Monitoring places of detention

Fourth **Annual Report** of the United Kingdom's National Preventive Mechanism **2012–13**

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Fourth annual report of the United Kingdom's National Preventive Mechanism

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Her Majesty's Chief Inspector of Prisons

Around the world, individuals deprived of their liberty are particularly vulnerable to ill-treatment – whether deliberately or resulting from neglect. Prisoners and other detainees rely on staff for their safety and most basic necessities, all too often they are held hidden from independent view and the characteristics that led to their detention may undermine their credibility if they complain.

The insight of those who drafted the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (OPCAT), and to which the UK became a signatory in 2003, was that a remedy against such ill-treatment was the regular visits of an independent body who could report on what they found and make recommendations for improvement. OPCAT requires each state party to establish a mechanism to undertake such visits, known as the National Preventive Mechanism or NPM.

The UK has a particularly complex NPM structure made up of 18 different bodies that reflect the different political, legal and administrative systems in England, Northern Ireland, Scotland and Wales and an existing long-established network of organisations covering a wide range of different types of detention. The UK NPM is coordinated by HM Inspectorate of Prisons (England and Wales).

All the places of detention within the NPM's remit were under financial pressure during the year, as were the NPM members themselves, and most faced a rapidly changing policy environment. How NPM members responded to these challenges and what they found during their inspections and visits are detailed in their individual annual reports. The challenge for the NPM overall, with its very limited central coordination resource, was to ensure its work as a whole was consistent and comprehensive.

Consistency was addressed through the regular sharing of information and practice at business meetings attended by all members and the continuing development of a small steering group to take forward work between the main business meetings. A separate sub-group on children was established to coordinate work and share best practice. Six key themes emerged, common to many forms of detention, where consistent basic principles should apply and which should be high on the list of priorities for all NPM members:

- the importance of learning, sharing and applying lessons from deaths in all sorts of custody as part of a preventive mandate
- identifying and applying common principles for monitoring the use and governance of restraint
- applying international human rights

standards and norms on solitary confinement to policy and practice, looking specifically at how segregation, separation and seclusion in places of detention may undermine these standards
- the recognition and monitoring of 'de facto' detention as relevant to the OPCAT mandate in the UK, and calling for effective processes to be in place to prevent abuse where it occurs
- protecting prisoners and detainees from reprisals or sanctions for cooperating with any part of the NPM
- ensuring that the treatment of children adheres to the Convention on the Rights of the Child wherever they are held.

In each of these areas we will look to establish common understanding, joint working where appropriate and comment on policy and proposed legislation in accordance with OPCAT Article 19 (c).

The need to ensure the NPM's work is comprehensive, and that all places of detention receive regular preventive visits, was underlined by the revelation of horrific abuse at the Winterbourne View Hospital for young adults with learning difficulties in 2011 and 2012 and the failure of the preventive mechanisms in place at that time. The start of court custody inspections and the second year of overseas escorts monitoring revealed some embedded bad practice that had become established in the previous absence of systematic inspection and monitoring. In 2013–14 we will work to identify and address any other type of detention that is not subject to independent statutory visiting.

In April 2014 the NPM will mark the five year anniversary of its designation in the UK. We look forward to working with all NPM members and others concerned with the prevention of cruel, inhuman and degrading treatment of those in detention, to reflect on the progress that has been made in this initial period and consult on our future priorities.

Nick Hardwick
Her Majesty's Chief Inspector of Prisons

Section one
Context

About the Optional Protocol to the Convention Against Torture (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. During such visits, the treatment of and conditions for detainees are monitored.

States that ratify OPCAT are required to designate a 'national preventive mechanism' (NPM). This is a body or group of bodies that regularly examine 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 and who are sufficiently diverse to represent the community in which it operates.

Additionally, the NPM must have the power to:

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

The NPM must also liaise with the Subcommittee on Prevention of Torture (SPT), an international body established by OPCAT with both operational functions (visiting places of detention in States parties and making recommendations regarding the protection of detainees from ill treatment) and advisory functions (providing assistance and training to States parties and NPMs). The SPT is made up of 25 independent and impartial experts from around the world, and publishes an annual report on its activities[1].

The UK's National Preventive Mechanism (NPM)

The UK ratified OPCAT in December 2003 and designated its NPM in March 2009. Designation of the NPM was the responsibility of the UK government and it chose to designate multiple, existing bodies rather than create a new, single-body NPM. This took into account the fact that many types of detention in the UK were already subject to monitoring by independent bodies, as envisaged by OPCAT, and the different political, legal and administrative systems in place in the four nations that make up

[1]http://www2.ohchr.org/English/bodies/cat/opcat/annual.htm

the UK. In designating existing bodies as members of the NPM, the government explicitly required that they have a statutory basis and be able to make unannounced visits to places of detention. The government concluded that 18 bodies operating in England, Wales, Scotland and Northern Ireland met those requirements, and they were formally designated in a statement to Parliament on 31 March 2009. During 2012–13, the members of the NPM were:

England and Wales

Her Majesty's Inspectorate of Prisons (HMIP)
Independent Monitoring Boards (IMB)
Independent Custody Visiting Association (ICVA)[2]
Her Majesty's Inspectorate of Constabulary (HMIC)
Care Quality Commission (CQC)
Healthcare Inspectorate Wales (HIW)
Office of the Children's Commissioner for England (OCC)
Care and Social Services Inspectorate Wales (CSSIW)
Office for Standards in Education, Children's Services and Skills (Ofsted)

Scotland

Her Majesty's Inspectorate of Prisons for Scotland (HMIPS)
Her Majesty's Inspectorate of Constabulary for Scotland (HMICS)
Scottish Human Rights Commission (SHRC)
Mental Welfare Commission for Scotland (MWCS)
Care Inspectorate (CI)[3]

Northern Ireland

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

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 Although the ICVA is listed as an organisation operating in England and Wales, its membership includes independent custody visitors who operate in Scotland (ICVS). It is anticipated that ICVS will be formally designated as a distinct member of the NPM in 2013.

3 The Care Inspectorate's detention monitoring role was formerly the function of the Scottish Commission for the Regulation of Care, or Care Commission. In April 2011, the Care Commission, the Social Work Inspection Agency and Directorate 6 of HM Inspectorate of Education became Social Care and Social Work Inspection Scotland (known as the 'Care Inspectorate'). It is anticipated that the Care Inspectorate will be formally designated as a member of the NPM in place of the Care Commission.

DETENTION SETTING	England	Wales	Scotland	Northern Ireland
Prisons	HMIP with CQC & Ofsted	HMIP with HIW	HMIPS	CJINI & HMIP with RQIA
	IMB	IMB		IMBNI
Police custody	HMIC & HMIP	HMIC & HMIP	HMICS	CJINI with RQIA
	ICVA	ICVA	ICVS	NIPBICVS
Court custody	HMIP	HMIP	HMIPS	CJINI
Children in secure accommodation	Ofsted (jointly with HMIP for secure training centres)	CSSIW	CI	RQIA
				CJINI
Detention under mental health law	CQC	HIW	MWCS	RQIA
Deprivation of liberty[4] and other safeguards in health and social care	CQC	HIW	CI and MWCS	RQIA
		CSSIW		
Immigration detention	HMIP	HMIP	HMIP	HMIP
	IMB	IMB	IMB	IMB
Military detention	HMIP & IMB	HMIP & IMB	HMIP & IMB	HMIP & IMB
Customs custody facilities	HMIC and HMIP	HMIC and HMIP	HMIC and HMIP	HMIC and HMIP

In addition, the Office of the Children's Commission for England (OCC) has the power to enter any setting where a child is accommodated or cared for, other than a private dwelling, and (with the child's consent) to interview the child in private. OCC has used this power to visit the youth justice secure estate, immigration settings and medium secure facilities.

The role of NPM coordination was assigned to HMIP and this function 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
- facilitating joint activities.

The NPM coordinator represents the interests of all members and the purpose of their role is to:

- liaise with all members of the NPM
- advise members on the effective implementation of OPCAT
- share information with members
- provide support on policy and human rights issues
- liaise with the SPT, other NPMs and external stakeholders
- prepare the annual report
- organise meetings and workshops.

Coordination is essential to the full and effective implementation of OPCAT in the UK, given the scale and complexity of the UK's unusual multi-body structure, and the fact that each member has a different mandate, power and geographical remit. At the same time, the independence of each individual

4 Deprivation of liberty legal safeguards apply only to England and Wales but organisations in Scotland and Northern Ireland visit and inspect health and social care facilities where people may be deprived of liberty.

NPM member must be respected, as well as their ability to set their own priorities for detention monitoring.

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 of, and conditions for detainees are published in the inspection or annual reports of each NPM member.

