in paragraph 58 of Annual Report 2012.

Cohabitation in the same CIE

55. The fact that foreign nationals who will be expelled from national territory, some of them from prison and others due to their mere irregular stay in Spain, live together at a single CIE, mentioned in paragraph

59 of Annual Report 2012 has continued to be observed at the visits made in 2013, which it appears will be remedied, as this Institution has been claiming, according to the new regulation.

13,986 repatriations of foreign nationals

56. In 2013 a total 13,986 repatriations of foreign nationals took place, according to the data provided by the Directorate General for the Police, the number of non-qualified expulsions having increased by 6.13%, the number of qualified expulsions having been reduced by 13.93%.

Table 32
Repatriations of foreign nationals in irregular situation in 2012 and 2013

	2012	2013	Difference
Returns*	6,271	5,002	-1,269
Non-qualified expulsions**	1,321	1,402	+81
Qualified expulsions ***	8,809	7,582	-1,227
TOTAL	**16,401**	**13,986**	**-2,415**

Source: Own preparation based on data furnished by the Ministry of the Interior.

* Persons who attempted to enter Spain through non-enabled border posts.

** Persons intercepted in Spain lacking documentation.

*** "The Ministry of the Interior created in 2009 the Brigade of Expulsion of Foreign Offenders of the National Police Force (Brigada de Expulsión de Delincuentes Extranjeros del Cuerpo Nacional de Policía –"BEDEX"), whose mission is the repatriation of foreign offenders with a large number of criminal and/or court criminal records (see paragraph 59), related to terrorism, organised bands, gender violence or any other particularly serious criminal fact and that imply a threat to public security.". This distinction is due to the explanation of the data made available by the Ministry of the Interior.

Provision of social services

57. In respect of the absence of social assistance services mentioned in paragraph 60 of Annual Report 2012, which was observed in all CIEs, other than those of Barcelona and Madrid, the new Regulation contains provisions on the matter, as this Institution had informed the DGP.

Lack of notification to detainees

58. The deficiency pointed out in paragraph 61 of Annual Report 2012, relating to the lack of notification to the detainees of the time when they are to be expelled continues not to be remedied, the General Headquarters for Foreign Nationals and Borders not having unified the criteria applicable to all the centres, based on the Orders of the various Courts having stay control functions.

Suggestions accepted

59. In respect of the video-surveillance system at these Centres, it is repeated that the criterion established in paragraphs 261 and 477 of Annual Report 2010 must be followed. After the visit to the CIE of Madrid, two Suggestions had to be made, which were accepted by the DGP, so that, when any incident occurs, its pictures must be taken ex officio for a person responsible for the centre, duly authorised for the purpose, to be able to view the previously recorded pictures. At the CIE of Murcia, the Suggestion to install cameras at the leisure room of the family unit, where women are usually confined, was accepted.

Unidentified officers

60. At the visit to the CIE of Murcia it was verified that the officers on the morning shift were not identified. Such failure to comply with the duty of identification, mentioned in paragraph 63 of Annual Report 2012, relating to the CIE of Algeciras, must be the subject of an effective disciplinary correction, as this Institution has informed the DGP, whenever it has reported this breach to it.

Suggestions on calls to detainees by megaphone

61. At the CIE of Madrid, a suggestion was made for all officers to be informed in writing and individually that calls to detainees through the megaphone should be made using their name and surname and record number and that the office should record with his signature that such information has been received, which suggestion was accepted by the DGP.

Lack of distribution of brochures on international protection in various languages

62. At the visits made this year, the lack of brochures on international protection in various languages prepared by the Office for Asylum and Refugees (Oficina de Asilo y Refugio –"OAR") continued to be observed, as mentioned in paragraph 64 of Annual Report 2012, and it should be placed on record in writing that the detainee had been offered the possibility of requesting asylum or refuge, stating these circumstances in the record of the detainee. After the visit made to the CIE of Murcia, where it was verified that this information was provided only to detainees who arrived at the Spanish coasts by boat and, only in Arabic, the DGP reported that information on the matter exists in various languages, such as English, French, Arabic, Chinese, Russian or Ukrainian. Nevertheless, the informative summarised forms delivered have been ineffective to date, so that it is essential to modify the current information system and again distribute the explanatory brochures in all languages. In addition, it is considered a priority for all detainees and not only those arriving by boat to be informed of the meaning of international protection, who may request it, etc., until such brochures are published. In this respect, a proceeding was instituted by the Migrations and Equal Treatment Department, of the Ombudsman's Office, and continues to be conducted.

Rooms with a toilet at the CIE of Madrid

63. At the visit made to the CIE in Madrid, it was observed, as mentioned in paragraph 65 of Annual Report 2012, that the necessary renovation works had been performed for all rooms to have a toilet and washbasin, as shown in the following photograph.

Toilet in the dormitories of the CIE of Madrid

Toilets in each dormitory

64. In this respect, as regards the CIE of Barcelona, there is news of the Order of 15 January 2014, of Courts of Investigation nos. 1 and 17 of Barcelona, Legal Ground 7 of which establishes: “It is estimated that the lack of toilets in the dormitories is an architectonic limitation that contravenes the principle of human dignity, since it makes satisfaction of this kind of body need, which is usually urgent and admits no delay, dependent on another person (a police). Because of this, the necessary works must be performed to install toilets in each dormitory”.

Toilets in the leisure room

65. In turn, at the CIE of Madrid, it was verified that renovation works had been performed at the women’s leisure room, providing it with toilets. The same works were observed at the CIE of Murcia, where the leisure rooms also had recently built toilets. Nevertheless, at this CIE, the detainees complained that night access to toilets was not permanent (“at night they do not call the officers to go to the toilet because they do not come and they have to relieve themselves in the washbasin”).

Toilets in the leisure room of the CIE of Murcia

Telephone calls from outside

66. Complaints were also received from detainees in respect of telephone calls from outside. At the CIE of Madrid it was again verified that, at the timetable enabled for the purpose, the telephone of the control room was off the hook, no switchboard having been installed, as the DGP reported at the time. On the other hand, at the CIE of Murcia, no calls from outside were permitted, as they were not permitted either at the CIE of Algeciras, alleging security problems, which was corrected in the new Regulation.

Use of mobile phones without cameras

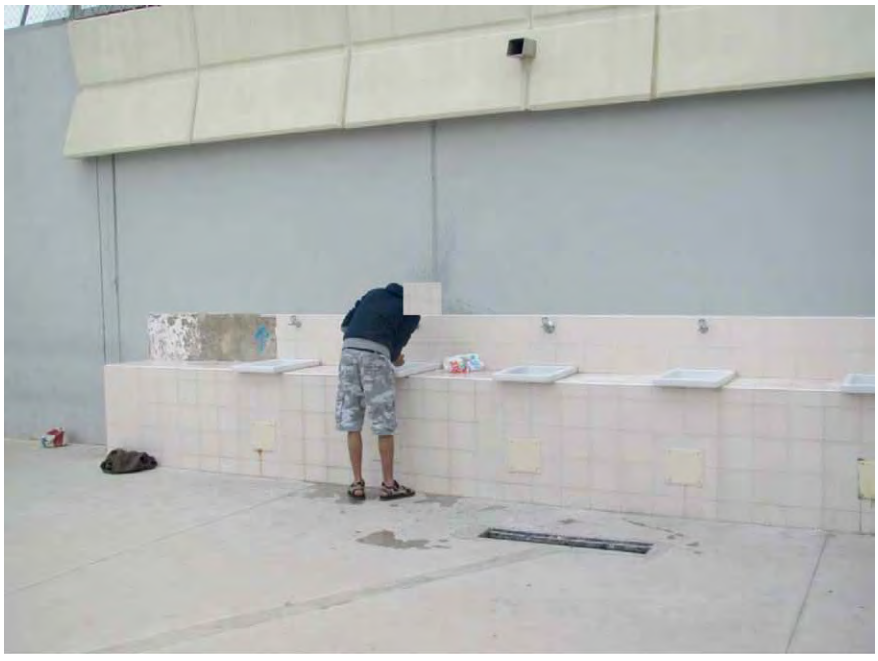
67. Notwithstanding the above, as this Institution was able to verify at certain centres of these features in EU countries, specifically at the visit made to the Administrative Retention Centre (CRA) MESNIL AMELOT of Paris, the use of mobile phones without cameras could be permitted, which would permit detainees both to receive calls from outside and to minimise the cost currently implied for them on buying telephone cards. The use of mobile phones would imply a certain degree of control by the persons responsible for the centre, such as the obligation to return them at the established rest hours or other necessary controls to safeguard the security of certain specific detainees.

Leisure, reading and sports material

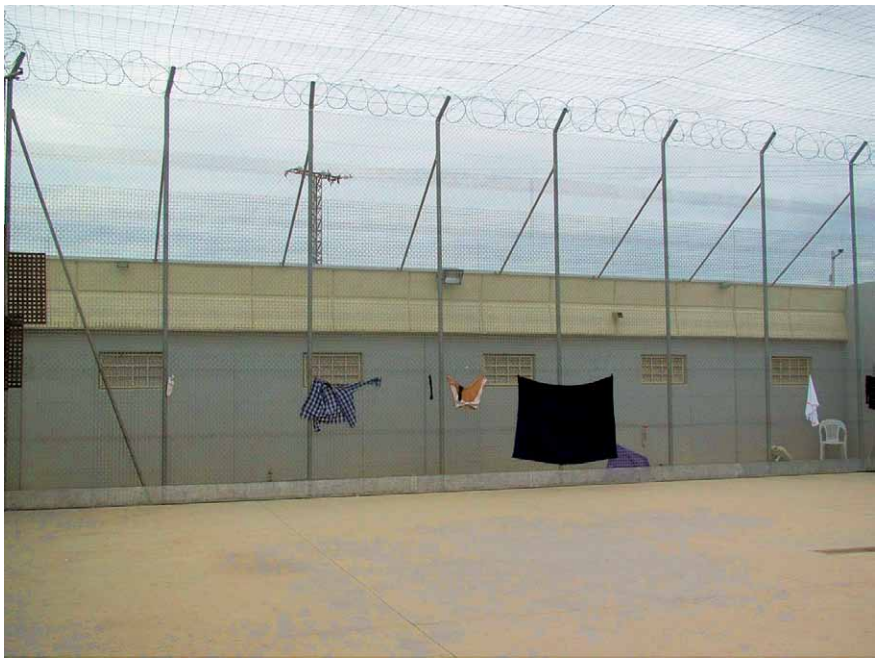
68. It must be pointed out, as this Institution has done, that CIEs should have leisure and reading material, in addition to adequate sports material, given the free time available to detainees, who may remain in hold for up to 60 days, and the complaints as to the lack of activities and training that, in this respect, are received at the visits made to these centres, such as those made by detainees at the CIE of Murcia.

69. The lack of a budgetary heading alleged by the DGP, to acquire a washing machine and drier at the centres lacking them, as is the case of the CIE of Murcia inter alia, causes the detainees to have to wash their own clothes so that the possibility of acquiring these household appliances should be considered, according to the criterion recorded in paragraph 68 of Annual Report 2012, for detainees to be able to maintain the most elementary standards of health and cleanliness, taking into account the time they may have to stay at the centre and that the new Regulation establishes, among the duties of the detainees, that they must maintain adequate standards of tidiness and cleanliness.

Acquisition of a washing machine and drier at centres lacking them



Internee washing his clothes in the basin in the year at the CIE of Murcia



Clothes hung on the fence of the yard of the CIE of Murcia

II.2. Military disciplinary establishments

Arrests of from one month and one day to two months; maximum four-month period

70. At Military Disciplinary Establishments (Establecimientos Disciplinarios Militares –"EDM") members of the Armed Forces may be arrested, for serious infringements, pursuant to article 8 of Basic Law 8/1998 of 2 December on the disciplinary regime of the Armed Forces, for a period between one month and two months although, in the case of two or more joined penalties of arrest, article 69 of said Law establishes that a maximum four months of deprivation of liberty may be imposed

According to the information provided by the Secretary of State for Defence, in 2013, the following arrests took place at the various EDM.

Table 33
Arrests in EDM in 2013

EDMs managed by the Army					EDMs managed by the Air Forces		EDMs managed by the Navy	TOTAL
EDM Centro (Colmenar Viejo, Madrid)	EDM Ceuta	EDM Melilla	EDM Tenerife (San Cristóbal de la Laguna, Santa Cruz de Tenerife)	EDM Las Palmas (Las Palmas de Gran Canaria)	EDM Norte (León)	EDM Las Palmas (Las Palmas de Gran Canaria)	EDM Sur (San Fernando, Cádiz)	
48	26	18	23	11	31	0	20	177

* Source: Own preparation according to data furnished by the Secretary of State for Defence (Ministry for Defence).

Visit

71. In 2013 only the EDM Centre, in Colmenar Viejo (Madrid) was visited, a visit to follow up that made in 2010.

Search of underwear and lack of privacy in telephone calls

72. The inmates stated that they had held a meeting with an army corporal to raise a complaint for the treatment they received from the only two women on the payroll, on considering that they were "ruder than their colleagues and treated them with less respect". The only woman arrested, employed as a soldier, stated that she felt uncomfortable with the body searches made on her, although they only searched her trouser pockets and boots. She also complained of the detailed search of her underwear, although she said that, lately, it was inspected using a scanner. Lastly, the arrestees considered that they were not allowed any privacy in telephone calls, since the custody personnel controlling the switchboard "hung up when they wished and were able to hear the conversations".

Maintenance and cleanliness of the facilities, food and toiletries and bed clothes

73. It was observed that the good state of maintenance and cleanliness of these facilities, observed at the visit made in 2010, continued to be maintained. Likewise, the food, toiletries and bed clothes provided to the detainees were correct. The living conditions were the same as at the previous visit, having access outdoors, and it was observed that adequate leisure material was provided, although, for

budgetary reasons, only one general and one sports newspapers were acquired.

Increase of the number of video cameras

74. In respect of the visit made in 2010, when video cameras only existed for the internal halls of the facilities and the yards, it was observed that the number of cameras had been increased, up to a total 15, recording 24 hours, currently covering all common areas. Black and white image recordings were kept for 15 days and colour recordings only for 12. Any member on service could view and search for images, but only five duly empowered persons were able to extract them.

Healthcare provided to detainees

75. Healthcare services provided to the detainees had not changed since the last visit and were provided by members of the Healthcare Military Corps, two days per week at the EDM and, where appropriate, by medical practitioners of public hospitals or healthcare centres. In emergencies, the 112 service was warned. A dispensary for check-up of detainees was available at the EDM and a medical check-up was made on all detainees upon their arrival at the centre, within a maximum 24 hours and, in the case of pregnant women, the instructions of the medical services were followed, even avoiding confinement in the EDM, suspending service of the penalty.

Visits of family relatives and friends, vis-à-vis meetings

76. Visits of family relatives of detainees are made in a room, at the entrance of the EDM, on a morning and afternoon timetable. Friends may only visit in the afternoons. In respect of vis-à-vis visits, which are not authorised, it may occur that various penalties are joined for serious infringements to be served in an EDM, so that arrestees may have to stay for up to four months. This means that an arrestee may be deprived of liberty for longer than a person who perpetrated a crime; however, the criminal would be entitled to a vis-à-vis visit on serving sentence at a military prison, in an area enabled for the purpose. For that purpose, since visits of this kind are not specifically prohibited by Ministerial Order 97/1993, the Ministry for Defence was requested to include this possibility in the Book of Internal Regulations. Said Ministry reported that it was waiting to receive the report from the legal services on the amendment to the law, and the report to adapt the facilities as recommended.

Conditions in which body searches are carried out

77. In respect of body searches, although it is considered that this practice is duly regulated by article 10 of Basic Law 9/2011, on rights and duties of members of the Armed Forces, the Book of Internal Regulations should specify the cases in which it is appropriate and the person who should perform them, pending amendment of the report of the legal services of the Ministry for Defence

Rights to inmates on admission to the centre

78. On entering the centre inmates are adequately informed of their rights and of the living and social rules of the centre. The relevant procedure for the filing of complaints, suggestions or requests is made available to the arrestees, which are referred through the statutory channels to the director of the centre for verification and answer, providing a receipt of their submission with the relevant record number. If necessary, complaints are referred to a higher instance.

On examining the personal records it was verified, firstly, that it is ensured that complaints of inmates are attended within the interpretation possibilities of legislation in force and that fast answers are given to requests and complaints.

Regulation of the use of mobile phones

79. At the various EDM visited by the NPM various practices were verified relating to the use of mobile phones by inmates. Thus, at EDM Norte, their use was authorised by way of exception particularly to communicate with countries of South America. At the EDM of Tenerife, their use is authorised when booths are not working or by way of exception; calls are made at the leisure room of security officers and the phone is delivered switched off when the call ends. At EDM Centro, access is permitted for the mere purposes of consulting the numbers on the directory. In turn, article 10.2 of Ministerial Order 97/1993 establishes that communications must be made through the switchboard operator. Accordingly, the Book of Internal Regulations should specify that the mobile phone may be accessed, at least, for the interested party to obtain the numbers kept in the phone even if the call is later made through the switchboard operator. This also occurs in exceptional cases authorised by the superior or due to breakdown of the telephone switchboard.

Telephone communication system safeguarding the right to privacy

Also, during the visit to EDM Centro it was verified that the technical system, in which telephone calls are made through the switchboard, might not preserve the privacy of such calls, if the switchboard operator so wishes. Accordingly, a communication system should be established that duly safeguards privacy in the communications. In both cases, the Ministry for Defence reported that it was waiting for the report of the legal services, on the legislative amendment to the Book of Internal Regulations, and that a change of legislation should be considered to regulate telephone communications for the purposes of compliance with the recommendation made by this Institution.

Situation of deprivation of liberty

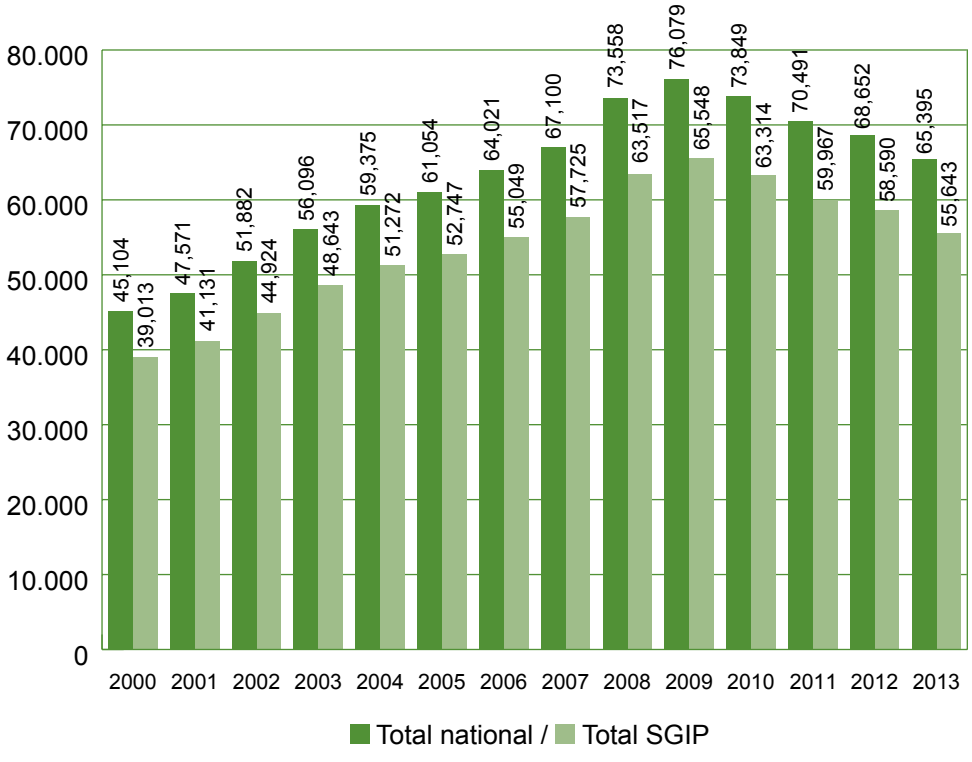
III. Long-term deprivation of liberty
§ 80 - § 221

III.1. Prisons answerable to the Office of the Secretary General for Penitentiary Institutions (Secretary General for Penitentiary Institutions –"SGIP") and the Department of Justice of the Government of Catalonia

Prison population is reduced

80. Prison population in Spain continues its reduction trend, having been reduced by almost 9,000 persons in the last four years, which had a favourable impact on certain prisons (Centros Penitenciarios –"CP") which had an occupancy above their optimum capacity.

Tabla 34
Evolution of Spanish prison population



Source: Own preparation based on data furnished by the SGIP.

Reduction of preventative detainees

The reduction of detainees at CPs, by gender, litigation-criminal situation and responsible Authority may be verified in the following table, in which it is also observed that the drop in the number of preventative detainees also continues. While in 2012, the percentage of detainees pending a trial was 15.8% of the total, in 2013 this percentage of 13.8%

Table 35

Distribution of the inmate population reporting to the SGIP and the Department of Justice of the Government of Catalonia, by gender and litigation-criminal situation in 2013

	SGIP			CATALONIA				
2012	PREVENTATIVES	CONVICTS	TOTAL SGIP	PREVENTATIVES	CONVICTS	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%**
2013	PREVENTATIVES	CONVICTS	TOTAL SGIP	PREVENTATIVES	CONVICTS	TOTAL CATALONIA	TOTAL	%
MEN	7,056	44,231	51,287	1,405	7,712	9,195	60,482	92.48%
WOMEN	710	3,646	4,356	121	514	649	5,005	7.52%
TOTAL	**7,766**	**47,877**	**55,643**	**1,526**	**8,226**	**9,752**	**65,395**	**100%**

Source: Own preparation based on data furnished by the SGIP.

Distribution of prison population

The following tables show the distribution of inmate population according to the degree of treatment and by autonomous communities, respectively.

Table 36

Distribution of convicted prison population according to degree of treatment in 2013

DEGREE	MEN	WOMEN	TOTAL	%
First Degree	1,060	78	1,138	2%
Second Degree	38,662	2,711	41,373	73.75 %
Third Degree	7,683	1,032	8,715	15.55 %
Not classified	4,538	339	4,877	8.70 %
TOTAL	**51,943**	**4,160**	**56,103**	**100 %**

Table 37

Distribution of prison population by autonomous communities, gender and litigation-criminal situation in 2013

AA.CC.	PREVENTATIVES		TOTAL PRE-VENTATIVES	CONVICTS		TOTAL CON-VICTS	TOTAL GENERAL
	Men	Women		Men	Women		
Andalusia	1,773	109	1,882	11,959	972	12,931	14,813
ARAGON	170	16	186	1,949	97	2,046	2,232
Asturias	103	9	112	1,129	131	1,260	1,372
Balearic Islands	237	26	263	1,320	107	1,427	1,690
C.A. Ceuta	77	3	80	98	18	116	196
C.A. Melilla	98	8	106	209	14	223	329
Canary Islands	500	73	573	2,789	181	2,970	3,543
Cantabria	67	4	71	552	17	569	640
Castile-La Mancha	214	9	223	1,613	26	1,639	1,862
Castile and Leon	288	28	316	4,584	318	4,902	5,218
Catalonia	1,405	121	1,526	7,712	514	8,226	9,752
Extremadura	125	11	136	1,006	53	1,059	1,195
Galicia	340	31	371	3,058	189	3,247	3,618
La Rioja	39	10	49	299	17	316	365
Madrid	1,793	267	2,060	5,942	737	6,679	8,739
Murcia	221	21	242	1,260	118	1,378	1,620
Navarre	51	5	56	236	17	253	309
Basque Country	112	16	128	1,074	148	1,222	1,350
Autonomous Community of Valencia	848	64	912	5,154	486	5,640	6,552
TOTAL	**8,461**	**831**	**9,292**	**51,943**	**4,160**	**56,103**	**65,395**

Source: Own preparation based on data furnished by the SGIP.

After the SGIP visit 105 inspection records were opened

81. According to the information made available by the SGIP, in 2013, 105 inspection records were opened for complaints for ill-treatment, of which 85 were dismissed, 13 were pending a court decision, 6 were being processed and one was transformed into a reserved information proceeding. In addition, 4 reserved information proceedings were instituted, of which one was pending a court decision, two were in progress and one gave rise to a disciplinary proceeding. The two disciplinary proceedings instituted were pending a court decision. In respect of the investigations carried out in 2012, mentioned in paragraph 73 of Annual Report 2012, one disciplinary proceeding concluded with a penalty imposed on an officer of 15 days of suspension of functions for a “serious lack of consideration towards inmates”.

36 reserved information proceedings and 106 informative proceedings of investigation by the Government of Catalonia

The Government of Catalonia reported that in 2013 it intensified its inspection work and, accordingly, 36 reserved information proceedings were instituted in addition to 106 informative proceedings of investigation for purported irregularities, malfunctions, misdemeanours and/or crimes by prison personnel in the discharge of their duties. Neverthe-

less, all the informative proceedings instituted for complaints for ill-treatment were dismissed since no indication and/or evidence of their perpetration was observed.

Eight visits to CPs

82. In 2014, eight visits were made to CPs, seven of them within the competence of the SGIP –the CPs of Córdoba, Puerto I and Puerto III (Cadiz), Segovia, Seville, Seville II and Villabona (Asturias)-, and one reporting to the Department of Justice of the Government of Catalonia, the CP for men of Barcelona (namely, "la Modelo"). The Ombudsman participated in five of them and, the Second Assistant to the Ombudsman participated in that of Barcelona.

Chart 5
Geographical location of CPs visited in 2013

Multidisciplinary nature

83. The visits made to the CPs of Puerto I and Puerto III (Cádiz), Segovia and Villabona (Asturias) were multidisciplinary and their duration was two and three days, carried out with the technical assistance of external technical experts specialised in Legal and Forensic Medicine. At said visits, many questions were reviewed related to the treatment given to inmates, following the methodology explained in paragraph 75 of Annual Report 2012.

Verification of compliance with the observations made by the CPT

At the visits made to the CP of Córdoba and for men of Barcelona, however, the main objective was to verify compliance with the specific observations made by the Committee for the Prevention of Torture

and other Cruel Inhuman or Degrading Treatment or Penalties of the European Council (CPT) at the inspections made on said CP at the visit it made to Spain in June 2011 the report of which was published on 30 April 2013. Such observations referred, mainly, to the application of coercive means at such prisons. At the visit to CP Puerto III (Cádiz), although more complete and of a multidisciplinary nature, the questions mentioned by the CPT in its report were also analysed.

Lastly, the visits to the CPs of Seville and Seville II were attended by the Ombudsman of Andalusia and information was obtained at them on the background information on record at the Institution, particularly the medical attention provided to inmates.

Features of the visited CPs

84. As regards the features of the prisons visited, it must be pointed out that the CPs for men of Barcelona, Puerto I (Cádiz), Segovia and Seville II were only for men. At the CP of Seville there were only 6 women at the time of the visit.

CP Puerto I is the only CP specific for inmates classified in the first grade

The CP Puerto I (Cádiz), in addition, is the only specific prison for inmates classified in the first grade. This regime is applied to those convicts that, either initially or due to an involution of their personality or conduct, are classified in first degree because they are extremely dangerous or obviously maladapted to the ordinary and open regimes, as provided for by articles 10 of the Penitentiary General Basic Law (Ley Orgánica General Penitenciaria –"LOGP") and 89 of the Penitentiary Regulation (Reglamento Penitenciario –"RP"). In addition, article 10 LOGP establishes, in section two, the possibility of applying this regime to preventative inmates "by way of exception and with absolute separation of the inmates, rendering account to the responsible court authority".

85. As regards their capacity and size, other than the CPs of Puerto I (Cádiz) and Segovia, occupied by 208 and 377 inmates, respectively, at the time of the visit, the rest are large prisons the occupancy of which is between 1,200 and 1,600 inmates.

Decrease of occupancy at the CP for men of Barcelona and Puerto III (Cádiz)

At the CPs for men of Barcelona and Puerto III (Cádiz) a reduction of occupancy was observed in the past years. In particular, at the CP of Barcelona, the problems of mass occupancy detected by the CPT at its visit in 2011 had been mitigated, being reduced from 1,800 inmates to 1,535 at the time of the visit, and to 1,330 at the beginning of 2014. Nevertheless, the number of inmates should not exceed 1,200. In this respect, the Department of Justice of the Government of Catalonia reported that the objective is to reduce gradually the occupancy of the CP until it is closed, forecast for the 2015-2016 period. The opening of the CP Puig de les Basses (Girona) and Mas d´Enric (Tarragona) to take place shortly will contribute to this.

The provision of medical practitioners should be sufficient

86. The healthcare provided at CPs is one of the matters to which most attention is given during the visits of the Ombudsman in her capacity as NPM. The provision of medical practitioners must be sufficient in accordance with the occupancy of the CP. At CP Puerto I, at the time of the visit, only one of the four places for medical practitioners contemplated in the list of posts of work was filled. Said provision is insufficient and causes malfunctions, both in the clinical emergency

healthcare and that arising from the adoption of coercive means and, in general, any others that require medical evaluation. Accordingly, a suggestion has been made for the measures necessary to be adopted as a priority to remedy the insufficiency of medical practitioners on a permanent basis.

Suggestion for healthcare services to be present 24 hours

87. Certain CPs, such as that of the CP of Segovia, do not have a medical practitioner, DUE or nurse present 24 hours a day. Although an emergency panel is on call it does not ensure immediate assistance when necessary. Accordingly, a suggestion was made for the CP to have medical healthcare in person 24 hours a day, according to paragraph 83 of Annual Report 2012.

The frequency of consultations on demand should be adequate

88. In addition, the frequency of the consultation on demand should be adequate. At CP Villabona (Asturias), it is held one day per week in each unit, the advisability of it being available more frequently should be considered, to avoid an excessive request for urgent consultations, which criterion was accepted by the SGIP, which gave the relevant instructions to the CP.

A record of requests for healthcare should be enabled

89. As mentioned in paragraph 87 of Annual Report 2012, CPs must enable a record of requests for both urgent and ordinary healthcare and of the data schedules by the healthcare services, to verify that requests for medical assistance are attended. At the CP of Segovia the record of requests for ordinary healthcare was kept using loose forms and there is not record of requests for urgent assistance, as there is not either at CP Villabona (Asturias). At the CP of Segovia, a book of requests for urgent assistance is kept, but this was rejected at CP Villabona (Asturias). Suggestions were made in both cases for the books that they are lacking to be enabled.

Recommendation for language not to hinder healthcare

90. The diversity of nationalities existing at certain CPs means that language may be a problem for correct medical attention to be provided, since it hinders communications between the professional and the inmate. Although another inmate is usually used to act as interpreter, this may affect the privacy of the patient. Accordingly, a recommendation was made to the SGIP for the necessary measures to be adopted for language not to be an obstacle to the fluid communication between the healthcare services and the inmates requesting attention, to ensure that it is correctly provided, without errors due to communication and without having effects on privacy, such as, for example, through interpretation services provided by telephone, in accordance with paragraph 80 of Annual Report 2012.

Action ex officio taken by the Ombudsman on restrictions to access a new treatment for patients with C hepatitis

91. The Security and Justice Department of the Ombudsman's Office commenced in 2013 an action ex officio against the SGIP, due to the restrictions that were apparently be imposed to access a new treatment for patients with hepatitis C. At the visit made to the CP of Seville with the Ombudsman of Andalusia information was requested on the matter, given the delicate situation of an inmate at the CP who had been prescribed said therapy at the Virgen del Rocío de Seville, despite which he had been waiting for more than one year to be provided with the medicines. The processing of that proceeding continued

in 2014 and account will be rendered of its result in the next Annual Report of the Ombudsman.

No problems were detected in transfers of inmates to external healthcare centres

92. At the visits made in 2013 no relevant problems were detected in the transfers of inmates to external healthcare centres due to lack of police control to conduct them. According to the information furnished by the SGIP, at the three CPs which in 2012 had a larger percentage of loss of medical appointments a major reduction was achieved in losses of medical appointments: from 26.04% to 4.95% at the CP of Seville, of 23.11% to 0% at the Prison Psychiatric Hospital of Seville, and –slightly lower - of 29.01% to 24.42% at the CP of Jaén. Said improvement was verified at the visits to the CPs of Seville and Seville II.

It would be advisable to set up the electronic clinical record of inmates

93. The clinical records of the inmates are not yet computerised, so that it would be advisable to set up the electronic clinical record and its connection to the system of the relevant public networks of healthcare services, according to paragraph 91 of Annual Report 2012.

Very limited use of tele-medicine

94. The use of tele-medicine is as yet very limited at most CPs. At the CP of Segovia, for example, it is only used to review electro-cardiograms, at CP Puerto I it was not used, so that it would be advisable to promote tele-medicine for medical consultations that so permit, to reduce the delay and displacement of inmates, in accordance with paragraph 88 of Annual Report 2012.

Psychological assistance to inmates

95. According to the information made available by the SGIP, one of the functions of the psychologists is to provide inmates with psychological assistance. Nevertheless, at certain visits it was observed that the ratio of inmates per professional renders it impossible to make psychotherapy consultations, which would be highly advisable given the high rate of mental health disorders among the prison population.

Insufficient psychiatric assistance

96. Likewise, at certain visits it was observed that the psychiatric assistance was insufficient for the number of inmates with psychiatric pathologies. At the visit to CP Seville II it was known that in November 2012 the agreement for cooperation existing between the SGIP and the Health Department of the Government of Andalusia, in the context of which specialists in psychiatry attended inmates with mental health pathologies, was terminated. Due to this, the Security and Justice Department of the Ombudsman's Office instituted a proceeding ex officio with the SGIP, of which account was rendered in the 2013 Annual Report, which states that a new agreement was made in August 2013. Nevertheless, the necessary arrangements should be made for all CPs to have specialised psychiatric assistance with the adequate frequency. Thus, for example, at CP Puerto III (Cádiz) it was observed that the provision of medical practitioners specialised in psychiatry was insufficient –which was noted by the CPT at the visit made in 2011-, since only one psychiatrist provides assistance once per month for a population of 1,350 inmates. Accordingly, a Suggestion was made for said CP to provide psychiatric assistance with greater frequency. However, the SGIP rejected the Suggestion, on considering that the psychiatric assistance that is provided by the Servicio Andaluz de Salud (Healthcare Service of Andalusia) is sufficient.

Little development of the PAIEM at certain CPs

97. At the visit made to CPs Puerto I (Cádiz), Segovia and Villabona (Asturias), in the light of the reviewed documentation and interviews made the conclusion was drawn that the PAIEM (framework program for integrated assistance to persons with mental diseases) is little developed at those CPs, so that the necessary efforts should be made for such program to continue being developed, with the participation of the medical team, enabling integrated therapeutic actions and attempting to include in it the greatest possible number of inmates who need it, as mentioned in paragraph 94 of Annual Report 2012. At CP Seville II, in addition to the PAIEM, a unit is available for inmates with mental health problems.

Adequate mechanisms should be available for the detection of mental diseases and the adoption of therapeutic measures

98. Penitentiary establishments should have adequate mechanisms to detect mental diseases, to be able to adopt the appropriate therapeutic measures instead of purely restricting and contention measures that may even aggravate certain pathologies. The particular case of one inmate of CP Puerto I (Cádiz), who had a large number of incidents, means of contention, penalties and transfers to other CPs (21 in the past 12 years, approximately two centres per year) is to be pointed out. At the interview held with him in which the external court medical technical expert participated, it was verified that he was not of sound mind. The cell of the inmate was empty, without belongings, the glass of the window had been removed to prevent the inmate from breaking it and eating it, which had occurred on a previous occasion. The inmate went out to the yard daily and sporadically to the gym. His clinical record stated that had been diagnosed to be mentally retarded and to have an anti-social personality, that was refractory to the pharmacological treatment and that his isolation caused him greater disquiet and a more maladapted conduct. The Security and Justice Department of the Ombudsman's Office was informed of the situation and instituted a proceeding ex officio with the SGIP, to know the reason for which the possibility of promoting the suspension of the sentence and its replacement by a security measure had not been considered, pursuant to article 60 of the Criminal Code, due to supervening serious mental disturbance, which appeared more adequate given the inmate's psychological state than the adoption of restrictive measures and transfer to other establishments, which in any case appeared to worsen the patient's mental disease.

At CP Puerto III (Cádiz) also one inmate was found in a delicate situation. The external technical expert held an interview with him and reviewed his clinical record. The inmate had an acute psycho-pathological syndrome, and had been assisted two weeks earlier by the psychiatrist, pending check-up two months later. Since his process had become more acute, the external technical expert estimated that the most adequate procedure would be to transfer the inmate to the nursing room for more direct control, and to demand an external psychiatric consultation. Nevertheless, the SGIP reported that, after he had been evaluated by various psychiatrists, it had been impossible to evidence any specific psychiatric pathology.

224 deceases in CPs

99. The SGIP and the Department of Justice of the Government of Catalonia reported that in 2013 224 deaths occurred at CPs: 162 at CPs reporting to the SGIP and 62 at CP reporting to Catalonia.

Table 38

Deaths of inmates of CPs reporting to the General Secretary for Penitentiary Institutions in 2013

TYPE	TOTAL	PRISON	HOSPITAL	OTHERS
Natural		36		
Suicide		29		
Drugs		27		
HIV/AIDS		1		
Accidental		2		
Pending		2		
Aggression		0		
Other causes		0		
	162	97	64	1*

* Transfer to hospital

Source: Own preparation based on data furnished by the SGIP.

Table 39

Deaths of inmates at CPs reporting to the Government of Catalonia in 2013

TYPE	TOTAL	PRISON	HOSPITAL	OTHERS
Natural	0			
Suicide	10			
Drugs	2			
HIV/AIDS	2			
Accidental	0			
Pending	0			
Aggression	0			
Other causes	48			
	62	23	19	20* **

* 10 On leave

** 10 In family

Source: Own preparation based on data furnished by the Department of Justice of the Government of Catalonia.

Investigations of deaths should be carried out by the central services

At CP Puerto I (Cádiz), a few weeks before the visit, an inmate died who had been admitted only one month before from another CP, the reason for his death being unknown at that time. It was stated that the reserved information proceeding on the death would be carried out by the CP itself. In the opinion of this Institution, it would be more adequate for the investigation to be carried out by the central services of the Secretary General for Penitentiary Institutions including not only this centre but instead also those at which the inmate stayed little before his death.

39 deaths by suicide

100. Of the deaths that occurred in 2013, 39 were due to suicide. In the light of the information made available at CP Villabona (Asturias), in 2013, two deaths occurred due to suicide before the visit, none of the deceased inmates was included at that time in the PPS (Program for the Prevention of Suicides) and that four suicide attempts occurred in 2012, only one of those inmates being included in the program, which would indicate the need to improve the practical implementation of the program to detect the suicide risk more efficiently. In addition, inmates supporting the PPS do not receive any specific training to perform the tasks entrusted to them, which should be remedied. The SGIP accepted the criterion of this Institution and, accordingly, amendments were made to the procedure of participation of the PPS and the controls of the scheduling of training courses will be increased.

Application of the PPS should be improved

Standard forms

At CP Puerto I (Cádiz), in turn, the review of the clinical records of the inmates showed that, in the check-ups made at their entry, the standard forms of the PPS are not used on a routine basis, with the relevant application of the scales for evaluation of the risk of suicide, which should be remedied.

Protocol for body and cell searches

101. At CP Puerto I (Cádiz) various statements were taken from inmates who informed us that they had been body searched without any overall or that their cell had been searched in their absence, so that the application at the centre of the body and cell searches protocol should be reviewed and it should be verified that overalls are available to the inmates, as established by paragraph 136 of Annual Report 2011

Action the case of suspicion that an inmate conceals narcotics

102. If it is suspected that an inmate conceals narcotic substances in his body, the SGIP adopts a protocol contemplated in point 3.5 of Instruction 3/2011, related to the Plan for general participation relating to illegal drugs at the penitentiary institution. Said paragraph 3.5 establishes that, if after a nude body search is made, it is still suspected that an inmate carries any narcotic substance in his body, he will be offered the possibility of submitting to a radiological test and, if negative, the director of the CP will request the responsible court authority for court authorisation for the purpose.

Recommendation for the X-ray exploration of inmates to be contemplated in a basic law

According to the SGIP, the making of radiological explorations in this cases is founded on article 23 LOGP and article 68 RP, which refer only to property and body searches, which, in the opinion of this Institution, are not similar to said tests and in any case are less damaging than these tests, so that it cannot constitute the specific legal provision of the measure limiting the right to privacy required by article 8 of the European Convention of Human Rights and Judgment 207/1996, of 16 December of the Constitutional Court. Accordingly, a Recommendation has been made to the Ministry for the Interior for it to undertake an initiative or reform of legislation, so that the radiological exploration of inmates at CPs to be contemplated expressly by a basic law as regards its most essential aspects, notwithstanding the fact that a provision of lower ranking may provide a more detailed regulation, including, inter alia, each and every one of the events and

requirements of the control, the features that the informed consent of the inmate of the measure should meet, the criteria to be taken into account to apply the principle of proportionality (the reasonableness of the suspicions, the seriousness of the crime...), the need to request a court order for body control if the inmate refuses to take the X-ray test and the contents of such request to the Judge for Penitentiary Surveillance, etc. Said Recommendation was rejected, notwithstanding the fact that, given the relevance of the matter, this Institution has again requested that its proposals be taken into account.

Performance of the test should be based on founded and strict criteria

103. Notwithstanding the need for a measure restricting fundamental rights to be contemplated by a basic law, since it is a measure of control of a medical nature but adopted for regimental reasons, this Institution must express its reservations on the matter, while mentioning that the criteria to found it must be well founded and restrictive. Council Directive 97/43/Euratom on health protection of individuals against the dangers of ionising radiation in relation to medical exposure, establishes that the responsible organisations and persons using ionising radiation must reduce unnecessary exposure of patients to radiation. In addition, as stated in the "Referral guidelines for imaging" of the Directorate-General for the Environment of the European Commission, measures for radiological protection commence by not making unnecessary tests.

Possible alternatives should be considered and the risk/benefit should be weighted

In the opinion of this Institution, any conflict between self-respect and the rights of the inmates and the duty of the Penitentiary Authority to maintain the security and good regimental order of the CP, must be resolved studying all possible alternatives and weighing up the risk/benefit that may be caused in each case. Unless the medical services consider that the life of the inmate is at risk for having within his body a strange object or narcotic substance, among other measures less detrimental to the rights of the inmates could also ensure the intended purpose, such as their transfer to a facility containing a toilet system that enables recovery of the narcotic substance, carrying out the appropriate medical monitoring and control of the inmate.

Mechanical restraint if the inmate does not give consent to submit to X-ray controls

104. At CP Puerto I (Cádiz) it was verified that, in the case of suspicion that inmates may conceal drugs in their body and that these do not give their consent to submit to radiological controls, the customary procedure is to restrain the inmate mechanically until the eventual expulsion of the substance naturally or until he consents to the radiological control. In the specific case of one inmate, after a few hours of immobilisation, he accepted to take the radiological test, the results of which were negative. At CP Puerto III the application of the same measure to one inmate was also observed. It cannot be agreed that in cases such as these it may be considered that the inmate voluntarily accepted to submit to such examination, since it may be inferred that his reasons were to avoid his immobilisation, or that the measure of mechanical restraint was suitable, since article 72 RP establishes that coercive measures "shall only be applied where no other less burdensome measure exists to achieve the sought purpose", such as that mentioned in the above paragraph. In respect of the case observed

at CP Puerto III (Cádiz)), the SGIP reported that the inmate was immobilised to prevent him from causing himself damage, after other measures had been adopted.

Recommendation for informed consent to make radiological explorations

105. Said Instruction 3/2011 contemplates in annex 6 (a) a document of informed consent of exploration using radiology/echography that, nevertheless, includes no information on the test that is to be made. Although they have limited effects on health, radiological explorations are not innocuous measures so that a Recommendation has been made for the document of informed consent of the SGIP to be amended for radiological explorations for them to be informed in writing, in comprehensible terms for them and sufficiently and adequately, for greater safeguard of the rights of the inmates, of the nature and effects of the radiological test that it is intended to perform on them and of the consequences that the carriage of foreign bodies or narcotic substances in their body may have. The SGIP reported that it will review said documents.

Information on the risks and consequences of the tests

106. In addition, in the opinion of this Institution, the request to the penitentiary surveillance judge for a court order for radiological exploration should contain information on the risks and consequences of the test to be performed on the inmate, the specific reasons for which such test is requested, the tests of the same kind that have been performed on him in the last year and their result, and any other information that may be relevant. The SGIP answered that information on the performance of previous radiological tests on the inmates will be included.

Rest between different isolation penalties

107. In respect of the serving of disciplinary penalties, in the review of the information at CP Puerto I (Cádiz) it was observed that, where various isolation penalties are imposed which joined imply more than 14 days of isolation, they are served consecutively, the second commencing on the day after the first one ends. This practice was also observed in certain isolated cases at CPs Puerto III (Cádiz) and Villabona (Asturias). This Institution considers that, for the benefit of the inmates, at least one day of rest should be allowed between these penalties, where they imply more than 14 days of isolation.

Reporting to the penitentiary surveillance judge

108. In respect of the notice to the penitentiary surveillance judge of the application of coercive measures, at CP Puerto I (Cádiz) it was observed that it is made at the earliest on the day after the measure, contravening article 72 RP, which establishes that it should be made immediately. In addition, at said centre, three cases of employment of essential physical force were observed in which apparently the date and time of cessation were not duly recorded, so that we are unaware of whether they were correctly reported to the penitentiary surveillance judge, a fact that was reported to the SGIP.

Inclusion of all concurrent factors

In addition, in the opinion of this Institution, the notice to the penitentiary surveillance judge should record, in addition to the date and time of commencement and cessation, and the reasons for adoption of the measure, the following matters: whether the measure was authorised by the director or only the medical report was submitted to him on the existence or not of impediments to adopt the measure, the total duration of the measure if cessation is reported, and whether or not the facts gave rise to the institution of a disciplinary proceeding.

At some CPs the use of mechanical restraint should be reviewed

109. At the visits, special attention was given to the application of mechanical restraint, observing that in a relevant number of immobilisations carried out at the CPs of Segovia, Puerto I and Puerto III (Cádiz) in the year before the visits in question, the duration exceeded 12 hours, in many cases reaching 24 hours. Also, at CP Puerto III (Cádiz), mechanical restraints were applied to certain inmates several times allowing little time to elapse between them. They are therefore restraints for long time periods, which should be exceptionally founded, given their serious effects on the rights of the inmates. Mechanical restraint is not a means of punishment and is instead a measure for contention the duration of which should be as short as required to cease the reasons for which it was applied. Accordingly, the SGIP has been requested to review the use of mechanical restraints at such CPs.

Immobilisations of one inmate not correctly recorded at CP Puerto I (Cádiz)

110. At CP Puerto I (Cádiz) it was observed that two long immobilisations were performed on an inmate consecutively allowing 5 minutes between them, during which he was released to eat. Although the Record of coercive measures records it as a single immobilisation, it was processed and notified to the penitentiary surveillance judge as a single immobilisation. Nevertheless, it would apparently have been more correct to record it as a single immobilisation, since it cannot be considered that releasing the inmate to eat implies cessation of the measure. In addition, in this case, the physical force that had to be used to tie the belts on the inmate was not reported to the Penitentiary Surveillance Court.

The lack of medical present 24 hours has effects on the adoption of coercive measures

111. The lack of medical presence 24 hours a day has direct implications on the adoption of coercive measures. Thus, at CP Puerto I (Cádiz), in one case, a regimental immobilisation was applied although, according to the description of the facts, apparently a healthcare action would have been more adequate, since there is no record that the inmate acted aggressively, the facts referring only to his anxiety and nervousness due to family problems. Taking into account that article 72 RP establishes that coercive measures should be used only “where no other less burdensome manner exists to achieve the sought purpose”, it appears that a medical correction of the situation would have been more adequate, as was reported to the SGIP. At this CP, various cases were also observed in which, despite the fact that the commencement of the mechanical restraint was ordered by the medical services, they were treated as regimental immobilisations.

