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national
preventive
mechanism

Monitoring places of detention

Sixth **Annual Report**
of the United Kingdom's
National Preventive Mechanism
1 April 2014 – 31 March 2015

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Introduction by Nick Hardwick

Her Majesty's Chief Inspector of Prisons

This annual report describes the work of the 20 inspection and monitoring bodies that make up the UK National Preventive Mechanism (NPM). The NPM fulfils the UK's obligations arising from its status as a party to the Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) to ensure the independent, preventive monitoring of all places of detention and carry out other effective preventive measures. The report focuses first on solitary confinement and isolation, the most restrictive form of custody any NPM member monitors. Second, it reviews the progress the NPM itself has been able to make in strengthening its own governance and effectiveness in order to share best practice and develop a consistent approach to tackling common concerns.

Our work on solitary confinement and isolation is a long-term project that began this year with developing a picture of how it is used across the range of establishments we monitor throughout the four nations of the UK. In the next stage, NPM members will aim to develop some consistent standards and methodology for monitoring its use.

In many cases, detainees are isolated legitimately to prevent harm or provide a calm environment that is in their best interest. However, prolonged solitary confinement or isolation can also have a detrimental effect on a detainee's mental health, exacerbate behaviour problems and increase the risks of their ill-treatment. It is already clear that poor governance, inconsistent practice and a soothing terminology allow some individuals to be held in solitary confinement for long periods without adequate safeguards – and that includes some of the most vulnerable people in detention, such as children and mentally ill people.

Solitary confinement and isolation go under many names: solitary confinement, isolation, separation, care and separation, unemployed disruptive, single unlock, loss of association, losses, basic for violence, basic, group separation, low stimulus, time out, intensive care suite, therapeutic isolation, single-person wards, enforced segregation, removal from association, temporary confinement, separation and reintegration, close supervision centres, special cells, confined to room, duty of care. There is a risk that some of this terminology can obscure the seriousness of the practice and the need for rigorous monitoring and governance.

What all of these processes have in common is individuals locked up on their own for long periods with limited contact with other detainees or staff.

In this report we have drawn on United Nations and international standards to define 'solitary confinement',[1] and draw a qualitative distinction between this and 'isolation' (see page 24 for definitions).

Our review shows that it would be possible to have two men with identical mental health needs, disruptive behaviour and self-harm risks held in very different conditions, depending where they ended up. A man in a prison segregation unit might be locked in a dirty cell for 23 hours a day, with no activity apart from a radio to listen to and very limited human contact. A man with identical characteristics might also be isolated in a secure hospital, where he would be kept in his own room, allowed as many of his own things as possible, and visited regularly by staff and health professionals who would help him reintegrate. A boy of 16 in a YOI might be disciplined by being confined in an adult segregation unit for some days; the same boy in a STC might be confined in his own room for a few hours for the same behaviour.

Inconsistencies in the use of isolation and solitary confinement, however, are just one example that demonstrates the need for NPM members to work effectively together to develop common standards and methodologies to improve treatment and conditions across the whole range of detention settings.

The summary of NPM members' work during the year contained in this report provides further examples of the pressures on the establishments we monitor, and the opportunities to share both the concerns and best practice that have arisen in response to this.

Last year, we reported on the major exercise we had undertaken five years after the NPM had been designed to assess how effective it was in fulfilling its responsibilities. This year we can report that real progress has been made. Awareness of their responsibilities arising from OPCAT has increased among NPM members, and this is increasingly reflected in their own monitoring and inspection processes and the development of human rights–based standards. NPM members have agreed to take action to reduce their reliance on seconded staff and avoid conflict of interest where this is necessary. Members are also working to develop and implement arrangements to ensure detainees and others do not face sanctions because of their contact with NPM members. An NPM website was developed during the year and went live shortly after the year end. NPM sub-groups on children, mental health and Scotland provide an opportunity to share best practice, and coordinate contact with government and detention authorities.

Progress on measures to strengthen the NPM's governance has been slower. Some NPM members in England were themselves subject to welcome calls from parliamentary committees and other bodies for their independence from their

1 Istanbul Statement on the Use and Effects of Solitary Confinement, 9 December 2007, at: http://www.solitaryconfinement.org/istanbul (accessed 14/10/15); United Nations Commission on Crime Prevention and Criminal Justice (2015), 'The Mandela Rules' (E/CN.15/2015/L.6/Rev.1), Rule 44.

sponsoring departments to be reviewed and strengthened. It was disappointing that the government did not accept these recommendations. The recruitment of an independent chair for the NPM as the first step in establishing its own board - capable of holding members to account for their work, ensuring appropriate consistency and developing a distinct NPM identity - was delayed because of concern by the Ministry of Justice, the responsible department.

Frustrating though these delays were, the UK NPM continued to attract widespread international attention as an example of best practice, and members had much contact with other NPMs and states interested in the UK system. About the time this report is scheduled to be published, in December 2015, the United Nations General Assembly is expected to adopt the *Mandela Rules*, a timely revision of the 1955 *Standard Minimum Rules for the Treatment of Prisoners* and a hugely important contemporary statement by the international community about the responsibility to treat prisoners decently and humanely.

This document reasserts the importance of independent detention monitoring. It would be a fitting time for the UK to demonstrate that its own arrangements for preventing ill-treatment of detainees have also continued to develop and meet the new international standards.

Nick Hardwick
Her Majesty's Chief Inspector of Prisons

Section one
Context

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

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

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

In order to carry out its monitoring role effectively, the NPM must:

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

Additionally, the NPM must have the power to:

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

The NPM must also liaise with the Subcommittee on Prevention of Torture (SPT), an international body established by OPCAT with both operational functions (visiting places of detention in states parties and making recommendations regarding the protection of detainees from ill-treatment) and advisory functions (providing assistance and training to states parties and NPMs). The SPT is made up of 25 independent and impartial experts from around the world, and publishes an annual report on its activities.[2] There are currently 80 states parties to OPCAT, and 62 designated NPMs.

2 See: http://www.ohchr.org/EN/HRBodies/OPCAT/Pages/OPCATIndex.aspx (accessed 14/10/15).

The UK's National Preventive Mechanism

The UK ratified OPCAT in December 2003 and designated its NPM in March 2009. Designation of the NPM was the responsibility of the UK government and it chose to designate multiple existing bodies rather than create a new, single-body NPM. This took into account the fact that many types of detention in the UK were already subject to monitoring by independent bodies, as envisaged by OPCAT, and the different political, legal and administrative systems in place in the four nations that make up the UK. Designations were made to the NPM in 2009 and 2013, and 20 individual bodies now make up the NPM.

England and Wales

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

Scotland

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

Northern Ireland

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

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

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

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

The NPM's biannual business meetings are its main forum for members to share findings, best practice, experiences and lessons from monitoring different types of detention and different jurisdictions. The NPM business plan and other decisions for members are taken at these meetings. This year, business meetings were held in June 2014 (Belfast), November 2014 (Bridgend, Wales) and March 2015 (London).

