Monitoring places of detention

Ninth **Annual Report**
of the United Kingdom's
National Preventive Mechanism
1 April 2017 – 31 March 2018

CP 17

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Presented to Parliament by the Lord Chancellor and Secretary of State for Justice
by Command of Her Majesty
January 2019

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Introduction by John Wadham, NPM Chair

I am pleased to present the latest annual report of the National Preventive Mechanism and in doing so, welcome the growing confidence of the NPM generally and, more particularly, the increasing influence of its 21 members. However, the risk of ill-treatment for those detained in settings across the UK has, if anything, increased since last year. NPM members this year continue to report concerns that detainees are not being held in safe and decent conditions. There were serious concerns about safety in a number of prisons and detention centres in England and Wales. We have discovered poor physical conditions and conditions not fit for purpose, and excessive or improper use of restraints on some of the most vulnerable detainees – including children and young people, those in mental health detention and those detained pending deportation from the UK.

For the first time this year, we have tried to ascertain the extent of our work – the number of visits and inspections – undertaken by NPM members. The figures show a very substantial output across our 21 members and the four nations we serve. To summarise:

- dedicated volunteers made at least 66,053 monitoring visits throughout the year to prisons, young offender institutions, immigration detention facilities, police custody, court custody and to observe escorts; and
- inspectors carried out at least 1,580 inspections across the UK.

I do not think that there is an NPM anywhere in the world that has reported anything like this number of visits to the places of detention in its country. This is an incredible achievement and a strength of the UK NPM model.

Every time an independent volunteer or inspector visits a place where people are detained it increases openness and transparency. The visit creates a less closed atmosphere and gives those detained an opportunity to voice their concerns. Importantly, it reduces the likelihood that the conditions of detention will deteriorate any further and reduces the chances that the detained person will be ill-treated. NPM members listen carefully to detainees and staff, make recommendations for change and drive forward improvements in conditions, reducing still further the risk of ill-treatment. At the core of the UK NPM's work is a human rights approach – placing the lived experience of detainees at the heart of the inspection and monitoring process and drawing on international standards and best practice to assess treatment and conditions in detention.

Unfortunately, there is still much more to do and those that visit and inspect are often swimming against the tide – a large and growing prison population, no limit on the period that people can be kept in immigration detention, and too many people in segregation or isolation (in prisons within prisons). However, by working together across the detention institutions and across the nations of the UK, NPM members can and do make a difference each year. The NPM continues to look for ways to strengthen our joint working processes. This year saw the creation of an NPM police custody sub-group to share and improve custody visiting and inspection practices. We also welcomed the development of new standards and methodology for joint inspections of custody suites designated to hold those detained under counter-terrorism legislation (TACT suites). This work was carried out by HM Inspectorate of Prisons and HM Inspectorate of Constabulary and Fire & Rescue Services.

At the national level, the NPM Secretariat has been working closely with the Ministry of Justice to ensure greater coordination between the governments and executives of the four countries, and has started on the drafting of a Protocol that should help to better structure these relationships and recognise the importance of an independent NPM.

However, we started the new year in April 2018 without the additional resources the NPM Secretariat so badly needed to ensure the full potential of joined-up work across member organisations, nations and the different detention settings is realised. In addition, some individual NPM members had their budgets cut. We also have to continue to spend time arguing for the need for the NPM to be placed on a legislative basis. This is time that the NPM Secretariat would rather spend supporting members to improve conditions in detention. Legislation would clarify the role of the NPM and its members and embed the mandate required by the United Nations. We should not go another year without the necessary guarantees of our independence. I am therefore very grateful that the United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) has supported these claims in such robust terms:

'The lack of a clear legislative basis for the NPM has long been a matter of concern to the SPT. We are aware that some take the view that this is not legally necessary under the OPCAT. The SPT disagrees with this position and should the SPT visit the UK on an official basis it is incontrovertible that this failing would feature in its report and recommendations – as it has in all other countries where there are similar shortcomings.

'The experience of the SPT is that the situation of an NPM remains precarious without its being underpinned by a clear legislative basis. We have seen, unfortunately, too many examples of cases in which states have put pressure on NPMs, directly or indirectly, which they have not been able to challenge for the want of a clear basis on which to do so. Practical effectiveness is dependent on functional independence, and the independence is threatened when the NPM is vulnerable to political pressure or political exigencies. The role of the SPT in relation to NPMs includes ensuring that they are protected from such

pressures. Hence, our unequivocal view that the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) requires, as a matter of practice, that the NPM has a clear legislative underpinning.'

Without government action on increased funding for the NPM Secretariat and much needed legislation, the NPM's future contribution to preventing ill-treatment will not be as significant as I would like it to be.

Nonetheless, we continue to look forward and in the next year, the government will face review by a key United Nations committee – the Committee against Torture. The government has already submitted its own assessment of the extent to which it complies with the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. It is now the turn of the NPM to comment on this assessment and put forward its own views. This is a very welcome opportunity and NPM members will be working hard to produce evidence to assist the Committee in making recommendations for concrete improvements to conditions in detention.

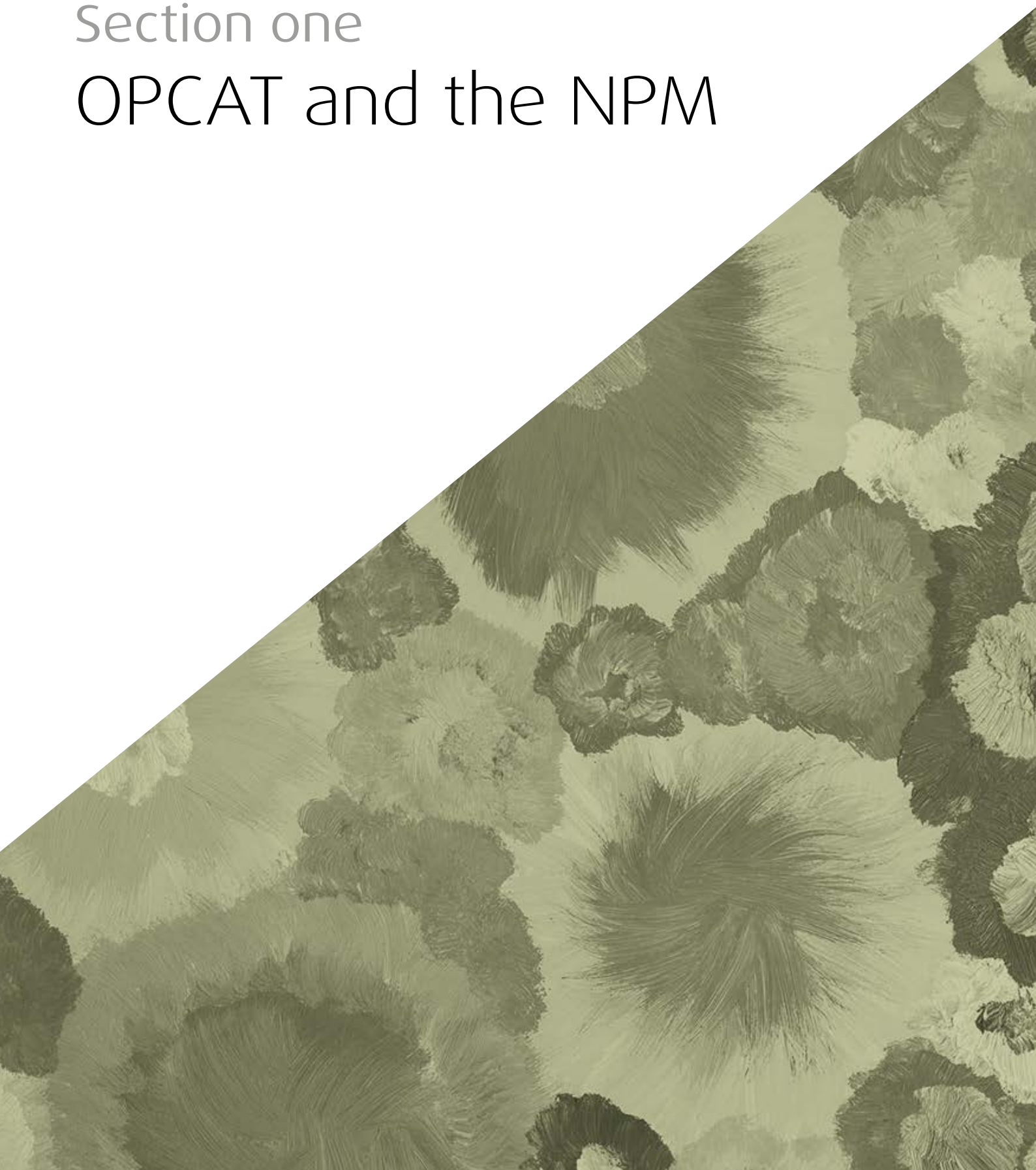
Next year is also the 10th anniversary of the UK's NPM, a time to both reflect on all that has been achieved and to look towards the next 10 years of the NPM. The anniversary marks the time for the NPM to move into its next phase – time for it to be better resourced and increasingly able to assist its members in upholding their OPCAT values and the spirit of the treaty, which states that:

'the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment can be strengthened by non-judicial means of a preventive nature, based on regular visits to places of detention…'.

I look forward to another productive year working with our NPM members as we head into this next phase.

John Wadham
Chair
UK National Preventive Mechanism

Section one
OPCAT and the NPM



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

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 examine conditions of detention and the treatment of detainees, make recommendations, and comment on existing or draft legislation with the aim of improving treatment and conditions in detention.

In order to carry out its monitoring role effectively, an 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 United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (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.[1]

1 All annual reports, including the most recent 11th annual report which covers the work carried out by the SPT in 2017, are available on the website of the Office of the High Commissioner for Human Rights, https://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=12&DocTypeID=27, accessed 9 July 2018.

There are currently 88 states parties to OPCAT, and 67 designated NPMs.[2]

Overview of the NPM

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. There are now 21 bodies designated to the NPM; the most recent designation was the Independent Reviewer of Terrorism Legislation on 12 January 2017.[3]

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)[4]
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)

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 facilities, mental health and military detention, as follows:

2 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 09/07/2018, https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9-b&chapter=4&clang=_en accessed 09/07/2018; Association for the Prevention of Torture, OPCAT database, available at http://www.apt.ch/en/opcat-database/, accessed 9 July 2018.

3 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 9 July 2018.

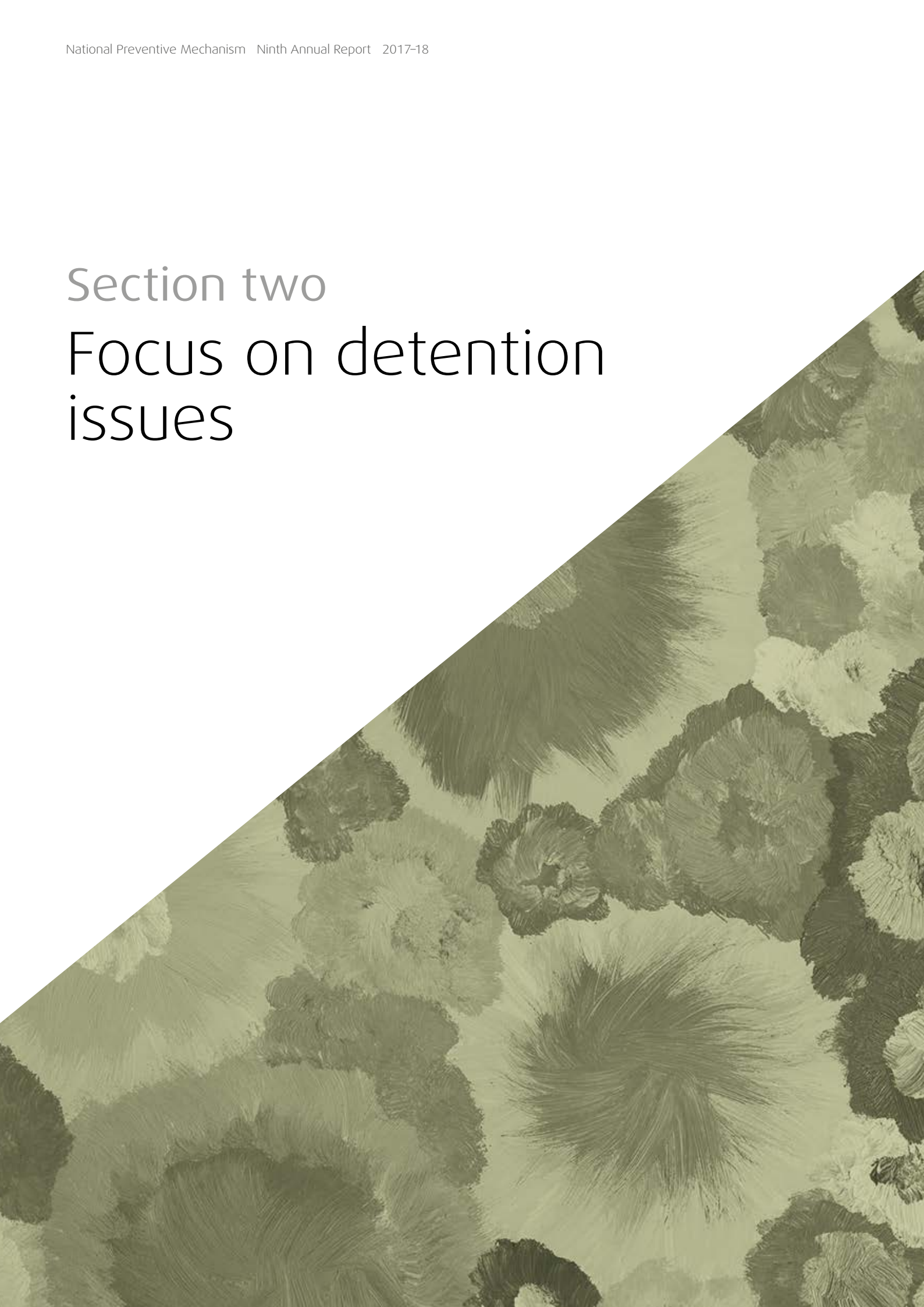
4 Care Inspectorate Wales changed its name from Care and Social Services Inspectorate Wales in January 2018.

