Monitoring places of detention

14th **Annual Report**
of the United Kingdom's
National Preventive Mechanism
2022/23

CP 1008

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14th Annual Report of the United Kingdom's National Preventive Mechanism

2022/23

Presented to Parliament by the Secretary of State for Justice
by Command of His Majesty

February 2024

CP 1008

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p14: **Hekate**, The Nelson Trust (Women's Community Services), Highly Commended Award for Mixed Media, 2023. Image courtesy of Koestler Arts.

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Foreword by Wendy Sinclair-Gieben UK NPM Chair

This is my second annual report as Chair of the UK National Preventive Mechanism (NPM). It is the 14th annual report in the life of the organisation. During that period, our members have produced thousands of reports, with recommendations for improvement based on their scrutiny of places holding those deprived of their liberty.

I must place on record my most sincere thanks to Dame Anne Owers whose term as National Chair of the Independent Monitoring Boards (IMB) came to an end this reporting year, concluding a longstanding association with the NPM. Dame Anne made a profound contribution to the work of detention monitoring and inspection in the UK and brought that expertise to the NPM. She leaves with a legacy to be proud of.

The UK NPM was established in 2009 with a mandate to carry out regular, independent visits to places of detention. The NPM's activities have expanded significantly since it was first established. They now include joint work focused on specific areas of Optional Protocol to the Convention Against Torture (OPCAT) compliance, as well as on thematic detention issues. This last year saw significant work on reviewing the governance and shifting the membership towards a more holistic strategic approach which is now coming to fruition.

In preparing to pen my foreword this year, I have spent some time reviewing previous forewords drafted by my excellent predecessors: John Wadham, David Strang and Nick Hardwick. These are individuals with different professional backgrounds, writing at different times and under different political contexts throughout our 14-year operation. Despite this, our reports are remarkably similar.

We continue to be concerned and report on entrenched issues of overcrowding in the prison estate and the lack of access to secure mental health facilities. Across detention in the four jurisdictions, we noted concerns with:

- the glacial return to a full rehabilitative regime post COVID-19
- staff shortages
- lack of rehabilitative activity
- closed cultures
- an increasing remand population
- lack of community interventions
- staff training to match the complexity of the changed cohorts in custody and to recognise the growth in mental health concerns and aging populations
- conditions and treatment in immigration detention
- issues of equality and discrimination
- unregistered settings
- distance from family and communities
- the rise of alcohol and substance use

Worryingly we note continued high numbers of deaths in prisons. The NPM Secretariat hosted a roundtable for members, ombudspersons and other investigative bodies to discuss this concern and to find methods to address preventable loss of life, including the lack of disaggregated data readily available.

This report, again, touches on many of those issues. I will not rehearse them here.

The UK NPM is made up of around 3,500 individuals, from 21 different organisations, carrying out an immense breadth and depth of scrutiny. The UK can and should be proud of a culture that opens the doors of closed institutions to independent bodies like us to report on the treatment and conditions of those held. The state recognises that those deprived of their liberty are in a uniquely vulnerable position to be subject to ill-treatment and vital scrutiny plays an important role in preventing this.

But to what end? If 14 reports from myself and my predecessors read similarly, what impact are we truly having? It is a challenge I have been putting to myself and to my team this year – and which will underline the strategy of the UK NPM to take forward areas of scrutiny, identify the barriers to improvement and make serious recommendations.

Of course, it would be unfair to paint such a bleak picture entirely unnuanced. There has been progress in several areas of concern, but there have also been steps back. The impact of COVID-19 on the justice system and in health settings should not be underestimated, but we still report on its effects in this reporting cycle despite the lifting of restrictions. On a local level, establishments are often able to respond to concerns and make reforms to improve the experience of detainees, though systemic issues often remain unaddressed. We consistently meet dedicated, skilled staff grappling with challenges of budget or policy that are out of their control but have profound effects on where they work and the people detained there.

The issues with detention in the UK are entrenched, complex and cross-cutting. A paradigm shift has long been required where detention is used only as a last resort and the system takes account of enlightened understanding. In the meantime, our organisations will continue to inspect and monitor places of detention to prevent ill-treatment, upholding our human rights mandate.

While this is the 14th annual report, the observant reader will note that it is only the 13th annual report to be laid in Parliament. Continued delays from government last year prevented us from laying the report in Parliament, leading us to publish on our website independently. This report will be laid in Parliament to comply with the state's obligation under Article 23 of OPCAT to support the publication of an NPM report. The Subcommittee on Prevention of Torture's guidance on the matter is clear that "[t]he states parties to the Optional Protocol have a legal obligation to publish and widely disseminate the annual reports of NPMs, which should be presented to and discussed in Parliament".

Next year, the NPM will celebrate our 15th anniversary. I hope we are able then to report on much more significant reforms, and that my foreword can be distinctly original from Mr Hardwick, Mr Wadham and Mr Strang.

I would like to thank all our partners, members and stakeholders for their continued commitment and support to this organisation.

Wendy Sinclair-Gieben

Wendy Sinclair-Gieben
UK NPM Chair

Introduction

The UK National Preventive Mechanism (NPM) is made up of 21 bodies that monitor and inspect places of detention in the UK to prevent torture and ill-treatment for those deprived of their liberty. Members collectively fulfil the NPM's mandate under the Optional Protocol to the Convention Against Torture (OPCAT). OPCAT is designed to strengthen protections for people deprived of their liberty, as it is recognised that they are particularly vulnerable to ill-treatment. According to OPCAT, efforts to combat torture and ill-treatment should focus on its prevention, which is best achieved by setting up an NPM to visit all places of deprivation of liberty independently, unannounced and on a regular basis. The UK ratified OPCAT in December 2003 and designated its NPM in March 2009.

The UK's multi-body NPM allows for deep expertise and a broad reach across detention settings. The collective NPM, and this report, provides a step back to look at systemic issues and good practice in different detention settings across the UK.

The issues identified in last year's annual report covered a reduction of provision for those deprived of their liberty in the UK, through a perfect storm of crises in staffing, funding, slow recovery from COVID-19 and associated restrictions. This year, despite co-ordinated responses by organisations to respond to system pressures resulting from the pandemic, and despite the lifting of national restrictions, some pandemic measures were still in place. Members have exhausted the lexicon when describing the recovery of detention settings from COVD-19 as "sluggish", "static", "unhurried" and "sedate". The effect is a national picture of unacceptable provision which has mostly failed to return to pre-COVID-19 levels.

Many of these issues remain in the reporting year 2022-23. Staffing levels remain a consistent problem across prisons, secure children's settings, police and court custody, and in deprivation of liberty for mental health across the UK. This report brings together some of the key themes and findings of our members who make regular visits to places of detention. Different detention settings are integrated under relevant themes. In a change to our usual reporting methodology, there is not a separate section for separate jurisdictions or for all different types of detention, but these are signposted throughout the narrative. The report should not be viewed as exhaustive of all detention issues raised but is intended as an overview of the key issues across detention settings in the UK.

There is a lack of a whole-system approach in criminal justice, hospitals and health services. However, where organisations did work together, positive results were observed. Partnership working was also a strength among members. As well as joint inspections, reviews and evaluations between members and other stakeholders, the reporting year saw renewed energy invested in the NPM Scotland Subgroup. In October 2022 the NPM Northern Ireland Subgroup was launched, holding its inaugural quarterly meeting on 14 April 2023.

Key member outputs and publications are summarised at the end of the report.

To stay informed on the work of the UK NPM, please subscribe to our stakeholder database by contacting **UKNPM@hmiprisons.gov.uk**, visiting **www.nationalpreventivemechanism.org.uk** and following us on Twitter @UKNPM.

Types of detention

Prisons and young offender institutions

- HMI Prisons (with CQC and Ofsted), and IMB (England)
- HMI Prisons (with HIW) and IMB (Wales)
- HMIPS with CI, SHRC and MWCS (Scotland)
- CJI and HMI Prisons with RQIA, and IMB NI (Northern Ireland)

Police custody

- HMICFRS (with CQC), and ICVA (England and Wales)
- HMICS, ICVS (Scotland)
- CJI with RQIA, NIPBICVS (Northern Ireland)

Escort and court custody

- Lay Observers and HMI Prisons (England and Wales)
- HMIPS (Scotland)
- CJI (Northern Ireland)

Detention under the Terrorism Act

- IRTL (United Kingdom)
- HMICFRS (with CQC) (England and Wales)
- ICVA (England and Wales)
- ICVS (Scotland)
- NIPBICVS (Northern Ireland)

Children in secure accommodation

- Ofsted (jointly with HMI Prisons and CQC in relation to secure training centres (England))
- CIW (Wales)
- CI (Scotland)
- RQIA, and CJI (Northern Ireland)

Children (all detention settings)

- CCE (England)

Detention under Mental Health Law

- CQC (England)
- HIW (Wales)
- MWCS (Scotland)
- RQIA (Northern Ireland)

Deprivation of liberty and other safeguards in health and social care

- CQC (England)
- HIW and CIW (Wales)
- CI and MWCS (Scotland)
- RQIA (Northern Ireland)

Immigration detention

- HMI Prisons and IMB

Military detention

- HMI Prisons (United Kingdom)

Customs custody facilities

- HMICFRS (with CQC), and HMICS

Geographical coverage

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

England
- Care Quality Commission (CQC)
- Children's Commissioner for England (CCE)
- Office for Standards in Education, Children's Services and Skills (Ofsted)

United Kingdom
- Independent Reviewer of Terrorism Legislation (IRTL)

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

Wales
- Care Inspectorate Wales (CIW)
- Healthcare Inspectorate Wales (HIW)

England and Wales
- His Majesty's Inspectorate of Prisons (HMI Prisons)
- His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)
- Independent Custody Visiting Association (ICVA)
- Independent Monitoring Boards (IMB)
- Lay Observers (LO)

The NPM Secretariat

A new Head of UK NPM Secretariat took up post this year, followed by three new appointments to the staff team. Over the year a new governing constitution was agreed and implemented, and an ambitious business plan for 2023 to 2025 was developed and agreed by members at the April 2023 conference. The business plan includes the creation of a recommendations database, which will in future hold the key issues from member output and provide a rich source of data.

The NPM Secretariat continues to lead and support joint OPCAT work across the UK. It is co-ordinating work to draw together recommendations across the membership, identify key themes to engage practitioners and policymakers, and strengthen the collective voice of the NPM to promote systemic change.

The NPM Scotland Subgroup

With Jim Farish as the new Chair, the NPM Scotland Subgroup continued work throughout the reporting year, sharing learning and best practice and using a collective voice to achieve greater impact with the Scottish Government. Health Improvement Scotland was invited to participate as an observer given their role inspecting healthcare arrangements in Scottish police custody and prisons. The Subgroup made a joint submission to a Scottish Government consultation on changes to custody arrangements and bail.

The NPM Northern Ireland Subgroup

In October 2022, NPM members from Northern Ireland agreed to form an NPM Northern Ireland Subgroup with Rachel Lindsay as Chair, to:

- share information on the work of the NPM bodies in Northern Ireland
- identify common issues and interests
- co-ordinate NPM activities in Northern Ireland
- explore possibilities for joint activity
- raise the profile of the work of the NPM
- improve liaison with the Northern Ireland Executive
- provide support to the NPM members in Northern Ireland in application of OPCAT requirements
- make use of self-assessment and peer evaluation tools as a method of measuring continued improvement

Members are: the CJI, IMB (NI), Northern Ireland Policing Board Independent Custody Visiting Scheme, Regulation and Quality Improvement Authority (RQIA), the UK NPM Head of Secretariat, and by invitation, the UK NPM Chair.