NPM coordination

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

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

HMI Prisons fulfils the role of NPM coordination and this function is performed with the purpose of:

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

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

NPM steering group

The NPM steering group supports decision-making between business meetings, and develops the NPM business plan and proposals to members. It is chaired by HM Chief Inspector of Prisons (England and Wales). The steering group met three times during the year (May, September, February).

In November 2014, ICVA ended its term on the steering group and was replaced by HMIC; in March 2015, HIW was replaced by CSSIW. As of March 2015, the NPM steering group membership was as follows:

- Nick Hardwick, HM Chief Inspector of Prisons (HMI Prisons)
- Theresa Nixon, Regulation and Quality Improvement Authority (RQIA)
- David Strang, HM Chief Inspector of Prisons for Scotland (HMIPS)
- Kevin Barker, Care and Social Services Inspectorate Wales (CSSIW)
- Judith Million, HM Inspectorate of Constabulary (HMIC).

NPM sub-groups

In October 2014, a sub-group formed of the Scottish members of the UK NPM was established (see Appendix I). The group aims to coordinate NPM activities in Scotland, provide support to NPM members, raise the profile of the work of the NPM and improve liaison with the Scottish Government. It is chaired by HM Chief Inspector of Prisons for Scotland.

In November 2014, NPM members established a mental health network as a sub-group of the wider NPM business meeting. The network brings together the different members who have a specialist interest in areas relevant to mental health detention in the UK, bringing a new opportunity for organisations with responsibilities for the monitoring and protection of people in health and social care detention settings to work collaboratively on issues with specific mental health impacts. It is chaired by the Care Quality Commission (see Appendix II).

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

The situation in detention during the year

Prisons

A serious decline in outcomes for prisoners was of concern to NPM members in England and Wales. In particular, inspection reports for 2014–15 indicated a sharp decline in safety and purposeful activity outcomes, with a 10% rise in assault incidents and a 33% increase in serious assaults on staff between 2013 and 2014. There were 76 self-inflicted deaths during the reporting year. Data from NOMS showed that 25 of those who took their lives were on an open assessment, care in custody and teamwork (ACCT) document – a case management system for prisoners identified as at risk of self-harm or suicide.

Outcomes for purposeful activity were only good or reasonably good in 25% of adult male prisons inspected during the year. The new core day, introduced across most adult prisons in this reporting year, was hampered by staff shortages, which impacted on prisoners' access to meaningful activity. Though overcrowding and staff shortages affected day-to-day living arrangements in many prisons, good individual relationships between staff and prisoners offset some of the worst problems these caused. There were concerns that the offender assessment system (OASys) sentencing planning process was well behind schedule, with many prisoners not having these appropriately completed.[4]

Health services had improved across the prison estate, but the emerging phenomenon of new psychoactive substances (NPS)[5] in prisons contributed to problems of debt and violence among prisoners.

Police and court custody

Although inspections have shown that conditions in police custody in England and Wales have improved over the last five years, it was of great concern that the number of deaths in or following police custody increased from 11 in 2013–14 to 17 in 2014–15.[6] Too many vulnerable people continued to be held in police custody, and greater efforts were needed to safeguard children and those with mental health problems and, where appropriate, divert them from the criminal justice system.[7] There was a welcome fall in the number of people detained in police custody as a place of safety under section 136 of the Mental Health Act 1983 from 8,667 in 2011–12 to 6,028 in 2013–14,[8] but although some forces had made excellent progress in addressing this, others continued to detain too many people in crisis.[9] Although high numbers of children continued to be detained overnight in police cells, and people from black and minority ethnic groups continued to be

4 See HM Chief Inspector of Prisons for England and Wales (2015), *Annual Report 2014-15*; and reports of the Independent Monitoring Boards, at http://www.imb.org.uk/reports/.
5 New drugs that mimic the effects of illegal drugs, such as cannabis, heroin or amphetamines, and may have unpredictable and life-threatening effects.
6 Independent Police Complaints Commission (2015) *Deaths during or following police contact: statistics for England and Wales 2014-15*.
7 HM Inspectorate of Constabulary (2015), *The welfare of vulnerable people in police custody*; see also http://www.blackmentalhealth.org.uk/index.php/expert-opinion-mainmenu-127/1584-home-office-a-bmh-uk-joint-summit-puts-diasporas-concerns-back-on-mental-health-agenda (accesed 14/10/15).
8 Health and Social Care Information Centre (2014), *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment, 2013-14*, table 9.
9 The new government announced its intention to prohibit the use of police cells as a place of safety for children and further reduce their use in the case of adults requiring mental health care and treatment. See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430149/QS_lobby_pack_FINAL_NEW_2.pdf, p.68 (accesed 14/10/15).

overrepresented in police custody, there was still no systematic collection of data that could provide an authoritative national view on police custody, vulnerability and discrimination.[10] Improvements in the collection and monitoring of information on the use of force and strip searches were needed, as well as in the quality and quality assurance of custody records, risk assessments and transfer of information about detainees.

NPM monitoring identified fragmented and ineffective leadership in court custody, and often filthy and unsanitary conditions. There was little understanding of the needs of vulnerable detainees, and the assessment of risk was poor.

Children in detention

The welcome fall in the number of children in custody in England and Wales continued in 2014–15, to an average population of 1,048 in 2014–15 (of whom an average of 43 were girls),[11] and led to reductions in the number of establishments holding children, resulting in children being detained, on average, further away from home. The most recent available data (for 2013–14) demonstrated an increase in the average number of days that children spent in custody on the previous year,[12] and NPM members documented evidence that the children who remained in custody exhibited a more concentrated combination of very challenging behaviour and complex needs than the wider range of children held in the past; establishments struggled to meet these needs.

In Wales, the number of 'justice' places for children remanded and sentenced by the courts reduced in line with demand in the only secure children's home, but the number of secure 'welfare' places for children subject to a secure welfare order increased. Inspections in England found concerning levels of violence and insufficient time out of cells in YOIs, but positive work in secure training centres and secure children's homes. Recorded rates of restraint, assault and self-harm have increased across the secure estate for children and young people to a five-year high.[13]

Health and social care detention

Dramatic increases in the numbers of deprivation of liberty applications and cases reaching the court of protection in England and Wales were reported during the year. This followed on from the Supreme Court judgment in *P v Cheshire West and Chester Council and another* and *P and Q v Surrey County Council*,[14] which expanded the understanding of the definition of 'deprivation of liberty' and as a result brought to light an increasing number of people who are recognised as deprived of their liberty. In the six months following the judgment, the numbers of requests from hospitals and care homes for deprivation of liberty safeguards authorisation increased at a rate likely to be at least eight times that of 2013–14. The numbers of applications to the court of protection for authorisation relating to community settings also climbed, and are predicted to climb higher. As a result, local authorities have an unacceptable backlog of