Political context and policy environment

The role and responsibilities of public bodies in the UK to protect the rights of those that fall within their care came repeatedly under the spotlight in 2012 and 2013. The publication of the public inquiry report into standards of care at Mid Staffordshire National Health Service Foundation Trust exposed a series of institutional failings that led to routine neglect of patients and failures to provide safe care[5]. Similarly, the psychological and physical abuse against people with learning disabilities that occurred at Winterbourne View private hospital came to light, demonstrating the shortcomings of existing accountability mechanisms in protecting the most vulnerable, or ensuring investigation into allegations of abuse[6].

Both of these shocking cases, although not focused specifically on places of detention, provided lessons for the UK NPM and its individual members. The importance of the UK NPM's preventive function is underscored by these examples, where monitoring and regulation failed those whose rights should have been protected. In response, the UK NPM has placed greater emphasis on ensuring coverage of all places of detention, as well as focusing its coordinated efforts on issues that have been insufficiently addressed to date.

UK-wide measures to limit public spending in 2012–13 have meant that the sectors NPM members inspect or monitor are operating with considerably reduced resources. Most NPM members have also seen their budgets reduce during the 2012–13 period. At the same time, a number of significant legislative developments and policy proposals affecting the sectors covered by the UK NPM have been introduced or are under discussion. In Scotland, the Police and Fire Reform Act radically changes the policing landscape, bringing eight police forces into one. A revised mental health strategy for Scotland brings a number of new commitments, and focuses attention on the rights of those with mental illness. In Wales, a Social Services and Well-being Bill was presented to the National Assembly in January 2013. The bill's imperative is to give people a stronger voice and real control over the social care services that they use. Regarding criminal justice, proposals for reviewing the organisation of the juvenile and women's custodial estate in England and Wales, as well as the 'transformation' of rehabilitation outcomes, were under discussion.

Overall, the total prison population in England and Wales fell from 87,868 at the end of March 2012 to 84,596 at the end of March 2013, a reduction of almost 4%. There was a 4% increase in people entering immigration

5 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013. Available at: http://www.midstaffspublicinquiry.com/report

6 http://www.southglos.gov.uk/Pages/Article%20Pages/Community%20Care%20-%20Housing/Older%20and%20disabled%20people/Winterbourne-View-11204.aspx

detention (28,735) and a 6% increase in those leaving immigration detention (28,761). Of those leaving immigration detention, 60% were removed from the UK. As of the end of March 2013, 2,853 people were in immigration detention, 6% fewer than the number recorded at the end of March 2012. In the first quarter of 2013, 37 children entered detention, a decrease of 16 on the first quarter of 2012. Projected figures for Scotland suggest an average daily prison population for 2012–13 of 8,300. The most recent figures available for Northern Ireland indicate a prison population of 1,774 in 2012. Due to earlier mis-recording of statistics, official published figures will not be updated until 2014.

In England, the population detained in hospitals under the Mental Health Act (MHA) at the end of March 2013 was 16,989, a slight decrease (3%) from the previous year. However, there were 50,408 detentions under the act during the year, suggesting that the duration of MHA detentions have fallen but their frequency increased[7]. In 2012–13 there were also 11,887 applications completed for deprivation of liberty under the (Deprivation of Liberty Safeguards (DoLS) framework introduced in 2009–10[8].This is a 4% increase on the 11,382 DoLS applications in 2011–12. In Scotland, there were 3,003 individuals subject to compulsory measures under mental health legislation in January 2013, around a third of whom were subject to community compulsory treatment.

There has been a major and increasing shift towards community measures since community compulsory treatment was introduced in 2005. There were 4,651 new episodes of compulsory treatment under mental health legislation in Scotland, a rise of around 3% from the previous year. Of these, 236 were admissions under criminal procedures. Only a quarter of all episodes of compulsion lasted for more than 28 days.

7 Health and Social Care Information Centre (2013) *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual Report, England, 2013.* 30 October 2013.

8 Health and Social Care Information Centre (2013) *Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England): Annual Report, 2012/2013.* August 2013

Section two
The fourth year

In 2012–13, all members of the UK NPM have continued to make regular visits to places of detention, monitor the treatment of, and conditions for, detainees and make recommendations to the relevant authorities.

In this NPM-wide annual report, we note the joint activities of the members, the development of NPM governance and coordination, and specific areas developed with a view to consolidating the implementation of OPCAT in the United Kingdom. Although we do highlight some member-specific developments of relevance to the fulfilment of the NPM role, the specific activities of NPM members, their findings and recommendations for action can be found in their individual annual reports.

NPM structure and coordination

In 2012–13, the UK NPM took steps to improve and consolidate its governance structure, as a means to strengthen the coordination of the joint and individual activities of the 18 members.

Business meetings

Biannual business meetings, attended by all members, continued as the main forum for sharing key findings, best practice, experiences and lessons from monitoring different types of detention and in different jurisdictions. Specific topics discussed at meetings in 2012–13 were:

- 'de facto' detention
- restraint and use of force
- deaths in custody and the roles of monitors and inspectors
- an event planned to mark five years since the UK NPM was designated
- the making of recommendations and their follow-up
- solitary confinement, segregation and isolation.

Steering group

Since the establishment of the NPM steering group in January 2012 – as a means to facilitate coordination and decision-making between biannual business meetings (see steering group terms of reference in Appendix 3) – its role has been developed and consolidated over the year. The steering group is made up of five members, including HMIP as coordinator of the NPM, and one representative of each of the four jurisdictions within the UK. The members of the steering group in 2012–13 were:

- Her Majesty's Inspectorate of Prisons (HMIP)
- Criminal Justice Inspectorate Northern Ireland (CJINI)
- Mental Welfare Commission for Scotland (MWCS)
- Health Inspectorate Wales (HIW)
- Independent Custody Visiting Association (ICVA)

Three meetings of the steering group were held in 2012–13, and served to develop an NPM business plan, as well as discuss strategic priorities and NPM responses to external requests. The steering group also took forward work reviewing how NPM members monitor recommendations.

Subgroup on children and young people

An important development during the year was the establishment of an NPM thematic subgroup focusing specifically on children and young people, proposed by the Office of the Children's Commissioner for England (OCC). NPM members with an interest in the rights of children and young people in detention began the process of establishing terms of reference and an agenda for future actions. The work of the subgroup is discussed in more detail later in the section (see Priority areas, p.21).

Member-specific developments

We provide here a brief overview of notable developments in the management, functions and approaches of NPM members of relevance to their compliance with OPCAT. Full reports on NPM members' specific activities, findings and recommendations can be found in their individual annual reports.

Institutional developments

The Care Inspectorate (CI) in Scotland moved to a national and specialist team structure to include teams for young people and criminal justice. The CI will be formally designated as a member of the NPM next year.

In April 2012, the Care and Social Services Inspectorate Wales (CSSIW) launched a new enforcement process, which included measures for expediting and escalating the process where urgent and/or serious failings are identified. This will strengthen CSSIW's ability to identify and respond to concerns similar to those encountered in Mid Staffordshire health services, should they arise. CSSIW's wide-ranging modernisation programme includes inspections of regulated services focusing on four quality themes, including 'the quality of life' which looks at rights, control and well-being. It also adopts the use of the Short Observational Framework for Inspection (SOFI), particularly in inspections where there are people with cognitive or communication difficulties.

The Care Quality Commission (CQC) made significant changes to its executive and Board-level leadership, and started on a reorganisation of regulatory and monitoring activities.

In October 2011, the Review of the Northern Ireland Prison Service by the Prison Reform Team (chaired by Dame Anne Owers) was published[9], which made 40 recommendations for fundamental change to the Northern Ireland Prison Service. Since then, CJINI have continued to assess and report on progress to the Oversight Group chaired by the Minister for Justice. Progress has been made and a number of recommendations have been implemented, but some of the recommendations refer to longer-term issues and CJINI will continue to assess developments over time[10].

Monitoring mental health detention

Work to help people receiving mental health and learning disability services know more about their rights, especially when being treated under compulsory powers, was taken forward by the MWCS and the Scottish Human Rights Commission (SHRC), in partnership with the Scottish Government and others. This included a special focus on parents detained under mental health legislation. Though Scottish mental health law requires hospitals to mitigate the effects of detention on parent relations, MWCS found staff did not understand their responsibilities. As a result, MWCS made several recommendations on improving parent's contact with their children.

MWCS examined whether individuals with learning disabilities receiving intensive ongoing community support may be being deprived of liberty unlawfully or excessively and conducted research on the issue. They found little evidence of this and were able to report favourably on some very good care.

9 http://www.dojni.gov.uk/index/ni-prison-service/nips-publications/independent-reports-reviews-nips/owers-review-of-the-northern-ireland-prison-service.htm

10 Summaries of these reports can be found at: http://www.dojni.gov.uk/index/ni-prison-service/nips-prison-review-oversight-group-reports.htm

The CQC began the process of improving links between its work under the Mental Health Act and its regulation of mental health services. This was with a view to protecting the rights of those in vulnerable circumstances, particularly those who, because of concerns about their safety and the safety of others, have had their freedom restricted by being detained and treated against their will. This will mean greater alignment of Mental Health Act activity and inspection visits and more involvement of Experts by Experience[11] in Mental Health Act monitoring.