Committee on the Prevention of Torture's visit

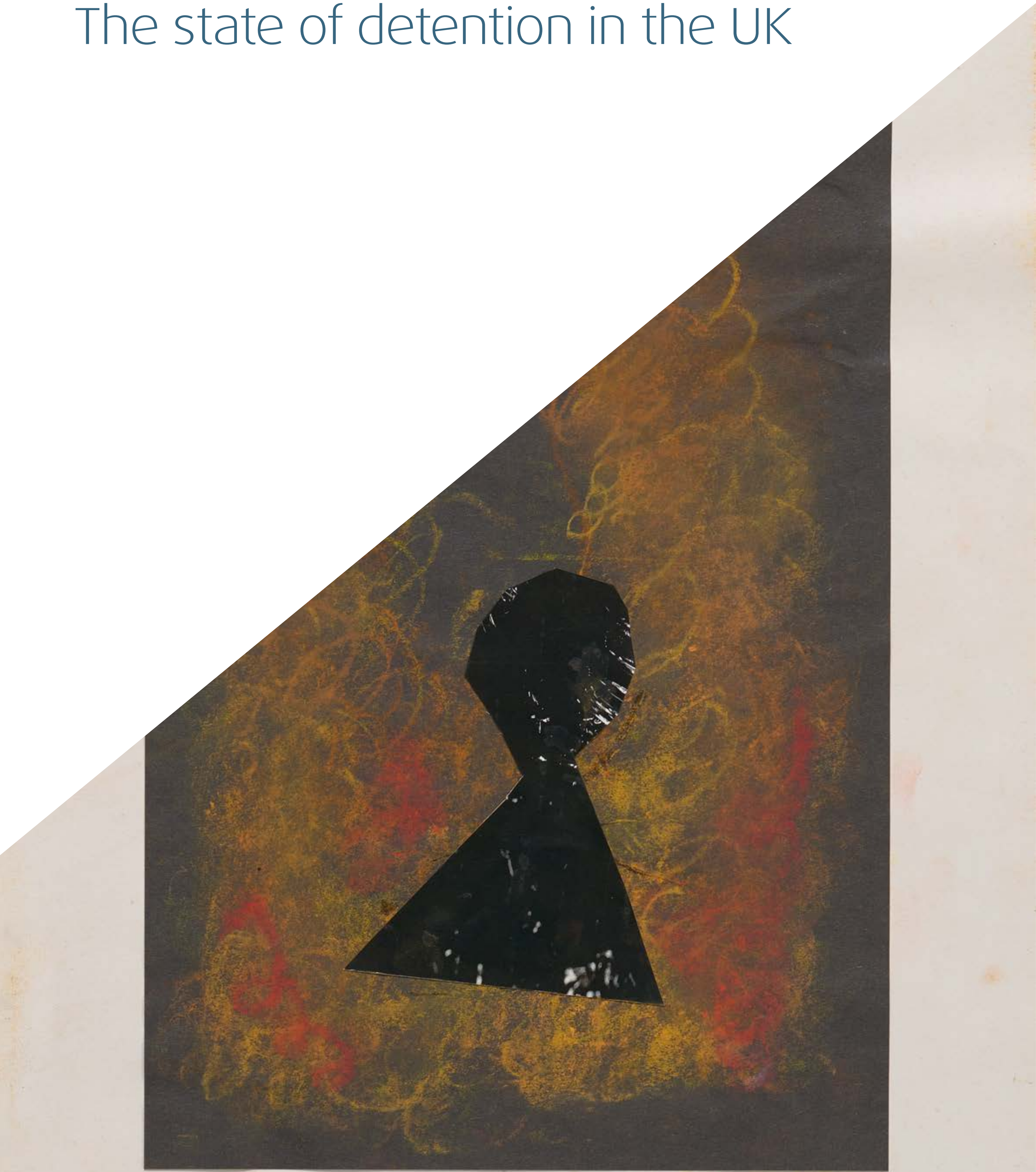
The UK NPM maintains a strong and beneficial relationship with the Council of Europe's Committee on the Prevention of Torture (CPT). We share learning, best practices and findings with each other to inform our work.

The CPT carried out an ad-hoc visit to Manston Short-Term Holding Facility, Western Jet Foil disembarkation site, and the Kent Intake Unit in November 2022.[1] The CPT communicated their report to UK authorities in February 2023, requesting a response containing a full account of actions taken to implement committee recommendations. The UK government's response is available on the Council of Europe's website.[2] The NPM will respond to the CPT's report and the UK government's response in the next reporting year. In the spring, the CPT visited detention facilities in the UK with a focus on immigration and will publish findings in the next reporting year.

1 Report to the United Kingdom government on the ad hoc visit to United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 25 to 28 November 2022 – Council of Europe **(coe.int)**

2 Response of the United Kingdom government to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to the United Kingdom – Council of Europe **(coe.int)**

The state of detention in the UK



Published in March 2022 as the previous reporting year ended, the Care Quality Commission's (CQC) progress report of 'Out of sight – who cares?' titled 'Restraint, segregation and seclusion review' begins:

> **"The 'Out of sight' report was intended to stop unacceptable practice... This has not happened."[3]**

Frustration with longstanding, repeated observations and recommendations is evident in the reports of NPM members from the reporting year that followed. In His Majesty's Inspectorate of Prisons' (HMIP) annual report for 2022-23, Chief Inspector Charlie Taylor states:

> **"I have become increasingly frustrated by prisons whose future plans are so vague that it is hard to see when progress is going to be made."[4]**

In its themed visit report on mental health support in Scotland's prisons, The Mental Welfare Commission for Scotland (MWCS) outlines:

> **"Our key messages of 2011 have not been realised."[5]**

Dame Anne Owers, then Chair of the Independent Monitoring Boards (IMB), stated to the House of Commons Justice Committee:

> **"My first national annual report started: 'Staffing issues dominated annual reports ...They affected every kind of prison and every aspect of prison life.' That was 2017-18. We repeated the message in 2019-20 and 2020-21. My most recent annual report began: 'Staffing problems, rather than Covid, are now the principal brake on safe, humane and rehabilitative regime'... We have constantly referred to the theme."[6]**

Criminal Justice Inspection Northern Ireland's (CJI) report, 'The operation of bail and remand in Northern Ireland', opens:

> **"The recommendations in this report yet again press for legislative reform to meet the needs of our criminal justice system today and tomorrow. We all know to achieve this we need a legislature and a place on a legislative programme."[7]**

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3 Out of sight – who cares? Restraint, segregation and seclusion review – Care Quality Commission **(cqc.org.uk)**

4 HM Chief Inspector of Prisons for England and Wales annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

5 Mental health support in Scotland's prisons 2021: under-served and under-resourced – Mental Welfare Commission for Scotland **(mwcscot.org.uk)**

6 House of Commons, Justice Committee, Oral evidence: The prison operational workforce, HC 91

7 The operation of bail and remand in Northern Ireland – Criminal Justice Inspection Northern Ireland **(cjini.org)**

An inspection report by His Majesty's Inspectorate of Prisons for Scotland (HMIPS) laments:

> **"It was extremely disappointing to find that many of the same issues that we had seen and reported on when we last inspected ... had not been resolved. In particular, despite significant efforts by management, the lack of experienced staff remained a critical concern."[8]**

His Majesty's Inspectorate of Constabulary in Scotland (HMICS) states in its annual report:

> **"At the end of March 2023, 84 recommendations were outstanding. These go back as far as 2015."[9]**

Ofsted's annual report charts a worsening situation for children waiting for a place in secure accommodation, compared to reports the previous year:

> **"In March this year, around 50 children who are at significant risk to themselves or others were waiting for a place in secure accommodation every day. This had almost doubled from 25 the previous year."**

Across jurisdictions and across settings of deprivation of liberty, conditions are not improving at sufficient pace, despite regular observations and recommendations by members.

The key finding of this annual report is the failure of institutions to adequately implement recommendations from NPM members.

Observations across all members suggest that without adequate investment from the UK and devolved governments to appropriately resource services, the recommendations and concerns expressed in reports will be impossible to fulfil. This is despite frequent findings of excellent practice and personal efforts by staff in what are very demanding circumstances.

Staff shortages, which are a consistent problem across justice and health and social care settings, impact on every other intervention and will underline the priority themes highlighted throughout this report. Relating to the 2021-22 'State of care' report, CQC identified that services were still gridlocked, while virtually every other member commented on the risks associated with a lack of adequate staff numbers and sufficiently trained and experienced staff.[10] Lack of access to purposeful and rehabilitative activity is a key issue identified across jurisdictions, exacerbating existing problems of isolation and forced idleness in prisons. In mental health contexts, workforce issues are compromising the quality of care that people have a right to expect and putting the safety of patients and staff at risk.[11]

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8 HMP Addiewell full inspection 7-18 November 2022 – HM Inspectorate of Prisons for Scotland **(prisonsinspectoratescotland.gov.uk)**

9 Annual report 2022-2023 – HM Inspectorate of Constabulary in Scotland **(hmics.scot)**

10 State of care 2021/22 – Care Quality Commission **(cqc.org.uk)**

11 Monitoring the Mental Health Act in 2021 to 2022 – Care Quality Commission **(cqc.org.uk)**

The exacerbating impacts of the lack of robust information sharing between services, adequate record keeping, analysis and investigation across different detention settings were noted to varying extents in inspections and reports by IMB, His Majesty's Inspector of Constabulary and Fire & Rescue Services (HMICFRS), CQC, HMICS, the Care Inspectorate, HMIP and the Independent Custody Visitors' Association (ICVA). The UK has a duty under OPCAT to ensure the effective sharing of information with the NPM. This requires the bodies that make up the UK's detention estate to keep accurate, thorough and up-to-date standards of record keeping and scrutiny. Joined-up care that continues as a person is moved through different services relies on necessary information being shared between them, and shared learning.

Inequality and discrimination are essential considerations across all the themes identified. Urgent action is needed, for example, to understand and address the over-representation of people from some ethnic groups, and particularly black people, detained under the Mental Health Act.[12] In prisons in England and Wales, there is evidence of explicit racism, but black prisoners and black prison staff explained that it was often the subtle and insidious racism that affected them most, and which was also more persistent.[13] Older people, people with disabilities, and LGBTQ+ people also faced gaps in support and access in prisons, immigration detention, court custody, police custody and in care settings, highlighting an unmet need.[14]

12 Draft Mental Health Bill 2022 – House of Commons and House of Lords (parliament.uk); Monitoring the Mental Health Act in 2021 to 2022 – Care Quality Commission **(cqc.org.uk)**

13 Thematic review: The experiences of adult black male prisoners and black prison staff – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

14 Inspection of court custody unit provision, Glasgow Sheriff Court and Justice of the Peace Court – HM Inspectorate of Prisons for Scotland **(prisonsinspectoratescotland.gov.uk)**; Inspection of court custody provision, Elgin Sheriff Court – HM Inspectorate of Prisons for Scotland **(prisonsinspectoratescotland.gov.uk)**; Annual report of the Independent Monitoring Board at HMP Dartmoor 2021/22 – **Independent Monitoring Boards**; Annual report of the short-term holding facilities in Scotland and Northern Ireland 2021/22 – **Independent Monitoring Boards**

Treatment and conditions

This year, conditions in prisons and immigration detention in the UK have been the subject of international comment and scrutiny. NPM members have also raised concerns throughout the year about elements of conditions and treatment in detention settings which are inconsistent with the Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), the European Prison Rules, and accepted norms for the dignified and humane treatment of those deprived of their liberty. The over-use of isolation in prisons, the under-documented and possibly disproportionate use of force and restraint in custody settings, and the living conditions in prisons and in immigration detention have been of particular concern.

Isolation restraint and segregation

In early 2023, a German court rejected the extradition of an Albanian man to the UK on human rights grounds, citing concerns about British prison conditions. In June 2023, an Irish court similarly refused to extradite a man to Scotland, based on the likelihood that he would face 22 hours a day confined to a small cell.[15]

Poor conditions and limited regime, despite good relationships between prisoners and staff, were reported in segregation units in prisons across the UK. While basic requirements were met – most prisoners in segregation were allowed a shower, 30 minutes of exercise and one telephone call a day – this is the bare minimum of what the NPM would expect.[16] Where possible further provision, including the expectation of more meaningful contact, must be made.

Though three prisons had improved provision of in-cell learning support by education staff, most prisoners had no opportunity to engage in activities. Long periods locked in cell in the general prison population also contributed to frustrations, leading to high levels of violence in over two thirds of inspected prisons in England and Wales.[17] Some segregation units were "bleak", with little access to meaningful regime or therapeutic support.[18] At other sites, weak oversight and monitoring made it impossible to see justification of prolonged segregation of a small number of women, some of whom were at risk of self-harm. HMIP found that separated children at most sites did not have an fair regime compared with the rest of the centre.[19]

An HMIPS thematic review into segregation in Scottish prisons, though published outside the reporting window, made findings of deep concern including the over-use of segregation for mental health across the prison estate. Too many prisoners faced detrimentally long periods in segregation known as Separation and Reintegration Units. They were unable to access a minimum of two hours of meaningful human contact per day in line with the Nelson Mandela Rules, and too little was

15 Germany refuses man's extradition to UK over jail concerns – **Scottish Legal News**

16 HM Chief Inspector of Prisons for England and Wales annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

17 HM Chief Inspector of Prisons for England and Wales annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

18 HM Chief Inspector of Prisons for England and Wales annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

19 HM Chief Inspector of Prisons for England and Wales annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

done to tackle individual problems that lead to Separation and Reintegration Unit stays and to support reintegration.[20]

In Northern Ireland, a 2022 review into the operation of segregation, known as Care and Supervision Units concluded that a number of prisoners in these units had experienced conditions amounting to solitary confinement.[21]

Use of force

Use of force had reduced in the male estate in **England and Wales**, though oversight and governance arrangements varied. Poor use of body-worn cameras meant that use of force in 12 prisons was not recorded.[22] Higher levels of force than necessary and bad language were used by officers towards prisoners at one prison, there was inadequate inquiry into reasons for use of force at another, and there was poor oversight at two more. A review into the experiences of black prisoners found persistently disproportionate use of force negatively impacted on black prisoners' experiences of custody.[23] One IMB noted that 50% of use of force was used on black prisoners, who made up 30% of the prison's population.[24]

IMBs noted that the use of PAVA spray had spread from prisons where it was planned for use into other prisons with no announcement. The possible rollout of PAVA spray to young offender institutions (YOIs) runs counter to CPT recommendations that PAVA spray "should not form part of the standard equipment of custodial staff and should not be used in confined spaces".[25] In YOIs and secure training centres in England and Wales, better behaviour management processes correlated with reduced levels of force.[26] Where pain inducing techniques were used inappropriately at Feltham, steps had been taken to address concerns recorded by HMIP.