Recommendation for permanent supervision of immobilised persons

112. Officers control regularly the mechanical restraints applied to the inmates. In this respect, the Recommendation already made to the SGIP as to the fact that immobilised persons should be permanently supervised is repeated, according to paragraph 103 of Annual Report

2012. The SGIP stated that it did not have sufficient human resources to carry out a permanent supervision.

Control of immobilised inmates

Notwithstanding such permanent supervision criterion, at some visits made, it was observed that not even the provisions of Instruction 3/2010 of the SGIP, of 6 March, on the protocol of action in security cases, are complied with, without any record of a control carried out at least once per hour by the officers to supervise the state of the immobilised inmates. This deficiency was observed in general at CP Puerto I (Cádiz), so that a Suggestion was made for it to be remedied immediately. In the case of CP Puerto III (Cádiz), this was detected in only one of the examined cases. Regardless of whether such deficiency was due to an omission in the surveillance documentation or to negligence in the compulsory control by the officers, the SGIP was informed that both the surveillance of the immobilised inmates should be intensified and that such task should be carried out by higher ranking officers, a conclusion that was accepted by the SGIP.

Control of hygienic conditions of the immobilisations

113. At CPs Puerto I and CP Puerto III (Cádiz), various statements were taken from inmates who had been unable to go to the toilet and had to relieve themselves while immobilised. Accordingly, the SGIP was informed that the control by the officers of the conditions of hygiene of the inmates, and of the temperature, ventilation and conditions of the immobilisation, had to be extreme and, to the extent possible, they should be untied to be able to relieve themselves, recording this in the book monitoring the measure. The SGIP accepted the criterion of the Ombudsman.

Improvement of the training of personnel in the application of mechanical restraint

114. In the reviewed records of mechanical restraints applied at CPs Puerto I and Puerto III (Cádiz), various cases were observed in which it was stated that the inmates had managed to loosen the belts which, since restraints are not controlled, could imply a risk of self-injury. Accordingly, it is considered necessary to review the manner in which mechanical restraint is applied at said CPs and, if required, to improve the training of the personnel in this area. The SGIP reported that, at CP Puerto III (Cádiz) courses are given on a six-monthly basis on the correct use of coercive measures. It must also be pointed out that a guide for mechanical restraints exists at the centre available to the officers at the special department.

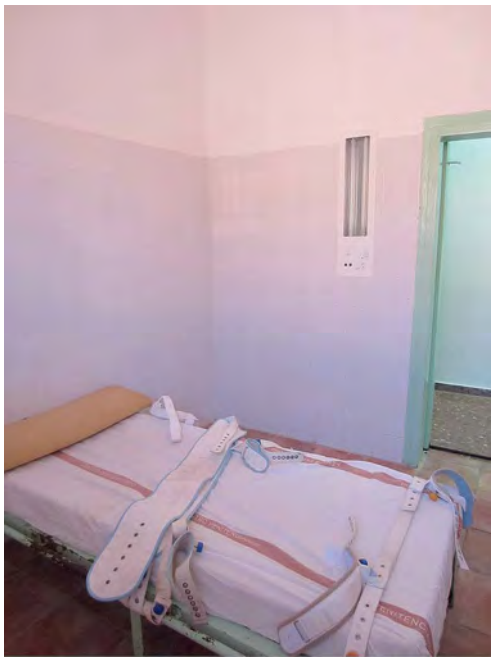
At the CP of Córdoba metal handcuffs continued to be used for immobilisations

115. The report on the visit made to the CP of Córdoba in 2011 by the CPT recorded the use of metal handcuffs to immobilise the inmates. Although at the visit of the NPM it was stated that instructions had been given for the use of cloth material restraints –the existence and state of use of which was verified -, some inmates stated that metal handcuffs continued to be used. The SGIP reported that handcuffs are only used for short restraints (such as transfers between departments), and that the use of cloth restraints is compulsory for immobilisations.

116. At the visits, it was also verified that the state of the facilities where inmates are immobilised is correct. At the CP of Córdoba it was verified that, in the mechanical restraints cell, the concrete block used as a bed had been replaced by a metal structure with a mattress, complying with the recommendations made by the CPT after its visit to this centre in 2011. In turn, at CP Puerto I (Cádiz), the beds used for mechanical restraint are placed beside the wall which makes it easier for inmates to cause themselves injuries, as occurred on various occasions, which should be remedied. Finally, at CP Puerto III (Cádiz), one of the restraints cell was dirty although more than 10 days had elapsed from its last use. The SGIP was informed that it should give instructions for cells to be cleaned immediately after their use, which was accepted.

The state of some restraint cells was not correct

Mechanical restraint bet at the CP of Córdoba



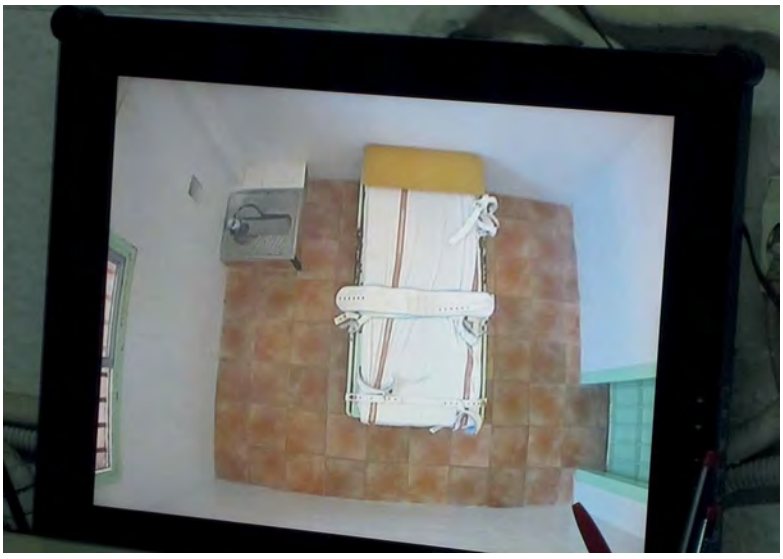
Mechanical restraint bed in CP Puerto I (Cádiz)

Mechanical restraint bed in CP Puerto III (Cádiz)

Absence of video-surveillance in mechanical restraint cells

117. Most CPs do not have video-surveillance in mechanical restraint cells. As an exception the CPs reporting to the Department of Justice of the Government of Catalonia, and some CPs of the SGIP, do have them, which is a good practice. This is the case of the CP of Córdoba and of one of the two immobilisation cells of CP Puerto I (Cádiz), at which, however, video recordings are not made. It must be remembered that, in the opinion of this Institution, the video-surveillance system should cover and record the pictures of all the cells where mechanical restraints are applied. The SGIP rejected this criterion, stating that it is impossible to for personnel to view the video-surveillance screens, given the number of personnel available.

Picture of a mechanical restraint cell in CP Puerto I (Cádiz), with video-surveillance



Suggestion to change the conditions of the isolation department in CP Villabona (Asturias)

118. At CP Villabona (Asturias), the isolation department has precarious architectural and highly restrictive features even for facilities of this kind. The metal mesh covering the yards of the unit, which are classified by the inmates as “cages” should be pointed out, since this is incompatible with facilities the purpose of which is for persons

deprived of liberty who may remain up to 22 hours confined in their cell to enjoy the possibility of going out of doors. For this reason it is considered, notwithstanding the desirable removal of the aforementioned metal meshes, that the use of this department should be limited to punishment consisting of isolation in a cell and for application of provisional isolation, but it should not be used as a unit for the permanent stay of inmates under the closed regime. Since the SGIP rejected the criterion of this Institution, a suggestion was made to such effect.

A cell and the yard of the isolation department of CP Villabona (Asturias)

119. With regard to the application of article 75 RP, although the criterion adopted by the SGIP does not conform to that issued by the Ombudsman, as was stated in paragraph 104 of Annual Report 2012, at the visits it was verified that its application complies at least with Instruction 3/2010, of 6 March, of the SGIP, on the protocol of action related to security matters. The SGIP reported that, due to the conclusions reached at the visits made by the NPM, application of article 75 RP was included as a matter to be verified at the visits of the Penitentiary Inspectorate. In addition, in May 2013, the Sub-directorate General for Penitentiary Treatment and Management issued Service Order No. 4/2013, in which the managements of the various CPs were reminded of the exceptional and secondary nature of these measures established by said Instruction and the appropriate procedure for their application.

After the visits made by the NPM, the application of article 75 RP is examined by the Penitentiary Inspectorate

120. As regards the visits made in 2013, at CP Puerto I (Cádiz), many records were reviewed and it was observed that article 75.1 RP was applied with certain frequency. At CP Puerto III (Cádiz), in turn, it was observed that, in more than 50% of the reviewed records, the duration of regimental restrictions exceeded one month, in two cases, it was longer than two months and, in another two, it exceeded three months. It was also observed that, in one case, the specific restrictions were not specified in the resolution for their application. In turn, application of article 75.1, with prohibition to use the yard for two days in certain cases in which there were suspicions that the inmates carried drugs did not appear to be sufficiently founded. Due to this, the SGIP was informed that application of article 75.1 RP should be reviewed at both

Acceptance of the observations of this Institution in respect of the application of the regimental restrictions of article 75 RP

centres. In respect of CP Puerto III (Cádiz), the SGIP reported that the observations of this Institution were accepted and, accordingly, the appropriate instructions had been given to the management of the CP.

The duration of regimental restrictions should be shortened

121. In more than 20% of the cases in which article 75.2 RP was applied in the year before the visit to CP Puerto I (Cádiz), its duration exceeded 3 months, reaching 6 months in one case and 7 months in another. This measure, although it seeks to protect the inmates, is in any case exceptional and involves regimental restrictions, so that the necessary steps should be taken to reduce its duration, along the lines mentioned in paragraph 111 of Annual Report 2012.

Medical action in cases of injuries, coercive means and isolation punishment

122. The medical action in the case of injuries, application of coercive measures or serving of the isolation penalties is also reviewed at the visits. As regards such action in the application of coercive measures, regardless of whether or not the medical practitioners act in accordance with the provisions of law and of regulation in force, in the opinion of this Institution, they should play a more active role, particularly when applying mechanical restraints, to verify whether the reasons for which it was adopted remain or have ceased, for the duration of the measure to be only the minimum time necessary, and to supervise the conditions in which it is implemented (state of the cell, of the bed, basic conditions of hygiene...), and use of concomitant medication. All the above forms part of the functions pertaining to medical personnel of CPs, from the point of view of protection of the health of the inmates and participation in the surveillance of the conditions in which coercive measures are applied. In addition, such actions should be recorded in forms established for the purpose to be completed after the regular medical checks, without prejudice to the fact that they may also be stated in the clinical record.

Recommendation accepted to improve medical participation in the application of mechanical restraint measures at the CP for men of Barcelona

After the visit to the CP for men of Barcelona, a Recommendation was made to the Department of Justice of the Government of Catalonia for the necessary instructions to be given for the purpose. Said recommendation was accepted and, accordingly, taking advantage of the integration of the penitentiary healthcare services into the Health Department of the Government of Catalonia after January 2014, the protocols of action will be reviewed to improve the medical participation in the application of mechanical restraint measures.

Medical exploration carried out through bar doors

123. At CP Villabona (Asturias), after the interviews held with the inmates, it was concluded that the medical exploration (including in certain cases auscultation) and the dispensation of medicines, in the case of provisional isolation or isolation punishment, is carried out through bar doors, without opening them, which should be limited to only those cases in which this is strictly necessary because founded suspicions exist of risk. The SGIP accepted the criterion of this Institution.

Confidentiality between the medical practitioner and the patients

Similarly, at CP Puerto I (Cádiz), certain interviewed inmates stated that occasionally ordinary medical consultations and medical check-ups in the case of coercive measures and isolation penalty were made in the presence of officers. Although it is understood that in certain

cases it may be necessary to extreme security measures, these should not violate the confidentiality between the medical practitioner and the patients or the right to privacy of patients.

Reminder of legal duty

124. At CP Puerto III (Cádiz), the medical report prior to compliance with the isolation penalty is issued by the medical practitioner of the unit in which the inmate resides, based on his clinical record and without carrying out a personal check-up, so that it has been necessary to remind them of the legal duty established by article 254.1 RP for isolation penalties to be applied issuing a medical report after a check-up by the medical practitioner of the establishment, which reminder was accepted by the SGIP, which gave the management of the CP the relevant orders.

Compulsory nature of the visit of the medical practitioner to the inmate

125. The visit of the medical practitioner is compulsory and cannot be waived by the inmate serving a provisional isolation penalty, so that the inmate is unable to reject the presence of the medical practitioner to verify the conditions in which the penalty is being served. The SGIP agreed with this criterion and, accordingly, gave the appropriate instructions.

Reminder of the legal duty that the medical practitioner must visit the inmates in provisional isolation daily

126. In most cases of mechanical restraints and provisional isolations reviewed at CP Puerto I (Cádiz), there was no record that the medical practitioner had made a personal check-up at the commencement of the measure, stating whether or not any clinical impediment existed, whether or not injuries were observed and –in the case of mechanical restraints – whether or not the situation could have been remedied from a healthcare point of view, which procedure does not conform to said Instruction 3/2010, of 6 March, on the protocol of action in security matters. On certain occasions, the medical check-up took place on the day after or at the time of cessation of the measure and in many others there was not even any record that it had occurred. Accordingly, a Reminder has been issued to the SGIP of the legal duty contemplated in article 72.2 RP, which establishes that, when the provisional isolation measure is applied, the inmate must be visited daily by the medical practitioner.

Documentation of the medical assistance provided to inmates to whom coercive measures or isolation penalties are applied

127. The documentation of the medical care provided to inmates to whom coercive measures are applied or on whom the isolation penalty is imposed is relevant. At CP Puerto I (Cádiz) such information is often not included in the clinical record of the inmate or in the record of application of coercive measures. At CP Puerto III (Cádiz), in turn, most interviewed inmates who were in isolation stated that they had not been visited by the medical practitioner, some of them although they had requested this. However, the book of medical assistance of the department recorded that various inmates had not requested or had rejected the visit. To avoid eventual inconsistencies, the infringement of article 254.1 RP and the eventual deprivation of the right to healthcare of the inmates, a mechanism should be established to permit the inmate to evidence that he requested medical assistance, which was accepted by the SGIP.

Recommendation for record to be made of the control of mechanical restraints

With regard to the record of the medical monitoring of immobilisations, a recommendation was made to the SGIP for all infirmaries of all CPs to be provided with a specific book to record mechanical restraints performed for healthcare purposes, to facilitate their surveillance and prevent the information from being dispersed, as currently occurs. The recommendation was accepted and, accordingly, the "Special Situations Control Form" was amended to include the medical monitoring of all mechanical restraints. Said document must be kept at the healthcare facilities. Nevertheless, it is not known whether the forms make up a single document, in book format, so that the information they contain cannot be mislaid, as could occur in the case of loose pages, so that the SGIP has been requested to report on the matter.

Suggestions to CP Puerto III (Cádiz) for adequate recording of the medical control of mechanical restraint measures

In turn, at the CP Puerto III (Cádiz) not all the mechanical restraint records contained the medical report on the absence of clinical impediments for application of the measure or the subsequent compulsory controls by medical practitioners, in those cases in which the measure was prolonged for several days. Accordingly, two Suggestions were made to the SGIP for it to ensure that all records of coercive measures of CP Puerto III (Cádiz) include such documents and for record to be made of the monitoring of the application of coercive measures in a book established for the purpose. The SGIP answered that the clinical record is the sole supporting document of the healthcare information of each inmate and reminded all CPs of the obligation to implement adequately in the clinical records of the inmates the medical or healthcare actions performed in the cases of application of coercive measures.

Acceptance of the criterion that injury records must be adequately completed

128. It continues to be observed that in records of injuries in certain cases the quality of the descriptions of injuries could be improved, and occasionally the section of statements of the inmate is not completed or, if completed, is excessively brief, as occurs in the cases of CPs Puerto I (Cádiz), Puerto III (Cádiz), Segovia and Villabona (Asturias). Accordingly, this Institution must repeat that injury records must be adequately completed, providing a detailed description of the injuries observed –including mention of the size, colour and presumable evolution data -, and an opinion on the compatibility of the observed injuries and the origin attributed to them by the inmate which must in any case be obtained by the acting professional, according to the criterion issued by the Ombudsman in paragraph 115 of Annual Report 2012. It is also necessary to record the specific time and place where the check-up is performed and for the signatory medical practitioner to be identified. All the above is essential for the subsequent legal classification of the facts. The SGIP accepted the criterion of the Ombudsman and, accordingly, reminders were sent to such effect to all CPs.

Recommendation to make photographs of the injuries rejected

129. In the opinion of this Institution, metric photographs of eventual injuries to inmates due to the application of coercive measures or for any other reason, would enrich the contents of the injury records, facil-

itating an eventual court investigation on providing the forensic medical practitioner with further information to evaluate the ethology of the injury and the compatibility of the production mechanisms, since the check-up may be performed by the forensic medical practitioner long after the injury occurred. Accordingly, a recommendation has been made to the Department of Justice of the Government of Catalonia for the necessary instructions to be given to make photographs of the injuries that may be observed in inmates and include them in the relevant injury reports, always after obtaining consent for the purpose from the injured person, according to the criterion of this Institution stated in paragraph 115 of Annual Report 2012. The recommendation was rejected by said Authority, as it was also by the SGIP at an earlier date, as was placed on record in paragraph 144 of Annual Report 2011.

Reminder of the legal duty for injury reports to be always notified to the duty court

130. Occasionally, the injury reports are not sent systematically to the responsible court authority and no copy is delivered to the inmates. In the cases of CPs Puerto III (Cádiz) and Villabona (Asturias), a reminder has been made of the legal duty, established in article 262 of the Criminal Procedure Law, for the injury report issued after the application of coercive measures, fights between inmates, self-injuries or injuries that the inmate may have at his admission into the centre to be notified to the duty court as soon as possible, the Authority not having competence to decide whether or not the injury reports must be sent to the court, pursuant to paragraph 114 of Annual Report 2012. Said reminder was accepted by the SGIP.

Inmates victims or witnesses of ill treatment or incorrect actions

131. In the confidential interviews held with inmates, they occasionally state that they were victims or witnesses of ill-treatment or incorrect actions of personnel. If they so wish, the information is conveyed to the Security and Justice Department of the Ombudsman's Office for it to take action with the Authority, to verify the facts. However, the inmates often fail to provide the necessary data for the purpose or do not wish the facts to be investigated. In such cases, they are informed of the possibility of reporting the facts to the Penitentiary Surveillance Judge and of bringing a complaint before the Ombudsman's Office at a later date, even providing them with a form for the purpose.

Sufficient mechanisms to detect situations that may be considered ill-treatment or torture

Notwithstanding the eventual complaints that may be brought by the inmates, one of the main objectives of the visits of the Ombudsman as NPM is to verify whether sufficient mechanisms exist to detect situations that may be considered to be ill-treatment or torture. In this respect, it is essential for inmates to have an efficient system to bring complaints and claims. Inmates may use various mechanisms for defence and complaint: firstly, they may bring them through the many professionals in contact with the inmates and the authorities of the CP, or by filing a claim with the Penitentiary Surveillance Judge, for criminal justice through a complaint to the duty court and the Ombudsman or the autonomous commissioners, in those cases in which they have

powers for the purpose. It must be ensured that the system is absolutely confidential, applications and requests to be made in a closed envelope.

Internal investigations must be carried out be personnel outside the CP where the facts occurred

As regards the internal investigations carried out by the penitentiary Authority in the case of complaints for ill-treatment, the criterion of this Institution, repeated in the annual reports of the Ombudsman, is that they should be conducted by specialised personnel not included on the payroll of the CP where the facts occurred. In addition, although the existence of contradictory versions of the inmates and officers is customary, the investigation of purported irregular conduct must be exhaustive, despite the judgment of truth that the Authority may have in a first analysis, the inmate's version to be heard in an atmosphere that encourages trust in the person explaining his problem, permitting him to submit and/or request evidence. In this regard, it is considered that the existence of video-surveillance system recordings is essential evidence to supplement the investigations, thus the importance given by this Institution to having such systems cover all areas, with the sole exception of those that could have effects on privacy (cells and toilets).

Increase Education and Respect Units

132. As regards the treatment programs applied at CPs it must be pointed out that Education and Respect Units continue to increase, along the lines of paragraph 118 of Annual Report 2012. At CP Puerto I (Cádiz), which as mentioned above is a CP exclusively for inmates classified in the first grade, in 2011 a respect unit was started up to "achieve standard conduct patterns permitting the inmate to return to the second degree in the best adaptive conditions".

Program of action under the closed regime

133. At CPs Puerto I, Puerto III (Cádiz) and Seville II, the Program for action under the closed regime, contemplated in Instruction 17/2011 of the SGIP was being applied, its progress having been verified particularly at CP Puerto III (Cádiz). At CP Puerto I (Cádiz), in turn, it was mentioned that, due to the particular feature that the centre is specific for inmates under the closed regime (although not all of them participate in said program), the assessments contemplated by said Instruction are not performed, a fact that, in the opinion of this Institution, would be advisable, to know the number of persons released due to progression to the second grade, application of article 100.2 RP or other reasons, and to carry out an overall assessment of the program. In any case, the living regime applied at this CP to inmates, which is more flexible than the closed regime applied in ordinary prisons, to ensure that these inmates adapt to and are integrated into the ordinary living regime and that they are included in the closed regime regimental situation for the least possible time is to be pointed out.

Programs for mentally ill inmates

134. To attend the mentally ill, specialised programs exist at the CPs carried out in cooperation with the National confederation of organisations for the benefit of the mentally ill (FEAPS). The CP of Segovia has a unit for persons with disabilities consisting of the Special Educational

Unit and the Unit of Convicts with mental or sensory disabilities. At the Special Educational Unit, inaugurated in 2004 and the first in Spain, inmates are held who are serving a security penalty of deprivation of liberty with confinement in a special educational unit. The existence of this unit is a good practice which covers a need existing in the criminal and penitentiary system.

Most inmates residing in this unit are diagnosed mainly with mental disorders, generally minor-moderate, often accompanied by other pathologies or disorders, such as personality or behavioural disorders (lack of impulse control, physical or oral aggressiveness to themselves or to others), drug dependencies and/or alcoholism, psychiatric pathologies, neurological pathologies and sensory disability (deaf and dumb, poor eyesight, etc.).

Unit for persons with disabilities of the CP de Segovia

135. At the unit for persons with disabilities of CP Segovia the therapeutic community principle contemplated by article 115 RP is applied, so that the Treatment Board assumes functions of the Management Board and of the Discipline Committee relating to the inmates. This measure is currently lacking legislative implementation, so that the Management Board of the CP prepared two operating protocols that were approved by the Sub-directorates General for Prison Management and Penitentiary Treatment and Management.

The general objectives of the unit for persons with disabilities consist of working in cooperation with the families of the inmates, teaching them strategies that afford them personal independence and searching for an alternative to their treatment when the date on which they are to be released is close. In respect of the specific objectives, it is intended to encourage personal cleanliness and tidiness habits, provide them with professional and academic training promote pre-working habits, promote education for health, train them in social abilities, correct acquired criminal conducts and keep the family permanently informed.

Yard of the unit for persons with disabilities of the CP of Segovia

Training of inmates to support to the unit for persons with disabilities

136. It was observed that the inmates engaged in supporting the unit for persons with disabilities receive no training to deal with the users of the program (despite the fact that they cooperate on a permanent basis in treatment tasks with the action team). The SGIP reported that, although they do not receive formal training, support inmates are trained by the Treatment Team of the unit. In addition, at the visit it was observed that they had limited contact with inmates of other units, which would be advisable. The SGIP stated that support inmates are assisted by treatment personnel and, in the case of exhaustion, their change to other productive activities is ensured.

The Educational Therapeutic Unit for the treatment of drug addictions of the CP of Villabona (Asturias)

137. The Educational Therapeutic Unit for the treatment of drug addictions (UTE) is a pioneer project of the CP of Villabona (Asturias), which has extended to other centres, such as the CPs of Seville and Seville II. Since its commencement in 1991, the UTE of said CP was extended and at the time of the visit it had 5 prison units in which 3 UTEs were located. The working method consists of self-help therapeutic groups acting on cognitive-behavioural aspects in an educational area context in contrast with the traditional prison system. For such purpose, inmates must observe rules that are specified in the "therapeutic contract" that they must sign on entering the UTE.

Although the action model of the UTE has been acknowledged in various fields and is a reference for penitentiary action in Spain, during the visit it was observed that an internal reorganisation was being carried out that could imply material changes to the project, so that the Security and Justice Area of the Ombudsman's Office commenced an action ex officio with the SGIP.

Lacks in leisure and sports activities

138. With regard to leisure and sports activities, it must be pointed out that CP Puerto I (Cádiz) does not have an occupational or sports monitor, which lack is aggravated by the fact that no NGO cooperates with the centre implementing specific programs. Accordingly, the necessary measures should be adopted to remedy the situation.

Identification badge

139. During the visit to CP Segovia it was observed that certain officers did not carry the compulsory identification, which should be remedied pursuant to paragraph 125 of Annual Report 2012. The SGIP repeated to the personnel the obligation to carry the identification badge.

Food as a cause for complaint

140. Inmates occasionally complain of the food. At CP Puerto I (Cádiz), for example, a relevant number of inmates complained that the amount of food had decreased since a few months ago, which was confirmed by certain officers and some complaints were also received on the quality of the food, which was reported to the. At the CP of Segovia, on the other hand, the food provided by the centre was very positively valued by most of the inmates interviewed.

Lacks in the video-surveillance systems

141. As in previous years, lacks in the coverage of the video-surveillance systems were detected at the visits, since certain departments of the centre are usually not covered by such systems, so that the criterion of this Institution, contained in paragraphs 334 and 447 of Annual Report 2010 and 120 of Annual Report 2011 had to be repeated. The

fact that no video-surveillance exists in the cells where immobilisations are carried out in most CPs, as mentioned above, is of particular relevance. The SGIP reported that, to the extent permitted by the budget, video-surveillance systems will be installed at those CPs at which, given their age, this is more efficient and has more favourable effects. Thus, they informed us that such systems had been installed at certain CPs such as those of Badajoz, Castellón, Cuenca, Madrid I, Melilla and Valladolid. In addition, as regards the protocol for the recording and storage of images taken by the video-surveillance systems, it was reported that an instruction to regulate video-surveillance in the penitentiary context is being prepared.

In addition, at the CP of Segovia, several cameras were broken down and cuts occurred in the electricity supply interrupting the recordings. The SGIP reported that the cameras were being gradually replaced and that the breakdowns had been repaired.

Absence of a mechanical opening centralised system in some CPs

142. At certain CPs, such as Puerto I (Cádiz) and Villabona (Asturias), cells did not have a centralised mechanical opening system, which would be advisable to enable an urgent and fast evacuation in emergencies, in accordance with paragraph 156 of Annual Report 2011. Nevertheless, the SGIP reported that it was currently not possible to install these systems at CPs that do not have them available given the high cost involved and the difficulty of carrying out these actions at operating CPs.

Age of some of the centres visited

143. The age of the visited centres differed. The oldest was the CP for men of Barcelona, of 1904; it was followed by CP Puerto I (Cádiz), of 1981; the CP of Seville, of 1989; CP Villabona (Asturias), of 1991; the CP of Segovia, of 2000; the CP of Córdoba of 2002; CP Puerto III (Cádiz), of 2007; and, the most recent, CP Seville II, of 2008. The age of the facilities was obvious at the CP for men of Barcelona and CP Puerto I (Cádiz). In respect of the former, it must be mentioned that it is expected to close when so permitted by the budget. In respect of CP Puerto I (Cádiz), the following deficiencies are to be pointed out: the water pipes have a bad odour, there is an excessive presence of mosquitoes, it has no heating or air conditioning for use by inmates, certain areas were in a poor state of repair, with damp in some cells, the unit yards had no roofed area to permit their use in bad weather conditions and the cells had a squat toilet instead of an anti-vandal toilet.

Squat toilet in a cell of CP Puerto I (Cádiz)

Plan for Amortisation and Creation of Penitentiary Establishments

With regard to the conclusions and resolutions issued by the Ombudsman relating to the CP facilities visited in previous years, it is to be noted that the Cabinet of Ministers approved on 5 July 2013 an amendment to the Plan for Amortisation and Creation of Penitentiary Establishments (Plan de Amortisación y Creación de Establecimientos Penitenciarios –"PACEP"), which contemplates improvement works proposed by this Institution.

III. 2. Prison psychiatric hospitals

144. A security measure is the legal consequence applied to a person who had a criminal conduct from which he was declared exempt of criminal liability. In these cases, the judge or court may apply, if necessary, a measure without deprivation of liberty or a measure of custody for medical treatment or special education in an establishment adequate for the type of abnormality or mental disorder observed.

Security measures of deprivation of liberty may be applied in prison psychiatric hospitals or units, prisons or psychiatric centres of the public healthcare network

In the case of persons with a mental disease, security measures of deprivation of liberty may be applied in penitentiary psychiatric hospitals or units, at ordinary penitentiary units or at psychiatric centres of the public healthcare network. The few alternatives for such security measures means that in most cases judges designate prisons and prison psychiatric hospitals for the purpose. The authorities having centres of this type are the two that exercise penitentiary powers: the Secretary General for Penitentiary Institutions, attached to the Ministry of the Interior, and the Department of Justice of the Government of Catalonia.

The fact that it is declared that the inmates cannot be held accountable means that they are persons with diseases, instead of convicts. Accordingly, the regulation of these establishments differs completely from that of the rest of penitentiary places and is contemplated in articles 183 to 191 RP.

Two prison psychiatric hospitals of the SGIP

145. The Secretary General for Penitentiary Institutions had two prison psychiatric hospitals (HPP), in Fontcalent (Alacant/ Alicante) and Seville. Due to its geographical location, the HPP de Seville is intended for the confinement of the male prison population of Andalusia, Canary Islands, Extremadura and the autonomous cities of Ceuta and Melilla, while the HPP of Alicante would take care of the rest of the Spanish territory and of the entire female psychiatric prison population although this is not always the case in practice. Persons declared not accountable on whom a security measure in an HPP has been imposed, persons who while involved in a criminal court proceeding require a psychiatric expert report or assessment to be performed on them and convicts on whom a security measure has been imposed due to supervening mental disease are to be found in HPPs.

Healthcare network of the penitentiary system of Catalonia

146. The penitentiary system of Catalonia has available a healthcare network created under the agreement reached in 2001 between the Departments of Justice and Health of the Government of Catalonia and the Mental Health Services of the Order of the Brothers Hospitallers of St. John of God. Under said agreement, said Order of the Brothers Hospitallers assumes the management of the prison psychiatric resources of Catalonia. The network consists of the following specialised resources:

Table 40

Specialised resources of the psychiatric network of the penitentiary system of Catalonia

RESOURCE	PROFILE OF PATIENTS
Polyvalent Psychiatric Unit of CP Quatre Camins	Long/medium stay patients, with behavioural problems and who do not need intense rehabilitation work. • External surgery/ambulatory treatment–day hospital. • Rehabilitation unit.
Prison Psychiatric Hospitalisation Unit of CP Brians-1 (UHPP-C)	Acute and disturbed patients. • Acute patients unit. Patients with serious psychotic condition or very disturbed. It is attempted that they stay two weeks at the most and are subsequently transferred to the subacute patients unit. • Subacute patients unit. Patients with a productive psychotic condition but without special handling problems. Patients may stay several months at it, depending on the type and duration of the measure. • Medium-long stay unit. • Unit of transit to community. It prepares the transit to the community of patients subject to a security measure.
Prison Psychiatric Rehabilitation Unit of CP Brians–2 (URPP)	Chronic patients with a rehabilitation profile and without serious behavioural disorders. • Crisis observation unit. • Intensive rehabilitation unit for serious mental disorders.

Apart from these specialised resources, the infirmaries of CP Brians-1, the CP for men of Barcelona and the CP for women of Barcelona have a specific psychiatric area attended also by personnel of St. John of God. They assist convicted mentally ill patients who cannot be handled in the responsible unit of the prison and must be interned in the infirmary, but whose condition is not sufficiently serious for their custody in a specialised unit.

In the penitentiary system of Catalonia, inmates are referred to a mental health treatment unit is made taking into account their psychiatric state not their legal-procedural situation. Thus, persons under security measures may be interned in the psychiatric infirmary of a CP or in one of the specialised units, depending on the clinical criterion, while convicts with psychiatric pathologies may stay either at one of such units or at an ordinary unit with ambulatory treatment.

Two visits to prison psychiatric hospitals in 2013

147. In 2011, the NPM made the first visit to a place of deprivation of liberty of this type, the HPP of Alicante, and, in 2013, the HPP of Seville and UHPP-C (Barcelona) were visited. The former is located in the complex of CP Seville I and the latter is within CP Brians 1 (Barcelona). All visits were multidisciplinary, with psychiatrists and psychologists forming part of the visiting team.

Chart 6
Geographical location of HPPs visited in 2013

Various organisational structures

148. The UHPP-C functions for all purposes as a hospital centre within a CP and it is the healthcare personnel who make key decisions in respect of the patients, including their transfer between the various units of the network. The HPP of Seville, however, has an organisation structure similar to that of ordinary CPs and psychiatrists have solely a clinical role. Accordingly, a Recommendation has been made to the SGIP for them to adopt the measures necessary to provide the organisation structure of the HPPs of Fontcalent (Alacant/Alicante) and Seville with a more healthcare nature, for them to be similar to hospital institutions.

Suggestion on excessive occupancy at the HPP of Seville

149. At the time of the visit, the HPP of Seville had 180 patients. According to the information provided, the average population of the centre is 182 patients and, although it formally has 184 places, it is an area initially designed for 120, making the handling of patients more difficult. The SGIP reported that one of the factors causing such excess occupancy is the scarce external resources provided to continue healthcare and the existing difficulties to refer patients to autonomic social healthcare resources, in addition to the fact that the court criterion of custody and release prevails. Accordingly, a suggestion was made to the SGIP for strategies to be considered to correct the current situation of excessive occupancy.

Table 41

Occupancy of psychiatric hospitals of the Secretary General for Penitentiary Institutions by gender and procedural-criminal situation at 31 December 2013

CENTRES	PREVENTIVE		PRISON SENTENCES		SECURITY MEASURES		TOTAL
	Men	Women	Men	Women	Men	Women	
Prison Hospital Seville	11	0	12	0	147	0	170
Prison Hospital Alicante	5	0	14	4	265	33	321
TOTAL	16	0	26	4	412	33	491
%	**3.25**	**0.00**	**5.29**	**0.81**	**83.93**	**6.72**	**100.00**

In respect of the UHPP-C (Barcelona), at the time of the visit, the number of patients was 46, in contrast with the 63 available places. According to the information provided, the average occupancy is between 80% and 90%.

Table 42

Patients of the UHPP-C in terms of units and legal-procedural situation in 2012

	ACUTE	SUBACUTE	REHABILITATION-1	REHABILITATION-2	TOTAL	%
Convicted	113	1	0	0	**114**	67.05
Preventative	35	0	0	0	**35**	20.59
Preventative in assessment	2	0	0	0	**2**	1.18
Security measures	18	0	1	0	**19**	11.18
TOTAL	**168**	**1**	**1**	**0**	**170**	**100.00**

Table 43

Entries and registrations of patients of the UHPP-C by units in 2012

	ACUTE	SUBACUTE	REHABILITATION-1	REHABILITATION-2	TOTAL	%
First entry	90	0	1	0	91	33.96
First re-entry	53	1	0	0	54	20.15
Re-entry	25	0	0	0	25	9.33
Change of unit	2	82	12	2	98	36.56
TOTAL ADMISSIONS	**170**	**83**	**13**	**2**	**268**	**100.00**
Releases	88	81	11	0	180	63.38
Releases change of unit	86	14	3	1	104	36.62
TOTAL RELEASES	**174**	**95**	**14**	**1**	**284**	**100.00**
Emergencies	0	0	0	0	245	0

Profile of the patients in the HPP of Seville

150. With regard to the profile of the patients, the HPP of Seville has three units for patients without a specific profile and one unit for miscellaneous patients: patients with decompensation of their previous pathology who require greater supervision (acute patients unit), isolation of patients with disruptive behaviours, newly admitted patients, patients with reduced mobility, patients included in the suicide prevention plan and patients with serious organic diseases. Since some of the functions assumed by this unit appear to be incompatible with each other, it would be advisable to have specific areas and resources available for them not to hinder each other. The SGIP reported that this is not possible given the current level of occupancy.

Reference unit in the penitentiary system of Catalonia

In turn, the UHPP-C (Barcelona) is the reference unit in the penitentiary system of Catalonia for acute patients requiring admission into hospital or who may benefit from certain specific programs implemented at the unit.

Information delivered to patients on admission

151. At the HPP of Seville, the information delivered to patients upon admission is adequate, although it would be desirable for such information to be available in other languages as well as Spanish, for it to be delivered both to patients and to their family relatives and for it to be situated in a prominent place in various locations of the centre. The SGIP reported that, where the budget so permits, the information will be made available in other languages.

The information conveyed regularly to the judge must be exhaustive

152. Given the particular features of confinement in these centres, the multidisciplinary team must issue a report every six months on the state and evolution of the patient for due control by the court. Based on such information, the Penitentiary Surveillance Judge may submit to the sentencing judge or court, at least on a yearly basis, a proposal for maintenance, replacement or substitution of the security measure of deprivation of liberty. At the HPP of Seville it was observed that, in the report that is sent to the Penitentiary Surveillance Judge, the section on action programs is not completed. In the opinion of this Institution, the information sent at regular intervals to the penitentiary surveillance judge should be exhaustive, a criterion that was accepted by the SGIP.

Recommendation for healthcare personnel in HPPs of the SGIP

153. These establishments must have available rehabilitating activities and individual rehabilitation programs for each patient. A recommendation has been made to the SGIP for both this centre and the HPP of Fontcalent (Alacant/Alicante) to increase healthcare personnel, to increase the actual possibilities of performing individual actions and rehabilitation activities. The SGIP accepted the Recommendation, although it is waiting until this is feasible given the economic situation. In addition, it is considered that the HPP of Seville should adopt the necessary measures for an individual action plan to be implemented with patients including an evaluation and a proposal of therapeutic objectives and activities, to be updated regularly. The SGIP accepted and, accordingly, the Multidisciplinary Team of the centre prepared a specific standard individual action plan.

Suggestion for reconsideration of timetable of activities in the HPP of Seville

154. Many patients complained of the lack of activities over a large part of the day. At the HPP of Seville, a suggestion was made for it to reconsider the timetable of activities and reinforce them, to prevent there being many times during the day when patients have nothing to do, particularly as regards those with greater rehabilitation potential.

Suggestions for rehabilitation activities to be increased in the HPP of Seville and the UHPP-C (Barcelona)

In addition, both at the HPP of Seville and at UHPP-C (Barcelona), many activities and trips, although classified as "therapeutic", are rather of an occupational or training nature. Two suggestions have been made for the number of rehabilitation activities, meaning specific training in abilities, to be extended according to an individual plan designed based on a personal evaluation. The Department of Justice rejected the Suggestion and the SGIP had not answered at the date of this report.

Educational assistance

155. The HPP of Seville has a school with a teacher reporting to the Department of Education, Culture and Sports of the Government of Andalusia. Since 88 students were registered in the 2012/2013 year, 47 of whom finished the school year, it would be advisable to engage another professional to be able to provide patients with better educational assistance. Said Department reported that it would consider this possibility depending on the demand. Lack of coordination between the teacher and the rest of professionals of the multidisciplinary team, particularly the psychologist, was observed. Their integration into the process with the rest of professionals would be advisable, for a joint working plan to be established and for the teacher to receive written guidelines or recommendations to deal with the most difficult patients, which criterion was accepted by the SGIP.

Grounds for release

156. Admission to HPPs may occur for various reasons, mainly imposition of the security measure (or sentence, in the case of the penitentiary system of Catalonia) or pursuant to the rehabilitation program (with court authorisation).

Cooperation of other public authorities is necessary

In the case of the HPP of Seville, prior to release, the Penitentiary Authority requests the cooperation of other public authorities with competence for the matter for the psychiatric treatment of the inmates to continue, if necessary, after their release from confinement and for patients whose personal and procedural situation so permits to be included in the rehabilitation programs and in the intermediate structures existing in the community mental healthcare model. In this respect, it must be pointed out that, at the HPP of Seville, a better coordination was observed with the Authority and the social healthcare resources than at the visit made in 2011 to the HPP of Fontcalent (Alacant/Alicante), where patients from many autonomous communities are admitted meaning that a greater effort must be made to connect with the autonomous health services and the respective social alternatives. In this respect the "Protocol for referral of patients to the public mental health network by agreement between the Healthcare Services of Andalusia, FAISEM (Fundación Pública Andaluza para la Integración

Social de Personas con Enfermedad Mental) and the HPP", currently being prepared, to enable patients to be assisted in an alternative surrounding before having served the time of deprivation of liberty that the maximum sentence would have implied, is a good practice, and progress should continue to be made along these lines. The SGIP reported that the Committee for analysis of cases of mentally ill persons subject to court proceedings of the Autonomous Community of Andalusia will be called to make progress in this field.

Recommendation to the SGIP for preparation of exit and accompanying of the patient to be reinforced

In turn, a recommendation has been made to the SGIP for preparation of the exit and accompanying of the patient in the first steps of the social reinsertion process to be reinforced, providing the adequate preliminary and subsequent support to the family and implementing the transfer of the patient to clinical and social services facilities of the area.

The good practice of the small facilities network

In the penitentiary system of Catalonia, the existence of a network of small facilities is a good practice that permits adapted programs to be prepared and work to be done for community insertion, without the patient losing contact with the environment. The Service of Alternative Criminal Measures, which specifically monitors these measures, is also to be pointed out. The risk assessment protocols, both general of the penitentiary institutions of Catalonia, and specific of the UHPP-C (Barcelona), which use objective evaluation scales that permit the minor, moderate or serious risk posed by a patient to be appraised, which may facilitate the making of administrative and court decisions, is also worthy of mention.

The provisions of the disciplinary system are not applicable to patients of HPPs

157. Article 188.4 RP establishes that the disciplinary regime provisions will not apply to patients of the HPPs. In the case of violation of cohabitation rules, measures will apply depending on the context and patient, of which patients of both centres complained. In respect of the HPP of Seville, a suggestion was made to the SGIP for the appropriate instructions to be given for the measures to be adopted in the event of violation of cohabitation rules to follow the adequate procedures for the adoption of therapeutic measures such as medical prescription and insertion in a therapeutic framework, which suggestion has not yet been answered. In respect of the UHPP-C (Barcelona), a suggestion was made to the Department of Justice of the Government of Catalonia, for the communication of the reason and logic of the rules to patients to be improved. This Suggestion was rejected.

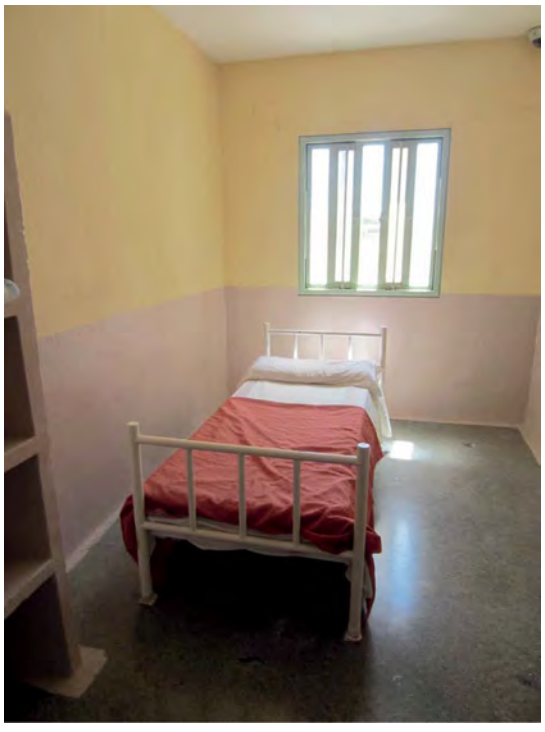
Isolation and coercive measures

158. In situations of lack of impulse control or behavioural disorders, when oral admonishment is unsuccessful, isolation and coercive measures are adopted.

At the HPP of Seville, the head of the service may decide –generally at the proposal of the psychiatrist or professional on shift – to move the patient to the acute patients unit. Subsequently, the fact is evaluated by the multidisciplinary team that may order the adequate therapeutic measures: 1) transfer to the acute patients unit, in an individual room

under restricted contact with other inmates; 2) transfer to the acute patients unit in a room with video-surveillance for patients with high risk of suicide; 3) transfer to the acute patients unit in isolation, going out to the yard without contact with other patients; 4) Regimental Special Surveillance (Vigilancia Especial Regimental – "VER"), for patients whose attitude intimidates, threatens or extorts the rest, or who recently attacked an officer or another inmate. Under the VER regime, the patient is held in the acute patients unit in an individual room and is allowed out to the yard for one hour without coinciding with the rest of the patients, and special security and violent act prevention measures are applied, such as daily search of the room and belongings. It was observed that the duration of the measure is approximately one week.

Observation room of the acute patients unit at the HPP of Seville



At UHPP-C (Barcelona), when such situations arise, the "living regime of Separation of the Patient from the Surroundings (Régimen de Vida con Separación del Paciente del Entorno –"RVSE") and the Restricted Living Regime (Régimen de Vida Restringido –"RVR") are applied. Under the RVSE, the patient remains, alone or with other patients, in a room free from potentially hazardous objects (room M-13 or "Mille"), in which he may be observed by the infirmary personnel. This room contains only one central table and several chairs anchored to the floor. Patients remain in room for between a few hours to days, the measure to be reassessed in the shift changes by the referral psychiatrist. The RVR is implemented in the room of the inmate. The inmate remains locked in the room, activities are suspended and he is only allowed to go to the yard at times when there are no other inmates.

Room M-13 or “Mille” of the UHPP-C

Regimental isolation measure should be included in a broader plan

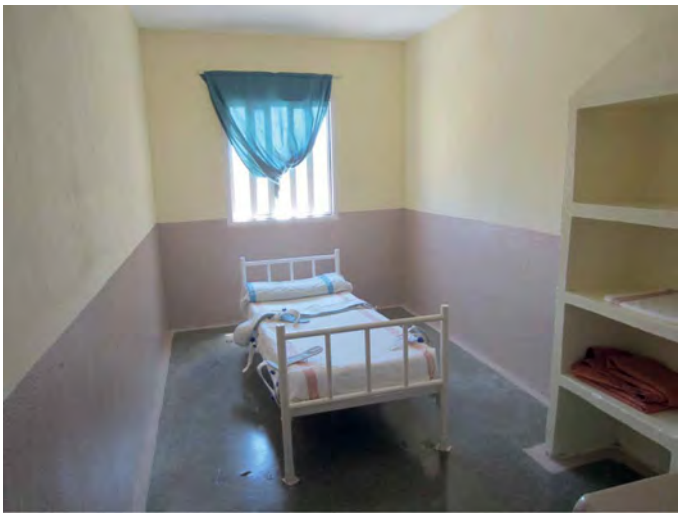
Application of mechanical restraints

the various protocols arise from the different objectives of the measure in each case.

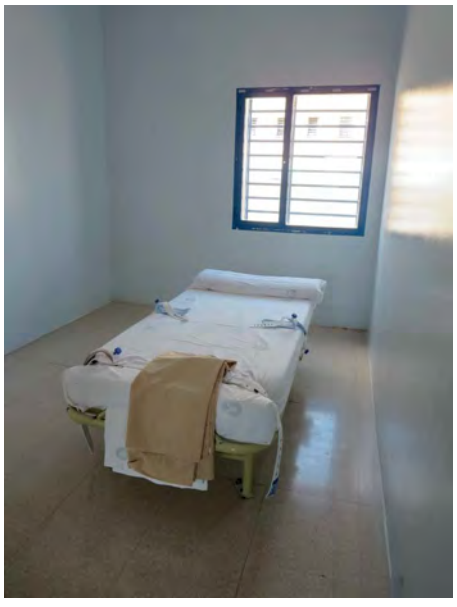
Mechanical restraints adequately recorded

At both centres it was verified that mechanical restraints were duly recorded, although at the UHPP-C (Barcelona) it was observed that, in certain cases, in the forms sent to the penitentiary surveillance judge the section on medical evaluation, related to whether or not injuries were observed after release from immobilisation, had not been completed, so that a suggestion was made to the Department of Justice of the Government of Catalonia for all sections of said document to be completed, which was rejected since said department considered that the forms were correctly completed. At the UHPP-C (Barcelona), in addition, two video-surveillance recordings of two mechanical restraints were viewed.