10 HM Inspectorate of Constabulary (2015), *op. cit*.
11 Ministry of Justice (2015) *Youth custody report: August 2015* at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/466486/youth-custody-data-august-2015.xls (accessed 14/10/15).
12 Ministry of Justice/ Youth Justice Board (2015) *Youth justice annual statistics 2013-14*.
13 Ministry of Justice/ Youth Justice Board (2015), *op. cit*.
14 UK Supreme Court, *P v Cheshire West and Chester Council and another* and *P and Q v Surrey County Council*, [2014] UKSC 19.

requests with 19,429 applications pending a decision at the end of September 2014 and a high number of people probably deprived of their liberty without authorisation. NPM members noted variation in the correct use of the safeguards by region, which indicated a lack of understanding of the Mental Capacity Act.[15]

Variation in the care provided to detained patients was noted. Too often, NPM monitoring found services that were not routinely involving patients in their treatment; issues of bed availability, and an increasing number of patients being detained far away from home.[16] NPM members continue to encounter *de facto* detention across a range of settings. The framework for investigating deaths in mental health detention was called into question for its lack of independence.[17]

Immigration detention

The main concerns for immigration detainees were the uncertainty about their detention and anxiety about their immigration case. These concerns were exacerbated for detainees who were vulnerable for some reason – and too often these vulnerabilities were not recognised or addressed. Increasing numbers of detainees reported not having access to legal advice to help apply for bail or for their immigration case. It is government policy that children are not held in immigration removal centres but children can be wrongly detained in 'age dispute' cases.[18]

Military detention

Inspection of military detention (the Military Corrective Training Centre and Service Custody Facilities) during the year identified strong relationships between staff and detainees, provision of good quality activities, and a focus on resettlement from the first day of detention.

Political context, legislative and policy developments

A referendum on Scottish independence took place in September 2014, with 55.3% voting against independence and 44.7% voting in favour. Among other constitutional issues, this meant the possibility that Scotland would have to consider separate ratification of international treaties, including OPCAT, did not have to be pursued. The UK general election of May 2015 led to a new majority government being formed by the Conservative party. Among the party's pre-election manifesto commitments was the plan to 'scrap the Human Rights Act, and introduce a British Bill of Rights' with a view to breaking the formal link between British courts and the European Court of Human Rights.[19] Significant gains were made by the Scottish National Party, which won 55 seats in the UK parliament.

Public expenditure reductions have taken place across all the sectors inspected by NPM members in the UK. In Northern Ireland, members reported that austerity

15 Care Quality Commission (2014), *Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2013/14*; UK Parliament, *Health: Deprivation of Liberty Safeguards, Question for short debate*, HL Deb 16 March 2015, volume 760, column 975-992 at http://www.publications.parliament.uk/pa/ld201415/ldhansrd/text/150316-0002.htm#15031643000129 (accessed 14/10/15).
16 Care Quality Commission (2015), *Annual Report and Accounts 2014-15*.
17 Equality and Human Rights Commission (2015), *Preventing deaths in detention of adults with mental health conditions, Executive summary*, p.5; Inquest (2015) *Deaths in mental health detention: an investigation framework fit for purpose?*.
18 During 2014, the Refugee Council's age dispute project secured the release of 25 detainees whose age had been disputed but who were later found to be children or a full age assessment was pending. Refugee Council (2014) *Age dispute project, end of year report 2014*.
19 Conservative Party (2015), The Conservative Party manifesto.

measures have led to significant changes to the delivery of criminal justice, including the budgets of NPM members.

There were many major developments in legislation and policy during the year affecting both the services that NPM members inspect and their own monitoring functions.

- The Social Care and Wellbeing (Wales) Act became law on 1 May 2014. The act provides the legal framework for improving the wellbeing of people who need care and support, and carers who need support, and for transforming social services in Wales; it will come into effect from April 2016.[20]
- The Immigration Act 2014 introduced limitations on the right to appeal Home Office immigration decisions to an independent tribunal, among other provisions.[21]
- The Children and Families Act 2014 changed the Children's Commissioner for England's primary function, which now involves 'promoting and protecting the rights of children' with regard to the UN Convention on the Rights of the Child, rather than 'promoting awareness of the views and interests of children'. It entered into force on 1 April 2014.[22]
- The Regulation and Inspection of Social Care (Wales) Bill, introduced in February 2015, seeks to reform the regulatory and inspection regime for both care and support services and local authority social services functions in Wales.
- The Public Services Reform (Inspection and Monitoring of Prisons) (Scotland) Order 2015[23] introduced a new system of independent monitoring of prisons to replace the existing Prison Visiting Committees, and passed responsibility for monitoring legalised police cells[24] to custody visitors. It will enter into force on 31 August 2015.
- The Criminal Justice and Courts Act 2015 received Royal Assent in February 2015 and established secure colleges as new places of detention for young people, setting out powers for HMI Prisons and Ofsted to inspect secure colleges if they are ever developed.[25] The Act also introduced mandatory prison sentences for those aged 16 years or older convicted of a second or subsequent offence of carrying a knife.
- The Care Act 2014 came into effect in April 2015, introducing a statutory framework for the delivery of social care in prisons and marking a significant change in the way prisons arrange and provide social care for offenders.
- The Revised Code of Practice for the Detention, Treatment and Questioning of Persons by Police Officers (Police and Criminal Evidence Act 1984 Code C) was issued in May 2014. This includes the revision to the law made in the previous year that allows 17-year-olds the right of access to an appropriate adult when in police custody.[26]

20 At: http://www.legislation.gov.uk/anaw/2014/4/contents (accessed 14/10/15).
21 At: http://www.legislation.gov.uk/ukpga/2014/22/contents/enacted (accessed 14/10/15).
22 At: http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted (accessed 14/10/15).
23 At: http://www.legislation.gov.uk/ssi/2015/39/contents/made (accessed 14/10/15).
24 Legalised police cells are where prisoners can be held for up to 30 days. They are found in police stations not near to prisons.
25 In July 2015, the Minister for Prisons, Andrew Selous MP, announced to parliament that the government would no longer go ahead with the creation of a 'secure college pathfinder' and work on the proposed site in the Midlands would cease.
26 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/364707/PaceCodeC2014.pdf

- Revisions to the Mental Health Act Code of Practice were published in January 2015 and apply in England. The revised document includes five new overarching principles that should inform all decisions under the act, and calls on MHA commissioners to consider human rights legislation and international conventions.[27]
- The Offender Rehabilitation Act 2014 introduced provisions about the release and supervision after release of offenders, including those on short sentences. Under the Act, all prisoners, regardless of the length of their sentence, will be subject to a minimum of 12 months supervision and rehabilitation support on their release.[28]
- Further to this Act, the 'Transforming Rehabilitation' programme began to be implemented with the reorganisation of rehabilitation services provided through 'community rehabilitation companies' (for medium- and low-risk offenders) and the National Probation Service (for high- and very high-risk offenders).[29]
- The Serious Crime Act 2015 created new offences relating to possession of knives and offensive weapons in prisons and throwing articles into prisons.[30]
- The Counter-Terrorism and Security Act 2015 establishes a duty on specified public bodies, including all prisons, YOIs, STCs and SCHs, to prevent people being drawn into terrorist activity.[31]
- The Mental Health Scotland Bill was introduced with a view to amending the Mental Health (Care and Treatment) (Scotland) Act 2003, including proposals to make provision about mental health disposals in criminal cases, and change and enhance provisions relating to the rights of the individual person.[32]
- The Children and Young People (Scotland) Act 2014 places additional duties on Scottish ministers and public bodies to ensure children's rights are integrated in their work, and increases the power of the Scottish Commissioner for Children and Young People to investigate complaints regarding their rights.[33]

Taken together, NPM members viewed the legislative developments in Wales as bringing a renewed emphasis on the centrality of outcomes for the citizen and their communities as the measure of success of public services. NPM members' efforts to strengthen their own inspection frameworks will support these efforts.