Detention setting	Jurisdiction			
	England	Wales	Scotland	Northern Ireland
Prisons and YOIs	HMI Prisons with CQC and Ofsted	HMI Prisons with HIW	HMIPS with CI and SHRC; MWCS	CJINI and HMI Prisons with RQIA
	IMB	IMB		IMBNI
Police custody	HMICFRS and HMI Prisons		HMICS	CJINI with RQIA
	ICVA		ICVS	NIPBICVS
Escort and court custody	Lay Observers and HMI Prisons		HMIPS	CJINI
Detention under the Terrorism Act	IRTL			
	ICVA		ICVS	NIPBICVS
Children in secure accommodation	Ofsted (jointly with HMI Prisons and CQC in relation to secure training centres)	CIW	CI	RQIA
				CJINI
Children (all detention settings)	CCE			
Detention under mental health law	CQC	HIW	MWCS	RQIA
Deprivation of liberty[5] and other safeguards in health and social care	CQC	HIW	CI and MWCS	RQIA
		CIW		
Immigration detention	HMI Prisons			HMI Prisons with CJINI
	IMB			
Military detention	HMI Prisons			
Customs custody facilities	HMICFRS, HMI Prisons and HMICS			

5 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.

Section two

Focus on detention issues



Overview of key inspection and monitoring findings for the year

NPM members (both individually and jointly) carry out a significant number of inspections and monitoring visits each year. An overview of the findings from these visits is provided below, followed by a summary of the thematic work undertaken by NPM members to explore and understand issues arising in detention in more depth. Some of the recommendations, proposals and observations made by NPM members (both individually and jointly) to address issues identified through inspection and monitoring work are included towards the end of this section.

Prisons

The picture in prisons across the UK continued to be varied, and NPM members reported concerns which were similar to those raised in previous years.

The number of self-inflicted deaths in prisons in England and Wales fell during the reporting year. However, incidents of self-harm in the 12 months to March 2018 rose to 46,859, an increase of 16% on the previous year.[6] Joint inspections of male prisons in England and Wales (carried out by HMI Prisons, CQC and Ofsted) and monitoring visits by the IMB noted some examples of good practice, but also serious concerns.

Significant weaknesses in assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm were noted in most of the prisons inspected. It was also of concern that recommendations made by the Prisons and Probation Ombudsman (PPO) following investigations of deaths had not been adequately implemented in a significant number of prisons inspected. HMI Prisons reported that the living conditions it found during inspections of HMP Wormwood Scrubs and HMP Liverpool were some of the worst inspectors had ever seen, and living conditions in several other prisons were very poor. However, despite pressures on the system, most men reported that the majority of staff treated them with respect.

The amount of time that men received out of their cells continued to be poor for many: 20% of men responding to HMI Prisons' survey reported that they were out of their cell for less than two hours a day on weekdays, and only 16% reported that they were out of their cell for at least 10 hours. Thirty-eight per cent of those aged 18–21 held in young offender institutions (YOIs) reported in the survey that they were unlocked for less than two hours a day. Inspections and monitoring found that staff shortages in some prisons impacted on time out of cell.

As reported last year, outcomes in women's prisons in England were generally better than those in men's prisons. However, an inspection of Peterborough found that outcomes in relation to safety were not sufficiently good. This was the first time since 2008 that a women's prison had been assessed as not providing sufficiently good outcomes for safety. Those held in women's prisons continued to present with complex needs and prisons were not always doing enough to support them. As in previous years, many prisoners in women's prisons were held far from home, which impacted

6 Ministry of Justice, *Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2018 Assaults and Self-harm to March 2018,* July 2018, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729496/safety-in-custody-bulletin-2018-Q1.pdf, accessed 9 August 2018.

on the visits they received and efforts to resettle them.[7]

In Northern Ireland, a joint inspection of Magilligan Prison by CJINI, HMI Prisons and RQIA found progress had been made in many areas, most significantly in improving the opportunities for prisoners to improve their skills, employability and self-confidence, and in the provision of mental health care. However, there were still concerns over the lack of an integrated drugs and alcohol strategy. A joint inspection of Maghaberry Prison and regular monitoring visits found that progress had been made in stabilising the prison and that there was a greater focus on improving outcomes for prisoners. However, shortcomings were found in the care and support provided to the most vulnerable prisoners, including that recommendations from critical reports into deaths in custody and serious self-harm at the prison were not being effectively implemented. The Monitoring Board remained concerned at the number of men held in segregation without a clear strategy for their return to normal location.[8]

In Scotland, HMIPS reported that outcomes for prisoners were generally satisfactory, and benefits had begun to be seen from the introduction of personal officers and throughcare support officers. HMIPS was particularly encouraged to see improvements being implemented as establishments responded positively to the observations and findings of Independent Prison Monitors. HMIPS welcomed government plans to replace HMP Inverness and HMP Greenock (two of the oldest prisons in Scotland) and continued progress towards the development of Community Custody Units for women, which will allow women to serve their sentence closer to their home and family.

However, HMIPS also noted some concerns throughout the year. There were insufficient places on treatment programmes to address identified offending behaviour and a consequent inability for some prisoners to progress. The health care picture was varied, with a range of concerns highlighted by HMIPS, including staffing levels, variations in prescribing processes, and a disturbing rise in instances of use of new psychoactive substances (NPS)[9] with a detrimental effect on health care staff resources.[10] It is hoped that the Health and Justice Collaboration Board, established by the Scottish Government to focus on improving prisoner health care, will help to address the perceived health and social care concerns within Scotland's prisons. HMIPS also raised concerns about the conditions for those on remand due to the inequality of access to

7 For detailed information about particular inspections, see https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/, and for monitoring reports, see the annual reports of each Board, which can be found at https://www.imb.org.uk. HMI Prisons provides a summary of its findings each year in its annual report, *HM Chief Inspector of Prisons for England and Wales, Annual Report 2017–18*, July 2018 https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/07/6.4472_HMI-Prisons_AR-2017-18_Content_A4_Final_WEB.pdf. All websites accessed 8 August 2018.

8 The relevant inspection reports can be found at http://www.cjini.org/TheInspections/Inspection-Reports, accessed 19 November 2018.

9 Drugs such as 'Spice' that are developed or chosen to mimic the effects of illegal drugs such as cannabis, heroin or amphetamines and which may have unpredictable and life-threatening effects.

10 Full details of inspection findings can be found at https://www.prisonsinspectoratescotland.gov.uk, accessed 20 November 2018.

purposeful activity and time out of cell, and the lengthy waiting times for health care appointments and treatment for remand prisoners. HMIPS therefore welcomed the Scottish Government's exploration of ways to reduce the use of remand, for example, through increased use of electronic monitoring. There is a growing number of older prisoners, those serving longer sentences, remand prisoners and those convicted of sexual offences in Scotland. These factors are likely to continue to place pressure on the size of the Scottish prison population for some time to come.

Children in detention

Last year's NPM annual report noted, with particular concern, HMI Prisons' conclusion, in February 2017, that no establishment it had inspected in England and Wales was safe to hold children. This year, HMI Prisons reported that there were early signs of improvement in safety at a number of establishments. However, joint inspections (by Ofsted, HMI Prisons and CQC) of each of the secure training centres (STCs) found that outcomes were either inadequate or required improvement and the inspection of Oakhill STC raised such serious concerns that an urgent letter was sent by the three organisations to the responsible Minister, the Parliamentary Under Secretary of State for Youth Justice, Victims, Female Offenders and Offender Health (who at that time was Dr Phillip Lee). As in previous years, concerns were raised about the high levels of violence in both STCs and YOIs and it was extremely troubling that HMI Prisons reported that levels of violence in STCs were the highest per head of those held than in any other type of establishment it inspected.

The use of force was found to be high across the YOI and STC estate, and while inspectors found that governance of the use of force had generally improved, there were problems, including incidents of disproportionate use of force and failures to wear or turn on body-worn cameras. Repeated concerns were also raised in relation to time out of cell in some YOIs, with many boys on normal location locked up for more than 22 hours a day. At worst, some boys were out of their cell for only half an hour each day. Conditions and regimes for those removed from normal location and placed in dedicated care and separation units were generally poor (except at Parc and Werrington) although use of these units had fallen. The unit at Feltham (which is shared with the adult site) was found to be a wholly unsuitable environment to hold children. HMI Prisons, IMB and LO all continued to find that a number of boys experienced delays in being escorted from court custody to YOIs, faced long journeys and/or arrived too late at night to receive a proper induction. A number of boys also travelled with adults, which compounded delays when adult prisoners were dropped off first.[11]

The picture in secure children's homes (SCHs) in England and Wales, which hold children for both criminal justice and welfare purposes, was reported to be better. In England, Ofsted found outcomes in only one SCH to be inadequate and of the remaining 13, only two were judged to be less than good.

11 For detailed findings from Ofsted and HMI Prisons, refer to their inspection reports at http://reports.ofsted.gov.uk and https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/ respectively (accessed 20 November 2018). More information about the findings of Lay Observers can be found in their *Annual Report to the Secretary of State for Justice*, July 2018 https://s3-eu-west-2.amazonaws.com/layobservers-prod-storage-nu2yj19yczbd/uploads/2018/07/Lay-Observer-Annual-Report-17-18.pdf, accessed 8 August 2018.

Unlike last year, when two deaths in SCHs were reported,[12] no deaths were reported this year. In relation to the Secure Centre in Wales, CIW found there was good access to education and leisure facilities, but that safeguarding improvements were needed to ensure children were adequately protected. HIW reported issues in relation to the number and length of restraints of children in one independent hospital in Wales.

The number of young people in custody in Scotland remained low during the year. However, Independent Prison Monitors raised concerns about the low levels of young men in HMP/YOI Polmont engaged in purposeful activity, and certain categories of young men not being able to access time outside every day. As a result of this, Monitors noted that some young men spent too much of their day locked in their cells.

In Northern Ireland, CJINI and RQIA found a child-centred ethos in place at Woodlands Juvenile Justice Centre (JJC) and reported that there had been good progress in implementing four strategic recommendations for improvement made by inspectors in 2015. Inspectors called for greater alignment between the JJC and the regional secure care centre. Following recommendations made by RQIA, some improvements were seen in care practices for children in regional secure care in Northern Ireland, including additional independent monitoring, increased oversight by the trust and planned audit arrangements to assess core outcomes.

Police custody

In England and Wales, changes to section 136 of the Mental Health Act 1983 (and related regulations) came into force in December 2017. These changes prevent the use of police stations as a place of safety for children and impose strict conditions on when adults may be held in police stations as a place of safety.[13] The changes contributed to the downward trend in the use of police custody as a place of safety, but this remained too high in some forces (often due to factors outside of the control of forces, such as a lack of available mental health beds). Inspectors and independent custody visitors continued to report delays transferring those who required assessment or treatment under the Mental Health Act (again, often due to factors outside of the control of forces), and inspectors reported concerns that children were held overnight in police custody when refused bail due to a lack of alternative accommodation being available, even when custody staff had made considerable efforts to find it. Inspectors also raised significant concerns about the use of force and, in all but two of the forces inspected by HMICFRS and HMI Prisons during the year, governance and oversight of the use of force was inadequate. This led to the organisations writing to all Chief Constables to advise them of the expectation that governance of the use of force be improved. HMI Prisons, HMICFRS and ICVA expressed concern that some forces forcibly removed clothing from detainees as a way of managing self-harm, instead of considering alternatives such

12 Further information can be found in the Prisons and Probation *Ombudsman Annual Report 2017–18*, p.49, available at https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2018/10/PPO_Annual-Report-2017-18_WEB_final.pdf, accessed 20 November 2018.

13 Section 136 of the Mental Health Act 1983 enables a police officer to remove (without a warrant or suspicion of a crime having taken place) someone who they believe to be 'suffering from mental disorder and to be in immediate need of care or control' to a place of safety, such as a hospital, or to keep them at such a place.

as higher levels of observation as the first option to manage this risk.

There were 23 deaths reported in or following police custody during the year, the highest figure in a decade.[14]

Review of deaths and serious incidents in police custody in England and Wales

In October 2017, the *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* was published.[15] The review was undertaken by Dame Elish Angiolini and commenced work in October 2015 to examine the procedures and processes around deaths and serious incidents in police custody in England and Wales, identify areas for improvement and develop recommendations. The report made a number of findings and recommendations relevant to the work of NPM members, including in relation to the use of restraint, intoxication, rousing of detainees, mental health and medical care. HMI Prisons and HMICFRS considered these recommendations in the revision of their *Expectations for Police Custody*. ICVA developed a briefing for its members and a training session for independent custody visitors on the review's findings and recommendations, which was delivered during 2018.

