
# Monitoring places of detention

Eighth **Annual Report**
of the United Kingdom's
National Preventive Mechanism
**1 April 2016 – 31 March 2017**

Cm 9563


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# Eighth Annual Report of the United Kingdom's National Preventive Mechanism

1 April 2016 – 31 March 2017

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

# Introduction by John Wadham

## NPM Chair

This has been my first full year as the National Preventive Mechanism (NPM) chair and, having shadowed our members as they visit and inspect places of detention across the UK, I remain very impressed by the dedication, experience and professionalism of members' staff and volunteers. The United Nations' Optional Protocol to the Convention Against Torture (OPCAT) provides us with a crucial framework to strengthen our work monitoring places of detention, and it encourages us to focus even more carefully on preventing ill-treatment in practice. UK NPM members have very sophisticated methodologies and well-embedded practices to deliver on the promise of OPCAT but, at the same time, OPCAT reminds us that the risk of ill-treatment is always present, and every year we must continue to renew our efforts to perform our essential *preventive* role. It is unfortunate that this year, as in previous years, examples of ill-treatment continue to surface. We must recognise that however successful we are, we cannot do this work alone; we need to welcome the parallel roles undertaken by lawyers for detained people, dedicated non-governmental organisations (NGOs) and the media in exposing malpractice in the institutions we visit and inspect.

Unfortunately this year NPM members have to report that:

- as in previous years, we observed a significant decline in outcomes for male prisoners in England and Wales. Overall levels of violence continued to rise in prisons and significantly more prisoners reported that they felt unsafe, with many prisoners observed to be self-segregating to avoid violence;
- there is clear evidence that children who continue to be imprisoned are increasingly vulnerable. Her Majesty's Inspectorate of Prisons (HMI Prisons) concluded in February 2017 that no establishment that it inspected in England and Wales was safe to hold children;
- conditions of detention were often poor across places of detention, including mental health wards, prisons and police and court custody;
- more needed to be done to address the mental health needs of those detained, both in the criminal justice and health systems; and
- there were a significant number of deaths in detention during the year, including of young people.

To do a better job next year we need to strengthen both the NPM and its members. A key challenge for us remains our informal status, lack of legislation and guarantees of independence and, finally, the inadequate nature of the resources available centrally. I have raised these issues with the government and it was particularly disappointing for me and for Peter Clarke (Her Majesty's Chief Inspector of Prisons in England and Wales) that the provisions on prisons in the Prisons and Courts Bill that was before the last parliament have not been reintroduced. This would have been an opportunity for the government to formalise the essential link between HMI Prisons and OPCAT and to set out the NPM's essential status in legislation. Sadly, we are one of very few NPMs anywhere in the world operating without legislation providing a secure basis for our work.

On the more positive side, we were very pleased to host the Chairperson of the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), Sir Malcolm Evans, at our March 2017 business meeting. He reminded us that the way in which OPCAT works in the UK has relevance well beyond the UK, and that the SPT considers it essential that any NPM has a clear, separate legal basis: *de facto* autonomy is not necessarily enough.

I was also pleased to attend the panel organised by the Foreign and Commonwealth Office (FCO) on the 10th anniversary of the entry into force of OPCAT, at which Baroness Anelay (then Minister of State at the Foreign and Commonwealth Office) expressed the FCO's continuing commitment to torture prevention.[1] We hope that this, and the government's enthusiasm for promoting the UK NPM internationally, will be reflected in concrete progress at home in addressing the weaknesses in our structure.

It has been a busy year. We published our isolation guidance, which is already being used by UK NPM members and NPMs internationally to strengthen their practice and make recommendations to detaining authorities for improving practice. We also began work on examining 'transitions and pathways' between places of detention, the details of which are set out later in this report.

We continue to engage widely with international and regional human rights bodies (the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and the SPT) and other inter-governmental bodies. More recently we joined with other NPMs in proposing to the Council of Europe, Organization for Security and Co-operation in Europe and EU that they support NPMs in establishing an NPM-led network, reflecting the fact that across the region NPMs have grown in confidence and standing and are ready to see a shift in approach to them from inter-governmental bodies.

1. The Rt Hon Baroness Anelay of St Johns DBE, 'Speech to mark the 10th Anniversary of OPCAT', 29 June 2016, https://www.gov.uk/government/speeches/speech-to-mark-the-10th-anniversary-of-opcat [accessed 09/11/17].

I would like to take this opportunity to thank Bristol University for their support. The University is taking forward two projects on crucial topics for the NPM (the tradition in the UK of volunteer visitors and monitors, and assessing the number of incidents of ill-treatment). I would also like to express my thanks to the Association for the Prevention of Torture, the Council of Europe and the many others who support our work. Thanks are due to the Steering Group, made up of members of the NPM, for the support that they give me in my work, and for the incredibly important work of the staff of HMI Prisons who coordinate the NPM and particularly Louise Finer – without her we would be a much less effective organisation.

Finally, I would like to welcome our newest member, the Independent Review of Terrorism Legislation, Max Hill QC, an important addition to the overall work of the NPM.

**John Wadham**
Chair of the UK NPM

# Section one
# Context

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

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

OPCAT entered into force in June 2006. States that ratify OPCAT are required to designate a 'national preventive mechanism' (NPM). This is a body or group of bodies that regularly examine conditions of detention, 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, the NPM must:

- be independent of government and the institutions it monitors;
- be sufficiently resourced to perform its role; and
- have personnel with the necessary expertise 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 whom 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 and conditions of 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.[2] There are currently 83 states parties to OPCAT, and 65 designated NPMs.[3]

## The UK's National Preventive Mechanism

The UK ratified OPCAT in December 2003 and designated its NPM in March 2009. Designation of the NPM was the responsibility of the UK government and it chose to designate multiple existing bodies rather than create a new, single-body NPM. This took into account the fact that many types of detention in the UK were already subject to monitoring by independent bodies, as envisaged by OPCAT, and the different political, legal and administrative systems in place in the four nations that make up the UK. There are now 21 bodies designated to the NPM, the most recent designation was the Independent Reviewer of Terrorism Legislation on 12 January 2017.[4]

### Scotland

Care Inspectorate (CI)
Her Majesty's Inspectorate of Constabulary in Scotland (HMICS)
Her Majesty's Inspectorate of Prisons for Scotland (HMIPS)
Independent Custody Visitors 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 and Social Services Inspectorate Wales (CSSIW)
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. All annual reports, including the most recent 10th annual report which covers the work carried out by the SPT in 2016, are available on the website of the Office of the High Commissioner for Human Rights, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=12&DocTypeID=27 [accessed 13/08/17].
3. United Nations Treaty Collection, 'Chapter IV: 9. b Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment', status as at 13/08/17, https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9-b&chapter=4&clang=_en [accessed 13/08/17]; Association for the Prevention of Torture, OPCAT database, available at http://www.apt.ch/en/opcat-database/ [accessed 13/08/17].
4. 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 09/11/17].

<table>
<tr><th rowspan="2">DETENTION SETTING</th><th colspan="4">Jurisdiction</th></tr>
<tr><th>England</th><th>Wales</th><th>Scotland</th><th>Northern Ireland</th></tr>
<tr><td rowspan="2">Prisons and YOIs</td><td>HMI Prisons with CQC and Ofsted</td><td>HMI Prisons with HIW</td><td rowspan="2">HMIPS with CI and SHRC; MWCS</td><td>CJINI and HMI Prisons with RQIA</td></tr>
<tr><td colspan="2">IMB</td><td>IMBNI</td></tr>
<tr><td rowspan="2">Police custody</td><td colspan="2">HMICFRS and HMI Prisons</td><td>HMICS</td><td>CJINI with RQIA</td></tr>
<tr><td colspan="2">ICVA</td><td>ICVS</td><td>NIPBICVS</td></tr>
<tr><td>Escort and court custody</td><td colspan="2">Lay Observers and HMI Prisons</td><td>HMIPS</td><td>CJINI</td></tr>
<tr><td rowspan="2">Detention under the Terrorism Act</td><td colspan="4">IRTL</td></tr>
<tr><td colspan="2">ICVA</td><td>ICVS</td><td>NIPBICVS</td></tr>
<tr><td rowspan="2">Children in secure accommodation</td><td rowspan="2">Ofsted (jointly with HMI Prisons and CQC in relation to secure training centres)</td><td rowspan="2">CSSIW</td><td rowspan="2">CI</td><td>RQIA</td></tr>
<tr><td>CJINI</td></tr>
<tr><td>Children (all detention settings)</td><td>CCE</td><td></td><td>CI</td><td></td></tr>
<tr><td>Detention under mental health law</td><td>CQC</td><td>HIW</td><td>MWCS</td><td>RQIA</td></tr>
<tr><td rowspan="2">Deprivation of liberty[5] and other safeguards in health and social care</td><td rowspan="2">CQC</td><td>HIW</td><td rowspan="2">CI and MWCS</td><td rowspan="2">RQIA</td></tr>
<tr><td>CSSIW</td></tr>
<tr><td rowspan="2">Immigration detention</td><td colspan="3">HMI Prisons</td><td>HMI Prisons with CJINI</td></tr>
<tr><td colspan="4">IMB</td></tr>
<tr><td>Military detention</td><td colspan="4">HMI Prisons</td></tr>
<tr><td>Customs custody facilities</td><td colspan="4">HMICFRS, HMI Prisons and HMICS</td></tr>
</table>

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 strategic plan is agreed and monitored at these meetings and other decisions which require the input of all members are made. This year, business meetings were held in September 2016 in Cardiff and March 2017 in London.

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 their liberty.

## NPM chair

On 12 May 2016, John Wadham took up the role of the first independent Chair of the NPM. His appointment was approved by NPM members during the April 2016 business meeting, following a recommendation of a selection panel, which was made up of four members of the NPM steering group and one independent panel member (Professor Rachel Murray from Bristol University). The panel reviewed applications made by candidates through an open selection process.

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 coordination in carrying out its role.

## NPM coordination

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.

HMI Prisons 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 UK NPM members;
- facilitating joint activities between members on issues of common concern;
- liaising with the SPT, NPMs in other states and other international human rights bodies;
- sharing experiences and expertise between the UK NPM and NPMs in other states;
- representing the NPM as a whole to government and other stakeholders in the UK; and
- preparing the annual report and other publications.

## NPM steering group

The 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 also of the different remits of organisations that make up the NPM.

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

The steering group met four times during the year in April 2016, June 2016, December 2016 and February 2017. As of March 2017, the NPM steering group membership was as follows:

- Peter Clarke, HMI Prisons;
- Theresa Nixon, RQIA;
- David Strang, HMIPS;
- Kevin Barker, CSSIW; and
- Katie Kempen, ICVA.

### NPM sub-groups

The NPM has three sub-groups which worked 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 HM Chief Inspector of Prisons for Scotland.

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 four times 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 chaired by the Regulation and Quality Improvement Authority.

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 staff from the Children's Commissioner for England and met twice during the year.

## The situation in detention during the year

### Prisons

The situation in prisons across the four nations presented a mixed picture during the year, but NPM members shared concerns around the need for improved support for vulnerable prisoners and improved mental health care, and the use of new psychoactive substances (NPS). Of particular concern was the increase in instances of self-harm and assaults in prisons in England and Wales, which reached record highs during the year. The number of self-harm instances was 40,414 for the year, an increase of 17% on the previous year. Of those instances, 2,771 required hospital attendance. There were 26,643 reports of assaults, an increase of 20% on the previous year. Of those incidents, 14% were serious, an increase of 22% from the previous year.[6] The number of self-inflicted deaths in prisons also continues to be of concern to NPM members. There were 121 self-inflicted deaths for the calendar year ending 2016, up from 90 in the previous year. Five of the deaths were of young adults aged 18–20.[7]

6. Ministry of Justice, July 2017, *Safety in Custody Statistics Bulletin, England and Wales, Deaths in prison custody to June 2017, Assaults and Self-Harm to March 2017*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/632625/safety-in-custody-quarterly-bulletin-mar-2017.pdf [accessed 22/08/2017].
7. Ministry of Justice, 2017, *Deaths in Prison Custody 1978 to 2016*, https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-march-2017 [accessed 22/08/17]. Updated figure of 121 provided by the Ministry of Justice.

As in previous years, there was a significant decline in outcomes for men in prison in England and Wales. In almost three-quarters of its reports on men's prisons, HMI Prisons was critical of the response of establishments to some factors contributing to self-harm. Significantly more prisoners reported to HMI Prisons that they felt unsafe during the year, with many prisoners observed to be self-segregating to avoid violence. The use of force by staff was high in many prisons and there were concerns about gaps in the governance of its use. Prison conditions in England and Wales were poor, with many prisoners being kept in dirty and overcrowded facilities. The amount of time that prisoners remained in cells was considered to be unacceptable by HMI Prisons. Staff shortages contributed to the poor outcomes in prisons throughout the year and were chronic in some establishments. As in previous years, the use of NPS was noted to be widespread.[8]

Outcomes in women's prisons inspected in England during the year were generally better than in the men's estate, but women in prison continued to present complex needs, reporting increased vulnerability and mental health problems. The number of women reporting that they had ever felt unsafe in prisons inspected during the year rose to 52% from 39% in the previous year. HMI Prisons noted that all women's prisons inspected during the year took the issues of women who had experienced domestic abuse, trafficking and/or who had worked in the sex industry seriously, but more needed to be done to provide them with sufficient support.[9]

Across Scotland, levels of violence in prisons have remained relatively stable in recent years, but concerns remain about the impact of the increased use of NPS. The provision of health care in prisons continues to be the issue which prisoners most frequently raise as a concern with Independent Prison Monitors. The number of older prisoners continues to rise, with the increase in length of sentences imposed by the courts and the prosecution of more cases of 'historic' crimes contributing to this rise. In preparation for the implementation of the Scottish Government's strategy for women in custody, which will develop more community-based custodial provision, over 100 women were transferred from HMPYOI Cornton Vale to HMPYOI Polmont. This allowed for the partial closure of some accommodation blocks at Cornton Vale and an overall improvement in the conditions for women in custody.

In Northern Ireland, a review of progress at Maghaberry Prison, which houses adult men, highlighted continuing concerns. These included failures to monitor the prison's own death in custody action plan (put in place to implement recommendations from the Northern Ireland Prisoner Ombudsman in relation to supporting prisoners vulnerable to suicide or self-harm) and the lack of an overall strategy to respond to safety concerns and vulnerable prisoners. The prison continued to face issues with drug abuse.[10] A joint inspection of Hydebank

8. HM Inspectorate of Prisons, 2017, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016–17*, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/07/HMIP-AR_2016-17_CONTENT_11-07-17-WEB.pdf [accessed 22/08/17].
9. *Ibid.*
10. Criminal Justice Inspectorate Northern Ireland, HM Inspectorate of Prisons, Education Training Inspectorate, Regulation and Quality Improvement Authority, 2016, *Report on an announced visit to Maghaberry Prison, 5–7 September 2016 to review progress against the nine inspection recommendations made in 2015*, http://www.cjini.org/getattachment/1d77c1e6-8311-413e-ad9d-b9f9aa384506/picture.aspx [accessed 09/10/2017].

Wood Secure College (which houses young men aged between 18 and 24) and Ash House (Northern Ireland's only establishment housing women) carried out in May 2016 found that outcomes had significantly improved since the previous inspection. As in England and Wales, staff and those detained in both institutions reported that NPS were easily available and inspectors noted that further work needed to be done to tackle drug and alcohol dependency. Further work was also needed at both institutions to improve support for prisoners with mental health issues.[11] At Hydebank Wood, as at Maghaberry, inspectors raised concerns that Ombudsman's recommendations in relation to suicide and self-harm prevention were not being sufficiently implemented.[12]

The total prison population in England and Wales as at 31 March 2017 was 84,652 (80,674 men and 3,978 women), relatively similar to the figure for the same time in the previous year:[13] The population in Scotland's prisons at the end of March 2017 was 7,436, which represented a reduction of approximately 2% from the year before.[14] The population in Northern Ireland also decreased, with the average daily population across the year reducing 7.5% to 1,472 (from 1,592 in the previous year).[15]

## Children in detention

NPM members welcomed the continued fall in the number of children held in custody across the UK.[16] However, while the overall population has fallen, data from England and Wales shows that the over-representation of children from black, Asian and minority ethnic backgrounds has increased: for the year ending March 2016, the proportion of

11. Criminal Justice Inspectorate Northern Ireland, HM Inspectorate of Prisons, Education Training Inspectorate, Regulation and Quality Improvement Authority, 2016, *Report on an unannounced inspection of Hydebank Wood Secure College, 9–19 May 2016*, http://www.cjini.org/getattachment/deb7ee5a-50c8-4b01-8586-c0abf5a523a8/picture.aspx, [accessed 09/10/2017] and *Report on an unannounced inspection of Ash House Women's Prison Hydebank Wood*, 9–19 May 2016, http://www.cjini.org/CJNI/files/ef/efa315e4-3288-47e1-85f6-2de9186916fc.pdf [accessed 09/10/2017].
12. Criminal Justice Inspectorate Northern Ireland, HM Inspectorate of Prisons, Education Training Inspectorate, Regulation and Quality Improvement Authority, 2016, *Report on an unannounced inspection of Hydebank Wood Secure College, 9–19 May 2016*, http://www.cjini.org/getattachment/deb7ee5a-50c8-4b01-8586-c0abf5a523a8/picture.aspx [accessed 09/10/2017].
13. Ministry of Justice, National Offender Management Service, HM Prison Service, and Her Majesty's Prison and Probation Service, *Population Bulletin: Weekly 31 March 2017*, https://www.gov.uk/government/statistics/prison-population-figures-2017 [accessed 22/08/17]. These figures do not include those in HMPPS-operated immigration removal centres or the home detention curfew caseload.
14. Scottish Prison Service, *SPS Prison Population*, available at: http://www.sps.gov.uk/Corporate/Information/SPSPopulation.aspx [accessed 06/10/2017]. These figures exclude those released on home detention curfew.
15. Department of Justice Northern Ireland, 2017, Analytical Services Group, *The Northern Ireland Prison Population 2016 and 2016/17 Research and Statistical Bulletin 27/2017*, https://www.justice-ni.gov.uk/sites/default/files/publications/justice/northern-ireland-prison-population-2016-2016-17.pdf [accessed 09/10/2017].
16. In England and Wales, the average number of children held in custody for the year ending March 2017 was 869, decreasing from 959 in the previous year and from 2,915 for the year ending March 2007 (at the time of access, figures for the year ending March 2017 were provisional). Provisional data available at the time of writing showed this trend was reversed in the first quarter of 2017–18. Ministry of Justice and Youth Justice Board for England and Wales, 2017, *Monthly Youth Custody Report, June 2017*, https://www.gov.uk/government/statistics/youth-custody-data [accessed 22/08/17]. In Scotland, the prison population under 18 as at 1 April 2016 was 70, and the population as at 31 March 2017 was 52. Scottish Prison Service, *SPS Prison Population*, http://www.sps.gov.uk/Corporate/Information/SPSPopulation.aspx [accessed 06/10/2017]. In Northern Ireland, the average daily child population in custody during the 2016–17 year was 23, down from 26 in 2015–16. The total number of children in custody during the year was 139, down 15% from the previous year. Youth Justice Agency, 2017, Analytical Services Group, *Youth Justice Agency Annual Workload Statistics 2016/17: YJA Statistical Bulletin 28/2017*, https://www.justice-ni.gov.uk/sites/default/files/publications/justice/yja-workload-stats-2016-17-edited02102017.pdf [accessed 10/10/2017].

children from these backgrounds detained in youth custody was 41.5%, steadily rising from 29.7% for the year ending March 2011.[17]

In addition, there is clear evidence that the children who are imprisoned are increasingly vulnerable. Between 2011 and 2016, the number of incidents of self-harm per 100 children detained in England and Wales rose from 4.1 to 8.9.[18] Two children were reported to have died in secure children's homes (SCH) in the early months of 2017. Both deaths are under investigation by the Prison and Probation Ombudsman and will be subject to an inquest.[19] The NPM understands that this is the first death of any child in a SCH for over a decade, but there is no regular published data to confirm this.

Data shows that the use of 'restrictive physical interventions' increased from 20.5 per 100 children for the year ending March 2011, to 27.8 for the year ending March 2016, as did the number of assaults (on children, staff or visitors), from 9.7 to 18.9 per 100 children.[20]

It is of particular concern that in February 2017 HMI Prisons concluded that no establishment that it inspected in England and Wales was safe to hold children. The physical conditions of secure training centres (STC) had deteriorated and safety was judged as 'requiring improvement' at two centres.[21] Safety at a third centre, Medway STC, which has been the subject of ongoing concerns (as highlighted in last year's NPM annual report), was inspected twice throughout the period and safety was judged to be inadequate on both occasions.[22] Of the four young offender institutions (YOI) inspected throughout the year by HMI Prisons, Ofsted and the CQC, only the two smallest establishments were judged to be reasonably safe.

17. Ministry of Justice, 2017, *Youth Justice Statistics 2015/16: Supplementary Tables, Table 7.9*, https://www.gov.uk/government/statistics/youth-justice-statistics-2015-to-2016 [accessed 09/10/2017].
18. Ministry of Justice, 2017, *Youth Justice Statistics 2015/16*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585897/youth-justice-statistics-2015-2016.pdf [accessed 22/08/17].
19. The Youth Justice Board for England and Wales, 2017, *Annual Report and Accounts 2016/17*, p.7, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/630201/YJB_Annual_Report_and_Accounts_2016-17_Web.pdf [accessed 09/11/17].
20. Ministry of Justice, 2017, *Youth Justice Statistics 2015/16* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585897/youth-justice-statistics-2015-2016.pdf [accessed 22/08/17].
21. HM Inspectorate of Prisons, 2017, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016–17,* https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/07/HMIP-AR_2016-17_CONTENT_11-07-17-WEB.pdf [accessed 22/08/17].
22. The complete inspection reports can be found on the Ofsted website, https://reports.ofsted.gov.uk/secure-training-centres/medway [accessed 22/08/17].

**HMYOI Wetherby and Keppel unit[23]**

In May 2016, HMI Prisons published the findings of a joint inspection carried out with Ofsted and the CQC of HMYOI Wetherby and Keppel unit, which provides care to some of the most vulnerable young people in England.

Although the use of force was lower than in comparable institutions, pain-inducing techniques were used and strip-searches were carried out while boys were restrained. Only one of the 21 recommendations made in relation to safety during the previous inspection had been fully achieved. Worryingly, inspectors concluded that due to missing records, it was impossible to accurately determine the extent of the use of force. In addition, planned interventions were not routinely reviewed or filmed and body-worn cameras were often not turned on.