Room prepared for mechanical restraint of the HPP of Seville



Room prepared for mechanical restraint of the UHPP-C of Barcelona



Include mental state of aggressor in injury reports

162. At the HPP of Seville, when one inmate attacks another, the injury report of the attacked inmate is remitted to the duty court but no document is kept rendering account of the mental state of the aggressor, in general and at the time of the aggression, which would be desirable. The SGIP accepted this criterion.

At the HPP of Seville the dosage and combination of medication should be reviewed

163. Excess medication has various important implications on the health and the welfare of patients: risks arising from cardiovascular side effects (high rates of metabolic syndrome, morbid obesity...), neuro-motor problems in the short term (walking difficulties) and in the mean and long terms (dyskinesia, trembling and others), an unkempt look and chronicity which has effects on the image and self-esteem of the patient, a feeling of fogginess and slowness, hindering the rehabilitation programs. Because of this, at the visits, the clinical records of certain patients are reviewed, analysing the medical and psychiatric record and, particularly, the pharmacological background of the inmates and the current prescription guidelines. At the HPP of Seville, a considerable number of the consulted clinical records recorded combinations and high dosage of medication. Accordingly, in the opinion of this Institution, the dosage and combination of the medication dispensed to patients should be reviewed, a criterion that was accepted by the SGIP.

Healthcare

164. In respect of healthcare, at the HPP of Seville it was observed that certain low-cost and high-impact healthcare technique means were lacking (such as a spirometer, a more modern electrocardiogram machine and minor surgery instruments), and that few programs were in place for chronic patients. The SGIP requested a report from the medical deputy director on such needs. At CP Brians-1 (Barcelona), the pilot experience of the drug addictions assistance and monitoring centre (CAS) is an example of good practice.

Management of clinical information at the HPP of Seville

165. As regards the management of clinical information, it would be advisable for an agreement to be reached between the Secretary General for Penitentiary Institutions and the Health Department of the Government of Andalusia for the professionals of the HPP of Seville to be able to access the clinical information of the Healthcare Service of Andalusia, to have available the medical records of the patients and avoid duplicated tests, among other advantages. The SGIP reported that this matter would be insisted on at the next meeting of the steering committee of the agreement between the two authorities.

Suicide prevention

166. At the HPP of Seville, instead of the Suicide Prevention Protocol (Protocolo de Prevención de Suicidios –"PPS") of the SGIP, the Suicide Risks Protocol (Protocolo de Riesgo de Suicidio –"PRS") is used, implying the transfer to unit 2 and the adoption of certain precautionary measures, such as the removal of belongings and potentially hazardous objects. The SGIP reported that the PRS is adapted to the features of psychiatric patients and patients are adequately monitored and controlled by psychiatrists and ancillary personnel.

Ongoing training of personnel

167. Both at the HPP of Seville and at the UHPP-C (Barcelona) courses are given for ongoing training of personnel (for example,

peaceful dispute resolution or handling of patients with mental diseases), which must be positively valued.

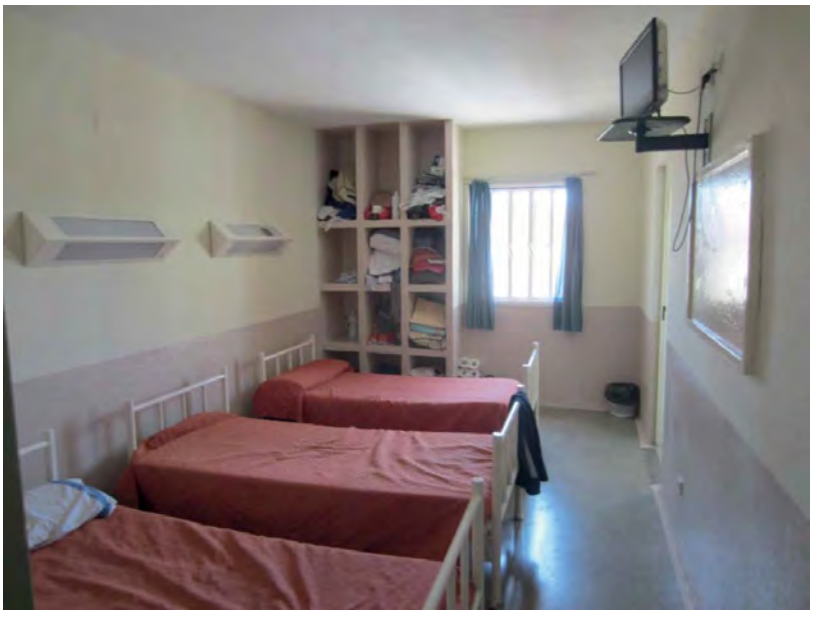
Favourable evaluation by inmates and their family relatives

168. Most inmates interviewed at the HPP of Seville and the UHPP-C (Barcelona) valued the professionalism and treatment of healthcare and non-healthcare personnel very favourably. Likewise, the valuation of the centre by the interviewed family relatives was very positive.

The facilities of the HPP of Seville limit their standard use as a social healthcare institution

169. In respect of the facilities, the HPP of Seville was inaugurated in 1990 and is within the complex of CP Seville I, although it has a completely independent functional, administrative and security structure. It depends on the CP Seville I only for preparation of food and exterior security. The fact that it is located within a prison complex and the facilities themselves nevertheless imply a limitation to its normal use as a social healthcare institution: isolation of population groups, little space in rooms, common areas and yards, areas designed rather for rehabilitation of patients, prison architecture, lack of accessibility, etc. The SGIP reported that the improvement of accessibility to the CP will be studied.

One three-person room in the HPP of Seville



One of the yards of the HPP of Seville

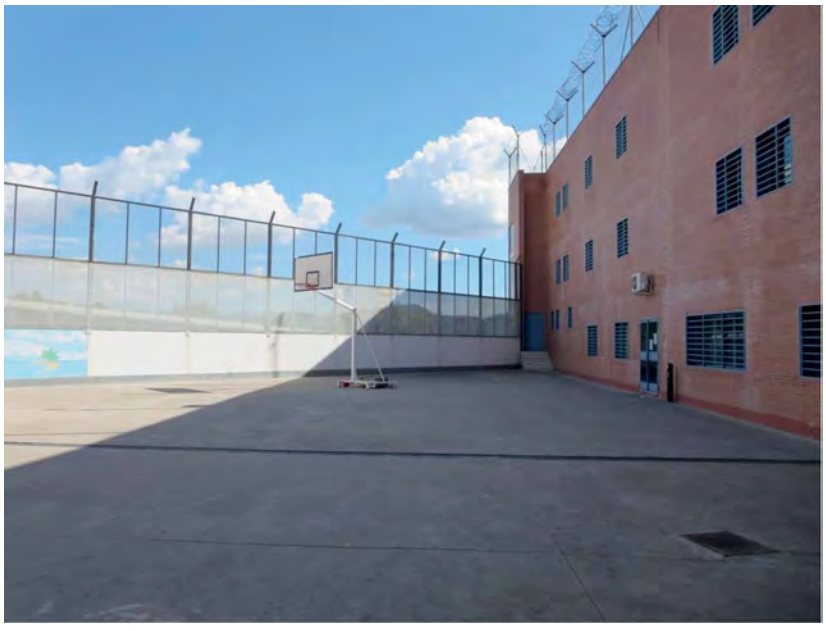
Gardens of the HPP of Seville

In turn, the UHPP-C (Barcelona) is located in the CP of Brians-1. Although the CP dates from 1991, the unit was created in 2003. The unit has modern healthcare inspired facilities, but very limited space, with small common areas and a very small yard. Because of this, a suggestion was made to the Department of Justice of the Government of Catalonia for the necessary measures to be adopted to correct the limited space of the facilities of the UHPP-C, which are adequate for short stays but not for patients who must stay at them for months or even years. Said department rejected the suggestion, stating that activities are performed at the facilities of the CP of Brians-1, and out of doors.

Modern healthcare inspired facilities of the centre of Barcelona, but limited space

Standard room of the sub-acute patients and re-habilitation units

Yard of the UHPP-C



Food of the HPP of Seville

170. At the HPP of Seville, food was poorly valued by most interviewed inmates. The SGIP reported that the Medical Deputy Manager had been given orders to increase supervision of the quality of the food provided.

Transfer of patients between centres of the SGIP could have effects on the state and evolution of the patient

171. The moving of patients between the HPP of Seville and the HPP of Fontcalent (Alacant/Alicante) or to other CPs means that the patient must go through various penitentiary centres for several days or even weeks until he reaches his destination. Thus, the transfer from Seville to Alicante may take up to two weeks from when the patient leaves Seville until he arrives at his destination, going through various penitentiary centres. This long trip is stressing to the patients of the HPP in a context in which adequate and complete dispensation of

the usual medicines can probably not be ensured. The SGIP reported that, in the most serious cases, in which the medical services do not advise an ordinary transfer, the transfer in a special and direct move is requested, although according to the data sent this kind of transfers is ordered only by exception. In the opinion of this Institution, it would be more adequate for the medical practitioner, before the manner in which the person is to be moved is decided, to report whether, if the transfer is carried out in the ordinary manner in a regular transportation –of the specific conditions of which he should be aware: number of hours of each journey, nights stayed at CPs and total duration of transportation– this could have effects on the state and evolution of the patient, taking into account his pathology, his past and current state, the risk of alterations in the taking of medicine and other circumstances of interest, to be able to assess with such information more adequately whether it is advisable to transfer the person in question in a special manner, to safeguard the patients' health.

III. 3. Centres for young offenders

16,172 final judgments

172. According to a report issued by the National Statistics Institute (Instituto Nacional de Estadística –"INE") published in September 2013, in 2012, a total 16,172 final judgments were entered at the Registry of Young Offender Criminal Liability Judgments, implying a decrease of 5.1% in respect of the previous year. The rate of young offenders aged from 14 to 17 years convicted per 1,000 inhabitants in the same age group was 9.3, in contrast with the 9.7 registered the previous year. By gender, male young offenders perpetrated 83.3% of the offenses and female young offenders 16.7%.

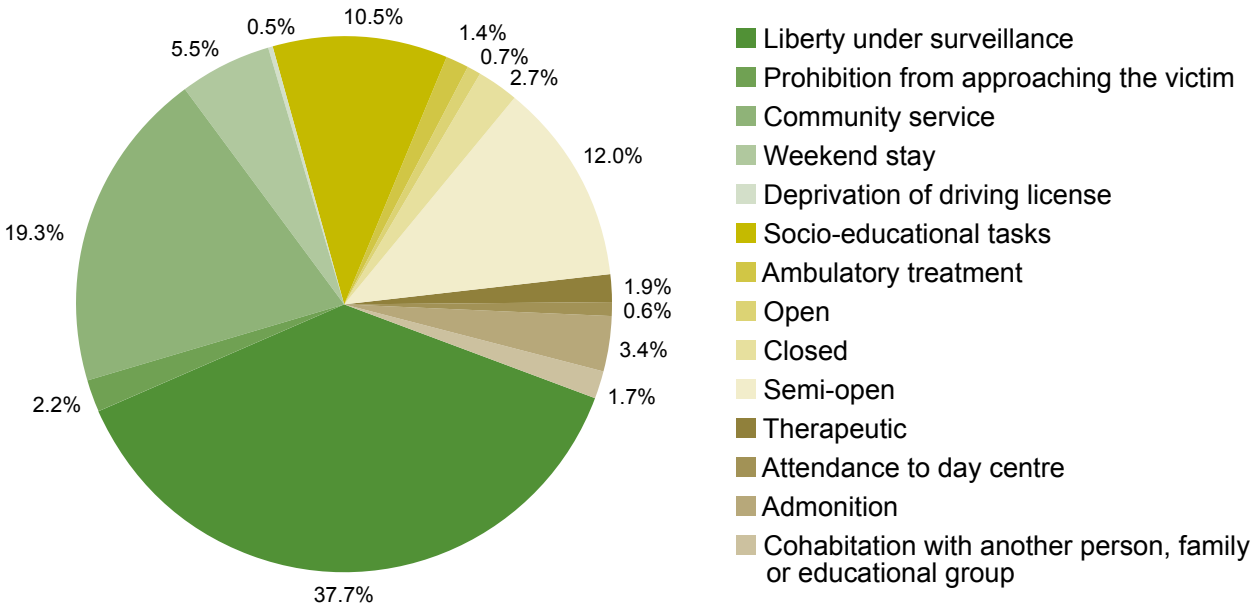
7.1% increase of measures

In 2012, judges ordered 25,393 measures, an increase of 7.1% in respect of the previous year.

Measured imposed by the court

173. The following tables refer to measures imposed by the courts on young offenders based on national and autonomous community data of year 2012, included in the last statistics published by the INE. The following picture shows in further detail the measures of custody under the various regimes having effects on the right to liberty.

Graphic 7
Type of court measures imposed on minors in 2012



Source: Operation by INE of the Central Registry of Young Offender Criminal Liability Judgments.

Table 44
Measures enforced in 2012 in autonomous communities and cities, according to custody regime

AUTONOMOUS COMMUNITIES	OPEN CUSTODY	SEMI-OPEN CUSTODY	CLOSED CUSTODY	THERAPEUTIC CUSTODY IN CLOSED, SEMI-OPEN OR OPEN REGIME
Andalusia	37	616	29	133
Aragon	2	101	5	18
Principality of Asturias	0	120	8	1
Balearic Islands	6	143	12	16
Canary Islands	5	56	3	78
Cantabria	0	21	1	13
Castile-La Mancha	62	144	30	28
Castile and Leon	8	71	18	11
Catalonia	6	347	351	26
Ceuta	0	15	13	0
Autonomous Community of Valencia	12	611	48	42
Extremadura	1	31	0	6
Galicia	5	147	74	33
La Rioja	0	26	4	0
Autonomous Community of Madrid	15	265	56	47
Melilla	0	31	4	5
Murcia	14	172	17	0
Navarre	0	42	2	3
Basque Country	9	99	5	10
TOTAL	**182**	**3,058**	**680**	**470**

Source: Operation by INE of the Central Registry of Young Offender Criminal Liability Judgments

Table 45

Measures adopted in 2012, according to custody regime and gender of young offenders

	OPEN CUSTODY	SEMI-OPEN CUSTODY	CLOSED CUSTODY	THERAPÉUTIC CUSTODY IN CLOSED, SEMI-CLOSED OR OPEN REGIME
Male	150	2,729	629	410
Female	32	329	51	60
TOTAL	**182**	**3,058**	**680**	**470**

Source: Operation by INE of the Central Registry of Young offender Criminal Liability Judgments.

Table 46

Measures adopted in 2012, according to custody regime and nationality of young offender

	OPEN CUSTODY	SEMI-OPEN CUSTODY	CLOSED CUSTODY	THERAPÉUTIC CUSTODY IN CLOSED, SEMI-CLOSED OR OPEN REGIME
Spanish nationals	145	2,080	359	384
Foreign nationals	37	978	321	86
TOTAL	**182**	**3,058**	**680**	**470**

Source: Operation by INE of the Central Registry of Young Offender Criminal Liability Judgments.

Complaints or claims

174. The following table shows information provided by autonomous communities and cities on complaints or claims received in 2013 for purported torture, ill-treatment, cruel or inhuman treatment suffered by inmates in centres for young offenders.

Table 47

Complaints and claims in 2013 for purported ill-treatment at centres for young offenders

AUTONOMOUS COMMUNITY OR CITY	INFORMATION	COMPLAINT/ CLAIMS
Andalusia	3 complaints filed at the responsible Courts of Investigation. All cases were dismissed for lack of charging grounds.	3
Aragon	No complaints.	0
Asturias	1 complaint before the Juvenile Court for the treatment received by one worker. The complaint was dismissed by the Juvenile Public Prosecution on not considering the action of the worker to be a criminal infringement.	1

Table 47
Complaints and claims in 2013 for purported ill-treatment at centres for young offenders

AUTONOMOUS COMMUNITY OR CITY	INFORMATION	COMPLAINT/ CLAIMS
Balearic Islands	3 complaints. The security enterprise of Es Pinaret imposed a disciplinary penalty on a security guard for two misdemeanours related to direct treatment of young offenders of the centre, who were provisionally removed. Suspension of entry for an unlimited duration of four security guards at Es Pinaret until conclusion of the investigation commenced by the National Police. Suspension of entry of a security guard in Es Fusteret until resolution of the complaint.	3
Canary Islands	No complaints	0
Cantabria	No complaints	0
Castile-La Mancha	No complaints	0
Castile and Leon	No complaints	0
Catalonia	1 complaint Separation from the service of one security guard of the Centre L´Alzina for disproportionate action during the physical restraint of a minor.	1
Ceuta	12 complaints at the Centre for Young Offenders “Punta Blanca” referred to the Juvenile Court	12
Comunitat Valenciana	12 complaints at the Centre for Young Offenders “Punta Blanca” referred to the Juvenile Court.	0
Extremadura	No complaints	0
Galicia	No complaints	0
La Rioja	No complaints	0
Autonomous Community of Madrid	No complaints	0
Melilla	No complaints	0
Murcia	No complaints	0
Navarre	Four complaints were processed against workers of the court measures centre of Ilundain, of which 2 were dismissed and the other 2 did not prevail.	4
Basque Country	No complaints	0

Source: Own preparation based on data furnished by autonomous communities and cities.

Six visits to centres for young offenders

175. In 2013 six visits were made to centres for young offenders (CMI), as shown in tables 48 and 49. The visit to the centre “Las Lagunillas”, in Jaén, was for follow up of the visit made in 2011 and that of “Albaidel”, in Albacete, was made to follow up the two made in 2011. Two of the visited centres were therapeutic: “Montefiz”, in Ourense, and the Therapeutic Unit of “Els Til·lers”, in Mollet del Vallés, Barce-

lona. All of them, except for that made to the centre of “Albaidel”, were multidisciplinary visits in which external technical experts in psychiatry and psychology participated. In addition, two Members of the Advisory Board of the NPM participated in the visit made to the Therapeutic Unit of “Els Til·lers”.

176. All the visited centres are publicly owned. That of “Albaidel”, in Albacete and that of “Sograndio”, in Oviedo, are publicly managed. That of “Las Lagunillas”, in Jaén, is managed by the Foundation Fundación DIAGRAMA; those of “Montefiz” and “Monteledo”, in Ourense, by the International Foundation O´Belén and the Foundation Camiña Social, respectively, and that of “Els Til-lers”, by the Foundation Sant Joan de Dèu.

All centres visited were publicly-owned

Chart 8
Geographical location of centres for young offenders visited in 2013

Capacity and places of visited centres

177. The capacity of each visited centre and the number of places occupied on the days of the visit are set out in the following table.

Table 48
Places and occupancy of visited centres for young offenders

CENTRES VISITED	NUMBER OF PLACES	OCCUPATI0N
CMI Albaidel (Albacete)	31	20*
CMI Els Til·lers (Mollet del Vallès, Barcelona)	12	12
CMI Las Lagunillas (Jaén)	56**	46***
CMI Montefiz (Ourense)	23	23
CMI Monteledo (Ourense)	45	28
CMI Sograndio (Oviedo, Asturias)	68	39****

Source: Own preparation based on data furnished by the centres.
* This is the occupancy of the 3rd visit, at the 1st 23 places were occupied and at the 2nd 21 places were occupied.
** The Centre Lagunillas has 56 places, but 48 places are arranged with the Authority.
*** This is the occupancy of the 2nd visit, at the 1st 37 were occupied
**** Two of the young offenders are under the weekend regime

Distribution of inmates

178. The distribution of inmates in the various centres, according to the agreed regimes and type of court decision was as follows:

Table 49
Custody regimes and type of court decision of centres for young offenders visited

CMI Albaidel	
Custody regime	**No. of minors**
Semi-open regime	15
Closed regime	5
Court decision	**No. of minors**
Final	15
Precautionary	5
CMI Els Til·lers	
Custody regime	**N.º menores**
Semi-open regime	3
Semi-open therapeutic regime	4
Closed regime	4
Closed therapeutic regime	1
Court decision	

Table 49

Custody regimes and type of court decision of centres for young offenders visited

Final	6
Precautionary	6
CMI Las Lagunillas	
Custody regime	**No. of minors**
Open regime	1
Semi-open regime	43
Closed regime	1
Weekend regime	1
Court decision	**N.º of minors**
Final	36
Precautionary	10
CMI Montefiz	
Custody regime	**No. of minors**
Semi-open therapeutic regime	18
Closed therapeutic regime	5
Court decision	**No. of minors**
Final therapeutic	14
Precautionary therapeutic	9
CMI Monteledo	
Custody regime	**No. of minors**
Semi-open regime	12
Closed regime	16
Court decision	**No. of minors**
Final	11
Precautionary	17
CMI Sograndio	
Custody regime	**No. of minors**
Semi-open regime	29
Semi-open therapeutic regime	2
Closed regime	5
Closed therapeutic regime	1
Weekend regime	2
Court decision	**No. of minors**
Final	34
Precautionary	5

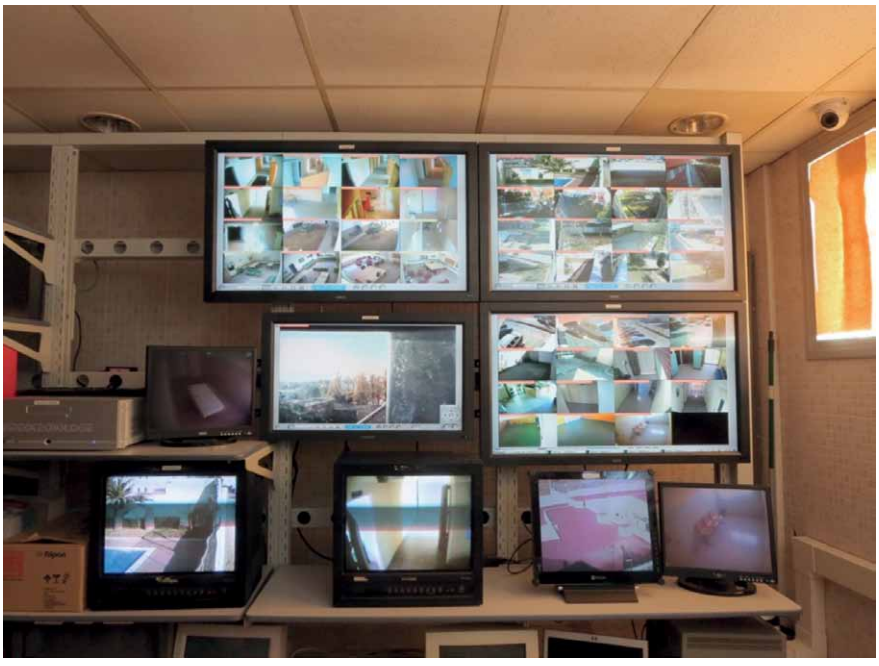
Video-surveillance system. Failure to meet criteria

179. Failure to comply in full with the criteria contemplated and implemented in paragraph 477 of Annual Report 2010 and paragraph 142 of Annual Report 2012, relating to the video-surveillance system continues to be observed. The centre of "Sograndio" has very limited coverage not including common areas of provisional isolation rooms. Those of "Las Lagunillas" and "Monteledo" do not include all common areas and that of "Montefiz" was lacking any video-surveillance system whatsoever. Nevertheless, the authorities responsible for these centres will take into account the criterion conveyed when so permitted by the budget.

Suggestion for removal of cameras in visit rooms, not accepted

In the case of "Albaidel" a Suggestion was made for the cameras installed in two visit rooms to be removed, since they could violate the right to personal and family privacy of the detainee young offenders. The Department of Health and Social Affairs of the Government of Communities of Castile-La Mancha did not accept the Suggestion on considering that these rooms are exposed to the passing of non-permitted substances and unauthorized objects by the family relatives of the minors and that they would imply a serious risk to their own health and to that of other detainee inmates.

Viewing screens at "Els Til·lers", Mollet del Vallès (Barcelona)



Formalities for admission or stay. Documentation

180. In respect of the formalities for entry or admission of young offenders, it was ascertained that these are sufficiently recorded, in accordance with the criterion established in paragraph 143 of Annual Report 2012. Likewise, according to paragraph 146 of Annual Report 2012, the information provided to inmates is explained clearly and comprehensively in various languages, its contents including all matters related to internal operation, rights and duties, disciplinary rules and means to file requests, claims and appeals. However, in "Sograndio", it was observed that the information provided did not conform to the level of training or knowledge of the Spanish language of many

of the inmates. The Directorate General for Justice and The Interior of the Government of the Principality of Asturias clarified that this circumstance is remedied in the interviews that educators hold for such purposes with all young offenders. The lack of delivery of copies of the internal regulations of the centre ("Monteledo") and the copy to interested parties of the complaints and claims made ("Els Tillers" "Montefiz", "Monteledo" and "Sograndio") has been remedied.

Suggestion for medical check up

181. At the monitoring visit made to the centre "Albaidel" it was again verified that no medical check-up was performed within the 24 hours following admission of a young offender, as required by the Admissions Protocol of the establishment, as recorded in paragraph 179 of Annual Report 2011. This circumstance caused a Suggestion to be made which was accepted by the Department of Health and Social Affairs of the Government of Communities of Castile-La Mancha.

Lack of information in writing of possibility of institution habeas corpus proceedings

182. The deficiency pointed out in paragraphs 476 of Annual Report 2010 and 147 of Annual Report 2012, relating to the lack of written information on the possibility of instituting habeas corpus proceedings ("Las Lagunillas", "Montefiz", "Monteledo"). In this respect, two suggestions were made to the Department of Justice and Interior of the Government of Andalusia, which accepted the criterion of this Institution, and to the Department for Labour and Welfare of the Government of Galicia, which had not answered at the date of this report.

Personal records. Filed at the centre

183. As mentioned in paragraph 177 of Annual Report 2011, the personal records of young offenders, after the measure has been served, may not be kept at the centre, which is not complied with in "Sograndio" or in "Las Lagunillas". At the latter centre, an instruction is being prepared to regulate the transfer of documentation from the dossiers to the responsible Delegations of Government.

Recording of restraint measures

184. We have observed that certain centres are lacking a specific Record of application of restraint means. At "Sograndio" one was created after the visit made by this Institution and at "Els Tillers" and "Las Lagunillas" two Suggestions were made which were accepted by the Department of Justice of the Government of Catalonia and the Department of Justice and The Interior of the Government of Andalusia.

Provisional isolation measure

Other times, although this has been remedied, it is not recorded whether the provisional isolation measure was used ("Las Lagunillas", "Monte- ledo"), or the duration of the applied means ("Sograndio"). Likewise, pursuant to paragraph 152 of Annual Report 2012, a suggestion was made to the Directorate General for Justice and The Interior of the Government of the Principality of Asturias, for them to establish protocols for the simultaneous use of means of restraint and provisional isolation, which was accepted.

Bed used for restraint at the Centre of "Montefiz" (Ourense)

Conditions of isolation measures

185. Isolation measures must be applied in a space especially designed for the purpose, meeting the same conditions of inhabitability as the rest of the spaces or rooms used at the centre, without prejudice to its being provided with the conditions necessary for the young offender not to be able to injure himself or other persons. These inhabitability conditions were not observed at "Montefiz", although this deficiency has been remedied.

Repairs at "Sograndio" after the visit

At "Sograndio", the isolation room are known both by inmates and by the rest of the personnel of the centre as "camarillas" and the only difference with the rest is that, at them, the doors have a small window that permits the inside of the room to be seen. After the visit made by this Institution, the necessary repairs were performed to prevent bad odour from the squat toilet in the toilets of the rooms or camarillas. Likewise, the deficiencies related to the windows of these rooms, on the second and third floors, which, because they were permanently open caused the temperature in the room to be inadequate were also remedied.

Room for separation from the group of “Sograndio” (Asturias)

Deficiencies in the rooms

186. Deficiencies were observed in rooms of young offenders that could affect their safety, such as lack of sound systems for calls or the mechanical opening of the doors (“Las Lagunillas”, “Montefiz” and “Sograndio”). Both the Department of Justice and Interior of the Government of Andalusia and the Department of Labour and Welfare of the Government of Galicia will proceed to remedy these deficiencies, when so permitted by the budget or when improvements are made to the centres. The Directorate General for Justice and the Interior of the Principality of Asturias do not consider this to be necessary, since they attend calls made by young offender s immediately.

Failure to apply disciplinary regime at “Els Til·lers” and at “Montefiz”

187. At the therapeutic unit of “Els Til·lers” and “Montefiz” the disciplinary regime contemplated by Basic Law 5/2000, of 12 January, regulating the criminal liability of young offender s, is not applied based on the exception of article 59.3 of Royal Decree 1774/2004, which considers that it is not applicable to minors who are serving a measure of therapeutic custody imposed due to a mental abnormality or disturbance in perception that impedes them from understanding the illicit nature of the facts or to act in accordance with such understanding, while they remain in such a state. On considering that they are not included within a disciplinary context, the measures of restraint are not reported to the young offender judge and cannot be appealed. Nevertheless, at the Therapeutic Unit of “Els Til·lers” of the 12 young offender inmates at the time of the visit, 7 were serving a court measure under a regime that was not therapeutic because it was considered that this was the centre most adequate for them. Accordingly, a Suggestion was made which was accepted by the Department of Justice of the Government of Catalonia so that, in those cases in which young offender s are admitted under a non-therapeutic custody regime, the court authority be requested to change the measure to therapeutic custody, pursuant to Basic Law 5/2000.

Disciplinary proceedings. Documentation

188. On reviewing the disciplinary records of the centres of "Las Lagunillas" and "Sograndio", it was observed that all formalities were perfectly recorded in documentary form and that not more than three days were allowed to elapse from commencement to the resolution of the dossier. The same circumstance was observed in "Montefiz", where the respective resolution was also immediately notified to the court and public prosecution. At "Monteledo", in addition, an exclusive IT program is available for disciplinary dossiers. At "Montefiz" and "Sograndio" instructions were given so that whenever the penalty imposed on a young offender is reduced for good behaviour, this be recorded in his disciplinary record.

Excessive use of separation from the group

189. Excessive use of the disciplinary penalty of separation from the group is used for very serious and serious misdemeanours at the centre of "Sograndio". Indeed, it was ascertained that in the 79 disciplinary proceedings instituted, the penalty of separation from the group had been imposed 78 times. It would be advisable to use alternatively other penalties such as deprivation of weekend leaves, deprivation of leisure outings or deprivation from participating in leisure activities, according to the criterion contemplated in paragraph 155 of Annual Report 2012. In this respect, the Directorate General for Justice and the Interior of the Principality of Asturias reported that this is customary practice. Likewise, the repetition of the imposition of the group separation penalty at this centre causes separation times to be joined that considerably exceed the maximum 7-day term, so that, in cases of long separations, after the 7 days are exceeded, the young offender is taken with a security guard to an empty room (usually that used to receive visits), and remain there for half an hour. After that time has elapsed, he is again locked in the separation room until the maximum permitted time has expired. In this case, after the visit of the Ombudsman, this practice was rectified and an interval of, at least, 12 hours is allowed to elapse from the end of the first penalty to the commencement of the next.

The regulation of the centre proposes that minors in a situation of separation should enjoy free time for two hours that commence compulsorily and for reasons of internal organisation at 08:00 h. This timetable means that inmates often decide not to leave the room although, after the visit made by the Institution, young offenders who do not go out to the yard in the morning are afforded the opportunity to do so in the afternoon.

Failure to report disciplinary penalties to lawyers

190. As contemplated in paragraph 156 of Annual Report 2012, the failure to notify to the lawyers of the young offender inmates the disciplinary measures imposed on them continued to be observed. The Department of Labour and Welfare of the Government of Galicia adopted the criterion of this Institution in respect of the centres "Montefiz" and "Monteledo". In this respect, a recommendation was issued to the Secretary of State of Justice, relating to the amendment of the second section of article 76 of Royal Decree 1774/2004, of 30 July, approving the Regulation implementing Basic Law 5/2000, of 12 January, regulating the criminal liability of young offenders, to impose on centres for

young offenders the obligation to notify to their lawyer all disciplinary penalties that may be imposed or to clarify the events in which such notification would be compulsory, at least when the penalty consists of the separation from the group, imposed for serious or very serious misdemeanours. The Secretary of State of Justice positively valued the recommendation and will commence to work on considering its inclusion in said regulation.

Healthcare and psychological assistance

191. In respect of healthcare and psychological assistance, "Las Lagunillas" has one medical practitioner, one nurse and two psychologists. The reference psychiatrist appears at the centre every 15 days and, although she does not attend psychiatric emergencies, she is available to answer telephone calls and settle doubts as to the prescribed treatments or to adjust the dose of medication in emergencies. At the time of the visit 7 minors were in psychiatric treatment for pathologies such as adaptive disorders, depressive conditions, attention deficit with hyperactivity disorders and dissocial disorders. At "Sograndio", the coordination with the Mental Health Services of the Principality is established, mainly, between the medical practitioner of the centre and the various professionals of the Mental Health Service to follow the same working lines and prevent overlapping actions.

Criteria for admission

It was observed that the inmates of the Therapeutic Unit of "Els Til·lers" complied with clear admission criteria, in other words, all admissions are correctly indicated from the psychiatric point of view, medication is correctly prescribed and special work is done on motivation and adherence to treatment, respecting the will of the recipient. Medical attention in "Montefiz" is provided by a medical practitioner and a nurse of a contractor company so that, since they are not included in the public healthcare network (the centre reports to the University Hospital Complex of Ourense), they have little communication with the primary healthcare medical practitioner and specialists, the inter-consultation being limited to analytical and other supplementary tests which are requested specifically, issue of prescriptions and assistance in emergencies. One psychiatrist and one qualified nurse are also available under a services contract, although the psychiatrist, in his daily work, is included in the public healthcare network, which makes the coordination of the young offenders easier, although he should be included in therapeutic activities as a referral psychiatrist.

Nursing personnel

The centre "Monteledo" has no nursing personnel available, and these tasks are performed by the medical practitioner or educator, which is not advisable despite the fact that the Department of Labour and Welfare declared that their presence is not compulsory.

Psychologists and healthcare personnel

It has been verified that the psychologists of "Montefiz" and "Monteledo" are involved and committed to understanding and supporting the adaptation of minors in the centre. Likewise the healthcare personnel of "Sograndio" have adequate training, with specialised profiles in caring for the attended population, performing multidisciplinary team work with good coordination.

Suicide prevention protocol

192. It was also observed that not all personnel of the centre of "Monteledo" are aware of the existence of a suicide prevention protocol, although measures have been put in place to ensure that it is known and available.

Infirmary room

193. In the infirmary room of the Therapeutic Unit of Els Til·lers", medication is placed in two locked wall cupboards, classified as "psychiatric medication" or "somatic medication". However, vials of medication for intramuscular injections and other frequently used drugs are within sight, on the wall, with easy free access, as are other drugs in the refrigerator and other risk objects such as scissors or needles, and biological risk products in the open bucket on the floor, so that the medical personnel have been requested to make the proposals for the necessary corrective measures to remedy the deficiencies.

Risk objects of the infirmary room of "Els Til·lers"

Medication of the infirmary room of "Els Til·lers"

Adult figure

194. As stated in Annual Report 2011, it would be advisable for an adult figure to be present to guide and accompany the minor during his stay at the centre. At “Monteledo” it was observed that the figure of the assigned referral tutor did not exist, since educators were rotated by periods, depending on the distribution of resources and duties from time to time; the criterion conveyed to the responsible Authority was accepted.

“Witness” samples of food

195. With regard to the keeping of “witness” samples of the food provided at the centres, for them to be tested in an eventual intoxication, it was observed that this practice was not carried out in “Montefiz” although this deficiency was remedied due to the visit of the Ombudsman.

III. 4. Social healthcare centres

Two visits to social healthcare centres

196. In 2013, two visits were made to social healthcare centres: The Healthcare Centre “El Pinar” (Teruel) and the Residential Centre “Santa Teresa de Arévalo”, of Arévalo (Ávila). Both visits were multidisciplinary and medical practitioners, psychiatrists and psychologists participated in them. The main issues that were reviewed were the admission procedure and the lawfulness of the involuntary stay of certain residents, the internal operation, living conditions, healthcare and psycho-social care, use of mechanical and pharmacological restraints, adequacy in terms of quantity and quality of personnel and adequacy of the facilities, among others.

Chart 9
Geographical location of social healthcare centres visited in 2013

Healthcare Centre "El Pinar"

The Healthcare Centre "El Pinar" (Teruel) is owned by the Social Services Institute of ARAGON (Instituto ARAGONés de Servicios Sociales –"IASS"), an autonomous body attached to the Department of Health Social Welfare and Family of the Government of ARAGON. It was previously a children's psychiatric hospital, a function that it performed until its reconversion into a healthcare assistance centre in 1988. It currently provides residential and healthcare services to persons over 18 years old with moderate, severe and profound mental disabilities, with degrees of dependence II and III. Residents include persons with psychiatric diagnostic (from the previous psychiatric hospital), persons diagnosed as having mental disabilities and persons with both diagnostics. It has 112 residential places and 10 places for day stays of which 11 and 10, respectively, were occupied at the time of the visit.

Residential Centre "Santa Teresa de Arévalo"

In turn, the Residential Centre "Santa Teresa de Arévalo", in Arévalo (Ávila), is a centre privately owned by Casta Servicios Sociosanitarios, S. A., and the EPTISA Group. It was previously a psychiatric hospital and currently used for custody under long- and medium-stay regime for psychiatric, psycho-geriatric and mentally retarded patients. According to the information made available, it has places arranged with

the Departments of Health and of Family and Social Affairs of Madrid Autonomous Community, the Department of Family and Equal Opportunities of the Government of Castile and Leon and the Provincel Deputation of Ávila. In addition, authorities such as the Madrid Agency for Adult Care (Agencia Madrileña de Tutela de Adultos), the Health Service of Castile-La Mancha, the Health Service of Galicia and insurance companies pay for individual places. The rest of the places are privately paid for by residents or their families. At the time of the visit, the centre had 297 places, of which 262 were occupied.

Deficiencies in the lack of court authorisation for non-voluntary admission

197. At the visits, deficiencies were observed as to the lack of court authorisation for the admission of persons without capacity to give their free consent to it, both incapacitated by the court and otherwise. At the Healthcare Centre "El Pinar" (Teruel), in the light of the documentation, the conclusion was drawn that the IASS does not require express court authorisation for the admission of persons in such situation, on considering that it is necessary only for admission into mental health centres. In the opinion of this Institution, the relevant factor, from the point of view of legal safeguards, is the capacity of a person to freely give his consent to his admission, with the consequent loss of liberty or restriction he may sustain to his rights, and not the grounds for the measure or the type of centre to which he is admitted. Accordingly, in such cases, the family relatives or tutors should request court authorisation for the involuntary admission pursuant to article 763 of the Civil Procedure Law and, simultaneously, such authorisation should be demanded as a requirement for admission, along the lines of the criterion contemplated in paragraph 173 of Annual Report 2012. The Department of Health, Social Welfare and Family of the General Deputation of Aragon reported that this question was being considered and that it had got in touch with the Public Prosecutor's Office to coordinate actions.

At the Residential Centre "Santa Teresa de Arévalo", in turn, various situations were observed: persons who had been voluntarily admitted, admissions at origin voluntary that later became involuntary, involuntary admissions with prior court authorisation (in the case both of incapacitated and non-incapacitated persons), urgent involuntary admissions with subsequent court ratification and admissions ordered as a precautionary measure in the incapacitation proceeding with a subsequent court order for ratification of the admission. When reviewing the dossiers, cases were detected of former patients that might not have capacity to give their free consent to continuing in the centre, and in respect of which no court authorisation had been given for them to remain there, so that such situations should be reviewed. The Department of Family and Equal Opportunities of the Government of Castile and Leon accepted the criterion of this Institution and, accordingly, requested the entity owner of the centre to regularise the cases mentioned.

Regular control of non-voluntary admissions

198. With regard to the regular control of involuntary admissions, it was observed that, in many cases, the medical reports sent on a six-monthly basis by the Residential Centre "Santa Teresa de Arévalo" to

the judge, relating to the need to maintain the measure of involuntary admission, pursuant to article 763.4 of the Civil Procedure Law, are identical or almost identical copies in which only the date is changed. To fully respect the safeguards of these inmates, such medical reports should be detailed and up to date, along the lines of paragraph 174 of Annual Report 2012.

Weighted use of legal incapacitation

199. At the visit it was verified that the Healthcare Centre "El Pinar" (Teruel) requires users to be declared incapacitated by the court for their admission. This Institution considers that, instead of requesting this systematically, the Centre should encourage weighted use of the legal incapacitating institution. Thus, in those cases in which it is considered advisable to request court incapacitation, given the possibility of its grading, it would be adequate to limit its effects to the terms strictly demanded by the healthcare support measure, duly evidencing the reason and purpose for which the declaration of incapacity is requested, in other words, the benefit that the person with a disability will obtain after the judgment declaring it is given. The Department of Health, Social Welfare and Family of the General Deputation of Aragon reported that this question is being considered and that it got in touch with the Public Prosecutor's Office to coordinate actions.

Information to inmates and family relatives of time of custody

200. At the Residential Centre "Santa Teresa de Arévalo", in Arévalo (Ávila), the voluntary admission document is a form bearing the name of the patient stating that he "accepts his admission". In the opinion of this Institution, it would be advisable for both residents and their family relatives to be properly informed on their admission of the type of stay in question (particularly if it is prolonged), the internal operating rules, the living regime, the therapeutic procedures or restrictions to which the patient will be submitted, etc. Such information should be drafted taking into account the features of the patients, ensuring that its wording and format are adequate for its understanding, in accordance with the criterion of the Ombudsman recorded in paragraph 179 of Annual Report 2012. The Department of Family and Equal Opportunities of the Government of Castile and Leon accepted the criterion of this Institution and, accordingly, will demand that all services contracts be correctly executed.

Internal Regulation

201. Centres of these features must have available internal regulations or a document setting out in detail the rules of the centre. Said regulation should be situated in a prominent public place and explained to detainees, families and tutors. At the visit it was verified that the Healthcare Centre "El Pinar" (Teruel) was lacking such a document, which should be remedied, which criterion was accepted by the Department of Healthcare, Social Welfare and Family of the General Deputation of Aragon, which reported that it was being prepared.

Measures for inadequate conducts of patients

202. Although social healthcare institutions do not have a disciplinary regime as such, the visited centres did have a system of reinforcement using incentives or measures applied in the case of certain inadequate behaviours of the inmates, such as the exchange of coffee for other

products, consuming more coffee than authorised, refusing to participate in certain activities, not cooperating in the assigned tasks, while being in condition to do so, lacks of respect, oral or physical aggression, etc. The consequences may be, for example, removal of 50% of the money and cigarettes for the next day, suspension of participation in certain activities or removal of the leave pass.

Residential rather than rehabilitation concepts predominates

203. Most centres for persons with a mental disease or disability have psychosocial rehabilitation programs on which they work, in group, on daily living and relations with the environment to permit residents to achieve the best possible cognitive performance. Nevertheless, at both centres, it was observed that the residential rather than the rehabilitation and reinsertion in the community features were developed. Although said centres are indeed currently targeted to patients with few rehabilitation possibilities, given both their own disability and the many years of custody, in both cases a large number of patients had psychiatric pathologies or disabilities that would require a more intensive rehabilitation program.

At the Healthcare Centre “El Pinar” (Teruel), activities are not included in multidisciplinary psychosocial rehabilitation plans, as would be advisable. The Department of Health, Social Welfare and Family of the General Deputation of Aragon accepted the criterion of this Institution and, accordingly, individual attention plans have been included.

Psychomotor room of the Healthcare Centre “El Pinar” (Teruel)

In addition, the annual reports of the Residential Centre “Santa Teresa de Arévalo”, of Arévalo (Ávila), set out a large number of individual workshops and actions, both for leisure and for rehabilitation, well founded, designed and under protocol. However, the current workforce of the centre does not permit such activities to be performed in small

groups, so that they are rather leisure activities with a certain rehabilitating component. Accordingly, the profile of the workforce should be adjusted to assume the rehabilitating tasks and favour reinsertion in the community. It was also observed that the individual rehabilitation plan existed in all the clinical records reviewed, that it includes specific sections on the psychiatric, psychological medicine, nursing, social work and physiotherapy services, and that it is reviewed every 6 months, which should be pointed out as a quality indicator.

Therapy room of the Residential Centre "Santa Teresa de Arévalo"

Psychiatric assistance

204. In respect of psychiatric attention, in the review of clinical records carried out at the Healthcare Centre "El Pinar" (Teruel) it was observed that, although one psychiatrist of the Healthcare Service of ARAGON visits the centre every 15 days, patients are lacking a psychiatric record, in many cases have not been diagnosed and their evolution cannot be traced, which was conveyed to the Department of Healthcare, Social welfare and Family of the General Deputation of Aragon. Said department stated that, since the centre was reconverted into a resource for dependent persons with a mental disability, it is unnecessary for psychiatric records to be kept. In the opinion of this Institution, since a large number of patients were admitted with a psychiatric pathology and the long period of their stay appears to render it advisable for them to be transferred to another centre more adequate to their profile, due to the destabilisation this could cause them, it is necessary to put in place alternative measures to provide them with the best attention. Accordingly, two suggestions were made for patients admitted with a psychiatric pathology to be re-evaluated, diagnosed and have an individual therapeutic plan prepared and to include medical records in a psychiatric attention folder, for the benefit of the patients, and to afford greater transparency and control over the quality of the attention.

Psychiatric follow-up

At the Residential Centre "Santa Teresa de Arévalo" it was verified that the psychiatric follow-ups of patients were variable, depending on

each therapist. In certain cases follow-ups were every fifteen days, but in most cases they were less frequent.

Activities in the mornings and afternoons

205. At the Healthcare Centre "El Pinar" (Teruel) the existence of activities on a morning and afternoon timetable is to be positively pointed out, in addition to group activities that aid detainees to feel positive emotions and create a good atmosphere between inmates, which it would be desirable to increase. The Residential Centre "Santa Teresa de Arévalo" also provides many activities, most of them on the morning timetable.

Activities at Healthcare Centre "El Pinar" (Teruel)

After the visit, two observation rooms were enabled at "El Pinar"

206. As regards medical attention, it is to be noted that no observation beds exist in the infirmary of the Healthcare Assistance "El Pinar" (Teruel), which would be advisable given the profile of the inmates. After the visit, the Department of Healthcare, Social Welfare and Family of the General Deputation of Aragon enabled two observation beds.

Adequate security of personal data of patients

207. When digitalising the records, the adequate security of the personal data of the patients must be ensured, restricting access to the most confidential information only to professionals with competence for this area of care, as the Residential Centre "Santa Teresa de Arévalo" was informed. In this respect, we must point out that the Healthcare Centre "El Pinar" (Teruel) has an electronic program that restricts access to data of the detainee depending on professional profile.

Suicide prevention plan

208. Although at the Residential Centre "Santa Teresa de Arévalo" suicide attempts do not appear to be a problem, given the profile of the inmates it would be advisable for a suicide prevention plan to be established.

Palliative care plan

209. The Healthcare Centre "El Pinar" (Teruel) does not have a "palliative care" plan for patients in an irreversible serious state, but whose death is not immediately expected. Nevertheless, the Department of Healthcare, Social Welfare and Family of the General Deputation of

Aragon reported that, when necessary, the Palliative Care Unit of the Hospital San José de Teruel provide the individual care plan.

Form of "early will" or "prior instructions"

210. None of the visited centres had the "early will" or "preliminary instruction" forms which the responsible authorities have available, neither have they considered informing the inmates and family relatives of this possibility, so that a protocol on the matter should be established and personnel should be trained in this respect, according to the criterion of this Institution recorded in paragraph 201 of Annual Report 2012. The Department of Health, Social Welfare and Family of the General Deputation of Aragon reported that given the great degree of dependence of inmates at the Healthcare Centre "El Pinar" it is not deemed advisable.

Respectful and adequate treatment

211. During the visits respectful and adequate treatment to inmates was observed, which was confirmed by the patients and family relatives interviewed.

Healthcare and body care

In addition, we must point out the high level of healthcare assistance and body care of the detainees of the Healthcare Assistance "El Pinar" (Teruel). It was verified that in pathologies usual in persons with a great degree of physical dependence such as pressure ulcers were reduced to the minimum and self-care and autonomy was encouraged in the detainees, occasionally even at the cost of a greater effort made by personnel.