Detainees in police custody in Scotland generally reported to HMICS and ICVS that they were satisfied with the treatment they received. However, HMICS continued to find some of the same issues and areas for improvement that had been highlighted in previous reports. In particular, HMICS reported concerns about the accuracy of risk assessments of detainees – it was not always clear why a detainee was considered low or high risk and the rationale for subsequent care plans was sometimes not apparent. This was despite the vulnerability questionnaire (used by police when booking a person into custody) being revised to include new questions that elicit additional information which should assist in the development of care plans for each detainee. In addition, HMICS had significant concerns about cleanliness and hygiene at Dundee custody centre, which resulted in immediate action from Police Scotland. Recurring issues raised by ICVS were non-gender specific care, including instances when no female staff were on duty to care for female detainees, and disparity of health care provision. During the year, the Criminal Justice (Scotland) Act 2016 came into force, introducing significant changes to arrest and detention procedures in Scotland. Inspections carried out by HMICS since the introduction of the Act found that staff had received training on the requirements of the Act and these requirements (such as ensuring appropriate authorisation of detention) were being met. However, improvements needed to be made in explaining detainee's legal rights, including by providing an easy to understand format for those with communication difficulties.

14 Independent Office for Police Conduct, *Deaths during or following police contact: Statistics for England and Wales 2017/18,* July 2018, available at https://www.policeconduct.gov.uk/news/iopc-publishes-figures-deaths-during-or-following-police-contact-201718, accessed 6 August 2018.

15 The report is available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf, accessed 20 November 2018.

In Northern Ireland, the use of custody as a place of safety increased significantly, with 19 detentions under Article 130(1) of the Mental Health (Northern Ireland) Order 1986, compared with five in 2016–17.

Immigration detention

HMI Prisons reported findings and recommendations from two inspections of immigration removal centres during the year, noting varied outcomes between the two centres. Improvements were seen at Yarl's Wood, where outcomes for detainees were at least reasonably good. However, for the third consecutive inspection, Harmondsworth failed to provide acceptable outcomes in relation to safety and respect. As reported in last year's NPM annual report, the quality of rule 35 reports had again improved, although, as in the previous year, a number of reports provided inadequate information to decision makers. Only 10% of rule 35 reports at Harmondsworth and about 30% of reports at Yarl's Wood led to release, leading HMI Prisons to report concerns about the number of people who continued to be detained despite professional evidence that they had been tortured. Although approximately two-thirds of people were detained for less than a month, HMI Prisons continued to report examples of people detained for significant periods of time, including four-and-a-half years in one case at Harmondsworth.

Brook House

In September 2017 the BBC broadcast a programme on Brook House, an immigration removal centre (IRC) next to Gatwick Airport, run by the contractor G4S on behalf of the Home Office.[16] The programme showed apparent ill-treatment of detainees, including violent and threatening behaviour by some staff towards detainees. In response, several members of staff were suspended and investigations were begun by G4S, the government and police. Prior to the conclusion of those investigations, NPM members raised concerns about whether such treatment could be occurring in other centres. HMI Prisons therefore employed an enhanced inspection methodology at a subsequent inspection of Harmondsworth immigration removal centre, including offering an interview to all detainees and providing all staff the opportunity to complete a confidential online survey. HMI Prisons will continue to use similar enhanced methodologies where it has heightened concerns about the safety of those held in immigration detention.

Inspections of non-residential short-term holding facilities generally found adequate conditions for those detained for short periods. However, some concerns were reported, including lengthy detention without access to shower and sleeping facilities, and detainees being escorted in handcuffs in public view at both Luton and Stansted Airports. HMI Prisons published one report of an inspection of an overseas escort on a chartered flight to Jamaica, which highlighted concerns about excessive use of restraints, including the use of waist restraint

16 BBC, *Panorama*, 'Undercover: Britain's immigration secrets', broadcast 4 September 2017.

belts on some detainees without proper risk assessment. IMBs continued to find excessive use of restraints on some other overseas escorts to charters throughout the year.

There were five deaths in or immediately following immigration detention reported during the year, three of which were self-inflicted. In the previous year, there were six reported deaths, including two that were self-inflicted and one manslaughter. Prior to 2016–17, deaths in or immediately following immigration detention (other than from natural causes) were rare.[17]

Health and social care detentions

Despite cuts to funding of health and social care services in England during the year, CQC found that services generally acted on matters raised during CQC's visits, and there was a general trend towards improvement in the areas measured on visits by its Mental Health Act (MHA) reviewers. This echoes the experience of CQC's regulatory visits, where 67% of the 93 NHS mental health trusts and independent hospitals originally rated as 'requires improvement' had improved to 'good' when they were reinspected.

However, CQC remained concerned about the quality and safety of care provided on mental health wards, and in particular on acute wards for adults of working age. Improvements were needed to replace or refurbish wards located in unsuitable buildings, incentivise staff to work in these challenging environments, and ensure that patients had access to the full range of care interventions. These factors limited the ability of services to provide the optimum care and treatment for patients detained under the MHA, and to do so in ways that met the expectations of the guiding principles set out in the MHA Code of Practice. CQC also raised concerns over safety from sexual assault and sexual harassment on mental health wards, including how services reacted to incidents.

During the year, CQC's findings in relation to Broadmoor and Rampton high secure hospitals led to CQC writing to the Secretary of State for Health and Social Care (at that time, the Rt Hon Jeremy Hunt MP) to advise him of concerns. These included a shortage of registered nurses, which led to restrictions on patients' access to therapies and activities and sometimes increased risk to patients, and that staff did not always monitor and review patients in seclusion and long-term segregation in line with guidance in the Code of Practice. Following this intervention both hospitals showed considerable improvement.

CQC continued to see variation in the application of Deprivation of Liberty Safeguards (DoLS) in England throughout the year, with unequal use across the health and social care sector. Delays in the processing of DoLS applications continued to be a problem. Regulatory changes to DoLS were planned by the government during the year. These changes aim to simplify the application and assessment process and reduce the bureaucracy of the present DoLs system.

HIW found individualised, patient-focused care across Wales and patients and

17 *HM Chief Inspector of Prisons for England and Wales Annual Report 2017–18*, July 2018, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/07/6.4472_HMI-Prisons_AR-2017-18_Content_A4_Final_WEB.pdf, accessed 8 August 2018.

relatives were, overall, positive about the care, support and treatment they received. No major failings were noted in the administration of the MHA throughout Wales, although recommendations were made for improvements to documentation in some independent settings. Non-compliance action was taken in two independent mental health settings relating to the excessive use of physical restraint and seclusion, and the registration of another independent setting was suspended due to indications of a significant risk to patient safety. The environments of many wards visited were not of the requisite standard, with some environmental issues impacting on patient privacy and dignity, and some on patient safety. Significant concerns about the environment of one unit led to it being found unfit for purpose and not conducive to providing safe care. Recommendations to improve medicines management were made on all inspections. Staff shortages were seen across the sector.

RQIA reported concerns about the lack of safe and therapeutic environments in three hospital sites in Northern Ireland. There were also concerns in relation to patient transfers between providers in some mental health inpatient facilities, resulting in a risk to patient and staff safety, and delays in discharge of patients with a learning disability. RQIA noted an increase in the number of admissions of children to adult wards in Northern Ireland, from two in 2016–17 to six in 2017–18. On five occasions the reason for admission was non-availability of beds in the Regional Treatment Centre. However, RQIA was satisfied with the safeguarding measures put in place by the provider during each admission.

Court custody

HMI Prisons and LO reported throughout the year that the physical conditions in the court custody suites inspected and monitored in England and Wales were poor, with many cells dirty and in a state of disrepair. Concerns about identification and management of detainee risk were also identified, which included failures to complete individual risk assessments for detainees, and HMI Prisons noted that handcuffs were often applied without an individual risk assessment. Both HMI Prisons and LO reported that many detainees spent longer than necessary in court custody, even when staff had requested their cases be prioritised. Court custody staff were generally found to be professional and friendly in their dealings with detainees.[18]

Thematic work on detention issues

The NPM as a whole and its members (both individually and jointly) undertake a range of thematic work on detention issues in order to explore areas of concern, gain a greater understanding of particular topics, provide information to policy makers to effect change and strengthen their own working practices.

NPM joint thematic work on detention

The NPM has completed work on two projects and begun work on a third.

18 For more detailed findings and recommendations see Lay Observers, *Annual Report to the Secretary of State for Justice*, July 2018, available at https://s3-eu-west-2.amazonaws.com/layobservers-prod-storage-nu2yj19yczbd/uploads/2018/07/Lay-Observer-Annual-Report-17-18.pdf, accessed 8 August 2018, and *HM Chief Inspector of Prisons for England and Wales Annual Report 2017–18*, July 2018, available at https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/07/6.4472_HMI-Prisons_AR-2017-18_Content_A4_Final_WEB.pdf, accessed 8 August 2018.

Isolation – guidance for NPM monitoring bodies

In January 2017, the NPM published its guidance on isolation in detention. The guidance provides a comprehensive framework that NPM members should apply when examining isolation in detention, which has the potential to give rise to ill-treatment. It aims to improve the consistency of monitoring of the use of isolation and allow NPM members to identify and promote good and improved practice. The guidance and its use in practice will provide a basis on which to formulate recommendations to strengthen policy.

NPM members continue to work to incorporate the guidance into their inspection and monitoring work. This has included:

- HMI Prisons using the guidance when scoping human rights standards for its revision of *Expectations: Criteria for assessing the treatment of and conditions for men in prisons* and *Expectations for immigration detention: Criteria for assessing the conditions for and treatment of immigration detainees;*
- discussion of the guidance at a meeting of IMB London Chairs which considered the use of segregation and the role of IMBs in segregation reviews; and
- ICVA disseminating the guidance to all schemes to consider in situations when detainees are held for extended periods where they are suspected of concealing drugs. ICVA will incorporate the guidance into its training on this issue in 2018–19.

Transitions and pathways

In 2015, NPM members agreed to focus joint efforts on examining the pathways between different detention settings for those with mental health needs, and the transitions from child to adult custody in criminal justice settings.[19] Given that NPM members usually examine treatment and conditions in detention by looking at an individual establishment, they were keen to explore issues relating to the treatment of detainees during movements from one establishment to another that this approach did not capture. The NPM wanted to identify and document the risks that moves between places of detention pose for detainees and how they are treated during these moves.

The work was completed last year and the findings were documented in our 2016–17 annual report. In 2017–18, the findings from the joint work were widely shared with stakeholders, parliamentarians and policy makers working on relevant issues, including the Chair of the Independent Review of the Mental Health Act 1983 (Professor Sir Simon Wessely). The next phase of this work will be to draft a series of short briefing notes highlighting the key findings and recommendations to disseminate the results of NPM's work more extensively.

Ill-treatment in detention

In June 2017, the NPM and the Human Rights Implementation Centre at the University of Bristol co-hosted a roundtable on complaints and capturing data on ill-treatment in detention in the UK. The roundtable brought together NPM members, academics, NGOs and government officials to discuss how

19 The transitions work was led by the NPM Children and Young People's sub-group, with contributions from the Children's Commissioner for England, Criminal Justice Inspectorate Northern Ireland and HM Inspectorate of Prisons. The NPM was only able to focus on penal custody for children in this exercise.

complaints of ill-treatment are recorded by places of detention, how ill-treatment is defined and perceived in different detention contexts and to what extent NPM members should take a harmonised approach to possible ill-treatment.

Following this, NPM members agreed to undertake a thematic project on ill-treatment in detention in 2018–19, with the aim of providing clear guidance on how NPM members should respond to such incidents.

NPM members' thematic work on detention

Throughout the year, as well as regular inspection and monitoring of individual establishments and detention settings, many NPM members examined specific, cross-cutting topics in detail or undertook thematic inspections to highlight concerns and drive change.

- In December 2017, CQC published a good practice resource on services that had successfully reduced their use of restrictive practices, including the use of restraint, seclusion and rapid tranquilisation.[20] This was in response to CQC's concern that, in England, inconsistent attention was paid to the MHA Code of Practice recommendation that called on mental health services to reduce restrictive interventions when responding to challenging behaviour. Throughout 2017–18, CQC researched incidents of sexual assault or sexual harassment on inpatient wards, leading to publication of a report with recommendations to improve future practice.[21]
- In November 2017, the CCE published *Children's Voices: The Wellbeing of Children in Detention in England*, a review of detained children's subjective views and experiences.[22] In March 2018, the CCE published a report, in collaboration with Dame Louise Casey, entitled *Voices from the Inside,* which focused on the life experiences of girls in custody.[23]
- In March 2018, HIW published *Mental Health Hospitals, Learning Disability and Mental Health Act Inspections.*[24] The annual report noted several positive findings, including in relation to patient satisfaction and positive rapport between patients and staff, but it also highlighted concerns such as the lack of robust processes for managing risk, too few inpatient beds and not enough staff with the right skills and knowledge.
- HMI Prisons published a number of thematic reports during the year including *Through the Gate Resettlement Services*

20 *Mental Health Act – A focus on restrictive intervention reduction programmes in inpatient mental health services,* available at https://www.cqc.org.uk/publications/themed-work/mental-health-act-restrictive-intervention-reduction-programmes, accessed 21 November 2018.