The report notes a dramatic decline in outcomes in the area of purposeful activity. It is of particular concern that purposeful activity outcomes had deteriorated in the Keppel unit, which had, in a previous inspection report, been noted as 'a model of how a specialist unit should be run'. For example, 31% of boys were locked in their cells during key work periods, compared with no boys in the previous inspection.

Staffing shortages were a problem across STCs, and these were considered to have had a detrimental effect on the performance of all of those inspected.[24] Of the 14 secure children's homes in England (all but one run by local authorities), 11 homes were judged as good or outstanding at their last full inspection.

The picture in Scotland was more positive than that in England and Wales. Throughout the year, the CI inspected each of the five secure care services in Scotland in which children under 18 are held.[25] As at the end of the year, the CI had assessed two services as good, one service as very good and two as excellent.[26]

## Police and court custody

NPM members highlighted a number of different concerns relating to police and court custody throughout the year.

In Scotland, following the deaths of two men in police custody in 2013 and the publication of the related Fatal Accident Inquiry reports in December 2015, Police Scotland invited HMICS to carry out additional inspections of the custody centres involved: London Road and Aikenhead Road. The unannounced inspections, carried out in April and May 2016, highlighted concerns about the accuracy of risk assessments of detainees, an issue that has been noted by HMICS during inspections of police custody across Scotland in previous years. At both custody

23. HM Inspectorate of Prisons, 2016, *Report on an unannounced inspection of HMYOI Wetherby and Keppel unit by HM Chief Inspector of Prisons, 22 February – 4 March 2016*, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2016/07/Wetherby-and-Keppel-Web-2016.pdf [accessed 21/08/17].
24. HM Inspectorate of Prisons, 2017, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016–17*, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/07/HMIP-AR_2016-17_CONTENT_11-07-17-WEB.pdf [accessed 22/08/17].
25. The details of the secure care services can be found at http://www.gov.scot/Topics/Justice/policies/young-offending/secure-care [accessed 21/08/17].
26. All inspection reports can be accessed at www.careinspectorate.com.

centres HMICS concluded that it was not always clear why a detainee was considered to be low or high risk and that the rationale for subsequent care plans was not always apparent. Concerns were raised over the sufficiency of methods used to safeguard the health and well-being of very high-risk detainees. HMICS also noted concerns about the mixing of male and female detainees and about constant observations of high-risk detainees being carried out, via CCTV, by staff of the opposite gender from the detainee.

In England and Wales, there were 14 deaths in or following police custody during the year, the same number reported for 2015–16. One of these involved a woman taking her own life while in police custody, the first time this had occurred since 2014–15. The number of apparent suicides following police custody decreased for the third consecutive year to 55.[27]

Of those forces in England and Wales inspected during 2016–17, all but one was considered to have significant weaknesses in relation to the use of force. All forces inspected reported that a high number of people with mental health problems were being detained. Efforts continued to be made by several forces to improve mental health services, but both inspectors and independent custody visitors found that waiting times for assessment and transfer under the Mental Health Act 1983 (MHA) remained high. Several forces made efforts throughout the year to divert people with mental health needs from police custody and to address the use of police custody as a place of safety under section 136 of the MHA.[28]

In Northern Ireland, the use of custody as a place of safety remained low, with five detentions under Article 130(1) of the Mental Health (Northern Ireland) Order 1986. This figure was unchanged from 2015–16.[29] Independent custody visitors in Northern Ireland observed increasing numbers of detainees who were 'flagged' by police on their custody record as being at risk of self-harm, suicide or who had mental health concerns, and increasing numbers of detainees requiring constant observation and close proximity checks.

The number of children arrested in England and Wales continued to fall during 2016,[30] but inspections continued to find children being detained unnecessarily with alternative options not being adequately explored. Children were not always provided with sufficient care and support.[31] Concerns were raised about the use of tasers and 'spit

27. Independent Police Complaints Commission, 2017, *Deaths during or following police contact: Statistics for England and Wales for 2016/17*, https://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Deaths_Report_1617.pdf [accessed 22/08/17].
28. HM Inspectorate of Prisons, 2017, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016–17*, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/07/HMIP-AR_2016-17_CONTENT_11-07-17-WEB.pdf [accessed 22/08/17].
29. Data provided to the Northern Ireland Policing Board (NIPB) on 13 June 2017 by Police Service Northern Ireland (PSNI) as extracted from NICHE. NICHE is an electronic case management and crime-recording system and PSNI regularly provides the NIPB with a range of statistical information as part of its oversight and accountability functions.
30. Howard League for Penal Reform, 2017, *Child arrests in England and Wales 2016: Research briefing*, http://howardleague.org/wp-content/uploads/2017/08/Child-arrests-in-England-and-Wales-2016.pdf [accessed 22/08/17].
31. HM Inspectorate of Prisons, 2017, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016–17*, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/07/HMIP-AR_2016-17_CONTENT_11-07-17-WEB.pdf [accessed 22/08/17].

hoods' against children by police forces in England.[32]

Lay Observers reported concerns about an increase in errors or missing information in Person Escort Records (used to record information about detainees when they are transferred between places of detention) in England and Wales. Key data such as medical history and risk factors were observed to be regularly missed, raising possible safety concerns for both those detained and staff.[33] Both lay observers and inspectors noted poor conditions in a number of court custody facilities.[34]

### Immigration detention

As at 31 March 2017, 2,930 people were held in immigration detention, which is relatively similar to the previous year's figure of 2,925. Figures for just after the close of the year (3 April 2017) showed that 337 people were held in prison establishments in England and Wales solely pursuant to immigration powers.[35] As in the previous year, inspections of adult immigration removal centres noted concerns about the prison-like environment of these centres. There were improvements in the application of Rule 35 protections but weaknesses remained, including delays which extended the detention of vulnerable people in some cases. A new Home Office policy on managing adults at risk, which was introduced during the year, was reported to not be widely understood and there was a lack of communication between staff in contact with at-risk detainees in centres and Home Office caseworkers who determine whether detention should continue. Communication failures were noted to result in an inability to identify and support adults at risk and monitor how detention was impacting them. Inspections found people with severe mental illnesses being detained and many cases of prolonged detention were found at all centres inspected.[36] In March 2017, the High Court heard a judicial review challenge to the way in which government policy and guidance defined torture for the purposes of identifying adults at risk.

For the year ending September 2016, 121 children entered immigration detention, a welcome decrease of 34% on the previous year and 89% from 2009.[37] During the year, Cedars pre-departure accommodation, a specialist facility holding families with children, was inspected and found to be a child-centred, decent and safe facility.

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**32.** Children's Rights Alliance for England, 2016, *State of Children's Rights in England 2016: Briefing 8 Policing & Criminal Justice*, http://www.crae.org.uk/media/118312/crae_scr2016_b8_cjs-web.pdf [accessed 11/10/17].

**33.** See also Lay Observers, 2017, *Annual Report to the Secretary of State for Justice 2016–2017*, https://layobservers.org/reports/ [accessed 26/10/17].

**34.** HM Inspectorate of Prisons, 2017, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016–17*, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/07/HMIP-AR_2016-17_CONTENT_11-07-17-WEB.pdf [accessed 22/08/17]. See also Lay Observers, 2017, *Annual Report to the Secretary of State for Justice 2016–2017*, https://layobservers.org/reports/ [accessed 26/10/17].

**35.** Home Office, 2017. *National Statistics: How many people are detained or returned?* https://www.gov.uk/government/publications/immigration-statistics-january-to-march-2017/how-many-people-are-detained-or-returned, [accessed 22/08/2017]. These figures cover only those detained in immigration removal centres (IRCs), short-term holding facilities (STHF) and pre-departure accommodation (PDA).

**36.** HM Inspectorate of Prisons, 2017, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016–17*, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/07/HMIP-AR_2016-17_CONTENT_11-07-17-WEB.pdf [accessed 22/08/17].

**37.** Home Office, 2016, *National Statistics: Detention*, https://www.gov.uk/government/publications/immigration-statistics-july-to-september-2016/detention#children-in-detention [accessed 22/08/17]. Updated figure of 121 provided by the Home Office.

However, Cedars was closed during the year, reportedly due to relatively low use and high maintenance costs, and NPM members noted concerns about achieving the same standards for families and children in other facilities.[38]

## Health and social care detentions

Detentions in England under the MHA were estimated to have risen by 2% from the previous year.[39] Detentions under the MHA have risen continuously for a number of years, and in 2015–16 reached 63,622, a 47% increase from 2005–06 and the highest figure reported during that 10-year period.[40] Inspections by CQC of England's three high secure hospitals during the year highlighted concerns about a shortage of nurses at Broadmoor and Rampton Hospitals, which it considered potentially put patients at risk at Broadmoor. Staff at Broadmoor and Rampton Hospitals did not adhere to guidance in the MHA Code of Practice on monitoring and reviewing seclusion and long-term segregation. All three hospitals applied 'night-time confinement' (a decision to lock patients in their room overnight, unrelated to the patient's behaviour or risk assessment). At Broadmoor and Rampton Hospitals, patients were subject to night-time confinement and, because of staff shortages, had restricted access to therapies and leisure activities during the day. CQC raised concerns with the Secretary of State that this was contrary to government guidance that night-time confinement should only be used where it 'will maximise therapeutic benefit for patients [...] for example, confining a group of patients at night may release staff to facilitate greater therapeutic input for patients during the day.'[41]

The trend of increased detentions under mental health powers was also evident in Scotland and Wales. In Wales, during the year 2015–16, there was a 4% increase in the number of formal admissions under the MHA and other legislation to 2,001.[42] Two new mental health hospitals able to admit detained patients were registered during the year, the first such registrations in Wales in a number of years. There was a rise in the number of episodes of compulsory detention under Mental Health (Care and Treatment) (Scotland) Act 2003 in Scotland during 2016–17. The number of emergency detention certificates completed rose to 2,458, an increase of 12% from the previous

38. HM Inspectorate of Prisons, 2017, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016–17*, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/07/HMIP-AR_2016-17_CONTENT_11-07-17-WEB.pdf [accessed 22/08/17].
39. NHS Digital, 2017, *Mental Health Act Statistics, Annual Figures: 2016–17, Experimental statistics*, http://digital.nhs.uk/catalogue/PUB30105 [accessed 10/09/2017]. Due to a change in the way these statistics are sourced and produced and to incomplete data, this is an estimate only and figures are not comparable to previous years. The statistics note that '45,864 new detentions were recorded in 2016/17 and 4,966 new Community Treatment Orders (CTOs), but the overall national totals will be higher as not all providers submitted data. For the subset of providers that submitted good quality detentions data in both 2015/16 and 2016/17, we estimate there was an increase in detentions of around 2 per cent from last year'.
40. NHS Digital, 2016, *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment*, http://www.content.digital.nhs.uk/catalogue/PUB22571/inp-det-m-h-a-1983-sup-com-eng-15-16-rep.pdf [accessed 23/08/17].
41. Care Quality Commission, 2017, *West London Mental Health NHS Trust: Quality Report*, http://www.cqc.org.uk/sites/default/files/new_reports/AAAF9938.pdf [accessed 10/10/2017]; *Mersey Care NHS Foundation Trust High Secure Services: Ashworth Hospital: Quality Report*, http://www.cqc.org.uk/sites/default/files/new_reports/AAAG3922.pdf [accessed 10/10/2017]; *Nottinghamshire Healthcare NHS Foundation Trust: Forensic inpatient/secure wards: Quality Report*, http://www.cqc.org.uk/sites/default/files/new_reports/AAAG2258.pdf [accessed 10/10/2017].
42. Statistics for Wales, 2016, *Admission of patients to mental health facilities in Wales, 2015–16*, http://gov.wales/docs/statistics/2016/160831-admission-patients-mental-health-facilities-2015-16-en.pdf [accessed 23/08/17].

year and of 25.9% over 10 years. The number of short-term detention certificates completed rose by 5% from the previous year to 4,371, and has increased by 34.1% over a 10-year period. Over the 10-year period in Scotland there has also been a 23% increase in the prevalence of longer-term compulsory treatment orders.[43]

In Northern Ireland, the number of compulsory admissions under the Mental Health (NI) Order 1986 decreased by 3.6% between 2015–16 and 2016–17, to 1,031 admissions in 2016–17.[44]

The use of deprivation of liberty safeguards (DoLS), which are used in England and Wales pursuant to the Mental Capacity Act 2005, continued to increase. In 2015–16, 195,840 DoLS applications were reported as having been made in England, the highest figure since their use was introduced in 2009. Over 40% of these applications had not been signed off by the end of 2015–16.[45] The CQC reported that the backlog of DoLS applications in England continued into 2016–17.[46] In Wales, the number of applications in 2015–16 rose to 12,298, an increase of over 15% on the previous year. Councils and health boards failed to process 74% of urgent applications within the seven-day timeframe, with two councils failing to meet the timescale for any urgent application.[47]

## Political context, legislative and policy developments

A UK-wide referendum on membership of the European Union was held on 23 June 2016, resulting in a majority vote in favour of leaving the EU. Soon after the referendum the Prime Minister, David Cameron, resigned and was replaced by Theresa May on 13 July 2016. This led to the formation of a largely new government, with Secretary of State for Justice Michael Gove replaced by Liz Truss on 14 July 2016.

Elections to devolved parliaments were held in Scotland, Wales and Northern Ireland on 5 May 2016. The Northern Ireland Executive has been unable to form a government since the resignation of the deputy First Minister on 9 January 2017, and political parties did not meet the 27 March 2017 deadline to form a coalition.

Secretary of State Liz Truss initially announced her intention to deliver the Conservative party manifesto pledge to replace the Human Rights Act with a 'British Bill of Rights', but in February 2017 announced that the government would delay any such Bill until after Brexit. The intention to introduce a presumption to derogate from the European Convention on Human Rights (ECHR) in future overseas military operations

43. Mental Welfare Commission Scotland, 2017, *Statistical Monitoring: Mental Health Act monitoring report 2016–17*, http://www.mwcscot.org.uk/media/387603/mental_health_act_monitoring_report_2016-17.pdf [accessed 11/10/17].
44. Department of Health, 2017, *Mental health and learning disability inpatients 2016/17*, https://www.health-ni.gov.uk/publications/mental-health-and-learning-disability-inpatients-201617 [accessed 10/09/2017].
45. NHS Digital, 2016, *Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England)*, http://content.digital.nhs.uk/catalogue/PUB21814/dols-eng-1516-rep.pdf [accessed 23/08/17].
46. Care Quality Commission, 2017, *The state of health care and adult social care in England 2016/17*, https://www.cqc.org.uk/sites/default/files/20171010_stateofcare1617_report.pdf [accessed 10/10/2017].
47. Health Inspectorate Wales, 2017, *Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care 2015–16*, http://cssiw.org.uk/docs/cssiw/report/170504dols1516en.pdf [accessed 23/08/17].

was announced by the Prime Minister.[48] The UK continued to receive international criticism for its plans to scrap the Human Rights Act and/or leave the jurisdiction of the European Court of Human Rights.

In June 2016, then Foreign and Commonwealth Office Minister Baroness Anelay expressed her determination to 'strengthen the UK's voice in the international system, including on the important human rights priority of torture prevention' at an event organised to mark the 10th anniversary of the entry into force of OPCAT.[49] She also announced that the total value of Foreign and Commonwealth Office-funded work on torture prevention during the year would be £725,000 and that this would be delivered through projects in 20 countries.

### Prisons and reform

At the State opening of Parliament in May 2016, the Queen announced that her government would legislate to reform prisons in England and Wales. Prison governors would be given 'unprecedented freedom' and would be able to ensure prisoners received better education. The plans would include replacing old prisons.[50] A White Paper setting out these plans in more detail was published in November 2016.[51]

In February 2017, the Secretary of State for Justice announced the creation of Her Majesty's Prison and Probation Service (HMPPS) to replace the National Offender Management Service (NOMS). HMPPS would take full operational management for prisons, while the Ministry of Justice would take on responsibility for future policy direction, setting standards, scrutinising prison performance and commissioning services. The government also announced that an additional £100 million would boost frontline prison staff by an extra 2,500.[52]

As part of the reform plans, in February 2017 the Prisons and Courts Bill was introduced to Parliament. This Bill aimed to introduce 'statutory purposes' of prisons: to protect the public, reform and rehabilitate offenders, prepare prisoners for life outside prison, and maintain an environment that is safe and secure. It would enshrine the Secretary of State's responsibility for prisons into law. Importantly, the Bill also introduced measures that would strengthen the role of HMI Prisons, including recognition of HMI Prisons as an entity, reference to OPCAT, a requirement on government to respond to HMI Prisons' recommendations, and an 'urgent notification' process for HMI Prisons to report 'significant concerns'. The Bill had reached Committee stage at the end of the reporting year and was widely supported by different political parties. Non-governmental organisations (NGOs) lobbied for 'the provision of an environment which is

48. The Rt Hon Harriet Harman MP. Letter to Rt Hon Michael Fallon MP, 13 October 2016, http://www.parliament.uk/documents/joint-committees/human-rights/correspondence/2016-17/HH_to_MF_re_derogation.pdf [accessed 09/11/17].
49. The Rt Hon Baroness Anelay of St Johns DBE, 'Speech to mark the 10th Anniversary of OPCAT', 29 June 2016, https://www.gov.uk/government/speeches/speech-to-mark-the-10th-anniversary-of-opcat [accessed 09/11/17].
50. See https://www.gov.uk/government/news/biggest-shake-up-of-prison-system-announced-as-part-of-queens-speech [accessed 09/11/17].
51. Ministry of Justice, 2016, *Prison Safety and Reform*, https://www.gov.uk/government/publications/prison-safety-and-reform [accessed 09/11/17].
52. See https://www.gov.uk/government/news/justice-secretary-launches-new-prison-and-probation-service-to-reform-offenders [accessed 09/11/17].

both decent and fair' to be included as an additional statutory purpose, among other amendments.[53]

Alongside these significant changes, in July 2016 the parliamentary Justice Committee opened an inquiry into prison reform, aiming to scrutinise the government's plans and their implementation. During the year it announced sub-inquiries into governor empowerment and prison performance, and estate modernisation.

The Joint Committee on Human Rights (JCHR) announced an inquiry on mental health and deaths in detention on 14 December 2016.[54] Reflecting that the number of deaths in prisons in England and Wales has soared in recent years, the JCHR inquiry sought to establish whether a human rights-based approach can lead to better prevention of deaths in prison of people with mental health conditions.

In August 2016, the Secretary of State for Justice announced the steps she would take to tackle extremism in prisons, following on from a government review of the topic which was published in summary. Plans included removing 'the most dangerous Islamist extremists' from the general prison population to hold them in specially-created units in the high security estate.[55]

The independent review of the treatment of, and outcomes for, Black, Asian and Minority Ethnic (BAME) individuals in the Criminal Justice System led by David Lammy MP was ongoing during the year.[56]

The Scottish Prison Service published its Value Proposition in December 2016, outlining changes in what is being delivered for those in custody and describing the future direction of travel for the training and development of prison staff.[57] The site for a new prison, HMP Highland, for people in custody from the Highlands and Islands, was announced in February 2017.[58]

In early 2017, the Health and Sport Committee of the Scottish Parliament began an inquiry into health and social care in prisons.[59]

**53.** Prison Reform Trust, 2017, *Briefing on the Prisons and Courts Bill, House of Commons, Second Reading, Monday 20 March 2017*, http://www.prisonreformtrust.org.uk/Portals/0/Documents/Parliament/Prisons%20and%20Courts%20Bill/HoC%20second%20reading%20briefing%E2%80%94Prisons%20and%20Courts%20Bill.pdf [accessed 09/11/17].
**54.** See NPM submission to the inquiry: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/human-rights-committee/mental-health-and-deaths-in-prison/written/48220.html [accessed 09/11/17].
**55.** Ministry of Justice, 2016, "Government sets out new measures to tackle extremism in prisons", https://www.gov.uk/government/news/government-sets-out-new-measures-to-tackle-extremism-in-prisons [accessed 27/11/2017].
**56.** See https://www.gov.uk/government/consultations/lammy-review-of-black-asian-and-minority-ethnic-bame-representation-in-the-criminal-justice-system-call-for-evidence [accessed 09/11/17].
**57.** Scottish Prison Service, 2016, *Unlocking our potential: a value proposition*, http://www.sps.gov.uk/Corporate/Publications/Publication-4733.aspx [accessed 09/11/17].
**58.** Scottish Prison Service, 2017, *New site for HMP Highland identified*, http://www.sps.gov.uk/Corporate/News/News-4817.aspx [accessed 09/11/17].
**59.** See http://www.parliament.scot/parliamentarybusiness/CurrentCommittees/103318.aspx [accessed 09/11/17].

### Strengthened policy for the care and management of transgender prisoners in England and Wales

In November 2016, after the completion of a review into the care and management of transgender offenders, NOMS published a new prison service instruction (PSI), *The Care and Management of Transgender Offenders*. It recognised a more flexible approach to locating transgender prisoners within the prison estate to reflect the fact that not all transgender people in prisons have legal recognition of their acquired gender. The PSI emphasised the need for early decision-making around the location of transgender prisoners, and introduced case and review boards to inform decision-making. Finally, the PSI introduced a commitment to publish official statistics on transgender offenders for the first time, and announced the establishment of a Transgender Advisory Board to develop guidance and policy further in the future.

## Mental health law

The Mental Capacity Act (Northern Ireland) 2016 received Royal Assent in May 2016. This pioneering law introduced to Northern Ireland for the first time a legal framework governing capacity and incapacity and requires decisions to be made based on a person's best interests.

The new Mental Health Act 1983 Code of Practice for Wales came into force on 3 October 2016.[60]

In Scotland, the government consulted on the implementation of provisions in the new mental health legislation and on proposals about secondary legislation relating to the new act. This included new arrangements for cross-border transfers and to deal with patients who had absconded from other jurisdictions. Consultations on the need to reform incapacity legislation in Scotland to ensure compliance with international human rights standards were led by the Mental Welfare Commission and the Centre for Mental Health and Capacity Law at Edinburgh Napier University.

In March 2017, the Law Commission published the final report from its review of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). The review concluded that there was a 'compelling case for replacing the DoLS' and that there was 'widespread agreement that the DoLS are overly technical and legalistic, and too often fail to achieve any positive outcomes for the person concerned or their family'. The current system was unable to deal with the increased numbers of people considered to be deprived of their liberty following the Supreme Court's decision in *Cheshire West* and the current system renders many people's rights 'theoretical and illusory'. The Law Commission proposed a new system of 'Liberty Protection Safeguards'.[61]

**60.** Welsh Assembly Government, 2016, *Mental Health Act 1983, Code of Practice for Wales*, http://www.wales.nhs.uk/sites3/documents/816/Mental%20Health%20Act%201983%20Code%20of%20Practice%20for%20Wales.pdf [accessed 09/11/17].

