national preventive mechanism

Monitoring places of detention

Tenth **Annual Report**
of the United Kingdom's
National Preventive Mechanism
1 April 2018 – 31 March 2019

CP 228

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Presented to Parliament by the Lord Chancellor and Secretary of State for Justice
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Introduction by John Wadham, NPM Chair

The United Kingdom's National Preventive Mechanism (NPM) has now been operating for more than 10 years. We have grown to become a 21-member network of independent inspectorates and lay-visiting bodies, carrying out over 66,000 visits to places of detention each year. I have been the independent chair of the NPM for over three years, after being appointed by NPM members in 2016. I am even more impressed now by the dedication of NPM members' staff and volunteers to deliver on the requirements of the Optional Protocol to the Convention Against Torture (OPCAT) and prevent torture and ill-treatment in places where people are deprived of their liberty.

The idea of preventing ill-treatment is fundamental to the work that the NPM does every day. In this report we set out the approach to our tasks and demonstrate how it prevents ill-treatment, with lots of examples of how NPM members achieve this.

Yet in 2018–19 NPM members still found too many unacceptable examples of the treatment and the day-to-day conditions for detainees. In too many instances, NPM members had raised these concerns before and they remained unaddressed. According to just two NPM members – HMI Prisons and the Care Quality Commission – in 2018–19 over 10,500 people were detained or deprived of liberty in places that were inadequate or too poor for safe detention.[1]

During 2018–19, NPM members noted with concern that the number of people detained under mental health legislation across the UK had increased. Limited bed availability combined with limited support for people in the community were cited as contributing factors to this rise – they result in more people with severe mental health problems not getting the right support, and being at risk of deteriorating to the extent that they need to be detained. The NPM welcomes the introduction of the Mental Health Units (Use of Force) Act 2018, which strengthens the requirement for staff in mental health hospitals in England and Wales to record the restraint that has been used. However,

1 Last year, CQC rated 5% of mental health organisations that can detain patients under the Mental Health Act inadequate in relation to safety. There are in excess of 40,000 such detentions a year, so CQC estimates that perhaps 2,000 such detentions could be to hospitals rated as unsafe. In 2018–19 there were a further 2,131 notifications to CQC of a Deprivation of Liberty Safeguards application outcome at locations that as of 22 August 2019 were rated inadequate for safety. HMI Prisons figures show that in reports published in 2018–19 6,003 out of 29,361 prisoners in prisons inspected were living in establishments judged to be poor in safety. CQC and HMI Prisons use different methodologies and assessment standards in their inspection reports. While CQC's lowest rating is 'inadequate', HMI Prisons rates establishments from 1–4, with 1 being 'poor' in outcomes of its four healthy prison tests.

although this Act will provide data on restraint in mental health hospitals in England and Wales, and some experimental data is available for England through the Mental Health Services Data Set (MHSDS), we remain concerned over the current lack of reliable figures on the numbers of times physical restraint is used in health and social care settings across Scotland, England and Wales.

NPM members also highlighted the damaging trends in prisons across the UK during the reporting year. Levels of violence and the use of force and restraint were high in a number of prisons, with not enough being done to address the underlying causes of this violence. There was often inadequate governance around the use of force, leading some members to raise initial concerns about the roll-out of PAVA spray – a synthetic pepper spray which temporarily incapacitates those it is sprayed upon – in men's prisons in England and Wales. In addition to this, the NPM expressed deep concern about the continuing and disturbing levels of self-harm in prisons.

We set out these, and many other issues, in our submission to the United Nations Committee Against Torture (CAT). The CAT held its sixth periodic review into the United Kingdom's efforts to implement this international treaty in May 2019, and our evidence – on cross-cutting issues and human rights concerns in prisons, police custody, mental health detention, immigration detention and health and social care – was particularly critical. This led directly to several of the challenging questions the committee asked the government in the public hearing, and formed the basis of some of the committee's final and critical conclusions.

We also used this important international review to re-state the need for a strict time limit for immigration detention. For many years, NPM members have documented the deleterious impact of indefinite immigration detention. Members who monitored places of immigration detention in 2018–19 also found that the safeguards put in place to prevent vulnerable people being detained were not working effectively. I sincerely hope this and other recommendations made in our CAT submission are taken up in earnest by the new Government.

I have been particularly worried by the recent revelations about cases of alleged abuse at hospitals Whorlton Hall and Muckamore Abbey, both places where vulnerable people with learning disabilities and/or autism are held on the presumption that they will be cared for and will be safe and supported. BBC's *Panorama* revealed shocking footage of the treatment of patients by staff in Whorlton Hall, and a police investigation into CCTV footage at Muckamore Abbey has so far identified around 1,500 alleged crimes, including physical and mental abuse of patients by staff at the hospital. In another significant development a public inquiry has been announced to investigate allegations of ill-treatment of people detained under immigration powers at Brook House Immigration Removal Centre, also revealed by an undercover documentary, in 2017.

Unfortunately, in 2018–19 there was still no strategy from the Government on how to strengthen the NPM by placing it on a statutory footing, giving it the powers it needs and guaranteeing its independence. A legislative basis for the NPM is the only way in which our ability to carry out our

mandate to prevent ill-treatment in line with international requirements can be ensured. The CAT also called for better resourcing for the NPM and we are now ready to discuss exactly how that should be delivered with the Government.

It is regrettable that the NPM still does not know what the Ministry of Justice's (MoJ) position is on the matter of NPM legislation, the fact that we have been trying to make progress with the MoJ on this crucial matter for five years, and the repeated recommendations from international human rights bodies and select committees stating clearly that the NPM should be put on a statutory footing.

The Subcommittee on Prevention of Torture (SPT), an international body set up under OPCAT, announced during the reporting year that it would be carrying out its first ever visit to the United Kingdom later in 2019: a significant moment for the NPM. At the time of writing, this visit had concluded and we are awaiting a report from the SPT. The NPM invested significant time in ensuring that the SPT understood our concerns about the situation in detention in the UK, as well as our view of the main challenges to meeting our responsibilities under OPCAT. The fact that the SPT decided to prioritise a visit to the UK was a reminder that there is much more to be done to make sure we fulfil our role to prevent ill-treatment.

John Wadham
Chair
UK National Preventive Mechanism

Section one
Context

About the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)

The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is an international human rights treaty designed to strengthen the protection of people deprived of their liberty. Its adoption by the United Nations General Assembly in 2002 reflected a consensus among the international community that people deprived of their liberty are particularly vulnerable to ill-treatment and that efforts to combat such ill-treatment should focus on prevention. OPCAT embodies the idea that prevention of ill-treatment in detention can best be achieved by a system of independent, regular visits to all places of detention. Such visits monitor the treatment of and conditions for detainees.

OPCAT entered into force in June 2006. States that ratify OPCAT are required to designate a 'national preventive mechanism' (NPM). This is a body or group of bodies that regularly examines conditions of detention and the treatment of detainees, makes recommendations, and comments on existing or draft legislation with the aim of improving treatment and conditions in detention.

To carry out its monitoring role effectively, the NPM must:

- be independent of government and the institutions it monitors;
- be sufficiently resourced to perform its role; and
- have personnel with the necessary expertise and who are sufficiently diverse to represent the community in which it operates.

Additionally, the NPM must have the power to:

- access all places of detention (including those operated by private providers);
- conduct interviews in private with detainees and other relevant people;
- choose which places it wants to visit and who it wishes to interview;
- access information about the number of people deprived of their liberty, the number of places of detention and their location; and
- access information about the treatment of and conditions for detainees.

The NPM must also liaise with the Subcommittee on Prevention of Torture (SPT), an international body established by OPCAT with both operational functions (visiting places of detention in states parties and making recommendations regarding the protection of detainees from ill-treatment) and advisory functions (providing assistance and training to states parties and NPMs). The SPT is made up of 25 independent and impartial experts from around the world, and publishes an annual report on its activities.[2] At the time of writing, there are currently 90 states parties to OPCAT, and 71 designated NPMs.[3]

2 All annual reports, including the most recent 12th annual report which covers the work carried out by the SPT in 2018, are available on the website of the Office of the High Commissioner for Human Rights, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=12&DocTypeID=27 [accessed 24/02/20].

3 United Nations Treaty Collection, "Chapter IV: 9. b Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment', status as at 08/01/20, https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9-b&chapter=4&clang=_en [accessed 08/01/20]; Association for the Prevention of Torture, OPCAT database, available at: http://www.apt.ch/en/opcat-database/ [accessed 01/12/19].

The UK's National Preventive Mechanism

The UK ratified OPCAT in December 2003 and designated its NPM in March 2009. Designation of the NPM was the responsibility of the UK government and it chose to designate multiple existing bodies rather than create a new, single-body NPM. This took into account the fact that many types of detention in the UK were already subject to monitoring by independent bodies, as envisaged by OPCAT, and the different political, legal and administrative systems in place in the four nations that make up the UK. The members of the NPM were designated by ministerial statement to Parliament and without any specific legislative underpinning, a fact which has been strongly criticised by the United Nations.[4] There are now 21 bodies designated to the NPM; the most recent designation was the Independent Reviewer of Terrorism Legislation on 12 January 2017.[5]

Scotland

Care Inspectorate (CI)
Her Majesty's Inspectorate of Constabulary in Scotland (HMICS)
Her Majesty's Inspectorate of Prisons for Scotland (HMIPS)
Independent Custody Visiting Scotland (ICVS)
Mental Welfare Commission for Scotland (MWCS)
Scottish Human Rights Commission (SHRC)

Northern Ireland

Criminal Justice Inspection Northern Ireland (CJINI)
Independent Monitoring Boards (Northern Ireland) (IMBNI)
Northern Ireland Policing Board Independent Custody Visiting Scheme (NIPBICVS)
Regulation and Quality Improvement Authority (RQIA)

England and Wales

Care Inspectorate Wales (CIW)
Care Quality Commission (CQC)
Children's Commissioner for England (CCE)
Healthcare Inspectorate Wales (HIW)
Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)
Her Majesty's Inspectorate of Prisons (HMI Prisons)
Independent Custody Visiting Association (ICVA)
Independent Monitoring Boards (IMB)
Lay Observers (LO)
Office for Standards in Education, Children's Services and Skills (Ofsted)

United Kingdom

Independent Reviewer of Terrorism Legislation (IRTL)

4 Letter to John Wadham from Head of SPT European Regional Team, January 2018, https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2019/01/2.-2018.01.29-reply-to-the-NPM-of-UK-copy-002.pdf [accessed 14/01/19]

5 Further information on the process of designation and a link to the Written Ministerial Statement can be found on the website of the NPM at https://www.nationalpreventivemechanism.org.uk/about/background/ [accessed 08/01/20].

The bodies which make up the UK NPM monitor different types of detention across the jurisdictions, including prisons, police custody, court custody, customs custody facilities, secure accommodation for children, immigration detention facilities, mental health and military detention, as follows:

<table>
<tr><th rowspan="2">Detention setting</th><th colspan="4">Jurisdiction</th></tr>
<tr><th>England</th><th>Wales</th><th>Scotland</th><th>Northern Ireland</th></tr>
<tr><td rowspan="2">Prisons and YOIs</td><td>HMI Prisons with CQC and Ofsted</td><td>HMI Prisons with HIW</td><td rowspan="2">HMIPS with CI and SHRC; MWCS</td><td>CJINI and HMI Prisons with RQIA</td></tr>
<tr><td>IMB</td><td>IMB</td><td>IMBNI</td></tr>
<tr><td rowspan="2">Police custody</td><td colspan="2">HMICFRS and HMI Prisons</td><td>HMICS</td><td>CJINI with RQIA</td></tr>
<tr><td colspan="2">ICVA</td><td>ICVS</td><td>NIPBICVS</td></tr>
<tr><td>Escort and court custody</td><td colspan="2">Lay Observers and HMI Prisons</td><td>HMIPS</td><td>CJINI</td></tr>
<tr><td rowspan="2">Detention under the Terrorism Act</td><td colspan="4">IRTL</td></tr>
<tr><td colspan="2">ICVA, HMI Prisons and HMICFRS</td><td>ICVS</td><td>NIPBICVS</td></tr>
<tr><td rowspan="2">Children in secure accommodation</td><td rowspan="2">Ofsted (jointly with HMI Prisons and CQC in relation to secure training centres)</td><td rowspan="2">CIW and HIW</td><td rowspan="2">CI</td><td>RQIA</td></tr>
<tr><td>CJINI</td></tr>
<tr><td>Children (all detention settings)</td><td>CCE</td><td></td><td>CI</td><td></td></tr>
<tr><td>Detention under mental health law</td><td>CQC</td><td>HIW</td><td>MWCS</td><td>RQIA</td></tr>
<tr><td rowspan="2">Deprivation of liberty[6] and other safeguards in health and social care</td><td rowspan="2">CQC</td><td>HIW</td><td rowspan="2">CI and MWCS</td><td rowspan="2">RQIA</td></tr>
<tr><td>CIW</td></tr>
<tr><td rowspan="2">Immigration detention</td><td colspan="3">HMI Prisons</td><td>HMI Prisons with CJINI</td></tr>
<tr><td colspan="4">IMB</td></tr>
<tr><td>Military detention</td><td colspan="4">HMI Prisons</td></tr>
<tr><td>Customs custody facilities</td><td colspan="4">HMICFRS, HMI Prisons and HMICS</td></tr>
</table>

6 Deprivation of liberty legal safeguards apply only to England and Wales as part of the Mental Capacity Act 2015, but organisations in Scotland and Northern Ireland visit and inspect health and social care facilities where people may be deprived of liberty.

The essential requirement of OPCAT – that all places of detention are independently monitored – is fulfilled by individual members of the NPM or by members working in partnership with one another. Detailed findings relating to the treatment and conditions of detainees are published in the inspection or annual reports of each NPM member.

The NPM's twice-yearly business meetings are its main forum for members to share findings, best practice, experiences and lessons from monitoring different types of detention and different jurisdictions. The NPM business plan is agreed and monitored at these meetings and other decisions which require the input of all members are made. This year, business meetings were held in September 2018 in London and in April 2019 in Cardiff.

NPM chair

The NPM's independent Chair is appointed by NPM members. John Wadham took up the role in 2016. The role of the Chair is to advise and support the NPM in fulfilling its mandate, including:

- chairing the NPM steering group meetings three to four times a year and NPM business meetings twice a year;
- supporting NPM members in developing and implementing NPM work and in fulfilling their NPM responsibilities; and
- speaking publicly on behalf of the NPM and representing the NPM at meetings with external stakeholders.

The Chair also supports the NPM Secretariat in carrying out its role.

NPM Secretariat

The NPM's Secretariat is based at HMI Prisons and coordinates the UK NPM to help achieve the full and effective implementation of OPCAT in the UK. It is made up of two employees who coordinate the NPM with the purpose of:

- promoting cohesion and a shared understanding of OPCAT among NPM members;
- encouraging collaboration and the sharing of information and good practice between UK NPM members;
- facilitating joint activities between members on issues of common concern;
- liaising with the SPT, NPMs in other states and other international human rights bodies;
- sharing experiences and expertise between the UK NPM and NPMs in other states;
- representing the NPM as a whole to government and other stakeholders in the UK; and
- preparing the annual report and other publications.

NPM steering group

The NPM steering group oversees the overall strategy and activities of the NPM. Its five members meet regularly and are representative of members in all four nations of the UK and, as far as possible, of the different remits of organisations that make up the NPM.

The NPM steering group supports decision-making between business meetings, and develops the NPM business plan and proposals to members.

In the reporting year, the steering group met four times. As of March 2019, the NPM steering group membership was as follows:

- Peter Clarke, HMI Prisons;
- Rachel Lindsay, CJINI;
- John Powell, HIW;
- Colin McKay, MWCS;
- Katie Kempen, ICVA.

NPM sub-groups

Since the NPM was designated, its members have taken the initiative to establish thematic sub-groups which allow them to strengthen collaboration, share information and prioritise topics of particular relevance to their NPM mandate. The NPM has four sub-groups which worked throughout the year.

The NPM's newest sub-group is the police sub-group, which examines cross-cutting issues for the four nations, sharing good practice and identifying areas of concern in police custody. NPM members who visit police custody recognised that the issues faced by people in short-term detention are often different from those held in longer-term detention and decided that a dedicated forum in which members could discuss detention in police custody, including detention under terror legislation, would be beneficial. The police sub-group held its first meeting in May 2018, and its second in November 2018. The sub-group is organised and chaired by Her Majesty's Inspectorate of Constabulary in Scotland.