To inform its role in monitoring detention in health and social care as part of the NPM, the CQC commissioned a comparative review of international monitoring mechanisms from the University of Bristol Human Rights Implementation Centre. The research commissioned will help the CQC understand the experiences of other countries in monitoring their mental health legislation, with a view to developing its own functions on the basis of international evidence and knowledge about best practice. This report will be made public in the next reporting period.

Case study

Taking action to improve monitoring of services caring for people with learning disabilities

Following the government's response to failings at Winterbourne View Hospital, the CQC has dedicated special attention to services caring for people with learning disabilities. Building on its awareness of continuing problems with the quality of care for people with learning disabilities, including lengthy stays in hospital away from their families and communities, the CQC has begun working with the Joint Improvement Team funded by the Department of Health and the Local Government Association with the aim of supporting commissioner assessments of all people with learning disabilities currently in the system.

Throughout 2012–13, the CQC continued to develop its approach to monitoring deprivation of liberty safeguards (DoLS) in hospitals and care homes. In January 2013, CQC published its third annual report on monitoring DoLS, and its fourth annual report will combine activity data about the use of safeguards from the Health and Social Care Information Centre (HSCIC), and information gathered from two surveys: one of organisations providing independent mental capacity advocate services, and another of local authorities in their role as supervisory bodies. A new mental capacity act policy manager will provide a specialist focus on CQC's monitoring work in this area.

11 Experts by Experience have personal experience of using or caring for someone who uses mental health services. In the context of Mental Health Act monitoring, Experts by Experience will have experience of detention under the Mental Health Act.

Prison monitors in Scotland

The advantages of a layered detention monitoring system – whereby lay monitors and professional inspectorates complement each other with different approaches to monitoring the same institutions – were set out in the NPM 2011–12 annual report. In 2011, the Scottish Government announced that it was going to abolish prison visiting committees. The NPM urged the Scottish Government to ensure that these proposals would not reduce protection for prisoners, and took into account OPCAT obligations. In response, the Scottish Government commissioned a review of proposals for prison monitoring, including their compatibility with OPCAT, to be conducted by Professor Andrew Coyle, Professor of Prison Studies at King's College, London. This review, published in January 2013, set out specific recommendations to ensure that future monitoring arrangements would be independent[12]. It recommended that:

- visiting committees be replaced by a new system of voluntary independent prison monitors, to be appointed through a transparent process, for specified periods and with a clearly defined role, with appropriate training, resources and support provided from sources other than the Scottish Prison Service
- monitors for each prison should submit an annual report to Scottish Ministers for publication
- a council of independent prison monitors should be formed, composed of one monitor from each prison
- visiting committees for the nine sets of legalised police cells should be abolished and their functions transferred to independent custody visitors.

The UK NPM was supportive of the Coyle review and urged the Scottish Government to consider implementing the recommendations made in order to ensure OPCAT compliance.

The Scottish Government responded with its intentions to reform the independent monitoring of prisons to ensure the best outcomes, while meeting OPCAT obligations. Its decision was that Her Majesty's Chief Inspector of Prisons for Scotland (HMCIPS) should oversee independent monitoring of prisons in the future. This, it affirmed, would provide an opportunity to integrate inspection and monitoring effectively, in a way that preserves the distinct (though complementary) functions of both. The Scottish Government also pointed to enhanced national leadership, and impact and profile of monitoring, given the Inspector's long-established independence and access to Ministers, Parliament and the media, as benefits of the new arrangement.

The Scottish Government proposed that to implement the new model, HMCIPS should employ four part-time prison monitors, supported by lay monitors, attached to each prison and representing the community. In overseeing the monitoring function, HMCIPS would be supported by an advisory group made up of key stakeholders from the justice sector and would provide guidance on monitoring, appointments and training.

Pilot study on recording the use of force by the Metropolitan Police Service

Following a request by the Ministerial Board on Deaths in Custody, the Independent Custody Visiting Scheme in London negotiated with the Mayor's Office for Policing and Crime (MOPAC) for its visitors to conduct a one-month pilot survey to look at how effectively use of force

12 The Scottish Government. *Review of Proposals to Improve Arrangements for Independent Monitoring of Prisons* (The Coyle Review), January 2013. At: http://www.scotland.gov.uk/Resource/0041/00414197.pdf

was being recorded by the Metropolitan Police Service (MPS). The request arose from concerns that information on use of force in MPS custody suites is not collated at local or force-wide level (since a 2010 government directive aimed at reducing bureaucracy eliminated the requirement to record use of force/restraint in standard or centralised form). The pilot study was conducted during existing weekly unannounced inspections by independent custody visitors through a questionnaire. Two-hundred and fifty-two questionnaire returns were received from 400 interactions with detainees. In 145 of these cases, restraints had been used, with handcuffs being the most severe form of restraint in 127 cases. Twenty-three injuries as a result of restraint had been recorded. On nine occasions where restraint had been used, no record had been made in the custody record. In five cases where injury had been sustained during restraint, there was no record of what treatment was given.

It has been recommended that a further survey be conducted over a longer period of time and across a wider number of police areas.

Ensuring full coverage of all places of detention, OPCAT Article 4.2

The UK NPM seeks to ensure that all places of detention in the UK are visited in line with the provisions of OPCAT. This requires continuous attention to changes in policy and legislation affecting both detention practices and the mandates of NPM members. New developments during the year include:

- visits to children and young people in medium secure units by the OCC (England)
- monitoring of secure homes for children and other people by the CI (Scotland)
- agreement to bring 'non-designated' police cells in Northern Ireland into the remit of the Northern Ireland Policing Board Independent Custody Visiting Scheme (NIPBICVS)
- inspection of court custody facilities in England and Wales by HMIP
- monitoring of overseas escorts by Independent Monitoring Boards (IMBs) and HMIP (UK).

The OCC began conducting visits to medium secure units (national secure forensic units) which provide inpatient forensic mental health treatment to children and young people aged between 12 and 19. Announced visits were carried out in four units, and the OCC were generally impressed with the standards of care and treatment of young people. They found education to be of high quality and believed the welfare-based and therapeutic approaches used would be beneficial in other detention settings. Recommendations to improve practice further were made in the following areas: informing young people about their rights; being vigilant to overt and covert bullying and encouraging young people to report it; ensuring access to core training for all staff; standardising language and practice relating to seclusion; and practice relating to transfers into and out of high-care environments across the units.

As part of its new remit, the CI began to monitor secure homes for children and young people as well as other residential services in Scotland.

In February 2013, the third NPM annual report made a formal recommendation to the Minister of Justice for Northern Ireland to legislatively bring non-designated police cells in Northern Ireland within the remit of the NIPBICVS. This recommendation was

given the full support of the Northern Ireland Policing Board and the Department of Justice (NI) has agreed to look into implementing the necessary legislative amendment required during 2014–15. In the interim, the NIPBICVS continues to monitor the number and location of detained persons held within non-designated custody suites. After identifying in 2011 that there was no independent inspection or monitoring of court custody facilities in England and Wales – in Scotland and Northern Ireland these are inspected by HMIP Scotland (HMIPS) and the CJINI – the Ministry of Justice asked HMIP to develop a programme for the inspection of these facilities. This began in 2012. In line with its existing inspection methodology, HMIP developed a set of Expectations, which describe the standards of treatment and conditions that each court custody suite should achieve for people in its custody. These are grouped under three inspection areas: leadership, strategy and planning; individual rights; and treatment and conditions. The focus is on outcomes rather than processes.

From 2012–13, HMIP completed inspections in Crown Courts and magistrates' courts with custody facilities in four regions: Cleveland, Durham and Northumbria, Merseyside and Cheshire, Lancashire and Cumbria, and Nottinghamshire and Derbyshire. A general trend in the findings was that court managers from Her Majesty's Courts and Tribunals Service, often lacked awareness of how cells were run and how detainees were treated. HMIP also noted a lack of clarity about who should take responsibility for detainee care arising from contractual arrangements between the National Offender Management Service Prisoner Escort and Custody Services and court custody and escort contractors.

Case study – court custody facilities

The inspection of Cleveland, Durham and Northumbria included visiting four Crown Court and 12 magistrates' court buildings with active custody suites in the region. This first full inspection of custody suites in a court area revealed custody staff who did their best to take care of detainees, in conditions which were, in many cases, poor, and with underdeveloped approaches to assessing and managing risk and to meeting legitimate needs. Improvements to buildings will require capital spends, but there is much that can still be done. The inspection found that:

- Detainees were sometimes held for relatively long periods before their case was heard because courts gave priority to other cases, or afterwards because it took time for prisons to confirm there was no other bar to release. It was welcome, however, that courts did not have cut-off times.
- In most places, detainees were not given clear information about their rights or how to make a complaint, and the telephone interpreting service had almost never been used.
- The physical condition of the cells area was deplorable at one particular facility, and poor at four other sites. In several places, detainees were not kept out of public view when handcuffed, especially when disembarking from vans and, for those with disabilities in particular, when being taken to or from court.
- Staff were generally helpful and polite to detainees, although many treated frequently-seen faces as needing little individual attention.