21 *Sexual safety on mental health wards,* available at https://www.cqc.org.uk/publications/major-report/sexual-safety-mental-health-wards, accessed 21 November 2018.

22 *Children's Voices: A review of evidence on the subjective wellbeing of children in detention in England,* available at https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/11/CCO-review-of-evidence-on-the-subjective-wellbeing-of-children-in-detention-in-England-2.pdf, accessed 21 November 2018.

23 *Voices from the inside: The experiences of girls in Secure Training Centres,* available at https://www.childrenscommissioner.gov.uk/wp-content/uploads/2018/03/CCO-Voices-from-the-Inside-MARCH-2018-1.pdf, accessed 21 November 2018.

24 *Mental Health Hospitals, Learning Disability and Mental Health Act Inspections,* available at http://hiw.org.uk/docs/hiw/publications/180329mhaen.pdf?lang=en, accessed 21 November 2018.

for Prisoners Serving 12 Months or More (jointly with HM Inspectorate of Probation), *Children in custody 2016–17, An analysis of 12–18-year-olds' perceptions of their experience in secure training centres and young offender institutions* (jointly with the Youth Justice Board), *Life in prison: Living conditions,* and *Incentivising and promoting good behaviour.*[25]

- HMIPS carried out a thematic study on the experience of older prisoners, publishing a report in July 2017 entitled *Who Cares? The Lived Experience of Older Prisoners in Scotland's Prisons.* The report highlighted the growing challenges of meeting the needs of an increasingly old and infirm prison population, covering social care, health care, activities, family contact, mobility, and personal fears. The report recommended that a clear strategy for older prisoners be developed.[26] HMIPS also undertook a series of inspections in HMP & YOI Polmont to understand the plans for the introduction of women and to assess any impact on the existing regime. The final report from these inspections was published in May 2017, and concluded that the arrival of women at Polmont did not have a detrimental impact on the regime and opportunities for the young men held there and that the women were able to benefit from more modern accommodation.
- Following a concerning visit report about poor arrangements for menstruating women and girls in police custody, ICVA led a campaign to improve menstrual care. ICVA published an open letter to the Home Secretary requesting a change to Police and Criminal Evidence (PACE) Act 1984 Code C. The call for improved legislation was welcomed by the then Home Secretary, and ICVA will continue its work with the Home Office over the forthcoming year to ensure the legislation is amended and there is improved guidance in the Authorised Professional Practice issued to police officers by the College of Policing.[27] ICVA also published a thematic report about detainee dignity and, in particular, nudity in police custody as a response to assessed risk of self-harm and the use of force when placing detainees in anti-rip clothing. The report used inspection evidence from HMI Prisons/HMICFRS and was disseminated within the NPM and to the National Police Chiefs Council.
- MWCS published a number of thematic reports. The first of these was a report of a thematic inspection of all medium and low secure forensic mental health services in Scotland. This identified areas of good practice, notably around care planning, but concerns about delays in moving to lower security, inconsistent practice around restrictions on security, and particular difficulties for small groups requiring specialist provision, including women and people with learning disabilities. The Scottish Government has responded to the report and the recommendations, including setting up

25 All of HMI Prisons' thematic reports are available at https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/?s&prison-inspection-type=thematic-reports-and-research, accessed 21 November 2018.

26 *Who Cares? The Lived experience of Older Prisoners in Scotland's Prisons*, available at https://www.prisonsinspectoratescotland.gov.uk/publications/who-cares-lived-experience-older-prisoners-scotlands-prisons, accessed 21 November 2018.

27 Information about this work is available at https://icva.org.uk/wp-content/uploads/2018/03/ICVA_Press_Release_FINAL.pdf, accessed 21 November 2018.

various working groups to take issues forward, and the MWCS will be involved in these groups.[28] In addition, MWCS published a monitoring report on the use of the MHA in the last 10 years, highlighting a consistent rise in the use of detention, and a concerning recent sharp increase in emergency detention. A number of further publications focused on ensuring that human rights are respected at various stages in the care pathway in acute mental health settings, including *Rights in Mind – a pathway to patients' rights in mental health services,*[29] *Human rights in mental health service*,[30] and a series of videos relating to rights in practice. In addition, it published a report entitled *The Right to Advocacy,*[31] following a review of how local authorities and health boards in Scotland meet their duty to ensure the availability of independent advocacy services for people with mental illness, learning disability, or related conditions.

Submitting proposals and observations

The NPM Secretariat and individual members of the NPM work actively to strengthen government policy that is relevant to detention and to the exercise of NPM powers. This year, involvement in consultations and the development of government policy included the following:

- In January 2018, the NPM Chair wrote to the Chair of the Independent Review of the Mental Health Act 1983 (Professor Sir Simon Wessely) raising concerns about the quality of data on mental health detention and sharing the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment's (CPT) recommendations for improving safeguards for patients to prevent ill-treatment. A follow up letter was sent in March 2018 to highlight the transitions and pathways work completed by the NPM.
- The NPM and HMI Prisons made a joint submission to the Council of Europe in relation to its draft Codifying Instrument of European Rules on the Administrative Detention of Migrants.
- CI made a number of submissions throughout the year, including to Scottish Government consultations on the Draft Police Act 1997 and Protection of Vulnerable Groups (Scotland) Act 2007 Remedial Order 2018, a draft strategy for preventing and eradicating violence against women and girls, and proposals for reform of the Adults with Incapacity (Scotland) Act 2000. Responses were also submitted to a parliamentary consultation on a proposed Children (Equal Protection from Assault) (Scotland) Bill and Police Scotland's consultation on the Annual Police Plan 2018/19. In addition, CI provided oral evidence to the Equalities and Human Rights Committee of the Scottish Parliament as part of its inquiry

28 *Visit and Monitoring Report: Medium and low secure forensic wards*, available at https://www.mwcscot.org.uk/media/385624/medium_and_low_secure_forensic_wards.pdf, accessed 9 July 2018.

29 *Rights in mind,* available at https://www.mwcscot.org.uk/media/367147/rights_in_mind.pdf, accessed 9 July 2018.

30 *Good Practice Guide: Human Rights in Mental Health Services,* available at https://www.mwcscot.org.uk/media/369925/human_rights_in_mental_health_services.pdf, accessed 9 July 2018.

31 *Visit and Monitoring Report: The Right to Advocacy,* available at https://www.mwcscot.org.uk/media/395529/the_right_to_advocacy_march_2018.pdf, accessed 9 July 2018.

into Destitution, Asylum and Insecure Immigration Status in Scotland. CI took up a position on the Secure Care Strategic Board, which was formed with the aim of delivering better experiences and outcomes for Scotland's most vulnerable young people. Under the auspices of the Secure Care Strategic Board, CI began co-chairing a group to develop a pathway for young people. This is aimed at improving their experiences and outcomes through a coherent set of expectations and standards across the continuum of intensive supports, ensuring that they are treated with respect and dignity and that their human rights are upheld. The CI also took up representation on the Programme Board for Health and Social Care in Prisons and will contribute to the work of this Board in developing defined outcomes and associated indicators for the health and well-being of people in prison, the transition of their care in and out of prison and developing models for health and social care integration in prisons.

- During the year, the CQC continued to engage with the independent review of the MHA, working with the review's advisory panel and working group. It also carried out a collaborative evaluation of the implementation of the MHA Code of Practice with patients, providers and experts, to help identify practical solutions to improve areas of practice. The evaluation focused on which service and professional factors can have an immediate impact on the experiences and outcomes for people affected by the Act.
- In March 2018, the CCE chaired a roundtable at 10 Downing Street which brought together Dr Phillip Lee, the then Parliamentary Under Secretary of State for Youth Justice, Victims, Female Offenders and Offender Health, prison governors, local government and voluntary organisations to identify the policy and operational challenges and solutions to improving outcomes for children and young people in custody.
- HMICFRS and HMI Prisons made joint submissions in relation to the Home Office Statutory consultation on the revision of PACE codes C, H, E and F and to the National Appropriate Adult Network's review of its National Standards. HMICFRS also continued to regularly present its inspection findings to the Home Office PACE Strategy Board.
- HMI Prisons responded to a number of consultations throughout the year, including: the Home Office's revision of Detention Services Order 'Care and management of transgender and intersex detainees' and Detention Services Order 'Surveillance Camera Systems'; the Advisory Board on Female Offenders in relation to the female offender strategy; the review of the Dying Well in Custody Charter by the National Health Service; the Advisory Council on the Misuse of Drugs consultation on the use of image and performance enhancing drugs; the London Assembly consultation on Women in the Criminal Justice System; the review of the Equality Monitoring Tool by Her Majesty's Prison and Probation Service; the annual review by the Medway Local Safeguarding Children Board of safeguarding and the use of restraint at Cookham Wood Young Offender Institution and Medway Secure Training

Centre; and the National Institute for Health and Care Excellence consultation on preventing suicide in community and custodial settings. In addition, HMI Prisons provided oral and written evidence to the House of Commons' Justice Select Committee's inquiry into Transforming Rehabilitation and written evidence to its Prisons Population 2022: planning for the future inquiry.

- HMIPS gave oral and written evidence on prisoner voting to the Equality and Human Rights Committee, and evidence on the use of remand to the Justice Committee of the Scottish Parliament.
- ICVA participated in the review of the MHA, providing information on key challenges and concerns in police custody, contributed to the Home Office guidance on commissioning of Appropriate Adult services for vulnerable adults in police custody, and participated in a consultation on PACE Code C, which formalised the rights of those attending voluntary interviews. In addition, ICVA presented its findings to the Ministerial Board of Deaths in Custody and the Home Office PACE Strategy Board on a regular basis throughout the year.
- IMBNI provided a response to the Northern Ireland Prison Service's discussion document, Prisons 2020.
- MWCS made submissions to the Scottish Parliament's Health and Sport Committee in relation to the inquiry into health care in prisons, and following a call for views on the Mental Health (Scotland) Act 2015. MWCS also submitted evidence to an independent review of legal aid in Scotland, to an engagement paper on the draft suicide prevention plan, and to proposals for reform of the Adults with Incapacity (Scotland) Act 2000.
- SHRC made a number of submissions throughout the year, including to proposals for reform of the Adults with Incapacity (Scotland) Act 2000, the Scottish Parliament's Inquiry into Human Rights, and in relation to a petition calling on the Scottish Parliament to urge the Scottish Government to conduct a wide review of mental health and incapacity legislation in Scotland and the Children (Equal Protection from Assault) (Scotland) Bill.

Collaboration and international scrutiny

Collaboration

The NPM and its members collaborated actively with a range of actors throughout the year, including NGOs expert in torture prevention, inspectorates and monitoring bodies from other countries, and academics.

The NPM continued to meet regularly with other European NPMs, including through attending meetings organised by the Council of Europe. In addition, in December 2017, the NPM Chair spoke at a meeting of the South East European NPM network hosted by the Serbian NPM, at which he talked about the UK NPM's inspection, monitoring and visiting methodology and provided examples from the work of HMIPS, HMI Prisons, ICVA and CQC. The NPM also took part in a meeting of European NPMs hosted by the Association for Prevention of Torture (APT) which discussed the idea of forming an NPM-led network of NPMs.

The NPM Secretariat continued to attend meetings of the Treaty Monitoring Working Group hosted by the Equality and Human Rights Commission and met with the Commission on a regular basis to discuss

common work. The NPM continued to enjoy a constructive relationship with the APT, which provided helpful advice to the NPM on a number of topics, and began meeting with the Secretariat of the Independent Advisory Panel on Deaths in Custody on a regular basis to discuss areas where work may be complementary.

CQC, MWCS, RQIA and the NPM Secretariat spoke as part of a panel at the International Academy of Law and Mental Health, discussing their role in carrying out OPCAT-compliant monitoring of places of mental health detention. The NPM participated in an expert meeting hosted by the University of Essex at which the findings of the CPT, in relation to mental health detention, were discussed. The Secretariat and Chair also attended an inaugural meeting of a UK 'torture prevention network' organised by University College London and SOAS University of London. Following this, a public panel event was convened at which the NPM Chair spoke about the work of the NPM.

NPM members continued to exchange their experience with bodies from around the world who were interested in OPCAT implementation and detention monitoring:

- CQC represented the NPM at a meeting in Germany organised by Action Mental Health, at which several NPMs discussed their approaches to monitoring mental health detention.
- HIW attended a conference on 'Monitoring homes for the elderly' which was co-organised by the German and Austrian NPMs, as well as the Council of Europe.
- HMICS provided advice and information to a prospective member of the Irish NPM regarding the monitoring of police custody.
- A member of the HMI Prisons inspection team attended a conference in Vienna in late January on behalf of the NPM at the invitation of the UN Office on Drugs and Crime. The conference discussed inspection of the rules relating to work in the UN Standard Minimum Rules for the Treatment of Prisoners and rehabilitation of prisoners. HMI Prisons also hosted a member of the Tunisian Commission for Prevention of Torture (the Tunisian NPM) to shadow an inspection, and visitors from the secondment programme run by the African Prisons Project to discuss the work of the NPM and prison inspection methodologies.
- Her Majesty's Chief Inspector of Prisons for Scotland attended a colloquium on NPM practices organised by the new Tunisian NPM and spoke about the experience of the NPM in monitoring conditions of detention for the most vulnerable.
- IMB provided training support to the IMB in Jersey, and began developing links with the IMB on the Isle of Man.
- The Engagement and Participation Officer of MWCS spoke to the Committee against Torture on the topic of involuntary detention. In addition, the MWCS Chief Executive attended the 2017 International Congress on Law and Mental Health and MWCS hosted a delegation from China, providing them with a presentation on forensic mental health services in Scotland.
- The NPM Secretariat and several members of the NPM (IMB, ICVA, CQC, HMI Prisons, HMIPS, HMICS, SHGRC,

RQIA, CJINI) met with staff from the Commonwealth Ombudsman of Australia (the future coordinator of the Australian NPM) to discuss NPM coordination and inspection and monitoring methodologies.