Ongoing training of personnel

212. Ongoing training of personnel is of great relevance for quality attention. In this respect, the ongoing training courses of personnel provided by Residential Centre "Santa Teresa de Arévalo", of special relevance, particularly those directly related to protocols of action with patients, is positively value and it would be desirable for this initiative to be continued in future. At the Healthcare Centre "El Pinar", since the profile of the professionals responds rather to healthcare than to rehabilitation purposes, the ongoing training of personnel should be scheduled in accordance with the objectives of the Centre.

Positive participation of residents

213. Positive participation of inmates is to be encouraged, both from a therapeutic point of view and from that of respect of their fundamental rights, pursuant to paragraph 191 of Annual Report 2012. However, the visited centres hardly had participation systems, although some of the residents with moderate disabilities could do so in groups, through the assignment of minor supervised tasks, etc. The Department of Healthcare, Social Welfare and Family of the General Deputation of Aragon reported that the activities in which inmates could participate would be reinforced at the Healthcare Centre "El Pinar" (Teruel).

Complaint books, suggestion boxes or books and/or satisfaction surveys

214. It would be advisable for complaint books to be available at the centres (implying a process of internal control of the service quality), in addition to suggestions boxes or books (implying an attempt to participate in the part of the detainees or their families in improving the centre) and/or satisfaction surveys (seeking to improve the service standards). The Department of Healthcare, Social Welfare and Family of the General Deputation of Aragon reported that a complaints book and a suggestions book have been enabled at the Healthcare Centre

"El Pinar". In addition, although the Residential Centre "Santa Teresa de Arévalo" had a book of claims, the only claim that had been filed had not been analysed and no answer had been offered to the claimant, which should be remedied.

Injury report. Completion and remittance to responsible court authority

215. According to the information provided, the Healthcare Centre "El Pinar" (Teruel) does not render account to the responsible authorities of any eventual aggressions or injuries and only informs the court if transfer to a hospital is required. In this respect, it must be remembered that, when the medical services assist a person who has been injured due to an aggression, the relevant injury report must be systematically completed and sent to the responsible court authority, as provided for by article 262 of the Criminal Procedure Law, recording the existence of the injuries, their features and the purported origin. The Department of Healthcare, Social Welfare and Family of the General Deputation of Aragon accepted the criterion of this Institution.

Physical and pharmacological restraints

216. As regards physical and pharmacological restraints, at the Healthcare Centre "El Pinar" (Teruel) it was observed that these were scarcely used, patients were not excessively medicated and the atmosphere was one of tidiness, rest and respect. Nevertheless, certain cases of "prolonged therapeutic restraints" were observed the suitability and adequacy of which should be reviewed. The Department of Healthcare, Social Welfare and Family of the General Deputation of Aragon stated that the protocols of restraint at social healthcare centres are being reviewed. In respect of pharmacological restraints, in the review of the clinical records, it was observed that these were applied to approximately one third of the patients, although they were applied measuredly and reasonably, and were almost always accompanied by the indication that they were used as the last resource.

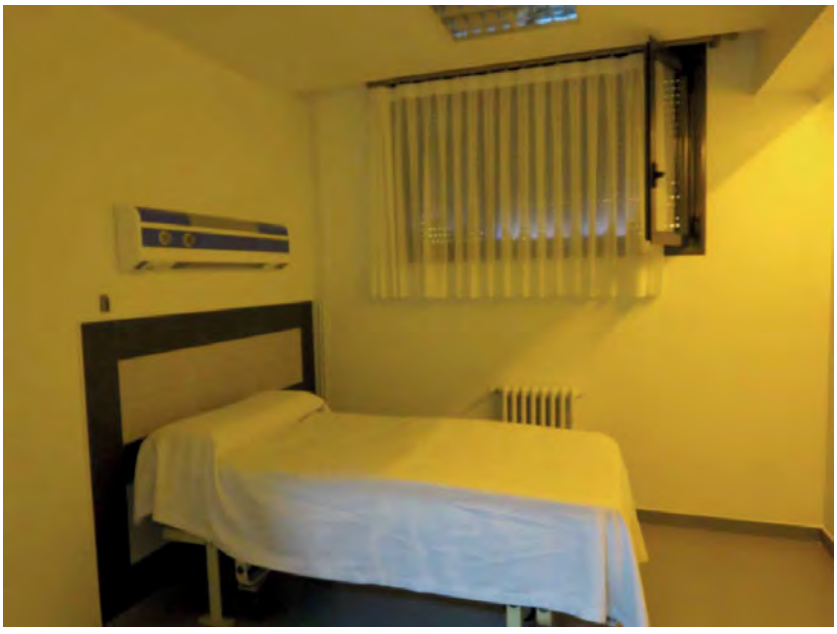
In turn, the Residential Centre "Santa Teresa de Arévalo" has a restraint protocol in accordance with international standards. The various professionals interviewed (nurses, assistants and keepers) declared to have received training courses on the matter. Restraint forms were to be found in all medical surgeries stating the time of commencement and end of the measure, the reason and medical indications and infirmary observation comments. Nevertheless, although the "protocol of therapeutic immobilisation" of the centre records that at least five persons should participate to ensure that the patient is not injured, because it is understaffed, restraints are carried out by only four persons. As to the medication of patients it was observed that the doses were well adjusted with good control of side effects.

Rooms for mechanical restraints

217. In respect of rooms for mechanical restraints, at the Healthcare Centre "El Pinar" (Teruel), the two rooms prepared for the purpose did not have video-surveillance systems with recordings to ensure the safety of the inmates during restraint and subsequently, which should be remedied. At the Residential Centre "Santa Teresa de Arévalo" after the visit a Suggestion was made for one isolation room that did not have a security camera, with items having metal borders that could imply physical risk to patients, lacking natural light, with a uniform colour on walls and ceilings and, finally, an inadequate structure and,

in addition, that could cause confusion syndromes in patients, to be closed, pursuant to paragraph 48 of the 16th General Report of the CPT (CPT/Inf (2006) 35). The Department of Family and Equal Opportunities of the Government of Castile and Leon proceeded to close the room. On the other hand, the new room for isolation of Unit Santa Cecilia was adequate.

Room for mechanical restraint at Residential Centre “Santa Teresa de Arévalo”



Adequate room for mechanical restraint at Residential Centre “Santa Teresa de Arévalo”

218. At Residential Centre “Santa Teresa de Arévalo”, the personnel customarily search the room for potentially hazardous objects or unauthorised belongings. It would be desirable that, when such searches have to be made for security reasons, they be done in the presence of the inmate and with his cooperation, to avoid the feeling of defencelessness and lack of privacy that the contrary practice could imply.

Room searches in presence of inmates

219. Centres of these features should have call or alarm systems in the rooms of the detainees or alternative systems in those cases in which immediate assistance of personnel to detainees is required. In this respect, lacks were detected at both centres.

Call or alarm systems in rooms

220. The centres should comply with the emergency and evacuation plans. The Healthcare Centre “El Pinar” (Teruel) did not have fume detectors or emergency exits and should make the necessary adaptations to the emergency evacuation facilities. The Department of Healthcare, Social Welfare and Family of the General Deputation of Aragon reported that the evacuation plan of the centre and the necessary works were being reviewed.

Emergency and evacuation plans

In turn, at the Residential Centre “Santa Teresa de Arévalo” (Arévalo, Ávila), because only one nurse and five support persons are available at night for the entire centre, the doors to the rooms are locked to prevent inmates from exiting them, which, in addition to the fact that not all rooms have call systems, could cause a safety problem, if urgent evacuation were necessary or should a patient need assistance at night. Accordingly, a solution should be found conforming to the emergency and evacuation plans.

Locked doors to rooms could create a safety problem

221. The facilities of the visited centres were in general correct, although in both cases certain renovations should be considered to

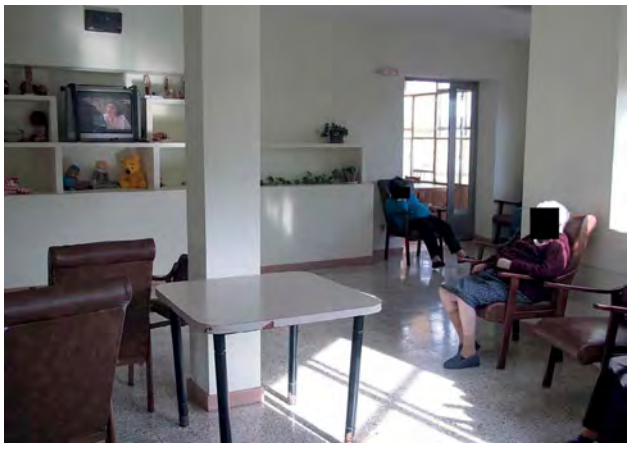
Facilities

increase the privacy of residents, particularly in the toilets, since although the lack of booths or separating walls benefits the accessibility and handling by personnel, it may violate the privacy of the patients.

One toilet of the Residential Centre “El Pinar” (Teruel)

One toilet of the Residential Centre “Santa Teresa de Arévalo” (Arévalo, Ávila)

The Healthcare Centre “El Pinar” (Teruel) had a cared for aspect and was in a good state of cleanliness and tidiness. The structure should be adapted to the needs of the inmates, particularly in those areas in which self-injuries or suicide attempts would be easier: doors with metal corners, windows with broken bars, metal structures on ceilings, etc. In addition, although it was reported that, in good weather conditions, the detainees take walks in the gardens of the centre, the gardens are not provided with outdoor facilities permitting rehabilitation activities to be performed in the open air, which would be advisable. The Department of Healthcare, Social Welfare and Family of the General Deputation of Aragon stated that the appropriate measures had been adopted to renovate certain structures, and that a plan for psycho-physical activities out of doors had been started.



One living room at the Healthcare Assistance Centre “El Pinar” (Teruel)

One room in the Healthcare Assistance Centre “El Pinar” (Teruel)

In respect of the Residential Centre “Santa Teresa de Arévalo” (Arévalo, Ávila) the cleanliness (other than in the cafeteria area), the quality of the facilities in the renovated part, the good evaluation by the residents of the food and the comfort of the common areas, the garden and the cafeteria, which are used as an area of positive interaction by most residents, are to be pointed out. Nevertheless, patients with a higher degree of autonomy should have wardrobes available to keep their belongings, as occurs in the renovated areas, and the customisation of areas should be actively encouraged, breaking the chromatic monotony and feeling of emptiness given by some of the rooms. In addition, although the level of occupancy of the centre at the time of the visit was less than its capacity, certain three-place rooms existed so that the necessary measures should be put in place for all rooms to have capacity for a maximum two persons.

Living room of the Residential Centre “Santa Teresa de Arévalo”

Two rooms of homes other than the Residential Centre “Santa Teresa de Arévalo

IV. Special purpose places of deprivation of liberty § 222 - § 264

IV.1. Hospital custody units

Hospital custody units

222. Hospital custody units (UCH), as mentioned in paragraph 211 of Annual Report 2012, are facilities at public healthcare hospitals where prison inmates are admitted to receive the relevant medical treatment, in the custody of officers of the CNP.

Follow up visit

223. In 2013 the UCH of the Provincel Hospital of Córdoba was visited. It was a monitoring visit since these facilities were visited in April 2010, as recorded in paragraphs 211 et seq. of the annual report of that year.

Departments

The conditions of these facilities were adequate at the time of the visit since healthcare assistance, food, cleanliness, etc., are those pertaining to a hospital.

Video-surveillance system

224. The video-surveillance system had not changed after the last visit, having only one camera that covers the entrance to this UCH and pictures a viewed on a bad quality black and white screen. The SGIP reported that it would consider the eventual changes to the current system permitting control to be improved within these facilities.

Absence of female custody personnel

225. This UCH continues not to have permanent female custody personnel. This Institution considers, as mentioned in paragraph 423 of Annual Report 2010, that the custody service should be provided by male and female personnel, at least when a woman is admitted or it is forecast that the interned men will receive visits from women, to be able to make the relevant searches. The DGP reported that, in specific events and at the request of the officers themselves or of the healthcare personnel of the hospital, female police personnel may be engaged.

Privacy of consultations

226. In respect of the privacy of consultations, it was reported that, in most cases, the door to the room remains open and an officer stays beside it. This Institution considers that the presence of an officer during the medical visit, in general and provided that no founded suspicions of risk exist to render this advisable, could affect the privacy of doctor-patient relationships, which was conveyed to the DGP, which reported that, depending on the problematic degree of the inmate, the appropriate security measures should be adopted, always respecting the opinions of the professionals.

IV.2. Foreigner repatriation operations

Central Unit of Expulsions and Repatriations

227. The Central Unit of Expulsions and Repatriations (Unidad Central de Expulsiones y Repatriaciones –"UCER"), reporting to the General Headquarters for Foreign Nationals and Borders (Comisaría General de Extranjería y Fronteras –"CGEF"), is responsible for executing the repatriation of those foreign nationals whose expulsion or repatriation has been decided by the responsible authority.

Supervision of a flight

228. In 2013, one technical advisor of the Ombudsman, accompanied by an external technical expert medical practitioner specialised in Legal and Court Medicine, supervised one FRONTEX flight for repatriation of foreign nationals, organised and operated by the Spanish authorities, with the participation of Italy, with destination in Ecuador and Colombia, its being the first time that this inspectorate covered the transfer within the aircraft.

Aspects of repatriation operation

229. The repatriation operation focused on 3 aspects:

a) Reception of foreign nationals by members of the CNP at the facilities located at the building close to Terminal 1 of Airport Adolfo Suárez de Madrid-Barajas, used by the UCER.

b) Transfer of repatriated persons in vehicles for approximation to the parking area of the aircraft ("jardineras") from the facilities of the UCER and subsequent boarding of the foreign nationals on an AIRBUS aircraft chartered by the General Headquarters of Foreign Nationals and Borders (Comisaría General de Extranjería y Fronteras –"CGEF"), with capacity for 299 seats.

c) Conduct of the flight from Madrid Barajas airport, stopping over at the airport of Quito and arriving at the airport of Bogotá.

Airport facilities

230. The inspection commenced at the facilities of the airport used by the UCER. In the flight, with arrival at Quito and Bogotá, 35 nationals of Ecuador and 56 of Colombia were repatriated. In addition, on this flight, the INTERPOL repatriated one national from Colombia and two from Ecuador, who had been expelled from Italy and were accompanied by five police officers of that country. Of the total repatriates, it was verified that, one national of Colombia and another of Ecuador were transferred from the CIE of Barcelona; one national of Colombia and one from Ecuador were transferred from the CIA of Murcia; 2 nationals of Colombia were transferred from the CIA of Valencia; and 17 nationals of Colombia and 9 from Ecuador were transferred from the CIE of Madrid.

Prior meeting

231. A meeting was held at which the head of the squad, the head of the operation of the UCER, the head of the operation of the UIP, the head of the documentation team, the person responsible for the medical team and a qualified nurse were present. At the meeting, the head of the squad provided a list of repatriates and informed the attendees of the distribution of the seats both of the repatriates and of

their escorts. Lastly, the head of the operation of the UCER reported that the escorts service consisted of 80 officers of the CGE y F (49 SME-SEDEX, 23 SPE, 7 Officers Units CGEF, one Chief Commissioner UCER), 60 UIP (Police Action Unit –"Unidad de Intervención Policial"), one Medical Practitioner, one ATS (qualified nurse), 12 officers of the INTERPOL and 5 escorts from Italy. Of the total escorts, 16 were women.

Conditions of the building used for reception

232. The building used by the UCER for reception of foreign nationals does still not have a video-surveillance system according to the criterion of this Institution, as mentioned in paragraph 224 of Annual Report 2012, which should be remedied.

Air conditioning system

233. The air conditioning system of the various rooms where both officers of the CNP and foreign nationals to be repatriated were found, did not work and the rooms on the ground floor of the facilities where foreign nationals remain before boarding, did not have a sufficient number of chairs for all of them to be able to sit. For this reason, two Suggestions were made to AENA and to the DGP, which were accepted. AENA reported that it had proceeded to repair the breakdown in the air conditioning system and the DGP reported that it had requested the supply of chairs.

Process for verification of the documentation

234. The process for verification of the documentation of repatriates was then observed, at a facility located at the entrance to the building, which formality was recorded in paragraph 239 of Annual Report 2012.

Conditions in which body searches were carried out

235. After the foreign nationals had been identified, a detailed body search was carried out in a corridor that was a transit area, so that officers who were carrying out body searches were mixed with other officers in transit through the facilities leading other foreign nationals. Women officers carried out body searches on women, although no differentiated place existed for such searches, so that they were visible to other foreign nationals and officers (men and women) passing by. On considering that the conditions on which these body searches were carried out were not adequate, since the necessary measures to preserve privacy were not observed, this deficiency was conveyed to the DGP which reported that adequate facilities had been enabled for these searches.

Restraint measures

236. In respect of restraint means, all repatriates had their wrists tied together with cloth straps which were removed to carry out the body searches and again placed after them until they boarded the aircraft.

Proportion of coercive measures

In this respect, the flight Service Order established: "The use of coercive measures with foreign nationals who refuse or violently object to their expulsion must be proportionate and respect the individual rights of the repatriates. Repatriates who are searched may be immobilised using means that do not jeopardise their self-respect and physical safety. The application of coercive measures may never compromise the vital functions of the repatriate. The decision to remove a coercive

measure provisionally shall fall within the competence of the Head of the Squad, after consulting the Operation Head. Coercive measures to be implemented will include, depending on the degree of resistance offered by the deportee, from immobilisation using straps in front, or behind to application of the immobiliser belt and will be ordered by the person responsible for the operation and decided in coordination with the Head of the Squad".

Healthcare

237. Healthcare in this operation was provided by one medical practitioner and one qualified nurse, both of them officers of the CNP, who were responsible for providing healthcare services to the persons to be repatriated. The function of these professionals commences with the collection of an emergency first aid kit containing the necessary items for first aid, and for treatment of customary symptoms, as shown in the following photographs.

First aid kit

First aid kit

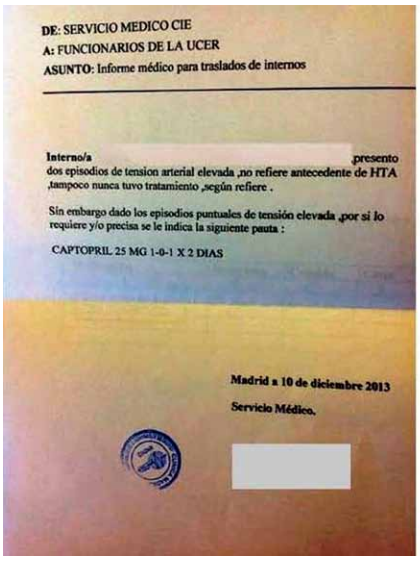
Medical documentation and eventual medication

Once at the facilities of the airport they were provided with the medical documentation and, eventually, the medication that accompanied those who were to be repatriated for their evaluation. It was reported that, if adequate medication was not available, they would issue a prescription and the officers of the CNP would go to a pharmacy to acquire it.

Medical documentation in envelopes

In the specific case of this flight, medical documentation was provided for nine persons: 6 of them nationals of Colombia and 3 of them nationals of Ecuador. The medical documentation was submitted in envelopes, accompanied by the medication and bearing the name of the person in question.

Medical documentation of two repatriates



DE: SERVICIO MEDICO CIE
A: FUNCIONARIOS DE LA UCER
ASUNTO: Informe médico para traslados de internos

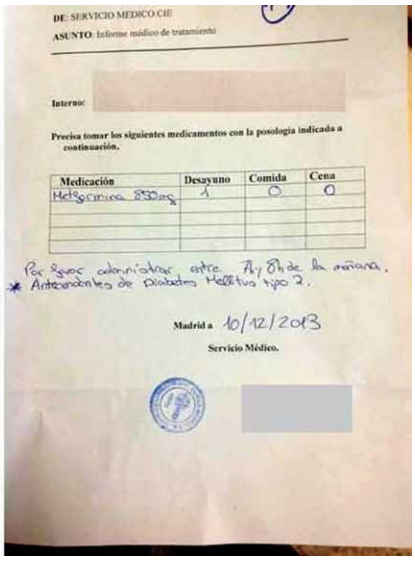
Interno/a ,presento dos episodios de tension arterial elevada ,no refiere antecedente de HTA ,tampoco nunca tuvo tratamiento ,según refiere .

Sin embargo dado los episodios puntuales de tensión elevada ,por si lo requiere y/o precisa se le indica la siguiente pauta :

CAPTOPRIL 25 MG 1-0-1 X 2 DIAS

Madrid a 10 de diciembre 2013

Servicio Médico.



DE: SERVICIO MEDICO CIE
ASUNTO: Informe médico de tratamiento

Interno:

Precisa tomar los siguientes medicamentos con la posología indicada a continuación.

Medicación	Desayuno	Comida	Cena
Metformina 850mg	1	0	0

Por favor administrar entre 7h y 8h de la mañana.
* Antecedentes de Diabetes Mellitus tipo 2.

Madrid a 10/12/2013

Servicio Médico.

Exact knowledge of health state of all repatriates

238. Not all citizens to be repatriated were submitted to a prior medical check-up, to confirm that no objection exists from the medical point of view to make the flight. Since the entire health control prior to boarding is limited to those cases in which the repatriates have a known particular medical condition and, particularly, those who require treatment, it is not ensured that it is known accurately whether the health state of all repatriates permits them to fly.

Medication during repatriation

239. In the opinion of the technical expert who made the visit, specialised in Legal and Court Medicine, it may occur that, even if the repatriates have pathologies, they may not be taking any treatment and thus be left outside the control of the medical practitioner. Not even in those cases in which the expelled citizen originates from a CP or a CIE, may it be ensured that all those with pathologies are taking any kind of medication at that time. In those cases in which they originate from a 72-hour detention, there is even more reason for this statement. In the opinion of this Institution, this situation should be corrected and, for such purpose, it would be necessary to consider two events:

A) If the foreign nationals originate from a CIE or CP, the check-up must always be carried out at the centres from which they originate. In these cases, the result will be accompanied by a summary of the

clinical record containing at least the background data, diagnostic and eventual prescribed treatment.

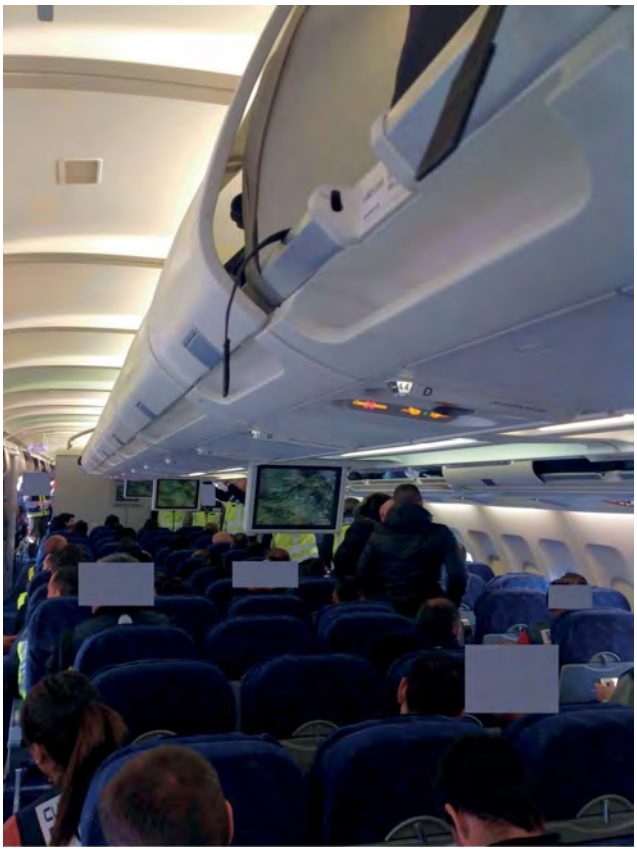
B) For those originating from places other than those mentioned above, the medical check-up must be carried out by the medical practitioner accompanying the operation during the flight.

The DGP reported, in the case of citizens arriving from CIEs, that the new Regulation establishes that a check-up must be performed on exiting the centre.

Boarding of repatriates

240. After these steps have been taken, the repatriates were boarded. The “jardineras” were parked at the back of the aircraft through which repatriates were to board. The escorts formed a corridor up to the steps leading to the aircraft and took the foreign nationals off the “jardineras”, one by one and at intervals, accompanied by an escort. Repatriates continues to have their wrists tied together with straps. During the boarding operation no incident occurred. Once in the cabin of the aircraft, the escorts accompanied the repatriates to the seats that had been previously established for each one of them.

Distribution in aircraft of repatriates and escorts



Defibrillator and refrigerator during the flight

241. After boarding, little after taking off, the straps were removed from the repatriates’ wrists without any incident during the flight. In respect of healthcare services, the requests made during the flight,

particularly by foreign nationals, were many and increased when the healthcare professional attended the area where they were located to assist somebody. In general, they were requests for painkillers, for headache pills or hypnotics. The medical practitioner attended the requests using a strictly medical criterion. No request was made for urgent assistance and no situation of vital risk occurred. Nevertheless, the aircraft had no defibrillator of any kind or any refrigerator. Both items are considered, in the opinion of this Institution, to be necessary, the first of them because it is currently available at many public places and it would be desirable to have one on flights of these features, provided that it were authorised for the type of aircraft that may be contracted and, the second, because it is needed to keep certain medicinal products, such as insulin, refrigerated. The DGP reported that it would consider the possibility of including defibrillators ad hoc and refrigerators in the flights.

Supervision of delivery of repatriated citizens

242. The technical expert of the Ombudsman's Office supervised the delivery of the 35 citizens from Ecuador to the local authorities, in the presence of the Councillor for the Interior of Ecuador. Officers of Italy proceeded to deliver their two citizens of Ecuador. Once in Bogotá, the delivery of the 56 citizens of Colombia, and of the citizen of Colombia transferred by the INTERPOL, to the local authorities, in the presence of the Councillor and Attaché of the Interior in Colombia, was supervised. The flight back was made by 40 Spanish citizens, who were serving sentences in prisons in Ecuador and Colombia, transferred by the INTERPOL for their admission into prison, and 5 other Spanish citizens in a situation of lack of protection transferred by the UCER.

Incidents

243. In respect of the incidents occurred in repatriation flights made in 2013, the DGP reported that six occurred as shown in the following table.

Table 50
Incidents during flights

FLIGHTS			
INCIDENT	DAY	DESTINATION	ORGANISER
One repatriate opposed strong resistance to boarding, attempting to avoid it. The Spanish escort personnel proceeded to tie him up to be able to take off.	14-02-2013	NIGERIA	FRONTEX
On disembarking, the immigrants and after boarding 24 of them in a bus, before the police of Mauritania, they started to run to board the aircraft again. They were rejected and 26 Spanish police officers were injured.	21-02-2013	MAURITANIA	CGEF

Table 50
Incidents during flights

FLIGHTS			
INCIDENT	DAY	DESTINATION	ORGANISER
Two repatriates offered resistance to boarding, so that they had to be immobilised for the purpose. They offered the same resistance until the aircraft took off.	24-04-2013	NIGERIA	FRONTEX
One repatriate, on disembarking, showed a hostile and aggressive attitude towards the escort team, and the minimum essential force had to be used to control them and deliver them to the authorities of Nigeria.	13-06-2013	NIGERIA	CGEF
One of the repatriates refused to board the aircraft voluntarily, showing violent opposition, so that he was boarded using the minimum force necessary for the purpose. Due to the struggle that took place in the aircraft for him to be seated in the allocated place, one of the seats was damaged, the citizen of Senegal having sustained no injuries.	25-07-2013	SENEGAL	CGEF
One of the repatriates showed strong resistance, biting one of the police officers on the leg, and was assisted by the medical services on board the aircraft.	22-08-2013	NIGERIA	FRONTEX

Incidents

Likewise, the DGP reported three incidents occurred with repatriates who were to be transported to Algeria by boat.

Table 51
Incidents during trips by boat

SHIP			
INCIDENT	DAY	DESTINATION	ORGANISER
One repatriate stated that he had swallowed a razor blade although, after the respective X-rays, it was considered that it could be a zip, his transfer being authorised by the medical services.	30-04-2013	ALGERIA	CGEF
One repatriate stated that he was epileptic. The emergency medical services supplied him with the medication necessary for the trip.	28-05-2013	ALGERIA	CGEF
One repatriate said he had swallowed a razor blade and, on being taken to hospital, declared that this was untrue.	26-12-2013	ALGERIA	CGEF

Repatriation operations

244. The following tables show the foreign national repatriation operations organised by FRONTEX and by the CGEF, in 2013, according to data made available by the DGP.

Table 52
Joint flights scheduled by FRONTEX in 2013

DATE FLIGHT	NATIONALITY	ORIGIN/SCALE	DESTINATION	TRAS.	ORGANISER
24/01	NIGERIA	MADRID	LAGOS	8	UNITED KINGDOM
30/01	ECUADOR	MADRID	GUAYAQUIL	52	SPAIN
	COLOMBIA		BOGOTA	56	
13/02	UKRAINE	MADRID/VIENA	KIEV	10	SPAIN
	GEORGIA		TIFLIS	12	
14/02	NIGERIA	MADRID	LAGOS	9	NORUEGA
23/04	SERBIA	MADRID/ DUSSELDORF	BELGRADE	1	GERMANY
24/04	PAKISTAN	MADRID/ATHENS	ISLAMABAD	18	SPAIN
24/04	NIGERIA	ROTTERDAM/ MADRID	LAGOS	9	HOLLAND
16/05	ALBANIA	MADRID/LILLE	TIRANA	6	IRELAND
28/05	GEORGIA	MADRID/VIENNA/ YEREVAN	TIFLIS	7	AUSTRIA
09/07	SERBIA	MADRID/ DUSSELDORF	BELGRADE	4	GERMANY
22/08	NIGERIA	MADRID	LAGOS	21	SPAIN
24/09	MACEDONIA	MADRID/ MONTPELLIER/ PARIS/ DUSSELDORF	SKOPJE	1	GERMANY
	SERBIA		BELGRADE	2	
08/10	ECUADOR	MADRID	QUITO	29	SPAIN
	COLOMBIA		BOGOTA	51	
17/10	NIGERIA	MADRID	LAGOS	9	HOLLAND
29/10	ALBANIA	MADRID/ROMA	TIRANA	2	FRANCE
22/11	PAKISTAN	MADRID/ BUDAPEST	ISLAMABAD	19	SPAIN
29/11	UKRAINE	MADRID/VIENA	KIEV	16	SPAIN
	GEORGIA		TBILISI	12	
11/12	ECUADOR	MADRID	QUITO	35	SPAIN
	COLOMBIA		BOGOTA	56	
ANNUAL TOTAL					**445**

Source: Own preparation based on data furnished by the DGP (General Headquarters for Foreign Nationals and Borders).

Table 53

International flights performed in 2013 by the General Headquarters for Foreign Nationals and Borders

DATE FLIGHT	NATIONALITY	ORIGIN/SCALE	DESTINATON	TRAS.
21/02	MAURITANIA	MADRID/TENERIFE	NOUAKCHOTT	40
28/02	NIGERIA	MADRID	LAGOS	29
		MALAGA		9
05/03	SENEGAL	MADRID	DAKAR	30
20/03	COLOMBIA	MADRID	BOGOTA	68
	DOMINICAN REPUBLIC		SANTO DOMINGO	27
08/05	NIGERIA	MADRID	LAGOS	36
	MAURITANIA	TENERIFE	NOUAKCHOTT	2
				13
06/06	SENEGAL	MADRID	DAKAR	31
		MALAGA		18
13/06	NIGERIA	MADRID	LAGOS	30
	MAURITANIA	LAS PALMAS	NOUAKCHOTT	5
19/06	ECUADOR	MADRID	QUITO	34
	COLOMBIA		BOGOTA	56
25/07	SENEGAL	MADRID	DAKAR	37
26/09	SENEGAL	MADRID	DAKAR	42
01/10	MAURITANIA	MADRID	NOUAKCHOTT	2
		TENERIFE		20
04/10	NIGERIA	MADRID	LAGOS	21
15/11	MAURITANIA	LAS PALMAS	NOUAKCHOTT	22
	GHANA	MADRID	ACCRA	18
19/11	SENEGAL	MADRID	DAKAR	32
03/12	NIGERIA	MADRID	LAGOS	26
ANNUAL TOTAL				**648**

Source: Own preparation based on data furnished by the DGP (General Headquarters for Foreign Nationals and Borders).

Table 54

Repatriations to Morocco via Ceuta carried out in 2013 by the General Headquarters for Foreign Nationals and Borders

DATE FLIGHT	ORIGIN/SCALE	DESTINATION	RETURNEES
04/01/2013	MADRID	CEUTA	14
	ALGECIRAS		6
11/01/2013	MADRID	CEUTA	16
	JEREZ		1
	ALGECIRAS		6
16/01/2013	MADRID	CEUTA	17
	JEREZ		1
	ALGECIRAS		5
22/01/2013	MADRID	CEUTA	5
	BARCELONA		15
23/01/2013	MADRID	CEUTA	15
	JEREZ		0
	ALGECIRAS		6
29/01/2013	MADRID	CEUTA	14
	JEREZ		1
	ALGECIRAS		3
31/01/2013	MADRID	CEUTA	5
	ALGECIRAS		5
06/02/2013	MADRID	CEUTA	20
08/02/2013	MADRID	CEUTA	8
	JEREZ		3
	ALGECIRAS		10
12/02/2013	MADRID	CEUTA	5
	BARCELONA		14
	JEREZ		1
14/02/2013	MADRID	CEUTA	10
	JEREZ		1
	ALGECIRAS		8
19/02/2013	MADRID	CEUTA	14
	JEREZ		2
	ALGECIRAS		5
21/02/2013	MADRID	CEUTA	10
	ALGECIRAS		9
26/02/2013	MADRID	CEUTA	3
	BARCELONA		17

Table 54

Repatriations to Morocco via Ceuta carried out in 2013 by the General Headquarters for Foreign Nationals and Borders

DATE FLIGHT	ORIGIN/SCALE	DESTINATION	RETURNEES
28/02/2013	MADRID	CEUTA	15
	JEREZ		0
	ALGECIRAS		5
05/03/2013	MADRID	CEUTA	9
	JEREZ		1
	ALGECIRAS		9
07/03/2013	MADRID	CEUTA	16
	JEREZ		1
	ALGECIRAS		2
12/03/2013	MADRID	CEUTA	3
	BARCELONA		17
	ALGECIRAS		1
14/03/2013	MADRID	CEUTA	20
	JEREZ		1
	ALGECIRAS		2
20/03/2013	MADRID	CEUTA	5
	BARCELONA		17
22/03/2013	MADRID	CEUTA	17
	JEREZ		1
	ALGECIRAS		7
26/03/2013	MADRID	CEUTA	14
	JEREZ		2
	ALGECIRAS		5
04/04/2013	MADRID	CEUTA	17
	JEREZ		2
	ALGECIRAS		1
09/04/2013	MADRID	CEUTA	16
	ALGECIRAS		7
11/04/2013	MADRID	CEUTA	6
	BARCELONA		8
16/04/2013	MADRID	CEUTA	15
	ALGECIRAS		5
18/04/2013	MADRID	CEUTA	10
	JEREZ		1
	ALGECIRAS		5

Table 54

Repatriations to Morocco via Ceuta carried out in 2013 by the General Headquarters for Foreign Nationals and Borders

DATE FLIGHT	ORIGIN/SCALE	DESTINATION	RETURNEES
23/04/2013	MADRID	CEUTA	16
	JEREZ		0
	ALGECIRAS		6
25/04/2013	MADRID	CEUTA	6
	BARCELONA		14
30/04/2013	MADRID	CEUTA	15
	JEREZ		1
	ALGECIRAS		5
07/05/2013	MADRID	CEUTA	14
	JEREZ		2
	ALGECIRAS		6
09/05/2013	MADRID	CEUTA	3
	BARCELONA		18
	ALGECIRAS		1
14/05/2013	MADRID	CEUTA	14
	JEREZ		4
	ALGECIRAS		3
17/05/2013	MADRID	CEUTA	14
	ALGECIRAS		4
21/05/2013	MADRID	CEUTA	12
	JEREZ		1
	ALGECIRAS		6
23/05/2013	MADRID	CEUTA	5
	BARCELONA		14
	ALGECIRAS		2
28/05/2013	MADRID	CEUTA	16
	JEREZ		1
	ALGECIRAS		6
30/05/2013	MADRID	CEUTA	14
	JEREZ		1
	ALGECIRAS		8
11/06/2013	MADRID	CEUTA	17
	ALGECIRAS		2
13/06/2013	MADRID	CEUTA	4
	BARCELONA		19
	ALGECIRAS		1

Table 54

Repatriations to Morocco via Ceuta carried out in 2013 by the General Headquarters for Foreign Nationals and Borders

DATE FLIGHT	ORIGIN/SCALE	DESTINATION	RETURNEES
18/06/2013	MADRID	CEUTA	14
	JEREZ		2
	ALGECIRAS		3
20/06/2013	MADRID	CEUTA	13
	ALGECIRAS		5
25/06/2013	MADRID	CEUTA	15
	JEREZ		1
	ALGECIRAS		8
27/06/2013	MADRID	CEUTA	3
	BARCELONA		15
	ALGECIRAS		2
02/07/2013	MADRID	CEUTA	15
	JEREZ		1
	ALGECIRAS		5
04/07/2013	MADRID	CEUTA	3
	BARCELONA		15
	JEREZ		1
10/07/2013	MADRID	CEUTA	16
	JEREZ		1
	ALGECIRAS		4
11/07/2013	MADRID	CEUTA	11
	JEREZ		1
	ALGECIRAS		10
17/07/2013	MADRID	CEUTA	12
	JEREZ		1
	ALGECIRAS		8
18/07/2013	MADRID	CEUTA	16
	ALGECIRAS		8
23/07/2013	MADRID	CEUTA	13
	JEREZ		1
	ALGECIRAS		4
25/07/2013	MADRID	CEUTA	1
	BARCELONA		18
	ALGECIRAS		3
01/08/2013	MADRID	CEUTA	14
	ALGECIRAS		7
06/08/2013	MADRID	CEUTA	10
	ALGECIRAS		9

Table 54

Repatriations to Morocco via Ceuta carried out in 2013 by the General Headquarters for Foreign Nationals and Borders

DATE FLIGHT	ORIGIN/SCALE	DESTINATION	RETURNEES
13/08/2013	MADRID	CEUTA	7
	BARCELONA		18
20/08/2013	MADRID	CEUTA	14
	JEREZ		2
	ALGECIRAS		7
22/08/2013	MADRID	CEUTA	13
	JEREZ		1
	ALGECIRAS		7
27/08/2013	MADRID	CEUTA	15
	JEREZ		2
	ALGECIRAS		5
29/08/2013	MADRID	CEUTA	2
	BARCELONA		14
	ALGECIRAS		1
03/09/2013	MADRID	CEUTA	10
	ALGECIRAS		11
05/09/2013	MADRID	CEUTA	7
	ALGECIRAS		9
10/09/2013	MADRID	CEUTA	10
	JEREZ		0
	ALGECIRAS		9
12/09/2013	MADRID	CEUTA	8
	JEREZ		4
	ALGECIRAS		9
17/09/2013	MADRID	CEUTA	15
	ALGECIRAS		2
19/09/2013	MADRID	CEUTA	3
	BARCELONA		17
	ALGECIRAS		1
24/09/2013	MADRID	CEUTA	16
	JEREZ		2
	ALGECIRAS		3
26/09/2013	MADRID	CEUTA	18
	ALGECIRAS		7

Table 54

Repatriations to Morocco via Ceuta carried out in 2013 by the General Headquarters for Foreign Nationals and Borders

DATE FLIGHT	ORIGIN/SCALE	DESTINATION	RETURNEES
01/10/2013	MADRID	CEUTA	13
	ALGECIRAS		5
04/10/2013	MADRID	CEUTA	17
	ALGECIRAS		7
08/10/2013	MADRID	CEUTA	12
	ALGECIRAS		10
10/10/2013	MADRID	CEUTA	4
	BARCELONA		19
14/10/2013	MADRID	CEUTA	17
	ALGECIRAS		4
22/10/2013	MADRID	CEUTA	16
	JEREZ		1
	ALGECIRAS		6
24/10/2013	MADRID	CEUTA	2
	BARCELONA		15
	ALGECIRAS		2
29/10/2013	MADRID	CEUTA	17
	JEREZ		3
	ALGECIRAS		4
31/10/2013	MADRID	CEUTA	13
	JEREZ		2
	ALGECIRAS		3
07/11/2013	MADRID	CEUTA	19
	ALGECIRAS		5
08/11/2013	MADRID	CEUTA	12
	ALGECIRAS		9
12/11/2013	MADRID	CEUTA	8
	ALGECIRAS		13
14/11/2013	MADRID	CEUTA	7
	BARCELONA		12
	ALGECIRAS		2
19/11/2013	MADRID	CEUTA	20
	JEREZ		1

Table 54

Repatriations to Morocco via Ceuta carried out in 2013 by the General Headquarters for Foreign Nationals and Borders

DATE FLIGHT	ORIGIN/SCALE	DESTINATION	RETURNEES
21/11/2013	MADRID	CEUTA	16
	ALGECIRAS		3
26/11/2013	MADRID	CEUTA	10
	JEREZ		1
	ALGECIRAS		5
28/11/2013	MADRID	CEUTA	5
	ALGECIRAS		6
03/12/2013	MADRID	CEUTA	11
	JEREZ		1
	ALGECIRAS		6
05/12/2013	MADRID	CEUTA	7
	BARCELONA		15
10/12/2013	MADRID	CEUTA	5
	JEREZ		2
	ALGECIRAS		2
19/12/2013	MADRID	CEUTA	19
	ALGECIRAS		1
27/12/2013	MADRID	CEUTA	2
	BARCELONA		9
	JEREZ		1
	ALGECIRAS		9
ANNUAL TOTAL			**1.807**

Source: Own preparation based on data furnished by the DGP (General Headquarters for Foreign Nationals and Borders).

Table 55

Repatriations to Morocco via Melilla carried out in 2013 by the General Headquarters for Foreign Nationals and Borders

DATE FLIGHT	ORIGIN/SCALE	DESTINATION	RETURNEES
4/01/2013	MADRID	MELILLA	3
10/01/2013	MADRID	MELILLA	1
11/01/2013	MADRID	MELILLA	3
	BARCELONA		13
16/01/2013	MADRID	MELILLA	6
23/01/2013	MADRID	MELILLA	4
31/01/2013	MADRID	MELILLA	1

Table 55

Repatriations to Morocco via Melilla carried out in 2013 by the General Headquarters for Foreign Nationals and Borders

DATE FLIGHT	ORIGIN/SCALE	DESTINATION	RETURNEES
6/02/2013	MADRID	MELILLA	5
	BARCELONA		4
14/02/2013	MADRID	MELILLA	4
	JEREZ		1
21/02/2013	MADRID	MELILLA	3
	BARCELONA		5
7/03/2013	MADRID	MELILLA	3
22/03/2013	MADRID	MELILLA	5
	JEREZ		1
	BARCELONA		2
17/05/2013	MADRID	MELILLA	4
	BARCELONA		15
1/08/2013	MADRID	MELILLA	5
8/08/2013	MADRID	MELILLA	1
14/08/2013	MADRID	MELILLA	1
27/08/2013	ALMERIA	MELILLA	16
12/09/2013	MADRID	MELILLA	4
	BARCELONA		4
26/09/2013	MADRID	MELILLA	2
	BARCELONA		2
30/09/2013	ALMERÍA	MELILLA	30
8/10/2013	MADRID	MELILLA	1
	BARCELONA		5
18/10/2013	MADRID	MELILLA	19
	BARCELONA		8
23/10/2013	MADRID	MELILLA	2
	ALMERÍA		14
20/11/2013	MADRID	MELILLA	1
21/11/2013	MADRID	MELILLA	1
	BARCELONA		3
28/11/2013	MADRID	MELILLA	1
19/12/2013	MADRID	MELILLA	5
	BARCELONA		2
ANNUAL TOTAL			**210**

Source: Own preparation based on data furnished by the DGP (General Headquarters for Foreign Nationals and Borders).

Table 56
Repatriations of citizens of Algeria by boat performed in 2013 by the General Headquarters for Foreign Nationals and Borders

INTERNATIONAL BOATS		
ROUTES	BOATS	ALGERIAN
ALICANTE/ORÁN	16	198
ALMERÍA/GHAZAOUET	51	552
ALMERÍA/ORÁN	3	29
TOTAL ALGERIA	**70**	**779**

Source: Own preparation based on data furnished by the DGP (General Headquarters for Foreign Nationals and Borders).

IV.3. Room for asylum and persons refused entry

Visits to rooms for asylum seekers and persons refused entry

245. In 2013, two visits were made to the Rooms for asylum and persons refused entry of terminals 1 and 4 satellite of Airport Adolfo Suárez de Madrid-Barajas. At the first of them, carried out in April, the Ombudsman and two technical experts of the Institution made a follow up visit, at which information was obtained on the most relevant aspects of the background information existing on these facilities, mainly the visit made in 2010. The second of these visits was made two months later, in the last days of June and three technical experts of the Ombudsman's Office participated accompanied by an external expert specialised in Legal and Forensic Medicine.

Facilities

246. Some of these rooms are those at which foreign nationals who have requested asylum in Spain remain, located at Terminal 4 satellite, and others are those at which foreign nationals whose entry into Spain was refused, for failure to meet the requirements established for the purpose, remain while their proceeding for rejection is processed and they are returned to their country of origin, located at Terminal 1 y en la Terminal 4 satellite. The duration of the stay of these latter persons at the facilities depends on the frequency of the flights of the companies with which they travelled to Spain, but, after 72 hours have elapsed without its having been possible to return them to their country of origin, court authorisation must be requested for them to be able to remain at these or at other facilities. The time of the stay of asylum seekers depends on the duration of the exam and other formalities of their request.

Healthcare

247. The purpose of the last visit, of a multidisciplinary nature, was to study the healthcare services provided to persons at these facilities, verify whether the deficiencies detected in previous visits had been finally corrected and proceed to an exhaustive review of the record books to determine the duration of the stay of persons refused entry and seekers of asylum.

Right to privacy

248. In respect of healthcare, it was observed that the right to privacy of persons withheld in both rooms was not safeguarded, since the reports on their health data are delivered to the persons responsible for administering medication to them (social workers or Red Cross volunteers), who need not know such reports, considering that it would be sufficient for them to know, only, the medication that they must provide and the time at which they must do so.

Issue of injury report

249. In the case of assistance provided to persons with injuries, the relevant injury report is issued only when the person in question intends to bring charges and is never conveyed to the court being instead delivered to the officer of the CNP accompanying that person, which is not considered appropriate since the report should always be remitted to the judge on duty.

Description of injuries

250. As regards the description of injuries, at these facilities the same deficiencies recorded in paragraph 55 of Annual Report 2012 were observed, without the decision having been made to photograph them to attach them to the court record.

Answer pending

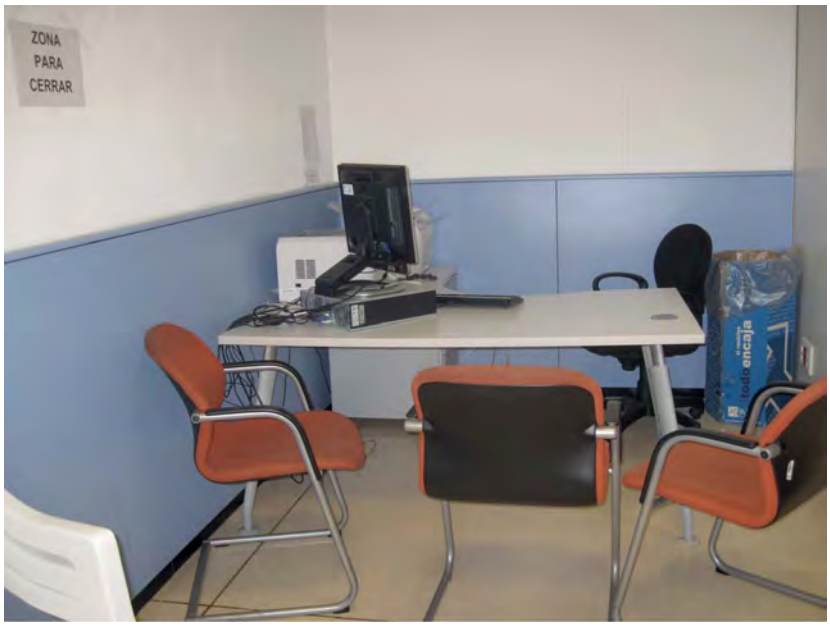
All these questions are pending an answer at the date of this report.