- The information coming in with detainees was generally good. While considerable care was taken with some vulnerable detainees, a thorough initial risk assessment was lacking.
- Women and children were not always kept appropriately separate from the main detainee population, in vans or in the cell areas, and there was limited provision for those with disabilities or faith-related needs.
- Searching and handcuffing procedures were a matter of routine rather than related to risk, and were not always consistent; some of the handcuffing raised safety issues. There was little use of force.
- Mental health services to the custody suites were good, including post-custody follow-up in the south of the area, and a scheme being piloted in the north where staff accompanied detainees to court.

The full inspection report can be found at: http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/court-custody-facilities-inspections/cleveland-durham-northumbria-201

As reported in the last NPM annual report, the IMBs and HMIP began monitoring and inspecting overseas escorts in 2011. The need for independent monitoring of overseas escorts was evidenced by the tragic death of Jimmy Mubenga while being restrained by escort staff on board an aircraft during his deportation from the UK to Angola in October 2010.

To take forward this work, HMIP conducted three inspections of detainees under escort, to Afghanistan (June 2012), Ghana (March 2013), and Sri Lanka (Dec 2012). During the same period IMBs monitored three detainees under escort to Ghana, Nigeria and Afghanistan.

Findings suggested that on the whole, escort procedures were well organised and escorts dealt with detainees sensitively and effectively. However, concerns were raised that not enough was done to reduce stress for detainees, that there was disproportionate use of force and restraint, and examples of unprofessional behaviour by escorts who used very offensive language in front of detainees and others. Concerns about detainees experiencing aggressive behaviour by home officials on arrival in their destination country, as well as the lack of information on their home country to help prepare for return, were also expressed. HMIP was also concerned that there were no recognised safe procedures for the use of restraint in the confined spaces of an aircraft.

Similarly to HMIP, IMBs reported examples of offensive language being used in front of detainees. They also found that the time taken between the detainee being discharged from the immigration removal centre and boarding their aircraft was excessive. However, on a more positive note, they observed a reasonably well-run operation, with a lot of attention being paid to detainees and their concerns, by both the immigration team and the overseas escort contractor.

Some of the recommendations made were:

- the UK Border Agency (whose responsibilities are now carried out directly by the Home Office) should ensure that escorting staff receive full accredited training for the use of force in any situation which may arise, especially on board an

aircraft – in the meantime, any ad hoc techniques used should be subject to rigorous management scrutiny to ensure safety and proportionality and used only for specific and risk-assessed reasons
- a UK Border Agency representative should be present during departure from the centre to address any last-minute immigration queries
- escort staff should undertake regular refresher child protection training, which should be agreed with the Local Safeguarding Children Board
- detainees should be at the centre of staff attention throughout the removal process
- staff should not make personal calls or text while accompanying individual detainees
- detainees should not be subject to repeated searching or long waits on coaches outside terminals
- all detainees should be told in a language they understand that they can call a legal adviser or other key contacts
- detainees should have enough medication to last until such time that they can reasonably see a health care practitioner at their final destination.

The UK NPM will continue to monitor the treatment of detainees being escorted overseas to ensure that they are being escorted safely and treated fairly under extremely difficult conditions, and ensure that recommendations are acted on.

Submitting proposals and observations on legislation, OPCAT Article 19(c)

In line with Article 19(c) of OPCAT, NPMs must have the powers to submit proposals and observations concerning existing or draft legislation. Over the year, NPM members have individually and collectively commented on a number of policy and legislative proposals relating to treatment in, and conditions of detention in their respective jurisdictions.

The NPM collectively submitted evidence to the Scottish Parliament Justice Committee's call for evidence on the Police and Fire Reform (Scotland) Bill – Chapter 16 (Independent Custody Visiting). The implications of the reforms around independent custody visiting in Scotland for compliance with OPCAT warranted a joint response from the NPM.

Individual NPM members have engaged in numerous policy and legislative processes, the main examples of which are set out as follows.

- CSSIW has supported the Welsh Government's Social Services and Well-being (Wales) Bill, introduced to the National Assembly for Wales on 28 January 2013, as it would give a stronger voice and real control to people using social care services.
- MWCS facilitated consultations over the future of the mental health tribunal in a proposed new structure, and also submitted its own recommendations. These were accepted by the Scottish Government and are now in the bill passing through the Scottish Parliament.
- MWCS also facilitated a review of the implementation of legislation allowing appeals against excessive security for people detained in hospitals other than the State Hospital. This led to proposals on which the MWCS has since offered its own comments.
- The CI has been closely involved with the Scottish Government and partner agencies in looking at the structure of Community Justice in Scotland and how changes will be implemented.

- The IMBs responded to the European Ombudsman's wide-ranging consultation on the operation of Frontex, making special reference to human rights infringements and the lack of a credible complaints procedure.
- The CQC laid before Parliament its third annual report on monitoring of the Mental Health Act, in January 2013. The report was widely referenced by the Health Select Committee in its post-legislative scrutiny of the Mental Health Act 2007[13].
- The Regulation and Quality Improvement Authority (RQIA) has have been working with the Department of Health, Social Services and Public Safety, which is preparing a draft Mental Capacity Bill for Northern Ireland, which will be put out for consultation next year.
- HMIPS provided evidence and comments to the Scottish Parliament Justice Committee on its annual report 2011–12, following up with further information on legalised police cells, as well as on the Prisons (Interference with Wireless Telegraphy) Bill (UK Parliament legislation), and the Scottish Government's draft budget scrutiny 2013–14 regarding the financing of the findings of the Commission on Women Offenders. It also took part in an evidence session on prison health care, and a Scottish Court Service consultation on *Proposals for a court structure for the future*.
- The SHRC made recommendations on Chapter 16 of the Police and Fire Reform (Scotland) Act, 2012, to ensure OPCAT compliance and give due consideration to the Subcommittee on Prevention of Torture (SPT) guidelines on NPMs when placing the independent custody visiting on a statutory footing (Section 91)[14].
- The OCC gave evidence to the House of Commons Justice Committee inquiry into the youth justice system of England and Wales and the House of Commons Home Affairs Committee's consultation on the draft Antisocial Behaviour Bill. It also responded to a consultation on the Mayor's Office for Policing and Crime, Police and Crime Plan 2013–17, a Department for Education consultation on local authority responsibilities towards children looked after following remand, and made a submission to the UN Committee Against Torture for its periodic review of the UK.
- HMIP gave evidence to Justice Select Committee inquiries into youth justice; female offenders; and older prisoners, as well as to the Independent Police Complaints Commission consultation into the way that deaths following police contact are investigated.

Priority areas

Sanctions (OPCAT Article 21)

At the first business meeting of 2013, it was decided that the issue of sanctions should be on the agenda of the UK NPM. 'Sanctions' refer to any punishment that may arise from a detainee having contact with an independent monitor. It is a broader term encompassing what is often referred to as 'reprisals', when punishment practices are inflicted by guards or detaining authorities against detainees who have reported to independent monitors[15].

13 http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/58402.htm
14 http://www.scottishhumanrights.com/publications/consultationresponses/article/policereformsubmission2012
15 Association for the Prevention of Torture (2012) 'Mitigating the risks of Sanctions related to Detention Monitoring' *Briefing No4.* At: http://www.apt.ch/content/files_res/Briefing4_en.pdf

Relevant OPCAT provisions on sanctions

Article 15

'No authority or official shall order, apply, permit or tolerate any sanction against any person or organisation for having communicated to the Subcommittee on Prevention or to its delegates any information, whether true or false, and no such person or organisation shall be otherwise prejudiced in any way.'

Article 21

'No authority or official shall order, apply, permit or tolerate any sanction against any person or organisation for having communicated to the national preventive mechanism any information, whether true or false, and no such person or organisation shall be otherwise prejudiced in any way.'

The SPT has made clear the obligation, under OPCAT, of States parties to ensure that reprisals do not occur following either their visits, or those conducted by NPMs[16,17]. Members have agreed that they should consider the arrangements they have in place to manage whistle-blowers and reprisals against detainees, staff or carers who communicate with them.

Although not believed to be a widespread problem in the UK, HMIP inspection evidence does suggest that there have been rare instances when prisoners/detainees have been subject to informal, unauthorised sanctions for engaging with inspection teams, or in an attempt to prevent such engagement. This is a particular concern for those prisoners who lack the competence to advocate on their own behalf.

The need to take preventive action against the issue of sanctions and have a clear response to any instances that do arise led to the decision that a protocol between the IMBs, HMIP and the Prisons and Probation Ombudsman should be drawn up. The protocol will set a broad principle for how these organisations will work together to protect any prisoner/detainee from sanctions or other prejudice should they, or someone acting on their behalf, communicate with them. It will provide reassurance that prisoners/detainees are able to freely communicate with each organisation without fear of sanctions or other prejudice. It is anticipated that when this protocol is complete it will be used as a template by other NPM members.