International scrutiny

The UK's record on human rights was examined by a number of UN and European treaty bodies and special mandates throughout the year. Several of these made findings and recommendations relevant to the work of the NPM.

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

The CPT conducted its eighth periodic visit to the UK from 30 March to 12 April 2016. The CPT delegation visited prisons, police custody and immigration detention. It also visited secure mental health establishments in England for the first time. The Committee met with government, NPM members and other stakeholders during its visit. The CPT's report was published in April 2017 and detailed concerns including: the lack of consistent regulation and collection of data on use of force and restraint in police custody; severe overcrowding, high levels of violence, poor living conditions and lack of purposeful activity in prisons; the use of night-time confinement and the necessity for, and duration of, long-term seclusion in mental health detention; and weaknesses in Rule 35 procedures in immigration detention. The CPT found that some children at YOI Cookham Wood were effectively being held in conditions of solitary confinement, which amounted to inhuman and degrading treatment. The Government's reply to the report was published in January 2018.[32] The CPT carried out a further short visit to England to discuss its findings with the UK Government, during which the delegation also met the NPM Chair. The NPM shared the findings of the CPT report throughout the year. As noted above, the NPM drew the findings to the attention of the Independent Review of the Mental Health Act 1983. NPM members discussed the recommendations made by the CPT during the October 2017 business meeting and the NPM Secretariat has included the CPT's findings in its training materials. The NPM Secretariat has also encouraged the government to disseminate the CPT's findings to all places of detention in the UK. In addition, the NPM Secretariat and Chair participated in an expert meeting hosted by the University of Essex, at which the CPT's findings in relation to mental health detention were discussed.

The CPT undertook a separate ad hoc visit to Northern Ireland between 29 August and 6 September 2017. The CPT examined the conditions of detention for and treatment of those detained at Maghaberry Prison, Ash House Women's Prison Hydebank Wood, Shannon Clinic, and a number of police stations. During this visit, the CPT delegation met with CJINI and RQIA and CJINI's Chief Inspector attended the CPT presentation of its preliminary observations to the government at the end of the visit. The report of the visit is expected to be published shortly.

32 The report of the CPT and the Government's reply are available at https://www.coe.int/en/web/cpt/-/council-of-europe-anti-torture-committee-publishes-response-of-the-uk-authorities, accessed 19 July 2018.

Committee on the Rights of Persons with Disabilities

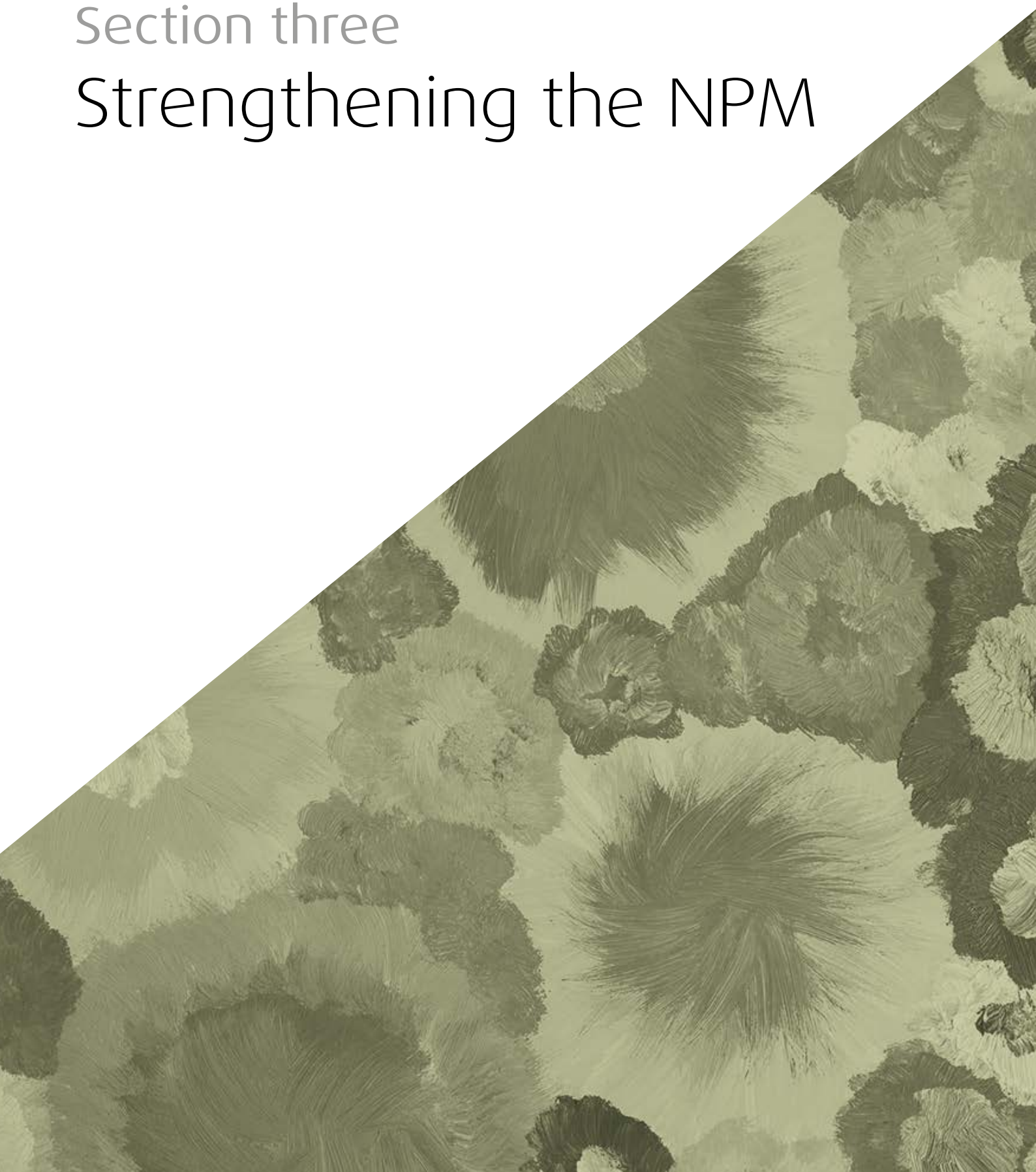
The UN Committee on the Rights of Persons with Disabilities examined the UK's compliance with its obligations arising from the Convention on the Rights of Persons with Disabilities in August 2017. Ahead of this, both the CCE and the SHRC submitted shadow reports for the Committee's consideration. The Committee made a number of recommendations to the UK government that are relevant to persons deprived of their liberty including: the elimination of all forms of substituted decision-making; repeal of legislation and practices authorising involuntary treatment and detention of persons with disabilities on the basis of actual or perceived impairment; the investigation and elimination of all forms of abuse of persons with disabilities in institutional facilities; and eradicating the use of restraint for reasons related to disability within all settings.[33]

Universal Periodic Review

The third Universal Periodic Review (UPR) of the UK took place in May 2017. A total of 227 recommendations were made, of which the UK government reported that it has implemented or will implement 96. The UPR process examined the government's implementation of all its human rights obligations, including in relation to deprivation of liberty and the prohibition of torture and other ill-treatment. Recommendations relevant to the mandate of the NPM included to: allow for individual complaints under CAT; enact a complete prohibition on torture; take measures to improve prisoner safety and conditions in prisons; consider adopting action plans to reduce prison crowding and to address self-harm in prisons; introduce a time limit on immigration detention.

33 *Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland*, UN Doc CRPD/C/GBR/CO/1, 3 October 2017, available at https://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/countries.aspx?CountryCode=GBR&Lang=EN, accessed 19 July 2018.

Section three
Strengthening the NPM



The NPM in 2017–18

In line with OPCAT, the NPM's mission is to prevent ill-treatment through independent inspection and monitoring of places of detention in the UK. Each year the NPM sets strategic goals which are designed to help it to fulfil this mission. For 2017–18 these goals were to prevent the ill-treatment of detainees by:

a) working together as members of the NPM to strengthen the protection of those in detention in the UK;
b) building an NPM that is effective in delivering all the requirements of OPCAT;
c) ensuring every NPM member delivers its own responsibilities under OPCAT; and
d) increasing the visibility and awareness of the prohibition of ill-treatment in detention, the Convention Against Torture, OPCAT and the role of the NPM in prevention.

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 October 2017 in Edinburgh and April 2018 in Belfast.

NPM Chair

John Wadham took up the role of the first independent Chair of the NPM in May 2016, following an open selection process and approval of his appointment by NPM members. His term was renewed by NPM members at the October 2017 business meeting.

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

Coordination is essential to the full and effective implementation of OPCAT in the UK, given the scale and complexity of the UK NPM's multi-body structure. Each NPM member has a different mandate, powers and geographical remit and sets its own priorities for detention monitoring, as well as contributing to joint NPM priorities.

Coordination of the NPM was designated to HMI Prisons, which is home to the NPM Secretariat. The Secretariat fulfils the role of NPM coordination and this is performed 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 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.

Income and expenditure for the NPM Secretariat 1 April 2017 to 31 March 2018	
Income	
MoJ	£61,155
Membership contributions	£19,500
TOTAL	**£80,655**
Expenditure	
Staff costs[34]	£64,357
Travel and subsistence	£2,187
Annual report design, printing and Welsh translation	£10,053
Other publications (factsheets, guidance, infographics)	£2,000
Meetings and refreshments	£635
TOTAL	**£79,231**

NPM steering group

The coordination function, activities and governance of the NPM are overseen by a steering group of five NPM members. They meet regularly and are representative of members in all four nations of the UK and of the different remits of the 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.

The steering group met four times during the year, in June 2017, September 2017, November 2017 and March 2018. As at the end of March 2018, the NPM steering group membership was as follows:

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

NPM sub-groups

The NPM's three existing sub-groups continued their work throughout the year.

The Scottish sub-group met twice during the year. 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. It is chaired by the Scottish member of the Steering Group, currently MWCS.

34 The UK NPM Secretariat consists of an NPM Coordinator/NPM Coordinator (maternity cover) (0.5 and 0.6 full-time equivalents) and an Assistant NPM Coordinator (0.5 full-time equivalent). The NPM Chair role is part-time and unpaid, with reasonable expenses for carrying out the role repaid. The UK NPM makes a contribution to salary costs of HMI Prisons staff who provide publications, communications, finance and HR support to the NPM Secretariat.

The mental health network, which brings together the different members who have a specialist interest in areas relevant to mental health detention in the UK, met twice during the year. 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 currently chaired by MWCS.

The NPM sub-group focused 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 the Children's Commissioner for England.

During the October 2017 business meeting, NPM members agreed to the creation of a fourth sub-group focusing on police custody. Members agreed that the group would be chaired by HMICS. The sub-group will commence work in the 2018–19 year.

Visits and inspections

The following table below sets out the number of inspections and monitoring visits by type of detention and jurisdiction carried out by NPM members during the year. Some places of detention may be subject to both inspection and monitoring or visits. An overview of each NPM member's remit is provided in section 1. A dash in the following table represents no inspection or visits having taken place. It is important to note that not all places of detention may be inspected each year. Instead, inspections take place in a cycle of between one and five years, depending on the analysed level of risk (which may increase, leading to inspection being brought forward in the cycle).[35] A number of separate places of detention may be visited as part of one inspection (for example, a number of court custody suites within one geographical location. Where this occurs, the following figures reflect the number of individual places of detention visited. The term inspection is used to refer to scrutiny of a detention setting by inspectorates or other bodies by paid staff, and the term visit refers to monitoring, visits or observations carried out by lay bodies or volunteers.

35 Individual NPM members determine their own inspection timetables. For an example, see HMI Prisons, *Inspection Framework,* May 2017, Section 3 (inspection programming), available at https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/02/1.-INSPECTION-FRAMEWORK-May-2017-1.pdf, accessed 19 July 2018.

Detention setting	Jurisdiction			
	England	Wales	Scotland	Northern Ireland
Prisons and YOIs (Inspection)	38	3	11	2
(Monitoring visits)	46,984	2,740	945	1,000
Police custody (Inspection)	31	7	4	-
(Independent custody visits)	6,922	525	1,455	448
Border force (Inspection)	7	-	1	-
Escort and court custody (Inspection)	20	-	-	-
(Observation visits)	1,691	110	-	
Detention under the Terrorism Act[36] (Independent custody visits)	133		1	38
Children in secure accommodation[37] (Inspection)	43	2	6	3
Detention under mental health law (Inspection)	1,165	34	113	59
Immigration detention[38] (Inspection)	11	-	1	-
(Monitoring visits)	IMB 2,691[39]	-	370	-
Military detention[40] (Inspection)	10	-	1	1
Customs custody facilities (Inspection)	6	-	1	-

36 Visits may take place when the terrorism suite is both active and inactive.

37 The number of monitoring visits to places holding children under 18 is noted in the prison/YOI figures due to the difficulty separating these figures where children are held on split sites with those over 18. The figure for Northern Ireland includes Woodlands Juvenile Justice Centre.