The Children's Commissioner reports that isolation and restraint were used too often across children's secure settings in England, including children's homes, in response to sometimes low-level incidents. In line with the principle of the best interests of the child, restraint should not be used to maintain order but only as a safety measure

20 A thematic review of segregation in Scottish prisons – HM Inspectorate of Prisons for Scotland **(prisonsinspectoratescotland.gov.uk)**

21 A review into the operation of Care and Supervision Units in the Northern Ireland Prison Service – Criminal Justice Inspection Northern Ireland **(cjini.org)**

22 HM Chief Inspector of Prisons for England and Wales annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

23 Thematic review: The experiences of adult black male prisoners and black prison staff – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

24 February 2023 – The role of Independent Monitoring Boards (IMBs) – Prison Reform Trust **(prisonreformtrust.org.uk)**

25 Written questions, answers and statements – Secure training centres and young offender institutions: pepper spray – UK Parliament **(questions-statements.parliament.uk)**; Report to the government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 30 March to 12 April 2016 – Council of Europe **(coe.int)**

26 HM Chief Inspector of Prisons for England and Wales annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

to protect a child or third party.[27] Any use of force in detention should always be necessary, justified and proportionate, States must ensure that children deprived of their liberty are treated with humanity and respect.[28]

Prison inspections in **Scotland** found generally acceptable to satisfactory practice in terms of use of force, with physical restraint only used when necessary and strictly in accordance with the law.[29] However, HMIPS' thematic review of segregation in prisons found serious allegations of violence and bullying of prisoners by staff, including during control and restraint procedures.[30] If proven, this is a clear instance of deliberate ill-treatment. However, when raised with the authority, leaders took swift action.

In **Northern Ireland**, a joint inspection (RQIA and CJI) of Maghaberry Prison found good governance and mostly low-level use of force. Where staff were found to have used excessive force, leaders took appropriate action.[31] Use of force had reduced since the last inspection in 2018 but it was slightly higher than in similar prisons in England and Wales. In Woodlands Juvenile Justice Centre, use of force had also reduced since the last inspection.[32] While there was good governance on use of force, CJI recommended improvements to record keeping to ensure follow up and evaluation of post-incident support.

In **police custody settings** in England and Wales, ICVA undertook a thematic review of the use of anti-rip clothing in police custody based on HMICFRS and HMIP reports. They found consistent issues when the clothing was used in the absence of risk information, often by force, and potentially as a punitive measure. The proportionality and justification of this practice was not adequately recorded, and the clothing was reported as being used unnecessarily for detainees on Level 4 observations. Crucially, serious concerns were raised about detainee dignity, particularly when clothes were removed by force. In some cases, detainees were left naked in order to manage behaviour, both in custody suites which used anti-rip clothing and those that did not. ICVA attained a pro bono legal opinion regarding the forced use of anti-rip suits in the absence of risk information. Where there are alternative methods available to monitor detainee likelihood of harming behaviours, the opinion concluded

27 Family contact in youth custody – Children's Commissioner **(childrenscommissioner.gov.uk)**

28 Convention on the Rights of the Child text – UNICEF **(unicef.org)**

29 HMP Castle Huntly full inspection 20 June to 1 July 2022 – HM Inspectorate of Prisons for Scotland **(prisonsinspectoratescotland.gov.uk)**; HMP Inverness full inspection 15-26 August 2022 – HM Inspectorate of Prisons for Scotland **(prisonsinspectoratescotland.gov.uk)**; **HMP** Addiewell full inspection 7-18 November 2022 – HM Inspectorate of Prisons for Scotland **(prisonsinspectoratescotland.gov.uk)**; HMP Greenock full inspection 27 February to 3 March 2023 – HM Inspectorate of Prisons for Scotland **(prisonsinspectoratescotland.gov.uk)**; HMP Shotts full inspection 9-20 May 2022 **(prisonsinspectoratescotland.gov.uk)**;

30 A thematic review of segregation in Scottish prisons – HM Inspectorate of Prisons for Scotland **(prisonsinspectoratescotland.gov.uk)**

31 An unannounced inspection of Maghaberry Prison 20 September-6 October 2022 – Criminal Justice Inspection Northern Ireland **(cjini.org)**

32 An unannounced inspection of Woodlands Juvenile Justice Centre – Criminal Justice Inspection Northern Ireland **(cjini.org)**

that this practice is likely to be unlawful, raising serious concerns of ill-treatment.[33]

HMICFRS and CQC identified the lack of scrutiny of use of force and restraint in police custody as a cause of concern in most inspections.[34] Inaccurate data, lack of completed forms for use-of-force incidents, incomplete custody records, and limited quality assurances prevented forces from demonstrating that when force was used it was necessary, justified, and proportionate. They also raised concerns over protecting and maintaining the dignity of detainees when their clothing was removed.

In Northern Ireland, independent custody visitors continued their mandate to make unannounced visits to police stations and report on the rights, health and wellbeing, and conditions of individuals detained in custody. Independent custody visitors escalated serious concerns around use of force and alleged criminal activity in police custody which they continue to monitor.[35]

Use of force: mental health settings

Of note when considering use of force in settings of deprivation of liberty is the Mental Health Units (Use of Force) Act 2018. Although the Act received royal assent in 2018, none of the provisions entered into force until March 2022, and some provisions are still to begin. Certain requirements were in place before the Act came into effect, such as enhanced level of detail about restrictive interventions (effective since 2019) and training certified as complying with the Restraint Reduction Network's standards. CQC notes that since the Act came into effect, the number of restrictive interventions has not decreased. However, this is in part because more providers have started to submit data. Anecdotal feedback from CQC inspectors and a review of policies have created a mixed picture of implementation. CQC now has a policy position on restrictive practices across all health and social care sectors and plans to undertake a sampling exercise with a cross-section of mental health providers in early 2024.

33 Anti-rip clothing in custody: Interim evaluation – Independent Custody Visiting Association **(icva.org.uk)**

34 Custody suites archives – His Majesty's Inspectorate of Constabulary and Fire & Rescue Services **(justiceinspectorates.gov.uk)**

35 Independent custody visiting report, April 2022 to March 2023 – Northern Ireland Policing Board **(nipolicingboard.org.uk)**

Living conditions

In prisons in England and Wales and Scotland, overcrowding was an ongoing and entrenched issue. HMIP repeatedly raised concerns regarding poor living conditions, including the use of cells designed for one person which were holding two. These cells were cramped, and often lacked privacy, sufficient furniture, adequate screening and proper quality in-cell toilets.[36] Overpopulation of Scottish prisons has been a key concern of HMIPS for over a decade, with many prisons still regularly operating above their design capacity.[37]

In immigration detention, the IMB observed that while staff made efforts to keep marquees at Manston clean and tidy, the state of the site was "squalid", and noted that "the cleanliness of the facility, overcrowding, close contact and sharing of blankets also raise[d] serious concerns for the risk of cross contamination of diseases".[38] These observations and the outbreaks of disease and the death of one detainee from diphtheria raise serious questions about dignity, inhuman and degrading treatment, and the state's positive obligation to protect the right to life.

Based on reports of dangerous conditions in UK immigration detention, the CPT conducted an ad-hoc visit to the UK this year. The CPT remarked that the Manston marquees were deemed adequate for accommodating people for up to 24 hours provided that their maximum capacity be lowered.

> **"The CPT also notes that, in its view, during the latter half of October 2022 and the beginning of November 2022 when Manston Short-Term Holding Facility was severely overcrowded, the cumulation of prolonged detention in very poor conditions may have resulted in many persons held at Manston Short-Term Holding Facility having been subjected to inhuman and degrading treatment."[39]**

In immigration removal centres, detainees were held for long periods, with five people held at Brook House for over six months (one for 16 months) with little prospect of removal.[40] Detainees continued to be held in detention because of a lack of suitable accommodation in the community, including highly vulnerable people who had been granted bail. Some had been waiting for suitable accommodation for five months.

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36 HM Chief Inspector of Prisons for England and Wales annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

37 HM Chief Inspector's annual report 2022-23 – HM Inspectorate of Prisons for Scotland **(prisonsinspectoratescotland.gov.uk)**

38 Letter to Select Committee Chairs from IMB National Chair regarding IMB observations of conditions at Manston Short-Term Holding Facility – **Independent Monitoring Boards**

39 Report to the United Kingdom government on the ad hoc visit to United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 25 to 28 November 2022 – Council of Europe **(coe.int)**

40 HM Chief Inspector of Prisons for England and Wales annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

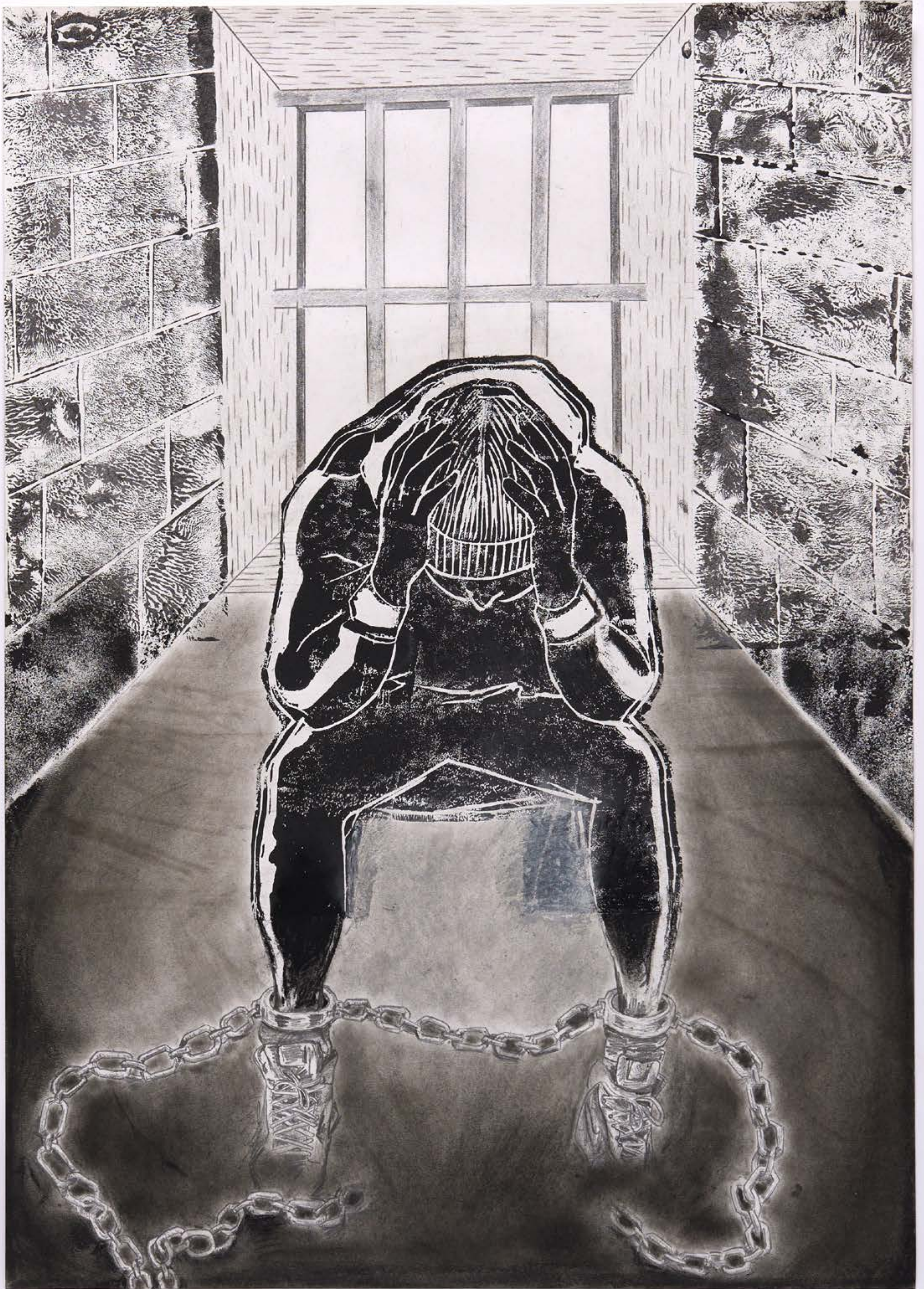
The courts have held that detention is only lawful if there is a reasonably imminent prospect of removal. In 2019, HMIP reported that "the lack of a detention time limit was often cited by detainees as affecting their feelings of wellbeing".[41] Detention must be proportionate, for as short a time as necessary, and avoid causing additional harm to detainees. Prolonged and indefinite detention risks making it impossible to fulfil these expectations.