Suggestions on the facilities and security measures

251. After reviewing the record books for years 2012 and 2013, it was verified that, at least, 162 persons in 2012 and 101 in 2013 had remained more than 72 hours waiting to be rejected, both at the facilities of the T1 and at those of the T4 satellite. Additionally, asylum seekers remain at the facilities of the T4 satellite for longer than three days. During this time period, persons who remain at the T4 satellite have no natural lighting and, both they and the persons remaining at the T1 are unable to go out of doors. Because of this, two suggestions were made to the DGP for both asylum seekers and persons who, waiting for rejection, must remain more than 72 hours at the facilities of the T4 satellite, to be relocated at the facilities existing at the T1 and for the security measures considered necessary to be adopted for these persons to be able to have contact with the exterior, at least one hour per day, to perform physical activity, enjoy the beneficial effects of solar radiation or, at least, breathe fresh air for that time. Both suggestions are pending an answer at the date of this report.

Suggestion for interviews to potential victims of trafficking

252. It was verified that the interviews with persons refused entry or asylum seekers, in which indications of human trafficking are observed, are held in an area enabled as an office, but without doors and that is lacking the minimum features to be considered adequate to create the necessary atmosphere of trust that a potential victim of human trafficking needs. It is an open area for transit so that any person could hear the conversations. For this reason, a suggestion was made to the DGP for interviews to potential victims of trafficking to be carried out in a closed office, to preserve their privacy, which was accepted by said managing body.



Open office for interviews of potential victims of trafficking with human beings

253. A suggestion was made to the DGP for audio-visual recordings to be kept of the interviews made to decide the non-admission into Spanish territory, to avoid eventual abuse of inadequate treatment to passengers or to place on record that the statements of the officer conform to those of the traveller. This suggestion is pending an answer at the date of this report.

Suggestion for audio-visual record to be kept of interviews

254. It was observed that those cases in which it was necessary to "isolate" persons who could be problematic or cause disturbances were located both at the facilities of the T1 and at those of the T4 satellite. Accordingly, a suggestion was made to the DGP, which reported that the appropriate instructions had been given for such measures to be entered on a record book. In addition, the request for video-surveillance cameras to be installed in these rooms, one at each terminal, is pending an answer from the DGP.

Suggestion for isolation of problematic persons

Isolation room in the T4 satellite

Maintenance and cleaning

255. Lastly, various conclusions were conveyed to AENA relating to the maintenance of the toilets and walls of some rooms, which were accepted, and the cleaning of certain rooms in the T1, which was rejected, so that a suggestion was made, that was finally accepted, AENA reporting that they had given instructions to the cleaning service, for it to clean the various rooms, after they had been vacated.

IV. 4. Means of transport for transportation of persons in custody

Visit to supervise a prisoner transfer operation

256. In 2013, a visit was made to supervise an operation for the transportation of prisoners by the Civil Guard from penitentiary centres of the Canary Islands to the Spanish mainland by air. Transfers may be performed on small flights, with a maximum 8 prisoners, or on large flights, containing several dozens of them. Flights are made from Las Palmas or Tenerife, to Jerez de la Frontera (Cádiz), from where a bus transports the prisoners to CP Puerto III (Cádiz), for their subsequent transportation to other CPs, either to continue serving sentence at other centres, or in transit to attend trials and court investigations, take extraordinary leaves or for other reasons. Once they arrive at CP Puerto III (Cádiz), prisoners who will use the return operation to be transported to the Canary Islands board the bus.

Multidisciplinary visit

257. During the visit, one aircraft arrived, transporting eight prisoners, at the airport of Jerez de la Frontera (Cádiz), the prisoners were disembarked and were boarded on the bus of the Civil Guard that would then transfer them to CP Puerto III (Cádiz), and an individual interview was held with each one of them. The visit was multidisciplinary and was attended by one external technical expert in Legal and Forensic Medicine.

Conditions of transfers

258. The Ombudsman's Office had background information of complaints processed for the conditions of certain transfers between the CPs of the Canary Islands and the mainland. Some prisoners complained that the custody officers wore balaclavas and that, during the flight, they made them place their heads on their thighs in a position similar to that used in emergencies. They also stated that, during the journey, they were not allowed to drink or eat, take medicines prescribed to them or use the toilets. The Directorate General for the Civil Guard reported on the matter that during the flight it is not permitted to provide meals to the inmates or escorts for security reasons, although it was permitted to administer medicines, which was done by the Penitentiary Institutions medical practitioner accompanying the inmates. Inmates were also permitted to go to the toilet during the flight, with the adequate security measures. One-use security straps were used since they were considered more hygienic, more suitable and safer than metal handcuffs.

State of the interior of the plane

259. The flight from Las Palmas took off at approximately 9:30 h a.m., local time, arriving at the airport of Jerez de la Frontera (Cádiz) at approximately 13.45 h. it was reported that flights usually take approximately 3.30 hours, and a difference of up to 45 minutes may exist depending on weather conditions. It was possible to access the aircraft, verifying that its state was correct.

Disembarking the plane

Interior of the aircraft in which the prisoners travelled

Medical assistance

260. One DUE of the CP of Las Palmas II was on board accompanying the prisoners, who stated that no medical or other incident occurred during the flight. According to her information, one member of the medical services of the CP, sometimes a medical practitioner and others a DUE, was always present in all flights, without being able to provide information as to the criteria used to decide whether one or the other type of professional was to do so, since this decision was made by the medical assistance management of CP Las Palmas II. Nevertheless, she stated that in more numerous transfers usually both a medical practitioner and a DUE remain on board.

Medication

Before leaving, the DUE administered the respective medication to each inmate. In addition, if the inmate had to take any medication before arriving to the CP of destination, the medication was provided by the DUE. The function of the DUE during the flight is exclusive on demand, should any inmate feel ill or need assistance, for which the DUE carries a first aid kit.

Recommendation on medical data

261. It was verified that, during the flight, the clinical records of inmates are kept, together with the luggage, in the hold, and are not available to the healthcare personnel, which in the opinion of this Institution would not be adequate if any medical action were required, particularly on the return flight, where it is impossible for the healthcare personnel who will travel with the inmates to review the clinical records in advance. Accordingly, the Ombudsman made a recommendation for the measures necessary to be adopted for the healthcare personnel to have available the medical data of the prisoners during the flight. The DGGC accepted the recommendation and reported that the necessary arrangements will be made to implement it.

Recommendation for identification of officers

262. It was verified that the officers of the Civil Guard of Las Palmas who custodied the inmates in the aircraft did not carry their identity number in a visible place, although they wore the statutory uniform, contravening the criterion of the Ombudsman, repeatedly stated, inter alia, in paragraph 227 of Annual Report 2011 of the NPM. The DGGC reported that, for operating reasons, the Civil Guard officers wore a tactic waist jacket over their uniform impeding their personal identification badge from being seen. Accordingly, a Recommendation was made for the appropriate measures to be put in place for the jackets to bear an identification number, which was accepted by the DGGC, which provided the jackets with a flap to adhere the identity number of the Civil Guard officers and gave the due orders for it to be carried at all times.

Treatment given

263. All inmates stated that the treatment given to them by the officers of the Civil Guard had been correct and that they had no complaint on the matter. Some of them stated that, since a few months ago, in transfers by plane they were no longer obliged to place their head between their legs for the entire flight and the officers no longer wore balaclavas. They were also asked whether the medication that had to be provided to them that morning had been administered, which they answered to the affirmative, that they had been given their medication in the morning before leaving by the healthcare personnel accompanying them during the trip. Even one inmate included in a methadone maintenance program had received his dose. During their transfer the inmates were tied using one-use security straps. The forensic doctor did not observe that any of them was too tight and no injuries caused by the straps were found on their wrists.

Examination of the interior of the bus of the GC

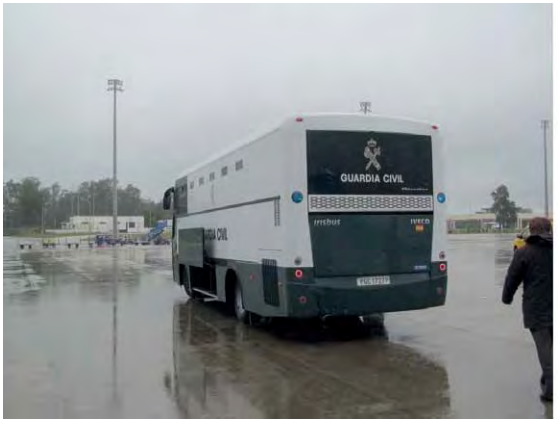
264. The inside of the bus of the Civil Guard in which the inmates would be transported to CP Puerto III (Cádiz) was examined. It was a type-B vehicle, as described in paragraph 427 of Annual Report 2010 of the NPM, in other words, for the transportation of up to a maximum 16 inmates and 6 custody officers, including the driver. These vehicles are divided into 6 double compartments for inmates, with a central corridor and two compartments (one in front and the other in the back) for escorts and the driver. It was observed that the state of maintenance and cleanliness of the vehicle was correct.

Recommendation for transportation of prisoners

Nevertheless, the bus did not have safety belts for the inmates or video-surveillance for recordings, which deficiencies were recorded, inter alia, in paragraphs 433 and 434 of Annual Report 2010 of the NPM. Accordingly, a recommendation was made to the DGGC for improvements to be made in the next acquisitions of vehicles for the transportation of prisoners, such as the installation of a video-surveillance system and safety belts. The DGGC accepted the recommendation, although subject to budget availability and to the validation of the security measures. The DGGC reported on the matter that they various prototypes of lightweight cellular vehicles (5 seats) are at the testing and evaluation stage with video-surveillance and retention systems. In respect of vehicles with greater capacity (from 12 to 28 seats), never-

theless, it has not been possible to carry out similar tests to establish the feasibility of such security systems.

Bus of the Civil Guard in which prisoners were transferred to CP Puerto III (Cádiz)



Institutional training and dissemination activities
§ 265 - § 268

265. With regard the dissemination and publicising in 2013 of the powers, operation and action of the NPM, technical experts of the Unit participated in various forums, such as the "Immigration Detention in Europe: Establishing Common Concerns and Developing Minimum Standards" Conference, organised by the Council of Europe, held in Strasburg on 21 and 22 November 2013, or the X University Master Course on the International Protection of Human Rights, organised by the Democracy and Human Rights Department of the University of Alcalá.

Dissemination and publicising work on the powers, operation and action of the NPM

266. On 12 November 2013 the Session "Protocol for preparation of injury reports for persons deprived of liberty" was held in which judges and experts in medicine, psychiatry, psychology and forensic medicine participated, including two members of the Advisory Board. As a result of this session, the Ombudsman will submit the report on Injury reports of persons deprived of liberty, with recommendations to the Authority.

Session "Protocol for preparation of injury reports for persons deprived of liberty"

267. In addition, cooperation existed between the NPM and human rights institutions of other countries, carrying out workshops on the mandate and activity performed by the Spanish NPM. Specifically, in 2013, work sessions were carried out with the National Commission for Human Rights and the Bar Association of Mauritania and the NPMs of Albany, Montenegro, Ukraine (the headquarters of the Madrid-Chamartín district were visited), and meetings were held with members of the NPM of Honduras and the NPM of Rio de Janeiro (Brazil). Likewise, the operation and powers of the Spanish NPM were explained to a delegation of officers of the Cabinet of Ministers of Palestine, in the context of a cooperation activity organised by the National Institute of the Public Administration.

Cooperation with NPM and human rights institutions of other countries

268. Lastly, it must be mentioned that on the working trips of personnel of the Institutions visits are occasionally made to Spanish prisoners in foreign CPs, to know their situation and the attention that they receive from the Spanish consular services. In 2013, the Ombudsman made three visits at which she interviewed Spanish prisoners: CPs "Sarita Colonias" in Callao and Ancón II in Lima, Peru (in April) and the CP of Bakirkoy in Istanbul (in September); and, also, the Secretary General and the Technical Expert Responsible for the Area of Equal Treatment and Migrations of the Ombudsman were visited and Span-

Visits to Spanish prisoners in foreign prisons

ish prisoners were visited at the CPs of La Picota, El Buen Pastor and La Modelo in Bogotá (in December). Due to such visits, action was taken by the Area of Migrations and Equal Treatment in respect of the particular situations of the interviewed inmates.

Appendix

Processing of complaints for ill-treatment by the Ombudsman § 269 - § 275

Summary of reactive activity performed by the Ombudsman

269. As was done in Annual Report 2012, it was considered appropriate to include an appendix to the report of the NPM containing a summary of the reactive activity performed by the Ombudsman in view of the purported perpetration of facts that may be classified as torture or cruel, inhuman or degrading treatment, through the relevant actions with the Authority, without prejudice to the information contained in the 2013 annual report of the Ombudsman. As stated in paragraph 265 of the annual report, many actions are suspended while the court proceeding that may have been instituted for the facts complained of is conducted.

Institution of a proceeding for purported mistreatment or ill treatment

270. When knowledge is obtained, either through a complaint or through the media, due to a visit of the NPM or in any other manner, of an action that could be ill-treatment or have effects on the right of persons deprived of liberty, a proceeding is instituted and information is requested from the Authority on the purportedly criminal or unlawful facts, to know both if they are true and the operation of the internal control devices of the Authority and the distribution of liability. In addition, action occasionally has to be taken with the Authority due to complaints received for excessive use of physical force or other coercive measures.

Institution of a proceeding ex officio in the case of a death

Likewise, when information is received of the death of a person deprived of liberty, a proceeding is instituted ex officio to know the circumstances of the death and the actions performed by the Authority.

Institution of a proceeding due to a death

271. In respect of the action of the Security Forces and Corps, in 2013, a proceeding was instituted due to the death of a citizen at the Hospital Clínic de Barcelona after his detention by the Mossos d'Esquadra. Since a court proceeding was being conducted and the penalising proceedings instituted by the Authority were suspended until the conclusion of said court proceeding, the Ombudsman also suspended its action, without prejudice to the criminal proceeding continuing to be conducted through the General Public Prosecution of the State.

Institution of 25 proceedings for purported ill treatment and 59 for mistreatment

As regards purported ill-treatment or mistreatment, in 2013, 25 and 59 proceedings were instituted, respectively. Section II.3.3 of Annual Report 2013 of the Ombudsman contains a summary of such actions. For example, the case of a citizen may be mentioned who, after bringing a complaint for purported fraud at the Headquarters of the CNP of the Usera-Villaverde District of Madrid, and after an incident originated with the officers, he was detained for resistance to the authority and spent all night handcuffed in the cell. The action continues to be conducted and the DGP was requested to report on the recording, storage and destruction of the images recorded of this specific incident.

22 investigation proceeding for death of inmates in prisons and 52 for ill-treatment

272. As regards CPs, in 2013, 22 proceedings were instituted to investigate the death of inmates at those centres. In addition, 52 proceedings were conducted on having knowledge of actions that could constitute ill-treatment. Occasionally, nevertheless, the complaints referred in general to ill treatment, degrading treatment or torture, so that the lack of a specific description of the facts impeded action from being taken before the penitentiary Authority. Section II.2 of Annual Report 2013 of the Ombudsman contains a summary of the actions performed in this regard.

Officer convicted for two sexual harassment crimes

In year 2013, Criminal Court number 2 of Almería rendered a prison sentence of two years with a fine of twenty months at the daily stipulated rate against an officer of the SGIP, for two crimes of sexual abuse of two inmates of the CP of Almería. Said court of Almería verified that the officer carried out unlawful body searches outside the timetable in a disproportionate manner and ordered humiliating and unlawful searches.

Version of the facts of the interested party

Although these are exceptional cases, the Authority must continue to convey a clear message on the dysfunctional and inadmissible nature of these practices, inter alia, by instituting disciplinary proceedings and establishing liability. In this respect, it was observed when conducting the proceedings that, in the internal actions of the Authority, those seeking to obtain the version of the facts of the interested person are gradually being included. This Institution insisted on the need for complaints for purported ill treatment, regardless of the judgment of truth they may generate in the Authority at a first glance, must be verified by making contact with the version of the inmate, who should be afforded the possibility of submitting or requesting evidence.

Investigation of irregular conduct

The investigation in administrative proceedings of incidents of this kind should take into account that the existence of inconsistent versions of inmates and officers will be customary. It is also to be expected that the versions of the facts provided by officers who are accused of purported ill-treatment will be consistent. In addition, the absence of injuries does not mean that the facts cannot have occurred as the inmate states, and does not make them less relevant. The criterion of this Institution is that the investigation of purported unlawful conducts, particularly difficult to verify, in addition to being performed by special-

ised personnel not included on the payroll of the establishment where the facts of the complaint occurred, should be in depth, exhaustive and include all possible channels of knowledge, including recordings of the video-surveillance system.

Suicide of a minor

273. In respect of centres for young offenders, in 2013, one proceeding was instituted for the suicide of a young offender at the centre for young offenders of Albaidel (Albacete). After the visit to the centre account of which is rendered in the respective section of this report, the Department of Healthcare and Social Affairs of the Government of Communities of Castile-La Mancha was requested to explain the reasons for which the suicide prevention protocol was not activated and, as the case may be, the reasons for which it was considered advisable to deactivate it. The centre has been requested to proceed to have all the metal bars in the rooms of minors replaced by built shelves, taking into account that the bars remained installed after the facts and although this was essential for the fatal result. In addition, review of the internal operating protocol of the centre was requested, encouraging that personnel be increased for each professional, both security personnel and minor care technical experts, to be able to perform adequately the tasks entrusted to them, reporting, in any case, the measures that it is intended to adopt, both at the personal level and with regard to the material means to prevent facts such as that occurred from being repeated.

Complaints for ill treatment in CIE

274. In 2013, two proceedings were conducted for complaints for purported ill-treatment at various CIEs. At one of them, the facts are being reviewed in a court proceeding, for which reason this Institution is unable to participate, pursuant to article 17 of Basic Law 3/1981, of 6 April. The other proceeding is currently being conducted.

Death of one inmate at the CIE of Barcelona

In addition, this Institution received notice of the death of an inmate at the CIE of Barcelona in the early hours of 3 December. The police authorities were requested to send certain information, in addition to videographic material. The result of said actions will be rendered account of in the Annual Report of the Ombudsman. A proceeding was also instituted after the death of a detainee at the CIE of Madrid in 2011. Said detainee had arrived from the CETI of Melilla where she had been diagnosed a disease that was not reported to the medical service of the CIE. The case is being investigated by the court, so that the Ombudsman's Office suspended its action, requesting the General Public Prosecution of the State for information on the conduct of the criminal proceeding. In its last notice the Public Prosecution reported that, after action had been dismissed by the judge of investigation, the family of the victim appearing in the criminal proceeding had lodged an appeal. At the date of this report, it was known that said appeal had been admitted.

Action in the case of discriminatory conduct

The Ombudsman's Office also takes action when it becomes aware of discriminating conduct, mainly in the identifications made on the highway by the Security Forces and Corps.

Action for purported ill-treatment at centres for senior citizens or persons with disabilities

275. Lastly, the Ombudsman's Office also takes action due to complaints or news of purported ill-treatment or mistreatment and residential centres for young offenders, senior citizens and persons with disabilities. Section II.8 of Annual Report 2013 of the Ombudsman's Office contains a summary of such actions.

Proceeding due to the death of a minor

Thus, in 2013, in respect of young offenders, one proceeding was instituted for a complaint related to a centre for the protection of minors and one proceeding ex officio for the death of a minor in a Centre for of Observation and Tutorship of Pamplona. In addition, two long proceedings related to the attention given to minors in residential centres were concluded: firstly, the Immediate Attention Centre (Centro de Atención Inmediata –"CAI") of Tafira (Las Palmas), at which one minor died at night, finally adopted the requested measures: increase of personnel and new guidelines for personnel working on the night shift. In another proceeding, Madrid Autonomous Community sent this Institution the records of inspection issued by the responsible bodies, to the Centre Picón de Jarama. Due to the conclusion of the actions attention was brought to the lack of confidential interviews with minors in inspections, which is considered a basic measure of supervision.

Attention and treatment to inmates and users of senior citizen homes

With regard to senior citizens, in 2013, four proceedings were conducted for complaints relating to the attention to and treatment of inmates and users of senior citizen homes. All the proceedings continued to be conducted at the beginning of 2014. In addition, in 2013 a Recommendation was made to the Town Council of Ciutadella de Menorca (Balearic Islands) in a proceeding instituted ex officio due to the violent death of an old lady in a geriatric home by another resident, to establish a protocol contemplating the measures for observation, security and surveillance that should be adopted with residents whose behaviour for pathologies show indications of risk to themselves or other persons which whom they are to treat. The recommendation was accepted and is at the stage of implementation.

Annexes

Tables 57-76

Conclusions and decisions arising from visits to facilities of the CNP in 2013

FACILITIES VISITED: Superior Headquarters of the CNP of Castile-La Mancha in Toledo

DATA OF THE VISIT: 29 October 2013 (unannounced) VISITING TEAM: Two technical experts of the Ombudsman's Office

PURPOSE OF THE VISIT: Follow up visit to verify whether the deficiencies observed in previous visits, the last made in 2010, had been corrected. During the visit the facilities and record books were inspected, and interviews were held with the police and custody officers, and with a person who was detained at the time of the visit.

RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted	Pending budget availability				
The hinges on the cell doors may be used by detainees to injure themselves or attempt to commit suicide.	Accepted	Instructions are given for correction.				
Officers carry weapons in the cell area.	Accepted	Instructions are given for correction.				
No specific food for diabetics.	Accepted	Specific food in provided from hospitality establishments.				
Inadequate completion of Registration and Custody Book of detainees.	Accepted	Compliance is repeated.				
Interviews with detainees before statement is taken without presence of lawyer.	Accepted	Instructions are given for correction.				

GOOD PRACTICES
Provide each detainee with a clean blanket.
Improvement of lighting in cell area.

FACILITIES VISITED: Higher Headquarters of the CNP of Valencia Autonomous Community

DATE OF VISIT: 28 November 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office and one member of the Advisory Council of the NPM
PURPOSE OF THE VISIT: Follow up visit to ascertain whether the deficiencies observed in the visit made in 2010 had been corrected. At the visit the facilities and record books were inspected and interviews were held with police and custody officers, and with detainees at the time of the visit.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted	Pending budget availability.				
Interviews with detainees without presence of lawyer.	Accepted	Instructions are given for co-rrection				
Ceramic toilets may be used for aggressions or self-injuries.	Accepted	Pending budget availability.				
Full body searches are not re-corded in the Detainees Regis-tration and Custody Book.	Accepted	Compliance is reminded.				
Inadequate completion of Detai-nees Registration and Custody Book.	Accepted	Compliance is reminded.				
Inadequate maintenance of cell area	Accepted	Instructions are given for co-rrection.				
The temperature of the cells was inadequate.	Accepted	Pending budget availability.				

FACILITIES VISITED: Provincial police station of the CNP of Burgos

DATE OF THE VISIT: 9 July 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: During the visit, the police and custody officers inspected the cell facilities and reviewed the record books, detention regime, access to medical attention and treatment given to persons deprived of liberty. One detainee was found at the time of the visit, with whom a confidential interview was held.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Pending budget availability.				
Full body searches are not recorded in the Detainees Registration and Custody Book	Accepted	Compliance is reminded.				
Ceramic toilets may be used for aggressions or self-injuries.	Accepted	Instructions are given for correction.				
Lack of sealable bags to keep belongings of detainees.	Accepted	Instructions are given for correction.				
No clean blankets are delivered to detainees.	Accepted	Instructions are given for correction.				
Dampness was observed in the cells.	Accepted	Instructions are given for correction.				
The cleaning service should be extended to include weekends.	Accepted	Referred to persons responsible for the cleaning service.				
Interviews with detainees before statement is taken without presence of lawyer.	Accepted	Instructions are given for correction.				

GOOD PRACTICES
Presence of offices in cells when detainees are there.

FACILITIES VISITED: Province Station of the CNP of Palencia

DATE OF VISIT: 8 July 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: During the visit, the police and custody officers inspected the cell facilities and reviewed the record books, detention regime, access to medical attention and treatment given to persons deprived of liberty. No detainees were present at the time of the visit.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS		
GENERAL	STATUS	ANSWER AUTH.

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
RECOMMENDATION	Provided that sufficient police personnel are available, constant presence of officers in cells when detainees are confined.	Accepted not performed	Referred to Operating Assistant Management of the CNP for change of previous instructions.

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Pending budget availability.
Full body searches are not recorded in the Detainees Registration and Custody Bookes.	Accepted	Compliance is reminded.
Address to the Department of Healthcare. Existence of medical reports in the investigations	Accepted	Instructions are given for correction.
Interviews with detainees before statement is taken without presence of lawyer.	Accepted	Instructions are given for correction.

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Prevent cell door lock from being used by detainees to injure themselves or attempt to commit suicide.	Accepted	

GOOD PRACTICES
Detainees are provided with clean blankets.

FACILITIES VISITED: Province police station of the CNP of Salamanca

DATE OF VISIT: 1 October 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: During the visit, the police and custody officers inspected the cell facilities and reviewed the record books, detention regime, access to medical attention and treatment given to persons deprived of liberty. No detainees were present at the time of the visit.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Pending budget availability.				
Horizontal bars on cell doors.	Accepted	Instructions are given for correction.				
No record of full body searches is made in the Detainees Registration and Custody Book.	Accepted	Instructions are given for correction.				
No clean blankets are delivered to detainees.	Accepted	Clean blankets are delivered.				
Detainees are not informed of the possibility of instituting habeas corpus proceedings.	Rejected	Reported orally.				
The complaints office does not preserve the confidentiality of the claimant.	Accepted	Instructions are given for correction.				

GOOD PRACTICES
Detainees enter the cell area from the car park.
A custody officer is always present at the cell area while detainees are present at these facilities.

FACILITIES VISITED: Province station of the CNP of Teruel

DATE OF VISIT: 9 April 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: During the visit, the police and custody officers inspected the cell facilities and reviewed the record books, detention regime, access to medical attention and treatment given to persons deprived of liberty.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed					
Cells do not have direct access from outside.	Accepted not performed	Report requested from the Heritage and Architecture Department on possibility				
The police record should not keep a copy of the medical report unless the requirements of the LOPD are met.	Accepted					
Addressed to the Department of Healthcare, Social Welfare and Family of the General Deputation of Aragon. The medical assistance reports issued by the healthcare services should be delivered only to the party concerned.	Accepted					
Officers are not always present at the cell area when detainees are there.	Accepted					

GOOD PRACTICES
The existence of sets of clothes and shoes to be used by detainees, if necessary.
Expressly place on record in the custody record that the detainee does not wish a meal.

FACILITIES VISITED: CNP District Station of Córdoba Este

DATE OF VISIT: 2 December 2013 (unannounced) VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: Monitoring visit to verify that the deficiencies observed in the previous visit, made in 2010, have been corrected. During the visit, the facilities and record books were inspected and interviews were held with the police and custody officers, and with the three persons who were detained at the time of the visit.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Pending budget availability.				
Officers are not present at the cells when detainees are there.	Accepted	One officer remains in cells when they contain detainees.				
Inadequate completion of the Detainees Registration and Custody Book	Accepted	Compliance is reminded.				
No clean blankets are delivered to detainees.	Accepted	Clean blankets are delivered.				

GOOD PRACTICES
Detainees access the cell area directly from the car park.

FACILITIES VISITED: Province station of the CNP of Zamora

DATE OF VISIT: 30 September 2013 (unannounced) VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: During the visit, the police and custody officers inspected the cell facilities and reviewed the record books, detention regime, access to medical attention and treatment given to persons deprived of liberty. No detainees were present at the time of the visit.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The facade should be repaired to prevent the entrance to the complaints office to be the same as that used by detainees.	Accepted	Measures were adopted to prevent access of citizens from coinciding with that for detainees.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted, not performed	Pending budget availability.				
No video-surveillance screen exists at the place where detainee custody officers are present.	Rejected		SUGGESTION	Install video-surveillance screen in cell control area.	Pending	
The pictures taken by one of the cameras could not be viewed correctly.	Accepted	Problem remedied.				
Lack of sound calling systems in cells.	Pending					
The temperature of the cells was inadequate.	Accepted, not performed	Conveyed to Subdirectorate General for Logistics.				
The lighting of the cells was not adequate.	Accepted, not performed	Conveyed to Subdirectorate General for Logistics.				
The cleanliness of the cells was not adequate.	Accepted	Appropriate instructions have been given.				
The concrete supports and floors of the toilets were in very bad state.	Accepted, not performed	Conveyed to Subdirectorate General for Logistics.				
The doors to the urinary and the toilet should be reinstalled to preserve the privacy of detainees.	Accepted, not performed	Conveyed to Subdirectorate General for Logistics.				
Ceramic toilets may be used for aggressions or self-injuries.	Accepted, not performed	Conveyed to Subdirectorate General for Logistics.				
No clean blankets are delivered to detainees.	Accepted, not performed	Requested from the Higher Police Headquarters of Andalusia Occidental.				
The Project for complete renovation of the facilities continues not to be provided for in the budget	Accepted, not performed	Conveyed to Subdirectorate General for Logistics.				

GOOD PRACTICES
Improvement of the video-surveillance system.
Inclusion in the form reading rights of the possibility of requesting habeas corpus.

FACILITIES VISITED: CNP District Station of Madrid Arganzuela

DATE OF VISIT: 16 July 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: During the visit, the police and custody officers inspected the cell facilities and reviewed the record books, detention regime, access to medical attention and treatment given to persons deprived of liberty.
RESPONSIBLE AUTHORITY: Directorate General for the Police (Ministry of the Interior)

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
One of the police records included a medical report containing personal data.			SUGGESTION	Give instructions for no copy of the medical report to be kept when medical assistance is provided to a detainee who has not given his consent to the transfer of data, other than in the exceptional events contemplated by the LOPD.	Accepted	
Officers are not always present in cells when detainees are there.	Rejected		SUGGESTION	Adopt the measures necessary for constant presence of officers when detainees are confined in the cells.	Rejected	
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Pending budget availability.				
The interphone located in the corridor of the cells does not work correctly.	Accepted					
Cells do not have direct access from outside.	Accepted not performed	Pending budget availability.				
Cells should be cleaned also on weekends.	Accepted					

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Lack of gloves to prevent infectious diseases.	Accepted	Instructions are given for correction.				
The temperature of the cells was inadequate.	Accepted not performed	Pending budget availability.				

GOOD PRACTICES
Correct completion of individual forms of chain of custody of detainees.

FACILITIES VISITED: CNP District Station of Madrid Centro

DATE OF VISIT: 1 July 2013 (unannounced)
VISITING TEAM: The Ombudsman and two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: Follow up visit to verify whether the deficiencies observed in previous visits were corrected. At the visit the facilities and record books were reviewed and interviews were held with detainees and officers of the CNP.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Attention should be given to the preparation of police records particularly when the detainee was injured during detention.	Accepted	Instructions are given for correction.				
Damp, leaks and cracks in walls should be repaired.	Accepted not performed	Included in properties subject to actions contemplated by 2014-2023 Director Plan for Real Estate Infrastructures as a priority				
Cell cleaning.	Accepted	Instructions are given for correction.				
Ventilation of cells, bad odour.	Accepted not performed	Instructions are given for correction.				
Insufficient size of cells	Accepted not performed	Included in properties subject to actions contemplated by 2014-2023 Director Plan for Real Estate Infrastructures as a priority				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
No clean blankets are delivered to detainees.	Accepted	Instructions are given for correction.				
A place should be enabled to place blankets and mats.	Accepted not performed	Included in properties subject to actions contemplated by 2014-2023 Director Plan for Real Estate Infrastructures as a priority				
Assess temperature.	Accepted not performed	Instructions are given for correction.				
The area enabled to bring complaints is lacking privacy.	Accepted not performed	Included in properties subject to actions contemplated by 2014-2023 Director Plan for Real Estate Infrastructures as a priority				
Repair or replacement of deteriorated furniture.	Accepted					
Officers are lacking adequate changing rooms.	Accepted					
Insufficient space to keep dossiers.	Accepted					

GOOD PRACTICES
Installation of a video-surveillance system according to the criterion of the Ombudsman.
Existence of a form to apply for habeas corpus proceeding.

FACILITIES VISITED: CNP District Station of Madrid Ciudad Lineal

DATE OF VISIT: 20 March 2013 (unannounced) VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: During the visit, the police and custody officers were interviewed, the cells were inspected, individual interviews were held with the detainees and the record books, detention regime, access to medical attention and treat given to persons deprived of liberty were examined.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed					
Inadequate completion of the Detainees Registration and Custody Book.	Accepted					
No gun racks exist.	Accepted not performed	Pending budget availability.				
The washbasins and squat toilets are ceramic and walls are coated with tiles, which could facilitate self-injuries.	Accepted not performed	Pending budget availability.				
The cells were not sufficiently clean.	Accepted not performed	Account rendered to Higher Police Headquarters of Madrid.				
Evaluate temperature in cells.	Accepted not performed	Pending budget availability.				
The blankets for detainees were dirty.	Rejected	Clean blankets available.				
Deteriorated mattresses.	Rejected	New material available.				
Meals should be adequately heated.	Accepted					
Officers are not always present in cell area when detainees are there.	Rejected	Officers patrol cells every 15 minutes.				
Full body searches should not be made on a routine basis.	Accepted					
No record is kept of full body searches.	Accepted	Reminded of obligation to make entry in police record and Detainees Custody Book.				

FACILITIES VISITED: CNP District Station of Madrid Chamartín

DATE OF VISIT: 10 September 2013
VISITING TEAM: Two technical experts of the Ombudsman's Office and on Delegation of the Ombudsman of Ukraine
PURPOSE OF THE VISIT: Follow up visit to verify whether the deficiencies observed at the visit made in 2010 were corrected. During the visit the delegation of the Ombudsman of Ukraine was able to observe the manner in which the facilities were inspected and the record books, the manner in which interviews were held with police and custody officers and the manner in which the only person detained and present at that time was interviewed.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Detainees are not provided with clean blankets.	Accepted					
Documents are filed in an inadequate place at the police station.	Accepted					
A copy of the report on the medical assistance provided to detainees that occasionally includes very personal data is kept.	Accepted					

GOOD PRACTICES
The form to control daily cleaning of the facilities.
Existence of the record of reading of rights in various languages.

FACILITIES VISITED: CNP District Station of Madrid Moratalaz

DATE OF VISIT: 18 November 2013 (unannounced) VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: During the visit, interviews were held with police and custody officers, the facilities of the cells and taking of statements were inspected, the record books, detention regime, access to medical attention and treatment given to persons deprived of liberty were reviewed.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The cells do not have direct access from the outside.	Accepted	Referred to JSP of Madrid to study alternatives.				
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Pending budget availability.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The grids of the systems to extract air from inside the cells, the metal beds and the glass of the wall window of a collective cell could be used by the detainees to cause themselves injuries.	Accepted	Instructions are given for correction.				
Ceramic toilets may be used for aggressions or self-injuries.	Accepted	Instructions are given for correction.				
The Detainees Registration and Custody Book is not adequately completed.	Accepted	Instructions are given for correction.				
Officers carry their weapon in the cells area.	Accepted	Instructions are given for correction.				
The complaints office does not preserve the confidentiality of the claimant.	Accepted	Instructions are given for correction.				
No fume detectors exist inside the individual cells.	Accepted	Instructions are given for correction.				

FACILITIES VISITED: CNP District Station of Madrid Puente de Vallecas

DATE OF VISIT: 23 July 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: Follow up visit to verify whether the deficiencies observed at the previous visit made in 2012 were corrected. At the visit the facilities and record books were inspected and interviews were held with police and custody officers and with the only person detained at the time of the visit.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.
The reports of the medical assistance provided to a detainee should be kept appropriately for conveyance to the judge.	Accepted	

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Install additional video-surveillance cameras in cells.	Accepted not performed	Pending budget availability.
SUGGESTION	Suggestion repeated for constant presence of officers in cell area when occupied.	Accepted	
SUGGESTION	Evaluate temperature.	Accepted	
SUGGESTION	Adopt necessary measures to prevent bad odour.	Accepted	
SUGGESTION	Provide facilities with additional blankets for detainees.	Accepted	
SUGGESTION	Install buzzer systems inside cells if no officer is permanently present.	Accepted	One officer is kept permanently responsible for custody of detainees.
SUGGESTION	Suggestion repeated for full body searches to be recorded in writing.	Accepted	

GOOD PRACTICES
The investigations record the information provided to the detainee of the possibility of requesting habeas corpus proceedings.
Improvements were observed in the completion of the Detainees Registration and Custody Book.

FACILITIES VISITED: CNP District Station of Madrid San Blas

DATE OF VISIT: 20 August 2013 (unannounced)
VISITING TEAM: The Ombudsman and two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: Follow up visit to verify whether the deficiencies observed in the previous visits, the last made in 2010, had been corrected. During the visit the facilities and record books were inspected and interviews were held with the police and custody officers. No detainee was present at the time of the visit.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
			SUGGESTION	Install video-surveillance cameras for complete coverage of the cell area.	Accepted	The view angle of the cameras has been changed. The area not covered is viewed directly by the officer responsible for custody of detainees.
			SUGGESTION	Detainees should enter through the car park, to prevent them from coinciding with citizens visiting the police station for any reason.	Accepted partially	Contact of detainees with citizens is always attempted to be avoided. The car park does not have adequate security conditions.
			SUGGESTION	The horizontal bars and cell door locks may cause self-injuries or suicide attempts of detainees.	Accepted not performed	The eventual replacement of said doors will be considered.
			SUGGESTION	No constant presence of officers in cell area when detainees are present.	Accepted	Instructions have been given for an officer to remain permanently at the cells whenever they contain any detainee.
The toilets and washbasin are ceramic, which could cause detainees to break them to cause themselves injuries or attack the officers.	Accepted not performed	Reported to JSP for their replacement.				
The interphone of the cells area was broken.	Accepted	Repaired.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Evaluate the temperature in the cells.	Accepted	Systems were reviewed to ensure their correct operation at all times.				
No clean blankets are delivered to detainees.	Accepted	Provided with clean, washed, treated and sealed blankets.				
Inadequate completion of Detainees Registration and Custody Book.	Accepted	Orders given for all vicissitudes that occur with detainees to be recorded.				
Full body searches are not recorded in the Detainees Registration and Custody Book.	Accepted	Instructions given for specific reasons to be recorded in detail.				
Relocate files of the first floor due to obvious lack of space at their current location	Accepted not performed	Possible relocation to mezzanine will be considered.				
Lack of maintenance of cell area including officers area.	Accepted	Remedied.				
The squat toilet is not adequate for persons who, given their age or physical condition, need to sit on the toilet.	Accepted not performed	Reported to JSP for replacement.				
GOOD PRACTICES						
Improvements observed in the lighting of the cells, repairs made to prevent filtrations and dam and installation of heaters.						

FACILITIES VISITED: CNP District Station of Madrid Tetuán

DATE OF VISIT: 21 March 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: During the visit, police and custody agents were interviewed, the cells were inspected, individual interviews were held with detainees and record books, detention regime, access to medical assistance and treatment given to persons deprived of liberty were reviewed.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Economic, Technical and IT Service requested to prepare report on budget and feasibility.				
No record is kept of full body searches.	Accepted					
Inadequate completion of Detainees Registration and Custody Book.	Accepted					
The ceramic toilet appliances and luminary could facilitate self-injuries.	Accepted not performed	Replacement requested.				
Delivery of expired food to detainees.	Accepted					
Entrance of detainees into facilities.	Accepted					
Cleaning of blankets.	Accepted	Reminder of obligation to obey instructions given by Assistant Director.				
Evaluate temperature in cells.	Accepted					
Bad odour in cells.	Accepted					
It was observed that one of the detainees had not been provided with a medical prescription	Accepted					
Lack of masks to avoid infectious diseases.	Accepted					

FACILITIES VISITED: CNP Local Station of Pozuelo de Alarcón (Madrid)

DATE OF VISIT: 6 August 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: During the visit the facilities and record books were inspected and interviews were held with the police and custody officers, and the only person detained at the time of the visit.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Pending budget availability.				
No record of full body searches is made in the Detainees Registration and Custody Book.	Accepted	No full body searches have been made for many years.				
No clean blankets are delivered to detainees.	Accepted	Instructions are given for correction.				
The temperature of the cells was inadequate.	Accepted not performed	Pending budget availability.				

GOOD PRACTICES
Immediate referral to the courts of the detainees, including on weekends and public holidays.

FACILITIES VISITED: CNP Local Station of Torrejón de Ardoz (Madrid)

DATE OF VISIT: 7 November 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: During the visit, interviews were held with the police and custody officers and detainees, and the cell facilities, record books, detention regime, access to medical attention and treatment given to persons deprived of liberty were inspected.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted	Pending budget availability.				
Deficient general state of the facilities.	Accepted	Instructions are given for correction.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The cell door locks may be used by detainees to injure themselves or attempt to commit suicide.	Accepted	Instructions are given for correction.				
The toilet appliances in the common bathroom are ceramic and may be used by detainees to injure themselves or attack the officers.	Accepted	Instructions are given for correction.				
Media exposure of detainees at the facilities.	Accepted	Instructions are given for correction.				
The temperature of the cells was inadequate.	Accepted	Instructions are given for correction.				
The extractor of the cell area does not work.	Accepted	Instructions are given for correction.				
The concrete bed for minors to rest is too small.	Accepted	Minors spend night at GRUME.				
Inadequate completion of Detainees Registration and Custody Book.	Accepted	Compliance is repeated.				

GOOD PRACTICES
Correct completion of the Detainee Young Offenders Record Book.

FACILITIES VISITED: CNP Central Inspectorate on Duty in Valencia

DATE OF VISIT: 28 November 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office and one member of the Advisory Council of the NPM
PURPOSE OF THE VISIT: Follow up visit to verify whether the deficiencies observed in the visit made in 2010 were corrected. During the visit the facilities and record books were examined and interviews were held with the police and custody agents and with the detainees held at the time of the visit.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
No record of full body searches is made in the Detainees Registration and Custody Book.	Rejected		SUGGESTION	Give orders for full body searches to be entered on the Detainees Registration and Custody Book.	Pending	
The video-surveillance system does not conform to the criteria of this Institution.	Accepted					
The plates protecting the cell locks may be used for detainees to injure themselves.	Accepted					
The Detainees Registration and Custody Book is not duly completed.	Accepted					
Ceramic toilets may be used for aggressions or self-injuries.	Accepted not performed					

FACILITIES VISITED: Central Registry of Detainees of Madrid (Moratalaz)

DATE OF VISIT: 24 and 25 July 2013 (unannounced)
VISITING TEAM: Ombudsman and two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: Follow up visit to verify whether the deficiencies observed in previous visits, the last of 2011, had been corrected. At the visit, the facilities and record books were inspected and interviews were held with the police and custody agents, and with some detainees.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS		
GENERAL	STATUS	ANSWER AUTH.

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
RECOMMENDATION	Perform ex officio the extraction of pictures taken by the cameras.	Pending	

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.
The opening of bags of belongings should be recorded in the custody form.	Accepted	
No gun racks in the facilities.	Accepted not performed	JSP of Madrid will be requested to consider possibility.

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Install sound call systems	Accepted not performed	
SUGGESTION	Avoid excessive occupancy of collective cells.	Accepted	
SUGGESTION	Install video-surveillance cameras in facilities where they are not available.	Accepted not performed	
SUGGESTION	Separate detainees who purportedly perpetrated a crime from detainees due to lack of proper documentation.	Accepted	
SUGGESTION	The temperature of the cells was not adequate.	Accepted	
SUGGESTION	Sufficient blankets should be provided for a clean blanket to be delivered to detainees.	Accepted	
SUGGESTION	Lack of toiletry products for detainees.	Accepted	

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
			SUGGESTION	Group in the same cells detainees designated so as not to interrupt the rest of them.	Accepted	Detainees are currently designated from the various facilities in which they are held other than on Saturdays, Sundays and public holidays.

GOOD PRACTICES
Improvements observed in the ventilation and cleaning of the facilities.

Tables 77-85
Conclusions and decisions arising from visits made to facilities of the Civil Guard in 2013

FACILITIES VISITED: Headquarters of the Civil Guard in Burgos

DATE OF VISIT: 9 July 2013 (unannounced) VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: During the visit, police and custody officers were interviewed, the call facilities were inspected and the record books, detention regime, access to medical assistance and treatment given to persons deprived of liberty were reviewed. No detainees were present at the time of the visit.
RESPONSIBLE AUTHORITY: Directorate General of the Civil Guard

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Pending budget availability.				
Inadequate completion of Detainees Registration and Custody Book.	Accepted	Instructions given by the Chief Headquarters to remedy the omissions.				
Lack of sealable bags to keep belongings of detainees.	Accepted	Control centre provided with a wardrobe to deposit belongings of each detainee. The bags were provided by the UOPJ of the Headquarters.				

GOOD PRACTICES
Mechanical opening of door cells.
Existence of a protocol for custody of detainees.
Control of detainees, avoiding their contact with custody officers.

FACILITIES VISITED: Headquarters of the Civil Guard in Córdoba

DATE OF VISIT: 2 December 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: Follow up visit to verify whether the deficiencies observed in the last visit, made in 2010, were remedied. During the visit, the facilities and the record books were inspected and interviews were held with the police and custody officers. No person was detained.
RESPONSIBLE AUTHORITY: Dirección General de la Civil Guard

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Pending budget availability.				
The temperature of the cells was inadequate.	Accepted not performed	Pending budget availability.				

GOOD PRACTICES
Entire renovation of the cell area and relocation to other facilities.
Constant presence of officers when detainees are in cells and notice warning of the prohibition from carrying weapons.
Correct completion of Detainees Registration and Custody Book. The record of information of rights to the detainee uses the term lawyer to report the right to legal assistance.
The blankets and mattress cover are washed after each use.

FACILITIES VISITED: Headquarters of the Civil Guard in Madrid (Tres Cantos)

DATE OF VISIT: 21 May 2013
VISITING TEAM: The Ombudsman and two technical experts of the Ombudsman's Office.
PURPOSE OF THE VISIT: The main purpose of the visit was to verify compliance with the observations of the CPT related to these facilities. For such purpose the persons responsible for the Centre were interviewed, the facilities were inspected and the record books were examined.
RESPONSIBLE AUTHORITY: Directorate General for the Civil Guard

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
No conclusions drawn (new detention facilities were opened and the previous ones were closed).						

FACILITIES VISITED: Headquarters of the Civil Guard in Palencia

DATE OF VISIT: 8 July 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office.
PURPOSE OF THE VISIT: During the visit, the responsible persons and custodial officers of detainees were interviewed, the cell facilities were inspected and the record books, detention regime, access to medical assistance and treatment given to persons deprived of liberty were examined. There were not detainees at the time of the visit.
RESPONSIBLE AUTHORITY: Directorate General for the Civil Guard

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Pending budget availability.				
Officers are not present at the cells when detainees are there.	Rejected	Surveillance through video cameras.				
Detainees enter through the main door.	Accepted	Adaptation and improvements works are forecast for the entrance to the barracks.				
The detainee young offenders record book is not duly completed.	Accepted	Instructions are given for correction.				
Ceramic toilets may be used for aggressions or self-injuries.	Accepted not performed	Pending budget availability.	SUGGESTION	Replace the current ceramic toilet by a steel anti-vandal toilet.	Accepted	It is being replaced.

GOOD PRACTICES
Correct completion of individual forms of the chain of custody of detainees.
The record of information of rights uses, only, the term lawyer to inform of the right to legal assistance.
Existence of a protocol for the custody of detainees.

FACILITIES VISITED: Headquarters of the Civil Guard in Salamanca

DATE OF VISIT: 30 September 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office.
PURPOSE OF THE VISIT: During the visit, the persons responsible and custody officers of detainees were interviewed, the cell facilities were inspected and the record books, detention regime, access to medical assistance and treatment given to persons deprived of liberty were reviewed.
RESPONSIBLE AUTHORITY: Directorate General for the Civil Guard

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.
No clean blankets are delivered to detainees.	Rejected	Used a maximum two times.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Pending budget availability.
Full body searches are not recorded in the Detainees Registration and Custody Book.	Accepted	Recorded after the visit.
Officers are not present at the cells when detainees are there.	Rejected	Control through video-surveillance screen.
Lack of sealable bags to keep belongings of detainees.	Rejected	Belongings are kept in the Unit that proceeded to detention.
The temperature of the cells was inadequate.	Accepted not performed	Pending budget availability.