38 This includes immigration removal centres (2), short-term holding facilities (5) and inspections of removals of detainees under escort (4).

39 This figure includes monitoring of removals of detainees under escort (8).

40 This includes the Military Corrective Training Centre and service custody facilities.

In total, NPM members carried out at least 1,580 inspections during the year and at least 66,053 monitoring visits.

NPM self-assessment

NPM members conduct a self-assessment each year using methodology based on the SPT's 'analytical self-assessment tool for NPMs'. The tool allows NPMs to examine their effectiveness and efficiency.[41] This is the fifth year in which the self-assessment has been carried out. Of the 21 NPM members, 20 completed the self-assessment and 80% of the assessments were peer reviewed. The peer review process involves NPM members sharing their responses with one another to receive constructive external review and ensure consistency of approach.

General findings

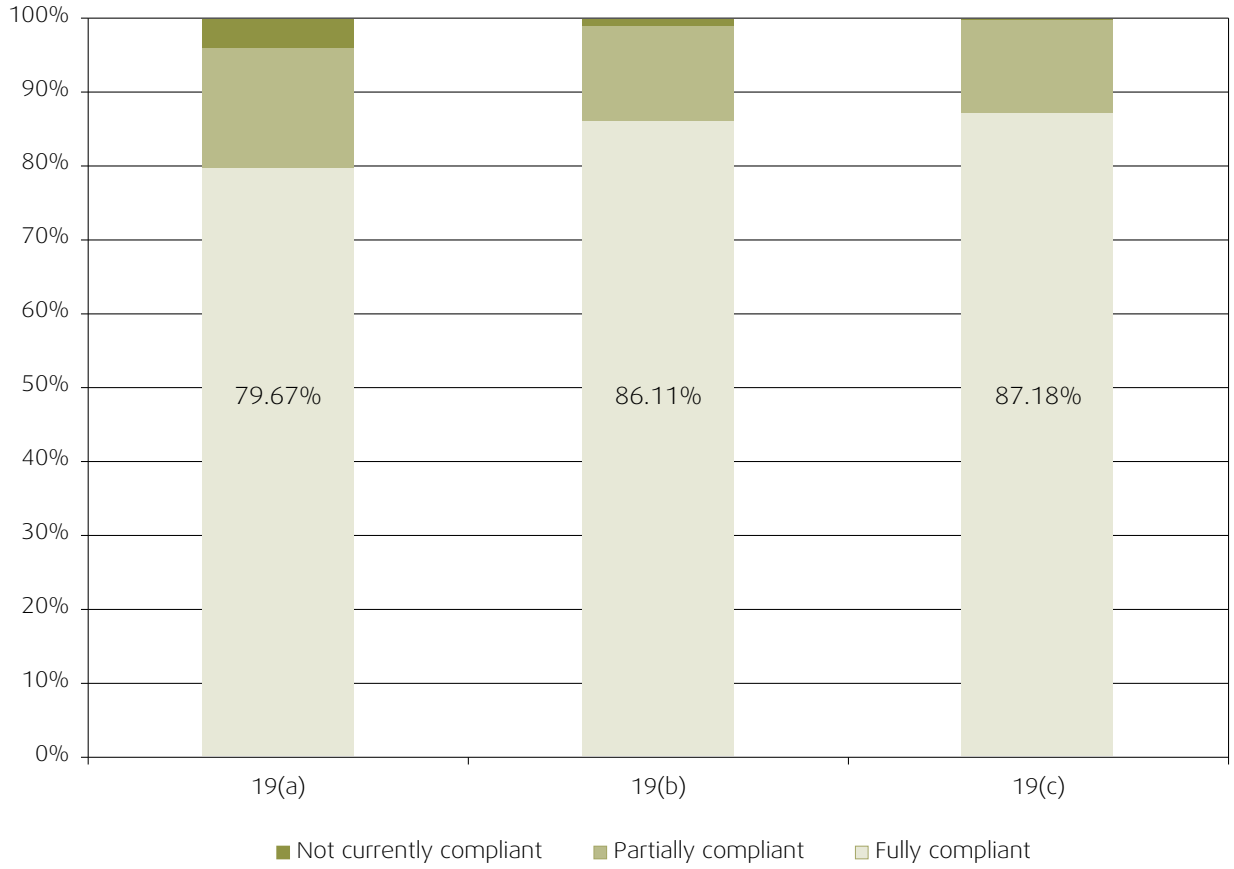
Members reported full compliance with 84.3% of the self-assessment questions, a slight decrease on the 86.5% compliance reported in the previous year.[42] Reported non-compliance increased to 2% from 1.6% in 2016–17. Further analysis shows that the decrease in reported compliance is largely due to additional members reporting this year than in the previous two years. Given the difference in members reporting across years, the year-on-year results should not be considered comparable. Rather, the results this year are likely to provide a more accurate picture of compliance.

The self-assessment responses were analysed in line with the three fundamental NPM powers set out in OPCAT Article 19, to: (a) examine the treatment of those deprived of their liberty; (b) make recommendations with the aim of improving their treatment and conditions; and (c) submit comments on existing and draft legislation. The following table shows the compliance NPM members reported with each of these powers.

41 The UK NPM's self-assessment questionnaire can be found in Appendix 8 of the Fifth Annual Report, available at https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2015/05/NPM-5th-Annual-Report-2013-14.pdf, accessed 21 November 2018. A full write-up of the self-assessment methodology is available at https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2015/08/UK-NPM-self-assessment-write-up.pdf, accessed 21 November 2018.

42 The percentages reported in this section are calculated using the responses provided by the 20 members that completed the self-assessment (rather than the 21 total members).

2018 Article 19 compliance



NPM members reported the highest level of compliance with powers to submit comments on existing and draft legislation. This increased to 87.2% from 85.3% in 2016–17 and 71.9% in 2015–16. Members reported similar levels of compliance in relation to the power to examine the treatment of those deprived of their liberty over the last three years: 79.7% compliance in 2017–18; 81.1% compliance in 2016–17; and 80.8% compliance in 2015–16. The level of reported compliance with the ability to make recommendations has fallen across the last three years from a high of 92.4% in 2015–16 to 86.1% in 2017–18.

Specific findings

- All members continued to report full compliance with the requirement to ensure that any confidential information acquired during their work is protected (Q 1.56) and in making recommendations to the relevant authorities with the aim of improving the treatment and conditions of persons deprived of their liberty and to prevent torture and ill-treatment (Q 1.2). All members also reported that they were fully compliant in relation to the following questions: that their visits reports focus on the most important issues (Q 1.28); and that they have established a simple and accessible procedure to provide

information to the general public (Q 1.52).
- Members continued to report the lowest levels of compliance for questions relating to sanctions, including: whether they had developed a strategy for the prevention of reprisals or threats against people interviewed during visits and people who provide information during visits (Q 1.36); whether they had a policy setting out the types of information that can be collected in group interviews and the types of information that should only be collected in private interviews (Q 1.37); and if they seek to ensure that a disciplinary or criminal investigation is initiated in cases of alleged reprisals (Q 1.42).
- As in previous years, a significant number of NPM members (just over two-thirds of those completing the self-assessment) remained only partially compliant in the area of gender balance and representation of ethnic and minority groups in visiting teams (Q 1.17).
- Organisations based in England were the most positive about their compliance, reporting 93.1% full compliance, compared with members working in both England and Wales who reported the lowest level of full compliance at 75.3%.
- Professional bodies reported a higher level of full compliance (87.6%) than lay bodies (76.6%).

Conclusion

The findings of the self-assessment are presented to the NPM membership at the business meeting following the completion of the analysis. In light of the lowest levels of reported compliance continuing to be in areas relating to sanctions and equality and diversity, members agreed that a focus on these two issues be included in the 2018–19 NPM business plan. In addition, the thematic work that the NPM will undertake on ill-treatment (see section 2) will consider issues relating to sanctions. We therefore hope to report increased compliance in these areas in coming years.

Developing the NPM

Throughout the year, the NPM continued to work for greater recognition and independence of the NPM and for the OPCAT-related work of the NPM itself and each of its individual members to be placed on a legislative footing. The NPM's view, supported by the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) is that the NPM must be placed on a statutory footing through legislation which recognises its independence and reflects the powers it has pursuant to OPCAT.

As noted in last year's annual report, the NPM Chair wrote to the Director of Judicial, Rights and International Policy at the Ministry of Justice (MoJ) in January 2017 to express his concern about the lack of legislation setting out the mandate of the NPM and its constituent bodies, and the lack of statutory guarantees of independence for the NPM or its members.[43] In addition, the NPM recommended that a statutory basis for the NPM be introduced into the Prisons and Courts Bill that was then before Parliament.[44]

43 *Eighth Annual Report of the United Kingdom's National Preventive Mechanism 1 April 2016 – 31 March 2017*, available at https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2018/02/6.4122_NPM_AR2016-17_v4_web.pdf, accessed 19 July 2018.

44 Public Bill Committee, *Written evidence submitted by John Wadham, Chair of the UK National Preventive Mechanism* (PCB 08).

This recommendation was not accepted and the Bill was subsequently withdrawn following the announcement of a General Election and the dissolution of parliament on 3 May 2017. The government subsequently confirmed that it would not reintroduce the Bill in the new parliament.

In June 2017, the acting Director General of Justice and Courts Policy Group replied to the NPM Chair's letter of January 2017. This letter confirmed that the position of the MoJ was that the NPM complies with the requirements of OPCAT without the need for a legislative basis.[45] In light of this, the NPM wrote to the SPT seeking its advice on the lack of legislative basis for the NPM and what is required for compliance with OPCAT.[46] The SPT replied to this letter in January 2018, confirming the view of the NPM that OPCAT requires it to be placed on a clear legislative basis and noting that the SPT would welcome the opportunity to clarify its position with the UK government at the earliest opportunity.[47] Following this, the NPM has encouraged the UK government, through the MoJ, to meet with the SPT to discuss the requirements of OPCAT.

Alongside efforts to secure a statutory footing, the NPM has continued to meet with officials from the MoJ to discuss other opportunities to strengthen the independence of the NPM and to raise awareness about its role. These meetings resulted in a commitment from the MoJ to develop a protocol between the NPM and the MoJ, setting out guarantees of independence for the NPM and its powers under OPCAT. The NPM has made it clear that this is an interim step to recognition in legislation. It was also welcome that the MoJ committed to hosting (alongside the Foreign and Commonwealth Office) a meeting with key government stakeholders, devolved administrations and NPM members to develop awareness of the NPM, its role and to strengthen relationships between these different stakeholders. This event is expected to take place in 2018–19.

The NPM Secretariat sought additional funding from the MoJ to undertake the work required to ensure it can fulfil its OPCAT mandate. This request was not met. In addition, towards the end of the year, several members of the NPM reported that they would be required by the UK Government to make cuts to their budgets for 2018–19.

In addition to work to strengthen its independence, the NPM has continued work to strengthen its inspection and monitoring practices. As in the previous year, the NPM and its members worked with Professor Rachel Murray and Dr Judy Laing from the Human Rights Implementation Centre at Bristol University on two projects. The first project aims to examine the extent of compliance of the lay visiting schemes within the NPM with OPCAT. It is hoped that the results of this project will be published in the coming year. As noted above, the second project relates to identifying and reporting incidents of ill-treatment in detention.

45 The letter is available at https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2018/02/Response-from-Scott-McPherson-to-JW-re-NPM-independence-1306170.pdf, accessed 19 July 2018.

46 See Appendix III of this report.

47 Ibid.

Member-specific developments

During the reporting year, there were several significant developments and positive impacts in relation to NPM members' OPCAT-related work.

In the last year, the **Care Inspectorate (CI)** inspected all five dedicated secure care units for young people. The CI also continued to work jointly with HMIPS on prison inspections, inspecting four prisons in 2017–18. The CI led on developing a methodology for joint inspections to report on the experiences of, and outcomes for, children and young people in need of protection. This includes children and young people in secure settings and care leavers up to 26 years old, including those who may have experience of adult custodial settings. The new model will be introduced in 2018–19. In addition, the CI continued to develop new methodology for care service inspections incorporating the new, human rights-based health and social care standards, *'my support, my life'* (2017).[48] During the year, this methodology was piloted in 40 inspections in care homes for older people and is now being evaluated to inform future decisions on scrutiny of care homes for older people and its wider applications to other service types, including secure care services. The CI created a dedicated page on its external website to profile the work of the NPM[49] and a dedicated NPM intranet page to raise staff awareness and share NPM guidance and reports.

Care Inspectorate Wales (CIW) continued to inspect the Secure Centre in Wales, making recommendations about the need to improve outcomes in relation to quality assurance, staffing and safeguarding. The Welsh Government developed new legislation to be introduced in April 2018 – the Regulation and Inspection of Social Care (Wales) Act 2016 – which will provide a new registration and inspection framework for regulated services in Wales.