Plans to build a new women's prison in Scotland, to replace the Cornton Vale prison, were scrapped and in January the Scottish Government announced plans to consult on the provision of smaller regional and community-based custodial facilities instead.

Over the year, a number of high profile cases of sexual abuse and exploitation of children from the past continued to come to light. There were increased efforts to investigate whether public bodies and others had taken their duty of care seriously to protect

27 At: https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983 (accessed 14/10/15).
28 At: http://www.legislation.gov.uk/ukpga/2014/11/contents/enacted (accessed 14/10/15).
29 See: https://www.gov.uk/government/collections/transforming-rehabilitation (accessed 14/10/15).
30 At: http://www.legislation.gov.uk/ukpga/2015/9/contents/enacted (accessed 14/10/15).
31 At: http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted (accessed 14/10/15).
32 At: http://www.scottish.parliament.uk/parliamentarybusiness/Bills/78451.aspx#sthash.UKrzXE6P.dpuf (accessed 14/10/15). This became the Mental Health (Scotland) Act 2015 when it received royal assent on 4 August 2015.
33 At: http://www.legislation.gov.uk/asp/2014/8/contents/enacted (accessed 14/10/15).

children from sexual abuse in the past. These included the Scottish Action Plan on Justice for Victims of Historic Abuse of Children in Care in November 2014 and a consultation on the establishment of a public inquiry,[34] and the establishment of an independent inquiry into child sexual abuse in England and Wales.[35] The extent to which abuses might have occurred in detention, including in the Medomsley Detention Centre (which closed in 1988 and which is subject to a criminal investigation[36]) has yet to be clarified. As a result of the investigations and prosecutions, the number of older prisoners is likely to increase across the detention estate.

Several bodies examined the role and functions of NPM members over the year, making important recommendations to be considered by government and the members themselves.

- The National Audit Office (NAO) published a comparative study of criminal justice inspectorates, including two NPM members (HMI Prisons and HMIC), which recommended further work to increase their impact and improve the follow up on both their own and others' recommendations.[37]
- The Equality and Human Rights Commission called for a statutory obligation on institutions to respond publically to the recommendations of inspectorate and regulatory bodies.[38]
- The NAO and the Public Accounts Committee[39] emphasised the importance of the independence of inspectorate bodies and a need to clarify and strengthen their relationship with the government departments that 'sponsor' them. The government subsequently confirmed it rejected the recommendation that there should be a review of these arrangements.
- The Justice Committee,[40],[41] the Public Administration Select Committee,[42] the Public Accounts Committee,[43] and the Harris Review (which set out steps to prevent and strengthen responses to deaths in custody of young adults) all recommended that HM Chief Inspector of Prisons should have a direct reporting line to parliament, instead of or in addition to the current reporting arrangements to the Ministry of Justice.
- The Justice Committee set out several serious concerns about the process initiated to appoint a new Chief Inspector of Prisons for England and Wales.

34 See: http://www.gov.scot/Resource/0046/00463120.pdf and https://consult.scotland.gov.uk/health-and-social-care/inquiry-into-historical-child-abuse (accessed 14/10/15).
35 See: https://www.csa-inquiry.independent.gov.uk/ (accessed 14/10/15).
36 See: https://www.durham.police.uk/news-and-events/Pages/News%20Articles/Operation-Seabrook---Medomsely-Detention-Centre.aspx (accessed 14/10/15).
37 The National Audit Office (2015). *Inspection: A comparative study*. London, The National Audit Office.
38 Equality and Human Rights Commission(2015), *Preventing deaths in detention of adults with mental health conditions*, London, Equality and Human Rights Commission.
39 House of Commons Committee of Public Accounts (2015), *Inspection in home affairs and justice*. London, The Stationery Office.
40 House of Commons Justice Committee (2015), *Prisons: planning and policies*. London, The Stationery Office.
41 House of Commons Justice Committee (2015), *Appointment of Chief Inspector of Prisons: matters of concern*. London, The Stationery Office.
42 House of Commons Public Administration Select Committee (2014), *Who's accountable? Relationships between Government and arm's-length bodies*. London, The Stationery Office.
43 House of Commons Committee of Public Accounts (2015), *Inspection in home affairs and justice*. HC 975. London, The Stationery Office.

The Public Services Reform (Inspection and Monitoring of Prisons) (Scotland) Order 2015 replaced prison visiting committees with a new system of monitors under the auspices of HMIPS, and gave responsibility to HM Chief Inspector of Prisons for Scotland to appoint prison monitoring coordinators.[44] In a similar vein, the Harris Review recommended that the responsibility for the oversight and funding of the IMBs should transfer to HMI Prisons.[45] The NPM welcomes explicit references to OPCAT and the visiting role of the UN SPT introduced in the Public Services Reform (Inspection and Monitoring of Prisons) (Scotland) Order 2015.[46]

The NPM also welcomes the explicit reference to OPCAT (and the Care Quality Commission's role as part of the NPM) in the new Mental Health Act Code of Practice.