The Scottish sub-group met twice during the year, in September and March 2019. The group coordinates NPM activities in Scotland, provides support to NPM members, raises the profile of the work of the NPM and improves liaison with the Scottish Government. During the reporting year the group was chaired by the Scottish member of the NPM Steering Group, Colin McKay, Chief Executive of the Mental Welfare Commission for Scotland. The group secured in principle support from the Scottish Government to recruit a part-time assistant coordinator.

The mental health sub-group, which brings together the different NPM members with responsibility for monitoring mental health detention in the UK, met twice during the year, in April and October 2018. This sub-group provides an opportunity for organisations with responsibilities for the monitoring and protection of people in health and social care detention settings to work collaboratively on issues with specific mental health impacts. The group is chaired by the Mental Welfare Commission for Scotland.

The NPM sub-group which focuses on children and young people in detention continued to serve as a mechanism for NPM members to exchange information and intelligence, and to consider joint work on issues affecting detained children. The group is chaired by staff from the Children's Commissioner for England and met in November 2018.

Spotlight on prevention

Article 1 of OPCAT states that a system of oversight must be established 'in order to prevent torture and other cruel, inhuman or degrading treatment or punishment'. OPCAT is a unique international treaty because it focuses on preventing human rights abuses before they happen rather than on the action that should be taken once a violation has happened.

Under OPCAT, oversight bodies like the SPT and NPMs are the best way of making the practice of prevention a reality. It is critical that, as an NPM, we ensure we are using international standards when examining whether the government is fulfilling its obligation to protect the human rights of people in detention. For its 10th year, the NPM has reflected on what prevention means and looks like in practice.

Preventive monitoring

Preventive monitoring means working to a wide-ranging set of standards that contribute to creating an environment where torture and ill-treatment is less likely to happen.[7]

A preventive approach, as defined by the Association for Prevention of Torture, means that visits to places of detention are proactive rather than reactive so that signs of ill-treatment are spotted before they occur. Although reports of mistreatment must be addressed by complaints or investigative bodies, preventive monitoring means developing a system of oversight where practices are routinely observed and analysed.

Visits should therefore be regular, opening facilities up to scrutiny and transparency. OPCAT does not outline the regularity or frequency with which NPMs should carry out visits – it is left to the discretion of the monitoring body.[8] Many independent custody volunteers, for example, aim to visit police stations every week to ensure effective oversight of detainees' well-being, and independent monitoring boards visit prisons around two or three times a week. Other NPM members prioritise visits based on certain risk factors or specific intelligence. Prisons are inspected by HMI Prisons at least once every five years, whereas high-risk establishments such as those holding children and young people are inspected more frequently.

A spirit of cooperation is another important feature of preventive monitoring. Inspectorates issue recommendations to the authorities responsible for the policies and practices that apply in places of detention. Recommendations facilitate a dialogue with these authorities with a view to improving the situation in detention. Lay visiting bodies engage routinely with those managing establishments to pass on any concerns and monitor progress against them. NPM members have at their disposal a variety of ways to raise their findings with officials, politicians, parliamentarians and wider stakeholder groups to secure their implementation.

7 Further information on prevention can be found in the SPT's document, *The approach of the Subcommittee on Prevention of Torture to the concept of prevention of torture and other cruel, inhuman or degrading treatment or punishment under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (CAT/OP/12/6), November 2010 available at http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2fPPRiCAqhKb7yhsquBlBCPFD%2bXLNadyD9hiZ4R2ifOm%2fkPeiu3sYGHOmGMsGCei%2fqxK3MyHYEY%2bGl%2b0olrf33FTl4nDSkhMm0WAHWDw1BE%2fFCFsu8qp2vhJ5DM

8 Hardwick and Murray, 'Regularity of OPCAT visits by NPMs', *Australian Journal of Human Rights*, April 2019, available at https://www.tandfonline.com/doi/abs/10.1080/1323238X.2019.1588054

A preventive approach is a broad one, whereby assessments of places of detention are informed by all aspects related to the deprivation of liberty. As an NPM, we engage in thematic work on systemic issues to ensure we are looking at the different factors that have an impact on an individual's time in detention. Alongside their routine inspections looking into the treatment and conditions of people in custody, HMICS also conducts inspections that focus on the strategic aspects of police custody, for example leadership and training within staff teams, as well as how those delivering custody learn from complaints made. This allows HMICS to understand enabling or inhibiting factors to an environment where rights are respected. A wide-ranging perspective that looks across individual establishments, types of detention facilities and nations can more accurately identify factors that may cause harm or ill-treatment.

Political context, policy and legislative developments

Throughout the year the political discourse continued to be dominated by Brexit. The debate around leaving the European Union (EU) included a strong emphasis on 'taking back control' of aspects of migration policy currently determined by EU law. The government's migration policy was placed under the spotlight as a result of the Windrush scandal, under which some long-term UK residents were wrongly deported or threatened with deportation by the Home Office. The government published a white paper on immigration in December 2018 stating an intention to bring immigration policy under UK law and institute a new border and immigration system to strengthen enforcement.[9] This was criticised by some for its lack of strategic approach to immigration policy.[10]

The absence of a Northern Ireland Assembly and Executive since January 2017 meant that there was no new legislation, political scrutiny or oversight by a Minister of Justice or Committee for Justice or Minister of Health or Committee for Health of places of detention, the NPM or Criminal Justice Inspection Northern Ireland reports. For example, the Prisoner Ombudsman for Northern Ireland has not been placed on a statutory footing, despite the necessary primary legislation being in place.[11] In addition, the implementation of the

9 HM Government, December 2018, *The UK's future skills-based immigration system*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/766465/The-UKs-future-skills-based-immigration-system-print-ready.pdf [accessed 04/12/19]

10 Institute for Government, March 2019, *Managing migration after Brexit*, https://www.instituteforgovernment.org.uk/sites/default/files/publications/IfG-Migration-After-Brexit_4.pdf [accessed 04/12/19]

11 The process for placing the office on a statutory footing progressed through the Northern Ireland Assembly and the Justice (No 2) Bill received royal assent on 12 May 2016. The underpinning Regulations could not be completed before dissolution of the Assembly on 26 January 2017.

Northern Ireland Mental Capacity Act (2016) was due to be completed in 2020 and there are concerns that this will be delayed.[12] Another consequence of the absence of an executive is the risk of 'stagnation and decay' in updating policies and advocating effectively for resources for change. The Institute for Government examined the impact of governing without Ministers and found that the absence of discussion about long-term funding of health care, including for mental health, was a particular issue.[13]

Mental health law

In mental health law there have been significant developments across the UK during the year. One change of note is that in January 2018, the Department of Health became the Department of Health and Social Care.

In England and Wales, in July 2018, the government published a Mental Capacity (Amendment) Bill which was passed in May 2019. The Act reforms the process for authorising arrangements for a person's care or treatment which amount to a deprivation of their liberty, where the person does not have the capacity to consent to these arrangements. Deprivation of Liberty Safeguards (DoLS) are to be replaced with what is intended to be a simpler scheme known as the Liberty Protection Safeguards. This change followed a 2014 Supreme Court ruling on the case of P v. Cheshire West, in which three individuals with severe learning disabilities were living in arrangements deemed by the court to represent a deprivation of liberty. The ruling placed increasing burdens on local authorities and health and social care practitioners administering the DoLS. The Law Commission subsequently recommended that DoLS be abolished and proposed a replacement scheme set out in a draft Bill.[14] The Act will be implemented in 2020, prior to which a revised Code of Practice will be published. During the passage of the Bill a proposal to introduce a new statutory definition of deprivation of liberty was dropped.

The Mental Health Units (Use of Force) Act 2018 was enacted in November 2018. The Act – which will increase protections and oversight of use of force in mental health settings in England – will come into force in 2020. The Act's provisions include stronger requirements and greater regulation over recording and reporting restraint in such settings, and for police to wear body cameras when called to assist health care staff in them. Importantly, the death of any patient in a mental health unit resulting from the use of force by staff there, will be subject to a review process by the Secretary of State. This legislation is known as Seni's Law, having arisen from the case of Olaseni 'Seni' Lewis who died in 2010 after prolonged restraint by 11 police officers

12 The parts of the Bill providing for the authorisation of deprivation of liberty eventually came into force on 2 December 2019. They allow a panel to authorise the detention, in circumstances amounting to a deprivation of liberty, of a person aged 16 and above with impaired capacity in a place where appropriate care or treatment is available for them. See https://www.mentalcapacitylawandpolicy.org.uk/all-or-at-least-part-go-for-the-mental-capacity-act-northern-ireland/ [accessed 05/12/19]

13 Institute for Government, September 2019, *Governing without ministers*, https://www.instituteforgovernment.org.uk/sites/default/files/publications/governing-without-ministers-northern-ireland.pdf [accessed 11/12/19]

14 Law Commission, March 2017, *Mental Capacity and Deprivation of Liberty*, https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/ [accessed 04/12/19]

while a voluntary inpatient in a mental health hospital.[15]

On the related issue of deaths in detention, in December 2018 the Scottish Government published a review of arrangements for investigating the deaths of patients being treated for mental disorder and set out a plan of action.[16] The key action was for the Mental Welfare Commission for Scotland to develop a system for investigating all deaths of patients who, at the time of death, were subject to an order under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or part VI of the Criminal Procedure (Scotland) Act 1995 (whether in hospital or in the community, including those who had their detention suspended).

The long-awaited report of an independent Review of the Mental Health Act 1983 (for England and Wales) was published in December 2018.[17] This highlighted three key challenges in the current application of the Act: the complex balance between respecting a person's autonomy and the duty of a 'civilised State' to protect the vulnerable under different Articles of the European Convention on Human Rights; the problem of fear – held by patients, the public, and professionals involved in the system; and the rise of coercion and the continuing legacy of stigma, discrimination and racism in society. The Review acknowledged that there was no simple solution but concluded that patients should be supported to make more choices for themselves and recommended a new right of appeal against compulsory treatment. In March 2019, the Scottish Government announced an independent review of the Mental Health (Care and Treatment) (Scotland) Act 2003 with the aim of improving rights and protections for those living with mental illness and removing barriers for those who care for their health and welfare. The Review will examine developments in mental health law and practice on compulsory detention and on care and treatment since the current legislation came into force in 2005.[18] It will build on a review previously announced, which is specifically looking at how mental health law affects people with learning disabilities and autism.[19]

In Wales, work has been ongoing to improve the quality of social care. Provisions in the Regulation and Inspection of Social Care (Wales) Act 2016 (RISCA) – requiring different types of providers of care and support, including those delivering services in secure establishments, to register with Care Inspectorate Wales – were implemented between April 2018 and April 2019 (see

15 INQUEST, November 2018, *Family celebrate lasting legacy as 'Seni's Law' receives Royal Assent*, https://www.inquest.org.uk/senis-law-assent [accessed 04/12/19]

16 Scottish Government, December 2018, *Review of the arrangements for investigating the deaths of patients being treated for mental disorder*, https://www.gov.scot/publications/review-arrangements-investigating-deaths-patients-being-treated-mental-disorder/ [accessed 04/12/19]

17 HM Government, December 2018, *Modernising the Mental Health Act*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf [accessed 04/12/19]

18 Scottish Government, March 2019, *Review of the Mental Health Act*, https://news.gov.scot/news/review-of-the-mental-health-act [accessed 04/12/19]

19 The report was published in December 2019. IRMHA, December 2019, *The Independent review of Learning Disability and Autism in the Mental Health Act, Final Report*, https://www.irmha.scot/wp-content/uploads/2020/01/IRMHA-Final-report-18-12-19-2.pdf [accessed 04/02/20]

section 2).[20] The Act strengthened the regulation and inspection of social care with the aim of improving the quality of care, support and well-being outcomes for people using services. Healthcare Inspectorate Wales received additional funding during the year to enable the appointment of additional inspection and support staff; the benefit to the work programme will not be fully realised until the following year.

In March 2019, the Scottish Government launched a review of forensic mental health services to examine demand for such services and their delivery in prisons, secure mental health facilities and rehabilitation services.[21] There are particular current challenges in providing for female patients who require high security services and children who need secure mental health care, resulting in cases being transferred to England. The issue of cross-jurisdiction transfers for female patients and children, in particular, was highlighted by the NPM following its cross-cutting work examining transitions and pathways between different mental health settings. These issues also affect Wales and Northern Ireland. The NPM documented that there is only one hospital which provides high secure provision for women in the UK and there are no secure mental health units for children and young people under 18 years old outside England.[22]

Prisons and reform

Questions have been raised about the sustainability of the prison populations in Scotland and England and Wales, with concerns over the capacity and infrastructure of the existing prison estate to accommodate projected increases.

Audit Scotland identified that the Scottish Prison Service (SPS) was operating beyond capacity in terms of prisoner numbers, following a rise in the population from 7,200 in April 2018 to over 8,100 in March 2019, with forecasts projecting further growth.[23] There was a projected deficit in budget with potential operational implications in achieving and maintaining prisoner and prison officer safety and security. Increased levels of sickness absence placed additional pressures on staff. These pressures led the SPS to temporarily suspend throughcare support services – under which prison officers support short-term prisoners in preparation for and following their release – so that experienced staff could be moved to core operational duties. The Government was working with the voluntary, third sector and local authorities to address this shortfall.

20 A person managing a prison or other similar custodial establishment is exempt from the definition if they are directly providing care and support to the individuals detained there. However, if care and support is being provided to detained individuals by a Domiciliary Support Service (for example a Domiciliary Support Service within a local authority) and not by a person managing the prison, then they are required to register with CIW.

21 Scottish Government, March 2019, *Improving mental health services*, https://news.gov.scot/news/improving-mental-health-services-1 [accessed 04/12/19]

22 UK National Preventive Mechanism, February 2018, *Monitoring places of detention. Eighth Annual Report of the United Kingdom's National Preventive Mechanism*, https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2018/02/6.4122_NPM_AR2016-17_v4_web.pdf, [accessed 04/12/19]

23 Audit Scotland, June 2019, *Scottish Prison Service 2018/19 Annual Audit Report to the Accountable Officer and the Auditor General for Scotland*, https://www.audit-scotland.gov.uk/uploads/docs/report/2019/aar_1819_scottish_prison_service.pdf [accessed 04/12/19]

SPS also looked to purchase additional prison spaces in two private sector prisons.[24] Other developments during the year included: SPS seeking to professionalise the role of the prison officer through the Prison Officer Professionalisation Programme (POPP), and the implementation by the end of the year of SPS's commitment to introduce smoke-free prisons.

The Scottish Government committed to extend the presumption against short sentences from three months or less to 12 months or less and announced £250 million for improvements to mental health services. The latter will include £35 million investment over five years to provide access to 800 additional mental health professionals in accident and emergency departments, GP practices, police custody suites and prisons. Scottish Parliament passed the Domestic Abuse (Scotland) Act 2018 which criminalises psychological domestic abuse and coercive and controlling behaviour. The Government created a National Performance Framework, launched in June 2018 with 11 national outcomes it is seeking to achieve to improve equality. Two outcomes are particularly important to justice: 'We live in communities that are inclusive, empowered, resilient and safe', and 'We respect, protect and fulfil human rights and live free from discrimination'.

There were significant announcements in England and Wales which sought to address the challenges with the safety and infrastructure of prisons and to set out proposed strategies and investment. Alongside ongoing efforts to recruit additional prison staff, a £30 million package was announced in July 2018 to tackle acute maintenance needs, safety and security measures and the provision of securely monitored in-cell telephones.[25] Her Majesty's Prison and Probation Service (HMPPS) also introduced a drugs taskforce and published a drugs strategy to address both supply and demand across the system. In August 2018, the Ten Prisons Project was launched with the aim of reducing violence in 10 prisons in England and Wales by focusing on reducing drug use, tackling violence, improving decency and building leadership capability. It was facilitated by £10 million additional funding.[26] The Minister for Prisons and Probation pledged to resign should the project not have the desired impact within 12 months. The Secretary of State for Justice acknowledged the high rate of imprisonment in England and Wales and proposed that caution be exercised in continuing to increase sentences. He believed there was a very strong case for abolishing short prison sentences (with some exceptions) and making greater use of community orders, while making no commitment to legislate.[27] The Government also continued with its preparation for constructing new prisons,

24 Later in 2019 this became a reality. See *The Scotsman*, September 2019, 'Scottish Government forced to pay for extra private prison places as overcrowding soars', https://www.scotsman.com/news/crime/scottish-government-forced-to-pay-for-extra-private-prison-places-as-overcrowding-soars-1-5012374 [accessed 04/12/19]

25 Justice Secretary launches fresh crackdown on crime in prison: David Gauke speech, July 2018, https://www.gov.uk/government/speeches/justice-secretary-launches-fresh-crackdown-on-crime-in-prison-speech [accessed 04/12/19]

26 The 10 prisons are Hull, Humber, Leeds, Lindholme, Moorland, Wealstun, Nottingham, Ranby, Isis and Wormwood Scrubs. See https://www.gov.uk/government/news/minister-announces-10-prisons-project-to-develop-new-model-of-excellence [accessed 05/12/19]

27 'Beyond prison, redefining punishment': David Gauke speech, February 2019, https://www.gov.uk/government/speeches/beyond-prison-redefining-punishment-david-gauke-speech [accessed 04/12/19]

including at Wellingborough, which is due to open in 2021.