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Deliver a clean blanket to each detainee.	Accepted	

GOOD PRACTICES
Direct entrance for detainees to the cell area.
Information to detainees that the facilities have a video-surveillance system.
Officers do not carry their weapon, which they keep in a gun rack, when they are in the cell area.

FACILITIES VISITED: Headquarters of the Civil Guard in Toledo

DATE OF VISIT: 29 October 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office.
PURPOSE OF THE VISIT: Follow up visit to verify whether the deficiencies observed in previous visits, the last made in 2010, have been remedied. During the visit, the facilities and record books were inspected and interviews were held with the police and custody officers. No detainee was present.
RESPONSIBLE AUTHORITY: Directorate General for the Civil Guard

GOOD PRACTICES
The entire renovation of the custody facilities, which permitted the officers control area, the cell area, the temperature and the ventilation to be improved.
Detainees enter through the back of the facilities, avoiding contact both with persons visiting the Headquarters for any reason and family relatives of the guards
Constant presence of officers when detainees are held.
When the cell area has to be entered weapons are deposited in a gun rack.
Correct completion of the Detainees Registration and Custody Book, keeping a copy of the custody form of the detainee of the position from which he originates.
Mechanical opening of cell doors, facilitates the exit in emergencies and permits less physical contact with detainees during custody.
Blankets and mattress covers provided to detainees are washed after a single use.
Cleaning of the facilities on weekends.
The record of information to detainees uses, only, the term lawyer to inform them of their right to legal assistance.

FACILITIES VISITED: Headquarters of the Civil Guard in Valencia

DATE OF VISIT: 29 November 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office and one member of the Advisory Council of the NPM.
PURPOSE OF THE VISIT: Follow up visit to verify whether the deficiencies observed in previous visits, the last made in 2010, have been remedied. During the visit, the facilities and record books were inspected and interviews were held with the police and custody officers. No detainee was present.
RESPONSIBLE AUTHORITY: Directorate General for the Civil Guard

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted	Pending budget availability.				
Ceramic toilets may be used for aggressions or self-injuries.	Accepted	Pending budget availability.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Squat toilets in bathrooms inadequate for older persons or those with physical difficulties.	Accepted	Pending budget availability.				
Lack of fume detectors.	Accepted	Pending budget availability.				
No clean blankets are delivered to detainees.	Accepted	Washed after each use.				
Evaluate temperature in cells.	Accepted	Pending budget availability.				
Searches are not recorded in the Detainees Registration and Custody Book.	Accepted	Compliance is reminded.				
One blank custody form of a person who had not been admitted into the cells.	Accepted	Compliance reminded.				

GOOD PRACTICES
Adequate completion of Detainees Registration and Custody Book.
Cleaning of the facilities on weekends.

FACILITIES VISITED: Headquarters of the Civil Guard of Zamora

DATE OF VISIT: 30 September 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office.
PURPOSE OF THE VISIT: During the visit, the facilities and record books were inspected and interviews were held with the police and custody officers. No detainee was present.
RESPONSIBLE AUTHORITY: Directorate General for the Civil Guard

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	RESPUESTA ADM.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Pending budget availability.				
Officers are not always present in cell area when detainees are there.	Rejected	Security personnel at a short distance and with video-surveillance.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
No fume detectors in cell area.	Accepted	The relevant budgets will be requested for their installation.				
The Detainees Registration and Custody Book is not adequately completed.	Accepted	Instructions given for its adequate completion.				
The ceramic toilet of the minors area could facilitate self-injuries.	Accepted	Budgets are being prepared to replace the appliances.				
The toilet for minors is lacking artificial light.	Accepted	Remedied.				
The belongings of detainees are placed in envelopes and left on a desk.	Accepted	A file with drawers and a lock will be enabled to remain at the detention centre.				

GOOD PRACTICES
Direct entrance of detainees to the cell area.
Certain positions of the province inform detainees, when they are transported to the Headquarters, that the facilities have video-surveillance.
Blankets are replaced and sent to be cleaned after use by one detainee.
When officers are in the cell area they do not wear their statutory weapon which they keep at the Headquarters access control.
The form of information of rights uses, only, the term lawyer to inform of the right to legal assistance.

FACILITIES VISITED: Detention Unit of the Information Service of the Civil Guard (Directorate General for the Civil Guard) in Madrid

DATE OF VISIT: 17 May 2013
VISITING TEAM: The Ombudsman and two technical experts of the Ombudsman's Office.
PURPOSE OF THE VISIT: The main purpose of the visit was to verify compliance with the observations of the CPT relating to these facilities. For such purpose, the persons responsible for the Centre were interviewed and the facilities were inspected.
RESPONSIBLE AUTHORITY: Directorate General for the Civil Guard

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
No conclusions are drawn because the facilities are closed.						

Table 86

Conclusions and decisions arising from the visits to facilities of the Local Police in 2013

FACILITIES VISITED: Local Police of Peñaranda de Bracamonte (Salamanca)

DATE OF VISIT: 9 July 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: During the visit, the police and custody agents of the detainees, the cell facilities were inspected and the record books, detention regime access to medical attention and treatment given to detainees were inspected. No detainees were present at the time of the visit.
RESPONSIBLE AUTHORITY: Directorate General for the Civil Guard

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Pending					
Horizontal bars on the cell doors.	Pending					
The ceramic toilet appliances may facilitate self-injuries by the detainees.	Pending					
Detainees are not informed of the possibility of instituting habeas corpus proceedings.	Pending					
Officers carry their weapon in the cells area.	Pending					
Detainees enter the headquarters through the main door.	Pending					
Lack of sealable bags to keep belongings of detainees.	Pending					
Lack of lockers or wardrobes to keep belongings of detainees.	Pending					
Lack of identification of officers.	Pending					

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The temperature of the cells was inadequate.	Pending					
No clean blankets are delivered to detainees.	Pending					
Lack of fume detectors in the cell area.	Pending					
The record of information of rights use the terms lawyer and barrister.	Pending					
GOOD PRACTICES						
Mattresses and pillows are delivered to detainees.						

Table 87

Conclusions and decisions arising from the visit to court facilities in 2013

FACILITIES VISITED: Cells of the Courts of Plaza de Castilla in Madrid

DATE OF VISIT: 29 August 2013 (unannounced)
VISITING TEAM: The Ombudsman and two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: Follow up visit to verify whether the deficiencies observed in the previous visit, made in 2010, have been remedied. In the visit the facilities were inspected and interviews were held with officers responsible for custody of the detainees and with certain detainees.
RESPONSIBLE AUTHORITY: Secretary General for Penitentiary Institutions

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
			SUGGESTION	Install video-surveillance cameras at all facilities where persons deprived of liberty remain, except for toilets and lawyer rooms.	Pending	
			SUGGESTION	Extreme facility maintenance actions.	Accepted	

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Improve ventilation systems of cells, particularly on the second basement.	Accepted	
SUGGESTION	Performs the necessary works for access to toilets not to affect privacy or cause bad odour.	Accepted not performed	The possibility of installing pivoting doors is being considered.

Tables 88-123
Follow up of visits to facilities of the CNP in previous years

HIGHER HEADQUARTERS OF ANDALUSIA OCCIDENTAL (SEVILLE)**		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER OF AUTHORITY (Directorate General Police)
The video-surveillance system does not conform to the criteria of this Institution.	55,477 (2010) 14 (2012)	Accepted.
Lack of sound call systems inside cells.	16 (2012)	Accepted, subject to feasibility and budgetary provision.
Some officers did not carry identification badge.	26 (2012)	Accepted.
Lack of heat-sealable plastic bags to keep belongings confiscated from detainees.	30 (2012)	Accepted.
Cleaning of blankets.	38 (2012)	Accepted.
Evaluate cell temperature.	34 (2012)	Accepted.
Bad odour observed in toilets.	34 (2012)	Accepted.
Broken and out of use toilets.	36 (2012)	Accepted.
Evaluation of lighting conditions of cells.	34 (2012)	Accepted.
Inadequate completion of Detainees Registration and Custody Book.	28 (2012)	Not accepted.
No record kept of full body searches.	29 (2012)	Accepted.
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER OF AUTHORITY
(Department of Healthcare and Social Welfare of the Government of Andalusia)		
(R) Specific measures should be adopted for public healthcare medical practitioners to ensure their obligation to protect confidentiality of information relating to data of all patients, including detainees and persons deprived of liberty, and remind all Provincel delegations of the criterion of this Department and of the Legal Counsel of the Healthcare Service of Andalusia on the matter.	22 (2012)	Pending an answer from the Authority.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL). ** Visited in 2012.		

HIGHER HEADQUARTERS OF ARAGON (ZARAGOZA)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER OF AUTHORITY
(S) Remind custody officers of the Higher Headquarters of ARAGON of the duty to record in the Detainees Registration and Custody Book, all vicissitudes that occur relating to detainee, thus ensuring the chain of custody and incidents.	28 (2012)	Accepted.
CONCLUSIONS	NO. PARAGRAPHS ANNUJAL REPORTS	ANSWER OF AUTHORITY (Directorate General Police)
The video-surveillance system does not conform to the criteria of this Institution.	55, 477 (2010) 14 (2012)	Accepted. Pending budget availability.
Doors to cells have a mesh that may facility self-injuries of detainees.	32 (2012)	Accepted. Will be rectified
Maintenance and repair of toilets.	36 (2012)	Accepted. Has been repaired.
Bad odour due to scarce ventilation.	34 (2012)	Accepted. Instructions are given for correction.
It was stated that facilities have no evacuation plan.	212 (2010) 63 (2011)	Accepted. At stage of implementation.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL). ** Visited in 2012.		

HIGHER HEADQUARTERS OF ASTURIAS*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
The video-surveillance system does not conform to the criteria of this Institution.	55, 477 (2010) 14 (2012)	Accepted. Pending budget availability
Lack of viewing screens in cell area.	55 (2010) 40 (2011)	Not accepted.
Bad odour observed in cells due to lack of ventilation.	34 (2012)	Accepted. Instructions are given for co-rrection.
* Visited in 2010.		

HIGHER HEADQUARTERS OF EXTREMADURA*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Lack of viewing screens in cell area.	55 (2010) 40 (2011)	Not accepted.
* Visited in 2010.		

HIGHER HEADQUARTERS OF GALICIA*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Lack of viewing screens in cell area.	55 (2010) 40 (2011)	Not accepted.
* Visited in 2010.		

HIGHER HEADQUARTERS OF MELILLA*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Lack of viewing screens in cell area.	55 (2010) 40 (2011)	Not accepted.
* Visited in 2010.		

HIGHER HEADQUARTERS OF MURCIA*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
The video-surveillance system does not conform to the criteria of this Institution.	55, 477 (2010) 14 (2012)	Accepted. Pending budget availability.
* Visited in 2010.		

HIGHER HEADQUARTERS OF BASQUE COUNTRY*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Direct access to cells area.	31 (2012)	Cells no longer operating. The new com-plex has access from the car park.
* Visited in 2010.		

POLICE STATION OF ALGECIRAS (CÁDIZ)**		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
(S) Use interpreter services to inform detainees of their situation.	39 (2012)	Accepted.

CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
The video-surveillance system does not conform to the criteria of this Institution.	55, 477 (2010) 14 (2012)	Accepted. Pending budget availability.
Items on cell doors that may facilitate self-injuries of detainees.	32 (2012)	Accepted. The observed deficiencies will be remedied.
No record kept of full body searches.	29 (2012)	Accepted. Performance will be supervised.
Habeas corpus. Complaint contains a previously printed entry: “not wishing to use said proceeding”.	19 (2012)	Not accepted.
Forms for information of rights continue to use the terms lawyer and barrister.	476 (2010) 18 (2012)	Not accepted. Knowledge exists of this suggestion.
No officer other than service head wore identification badge.	26 (2012)	Accepted. A reserved information proceedin has been opened to establish disciplinary liability, if any.
Cleaning of blankets	38 (2012)	Accepted.
Belongings of detainees were not kept in available heat-sealable bags.	30 (2012)	Accepted.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL). ** Visited in 2012.		

POLICE STATION OF ALGECIRAS-PORT (CÁDIZ)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
No video-surveillance system in this facility.	55, 477 (2010) 14 (2012)	Accepted. Pending budget availability.
No record kept of full body searches.	29 (2012)	Accepted. Compliance is repeated.
No written information provided of possibility of instituting habeas corpus proceeding.	476 (2010) 19 (2012)	Not accepted.
Cell doors have horizontal bars that may facilitate self-injuries of detainees.	32 (2012)	Accepted. Conveyed to Port Authority for their modification.
The squat toilet in the bathroom is not adequate for detainees who because of their age or physical condition need to sit on toilets.	33 (2012)	Another toilet exists with a seat.
* Visited in 2012.		

POLICE STATION OF DISTRICT ALICANTE/CENTRO**		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Lack of sound call systems inside cells.	16 (2012)	Accepted, Pending budget availability.
Some officers did not carry identification badge.	26 (2012)	Accepted.
Cleanliness inside cells was not adequate.	34 (2012)	Accepted.
Cleaning of blankets.	38 (2012)	Accepted.
The video-surveillance system does not conform to the criteria of this Institution.	55, 477 (2010) 14 (2012)	Accepted. Pending budget availability.
Lack of viewing screens in cells area.	55 (2010) 40 (2011)	Accepted. Pending budget availability.
* Visited in 2010 and 2012.		

POLICE STATION OF AVILÉS		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Lack of viewing screens in cells area.	55 (2010) 40 (2011)	Accepted, Pending budget availability.
* Visited in 2010.		

POLICE STATION OF CÁDIZ*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Lack of viewing screens in cells area.	55 (2010) 40 (2011)	Accepted, Pending budget availability.
* Visited in 2010.		

POLICE STATION OF CÁCERES*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Lack of viewing screens in cells area.	55 (2010) 40 (2011)	Accepted, Pending budget availability.
* Visited in 2010.		

POLICE STATION OF CARTAGENA (MURCIA)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
The video-surveillance system does not conform to the criteria of this Institution.	55, 477 (2010) 14 (2012)	Accepted. Pending budget availability.
* Visited in 2010.		

POLICE STATION OF CÓRDOBA DISTRICT ESTE*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Maintenance and upkeep of cells.	36 (2012)	Accepted. Pending study.
* Visited in 2010.		

POLICE STATION OF GIJÓN (ASTURIAS)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Lack of viewing screens in cells area.	55 (2010) 40 (2011)	Accepted. Pending budget availability.
* Visited in 2010.		

POLICE STATION OF JEREZ DE LA FRONTERA (CÁDIZ)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
The video-surveillance system does not conform to the criteria of this Institution.	55 y 477 (2010) 14 (2012)	Accepted. The video-surveillance system has been installed.
* Visited in 2010.		

POLICE STATION OF LEÓN*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Lack of viewing screens in cells area.	55 (2010) 40 (2011)	Accepted. Pending budget availability.
* Visited in 2010.		

POLICE STATION OF LLEIDA*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
The video-surveillance system does not conform to the criteria of this Institution.	55, 477 (2010) 14 (2012)	Accepted. Pending budget availability.
* Visited in 2010.		

POLICE STATION OF MADRID DISTRICT CARABANCHEL*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
The video-surveillance system does not conform to the criteria of this Institution.	55, 477 (2010) 14 (2012)	Accepted. The video-surveillance system has been installed.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department Healthcare Madrid Community)
One of the police complaints recorded a medical report containing personal data of clinical record and medical check-up of detainee.	22 (2012)	Accepted.
* Visited in 2012.		

POLICE STATION OF MADRID DISTRICT LATINA**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
(R) Medicines of detainees occasionally acquired by police station officers without budget for the purpose.	25 (2012)	Accepted. A provision is made in the budget.
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department Healthcare Madrid Community)
(R) Medical assistance reports issued to be delivered only to interested person.	22 (2012)	Accepted.
(R) When medical assistance is provided and injuries are observed in patient, the report to be issued should not include personal data such as medical record and clinical record of patient.	22 (2012)	Accepted.
* Recommendations (RE); Suggestions (S); Reminders of Legal Duties (RDL). **Visited in 2012.		

POLICE STATION OF LEGANÉS (MADRID)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
(S) The cells are lacking air conditioning and heating, and systems for air renewal and extraction, which deficiencies affecting cell temperature and ventilation should be remedied.	34 (2012)	Accepted.
(S) The necessary instructions should be given for mobility difficulties, movement disability or baby pus-hcart carriers to be able to use the elevator-platform fast without difficulty to access or abandon the buil-ding.	44 (2010)	Accepted.

POLICE STATION OF LEGANÉS (MADRID)**		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
The video-surveillance system does not conform to the criteria of this Institution.	55, 477 (2010) 14 (2012)	Accepted. The video-surveillance system has been installed.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL) ** Visited in 2012.		

POLICE STATION OF MADRID DISTRICT MONCLOA-ARAVACA*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
The video-surveillance system does not conform to the criteria of this Institution.	55 y 477 (2010) 14 (2012)	Accepted. The video-surveillance system has been installed.
The cell doors have a plate around the lock that may facilitate self-injuries of detainees.	32 (2012)	Accepted. Instructions are given for correction.
Evaluate temperature in cells.	34 (2012)	Accepted. Instructions are given for correction.
* Visited in 2012.		

POLICE STATION OF MADRID DISTRICT USERA-VILLAVERDE*		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
(S) Custody officers of district station of Usera-Villaverde should be reminded of their obligation to carry their identification badge at all times, pursuant to Instruction 13/2007, of the Secretary of State for Security, adopting adequate disciplinary measures in the case of infringement.	26 (2012)	Accepted and a notice is sent to all units reminding them of the identification obligation.
(S) One of the rooms for taking of statements should be used for interviews of detainees with their lawyers, to ensure their privacy.	20 (2012)	Accepted.
(S) The broken glass of cell no. 2 should be immediately repaired and the cell should be closed in the meanwhile.		Accepted.
CONCLUSIONES	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY ANNUAL (Directorate General Police)
The video-surveillance system does not conform to the criteria of this Institution.	55, 477 (2010) 14 (2012)	Accepted. The video-surveillance system has been installed.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL). ** Visited in 2012.		

POLICE STATION OF MADRID DISTRICT VALLECAS PUENTE**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
(S) The cell facilities do not have a specific area for searches, ensuring privacy of detainees.	29 (2012)	Accepted. Instructions are given for correction.
(S) The appropriate measures should be adopted for officers to be permanently present in cell area when cells are occupied by detainees.	17 (2012)	Accepted. Instructions are given for correction.
(S) It is considered necessary for appropriate instructions to be given so that, unless the detainees request otherwise, the lighting conditions of the cells are adequate.	34 (2012)	Accepted. Technical possibilities will be studied.

CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
The video-surveillance system does not conform to the criteria of this Institution.	55,477 (2010) 14 (2012)	Accepted. The video-surveillance system has been installed.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL). ** Visited in 2012 and 2013.		

POLICE STATION OF MÁLAGA*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
The video-surveillance system does not conform to the criteria of this Institution.	55 y 477 (2010) 14 (2012)	Accepted. Instructions are given for correction.
The lack of a video-porter on the door for access to the cells from within the building has effects on intrusion prevention, detection, reaction and response.		Accepted. Instructions are given for correction.
The bed heads on transit cells and the ceramic toilet appliances may be used by detainees to cause themselves self-injuries.	32 (2012)	Accepted. Instructions are given for correction.
No record kept of full body searches.	29 (2012)	Accepted.
No written information provided on the possibility of instituting habeas corpus proceeding	476 (2010) 19 (2012)	Not accepted.
Forms for information of rights continue to use the terms lawyer and barrister.	476 (2010) 18 (2012)	Not accepted.
“Interviews” with detainees before statement is taken without a lawyer present.	20 (2012)	Accepted. Instructions are given for correction.
Some cells have a toilet seat within them.	33 (2012)	Accepted. Instructions are given for correction.
Squat toilets are inadequate for detainees who, given their age or physical condition, must sit on the toilet.	33 (2012)	Accepted. Instructions are given for correction.
Some officers did not carry identification badge.	26 (2012)	Accepted. Instructions are given for correction.
Evaluate cell temperature.	34 (2012)	Accepted. Instructions are given for correction.
Cleaning of blankets.	38 (2012)	Accepted. Instructions are given for correction.
It was reported that blankets, after three washes, lose their fireproof property.		Accepted. Instructions are given for correction.
Lack of masks and gloves to avoid catching infectious diseases.	24 (2012)	Accepted. Instructions are given for correction.
Lack of anti-cut gloves for body searches on detainees.		Accepted. Instructions are given for correction.
* Visited in 2010 and 2012.		

POLICE STATION OF MARBELLA (MÁLAGA)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
The air extractor of the cell area causes bad odour in the facilities of the Local Police.		Accepted. Instructions are given for correction.
* Visited in 2012.		

POLICE STATION OF MEDINA DEL CAMPO (VALLADOLID)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
The video-surveillance system does not conform to the criteria of this Institution.	55 y 477 (2010) 14 (2012)	Accepted. The video-surveillance system has been installed.
No written information provided on the possibility of instituting habeas corpus proceeding	476 (2010) 19 (2012)	Not accepted.

CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
No record kept of full body searches.	29 (2012)	Accepted.
Forms for information of rights continue to use the terms lawyer and barrister.	476 (2010) 18 (2012)	Not accepted.
The ceramic toilet appliances may be used by detainees to injure themselves.	32 (2012)	Accepted. Pending budget availability.
The furniture of the officers area is deteriorated.	48 (2010)	Accepted. Instructions are given for correction
Lack of sound call systems inside cells.	16 (2012)	Accepted. Pending budget availability.
* Visited in 2012.		

POLICE STATION OF MÉRIDA (BADAJOZ)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
The video-surveillance system does not conform to the criteria of this Institution.	55 y 477 (2010) 14 (2012)	Accepted. Pending budget availability.
No written information provided on the possibility of instituting habeas corpus proceeding	476 (2010) 19 (2012)	Not accepted.
No record kept of full body searches.	29 (2012)	Accepted. Compliance is reminded.
Some officers did not carry identification badge.	26 (2012)	Accepted. Compliance is reminded.
Forms for information of rights continue to use the terms lawyer and barrister.	476 (2010) 18 (2012)	Not accepted.
Evaluate cell temperature.	34 (2012)	Accepted.
The cleaning service of the cell area should include weekends.	34 (2012)	Accepted.
* Visited in 2012.		

POLICE STATION OF PLAYA DE PALMA DE MALLORCA (BALEARIC ISLANDS)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
The video-surveillance system does not conform to the criteria of this Institution.	55 y 477 (2010) 14 (2012)	Accepted. Pending budget availability.
* Visited in 2010.		

POLICE STATION OF DONOSTIA/SAN SEBASTIAN*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Direct access to cells area.	31 (2012)	Accepted. The station moves to a new location.
* Visited in 2010.		

POLICE STATION OF TORRELAVEGA (CANTABRIA)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Bad odour was observed in cells due to lack of ventilation.	34 (2012)	Accepted.The station has been fully renovated
Direct access to cells area	31 (2012)	Accepted. The station has been fully renovated.
* Visited in 2010.		

POLICE STATION OF TORREMOLINOS (MÁLAGA)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
The video-surveillance system does not conform to the criteria of this Institution.	55 y 477 (2010) 14 (2012)	Accepted. Pending budget availability.
No written information provided on the possibility of instituting habeas corpus proceeding	476 (2010) 19 (2012)	Not accepted.
No written record is kept of full body searches made.	29 (2012)	Accepted. Instructions are given for correction.
Maintenance and upkeep of cells.	36 (2012)	Accepted. Instructions are given for correction.
Some officers did not carry their identity badge.	26 (2012)	Accepted. Instructions are given for correction.
The forms for information of rights continue to use the terms lawyer and barrister.	476 (2010) 18 (2012)	Not accepted.
Calls made to lawyers are not entered, in most cases on the telephone calls book.	54 (2011)	Not accepted.
Lack of thermosealable bags to keep confiscated belongings of detainees.	30 (2012)	Not accepted.
Inadequate completion of Detainees Registration and Custody Book.	28 (2012)	Accepted. Instructions are given for correction.
Cleaning of blankets.	38 (2012)	Accepted. Instructions are given for correction.
Lack of masks and gloves to avoid catching infectious diseases.	24 (2012)	Accepted. Instructions are given for correction.
* Visited in 2010 and 2012.		

POLICE STATION OF VIGO-REDONDELA (PONTEVEDRA)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
The video-surveillance system does not conform to the criteria of this Institution.	55 y 477 (2010) 14 (2012)	Accepted. Instructions are given for correction.
Bad odours were observed in the cells due to lack of ventilation.	34 (2012)	Accepted. Instructions are given for correction.
* Visited in 2012.		

POLICE STATION OF ZARAGOZA DISTRICT ACTUR-REY FERNANDO**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
(R) The necessary measures should be adopted for each facility of the CNP of Zaragoza having cells to keep a record of the number of detainees in transit through it.	28 (2012)	Accepted.
(S) The custody officers of the District Station of Actur-Rey Fernando of Zaragoza should be reminded of the duty to record, in the Detainees Registration and Custody Book, all the vicissitudes that occur relating to the detainee, thus ensuring the chain of custody and incidents.	28 (2012)	Accepted.
(S) The doors of the cells of the District Station of Actur-Rey Fernando or Zaragoza should be replaced by others affording greater security, given the potential risk they entail for detainees.	32 (2012)	Accepted. Instructions are given for correction.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL). ** Visited in 2010 and 2012.		

Tables 124-130
Follow up of visits to facilities of the Civil Guard made in previous years

HEADQUARTERS OF CUENCA*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Civil Guard)
Difficulties for emergency evacuation given the narrow passage, hindered by the cell doors.	62 (2011)	Not accepted. The width of the access cannot be increased.
* Visited in 2011.		

HEADQUARTERS OF ALGECIRAS-PUERTO (CÁDIZ)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Civil Guard)
(S) No blankets are delivered.	38 (2012)	Accepted.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Civil Guard)
The video-surveillance system does not conform to the criteria of this Institution.	55,477 (2010) 14 (2012)	Accepted. Pending renovation of the facilities.
The room used to keep confiscated drugs does not meet the necessary health and safety requirements.		Accepted. Confiscated drugs will be deposited in other rooms.
No record is kept of full body searches.	29 (2012)	Accepted. Instructions for the purpose are repeated.
Inadequate completion of Detainees Registration and Custody Book.	28 (2012)	Accepted. Instructions for the purpose are repeated.
No written information provided on the possibility of instituting habeas corpus proceeding	476 (2010) 19 (2012)	Accepted. Instructions for the purpose are repeated.
The broken tile of one cell may facilitate self-injuries of detainees.	32 (2012)	Remedied.
The size of the cells is not adequate.	35 (2012)	Accepted. Pending renovation of the facilities.
Officers carry their statutory weapon with loader in the cells area.	27 (2012)	Accepted. Instructions for the purpose are repeated.
The squat toilet is not adequate for detainees who, given their age or physical condition, need to sit on the toilet.	33 (2012)	Accepted. Pending renovation of the facilities.
The belongings of detainees are kept in bags.	30 (2012)	Accepted. Bags have been requested.
Evaluate cell temperature.	34 (2012)	Accepted. Pending renovation of the facilities.
Bad odour was observed in one of the cells due to lack of ventilation.	34 (2012)	Accepted. Pending renovation of the facilities.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL). ** Visited in 2012.		

HEADQUARTERS OF ARGUINEGUÍN (LAS PALMAS)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Civil Guard)
(S) Install a video-recording system in accordance with the criteria of this Institution.	38, 39 (2011)	Not accepted. The installation of video-surveillance at all centres is considered more necessary.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL). ** Visited in 2010 and 2011.		

HEADQUARTERS OF BOLLULOS PAR DEL CONDADO (HUELVA)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Civil Guard)
(R) Install a video-recording system in accordance with the criteria of this Institution.	38 y 39 (2011)	Not accepted. The installation of video-surveillance in all centres is considered more necessary
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL). ** Visited in 2011.		

HEADQUARTERS OF EL EJIDO (ALMERÍA)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Civil Guard)
(R) Install a video-recording system in accordance with the criteria of this Institution.	38, 39 (2011)	Not accepted. The installation of video-surveillance systems in all centres is considered more necessary.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL). ** Visited in 2011.		

HEADQARTERS OF OLITE (NAVARRE)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Health of Government of Navarre)
One of the police charges included a medical report containing personal data of the clinical record and medical check of the detainee.	22 (2012)	Accepted. Instructions are given for correction.
* Visited in 2012.		

HEADQUARTERS OF VIGO (PONTEVEDRA)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Civil Guard)
The video-surveillance system does not conform to the criteria of this Institution.	55,477 (2010) 14 (2012)	Accepted. Pending budget availability.
Officers are not permanently present in cells when these are occupied by detainees.	17 (2012)	Accepted.
The broken tiles of a cell may facilitate self-injuries of detainees.	32 (2012)	Accepted. Instructions are given for correction.
Evaluate cell temperature.	34 (2012)	Accepted. Instructions are given for correction.
* Visited in 2012.		

Tables 131-133
Follow up of visits made to autonomous police facilities in previous years

POLICE STATION OF THE MOSSOS D'ESQUADRA OF L'HOSPITALET DE LLOBREGAT (BARCELONA)		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of the Interior of the Government of Catalonia)
The vans used to transport detainees do not have safety belts.	214 (2011)	Accepted. Instructions are given for correction.
Cleaning of blankets.	38 (2012)	Not accepted.
Third parties are allowed to supply food from outside to detainees.	69 (2011)	Not accepted.
* Visited in 2012.		

POLICE STATION OF THE MOSSOS D'ESQUADRA OF GIRONA**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of the Interior of the Government of Catalonia)
(R) Protocol of action for cases of detainees who are or may be pregnant.	23 (2012)	Accepted. Instructions are given for correction.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL). ** Visited in 2011.		

POLICE STATION OF FORAL POLICE OF ESTELLA (NAVARRE)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Presidency, Justice and Interior of Government of Navarre)
The video-surveillance system does not conform to the criterial of this Institution.	55,477 (2010) 14 (2012)	Accepted. In April 2013, the system was completed with four additional cameras. With these actions the route of any detainee from his accessing the building to the cell in question is covered.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Health of Government Navarre)
One of the police records contained a medical report containing personal data of clinical record and medical checkup of detainee.	22 (2012)	Accepted. Instructions are given for correction.
* Visited in 2012.		

Tables 134-137
Follow up of visits made to court facilities in previous years

COURTS OF FIRST INSTANCE AND INVESTIGATION, CRIMINAL AND GENDER VIOLENCE OF THE COURT DISTRICT OF LAS PALMAS DE GRAN CANARIA (LAS PALMAS)*		
CONCLUSIONS	N.º PARÁGRAFOS INFORMES ANUALES	ANSWER AUTHORITY (Department of Presidency, Justice and Equality)
Food of detainees and prisoners.	37 (2012)	Accepted.
* Visited in 2010.		

COURTS OF FIRST INSTANCE AND INVESTIGATION AND GENDER VIOLENCE OF THE COURT DISTRICT OF SAN BARTOLOMÉ DE TIRAJANA (LAS PALMAS)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Presidency, Justice and Equality)
Food of detainees and prisoners.	37 (2012)	Accepted.
* Visited in 2010.		

COURTS OF MELILLA**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary of State for Justice)
(S) Horizontal bars on cell doors.	32 (2012)	Not accepted.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL). ** Visited in 2010.		

CITY OF JUSTICE OF MÉRIDA (BADAJOZ)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary of State for Justice)
(S) The video-surveillance system should be adapted to the criteria of this Institution.	477 (2010) 14 (2012)	Accepted. Pending budget availability.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General Police)
Identification of officers.	26 (2012)	Accepted. Instructions are given for correction.
The telephone booths of the cells area are not used.	20 (2012)	Not accepted.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary of State for Justice)
Record book of admissions and exits of detainees	28 (2012)	Accepted.
Gun rack in cells area	27 (2012)	Accepted. Pending budget availability
Office material.		Accepted.
Furniture of custodial officers room.		Accepted.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
Information on infectious diseases.	23 (2012)	Accepted.
If transfer is carried out early in the morning, inmates arrive without having taken breakfast or medication in prison.		Not accepted.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL). ** Visited in 2012.		

Tables 138-146
Follow up of visits to facilities of local police made in previous years

LOCAL POLICE OF EJEA DE LOS CABALLEROS (ZARAGOZA)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of Ejea de los Caballeros)
(S) Detainees should be informed in writing of the possibility of instituting habeas corpus proceedings.	476 (2010) 47 (2011) 19 (2012)	Accepted.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of Ejea de los Caballeros)
The video-surveillance system does not conform to the criteria of this Institution.	477 (2010) 14 (2012)	Accepted. Pending budget availability.
Protocol for infectious diseases and pregnant detainees.	23 (2012)	Accepted. Instructions are given for correction.
Lack of sound call systems inside cells.	16 (2012)	Accepted. Instructions are given for correction.
Cleaning of blankets.	38 (2012)	Accepted. Instructions are given for correction.
Deteriorated mattresses.	38 (2012)	Accepted. Instructions are given for correction.
Horizontal bars on cell doors.	32 (2012)	Accepted. Pending budget availability.
Lack of forms for information of rights in various languages.	18 (2012)	Accepted. Instructions are given for correction.
Identification of officers.	26 (2012)	Accepted. Instructions are given for correction.
Supply of food from outside.	69 (2011)	Not accepted.

LOCAL POLICE OF EJEA DE LOS CABALLEROS (ZARAGOZA)**		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Departament of Healthcare, Social Welfare and Family of the General Deputation of Aragon)
One of the police records contained a medical report including personal data of the clinical record and medical check-up of the detainee.	22 (2012)	Accepted. Instructions are given for correction.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL)		
** Visited in 2012.		

LOCAL POLICE OF FUENGIROLA (MÁLAGA)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of Fuengirola)
The video-surveillance system does not conform to the criteria of this Institution.	477 (2010) 14 (2012)	Accepted. Pending budget availability.
No written information of the possibility of instituting habeas corpus proceedings is provided.	476 (2010) 19 (2012)	Accepted, Instructions are given for correction.
Identification of officers.	26 (2012)	Accepted, Instructions are given for correction.
Horizontal bars on cell doors.	32 (2012)	Accepted, Instructions are given for correction.
No record is kept of full body searches made.	29 (2012)	Accepted.
The squat toilet is not adequate for detainees who, given their age or physical condition, need to sit on the toilet.	33 (2012)	Accepted, Instructions are given for correction.
The forms for information of rights continue to include the terms lawyer and barrister.	476 (2010) 18 (2012)	Accepted.
The belongings of detainees are kept in bags.	30 (2012)	Accepted.
* Visited in 2012.		

LOCAL POLICE OF MARBELLA (MÁLAGA)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of Marbella)
The video-surveillance system does not conform to the criteria of this Institution.	477 (2010) 14 (2012)	Accepted. Pending budget availability.
No information is provided on the possibility of instituting habeas corpus proceedings.	476 (2010) 19 (2012)	Accepted. Instructions are given for correction.
Officers are not always present in the cell area when detainees are there.	17 (2012)	Accepted. Pending adaptation of the video-surveillance system and more personnel.
Horizontal bars on cell doors.	32 (2012)	Accepted. Instructions are given for correction depending on budgetary availability.
No record kept of full body searches.	29 (2012)	Accepted. Instructions are given for correction.
Entrance of detainees to the facilities.	466 (2010) 31 (2012)	Accepted. Pending budget availability.
Evaluate the temperature of the cells area.	34 (2012)	Accepted. Instructions are given for correction.
Damp on walls.	36 (2012)	Accepted. Instructions are given for correction.
Identification of officers.	26 (2012)	Accepted.
The squat toilet is not adequate for detainees who, given their age or physical condition, need to sit on the toilet.	33 (2012)	Accepted. Pending budget availability.
Forms for information of rights continue to use the terms lawyer and barrister.	476 (2010) 18 (2012)	Accepted. Instructions are given for correction.

LOCAL POLICE OF MARBELLA (MÁLAGA)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of Marbella)
Belongings of detainees are kept in bags.	30 (2012)	Accepted.
Mattresses larger than concrete beds.	38 (2012)	Accepted.
* Visited in 2012.		

LOCAL POLICE OF MEDINA DEL CAMPO (VALLADOLID)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of Medina del Campo)
The video-surveillance system does not conform to the criteria of this Institution.	477 (2010) 14 (2012)	Remedied.
Horizontal bars on cell doors.	32 (2012)	Accepted. Pending budget availability.
No record is kept of full body searches.	29 (2012)	Accepted. Instructions are given for correction.
Entrance of detainees to the facilities.	466 (2010) 31 (2012)	Accepted. Pending budget availability.
Location of the cells.		Accepted. Pending budget availability.
The forms for information of rights continue to use the terms lawyer and barrister.	476 (2010) 18 (2012)	Accepted.
Lack of a wardrobe to keep personal belongings of detainees.	30 (2012)	Accepted. Pending budget availability.
Cleaning of blankets.	38 (2012)	Accepted. Pending budget availability.
No matresses or mats are provided to detainees.	38 (2012)	Accepted. Pending budget availability.
Toilet seat inside cells.	33 (2012)	Accepted. Pending budget availability.
Evaluate temperature of cells area.	34 (2012)	Accepted. Pending budget availability.
Bad odour in cells.	34 (2012)	Accepted. Pending budget availability.
Cleaning of cells.	34 (2012)	Accepted. Pending budget availability.
* Visited in 2012.		

LOCAL POLICE OF TAFALLA (NAVARRE)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of Tafalla)
The video-surveillance system does not conform to the criteria of this Institution.	477 (2010) 14 (2012)	Accepted. Pending budget availability.
Officers are not always present in cells area when detainees are there.	17 (2012)	Accepted.
Protocol for infectious diseases and pregnant detainees.	23 (2012)	Accepted.
No written information is provided on the possibility of instituting habeas corpus proceedings.	476 (2010) 19 (2012)	Accepted.
No record kept of full body searches.	29 (2012)	Accepted.
Inadequate completion of detainees custody book.	28 (2012)	Accepted.
No book for minor detainees.	28 (2012)	Accepted.
Lack of forms for information of rights in various languages.	18 (2012)	Accepted.
Identification of officers.	26 (2012)	Accepted.

LOCAL POLICE OF TAFALLA (NAVARRE)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of Tafalla)
Officers carry loaded weapon in cells area.	27 (2012)	Accepted.
Entrance of detainees to the facilities.	466 (2010) 31 (2012)	Accepted.
Cell door windows have vertical bars.	32 (2012)	Accepted.
Concrete beds of cells have sharp borders.	32 (2012)	Accepted.
No fire protection systems exist in the cells area.	212 (2010) 63 (2011)	Accepted. Pending budget availability.
Evaluate temperature of cells area.	34 (2012)	Accepted.
Belongings of detainees are kept in bags.	30 (2012)	Accepted.
No mattresses or mats are provided.	38 (2012)	Accepted.
* Visited in 2012.		

LOCAL POLICE OF ZAFRA (BADAJOZ)*		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of Zafra)
(S) The video-surveillance system does not conform to the criteria of this Institution.	477 (2010) 14 (2012)	Accepted. Pending budget availability.
(S) Horizontal bars on cell doors.	32 (2012)	Accepted. Pending budget availability.
(S) Entrance of detainees to facilities through main door.	31 (2012)	Accepted. Pending budget availability.
(S) No written information is provided of the possibility of instituting an habeas corpus	19 (2012)	Accepted. Pending budget availability.
(S) No gun racks exist. Officers carry loaded statutory weapon in cells area.	27 (2012)	Accepted. Pending budget availability.
(S) Close existing toilets and replace squat toilets since they are not adequate for detainees who, given their age or physical condition, need to sit on the toilets.	33 (2012)	Accepted. Pending budget availability.
(S) Evaluate temperature of cells area.	34 (2012)	Accepted. Pending budget availability.
(S) Cleaning of cells.	34 (2012)	Accepted. Pending budget availability.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of Zafra)
No record is kept of full body searches.	29 (2012)	No registrations are concluded by the Local Police.
Identification of officers.	26 (2012)	Accepted. Instructions are given for correction.
Belongings of detainees are kept in bags and no lockers exist.	30 (2012)	Accepted. Instructions are given for correction.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL).		
** Visited in 2012.		

LOCAL POLICE OF BERJA (ALMERÍA)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of Berja)
(S) Installation of a video-surveillance system.	477 (2010) 14 (2012)	Accepted. Pending budget availability.
(S) Written possibility of instituting habeas corpus proceedings.	476 (2010) 19 (2012)	Accepted.
(S) Carry weapon in cells area.	53 (2011) 27 (2012)	Accepted.

LOCAL POLICE OF BERJA (ALMERÍA)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of Berja)
(S) Not deliver blankets used by another detainee.	71 (2011) 38 (2012)	Accepted. Pending budget availability.
(S) Evaluate cell temperature all year.	65 (2011) 34 (2012)	Accepted. Pending budget availability.
S) Lack of heat sealed bags to keep belongings of detainees.	72 (2011) 30 (2012)	Accepted. Pending budget availability.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL).		
** Visited in 2012.		

LOCAL POLICE OF LA CAROLINA (JAÉN)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of La Carolina)
(S) Protocol for detainees with infectious-contagious diseases and pregnant detainees.	49 (2011) 23 (2012)	Accepted. A protocol of action is prepared.
(S) Not deliver blankets used by another detainee.	71 (2011) 38 (2012)	Accepted.
(S) Proceed to renovate the cell doors to avoid self-injuries of detainees.	62 (2011) 32 (2012)	Accepted.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL).		
** Visited in 2012.		

LOCAL POLICE OF VALVERDE DEL CAMINO (HUELVA)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Town Hall of Valverde del Camino)
(S) Installation of a video-surveillance system.	477 (2010) 38, 39 y 40 (2011) 14 (2012)	Accepted. Pending budget availability.
(S) Protocol for detainees with infectious diseases and pregnant detainees.	49 (2011) 23 (2012)	Accepted. A protocol of action is prepared.
(S) Not deliver blankets used by another detainee.	71 (2011) 38 (2012)	Accepted.
(S) Use only the term lawyer in form for information of rights to detainee.	476 (2010) 45 (2011) 18 (2012)	Accepted.
(S) Lack of heat sealed bags to keep belongings of detainees.	72 (2011) 30 (2012)	Accepted. A machine is acquired to heat seal the bags.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL).		
** Visited in 2011.		

2. Mean-term deprivation of liberty

2.1. Centres for detention of foreign nationals

Tables 147-149

Conclusions and decisions arising from visits to centres for detention of foreign nationals made in 2013

FACILITIES VISITED: Centre for Detention of Foreign Nationals of Barcelona

DATE OF VISIT: 4 December 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: Obtain information on the death of an inmate and verify whether the deficiencies observed in previous visits relating to the establishment of a suicide prevention protocol and the installation of cameras in places where inmates are isolated had been remedied. For such purpose, interviews were held with inmates and personnel of the centre, the personal and clinical record of the deceased were examined, the cell where death took place was inspected and a copy of the recordings made that night by the security cameras was requested.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
			RECOMMENDATION	Prepare a suicide prevention protocol, as is done in the SGIP, for persons deprived of liberty at CIEs.	Accepted	The General Headquarters for Foreign Nationals and Borders prepared an Instruction on the matter.

FACILITIES VISITED: Centre for Detention of Foreign Nationals of Madrid

DATE OF VISIT: 25 June 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office and one external expert specialised in forensic medicine
PURPOSE OF THE VISIT: The main purpose of the visit was to verify compliance with the recommendations made by the NPM after visiting this Centre.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.
When incidents occur recordings are not extracted ex officio.	Rejected	They wait until the court authority, any other authority or any police service needing them for any investigation requests the recordings.
Unless one responsible person of the CIE should have access to view the recorded pictures.	Rejected	Only Electronic Security personnel have access.
Ensure the right to privacy of inmates in medical consultations..	Accepted	Remedied.
Improve the quality of the description of injuries or make photographs.	Accepted	Injuries are detailed but the matter will be conveyed to the JSP of Madrid to consider whether it is necessary to improve the preparation of the reports where injuries occur.

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Call inmates by megaphone stating their name, surnames and record number.	Accepted	The officers were informed in writing individually and acknowledged receipt with their signature
SUGGESTION	Remit injury reports to the court on shift.	Accepted	Remedied.
SUGGESTION	Adopt measures for the telephone of the control area, where calls are received from family and friends is not off the hook outside restricted call hours.	Accepted partially	It is only left off the hook when inmates are sleeping or eating.
SUGGESTION	Give instructions to the director of the CIE of Madrid so that, if an incident occurs, the pictures be extracted ex officio.	Accepted	Instructions have been given for the images to be extracted in a separate disk.
SUGGESTION	Adopt the measures considered necessary for a duly authorised person responsible of the CIE to be able to access viewing of the recorded pictures.	Accepted	Remedied.

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Neither the format nor the contents of the clinical record conform to Law 41/2002.	Accepted	Remedied.				
No record is kept of requests for healthcare assistance and scheduled appointments.	Accepted	Remedied.				
Complete clinical record with test results.	Rejected	Upon admission of an inmate a medical check-up is made. The test results do not appear necessary or founded.	SUGGESTION	Complete the clinical record of each inmate with tests to detect the consumption of toxic substances immediately.	Rejected	The performance of tests is left at the discretion of the medical practitioner that performs the check up for admission.
Perform medical check-ups in cases of isolation.	Accepted	Remedied.				

GOOD PRACTICES
Toilets have been installed in all rooms of the centre, and in the leisure room for women, as repeatedly requested by this Institution.

FACILITIES VISITED: Centre of Detention of Foreign Nationals of Murcia

DATE OF VISIT: 21 and 22 May 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office and one external technical expert in forensic medicine
PURPOSE OF THE VISIT: During the visit, the management, medical team and a significant number of inmates were interviewed. The facilities were inspected, the record books, personal records of inmates and healthcare provided to inmate were examined.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Injury reports should be remitted to the court authority.	Accepted	They are sent to the Court on Shift.				
Some detainees stated that they did not receive visits from their designated free lawyers because they were in different provinces.	Rejected	It cannot be a problem that may be resolved by the Centre.				
Inmates are not allowed out to the yards in the afternoon. The three yards have not yet been provided with a roofed area.	Accepted	The timetable to go out the yards has been extended to include afternoons. The matter of the roofing of the yards has been referred to the General Headquarters for Foreign Nationals and Borders				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Install a washing machine and drier at the centre, for inmates to be able to maintain the most elementary standards of cleanliness and tidiness in their clothing.	Accepted not performed	Pending budget availability.				
Lack of leisure and reading and sports material.	Accepted not performed	Pending budget availability.				
The wall of the toilets in the isolation area had broken tiles.	Accepted	Repaired.				
The toilets do not have separating walls for showers to preserve the privacy of the inmates.	Accepted not performed	Pending budget availability.				
Inform the inmates that they may only use the post box in the canteen.	Rejected	Inmates have information on the matter.				
Inmates stated that they do not always have paper and pen to write complaints.	Rejected	The Centre always provides paper and pen to any inmate who so requests to write a complaint.				
It was observed that certain printed forms provided to inmates upon admission, with the rights and duties, were delivered in a language unknown to the inmate in question.	Accepted	They exist in various languages.				
No record is kept of full body searches made.	Accepted	Procedures have been enabled to place such searches on record.				
Rooms are not searched in the presence of inmates.	Accepted	Since the change of management searches are made in the presence of inmates				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
All officers providing services on the morning shift were lacking the mandatory identification badge.	Accepted	The Management of the Centre has given instructions for the correct identification of the officers, infringement of which will imply the institution of the respective disciplinary proceeding.				
It is considered necessary for permanent healthcare services to be available, to ensure medical and DUE attention at all times permitting initial check-ups for admission to be made as soon as possible.	Rejected	The Medical Service of the Centre consists of one medical practitioner and two nurses, on morning and afternoon shifts, the medical practitioner being on call on weekends and public holidays.				
Ensure adequate specialised assistance to detainees, including psychological, psychiatric and dental treatment.	Rejected	The specialised assistance of inmates is covered by transferring them to the Hospital Virgen de la Arrixaca.				
Establish a record of requests for healthcare assistance and scheduled appointments of healthcare services. Inmates must be informed of the manner in which to access the medical service.	Accepted	A record has been enabled for requests for healthcare services and scheduled appointments of which the inmates are informed upon arrival at the CIE.				
Ensure the right to privacy of the inmate at medical consultations, permitting the door for access to the medical surgery to be closed.	Accepted	Remedied				
Adapt the clinical record of inmates to the standard form contemplated by Law 41/2002.	Accepted	Remedied				
Ensure that language is not a hindrance to fluid communication between the healthcare services and the inmates.	Rejected	The Centre has an Arabic, French and English interpreter available to inmates and present at the consultation if required.				
Accuracy when describing the injuries. Otherwise take photographs of them.	Rejected	The centre always issues a detailed injuries report conforming to the standard form.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
No program exists to detect risk of self-injury and no Suicide Prevention Protocol exists.	Accepted	Internal rules have been prepared to minimise self-injuries and prevent suicide attempts-				
Proceed to improve cleaning of leisure room for smokers.	Rejected	It is cleaned daily although its maintenance during the rest of the days is the responsibility of the inmates.				
Proceed to install video-surveillance system in the family unit.	Rejected	This unit is occupied by women, who are usually in underwear, so that it is considered that a security camera in the room could violate their privacy.	SUGGESTION	Install a video-surveillance system in the leisure room of the family unit, according to the criterion established in paragraph 477 of Annual Report NPM 2010, informing the persons deprived of liberty of these recordings and the authority before which they may exercise their rights pursuant to personal data protection legislation.	Accepted	
The bone tests made on three inmates, who declared to be minors, did not meet the minimum requirements to consider the medical diagnosis to be correct.	Rejected	These tests are not within the competence of the CIE				
No information is provided on the possibility of requesting asylum unless they arrive by boat and, then it is only offered in Arabic	Accepted	A protocol will be prepared in each CIE to ensure access to such information.				
Complete clinical record with test results.	Accepted	Remedied				
No separation walls exist between the various booths of the visitors room.	Accepted	One-meter separating walls have been installed.				