The Children's Commissioner for England issued several briefings to MPs on the Illegal Migration Bill (now Act), including on her concern for children detained at the Kent Intake Unit and at Manston, given the living conditions. The Independent Reviewer of Terrorism Legislation noted the Nationality and Borders Act, passed in 2022, could create some changes in detention under Schedule 7 of the Terrorism Act 2000, in that it applies Schedule 7 wherever people arrive to the UK, not only at ports.[42] Schedule 7 is a national security port and border power. It enables an examining officer to stop, search, question and detain a person travelling through a port, airport or border area to determine whether they have been involved in the commission, preparation or instigation of acts of terrorism.[43] Detention is possible up to a maximum of six hours and must happen if the person is examined for more than one hour.

41 Report on an unannounced inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons 30 May-16 June 2022 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

42 Response by the Independent Reviewer of Terrorism Legislation **(independent.gov.uk)**

43 Terrorism Act 2020, Schedule 7



Mental health

The prevalence of acute and complex mental health issues among those in contact with the criminal justice system, and shortfalls and delays in their treatment once detained, is a longstanding issue of concern among NPM members. The serious mental health need, particularly the number of people who needed hospital treatment but were held in custody, prompted NPM members to form a Task and Finish Group on mental health to build on the findings outlined below through shared learning and outputs. Low staff numbers, incomplete records and information sharing, and conditions exacerbating poor mental health are reported in police custody, prisons, secure children's settings and in immigration detention. Meanwhile a shortage of available beds in health settings and hospitals, a lack of complete community provision, and insufficient awareness of the law and procedures in the health and social care sector lead to potentially unlawful deprivation of liberty and an increased likelihood of closed cultures developing.

In the criminal justice system

Police and court custody

In police custody in **England**, delays to Mental Health Act assessments and further waits for transfer to a mental health facility suggested Mental Health Act referral pathways are not working as effectively as they should, with significant challenges in accessing beds at health-based places of safety when required.[44] In some forces, insufficient support from mental health services to deal with people with mental ill health at the scene of an incident at times led to detention under Section 136 of the Mental Health Act when other solutions may have been available.[45]

Lack of information on liaison and diversion interventions, how many Mental Health Act assessments were carried out, how long detainees waited for assessment, or how long they waited for transfer, was a problem in many of the forces inspected. This makes it difficult for forces and mental health services to understand how well detainees with mental ill health are dealt with in custody. Insufficient recording or sharing of this information could increase risks for detainees, as staff on different shifts or from different services would not find the information necessary in order to meet their needs promptly and minimise risks.

As noted by Lay Observers, the poor quality of Person Escort Records prevents escort officers from making proper risk assessments, which can adversely affect the management of healthcare needs in transportation or in court custody.[46] Gaps in record keeping mean that outcomes for detainees and the appropriateness of their treatment cannot be comprehensively monitored. The UK is obliged under OPCAT to make available to the NPM all information referring to the treatment of people deprived of their liberty,

44 Custody suites archives – His Majesty's Inspectorate of Constabulary and Fire & Rescue Services **(justiceinspectorates.gov.uk)**

45 Report on an inspection visit to police custody suites in Greater Manchester – His Majesty's Inspectorate of Constabulary and Fire & Rescue Services **(justiceinspectorates.gov.uk)**; Report on an inspection visit to police custody suites in Dorset – His Majesty's Inspectorate of Constabulary and Fire & Rescue Services **(justiceinspectorates.gov.uk)**; Report on an unannounced inspection visit to police custody suites in Gloucestershire – HM Inspectorate of Constabulary and Fire & Rescue Services **(justiceinspectorates.gov.uk)**

46 Lay Observers annual report 2021-2022 – **Lay Observers**

as well as the conditions of their detention.[47] If information is not properly collected and stored, it is very unlikely the state will be able to fulfil this obligation.

There were also examples of good practice in terms of joint work between forces and mental health service partners, with training on mental health issues and close working with mental health nurses in particular leading to fewer Section 136 Mental Health Act detentions, higher diversion from custody, and the provision of a range of support options.[48]

Over the reporting year, ICVA was approached by members at Sussex Police and Crime Commissioners Office about the levels of artificial lighting in police custody cells and the impact this had on ability to rest, particularly for neurodiverse people and people with mental health challenges. Based on this and previous reports received, ICVA "was concerned that rest periods being disturbed by too bright lighting could possibly constitute a breach of human rights articles".[49]

Under the European Prison Rules, artificial light must satisfy recognised technical standards.[50] The Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules) require the provision of artificial light "sufficient for the prisoners to read or work without injury to eyesight".[51] Exposure to 24-hour artificial light beyond this level can impact human health by disturbing sleep and circadian rhythms and can cause physical discomfort and visual disturbance through glare.[52] Sleep deprivation is a method of psychological torture.[53] Although sleep disturbance and lack of sleep in UK police custody is a consequence of high levels of artificial lighting, the scope for damaging impacts on individuals in custody is concerning. Rule 43 of the Nelson Mandela Rules prohibits restrictions or disciplinary sanctions from involving the placement of a prisoner in a dark or constantly lit cell.

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47 OPCAT Article 20 (b).

48 Report on an inspection visit to police custody suites in Greater Manchester – His Majesty's Inspectorate of Constabulary and Fire & Rescue Services **(justiceinspectorates.gov.uk)**; Report on an unannounced inspection visit to police custody suites in North Wales Police – HM Inspectorate of Constabulary and Fire & Rescue Services **(justiceinspectorates.gov.uk)**; Report on an unannounced inspection visit to police custody suites in West Mercia Police – HM Inspectorate of Constabulary and Fire & Rescue Services **(justiceinspectorates.gov.uk)**; Report on an unannounced inspection visit to police custody suites in Gloucestershire – HM Inspectorate of Constabulary and Fire & Rescue Services **(justiceinspectorates.gov.uk)**; Report on an unannounced inspection visit to police custody suites in Hertfordshire – HM Inspectorate of Constabulary and Fire & Rescue Services **(justiceinspectorates.gov.uk)**; Report on an inspection visit to police custody suites in Lincolnshire – HM Inspectorate of Constabulary and Fire & Rescue Services **(justiceinspectorates.gov.uk)**

49 Lux lighting in custody: an impact report – Independent Custody Visiting Association **(icva.org.uk)**

50 European Prison Rules – Council of Europe **(coe.int)**

51 The United Nations Standard Minimum Rules for the Treatment of Prisoners – United Nations Office on Drugs and Crime **(unodc.org)**

52 The neglected pollutants: the effects of artificial light and noise on human health – House of Lords **(parliament.uk)**

53 Befogging reason, undermining will: Understanding the prohibition of sleep deprivation as torture and ill-treatment in international law – Torture journal **(tidsskrift.dk)**

ICVA requested a review of current brightness (lux) levels in cells by the National Police Estate Group. This review led to an amendment of the Custody Design Guide to reduce lux levels by 33% for new build sites and large-scale refurbishments across England and Wales. Evaluation of impact is taking place in the 2023-24 reporting year.

In **Scotland**, HMICS launched a thematic review in January 2023 into policing mental health.[54] This aims to assess the state, efficiency and effectiveness of Police Scotland's provision of mental health-related policing services. In partnership with Healthcare Improvement Scotland, a broader national baseline review of healthcare provision within police custody centres in Scotland was published in January 2023.[55] It found wide variation in access to healthcare in police custody across Scotland with inconsistent access to secondary mental health assessments, and identified the need for NHS boards to gather more robust evidence of local population needs to support the design and delivery of healthcare provided in custody. The review also noted examples of good practice in the delivery of healthcare to people in police custody, and in collaborative working both locally and nationally, suggesting ways forward in continuous healthcare provision in custody. While some findings were concerning, ultimately the new layer of scrutiny through joint inspections with Healthcare Improvement Scotland will highlight areas for further development and improve healthcare for those held in police custody. The Independent Custody Visiting Scheme Scotland identified that the lack of suitable alternative places of safety for children contributed to exceptional circumstances leading to a total of 4,261 children held in custody over the reporting year, an increase from the following two years.[56] The Independent Custody Visiting Scheme Scotland noted an increase in the percentage of people declaring mental health vulnerabilities in custody to 42% – 41,761 people.

Prisons

In **Scotland**, 13 of 44 deaths in prison custody in 2022 were by intentional self-harm.[57] HMIPS interviewed many prisoners who had self-harmed in segregation where the poor conditions and limited stimulation available risked "stark deterioration" in their mental health.[58] HMIPS noted significant and sustained pressures on healthcare staff having detrimental impacts on patient care, despite considerable efforts made in difficult circumstances by prison staff and the North Lanarkshire Health and Social Care Partnership to support healthcare needs at HMP Shotts. At HMP Addiewell, 75% of prisoners said that it was either quite difficult or very difficult to access mental healthcare.

MWCS published a themed visit report in April 2022, 'Mental health support in

54 Policing mental health in Scotland: a thematic review - Terms of reference – HM Inspectorate of Constabulary in Scotland **(hmics.scot)**

55 Joint national baseline review of healthcare provision within police custody centres in Scotland – HM Inspectorate of Constabulary in Scotland **(hmics.scot)**

56 Independent Custody Visiting Scheme Scotland annual report 2022-23 – Scottish Police Authority **(spa.police.uk)**

57 10. Deaths in custody by cause of death - Deaths in prison custody in Scotland 2012-2022 – Scottish Government **(www.gov.scot)**

58 A thematic review of segregation in Scottish prisons – HM Inspectorate of Prisons for Scotland **(prisonsinspectoratescotland.gov.uk)**

Scotland's prisons 2021: under-served and under-resourced'. This comprehensive report emphasises that "prison is not the place for seriously and acutely mentally ill prisoners".[59] Despite committed staff and some good areas of practice, key messages from 2011 had not been realised. Reliance on small numbers of specialist staff, lack of overarching strategic approach, lack of mental health resources, and no consideration for proactive post-pandemic planning or additional resources to support prisoners and staff were ongoing concerns. Care plans and dynamic review based on individual prisoners' needs were lacking – a particular concern for those placed in segregation.

In **England and Wales**, the year ending December 2022 saw a reduction in self-harm incidents per 1,000 male prisoners compared with the previous calendar year.[60] However, the number of deaths by suicide in the 12 months to March 2023 was 78, consistent with the previous year's 77. Weaknesses in preventive measures for suicide and self-harm, including poor oversight and lack of planning to improve outcomes were noted, and at some prisons insufficient analysis of data to understand the main causes of self-harm was highlighted. At other institutions, serious incidents were not systematically investigated to learn lessons. Insufficient analysis and learning prevents institutions from reforming practices and identifying long-term change to better protect prisoners' right to life. The state has a positive obligation to protect the right to life – not only must it refrain from taking a life, it must also take appropriate steps to safeguard the lives of those within its jurisdiction through preventive operational measures.[61]

An inspection of Maghaberry Prison in **Northern Ireland**, undertaken jointly by RQIA, CJI and the Education and Training Inspectorate identified that there had been seven self-inflicted deaths since the last inspection in 2018, but not enough evidence of institutional learning from each person's death.[62] Rates of self-harm were rising, there was very poor oversight of the management of prisoners in crisis, including those in Care and Supervision Units. CJI stated, "leaders had not done enough to understand this rise and there was no clear plan to address it".[63] There was insufficient response to recommendations following an enquiry into deaths in custody, with the three main recommendations in this area not achieved. Access to psychologically informed treatment services was a key concern during the inspection, though 33% of people in the prison said the overall quality of health services was very or quite good, and 23% said they had been helped with their mental health problem.[64] Half of prisoners reported spending less than two hours out of their cell on a typical weekday.

Long periods of time locked in cell, and the frustration and anxiety this causes, as well as

59 Mental health support in Scotland's prisons 2021: under-served and under-resourced – Mental Welfare Commission for Scotland **(mwcsot.org.uk)**

60 Annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

61 Guide on Article 2: right to life – European Court of Human Rights **(coe.int)**

62 An unannounced inspection of Maghaberry Prison 20 September-6 October 2022 – Criminal Justice Inspection Northern Ireland **(cjini.org)**

63 An unannounced inspection of Maghaberry Prison 20 September-6 October 2022 – Criminal Justice Inspection Northern Ireland **(cjini.org)**

64 An unannounced inspection of Maghaberry Prison 20 September-6 October 2022 – Criminal Justice Inspection Northern Ireland **(cjini.org)**

lack of purposeful activity and interventions were cited by prisoners as contributors to self-harm. Poor regime quality also limited the quality of relationships between staff and prisoners. There was very limited keywork taking place in English and Welsh prisons. Only two had effective key work in place, and elsewhere sessions covered basic welfare checks instead of meaningful focus on progress and achieving sentence plan targets, where keywork sessions had been reintroduced at all.[65] **Difficulties in recruitment, training and retention of experienced staff** exacerbated these conditions. Ongoing delays to access mental health services and sometimes an over-reliance on pharmaceutical, rather than therapeutic, support prevented patients from addressing underlying trauma, undermining their health outcomes. All prison inspectorates and monitoring bodies recorded deep concern for mentally unwell prisoners waiting protracted time to transfer to specialist mental health inpatient facilities for treatment under Mental Health Acts.