Despite this investment, the Justice Select Committee highlighted a large backlog of major maintenance work in prisons. The Prisons Minister estimated in August 2018 that the current amount needed for major maintenance work in public prisons was £716 million, yet, for the year 2018–19, only £90 million was allocated towards it. In its subsequent report, the Committee reiterated a recommendation made by its predecessor Committee in 2017 to strengthen the statutory foundations of the Prison and Probation Ombudsman and National Preventive Mechanism.[28] The Prison Service took over HMP Birmingham from G4S temporarily in August 2018 after an Urgent Notification issued by HM Inspectorate of Prisons; on 1 April 2019 it was announced that this transfer would be permanent.

A High Court Judicial Review hearing against Sodexo Justice Services and the Secretary of State for Justice took place on 4 and 5 July 2018, following five incidents of unlawful strip-searching at HMP Peterborough the previous year.[29] Sodexo Justice Services admitted systemic breaches in relation to Prison Service Instruction 07/2016 and Article 8 of the European Convention on Human Rights (ECHR)30, including not having adequately trained its staff in relation to strip searches. The Court found that measures put in place by the Secretary of State to safeguard strip-searching processes were not adequate and effective to prevent breaches of Article 8 ECHR by Sodexo because they did not ensure that proper and suitable systems were in place for training staff on strip-searching. The overuse of strip-searching at HMP Peterborough had been highlighted by HMI Prisons in its 2014 and 2017 inspection reports and the resulting reduction was then monitored and noted in the 2017–18 report from the IMB at the prison.[31]

28 House of Commons Justice Committee, April 2019, *Prison population 2022: planning for the future sixteenth report of session 2017-19*, https://publications.parliament.uk/pa/cm201719/cmselect/cmjust/483/483.pdf [accessed 04/12/19]

29 LW & Ors v Sodexo Ltd & Anor (Rev 1) [2019] EWHC 367 https://www.bailii.org/ew/cases/EWHC/Admin/2019/367.html [accessed 04/12/19]

30 Article 8 of the European Convention on Human Rights is the right to respect for private and family life.

31 HMI Prisons, January 2018, Press release: 'Peterborough women's prison – respectful but undermined by deteriorating safety and concerns over force and strip-searching', https://www.justiceinspectorates.gov.uk/hmiprisons/media/press-releases/2018/01/peterborough-womens-prison-respectful-but-undermined-by-deteriorating-safety-and-concerns-over-force-and-strip-searching/ [accessed 24/02/20]; Independent Monitoring Board at HMP/YOI Peterborough, August 2018, *Annual Report of the Independent Monitoring Board at HMP/YOI Peterborough for reporting year April 2017–March 2018*, https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2018/08/Peterborough-2017-18.pdf [accessed 24/02/20]

There was ongoing work by the Ministry of Justice to address inequality, in particular to implement recommendations made by David Lammy MP in his 2017 report to reduce discriminatory treatment of black and minority ethnic prisoners and the introduction of a new programme to improve outcomes for female prisoners under the Female Offender Strategy, launched in June 2018.[32]

HMPPS's new Chief Executive Officer, Dr Jo Farrar, began her tenure on 1 April 2019. Since the previous April, HMPPS had continued implementing the Offender Management in Custody Model (OMiC) in adult prisons in England and Wales to coordinate and sequence an individual's journey through custody and following release. The OMiC framework includes allocating every male prisoner a key worker for support during their time in detention. As part of reforms, announced in November 2016, to clarify the responsibilities of prison governors and empower them to make local decisions, HMPPS had been reviewing its operational policies with the purpose of simplifying them.[33] During the latter part of 2018 and early 2019, it published a series of Policy Frameworks to clarify and replace some existing guidance (issued through Prison Service Instructions (PSIs) and Prison Service Orders (PSOs)).[34] The Government also announced long-awaited plans for the future of probation services, bringing offender management back under the National Probation Service while retaining some private and voluntary sector provision to support rehabilitation and resettlement.

Children in detention

In Northern Ireland and in England and Wales, plans were made to change the nature of secure accommodation for children in different respects. During 2018, the Departments of Health and Justice in Northern Ireland established a project board to create one integrated facility to provide care and custody for children and young people; this facility will integrate services currently delivered in Woodlands Juvenile Justice Centre and the Lakewood Secure Care Children's Home in one campus.

In June 2018 more details emerged about the Government's vision for establishing secure schools in England and Wales.[35] The Government's proposal – which followed Charlie Taylor's review of the youth justice system – intends that secure schools will replace young offender institutions and secure training centres. Secure schools in England will be registered and inspected as secure children's homes (SCHs) with

32 David Lammy MP was commissioned to conduct an independent review into the treatment of, and outcomes for, black, Asian and minority ethnic individuals in the criminal justice system. In his report, known as the Lammy Review, he made recommendations to improve monitoring of ethnicity, outcomes of BAME individuals in prison, including those related to the Incentives and Earned Privileges (IEP) system, use of force and the complaints system, and the diversity of prison staff. See https://www.gov.uk/government/publications/lammy-review-final-report [accessed 24/02/20]; The Female Offender Strategy placed emphasis on community-based provision for women, though there was limited additional funding for developing this. See https://www.gov.uk/government/publications/female-offender-strategy [accessed 24/02/20]

33 Ministry of Justice, November 2016, *Prison Safety and Reform*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/565014/cm-9350-prison-safety-and-reform-_web_.pdf [accessed 24/02/20]

34 Ministry of Justice, September 2018, *Prison and Probation Policy Frameworks*, https://www.gov.uk/government/collections/prison-probation-policy-frameworks [accessed 24/02/20]

35 The UK Government has still not announced its plans to open secure schools. Plans to open the first secure school, on the site of Medway Secure Training Centre, have been delayed. See: https://www.cypnow.co.uk/News/article/moj-confirms-delay-to-secure-school-opening [accessed 05/12/19]

Ofsted and inspected as 16–19 academies. The Scottish Government introduced legislation with the intention of raising the age of criminal responsibility to 12 years old.[36] In November 2018, the Government commissioned HM Chief Inspector of Scottish Prisons to investigate the provision of mental health services for young people entering and in custody at HMP YOI Polmont, following the deaths of two individuals.[37] At the Government's request, the review was led by the Chief Inspector with a health care professional with relevant experience and other agencies.[38] More broadly, the Government announced the creation of a Child and Young Persons' Mental Health Taskforce and a Youth Commission for mental health services.

Police custody

In summer 2018, ICVA worked with the College of Policing to update professional practice guidance for police detention and custody in England and Wales around menstrual protection for women and girls. The guidance now says that female detainees should be advised that: they can speak to a female officer in private; security camera footage of toilet areas is pixelated; hand washing and shower facilities are available on request; if they require or are likely to require any menstrual products while they are in police custody they will be provided free of charge, including any replacements. ICVA was also instrumental in securing the agreement of the Home Office to change legislation under the Police and Criminal Evidence Act (PACE) to require police forces to respect the dignity of female detainees and deliver appropriate care to menstruating detainees.[39]

Police Service Northern Ireland's three-year estate strategy will result in police station closures, 12 of which have already occurred. However, there was ongoing transformation of police custody health care, with the aim of developing and implementing a multi-disciplinary, patient-focused model, with an embedded nursing service, in collaboration with the Public Health Agency (PHA), Departments of Health and Justice and Health and Social Care Trusts (HSCT).

The Scottish Human Rights Commission (SHRC) expressed significant concerns about the human rights implications of the proposed police use of digital device triage systems, and gave evidence to the Scottish Parliament on two occasions.[40] These

36 This received Royal Assent in June 2019, outside the reporting period.

37 The resulting report was published in May 2019, outside the reporting period. See HM Inspectorate of Prisons for Scotland, May 2019, *Report on Expert Review of Provision of Mental Health Services at HMP YOI Polmont*, https://www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/Report%20on%20Expert%20Review%20of%20Provision%20of%20Mental%20Health%20Services%20at%20HMP%20YOI%20Polmont%20-%20Final%20Version.pdf [accessed 05/12/19]

38 HM Inspectorate of Prisons for Scotland, August 2019, *Annual Report 2018-19*, https://www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/Annual%20report.pdf [accessed 05/12/19]

39 Independent Custody Visiting Association, August 2018, *ICVA Welcomes Increased Dignity for Female Detainees, Press Release*, https://icva.org.uk/wp-content/uploads/2018/08/2018.08.21-Menstruation-ICVA-Press-Release.pdf [accessed 05/12/19]; HM Government, August 2019, *Guide to the 2019 revisions to the Police and Criminal Evidence Act 1984 (PACE)*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/826408/2019_Guide-to-2019Revised-CodesC_H.pdf [accessed 05/12/19]

40 Scottish Parliament, September 2018, *Justice Sub-Committee on Policing Scottish Parliament Session 5*, http://www.parliament.scot/parliamentarybusiness/report.aspx?r=11670&mode=pdf [accessed 05/12/19]; Scottish Parliament, November 2018, *Justice Sub-Committee on Policing Scottish Parliament Session 5*, http://www.parliament.scot/parliamentarybusiness/report.aspx?r=11785&mode=pdf [accessed 05/12/19]

systems, known as 'cyber kiosks', would provide faster digital forensic capabilities to examine seized mobile devices, including those handed over voluntarily. The SHRC's concerns related to the apparent absence of proper safeguards around access to personal and sensitive data within this process.[41]

Court custody

HM Chief Inspector of Prisons in Scotland drew attention to the potential for better use of video-link facilities, and a smarter approach to prisoner transportation. She proposed that this would provide financial savings and reduce the transport and prisoner risk, the numbers of prisoners attending for short procedural court appearances, and the inconvenience suffered by prisoners from long hours of travel or detention for very brief court appearances.[42]

In early 2018, the Government issued a public consultation on a strategy for court buildings and facilities in England and Wales.[43]

Immigration detention

In July 2018, Stephen Shaw published a follow-up to his 2015 independent review of the welfare of vulnerable people in immigration detention, after the Home Office asked him to examine the extent to which it had adopted his recommendations and the impact this had on practice.[44] He welcomed the Government's progress in implementing his recommendations, reducing the use of immigration detention and the average length of detention, and improving conditions for those held. Nevertheless, he found 'a gap between the laudable intentions of policymakers and actual practice on the ground', particularly in relation to the number of vulnerable people held in detention. His recommendations included improvements to protections for vulnerable adults, strengthening quality assurance processes and their oversight, and proposals for devising alternatives to detention.

The Government announced in July 2018 a commitment to further reforms to immigration detention, but suggested there was insufficient evidence to take a view on the issue of time limits.[45] Of note was a proposal to increase transparency around immigration detention by publishing more data and by commissioning the Independent Chief Inspector of Borders and Immigration to report each year on the adults at risk in immigration detention policy.[46]

41 *Police Scotland Serving a Changing Scotland*, https://www.scotland.police.uk/about-us/serving-a-changing-scotland/cyber-kiosk, [accessed 05/12/19]

42 HM Inspectorate of Prisons for Scotland, August 2019, *Annual Report 2018-19*, https://www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/Annual%20report.pdf [accessed 14/01/20]

43 Ministry of Justice, January 2018, *Fit for Future: transforming the Court and Tribunal Estate*, https://consult.justice.gov.uk/digital-communications/transforming-court-tribunal-estate/supporting_documents/hmctsstrategyapproachconsultation.pdf [accessed 14/01/20]

44 Stephen Shaw, July 2018, *Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons - A follow-up report to the Home Office*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728376/Shaw_report_2018_Final_web_accessible.pdf [accessed 05/12/19]

45 Oral statement to Parliament, Home Secretary statement on immigration detention and Shaw report https://www.gov.uk/government/speeches/home-secretary-statement-on-immigration-detention-and-shaw-report [accessed 05/12/19]

46 HM Government, December 2018, *The UK's future skills-based immigration system*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/766465/The-UKs-future-skills-based-immigration-system-print-ready.pdf [05/12/19]

In relation to transparency, in September 2018, Stephen Shaw raised with the Home Affairs Committee that the Home Office did not conform to the practice of publishing data on deaths of immigration detainees. The *Guardian* and *Independent* newspapers have identified other ways in which there had been a lack of transparency of Home Office data. In December 2018, the *Independent* alleged that the Home Office had deliberately deleted records about the death of an immigration detainee, Michal Netyks, who had been due to be released after serving a custodial sentence.[47] The newspaper also highlighted a number of cases where people formally identified by the Home Office as modern slavery victims, or displaying clear signs that they were victims, had been detained or threatened with deportation.[48] They found that 507 people who had escaped exploitation were detained under immigration powers in 2018, despite Home Office guidance that this group should not be placed in detention.[49] The Guardian reported in September 2018 that the Home Office lost almost three-quarters of appeals against immigration rulings.[50] In December 2018, the Home Office announced the establishment of a team to review new evidence in all pending immigration appeals.

The situation in detention during the year

Prisons

Significant concerns regarding the situation in prisons across the four nations were highlighted by NPM members, including the continued prevalence and impact of new psychoactive substances (NPS) on prisoners' health and safety, and the need for substantial improvements to in-prison mental health care. The total prison population in England and Wales as at 29 March 2019 was 82,643 (78,806 men and 3,837 women), a comparable level to the same point in the previous year.[51] The population in Scotland's prisons at the end of March 2019 was 8,122, an increase of 709 (almost 9%) in the overall number of people in prison in Scotland over the last year, and equivalent to one additional large prison.[52] The prison population in Northern Ireland remained largely the same, with the average daily population across the year at 1,448.[53]

47 *The Independent*, December 2018, 'Home Office accused of 'denial and obfuscation' after deleting records on death of immigration detainee', https://www.independent.co.uk/news/uk/home-news/home-office-immigration-detention-denial-deleting-records-death-michal-netyks-poland-a8693121.html [accessed 05/12/19]

48 *The Independent*, July 2019, 'Home Office accused of covering up plight of hundreds of trafficking victims wrongly detained in immigration centres', https://www.independent.co.uk/news/uk/home-news/home-office-modern-slavery-trafficking-victims-immigration-detention-detained-foi-data-a9007251.html [accessed 05/12/19]

49 *The Independent*, July 2019, 'Home Office forced to defend 'cover-up' over detention of hundreds of modern slavery victims', https://www.independent.co.uk/news/uk/home-news/home-office-modern-slavery-victims-immigration-detention-caroline-nokes-diane-abbott-parliament-a9008836.html [accessed 05/12/19]

50 The *Guardian*, September 2018, 'Home Office loses 75% of its appeals against immigration rulings', https://www.theguardian.com/uk-news/2018/sep/03/inhumane-three-quarters-of-home-office-asylum-appeals-fail [accessed 05/12/19]

51 Ministry of Justice, National Offender Management Service, HM Prison Service, and Her Majesty's Prison and Probation Service, Population Bulletin: Weekly 29 March 2019, https://www.gov.uk/government/statistics/prison-population-figures 2019 [accessed 12/10/19]

52 HM Inspectorate of Prisons for Scotland, August 2019, *HM Chief Inspector of Prisons for Scotland: Annual Report 2018-19*, https://www.prisonsinspectoratescotland.gov.uk/publications/hm-chief-inspector-prisons-scotland-annual-report-2018-19?page=9 [accessed 18/10/19]

53 Department of Justice, September 2019, *The Northern Ireland Prison Population*, https://www.justice-ni.gov.uk/sites/default/files/publications/justice/ni-prison-population-18-19.pdf [accessed 08/01/20]

Overall, NPM members judged prison conditions in England and Wales to be poor, with many prisoners being kept in dirty and overcrowded facilities. The amount of time that prisoners remained in cells was again considered to be unacceptable by HMI Prisons. This has been a recurring concern in HMI Prisons reports over many years. In only a third of the adult male prisons inspected was purposeful activity judged to be good or reasonably good. IMBs welcomed the staffing increases but noted that the number and proportion of new and inexperienced staff had implications for safety and equitable treatment of prisoners. In many cases access to time out of cell, education and work continued to be restricted. Boards also raised serious concerns about the use of segregation units to deal with prisoners with severe mental health conditions, who could not be transferred because of the chronic shortage of appropriate specialist mental health services, and who, in some cases, spent unacceptably long periods in solitary confinement. The disturbing rise in levels of self-harm incidents and assaults continued, with a further year of record highs. The number of self-harm incidents was 57,968 for the year, up 24% from the previous 12 months. There were 34,425 recorded incidents of assault, an increase of 11% from the previous year. Of these incidents, 11% were classified as serious.[54]

There were 317 deaths in prison custody in the year, up 18 from the previous year. Of these, 87 deaths were self-inflicted, an increase of 14 from the previous year.[55] It was of concern that HMI Prisons found that, as in the previous two years, recommendations made by the Prisons and Probation Ombudsman (PPO) following a death had not been adequately addressed in about a third of prisons inspected.