**61.** Law Commission, 2017, *Mental Capacity and Deprivation of Liberty Summary*, http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/ [accessed 09/11/17].

## Children in detention

In September 2016, Sir James Munby, President of the High Court Family Division in England and Wales, called for legal clarity in relation to English courts placing children in secure units in Scotland.[62] In January 2017, the Scottish Parliament passed a legislative consent motion[63] inserting a clause into the Children and Social Work Bill to allow local authorities in England and Wales to place children in Scotland, and vice versa. Sir James Munby had noted a recent increase in local authorities in the north of England placing children in secure accommodation in Scotland, due to a shortage of places, and argued that such care orders could not be legally enforced. The Children and Social Work Act received Royal Assent in April 2017.

In February 2017, the Youth Custody Improvement Board (YCIB) that had been appointed in May 2016 published its report looking at the current state of the youth custodial estate in England and Wales, and concluded that it shared the previously-expressed view of the Youth Justice Board that the youth secure estate was 'not fit for the purpose of caring for or rehabilitating children and young people'.[64] The YCIB noted that it found this analysis 'astonishing' given that the Youth Justice Board (YJB) had been in operation in over a decade, and raised the question as to why the YJB and Ministry of Justice (MoJ) had not been able to intervene to remedy the situation. Following on from this report, the Secretary of State for Justice announced that she had appointed a new Chair of the YJB and that the government would create a new Youth Custody Service 'as a distinct arm of HMPPS'. Responsibility and accountability for commissioning youth custody services, setting clear standards and for intervening to address poor performance would be transferred to the MoJ.[65]

## Police custody

Full implementation of the Criminal Justice (Scotland) Act 2016, which will introduce significant changes relevant to detention, was still pending (see seventh NPM annual report).

By early 2017, Police Scotland had rolled out a national custody IT system, replacing the eight systems used by legacy forces. A national system will facilitate the gathering of consistent data about custody which should provide Police Scotland with improved data to use when planning and delivering its custody service.

Guidance on the implementation of the Police and Crime Act 2017 in England and Wales was also pending. At the time of writing it was not clear whether the guidance would rule out the use of police custody as a place of safety under Section 135/136 of the Mental Health Act.

62. *In the Matter of X (A Child), In the Matter of Y (A Child)*, [2016] EWHC 2271 (Fam)., https://www.judiciary.gov.uk/judgments/in-the-matter-of-x-a-child-and-in-the-matter-of-y-a-child/ [accessed 13/11/17].
63. A motion agreeing that Westminster may pass legislation on a devolved issue.
64. Alan Wood (Chair), Professor Dame Sue Bailey and Rob Butler, 2017, *Findings and Recommendations of the Youth Custody Improvement Board*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/594448/findings-and-recommendations-of-the-ycib.pdf [accessed 09/11/17].
65. See https://www.gov.uk/government/speeches/youth-justice-update [accessed 09/11/17].

Although never published in a final version, the draft Concordat for Children in Custody in England led to work ensuring children do not spend excessive time in custody and places an onus on moving children, post charge, to local authority accommodation. While this document simply highlights existing legislation and guidance, it represents a *de facto* change in practice, as the rules had not been implemented.

Publication of the independent review into deaths and serious incidents in police custody was still awaited at year end.[66]

In November, press reports cited information obtained under freedom of information legislation that 17 of the 49 police forces in the UK were using mesh fabric spit hoods, and that other forces were considering using them.[67] Their use was considered an operational decision for individual forces, and was strongly criticised by some non-governmental groups. Data suggested that since 2011, spit hoods had been used at least 2,486 times – in 635 cases on people with suspected mental health issues. In August 2016, ACC Tim Jacques, chair of the National Police Chiefs' Council portfolio for Health, Safety and Welfare, wrote to all chief constables recommending that forces give serious consideration to providing spit hoods to all frontline officers.[68]

## Immigration detention

In July 2016, the UK government announced they would close Cedars, the only secure pre-departure accommodation designed to hold families with children. Cedars was opened in 2011 as part of government commitments to end the routine detention of children for immigration purposes. The decision to close Cedars followed on from concerns about the high cost and low and decreasing levels of use.[69] The government announced its plan to replace Cedars with new pre-departure accommodation near Gatwick Airport, in a separate unit at Tinsley House immigration removal centre.

In September 2016, the government announced it would close the only immigration removal centre in Scotland, Dungavel, replacing it with a new short-term holding facility near Glasgow Airport. However in February this decision was reversed, citing as a reason the local council's decision to block the new holding facility.

The Immigration (Guidance on Detention of Vulnerable Persons) Regulations 2016 came into force on 12 September 2016.[70] It implemented the Adults at Risk in Immigration Policy which specifies matters to be taken into account in determining whether a person would be particularly vulnerable to harm if they were to be

**66.** See https://www.gov.uk/government/speeches/home-secretary-announces-review-of-deaths-in-policy-custody [accessed 09/11/17]. The report was published following the end of the 2016/17 year, in October 2017, https://www.gov.uk/government/publications/deaths-and-serious-incidents-in-police-custody.
**67.** BBC, 2016, "Cruel' spit hoods used by third of UK police forces', http://www.bbc.co.uk/news/uk-england-37938056 [accessed 09/11/17].
**68.** Police Federation, 2016, 'Spit and bite guards', http://polfed.org/spitguards [accessed 09/11/17].
**69.** Stephen Shaw, 2016. *Review into the Welfare in Detention of Vulnerable Persons, A report to the Home Office*, 3.143–3.155 and recommendation 5. https://www.gov.uk/government/publications/review-into-the-welfare-in-detention-of-vulnerable-persons [accessed 13/11/17].
**70.** See http://www.legislation.gov.uk/uksi/2016/847/contents/made [accessed 09/11/17].

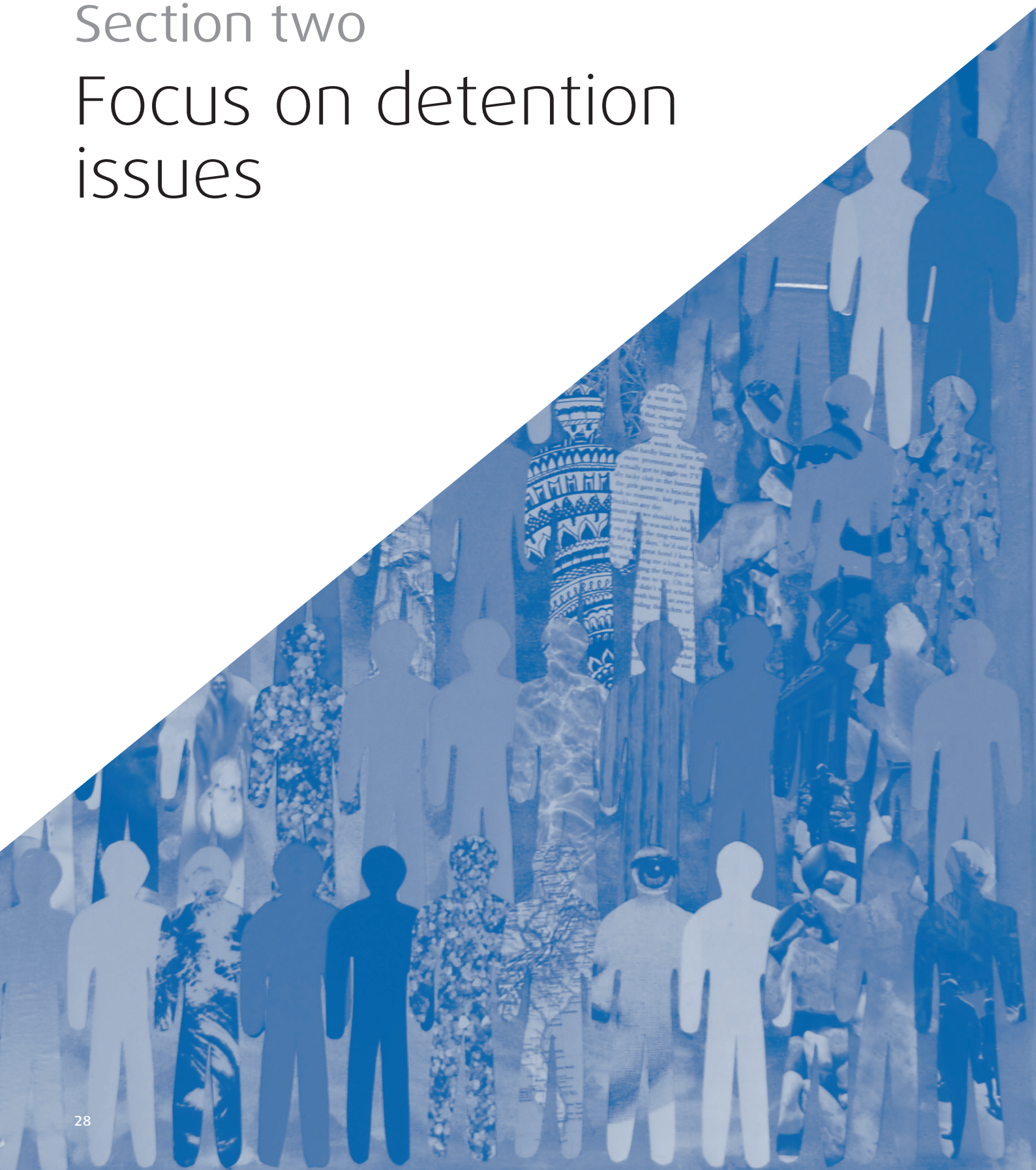
detained or were to remain in detention and, if so, whether the detention should happen or continue.[71] The new guidance was widely criticised for leading to 'a worsening of protection for vulnerable people in detention'.[72] Immigration lawyers and advocacy groups were concerned that the new policy limited the definition of torture to exclude non-state actors, increased the burden of evidence on vulnerable people and balanced vulnerability against a wider range of other factors.

**71.** Home Office, 2016, *Immigration Act 2016: Guidance on adults at risk in immigration detention*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/547519/Adults_at_Risk_August_2016.pdf [accessed 09/11/17].

**72.** *The Guardian*, 2016, 'New immigration detention policy for 'adults at risk' needs urgent review', https://www.theguardian.com/society/2016/sep/11/new-immigration-detention-policy-for-adults-at-risk-needs-urgent-review [accessed 13/11/17].

Section two

# Focus on detention issues



## Isolation – guidance for NPM monitoring bodies

In January 2017, the NPM published its guidance on isolation in detention. The guidance was developed following the review of isolation and solitary confinement across detention settings conducted by NPM members in 2014–15, and draws on international best practice.

The guidance builds on the findings of the review and 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 with which NPM members monitor the use of isolation, and allow them 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.

Following its publication, the guidance was distributed by NPM members to their respective inspectors, monitors and custody visitors. NPM members continue to work to incorporate the guidance into their inspection and monitoring work.

## Pathways in detention

NPM members agreed in 2015 to focus joint efforts on examining pathways between different detention settings. Given that NPM members usually examine treatment and conditions in detention by looking at an individual establishment, we were keen to explore issues relating to the treatment of detainees during movements from one establishment to another that this approach did not capture. This joint work would allow NPM members to identify and examine the pathways across detention settings[73] that extend beyond the scope of individual bodies, or fall outside members' usual monitoring methodology.

These pathways exist for a range of reasons. The ones we looked at all related in some way to mental health needs, whether these were the reason for initial detention, or became a factor requiring that the detainee be moved from one place of detention to another. Specifically, we looked at pathways between different mental health settings; pathways from police custody arising from mental health issues; and prison to mental health settings.

The NPM role, as set out in OPCAT, is focused on preventing ill-treatment in detention. Monitoring places of detention with a preventive approach requires a focus on 'analysing the place of detention as a system [...], to identify problems which could lead to torture or ill-treatment.'[74] Our interest is in examining pathways as an element of the detention system in the UK, and the risks

**73.** With a focus on pathways that have a start and end place in detention.
**74.** Association for the Prevention of Torture, *What is preventive monitoring?* https://www.apt.ch/en/preventive-visits/ [accessed 13/11/17].

that may arise from them, as well as an inability to access them. These risks include:

- delays in accessing appropriate treatment, which can lead to people becoming more ill, with potential long-term consequences;
- being held in an unsuitable (including non-therapeutic) environment;
- excessive levels of security or excessively restrictive environments;
- absent protections for detainees against restrictive practices or harm;
- loss of continuity of care and a failure to transfer information about detainee's needs;
- decisions about accessing pathways being limited by availability and financial constraints rather than the detainee's needs;
- systems focused on the process or bureaucracy of the transfer rather than the outcome;
- equality issues relating to the availability of facilities for men and women that affect pathways;
- distance from home.

### Pathways from mental health to mental health settings[75]

Mental health services in the UK are organised nationally (Ashworth, Broadmoor and Rampton high secure hospitals in England and Wales, and the State Hospital in Scotland which is also the high secure facility for Northern Ireland), regionally (medium secure units organised across different health authorities) and locally (low secure hospital care which is provided in a range of units normally located within an individual health board or authority area). Pathways between these different types of services are common and arise for a number of reasons, which we will explore below.

#### Legal and policy framework

Each jurisdiction has specific legislation that governs detention and treatment in secure hospitals:

- Mental Health Act 1983, amended in 2007 (for England and Wales);
- Mental Health (Care and Treatment) (Scotland) Act 2003, amended by the Mental Health (Scotland) Act 2015;
- Mental Health (Northern Ireland) Order 1986.

The legislation in each jurisdiction provides a framework for both the transfer of detained patients from one part of the UK to another and the review of patients' detention by mental health tribunals. There are clear pathways for professionals to follow when deciding on transfers, and there are regulations setting out protocols, timescales and the roles and responsibilities of governments in each jurisdiction.[76] Final decisions on any proposed cross border transfers between secure care units will be authorised at ministerial level.

**75.** NPM members reviewed key policy documents and legislation to provide an overview of pathways between secure mental health settings, within and between jurisdictions. No specific fieldwork was undertaken for this project, but data from the Mental Welfare Commission for Scotland's themed visit to all medium and low secure wards in Scotland between October and December 2016 informed this report. See Mental Welfare Commission for Scotland, 2017, *Visit and monitoring report: Medium and low secure forensic wards*, http://www.mwcscot.org.uk/media/385624/medium_and_low_secure_forensic_wards.pdf [accessed 11/11/17].

**76.** See: Mental Health Act 1983 Part VI –Removal And Return of Patients within the United Kingdom; Mental Health (Care and treatment) (Scotland) Act 2003, S290 and regulations – Scottish Statutory Instrument 2005 No. 467, as amended by Scottish Statutory Instrument 2017 No. 229.

Uniquely in the UK, since November 2015 Scottish mental health legislation[77] gives patients in high *and* medium secure care the right to apply to a tribunal for an order declaring that they are detained in conditions of excessive security which, if successful, should lead to their transfer to a lower level of security. This right previously only applied to patients detained in the high secure State Hospital.

There have been significant reviews[78] of secure care services in each jurisdiction within the past decade, resulting in important recommendations for future service delivery, including improving the flow between different levels of services, pathways within the system of secure care provision, gaps in secure care provision and configuration of the secure estate.

## Key principles

International standards set out that patients should have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to their health needs and to protect the physical safety of others.[79] In 1992, the Reed Report called for services to be provided according to individual need, near to the patient's home or family, as far as possible in the community but otherwise in conditions of no greater security than is justified, with the ultimate aim of rehabilitation. All of these principles have been adopted or supported in key policy documents since.

## Issues identified by NPM members

### *Organisation and availability of secure services across the UK*

Over the last two decades there has been a progressive reduction in the number of beds in high secure hospitals in the UK in favour of expansion of medium and low secure bed provision. However, recent reviews and reports have highlighted that this expansion has not been coordinated strategically and the planning and commissioning of many services is fragmented.[80] There has been a largely *ad hoc* approach to commissioning new services, with significant differences in what has been commissioned in different areas leading to variations in service provision across geographical areas and jurisdictions. As a result, provision of care is patchy, with very limited range in many areas and patients unable to move around the system as needed.

In addition, a large and increasing proportion of medium- and low-secure services are provided in the independent sector. While these services will have developed in response to identified needs, they may not always be located in geographical areas where needs are most prevalent. This is a

**77.** Mental Health (Scotland) Act 2015, s. 14–18.
**78.** Centre for Mental Health and National Mental Health Development Unit, 2011, *Pathways to unlocking secure mental healthcare*. Northern Ireland Department of Health, 2007. *Bamford Review of Mental Health and Learning Disability* (Northern Ireland). Welsh Assembly Government, 2009. *A Review of Secure Mental Health Services*. NHS England mental health taskforce, 2016. *The Five Year Forward View for Mental Health*. In 2016–17, a Forensic Estate Group was commissioned by the Scottish Government to review the clinical models of forensic mental health inpatient services in Scotland.
**79.** UN General Assembly Resolution 49/119 'Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care'.
**80.** For example, Joint Commissioning Panel for Mental Health, 2013, *Guidance for commissioners of forensic mental health services*; Welsh Assembly Government, 2009, *A Review of Secure Mental Health Services*.

particular problem for women, with 75% of all low secure units in England and Wales and the two units providing a large share of dedicated beds for women in Scotland being in the independent sector.[81]

There is under-provision of beds in many areas (this has been recognised as a problem that needs solving particularly in England and Wales),[82] with many people placed in services outside their home area, creating difficulties with discharge planning back to their home. There is a lack of provision of secure care services, particularly low secure beds, for women across the UK.

A 2015 study in Northern Ireland identified that 105 patients required low secure care that was currently unavailable.[83] During its recent visits to medium and low secure services, the Mental Welfare Commission for Scotland (MWCS) was told of people in medium security facilities on waiting lists for low security placements, and patients in low security facilities waiting to move to rehabilitation services or a community setting. In total, 89 out of 400 patients had been identified as ready for discharge. It is anticipated that a comparable situation would be found in England and Wales.

Similarly, there is lack of provision for children with specific conditions who need secure care (including for girls with a learning disability or emerging borderline personality disorder). In addition, pathways for children out of medium secure care are often hindered by the lack of provision in units with lower security and/or appropriate community services. As a result, some children find themselves remaining in secure mental health care until they are 18 so that they can be discharged to adult inpatient services when it was agreed in principle that they could have been discharged earlier.

### *Cross-jurisdiction transfers*

Rampton Hospital is the only high secure provision for women in the UK. There is a service level agreement (SLA) for Rampton Hospital to provide high secure care for patients from Scotland, but because of the considerable bed pressure the Rampton service faces, it is likely that female patients in Scotland requiring high secure care may face difficulties accessing services.

In medium/low secure care in Scotland there are 54 beds designated for female patients and a further 34 that can be used for men or women (out of 439 beds in total). There is no dedicated medium secure provision for women in Wales and a limited number of beds for women in a mixed medium secure unit.

Evidence from all jurisdictions indicates that female patients in particular experience difficulties moving on through a secure care pathway, especially moving down to low secure care, because of the lack of low secure beds in many areas. As a result, 40% of women in low secure care are held in units away from, and often at a considerable distance from, their home area.[84]

**81.** Harty, Somers and Bartlett, 2012, 'Women's secure hospital services: national bed numbers and distribution' in *Journal of Forensic Psychiatry and Psychology*.
**82.** Harty, Somers and Bartlett, 2012, *ibid.* Welsh Assembly Government, 2009. *A Review of Secure Mental Health Services.*
**83.** Harty, Somers and Bartlett, 2012, *ibid*; Bartlett A et al., 2014. 'Pathways of care of women in secure hospitals' in *British Journal of Psychiatry*. See also Welsh Assembly Government, 2009. *A Review of Secure Mental Health Services.*
**84.** Harty, Somers and Bartlett, 2012, *ibid.*

The Bamford Review identified gaps in provision in Northern Ireland, where even with the opening of the Shannon Clinic (a medium secure facility), problems arise with allowing people transferred outside Northern Ireland to return and in allowing people to move on when appropriate from the Shannon Clinic.

There are no secure mental health units for children and young people aged under 18 outside England and, as a result, where children from Scotland, Wales or Northern Ireland need secure mental health care, this is contracted on an individual basis and they are sent to England. There are well-known issues about the complexity of the process for these cross-border transfers, with mental health tribunals in Scotland having been reluctant to grant compulsory measures when a child is going to transfer directly from a secure residential facility in Scotland to a secure hospital in England, without first being admitted to a hospital in Scotland.

A review in Scotland of referrals made and admissions to medium secure children's services in England over a 10-year period concluded that there is a need for secure mental health provision for children in Scotland, and work is now underway to develop a unit as a national service.[85]

### *Security levels*

NPM members have noted that while there is now general consensus about definitions of security levels, which focus on physical, procedural and relational security elements, there are still variations in the restrictions experienced by patients at different levels of security.[86] Some patients in Scotland reported to MWCS that they experienced more restrictive conditions in low secure wards than in medium secure wards. These issues become evident as patients move around the system.

In addition, there needs to be greater clarity about how decisions are taken on what security level is appropriate to ensure individuals are detained in the least restrictive environment possible, under conditions of no greater security than is justified by the degree of risk they present to themselves or others. Some reports suggest decisions about allocation to a specific security level can be arbitrary,[87] and concerns have been raised about whether at the time of admission patients are always admitted to a service that provides an appropriate level of security to meet their needs.

**85.** Scottish Government, 2017, *Mental Health Strategy 2017–27*, page 25 and Action 20.
**86.** Joint Commissioning Panel for Mental Health, 2013, *Guidance for commissioners of forensic mental health services*, p7, https://www.jcpmh.info/wp-content/uploads/jcpmh-forensic-guide.pdf [accessed 13/11/17].
**87.** David Melzer Dr, Brian DM Tom, Traolach Brugha, Tom Fryers, Rebecca Gatward, Adrian Grounds, Tony Johnson & Howard Meltzer, 2014, *Access to medium secure psychiatric care in England and Wales. 1: A national survey of admission assessments.* Centre for Mental Health and National Mental Health Development Unit, 2011, *Pathways to unlocking secure mental health care.*

NPM members have identified a lack of clarity about the function of medium and low secure mental health services. MWCS recently concluded that there are generally two distinct groups of patients held in low secure services – people with forensic histories who have transferred down from higher security levels, and people who have been transferred into low secure services because general psychiatric wards were experiencing difficulties managing stressed, distressed or agitated behaviour. The latter has been found to be the case more generally, with patients migrating into medium or low secure services because they have proven difficult to support in mainstream mental health care when they are acutely unwell rather than because treatment in a secure setting is indicated by the risk they pose.[88]

There are concerns that for people with a learning disability (who constitute a significant percentage of those in low and medium secure units in the UK) the lack of movement from secure care to community settings means that they are admitted to higher levels of security than required. It has also led to Scottish patients with a learning disability being transferred to units in England because of a lack of provision at a particular security level, which leads in turn to difficulties arranging transfers back.