GOOD PRACTICES
Toilets accessible from the leisure rooms have been installed, which enables detainees to use them without requesting the officers.
A specific room has been enabled to keep luggage of inmates, which these may access after informing the officers, as this Institution had been claiming.

2.2. Military disciplinary establishments

Table 150

Conclusions arising from the visit to the military disciplinary establishment made in 2013

FACILITIES VISITED: Military Disciplinary Establishment (Base San Pedro) in Colmenar Viejo (Madrid)

DATE OF VISIT: 19 April 2013 (unannounced) VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: Visit to follow up that made in 2010, to verify the degree of compliance with the recommendations made at the time. At said visit, interviews were held with the persons responsible for the establishment and with the penalised militaries.
RESPONSIBLE AUTHORITY: Sub-Secretary of the Ministry for Defence

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Lack of privacy in telephone communications.	Accepted not performed					
Amendment to Internal Regulations relating to personal searches.	Accepted not performed					
Amendment of Internal regulations on vis-à-vis visits.	Accepted not performed					
Amendment of the Internal Regulations for access to cell phone to be enabled.	Accepted not performed					

GOOD PRACTICES
The EDM has been provided with additional video-surveillance cameras, as was requested by this Institution after the visit made in 2010.
Changing rooms have been enabled for officers providing services at the EDM, as had also been requested by this Institution.
The good state of repair and cleanliness of the facilities, and the provision of leisure material of the EDM.
It is ensured that complaints of inmates are attended within the possibilities of interpretation of the regulation in force. The fast response to requests and claims is also to be pointed out.

3. Long-term deprivation of liberty

3.1. Prisons

Tables 151-156

Conclusions and decisions arising from the visits made to prisons in 2013

FACILITIES VISITED: Prison of Córdoba

DATE OF VISIT: 10 May 2013
VISITING TEAM: The Ombudsman and three technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: The main purpose of the visit was to verify compliance with the observations of the CPT on restraint related to the prison of Córdoba. For such purpose, the restraint places located in unit 15 and the infirmary unit were visited and confidential interviews were held with the inmates on whom this measure had been imposed this year.
RESPONSIBLE AUTHORITY: Secretary General for Penitentiary Institutions

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Statements were taken that in certain cases metal handcuffs are used for immobilisations, which is not correct.	Accepted	The use of cloth restraints for immobilisations is compulsory.				
The video-surveillance system in the restraints cell does not permit recordings to be kept. The criterion of the Ombudsman must be repeated as to the fact that persons who are immobilised must be permanently supervised.	Rejected					

GOOD PRACTICES
The observations made by the CPT on the conditions of the bed for immobilisation in the isolation unit were attended.

FACILITIES VISITED: Prison for men of Barcelona (Cárcel Modelo)

DATE OF VISIT: 24 May 2013
VISITING TEAM: The Second Assistant to the Ombudsman and two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: The main purpose of the visit was to verify compliance with the observations made by the CPT related to the Prison for men of Barcelona (Cárcel Modelo). For such purpose, the Sixth Gallery was visited and confidential interviews were held with the inmates.
RESPONSIBLE AUTHORITY: Directorate General for Penitentiary Services of the Government of Catalonia

CONCLUSIONS		
GENERAL	STATUS	ANSWER AUTH.
Photographs should be included in the injury reports.	Rejected	

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
RECOMMENDATION	The injury reports should include photographs.	Rejected	

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.
The number of inmates should not exceed 1,200.	Accepted	The occupancy has dropped. Its gradual reduction is forecast.
Further involvement of medical practitioners in mechanical restraints.	Rejected	
Improvement of the system of registration of complaints establishing a standard form with self-copy paper.	Rejected	Inmates are delivered a sealed copy, and in relevant arrangements the application copies are on self-copy paper
Delivery to inmates upon admission of a form informing them of their rights.	Rejected	They are provided with an informative form and a system of customised attention to resolve eventual doubts is established.

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
RECOMMENDATION	Issue instructions for medical practitioners to assume a more active role in application of coercive means. (The action protocols will be reviewed). Extension of actions.	Accepted	

GOOD PRACTICES
Forecast opening of the CPs Puig de les Basses (Figueres) and Mas d'Enric en Tarragona which will probably decongest the CP of Barcelona for Men.
The Government of Catalonia has a specific circular letter on coercive means, pointing out medical supervision and video-surveillance.

FACILITIES VISITED: CP Puerto I at El Puerto de Santa María (Cádiz)

DATE OF VISIT: 27-29 de mayo de 2013
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office and one technical expert in forensic medicine
PURPOSE OF THE VISIT: During the visit particular attention was given to the application of coercive measures, the disciplinary regime and the healthcare provided at the centre. Likewise, confidential interviews were held with inmates.
RESPONSIBLE AUTHORITY: Secretary General for Penitentiary Institutions

CONCLUSIONS		
GENERAL	STATUS	ANSWER AUTH.

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
RECOMMENDATION	Sent to the Ministry of the Interior. Undertake a legislative initiative to regulate under a basic law the measures for X-ray tests.	Pending	
RECOMMENDATION	Sent to the Ministry of the Interior. Amend the documents of informed consent for X-ray tests of the Secretary General for Penitentiary Institutions.	Pending	

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Remedy the deficiency of failure to record that a control was carried out every hour by the officers on the immobilised inmates.	Pending	
SUGGESTION	Adopt measures necessary to remedy the insufficiency of medical practitioners on a permanent basis.	Pending	

CONCLUSIONS			DECISIONS			
GENERAL	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
			REMINDER	In most cases of mechanical restraints and provisional isolations reviewed there is no record that the medical practitioner performed a personal check up on the inmates at the commencement of the measure, implying an infringement of article 72.2 of the RP.	Pending	
Injury reports should be adequately completed.	Pending					
In many cases the copy of the respective injury reports was not on record.	Pending					
The application of coercive measures or serving of the isolation penalty is often not on record in the clinical record.	Pending					
It would be necessary to review that immobilisations are performed for the minimum time necessary	Pending					
Various cases in which the commencement of the mechanical restraint was ordered by the medical services but treated as regimental immobilizations.	Pending					
The absence of a medical practitioner at night at the centre has direct implications on the adoption of coercive measures which might not be necessary.	Pending					
Two immobilisations of an inmate made consecutively should have been recorded as a single application.	Pending					

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Inmates should be untied to be able to relieve themselves.	Pending					
It would be necessary to review the manner in which mechanical restraints are applied at the centre.	Pending					
The video-surveillance system should cover and record the pictures of all cells where mechanical restraints are applied.	Pending					
The bed for mechanical restraints are not in the centre of the cells.	Pending					
Three cases of mechanical restraints were observed in which the date and time of release were not recorded.	Pending					
Allow at least 24 hours of rest when the serving of penalties implies more than 14 days of isolation.	Pending					
Application of article 75.1 RP should be reviewed.	Pending					
The duration of the limitations of article 75.2 of the RP should be reviewed.	Pending					
The standard forms of the Suicide Prevention Program (PPS) are not used on a routine basis.	Pending					
No application of telemedicine.	Pending					
Security measures that violate confidentiality between the medical practitioner and the patients and their right to privacy should not be adopted.	Pending					

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The Framework program for integrated attention to the mentally ill (PAIEM) is little implemented and the medical services are little involved.	Pending					
The centre applies the Program for action under the closed regime but the evaluations contemplated by Instruction 17/2011 are not made.	Pending					
The reserved information proceeding due to death of an inmate should be carried out by the central services of the SGIP.	Pending					
Some inmates stated that full body searches were carried out without an overall or searches were made of cell without their presence.	Pending					
If it is suspected that inmates may introduce illegal drugs, X-rays are made. Other measures less detrimental to the rights of the inmates could also achieve the sought purpose.	Pending					
The request made to the penitentiary surveillance judge for a court order for X-ray should include information on the risks and consequences of the test to be carried out.	Pending					
The video-surveillance system does not conform to the criteria of this Institution.	Pending					
Cells do not have a centralised mechanical door opening system.	Pending					

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Existence of many mosquitoes.	Pending					
Water pipes cause bad odour.	Pending					
No hearing or air conditioning.	Pending					
Deficient state of maintenance.	Pending					
The unit yards do not have any roofed area.	Pending					
It has squat toilets instead of anti-vandal seat toilets.	Pending					
Both the quantity and the quality of the food provided should be reviewed.	Pending					
The adoption and end of coercive measures should be reported immediately to the penitentiary surveillance judge.	Pending					
The notice to the penitentiary surveillance judge of the application of coercive measures should record other aspects.	Pending					
The centre does not have an occupational or sports leader.	Pending					
If the inmates does not voluntarily accept to receive an X-ray a court order should be requested and it is not correct to adopt other measures.	Pending					
In the Record Book of coercive measures, the sections on the medical report on the initial check-up and follow up report are not completed.	Pending					

GOOD PRACTICES
The living regime applied at the centre to inmates of first grade.
The respect unit which started up in 2011, to achieve standard behaviour patterns permitting the inmate to return to the 2nd grade.

FACILITIES VISITED: CP Puerto III at El Puerto de Santa María (Cádiz)

DATE OF VISIT: 23 and 24 May 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: the Ombudsman, two technical experts of the Ombudsman's Office and one external technical expert in forensic medicine.
PURPOSE OF THE VISIT: The main purpose of the visit was to verify compliance with the observations of the CPT relating to CP Puerto III. For such purpose, unit 15, the infirmary unit and one women's unit were visited and confidential interviews were held with inmates.
RESPONSIBLE AUTHORITY: Secretary General for Penitentiary Institutions

CONCLUSIONS		
GENERAL	STATUS	ANSWER AUTH.
No specific book is kept for healthcare immobilisations.	Rejected	

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
RECOMMENDA-TION	Provide infirmaries of all CPs with a book to record health-care mechanical restraints.	Accepted	The Special Situations Control Form has been amended to in-clude mechanical restraints.

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.
Mechanical restraints for long time periods.	Rejected	This was reviewed and it is con-sidered that the application con-forms to legislation in force.
At least one day of rest should be allowed when the successive serving of penalties implies more than 14 days of isolation.	Accepted	
Immobilisation is not adequate in the case of suspicion of pos-session of psychotropic drugs.	Rejected	Immobilisation in such case occurred to prevent the inmate from causing himself damage, after other measures were adopted.
The placing of belts should be improved with further training.	Rejected	Since 2010 personal defence courses are given on a six-monthly basis and coercive measures are correctly applied.
Control of hygiene in immobili-sations and of the conditions in which they are performed should be extreme.	Accepted	

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.
Deficiencies were observed in the medical control of regimental immobilisations.	Rejected	
The cells used for mechanical restraints do not have a video-surveillance system.	Rejected	The ongoing observation of screens would not be possible.
Cells used for mechanical restraints should be cleaned after use.	Accepted	
When article 75.1 RP is applied the specific regimental limitations should be specified.	Accepted	
The application of article 75.1 of the RP at the centre should be reviewed.	Accepted	
Arrangements should be made for greater frequency in psychiatric assistance.	Rejected	
The remittance of injury reports to the court depending on their severity should not be discretional.	Rejected	
Injury reports should be fully and adequately completed.	Accepted	Reminders to such effect have been sent to all CPs.
Many areas not covered by the video-surveillance system.	Rejected	The Recommendation made in general was repeated. It was accepted and is pending budget availability.
A certain degree of excessive occupancy exists.	Rejected	No department is occupied at 100% of its capacity.

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Ensure that all dossiers of coercive measures include documents of the medical check-ups.	Rejected	
SUGGESTION	Take necessary steps for CP Puerto III to have more frequent psychiatric assistance.	Rejected	It is considered sufficient.
REMINDER	The notice of injuries or other criminal facts to the court authority is not made pursuant to article 262 of the Criminal Procedure Law.		

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Immobilisations are controlled every hour which is considered insufficient.	Rejected	The human resources are insufficient for permanent supervision.				
The limitation not to go out to the yard for two days when suspicions exist that the inmates carry illegal drugs is a measure that does not appear to be sufficiently founded.	Accepted					
The medical report prior to serving the isolation penalty is performed without personal check up of the medical practitioner.			REMINDER	Reminder of article 254.1 RP, which establishes that isolation penalties must be served with a medical report and check up by the medical practitioner of the establishment.	Accepted	
A mechanism should be established to permit inmates serving the isolation penalty to evidence that they have requested medical assistance.	Accepted					
Both surveillance by the officers of immobilised inmates and control of such task by their superiors should be intensified.	Accepted					
The medical follow up of the coercive measures is recorded only in the clinical records of the inmates.	Rejected		SUGGESTION	Give instructions for coercive measures to be recorded in a book of medical follow up.	Accepted partially	It will be made in the Form for Control of Special Situations and all CPs have been reminded of the obligation to have the medical record in adequate documentary form.
The external technical expert interviewed and examine the clinical record of an inmate, appearing to be the most adequate procedure where he is transferred to the infirmary and requires psychiatric treatment.	Rejected	No specific psychiatric pathology has been evidenced (extension of actions).				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The visit of the medical practitioner in the case of isolation penalty is compulsory, so that the inmate may not refuse to have the professional verify the conditions in which the penalty is being served.	Accepted					

GOOD PRACTICES
The existence of a mechanical restraints manual in the special department.
The existence of 5 respect units.
The progress of the Program of closed regime.

FACILITIES VISITED: CP Segovia

DATE OF VISIT: 15 and 16 April 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office and one external technical expert in forensic medicine.
PURPOSE OF THE VISIT: During the visit, the persons responsible for the Centre were interviewed, the facilities were inspected, various records of inmates and the healthcare services provided at the centre were reviewed. Interviews were also held with various inmates.
RESPONSIBLE AUTHORITY: Secretary General for Penitentiary Institutions

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Pending budget availability.				
Cuts in the electricity supply imply interruption of recordings.	Accepted	The problem has been remedied.				
Several cameras were broken.	Accepted	The cameras are being gradually replaced.				
Various officers did not carry their mandatory identification badge.	Accepted	The obligation to wear the identification badge has been repeated to personnel.				
The centre should have personal medical healthcare assistance available 24 hours per day.	Rejected	Emergencies may be attended using the located service on shift or the emergency services.	SUGGESTION	Adopt the necessary measures for medical assistance to be available in person 24 hours per day.	Pending	

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Requests for scheduled medical assistance are recorded in loose forms. There is no record of requests for urgent assistance.	Accepted partially	A book of requests for urgent assistance has been established.	SUGGESTION	Enable a book of requests for medical assistance scheduled at the centre, to prevent the loss or change of any of the forms of consultation currently used.	Pending	
Clinical records of patients are not digitalised.	Rejected	This depends on the public healthcare services. Extension of actions as to whether any formal request has been made or contact has been made to such effect with the Healthcare Services of Castile and Leon.				
A larger number of medical consultations should be made through telemedicine.	Rejected	This depends on the public healthcare services. Extension of actions as to whether any formal request has been made or contact has been made to such effect with the Healthcare Services of Castile and Leon.				
The injury reports do not conform to the criteria of this Institution.	Accepted	Instructions have been given to the centre.				
An interpretation system should be available when medical assistance must be provided to foreign nationals.	Rejected	This is not possible for budgetary reasons.	RECOMMENDATION	Adopt at all CPs attached to the SGIIPP the measures necessary for language not to be an impediment for fluid communication between the healthcare services and the inmates requesting assistance, to ensure that it is provided correctly, without errors attributable to the communication and without effects on privacy, through telephone interpretation services.	Pending	

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
It would be desirable for technical personnel to be available to operate the X-ray machine.	Rejected	It is not considered necessary, given the current volume of the demand.				
It should be ensured that immobilisations are made for the shortest time necessary.	Accepted	Application of the measure has been reviewed and it will be verified that the criteria of need and proportionality were respected.				
Inmates for support of the Special Educational Unit did not receive information.	Rejected	Although they do not receive formal training, they are trained by the Treatment Team of the unit. Extension of actions on the implications for inmates supporting the Special Education Unit of failing to receive formal training.				
Inmates supporting the Special Unit may be psychologically affected.	Accepted	Support inmates are assisted by treatment personnel and, in the case of exhaustion, it is ensured that they are changed to another activity.				
The Framework program for integrated assistance to the mentally ill (PAIEM) is little developed at the centre.	Accepted	It is being monitored by the central services.				
Inmates providing support to the Special Educational Unit have not received training relating to the Suicide Prevention Program (PPS).	Rejected	The inmates included in the Suicide Prevention Plan are admitted to the infirmary and assisted by inmates of support of the infirmary.				

GOOD PRACTICES
The food of the centre is very positively valued by most interviewed inmates.
The existence of the special education unit, pioneer in Spain.

FACILITIES VISITED: CP Villabona (Asturias)

DATE OF VISIT: 30 September and 1 October 2013 (unannounced)
VISITING TEAM: The Ombudsman, two technical experts of the Ombudsman's Office and one external expert in forensic medicine.
PURPOSE OF THE VISIT: During the visit, the persons responsible for the Centre were interviewed, the facilities were inspected and various records of the inmates and the healthcare assistance provided at them were examined. Inmates were also interviewed.
RESPONSIBLE AUTHORITY: Secretary General for Penitentiary Institutions

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.
Injury reports must be adequately completed.	Accepted	The centre has been again reminded of the obligation to complete them adequately and follow them up to correct malfunctions.
The medical check-up and the dispensation of medicines is carried out through the doors, which should be limited only to those cases in which this is strictly necessary.	Accepted	Extension of actions on whether instructions were given to the centre for medical assistance to be provided only through the doors only in very exceptional and founded cases.
The video-surveillance system should cover and record the pictures of all the cells where mechanical restraints are performed.	Rejected	The recommendation made at a previous visit is repeated.
An adequate protocol should be established for the system for requests for urgent healthcare services..	Rejected	
It would be advisable to organise the consultation on demand differently for it to be more frequent.	Accepted	The relevant instructions have been given

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Enable a book of requests for urgent medical assistance at the centre (it was accepted at the CP of Segovia).	Pending	

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
It would be advisable to set up a psychological consultation in the centre.	Rejected	The psychologist of the centre has been attributed the psychological assistance to inmates. Extension of actions on the functions of psychologists at CPs and whether these include offering psychotherapy services to the inmates and whether the current allocation of psychologists permits such services to be offered in practice.				
The taking of psycho-medicines should be directly supervised.	Rejected	This depends on the medical criterion, according to the personal features of the patient.				
The clinical records of the inmates are not digitalised.	Rejected	This depends on the public healthcare services. Extension of actions as to whether any formal request or contact has been made to such effect with the Principality of Asturias.				
An interpretation system should be available when necessary in the medical assistance provided to foreign nationals.	Rejected	A form is available in various languages to make the medical check-up for admission. (A RE has been made in CP Segovia, 13015339).				
An attempt should be made to improve the practical implementation of the program to detect suicide risk more efficiently.	Accepted	Amendments have been made to the procedure for action of the Suicide Prevention Program.				
Inmates of support of the PPS receive no specific training to perform the tasks entrusted to them.	Accepted	Controls on the scheduling of courses will be increased.				
The PAIEM (framework program for assistance to the mentally ill) is little developed at the centre.	Accepted	Gradually further developed.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The request to the penitentiary surveillance judge for a court order to make X-rays should include information on the risks and consequences of the test to be performed.	Accepted partially	Information will be included on the performance of previous X-ray tests on the inmates. The information on the effects of radiation may be dispensed by the forensic medical practitioners.				
The video-surveillance system does not cover the entire facilities.	Accepted, not performed	Pending budget availability.				
The cells do not have a centralised mechanical door opening system.	Accepted, not performed	Pending budget availability.				
The isolation department has excessively restrictive architectural features.	Rejected		SUGGESTION	Give appropriate instructions for the use of the isolation department in the centre to be limited to serving isolation penalties in the cell and application of provisional isolation and not as a unit for permanent stay of inmates	Pending	
			REMINDER	Complete the injuries report systematically and send it immediately to the court authority, pursuant to article 262 of the Criminal Procedure Law in accordance with criterion 114 of Annual Report 2012 of the NPM (Accepted at CP Puerto III-13021839).		
Healthcare personnel should inform them in writing, in terms comprehensible to them of the nature, risks and consequences of the X-ray test.	Accepted, not performed	The documents will be reviewed.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Allow at least 24 hours of rest to elapse when the serving of penalties implies more than 14 days of isolation.	Pending	Extension of actions. El criterion of this Institution had already been accepted in proceeding 13021839 (CP Puerto III). In any case it is considered that, indeed, article 263.3 of RP would not apply due to the right of the SGIP to grade the penalties but this would be in the benefit of the prisoner.				

GOOD PRACTICES
Pharmaceutical availability at the Centre, which facilitates the preparation and dispensation of medication for inmates.
They should be informed by the healthcare personnel in writing, in terms comprehensible for the, of the nature, risks and consequences of the X-ray test.

Tables 157-159
Conclusions and decisions arising from visits to CPs in previous years

CP DEPENDINGS OF THE GENERAL SECRETARY FOR PENITENTIARY INSTITUTIONS		
DECISIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER OF AUTHORITY
Extension of video-surveillance systems.	78 (2012)	It is accepted. They will be gradually installed, depending on budgetary availability, at the oldest centres and at those in which the cost is most efficient. They have been extended at the CPs of Badajoz, Castellón, Cuenca, Madrid I, Melilla y Valladolid.
Provide the mechanical restraint cells with video-surveillance systems.	78 (2012)	Not accepted due to lack of budget availability and of personnel to view the pictures.
Supervise inmates mechanically immobilised permanently.	103 (2012)	Not accepted due to lack of sufficient human resources.
Installation of a mechanical opening system for cell doors.	159 (2011)	Not accepted, due to lack of available budget and for technical reasons.
Prepare a unified system for the collection of itemised information in case of mechanical restraints recording the identification data of the inmate, its reason, stating whether it is regimental or for healthcare, the type of immobilisation (full or partial),the personnel participating in it, the time of application and suspension, whether or not medication is used simultaneously, the timetable control of the general state and restraints applied and the vicissitudes that occur during restraint (toilet, food, etc.).	103 (2012)	It is not accepted. The data recorded in accordance with Instruction 3/2010 are considered sufficient.
Give the necessary instructions for medical actions in the case of coercive measures, serving of isolation penalty or application of article 75 of the RP to be recorded in documentary form.	103 y 110 (2012)	Accepted
CONCLUSIONS	**NO. PARAGRAPHS ANNUAL REPORTS**	**ANSWER OF AUTHORITY**
The criterion adopted in general by the SGIP in respect of the application of article 75 RP does not conform to that expressed by the Ombudsman for many years.	104 (2012)	The application of this article has been included as an aspect to be evaluated in visits made by the Penitentiary Inspectorate, to verify the degree of compliance with Instruction 3/2010.
Inclusion of photographs in injury reports.	115 (2012)	Not accepted.
Set up of electronic clinical record and connection to the network of the healthcare services.	91 (2012)	Accepted, pending budget availability.
No guidelines establishing the contents of the compulsory medical check-up in situations of isolation or application of article 75 of the RP, or the contents of the reports. Accordingly, the adequate protocol should be prepared for the medical check up to be made in these cases.	113 (2012)	Not accepted, it is not considered necessary to establish further protocols for medical check-ups in these cases, since the practice of the medical profession determines the healthcare action to be taken.
The recording and storage of the pictures captured by the video-surveillance systems does not conform to the criterion of the Ombudsman.	78 (2012)	It is accepted and an instruction regulating video-surveillance in prisons.

CP ATTACHED TO THE DEPARTMENT OF JUSTICE OF THE GOVERNMENT OF CATALONIA		
DECISIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER OF AUTHORITY
Establish at CPs a record of requests for healthcare and of appointments scheduled by the healthcare services.	87 (2012)	Not accepted. It is considered sufficient for requests for healthcare and scheduled appointments to be entered on the medical cards of the inmates.
Enable a specific protocol for initial check-up of inmates, for further uniformity in the criteria of the professionals	84 (2012)	Not accepted. The medical check-up of customary and systematic practice upon admission is considered sufficient.

CP WITH HEALTHARE SERVICE DEPENDENT ON THE DEPARTMENT OF HEALTH OF THE BASQUE GOVERNEMENT		
REMINDER OF LEGAL DUTIES	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
Reminder of the duty to complete systematically the injuries report when an injured person is assisted, pursuant to article 262 of the Criminal Procedure Law.	114 (2012)	Pending an answer from the Authority.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY
Include photographs in injury reports.	115 (2012)	Accepted.

Tables 160-172
Follow up of visits made to CPs in previous years

CP OF ALCALÁ DE GUADAÍRA (SEVILLE)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
Material increase in the occupancy of the centre.	77 (2012)	Decrease of occupancy.
Suppression of the family mediation program.	117 (2012)	It was a pilot program that should be adjusted for its implementation.
Lack of sports leaders.	120 (2012)	Accepted. Instructions are given for correction.
Suspension of the Legal Penitentiary Guidance and Assistance Service (SOAJP).	123 (2012)	Not accepted. The original agreement is terminated.
Identification of officers.	125 (2012)	It is accepted and the obligation is regularly reminded.
Lack of interphones or sound call systems from cells.	79 (2012)	Accepted. The interphone system is being remodelled.
Lack of fume detectors in cells.	159 (2011)	Not accepted, no immediately forecast installation.
* Visited in 2011 and 2012.		

CP OF A LAMA (PONTEVEDRA)*		
SUGGESTIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
Increase of clinical assistants.	90 (2012)	Not accepted.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
Notable increase in the past years of full nude searches.	100 (2012)	Body searches should be included in a more complete protocol to increase the efficacy of the measure.
Review of temperature of facilities.	131 (2012)	Accepted. Instructions are given for correction.
Stricter observation of mental state of inmates in the Suicide Prevention Program.	99 (2012)	Not accepted.
Courses on security, restraint and vital support actions.	124 (2012)	Accepted.
Training program for personnel on mental health and drug dependence.	124 (2012)	Accepted.
Review of the state of cells.	112 (2012)	Accepted.
* Visited in 2012.		

CP OF ARABA/ÁLAVA (NANCLARES DE OCA)*		
SUGGESTIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
The living conditions in the observation cells of the closed department are not acceptable.	112 (2012)	Accepted. The CP is ordered to cease to use them and the SGIP will study their use and, if appropriate, prepare a protocol to regulate their exceptional use.
Provide the centre with necessary personnel at least for its partial operation.	77 (2012)	Not accepted. The List of Post of Works is 95% filled, which is not to the detriment of the normal operation of the centre.
Remind the personnel of the CP that it is an obligation of all officers –including medical personnel – to report any abnormality or deficiency observed in the cells where coercive measures, the isolation penalty or article 75 of the RP are applied.	112 (2012)	It is accepted and a request to such effect will be sent to the Director of CP Araba/Álava.
Adopt the necessary measures for inmates who perform support or accompanying tasks to receive always specific training before performing that work.	99 (2012)	It is not accepted, it may occasionally occur that support inmates have not yet received the training course, but these inmates have the adequate profile.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
The situation of one inmate of one of the observation cells appears to respond to lack of rigueur or excessive predominance of regimental aspects over those of a healthcare nature.	112 (2012)	It is accepted and the application of limitation measures of article 75 RP is reviewed at all CPs.
The specific regimental limitations of article 75 RP do not apply.	109 (2012)	It is accepted and application of article 75 RP is reviewed.
One inmate to whom article 75 RP was being applied stated that he had not been allowed out to the yard.	108 (2012)	It is accepted and application of article 75 RP is reviewed.
Duration of the application of article 75 RP.	107 (2012)	It is accepted and application of article 75 RP is reviewed.
Instructions should be given for the validation of the medical services to be recorded in the records of application of article 75 RP.	110 (2012)	It is accepted and application of article 75 RP is reviewed.
The video-surveillance system does not conform to the criterion of the Ombudsman.	78 (2012)	Not possible due to budgetary reasons.
When fights result in injuries, the pictures of the video-surveillance system should be sent ex officio to the Court.	78 (2012)	Accepted.
Some units remain closed due to lack of personnel.	77 (2012)	Their opening is not feasible due to budgetary limitations.
Sufficient belongings should be available during transfers between centres.	127 (2012)	Instruction 6/2005 contemplates that inmates who so request will be authorised to access their luggage during transfers.
Extension of treatment programs, offer of remunerated positions and places in production workshops.	117 (2012)	The centre has programs and activities at the same level as the rest of the centres.
TV in the cell during application of article 75 RP.	108 (2012)	It is accepted and application of article 75 RP is reviewed.
Creation of a psychological consultation.	97 (2012)	All inmates are allocated a psychologist of the centre, whose functions include psychological assistance.
The Integrated Program of Assistance to the Mentally Ill (PAIEM) should continue to be developed.	94 (2012)	Accepted. The SGIP is considering guidelines and actions enabling its improvement.
Start-up of the therapy with animals.	117 (2012)	It is accepted and the necessary arrangements are being made, although no specific date to start it up.
Privacy in telephones of certain units.	122 (2012)	It is accepted. The advisability of implementation is being considered.

CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department Healthcare Basque Government)
Give the necessary instructions for medical actions in the case of coercive measures, serving of isolation penalty or application of article 75 of the RP to be recorded in documentary form.	103 y 110 (2012)	Pending answer from the Authority.
Establish adequate protocol to apply the system for urgent healthcare.	87 (2012)	A protocol of action has been prepared to refer emergency warnings from unit to healthcare professional on shift.
Increase the frequency of consultations of demand.	85 (2012)	Improvement of access to infirmary consultation is pending.
Detailed description of the type of injury suffered in injury reports.	115 (2012)	Accepted.
Direct supervision when psycho-medicines are taken.	90 (2012)	Responsible consumption of medication is encouraged and between 70 and 80 patients receive medication directly observed.
Compatibility of programs “Sánit” and “Osabide Global”	91 (2012)	Compatibility is impossible. Work is being performed to create a tool that is useful and may replace Sanit.
X-ray equipment does not work.	92 (2012)	As a faster, more efficient and safe diagnostic alternative echography machine is being implemented.
Possibility of having the Osakidetza provide inmates with psychological assistance.	97 (2012)	The Mental Health Network of Álava provides psychiatric and psychological
* Visited in 2012.		

CP OF BILBAO (BASAURI –BIZKAIA)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
The yard does not have a roofed area permitting its use in bad weather.	Tabla 36 (2011)	Not accepted for technical reasons and lack of budget availability.
* Visited in 2010.		

CP OF CASTELLÓ/CASTELLÓN *		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
Lack of interphones or sound systems to call from cells.	121 (2011)	Accepted. It is being installed.
* Visited in 2011.		

CP OF LAS PALMAS I (LAS PALMAS DE GRAN CANARIA)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
The toilets of some departments have no hot water.	158 (2011)	Accepted. The necessary actions have been performed to ensure the existence of hot water.
Video-surveillance systems.	477 (2010) 120 (2011)	Accepted. Included in the Plan for Cancellation and Creation of Penitentiary Establishments (PACEP) and referred to the Company of Penitentiary Infrastructures and Equipment for execution with priority 2 over 4.
Interphones in cells.	121 (2011)	Same.
* Visited in 2011.		

CP OF MADRID V*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
Need to provide the infirmary with a more modern echography machine in the dentist consultation.	Tabla 36 (2011)	Not considered a priority but the centre has been provided with an electro-cardiograph machine, large X-ray machines and hospital beds.
* Visited in 2010.		

CP OF MARTUTENE*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
Lack of interphones or sound systems to call from some cells.	Tabla 36 (2011)	Not accepted since a new CP is to be built.
* Visited in 2010.		

CP OF MELILLA*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
Problems of objects thrown from outside.	154 (2011)	Accepted. Concertinas are installed.
* Visited in 2011.		

CP OF THE WOMEN OF BARCELONA*		
SUGGESTIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Justice of the Government of Catalonia)
Reduce occupancy of the CP.	77 (2012)	Partly accepted. The number of inmates has been reduced and attempts are being made to improve the occupancy levels. In addition it is intended to renovate the centre.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Justice of the Government of Catalonia)
The video-surveillance system does not conform to the criterion of the Ombudsman.	78 (2012)	Accepted, will be increased when this is permitted by the available budget.
Remittance to the Court of Shift of the injury reports (article 262 LECrim).	114 (2012)	All injuries that may imply criminal conduct are reported.
More precise description of the type of injury in clinical records.	115 (2012)	Accepted. Instructions are given for correction.
Attach photographs to injury reports.	115 (2012)	Pending an answer from the Authority.
Inmates with diverse psychiatric pathologies live together in the same cell.	96 (2012)	Only when the psychiatric pathologies are not severe and do not jeopardise cohabitation in the department.
Program for the detection of suicide risk.	99 (2012)	All CPs have a protocol for the prevention of serious self-injury conducts.
Establish a program for integrated assistance of the mentally ill.	94 (2012)	When necessary the inmates are referred to the specialised psychiatric assistance units of the public network or the penitentiary system.
Set up a psychological consultation.	97 (2012)	The centre has a service providing psychological assistance on demand or in emergencies.

CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Justice of the Government of Catalonia)
Informative forms on basic matters of the CP in various languages.	80 (2012)	Translation mechanisms and intercultural mediators are available when necessary.
Simultaneous translation system.	80 (2012)	Translation mechanisms and intercultural mediators are available when necessary.
Lack of sports leader.	120 (2012)	Accepted, provisionally covered with volunteers.
Problems in telephone communication with Dominican Republic and Nigeria.	122 (2012)	Accepted, resolved in the case of the Dominican Republic and attempts are being made for resolution for Nigeria.
Works necessary for maintenance of the centre pending budgetary availability.	131 (2012)	The necessary works for showers and roof have been performed.
Temperature should be evaluated.	131 (2012)	The centre has heating and air conditioning in the main areas.
Measures should be adopted for shower water temperature to be adequate.	131 (2012)	The maintenance services review the water temperature regularly and are studying structural solutions to find a final solution.
* Visited in 2012.		

CP OF MURCIA II *		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
The video-surveillance system does not conform to the criterion of the Ombudsman.	78 (2012)	Accepted, pending budget availability.
Various officers did not wear their badge.	125 (2012)	Accepted and instructions are given for correction.
Lack of personnel causes 4 units to remain closed.	77 (2012)	Not accepted. Lack of budgetary availability.
Injury reports should describe the injuries more adequately and include photographs.	115 (2012)	Not accepted.
Lack of development of PAIEM.	94 (2012)	Accepted.
Specific scales should be used on a routine basis to evaluate the risk of suicide in the check-up made upon admission of the inmate to the centre.	99 (2012)	Accepted.
It would be advisable to implement telemedicine.	88 (2012)	Arrangements are made with the Sub-Directorate General for Information Technologies of Murcia Autonomous Community for its implementation.
Set up a record of requests for healthcare.	87 (2012)	Accepted.
Extension of the agreement for attendance of a medical practitioner specialised in internal medicine.	86 (2012)	Accepted.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General for the Civil Guard)
During the visit the opportunity was afforded to attend the reception of inmates for transportation, and it was verified that two civil guards were not identified.	26 (2012)	Not accepted.
* Visited in 2012.		

CP OF OCAÑA II (TOLEDO) *		
SUGGESTIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
Provide the CP with the necessary fire detection and extinguishment items.	131 (2012)	Accepted and expressly contemplated in the Plan for Cancellation and Creation of Prisons.
Video-surveillance systems.	477 (2010) 120 (2011)	Not accepted due to lack of budgetary availability.
Adaptation and improvement of maintenance of cells of unit 7.		Pending an answer.
Location of showers in unit yards		Pending an answer.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
In notifications to the Penitentiary Surveillance Judge the specific reasons for the adoption of measures pursuant to article 75.1 RP are not correctly specified.	105 (2012)	Accepted and the appropriate instructions have been given to the Management.
The use of article 75.1 RP when a cell phone is confiscated from an inmate does not appear to be founded.	105 (2012)	Accepted and the appropriate instructions have been given to the Management.
Application of article 75.1 RP at this CP does not appear to conform to the exceptional application that should preside over the use of this measure.	106 (2012)	Accepted and the appropriate instructions have been given to the Management.
The duration of the application of article 75.1 RP should be reviewed.	107 (2012)	Accepted and the appropriate instructions have been given to the Management.
In cases in which regimental limitations had a duration or one day or a few hours, their grounds are not understood.	107 (2012)	Accepted and the appropriate instructions have been given to the Management.
The application of article 75.1 RP gives rise to a living regime similar to that of isolation penalties or the closed regime.	108 (2012)	Accepted and the appropriate instructions have been given to the Management.
The specific limitations arising from the application of article 75.1 RP are not specified in the notification to the judge or in any of the notifications to the interested parties.	109 (2012)	Accepted and the appropriate instructions have been given to the Management.
The necessary measures should be adopted to reduce the number of times when it is necessary to apply article 75. 2 RP.	111 (2012)	Accepted and the appropriate instructions have been given to the Management.
The long duration of application of article 75.2 RP could mean that the necessary measures have not been adopted with the required diligence.	111 (2012)	Accepted and the appropriate instructions have been given to the Management.
The use of provisional isolation in the centre should be reviewed.	102 (2012)	Accepted and the Management of the centre has been requested to extreme strict compliance with the law in the use of coercive measures.
One case was observed in which a notice to the Penitentiary Surveillance Judge only records the isolation provisional isolation and mechanical restraint with belts but not physical force.	102 (2012)	Accepted and orders are given to correct this action in future.
The records do not state the precise time at which medical control is performed in the case of mechanical restraints.	103 (2012)	Accepted and instructions have been given to the medical services.
Inconsistency is observed between the medical report and the injection of medicines in an inmate.	103 (2012)	The inmate, given his pathology, requires treatment in the case of anxiety.
The reference hospital does not have beds with restricted access and police surveillance for patients with a psychiatric pathology.	95 (2012)	This need was discussed in the negotiation of healthcare cooperation agreements with the Board of Communities of Castile-La Mancha.
Instructions should be given relating to the extraction and keeping of pictures of incidents.	78 (2012)	Accepted and pending a report on the protocol to regulate the recording and storage of pictures.

CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
The cells of unit 3 do not have interphones.	79 (2012)	Accepted and contemplated expressly in the Plan for Cancellation and Creation of Prisons.
The water of the showers of unit 7 is cold.	131 (2012)	Accepted and broken parts have been replaced.
The prices of the store are between 20% and 30% higher than those outside the centre.	126 (2012)	The price of some products have been reduced and in others instructions have been given for products with cheaper prices to be available.
* Visited in 2012.		

CP OF TENERIFE II*		
SUGGESTIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
Adopt the measures necessary for cells to comply with the criterion of the Ombudsman.	155,157 y 158 (2011)	Video-surveillance systems are being installed in the units, the heating and hot water needs will be met. However, it is not feasible to make the cells larger.
* Visited in 2011.		

3.2. Prison Psychiatric Hospitals

Tables 173-174
Conclusions of visits to prison psychiatric hospitals made in 2013

FACILITIES VISITED: HPP of Seville

DATE OF VISIT: 24, 25 and 26 June 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: the Ombudsman, two technical experts of the Ombudsman's Office and three external technical experts, two psychiatrists and one psychologist.
PURPOSE OF THE VISIT: During the visit, the management, the medical team, various members of personnel and a significant number of inmates were interviewed. In addition, the facilities were inspected, the record books, personal records and clinical records were examined, and special attention was given to the psychiatric and therapeutic assistance given to the inmates.
RESPONSIBLE AUTHORITY: Secretary General for Penitentiary Institutions

CONCLUSIONS		
GENERAL	STATUS	ANSWER AUTH.
The executive organisational structure has not been improved.	Rejected	
The social work department should be able to make visits for preparation of exit and accompanying of patient in the social reinsertion process.	Rejected	Unfeasible given the number of social workers and economic costs of the visits. Nevertheless work is performed in coordination with external social services.
The planned improvements in respect of the increase of psychologists and occupational therapists have not been made.	Rejected	

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
RECOMMENDATION	Adopt the necessary measures to provide the organisational structure with a healthcare nature for the centres to be more similar to hospital institutions.	Pending	
RECOMMENDATION	Reinforce the preparation of the exit and follow up of patients who are released.	Pending	
RECOMMENDATION	Increase healthcare personnel, to reinforce the actual possibilities of performing individual actions and rehabilitation activities.	Accepted not performed	Pending budget availability.

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.
Lack of activities most of the day.	Rejected	To extend the timetable would interfere in other healthcare actions.
The number of rehabilitation activities should be increased and included in an individual plan.	Rejected	
It would be advisable to establish a system permitting therapeutic measures to be differentiated from disciplinary measures.	Rejected	All actions affecting restrictions of patients are of a therapeutic nature.
Excess occupancy of 30%.	Rejected	Scarce external resources exist to continue assistance of mentally ill patients
An individual plan for action with patients should be implemented.	Accepted	
The budget for therapeutic outings has been reduced.	Rejected	The current budget permitted a high level of outings to be maintained.
The information delivered to patients should be available in various languages.	Accepted not performed	Pending budget availability.
Regimental isolation measures should be included in a more global plan and recorded in the individual action plan.	Accepted not performed	Will be studied.
In notices to the penitentiary surveillance judge of healthcare isolations, it would be advisable to provide in-depth explanations of the need to adopt the measure.	Accepted not performed	Will be discussed with medical practitioners (increase of actions).

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Reconsider timetable of activities and reinforce them, particularly those with greater rehabilitation potential.	Pending	
SUGGESTION	Extent rehabilitation activities.	Pending	
SUGGESTION	Give the appropriate instructions for measures that are adopted, in the case of violation of living rules, to follow the adequate procedures for the adoption of therapeutic measures.	Pending	
SUGGESTION	Consider alternatives or strategies in respect of the current situation of excessive occupancy and deficiencies of the facilities	Pending	

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
When one patient attacks another, together with the injuries report, a report should be remitted recording the mental state.	Accepted					
The existence of an own vehicle of the centre would permit activities and outings.	Rejected	Availability of an own vehicle of the centre is not contemplated given the administrative, technical and personal difficulties.				
The doses and combinations of medication of patients should be reviewed.	Accepted	Instructions have been given to the psychiatrists.				
Certain healthcare technical means that would be advisable are lacking.	Accepted, not performed	A report has been requested from the new medical deputy director of the centre, on needs of this type of technical means.				
Few programs for chronic patients.	Accepted, not performed	The situation will be reviewed.				
It would be advisable to consider the possibility of adopting a suicide prevention program such as the standard program of the SGIP.	Rejected	The suicide risk protocol existing at the hospital has been adapted to the features of the psychiatric patients, with adequate follow up and control of patients by the psychiatrists and ancillary personnel.				
The facilities are not accessible.	Accepted, not performed	Performance will be considered if technically feasible.				
The use of yards and gardens should be optimised.	Accepted, not performed	A report on the feasibility of setting up a solar protection system in both HPPs has been requested.				
The sports facilities should be structured in a manner such that they may be used for rehabilitation of patients.	Rejected	The sports facilities are used on a daily basis by those patients who express their interest in practicing sports.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Food was negatively valued by the interviewed inmates.	Accepted, not performed	Orders have been given to the new deputy medical director for greater supervision of the quality of the rations.				
In transfers the patient remain in transit through various prisons for several days or weeks until arriving at destination, which is not adequate for persons with a mental disease.	Rejected	In the most serious cases, in which the medical services do not advise ordinary transportation, special and direct transportation is used (Extension of actions).				
Make progress in the channel open by the protocol for referral of patients to the Mental Health public network by agreement between the SAS, FAISEM and the HPP.	Accepted, not performed	It is forecast to call the Committee of Analysis of Cases of mentally ill patients submitted to court proceedings of the Autonomous Community of Andalusia for it to assemble shortly to make progress in this field				
It would be advisable for an agreement to be reached for the professionals of the centre to be able to access the clinical information of the Healthcare Service of Andalusia (SAS).	Accepted, not performed	This matter will be emphasized at the next meeting of the steering committee of the agreement between the SGIP and the Healthcare Service of Andalusia.				
Lack of coordination between the teacher and the rest of professionals of the multidisciplinary team.	Accepted					
The section of programs for action is not completed in the decision to remit the report on the situation to the penitentiary supervision judge.	Accepted	The individual action program will be included.				
The facilities have deficiencies that are difficult to correct in the current location.	Rejected	The purpose is to mitigate the architectural limitations with the individual assistance and the existing procedures.				
It would be desirable for the various functions assumed by unit 2 to have specific space and resources.	Rejected	This is not possible given the current level of occupancy.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The possibility of including another professional to provide better education to patients of the HPP should be considered.	Rejected	The workforce of teachers has not been increased since students have only recently increased, notwithstanding the fact that depending on the evolution of the demand, the possibility of a certain increase of teaching personnel in this section may be considered.				

GOOD PRACTICES
The training courses for personnel carried out regularly, in accordance with the Strategic Action Plan for Prison Psychiatric Hospitals.
The assignment and management of rooms and colleagues in residential units makes the best of the available resources.
The procedure of the Protocol for referral of patients to the Metal Health public network by agreement between the SAS, FAISEM and the HPP is an important step taken.
Most interviewed inmates valued the professionalism and treatment of the healthcare and other personnel very favourably.
The interviewed family relatives valued the centre very positively.
The coercive measures are used by exception and for a very limited time and are duly recorded in documentary form and reported to the penitentiary supervision judge.

FACILITIES VISITED: Prison Psychiatric Hospital and psychiatric infirmary of CP Brians 1 (Barcelona)

DATE OF VISIT: 7, 8 and 9 October 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office and one external technical expert (psychiatrist).
PURPOSE OF THE VISIT: During the visit, the management, the medical team, various members of personnel and patients were interviewed. In addition, the entire facilities were inspected, the record books, personal records and clinical records, among other documents, were examined and special attention was given to psychiatric and therapeutic assistance provided to inmates.
RESPONSIBLE AUTHORITY: Departments of Justice and Health of the Government of Catalonia. Management under responsibility of the Mental Health Services of Parc Sanitari Sant Joan de Déu

CONCLUSIONS			DECISIONS			
GENERAL	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Very limited space, adequate for short stays but not for stays of months or even years.	Rejected		SUGGESTION	Adopt the measures necessary to correct the limited space of the facilities.	Rejected	Patients have access to services and departments of the entire CP Brians 1.
It would be advisable to review the protocols for restraints and unify criteria.	Rejected	The various protocols arise from the different objectives of the measure.	SUGGESTION	Complete the forms of adoption of the mechanical restraint measure adequately.	Rejected	All compulsory information is sent to the judge.