There was an overall decline in safety, purposeful activity and respect outcomes compared with the previous inspection scores for some men's prisons in England and Wales.[56] Levels of violence had increased in more than half of the prisons inspected by HMI Prisons. Reports on HMPs Exeter, Birmingham and Bedford, in particular, highlighted the urgent need for improvement, and resulted in Urgent Notifications being issued. Indeed, category B and C men's prisons – holding the majority of prisoners – were of most concern. Of the 28 local and training prisons inspected during the year, 22 were judged to be poor or not sufficiently good in regard to safety.[57] The significant deterioration in conditions and regimes, the increasing use of NPS and rising self-harm and violence in local and training prisons was also highlighted by the IMB.[58]

54 Ministry of Justice, July 2019, *Safety in Custody quarterly: update to March 2019,* https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-march-2019 [accessed 18/10/19]

55 Ministry of Justice, April 2019, *Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to March 2019*; Assaults and Self-harm to December 2018, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/797074/safety-custody-bulletin-q4-2018.pdf [accessed 18/10/19]

56 For all 'healthy prison assessments' carried out by HMI Prisons, more scores remained 'unchanged' from previous inspections than declined or improved.

57 HM Inspectorate of Prisons, July 2019, *HM Chief Inspector of Prisons for England and Wales Annual report 2018-19*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814689/hmip-annual-report-2018-19.pdf [accessed 18/10/19].

58 Independent Monitoring Boards, June 2019, *Annual Report,* https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2019/06/IMB-NATIONAL-ANNUAL-REPORT-PUBL-5-JUNE-2019.pdf [accessed 18/10/19]; *Introducing the use of PAVA spray in prisons*, October 2018, https://prisonjobs.blog.gov.uk/2018/10/09/introducing-the-use-of-pava-spray-in-prisons/ [accessed 05/12/19]

The use of force by staff was high in many prisons and there were concerns about weaknesses in the governance of its use. The rollout of PAVA spray – a synthetic pepper spray which temporarily incapacitates those it is sprayed on – in the adult male estate (following a pilot) and the associated guidance to prisons was announced this year and was due to commence in April 2019;[59] IMBs raised significant initial concerns about the lack of robust governance guidance.

However, the introduction of key workers (a prison officer assigned to each prisoner to provide regular support and engagement) through the new OMiC model was seen as a promising development by HMI Prisons and IMBs.

While two-thirds of prisoners were positive about the way they were treated by staff, HMI Prisons reiterated the frequent finding that prisoners from black and minority ethnic backgrounds did not have such positive views of their treatment and conditions. For example, only 56% of men from a black or minority ethnic background felt that most staff treated them with respect, compared with 74% of white men.[60]

Outcomes in women's prisons inspected in England were generally better than for men. However, levels of self-harm were very high and had increased throughout the women's estate by 24% in 2018.[61] Inspectors found that support available to women to maintain contact with families and friends varied from prison to prison, and that due to distances from home this was problematic in many cases. At HMP Eastwood Park, the Independent Monitoring Board noted that there were 50 to 60 open ACCTs (case management for prisoners at risk of self-harm) every month, and that a rise in violence was linked to the return to custody of women who had been recalled.[62]

In Scotland, the four inspections conducted by HMIPS in the year found that prisoners reported feeling largely safe and that there was evidence of positive and respectful relationships between staff and prisoners. Nevertheless, HMIPS and its Independent Prison Monitors reported that overcrowding had begun to compromise the delivery of full and effective regimes. For example, they noted adverse impacts such as staff having less time to deal with individuals, prisoners being located further away from home, and an increase in the waiting list for offender behaviour programmes. Consistent delivery of health care was noted as a particular challenge across the majority of the estate. The most frequent request for assistance by prisoners from Independent Prison Monitors related to medical issues, in particular differences in prescribing practices by health care providers. HMIPS was also concerned about the management of equality and diversity issues within prisons, and noted the

59 HM Government, October 2018, *Prison officer safety equipment rolled out*, https://www.gov.uk/government/news/prison-officer-safety-equipment-rolled-out [accessed 05/12/19]

60 HM Inspectorate of Prisons, July 2019, *HM Chief Inspector of Prisons for England and Wales Annual report 2018-19*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814689/hmip-annual-report-2018-19.pdf [accessed 18/10/19].

61 Ministry of Justice, *Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to March 2019, Assaults and Self-Harm to December 2018*, https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-march-2019

62 Independent Monitoring Boards, June 2019, *Annual Report*, https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2019/06/IMB-NATIONAL-ANNUAL-REPORT-PUBL-5-JUNE-2019.pdf [accessed 18/10/19]

need for improved monitoring, tracking, and reporting of protected characteristics.

Serious concerns about the treatment of prisoners held in segregation at Cornton Vale women's prison were identified by the Council of Europe's Committee for the Prevention of Torture (CPT) during its 2018 visit to Scotland. Women in need of urgent care and treatment in a psychiatric facility were found to be held for long periods in solitary confinement. Disturbingly, the CPT considered that neither the Separation and Reintegration Unit (SRU) nor Ross House (an accommodation unit) were suitably equipped or staffed to provide proper care for the vulnerable women held at the time of the visit.[63]

In Northern Ireland, a joint thematic review of the safety of prisoners by RQIA and CJINI found the Care and Supervision Unit for young men aged between 18 and 24 at Hydebank Wood College to be unsafe. This Unit was consequently relocated to another part of the college with an improved physical environment. A multi-agency inspection of Maghaberry Prison, which houses adult men, noted good improvements to health services and medication management, as well as to staff morale and leadership. Reductions in levels of violence and disorder were also positive developments. The inspection team indicated that further work was required to support the most vulnerable prisoners within Maghaberry, including improved management and care of men who had self-harmed or were at risk of doing so.[64]

Children in detention

Overall, NPM members welcomed the continued fall in the number of children held in custody across the UK during the year.[65] Inspections in Scotland, England and Wales assessed some improvements in safety outcomes. However, concerns were raised about the increasing proportion of young people remanded to custody and the increased disproportionality of children and young people from black and minority ethnic backgrounds detained.

In Northern Ireland, the RQIA progressed enforcement action in 2017–18 in relation to aspects of care in Lakewood Secure Children's Home, where it had concerns about the management of complaints from the young people, restriction of young people in their bedroom environments and safeguarding.

Inspections of all five dedicated secure care services for children and young people in Scotland evaluated the quality of care as very good or better for the year 2018–19. Inspectors noted an increase in relationship-based practice which recognises the importance of the human relationships staff have with the people they work with, services becoming more trauma-aware, and significant improvements to physical environments.

63 Committee for the Prevention of Torture, October 2019, *Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)*, https://rm.coe.int/1680982a3e [accessed 27/10/19]

64 Report on an unannounced inspection of Maghaberry Prison 9–19 April 2017, November 2018, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/11/CJINI-Maghaberry-Prison-unannounced-with-tables.pdf [accessed 05/12/19]

65 HM Prison and Probation Service, September 2019, *Youth Custody Report*, https://www.gov.uk/government/statistics/youth-custody-data [accessed 05/12/19]

In England and Wales, levels of violence across YOIs and STCs remained high and bullying, often connected to the operations of gangs, was a constant concern. However, there was some improvement in overall safety outcomes, which was a positive finding following HMI Prisons' conclusion in February 2017 that no such establishments were safe to hold children. Nevertheless, all three STCs in England were still deemed by Ofsted, HMI Prisons and the CQC to 'require improvement to be good'. These judgements reflected concerns about high levels of violence, use of force and physical restraint, the safety of children and staff, and the levels of skill and knowledge among staff to care appropriately for the children. HMI Prisons considered that most children in YOIs were not spending enough time out of their cells[66] and all YOI IMBs in England reported that there was a problem of 'keep aparts' where a young person cannot be placed on certain units for his own safety, or because there is a high risk of him assaulting others.[67] Of the 13 secure children's homes, nine were judged by Ofsted as at least good and four were judged as 'requires improvement to be good'.[68]

There were no self-inflicted deaths in YOIs or STCs during 2018–19 in England and Wales. Levels of self-harm had remained the same at Wetherby and Werrington and were lower than in other establishments. Self-harm had decreased at both Feltham A and Parc, but remained high on the Keppel Unit at Wetherby, reflecting the fact that it provides care to some of the most vulnerable young people in England.

In HMI Prisons' survey, 49% of children in YOIs and 62% of children in STCs said that they had been physically restrained while in custody. Use of force had increased at Werrington and Wetherby YOIs, and on the Keppel Unit. However, HMI Prisons noted that most behaviour management strategies had made a welcome shift towards instilling a reward-led culture that encouraged good behaviour. These positive initiatives needed to be embedded more widely. HMI Prisons also recognised that there had been some improvements in tackling and reducing violence among the complex population of young men held at Feltham A – assaults on boys had reduced by a third and assaults on staff had reduced by more than 80%. Nevertheless, the Inspectorate noted that this could 'prove to be fragile if investment falls away or leadership loses its focus.'[69]

The proportion of children and young people from black and minority ethnic backgrounds detained in youth custody continued to increase, having been steadily rising since the year ending 2011 when it was 29.7%. In England and Wales, for the year ending March 2018, more than half (51%) of boys in YOIs and 42% of children in STCs identified

66 HM Inspectorate of Prisons, July 2019, *HM Chief Inspector of Prisons for England and Wales Annual report 2018-19,* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814689/hmip-annual-report-2018-19.pdf [accessed 18/10/19].

67 Written Evidence from the Independent Monitoring Boards (IMBs) to Justice Committee inquiry into Children and Young People in Custody http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/justice-committee/children-and-young-people-in-custody/written/106134.html [accessed 05/12/19]

68 A further one remained as 'inadequate' from an inspection in October 2016. This provision is temporarily closed and there been no children living at the home since 2016.

69 The Chief Inspector of Prisons triggered the Urgent Notification process for HMP Feltham A on 24 July 2019 on the basis of a marked decline in safety and care.

as being from a black and minority ethnic background.[70] This was the highest rate recorded in HMI Prisons' surveys in YOIs.

Over this year there has been a spotlight on conditions for children in detention in various different settings. In April 2018, the Joint Committee on Human Rights (JCHR) began an inquiry on youth detention focusing on solitary confinement and restraint. Following evidence about the inappropriate detention of children and young people with learning disabilities and/or autism in mental health hospitals, it issued a further call for evidence specific to this issue. The Committee found that there was excessive use of separation and restraint in hospitals and custody and that the rights of children in detention are often not enforced.[71] It stated that 'the systems in hospitals and custody do not do enough to ensure that children are sufficiently aware of their rights and of how to appeal if their rights have been breached'. The Committee also concluded that 'the deliberate infliction of pain in [YOIs] is unacceptable under any circumstances under rights legislation'. The NPM shares this view and welcomes the unequivocal stance from the JCHR. The report calls for the prohibition of restraint for maintaining 'good order and discipline' in all but the most exceptional of circumstances.

The Children's Commissioner for England raised concerns about the steadily increasing proportion of children remanded into custody, and the worrying implication this trend has for children's rights. Children on remand accounted for 28% of the entire youth custody population and the majority (66%) were not subsequently given a prison sentence.[72] The Commissioner also challenged the increase in the number of episodes of segregation in youth custody in England and Wales over the past four years, despite the overall number of children detained having fallen.

Although not applying directly to places of detention, Scotland's Children and Young People's Commissioner has examined seclusion and restraint practices in schools and considered whether these constitute a deprivation of liberty.[73] The Commissioner found varying practices in recording the use of seclusion and restraint in schools and that in some local authorities, children may be subject to restraint and seclusion without any policy or guidance in place to support lawful and rights-compliant practice. The Commissioner recommended that the Scottish Government should publish a rights-based national policy and guidance on restraint and seclusion in schools.

70 HMI Prisons and Youth Justice Board, January 2019, *Children in Custody 2017–18. An analysis of 12–18-year-olds' perceptions of their experiences in secure training centres and young offender institutions.* Further data is available from Ministry of Justice, January 2020, Youth Justice Statistics 2018 to 2019, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/01/6.5164_HMI_Children-in-Custody-2017-18_A4_v10_web.pdf [accessed 04/02/20] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/862078/youth-justice-statistics-bulletin-march-2019.pdf [accessed 05/12/19]

71 Joint Committee on Human Rights, April 2019, *Youth detention: solitary confinement and restraint, Nineteenth Report of Session 2017-19*, https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/994/994.pdf [accessed 05/12/19]. Note that the report was published in May 2019, outside the reporting period.

72 Ministry of Justice, January 2020, *Youth Justice Statistics 2018 to 2019*, https://www.gov.uk/government/statistics/youth-justice-statistics-2018-to-2019 [accessed 04/02/20]

73 Children and Young People's Commissioner Scotland, December 2018, *Restraint and Seclusion in Scotland's schools: Commissioner publishes first investigation report*, https://www.cypcs.org.uk/news/in-the-news/restraint-and-seclusion-in-scotlands-schools-commissioner-publishes-first-investigation-report [accessed 13/01/20]

Police custody

NPM members highlighted the considerable vulnerability and health care needs of many people in police custody, where the ongoing high use of force across England, Wales and Scotland remained a serious concern.

HMICS found that across the 17 custody centres it inspected in Scotland, staff were committed to providing a good standard of care, but the quality of the custodial environment varied and was often poor, hampering the effective and efficient management of detainees. HMICS raised concerns around the inconsistencies in practice between custody centres, as well as the ability to safeguard the health care needs of highly vulnerable detainees.[74]

In England and Wales, there were 16 deaths in or following police custody during the year, a decrease on the 23 in the previous year. Fourteen of these were men and two were women. Ten people were identified as having mental health concerns. There were 63 apparent suicides following police custody.[75]

In the nine reports of inspections of police forces in England and Wales published during 2018–19, the governance and oversight of the use of force was a cause of concern in five of them, and an area for improvement in the remaining four.[76] Other areas of concern included the ongoing presence of ligature points in custody suites; poor recording on custody records with the reasons for some decisions not clear enough; and some long waits for children and vulnerable adults before receiving support from an appropriate adult.[77] Too few forces were recording information about the ethnicity or other protected characteristics of detainees.

Greater investment and improvements in mental health support were noted in all the forces inspected, and inspectors found that people with mental illness were being held in cells as a place of safety (under section 136 of the Mental Health Act 1983) only in exceptional circumstances. This followed amendments to the Act intended to limit the use of police stations as a place of safety which came into force in December 2017. However, for those who were held, waiting times for assessment and transfer under the Mental Health Act remained high.[78]

Independent Custody Visitors reported that detainees were largely being treated with dignity by staff and noted improvements in the menstrual care provided to women and girls in police custody. Inspections continued to find children being detained unnecessarily in police cells, often because suitable alternative accommodation, such as local authority beds, was not available.

74 HM Inspectorate of Constabulary in Scotland, October 2018, *Inspection of Custody Centres across Scotland*, https://www.hmics.scot/sites/default/files/publications/HMICS20181019PUB.pdf [accessed 13/01/20]

75 Independent Police Complaints Commission, 2019, *Deaths during or following police contact: Statistics for England and Wales for 2018/19*, https://www.policeconduct.gov.uk/sites/default/files/Documents/statistics/deaths_during_following_police_contact_201819.pdf [accessed 17/10/2019]

76 HM Inspectorate of Prisons, 2019, *HM Chief Inspector of Prison for England and Wales Annual report 2018–19*, https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/annual-report-2018-19/ [accessed 13/01/20].