Similarly, patients with a personality disorder may remain in secure care, or at a particular security level, because of the lack of step-down services.

The introduction of excessive security appeals in Scotland (initially only in relation to the high secure State Hospital) is considered to have been an important driver in the development of medium secure services and, where an appeal is successful, allows patients to access pathways through detention settings. In Scotland, from November 2015 to March 2017, after the right to appeal was extended to medium secure hospitals in the Mental Health (Scotland) Act 2015, the Mental Health Tribunal Service received 56 applications relating to patients being detained in excessive security. Of these, 23 were successful. In addition, seven of the 56 people were transferred to a lower security setting before a tribunal hearing.

A consistent concern is that pathways through secure care are often blocked and once patients are in secure mental health care, they become stuck in the system. The implications of this are that many people are held in conditions of excessive security. The need to address this issue has been recognised, requiring better definition, standardisation and integration of services as part of a whole pathway approach within and beyond secure care.[89]

In England, CQC has heard of concerns from clinicians and patients over delays in obtaining Ministry of Justice (MoJ) permission for leave or transfer, given current staffing difficulties in the MoJ's casework section. It is of particular concern that such delays could cause patients to remain in hospital, or at particular levels of hospital security, for longer periods than is clinically necessary.

**88.** Centre for Mental Health and National Mental Health Development Unit, 2011, *Pathways to unlocking secure mental healthcare.*
**89.** Mental Health Taskforce, 2016, *The five year forward view for mental health.*

## Conclusion

Although there is universal agreement across and within jurisdictions about the purpose of secure mental health care and that there should be clear pathways between levels of security and types of care, in many instances patients are not able to receive the right services in the right place at the right time.

It is welcome that there has been increasing focus on developing standards, reviewing and improving the quality of care and treatment in secure settings, and that most of the challenges in the provision of services, including the lack of coordination in planning and commissioning, are recognised.

However, the difficulties set out can have significant impact on individual patients, who become frustrated with delays, and may disengage from treatment when they are aware they should be moving on, with consequent risks that their mental health might deteriorate. Many patients end up far away from home as a result of ineffective or non-existent pathways, and this can compromise rehabilitation and discharge planning, especially when planning a move from secure care to community placement, which may be at some distance from the inpatient unit.

## Pathways from police custody arising from mental health issues[90]

NPM members considered the pathways from police custody that arise from concern by police (including, for example, arresting officers, custody staff and health care staff working within the custody setting) about the mental health of the detainee. NPM members decided to focus on this because their regular monitoring highlights an increasing number of detainees in police custody who are vulnerable due to mental health issues.

There are two situations in which these pathways can be needed. Firstly, when a detainee is being held by police under relevant mental health legislation (as a 'place of safety') and, secondly, when a detainee has been arrested for a criminal offence and mental health issues are identified as a risk factor during the initial assessment by the custody officer, and a subsequent assessment by a forensic doctor or nurse raises further concerns. In both instances, police may seek to have the detainee transferred into a mental health setting for their own safety or to facilitate a mental health assessment. The pathway therefore usually occurs when the detainee is transferred from the custody suite to a mental health facility. The detainee may subsequently be transferred back into police detention (for example when an assessment has been conducted). A further pathway may also arise when a detainee is transported from police custody to court custody

**90.** Data and information on this topic was collected between September 2016 and April 2017 by ICVA, NIPB ICVS and CJI. Custody visitors from the NIPBICVS and ICVA collected data using a pre-defined data set which was collated by the Scheme Manager in the NIPB and the Office of the Kent Police and Crime Commissioner (OPCC) respectively during their regular visits to custody. Nine of the 42 ICV Schemes (and associated OPCCs) responded to the survey. CJI was not undertaking inspection work in relation to police custody so used information gathered during the 2015 inspection and via a focus group with custody officers. NPM members in Scotland (HMICS and the Scottish ICVS) had hoped to contribute but due to the custody legacy systems of Police Scotland were unable to obtain any meaningful data.

(to appear before the court post-charge for a decision to be made whether to bail or remand them) and a mental health issue arises which requires transfer to a health setting.

The proper identification and assessment of mental health issues in police custody is critical in order to ensure detainees are given proper support and treatment at the earliest stage. Failure to provide this could potentially lead not only to deterioration of the detainee's mental health but may also impede the criminal justice process.

### Legal and policy framework

Mental health legislation governs the use of police custody as a place of safety in England and Wales[91] and Northern Ireland.[92] When the Policing and Crime Act 2017 enters into force in England and Wales, police custody will no longer be a place of safety for children, and should only be used in exceptional circumstances for adults (the lack of a health-based place of safety will not be considered an exceptional circumstance). In Scotland, mental health legislation does not deem a police station to be a 'place of safety' except where there is no other available suitable accommodation.[93] Alongside this legislation, specific agreements have been developed between police and health care partners in Northern Ireland and England and Wales (for example, a memorandum of understanding, multi-agency protocol, etc) which provide guidance on multi-agency working between police and health partners, including in the area of mental health provision.[94] In Scotland, the Mental Health Act Code of Practice encourages the development by the police, NHS and local authorities of local Psychiatric Emergency Plans.

### Availability of data

NPM members found wide variation in the availability of data relating to the pathways out of police custody to mental health settings.

Data on the number of people detained in police stations under place of safety provisions is published by the Health and Social Care Information Centre in England and Wales. In Northern Ireland, a reporting requirement has been introduced under Section 156 of the Mental Capacity Act (Northern Ireland) 2016, but this has not yet entered into force. In Scotland, the Mental Welfare Commission publishes annually the numbers of people detained under place of safety provisions, and how many of them are held in a police station.[95] It published more detailed analysis in 2016.[96]

Independent Custody Visitor schemes' own analysis of Section 136 data identified that though there had been a rise in the overall

**91.** Section 136 of the Mental Health Act (1983) provides for a constable to remove an apparently mentally disordered person from a public place to a place of safety for up to 72 hours for the specified purposes. The place of safety could be a police station or hospital (often a special Section 136 suite).
**92.** The Mental Health (Northern Ireland) Order 1986 makes a similar provision to that in England and Wales. The Mental Capacity Act (Northern Ireland) 2016 retained this provision.
**93.** Mental Health (Care and Treatment) Scotland Act 2003, s. 297.
**94.** In Northern Ireland, this was yet to be signed off.
**95.** Mental Welfare Commission for Scotland, 2016, *Mental Health Act Monitoring 2015–16*, http://www.mwcscot.org.uk/media/342871/mental_health_act_monitoring_2015-16.pdf [accessed 13/11/17].
**96.** Mental Welfare Commission for Scotland, 2017, *Place of Safety Monitoring Report 2016*, http://www.mwcscot.org.uk/media/373113/place_of_safety_monitoring_report_2016.pdf [accessed 13/11/17].

use of Section 136 powers, the number of people detained and taken to police custody has fallen in the last two years. For adults this was down from 6,667 in 2013–14 to 2,100 in 2015–16, a fall of 68.5%; for children it was down from 256 in 2013–14 to 43 in 2015–16, a reduction of 83.2%. In Northern Ireland and Scotland, the numbers were much smaller (five detainees in both 2015–16 and 2016–17 in Northern Ireland and seven detainees in 2015–16 in Scotland).

Though the collection of data on Section 136 and similar provisions in recent years is a welcome development, there are concerns about the limitations of the data that is available.[97] Furthermore, there is no data available from anywhere in the UK about how many detainees not held under 'place of safety' legislation required transfer to a mental health facility following a period of time in police custody. NPM members are concerned that there is no data available about the (potentially greater) number of individuals transferred to mental health facilities, despite their having been arrested for or committed a criminal offence.

### Alternatives to police custody for those with mental health issues

The NPM shares widespread concerns about the suitability of police custody for those with mental health issues, either as a place of safety or for those with serious mental health issues who have come into the criminal justice system.[98]

In England and Wales the fall in the use of police custody for Section 136 detentions has been achieved by increasing the provision and availability of health-based places of safety (HBPoS). In 2013–14, 74.5% of Section 136 detainees were taken to an HBPoS, by 2015–16 this had risen to 92.6%. In Scotland, the reasons for the fall in the use of police stations are unclear, and wide regional variations suggest there may be inconsistencies in police practice, either in the use of the legislation, or in recording its use.

There have been a range of initiatives aimed at providing alternatives to, or easier routes out of, police custody for detainees with mental health issues. The Police Service of Northern Ireland (PSNI) previously operated two pilots in police custody; one involving community psychiatric nurses and one involving drug alcohol referral teams, but these ceased when funding was lost. PSNI is now considering the use of street triage for crisis care, following successful pilots in England. In Scotland, Police Scotland has developed training for officers to raise awareness of mental health distress, and a community triage scheme involving support from community psychiatric nurses has been piloted in Glasgow and Edinburgh.[99] In England and Wales, liaison and diversion nurses should support the pathway out of detention. This works effectively in some areas, but in others custody visitors reported reduced availability of nurses due to the

**97.** HM Inspectorate of Constabulary, 2015, *The welfare of vulnerable people in police custody*, pp47–49 [accessed 13/11/17].
**98.** See Department of Health, 2009, *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system.*
**99.** Scottish Government, 2017, *Mental Health Strategy 2017–2027.*

resource being shared across a wider force area or the lack of approved mental health professionals. This, alongside the lack of suitable accommodation, had a detrimental impact on how quickly detainees were transferred out of police care into health settings. These type of schemes aim to ensure that appropriate mental health assessments are conducted at the earliest possible opportunity, to divert those with mental health issues away from the criminal justice system and ensure they receive appropriate mental health support in police custody and beyond.

### NPM concerns

A lack of suitable places in health establishments (for example place of safety availability in hospital emergency departments or places in mental health hospitals) was a frequent barrier to effective and efficient pathways out of police custody, though available data does not shed light on the extent of this problem. NPM members' monitoring identified several problems arising from the lack of available places in health care establishments to receive those in police custody: delays in having the individual transferred out of police custody, the negative impact of time spent in police custody on the individual held (including exacerbating their mental health issues), and a lack of proper mental health assessment and appropriate mental health care.

In addition, difficulties arose when the detainee was under the influence of alcohol and/or drugs as health professionals could be reluctant to accept the individual, particularly if they were violent. It could also be difficult for police to ascertain if the individual had a mental health issue or if they were under a drug-induced psychosis. A lack of police training or awareness about mental health issues contributed to this. Finally, NPM members were concerned that the number of individuals being brought to custody suites could delay the process of identification of mental health issues and the need for input from mental health services.

### Conclusion

There has been significant attention in recent years to the situation of detainees in police custody who have serious mental health problems. Though some improvements have been made in relation to the reliance on police custody as a place of safety in England and Wales, and numbers in Scotland and Northern and Ireland appear small, further attention is needed to strengthen the availability and efficiency of pathways out of police custody. The lack of places in mental health establishments to which detainees can be transferred is a significant problem, and NPM members have also identified issues around the willingness of health care providers to receive individuals suffering mental health issues who have ended up in police custody.

It is of concern that there is a widespread lack of data about mental health need in police custody to inform the need for mental health provision. Although data is available in relation to the use of police custody as a place of safety, there is apparently no data on the wider issue of detainees in police custody who require a full mental health assessment or to be transferred to a mental health establishment. Without this data police forces cannot challenge health care providers or their commissioning bodies about the perceived lack of provision, and steps cannot be taken to address this.

In England and Wales and Northern Ireland funding cuts have led to the withdrawal or reduction of mental health professionals situated in police custody suites. This leaves the police (and the forensic mental health staff who provide general health care to detainees) vulnerable due to a lack of specialist support and advice. The pathway becomes more challenging to manage as there is a lack of early assessment by trained staff and a greater likelihood that detainees will need to be transferred to a mental health facility for assessment. This potentially increases the risks to the detainee, who will be kept in an inappropriate location for a longer period of time, and to the custody officer responsible for their safe detention and care. It may also mean the police have less time to source a health-based place of safety before the need to charge or release.

### Pathways from prisons to mental health settings[100]

The inappropriate detention of people with mental health problems in prisons and the prevalence of mental health problems among prisoners have been a matter of public concern over many years.[101] The provision of health care in prisons more generally is a growing concern for NPM members, and will be prioritised over the next year by members of the NPM's Scottish sub-group. In addition to the need to provide appropriate physical and mental health care to all prisoners, individual NPM members have identified concerns about the situation of prisoners with serious mental health issues requiring inpatient treatment, which requires a pathway from prisons to secure mental health care.[102] The absence or inaccessibility of such a pathway can pose significant risks to the ability to offer appropriate and timely treatment and prevent further deterioration of mental health conditions.

A turning point in the understanding of mental health issues in the criminal justice system came in 2009 with the publication of the Bradley Report. As a result of this, there has been greater focus on developing liaison and diversion schemes to ensure that people in need of treatment for mental disorders in hospital are identified by police and courts and are not sent to prison. However, despite the intention to introduce and implement such schemes, research shows that there has been a decline of more than 25% in the use of hospital orders (which allow defendants to be sent for medical care instead of receiving a prison sentence) since 2011.[103]

**100.** A literature search was undertaken to inform the development of this project. Input was provided by CJINI, HIW, HMIPS, IMB, IMBNI, MWCS and RQIA.

**101.** See Department of Health, 2009, *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system.*

**102.** Criminal Justice Inspectorate Northern Ireland, HM Inspectorate of Prisons, Education and Training Inspectorate, Regulation and Quality Improvement Authority, 2016, *Report on an unannounced inspection of Hydebank Wood Secure College 9–19 May 2016; Report on an unannounced inspection of Ash House Women's Prison, Hydebank Wood 9–19 May 2016; Report on an unannounced inspection of Maghaberry Prison 11–22 May 2015* (and subsequent follow-up reports). HM Inspectorate of Prisons, 2017, *HM Chief Inspector of Prisons for England and Wales Annual Report 2016–17*. HM Inspectorate of Prisons for Scotland, 2008, *Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons.*

**103.** Yeung, P, 2016, 'Rise in prisoners moved to mental health hospitals' in *The Guardian*, 14 September 2016.

Table 1: Legislative instruments

| | Transfer from prison of a person who is suffering from a mental disorder for which medical treatment is available in the hospital | Transfer from hospital to prison following completion of hospital medical treatment |
|---|---|---|
| **England and Wales** | Mental Health Act 1983 Section 47, Section 48 and Section 49 (restrictions) | Mental Health Act 1983 Section 50 |
| **Northern Ireland** | Mental Health (NI) Order 1986 Article 53 and 54 (removal to hospital) | Mental Health (NI) Order 1986 Articles 56 and 57 |
| **Scotland** | Mental Health (Care and Treatment) (Scotland) Act 2003 Section 136 | Mental Health (Care and Treatment) (Scotland) Act 2003 Section 216(2) *[Revocation by Scottish Ministers]* |

## Legal and policy framework

Involuntary psychiatric treatment of people detained in prisons is not permitted in the UK, to safeguard detainees from potential abuse. Instead, legislative frameworks across the UK provide for the transfer of detainees who require assessment and treatment for mental disorder to hospital, and their subsequent return to prison when the health episode is completed (see Table 1).

Codes of practice guide appropriate care and treatment under relevant legislation in England, Wales and Scotland and one is being drafted in Northern Ireland.[104]

To effect the transfer of a person from a prison to a hospital and vice versa, a transfer direction is required to provide legal authority. In England and Wales the transfer direction is provided by the Secretary of State for Justice, in Northern Ireland the Minister of Justice and in Scotland by the Scottish Ministers. There is no right to appeal for prisoners who do not want to be transferred from prison to hospital, although some patients (including all patients transferred from prison in Scotland) can apply to a tribunal to revoke the transfer once it has taken effect.

After the recommendation in the Bradley report that prisoners requiring hospital assessment and treatment should be transferred from prison to hospital within 14 days, guidelines were introduced in England and Wales with the intention that a prisoner should be transferred to a mental health unit within 14 days of the first medical recommendation for transfer.[105] During this 14 days, a second medical opinion was to be sought and all administrative tasks, including finding a bed, should also be completed. In Scotland, once the Direction has been signed by Scottish Ministers, the transfer must take place within seven days, although the Act does not specify a time period before the application for a Direction must be determined.

**104.** England and Wales: *Mental Health Act 1983: Code of Practice* (2015) chapter 22. Scotland: *Mental Health (Care and Treatment) (Scotland) Act Code of Practice*, Volume 3: Compulsory Powers in Relation to Mentally Disordered Offenders.
**105.** Department of Health, 2011, *The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act.*

## In practice

The NPM requested data on the number of transfers from prisons to hospitals and was informed that in 2016–17 there were 1,083 transfers in England (983 men and 100 women), 15 in Northern Ireland (12 adult men, one young male and two women) and 57 in Scotland (50 men and seven women).[106] Information obtained by a freedom of information request cited in a newspaper article suggests that the number of male prisoners being transferred to hospital grew by more than 20% between 2011 and 2014 in England and Wales.[107] The most recent data we accessed showing the number of patients returned from hospital to prison was 305 during 2015.[108] In 2016, 1,175 prisoners were transferred to a secure hospital under the Mental Health Act 1983, of whom 104 were women and 1,071 were men.[109]

Not all prisons are involved in transferring detainees to secure hospitals for treatment, and in England in 2016–17, 31 out of 112 did not initiate any transfers and 80 prisons had 12 or fewer transfers. Most transfers were from category A and B prisons that had 'inpatient' units and where the most seriously mentally disordered prisoners were usually detained.[110]

It appears that there is no central record of how many prisoners are currently awaiting a transfer to a secure hospital.[111]

Table 2: The 10 prisons in England from which most prison to hospital transfers are made

| Prison | Detainee gender | Security category | Number of Mental Health Act transfers from prison to hospital initiated and/or completed in 2016–17 |
|---|---|---|---|
| **Pentonville** | Male | B | 106 |
| **Wandsworth** | Male | B | 66 |
| **Leicester** | Male | B | 50 |
| **Woodhill** | Male | B | 37 |
| **Belmarsh** | Male | A | 33 |
| **Long Lartin** | Male | A | 33 |
| **Thameside** | Male | B | 33 |
| **Wormwood Scrubs** | Male | B | 31 |
| **Bronzefield** | Female | B | 30 |
| **Preston** | Male | B | 27 |

**106.** Data from different jurisdictions may not be collected in standardised ways and definitions may vary, so this data is not comparable and may not be entirely accurate.
**107.** Yeung, P, 2016, 'Rise in prisoners moved to mental health hospitals' in *The Guardian*, 14 September 2016.
**108.** NHS England, 2017, Written evidence to the Justice Committee inquiry on governor empowerment, http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/justice-committee/prison-reform/written/46720.html [accessed 13/11/17].
**109.** Hansard, 2017, Prisoners: Mental Illness, Written Answer to David Hanson MP, 12 September 2017.
**110.** NHS England Central Database Working Document 090617 PT MH Assessments and Secure Transfers (email correspondence between HM Inspectorate of Prisons and NHS England).
**111.** National Audit Office, 2017, *Mental Health in Prisons*, paragraph 3.37, https://www.nao.org.uk/wp-content/uploads/2017/06/Mental-health-in-prisons.pdf [accessed 13/11/2017].

## Issues identified by NPM members

### *Appropriate location*

International human rights standards set out the requirement that 'Prisoners who require specialized treatment [...] shall be transferred to specialized institutions or to civil hospitals'.[112] NPM members have frequently raised concerns in their inspection reports about the appropriateness of the prison environment for detainees with serious mental health problems.

It is of particular concern that prisoners awaiting transfer to hospital are often found in segregation units.[113] During its 2016 visit, the European Committee for the Prevention of Torture (CPT) noted that the inpatient health care unit at HMP Pentonville was primarily being used to hold psychiatric patients, and concluded that such units should 'not become a substitute for the transfer of a patient to a dedicated facility'.[114] Similar concerns were identified by HMI Prisons, which reported that prisoners awaiting transfer were being managed either in the inpatient unit, the segregation unit or on open landings on the wings, and that in all three environments their mental disorders were not being assessed or treated as would occur in a hospital facility. In segregation and on the wings their vulnerabilities would have been exposed, leading to a potential deterioration in their mental states.[115]

The Prisons and Probation Ombudsman (PPO) reported that prisons had tried to arrange transfers to hospital for one in 10 of the 139 prisoners who died from suicide between 2012 and 2014 and had identified mental health problems at the time.[116] The PPO found further cases where prisoners had not received appropriate support for their mental health problems, while waiting for a transfer or waiting to be assessed for a transfer to a secure hospital.

**Case study – Dean Saunders**

On 4 January 2016, a 25-year-old prisoner held at HMP Chelmsford, Dean Saunders, committed suicide. The independent investigation into his death, conducted by the PPO, noted that on 21 December 2015 a prison psychiatrist had assessed Mr Saunders as suitable for transfer to a secure hospital, but did not complete the first recommendation required for a transfer under the Mental Health Act because the local secure hospital did not have a bed available. The first recommendation was completed several days later on 31 December. Though the local hospital had a place for Mr Saunders, prison health care staff believed they needed a second recommendation from the prison psychiatrist, who was on leave until 5 January, when in fact a signature from any other doctor would have

**112.** United Nations Office on Drugs and Crime, 2015, *The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, Rule 27.
**113.** See, for example, Criminal Justice Inspectorate Northern Ireland, HM Inspectorate of Prisons, Education and Training Inspectorate, Regulation and Quality Improvement Authority, 2016, *Report on an unannounced inspection of Ash House Women's Prison, Hydebank Wood 9–19 May 2016*; HM Inspectorate of Prisons, 2017, *Report on an announced inspection of HMP Pentonville, 9–13 January 2017*.
**114.** Committee for the Prevention of Torture, *Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 30 March to 12 April 2016*, CPT/Inf (2017) 9, paragraph 66.
**115.** HM Inspectorate of Prisons, 2017, *Report on an announced inspection of HMP Pentonville, 9–13 January 2017*.
**116.** Prisons and Probation Ombudsman, 2016, *Learning from PPO Investigations: Prisoner mental health*. It is not known whether the deaths would have occurred had the prisoners been in hospital rather than prison.

sufficed. This meant that though all those involved in his care agreed that prison was not an appropriate place for him, the opportunity to transfer Dean Saunders to a more suitable placement in a hospital was missed. In their evidence to the Joint Committee on Human Rights, Dean Saunders' parents said they had been told not to worry, that 'He's secure until we can get him transferred'. The PPO concluded that the criminal justice system did 'too little to protect this very vulnerable young man' and an inquest jury found that Dean Saunders and his family were 'let down by serious failings in both mental health care and the prison system' and that the cause of death was 'contributed to by neglect'.