> **"All too often, those in mental health crisis were held in conditions that were clearly detrimental to their health and well-being, usually in segregation or inpatient units."[66]**

There was some resilient and active access for prisoners requiring urgent intervention, as well as good focus on early days in custody, effective co-ordination of discharge arrangements, and general good management of post-release support coordination. Positive results achieved by a designated unit for men with complex mental health needs at HMP Hewell were noted by the IMB.[67] Nonetheless, the IMB also noted the "unacceptably long" wait for transfer to external specialist psychiatric units.

For **women** in prison in England and Wales, self-harm rates increased in the reporting year, and there was a lack of active care to prevent crises. Low use by staff of body-worn cameras made it difficult to evidence whether the use of force to stop self-harming behaviour were proportionate or appropriate for women in crisis. There was high mental health need, and some prisons held acutely unwell women who should have been in hospital. Though general health care was broadly good, delivery was sometimes hindered by lack of staff. Services for women with personality disorder and highly complex needs were good, though as in other areas, consistent delivery was hampered by staff shortages. As continuously reported and yet not resolved, HMIP continued to find remanded and recalled women, women held in prison for their own protection, and women in prison as a "place of safety" on remand or recall to custody, while waiting for an assessment under the Mental Health Act in prisons – many of whom could have been cared for in community settings. As an example, the IMB at HMP/YOI Eastwood Park observed that four women with serious mental illness were held in an unsuitable unit. One woman with acquired brain injury endured 1,484 days of continuous

65 HM Chief Inspector of Prisons for England and Wales annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

66 HM Chief Inspector of Prisons for England and Wales annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

67 Annual report of the Independent Monitoring Board at HMP Hewell 2021/22 – **Independent Monitoring Boards**

segregation before her transfer to a medium secure hospital.[68]

Insufficient mental health services **in the community** to meet high levels of need meant that early warning opportunities were missed, resulting in women with complex mental health issues and women who were acutely mentally unwell being sent to prison. The IMB found that this was a particular issue with the services in Wales, compared to those in other areas.[69]

Social isolation, lack of meaningful activity, and continuous segregation amounting to solitary confinement contribute to inhuman and degrading treatment or punishment.[70] The CPT understands the term "solitary confinement" as meaning whenever a prisoner is ordered to be held separately from other prisoners – for example, as a result of a court decision, as a disciplinary sanction imposed within the prison system, as a preventative administrative measure or for the protection of the prisoner concerned.[71] The Istanbul statement on solitary confinement notes that in many jurisdictions "solitary confinement is also used as a substitute for proper medical or psychiatric care for mentally disordered individuals".[72]

CJI's review of the operation of bail and remand in **Northern Ireland** identified that 58% of women on remand in 2018 were in custody because of mental health, alcohol misuse, homelessness or suicide attempts.[73] In **court custody**, CJI found that staff had a good understanding of specific individual needs of groups, such as women who are pregnant or breastfeeding. There was sufficient staff and provision to respond to the welfare needs of detained women, who were transported and held separately from men.[74]

Women in **Scotland** were particularly affected by waiting times for mental health treatment, with those requiring high secure in-patient treatment forced to transfer to England.[75] Two women's Community Custody Units opened this year, and it is hoped that the bespoke setting based on trauma-informed principles will provide a route map of best practice for women in custody across the UK.

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68 Annual report of the Independent Monitoring Board at HMP/YOI Eastwood Park for reporting year 1 November 2021-31 October 2022 – **Independent Monitoring Boards**

69 Senedd Equality and Social Justice Committee's inquiry into women's experiences in the criminal justice system – Independent Monitoring Boards **(imb.org.uk)**

70 The right to be free from torture or cruel, inhuman or degrading treatment or punishment: for ombudsman schemes – Equality and Human Rights Commission **(equalityhumanrights.com)**

71 Solitary confinement of prisoners – Council of Europe **(coe.int)**

72 Istanbul statement on the use and effects of solitary confinement (2007)

73 The operation of bail and remand in Northern Ireland – Criminal Justice Inspection Northern Ireland **(cjini.org)**

74 Court custody: The detention of persons in the custody of the court in Northern Ireland – Criminal Justice Inspection Northern Ireland **(cjini.org)**

75 HM Chief Inspector's annual report 2022-23 – HM Inspectorate of Prisons for Scotland **(prisonsinspectoratescotland.gov.uk)**

Children's settings

For children in custody in Scotland, the Scottish Human Rights Commission's submission to the United Nations Convention on the Rights of the Child in December 2022 flagged concerns about detention conditions, particularly during the pandemic. These included inadequate access to physical activity, education and training opportunities, the disproportionate length of time spent in cells, and the high rates of mental ill health.[76] Young people referred to loneliness and boredom as key issues affecting their wellbeing.

However, at Woodlands Juvenile Justice Centre in **Northern Ireland**, the general standard of health services was good and child centred, with appropriate referrals made during custody and on release, and a therapeutic and responsive Child and Adolescent Mental Health Service in reach.[77] Many young people admitted to Woodlands had mental health issues which could be considered as disabilities, including Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, and cognitive or processing impairments. Each child was assessed on their arrival by health care and their needs were explored during initial assessments. Not all children admitted to Woodlands were referred or remained in detention long enough to see the in-reach team. Recommendations made by CJI at the previous inspection had been largely met, resulting in a much more integrated Child and Adolescent Mental Health Service team. There was evidence in case files that children were involved in discussions about their care and treatment. Young people who participated in the inspection were very positive about their engagement and the support provided, but there was a gap in in gathering formal service user experience.

In England and Wales there was mixed support to prevent suicide and self-harm among children in custody. Health services delivered a generally good service for children, though access to an appropriate range of mental health treatments for children to address their emotional and psychological trauma was outstanding at HMP/YOI Parc, despite being raised as a key concern in 2019.[78] The Children's Commissioner for England linked poor retention among staff to high levels of violence in YOIs and limits to opportunities for meaningful education and training that could have turned lives around, though smaller settings did sometimes provide safe and calm environments with enriching activities.[79] There is currently one operational Secure Training Centre in England: Oakhill. Oakhill provides for up to 80 children between 12 and 17 years of age who are remanded to custody or serving a custodial sentence. Oakhill is not providing good enough care for children as reflected in the joint inspectorates reports, and the environment provided does not meet the needs of vulnerable children.[80] The government's manifesto commitment to establish secure 16 to 19 academies dually

76 Letter from the Chair of the Scottish Human Rights Commission **(scottishhumanrights.com)**

77 An unannounced inspection of Woodlands Juvenile Justice Centre – Criminal Justice Inspection Northern Ireland **(cjini.org)**

78 HM Chief Inspector of Prisons for England and Wales annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

79 Family contact in youth custody – Children's Commissioner **(childrenscommissioner.gov.uk)**

80 Oakhill secure training centre: annual inspection – Ofsted **(ofsted.gov.uk)**

as secure children's homes and 16 to 19 academies is progressing.[81]

In **Northern Ireland**, RQIA completed two inspections to the regional secure children's service. The inspection found a continued increase in the complexity of needs within the children and young people requiring admission to the service. This led to an increase in the use of restrictive practices, to support the safety of the individual children and young people and staff. RQIA has raised concerns regarding the severity of the conditions suffered by the children and young people and the availability of resources in the regional secure centre. We are concerned there may be a correlation between children remaining in a secure setting and subject to restrictions, for longer than is necessary. RQIA have identified that regional co-ordination is required to reach a consensus on agreed processes for admission to and discharge from to the regional secure centre.[82]

Immigration detention

There was concern across all sites about the lack of access to mental health services, and the detrimental effects of continuing detention on some detainees. The Home Office recognised more than a third of detainees at Brook House as vulnerable under its "adults at risk" policy. Three of the 25 women at Derwentside during HMIP's inspection were assessed at the highest level of vulnerability, at which point ongoing detention is inherently detrimental to wellbeing.[83] Rule 35 of the Detention Centre Rules 2001 requires immigration detention medical staff to report to the Home Office if they have concerns that an individual's health is likely to be injuriously affected by continued detention. Despite this, inspection and monitoring evidenced that in practice, people continued to be detained at all sites even after concerns were raised regarding their fitness for detention. Continued detention against the guidance of medical professionals could potentially cross the threshold into ill-treatment.[84]

Initial and ongoing health assessments at Western Jet Foil were undermined by often being held in communal spaces without the routine use of interpreters, which compromised identification of health and treatment needs.[85] **Poor recording of information**, including on vulnerability and use of force, was noted. High numbers of people held for long periods at Manston Short-Term Holding Facility and outbreaks of infectious diseases led HMIP to conduct a second inspection at the site in February 2023. The report was published in the 2023-24 calendar year but refers to general improvements across sites contrasted with a major concern about leadership at Manston. Insufficient governance arrangements led to gaps in safeguarding processes, failure to make sufficient use of interpreting services, no proper oversight and inadequate data on

81 Secure schools: Police, Crime, Sentencing and Courts Act 2022 factsheet Oakhill secure training centre: annual inspection – GOV.UK **(www.gov.uk)**

82 RQIA annual report and accounts 1 April 2022-31 March 2023 – Regulation and Quality Improvement Authority **(rqia.org.uk)**

83 HM Chief Inspector of Prisons for England and Wales annual report 2022-23 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

84 The Detention Centre Rules 2001 **(legislation.gov.uk)**

85 Report to the United Kingdom government on the ad hoc visit to United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 25 to 28 November 2022 – Council of Europe **(coe.int)**

use of force or violent incidents, and possibly failure to identify or handle welfare issues.[86]

At short-term holding facilities in **Northern Ireland**, an IMB report published in August 2022 noted that the very low number of windows with openings did not allow for free flow of air in holding rooms and the residential short-term holding facility.[87] This was a major concern in terms of ventilation during and after the COVID-19 pandemic.

Reflecting on similar findings across the UK, the NPM Task and Finish Group on mental health in detention has encountered a serious gap in reporting, which obscures the extent of the issue as well as the points at which service provision and transfer can improve. Early reflections point to the need for a monitoring mechanism to identify causes of delay in transfers from prisons to hospitals, and a minimum data set on mental health.

Detention in mental health and welfare settings

There are various procedures in different jurisdictions of the UK to lawfully deprive a person of their liberty in a hospital or care setting in order to keep them safe, where they lack the capacity to consent to their care or treatment and where it is in their best interests and is necessary and proportionate. Under the Human Rights Act 1998, which applies across the UK, a person can only be deprived of their liberty where this is in specific circumstances and in accordance with a procedure prescribed in law.[88]

England and Wales

In England and Wales, a person can be detained under relevant sections of the **Mental Health Act 1983**, according to the assessment of (usually) an approved mental health professional, a doctor with specialist training and another doctor.[89] The Act provides authority for hospitals to detain and treat people who have a mental illness and need protection either for their own health or safety, or for the safety of other people. The Mental Health Act also provides powers for community treatment orders and guardianship.[90] CQC's last Mental Health Act report stresses that action is needed to resolve inequalities, particularly disproportionate detention and use of community treatment orders on

86 Report on an unannounced inspection of short-term holding facilities at Western Jet Foil, Manston and Kent Intake Unit, by HM Chief Inspector of Prisons, 30 January-17 February 2023 – HM Inspectorate of Prisons **(justiceinspectorates.gov.uk)**

87 Scotland and Northern Ireland Short-Term Holding Facilities 2021-22 annual report – Independent Monitoring Boards **(imb.org.uk)**

88 European Convention of Human Rights, 'Article 5, in UK law by virtue of the Human Rights Act 1998', 9 November 1998 **(legislation.gov.uk)**

89 What is the Mental Health Act? – Rethink Mental Illness **(rethink.org)**

90 Monitoring the Mental Health Act in 2021 to 2022 – Care Quality Commission **(cqc.org.uk)**

black people and people from some ethnic minority groups, including those from areas of deprivation.[91] Mental health services data suggests that community treatment orders are used over 11 times more on black people than white people.[92]

The quality of care delivered to people detained under the Mental Health Act was compromised by workforce issues and staff shortages, particularly a shortfall in qualified mental health nurses. Under-skilled and under-staffed facilities remained "the greatest challenge for the mental health sector" and affected patients' access to therapeutic care, reduced their involvement in decisions about their care, and resulted in the cancellation of ward activities and leave.[93] These difficulties led to increased aggression among patients and compromised the safety of patients and staff, as staff's ability to respond to incidents was compromised by the sustained pressure they are working under, where level of responsibility often outstrips level of qualification. CQC is increasingly concerned about the material conditions of wards and inpatient environments, many of which are "in urgent need of updated and repair". This affects the morale of patients and staff, as well as creating difficulties such as not being able to eat together and unavailability of locked spaces.[94]

Throughout the year, CQC found that gaps in community care add to the pressure on mental health inpatient services, many of which struggle to provide appropriate places and face delays in admission, transfer and discharge.[95] A survey of the experiences of people who use community health services showed that those experiences remained poor, and that areas with the poorest historical results were still lowest in 2022.[96] More needs to be done to improve support in the community and to increase the availability of inpatient beds. This was a particular problem for children and young people. Lack of availability led to a 32% increase in the number of under 18s admitted to adult psychiatric wards in 2021-22 compared to 2020-21.