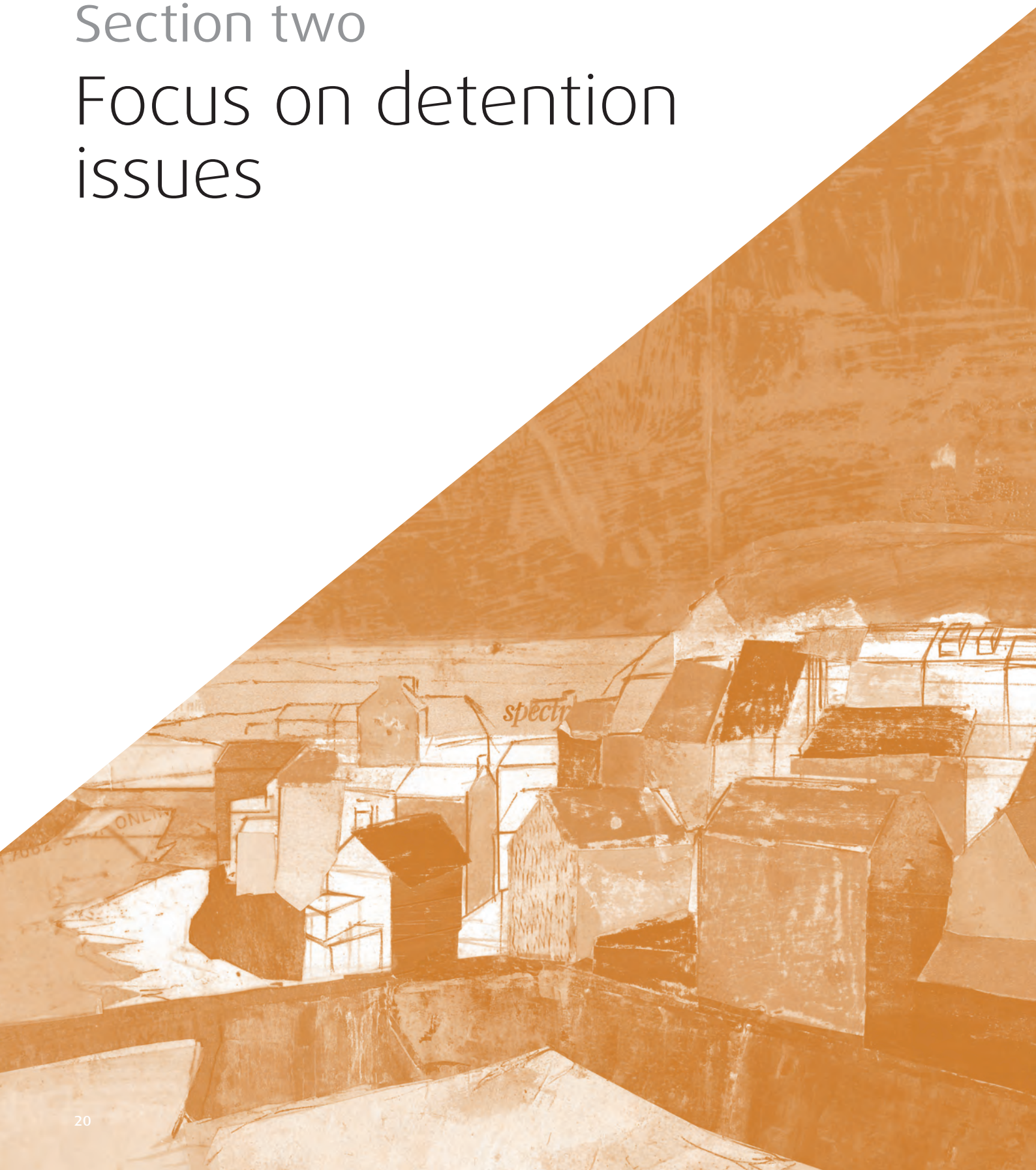
A Joint Ministerial Council Communiqué was agreed by political leaders and representatives of the UK and the overseas territories in December 2014. This included a commitment to extend core UN human rights conventions to the territories, but no explicit reference to OPCAT which was disappointing.[47] The sharing of best practice on prison management between the overseas territories and the UK is to be welcomed, but falls short of the standards required by OPCAT.

In July 2014, HM Chief Inspector of Prisons (England and Wales) wrote to the then Secretary of State for Defence expressing disappointment with the announcement that the Baha Mousa inquiry recommendation that HMI Prisons should conduct independent inspection of the UK's Afghanistan detention facilities was no longer necessary. While the UK presence in Afghanistan was winding down, the letter expressed the importance that the principle of independent inspection of UK-controlled places of detention overseas should be established and applied on future occasions where this occurs. HMI Prisons actively sought the inclusion of powers to inspect military detention into the five-yearly Armed Forces Bill, in order to put existing arrangements on a statutory footing. As this report was being finalised, HMI Prisons was told that the government no longer intended to put the inspection of military detention onto a statutory footing, which was disappointing.

44 At: http://www.legislation.gov.uk/ssi/2015/39/contents/made (accessed 14/10/15).
45 The Harris Review (2015), *Changing prisons, saving lives: report of the independent review into self-inflicted deaths in custody of 18-24 year olds.*
46 This is the second reference to OPCAT in NPM members' statutes, the first being in the Police and Fire Reform (Scotland) Act (93).
47 At: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388001/JMC_Communique_FINAL.pdf (accessed 14/10/15).

Section two

Focus on detention issues



Isolation and solitary confinement

From 2014–15, members of the NPM focused attention on isolation and solitary confinement in detention settings, using human rights-based criteria to identify current practices across the detention settings that they monitor. This thematic approach responds directly to suggestions from the UN Subcommittee for the Prevention of Torture that the UK NPM takes measures to strengthen the consistency of its work.

Background

Across detention settings, prisoners and detainees may be separated, secluded or isolated from others. This might arise for one of a range of intended or unintended reasons, including:

- as a disciplinary sanction, arising from offences or disruption caused within the place of detention;
- as an administrative measure, to deal with disruptive or dangerous behaviour;
- as a preventive measure against future harm or risk;
- as a measure to protect a prisoner from others;
- as a result of a regime and/or physical environment that restricts contact with others.

Human rights standards deem acceptable the practice of separating prisoners based on the likelihood of their exercising 'a bad influence',[48] but any restrictions imposed on persons already deprived of their liberty must be the minimum necessary and proportionate to the legitimate objective for which they are imposed.[49]

While some restrictions may be legitimate, the justification for such measures and their severity need to be examined carefully by monitoring bodies. The imperative for NPM members to do this is that where out of sight, detainees' rights can be overlooked or undermined. The psychological and physiological impact of isolation also justifies increased scrutiny of the practices.

At their most severe, isolation practices can amount to solitary confinement, which is defined as follows:

> 'Solitary confinement is the physical isolation of individuals who are confined to their cells for 22 or more hours a day. Where this lasts for a period in excess of 15 consecutive days it is known as prolonged solitary confinement. In many jurisdictions prisoners are allowed out of their cells for one hour of solitary exercise. Meaningful contact with other people is typically reduced to a minimum. The reduction in stimuli is not only quantitative but also qualitative. The available stimuli and the occasional social contacts are seldom freely chosen, are generally monotonous, and are often not empathetic.'[50]

48 United Nations, *Standard minimum rules for the treatment of prisoners* (1955), 67(a). United Nations Commission on Crime Prevention and Criminal Justice (2015), *op. cit.*, 93(1)(a).
49 Council of Europe, *Recommendation on the European Prison Rules* (CM/Rec(2006)2), 3.
50 Istanbul Statement on the Use and Effects of Solitary Confinement (9 December 2007); United Nations Commission on Crime Prevention and Criminal Justice (2015), *op. cit.*, Rule 44.

In his 2011 report to the UN General Assembly, the UN Special Rapporteur on Torture set out his authoritative view that solitary confinement should not be used on children or persons with mental disabilities.[51]

Methodology

The UK NPM agreed common definitions of isolation and solitary confinement as a basis for monitoring. This two-layered definition allowed NPM members to capture both general practice – where prisoners are physically isolated for one of a number of reasons – and practice in its most extreme form, amounting to solitary confinement, regardless of the way the practices were named or whether they were found in facilities designated for the purpose of isolation.