NPM members are concerned that the lapses in understanding the transfer pathway evidenced in this case are not untypical.

### *Timeliness of transfers*

International human rights standards emphasise that arrangements for prisoners who are diagnosed with severe mental disabilities and/or health conditions, for whom staying in prison would mean an exacerbation of their condition, 'shall be made to transfer them to mental health facilities as soon as possible'.[117]

The NPM was able to access NHS England data showing the timeliness of transfers from prison to hospital in England and Wales in 2016–17.[118] This showed that from a total of 1,083 transfers from prison to hospital, 366 (33.7%) were completed within the agreed 14-day time period and 717 (66.3%) were not. Seventy-six prisoners (7.1%) waited for 140 days or longer.[119] The same data indicated that men were less likely to be transferred within the guideline target of 14 days than women. Transfers of 67.7% of men were not completed in 14 days, compared with 54% of women. Some men (7.6%) and women (2%) waited for 140 days or longer. Data on delays in transfers obtained for a debate on prison safety in Parliament by Luciana Berger MP showed, in her words, 'such ubiquitous failure [that] would never be tolerated in the outside world'.[120]

More specifically, the NPM understands that delays often arise for administrative reasons between the first and second assessments, which prolongs the waiting time from first assessment to transfer. These delays are hard to quantify as data is not captured centrally.

A study published in 2016 examined the transfer of 64 male prisoners in England and Wales and found that the mean time from referral to hospital admission was 76 days. They noted that a sizeable number of prisoners were left in prisons for excessive periods of time with suspected mental disorders, for which treatment is readily available in hospital but cannot be administered without consent in prisons.[121]

**117.** Nelson Mandela Rules, Rule 109.1.
**118.** NHS England Central Database Working Document 090617 PT MH Assessments and Secure Transfers (email correspondence between HMI Prisons and NHS England).
**119.** This data refers to the time interval from first referral to hospital admission.
**120.** Hansard, 2017, Suicide and Self Harm in Prison (England). 1 March 2017, Volume 622.
**121.** R Sharpe, B Vollm, A Akhtar, R Puri, and B Bickle, 2016, 'Transfers from prison to hospital under Sections 47 and 48 of the Mental Health Act between 2011 and 2014' in *The Journal of Forensic Psychiatry and Psychology*, Volume 27 (4), 2016.

At its most recent inspection of HMP Pentonville, HMI Prisons and its partners noted that the range of transfer times from referral to arrival at a hospital was 0–187 days, with only 15% of prisoners transferred within the 14-day guideline.

We were unable to obtain data for Northern Ireland, but NPM members report delays beyond 14 days, sometimes lasting weeks, due to bed availability and the need for a consultant from the receiving hospital (usually the Shannon Clinic in Belfast) to come to the prison to assess the person and determine if it is a suitable case. We understand the experience in Scotland to be that, in most cases, a hospital place can be found reasonably quickly for a prisoner who needs to be admitted, although there are pressures in the medium secure hospital estate, and delays can occur, particularly for prisoners with complex needs.

Evidence from various sources available to the NPM, including complaints from prisoners to NPM members, indicate that there are often delays in the process of assessment for transfer, essentially before the 14-day guideline starts to be counted. This was also commented on by the PPO who indicates that the recording of the length of wait for transfer to secure hospital does not generally begin until an assessment has taken place, which opens up the possibility of assessments being pushed back until there is the prospect of a place being available.[122]

Some of the difficulties in achieving timely transfers of prisoners to mental health hospitals reported to NHS England health and justice quality surveillance groups were shared with HMI Prisons. These included: disagreements about transport arrangements, ineffective communication between mental health teams and prison officers, contradictory policy and good practice guidelines (e.g. between Department of Health guidance, health and justice performance indicators, and contract specifications). A forensic psychiatrist interviewed by HMI Prisons reported many frustrations and 'incessant time on the phone' attempting to expedite transfers to secure hospitals. More specifically, she cited problems arising from clinicians taking different views on cases, ineffective communications between medium secure unit staff acting as 'gatekeepers' to accessing other secure hospitals, and the fact that some psychiatric intensive care units will not take transferees from prisons.[123]

**122.** Prisons and Probation Ombudsman, 2016, *Learning from PPO investigations: Prisoner mental health.*
**123.** Further analysis of the problems and difficulties associated with the transfer process is detailed in RCPsych, 2011, *Prison transfers: A survey from the Royal College of Psychiatrists. Occasional Paper OP81.*

**Case study – HMP Bristol: a mixed picture**

During its 2017 inspection of HMP Bristol (Category B men's prison), HMI Prisons identified very good links between the prison's mental health service provider and the local NHS medium secure unit (MSU). The prison psychiatrist also practiced at the MSU and a forensic psychiatrist from the MSU attended the weekly prison health multidisciplinary meeting, which kept the prison on the MSU's agenda. As a result, transfer times to the unit were reasonably good. This was not the case for transfers to high secure units or MSUs that were further away. The transfer time was being counted from when a bed became available, which is not compatible with the 14-day guideline. HMI Prisons noted that most prisoners were admitted to a hospital within two to four weeks, but between April 2016 and February 2017, six out of 14 transfers had taken longer than five weeks to complete.

### *Capacity in secure mental health services*

Across the UK, capacity constraints in secure mental health services hinder the pathway from prisons and lead to prisoners being transferred across jurisdictions.

In Northern Ireland, the lack of a local high secure hospital means that some prisoners are sent to Carstairs (in Scotland) or Ashworth, Broadmoor or Rampton (in England).[124] Similarly in Wales there are no high secure hospital beds.

Successive inspections by HMIPS have identified delays in transfers from prisons for women and men due to the insufficient provision of medium secure hospital beds in Scotland. The absence of high secure mental health beds for female prisoners has been identified as an area of concern in Scotland by the MWCS. The matter is under consideration by the Scottish Government, although the way forward has not been agreed.

In England, there are insufficient secure mental health beds to meet demand.[125] Lack of access to secure hospital beds is the most frequently cited reason for delayed transfers from prison to secure mental health services. The NPM is aware that there are aspirations to increase capacity but this will not be achieved for several years.

### *Transfers at the end of prison sentences*

The failure to effect transfers before a prisoner has completed his or her sentence means that opportunities to prevent mental deterioration through appropriate treatment may have been missed and/or the public placed at risk. One NPM member identified three cases where prisoners had been released before the prison had completed the process for transfer to a secure hospital. This was of concern because the prisoners in question had suspected mental disorders which may have responded to treatment and/or a mental disorder which may have been a factor in the offence/alleged offence.

**124.** Criminal Justice Inspectorate Northern Ireland, 2010, *Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland*, http://www.cjini.org/getattachment/24d6cd45-20bb-4f81-9e34-81ea59594650/Mental-Health-and-the-criminal-justice-in-Northern.aspx [accessed 13/11/17].
**125.** Department of Health, 2000, *The NHS Plan, A plan for investment, A plan for reform*, page 118.

**Account from a forensic psychiatrist**

A forensic psychiatrist interviewed by HMI Prisons related the story of a patient who had been under her care in prison. The man had been seen by the liaison and diversion worker at court who recommended admission to a mental health hospital, but the judge remanded the man to prison. After three days at the receiving prison the man was relocated to the 'inpatient' unit. The forensic psychiatrist made a referral for a possible low secure hospital placement and established that the Psychiatric Intensive Care Unit was unwilling to take him. Low secure staff assessed the patient six days after referral and accepted him for transfer 20 days after referral but indicated that a bed was unlikely to be available for another month. While in the inpatient unit the patient was regularly on three-officer unlocks. Forty days after first referral the man appeared in court once again, but this was a different court with no liaison and diversion service. The man was given unconditional bail and allowed to leave the court. The attempt to transfer the man for mental health assessment and treatment had failed. Because of the safety precautions indicated for this detainee while in prison, the prison mental health team were concerned for his safety and the safety of others in the community due to his untreated behaviours.

## Conclusion

It is of particular concern to the NPM that the failure to effect transfers efficiently can cause deterioration in prisoners' well-being. The evidence gathered by NPM members makes clear that the problems with transfers between prisons and secure hospitals identified over the last decade, not least in the Bradley Report, have not gone away. In fact, analysis by HMI Prisons of its inspection recommendations shows a year-on-year increase in the proportion of inspections in which recommendations are made about Mental Health Act transfers. Though this data should be treated with caution because HMI Prisons inspects different prisons every year, it is notable that in 2016–17, HMI Prisons made a recommendation to improve the timeliness of transfers in more than half (56%) of its published inspection reports.

The lack of public and comparable data, particularly from Scotland, Northern Ireland and Wales, makes it difficult to analyse the extent of the problem across the UK.

The NPM welcomes recent scrutiny of these issues by the National Audit Office (NAO), the Joint Committee on Human Rights (JCHR) and the Committee for the Prevention of Torture (CPT). All agree that the current recommended 14-day target is not being met and that this requires review. They made the following specific suggestions:

- that a legal maximum time between the diagnosis and transfer of detainees requiring care in a secure hospital should be introduced (JCHR);
- that the MoJ and NHS England should routinely report how many prisoners are waiting to be transferred (NAO);
- that all patients transferred from prison should automatically trigger a review by the Mental Health Tribunal of the transfer measure.[126]

**126.** Council of Europe, 2017, *Report to the Government of the UK on the visit to the UK carried out by the European CPT from 30 March 10 to 12 April 2016*, paragraph 176, https://rm.coe.int/168070a773 [accessed 13/11/17].

These recommendations were made with the English system in mind, but their implementation across the four nations of the UK should be considered.

The NPM agrees with the need to review the current 14-day guideline, but this should be done with a view to removing the obstacles to its implementation and reducing it further in future (as recommended by the CPT), rather than extending the time period in response to current delays. In addition, stronger mechanisms are needed to ensure transfer assessments cannot be delayed as a means of postponing the start of the 14-day guideline.

## Conclusions

For an individual detainee, a period of deprivation of liberty is likely to involve moving through well-trodden pathways through detention (police custody to court custody to prison; medium secure hospital to low secure unit). But for many other detainees, it will also include moving between a range of facilities in response to their individual situation and needs (child to adult facilities; prison to mental health hospital).

Initial decisions to detain focus on the immediate destination, but the individual experience will cover a range of settings and facilities over time. The NPM's work looking at pathways in detention illustrates an often fragmented system that struggles to facilitate the pathways needed to ensure detainees are able to move around in response to their changing needs, or to ensure that detainees are held in the most appropriate location. We highlight a range of situations in which detainees' changing mental health needs mean the failure to transfer them to a place where they can receive treatment in an appropriate setting is a risk factor in potential ill-treatment.

There are inevitable challenges posed by different detention systems operating to different legislation and under the responsibility of different governments and departments. In addition, the diversification of commissioning arrangements and models of service delivery have led to geographical variations in services and competing or conflicting interests, all of which can complicate the pathway of the detainee to an appropriate facility.

There is a concerning lack of data about detention pathways and the numbers of people moving through them. Their complexity makes them difficult to understand and therefore difficult to scrutinise.

Most of the pathways NPM members examined concern detainees with mental health problems. Although understanding of the problems of mental ill-health and needs in detention has grown over the last decade, this has not always led to action to match the need for smooth pathways between types of detention and sufficient capacity within the system as a whole to facilitate movement. As a result of the current challenges, there are many people detained in unsuitable locations whose mental health may be deteriorating further as a result, and many people detained in overly restrictive detention settings rather than progressing towards eventual release from detention. In many instances, the NPM's research showed

up problems that would be avoided if there was better community provision preventing the need for, or offering alternatives to, detention.[127]

Human rights standards are primarily focused on types of detention or establishments, and there is little in the way of international precedent or legal authority to guide the NPM or detention authorities in the UK on what is expected of them. There has been little discussion of the human rights implications of detainees moving, or trying to move, along different pathways. There are however, important principles that should clearly be applied, including the principle of 'least restrictive environment', standards relating to detainees' distance from home, and the responsibility to prevent ill-treatment.

Furthermore, legal protections are less clear and possibly harder to apply when a detainee is moving, or should be moved, from one place to another. In this respect, the development in Scotland to extend the right to appeal excessive security levels in medium secure hospitals is significant, as is the CPT recommendation that there be oversight from mental health tribunals of all prison-hospital transfers.

The NPM's work, conducted alongside its members' existing inspection and visiting programmes, has only been able to look at some of the pathways and in limited detail. Our work reviewing existing literature and current practice allows us to identify issues relating to the treatment of detainees arising from pathways that warrant further study. These include:

- how the distribution of national and local resources and specific commissioning arrangements influence the pathways available to detainees;
- how cost imperatives influence the pathways detainees travel;
- the loss of continuity of services as a result of detainee moves;
- the impact on a detainee of choosing to transfer them to one or other option;
- the different thresholds applied to decisions to transfer detainees from one place to another;
- the availability of pathways for particular groups, including women and children;
- the desirability of reducing or maintaining a child's regime and privileges in anticipation of a move to a more restrictive setting.

### Recommendations and future actions

The NPM makes the following recommendations to authorities responsible for aspects of the pathways identified above.

#### Pathways from mental health to mental health settings

- Strengthen the planning of secure mental health services with a view to this becoming more coordinated (including between jurisdictions for national resources) and based on better information about local and national needs.
- Consider the need for extending the right to appeal against being held in conditions of excessive security beyond its existing application in Scotland.

**127.** See also House of Lords, House of Commons Joint Committee on Human Rights, 2017, *Mental Health and Deaths in Prison: Interim Report*, paragraph 22.

- NPM members should use their influence to maintain the national focus in their jurisdictions on improving the coordination of service planning.
- NPM members should gather information and report on delayed discharges and people detained in conditions of excessive security when monitoring secure mental health services.

### Pathways from police custody arising from mental health issues

- Forces should ensure they sufficiently evidence the numbers of detainees who have significant mental health issues and have needs which require enhanced support over and above that which can be provided in the custody suite. This data should be able to be disaggregated for equality monitoring purposes to ensure public bodies are able to effectively discharge their equality duties.
- NPM members should consider paying closer attention to the destination of detainees transferred from police custody, as well as delays in pathways out.

### Pathways from prisons to mental health settings

- Collect and publish data on transfers from prisons to mental health settings and on the return to prison in the UK, to include data on delays and at what stage in the transfer process these occur.
- Review the current 14-day transfer guideline with a view to removing the obstacles to its implementation and reducing it further in future, and consider the introduction of a legal maximum time between the first medical recommendation and transfer of detainees requiring care in a secure hospital.
- Consider the recommendation of the CPT that all patient transfers from prison should automatically trigger a review by the Mental Health Tribunal, or alternatively, extending the right to appeal against transfer currently in place in Scotland.

### Future actions for the NPM

The NPM will follow up on the work conducted so far by discussing how its members can make sure they are fulfilling their role of preventing ill-treatment when detainees are moving between the types of facilities they inspect or visit. This may include:

- understanding all possible pathways and identifying blockages and problems;
- examining preparation for detainee pathways during inspections and visits;
- identifying detainees who are stuck in inappropriate locations and reporting on the issues they face;
- engaging with authorities who plan/commission detention facilities and their distribution with a view to ensuring pathway problems are mitigated and services are organised to answer needs.

The NPM also intends to discuss what elements of the existing human rights framework and international standards relating to detention should govern pathways and transitions, with a view to influencing future thinking in this area.

## Transitions from child to adult custody

The forms of penal custody for children vary considerably across the UK and members of the NPM's Children and Young People's sub-group identified the need to map out the transitions between these and adult facilities, as well as the process by which these transitions are made.[128]

As with the pathways examined previously, the move from child to adult custody can pose risks for the treatment of detainees. The jump to adult facilities for some children is particularly dramatic: in England and Wales girls move directly from secure children's homes or secure training centres to adult prisons (as there are no YOIs for girls or young adult women); in Scotland children are placed in adult female or young adult male facilities at 16 years of age.

There are significant risks when the transition to adult custody is not planned or managed well. In 2016, the PPO (England and Wales) published a report into the death by suicide of Joshua Collinson, an 18-year-old prisoner at HMP Swinfen Hall. The report highlights disjointed and poorly managed transition arrangements, as well as poor information sharing between establishments – as a result of which key information about his mental health problems and needs were not shared. The PPO recommended that in future, 'transition arrangements for young people moving to adult custody include a jointly agreed management plan covering at least the first six months after transfer, outlining how their needs will be met, and how their risks and vulnerabilities will be managed'.[129]

**128.** This work was led by the NPM Children and Young People's sub-group, with contributions from the Children's Commissioner for England, CJINI and HMI Prisons. The NPM was only able to focus on penal custody for children in this exercise.

**129.** Prisons and Probation Ombudsman, 2015, *In depth investigation into the death of Mr Joshua Collinson a prisoner at HMP Swinfen Hall on 3 September 2015*, https://s3-eu-west-2.amazonaws.com/ppo-dev-storage-4dvljl6iqfyh/uploads/2017/01/L137-15-Death-of-Mr-Joshua-Collinson-Swinfen-Hall-03-09-2015-SID-18-21-1.pdf [accessed 13/11/17].

Table 3: Mapping transitions from the children's to the adult custodial estate

| | England and Wales | | Northern Ireland | | Scotland | |
|---|---|---|---|---|---|---|
| | **Boys** | **Girls** | **Boys** | **Girls** | **Boys** | **Girls** |
| **Children's custodial provision** | Three different types of provision: secure children's homes which also accommodate welfare cases (mixed sex); secure training centres (mixed sex); and YOIs (male only). Placement dependent on age and assessed vulnerability. | Two different types of establishment: secure children's homes which also accommodate welfare cases (mixed sex); and secure training centres (mixed sex). Placement dependent on age and assessed vulnerability. | A single (mixed sex) juvenile justice centre. | A single (mixed sex) juvenile justice centre. | Two different types of provision: five secure care establishments (mixed sex) which also accommodate welfare cases (four are managed by different voluntary sector providers; one by a local authority); a single mixed sex YOI which also provides for young adults but children are held separately. | Two different types of provision: five secure care establishments (mixed sex) which also accommodate welfare cases (four are managed by different voluntary sector providers; one by a local authority); a single mixed sex YOI which also provides for young adults but children are held separately. |
| **Adult custodial provision to which children transition** | Young adult YOIs, though in practice these are increasingly coterminous with adult prisons and young adults are not necessarily separate in such establishments. | Adult female prisons. In theory distinct provision for young adults but in practice there is rarely any distinction. | A single young offender institution. | A single women's prison. | A single mixed sex YOI which holds children and young people aged 16–21 (23 in some circumstances). (Currently adult prisoners also held on a temporary basis.) | A single mixed sex YOI which holds children and young people aged 16–21 (23 in some circumstances). (Currently adult prisoners also held on a temporary basis.) |
| **Age of transition** | Generally 18 years old. | Generally 18 years old. | Generally 18 years old. | Generally 18 years old. | Before 18th birthday. 16–17-year-olds are held separately. | Before 18th birthday. 16–17-year-olds are held separately. |
| **How is transition managed?** | Protocol published by National Offender Management Service (now HMPPS) and guidance by Youth Justice Board – but this does not appear to be well known or consistently followed.<br><br>Sometimes there is a phased transition, e.g. from secure children's home to young offender institution (YOI) to young adult YOI. But direct transfer to adult facilities may also occur. Children often not given prior notice of transfer. | Protocol published by National Offender Management Service (now HMPPS) and guidance by Youth Justice Board – but this does not appear to be well known or consistently followed.<br><br>Sometimes there is a phased transition, e.g. from secure children's home to young offender institution (YOI) to young adult YOI. But direct transfer to adult facilities may also occur. Children often not given prior notice of transfer. | Transition managed according to established protocol which lays out transition stages, information sharing and provides for a transition plan for each child. | Transition managed according to established protocol which lays out transition stages, information sharing and provides for a transition plan for each child. | Secure care establishments have developed links/ partnerships with YOI – to share information prior to transition, allow child to meet personal officer, visit the YOI in advance of transfer, etc. | Secure care establishments have developed links/ partnerships with YOI – to share information prior to transition, allow child to meet personal officer, visit the YOI in advance of transfer, etc. |
| **Is published/ unpublished data available on the number of children who transition to adult custody?** | No published data. Youth Justice Board may be able provide information on children turning 18 while in custody but this is not routinely extracted. No figures provided to date. | No published data. Youth Justice Board may be able provide information on children turning 18 while in custody but this is not routinely extracted. No figures provided to date. | Unpublished data available. Number of boys transitioning to adult custody has declined significantly over the past five years from 18 per annum to eight. | Unpublished data available. No girls have transitioned to adult custody in past five years. | No data provided as yet but secure care establishments indicate that transition is becoming less frequent. | No data provided as yet but secure care establishments indicate that transition is becoming less frequent. |

## The process of transferring a child to adult custody

### Transfers from young offender institutions (YOIs)

Most children who transfer to adult custody in England and Wales do so from YOIs holding 15–17-year-old boys. It is the responsibility of casework teams within these establishments to prepare boys as they approach their 18th birthday. There are also many instances in which children are remanded close to or soon after their 18th birthday. In these cases, they are sent to the children's estate for a planned transition. The success of planning in these scenarios depends on the links and support from receiving establishments.

In all cases transitions from YOIs are discussed from an early stage in sentence planning meetings which means family/carers are involved and know what the likely options will be. Often there are specific managers who lead on the issue within an establishment. These managers or caseworkers will canvass views on the most suitable establishment for the boy to move to around six months prior to transition, taking into account identified offender behaviour programmes or education needs and family ties. This model works most successfully when receiving establishments and the National Probation Service or Community Rehabilitation Company contribute to the process by attending transition planning meetings in person or via videolink. This enables the boy's questions to be answered and gives him a more accurate view of what will happen to him once he moves to the adult estate.

HMI Prisons has identified particularly good examples of the adult estate supporting transition planning at HMP Belmarsh (from HMYOI Cookham Wood), HMYOI Deerbolt and Aylesbury (from HMYOI Werrington and HMYOI Cookham Wood) and HMP/YOI Swinfen Hall from several childrens' institutions.[130] However, in some cases there was no input from the receiving establishment. This left caseworkers unable to effectively answer more specific questions from boys or their families.