In England, the number of children admitted to inpatient mental health wards and the number of detentions of children under the Mental Health Act continued to fall.[97] However, the Children's Commissioner for England concluded that crisis admissions of children to inpatient wards and detentions under the Mental Health Act would be prevented by earlier community support and intervention.[98] The Children's Commissioner has called for improved services for children with mental health difficulties at an early stage and better support for families.[99]

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91 Monitoring the Mental Health Act in 2021 to 2022 – Care Quality Commission **(cqc.org.uk)**

92 Mental Health Act community treatments orders (CTO): focused visits report – Care Quality Commission **(cqc.org.uk)**

93 Monitoring the Mental Health Act in 2021 to 2022 – Care Quality Commission **(cqc.org.uk)**

94 Monitoring the Mental Health Act in 2021 to 2022 – Care Quality Commission **(cqc.org.uk)**

95 Monitoring the Mental Health Act in 2021 to 2022 – Care Quality Commission **(cqc.org.uk)**

96 Community mental health survey 2022 – Care Quality Commission **(cqc.org.uk)**

97 Children's mental health services 2021-22 – Children's Commissioner **(childrenscommissioner.gov.uk)**

98 Children's mental health services 2021-22 – Children's Commissioner **(childrenscommissioner.gov.uk)**

99 The Children's Commissioner's submission to the United Nations Committee on the Rights of the Child – Children's Commissioner **(childrenscommissioner.gov.uk)**

They also expressed concern about children deprived of their liberty in settings other than a hospital who were effectively hidden from view and invisible to statistics. Her research suggests that over ten times as many children are deprived of their liberty in this way in 2023 compared to 2017-18.[100]

The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005, providing extra safeguards if restrictions or restraints will deprive a person of their liberty in a care home or hospital. In other settings, the Court of Protection can authorise a deprivation of liberty.[101]

In England, closed cultures and potential breaches of human rights were an identified risk in a wide range of health and social care settings. CQC found increased risk in services for autistic people and people with a learning disability. In their 2021-22 'State of care' report, CQC highlighted that visits to these services remained restricted through 2022 following the impact of the pandemic, with profound effects on the people living there. Just four of CQC's recommendations for change published in the 'Out of sight' report had been partially met out of 17. 13 were not met at all.[102] Some people deprived of their liberty in hospital did not have good quality independent reviews, and without recognition under the definition of long-term segregation, there were further obstacles to their adequate monitoring and scrutiny. Echoing its findings from the previous year, CQC remarked that health and social care services were still "gridlocked" in England, with staff shortages affecting all health and social care, as staff were drawn to sectors with less stressful conditions and higher pay.[103] CQC was concerned that ongoing problems with the DoLS process led to a risk of unlawful deprivations of liberty, with patients being potentially left without safeguards, rights or protections in place.[104] CQC's monitoring and assessment activities raised concerns that there was an increase in restrictive practice where DoLS was not applied for or authorised.

Lack of knowledge or understanding of DoLS among staff, poor quality of training on Mental Capacity Act assessments, and delays and backlogs in applications continue to be key issues impacting the DoLS system in England. In the adult social care sector, less experienced managers were found to lack an understanding of the need to apply for DoLS, particularly on the expiration of previously granted authorisations.

DoLS orders for children increased by 462% in the last three years in England, indicating a real need for settings to support children's needs, including secure settings and step-down care.[105] Concerningly, a lack of secure

100 Children's mental health services 2021-22 – Children's Commissioner **(childrenscommissioner.gov.uk)**

101 Deprivation of Liberty Safeguards (DoLS) at a glance – Social Care Institute for Excellence **(scie.org.uk)**

102 Out of sight – who cares? Restraint, segregation and seclusion review – Care Quality Commission **(cqc.org.uk)**

103 The state of health care and adult social care in England 2021/22 – Care Quality Commission **(cqc.org.uk)**

104 The state of health care and adult social care in England 2021/22 – Care Quality Commission **(cqc.org.uk)**

105 Submission to United Nations Committee on the Rights of the Child – Children's Commissioner **(childrenscommissioner.gov.uk)**

placements or other suitable provision is leading to more children being placed on DoLS orders. A third of these children are thought to have been in unregistered provision at some point – further away from regulatory oversight despite their vulnerability. Ofsted continues to have limited powers despite a commitment from the then Secretary of State in 2021 to extend them. The Children's Commissioner welcomed the launch of the National DoLS Court at the Royal Courts of Justice as a step towards ensuring greater expertise and scrutiny in granting DoLS orders. However, as of October 2023, this measure is replaced by the National DoLS List, which will continue to be overseen through the Family Division.[106] The Children's Commissioner described children's in-patient wards as potentially frightening spaces that separated children from family and friends, disrupted education and involved high levels of restraint. The government is currently carrying out a rapid review into mental health inpatient settings, in response to cases of children experiencing abuse and mistreatment. While it is pleasing to see the government take proactive action to review these cases, it is deeply concerning that the threshold into ill-treatment has clearly been crossed. In Scotland, the Care Inspectorate published an inspection of experiences for children on DoLS orders in June 2023, alongside guidance for providers, social workers and placement commissioners.[107] Just outside the reporting period, the findings will be explored further in next year's annual report.

DoLS applications to local authorities in Wales had increased but were lower than pre-pandemic levels. Though the number of applications to health boards was consistent, there was an increase in urgent applications since 2019. The increase in demand for care and support following COVID-19 and recovery created significant pressures on health and social care services, coinciding with a "crisis point" in workforce recruitment and retention. This has impacted on DoLS assessment processes, leaving health boards and local authorities concerned that people may have been deprived of their liberty unlawfully.[108] Nearly all supervisory bodies in Wales were unable to assure themselves that people's human rights were not being breached by unlawful deprivation of liberty due to ongoing delays in DoLS applications being assessed.[109] However, there was a significant improvement on the last reporting year in that most people were supported and represented in matters relating to their deprivation of liberty in Wales.

In Wales, as in other nations across the UK, some children who are deprived of their liberty are placed in illegal unregistered settings. These arrangements are not covered by any of the existing UK NPM members. Yvette Stanley, Ofsted's Director for Social Care, recently stated that:

106 Revised National Listing Protocol for applications that seek deprivation of liberty orders relating to children under the inherent jurisdiction – Courts and Tribunals Judiciary **(judiciary.uk)**

107 Depriving and restricting liberty for children and young people in care home school care and secure accommodation services – Care Inspectorate **(careinspectorate.com)**; Placing children: deprivation of liberty orders – Care Inspectorate Wales **(careinspectorate.wales)**

108 Deprivation of Liberty Safeguards: Annual monitoring report for health and social care 2021-22 – Health Inspectorate Wales **(hiw.org.uk)**

109 Deprivation of Liberty Safeguards: Annual monitoring report for health and social care 2021-22 – Care Inspectorate Wales **(careinspectorate.wales)**

"It's unacceptable that some of our most vulnerable children with very complex needs are living in places with the least oversight, where we do not know if they are safe, or if the people caring for them are suitable or skilled enough to meet their needs."[110]

In 2022-23 the average number of children who are a serious risk to themselves or others waiting for a place in a secure children's home has increased to 51, according to the Department for Education's data. Secure children's homes look after children who are remanded to custody, are serving a custodial sentence, but also children who are a significant risk to themselves or others who are not detained for justice reasons. Secure children's homes are generally performing very well. Children receive good care, good education and are supported to address the reasons they have ended up in secure care. The therapeutic approach, using the Framework for Integrated Care (SECURE STAIRS), has brought significant benefits to children and the staff caring for them.[111] Some of the children subject to DoLS are children who would have been placed in a secure children's home if a place had been available. Some of the provisions being used to look after these children are unregistered and therefore do not have the safeguards that a registered provision brings. The complexity of need of the children placed in secure children's homes continues, while some children are placed due to lack of appropriate provision that can meet their mental and emotional needs and keep them safe. They generally continue to provide a good level of care to the children they look after, despite facing recruitment and retention challenges that are similar to other sectors.

Northern Ireland

In Northern Ireland, DoLS are covered by the Mental Capacity Act (NI) 2016. Authorisation can be given by two professionals to detain a person in hospital for 14 days, which can be extended by another 14 days. In non-hospital settings, a trust panel makes this authorisation. RQIA are mindful of the importance of adequate resourcing to enable it to effectively execute its new statutory responsibilities set out under the Mental Capacity Act to strengthen protections for people detained under a DoLS under the Mental Capacity Act (2016) and are actively pursuing this.

RQIA monitors detention with mental health settings under the Mental Health (Northern Ireland) Order 1986, reviewing 9,200 forms during the year. RQIA safeguards the rights of detained patients who refuse their prescribed treatment, or do not have the capacity to consent to treatment. In delivering this responsibility, RQIA appoints experienced consultant psychiatrists as second opinion appointed doctors to provide a second opinion on the proposed treatment, including medication reviews and electroconvulsive therapy where there may not be the consent of the patient. During the year, 551 requests were managed for the provision of second opinion in relation to Part IV of the Mental Health (Northern Ireland) Order 1986, including 508 medication reviews and 43 relating to electroconvulsive therapy.[112] RQIA conducted 27 inspections to mental health hospitals in Northern Ireland, noting

110 Ofsted warns against use of unregistered children's homes – GOV.UK **(www.gov.uk)**

111 NHS commissioning: Children and young people – NHS **(england.nhs.uk)**

112 RQIA annual report and accounts 1 April 2022-31 March 2023 – Regulation and Quality Improvement Authority **(rqia.org.uk)**

significant staff shortages and the majority of inpatient wards operating over capacity on a regular basis. A lack of sufficient inpatient learning disability beds resulted in delays to admissions or admissions to mental health wards, which is impacting on the overall availability of mental health places.[113]

Training on DoLS was mainly up to date, with two exceptions. RQIA did not record concerns regarding the consideration of capacity for service users requiring high levels of supervision.[114] In one care home, an area of improvement was stated for a second time regarding out-of-date DoLS training.[115] The Nelson Mandela Rules, which while designed for prisons also set minimum standards for those deprived of their liberty in other settings, outline the importance of adequate education and training for staff under Rule 75. They require tailored training for general and specific duties for all staff before entering duty, with administrations responsible for continuously providing training on relevant legislation, regulations and policies, rights and duties of staff, security and safety, and first aid as a minimum (Rule 76).

Scotland

In Scotland, the Mental Health (Care and Treatment) (Scotland) Act 2003 allows emergency detention for up to 72 hours when recommended by a doctor and, where possible, a mental health officer, short-term detention in hospital if recommended by a psychiatrist and mental health officer, and compulsory treatment orders on application by a mental health officer.[116] Protections for those aged 16 and over who are deprived of their liberty in Scotland come under the Adults with Incapacity (Scotland) Act 2000, and include the Section 47 certificate of incapacity, completed by a healthcare professional who must prove that treatment complies with the Act.

MWCS conducted a broadly positive inspection of the State Hospital at Carstairs, where nursing staff received ongoing training to meet the complex needs of patients, which would soon be complemented by peer support training.[117] Care plans were detailed and person-centred with evidence of patient

113 RQIA annual report and accounts 1 April 2022-31 March 2023 – Regulation and Quality Improvement Authority **(rqia.org.uk)**

114 Inspection report: 30 June 2022 – Regulation and Quality Improvement Authority **(rqia.org.uk)**; Inspection report: 27 October 2022 – Regulation and Quality Improvement Authority **(rqia.org.uk)**; Inspection report: 9 December 2022 – Regulation and Quality Improvement Authority **(rqia.org.uk)**; Inspection report: 20 September 2022 – Regulation and Quality Improvement Authority **(rqia.org.uk)**; Inspection report: 30 December 2022 – Regulation and Quality Improvement Authority **(rqia.org.uk)**; Inspection report: 17 November 2022 – Regulation and Quality Improvement Authority **(rqia.org.uk)**; Inspection report: 24 May 2022 – Regulation and Quality Improvement Authority **(rqia.org.uk)**; Inspection report: 19 May 2022 – Regulation and Quality Improvement Authority **(rqia.org.uk)**; Inspection report: 1 November 2022 – Regulation and Quality Improvement Authority **(rqia.org.uk)**; Inspection report: 23 March 2023 – Regulation and Quality Improvement Authority **(rqia.org.uk)**; Inspection report: 20 March 2023 – Regulation and Quality Improvement Authority **(rqia.org.uk)**; Inspection report: 6 March 2023 – Regulation and Quality Improvement Authority **(rqia.org.uk)**

115 Inspection report: 9 September 2022 – Regulation and Quality Improvement Authority **(rqia.org.uk)**

116 Mental Health Act – Mental Welfare Commission for Scotland **(mwcscot.org.uk)**

117 Search – Mental Welfare Commission for Scotland **(mwcscot.org.uk)**

involvement, though there were ongoing and significant staffing difficulties which impacted on patient care.