CONCLUSIONS		
GENERAL	STATUS	ANSWER AUTH.
All the sections of the forms remitted to the penitentiary surveillance judge reporting the mechanical restraint of a patient should be completed.	Rejected	
The communication of rules should be improved and their arbitrary application should be avoided.	Rejected	
Certain rules of the unit should be reconsidered.	Rejected	The health and safety conditions of the UHPP-C arise from the features of the mentally ill patient in the penitentiary context.
It would be advisable to establish a system of complaints to the director ensuring their confidentiality.	Rejected	Patients may send complaints in closed envelopes.
The rehabilitation programs and psychotherapy actions should be reinforced.	Rejected	

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Adopt the measures necessary to improve communication on the meaning and logic of the rules of the UHPP-C.	Rejected	The logic and meaning of the rules is explained to patients on admission.
SUGGESTION	Reinforce rehabilitation and psychotherapy activities.	Rejected	

GOOD PRACTICES
A small size network of resources permits adapted programs to be prepared, to work on social reinsertion and to prevent the patient from losing contact with the environment.
The Alternative Criminal Measures Service that specifically monitors the follow up of these measures.
According to the healthcare nature of the centre, is actually the healthcare personnel that makes key decisions on patients.
The risk assessment protocols.
The pilot experience of the CAS for assistance to drug addictions of CP Brians-1.

Tables 175
Follow up of visits made to HPPs in previous years

PRISON PSYCHIATRIC HOSPITAL OF FONTCALENT (ALACANT/ALICANTE)*		
SUGGESTIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)
Provide women's unit with electrical thermos with sufficient capacity	158 (2010)	Accepted. Pending budget availability.
* Visited in 2011.		

3.3. Centres for young offenders

Tables 176-181
Conclusions of visits made to centres for young offenders in 2013

FACILITIES VISITED: Centre for therapeutic custody of young offenders Montefiz in Ourense

DATE OF VISIT: 15 and 16 October 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office and two external technical experts (one psychiatrist and one psychologist).
PURPOSE OF THE VISIT: During the visit, the management, the technical team and workers of the centre were interviewed. Confidential interviews were held with certain inmates and questionnaires were completed by all inmates. The facilities were inspected, the record books, personal and disciplinary records, application of restraint measures and healthcare provided to inmates were examined.
RESPONSIBLE AUTHORITY: Department of Labour and Welfare of the Government of Galicia

CONCLUSIONS			RESOLUCIONES			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The centre is in an isolated place, which hinders and jeopardises pedestrian access.	Rejected	It is the best option within the budgetary availabilities of the Authority.				
Minors are not informed of the possibility of instituting habeas corpus proceedings.	Rejected		SUGGESTION	Minors are not informed of the possibility of instituting habeas corpus proceedings.	Pending	
The video-surveillance system does not conform to the criteria of this Institution.	Accepted, not performed	When permitted by the budget availability.				
No videoconference system exists at the centre permitting certain formalities to be carried out with Young Offender Courts and Public Prosecution.	Accepted	The necessary arrangements are being made to install it.				
The centre does not have a suicide prevention protocol.	Accepted					

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The medical practitioner, psychiatrist and nurse are not included on the payroll of the centre.	Rejected	This is not detrimental to the healthcare provided and the medical practitioner is available 24 hours for emergencies.				
The psychiatrist is not included as a reference in therapeutic actions with minors.	Rejected	He participates in the meetings of the clinical team.				
The electronic register of disciplinary records does not permit statistics to be obtained.	Accepted	The Directorate General for Family and Inclusion has an electronic record that permits statistic operation. This is also the case of the annual reports of the Centre.				
The record does not state the possibility of reduction of penalty for good behaviour of the minor.	Accepted					
The lawyers of the young offenders are not informed of the decisions in the disciplinary proceedings.	Accepted					
No copies of complaints and requests made by minors are delivered.	Accepted	It is remedied and will be included in the update of Circular 12/2008, of 16 May.				
The room for application of the provisional isolation measure does not meet the minimum living conditions.	Accepted					
The duration of a situation of isolation should not exceed six hours and the minor should be accompanies or supervised by an educator during that time.						
Al the rooms of Unit 1 should have minimum furniture.	Accepted					
Some rooms do not have sound call systems.	Accepted not performed	It will be taken into account for future improvements.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The doors to the rooms do not have mechanical opening systems.	Accepted not performed	It will be taken into account for future improvements.				
The security system used on the windows of Unit 1 permits little natural light to enter.	Accepted					
No food samples are kept.	Accepted	This practice has been included in the routine of the centre.				

GOOD PRACTICES
The treatment given by the director and tutors to young offenders is professionally adequate.
The effort of the various professionals to keep good standards of internal coordination holding weekly meetings of the various teams is to be pointed out.
The involvement and commitment of psychologists to understand and support the adaptation of minors in the centre.
It was verified that all formalities were entered in the reviewed disciplinary records.
The formalities of the disciplinary records are immediately reported to the responsible court and public prosecution.

FACILITIES VISITED: Centre for young offenders of Sograndio (Asturias)

DATE OF VISIT: 10, 11 and 12 June 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office and one external technical expert psychologist.
PURPOSE OF THE VISIT: During the visit, the management, the workers of the centre, the psychiatrist and the psychologist were interviewed. Confidential interviews were held with certain inmates and questionnaires were self-completed by all inmates. The facilities, particularly the therapeutic unit, were inspected, the record books, personal and disciplinary records and the application of restraint measures and healthcare provided to inmates were reviewed.
RESPONSIBLE AUTHORITY: Department of Presidency of the Principality of Asturias

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The dossier of information provided on admission of the minors, given its terms, is not adequate for the training level or knowledge of the Spanish language of many of the inmates so that this written information not only does not encourage inmates to read it but also hinders its understanding.	Accepted	Educators explain all the articles to the minors in the specific interviews.				

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.
The centre keeps the register of personal records of minors released in 2010 and 2011.	Accepted	Filed as established by law.
Video-surveillance and recording system even in rooms used for provisional isolation.	Accepted	Instructions are given for correction.
No free legal assistance to minors.	Accepted	Instructions are given for correction.
No videoconference system.	Rejected	Lack of budgetary availability.
The centre does not have a program of phases or progress.	Accepted	Inmates are distributed in accordance with the criterion established by law.
No book of complaints and requests or standard forms.	Accepted	Instructions are given for correction.
No specific record of restraint measures.	Accepted	An electronic record has been created.
The report does not record the duration of the provisional isolation measure.	Accepted	The disciplinary record states the duration of the provisional isolation measure.
No protocols exist for simultaneous use of restraint measures, such as physical restraint, mechanical restraint and provisional isolation.	Accepted	Instructions are given for correction.

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Installation of video-surveillance cameras inside rooms used for provisional isolation to be able to supervise the manner in which the restrain measure was applied and its duration.	Accepted not performed	It will be taken into account when budgetary availability so permits.
SUGGESTION	Place on record, in reports issued on application of provisional isolation measure as means of restraint of minors, the duration of the measure	Accepted	Instructions are given for remedy.
SUGGESTION	Establish protocols for simultaneous use of measures of restraint, such as physical restraint, mechanical restraint and provisional isolation.	Accepted	Remedied.

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The restraint processes are carried out by security personnel in the absence of an educator	Accepted	Whenever possible the educator participates although this is not always possible for service organisation reasons.				
No record is included in the dossier of the possibility of reduction of penalty for good behaviour of the minor.	Accepted	Instructions are given for correction.				
Excessive use of the disciplinary penalty of separation from the group for very serious or serious misdemeanours.	Accepted	Alternative systems are used such as deprivation from weekend releases, deprivation of recreational outings and deprivation of participating in recreational activities.				
Separation times that exceed by far the maximum 7-day period.	Accepted	An hourly interval of at least twelve hours between the end of the first penalty and the commencement of the second is allowed				
Enjoyment of free time for two hours in situation of separation that commences compulsorily at 8.00 h.	Accepted	They may enjoy free time in the afternoon if they did not do so in the morning.				
Personal and room searches carried out by security personnel without presence of other personnel of the centre.	Accepted	When the personnel organisation so permits an educator is present.	SUGGESTION	Ensure that personal, property and room searches are always made in the presence of an educator or coordinator.	Accepted	Remedied.
Rooms or booths for separation have a squat toilet. Bad odour is caused.	Accepted	Instructions are given for correction.				
Temperature in the booths.	Accepted	Instructions are given for correction.				
The rooms to the doors do not have a mechanical opening system.	Rejected	Not considered necessary because calls on the doors are attended.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Room do not have sound call systems.	Rejected	Not considered necessary, because knocks on the door are attended.				
Lack of a position of coordinator and office assistant on the payroll of the centre.	Accepted	Both positions have been created.				

GOOD PRACTICES
It was verified that all formalities of disciplinary records are fully recorded and that they are diligently processed.

FACILITIES VISITED: Centre for young offenders Las Lagunillas in Jaén

DATE OF VISIT: 2 and 23 April 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office and one external technical expert psychiatrist.
PURPOSE OF THE VISIT: During the visit, the management, the medical team and a significant number of inmate were interviewed. The facilities were inspected, the record books, personal and disciplinary records and the application of restraint measures and healthcare provided to inmates were reviewed.
RESPONSIBLE AUTHORITY: Department of Justice and Interior of the Government of Andalusia

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Minors are not informed of the possibility of instituting habeas corpus proceedings.	Rejected		SUGGESTION	Minors are not informed of the possibility of instituting habeas corpus proceedings.	Accepted	Instructions are given for information to be provided.
The centre does not have a specific book to record restraint measures.	Rejected		SUGGESTION	Record in the reports on the application of restraint measures, whenever a measure of provisional isolation is applied to a minor, and in a specific record of restraint measures.	Accepted	
The video-surveillance system does not conform to the criteria of this Institution.	Accepted, not performed	When permitted by budgetary availability.				
The personal records should not be kept filed at the centre when the minors are released.	Accepted	An Instruction is being prepared to regulate the referral of the records to the responsible Delegations of Government.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Restraint measure reports do not record the provisional isolation.	Accepted	Recorded in the record and electronic system of the centre.				
Some rooms do not have sound call systems.	Accepted, not performed	When permitted given budgetary availability.				
Manage vocational training courses with official qualifications.	Rejected	No calls have been published.				

GOOD PRACTICES
It was verified that all formalities of disciplinary records were perfectly recorded and diligently processed.
It was observed that the use of the videoconference system with young offender course was well used.
Notices made to the court or public prosecution record in detail the facts and grounds on which it was decided to adopt a restraint measure.

FACILITIES VISITED: Centre for young offenders Monteledo in Ourense

DATE OF VISIT: 16 and 17 October 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office and two external technical experts (one psychiatrist and one psychologist).
PURPOSE OF THE VISIT: During the visit, the management, the workers of the centre, the psychiatrist and the psychologist were interviewed. Confidential interviews were held with certain inmates and questionnaires were self-completed by all inmates. The facilities, particularly the therapeutic unit, were inspected, the record books, personal and disciplinary records and the application of restraint measures and healthcare provided to inmates were reviewed.
RESPONSIBLE AUTHORITY: Department of Labour and Welfare of the Government of Galicia

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The centre is located in an isolated spot hindering and jeopardising pedestrian access.	Rejected	It is the best option within the budgetary availabilities of the Authority.				
Young offenders are not provided with a personal copy of the internal regulation.	Accepted	Oral and written information on the Internal Regulations is provided.				
Minors are not informed of the possibility of instituting habeas corpus proceedings.	Rejected		SUGGESTION	Minors are not informed of the possibility of instituting habeas corpus proceedings.	Pending	

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted, not performed	When so permitted by budgetary availability.				
Some rooms are provided with a bed anchored to the floor, without any other furniture, and a window with inner bars that could facilitate attempts of self-injury or suicide.	Accepted					
The centre does not have a videoconference system to facilitate certain processes with the Young Offenders Courts and Public Prosecutions.	Accepted	The necessary arrangements are being made for its installation.				
No copies of complaints and requests filed by minors are delivered.	Accepted	Remedied and will be included in the update of Circular 12/08 of 16 May.				
The records of the minors, after they are released, are destroyed, but the documentation that is destroyed is not controlled.	Accepted	The necessary amendments were made for the destroyed documentation to be recorded and to ensure confidentiality of the records.				
No restraint protocol or crisis protocol is available.	Accepted					
The centre has a suicide prevention protocol but not all personnel are acquainted with it.	Accepted					
No nursing personnel are available.	Rejected	Not compulsory which was the reason for which it was not included in the terms of tender.				
Not all records of all inmates are available and clinical records are prepared using the same format.	Accepted					

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
No tutor position exists and the current distribution of resources and duties of each professional means that the main task of educators is not education.	Accepted					
In case of a serious or very serious misdemeanour a semi-isolation measure is applied that is not reported to the judge.	Accepted					
Reports on the application of restraint measures do not record provisional isolation.	Accepted					
The rooms do not have sound call systems.	Accepted, not performed	Will be taken into account for future improvements.				
The doors to the rooms do not have mechanical opening systems.	Accepted, not performed	Will be taken into account for future improvements.				
Free legal assistance to minors is practically nil.	Rejected	Not the responsibility of the centre but means are provided for this to be done.				
The lawyers of the minor inmates are not informed of the decisions of disciplinary proceedings imposing the penalty of separation from the group.	Accepted					

GOOD PRACTICES
The treatment given by the director to young offenders is professionally adequate.
The involvement and commitment of psychologists to understand and support the adaptation of minors to the centre is to be pointed out.
It was verified that all formalities were perfectly recorded in the reviewed disciplinary records. An electronic program exclusively for disciplinary records exists.
The formalities of disciplinary proceedings are immediately reported to the responsible court and public prosecutor.

FACILITIES VISITED: Regional Centre for Minor and Young Offenders Albaidel, in Albacete

DATE OF VISIT: 11 December 2013 (unannounced) VISITING TEAM: Two technical experts of the Ombudsman's Office.
PURPOSE OF THE VISIT: Obtain information on the death of a minor and verify whether the deficiencies observed in previous visits had been remedied. For such purpose, interviews were held with minors and personnel of the centre, the personal and clinical record of the deceased minor were reviewed, the room where death took place was inspected and a copy of the recordings made by the security cameras were requested.
RESPONSIBLE AUTHORITY: Department of Healthcare and Social Affairs of the Government of Communities of Castile-La Mancha

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
			SUGGESTION	Ensure that a medical check-up is performed within the first 24 hours of admission of a minor.	Accepted	This is customary practice. Otherwise, the management of the centre will inform the responsible body to adopt the necessary measures for performance of this obligation.
			SUGGESTION	Remove the video-surveillance cameras installed in two family visit rooms, since they violate the right to personal and family privacy.	Rejected	These places are exposed to the passing of prohibited substances and unauthorised objects by the families of the minors and would imply serious risk to their own safety and that of other inmates.

FACILITIES VISITED: Therapeutic unit of the centre for young offenders Els Til·lers, in Mollet del Vallès (Barcelona)

DATE OF VISIT: 12 and 13 December 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office, two external technical experts (psychiatrists) and two members of the Advisory Council.
PURPOSE OF THE VISIT: During the visit, the director of the centre, the management and workers of the therapeutic unit were interviewed. Confidential interviews were held with all the inmates and they self-completed questionnaires. The facilities were inspected, the record books, personal records and application of restraint measures and healthcare provided to inmates were reviewed.
RESPONSIBLE AUTHORITY: Departments of Justice and the Interior of the Government of Catalonia

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The nature of these facilities should be clearly defined and the governing regulation should be finally approved.	Accepted	It engages exclusively in providing assistance to minors interned decision of young offender judges in the context of Basic Law 5/2000.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The disciplinary regime contemplated by Basic Law 5/2000 is not applied.	Rejected	Not applied based on the exception of article 59.3 of Royal Decree 1774/2004.	SUGGESTION	Request the court authority, in those cases in which minors are admitted under the non-therapeutic custody regime, of the change of measure to therapeutic custody, pursuant to Basic Law 5/2000.	Accepted	Procedure currently as suggested.
The restraint measures adopted at the Therapeutic Unit are not reported to the Young Offenders Judge and cannot be appealed.	Accepted	The Therapeutic Unit has been requested not to use for internal purpose, or when preparing statistics, the same terminology used by LO 5/2000, to define restraint measures, to avoid confusion.				
No copies of complaints and requests of minors are delivered. Neither are they notified in writing of the answer given by the management.	Accepted	The management of the centre was reminded of the need to comply with the Circular of the Directorate General for Criminal Execution to the Community and Juvenile Justice, which contemplates delivery of a copy.				
No specific record of restraint measures is kept.	Accepted	The restraint measures, reasons for their use and application and reporting procedure are those established by the law and the regulation and are always reported to the judge. The therapeutic accompanying regime applied to some minors provisionally and individually are not measures of restraint and are unrelated to them.	SUGGESTION	Create a specific register of measures of restraint recording all measures used, whether mechanical restraint, personal constraint, separation from the group or provisional isolation, the duration of the measures and the reasons for which they were used, for them to be reported in their entirety to the judge and to the Young Offenders Public Prosecutor, regardless of the internal names given to such restraint measures.	Accepted	Register exists.

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The doors to the rooms do not have mechanical opening systems.	Rejected	Not considered necessary because rooms have internal buzzer system and interphone and there is a closed camera circuit.				
No samples are kept of food provided for the time established by law.	Accepted	The concessionaire of the new service keeps samples of all meals served.				
Frequently used medicines are in sight, with easy free access.	Accepted	Medical personnel has been notified or instructions to make proposals of necessary correction measures to remedy these deficiencies.				
Further participation of minors in self-care.	Accepted	Instructions have been given for formulas to be considered enabling greater autonomy in these aspects.				
Lack of occupational and vocational workshops and of specific labour training given by specialised personnel.	Rejected	The provisional nature of the stay together with the psychiatric situation and corresponding difficulty to handle tools or instruments led to its being considered unnecessary to have these workshops.				
The officers of the security forces and corps, responsible for transportation of minors, wear the official uniform, and the vehicle used bears the official signs.	Rejected	The uniforms of the officers and use of the distinctive signs increases the protection of minors and does not compromise their self-respect or safety or privacy.	SUGGESTION	Give appropriate orders for transportation of minors to departments or processes outside the centre is carried out by officers of the Mossos d'Esquadra not wearing a uniform and in vehicles without distinctive signs.	Pending	

GOOD PRACTICES
The professionals have good training with profiles specialised in attending the target population. True multidisciplinary team work is performed with good coordination within the Therapeutic Unit.
All admissions are correctly indicated from the psychiatric point of view. No abuse of psychiatric medication appears to exist, when it is indicated explaining the indication to the inmate, with special work on motivation and adherence to treatment, respecting the will of the recipient.

Tables 182-186
Follow up of visits made to centres for young offenders in previous years

CMI "ALBAIDEL" (ALBACETE)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary of State for Justice)
(R) Reform of section two of article 76 of R.D. 1774/2004, of 30 July.	175 (2011)	Accepted. Work is to start on considering inclusion in the Regulation.
*Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL).		
* Visited in 2011 and 2013.		

CMI "LAS PALMERAS" (MADRID)*		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Presidency, Justice and Spokesman of Government Madrid Autonomous Community)
Minors are forbidden to speak between themselves of certain matters.	157, 262 (2012)	Accepted. The members of the educational team participate from an educational position.
Free right of minors to communicate.	157, 262 (2012)	Accepted.
The centre is lacking an electronic register of disciplinary records, of the application of restraint measures and of body searches.	154 (2012)	Accepted. Instructions are given for correction.
Prior information on mental health.	160, 262 (2012)	Accepted. Minors admitted to the centre are evaluated by the professional of the medical service within a term of not less than 24 hours.
Residential resource for minors who leave the centre aged over 18 years old.	161 (2012)	Accepted. It is ensured that an appropriate resource is assigned before end of the custody measure.
* Visited in 2012.		

CMI "PI GROS" (CASTELLÓ/CASTELLÓN)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary of State for Justice)
(R) Reform of second section of article 76 of R.D. 1774/2004, of 30 July.	175 (2011)	Accepted. Work is to start on considering inclusion in the Regulation.
*Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL).		
** Visited in 2011.		

CMI "TERESA DE CALCUTA" (MADRID)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Presidency, Justice and Spokesman of Gov. of Madrid Autonomous Community)
(S) Establish protocols for simultaneous use of measures of restraint, such as physical constraint, mechanical restraint and provisional isolation.		Accepted. A protocol of action is prepared
(S) Include, among the information provided to minors upon their admission to the centre, that relating to cases in which a person deprived of liberty may request a habeas corpus proceeding.	147 (2012)	Accepted.
(S) Make body searches always in the presence of an educator and with the participation of healthcare personnel, if in addition the cavities of the inmate are explored.	153 (2012)	Accepted.

CONCLUSIONS	No. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Presidency, Justice and Spokesman of Gov. of Madrid Autonomous Community)
Video-surveillance system.	142 (2012)	Accepted
In rooms for separation from the group, the bed has metal borders, which may be cause serious self-injuries.	152 (2012)	Not accepted. It is considered more hazardous to the physical safety of the minor and of the personnel of the centre for the bed to be loose.
Lack of documentation of foreign minors and young persons.	148 (2012)	Accepted. Aware of the relevance of regularizing in documentary form minors serving a custody measure.
Book of complaints.	150 (2012)	Accepted. The advisability of creating a complaints book will be considered.
Record book of body searches.	153 (2012)	Accepted. The advisability of creating a complaints book will be considered. Accepted. The advisability of setting up a complaints book will be considered.
Educational corrections.	155 (2012)	Accepted. They are recorded in the Book kept for the purpose at each of the Units of the Centre.
The centre is attended by a medical practitioner not included in the general healthcare network of Madrid Autonomous Community.	159 (2012)	Not accepted. The entity responsible for management of the Centre does not have decision-making capacity on this matter.
The centre is lacking vital reanimation or support means.	159 (2012)	Not accepted. The Centre has urgent cases and emergencies equipment.
The psychiatrist is not actively and frequently included as a referring party in therapeutic actions with minors.	160 (2012)	Not accepted. The Centre has 2 psychiatrists, one devoted solely and exclusively to the Therapeutic Unit
Therapeutic custody.	160 (2012)	Not accepted. Own criteria have been established that are of use to consider whether the adoption or maintenance of a measure of therapeutic custody is advisable or necessary.
Specific unit for offenders with a minor-moderate mental disability.	162 (2012)	Not accepted. The possibilities of evaluation and action through multi-disciplinary teams, the flexibility when adjusting the therapeutic objectives individually and the possibilities afforded by the mental health Unit to adapt the procedure of the various activities to the capabilities of the minor, enable and adequate and specialised action in cases of minors with mental disabilities.
CONCLUSIONS	No. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Presidency, Justice and Spokesman of Gov. of Madrid Autonomous Community)
Double-view mirrors in visit rooms.	158 (2012)	Not accepted. The existence of a double mirror enables communication to be conducted as if in another surrounding, in other words, using as a reference life in liberty.
*Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL).		
** Visited in 2012.		

CMI "ZAMBRANA" (VALLADOLID)**		
DECISIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Presidency Government of Castile and Leon)
(S) Informative Guide on the rules of the centre.	146 (2012)	Accepted. Instructions are given for correction.
(S) Information on rights and obligations in various languages.	146 (2012)	Accepted. The guide will gradually be published in other languages.
(S) Notice to the lawyer of the disciplinary penalty.	156 (2012)	Not accepted.
(S) Video-surveillance system.	142 (2012)	Accepted. Will be included as a criterion to be evaluated for award in the next invitation to tender for the surveillance contract.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Family and Equal Opportuniites Gov. of Castile and Leon)
Habeas corpus.	147 (2012)	Accepted.
Personal records.	143 (2012)	Not accepted.
Notice of admission if minor is a foreign national.	148 (2012)	Accepted.
Book of restraint measures and provisional separation.	151 (2012)	Accepted.
Excessive term for institution of disciplinary proceedings after date of misdemeanour.	154 (2012)	Accepted.
Anxiety crises treated as disciplinary misdemeanours.	152 (2012)	Not accepted.
Differentiation of the Therapeutic Custody Unit.	160 (2012)	Not accepted.
Therapeutic interment by judgment.	160 (2012)	Not accepted.
No differences in action with a minor for therapeutic custody from any other.	160 (2012)	Not accepted.
Benefits of therapeutic custody beyond admission.	160 (2012)	Not accepted.
Fragmented and little coordination in actions of professionals of the centre.		Not accepted.
*Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL).		
** Visited in 2012.		

3.4. Social healthcare centres

Tables 187-188
Conclusions of visits made to social healthcare centres in 2013

FACILITIES VISITED: Healthcare Centre El Pinar en Teruel

DATE OF VISIT: 8 and 9 April 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office and two external technical experts (one medical practitioner and one psychiatrist).
PURPOSE OF THE VISIT: During the inspection, the possible deprivation of liberty of certain residents admitted into the centre without their consent, the admission procedure, the internal operation of the centre, the living conditions of the residents, the healthcare and psycho-social assistance, the use of mechanical and pharmacological restraints, and the adequacy in terms of quantity and quality of the personnel of the centre, among other matters, were reviewed.
RESPONSIBLE AUTHORITY: Social Services Institute of ARAGON (Department of Healthcare, Social Welfare and Family of the General Deputation of Aragon

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Court authorisation should be requested for non-voluntary admissions.	Accepted, not performed	This is being considered from the legal point of view and they got in touch with the Public Prosecutor's Office to coordinate actions (Extension of Actions).				
The Centre should encourage a more weighted use of the legal institution of incapacitation.	Accepted, not performed	This is being considered from the legal point of view and they got in touch with the Public Prosecutor's Office to coordinate actions (Extension of Actions).				
The Centre does not have internal Regulations which should be remedied.	Accepted	It is being prepared.				
The autonomy and positive participation of residents should be encouraged.	Pending	Certain programs attempt to encourage the autonomy of residents (Extension of actions).				
The active participation of family relatives should be encouraged.	Accepted	An attempt will be made to reinforce activities for participation of family relatives.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
It would be advisable for a complaints book, suggestions book and/or satisfaction interviews to be available.	Accepted	A book of complaints and a suggestions box have been enabled.				
Lack of official visits book.	Accepted	It will be enabled.				
Individual assistance programs should be designed with a rehabilitation component and integration perspective.	Rejected		SUGGESTION	Give appropriate instructions for patients admitted with a psychiatric pathology to be re-evaluated and have an individual therapeutic plan established.	Pending	
A multidisciplinary psychosocial rehabilitation program should be prepared.	Accepted	Individual assistance programs have been included (Extension of actions).				
Personnel should receive ongoing training in accordance with the objectives of the Centre.	Pending	Extension of actions.				
No own plan for palliative care.	Rejected	When necessary, the Palliative Care Unit of the Hospital San José de Teruel provides the initial care plan.				
It could be considered including in new admissions less deteriorated residents to favour a change.	Rejected	It is not considered advisable since they are major degree dependents.				
Integration should be sought with the local psychiatric rehabilitation resources.	Rejected	This depends on the Mental Health Services of the Healthcare Service of ARAGON.				
The psychiatric clinical records of patients should be prepared and their diagnoses should be updated.	Rejected	This depends on the Mental Health Services of the Healthcare Service of ARAGON.	SUGGESTION	Adopt the measures necessary for the medical record of patients to include a section on psychiatric assistance.	Pending	
The call systems in rooms should be put again into use or alternative systems should be considered.	Pending					

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The necessary adaptations should be made for emergency evacuation.	Accepted	The evacuation plan of the centre and the necessary works are under study.				
Renovations necessary to improve certain structures.	Accepted	The appropriate measures have been adopted (Extension of actions?).				
The gardens of the centre are not provided with facilities to permit rehabilitation activities out of doors.	Accepted	A plan for psycho physical activities to be performed out of doors has been started up.				
No social room of common space exists in which persons from different units may socialize.	Rejected	The cafeteria is used for various activities.				
There is no protocol of early will.	Rejected	Given the large degree of dependence of the inmates it is not considered advisable.				
The structure should be renovated to increase privacy of inmates.	Pending					
No observation beds are available in the infirmary.	Accepted	Accepted and two observation rooms have been enabled.				
No reanimation equipment is available.	Rejected	A heart stop cart is available with medication and equipment to act out of hospital in emergencies or cardiorespiratory stop.				
The suitability and appropriateness of long therapeutic restraints should be reviewed.	Accepted	The Government of ARAGON is reviewing the protocols of restraint and social healthcare centres.				
The psychiatric service should be reinforced.	Pending	Psychiatric assistance is coordinated with the Mental Health Services of the Healthcare Service of ARAGON (Extension of Actions).				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The rooms for restraints do not have video-surveillance systems.	Pending					
When an injured person is assisted the relevant injury report should be completed and sent to the court authority.	Accepted					

GOOD PRACTICES
Self-care and autonomy of the inmates is encouraged.
Existence of activities in the morning and afternoon.
Group activities help to create a positive atmosphere among colleagues of residence.
Good state of cleanliness and tidiness.
Computer program restricting access to data of inmate according to professional profile.
The centre provides a high level of healthcare and physical care of inmates.
The Centre has assistance standards that safeguard the self-respect of inmates.

FACILITIES VISITED: Healthcare Centre Santa Teresa de Arévalo, en Arévalo (Ávila)

DATE OF VISIT: 16 and 17 September 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office and three external technical experts (two psychiatrists and one psychologist).
PURPOSE OF THE VISIT: During the visit, the director, the medical team, various members of personnel and a significant number of patients were interviewed. In addition, the facilities were inspected, the personal and clinical records were reviewed, and particular attention was given to the psychiatric and therapeutic assistance provided to inmates.
RESPONSIBLE AUTHORITY: Department of Family and Equal Opportunities of the Government of Castile and Leon

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
			SUGGESTION	Close isolation rooms that do not have a security camera and have an inadequate structure. It is accepted and immediately closed.	Accepted	

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The records of the patients should be reviewed and, if necessary, authorisation should be requested from the court for them to remain at the centre.	Accepted	The owner has been requested to regularise these cases.				
The regular medical reports sent to the judge should be exhaustive and up to date.	Pending					
No protocol or forms of early will/prior instructions is available.	Rejected	The autonomous community social services legislation only requires a small ratio of medical personnel (Extension of actions).				
A suicide prevention plan should be established.	Pending					
The doors to the rooms are locked at night and not all rooms have a call system which could cause a serious security problem.	Pending					
It would be desirable for property searches in rooms to be made in the presence of the inmate.	Pending					
The active participation of the family should be encouraged.	Pending					
The only complaint made had not been reviewed or answered.	Pending					
The adequate confidentiality of the personal data of patients should be ensured.	Pending					
It would be advisable for all rooms to have capacity for a maximum two persons.	Pending					

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The lack of hygiene and cleanliness in the cafeteria area should be remedied.	Pending					
The customisation of spaces should be encouraged and wardrobes should be provided for personal belongings.	Pending					
It would be desirable to find a system to ensure the privacy of the toilets.	Pending					
The profile of the workforce should be adjusted to assume rehabilitation work and favour reinsertion in the community.	Pending					
Mechanical restraints are performed with four persons, instead of the five established in the protocol for therapeutic immobilisation of the centre.	Pending					
The interested parties and their families must be appropriately informed upon their admission of the type of interment, the internal operating rules, the living regime, etc.	Accepted	All services contracts will be required to be correctly executed.				

GOOD PRACTICES
Clinical records are adequately completed, conform to international standards and have an individual treatment plan.
It has an adequate restraint protocol in accordance with international standards.
The new isolation room of Unit Santa Cecilia.
In the medication of the patients adjusted doses and good control of side effects were observed.
Ongoing training courses for personnel.
The cleanliness, comfort, quality of the facilities of the renovated part and the food are to be pointed out.

Tables 189-190
Follow up of visits made to social healthcare centres in previous years

GENERAL CONCLUSIONS		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Secretary of State for Justice)
Draft basic law to regulate non-voluntary admission of a civil nature	167 y 168 (2012)	Accepted and the pre-project for a Basic Law is being prepared to regulate the non-voluntary admission due to mental disorder.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Fiscal General del Estado)
Promote weighted use of the legal institution of incapacitation	175 (2012)	Participation in work of Provincial Public Prosecutor offices in the protection of persons with disabilities.
Regular control of non-voluntary admissions	174 (2012)	The Public Prosecutor makes regular visits to these establishments.
ASSISTED SOCIAL HOME SAN JOSÉ (TOLEDO)*/**		
SUGGESTIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Provincial Deputation of Toledo)
Demand court authorisation for non-voluntary admission where it is observed that the person may not have capacity to give his consent freely.	173 (2012)	Accepted.
Report to the Public Prosecutor Office deterioration of the capacity of inmates after their voluntary admission.	173 (2012)	Accepted.
Include, when the Centre informs the Public Prosecutor Office of the eventual incapacity of a resident, evaluation of its scope.	175 y 176 (2012)	Accepted.
Review the personal records to verify that court authorisation for admission has been requested in those cases in which the inmates did not have capacity to give their consent.	173 (2012)	Accepted.
Set our objectives, functions of the various professionals and evaluation indicators, and give more importance to the regional evaluation of reinsertion in the community of certain inmates.	180, 189 y 203 (2012)	Accepted.
Perform a multidisciplinary evaluation of inmates and set working objectives based on individual treatment plan.	181 (2012)	Accepted.
Encourage active participation of family relatives in the life of the centre.	191 (2012)	Accepted.
Avoid practice consisting of inmates who are not incapacitated being subject in certain decisions to the agreement reached by the centre with his family.	177 (2012)	Accepted.
Adopt the necessary measures for creation of at least one more psychologist position.	182 (2012)	Accepted.
Adopt the measures necessary for a psychiatrist to review the records and update the diagnoses and treatments of psychiatric patients at least twice per year.	182 (2012)	Accepted.
Respect the right to privacy and to have relationships of affection within the centre, and protect inmates who need this given their own disability.	190 (2012)	Accepted.
Inform inmates with capacity to state their will on the legal possibility of making a Declaration of Early Will.	201 (2012)	Accepted.
CONCLUSIONS	NO. PARAGRAPHS REPORTS	ANSWER AUTHORITYANNUAL (Provincial Deputation of Toledo)
Exhaustive and updated regular medical reports.	174 (2012)	Accepted and instructions are given.
Adopt the standard procedure for admission to a residential centre.	178 (2012)	A first provisional location is made and, after the evaluations, the final location is decided.

CONCLUSIONS	NO. PARAGRAPHS REPORTS	ANSWER AUTHORITYANNUAL (Provincial Deputation of Toledo)
Allocation to pavilions depending on functionality and rehabilitation potential.	178 (2012)	All pavilions have therapeutic rehabilitation programs.
Place information to residents in a visible place or where it may be consulted.	179 (2012)	Accepted and the information will be displayed in a visible place.
Review the drafting and format of information documents.	179 (2012)	Accepted and a more comprehensible form will be adapted for inmates.
Internal Regulation.	180 (2012)	Accepted and a Committee has been created for the purpose.
Promotion of occupational therapy area.	183 (2012)	Accepted and promoted with leaders, coordination and new rooms.
Lack of inter-disciplinary focus in occupational therapies.	183 (2012)	Accepted and a Coordinator has been appointed for the Psychosocial Area.
Lack of activities.	187 (2012)	Accepted and a leisure, games and free time room has been enabled with a coordinator.
Establish areas for cohabitation of couples.	190 (2012)	The necessary measures have been adopted when this has been expressly requested.
Encourage participation of inmates.	191 (2012)	Accepted and the participation of the inmates has improved.
Filing of complaints and/or suggestions.	192 (2012)	Accepted and a complaints/suggestions box is enabled.
Book of official visits.	194 (2012)	The centre has a Book of official visits.
Review the allocation of the medical professionals to the various pavilions.	197 (2012)	The medical practitioners have experience in geriatric medicine and psychiatry.
Update of the “Protocol for use of restraints”.	198 (2012)	Accepted and a “Protocol for restriction of movements and/or isolation in the Assisted Social Residence” has been prepared.
Adopt criteria in respect of “palliative care”.	200 (2012)	The professionals of the centre are prepared to handle palliative care in terminal patients.
Electronic clinical records, common database and confidentiality of data.	202 (2012)	Accepted and work is being performed to update the IT systems.
Excessive level of rotation of personnel.	204 (2012)	Accepted and greater stability has been achieved in the temporary contracts.
Necessary renovations to improve certain structures.	207 (2012)	Accepted and repairs and renovations are being performed on certain structures to improve the security.
Rooms with a maximum capacity for two persons.	208 (2012)	Only one three-bed room remains, which will be remedied upon the next exit from the pavilion.
Call or alarm system in the rooms.	209 (2012)	Accepted. When the user has capacity, an individual call system has been provided.
Review of the emergency and evacuation plan.	210 (2012)	Accepted, and the plan is at the state of award.

SUGGESTIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Department of Healthcare and Social Affairs of the Government of Communities of Castile-La Mancha)
Adopt the measures necessary for admissions to take place only with prior consent of the interested party or authorisation from the court.	173 (2012)	Accepted and instructions have been given for it to be verified that admissions to the Centre take place with consent or court authorisation.
Adopt the measures necessary so that in the case of deterioration of the capacity of inmates after their voluntary admission, the persons responsible for the Centre report this to the Public Prosecutor Office, for the relevant protection measures to be adopted.	173 (2012)	Accepted. Instructions are given for compliance.
CONCLUSIONS	**NO. PARAGRAPHS ANNUAL REPORTS**	**ANSWER AUTHORITY (Department of Healthcare and Social Affairs of the Government of Communities of Castile-La Mancha)**
Measures to be adopted to meet waiting lists to obtain a place in the centre.	172 (2012)	Since 31 December 2011, the Department does not have places arranged with the Centre.
CONCLUSIONS	**NO. PARAGRAPHS ANNUAL REPORTS**	**ANSWER AUTHORITY (Bar Association of Toledo)**
Creation of a shift ex officio for persons with disabilities	169 (2012)	No resources are available to create a specific legal guidance service for persons with disabilities.
*Visited in 2012.		
** In the Healthcare and Social Policy Area of the Ombudsman's Office one complaint is being processed for the closing shortly of the Day Centre Service of the Assisted Social Home "San José".		

4. Special-purpose places of deprivation of liberty

4.1. Hospital custody units

Tables 191

Conclusions and decisions arising from a visit to a Hospital Custody Unit in 2013

FACILITIES VISITED: Custody Unit in the Provincial Hospital of the University Hospital Complex Reina Sofía of Córdoba

DATE OF VISIT: 3 December 2013 (unannounced)
VISITING TEAM: Two technical experts of the Ombudsman's Office
PURPOSE OF THE VISIT: Follow up visit to verify whether the deficiencies observed in the previous visit, made in 2010, had been remedied. At the visit, the installations and record books were inspected and interviews were held with the police and officers responsible for custody of the detainees. No inmates were in confinement at the time of the visit.
RESPONSIBLE AUTHORITY: Secretary General for Penitentiary Institutions

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The video-surveillance system does not conform to the criteria of this Institution.	Accepted not performed	Possible modifications will be considered.				
The room for security and/ or psychiatric patients has a door that may be used for self-injuries.	Rejected	It is not considered evidenced that this type of door may facilitate self-injuries of inmates.				
Addressed to the Directorate General for the Police. The presence of an officer during the medical visit, whenever not exceptionally founded may affect the privacy of medical practitioner-patient relationships.	Accepted	Depending on the prison reports relating to the degree of conflictive conduct of the prisoner, the appropriate security measures are adopted.				

Table 192
Follow up of visits to Hospital Custody Units in previous years

HOSPITAL CUSTODY UNITS OF HOSPITAL GREGORIO MARAÑÓN (MADRID)**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General for the Police)
(R) Information to inmates on identification of officers.	219 (2012)	Not accepted.
CONCLUSIONS	**NO. PARAGRAPHS ANNUAL REPORTS**	**ANSWER AUTHORITY (Secretary General for Penitentiary Institutions)**
The video-surveillance system does not conform to the criteria of this Institution.	477 (2010) 218 (2012)	Accepted.
Opening system of the door to the isolation room.	214 (2012)	Accepted.
Protocol for information of prophylactic measures.	217 (2012)	Not accepted.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL).		
** Visited in 2012.		

Tables 193

Conclusions and decisions arising from the visit made in 2013

FACILITIES VISITED: Operation for repatriation from Airport Adolfo Suárez of Madrid-Barajas to Bogota (Colombia)

DATE OF VISIT: 11, 12 and 13 December 2013

VISITING TEAM: Multidisciplinary visit: one technical expert of the Ombudsman's Office and one external technical expert in forensic medicine

PURPOSE OF THE VISIT: During the visit the arrival to the airport of the foreign nationals to be repatriated, their boarding on the plane, and the procedure followed throughout the flight were supervised. 91 persons were expelled (56 citizens of Colombia and 35 citizens of Ecuador). 145 national police officers participated in the operation. The same aircraft was used to collect 8 Spanish prisoners in Quito and 31 in Bogota who were transported to Spain to continue serving their penalties.

RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
			SUGGESTION	Addressed to AENA. Repair urgently the air conditioning of the departments used by the UCER for the repatriation of foreign nationals.	Accepted	It has been repaired.
			SUGGESTION	Provide the area where foreign nationals wait for boarding with sufficient seats.	Accepted	Their supply has been requested from the Economic and Technical Division.
No prior medical check-up was made before the flight to confirm that there is no objection from the medical point of view to make the flight.	Accepted	According to the new Regulation for CIEs, each and every one of the irregular immigrants must go through a medical check-up both on entry and on leaving the centres.				
It was verified that no defibrillator existed on board.	Accepted not performed	The possibility of including ad hoc equipment is being considered since the current defibrillators may interfere in the systems of the aircraft.				
It was verified that no refrigerator existed on board, necessary to keep certain medicines cool.	Accepted	It was not considered necessary since the aircraft has its own cooling systems.				

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
In body searches the necessary measures were not observed to preserve privacy.	Accepted	Adequate facilities have been enabled.				

GOOD PRACTICES
The healthcare service consisted of a medical practitioner and DUE responsible for meeting any eventuality that may occur from the healthcare point of view in the repatriation flight, which does not always occur.

Tables 194-195
Follow up of visits to Operations for the repatriation of foreign nationals made in previous years

OPERATION (FRONTEX) FOR REPATRIATION OF FOREIGN NATIONALS TO NIGERIA AIRPORT ADOLFO SUÁREZ OF MADRID-BARAJAS**		
DECISIONS*	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General for the Police)
(S) The personnel of the UCER do not wear their identity badge.	226 (2012)	Not accepted.
(S) Report to inmates sufficiently in advance the time when their expulsion is to take place and its details.	231 (2012)	Accepted.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General for the Police)
The vide-surveillance system of the facilities of the UCER does not include recording and is very limited in the repatriates waiting area.	224 (2012)	Accepted. Instructions are given for co-rrection.
No individual custody forms exist for repatriates from when they leave their place of origin.	228 (2012)	Not accepted.
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General for the Police)
No means is official established for repatriates to be able to file their complaints in respect of the expulsion operation.	225 (2012)	Not accepted. They may submit them in the diplomatic delegations of Spain.
Whenever medical assistance is provided for injuries the injury records should be conveyed to the court authority.	235 (2012)	They are remitted.
Medical check up to authorise the trip.	233 (2012)	Not accepted. Extreme care is taken in cases of health problems.
The medical reports, when the medical practitioner does not understand the Spanish language, should be provided in multi-language	234 (2012)	These are provided whenever necessary.
The vans and buses used for transportation of repa-triates are not provided with safety belts.	227 y 264 (2012)	Accepted. It is forecast for acquisitions of new vehicles.
* Recommendations (R); Suggestions (S); Reminders of Legal Duties (RDL).		
** Made in 2012.		

OPERATION (CGEF) FOR REPATRIATION OF FOREIGN NATIONALS TO COLOMBIA AND ECUADOR AIRPORT ADOLFO SUÁREZ OF MADRID-BARAJAS		
CONCLUSIONS	NO. PARAGRAPHS ANNUAL REPORTS	ANSWER AUTHORITY (Directorate General for the Police)
Independence and impartiality of medical practitioners who participate in the repatriation operation.	242 (2012)	Not accepted.
The medical practitioners do not know in advance the type of medical circumstances.	242 (2012)	Accepted. Instructions are given for co-rrection.
The persons to be repatriated should know sufficiently in advance the time when they are to make the flight to be able to warn their families of these circumstan-ces.	231 (2012)	Accepted.

4.3. Rooms for asylum seekers and persons whose entry is refused

Table 196

Conclusions arising from the military disciplinary establishment visited in 2013

FACILITIES VISITED: Rooms for persons whose entry is refused and for asylum seekers of Terminals 1 and 4 Satellite of the Headquarters of the National Police Force at the Airport Adolfo Suárez of Madrid-Barajas

DATE OF VISIT: 26 June 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office and one external technical expert in forensic medicine.
PURPOSE OF THE VISIT: During the visit, the healthcare provided to the persons in both rooms and the conditions in which they stay at them were reviewed.
RESPONSIBLE AUTHORITY: Directorate General for the Police

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Locate at the facilities existing at the T1, both persons seeking asylum and those who, while pending rejection, must remain for more than 72 hours at the facilities of the T4 satellite.	Pending	
SUGGESTION	Adopt the security measures considered necessary for these persons to be able to be in contact with the exterior for at least one hour per day.	Pending	
SUGGESTION	Have audio-visual record of interviews carried out to decide the non-admission into national territory.	Pending	
SUGGESTION	Record in writing those cases in which it is necessary to isolate persons located both at the facilities of the T1 and at those of the T4 satellite.	Pending	Instructions have been given for an entry to be made in the Record Book of Non-Admissions when a person has to be isolated for security reasons.

CONCLUSIONS		
SPECIFIC	STATUS	ANSWER AUTH.
The video-surveillance of the facilities of the T1 and T4 satellite do not meet the criteria of this Institution	Pending	
Addressed to AENA. The collectors of the toilets of the facilities of the T1, located to the left of the entrance control are in a poor state causing bad odour.	Accepted	Instructions have been given for this to be remedied.
The food and drink vendor machines at the entrance were not working correctly.	Pending	
Lack of privacy in medical consultations.	Pending	
Unify injury reports.	Pending	
Obligation for the medical practitioner to complete the court report of injuries whenever he assists a person who states to have been injured even if he objectively observes no injury.	Pending	
Establish protocol for initial medical check-up.	Pending	

DECISIONS			
TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
SUGGESTION	Enter on the record books the granting of custody by the court authority of persons who remain at the facilities for more than 72 waiting for their rejection.	Accepted	All court decisions granting interment exceeding 72 hours, are entered and a copy of the request and of the granting decision is kept in the dossier.
SUGGESTION	Hold interviews with potential victims of trafficking, in a closed office to preserve their privacy.	Accepted not performed	The necessary renovation works are planned and budgeted pending performance.
SUGGESTION	Addressed to AENA. Give appropriate instructions for cleaning tasks to be performed when persons have left the room.	Accepted	The mechanisms for communication and coordination necessary have been established with the companies responsible for this service.

4.4. Means of transport for persons in custody

Tables 197

Conclusions and decisions arising from the visit made in 2013

FACILITIES VISITED: Operation for transportation of eight prisoners from the CPs of Las Palmas and Las Palmas II (Las Palmas de Gran Canaria) to the CP of El Puerto III, at El Puerto de Santa María (Cádiz)

DATE OF VISIT: 12 March 2013 (unannounced)
VISITING TEAM: Multidisciplinary visit: Two technical experts of the Ombudsman's Office and one external technical expert in forensic medicine
PURPOSE OF THE VISIT: During the inspection, the operation for disembarking from the aircraft and boarding the bus of the Civil Guard was supervised, some of the civil guards and the Qualified Nurse participating in the operation were interviewed and individual interviews were held with the eight prisoners.
RESPONSIBLE AUTHORITY: Directorate General for the Civil Guard

CONCLUSIONS			DECISIONS			
GENERAL	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
The officers did not wear their identity number in a visible place.			RECOMMENDA-TION	Measures necessary for the jackets worn by the civil guards over their uniforms to carry an identity number.	Accepted	The jackets have been provided with a tape to adhere the identity number and orders have been given for such identity to be carried
The clinical records of the inmates are kept in the hold of the aircraft and are therefore not available to the healthcare personnel.		A Recommendation is made.	RECOMMENDA-TION	Measures necessary for healthcare personnel to be able to have the medical data of the prisoners available during the flight.	Accepted	
Lack of safety belts in the bus of the Civil Guard.		A Recommendation is made.	RECOMMENDA-TION	The next acquisitions of vehicles for the transportation of prisoners should include improvements, such as the installation of a video-surveillance system and safety belts.	Accepted, not performed	Its execution is subject to the validation of the security systems.

CONCLUSIONS			DECISIONS			
SPECIFIC	STATUS	ANSWER AUTH.	TYPE	BRIEF DESCRIPTION	STATUS	ANSWER AUTH.
Lack of video-surveillance with recording system in the bus of the Civil Guard.	Rejected					

GOOD PRACTICES
Inmates are not obliged to place their head between their legs and the officers did not wear balaclavas, according to the interviews held with transported prisoners.

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