In addition to these meetings, caseworkers shared information with the adult establishment around education and other interventions the boy had completed or may need to complete in the adult estate. While this planning provided useful information to prepare and reassure boys who would transition, it did not always impact on the detainee's experience of their early days at the adult establishment. HMI Prisons inspections have identified that this experience is not always positive. For example, at one young adult YOI HMI Prisons found that reception, first night and induction processes did not ensure that all needs were met or that new arrivals understood what would happen next.[131]

**130.** HM Inspectorate of Prisons, 2015, *Report on an announced inspection of HMP Belmarsh, 2–6 February 2015*. HM Inspectorate of Prisons, 2017, *Report on an unannounced inspection of HMP/YOI Swinfen Hall, 24 October – 4 November 2016*. HM Inspectorate of Prisons, 2017, *Report on an unannounced inspection of HMYOI Werrington, 13–24 February 2017*, paragraph 4.10. HM Inspectorate of Prisons, 2017, *Report on an unannounced inspection of HMYOI Cookham Wood, 12–23 September 2016*.

**131.** HM Inspectorate of Prisons, 2017, *Report on an unannounced inspection of HMP/YOI Swinfen Hall, 24 October – 4 November 2016*.

### Transfers from secure children's homes (SCHs)

Secure children's homes (SCHs) have very limited experience of transitions directly to the adult estate, because historically they have held younger children who may be less likely to be in custody for long enough to make the transition. Indirect transition, whereby a child moves to a children's YOI in preparation for making the transition to the adult estate, has tended to be encouraged.

However, as a consequence of the considerable rise in the average age of children in custody and the increase in the average length of custody, children in SCHs are more likely to move directly to adult settings.

The Children's Commissioner identified different approaches to transitions in four SCHs visited. The first three of these had identified two or three children who would finish their sentence in the adult estate and the fourth had held two children who would ultimately end up in the adult estate but had been transferred to children's YOIs in the past year.

#### *Secure children's home 1*

This SCH had generally transferred children whose sentences meant they would end up in the adult estate to HMYOI Wetherby as an interim placement. This occurred as a planned move, and was agreed at a review with the child's Youth Offending Team (YOT) worker and a governor from Wetherby who talked to the child about the arrangements for the move and the differences in regime. The SCH was also given materials about the YOI to be used by key workers to prepare the child for the move.

There was no set age at which this process occurred, and there had been debates within the SCH about the advantages and disadvantages of keeping children as long as possible, or transferring them relatively early (especially when a child has a long sentence), in which case there was then a question about whether it was better for them to move onto the next establishment sooner or later. In practice, the transition age was decided on a case-by-case basis, depending on the child's educational progress and vulnerability.

#### *Secure children's home 2*

This SCH had limited experience of transfers, but in the past had generally attempted to negotiate a transfer of the child to the Anson Unit at HMYOI Wetherby (a dedicated unit for children serving long-term sentences) at an appropriate point. This placement would serve as a stepping stone before moving to the adult estate.

#### *Secure children's home 3*

This SCH tried to keep children as long as possible, even if their sentence took them a little past their 18th birthday. The SCH took the view that children should remain in the least restrictive form of custody possible for as long as possible, and so would agree with the YJB, at an early stage, that the child would remain in the SCH until the point of transition to the adult estate. In one current case, the SCH were trying to ensure a child due to transfer to the adult estate achieved as highly as possible in education prior to transfer in order to support an argument that he should be sent to an establishment that offered a realistic prospect of progressing to A levels.

*Secure children's home 4*

In this SCH, it was suggested to Children's Commissioner's staff that the YJB were unwilling to support lengthy post-18 placements because of cost, despite changes to Care Standards regulations allowing SCHs to do so. The tendency was for girls to remain at the SCH if they were to be released within six months of their 18th birthday, but boys were more likely to be transferred unless they were due to be released soon after turning 18.

Where it was clear that children would end up spending considerable time in the adult estate, the SCH was developing a planned approach to prepare them for the transition. In one case, a boy had been transferred to the Keppel unit at HMYOI Wetherby at the age of 17 for a period, to prepare for his move to a young adult YOI. In another case, it was agreed that a 15-year-old boy on a life sentence, who had consistently been held on the enhanced regime, would be transferred to the Anson unit at Wetherby. The SCH had arranged for a case worker from the Anson unit to speak to the child about the regime he would be moving to. In preparation, the SCH moved him to a standard size bedroom and gradually towards a less generous regime with fewer possessions and reduced privileges that would be more similar to the regime he would experience in the YOI. After the move, he contacted the SCH to thank them for helping him to prepare for the change.

**Transfer from Woodlands Juvenile Justice Centre to Hydebank Wood Secure College**

In 2016, nine boys transitioned from Woodlands Juvenile Justice Centre to Hydebank Wood Secure College in Northern Ireland, all of them aged 18. Four of them were sentenced and five on remand. No girls had made the transition.

A protocol between Woodlands and Hydebank Wood aimed to support the successful transition of children through effective information sharing and collaboration. The principles underpinning the protocol were that children eligible for transition be identified at the earliest point, and their individual needs (to include legal status, risk of harm to self and others, mental health, physical health, education, training and employment, ethnicity, race, religion, culture and participation in reducing offending programmes) were reflected in a transition plan focused on providing a flexible and continuous service. Prior to transition, the child was given a pack of information (including a DVD and photographs) about Hydebank Wood.

All relevant information about the child (including about education) should be shared before they moved to adult services, and the child and their families should be involved in the planning. Though the protocol states that a transition planning meeting should take place three months before transfer, in practice due to uncertainties around children getting bail, it was often only held a month before. After the child had been transferred, representatives from Woodlands were able to attend meetings and visits if required.

## Conclusions

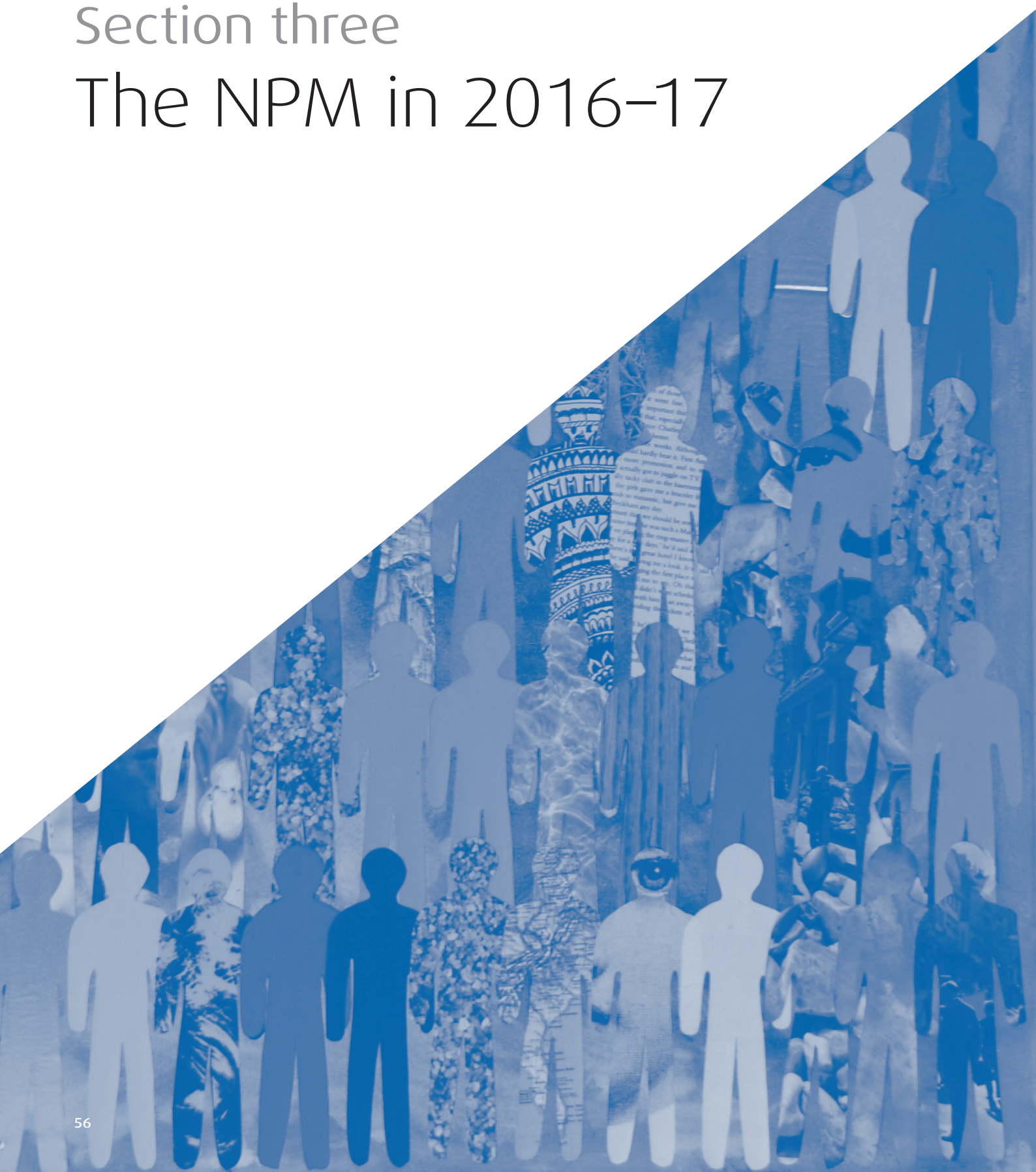
The experience of these YOIs, four SCHs in England and the Woodlands Juvenile Justice Centre in Northern Ireland, suggest that there is considerable thought and planning behind most transitions. However, it is noticeable that though there are similarities in the approaches employed by different establishments (providing information to children, bringing staff from the receiving establishment to meet the child prior to transfer) they differ in some significant aspects. In particular, the approach to gradually restrict a child's regime and privileges in one SCH is in contrast to the approach in another where they seek to keep children in the least restrictive form of custody possible for as long as possible.

The significant resources committed to planning the transition to adult custody can only impact positively on outcomes if they inform the provision of services to young adults during their induction and first few months in the adult estate. The findings from NPM members in England and Wales show that because there are a large number of institutions accepting young adults from the children's estate, there are also wide variations in how they are received. Institutions that regularly receive prisoners from the children's estate should have robust arrangements in place to develop individualised plans for their induction and early days in the adult estate. The case of Joshua Collinson highlights the risks that arise from any transfer process when the vulnerabilities of young detainees are not considered or information passed on between establishments.

Through this work, the NPM and its members aimed to strengthen their understanding of the transitions that exist, the variation between them and the processes behind them. It will feed into discussions at the NPM's children and young people's sub-group on how to strengthen NPM monitoring of these processes.

## Section three

# The NPM in 2016–17



## Strengthening the NPM

In January 2017, the NPM Chair wrote to the Director of Judicial, Rights and International Policy at the Ministry of Justice setting out a range of issues relating to the NPM's independence and governance that are of concern to the NPM (see Annex I). In particular, the letter expressed concern about the lack of legislation setting out the mandate of the NPM itself and its constituent bodies, the lack of statutory guarantees of independence for the NPM or its members, and the lack of a separate budget. These limitations have significant consequences for the NPM both in terms of its formal compliance with the United Nations' Optional Protocol to the Convention Against Torture (OPCAT) and with guidance from the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), and for its credibility, reputation, effectiveness and accountability. The letter also set out the Chair's view that the nominal amount set aside for NPM coordination in the overall HMI Prisons budget is unsuitable for a multi-body NPM requiring complex coordination. At the end of the reporting year the NPM had not received a reply.

The NPM also raised the need for legislation in the Justice Committee's inquiry on prison reform[132] and the Joint Committee on Human Rights inquiry on mental health and deaths in prisons.[133]

The NPM's concern that these issues hinder its OPCAT compliance was underscored by the report published by the SPT following its advisory visit to the Netherlands, where there is a multi-body NPM with some similar characteristics. In its report, the SPT sets out the clear requirement to have a 'separate legislative text regulating NPM-specific functions, and NPM mandate, the relationship between NPM members and other bodies [...]'. In addition, the SPT stated that it 'deems the adoption of a separate NPM law as a crucial step to guaranteeing [OPCAT] compliance'.[134]

On the basis of these concerns and the clear position elaborated by the SPT, the NPM recommended that a statutory basis for the NPM be introduced into the Prisons and Courts Bill that was before Parliament.[135] It was disappointing that the government did not accept this recommendation.[136] To date the NPM has yet to receive a clear response from the government as to its position on the desirability of NPM legislation, though its actions suggest reluctance. The Prisons and Courts Bill introduced by the government included a welcome reference to HMI Prisons' OPCAT role, though attempts to

**132.** Written evidence from the UK National Preventive Mechanism, January 2017, http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/justice-committee/prison-reform/written/45906.html [accessed 13/11/17].
**133.** Written evidence from the UK National Preventive Mechanism, March 2017, http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/human-rights-committee/mental-health-and-deaths-in-prison/written/48220.html [accessed 13/11/17].
**134.** UN SPT, 2016, *Visit to the Netherlands for the purpose of providing advisory assistance to the national preventive mechanism: recommendations and observations addressed to the State party*, CAT/OP/NLD/1, http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2fPPRiCAqhKb7yhsgiAnytcXxlWnYdDFRlJcNPek7dfRjpqX4Nu%2bcche4lj1AO%2bAYSGegH%2bwcNwX0kkQF9XABYH1bqUTI0BfBYVBT29yOnvK4QlFYsb8st6Lni6 [accessed 27/08/17].
**135.** Public Bill Committee, *Written evidence submitted by John Wadham, Chair of the UK National Preventive Mechanism* (PCB 08).
**136.** The need for the NPM to be placed on statutory footing was supported by the Chair of the Justice Committee, Bob Neill MP (Topical Questions, 25 April 2017, Volume 624) and in the Justice Committee's *14th Report – Prison Reform: Part 1 of the Prisons and Courts Bill*, HC 1150, 28 April 2017.

strengthen this introduced by Labour (which the NPM welcomed) were rejected at the Public Bill Committee by Prisons Minister Sam Gyimah MP and withdrawn.[137,138]

In January 2017, the NPM Chair also responded to a letter from Sam Gyimah, notifying him of the conclusions of a governance review of the Independent Monitoring Boards (IMBs). The Chair expressed satisfaction that the new governance model is an improvement on previous arrangements, but set out his concerns that the IMB secretariat would continue to be line managed by civil servants sitting in the Ministry of Justice (MoJ), which also has operational responsibility for most of the places IMBs monitor.

With a view to strengthening its public profile and publicising its work, the NPM established a Twitter feed (@uknpm) in November 2016. During the year the Twitter feed was used to promote NPM projects, the detention-related work and reports of its members, and international developments related to torture prevention and detention.

Through the 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 aimed at strengthening the NPM's OPCAT compliance. The first project aimed to examine the extent of compliance of the lay visiting schemes within the NPM with OPCAT. The second project set out to identify how incidents of ill-treatment in detention/deprivation of liberty contexts are recorded and the mechanisms available to deal with them. Desk research was conducted during the year for both projects.

## Member-specific developments

The Care Inspectorate (CI) and Healthcare Improvement Scotland led the development of Scotland's new Health and Social Care Standards on behalf of the Scottish Government. Following extensive consultation and engagement with people experiencing, providing and commissioning care, the new standards were launched on 9 June 2017.

The CI implemented major changes to its inspection methodology with effect from 1 July 2016. The new approach, to inspect against quality themes rather than quality statements, aims to enable inspectors to review the quality of care provided in a more holistic way, and shorter inspection reports will make it easier for people to access scrutiny findings. In addition to its ongoing inspection work, the CI carried out targeted scrutiny work throughout the year in relation to care homes, housing support services and care at home services supporting people with a learning disability. This work was undertaken following the publication in 2013 of Scotland's 10-year strategy for supporting people with a learning disability. The CI published the results of its two-year programme of focused inspection work

**137.** Hansard, 2017, *Prisons and Courts Bill (Third sitting), 29 March 2017* https://hansard.parliament.uk/Commons/2017-03-29/debates/fed3b6b9-d00b-449f-9a4a-35e3806682e4/PrisonsAndCourtsBill(ThirdSitting) [accessed 13/11/17].

**138.** The Prisons and Courts Bill was dropped after the announcement of a snap General Election and Parliament was dissolved. At the opening of the new parliament in June 2017, there was no indication in the Queen's Speech that the government intended to reintroduce prisons legislation, and a 'Courts Bill' was reintroduced without any of the previous provisions relating to prisons.

in this area in March 2017.[139] The CI also commenced an inspection focus in two further areas: dementia in care homes for older people in order to support scrutiny of the National Dementia Strategy; and child sexual exploitation to ensure staff working in residential care are able to recognise and respond appropriately to support vulnerable children and young people who may be at risk.

The Care Quality Commission (CQC) inspected the three high secure hospitals in England between November 2016 and March 2017, serving a warning notice on the NHS trust that manages Broadmoor Hospital following the inspection there. In addition to its inspections of high secure hospitals, CQC continued with its programme of comprehensive inspections of all specialist mental health services in England, work which began in 2014. The CQC undertook a national review of the way the NHS trusts identify, report, investigate and learn from the deaths of people using their services in 2016. The report, *Learning, candour and accountability*, published in December 2016, identified missed opportunities to learn from patient deaths and that too many families are not included or listened to when investigations are carried out. The report has informed a programme of work across the country to improve the action taken following a death and to improve care for future patients and their families, including patients who die while detained by the state.

The Children's Commissioner for England (CCE) continued to conduct announced and unannounced visits to children's custodial settings. During 2016–17, this work focused on secure children's homes in order to understand the vulnerabilities of children in this type of setting, and how their needs were being met. The CCE also expanded the focus of its visits to places of detention, piloting visits to the six medium secure and forensic child and adolescent mental health service units in order to better understand the children who are detained in these settings, how the units function and their interaction with the youth justice sector. In addition, the CCE conducted research on the provision of non-familial appropriate adults to children in police custody to ascertain whether and to what extent this contributes unnecessarily to the period of time children spend in police detention, and how that period might be reduced.

The CCE continued to participate in the National Care Leavers Forum coordinated by Her Majesty's Prison and Probation Service, the work of which focuses on improving the identification of young people in custody who have previous care experience and enhancing their access to entitlements.

Criminal Justice Inspection Northern Ireland (CJINI) continued its programme of inspection work and also commenced a thematic inspection of prisoner resettlement in the Northern Ireland Prison Service, on which it will conclude in late 2017.

**139.** Care Inspectorate, 2017, *THE KEYS TO LIFE: Report of the Care Inspectorate's Inspection Focus Area 2014–2016*, http://www.careinspectorate.com/images/documents/3741/Keys%20to%20life%20report.pdf [accessed 13/11/17].

Health Inspectorate Wales (HIW) continued its work inspecting and regulating hospitals with detained patients, including monitoring the use of the Mental Health Act 1983, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that services discharge their powers and duties in relation to patients who are detained or subject to DoLS, and that *de facto* detention is not used. HIW introduced new inspection tools to enhance the monitoring of the Mental Health Act 1983 and to reflect the changes within the new Mental Health Act – Code of Practice for Wales, that came into force in October 2016. Work continued to strengthen the provision of Second Opinion Appointed Doctors (SOAD) by recruiting, training and inducting a number of new SOADs. HIW's inspection work throughout the year identified a number of patients within independent hospitals who were inappropriately placed, resulting in HIW taking a more proactive role throughout the year to contact commissioning agencies to note that alternative placements for such patients must be located.

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)[140] conducted eight inspections of police custody between April 2016 and March 2017, jointly with Her Majesty's Inspectorate of Prisons. These inspections assessed outcomes for detainees against the revised Expectations for Police Custody introduced from April 2016. This has strengthened the approach to inspection, reflecting areas identified for improvement in the NPM self-assessment. In particular, there is now a greater focus on the welfare and treatment of vulnerable people and children in police custody, and on diverting them away from custody where possible.

Her Majesty's Inspectorate of Constabulary in Scotland (HMICS) continued to inspect places of police custody in Scotland. Following the deaths of two men in police custody in 2013 and the publication of the associated Fatal Accident Inquiry reports in December 2015, Police Scotland invited HMICS to carry out additional inspections of the custody centres involved. These inspections, carried out in April and May 2016, aimed to provide assurance about the delivery of custody at both custody centres and to assist Police Scotland in developing its own, internal audit and improvement processes. Police Scotland has since been developing an internal scrutiny/continuous improvement team in custody-based partly on suggestions from HMICS and learning from the two inspections.

HMICS has been discussing the possibility of developing joint inspections of police custody with Healthcare Improvement Scotland (HIS). HMICS believes that joint inspections with HIS, the body responsible for inspecting the National Health Service in Scotland, will maximise the OPCAT compliance of its monitoring and allow for a more holistic assessment of the treatment of and conditions for detainees in police custody. It is hoped that joint inspections will be able to commence before the end of 2017–18.

Her Majesty's Inspectorate of Prisons (HMI Prisons) published 86 individual inspection reports on prisons, police custody suites, immigration removal centres and other custodial establishments during the year. In addition to its inspection role, HMI Prisons also published revised Expectations for police custody (together with HMICFRS)

**140.** HMIC changed its name to HMICFRS in July 2017, reflecting the organisation's expansion to become a fully integrated inspectorate for the police and fire and rescue services.

following extensive public consultation. Work began on drafting revised Expectations for adult male prisons, including scoping of the relevant international human rights standards and a public consultation. HMI Prisons also continues to carry out thematic research work, with a number of reports being published throughout the year, including a review of short-term holding facilities for the period 2011–16, a report on the way forward for prisoners serving sentences of imprisonment for public protection, and a report on the impact of distance from home on children in custody. HMI Prisons made proposals to the MoJ for strengthening its powers in legislation in line with OPCAT requirements, to inform the drafting of the Prisons and Courts Bill.

In addition to carrying out its overall responsibility for the monitoring of prisons in Scotland, Her Majesty's Inspectorate of Prisons Scotland (HMIPS), published standards for the inspection of court custody in March 2017. The standards were developed following a period of consultation and are based on international human rights standards. HMIPS also implemented a new database for recording the observations of independent prison monitors, which allows reports to be run and trends analysed. A free-phone confidential telephone number was established which is available to prisoners and others and allows concerns to be raised and requests to see a monitor made. During the year, HMIPS carried out a follow-up inspection of HMP & YOI Cornton Vale. The recommendations from this inspection led to the early closure of areas of the prison and the transfer of 100 women to a more suitable establishment.

The Independent Custody Visiting Association (ICVA) has continued its work collating national data on visits to police custody and the successes and challenges that volunteers face once there. This data has allowed ICVA to raise thematic findings with the Home Office and other national partners such as the National Police Chiefs' Council. ICVA highlighted the issue of voluntary interviews, where detainees may be held in *de facto* detention but do not have access to independent monitors, with the Home Office and other national partners. This led to a national project that will implement new guidance and practice with the aim of safeguarding detainees and ensuring OPCAT compliance. ICVA also discussed voluntary interviews with the National Custody Forum, which it joined this year, and these discussions have led to a project to consider the independent oversight and safeguards for those attending interviews voluntarily. The Forum is a National Police Chiefs' Council-led partnership that seeks to implement the National Custody Strategy and improve standards within custody across the UK.