Inspections of secure accommodation for young people in **Scotland** found good or very good services. However, an inspection completed just after the reporting year ended found significant challenges caused by staffing issues, with unclear management arrangements and a need for improvement in quality assurance processes to ensure consistently safe care.[118] In other accommodation, respect for young people was strong, with good staff relationships with young people, good environments for young people, and strong quality assurance, though recruitment and staffing had been a big challenge at one centre.[119]

Mental health detention: contributions to developing legislation

Liberty Protection Safeguards were introduced by the Mental Capacity (Amendment) Act 2019 to replace DoLS as the system to lawfully deprive people over the age of 16 of their liberty in England and Wales. The UK government consulted on the draft Liberty Protection Safeguards code of practice between March and July 2022, and the Welsh Government consulted on draft regulations supporting the implementation of the Liberty Protection Safeguards in Wales.

The Welsh consultation concluded that Care Inspectorate Wales, Healthcare Inspectorate Wales and Estyn should be the monitoring bodies for Liberty Protection Safeguards in Wales with quarterly reporting responsibilities as an additional safeguard. However, concerns were expressed that duplication of responsibility might occur where there are already duties for providers to notify Care Inspectorate Wales and Healthcare Inspectorate Wales under the Regulation and Inspection of Social Care (Wales) Act 2016.[120] The Amendment Act and Liberty Protection Safeguards have been delayed until an unspecified date. The Children's Commissioner for England responded to the UK government's consultation on proposed changes to the Mental Capacity Act 2005 Code of Practice and the implementation of the Liberty Protection Safeguards, raising concerns that they would offer less robust safeguards for 16- and 17-year-olds compared to existing arrangements.[121]

At the beginning of 2021, the UK government announced reforms to the Mental Health Act 1983 in England and Wales. Giving evidence to the Joint Committee on the Draft Mental Health Bill, CQC raised points about the realistic projection of resourcing and workforce implications to meet the ambitions of the

118 Unannounced inspection of St. Mary's Kenmure Secure Accommodation Service, 27 April 2023 – Care Inspectorate (careinspectorate.com)

119 Unannounced inspection of Good Shepherd Centre Bishopston, 25 May 2023 – Care Inspectorate (careinspectorate.com); Unannounced Inspection of Kibble Safe Centre, 1 December 2022 – Care Inspectorate (careinspectorate.com); Unannounced Inspection of Rossie Secure Accommodation Services, 30 January 2023 – Care Inspectorate (careinspectorate.com)

120 Consultation summary of responses – Draft regulations for Wales: Liberty Protection Safeguards – Welsh Government **(gov.wales)**

121 Submission to United Nations Committee on the Rights of the Child – Children's Commissioner **(childrenscommissioner.gov.uk)**

Bill.[122] CQC and MWCS both responded to the proposal of advance choice documents, advocating for their statutory inclusion to improve a person's role in their own decision-making during episodes of compulsion. The involvement of a person in their own care to the extent possible is key to the principle of consent to care.

In **Scotland**, the Care Inspectorate and the Scottish Human Rights Commission responded to consultations on proposals for a National Care Service. The Care Inspectorate highlighted needs for a person-centred, human rights-based approach underpinned by the Health and Social Care Standards. Clarification from Scottish Government regarding the inclusion of children's and justice services is still outstanding, and the Care Inspectorate is concerned that the National Care Service will result in shared responsibility between ministers, local authorities and health boards, which could dilute responsibility unless the specific role of each actor is clearly defined. In all actions concerning children, whether undertaken by public or private social welfare institutions, the best interests of the child must be a primary consideration.[123]

MWCS responded to the Scottish Government's consultation on the Scottish Mental Health Law Review in June 2022. They cited the over-use of detention in response to self-harm and psychosis among children, and called for an end to provisions in law that allow for detention proceeding from a community setting on the basis of a single medical professional viewpoint.[124]

MWCS also submitted proposals for a new system of review of deaths in mental health detention in Scotland, recommending that an independent body conduct timely reviews. Timely and independent scrutiny is necessary to identify opportunities for change to better protect prisoners' right to life and fulfil states' positive obligations to safeguard the lives of those within their jurisdictions.

In March 2023, RQIA contributed to the Northern Ireland consultation on the Department of Health's new regional policy on the use of restrictive practices.[125] This policy provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion across all areas where health and social care is delivered in Northern Ireland. The emphasis is on eliminating their use, but certainly on minimising their use. It is applicable to everyone – children, young people, adults and older people, to all health and social care staff and within all health and social care services.

Members have been active in fulfilling their mandate under OPCAT Article 19 (C) to submit proposals and observations concerning existing or draft legislation. This is an important element of the NPM's preventive function by contributing a human rights perspective to legal and policy developments which will affect people deprived of their liberty in the future.

122 Draft Mental Health Bill 2022 – House of Commons and House of Lords (parliament.uk); Written evidence submitted by the Care Quality Commission **(committees.parliament.uk)**

123 United Nations Convention on the Rights of the Child Article 3(1)

124 Scottish Mental Health Law Review: consultation response – Mental Welfare Commission for Scotland **(mwcscot.org.uk)**

125 Regional policy on the use of restrictive practices in health and social care settings – Department of Health, Northern Ireland **(health-ni.gov.uk)**

Children: distance placements and closed cultures

Inspectors for the Care Inspectorate reported an increase in the number of children being placed on a cross-border or long-distance basis in regulated care homes in **Scotland**, flagging the negative impact on children, whose rights may be less protected due to inadequate planning, poor practice and lack of resources in home communities.[126] Cross-border and long-distance placements disrupt family contact, communities, culture, education, advocacy, understanding of rights, transition and placement planning. Article 9 of the United Nations Convention on the Rights of the Child requires states to respect the rights of the child separated from one or both parents to maintain personal relations and direct contact with both parents regularly, except where it is contrary to their best interests.

Reflecting on the significant number of cross-border placements for children, Care Inspectorate remarked:

> "While a legal pathway for placements to care homes from England, Wales and Northern Ireland exists, questions persist particularly around orders made under Section 20 of the Children Act 1989, interim care orders, and the legal effect of deprivation of liberty orders in Scotland. Cases have been challenged where it has been argued children have been deprived of their liberty unlawfully in care home establishments that are not authorised under Scottish legislation to do this."

English placing authorities are bound by the Children Act 1989 and the Care Planning, Placement and Case Review (England) Regulations 2010 to plan effectively for placements, engage with the receiving authority, and share information with the receiving service. English local authorities placing a child into Scottish residential care under deprivation of liberty restrictions must follow relevant Scottish regulations to ensure that the order is legally recognised.[127] The placing local authority must provide an undertaking in writing to specified people ahead of the child moving to Scotland and can share any other relevant information with the relevant Scottish local authority. The Care Inspectorate and Ofsted have developed a protocol for sharing information where there are concerns about the actions or inactions of a local authority in each other's jurisdiction, but there remain limits on the action that can be taken to mandate improvements. Cross-border placements do not appear to present such accountability problems between England and Wales due to the integrated legal systems. However, community and education disruption will still affect the children concerned. Care Inspectorate Wales and Healthcare Inspectorate Wales clarify that where some Welsh people receive care and support or treatment in care homes and hospitals outside Wales, the DoLS assessments remain the responsibility of the Welsh supervisory bodies.[128]

126 Report on distance placements: exploration of practice, outcomes, and children's rights, May 2022 – Care Inspectorate **(careinspectorate.com)**

127 **Cross-border Placements (Effect of Deprivation of Liberty Orders) (Scotland) Regulations 2022**

128 Deprivation of Liberty Safeguards: Annual monitoring report for health and social care 2021-22 – Care Inspectorate Wales **(careinspectorate.wales)**

The placement of people in hospital settings far from home, a particular problem for autistic people and people with a learning disability, increases the risk of closed cultures developing.[129] Closed cultures are also exacerbated by staff shortages and increased use of agency staff, leading to disruptions to continuity of care – an inherent risk factor in the development of a closed culture. Acknowledging ongoing media coverage of abusive cultures in care settings, CQC is particularly aware of the risk of ill-treatment of autistic people and people with a learning disability in such cultures. CQC has continued to develop their approach with the aim of identifying and taking action if services are failing to meet people's needs.

From February to June 2023, the Northern Ireland Policing Board undertook a human rights review: 'Children and young people: Strip searching in police custody.[130]

Recommendations included re-writing Article 55 of the Police and Criminal Evidence Act to ensure that custody officers must have honest and objective bases for suspecting a prohibited item before a strip search can be authorised. Then, strip searches of children should only occur when there is no alternative means to find the item, protect the person or protect others. The review recommended that custody staff clearly record details of their decisions to conduct strip searches. The Police Service of Northern Ireland should publish annual disaggregated figures on the strip searching of children, including reasons and outcome, whether an appropriate adult was present and if not, why not.

Concerning the strip-searching of children, reliability of data and inaccurate information is a concern across the UK, raised in the context of a human rights review in Northern Ireland.[131] Police forces submit data on strip searches to the Home Office on a voluntary basis. In Northern Ireland, a particular issue is that the absence of items found by a strip search calls into question the nature of the intelligence or evidential basis for the search. In all actions affecting children, the best interests of the child must be a primary consideration according to the United Nations Convention on the Rights of the Child (Article 3). Any interference with privacy must be in accordance with the law, necessary for a legitimate aim, and proportionate (European Convention on Human Rights Article 8, and United Nations Convention on the Rights of the Child Article 16).

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129 Monitoring the Mental Health Act in 2021 to 2022 – Care Quality Commission **(cqc.org.uk)**

130 Human Rights Review – Children and young people: Strip searching in police custody – Northern Ireland Policing Board **(nipolicingboard.org.uk)**

131 Human Rights Review – Children and young people: Strip searching in police custody – Northern Ireland Policing Board **(nipolicingboard.org.uk)**

NPM members; current work and priorities

The Care Inspectorate

The Care Inspectorate conducted unannounced inspections of all five registered secure accommodation services this year. In addition, they published the 'Report on distance placements: exploration of practice, outcomes, and children's rights' in May 2022. With HMICS, HMIPS and His Majesty's Inspectorate of Prosecution in Scotland, the Care Inspectorate conducted a joint review of diversion from prosecution. They also consulted on the Barnahus Standards and on the Scottish Government's proposals for a National Care Service.

Care Inspectorate Wales

With Healthcare Inspectorate Wales, Care Inspectorate Wales monitors Deprivation of Liberty Safeguards in Wales, producing the annual monitoring report for health and social care. Care Inspectorate Wales drafted a monitoring and reporting strategy of Liberty Protection Safeguards for Wales and contributed to the UK government's consultation on Liberty Protection Safeguards.

Care Quality Commission (CQC)

CQC publishes the 'Monitoring the Mental Health Act' and the 'State of care' reports every year, reporting on the protection and treatment of those detained under the Mental Health Act and those deprived of their liberty in health and social care settings. In November 2022, CQC published a focused visits report on Mental Health Act community treatment orders. In August 2023, CQC published its new restrictive practice policy position, covering expectations that providers promote positive cultures where staff listen to and understand people in their care, promote trust, support recovery, and protect the safety and wellbeing of all patients and people using services.[132] CQC expects providers to analyse any incidents of restrictive practice in order to learn from them and reduce their occurrence. CQC regulates registered providers, including the training requirements for staff which, under the Health and Care Act 2022, includes a requirement on learning disability and autism.[133]

CQC also monitors, inspects and regulates health and social care in the criminal justice and immigration detention systems to make sure people who use services in secure settings receive the same quality of care as the rest of the population. CQC is undertaking ongoing thematic work with HMIP on causes of delays in mental health transfers from prisons, YOIs and secure children's homes.

CQC has a duty under the Mental Health Act to monitor how services exercise their powers and discharge their duties when patients are detained in hospital or are subject to community treatment orders or guardianship. CQC visits and interviews people currently detained in hospital and has specific duties under the Mental Health Act, such as to provide a second opinion appointed doctor service, review Mental Health Act complaints, and make proposals for changes to the code of practice. CQC is also contributing to consultations regarding the Mental Health Act reform in England.