Children and young people

In acknowledgment of the specific challenges faced by children and young people in detention in the UK, and the need to share expertise and good practice among the NPM, a subgroup on children and young people was established in early 2013, chaired by the OCC.

16 Committee Against Torture (2013). *Statement of the Committee against Torture on reprisals,* adopted at its fifty-first session (28 October–22 November 2013). CAT/C/51/3. At: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT%2fC%2f51%2f3&Lang=en

17 Subcommittee on Prevention of Torture (2010) *Guidelines on national preventive mechanisms.* CAT/OP/12/5. At: http://www2.ohchr.org/english/bodies/cat/opcat/docs/SPT_Guidelines_NPM_en.doc

Children in detention in the UK are extremely vulnerable – by virtue of their age and capacity; their detained status; and in many cases, individual characteristics such as mental illness, neurodisability,[18] prior estrangement from parents/carers (for example, as a result of care proceedings or unaccompanied/separated migration to the UK) or experiencing abuse or neglect. They are detained in a variety of settings including youth justice custody, police detention, secure forensic mental health facilities, secure care, and, in the immigration context, at port, in short-term holding facilities and in immigration removal. Even within some of the individual categories there is much variation in the type of setting – with some being designed specifically for children (or, in immigration removal, families) and others adapted from an adult model.

NPM oversight for these settings is led by a number of different NPM members responsible for their inspection: in England alone, this includes HMIP and IMBs for young offender institutions, immigration detention and court custody; Her Majesty's Inspectorate of Constabulary (HMIC) and HMIP jointly for police custody; Ofsted and HMIP jointly for secure training centres; Ofsted for secure children's homes; the CQC for secure forensic mental health facilities and other child and adolescent mental health services[19]. The different lay visiting organisations again have responsibility for different institutions. Other NPM members, including the OCC, have a function that includes visits to different settings – but may not replicate the inspectorates' functions.

It is a complex picture and the NPM must meet the challenge of ensuring that cruel, inhuman and degrading treatment and punishment is prevented in all these settings. International law recognises the particular status, needs and vulnerabilities of detained children by specific guarantees that operate in addition to the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) and its Optional Protocol, and other general human rights treaties.

18 Office of the Children's Commissioner (2012) *Nobody made the connection: The prevalence of neurodisability in young people who offend.* London: Office of the Children's Commissioner. At: http://www.childrenscommissioner.gov.uk/content/publications/content_633

19 Ofsted and CQC have a role in inspecting education and health provision, respectively, in settings where another NPM member is the primary inspectorate.

International legal standards relevant to children and young people in detention

The body of international law relating to children in detention includes both guarantees specific to children – such as the right to be separated from adults in detention unless it is in his or her interests not to be – and enhanced versions of principles applying to adults, in recognition of children's need for special protection and treatment appropriate to their age. In relation to the prohibition on torture and cruel, inhuman or degrading treatment or punishment itself, it is recognised that treatment may be cruel, inhuman or degrading for a child when it would not necessarily be so for an adult.

The UN Convention on the Rights of the Child reproduces the UNCAT prohibition of torture and other cruel, inhuman or degrading treatment or punishment (TCIDT), and provides additional requirements for children in detention (Article 37):

- Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age
- The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time
- Children in detention shall be treated in a manner which takes into account the needs of persons of his or her age. They shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances
- The right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Other UNCRC rights that provide important safeguards against TCIDT include: the rights to life and optimal development; health; not to be separated from parents unless in the child's best interests; freedom from violence, neglect and abuse; and to have his or her views heard and given due weight in all matters affecting him or her (Articles 6, 24, 9, 12, 19).

Further standards have been developed in the following documents:

- UNCRC General Comment on the Treatment of Unaccompanied and Separated Children Outside their Country of Origin
- UNCRC General Comment on the Rights of Children in Juvenile Justice
- UN CRC General Comment on the Right to Freedom from All Forms of Violence
- UN Rules for the Protection of Juveniles Deprived of their Liberty
- UN Standard Minimum Rules for the Administration of Juvenile Justice ('Beijing Rules')
- CPT Standards for Juveniles Deprived of their Liberty
- Guidelines of the Committee of Ministers of the Council of Europe on child-friendly justice.

The nature of detention of children in the UK – in a variety of settings across the jurisdictions – makes it important for NPM members to consistently identify common challenges, share good practice and make recommendations. By focusing on the specific needs of children and young people in detention, the children and young people subgroup will support the NPM to fulfil its preventive role[20] through sharing good practice on visits and inspections, a holistic and system-wide analysis of the situations where children are at risk of ill-treatment, and making recommendations designed to improve policy and practice for children in detention.

The subgroup first met on 18 March 2013 and meets three times a year. It is chaired by the Deputy Children's Commissioner for England and reports to the NPM steering group. The terms of reference – discussed at the first subgroup meeting and subsequently approved by the steering group – can be seen in Appendix 4.

At its first meeting, the subgroup discussed a joint response to the Ministry of Justice's consultation paper *Transforming Youth Custody*[21], which proposed the creation of secure colleges for children in youth justice custody. This response was submitted in 2013, and greatly benefited from the expertise and range of experience of subgroup attendees and other NPM members. Future work of the subgroup will include thematic discussions around children's health in secure settings, segregation practices for children in detention, under-18s in police custody and children in immigration detention.

'De facto' detention

UK NPM members identified concern for the practice of de facto detention, where individuals who are not formally detained by law are deprived of their liberty in practice. With this come significant risks for individuals who do not enjoy a proper process for the review of their detention. The NPM identified a concern that those inspecting the conditions in which detention takes place may miss individuals who are de facto detained. Furthermore, general acceptance by professionals, carers and the public that such de facto detention is acceptable for some individuals because they cannot exercise choice may further jeopardise their human rights.

UK NPM members identified the following settings where individuals are at risk of being de facto detained, including mental health and learning disability hospital care general hospital care, care homes, children's homes and residential schools, and community settings, including shared and individual tenancies.

The definition of de facto detention is a complex one, in which the cumulative effect of several factors can constitute deprivation of liberty, where one factor alone may not. These factors include:

- whether the person is confined in a restricted space for a not negligible length of time
- whether the person has given valid consent to the confinement
- whether the state is responsible (for example, independent care homes may breach Article 5 of the European Convention on Human Rights if they

20 See guidance in: Association for the Prevention of Torture. *Optional Protocol to the UN Convention against Torture: Implementation Manual,* Chapter V – Operational Functioning of NPMs. At: http://www.apt.ch/content/files_res/opcat-manual-english-revised2010.pdf

21 See: http://www.justice.gov.uk/downloads/about/hmipris/npm-response-transforming-youth-custody.pdf

unlawfully detain an individual who has been placed there by, or with the permission of, a state authority)
- whether the person is free to leave
- duration of the measure
- physical restraint
- sedation
- contact with the outside world
- the overall purpose of measures to control or restrict the individual's movements
- whether there is relevant comparator.

In order to address these concerns, NPM members submitted reports on action taken during the year to identify and challenge de facto detention. The greatest challenges identified – where individuals were subject to apparent deprivation of liberty without proper legal authorisation, and situations where the legal framework did not offer individuals appropriate protection – occurred in health and social care settings, including settings in the community, where individuals were receiving care and treatment because of health and social care needs. The situations in which NPM members identified de facto detention were as follows:

- people with dementia in mental health care, general hospitals and care homes – individuals may be prevented from leaving the facility for reasons of safety, but may consequently be thwarted from going where they want and confined to an enclosed space
- people with mental illness or learning disabilities where they are not formally detained but are in locked facilities or are regarded as 'detainable if wishes to leave'
- people with any of these conditions receiving care and treatment in community settings, including individual or shared tenancies, day care or respite care in small community settings – they may have 24-hour care that exercises great control over their movements or even be locked into their own homes or rooms for periods
- children receiving care in residential or hospital settings – a particular issue is consent to restrictive measures or forcible treatment by parents or others exercising parental responsibilities.

In total, 19 cases of apparent de facto detention were reported. The following settings and client groups were identified.

Settings where de facto detention was reported	
Care home	4
Hospital	12
Low secure unit	1
Supported living service	1
Supported living for children or adolescents	1
Total	**19**

Client group identified by report	
Alcohol-related brain damage	1
Mental illness	7
Dementia	6
Learning disability	4
Neurological	1
Total	**19**

The most common issue was apparent de facto detention in hospital. Three reports refer to individuals in community placements where they have individual or shared tenancies.

Issues identified (more than one per case)	
Non-detained hospital patients have restrictions	12
Non-detained hospital patients are restrained	2
Informal community residents have restrictions	3
Service users with a proxy are restrained	0
Service users with a proxy are restricted	3
Practical issue (fluctuating capacity)	1
Practical issue (use of DOL* when MHA** more appropriate)	1
Total	**22**

*DOL = Deprivation of Liberty Safeguards (England and Wales only)
**MHA = Mental Health Act

In most cases, the NPM member took action to bring the matter to the attention of staff and managers. In most cases, this resulted in a formal report to managers of the service.