77 HM Inspectorate of Constabulary and Fire & Rescue Services, 2018, *State of Policing. The Annual Assessment of Policing in England and Wales*, https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/state-of-policing-2018.pdf [accessed 05/12/19]

78 Ibid.

In early 2019 HMICFRS and HMI Prisons carried out the first inspection of Terrorism Act (TACT) custody facilities. The inspection assessed outcomes for detainees at the five custody suites across England, along with the national framework for TACT detention suites provided through, and overseen by, the National Counter Terrorism Policing Network. The inspection found that there was good treatment and levels of care for detainees held under TACT, but governance arrangements for TACT detention were limited. The report, published in August 2019, made recommendations to both counter terrorism policing and the forces hosting the TACT suites to address these concerns.

Court custody and escorts

HMI Prisons observed a commitment to improve outcomes for detainees across all court areas it inspected, with a clear focus on welfare. Nevertheless, it found excessive use of handcuffs and searching in court custody facilities. Despite some concerted attention by Her Majesty's Courts and Tribunal Service to improving court environments, physical conditions overall in court cells remained poor. The lack of consistent mental health support for detainees in court cells was also a concern. Lay Observers reported grave concerns regarding the quality and completeness of information in person escort records (used to record information about detainees when they are transferred between places of detention) in England and Wales, including a lack of information about health conditions and self-harm risks which, in turn, led to inappropriate use of handcuffing. Between October 2018 and March 2019, 55% of the person escort records examined were unsatisfactory. For example, key data such as appropriate medical contact numbers were regularly missed, impacting on decency and welfare.[79] Other serious concerns included children and young people being left alone in court custody cells despite the requirement that they be accompanied; long journeys to and from court for children and young people – including daily round trips during trials of up to four hours; and lengthy waits in court custody at the conclusion of hearings while transport arrangements to YOIs were made.

Immigration detention

At the end of March 2019, there were 1,839 people held in the UK detention estate, a third (33%) less than last year.[80] This reflected a fall in the volume of people entering immigration detention of 10% in the year to December 2018. It was of concern, however, that 355 detainees were held in prison establishments.[81] The IMBs noted that this dramatic fall in numbers across the estate brought an end to overcrowding, enabled improvements and led to higher standards of cleanliness. HMI Prisons found outcomes were good or reasonably good across the immigration removal centres inspected in 2018–19. Reports on the wrongful detention and deportation of Windrush citizens formed the backdrop to the 2018 decrease in the number of people entering immigration

79 Lay Observers, 2019, *Annual Report of Chair of Lay Observers 2018–19*, https://s3-eu-west-2.amazonaws.com/layobservers-prod-storage-nu2yj19yczbd/uploads/2019/09/Lay-Observers-18-19-Annual-Report-180919-FINAL.pdf [accessed 18/10/19]

80 Home Office, May 2019, *Immigration statistics, year ending March 2019*, https://www.gov.uk/government/publications/immigration-statistics-year-ending-march-2019/summary-of-latest-statistics [accessed 18/10/19]

81 National Statistics, May 2019, *How many people are detained or returned?* https://www.gov.uk/government/publications/immigration-statistics-year-ending-march-2019/how-many-people-are-detained-or-returned [accessed 05/12/19]

detention. The Joint Committee on Human Rights led an inquiry into the Home Office's treatment of these individuals and published a report on the scandal in June 2018.

However, ongoing concerns were raised regarding the safety of detainees, high levels of use of NPS and related violence. For example, the Heathrow IMB reported a significant drugs problem, gang activity and violent incidents and at Brook House there were 55 reports of actual or suspected bullying over the year. IMBs at three centres – Heathrow, Brook House and Campsfield House – raised concerns about the high levels of handcuffing for detainees being escorted on external visits and the IMB Charter Flight Monitoring Team expressed similar concerns about the overuse of waist restraint belts on removal flights.[82]

IMBs raised concerns about the operation of the Home Office 'adults at risk' policy and its effectiveness in keeping the most vulnerable people out of detention,[83] and weaknesses in rule 35 protections were identified by HMI Prisons at Tinsley House, a small IRC holding just under 140 detainees.[84] The adults at risk policy aims to ensure that risk factors related to vulnerability are balanced against 'immigration control factors' (i.e. the length of time in detention, public protection issues and compliance issues). In their evidence to Stephen Shaw's follow-up review, several organisations were concerned about whether this balance was being achieved, particularly with regard to the evidence levels and screening for vulnerability.[85] The Independent Chief Inspector of Borders and Immigration will, in future, report annually on how the policy is operating.

Detention outcomes and detention without limit all remained problematic. IMBs voiced ongoing concerns about the impact on detainees' mental and physical health of the absence of a statutory time limit and about the high proportion of detainees who were released from IRCs rather than being removed. However, they welcomed the reduction both in the number of people detained and the number held for excessively long periods, and the introduction of an automatic referral to a bail hearing for most detainees after four months in detention. IMBs will monitor how this affects periods of detention.

The investigation of alleged abuse of detainees at Brook House IRC, aired in undercover footage by BBC's *Panorama* in September 2017, was subject to legal challenge during the year. Two of the detainees brought judicial review proceedings to call on the Home Office to establish an independent inquiry into the abuse, in line with duties under Article 3 of ECHR (the prohibition of torture). Shortly before the final hearing in the case the Home Office requested

82 Independent Monitoring Boards, October 2019, *National Annual Report for the Immigration Estate 2018*, https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2019/10/IMBIDE-Annual-Report-2018-FINAL-003.pdf [accessed 05/12/19]

83 A revised policy came into force in July 2018.

84 HM Inspectorate of Prisons, June 2018, *Report on an unannounced inspection of Tinsley House Immigration Removal Centre*, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/08/Tinsley-House-Web-2018.pdf [accessed 05/12/19]

85 Shaw, S., July 2018, *Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons. A follow-up report to the Home Office*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728376/Shaw_report_2018_Final_web_accessible.pdf [accessed 18/10/19]

that the PPO undertake a 'dedicated, bespoke, independent, Article 3-compliant investigation'.[86] At the end of the reporting year, lawyers had challenged the fact that the PPO inquiry would not have the power to compel witnesses and a verdict from the High Court was awaited. G4S, which ran Brook House IRC, had commissioned an investigation; this identified weaknesses in management processes and arrangements around staff training, appraisal and development, as well as the governance of the use of force.[87]

Health and social care detentions

A general trend in increased detentions under mental health powers was evident across the UK. The latest available data for Wales showed that the number of formal admissions under the Mental Health Act and other legislation during the year 2016–17 increased by 3% to 1,779.[88] In Northern Ireland, the number of compulsory admissions to mental health hospitals under the Mental Health (NI) Order 1986 increased by 119 (12.1%), from 987 in 2014–15 to 1,106 in 2018–19.[89] There was an estimated 2% increase in mental health detentions in England during 2018–19, although there are shortcomings with the quality of available data.[90] In Scotland, in 2018–19 there were 6,038 new episodes of compulsory treatment during the year – the highest figure since the current legislation came into force in 2005.[91]

In December 2018, after public pressure about poor treatment of people with mental health problems, learning disabilities and/or autism, including children, the CQC was commissioned by the Secretary of State for Health and Social Care to undertake a review in England of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism.[92] Interim findings, published in May 2019, identified that services found it challenging to meet the needs of those held in segregation, many staff lacked the necessary skills to deal with people in segregation, some wards were unsuitable environments, and there were delays in

86 The *Guardian*, October 2018, *Home Office agrees to inquiry into immigrant abuse allegations*, https://www.theguardian.com/uk-news/2018/oct/11/home-office-agrees-inquiry-immigrant-abuse-claims-detainees-removal-centres [accessed 14/01/20]

87 K. Lampard VERITA, February 2018, *Managers need to model the right behaviours for a successful organisational culture*, https://www.verita.net/blogs/managers-need-to-model-the-right-behaviours-for-a-successful-organisational-culture/ [accessed 05/12/19]

88 Welsh Government, January 2018, *Admission of patients to mental health facilities*: April 2016 to March 2017, https://gov.wales/admission-patients-mental-health-facilities-april-2016-march-2017 [accessed 05/12/19]

89 Department of Health, August 2019, *Mental Health and Learning Disability Inpatients 2018-19*, https://www.health-ni.gov.uk/news/mental-health-and-learning-disability-inpatients-2018-19 [accessed 04/02/20]

90 NHS Digital Mental Health Act Statistics, October 2019, *Annual Figures 2018–19*, https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures [accessed 05/12/19]

91 Mental Welfare Commission, October 2019, *Annual statistical monitoring*, https://www.mwcscot.org.uk/sites/default/files/2019-11/MHA-MonitoringReport2019.pdf [accessed 05/12/19]

92 Care Quality Commission, November 2018, *Terms of reference of the use of restraint, prolonged seclusion and segregation for people with mental health problems, learning disabilities and/or autism*, https://www.cqc.org.uk/sites/default/files/20181203_restraint-thematic_tor.pdf [accessed 05/12/19]

discharging people due to a lack of suitable care in a non-hospital setting.[93]

In June 2019, the CQC reported on a review of the Mental Health Act Code of Practice.[94] Concerningly, it found that providers lacked understanding about how to promote, apply and report on the guiding principles in the Code, which included the principles of using the least restrictive option and maximising independence, as well as involving and empowering patients, and treating them with dignity and respect. It proposed that further joint working was needed to ensure people in need of urgent care have timely access to a bed that is close to home, in line with the expectation of section 140 of the Mental Health Act.

CQC reported a continued general trend of improvement in England, but a deterioration in ratings for safety in mental health services, which it attributed to shortages of staff and a lack of qualified staff.[95] For example, people who needed support from mental health, learning disability or autism services were more likely than people without these conditions to get poor care or be at crisis point before they received the care they needed. They were also likely to be detained in unsuitable services far from home because they had not been helped sooner or were unable to access care at all. In particular, CQC stated that too many people with a learning disability and/or autism were in hospital because of a lack of local community services. Since October 2018, CQC has rated 14 mental health hospitals that admit people with a learning disability and/or autism 'inadequate' and placed them under special measures.[96] In the majority of mental health inpatient services rated as 'inadequate' or 'requires improvement' since October 2018, the inspection reports identify a lack of appropriately skilled staff as an issue. CQC also reported that there was a 14% fall in the number of mental health beds between 2014–15 and 2018–19.

In May 2019, BBC's *Panorama* exposed a culture of abuse at Whorlton Hall, a secure hospital for people with learning difficulties and/or autism in County Durham. Camera footage showed staff physically abusing and bullying and intimidating patients. CQC has commissioned an independent review into its regulation of Whorlton Hall by Professor Glynis Murphy.[97]

93 Care Quality Commission, May 2019, *Interim report: Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism*, https://www.cqc.org.uk/publications/themed-work/interim-report-review-restraint-prolonged-seclusion-segregation-people [accessed 05/12/19]

94 Care Quality Commission, June 2019, *Mental Health Act Code of Practice 2015: An evaluation of how the Code is being used*, https://www.cqc.org.uk/publications/major-report/mental-health-act-code-practice-2015-evaluation-how-code-being-used [accessed 05/12/19]. Note the review was requested from the Department of Health and Social Care (DHSC) during the reporting period.

95 Care Quality Commission, October 2019, *State of Care 2018–19*, https://www.cqc.org.uk/publications/major-report/state-care#access [accessed 13/01/20]

96 These figures are taken from CQC's *State of Care 2018–19* (ibid). The data used comes from CQC's inspections and ratings published as at 31 July 2019, meaning that some of these ratings may have been made outside of the timeframe of this annual report.

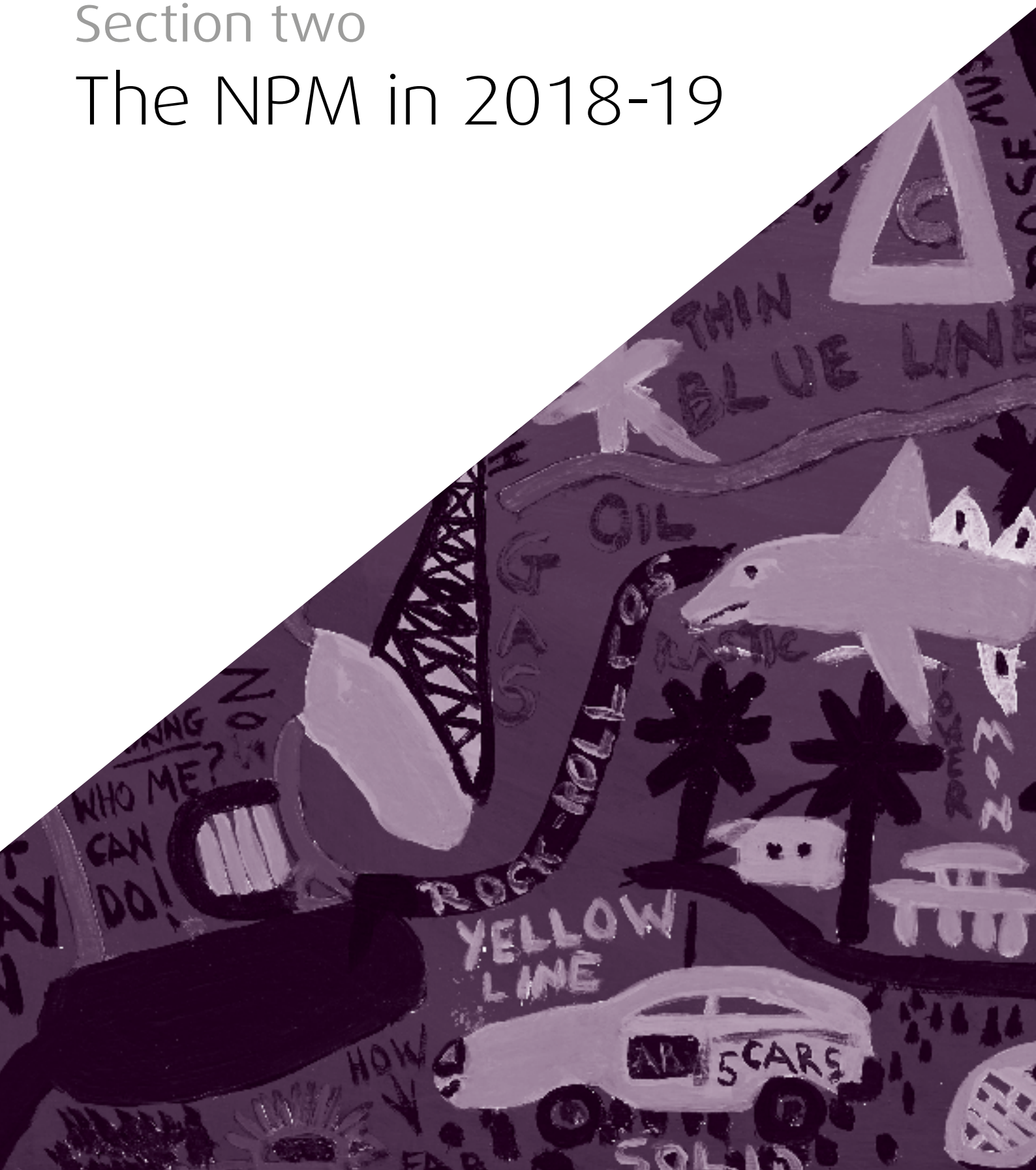
97 BBC, 22 May 2019, *Whorlton Hall abuse and how it was uncovered*, https://www.bbc.co.uk/news/health-48369500 [accessed 13/01/20]; Care Quality Commission, 19 June 2019, *Update on independent review into regulation of Whorlton Hall*, https://www.cqc.org.uk/news/stories/update-independent-review-regulation-whorlton-hall [accessed 13/01/20]

Health Inspectorate Wales undertook 17 mental health hospital inspections, including one specifically for learning disabilities, during the year. Its findings of patients' treatment were largely positive, and notably some services were working hard to reduce restrictive practices. However, care and treatment planning was poor, with improvements needed to manage risk in independent settings. One area of particular concern was the maintenance and refurbishment of wards which, in some cases, was having a detrimental effect on patient care, privacy and dignity and patient safety.