132 Restrictive practice – a failure of person-centred care planning? – Medium **(carequalitycomm.medium.com)**

133 Training staff to support autistic people and people with a learning disability – Care Quality Commission **(cqc.org.uk)**. From 1 July 2022, a new legal requirement introduced by the Health and Care Act 2022 requires all CQC-registered providers to ensure their staff receive learning disability and autism training at a level appropriate to their role.

The Children's Commissioner for England

Among many reports published throughout the reporting year, the Children's Commissioner's reports on family contact in youth custody and on children's mental health services during 2021-22 were published in March 2023.

The Children's Commissioner engaged substantially with government on the Illegal Migration Bill (now Act), publishing priorities for amendment drafting (24 March 2023), a briefing to MPs (13 March 2023), a briefing for MPs ahead of the report stage of the Illegal Migration Bill (25 April 2023), and a briefing for peers on the Illegal Migration Bill on 10 May 2023.

In December 2022, the Children's Commissioner submitted evidence to the United Nations Committee on the Rights of the Child.

Following an August 2022 analysis of strip search of children by the Metropolitan Police Service, the Children's Commissioner conducted their first project on strip searching, publishing a report on strip search of children in England and Wales in March 2023.

Criminal Justice Inspection Northern Ireland (CJI)

CJI published five inspection reports and was awaiting publication on the sixth at the end of this reporting year. In September 2022, CJI published an announced inspection of Woodlands Juvenile Justice Centre (in partnership with the RQIA and the Education and Training Inspectorate) that related to its NPM function. A youth friendly version of the report was also published and well received. Other inspection work in Northern Ireland's prisons completed in-year will be published in the 2023-24 financial year.

CJI also inspected probation approved premises (March 2023), examining the conditions for those released on license from prison.[134] CJI is the designated oversight body for the first review of Part 1 of the Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021, in addition to CJI's inspection programme.

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales monitors how health boards and independent providers discharge their powers and duties under the Mental Health Act 1983, amended in 2007, on behalf of Welsh ministers. Healthcare Inspectorate Wales has extensively revised Mental Health Act compliance methodology to assist reviewers who monitor how the health boards and independent providers discharge their duties under the Act. In addition, they operate the second opinion appointed doctor service for Wales. This service safeguards the rights of people who, while detained under the Mental Health Act, have refused prescribed treatment or have been assessed as unable to consent to the treatment.

In 2022-23 Healthcare Inspectorate Wales undertook a total of 22 onsite inspections of a range of healthcare settings of both NHS and independent hospitals. The ward accommodated a range of patients that included adults with mental health issues, older people, adults with learning disabilities and the Child and Adolescent Mental Health Service. Healthcare Inspectorate Wales jointly visited three community mental

134 A review of probation approved premises in Northern Ireland – Criminal Justice Inspection Northern Ireland **(cjini.org)**

health teams with Care Inspectorate Wales. The reports on these visits will be published in the autumn of 2023. Healthcare Inspectorate Wales also undertook a local review of discharge arrangements for adult patients from inpatient mental health services in Cwm Taf Morgannwg University Health Board. This resulted in a number of significant recommendations being made to the health board.

His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)

HMICFRS evaluated its joint custody inspection programme this year, identifying a number of areas where custody inspections have led to improvements in the welfare and dignity of detainees. This includes through changes to legislation and Police and Criminal Evidence Act codes of practice. HMICFRS inspected nine police custody suites across England and Wales throughout the year. In June 2022, HMICFRS published version 4 of the expectations for police custody.

His Majesty's Inspectorate of Constabulary in Scotland (HMICS)

HMICS conducted five reviews over the reporting year: the joint review on diversion from prosecution, the joint national baseline review of healthcare provision within police custody centres in Scotland, the assurance review of Scottish Police Authority toxicology provision, an assurance review of Police Scotland's contact assessment model, and an assurance review of Police Scotland's strategic workforce planning.

As well as inspections of police custody suites, HMICS conducted a thematic inspection of domestic abuse (phase 1), joint inspections of adult support and protection services, and joint inspections of services for children and young people at risk of harm.

HMICS made 45 recommendations to Police Scotland, the Scottish Police Authority and Scottish Government throughout the year. They agreed with Police Scotland and the Scottish Police Authority to discharge 42 recommendations from inspections completed between 2015 and 2021. 84 recommendations were outstanding at the end of the reporting year.

His Majesty's Inspectorate of Prisons (HMIP)

HMIP published 83 inspection, independent review of progress and thematic reports between 1 April 2022 and 31 March 2023. In October, HMIP also carried out an extra-jurisdiction inspection in Northern Ireland. One urgent notification letter was issued regarding HMP Exeter.

Thematic reports covered:

- the experiences of adult black male prisoners and black prison staff
- the experience of immigration detainees in prisons
- children in custody
- the impact of the COVID-19 pandemic on the criminal justice system
- multi-agency public protection arrangements
- a thematic review of outcomes for girls in custody
- a joint thematic inspection of offender management in custody – pre-release (with His Majesty's Inspectorate of Probation)
- weekends in prison.

HMIP made written submissions to the Justice Committee's pre-legislative scrutiny of the draft Victims Bill (a criminal justice joint inspection submission), the Joint Committee on the draft Mental Health Bill, and the Equality and Human Rights Commission's statutory review of equality and human rights in Britain. The Chief Inspector of Prisons gave oral evidence to the Justice Select Committee on the work of the criminal justice inspectorates, the role of adult custodial remand in the criminal justice system, and the prison operational workforce, and to the Joint Committee on Human Rights on the human rights of asylum seekers in the UK.

His Majesty's Inspectorate of Prisons for Scotland (HMIPS)

HMIPS conducted four full prison inspections and seven court custody unit inspections over the reporting year. They gave evidence to four Scottish Parliament sessions and to two public inquiries, as well as responding to Scottish Government consultations on the proposed Children Care and Justice Bill and the proposed Bail and Release Bill. HMIPS conducted four thematic reviews in collaboration with key stakeholders on progression, segregation, diversion from prosecution, and control and restraint assurance for the Cabinet Secretary.

Independent Custody Visiting Association (ICVA)

ICVA have had three main areas of policy work in the reporting year. ICVA have worked with schemes to examine the **lighting levels** following reports from detainees stating that the lighting was too bright for them to be able to sleep in cells. The result of this policy work was that the National Design Guide for police custody suites (applicable to new builds and large-scale refurbishments) has been amended to a lower lighting level, more effectively balancing operational need with detainee comfort. All existing suites have been asked to check the lighting levels and amend to the lower light if possible.

ICVA have continued their work on reducing the inappropriate use of anti-rip clothing in custody. In December 2023, they published an interim evaluation into work with a pilot site in Dyfed Powys which made recommendations to policing stakeholders regarding the use of the clothing, by force, in the absence of risk information.[135] The response to these recommendations was broadly positive and ICVA will produce a full-term evaluation in 2024, including an update on responses to the recommendations and ongoing work.

The third thematic area of policy impact is work regarding the establishment of a new referral pathway for women experiencing symptoms of perimenopause and menopause in police custody. Sussex Police and Crime Commissioners Office and ICVA worked on a series of recommendations to policing stakeholders to establish a new referral pathway, generating a care plan for women in custody experiencing symptoms. This work is expected to conclude in 2024.

135 Anti-rip clothing in custody: Interim evaluation – Independent Custody Visiting Association **(icva.org.uk)**

Independent Custody Visiting Scheme Scotland

Independent custody visitors ensure that police custody provision in Scotland upholds the international standards set by the United Nations to prevent torture, and the cruel, inhuman or degrading treatment of people in custody. Independent custody visitors undertook more than 1,000 visits during the reporting year and spoke to over 1,600 people in custody. The Independent Custody Visiting Scheme Scotland launched a new reporting template this year to streamline the recording of observations and improve data quality. Work is ongoing to digitise reports.

Independent Monitoring Board (IMB)

The IMB National Chair and members of the management board gave oral and written evidence to parliamentary committees and groups on topics including conditions in immigration detention, imprisonment for public protection sentences, women's experiences in the criminal justice system, and staffing in prisons.

Independent Monitoring Boards (Northern Ireland)

HMP Maghaberry, HMP Magilligan, and Hydebank Wood College and Women's Prison each have an IMB. IMB continued to monitor progress on recommendations and improvements outlined in CJI's review of Care and Supervision Units throughout the year.

Independent Reviewer of Terrorism Legislation

The Independent Reviewer of Terrorism Legislation continues to work on their core mandate, working closely with partners to address and mitigate concerns.

Lay Observers

Lay Observers raised serious concerns about the treatment of detainees, particularly focusing on children and young people and the impact of staff shortages. Lay Observers were concerned about unnecessary delays in travel times to and from courts, and to release following court appearances. Observers found that nearly a fifth of all official documents lack accurate and complete information – preventing custody officers making effective risk assessments and putting detainees at risk.

Mental Welfare Commission for Scotland (MWCS)

MWCS found that mental health services in prisons in Scotland needed urgent action, ten years after it published similar findings. During the year, MWCS responded to Scotland's Mental Health Law Review, contributed an analysis of compulsory treatment for mental ill health for future law reform, and identified a rise in numbers of young people admitted to adult mental health wards.

Ofsted

Ofsted leads inspections of secure training centres supported by HMIP and CQC. Findings continue to show that children do not receive good enough care, with no secure training centre being judged higher than 'requires improvement to be good' since 2016. Ofsted inspects and regulates 13 secure children's homes in England, supported by CQC. Inspection findings show that generally, secure children's homes provide a good level of safe care to children. Ofsted has continued to work closely with Ministry of Justice and the Youth Custody Service, supporting their understanding of the requirements to register the first secure 16 to 19 academy that will be regulated by Ofsted and inspected by Ofsted and the CQC. Ofsted also supports HMIP inspections of YOIs in England assessing education provision.

Northern Ireland Policing Board Independent Custody Visiting Scheme

Custody visitors made 489 visits and checked 960 custody records throughout the 2022-23 reporting period. Independent custody visitors visited approximately 14% of those individuals arrested under the Terrorism Act and 2.5% of those arrested under the Police and Criminal Evidence Act.

The most frequent matters raised by independent custody visitors related to medical attention, followed by detainees requiring an appropriate adult, needing to inform somebody of their detention, and having adequate food and drink.

Custody visitors were consulted on their findings for the Policing Board's human rights report, which was published in January 2023. The Policing Board is progressing recommendations, including the review and update of the independent custody visitors handbook in conjunction with the board's human rights advisor. Once completed, the handbook will be issued to existing independent custody visitors and to the Police Service of Northern Ireland for consultation.

The Regulation and Quality Improvement Authority (RQIA)

RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

It is RQIA's general duty under the Mental Health (Northern Ireland) Order 1986 to keep reviewing the care and treatment of people suffering or appearing to be suffering from mental disorder. It has specific responsibilities to assess the health and social care services (whether in an acute or a community setting) provided to people with mental ill health or a learning disability, and to inquire into any case where there may be ill-treatment, deficiency in care or treatment, improper detention in a hospital or guardianship, or risk of loss or damage to a patient's property due to their mental disorder. RQIA undertakes inspections across 51 mental health and learning disability wards and the regional children's secure unit. It reviews over 8,000 mental health order assessment forms and 1,000 detention dormitories each year. It oversees requests for the provision of second opinions in relation to Part IV of the Mental Health (Northern Ireland) Order 1986, including medication reviews and reviews relating to electroconvulsive therapy. It also assesses the quality of health care in prisons though joint inspections with the Criminal Justice Inspectorate, the Criminal Justice Inspection Northern Ireland, and the Education and Training Inspectorate.

Scottish Human Rights Commission

The Scottish Human Rights Commission raised a range of human rights concerns with United Nations bodies over the year. The Commission reported into the United Nations Universal Periodic Review of the UK in April 2022 and raised issues of concern for human rights protection and realisation in Scotland through direct engagement with member states throughout the summer and autumn of 2022. The UK Universal Periodic Review dialogue was conducted in November 2022, where a number of concerns about criminal justice and conditions in places of detention featured. The Commission continues to engage with the UK government and Scottish Government to support implementation of recommendations and is planning work relating to Scottish-specific implementation. In January 2023, the Commission submitted a parallel report to the United Nations Committee on Economic, Social and Cultural Rights and a supplementary note to the United Nations Committee on the Rights of the Child. The Commission also gave oral evidence to the Committee on Economic, Social and Cultural Rights in March 2022.

The Scottish Human Rights Commission also provided briefings and oral evidence to Scottish and UK parliamentary committees regarding legislation affecting places of detention. This includes to the Joint Committee on Human Rights' legislative scrutiny of the Bill of Rights Bill, the National Care Service (Scotland) Bill, and the Scottish Mental Health Law Review. The Commission also published materials to support consideration of a new Human Rights Bill in Scotland, including a briefing on minimum core obligations for the Scottish Parliament's Equality, Human Rights and Civil Justice Committee's capacity building inquiry.

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