Actions taken (one per issue)	
Discussed with all parties involved	5
Report to managers of hospital/service	9
Discussed with all parties and report to managers	3
Discussed with staff/managers	3
No action noted	2
Total	**22**

The broad categories of recommendations made either in discussion or formal reports were:

Recommendations (more than one per case)	
Service must consider seeking proper legal authorisation	3
Service must assess/reassess capacity of service user	5
Service must consider changing/ reducing level of restriction	6
Service must ensure staff have proper training	7
Service must develop clear policy	4
Service must ensure service users know their rights	5
None recorded	3
Total	**33**

Case study

A woman who had a dementia was admitted to a medical ward in a rural general hospital as an 'informal' patient. The circumstances of her admission meant that she was heavily sedated on arrival.

For a 52-hour period after admission, she was actively trying to leave and was prevented from doing so by use of restraint and heavy sedation. She was then transferred to a psychiatric ward.

Her welfare attorney had been consulted over her stay in hospital. The doctor treating her had taken this as a legal authority and had not considered detention under the Mental Health Act. He had not obtained the attorney's permission to use sedation.

This person was effectively being de facto detained against her will. Staff had poor understanding of relevant legislation and poor support in providing care for confused individuals. The NPM member made recommendations for better training and support for staff and Government action to ensure better dementia care in remote hospitals.

Through this review of member actions, we were able to identify the responses currently provided by NPM members when they identify cases of de facto detention. Recommendations for policy and training accounted for 13 of the 33 recommendations. Assessment of capacity and ensuring that individuals know their rights also featured strongly.

It is of note that when making recommendations about the level of restriction of liberty, member organisations were more likely to focus on the necessity for restriction than its legality. This reflects the principle of least restriction of freedom that runs through most of the recent UK legislation on mental health and incapacity law.

The evidence generated in this review has helped the NPM identify the type of practices constituting de facto detention, as well as the actions currently taken when cases are identified. As a result, the NPM has decided to continue looking into the issue, and will provide a further update to this work in its next annual report.

International collaboration

Many requests were received from international counterparts interested in the UK's multi-body NPM as well as the functions of its individual members. The NPM coordination has played a role in ensuring that these requests can, as far as possible, be honoured, as well as linking up the requests with appropriate NPM members. In turn, hosting international delegations in the UK or participating in visits abroad have helped NPM members develop their expertise and understanding of OPCAT issues beyond their current remit.

In April 2012, MWCS participated in a round-table discussion with a delegation from the Norwegian government, advising on the use of mental health consultation by remote video link, especially in relation to decisions on involuntary treatment.

Between October and December 2012, HMIP visited delegations of police officers from Ethiopia, human rights lawyers from Japan, and representatives of the Correctional Institution Inspection Committee of the State of Ohio, USA and the Chilean Embassy. Where possible, HMIP facilitated inspection shadowing for these international visitors.

In January 2013, HMIP began work with the Bahraini Ombudsman, the National Institute of Human Rights and non-governmental organisations (NGOs) in Bahrain, as part of a project to support the development of a NPM in Bahrain. A number of practice inspection visits to Bahraini detention facilities were organised, and training visits for members of the Ombudsman and National Institute of Human Rights to participate in HMIP inspections in the UK were also held. Supported by the UK Foreign and Commonwealth Office, HMIP has operated independently of the government and has encouraged consultation with the UN Subcommittee on the Prevention of Torture and the Association for the Prevention of Torture to promote adherence to international standards.

Committee for the Prevention of Torture (CPT) visit

In September 2012, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) made a seventh periodic visit to the UK.

The CPT is a non-judicial preventive mechanism set up under the Council of Europe's European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. It is a body made up of independent and impartial experts who serve in their individual capacity. The CPT organises visits to places of detention, in order to assess how persons deprived of their liberty are treated. CPT delegations have unlimited access to places of detention, and the right to move inside such places without restriction. They interview persons deprived of their liberty in private, and communicate freely with anyone who can provide information.

The majority of the visit focused on detention facilities in Scotland, and in particular the CPT examined the conditions of detention of women prisoners, female young offenders, adult males on remand and those persons placed in segregation. It also visited a medium secure psychiatric facility and looked into the treatment of persons detained by the police. The delegation also visited two immigration removal centres in England.

The CPT reported that they received excellent cooperation throughout their visit. NPM members, including HMIPS, supported and facilitated the visit.

After each visit, the CPT sends a draft report to the State concerned and requests a detailed response to the issues raised. The report is then finalised after the State has the chance to respond. Reports can be made public on agreement of the State in question. At the time of writing, the report had not yet been made public[22].

22 CPT reports and UK responses can be found at: http://www.cpt.coe.int/en/states/gbr.htm

Section three

Looking ahead to year five

In 2012–13, NPM members have continued to monitor the treatment and conditions of detainees and contribute to the overall effective implementation of OPCAT in the UK. They will continue to monitor the implementation of their recommendations, with a view to preventing ill treatment in all places of detention.

Plans for the NPM's fifth year include the following:

- appoint a new NPM coordinator
- organise an event in April 2014 to mark five years since the UK NPM was designated, in conjunction with the Human Rights Implementation Centre at the University of Bristol
- continue to monitor the area of de facto detention with the aim of producing recommendations to inspection/monitoring bodies
- develop the role of the subgroup for children and young people. Further meetings are planned, focusing on health, segregation/single separation of children in detention, and police and immigration detention of children. Meetings will be output-focused to allow coordinated action by the NPM on issues of concern relating to children in detention
- discuss the NPM's focus on deaths in custody and segregation/solitary confinement and isolation
- develop and implement a protocol to ensure prisoners/detainees are protected from any sanctions arising from their communication with HMIP, IMBs or the Prisons and Probation Ombudsman (the latter is not a member of the NPM) with the intention of rolling it out to other NPM members
- review the membership of the NPM steering group, in line with the steering group terms of reference
- strengthen dialogue with the UN Subcommittee on the Prevention of Torture, with a view to the Subcommittee on Prevention of Torture (SPT) giving constructive guidance for particular areas for the NPM to focus on and strengthen
- review the UK NPM's working methods and compliance against OPCAT and subsequent SPT guidelines.

Section four
Appendices

Appendix One

Written Ministerial Statement – 31 March 2009[23]

Optional Protocol to the Convention against Torture (OPCAT)

The Minister of State, Ministry of Justice (Mr Michael Wills):

The Optional Protocol to the Convention Against Torture (OPCAT), which the UK ratified in December 2003, requires states party to establish a 'national preventive mechanism' to carry out a system of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

OPCAT provides that a national preventive mechanism may consist of one body or several. The government intend that the requirements of OPCAT be fulfilled in the UK by the collective action of existing inspection bodies.

I am designating the following bodies to form the UK NPM. If it is necessary in future to add new inspection bodies to the NPM, or if bodies within the NPM are restructured or renamed, I will notify Parliament accordingly.

England and Wales

- Her Majesty's Inspectorate of Prisons (HMIP)
- Independent Monitoring Boards (IMB)
- Independent Custody Visiting Association (ICVA)
- Her Majesty's Inspectorate of Constabulary (HMIC)
- Care Quality Commission (CQC)
- Healthcare Inspectorate of Wales (HIW)
- Children's Commissioner for England (CCE)
- Care and Social Services Inspectorate Wales (CSSIW)
- Office for Standards in Education (Ofsted)

Scotland

- Her Majesty's Inspectorate of Prisons for Scotland (HMIPS)
- Her Majesty's Inspectorate of Constabulary for Scotland (HMICS)
- Scottish Human Rights Commission (SHRC)
- Mental Welfare Commission for Scotland (MWCS)
- The Care Commission (CC)

Northern Ireland

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

23 HC Col 56WS, 31 March 2009.

Appendix Two

Member overview

In the first annual report of the UK NPM, we profiled each of the NPM members, setting out detailed information on their mandate, structure and methodology. Rather than replicate that information in subsequent annual reports, we have set out below a short description of each member, as a reminder. We have also included details of any significant changes during 2012–13. Detailed information about each member can be found in our first annual report, the online database of UK NPM members, or the annual reports or websites of the individual members.[24]

As in previous annual reports, 19 organisations are included below, even though only 18 are designated as members of the NPM. The 19th organisation – Independent Custody Visitors Scotland – has not been designated separately but is a member of the designated ICVA.