NPM working definitions

Isolation

The physical isolation of individuals who are confined to cells/rooms for disciplinary, protective, preventive or administrative reasons, or who by virtue of the physical environment or regime find themselves largely isolated from others. Restrictions on social contacts and available stimuli are greater than for the general detainee population.

Solitary confinement

The physical isolation of individuals who are confined to cells/rooms for more than 22 hours a day. Meaningful contact with others is reduced to a minimum and there is a quantitative or qualitative reduction in stimuli. Available stimuli and occasional social contacts are seldom freely chosen, generally monotonous and often not empathetic.

NPM members provided responses to a common monitoring template based on their visits and/or databases. The responses from NPM members have been summarised and written up according to types of detention setting as a way of identifying common practices across jurisdictions. The evidence provides a snapshot of findings from NPM members rather than an exhaustive account or comprehensive piece of research. Key themes from all settings are presented at the end.

Prisons

HMIPS and HMI Prisons examine isolation as part of their regular inspections and contributed evidence to this review from one and 12 inspections respectively.[52] CJINI also inspects prisons and reports on segregation, but conducted no relevant inspections during the reporting period. Prisons inspectors review individual prisoners' files, check minutes of meetings relating to the oversight of isolation, speak to prisoners and staff and observe practices to formulate judgments relating to its use. Criteria and standards for these inspections are published.[53] Information from one IMB in England and Wales and the IMBNI Secretariat was also submitted.

Background

Human rights standards identify that the practice of isolating prisoners can arise as a disciplinary sanction, for the purposes of protection, or as an administrative decision for preventive purposes. Solitary confinement should only be used as a last resort, and in exceptional circumstances.

51 United Nations General Assembly, Report of the Special Rapporteur on Torture, A/66/268, 5 August 2011.
52 All of these inspections were of men's prisons.
53 At: http://www.gov.scot/Publications/2015/03/8256/0 and http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/#.Vbjq9qPsqQA (accessed 14/10/15).

There should be procedural safeguards for all instances of solitary confinement, which should last for the shortest possible time. They also require that prisoners are provided with a satisfactory programme of activities: 'prisoners cannot simply be left to languish for weeks, possibly months, locked up in their cells, and this regardless of how good material conditions might be within the cells'. Regimes should provide eight hours or more a day outside their cells, engaged in purposeful activity of a varied nature, including at least one hour of exercise in the open air daily.[54]

Where isolation and solitary confinement occur

Across the UK, prisoners can be isolated in special units or cells ('segregation', 'care and separation' or 'separation and reintegration' units). In England and Wales, this can be for the maintenance of 'good order or discipline' or in prisoners' 'own interests' (Prison Rule 45(1)). Prisoners can also be placed in these units under 'cellular confinement' as a punishment (Prison Rule 55 (1) (e)) or pending adjudication (Prison Rule 53(4)). 'Special cells' are used for isolating prisoners who are 'refractory or violent' and should be used only for short periods.[55] In Scotland, prisoners may be isolated to protect the health and welfare of themselves or others (Prison Rule 41), for 'good order of discipline', to protect the interests of any prisoner and ensure the safety of others (Prison Rule 95), or for punishment (Prison Rule 114).[56] In Northern Ireland, most formal segregation arises on the basis of restriction of association for good order or discipline, to ensure safety or in the prisoner's own interests (Rule 32).[57]

In many instances, prison inspectors in England and Wales found that the regimes in segregation units amounted to solitary confinement.

In addition, in England and Wales, the 'close supervision centre' (CSC) system (a form of deep custody within the high security estate) is a form of administrative segregation that removes individual prisoners from the mainstream population for the maintenance of good order or discipline or for reasons of safety (Prison Rule 46). Some prisoners on the 'managing challenging behaviour scheme' are also kept apart from the mainstream population in discrete units or segregation units.[58]

In England and Wales, inspectors found that prisoners on basic regimes[59] or if unemployed were often locked in their cells for long enough periods for the regime to amount to solitary confinement. They also found prisoners isolated while placed in health care units.

54 European Committee for the Prevention of Torture (2015), *CPT Standards*, CPT/Inf/E (2002) 1 – Rev 2015, paras 47-48, 53-64; Shalev, S. (2008) *A Sourcebook on Solitary Confinement*. London: Mannheim Centre for Criminology, London School of Economics.

55 The Prison Act 1952 s14 (6) at: http://www.legislation.gov.uk/ukpga/Geo6and1Eliz2/15-16/52/contents (accessed 14/10/15).

56 The Prisons and Young Offenders Institutions (Scotland) Rules 2011. At: http://www.legislation.gov.uk/ssi/2011/331/contents/made (accessed 14/10/15).

57 The Prison and Young Offenders Centres Rules (Northern Ireland) 1995. At: https://www.dojni.gov.uk/publications/northern-ireland-prison-service-prison-rules (accessed 14/10/15).

58 HM Inspectorate of Prisons (2015), *Report on an unannounced thematic inspection of the Close Supervision Centre system by HM Chief Inspector of Prisons, 9-20 March 2015*.

59 See National Offender Management Service, *Prison Service Instruction 30/2013, Incentives and Earned Privilieges*, at: http://www.justice.gov.uk/downloads/offenders/psipso/psi-2013/psi-30-2013-1.doc#section4 (accessed 14/10/15)

In one women's prison, which was not included in this review, inspectors previously noted that there was no formal segregation unit and the small number of women who were subject to formal punishment served this on the units in their own cell. Although oversight of this arrangement did need to be improved, it was viewed as an improvement on the use of segregation units normally seen in women's prisons.[60]

The dramatic increase in the number of lockdowns because of staff shortages in one Northern Ireland prison at the end of 2014 might also have increased the instances of isolation at the time.[61]

Case study: solitary confinement of unemployed prisoners

On an inspection of a large, overcrowded local prison holding over 1,600 men, inspectors found around 600 prisoners on normal location were unemployed. Many of these men received around only one hour out of their cell each day due to a regime that had been severely affected by staff shortages. Those on the basic regime received exercise for half an hour a day. If they were unemployed, they were only out of their cells, on association, for about an hour on two days a week. On Sundays, all prisoners received an hour's exercise, but otherwise were locked in their cells all day unless they wished to attend corporate worship. Unemployed prisoners in general received exercise daily, and otherwise had a 'showers and domestics' period, which varied in length between 45 and 90 minutes.

Specific issues identified through monitoring

Terminology

Isolation and/or solitary confinement were a main feature in the specially designated units named above. They were also the defining characteristic of the following practices or terms in specific instances: accommodation in specified conditions; removal from association; confined to room; duty of care.

Case study: 'duty of care'

NPM monitoring discovered a restricted regime in a high security prison known as 'duty of care', aimed to protect those at risk of being a victim of retaliatory violence. Prisoners on this informal regime remained on a main wing of the prison, but could only spend 30 minutes a day out of their cell (although unofficially some had more). They could attend visits and corporate worship if escorted. Ten men had been subject to this regime for over a month, five for over two months and one for over seven months. The regime amounted to solitary confinement and had insufficient governance or review.