ICVA continued to work to support and strengthen independent custody monitoring schemes, reviewing training and developing new induction packages for schemes. ICVA held a conference which briefed schemes on new issues within custody and highlighted the work of the NPM and importance of OPCAT. ICVA also conducted a health-check of all schemes to understand compliance with its Code of Practice and, by extension, with OPCAT, which helped it to design a 2017–18 business plan that enables schemes to achieve better compliance. Finally, ICVA

developed and launched a members' website for all custody visiting schemes, which brings together a library of resources for schemes to improve practice and fulfil OPCAT requirements.

Independent Custody Visitors Scotland (ICVS) continued to visit Police Scotland custody suites, with volunteers completing nearly 1,600 unannounced visits in the period. ICVS saw an increase in both the number of detainees to whom it was able to offer visits (up 5%) and detainees accepting visits (up 23%) on the previous year. ICVS incorporated the responsibility of monitoring legalised police cells (LPCs) into its business practice and bespoke training was developed in preparation for the implementation of the Criminal Justice (Scotland) Act 2016. This training will be delivered to all volunteer custody visitors prior to the Act coming into force. ICVS also disseminated the NPM guidance on isolation in detention to all visitors and highlighted it to custody staff within Police Scotland.

Following two reviews of its role and governance in recent years, the Independent Monitoring Board (IMB) began introducing a new management structure which would include the recruitment of a paid National Chair who will be supported by a new management board. The IMB also published its 'Core Brief', which set out its core functions and its relationship with OPCAT and the NPM. The Training and Development Working Group has undertaken work to ensure that all training programmes are underpinned with references to OPCAT and NPM, and has expanded its online training provision. A revised annual report template was agreed in January 2017 to provide guidance on how to report more effectively to Ministers and the general public on the operation of the establishments monitored by Boards. The new template aims to ensure greater consistency of monitoring and greater insight in reporting on the fair and humane treatment of detainees. In addition, the IMB agreed a definitive procedure with the Home Office for the monitoring of deportation and extradition flights. IMBs have reported success in improving facilities for detainees throughout the year. For example, after specific, targeted monitoring by the IMB of the visitor facilities at HMP Belmarsh, additional phone lines and seating were added to reduce pressure on the facilities.

The Independent Reviewer of Terrorism Legislation (IRTL) was designated as a member of the NPM on 12 January 2017, and a new Independent Reviewer, Max Hill QC, began his tenure in the role on 1 March. His predecessor published his annual report on the operation of the Terrorism Acts in December 2016, noting the numbers of persons detained and the conditions of their detention.

The IRTL monitors all terrorism-related arrests and detentions, primarily under the Terrorism Act 2000. The IRTL works closely with ICVA to assist in this role, and since the terrorism attacks on Westminster Bridge in London on 22 March 2017 there has been an unprecedented level of activity for all concerned. The IRTL will publish an updated picture in his annual report at the end of 2017. The IRTL's role includes reviewing daily reports from each of the terrorism suites

which happen to be open. Independent custody visitors confirm to him that each detainee has knowledge of their rights and entitlements, and provide reports on detainees' health and welfare, conditions and facilities, and any special needs or other relevant issues.

Building on the recent introduction of standard reporting levels, Lay Observers (LO) have introduced electronic visit reports providing both specific ratings and narrative to support those ratings. LO has compiled national statistics from reports to identify trends and key issues to present to HM Courts & Tribunal Service and to escort contractors. In addition, LO launched a survey in early 2017 to provide a baseline of all key facilities across the court estate. There was a focus on health care throughout the year, with the LO National Council monitoring and reporting monthly on the health care risk assessments prepared by prisons and police custody suites for escort and court custody, the availability of prescribed medication to those detained, the quality of mental and physical health care support available in court custody, and the impact of any inadequacies on the ability of the person detained to participate in the court procedure. Significant concerns were raised about the lack of access to a confidential complaints process and unacceptably long waiting times for children and young people prior to and after their hearing.

Mental Welfare Commission for Scotland (MWCS) carried out two large-scale themed visiting projects during the year. One project examined the care and treatment in all adult acute admission wards, including a specific focus on whether key rights were being respected and legislative safeguards were being complied with. The second project looked at care and treatment provided in all medium and low secure facilities in Scotland, because of the higher levels of restriction people detained in secure settings will experience. A report on the first project was published during the year and a report on the second project will be published in 2017. In addition, MCWS published good practice guidance on supported decision-making, reflecting the expectations in the Convention on the Rights of Persons with Disabilities. MWCS organised several consultation events looking at the need to reform incapacity legislation in Scotland to ensure its compliance with international human rights standards. MWCS also continued to expand its work with partners, as part of a group sharing intelligence between national agencies in Scotland about the quality of health and social care. This new group meets regularly and promotes coordinated activity when potential or actual risks to the quality of care and treatment are identified, including any issues that relate to the work of the NPM.

The Northern Ireland Policing Board, which monitors the compliance of the Police Service Northern Ireland with the Human Rights Act 1998, continued to put in place existing steps to ensure the effective and efficient operation of the Independent Custody Visiting Scheme (NIPBICVS). Custody Visitors carried out 633 visits during the year, 27% more than the number carried out in the previous year. They met with 517 detainees, carrying out checks on their rights, health and well-being, and conditions of detention.

The **Office for Standards in Education, Children's Services and Skills (Ofsted)** continued to lead the joint inspections of England's secure training centres (STCs) and to inspect and regulate secure children's homes (SCHs) in England. Ofsted published a new Social Care Common Inspection Framework (SCCIF) in February 2017, under which secure children's homes are now inspected.[141] It focuses on evaluating the experiences and progress of children and what makes the most difference to their lives, and expressly states that all SCCIF inspections must take into account the Convention on the Rights of the Child (CRC). The SSCIF also references the contribution of inspections to OPCAT and Ofsted's responsibilities as a member of the NPM. The development of the SSCIF took into account Ofsted's findings from its contribution to the NPM survey on isolation in secure settings. In both STC and SCH inspections, inspectors now evaluate the use of single separation.

The **Regulation and Quality Improvement Authority (RQIA)** visited all mental health and learning disability wards in Northern Ireland on at least one occasion during the year, conducting a total of 55 inspections. RQIA also screened patient detention, assessment and holding forms, which the five Health and Social Care (HSC) trusts are required to submit: 10,988 forms were examined with an error rate of 3.9%. As a result of RQIA intervention, the detention of seven patients who were improperly detained was terminated. In addition, RQIA undertook focused work in two areas throughout the year, conducting an independent review of services for women in Northern Ireland who experience mental ill health during or after pregnancy (perinatal mental health) and publishing a report on the findings of the administration of electroconvulsive therapy by the five HSC trusts in Northern Ireland for the period from 1 April 2013 to 31 March 2016.

In March 2017, RQIA hosted a knowledge exchange event with care regulators from across the United Kingdom and Republic of Ireland, which included NPM members (CQC, CI and Care and Social Services Inspectorate Wales) and other organisations (the Health Information and Quality Authority). The event allowed organisations to hear about best practice in regulation and to learn from the experience of other regulators.

In addition to making a number of submissions to international bodies throughout the year, the **Scottish Human Rights Commission (SHRC)**, prepared a factsheet and provided recommendations for the public on detention, hate crime and human trafficking.

**141.** Ofsted, 2017, *Social care common inspection framework*, www.gov.uk/government/collections/social-care-common-inspection-framework-sccif [accessed 13/11/17].

## Joint working between NPM members

As well as collaborating on joint NPM thematic projects, members of the NPM work together on a wide range of initiatives aimed at strengthening their OPCAT compliance and detention monitoring. Joint working arrangements have continued throughout the year in order to prevent and address any sanctions that may occur as a result of contact with an NPM member.[142]

In addition, a number of NPM members continued to work together on joint inspections. In Scotland, SHRC and CI joined HMIPS on all inspections. In Northern Ireland, HMI Prisons, CJINI and RQIA continued to work together to carry out inspections of prisons, and CJINI and RQIA worked together to carry out inspections of police custody.

In England, Ofsted's further education and skills inspectors conducted inspections of learning and skills and work activities in prisons and young offender institutions (YOIs) as part of joint inspections led by HMI Prisons, with the CQC inspecting health care in the same facilities. HMI Prisons also continued to carry out joint inspections of police custody with HMICFRS in England and Wales. In Wales, HMI Prisons worked together with HIW to carry out inspections of prisons.

## Submitting proposals and observations on legislation (OPCAT article 19(c))

Most NPM members work actively to strengthen government policy that is relevant to the detention settings they monitor and to their own functions. In addition, the NPM coordination makes submissions and provides evidence on issues relevant to the NPM as a whole. This year, the NPM provided a brief submission to the House of Lords International Relations Committee inquiry into the UK priorities for the new UN Secretary General.[143] The NPM also made a submission to the Joint Committee on Human Rights Inquiry into Mental Health and Deaths in Prison.[144] The submission detailed the findings of the joint project on isolation and solitary confinement carried out by NPM members, noting the lack of consistency and oversight of these practices which could lead to people with identical mental health issues being held in different conditions.

As noted above, there has been continued work to strengthen the NPM, and this included the Chair of the NPM providing written and oral evidence to the Justice Committee's inquiry on prison reform in January 2017, noting that the failure to provide a legislative basis for the NPM is in violation of the requirements of the SPT.[145]

**142.** States parties are required by Article 21(1) of OPCAT to ensure that no sanctions occur following the provision of information to an NPM.
**143.** See: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/justice-committee/prison-reform/oral/46581.html [accessed 13/11/17].
**144.** See: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/human-rights-committee/mental-health-and-deaths-in-prison/written/48220.html [accessed 13/11/17].
**145.** See: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/justice-committee/prison-reform/written/48826.html and http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/justice-committee/prison-reform/oral/46581.html [accessed 13/11/17].

Members' involvement in consultations and the development of government policy included the following.

- The CI made a number of submissions throughout the year, including to: the Scottish Parliament Health and Sport Committee's inquiry into how health and social care is delivered in prisons; the consultation on section 35(2) and (3) of the Protection of Vulnerable Groups (Scotland) Act 2007 (April 2016); the consultation on the implementation of certain sections of the Mental Health (Scotland) Act 2015 and associated regulations (Part 1); the consultation on the implementation of certain sections of the Mental Health (Scotland) Act 2015 and associated regulations (Part 2); the review of learning disability and autism in Scottish mental health law – a scoping consultation; and the consultation on the Minimum Age of Criminal Responsibility.
- The CCE provided written evidence to the Justice Committee's inquiry into the disclosure of children's criminal records, and to the consultation on the Sentencing Council's revised Overarching Principles for Sentencing Youth. The CCE also contributed to the Review of the Youth Justice System in England and Wales, in particular exploring what models could replace YOIs and secure training centres for children.
- CJINI presented evidence to the Committee for Justice in relation to its July 2016 report of an announced inspection of Maghaberry Prison.
- As part of its role as a member of the Home Office PACE Strategy Group, ICVA contributed to consultations on the drafting of the Police and Crime Act 2017. ICVA also provided both verbal and written submissions to the Dame Elish Anglioni review into Deaths in Custody.
- HMI Prisons provided comments on a number of draft Detention Services Orders and Prison Service Instructions and Orders, and made submissions to a range of consultations, including: the Work and Pensions Committee inquiry on support for ex-offenders; the Women and the Criminal Justice System inquiry; the National Institute for Health and Care Excellence (NICE) review of the physical health of people in prison; the National Offender Management Service review of the incentives and earned privileges scheme; the Lammy review of black and minority ethnic representation in the criminal justice system; the Advisory Council on the Misuse of Drugs inquiry into older drug users; the Health in Justice and Other Vulnerable Adults review of women in the criminal justice system in London: a health strategy; the Justice Committee inquiry into prison reform; the Independent Advisory Panel on Deaths in Custody inquiry into deaths of women in custody; and the Joint Committee on Human Rights inquiry into mental health and deaths in prison.
- HMIPS gave evidence to the Scottish Parliament Health and Sport Committee on health care in prisons.
- The IMB provided both written and verbal evidence to the Justice Committee's investigation into prison reform.
- MWCS provided responses to consultations on the implementation of provisions in the new mental health legislation in Scotland, on proposals about secondary legislation relating to the new act, and on a new mental health strategy for Scotland (Consultation on the implementation of certain sections

of the Mental Health (Scotland) Act 2015 and associated regulations (Part 1), Consultation on the implementation of certain sections of the Mental Health (Scotland) Act 2015 and associated regulations (Part 2) and consultation on the Scottish Government's new Mental Health Strategy).

- Following on from the oral and written evidence that it provided to Lord Laming's inquiry into looked after children and offending, Ofsted participated in a cross-sector forum led by the Youth Justice Board for England and Wales that considered the over-representation of children in care in the criminal justice system and how to improve outcomes for such children.
- RQIA contributed to Phase 1 of the development of the draft code of practice and regulations for the new Mental Capacity Act (Northern Ireland) 2016. The Act introduces in Northern Ireland for the first time a legal framework governing capacity and incapacity.
- The SHRC provided a submission to the Consultation on the Scottish Government's Draft Delivery Plan 2016–2020 in relation to the Convention on the Rights of Persons with Disabilities, commenting on the need to ensure that people with mental health conditions who are detained are placed appropriately and receive adequate treatment. In addition, the SHRC provided evidence to the Scottish Parliament on destitution, asylum and insecure immigration status in Scotland.

## International scrutiny and collaboration

### Scrutiny

The UK's record on detention was scrutinised in several reviews during the year by UN bodies established to examine the implementation of human rights treaties.

### Committee on the Rights of the Child

The UN Committee on the Rights of the Child reviewed the UK's progress in implementing the CRC in May 2016. It adopted its Concluding Observations in June 2016.[146] The Children's Commissioners for England, Scotland, Wales and Northern Ireland submitted a joint shadow report to the review, as did the SHRC.

The Committee's Concluding Observations identified extensive concerns and recommendations relating to detained children. These included calls to: abolish all methods of restraint used against children for disciplinary purposes and to ban any technique designed to inflict pain on children; collect and publish disaggregated data on the use of restraint and other restrictive interventions; expedite the prohibition of placing children with mental health needs in adult psychiatric wards and police stations; cease the detention of asylum-seeking and migrant children (in relation to the detention of children in short-term holding facilities, and age-disputed children being detained in adult facilities); establish the statutory principle that detention should be used as a measure of last resort, for

**146.** UN Committee on the Rights of the Child, 2016, *Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland* (CRC/C/GBR/CO/5), http://www.crae.org.uk/media/93148/UK-concluding-observations-2016.pdf [accessed 13/11/17].

the shortest possible period of time and not used discriminatorily against certain groups of children; ensure child detainees are separated from adults in all detention settings; and immediately remove all children from solitary confinement, prohibit its use in all circumstances and regularly inspect the use of segregation and isolation in child detention facilities.

The then Minister of State for Vulnerable Children and Families, Edward Timpson, expressed the government's commitment to implementing the CRC in a written ministerial statement to Parliament on 17 October 2016. The Minister welcomed the Concluding Observations, which he considered a 'helpful and important guide to making sure that our policies – whether they hold direct or indirect consequences – consider children', and encouraged all government departments to take them into account.

### Committee on Economic, Social and Cultural Rights

The UN Committee on Economic, Social and Cultural Rights reviewed the UK's progress in implementing the International Covenant on Economic, Social and Cultural Rights in June 2016. In a submission to the review, the SHRC raised concerns about the increase in the number of mental health issues in prisons, the effectiveness in practice of Scottish mental health legislation, and the wide variation in the understanding and interpretation of the sections of the 2003 Act that allow restrictions to be placed on people who are detained.

In its Concluding Observations, the Committee expressed concern about the lack of adequate resources provided to mental health services, recommending that the UK 'continue its efforts […] to ensure the accessibility, availability and quality of mental health care, including for persons in detention'.[147]

### Committee on the Rights of Persons with Disabilities

Both the CCE and the SHRC submitted shadow reports to the UN Committee on the Rights of Persons with Disabilities, which was due to review the UK in August 2017. The Committee set out a number of questions on topics relating to detention for the UK government to answer during the review. These included: legislative safeguards protecting persons with disabilities against deprivation of liberty on the basis of impairment; measures taken to eliminate involuntary detention of persons with disabilities; measures taken in response to the abuse of persons with disabilities in detention and care settings; and the use of restraints.[148]

**147.** UN Economic and Social Council, 2016, *Committee on Economic, Social and Cultural Rights, Concluding observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland* (E/C.12/GBP/CO/6), paragraph 58 http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW3XRinAE8KCBFoqOHNz%2FvuCC%2BTxEKAI18bzE0UtfQhJkxxOSGuoMUxHGypYLjNFkwxnMR6GmqogLJF8BzscMe9zpGfTXBkZ4pEaigi44xqiL [accessed 13/11/17].

**148.** UN Convention on the Rights of Persons with Disabilities, 2017, *Committee on the Rights of Persons with Disabilities, List of issues in relation to the initial report of the United Kingdom of Great Britain and Northern Ireland* (CRPD/C/GBR/Q/1), http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2fPPRiCAqhKb7yhspCUnZhK1jU66fLQJyHIkqNcV0%2bbbuLXeQ%2fdBVXpGv7ordThA%2fcAhrT1NTqH2Zn%2f35xqULqacJsNBSBmE8qWT9qRXZj9cTaa1cYf4R%2frDnjJ [accessed 13/11/17].

### Council of Europe Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

The CPT conducted its eighth periodic visit to the UK from 30 March to 12 April 2016. The CPT delegation visited prisons, police custody, immigration detention and secure mental health establishments in England. This was the first time that the CPT had visited secure mental health establishments in England. The Committee met with government, NPM members and other stakeholders during their visit. The UK NPM coordination provided advice and contacts to the CPT secretariat in advance of the visit. The CPT's report was published in early April 2017 and its findings will be considered in the ninth NPM annual report.

The CPT also conducted its first ever visit to the UK's Sovereign Base Area (SBA) in Cyprus in February 2017, which is an Overseas Territory of the UK. The delegation assessed the conditions of detention and treatment of people held in Dhekelia Prison, police stations and the British Forces' Service Custody Facility. They also assessed the situation of migrants held within the SBA.

### NPM Observatory

In July 2016, the NPM learned of plans by a group of torture prevention experts and French academics to establish an 'independent observatory of NPMs'. The observatory set out its initial aims to 'contribute to the development of [NPMs'] preventative function by providing an independent, consistent and constructive assessment of their effectiveness. Just as the independent assessment by NPMs of places of detention should be an encouragement to improve torture prevention measures, so constructive, independent assessment of NPMs themselves should encourage development of their own effectiveness.' The NPM Observatory was subsequently established as an NGO in France.

Members of the UK NPM discussed the plans during the year, concluding that they had some concerns about the proposals made by the NPM Observatory. NPM members welcome the national and international scrutiny they receive and are keen to strengthen the NPM through receiving feedback; however, it is not clear from the initial proposals what additional scrutiny and feedback the Observatory would provide to members beyond that already received. Some members were concerned that their own legal structures would make it impossible for them to subject themselves to the NPM Observatory's scrutiny because of its status as a French NGO. The UK NPM shared the disappointment expressed by some other European NPMs that they had not been involved or consulted in the development of the plans. The NPM Chair attended a consultation meeting organised by the Observatory in February 2017 and provided suggestions on how the Observatory's role could be made more useful to NPMs like the UK's. To date the UK NPM has not committed to inviting or entering a formal relationship with the NPM Observatory.

## Collaboration

As in previous years, the NPM and its members collaborated actively with a range of international actors, including NGOs expert in torture prevention, inspectorates and monitoring bodies from other countries, and academics.

The NPM continued to enjoy a constructive relationship with the Association for Prevention of Torture (APT), which has provided helpful advice to the NPM on a number of topics. In turn, the UK NPM has shared its expertise with the APT through a number of projects and events. The UK NPM was featured in the APT's *Putting prevention into practice*, published for the 10th anniversary of the entry into force in 2006.[149]

MWCS attended the APT's Jean-Jacques Gautier Symposium on monitoring of psychiatric institutions in Geneva in September 2016. MWCS' participation included a presentation by MWCS' engagement officer discussing his personal experience of restrictions when he was detained in hospital.[150] In September 2016, the NPM coordinator spoke at the launch of the APT's new publication *Does Torture Prevention Work?*.[151]

In October 2016, the NPM coordinator attended a one-day roundtable with other NPMs convened by Open Society Foundations Justice Initiative and Bristol University to discuss the implications of counter-terrorism measures upon the mandate of NPMs and of the SPT.

The UK NPM was pleased to have the opportunity to meet and share experiences with other NPMs at the Organization for Security and Cooperation in Europe (OSCE)/ Office for Democratic Institutions and Human Rights (ODHIR) and the APT 'Annual meeting of NPMs from the OSCE region' in October 2016.

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

- CQC hosted a delegation from Japan of the Department of Psychiatric Rehabilitation, National Institute of Mental Health, who were carrying out government-commissioned research on Japan's mental health policy. Models of monitoring (and of second opinion safeguards) were considered by the delegation in their report to the Japanese government. In addition, CQC officers were released to work with the Council of Europe in 2016–17 on a consultation on the development of a quality assurance process for prison health care services and mental health services within the Republic of Georgia. This involved participation in two consultation events in Georgia and CQC hosted the Georgian delegation by return. The aim is to build a strengthened model of monitoring psychiatric detention in Georgia.

**149.** Association for the Prevention of Torture, 2016, *Putting prevention into practice, 10 years on: the Optional Protocol to the UN Convention Against Torture*, http://apt.ch/en/resources/putting-prevention-into-practice-opcat-10-anniversary-booklet-2016/?cat=60 [accessed 13/11/17].

**150.** See the outcome report of this symposium here: http://apt.ch/en/2016-monitoring-of-psychiatric-institutions/ [accessed 13/11/17].

**151.** The publication is the result of four years of independent research led by Dr Richard Carver, Oxford Brookes University, and Dr Lisa Handley, USA. More information about this work can be found on the Association for the Prevention of Torture's website, http://www.apt.ch/en/resources/yes-torture-prevention-works-insights-from-a-global-research-study-on-30-years-of-torture-prevention/?cat=59 [accessed 13/11/17].