Care and Social Services Inspectorate Wales
CSSIW regulates and inspects all social care services in Wales. This includes secure accommodation, where children are placed either for their offending behaviour or because they pose a significant risk to themselves or others. CSSIW also monitors the deprivation of liberty safeguards during its regular inspections of adult care homes.
www.cssiw.org.uk
http://cssiw.org.uk/docs/cssiw report/130110annualen.pdf

Care Quality Commission
CQC is an independent statutory organisation responsible for monitoring, inspecting and regulating health and adult social care services in England, to make sure they meet fundamental standards of quality and safety. CQC also monitors the operation of the Mental Health Act 1983, including those who are detained under mental health law. CQC carries out inspections of health care in prisons and immigration detention alongside Her Majesty's Inspectorate of Prisons (HMIP) and participates in inspections of police custody alongside HMIP and Her Majesty's Inspectorate of Constabulary.
www.cqc.org.uk
http://www.cqc.org.uk/sites/default files/media/documents/annual report_2012_2013.pdf

Criminal Justice Inspection Northern Ireland
CJINI is a statutory body with responsibility for inspecting all aspects of the criminal justice system. CJINI's mandate is broad and it may inspect a range of places of detention, including prisons, a juvenile justice centre, police custody and court custody.
www.cjini.org
http://www.cjini.org/CJNI/files/c8/c806f120 211a-4990-8a41-416ce13eaeda.pdf

24 The online database of UK NPM members, compiled by the Human Rights Implementation Centre at the University of Bristol in association with the members themselves, is available at: http://www.bristol.ac.uk/law/research/centres-themes/hric/hricnpmukdatabase/index.html.

Healthcare Inspectorate Wales
HIW regulates and inspects all health care in Wales. Part of this role involves monitoring compliance with mental health legislation and ensuring that health care organisations observe the deprivation of liberty safeguards under the Mental Health Capacity Act 2005. In doing so, HIW works closely with CSSIW (see above), which monitors the use of deprivation of liberty safeguards in social care settings. HIW also participates in HMIP-led inspections of prisons in Wales, assessing the health care provided to prisoners and ensuring that it is equivalent to that provided in the community.
www.hiw.org.uk

Her Majesty's Inspectorate of Constabulary
HMIC has a statutory duty to inspect and report on the efficiency and effectiveness of policing. Following the ratification of OPCAT, HMIC's role has included carrying out inspections of police custody facilities in England and Wales in partnership with HMIP. The new inspection programme for Border Force customs custody facilities commenced in December 2012.
www.hmic.gov.uk
http://www.hmic.gov.uk/media/annual report-2011-12.pdf

Her Majesty's Inspectorate of Constabulary for Scotland
In 2012–13, the role of HMICS was to monitor and improve police services in Scotland. HMICS inspected various aspects of policing and published a report on the care and welfare of detained persons in police custody in January 2013. Since the merger of Scotland's eight police forces into one national service on 1 April 2013, the role of HMICS under the Police and Fire Reform (Scotland) Act 2012 has been to monitor the state, efficiency and effectiveness of the Police Service of Scotland and the Scottish Police Authority. HMICS will continue to monitor the treatment of and conditions for detained persons with an inspection of custodial facilities within the new national service scheduled to take place in early 2014.
http://www.hmics.org/
http://www.hmics.org/publications/hmics annual-report-2012-13

Her Majesty's Inspectorate of Prisons
HMIP is an independent statutory organisation that carries out regular inspections of places of detention to assess the treatment of and conditions for detainees. HMIP inspects all prisons in England and Wales, including young offender institutions, all immigration removal centres, short-term holding facilities and escort arrangements for immigration detainees, and all police custody facilities in association with HMIC. By invitation, HMIP also participates in inspections of prisons in Northern Ireland (in partnership with CJINI) and inspects some military detention facilities. In 2012, HMIP was granted powers to inspect court custody facilities and also began inspecting secure training centres in partnership with Ofsted, and customs custody facilities with HMIC.
www.justice.gov.uk/about/hmi-prisons/index.htm
http://www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hm-inspectorate-prisons-annual-report-2012-13.pdf

Her Majesty's Inspectorate of Prisons for Scotland

HMIPS inspects prisons, including young offender institutions, paying particular attention to the treatment of and conditions for prisoners. It also inspects prisoner escort arrangements – this includes the conditions in which prisoners are transported from one place to another – as well as court custody facilities or other places where prisoners are held temporarily outside a prison.

http://www.scotland.gov.uk/Topics/Justice/public-safety/offender-management/offender/custody/Prisons/hmip

http://www.scotland.gov.uk/Publications/2013/06/4575/0

Independent Custody Visiting Association

ICVs are volunteers from the community who visit all police stations where detainees are held to check on their welfare. Custody visiting is statutory and visitors have the power to access police stations, examine records relating to detention, meet detainees for the purpose of discussing their treatment and conditions, and inspect facilities, including cells, washing and toilet facilities, and facilities for the provision of food. One of ICVA's key roles is to look at the skills base of independent custody visitors and to ensure that they are confident and able to conduct visits to the majority of people in custody and make those visits as effective as possible. With this in mind they have recently developed two training modules focusing on juveniles and the issue of mental health. The aim of these modules is to provide increased confidence, empathy and mutual respect during visits and enable a better understanding of the challenges relating to two categories of potentially vulnerable detainees within police custody.

www.icva.org.uk

http://icva.org.uk/uploads/publications/ICVA_Annual_Report_12-13.pdf

Independent Custody Visitors (Scotland)

ICVs in Scotland carry out regular, unannounced visits to police stations to monitor the treatment of and conditions for detainees. Custody Visitors in Scotland have not yet been designated separately as a member of the UK NPM but are members of the ICVA, although they retain their own funding and management framework. By virtue of the Police and Fire Reform (Scotland) Act 2012, custody visiting in Scotland is now a statutory scheme.

Independent Monitoring Boards

IMBs have a statutory duty to satisfy themselves about the state of the prisons or immigration detention facilities they visit, their administration and the treatment of prisoners or detainees. The Boards are made up of unpaid members of the community and fulfil their duties by carrying out regular and frequent visits to establishments. There is a Board for every prison in England and Wales and every immigration removal centre in England, Wales and Scotland, as well as for some short-term holding facilities for immigration detainees. They have also been monitoring some charter flights in the past year. Board members are appointed by the Secretary of State.

www.justice.gov.uk/about/imb.htm

http://www.justice.gov.uk/downloads/about/imb/behind-closed-doors-2012.pdf

Independent Monitoring Boards (Northern Ireland)

IMBs in Northern Ireland are statutory bodies whose role is to monitor the treatment of prisoners and the conditions of their imprisonment. The Boards are made up of unpaid members of the community and fulfil their duties by carrying out regular visits to establishments. There are three Boards in Northern Ireland, one for each prison. Board members are appointed by the Northern Ireland Justice Minister.

www.imb-ni.org.uk

http://www.imb-ni.org.uk/publications.htm

Mental Welfare Commission for Scotland

MWCS is an independent statutory organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or related condition. The mandate of MWCS is broad and its activities include monitoring the care and treatment of people detained under mental health law.

www.mwcscot.org.uk

http://www.mwcscot.org.uk/media/138481/annual_report_-_easy_read_2012-13.pdf

Northern Ireland Policing Board Independent Custody Visiting Scheme

As in the rest of the UK, police custody suites in Northern Ireland receive regular, unannounced visits from custody visitors. Volunteers from the local community, custody visitors monitor the rights, health and well-being, and conditions of detention of those detained in police custody.

www.nipolicingboard.org.uk/index/publications/custody-visitors.htm

http://www.nipolicingboard.org.uk/northern_ireland_independent_custody_visiting_scheme_final_pdf.pdf

Office for Standards in Education, Children's Services and Skills

Ofsted is a regulatory and inspection body that seeks to promote excellence in the care of children and young people, and in education and skills for learners of all ages. In the context of detention, Ofsted inspects the care and educational provision for children in secure accommodation, and assesses the provision of education and training in prisons, young offender institutions and immigration removal centres as part of HMIP-led inspections.

www.ofsted.gov.uk

http://www.ofsted.gov.uk/filedownloading/?file=documents/annual-reports/s/Social%20Care%20Annual%20Report%20201213.pdf&refer=0

Office of the Children's Commissioner for England

The role of the Children's Commissioner is to promote awareness of the view and interests of children in England, to promote and protect their rights, and in particular to focus on those whose voices are least likely to be heard. The Commissioner has the power to enter any premises other than a private dwelling for the purpose of interviewing any child accommodated or cared for there, if the child consents. While the Commissioner does not carry out a regular programme of visits or inspections, she has a broad power to enter premises where children may be detained.

www.childrenscommissioner.gov.uk

http://www.childrenscommissioner.gov.uk/content/publications/content_702

Regulation and Quality Improvement Authority

The RQIA is empowered to monitor the availability and accessibility of health and social care services in Northern Ireland and promote improvement in the quality of

these services. A key element of its role is to inspect the provision of health and social care in places of detention, including prisons, secure accommodation for children or places where people are detained under mental health law. The RQIA has also been asked to monitor the implementation of the health recommendations from the Northern Ireland Prison Review Team Report 2011[25].
www.rqia.org.uk
http://www.rqia.org.uk/cms_resources/RQIA%20Annual%20Report%20and%20Accounts%202010-11.pdf

Care Inspectorate
Established by the Public Services Reform (Scotland) Act 2010 the CI is the independent scrutiny and improvement body for social work and social care and support services for people of all ages. The Inspectorate was established in April 2011 from three previously existing scrutiny bodies: the Scottish Commission for the Regulation of Care (Care Commission) for care services, the Social Work Inspection Agency (SWIA) which carried out strategic inspections of social work services in the community, and a directorate of Her Majesty's Inspectorate of Education (HMIE) which carried out joint inspections of services to protect children. As part of its new remit, the CI regulates secure homes for children and young people as well as other residential services.