In February 2018, **Care Quality Commission (CQC)** published its annual report to Parliament on how health services in England are applying the Mental Health Act.[50] The report notes individual examples of good practice, but again highlights longstanding concerns, including limited improvement in aspects of care planning that are important to supporting the recovery of patients and their discharge from inpatient services, and some patients not being informed of their rights on admission, and/or not receiving physical health checks on admission. CQC is also a key contributor to the Transforming Care programme. This aims to ensure that people with learning disabilities and challenging behaviour are effectively supported to live in their communities, close to home, and are only admitted to a mental health hospital when that is the intervention most suited to their needs at the time. As part of this, it published Registering the Right Support, which outlines its approach to registering

48 Standards are available at https://www.gov.scot/publications/health-social-care-standards-support-life/, accessed 21 November 2018.

49 Available at http://www.careinspectorate.com/index.php/national-preventive-mechanism, accessed 21 November 2018.

50 *Monitoring the Mental Health Act in 2016/17*, available at http://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-report, accessed 21 November 2018.

providers of services for people with a learning disability and/or autism.[51]

In June 2017, CQC wrote to the Secretary of State for Health and Social Care to advise him of concerns identified during inspections of high secure hospitals in England, which had taken place between November 2016 and March 2017. Throughout the year, CQC engaged closely with Broadmoor and Rampton high secure hospitals, NHS England, and the National Oversight Group for the hospitals to monitor the response to its concerns. This led to some improvements, including increasing staffing numbers and the hospitals working together to share good practice and training. CQC also raised concerns over the provision rehabilitation services in units that are often out-of-area and may be unduly restrictive.[52] It recommended that the government and its agencies work with local health and care systems to reduce the number of patients placed in such units.

Throughout the year, the office of the **Children's Commissioner for England (CCE)** talked to children in custody about their experiences and well-being as part of a rolling programme of visits to establishments holding children. The aim of the work is to improve the outcomes and life chances of children who are detained. During the year, the Commissioner raised particular concerns to Ministers and policy makers about safety, periods of isolation in cells, restraint, mental health support, access to appropriate education and rehabilitation. The Commissioner continued to liaise with Children's Commissioners in Scotland, Wales and Northern Ireland on common issues of concern. A joint reciprocal agreement of understanding is in place with the Children's Commissioner for Wales to observe and monitor the well-being of children who are detained out of their home country. The CCE's advice and representation service 'Help at Hand' received a number of enquiries during the year from children and young people in custody who were concerned that their rights were not being upheld. In a number of cases, the Commissioner wrote to the governor to seek resolution to the issue. Additionally, the Commissioner has made representations to responsible local authorities on behalf of children in the custodial estate. Many cases have centred on inadequate release planning, with children having no accommodation secured in the weeks and days leading up to their release. Other children felt their views and feelings were not being taken into account in release planning, or they were not able to communicate effectively with the local authority. The CCE has successfully secured positive outcomes for a number of children on whose behalf representations were made.

Criminal Justice Inspection Northern Ireland (CJINI) secured permission to publish reports from June 2017 (in the absence of an executive in Northern Ireland). CJINI carried out three inspections during the year: Maghaberry Prison in April 2017 as an unannounced follow-up to the 2015 recommendations; Magilligan Prison in June 2017; and the Juvenile Justice Centre. Reports were published on the two prison

51 *Registering the Right Support,* available at https://www.cqc.org.uk/sites/default/files/20170612_registering_the_right_support_final.pdf, accessed 21 November 2018.

52 *Mental health rehabilitation inpatient services,* available at https://www.cqc.org.uk/sites/default/files/20180301_mh_rehabilitation_briefing.pdf, accessed 21 November 2018.

inspections in 2017 and a report on the Juvenile Justice Centre was published in June 2018. In addition, CJINI undertook thematic inspections of resettlement and equality and diversity, the findings of which will be published later in 2018.

During the year, **Healthcare Inspectorate Wales (HIW)** continued with its regular programme of visits to hospitals where people are deprived of their liberty either by virtue of detention under the Mental Health Act or Deprivation of Liberty Safeguards. HIW also continued to undertake joint inspections of police custody and continued to monitor the effectiveness of the Welsh Mental Health Care Crisis Concordat that puts a framework in place to prevent individuals with a suspected mental health issue being admitted into police custody under section 136 of the Mental Health Act. HIW finalised its guidance for Second Opinion Appointed Doctors and it is anticipated that this will be published in June 2018.

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) jointly carried out eight police custody inspections in England and Wales, and an inspection of the custody arrangements for Border Force. The inspections showed that most detainees held in police custody were treated respectfully and received good levels of care. Inspections continued to find that scrutiny of the use of force on detainees remained weak in most police forces visited, leading to a letter being sent to all Chief Constables in early 2018 to raise these issues. Work began to revise the *Expectations for Police Custody* to incorporate the changes introduced by the Police and Crime Act 2017 and the recommendations made by Dame Elish Angiolini in her *Report of the Independent Review of Deaths and Serious Incidents in Police Custody,* which was published October 2017. A tailored inspection methodology and set of *Expectations* was also developed with HMI Prisons to support the inspection of Terrorism Act (TACT) custody facilities, planned for the 2018–19 inspection programme.

In January 2018, **Her Majesty's Inspectorate of Constabulary in Scotland (HMICS)**, published a report on police custody centres located in Tayside Division. This followed inspections of three centres in Tayside in September 2017, and a reinspection of one of those centres in November 2017 due to significant concerns HMICS had about cleanliness and hygiene issues. HMICS continues to work towards joint inspections of police custody with Healthcare Improvement Scotland (HIS). In preparation for these joint inspections, HIS inspectors shadowed HMICS on its inspection of one of the Tayside centres. HMICS also participated in the inspection of custody arrangements for Border Force, led by HMICFRS and HMI Prisons, visiting the custody centre at Glasgow Airport.

Throughout the year, **Her Majesty's Inspectorate of Prisons (HMI Prisons)** continued its regular programme of inspections of prisons, establishments holding children and young people, immigration detention, police and court custody, Border Force customs custody suites and military detention. HMI Prisons published two revised editions of its Expectations during the year following extensive consultation. *Expectations: Criteria for assessing the treatment of and conditions for men in prisons*, was published in July 2017. In January 2018, the fourth edition

of *Expectations for immigration detention* was published. Work began on drafting Expectations for the inspection of TACT detention (jointly with HMICFRS) and on revising *Expectations: Criteria for assessing the treatment of children and young people and conditions in prisons*.

In January 2018, following an inspection of HMP Nottingham carried out with Ofsted and CQC, HMI Prisons issued the first Urgent Notification letter pursuant to the new protocol announced by the Secretary of State in November 2017. The Urgent Notification protocol allows HM Chief Inspector of Prisons to write to the Secretary of State within seven calendar days of the end of an inspection, providing notification of significant concerns and the reasons for those concerns. The Secretary of State must respond within 28 days. Both the Urgent Notification letter and the Secretary of State's response are published. Inspectors found HMP Nottingham to be 'fundamentally unsafe' and in the Urgent Notification letter HMI Prisons expressed concern that this was the third consecutive inspection where the safety of the prison was assessed as poor. In the two years since the last inspection, levels of self-harm had risen significantly, there had been eight apparently self-inflicted deaths, and there were repeated failures to achieve or embed recommendations for improvement made by the Prisons and Probation Ombudsman (PPO). The Secretary of State's response set out how the authorities planned to deal with the issues raised by HMI Prisons and the action plan they had put in place to address the most serious and urgent concerns.

The Deputy Chief Inspector of **Her Majesty's Inspectorate of Prisons for Scotland (HMIPS)** became a member of the prisoner health care workstream of the Health and Justice Collaboration Board (established by the Scottish government). In addition, HMIPS received the Investing in Volunteers accreditation for its Independent Prison Monitor role.

The **Independent Custody Visiting Association (ICVA)** worked with the Independent Reviewer of Terrorism Legislation (IRTL) to develop and launch new training materials and report forms for Independent Custody Visitors (ICVs) who visit those detained under the Terrorism Act. ICVA and the IRTL launched these materials at a TACT conference held at Red Lion Chambers. ICVA established a TACT network group of scheme managers who, with the IRTL, meet quarterly to share good practice, identify trends in custody visiting and work with partners to ensure high-quality reporting. In addition, ICVA worked to embed reports from HMI Prisons and HMICFRS in its monitoring, by highlighting areas that custody visitors can be mindful of when undertaking their work.

During the year, all Police Scotland custody centres were visited by **Independent Custody Visitors (ICVs)** from Independent Custody Visiting Scotland (ICVS). A total of 2,701 detainees accepted a custody visit, none of whom made an allegation of ill-treatment. Some ICVs reported delays in access to police stations and custody areas, which led to visits being abandoned. Training of ICVs was ongoing throughout the year. In January 2018, ICVs received a briefing on the Criminal Justice (Scotland) Act 2016, which came into force in January 2018.

The briefing highlighted the most relevant sections to care, welfare and human rights and the impacts on custody visiting. New and existing ICVs also received training on equality and human rights and TACT detention. The annual ICVS conference in Glasgow was attended by a record number of ICVs and speakers included the IRTL.

In November 2017 **Independent Monitoring Boards (IMB)** welcomed a new National Chair, Dame Anne Owers, as the first step in implementing new governance arrangements. A series of internal forums was held to update board chairs on the proposed new governance structure and gain their feedback on key issues. The aim is to strengthen the independence, effectiveness and impact of the work of IMBs. A new annual report template was launched to ensure that Boards report in a clear and structured way. Training for both Board chairs and new members has been further developed and rolled out, supported by an e-learning platform.

Independent Monitoring Boards (Northern Ireland) (IMBNI) continued with its regular visits programme. Issues raised throughout the year included delays in the time taken to complete reviews of decisions to restrict individual prisoner's association, and the need for greater oversight of the care and separation unit at Maghaberry Prison. The Boards and Executive Council successfully sought an independent review of IMBNI to ensure that the Boards, Executive Council and Secretariat remain fit for purpose in an ever-changing environment.

This year has been one of unprecedented activity for the **Independent Reviewer of Terrorism Legislation (IRTL)** and others working in the area of TACT detention, following the terrorism attacks on Westminster Bridge in London on 22 March 2017. The IRTL continued to work closely with ICVA, whose custody visitors undertake visits to TACT detainees and whose reports on visits are provided to the IRTL. Very few concerns were raised by detainees throughout the year in relation to the conditions of their detention. The IRTL attended the ICVA Board meeting in April last year, attended and spoke at the ICVS Scotland Annual Conference in May 2017 and hosted an ICVA conference in August 2017 for TACT scheme managers to discuss issues and good practice. In addition, he continued to liaise with members of the National Appropriate Adult Network to hear their experiences of TACT detentions.

The annual report of the IRTL was laid before parliament in January 2018 and noted a reluctance by detainees to give consent to ICVA visits within the TACT custody facility in Northern Ireland. The IRTL subsequently worked to promote an understanding of the independence of custody visitors, which led to a change in policy where ICVA volunteers self-introduce to detainees. The report also highlighted the need for consistency across the UK in relation to the practice of obtaining a verbal response from a sleeping detainee.

The **Lay Observers'** 2016–17 annual report was published in October 2017 and covered a wide range of recommendations – most fundamentally the lack of a unified and coherent approach to assure the exercise of the duty of care to persons under escort and in court custody. The Chair reported that the welfare of detained persons was at risk due to inadequate access to health care, unacceptable conditions in custody suites,

unsatisfactory escort and court custody arrangements for children and young people and the lack of accurate Person Escort Records (PERs). The records sent by police and prisons when handing over custodies to the Prisoner Escort and Custody Services (PECS) were frequently inaccurate. Work to strengthen the LOs continued, with new health monitoring guidance being published for all observers to use and a protocol being agreed with PECS regarding the entry of observers into custody suites.

During the year, the **Mental Welfare Commission for Scotland (MWCS)** continued its programme of visits to services where people may be detained for the purpose of receiving care and treatment or may be receiving care and treatment while detained in other institutions, publishing a report on recommendations and outcomes from these visits in September 2017. In addition, MWCS published a number of thematic reports.

In June 2017 the **Northern Ireland Policing Board's (the Board) Independent Custody Visiting Scheme (NIPBICVS)** recognised the commitment of its volunteers by celebrating Volunteers Week for the first time. In July, the Board was reaccredited with Investing in Volunteers, the UK quality standard for good practice in volunteer management. Training of ICVs continued throughout the year, including sessions on equality, transgender awareness and TACT detention, in addition to the hosting of the Board's annual Volunteer Conference. Learning from the transgender awareness training session was shared with key stakeholders, including the Police Service of Northern Ireland (PSNI), which has now introduced transgender training for new custody suite sergeants in Northern Ireland. Board officials undertook work throughout the year to strengthen the work undertaken by ICVs. The ICV Handbook was reviewed in order to improve accuracy and relevance and ensure practice matched policy. Self-introduction was introduced for ICVs visiting TACT detainees. Finally, the forms ICVs complete after their visit with detainees were amended to improve the quality and accuracy of data capture and support the provision of appropriate information to other stakeholders, including the IRTL.