Length of isolation: formal and informal practices

There was considerable variation in the length of time prisoners spent isolated. In general, the overall lengths of stay in a separation or segregation unit were shorter than the time some prisoners spent isolated on cellular confinement or informally isolated on a 'basic' regime. There were, however, exceptions including in one Northern Ireland

60 HM Inspectorate of Prisons (2013), *Report on an unannounced inspection of HMP Eastwood Park by HM Chief Inspector of Prisons, 11-22 November 2013.*

61 Northern Ireland Assembly, Question AQW 41221/11-15. See: http://aims.niassembly.gov.uk/questions/printquestionsummary.aspx?docid=221039 (accessed 14/10/15).

prison, where one NPM member found men in the care and separation unit fearful of returning to their wing who had remained there for months, and one who had been in segregation for several years. Average lengths of stay in segregation units in England and Wales ranged from three days to 12 days but could be considerably longer.

Some of the men in CSCs had been there continuously for several years, including one who had been selected for the CSC in 1999. In most instances, the time spent in 'special accommodation' lasted a few hours, but in two prisons an NPM member found several instances of prisoners being held all night or for over 15 hours.

Rationale and justification

In many instances, NPM members find decision-making for isolation under the specific prison rules set out above to be justified and a clear rationale given. However, in several prisons included in this review they were not convinced that all segregation or the use of special accommodation were necessary or as a last resort. In one prison, inspectors found overuse of segregation 'pending adjudication' or 'pending investigation by security'.

Prisoners identified as at risk of suicide or self-harm are managed using assessment, care in custody and teamwork (ACCT) procedures, which are aimed at reducing risk through care planning.[62] Prisoners on an ACCT should only be segregated in exceptional circumstances, with clearly documented reasons and evidence of other options exhausted. However, NPM members have consistently raised concerns about the segregation of at-risk prisoners. In several instances in this review, NPM members found that high numbers of prisoners on ACCTs had been held in segregation and questioned whether there were, in fact, the exceptional circumstances that warranted their segregation. In one prison, 45 prisoners on ACCT documents had been segregated in the six months before the inspection. It was of great concern that five prisoners took their own lives while in segregation units in 2014–15, of whom one was on an ACCT at the time.

In one prison an NPM member noted that safety algorithms were applied to take into account prisoners' mental health before segregation was approved, and in another it was clear from interactions with staff that mental health needs and vulnerabilities were considered, but these were not recorded in full.

In one prison, outside the scope of this review, inspectors found several prisoners 'self-isolating' because they were afraid to leave their cells because of threats from other prisoners or unresolved debt. All had extremely restricted regimes and none had any formal support, reintegration or management plans.[63] Inspectors have also reported on prisons where men committed misconduct so they would be taken to the segregation unit where they would be safe from gangs and bullying, and then often transferred to another prison.[64]

62 National Offender Management Service, *Prison Service Instruction 64/2011 Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*. At: http://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-64-2011-safer-custody.doc (accessed 14/10/15).

63 HM Inspectorate of Prisons, 2015), *Report on an unannounced inspection of HMP Humber, by HM Chief Inspector of Prisons, 13-24 July 2015.*

64 HM Inspectorate of Prisons (2014), *Report on an unannounced inspection of HMP Guys Marsh, by HM Chief Inspector of Prisons, 10-21 November 2014.*

Conditions and regime

Case study: an inspector reports conditions in a care and separation unit (CASU)
The cells in the CASU were particularly poor. They were covered in graffiti, had no toilet screening and most had no table. They were in a worse condition than normal location. One cell had what looked like smeared excrement on the door frame. The prisoner who occupied this cell told me this had been there when he moved into the cell three weeks previously. These issues were addressed during the inspection but there was no information about how long they had existed before the inspection.

There was wide variation in the conditions in which prisoners were isolated. In Scotland, conditions in 'separation and reintegration' units were generally considered to be good, with one exception in an older prison. Segregation cells normally had the same furniture as on the main location. In one case, the NPM member noted that cell walls had been damaged by the cleaning processes during and after dirty protests.

In Northern Ireland, conditions were generally good and communal areas in segregation facilities were clean, but cells were often dirty. Most segregation cells had a television.

NPM monitors found reasonable or good conditions in three of the prisons in England that were included in this review. In other prisons they found graffiti on cell walls, cold or dirty cells and unscreened toilets. Most segregation cells were adequately furnished and in one prison inspectors noted fixed metal furniture. In some instances prisoners had televisions in segregation but in two prisons where it was unusual for prisoners to have televisions, battery powered radios were hard to obtain. In another, radios were not permitted regardless of the reason for the segregation. One segregation unit in this review had a small library. Normalising features, such as posters, were noted in the communal areas of one segregation unit and some of the CSC units.

In several establishments, including the CSCs, NPM members were concerned to find exercise yards that were cage-like or provided no view of the outside that was not filtered through fences or razor wire.

The special accommodation cells that NPM members visited as part of this review were unfurnished and inspectors noted that conditions were grim. In one, the cell had a low level hard plinth and some natural light but it was cold and the decoration was worn. One NPM member noted that prisoners who threatened staff when they tried to open cell doors might not even get water for very long periods, and could be put into non-rip clothing if thought to be at risk of self-harming.

The regime available for formally isolated prisoners also varied. In some prisons, staffing levels limited the time that could be spent out of cells in segregation units, or meant that regimes were not delivered consistently. In one Northern Ireland prison, men in segregation had only inconsistent access to showers, exercise and telephones as this depended on staff availability. Exercise in English prisons was often solitary and did not last for a full hour, as required. In one prison, showers and telephone calls were only provided three times a week to men in the segregation unit. In another prison, prisoners who were subject to 'multi-unlock' (where several members of staff have to be

present to open their doors or escort them) had more limited access to exercise, showers and telephone calls.

Case study: limitations on the regime in a segregation unit

Half an hour exercise, use of telephone, chance to clean the cell and a short walk to the servery were the only daily entitlements to leave the cell, because showers were in cell. Exercise took place individually, and we saw that basic grade officers exercised discretion to refuse telephone calls if the prisoner was judged to be behaving inappropriately.

Access to corporate worship was supposed to be offered on a risk-assessed basis, but in several instances NPM members found no examples where it had been provided.

In the CSC, inspectors found that most men had reasonable opportunities for time out of cell, contact with peers and staff, and reasonably constructive regimes.

The prisoners who found themselves informally isolated in their cells could access only a limited regime and their contact with others depended on their access to only a limited time out of their cells. In one prison, men on basic regime could only have two showers a week, and in others they had only 30 or 60 minutes a day for exercise or domestic duties. In several establishments, prisoners had no access to education. In one prison, the NPM member noted that prisoners had their televisions and radios removed and had been given a basic prison radio instead. Visits for 20 prisoners on a basic regime in one prison had been restricted to 30 minutes in closed visits booths.

In one prison where inspectors found prisoners with significant mental health needs isolated in the inpatient unit of the health care department, they noted that the men were subject to controlled unlock protocols and had very little contact with staff, and less with peers.