The CI has not yet been formally designated as a member of the UK's NPM but is the successor to a previously designated member, the Care Commission.
www.careinspectorate.com
http://www.careinspectorate.com/index.php?option=com_docman&task=doc_download&gid=1041&Itemid=100175

Scottish Human Rights Commission
SHRC is an independent statutory body with the power to enter places of detention and report on the rights of detainees. The Commission's general duty is to promote awareness, understanding and respect for human rights and, in particular, to encourage best practice in relation to them.
www.scottishhumanrights.com
http://scottishhumanrights.com/application/resources/documents/SHRCAnnualReport2011_12Final.pdf#search="annual%20report"

Appendix Three

Terms of reference for the NPM steering group

Background

At a meeting of the NPM members in Edinburgh on 9 May 2011, a proposal was put forward regarding the operational structure of the NPM. It was suggested that the members consider establishing an executive committee or steering group for the NPM to facilitate decision-making and take forward joint work. There was considerable initial interest in the proposal and it was agreed that HMIP would prepare a more detailed proposal for consideration by the members.

Proposal

To establish a steering group for the UK NPM.

Purpose

The NPM is currently made up of 18 bodies with HMIP performing a coordinating role. So far, we have operated on a consensus basis but inevitably, with such a large and diverse membership, it can prove challenging and time consuming to secure agreement among the members and to progress issues quickly, if at all. These challenges are only likely to increase as the government considers expanding the NPM membership (potentially from 18–21). From the coordinator's point of view, there is a need for a mechanism to progress joint activities in the periods between meetings of the whole NPM or to be able to take decisions quickly, without always requiring all 18 members to be consulted. If we wish to do more collectively under the banner of the NPM – and several members have expressed a wish to do so – then a mechanism such as a steering group can facilitate this. Moreover, the level of engagement with the NPM varies between members: it is hoped the steering group can assist in promoting engagement among all members.

The suggested role of the steering group will be to:

- facilitate decision-making relating to the NPM
- set the strategic direction for coordinated/joint NPM activity
- assist in planning future joint activities
- advise and support HMIP and the NPM coordinator in their roles
- monitor and assess the value of joint activities
- promote engagement of all members in joint NPM activity
- act on behalf of the NPM
- represent all members of the NPM as best it can, taking into account the different roles of the members and the contexts in which they operate.

The existence of a steering group is not intended to detract from the input of the 18 individual members of the NPM. HMIP, the coordinator and/or the steering group will continue to seek the input of all members regarding particularly significant or potentially contentious issues. The steering group will try to represent the interests of the NPM as a whole but its decisions are not binding on individual members.

The role of the steering group and its structure may be developed in the future in light of our experience.

Membership

To be effective, the steering group should be small but we should also ensure the group represents the wider NPM as much as possible. The selection of steering group members should take into account the different types of detention visited and the different jurisdictions in which the members operate as well as the nature of the bodies themselves (such as lay and professional bodies). It will be impossible for the steering group members to represent all places of detention visited, but diversity will be sought. Given HMIP's role in coordinating the NPM, Her Majesty's Chief Inspector of Prisons will necessarily be a standing member of the steering group. Consideration should also be given to whether HMIP or another member should chair the group.

It is proposed that volunteers to serve on the steering group are sought and that four people will be selected by the NPM coordinator on the basis of ensuring an equitable spread among types of detention visited and lay/professional bodies. There will be one member each for England, Wales, Scotland and Northern Ireland. Membership of the steering group should be limited to two, two-year terms and that such terms are staggered.

Where a representative of a lay body is a member of the steering group, reasonable expenses associated with that membership (likely to be travel costs only) may be borne by HMIP. All other steering group members will be expected to bear their own costs.

Working methods

It is expected that steering group members will be in regular contact with the NPM coordinator and that as much work as possible will be conducted via email and telephone contact. Meetings of the steering group will also take place twice a year. The work of the group will be transparent and it shall report back to all NPM members on their discussions and decisions. A secretariat function for the steering group will be performed by the NPM coordinator.

Appendix Four

Terms of reference for the children and young people's NPM subgroup

1. Introduction

Since its establishment in 2009, the bodies that make up the UK NPM have monitored whether the UK government meets its UN Treaty obligations regarding the treatment of anyone held in any form of custody.

Children and young people are considered a part of the NPM's work alongside the treatment of adults and the NPM's regular business meetings have included child-centred discussions. However business meetings provide limited capacity to have regular specialist discussion.

As a result the NPM membership agreed in 2013 to establish a specialist subgroup to focus on children and young people. This group would provide the capacity for those with expertise and experience of working with children and young people to support the wider NPM with specialist advice, information and recommendations.

2. Background

Children and young people under 18 represent a tiny minority of people in detention in the UK. They are vulnerable both because of their age and capacity, and because they are detained. Many will also have faced difficult experiences in their lives before detention.

Children in detention also have additional rights and protections, set out in the UN Convention on the Rights of the Child and other international instruments, as well as in domestic law.

Children are detained in a variety of settings across the different jurisdictions of the UK. This can make it hard for NPM members to identify common challenges, share good practice and make recommendations.

By focusing on the specific needs of children and young people in detention, this subgroup will support the NPM to fulfil its preventive role[26] through sharing good practice on visits and inspections, a holistic and system-wide analysis of the situations where children are at risk of ill-treatment, and making recommendations designed to improve policy and practice for children in detention.

3. Chairing, reporting and membership

The NPM subgroup will be chaired by the Deputy Children's Commissioner for England, with support from the OCC.

It will report to the NPM steering group, and meet three times a year. These meetings will be coordinated with the steering group meetings.

The subgroup will be open to NPM members with an interest in the rights of children and young people in detention, across a range of settings.

25 See guidance in *Association for the Prevention of Torture, Optional Protocol to the UN Convention against Torture: Implementation Manual,* Chapter V - Operational Functioning of NPMs. At: http://www.apt.ch/content/files_res/opcat-manual-english-revised2010.pdf

4. Objectives

The objective of the subgroup would be to enhance the overall effectiveness of the NPM's work on the rights of children and young people in detention.

The group would do this by:

- sharing practice, experience and intelligence among NPM members on issues relating to children and young people in custody
- identifying key issues and concerns relating to children and young people that are then communicated to NPM business meetings via the steering group
- making recommendations on behalf of the NPM to government and stakeholders on ways to ensure protection of the rights of children and young people in detention
- contributing to the NPM's annual report and providing oversight and comment on sections relating to children and young people.

5. Term and review procedures

The subgroup will propose an annual list of topics that it will examine. This list will be sent to the NPM steering group for approval.

The steering group will review the effectiveness of the subgroup's work at the end of the year, based on a report and self-assessment.

Appendix Five

List of abbreviations

CI	Care Inspectorate
CJINI	Criminal Justice Inspection Northern Ireland
CPT	Committee for the Prevention of Torture
CQC	Care Quality Commission
CSSIW	Care and Social Services Inspectorate Wales
HIW	Healthcare Inspectorate Wales
HMCIPS	Her Majesty's Chief Inspector of Prisons for Scotland
HMIC	Her Majesty's Inspectorate of Constabulary
HMICS	Her Majesty's Inspectorate of Constabulary for Scotland
HMIP	Her Majesty's Inspectorate of Prisons
HMIPS	Her Majesty's Inspectorate of Prisons for Scotland
ICVA	Independent Custody Visiting Association
ICVS	Independent Custody Visitors Scotland
IMB	Independent Monitoring Board
IMBNI	Independent Monitoring Boards (Northern Ireland)
MWCS	Mental Welfare Commission for Scotland
NGO	Non-governmental organisation
NIPBICVS	Northern Ireland Policing Board Independent Custody Visiting Scheme
NPM	National Preventive Mechanism
OCC	Office of the Children's Commissioner for England
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
RQIA	Regulation and Quality Improvement Authority
SHRC	Scottish Human Rights Commission
SPT	Subcommittee on Prevention of Torture
UKBA	United Kingdom Border Agency

Appendix Six

Further information about the UK NPM

If you would like further information about the UK NPM, please contact the NPM 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 On the Rocks No 2, HMP Frankland, Alpha Hospitals, Platinum Award for Watercolour at the 2012 Koestler Awards. The Koestler Trust is a prison arts charity, inspiring offenders, secure patients and detainees to take part in the arts, work for achievement and transform their lives. For more information visit: www.koestlertrust.org.uk

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