Across mental health and learning disability facilities inspected in Northern Ireland, concerns were raised about the lack of safe and therapeutic environments. In the second half of the year there were concerns about the ill-treatment of patients detained under the Mental Health (Northern Ireland) Order 1986 at Muckamore Abbey Hospital, which provides inpatient mental health services for patients with a learning disability. A multidisciplinary inspection of the hospital undertaken by RQIA in February 2018 identified concerns in a number of areas of practice, including the use of restrictive practices and specifically seclusion practices. The events, reported in 2017, are now subject to a major police investigation.

Section two

The NPM in 2018-19



NPM objectives

Each year, the NPM agrees a business plan to guide the work we do and ensure we meet the requirements of OPCAT. In 2018–19 the NPM worked to four objectives, to:

- work together as members of the NPM to strengthen the protection of those in detention in the UK
- ensure every NPM member delivers its own responsibilities under OPCAT
- build an NPM that is effective in delivering all the requirements of OPCAT
- increase the visibility and awareness of the NPM's role in prevention, OPCAT, the prohibition of ill-treatment in detention and the Convention Against Torture.

Strengthening the NPM

Lack of statutory framework

We remain concerned that the NPM is still not provided for in legislation. We sought to address the lack of formal legal recognition of the independence and role of the NPM collectively and of its 21 individual members in 2018–19, but we were disappointed by the lack of action by the government to address this significant failing.

The NPM wrote to the Joint Committee on Human Rights and the Justice Select Committee, who have, in the past, called for the NPM to be placed on a statutory footing.[98] We sent a letter to Harriet Harman (See Appendix I), Chair of the Joint Committee on Human Rights, in September 2018. In the letter we highlighted that the absence of legislation for the NPM fails to meet the requirements of OPCAT.

The NPM also wrote to Bob Neill, Chair of the UK Parliament's Justice Select Committee, in August 2018 (See Appendix II). Our letter welcomed the Justice Committee's recommendation to government that the NPM be placed on a definitive statutory basis should legislation on prison reform be brought forward.[99] We were pleased that the Justice Committee's 'Prison Population 2022' report, published in April 2019, made a further recommendation to strengthen the statutory foundations of the NPM.[100]

MoJ/NPM Protocol

The MoJ and NPM agreed that it would be useful to draft a Protocol. The NPM considers this an interim step towards, not in place of, legislation for the NPM. Progress towards finalising the protocol has been made during the year. The Protocol will set out, at a high level, the role of the MoJ and NPM in relation to OPCAT, as well as arrangements regarding the membership, governance, budget and structure of the NPM.

Funding

We are pleased that after submitting a funding proposal to the Scottish Government in July 2018 we secured funding to provide for a part-time Scottish NPM assistant coordinator, who took up post in late 2019.

98 Justice Committee, April 2017, *14th Report – Prison Reform: Part 1 of the Prisons and Courts Bill, Topical Questions, 25 April 2017, Hansard Volume 624*, https://publications.parliament.uk/pa/cm201617/cmselect/cmjust/1150/1150.pdf [accessed 13/01/20]

99 Ibid

100 Justice Committee, April 2019, *16th Report – Prison population 2022: planning for the future*, https://publications.parliament.uk/pa/cm201719/cmselect/cmjust/483/483.pdf [accessed 05/12/19]

The role of the Scottish NPM assistant coordinator is an important step toward greater capacity for the NPM. The role will support and link up the work of the different Scottish members of the NPM on common themes which are relevant across different types of detention. The Scottish assistant coordinator will also: develop opportunities to influence relevant policy and legislation in Scotland; support the NPM's engagement with the Scottish Parliament; broaden the NPM's approach to the prevention of ill-treatment in Scotland; and improve awareness of the requirements of OPCAT among Scottish stakeholders.

Wider engagement and visibility

The NPM continues to work with other stakeholders on matters that relate to the NPM's work. In July 2018, the Secretariat met with the Independent Advisory Panel on Deaths in Custody (IAP) and Ministerial Board on Deaths in Custody to discuss areas of common interest, such as data on deaths in custody following from the NPM's detention data mapping project.

In October 2018, the MoJ organised an 'NPM awareness-raising event'. The event aimed to bring together NPM members, their government sponsors and relevant policy leads from across the UK to raise awareness of OPCAT and the work of NPM members. Those present discussed the role of the NPM and future opportunities for joint working between NPM members and their government sponsor bodies.

Member-specific developments

Throughout 2018–19 NPM members engaged in work relevant to their NPM role. A number of members, such as CI and HMIPS, produced revised standards for inspections that embedded human rights into their processes. ICVA launched a brand new methodology in the year and HMI Prisons further developed its methodology. Across the NPM, members also produced a wealth of new evidence and recommendations on the state of detention in the UK, from visit reports to thematic analyses on certain issues in places of detention.

In 2018–19 the **Care Inspectorate (CI)** began to develop a new methodology for inspecting care services, which incorporated the Scottish Government's 2017 human rights-based health and social care standards. The CI also published a new Quality Framework for Care Homes for Older People in 2018, setting out what the CI expects to see in care homes during inspections to help services evaluate their own performance. Inspections based on the new framework started at the end of July 2018, and the CI has since commenced work to develop its quality frameworks for other settings it monitors, such as for adult care home services, care homes for children and young people and for children and young people in secure care.

To help independent service providers and local authorities meet the needs of young people, CI published guidance on the admission of young people into residential establishments, including secure children's homes. CI and Education Scotland also produced joint guidance on physical

restraint principles to support inspectors in their scrutiny and improvement roles. This guidance is structured around the UN's Convention on the Rights of the Child. CI continued to sit on the Scottish Government's Programme Board for Health and Social Care in Prisons. The board aims to address structural barriers to improving health and social care in prisons, taking account of the transition of care in and out of prison and the role of integration joint boards and health boards in the delivery of health and social care in prisons. During 2018–19, CI appointed a new Chief Executive, Peter Macleod, who took up post in January 2019.

In addition to carrying out an inspection of 17 police custody facilities across Scotland, **Her Majesty's Inspectorate of Constabulary in Scotland (HMICS)** also started work on a new approach for gathering data on detainees' experiences of police custody. Inspectors noted that detainees can be reluctant to speak with inspectors during their time in police custody. To address this, and in light of concerns about the experience of women in custody in particular, HMICS approached third sector organisations who worked with women with experience of police custody and held a focus group with them. This approach has given HMICS new insights into the experience of women in custody. HMICS plans to extend this work to other groups such as children and men.

Her Majesty's Inspectorate of Prisons for Scotland (HMIPS) began to collaborate with Health Improvement Scotland in 2018, to assess the quality of health care during inspections of prisons and young offender institutions. HMIPS conducted four full prison inspections and made two return prison inspections, and undertook five court custody inspections in 2018–19. HMIPS reviewed and improved the standards used when inspecting court custody units. HMIPS also published a collaborative thematic review, with HMICS, on Home Detention Curfew.

Independent Prison Monitors (IPMs), who are a formal part of the HMIPS structure, volunteered over 5,000 hours of their time in monitoring Scotland's prisons on 917 occasions, dealing with more than 900 requests from prisoners. During 2018–19 IPMs had a more direct communication with and influence on the inspection work carried out by HMIPS. HMIPS also devised a new action plan to help IPMs assess the action of the Scottish Prison Service in response to inspection findings and recommendations to improve the overall monitoring of ill-treatment in Scotland's prisons.

In November 2018 HMIPS was asked by the Scottish Cabinet Secretary for Justice to undertake an expert review of mental health services in HMP YOI Polmont, following two self-inflicted deaths in the prison. The review was led by an external clinical expert. Although the report was not published in the reporting year, much of the review work was done during this time and highlighted the need for improved sharing of information between external agencies and the Scottish Prison Service to improve risk management when entering and leaving custody, and greater action to minimise social isolation, particularly in the first weeks of custody.

In May 2018 HMIPS launched a new set of inspection standards and 'Panel Principles' which the **Scottish Human Rights Commission (SHRC)** helped

to develop. These ensure that the human rights principles of Participation, Accountability, Non-discrimination and equality, Empowerment and Legality (PANEL) are intertwined through each part of the prison inspection process. SHRC continued to work with HMIPS on its regular prison inspection regime. SHRC also submitted a response to the Committee against Torture's review into the United Kingdom to capture the protection of people's human rights in Scotland.

Independent Custody Visiting Scotland (ICVS) volunteers carried out over 1,363 visits in 2018–19.[101] Working with Police Scotland, ICVS identified ways to make independent custody visits more effective. A pilot ran in two custody centres in the West of Scotland. These pilots used ICVS 'points of contact' to improve the relationship with the on-duty custody sergeant, reducing the number of delays to visits and abandoned visits in these custody suites.

Custody volunteers raised concerns around the issuing of the Letter of Rights to people in custody. Letter of Rights leaflets list the rights of people in police custody to ensure they are treated fairly by the police. Police Scotland has a statutory obligation to provide detainees with these leaflets under The Right to Information (Suspect and Accused Persons) Scotland Regulations 2014. Since these concerns were raised improvements have been made to the monitoring of this provision. Custody visitors now ask people in detention if they have received a Letter of Rights and whether they understand its content.

In its monitoring work the **Mental Welfare Commission for Scotland** highlighted increased use of compulsory powers under mental health and incapacity law, with particular concerns about the rise in detention of young people, particularly in adult services. It published analysis of the use of Place of Safety orders under the Scottish Mental Health Act by the police, with recommendations to improve consistency of practice in the future. That has led to further work reviewing local Psychiatric Emergency Plans. The Commission was heavily involved in work to review the investigation of deaths of patients in mental health services, which led to the Government asking it to develop a new system of review for deaths of detained patients. The Commission continued to highlight its concerns about the number of people with learning disabilities it visited who continued to be in hospital, often subject to detention, despite having been assessed as able to be supported in the community.

Criminal Justice Inspection Northern Ireland (CJINI) published two inspection reports on places of detention in 2018–19. Its inspection report on Maghaberry Prison was published in November 2018, and highlighted the encouraging levels of progress made in the prison since its previous inspection in 2015. The report concluded that the outcomes for men held were some of the best seen by CJINI in similar prisons in recent years. Throughout the year, CJINI made efforts to focus on monitoring the conditions in Maghaberry and organised a programme of regular inspections, reviews of progress visits and unannounced visits to the prison.

101 Scottish Police Authority, 2019, *Annual Review 2018-19. Independent Custody Visiting Scotland*, http://www.spa.police.uk/assets/128635/293559/icvannualreview201819 [accessed 04/02/20]

The positive findings from the last inspection are, in part, a result of this constant focus. CJINI's report on Woodlands Juvenile Justice Centre was published in June 2018. CJINI reported a high standard of care for children in the facility.

The **Independent Monitoring Boards in Northern Ireland** attended an NPM training session with the NPM Secretariat in March 2019. IMBNI also recruited additional board members to the teams at Maghaberry and Hydebank Wood prisons, increasing the level of scrutiny there.

During the year, the board at Hydebank Wood highlighted to the Prison Governor and CJINI concerns relating to the isolation of prisoners for periods of up to 28 days, with some held in special accommodation which incorporated chemical toilets rather than normal facilities. In addition, the IMB highlighted some variation in the treatment of prisoners by night staff in comparison with day staff. This resulted in the provision of additional Northern Ireland Prison Service training, especially for night staff, with the aim of improving care for prisoners. IMBNI continues with efforts to increase the visibility of its boards to prisoners by displaying posters around prisons and attending education and work areas during the day.

The Northern Ireland Policing Board Independent Custody Visiting Scheme (NIPBICVS) had a busy year in 2018–19. Following the Assembly election in March 2017, a Northern Ireland Executive was not formed nor a Justice Minister appointed. That meant that the Northern Ireland Policing Board could not be fully constituted and members could not be appointed. In November 2018, the Secretary of State for Northern Ireland introduced the Northern Ireland (Executive Formation and Exercise of Functions) Act 2018. This legislation provided the scope for the appointment of members to the Northern Ireland Policing Board, allowing for the Board to be reconstituted on 1 December 2018. However, during this time independent custody visitors were still able to carry out visits to police stations. From April 2018 to March 2019 NIPBICVS carried out 508 custody visits across Northern Ireland, 41 of which were to TACT suites.

Following inspections of police custody in Northern Ireland by CJINI and RQIA, recommendations were made for better health care within custody suites. During April 2018 the Public Health Agency began evaluating the Custody Pathfinder Programme, a custody health care reform initiative. The Policing Board's Custody Visitors are actively participating in the review methodology and are a key stakeholder in the group.

NIPBICVS continued to carry out training sessions to ensure independent custody visits were effective and preventive, including sessions on human rights, equality and mental health.

During 2018–19 the **Regulation and Quality Improvement Authority (RQIA)** began an internal restructure, which has enabled more effective inspection programming. Towards the end of this reporting period RQIA also implemented a refreshed multidisciplinary inspection methodology, which combines an evaluation of systems delivering care with a detailed examination of leadership, governance and assurance arrangements within and across the facilities

being inspected. RQIA also began work to embed human rights more firmly in routine inspections and to reflect this approach more clearly in inspection reports. This work was supported through a series of training sessions delivered by a human rights expert.

A joint thematic review on the safety of prisoners in Northern Ireland undertaken collaboratively by RQIA and CJINI was completed in September 2018. During this review, RQIA identified a number of concerns relating to the physical environment in the Care and Supervision Unit (CSU) at Hydebank Wood Secure College.

Care Inspectorate Wales (CIW) implemented a new organisational structure due to changes made in the Social Services and Well-being (Wales) Act 2014 which came into force in 2016, and those brought about by the implementation of the Regulation and Inspection of Social Care (Wales) Act (RISCA) in 2018. CIW's structure has changed from a regionalised regulation and inspection model to one that works across Wales. The new CIW social care structure continues to prioritise responsibilities relating to the prevention of ill-treatment in children's homes and the examination of Deprivation of Liberty notifications that come from adult care homes.

To follow-up recommendations made about the provision of social care for adults and children in the secure estate, CIW continued to conduct routine performance reviews with local authorities throughout Wales. During 2018–19 CIW also undertook an informal survey with local authorities on arrangements for the delivery of care across the Welsh adult secure estate.

In December 2018, the Secretary of State for Health and Social Care asked the **Care Quality Commission (CQC)** to undertake a thematic review of restraint, seclusion and segregation, following reports of inappropriate use of seclusion and restraint and excessive lengths of stay for patients. The first phase of this work focused on people who are cared for in segregation on a learning disability ward or a mental health ward for children and young people.

In March 2018 CQC highlighted to NHS England and NHS Improvement concerns about the high number of people placed in mental health rehabilitation hospitals a long way from home. As a result, NHS England and NHS Improvement set up a team to work with local health and care communities to develop services capable of meeting these people's complex needs.

During the year CQC also provided training on OPCAT and the NPM role to a range of groups within its organisation, including the overarching mental health group concerned with the registration and inspection of hospitals and social care homes. The new Chief Executive of CQC, Ian Trenholm, was appointed in May 2018.

The **Children's Commissioner for England (CCE)** continued to organise the NPM Children and Young Persons sub-group, which allows member organisations who inspect and monitor places that hold children to share knowledge and work jointly on emerging issues and concerns. The CCE's team was expanded in 2018–19, which meant that it could increase the number of visits it undertook to places of detention or areas in which children were deprived of their liberty. The CCE team has since visited

youth justice, mental health and social care institutions more frequently.

During 2018–19, **Healthcare Inspectorate Wales (HIW)** received additional funding that will enable it to appoint more inspection and support staff and strengthen its work programme in 2019–20. HIW has also altered its inspection methodology to take into account changes to the Mental Health Act, introduced by the Police and Crime Act 2017. In 2018–19 HIW experienced increased public and media interest in its work, with the organisation more frequently being asked to speak at public events.

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) has continued to influence improvements to standards in police custody and outcomes for detainees by engaging positively with the national police lead for custody in England and Wales, and by presenting to the national police custody forums. It has also actively sought to help forces improve by offering opportunities for police officers delivering custody services to shadow inspections and increase their understanding of the services expected - and to take good practice back to their own forces.

Her Majesty's Inspectorate of Prisons (HMI Prisons) published 73 inspection reports in 2018–19. These included inspection reports on 35 prisons holding adult men, three prisons holding adult women, four inspections of young offender institutions (YOIs) holding children under the age of 18, and four inspections of three secure training centres (STCs) holding children aged 12 to 18, carried out jointly with Ofsted. HMI Prisons inspected four immigration removal centres, one family detention unit, eight short-term holding facilities, and two charter flight removals. It also inspected police custody suites in seven force areas with HMICFRS, TACT suites around the country, three court custody areas, and one extra-jurisdiction inspection at a prison in Northern Ireland.