The Office for Standards in Education, Children's Services and Skills (Ofsted) continued to lead joint inspections of England's three secure training centres (STCs). Ofsted, with its partner inspectorates, began a review of the STC inspection framework, with agreed changes to be implemented from April 2019. It also continued to inspect secure children's homes (SCHs) in England. Ofsted's new social care common inspection framework (SCCIF) was implemented in February 2017, and all children's homes, including SCHs, are now inspected under this framework. CQC agreed to assist Ofsted in its full inspections of SCHs from April 2018. Throughout the year, Ofsted joined HMI Prisons to evaluate learning and skills and work activities in prisons and young offender institutions (YOIs) in England.

During the year, the **Regulation and Quality Improvement Authority (RQIA)** began an internal programme of transformation and reform to consider how it could be best structured to deliver its priorities into the future, and to ensure it remains best placed to respond to the changing external environment. In partnership with Queen's University Belfast, RQIA reviewed and evaluated evidence about the effectiveness

of an inspection assessment framework, specifically the use of rating scales, in facilitating improvements in quality of care outcomes in health and social care. Findings from the project will be used to inform the development of RQIA's inspection framework. In support of this work, and in partnership with Ulster University, RQIA initiated a project to develop a risk-adjusted, dynamic and responsive (RADaR) framework to identify, quantify and respond to regulatory risks more robustly. This will allow RQIA to identify those services where the quality of care is poor or changing and as such may require additional inspection. A pilot RADaR inspection framework was developed, which will be tested and refined during 2018–19, prior to its development for use across all of RQIA's inspection programmes.

In addition to work to strengthen its inspection methodology and framework, RQIA continued its regular programme of inspections, undertaking inspections of all wards where people are detained and examining over 11,000 patient detention, assessment and holding forms. RQIA also joined inspections of Maghaberry and Magilligan Prisons, examining the provision of health care.

The **Scottish Human Rights Commission (SHRC)** continued to work jointly with HMIPS to undertake inspections of prisons in Scotland, particularly focusing on equality and diversity. SHRC provided assistance to HMIPS in ensuring its revised standards for inspection and monitoring were human rights-based. In addition, SHRC held capacity building and workshop events with members of the Scottish Parliament and public authorities to raise the significance of international standards, including CAT and OPCAT, in their work. SHRC produced a guide to help advocates effectively support people to secure their rights, including those in detention.

Section four

Looking ahead to 2018–19

The members of the National Preventive Mechanism (NPM) agree a revised business plan each year.

The NPM agreed the following objectives for its work in 2018–19:

- 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 the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT);
- build an NPM that is effective in delivering all the requirements of OPCAT; and
- increase the visibility and awareness of the NPM's role in prevention, OPCAT, the prohibition of ill-treatment in detention and Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

The NPM carries out several projects each year to meet its objectives. For 2018–19, the NPM will focus on three key projects:

- scoping and research for the NPM's third thematic project on ill-treatment in detention, including how members identify and respond to ill-treatment;
- providing a written submission and briefing to the United Nations Committee against Torture's periodic review of the UK; and
- continuing work to strengthen NPM governance and OPCAT compliance, including agreeing a Memorandum of Understanding (or Protocol) with government as a step to legislation and organising an awareness-raising event with government.

Section five
Appendices

Appendix I
Glossary

APT	Association for the Prevention of Torture
CAT	Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
CCE	Children's Commissioner for England
CI	Care Inspectorate
CIW	Care Inspectorate Wales
CJINI	Criminal Justice Inspection Northern Ireland
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CQC	Care Quality Commission
CRC	Convention on the Rights of the Child
DoLS	Deprivation of Liberty Safeguards
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 Visiting 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
PSNI	Police Service of Northern Ireland
PPO	Prisons and Probation Ombudsman
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
YJB	Youth Justice Board
YOI	Young offender institution

Appendix II

Further information about the UK NPM

If you would like further information about the UK NPM, please contact the NPM Coordinator or Assistant Coordinator. For further information about a particular member, you may wish to contact them directly.

Louise Finer
National Preventive Mechanism Coordinator

Jade Glenister
National Preventive Mechanism Assistant Coordinator

Her Majesty's Inspectorate of Prisons
3rd Floor
10 South Colonnade
Canary Wharf
London
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Website: http://www.nationalpreventivemechanism.org.uk/
Twitter: @uknpm

Appendix III

NPM correspondence with the SPT

UK National Preventive Mechanism
c/o HM Inspectorate of Prisons
Clive House
5th floor
70 Petty France
London, SW1H 9EX
Phone: 020 3334 0358
E-mail: louise.finer@hmiprisons.gsi.gov.uk

Mari Amos
UN Sub-committee on Prevention of Torture
Office of the High Commissioner for Human Rights
Palais Wilson
52, rue des Paquis
CH-1201 Geneva

15 November 2017

Dear Mari,

Advice from the Sub-Committee on the Prevention of Torture

I am writing on behalf of the National Preventive Mechanism of the United Kingdom to request the advice of the Sub-Committee on the important issue of compliance with the Optional Protocol to the Convention Against Torture.

As you know the members of the UK NPM were designated by the UK government in 2009, with additional designations in 2013 and 2017.[53] All the organisations designated to the NPM were already functioning, many of them from before OPCAT was agreed by the UN, and the government decided that they were already carrying out the functions necessary for OPCAT. At the time of the initial designations, the Chief Inspector of Prisons (England and Wales) was asked to take on a co-ordination role for the NPM.[54]

53 Optional Protocol to the Convention Against Torture (OPCAT), Written Statement - 490 c56WS, 31 March 2009; Convention Against Torture, Written Statement - 571 c41WS, 3 December 2013; Optional Protocol to the Convention Against Torture (OPCAT), Written statement - HLWS412, 12 January 2017.

54 HMI Prisons' coordination role is set out in *Protocol between The Ministry of Justice as the Department and HM Chief Inspector of Prisons* (27 February 2017) at paragraph 3.3.

Currently, only two of the 21 members of the NPM have any reference to their OPCAT mandate written into the legislation that created them and which defines their role. The Police and Fire Reform (Scotland) Act 2012 and the Public Services Reform (Inspection and Monitoring of Prisons) (Scotland) Order 2014 set out that the purpose of independent custody visiting and the functions of HM Chief Inspector of Prisons for Scotland respectively are "pursuant to the objective of OPCAT".

The NPM itself is not recognised more generally in any legislation and has no separate legal identity. In 2015 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, I am pleased to report, selected and appointed me without any involvement from the UK Government. However, the Chair, like the NPM itself, is also not recognised in legislation (nor given any of the required powers, immunities or status). You will note in our letter to the government (attached, 13 January) we have set out in detail why we believe this matters.

This year the Government introduced legislation, the Prisons and Courts Bill, which would have strengthened the legislative basis of HM Chief Inspector of Prisons and referred specifically to the OPCAT role (clause 2, proposed amendment to the Prison Act 1952, extract attached) but the legislation fell when the Government called an election and the Government has stated that it does not intend to bring that before Parliament again in the near future. We suggested to the Government and Bill Committee that they could use that legislation to recognise the UK's NPM[55] and we drafted a short amendment to that Bill (attached) but unfortunately the Government did not take up that suggestion. It was, however, promoted by the Opposition in Parliament.

We have also raised the need for NPM legislation with the Parliamentary Joint Committee on Human Rights and Justice Committee,[56] who supported this proposal.[57]

Separately you may remember that there was a complaint to the Subcommittee that one of our members (the Independent Monitoring Boards, IMB) was subject to unjustified interference by the UK Government (by "sacking" the local chair) and we wrote to you about this. This coincided with a review of the governance arrangements for the IMB and we wrote to the Minister concerned to raise the need for greater separation between the IMB secretariat and the Ministry of Justice (letter of 24 January 2017 attached) and met with him to discuss the issues. Although we never received a substantive written reply to our specific

55 Public Bill Committee, *Written evidence submitted by John Wadham, Chair of the UK National Preventive Mechanism* (PCB 08) at https://publications.parliament.uk/pa/cm201617/cmpublic/PrisonsCourts/memo/PCB08.htm

56 Oral evidence to the Justice Committee, http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/justice-committee/prison-reform/oral/46581.html; Written evidence from the UK NPM to the Justice Committee, http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/justice-committee/prison-reform/written/45906.html, January 2017; Written evidence from the UK NPM to the JCHR http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/human-rights-committee/mental-health-and-deaths-in-prison/written/48220.html, March 2017

57 Justice Committee's *14th Report – Prison Reform: Part 1 of the Prisons and Courts Bill*, HC 1150, *28 April 2017;* Topical Questions, 25 April 2017, Hansard Volume 624.

concerns, at our meeting the Minister indicated that he did not accept our criticism of the arrangements and the changes suggested in the review were implemented without taking our concerns on board (see attached letter of 13 February 2017).

The nature of the devolved constitutional arrangements in the United Kingdom means that many of our members are created by, and subject to, separate legislation and amending that legislation is outside the competence of the Westminster Parliament. However, as far as we are aware, there has been no discussion with the devolved governments or parliaments about the changes that we have suggested.

It is worth noting that we are continuing to discuss with Government officials what else could be achieved to recognise the NPM in the absence of any legislation. However, we believe that the absence of legislation setting out the OPCAT mandate and responsibilities of each of the designated organisations, specifically protecting their independence, is wrong in principle and does not comply with OPCAT itself or the SPT's own guidelines. 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 our reputation internationally.

As you can see from the attached correspondence (our letter of 13 January 2017 and the reply 13 June 2017), the Government considers the arrangements for the UK NPM are already compliant with OPCAT. We understand that the SPT raised the need for a legislative basis for the UK NPM prior to its designation, and would welcome your specific advice on what, if anything, would be needed for the UK NPM to comply with OPCAT. The Government is aware that we are approaching you for advice and we have copied Ministry of Justice and Foreign and Commonwealth Office ministers and officials as well as representatives of devolved governments.

Yours sincerely,

John Wadham
Chair of the UK NPM

cc Dr Phillip Lee MP, Parliamentary Under Secretary of State for Youth Justice, Victims, Female Offenders and Offender Health

Lord Ahmad of Wimbledon, Minister of State for the Commonwealth and the UN, Foreign & Commonwealth Office

Dominic Lake, Deputy Director of the Human Rights and Intergovernmental Relations, Ministry of Justice

Matthew Deith, Team Leader, Security and Justice, Foreign and Commonwealth Office

Professor Sir Malcolm Evans, Chairperson, UN SPT

Neil Rennick, Director of Justice, Scottish Government

Brian Grzymek, Criminal Justice Policy & Legislation Division, Department of Justice, Northern Ireland Executive

Andrew Felton, Head of Justice Policy, First Minister and Cabinet Office, Welsh Government

David Jones, Conventions Manager, Education and Public Service, Welsh Government

Attached: Letter from John Wadham to Scott McPherson, 13 January 2017
Response to John Wadham from Scott McPherson, 13 June 2017
Letter from John Wadham to Sam Gyimah MP, 2 January 2017
Response to John Wadham from Sam Gyimah MP, 13 February 2017
Excerpt from the Prisons and Courts Bill (as introduced to Parliament) and proposed amendments re OPCAT
Proposed NPM amendment to Prisons and Courts Bill to recognise NPM

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REFERENCE: MA

Geneva, 29 January 2018

Dear Mr. Wadham,

I have the honour to write to you on behalf of the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), established in accordance with the Optional Protocol to the Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (OPCAT), in my capacity as Head of the European Regional Team and SPT country rapporteur for the United Kingdom of Great Britain and Northern Ireland.

I would like to thank you for your letter dated 15 November 2017 in which you set out a number of developments concerning the question of the legal basis of the UK NPM. As I am sure you are aware, the lack of a clear legislative basis for the NPM has long been a matter of concern to the SPT. We are aware that some take the view that this is not legally necessary under the OPCAT. The SPT disagrees with this position, and should the SPT visit the UK on an official basis it is incontrovertible that this failing would feature in its report and recommendations – as it has in all other countries where there are similar shortcomings.

The experience of the SPT is that the situation of an NPM remains precarious without its being underpinned by a clear legislative basis. We have seen, unfortunately, too many examples of cases in which states have put pressure on NPMs, directly or indirectly, which they have not been able to challenge for the want of a clear basis on which to do so. Practical effectiveness is dependent on functional independence, and the independence is threatened when the NPM is vulnerable to political pressure or political exigencies. The role of the SPT in relation to NPMs includes ensuring that they are protected from such pressures. Hence, our unequivocal view that the OPCAT requires, as a matter of practice, that the NPM has a clear legislative underpinning.

Whilst a welcome development, it has to be said that the wording previously proposed for inclusion in the Prisons and Court Bill fell far short of what we would expect, amounting to little more than a legislative acknowledgement of the NPM. On the information available to us, it seems to offer no substantive safeguards for the day-to-day execution of the OPCAT mandate by the UK NPM.

…//…

Mr. John Wadham
Chair of the UK NPM

The SPT is conscious that it has not yet undertaken a formal visit to the UK under its OPCAT Article 11(a) mandate. This has, perhaps, denied it the opportunity to formally and officially make its views known to the UK Government. We are, however, in no doubt that the views of the SPT on this matter are in fact known by the UK Government. We would welcome any opportunity to clarify our position directly with the Government, formally or informally, that might be made available and believe it would be beneficial were this to be at the earliest opportunity.

Yours sincerely,

Mari Amos

Head of the European Regional Team
Subcommittee on Prevention of Torture

The image used in this report is a detail from *Reef*, a painting by a detainee at HM Prison Barlinnie (copyright © 2019 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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