- CJINI hosted a delegation from Lebanon's Internal Security Force in March 2017, at which the CJINI's inspection process was discussed, as well as its role in the NPM. This followed on from a visit of the Lebanese Inspectorate General in January 2016.
- HIW and the CI continue to be members of European Partnership for Supervisory Organisations in Health Services and Social Care (EPSO). This group considers key issues such as restraints.
- The IMB and HMI Prisons met with delegates from the South African Judicial Inspectorate for Correctional Services to discuss the unique challenges in managing lay monitors and prison inspection methodology. HMI Prisons subsequently participated in workshops with prison authorities and inspectors in Cape Town.
- HMI Prisons hosted a delegation of prison staff from Kenya participating in a secondment in the UK organised by the African Prisons Project.
- HMIPS provided a briefing to a Council of Europe delegation of prison and probation senior personnel and parliamentarians from Ukraine, discussing alternatives to custody, early release from prison and torture and ill-treatment prevention.
- The NPM coordinator shared experience of multi-body NPMs with authorities involved in planning new NPMs in Australia and Indonesia.

## NPM self-assessment

Each year, NPM members conduct a self-assessment using methodology based on the SPT's 'analytical self-assessment tool for NPMs'. The tool allows NPMs to examine their effectiveness and efficiency.[152] This is the fourth year in which the self-assessment has been carried out. Seventeen of the 21 NPM members completed the self-assessment. A number of NPM members peer-reviewed their responses with one another in order to share learning and receive constructive external review.

### General findings

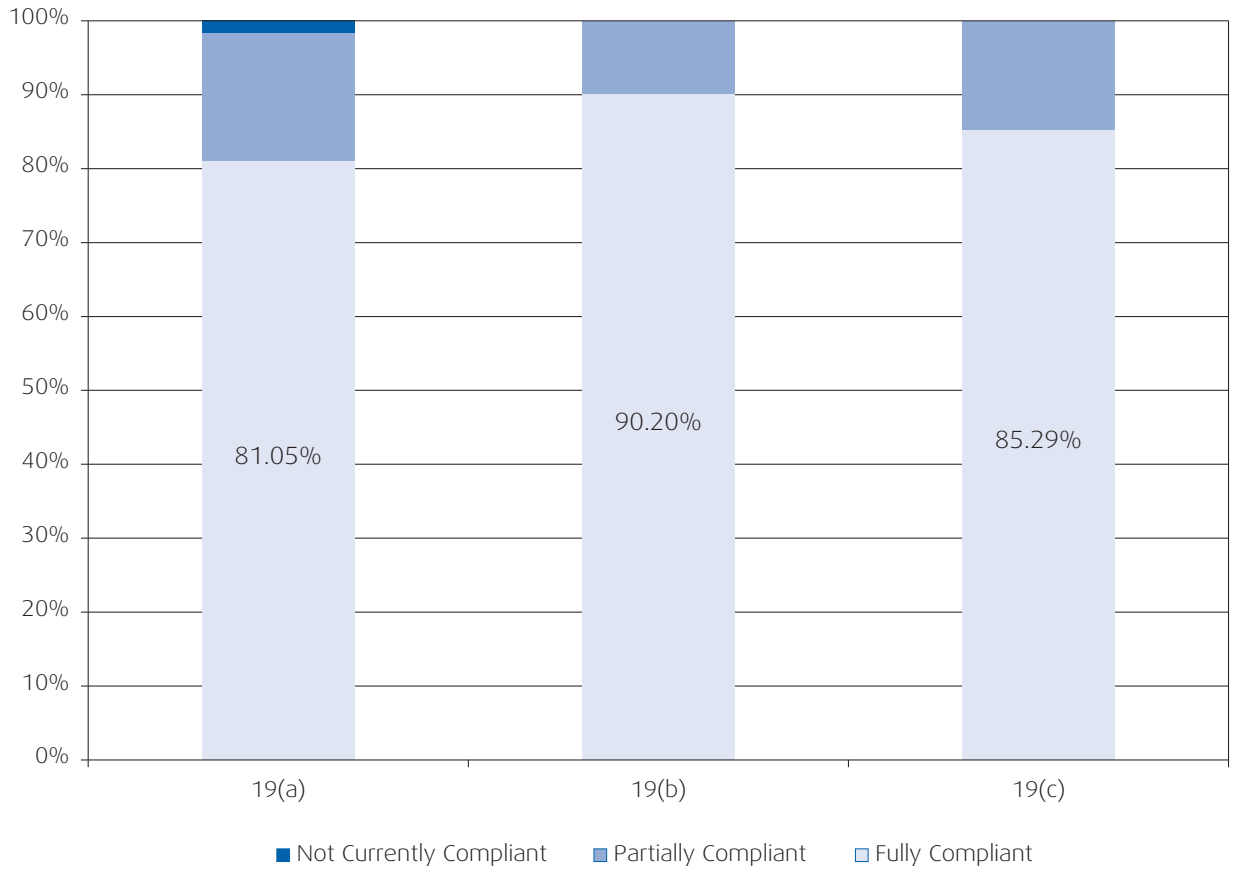
Members reported full compliance with 86.5% of the self-assessment questions, a slight increase on the 86% compliance reported in the previous year.[153] This continues the upward trend in compliance from previous years, from 79.5% full compliance in 2013–14 and 82.8% full compliance in 2014–15. Reported non-compliance fell from 1.8% in 2015–16 to 1.6% this year.

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. Table 4 shows the compliance NPM members reported with each of these powers.

**152.** 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 21/08/17]. 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 21/08/17].

**153.** The percentages reported in this section are calculated using the responses provided by the 17 members that completed the self-assessment (rather than on the basis of the 21 total members).

Table 4: 2017 Article 19 compliance




As in previous years, NPM members reported the highest level of compliance with powers to make recommendations. Members have reported steady increases in the power to examine the treatment of those deprived of their liberty, up from 80.84% compliance in 2015–16, 76.1% compliance in 2014–15 and 73.77% compliance in 2013–14.

### Specific findings

- All members reported that they were fully compliant across several questions, including 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), and having a mechanism for urgent action procedures (Q 1.45). Members continued to report full compliance with the requirement to ensure that any confidential information acquired during their work is protected (Q 1.56).
- Progress was reported for the third consecutive year in the area of gender balance and representation of ethnic and minority groups in visiting teams (Q 1.17). However, 11 NPM members remain only partially compliant in this area.
- 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); act upon information which gives rise to concerns about possible reprisals received from others (Q 1.40); and seek to ensure that a disciplinary or criminal investigation is initiated in cases of alleged reprisals (Q 1.42).
- Other questions with the lowest levels of compliance reported were whether the NPM has: 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 a strategy that includes cooperation on follow-up of cases of suspected or documented torture or ill-treatment (Q 1.50).
- Organisations based in Northern Ireland were the most positive about their compliance, reporting 92.7% full compliance, compared with members from England who reported the lowest level of full compliance at 79.1%.
- As in previous years, lay bodies reported a higher level of full compliance (89.2%), compared with professional bodies (85.5%).

### Conclusion

The findings of the self-assessment are presented to the NPM membership each year at the business meeting following the completion of the analysis. Members then discuss the findings in order to develop actions to be taken in areas that require further progress, both at the level of individual organisations and for the NPM as a whole. Discussions this year are expected to focus on sanctions and follow up of cases of suspected or documented torture or ill-treatment.

Section four

# Looking ahead to 2017–18

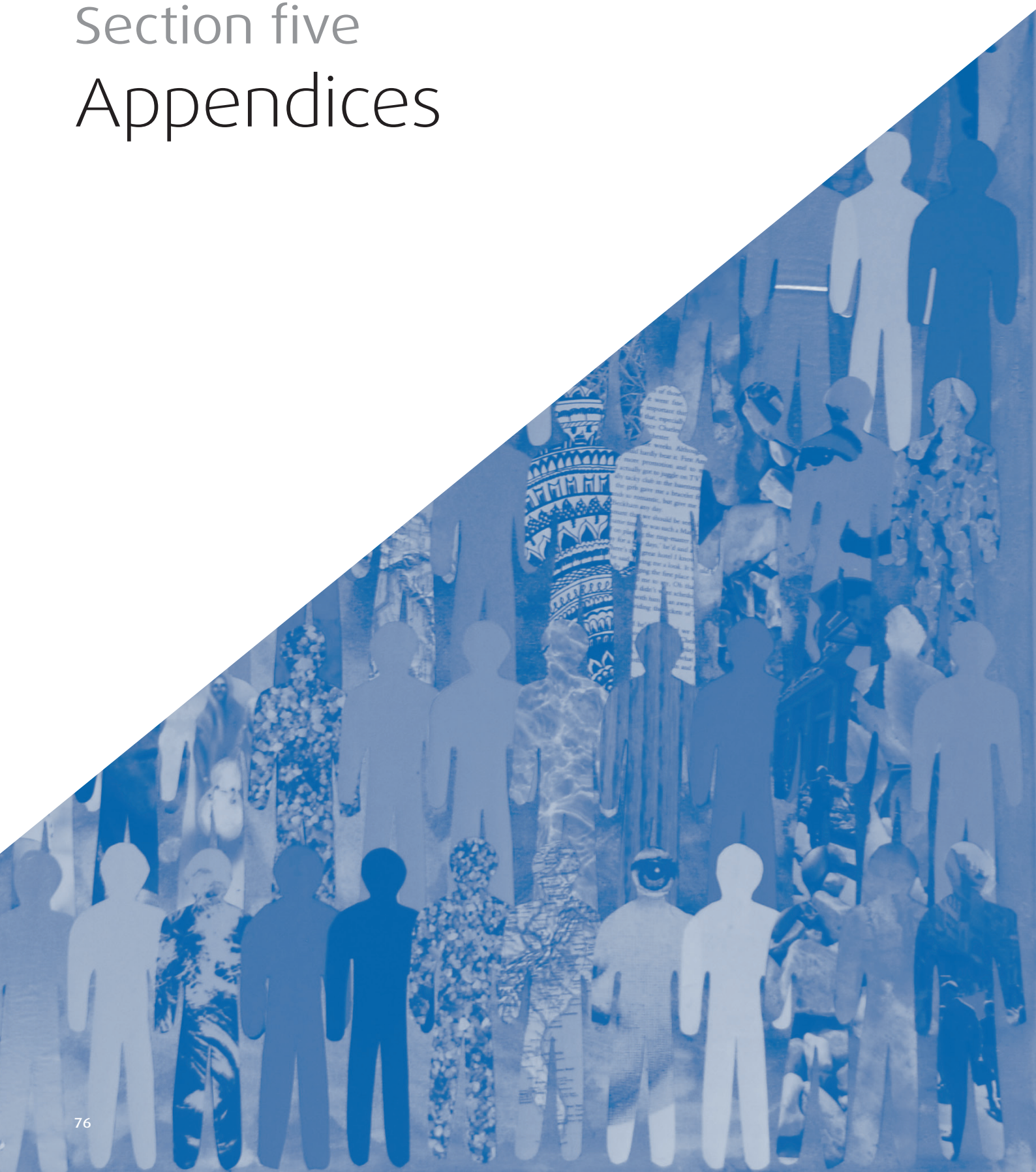
National Preventive Mechanism (NPM) members agree a revised strategic plan each year. The NPM has agreed the following objectives for its work in 2017–18.

- Work together with all members of the NPM to strengthen the protection of those in detention in the UK.
- To build an NPM that is effective in delivering all the requirements of the United Nations' Optional Protocol to the Convention Against Torture (OPCAT).
- To ensure each NPM member delivers its own responsibilities under OPCAT.
- To increase the visibility and awareness of the prohibition of ill-treatment in detention, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, OPCAT and the role of the NPM in prevention.

Specific projects that the NPM will undertake during the year include the following.

- Provide training to NPM members and others on the NPM's guidance on isolation in detention.
- Undertake a second detention mapping exercise, to identify the number of people detained in the UK at a given time.
- Continue the NPM's thematic project on the transitions and pathways between different types of detention, which focuses on: pathways from police custody arising from mental health issues; transitions between children's and adults' custodial provision; pathways between secure mental health settings; pathways between prisons/IRCs and mental health settings.
- Carry out work to determine the scope of the third thematic project to be undertaken by the NPM.
- Submit to the United Nations Committee against Torture's periodic review of the UK.
- Continue work to strengthen NPM governance and OPCAT compliance, working closely with government officials to achieve this.

# Section five
# Appendices



# Appendix I

## Letter from NPM Chair to Director of Judicial, Rights and International Policy at the Ministry of Justice, January 2017

UK National Preventive Mechanism
c/o HM Inspectorate of Prisons
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13 January 2017

Scott McPherson
Director of Judicial, Rights, and International Policy
Ministry of Justice
102 Petty France
London SW1H 9AJ

Dear Scott,

When we met in August 2016 we discussed my initial impressions of the NPM as its newly appointed independent chair. After eight months in my role as NPM Chair I have had opportunity to meet with all members of the NPM, shadow a number of visits or inspections of places of detention with members, as well meet as many of its stakeholders in the UK and international bodies (including several members or ex-members of the SPT and the CPT).

As a result I have been able to review the extent to which the UK NPM's structure complies with the requirements of OPCAT, taking into account the advice provided by the SPT to NPMs.[1] As you know from our initial discussion, the UK NPM's lack of legislation setting out both the mandate of the NPM itself and its constituent bodies, is a concern to us. It also troubles me that there are no statutory guarantees of independence for the NPM or its twenty members, and that the NPM does not have a separate budget.

My initial impression after spending time with members and meeting external stakeholders makes me concerned that these have a number of real consequences, as follows:

1. It clearly undermines the UK's formal compliance with OPCAT and the SPT's subsequent guidance and were the SPT to conduct a visit to the UK, we would be strongly criticised.
2. The UK government promotes the UK NPM around the world, yet our credibility is quickly questioned when other States learn of our lack of legislation.
3. Unless the NPM is incorporated into members' statutory requirements it affects the delivery of the NPM's overall mandate in practice, as many of its members' functions are much wider than their specific NPM mandate and this particular function may not always be a priority for them. Currently, the NPM role could be expressed merely as an aim in an organisation plan that is subject to change from year to year.
4. The NPM itself should be accountable to parliament.[2,3] Parliament should set out in statute what is required of the NPM, so that it is able to hold the NPM to account for the mandate it has set out as well as its performance and finance. The absence of legislation also means the NPM is unable to lay its annual report in Parliament directly. It also hinders the ability of the NPM's stakeholders to hold them to account for their NPM work.
5. The NPM has a responsibility to assess how the government complies with its domestic and international human rights obligations relating to detention. Parliamentary accountability would provide the NPM with the appropriate independence from government to fulfil this role impartially.
6. The absence of a Parliamentary guarantee of the mandate and the independence of the NPM and its members can have a negative effect, allowing governments, particularly in times of austerity, to influence the critical approach that may sometimes need to be taken by them. A government could, in theory, decide to change the NPM and designation of members without the authority of Parliament.

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**1.** "The mandate and powers of the NPM should be clearly set out in a constitutional or legislative text", UN SPT, *Guidelines on national preventive mechanisms*, 9 December 2010 (CAT/OP/12/5); see also UN SPT, *Analytical self-assessment tool for NPMs*, 6 February 2012 (CAT/OP/1).

**2.** OPCAT Article 18(4): "When establishing national preventive mechanisms, States Parties shall give due consideration to the Principles relating to the status of national institutions for the promotion and protection of human rights." See also Office of the UN High Commissioner for Human Rights (OHCHR), 'Principles relating to the Status of National Institutions (The Paris Principles)'; OHCHR 'Belgrade Principles' on the Relationship between NHRIs and Parliaments. See also: http://www.ohchr.org/EN/NewsEvents/Pages/ParliamentsAndNHRIs.aspx

**3.** There are currently two legislative texts that refer to the NPM and OPCAT. The Police and Fire Reform (Scotland) Act 2012 (http://www.legislation.gov.uk/asp/2012/8/contents/enacted) refers explicitly to the SPT and OPCAT (s. 93–96). The Public Services Reform (Inspection and Monitoring of Prisons) (Scotland) Order 2015 which introduces reference to the SPT and OPCAT into the Prisons (Scotland) Act 1989 (http://www.legislation.gov.uk/ssi/2015/39/contents/made?article-3-2-c)

7. The lack of a separate budget for the NPM, and in particular its coordination functions, compromises the NPM's financial and operational autonomy and inhibits the conduct of its affairs. NPM members are unable to guarantee the stability of their NPM work from year to year because of the discretionary way their budgets are set. The current informal arrangement between the Ministry of Justice and HM Inspectorate of Prisons, through which a nominal amount for NPM coordination is included in the overall HMIP budget, is unsuitable for a multi-body NPM requiring complex coordination.

These concerns have been put clearly into relief by the SPT's recent report on the similar, multi-body NPM in the Netherlands.[4] This report, published after the SPT's visit to the Netherlands in July 2015, raises a number of concerns which are directly applicable to the UK NPM. I have enclosed a complete copy of the report.

In particular, the SPT clearly sets out the need for the mandate of a multi-body NPM to be set out in legislation:

> *"While acknowledging the existence of legal provisions providing the foundational basis for each individual institution within the NPM, a striking weakness in the current functioning of the NPM is the absence of a separate legislative text regulating NPM-specific functions, an NPM mandate, the relationship between NPM members and other bodies [...], and other issues that ought to be regulated, in line with part IV of the OPCAT."* (paragraph 24)

And,

> *"While the institutional format of the NPM is left to the State Party's discretion, it is imperative that the State party enact NPM legislation which guarantees an NPM in full compliance with OPCAT and the NPM Guidelines. Indeed, the SPT deems the adoption of a separate NPM law as a crucial step to guaranteeing this compliance [...]."* (paragraph 26)

In addition, the SPT identifies difficulties for an NPM made up of inspectorates that perform NPM functions as part of their broader remit and recommends that their NPM functions be segregated and performed autonomously (paragraph 38). Finally, the SPT reiterates its recommendation that the NPM should have a separate budget line in the State budget, to ensure its continuous financial and operational autonomy (paragraph 27).

It seems to me that this report by the SPT could have easily been written about the UK's NPM: I believe that our system has many of the very same flaws. The NPM enjoys good cooperation between most NPM members, but where this works it is because of goodwill rather than any formal requirement or accountable structure. As far as I am aware, the Dutch and the UK NPMs are the only NPMs anywhere in the world that do not have the necessary

**4.** UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Visit to the Netherlands for the purpose of providing advisory assistance to the national preventive mechanism: recommendations and observations addressed to the State party. Report of the Subcommittee. (CAT/OP/NLD/1).

legislation. I understand that the SPT raised concerns about the UK's early plans to designate an NPM without legislation, and so I believe that we could, properly, be strongly criticised for not having addressed this issue.

In light of the above, I would like us to discuss these issues further at our next meeting. I think it would be helpful for us to develop a "roadmap" for the UK as the SPT suggested for the Netherlands, to make sure we can continue to enjoy our international standing and continue the efforts already made to strengthen our contribution to the prevention of ill treatment in detention.

We obviously do not have control over when the SPT might choose to visit the UK but in any event I will, at some point, need to raise these issues directly with the SPT and with the United Nations Committee Against Torture in advance of the examination of the UK's periodic report later this year.

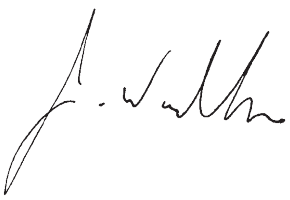
Regarding NPM legislation, I would like to propose the following:

- A legislative opportunity to establish the mandate of the UK NPM and its independence should be identified and pursued (perhaps in the proposed Prisons Bill). At the same time, we should establish whether separate devolved legislation or a consent mechanism would be needed for devolved administrations.
- This should include both the core NPM functions, and a duty on the named NPM members to cooperate with each other and with the NPM itself in performing the overall NPM role (with a power of the Secretary of State to add or remove members by statutory instrument);
- Opportunities for individual NPM members to include their responsibilities under OPCAT by amendment in their legislation to be sought during the current Parliament; and
- A recognition of HMI Prisons' role under OPCAT be included in the Prisons Bill currently being drafted, which is particularly important for its own credibility given its coordination role for the NPM.

As discussed at our last meeting, we plan to publish this letter when appropriate.

I look forward to discussing with you soon,

Yours sincerely,



John Wadham
Chair
UK National Preventive Mechanism

# Appendix II

## Glossary

| | |
|---|---|
| APT | Association for the Prevention of Torture |
| CCE | Children's Commissioner for England |
| CI | Care Inspectorate |
| CJINI | Criminal Justice Inspection Northern Ireland |
| CPT | Committee for the Prevention of Torture (Council of Europe) |
| CQC | Care Quality Commission |
| CRC | Convention on the Rights of the Child |
| CSSIW | Care and Social Services Inspectorate Wales |
| DoLS | Deprivation of liberty safeguards |
| ECHR | European Court of Human Rights |
| FCO | Foreign and Commonwealth Office |
| HIW | Healthcare Inspectorate Wales |
| HMICFRS | Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services |
| HMICS | Her Majesty's Inspectorate of Constabulary in Scotland |
| HMI Prisons | Her Majesty's Inspectorate of Prisons |
| HMIPS | Her Majesty's Inspectorate of Prisons for Scotland |
| HMP | Her Majesty's Prison |
| HMPPS | Her Majesty's Prison and Probation Service |
| ICVA | Independent Custody Visiting Association |
| ICVS | Independent Custody Visitors Scotland |
| IMB | Independent Monitoring Board |
| IMBNI | Independent Monitoring Boards (Northern Ireland) |
| IRC | Immigration removal centre |
| IRTL | Independent Reviewer of Terrorism Legislation |
| JCHR | Joint Committee on Human Rights |
| LO | Lay Observers |
| MHA | Mental Health Act 1983 |
| MoJ | Ministry of Justice |
| MWCS | Mental Welfare Commission for Scotland |
| NGO | Non-governmental organisation |
| NIPBICVS | Northern Ireland Policing Board Independent Custody Visiting Scheme |
| NOMS | National Offender Management Service |
| NPM | National Preventive Mechanism |
| NPS | New psychoactive substances |
| OSCE | Organization for Security and Co-operation in Europe |
| Ofsted | Office for Standards in Education, Children's Services and Skills |
| OPCAT | Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment |

| | |
|---|---|
| PACE | Police and Criminal Evidence Act 1984 |
| PSI | Prison Service Instruction |
| PPO | Prisons and Probation Ombudsman |
| PSO | Prison Service Order |
| RQIA | Regulation and Quality Improvement Authority |
| SHRC | Scottish Human Rights Commission |
| SPT | United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment |
| SCH | Secure children's home |
| STC | Secure training centre |
| YJB | Youth Justice Board |
| YOI | Young offender institution |

# Appendix III

## 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.

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The image used in this report is a detail from *Inside out*, a mixed media artwork by a detainee at the Atkinson Secure Unit, a secure children's home (copyright © 2018 The Koestler Trust, all rights reserved).
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