HMI Prisons inspections are carried out against published criteria known as 'Expectations'. During 2018–19, HMI Prisons published two revised sets of Expectations and, with HMICFRS, its first criteria of assessment for the treatment of and conditions for detainees held in designated TACT custody suites, which hold those detained for terrorism-related offences. In addition to this HMI Prisons published thematic reports on: close supervision centres in prison; social care in prisons in England and Wales (with CQC); an analysis of children's perceptions of their experiences in secure training centres and young offender institutes; and a review of the management and supervision of men convicted of sexual offences.

HMI Prisons has introduced two important developments to its inspection methodology over the last two years. In this reporting year, the new independent reviews of progress (IRPs) were introduced and the Urgent Notification process, which was introduced last year, was embedded. The Urgent Notification process allows the Chief Inspector to write to the Secretary of State following the identification on inspection of significant concerns relating to the treatment and conditions of those detained. The Secretary of State commits to respond publicly to the concerns raised by the Inspectorate within 28 calendar days. The publication of both the Chief Inspector's notification and the Secretary of State's response increases the level of transparency around struggling prisons. The Chief Inspector issued three Urgent Notification letters to the Secretary of State during the year, expressing the Inspectorate's serious concerns, following the inspections of HMPs Exeter, Birmingham and Bedford.

The IRP methodology was developed to introduce independence into the assessment of the achievement of the Inspectorate's recommendations. IRP methodology provides an assessment of how far prisons have implemented HMI Prisons' key recommendations, in particular following concerning prison inspections. The Chief Inspector will identify establishments for an IRP based on a number of factors, including: healthy prison test scores over time; the key risks at the establishment; and levels of confidence in the capacity for change and improvement. They will be embedded in 2019–20. HMI Prisons aims to conduct between 15 and 20 IRPs each year.

During the year, the **Independent Custody Visiting Association (ICVA)** conducted a pilot change to its methodology, which was led by the Office of the Police and Crime Commissioner for Derbyshire and took place across the force area. The new methodology instructs independent custody visitors to look more closely at how vulnerable people are treated during their time in custody by examining custody records, with a focus on detainee rights, entitlements and well-being. Independent custody visitors in Derbyshire found that the pilot improved and strengthened safeguards for vulnerable detainees. ICVA began work with other ICV schemes around the country to see whether similar improvements can be replicated.

ICVA also started work on developing a stronger understanding of OPCAT and the NPM within independent custody visiting schemes throughout its workstreams. ICVA has produced new training material for schemes that details the international law regarding torture and ill-treatment and the importance of adopting a reprisals policy.

In 2018 the **Independent Monitoring Boards (IMB)** in England and Wales put in place a new governance structure. The new structure aims to strengthen the independence and effectiveness of the organisation by creating the position of an independent National Chair and strengthening regional support for Boards. In 2018, the IMB Secretariat wrote to Government asking for statutory underpinning for this new structure. Statutory underpinning is necessary for the IMB to achieve status as an independent arms-length body with the ability to recruit staff. Additional funding for the Secretariat from the Home Office was sought and agreed for 2019–20, which will help the

Secretariat organise visits to places of detention according to risk and enhance the training given to volunteers.

The IMB also began a project to review the number of volunteers on each of its monitoring boards and to update its National Monitoring Framework to ensure the number and nature of monitoring visits to prisons and immigration removal centres delivers on the NPM responsibilities of prevention, independence, and a commitment to OPCAT.

There were several developments in the **Lay Observers (LO)** organisation in 2018–19. The LO National Council expanded, with two new members appointed in the year. LO monitoring of the transportation of people held in court custody to prison was strengthened and extended. In October 2018, LO also introduced a revised set of expectations, along with a new reporting form, for volunteers to use during visits to court custody. As a result of LO reports on health care issues, the organisation was invited to be a representative to an NHS England group that examines health care needs in court custody.

Ofsted strengthened its oversight of the secure children's estate by increasing capacity in its inspection team, appointing a new Senior Officer to its secure estate work who will liaise with government departments and stakeholders and represent Ofsted within the NPM. Following this, Ofsted's work on secure children's homes moved to a regionalised model, meaning that regional managers are now operationally responsible for regulatory and inspection work while the Senior Officer retains a national oversight. Ofsted has retained a specialist national secure estate inspection team within this model.

Ofsted also published two new guidance documents for inspectors in the reporting year. The revised *Joint Inspection Framework* for the inspection of secure training centres, published in March 2019, has a sharpened focus on the experiences and progress of children. Ofsted's enhanced guidance for the inspection of secure children's homes as part of the Social Care Common Inspection Framework, also published March 2019, reflects the specialist and unique nature of secure provision.

The government had not filled the role of **Independent Reviewer of Terrorism Legislation (IRTL)** during the reporting year. This meant that the liaison between IRTL and ICVA to report on the conditions in detention for those detained under terrorism legislation was temporarily suspended, with ICVA supporting Police and Crime Commissioners (PCCs) to ensure effective scrutiny and reporting on those detained under terrorism law until the post was filled.

Jonathan Hall QC was appointed to the role on 29 May 2019 and in November 2019 submitted a draft of his first annual report (on the operation of the Terrorism Acts in 2018) to the Home Office for security and fact checking. It will be published by the Government in due course. The report will include consideration of the role played by independent custody visitors, and of the report submitted by HMI Prisons and HMICFRS in 1 August 2019, and whether there is any need to change the law governing the detention of terrorist suspects.

Joint working across the NPM

Working together as members of the NPM to strengthen the protection of those in detention in the UK is one of the NPM's strategic goals.[102] As well as collaborating during inspections and on joint NPM thematic projects, members of the NPM work together on a wide range of initiatives aimed at strengthening their OPCAT compliance and detention monitoring. Some notable examples from the year include:

- Work between ICVA, HMICFRS and HMI Prisons was strengthened in 2018–19. ICVA agreed a formal way of working with the inspectorates and independent custody visiting schemes, which includes ensuring the scheme manager receives a bespoke report based on the inspectorates' reports, setting out findings that are particularly significant for the independent custody visitors. These new arrangements help to ensure that ICV schemes and the inspectorates can discuss specific findings and share their expertise.
- In April 2018, Ofsted and CQC drew up an agreement that CQC will support Ofsted in leading inspections of secure children's homes, putting previous informal arrangements on a formal footing, and helping to improve the consistency of inspections.
- CI continues to support HMIPS on inspections of prisons – this year it observed three prison inspections to HMP Addiewell, HMP YOI Polmont and HMP Grampian. The involvement of CI enables a more comprehensive assessment of the care and support provided to prisoners, with a particular focus on social care adaptations and communication between the prison and other agencies.
- HMICS and CI, working with other partners including Healthcare Improvement Scotland, introduced a new model for the joint inspection of the care of young people and children, focusing on improving outcomes for children in residential and secure care. So far three joint inspections have been carried out under this framework.
- To help organise and strengthen a more joined up approach to monitoring treatment and conditions in police custody in Scotland, HMICS and ICVS have formalised arrangements for sharing information through a memorandum of understanding. Working together with HMICS, ICVS is currently working on creating a sanctions policy to ensure that detainees are able to speak to custody visitors openly and without fear of reprisal.
- HMI Prisons and the IMB continue to work together. The IMB sent a letter to Ministers in May 2018 expressing serious concerns about inhumane treatment at HMP Birmingham. HMI Prisons carried out an inspection in July and August 2018, in part due to the concerns noted by the IMB. Following the inspection, HMI Prisons invoked the Urgent Notification process with the Secretary of State regarding HMP Birmingham, highlighting inspection findings that the prison was in an 'appalling state' and 'fundamentally unsafe'.[103] As a direct result, ministers decided that the management of

102 National Preventive Mechanism, January 2019, *'The NPM in 2017-18', Ninth Annual Report*, https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2019/01/6.5163_NPM_AR_2017-18_WEB.pdf [accessed 05/12/19]

103 HM Inspectorate of Prisons, September 2018, *Report on an unannounced inspection of HMP Birmingham*, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/12/HMP-Birmingham-Web-2018.pdf [accessed 05/12/19]

the prison should be returned from the contractors, G4S, to HMPPS and immediate measures were put in place to address conditions for prisoners.

- CIW joined HMI Prisons and CQC to undertake a thematic review of social care in prisons in England and Wales. CIW carried out fieldwork at HMP Cardiff where it identified good practice around the initial screenings and assessments by local authority social care teams, which took place within 24 hours of an individual's entry into prison.
- CJINI continues to conduct prison visits with other NPM members, such as RQIA and the IMB in Northern Ireland. This provides additional resources to enhance the thoroughness of its inspections, allows sharing of inspection methodologies, and enables comparisons to be made with prisons in England and Wales. It also enables the South Eastern Health and Social Care Trust, which provides health care services in Northern Ireland's prisons, to be inspected and held accountable for services delivered. The IMB is a key partner in providing information to the inspectorates about the ongoing issues in the prison and the experiences of detainees, which members gain from the regularity of their visits; this can be used to inform the inspection findings and recommendations. A joint inspection of police custody with RQIA is planned for 2019–20.

Submitting proposals and observations on legislation

OPCAT requires NPMs to submit proposals and observations to existing or draft legislation to support the prevention of torture and ill-treatment in places of detention. There are a number of ways NPM members are consulted on, or seek to influence, the development of detention policy and legislation using the evidence from their monitoring of the treatment of and conditions for detainees.[104] Most commonly, NPM members contribute to formal policy consultations, Parliamentary inquiries, and draft legislation, as well as direct discussions with policy makers and politicians. For example:

- CI sat on the reference group of the Scottish Government-commissioned review of mental health services for young people in custody. This followed the self-inflicted deaths of two people at HMP YOI Polmont, and was carried out by an independent expert for HMIPS. CI also submitted evidence to: the Justice Committee in Scottish Parliament's investigation into secure care provision; the Age of Criminal Responsibility (Scotland) Bill; a consultation on the Protection of Vulnerable Groups and the Disclosure of Criminal Information; and a review of part one of the Children (Scotland) Act 1995, which reviewed the creation of a family justice modernisation strategy.
- SHRC gave written evidence to the Scottish Equality and Human Rights Committee inquiry into Prisoner Voting. SHRC drew on jurisprudence from the European Court of Human Rights in its

104 Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Art. 19, A/RES/57/199, 2002, available at https://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCAT.aspx [accessed 14/01/20]

written and oral evidence, arguing that an automatic blanket ban on prisoner voting is a disproportionate measure.

- MWCS made detailed proposals to the Scottish Government in its response to a consultation on reform of incapacity law, highlighting the need to address obligations under the UN Convention on the Rights of Persons with Disabilities.
- Ofsted provided feedback to the Youth Justice Board consultation in November 2018 to develop and implement standards for children in the youth justice system. Ofsted also submitted written and oral evidence to the Independent Inquiry into Child Sexual Abuse (IICSA). In its evidence, Ofsted noted the marked difference in its inspections of secure children's homes in comparison with secure training centres. Citing its Annual Report, published in December 2017, Ofsted stated that inspectors of STCs had 'serious concerns' about the safety of both children and staff, the rising levels of violence between children and young people, assaults on staff, and difficulties in staff retention.[105]
- The CCE presented evidence to the Joint Committee on Human Rights on its inquiry into 'Youth Detention: Solitary Confinement and Restraint', highlighting the unacceptable time that some children are held in separation or segregation. The CCE has also been working with government officials on the development of new Liberty Protection Safeguards to discuss how these will ensure that the rights of children are respected.
- The IMB Secretariat provided evidence to both the Home Affairs Committee and the Joint Committee on Human Rights inquiries into immigration detention. It drew attention to the damaging effect of indeterminate and, in some cases lengthy, periods of immigration detention on the well-being and mental health of detainees, as evidenced in IMB reports. It also highlighted other issues, including: the use of separation units to house vulnerable detainees suffering from mental illness; the concerning levels of drug use and violence in some immigration removal centres; and overcrowding and unacceptable living conditions, caused largely by inadequate and delayed maintenance. The IMB provided evidence to the JCHR on the deleterious effects of detention policy on the people volunteers met in detention, and raised serious reservations about the effectiveness of the 'Adults at Risk' policy in keeping the most vulnerable out of detention.
- The IMB also provided written evidence to the Justice Committee's inquiry into the prison population, focusing on the impact of indeterminate sentences for public protection (IPPs), the inappropriate use of prison for those with a mental illness, and the vulnerability of the female prison population.
- HMIPS gave evidence to the Equalities and Human Rights Committee inquiry into prisoner voting in Scotland, supporting the extension of voting rights to all prisoners. HMIPS also provided written evidence to the Justice Committee on the Management of Offenders (Scotland) Bill where it supported the greater use of electronic monitoring as an alternative to custodial sentencing.

105 Independent Inquiry into Child Sexual Abuse, February 2019, *Sexual Abuse of Children in Custodial Institutions: 2009–2017 Investigation Report*, https://www.iicsa.org.uk/key-documents/9560/view/sexual-abuse-children-custodial-institutions-investigation-report-february-2019.pdf [accessed 12/12/19]

- HMICS submitted joint written evidence with the NPM to the Scottish Parliament Justice Committee's post-legislative review of the Police and Fire Reform (Scotland) Act 2012. It highlighted the need for a statutory basis for HMICS's custody work. As a result of its 2018 inspection, HMICS also provided feedback on appropriate adult services to Scottish Government policy officers working on reviewing and revising these arrangements.
- ICVS has informed Police Scotland's policy by providing input to the Care and Welfare Standard Operating Procedure. ICVS gave specific advice on sanitary provision in police custody and on gender-specific care.
- HMI Prisons has used its inspection findings to make observations and recommendations to the following: Commission on Justice in Wales, Review of the Criminal Justice System in Wales (1 June 2018); Health and Social Care Committee, Prison Healthcare (1 June 2018); Joint Committee on Human Rights, Youth Detention: Solitary Confinement and Restraint (19 June 2018); Advisory Council on Misuse of Drugs, Custody-Community Transitions (20 June 2018); Joint Committee on Human Rights, Immigration Detention (6 September 2018); Home Affairs Committee, Macpherson: 20 Years On (15 February 2019); Independent Chief Inspector of Borders and Immigration, Call for evidence: 'Adults at Risk' in immigration detention (7 March 2019).[106]
- Representatives from all three independent monitoring boards in Northern Ireland met the Director General of Northern Ireland Prison Service (NIPS) to discuss issues raised in previous annual reports and provided feedback on NIPS plans for a 'no smoking' policy, young leadership programme and new changes to pre-release testing arrangements. IMBNI at Hydebank Wood responded to the NIPS consultation on Prison Services Estates 2020 in December 2018 and attended a meeting with the Director General of NIPS on the consultation in February 2019. IMBNI made recommendations regarding the building of a women's prison within Hydebank Wood.
- CQC provided a contribution to the 2018 Health and Social Care Select Committee inquiry into prison health through written submission and committee attendance. CQC took this opportunity to raise concerns over the vulnerability of people detained within the criminal justice system, including their restricted choices and the impact of the Care Act 2014, which removed statutory independent scrutiny by local safeguarding adult's boards. Subsequent government recommendations stressed the importance of strengthening CQC's role in regulating prison health and social care services.
- CQC continued to engage with the independent review of the Mental Health Act 1983, chaired by Professor Sir Simon Wessley. CQC welcomed the review report, published in December 2018, and committed to providing assistance and advice to government in drawing up its priorities for change. As part of this commitment, CQC has continually suggested that a three-month period for a second opinion appointed doctor is too long a wait to be an effective safeguard or to meet the developing expectations of

106 For more information on HMI Prisons' submissions see: https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/chief-inspectors-submissions-and-letters/

international law. Its recommendation has now been recognised and progress on what practical alternative arrangements can be made are underway.

- CQC also raised, with government officials, the legal problems relating to the discharge of patients from detention in hospital under the Mental Health Act into environments, such as adult social care homes, where they continue to be deprived of liberty under the Act. The Supreme Court's ruling on this matter in the MM case this year (Secretary of State for Justice v MM [2018] UKSC 60) suggests that some changes to the statute may be helpful to ensure that legal hurdles do not prevent patients from being cared for in the least restrictive environment available.

The UK Supreme Court heard the case of the **Secretary of State for Justice v MM** in July 2018, and gave judgement on 28 November 2018.

The case concerned a patient, MM, who was detained in a hospital under section 37 of the Mental Health Act, together with a restriction order under section 41. MM applied to the First-tier Tribunal (FfT) for a conditional discharge from hospital. A conditional discharge can only be authorised by an FfT or the Secretary of State for Justice. MM's discharge would require him to live in a setting where he would not be free to leave, and would not be allowed out without an escort. Although a suitable placement had not been found, MM consented to being placed in such a setting.

Despite this, the FfT ruled that it did not have the power to discharge MM with a care plan that would amount to a deprivation of his liberty or impose such conditions on him.

The Supreme Court, in a majority of 4–1, found that the Mental Health Act 1983 does not give powers to the FfT or Secretary of State to impose conditions that amount to a deprivation of liberty, even if the patient consents.

International scrutiny and collaboration

Throughout 2018–19 the UK NPM engaged with two international human rights bodies. The Committee against Torture (CAT) and the Council of Europe Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) have a mandate to assess States parties' compliance with international law on the prohibition and prevention of torture. The CAT holds periodic review sessions with States parties and the CPT can conduct visits to places of detention. These processes put UK detention practices under an international spotlight, providing important scrutiny in line with international human rights standards.

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment

In October 2018, the CPT visited Scotland.[107] The delegation went to five prisons and five police stations, assessing the treatment of and conditions for detainees. The Committee also met with NPM representatives during their visit. The NPM enjoys a constructive working relationship with the CPT, and visits are extremely important for the NPM, providing an opportunity to raise our concerns with an international expert body. Further, the CPT's visits and reports provide both the NPM and government authorities with instructive recommendations on how best to protect the rights of people in detention.

Recommendations on the NPM made by organisations contributing to the CAT review:

'The UK should place the NPM under statutory footing to provide it with formal status and guarantee its independence. The UK should ensure that the bodies under the NPM, including the NPM Secretariat, has sufficient human, material and financial resources to operate independently and effectively, and that its mandate includes military detention facilities overseas.' REDRESS, Civil Society Alternative Report to UN Committee against Torture

'The UK Government should:

- *Ensure that the NPM has access to all places of detention and their installations and facilities, including UK-controlled places of detention overseas, to regularly examine the treatment of people deprived of their liberty.*
- *Introduce legislation to ensure and safeguard the independence of the NPM and provide sufficient resources to permit the effective implementation of its mandate in line with the requirements of the OPCAT.'* Equality and Human Rights Commission, Submission to the UN Committee against Torture in response to the UK List of Issues

107 Council of Europe Committee for the Prevention of Torture, October 2019, Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 17 to 25 October 2018, https://rm.coe.int/1680982a3e [accessed 14/01/20]

Committee against Torture

The CAT scrutinises countries by conducting a review in Geneva every few years. The Committee stressed the importance of receiving information from NPMs, as well as NGOs and human rights commissions, ahead of the review session, which took place in Geneva in May 2019.

NPM members prioritised drafting a submission for the Committee to inform its review. The submission highlighted cross-cutting issues in places of detention across the UK, noting human rights concerns in prisons, police custody, mental health detention, immigration detention and health and social care.

Further, the CAT review was an opportunity for the NPM to work with the Equality and Human Rights Commission (EHRC) which held an awareness-raising event on the CAT process and supported a comprehensive civil society submission for the review.

Collaboration

As in previous years, the NPM and its members collaborated actively with a range of international actors, including monitoring bodies and inspectorates from other countries, academics and NGOs. The NPM and its members provided input to other NPMs, expert forums and new detention monitoring initiatives over the year, as follows.

- The NPM continues to work closely with the Geneva-based NGO, Association for the Prevention of Torture (APT), with whom we discussed the need for an NPM-led network in Europe. The Council of Europe provided the NPM Chair and a member of staff from the APT with the opportunity to give an update on the proposals for an NPM-led network at a meeting of the European NPM Forum in Ljubljana on 17 and 18 April 2019.
- The NPM Chair and an inspector from HMI Prisons' immigration team attended the Second Regional Meeting on Torture Prevention with the Organization for Security and Co-operation in Europe Office for Democratic Institutions and Human Rights (OSCE/ODIHR), and the Association for the Prevention of Torture (APT) in Milan in December 2018. They provided input into an expert discussion on monitoring immigration detention, as well as the different roles NPMs can play in torture prevention.
- The NPM Secretariat continued to support the efforts of authorities and wider stakeholders engaged in the process of establishing an NPM in Australia, meeting with the Principal Commissioner for Children and Young People in Victoria, Australia and continuing its discussions with others.
- The Head of the NPM Secretariat presented on the NPM to the Annual Faculty of Forensic Psychiatry at a conference in Vienna in March in a plenary session on rights and responsibilities in detention.
- A representative from CQC spoke at a seminar in Copenhagen on 'Enhancing Monitoring Methodologies for NPMs'. They, along with ICVA, also hosted the South African Human Rights Commission as part of a study trip to the UK.
- ICVA met with a delegation from China comprising lawyers and scholars with an interest in torture prevention and ill-treatment.

- HMICS was invited to Ireland by the Irish Penal Reform Trust to advise on setting up an NPM. HMICS spoke at two events, on human rights in detention and on the potential scrutiny bodies in Ireland who may be designated as members of the Irish NPM.
- During 2018, the IMB was asked by the Office of the Deputy Governor of the Cayman Islands to advise on an independent board to monitor detention on the islands. The national chair and a member of the IMBs' national training team provided information, carried out an exploratory visit and produced a report for the Deputy Governor's office. Two members of the national training team then provided training to the recently appointed monitoring team in the Cayman Islands, and the Cayman board chair attended an IMB board leadership course.
- The Northern Ireland Policing Board welcomed representatives from the Jamaican Civilian Oversight Authority to Northern Ireland in July 2018 and gave a comprehensive introduction on the oversight role of independent police custody visiting. In February 2019 representatives from the Promotion and Protection of Human Rights in Armenia Project visited the Police Service Northern Ireland for a three-day visit, and the NIPBICVS contributed a discussion on volunteer oversight in police custody.
- IMBNI organised visits from a representative from the Prisoner Ombudsman's Office in New Zealand and a representative from the Northern Australia Aboriginal Justice Agency visited Hydebank Wood to look at the implementation of OPCAT in the UK.

Section three

Looking ahead to 2019-20

Visit from the United Nations Subcommittee for Prevention of Torture

On 26 November 2018, the SPT sent confirmation to the UK Government that it would be including the UK in its visiting programme for 2019–20. This announcement came after the SPT invited the MoJ to address its session in Geneva in June 2018. It will be the first formal visit from the UN body to the UK.

The SPT conducts visits to member countries to look at the state of detention. It can also advise and assist NPMs during its visit on how to best implement OPCAT within the places of detention they monitor or inspect.

The visit from the SPT in 2019–20 is a key milestone for the NPM in its 10 years of existence. It presents the NPM with the chance to account for its work to date, and the report that the SPT will write as a result of its visit will serve as an authoritative account of our work. The SPT will make recommendations about areas in which the NPM must improve, and we expect issues such as our status and resourcing to be raised. We hope the SPT's report will lead to reinvigorated opportunities to work with the government towards strengthening the NPM.

The visit will also draw public attention to the UK NPM and its unique multi-body model, and the SPT's recommendations will inform our future practice and priorities. Accordingly, the NPM's primary focus over 2019–20 was to prepare for this important visit. This has meant coming together as an NPM to discuss the ways in which we work individually and collectively to protect the rights of people in detention from ill-treatment. We have worked to promote the visit with the government and other stakeholders, to highlight its importance to our reputation for implementing human rights protections. After the visit, the NPM will dedicate time to considering the SPT's recommendations and how these need to be captured in our future work.

The NPM has also agreed the following plans for our next business year:

- To celebrate the NPM's 10th year, we will publish a report to mark the anniversary. The short report will illustrate how member organisations work together and across the four nations to prevent ill-treatment and detail how the NPM has become more OPCAT-compliant.
- We aim to resume thematic work on ill-treatment, together with academics from Bristol University's Human Rights Implementation Centre.
- The NPM has already begun work to increase our public visibility and raise awareness of OPCAT. In 2019–20 we aim to prepare new and improved training materials on the UK NPM and OPCAT. We also hope to generate more public and media interest in our work to strengthen the understanding of preventive monitoring.

Section four

Appendices

Appendix I

Letter from NPM Chair John Wadham to Chair of Joint Committee on Human Rights, Harriet Harman

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17 September 2018

Dear Harriet

UK National Preventive Mechanism (NPM)

I am writing as the independent Chair of the UK NPM following a recent conversation you had with my NPM colleague, Katie Kempen of the Independent Custody Visiting Association. I understand she shared details of some of the work that the NPM undertakes to prevent ill-treatment of people in all forms of detention.

There are clear shared interests and overlaps between the NPM's work inspecting and monitoring all forms of detention across the UK and the Joint Committee's current work (indeed we have submitted evidence, jointly with our NPM colleagues from the Children's Commissioner for England's office, to the Committee's ongoing inquiry into restraint and solitary confinement of children and young people in detention settings). I would be delighted to meet with you to discuss our common areas of interest.

I would also value the opportunity to discuss an important issue of the UK's compliance with a UN treaty ratified by the UK and designed to protect human rights in the UK. The Optional Protocol to the Convention Against Torture (OPCAT), requires states that ratify the treaty to create or designate National Preventive Mechanisms. The current members of the UK NPM were designated by the UK government in 2009, with additional designations in 2013 and 2017. All the organisations originally designated were already functioning, many of them from some years before OPCAT was agreed by the UN, and the government decided that they were already carrying out the functions necessary for OPCAT. Currently, only two of the 21 members of the NPM (both in Scotland) have any reference to their OPCAT mandate written into their legislation.

The NPM itself has neither been recognised nor set up as an independent institution by legislation and has no legal identity. It was only in 2015 that the members of the NPM themselves decided to create a distinct role for the Chair of the NPM, independent of the other members of the NPM, and selected and appointed a Chair but without any support from the UK Government. As result, the Chair, like the NPM itself, is not recognised in legislation (nor given any of the required powers, immunities or status).

I strongly believe there is a need for separate legislation for the UK NPM and, in particular, a need to guarantee the independence of the NPM itself and to recognise the importance of NPM members' work to prevent ill treatment of detainees under OPCAT. The absence of legislation setting out the OPCAT mandate and responsibilities of each of the designated organisations (and specifically protecting their independence) does not comply with OPCAT or the guidelines from the expert body set up by the UN to advise on implementation - the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT). It is our view that, in addition to recognising the specific NPM role of its members in their own originating legislation, the NPM as a co-ordinating entity led by an independent Chair needs to be recognised separately in statute. This is important for our role nationally and for our reputation internationally. I continue to raise this issue with the Ministry of Justice and we will be raising it with the UN Committee against Torture as they consider the UK Government's track record on compliance with the Convention against Torture in May 2019.

I would welcome the opportunity to discuss this further with you would be available to meet you at your convenience. As always, if there is any other information that would be of use to you or the Committee from myself or the NPM Secretariat, please do not hesitate to let me know.

Yours sincerely,

John Wadham
Chair
UK National Preventive Mechanism

Appendix II

Letter from NPM Chair John Wadham to Justice Select Committee Chair, Sir Robert Neill

UK National Preventive Mechanism
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1 August 2018

Dear Mr Neill

UK National Preventive Mechanism (NPM)

You will remember that last year the NPM submitted written evidence to the Justice Select Committee's inquiry on prison reform. In that evidence, we raised our concerns about the lack of separate legislation for the UK NPM and, in particular, the need to guarantee the independence of the NPM itself and to recognise the importance of NPM members' work to prevent ill treatment of detainees under the Optional Protocol to the United Nations Convention against Torture (OPCAT).

I was therefore grateful that the Justice Committee, in its Report on prison reform (which scrutinised the provisions in Part 1 of the Prisons and Courts Bill), recommended the opportunity should be taken to place the NPM "on a definitive statutory basis, in accordance with the UK's international obligations as a party to OPCAT" should legislation on prison reform be brought forward. It was disappointing that opportunity was lost when government did not re-introduce such legislation. Nonetheless, the NPM has continued working towards improved recognition of its independence, and I am therefore writing to update you on recent developments that have taken place.

The position in relation to enacted legislation remains as it was when the Justice Committee was examining this issue: only two of the 21 members of the NPM (both based in Scotland) have any reference to OPCAT written in to their legislation. As a result, the lack of formal legislative recognition of the independence and OPCAT role of the NPM collectively and of its individual members has remained a key challenge for the NPM.

We continue to believe the absence of legislation setting out the OPCAT mandate and responsibilities of each of the designated organisations, specifically protecting their independence does not comply with OPCAT or the guidelines from the expert body set up by the UN to advise on implementation - the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT). It is our view that, in addition to recognising the specific NPM role of its members in their own originating legislation, the NPM as a co-ordinating entity led by an independent Chair needs to be recognised separately in statute. This is important for our role nationally and for our reputation internationally. I have therefore again raised this issue with the Ministry of Justice (correspondence attached), with the support of the SPT (correspondence also attached).

In parallel with our efforts to guarantee the independence of the NPM through specific legislation, we have asked the Ministry of Justice to implement other measures to strengthen the NPM. In our view, these measures would be interim steps towards, not in place of, legislation. One of the options being discussed is a Protocol between the Ministry of Justice and the Chair of the NPM (modelled on the Protocol between HM Inspectorate of Prisons and the Ministry of Justice that was adopted last year and which your Committee was integral to delivering). There has been some progress towards this, with the Ministry completing a first draft. However, a number of key areas, including those relating to the independence of the NPM and a road-map towards legislation (either within the Protocol itself or in Written Ministerial Statement), are yet to be agreed

I would welcome the opportunity to discuss this further with yourself and the Committee and would be available to meet you at your convenience. As always, if there is any other information that would be of use to the Committee from myself or the NPM Secretariat, please do not hesitate to let me know.

Yours sincerely,

John Wadham
Chair
UK National Preventive Mechanism

Encs.

cc Dominic Lake, Deputy Director, Human Rights & Intergovernmental Relations, Ministry of Justice

Appendix III

Glossary

APT	Association for the Prevention of Torture
CCE	Children's Commissioner for England
CI	Care Inspectorate
CJINI	Criminal Justice Inspection Northern Ireland
CPT	Committee for the Prevention of Torture (Council of Europe)
CQC	Care Quality Commission
CRC	Convention on the Rights of the Child
CIW	Care Inspectorate Wales
DoLS	Deprivation of liberty safeguards
ECHR	European Court of Human Rights
FCO	Foreign and Commonwealth Office
HIW	Healthcare Inspectorate Wales
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services
HMICS	Her Majesty's Inspectorate of Constabulary in Scotland
HMI Prisons	Her Majesty's Inspectorate of Prisons
HMIPS	Her Majesty's Inspectorate of Prisons for Scotland
HMP	Her Majesty's Prison
HMPPS	Her Majesty's Prison and Probation Service
ICVA	Independent Custody Visiting Association
ICVS	Independent Custody Visitors Scotland
IMB	Independent Monitoring Board
IMBNI	Independent Monitoring Boards (Northern Ireland)
IRC	Immigration removal centre
IRTL	Independent Reviewer of Terrorism Legislation
JCHR	Joint Committee on Human Rights
LO	Lay Observers
MHA	Mental Health Act 1983
MoJ	Ministry of Justice
MWCS	Mental Welfare Commission for Scotland
NGO	Non-governmental organisation
NIPBICVS	Northern Ireland Policing Board Independent Custody Visiting Scheme
NPM	National Preventive Mechanism

NPS	New psychoactive substances
OSCE	Organization for Security and Co-operation in Europe
Ofsted	Office for Standards in Education, Children's Services and Skills
OPCAT	Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
PACE	Police and Criminal Evidence Act 1984
PSI	Prison Service Instruction
PPO	Prisons and Probation Ombudsman
PSO	Prison Service Order
RQIA	Regulation and Quality Improvement Authority
SHRC	Scottish Human Rights Commission
SPT	United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
SCH	Secure children's home
STC	Secure training centre
YOI	Young offender institution

The image used in this report is a detail from *Wishful Thinking*, a painting by a prisoner at HMP Oakwood (copyright © 2020 The Koestler Trust, all rights reserved). The Koestler Trust is a prison arts charity, inspiring offenders, secure patients and detainees to take part in the arts, work for achievement and transform their lives.

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