Good practice from one prison in England

Communal areas in the segregation unit were clean and brightly decorated, flooring had been repaired and normalising features such as murals and posters on walls improved the environment. The 16 cells located across two landings were clean and free from graffiti. They were adequately furnished and some were equipped with televisions. The daily regime for prisoners located in the segregation unit was better than we often find and included daily access to exercise, telephones and showers. Prisoners were sometimes allowed to dine out of their cells if they posed no risk to others and some had been allowed short periods of association following risk assessment.

Procedures and governance

In Scotland, those held in separation and reintegration units for more than three months have individual care plans, and their cases are reviewed by a multidisciplinary committee. Prisons in England and Wales are supposed to develop care plans for individual prisoners held in segregation for over a month and segregation monitoring and review groups (SMARG), but these provided varying levels of oversight. In two prisons, inspectors found SMARG monitoring was sophisticated in identifying the individuals ending up repeatedly in segregation; in another prison SMARG monitoring had lapsed and so the personal knowledge of staff was relied on to identify repeat isolations.

The IMBs have a specific role in segregation reviews, as they are informed of decisions to segregate and can attend case conferences and reviews where they can make their views known.[65] However, one IMB in England and Wales reported difficulties in attending the first reviews of segregation (within 72 hours). Other NPM members might attend segregation case conferences during inspections as part of their observation.

In July 2015, the Supreme Court ruled in the case of *R (on the application of Bourgass and another) v Secretary of State for Justice* that the delegation of ministerial responsibilities to extend segregation in England and Wales beyond 72 hours was unlawful in two cases of long-term segregation. [2015] UKSC 54

Although there is considerable internal review of decisions to place or extend placements in the CSC, one NPM member has expressed concern at the lack of external review of these decisions.

In England and Wales, health staff should assess an individual who has been formally segregated within two hours to ensure they are mentally and physically able for segregation, using a standardised algorithm. Health staff visit all prisoners who are segregated or subject to cellular confinement daily and attend the formal multidisciplinary meetings to review ongoing segregation. In some prisons, mental health staff lead on this role, which is good practice due to the potential negative impact of segregation on mental health and the high proportion of prisoners with mental health issues held in segregation. One NPM member has observed good quality engagement from health staff, but often health staff are only present at the door of the cell along with several officers, with little opportunity for confidential consultations.

In Scotland, prisoners in the separation and reintegration units are generally seen daily by health care staff and can request visits as required. A smaller number of prisoners – normally those held for extended periods – are assessed by a psychologist or psychiatrist.

NPM members considered whether the governance of segregation allowed prisons to identify any disproportionate representation from specific groups of prisoners. Data recording the number of prisoners with protected characteristics[66] held in segregation are not held centrally.[67] In one prison, inspectors identified disproportionate overrepresentation of both black and minority ethnic and young adult prisoners in the segregation unit. Although managers of the CSC system were aware of the disproportionately high number of black and minority ethnic and Muslim prisoners held, they did not understand the reasons for this.

Although formal isolation is subject to many safeguards that take into account its effect on prisoners and the need for oversight, the 'informal' isolation and solitary confinement that arises from restricted regimes is rarely subject to similar procedures. NPM members noted that the authorisation to

65 In the 1970s, the Boards of Visitors (which later became IMBs) themselves played a disciplinary function and could impose punishments on prisoners, including 'loss of remission'. This role was amended in 1992 as a result of legal challenges and the recommendations of the Woolf Report.
66 The grounds upon which discrimination is unlawful. See: http://www.equalityhumanrights.com/private-and-public-sector-guidance/public-sector-providers/public-sector-equality-duty/what-equality-duty (accessed 14/10/15).
67 UK Parliament, Written Question No. 218558 18/12/2014.

place a prisoner on a 'basic' regime, which in some cases led to significant isolation and even solitary confinement, was at a lower level than that applied to prisoners put in segregation. Furthermore, there were no safeguards for prisoners identified as at risk through the ACCT process. In one prison where inspectors found informal isolation on a wing, prison staff had discussed and agreed a 'compact' for the arrangement with the prisoner. Formal health care arrangements that apply in segregation units in England and Wales are not in place for informal isolation on the wing, which means these prisoners are not regularly reviewed to assess the impact of segregation or to offer support. It is possible that informally isolated prisoners might not engage with health care as they rely on staff escorting them to that department, which could lead to health needs not being met.

Reintegration

Many isolated prisoners are reintegrated into the main prison, and some are transferred out, or sent from formal isolation units to health care units or hospitals. In Scotland, management plans are usually prepared for prisoners held in isolation for long periods, but these were found to be of variable quality. In England and Wales, several prisons only had *ad hoc* reintegration planning, or this was not written down. One NPM member noted that there were no plans or support to ensure 'self-isolating' prisoners could reintegrate into the prison regime.

Conclusion

The evidence gathered in this review highlights a number of concerns about the practices amounting to isolation and solitary confinement in prisons.

NPM members have identified a wide variation in the conditions in the designated facilities where prisoners are formally isolated. The regime that prisoners can access also varies widely from prison to prison, and NPM members have identified several situations where access to even a minimum regime is inconsistent and/or has been adversely affected by staffing levels.

The number of instances where prisoners are informally isolated, and in many cases in conditions that amount to solitary confinement, over long periods of time is of great concern. Governance of the basic regimes or of unemployed prisoners does not provide safeguards against the impact of isolation or solitary confinement, and the lack of specific health care reviews could leave prisoners at risk. The extent to which prisoners are isolated and even in solitary confinement as a result of restricted regimes and staff shortages warrants greater attention.

Although the idea that there should be formal procedures to ensure segregated prisoners do not come to harm as a result of isolation, and to ensure appropriate reviews, is well embedded in prison processes, all NPM members reported concerns with their implementation. NPM members have frequently raised their concerns about the number of vulnerable prisoners who are formally segregated, and the numbers of deaths that have occurred in segregation units are a reminder of the serious risks. Oversight at management level to ensure monitoring of segregation, which should guide efforts to ensure the appropriate use of segregation and address any disproportionate representation of black and minority ethnic and Muslim prisoners among other issues, also varied.

It was striking to find that reintegration planning for isolated prisoners was *ad hoc* at best in the examples reviewed by NPM members.

NPM members will continue to scrutinise these practices, and there will be further thematic work to examine segregation practices in Scotland.

Children in detention

NPM members that monitor places of detention where children are held scrutinise isolation practices as part of their existing monitoring powers, reporting on their findings and raising concerns and making recommendations in their reports.

CCE can visit any setting where a child is accommodated or cared for, other than a private dwelling. It considered its conclusions from seven visits to the youth justice secure estate in 2013–14 (its last complete reporting period).

Ofsted conducts inspection/regulatory visits of secure children's homes (SCH) and inspections of secure training centres (STC) (with CQC and HMI Prisons). It drew conclusions from a sample of 10 SCH inspection reports and four STC inspection reports, as well as the feedback from four semi-structured interviews with inspectors.

CSSIW fed its conclusions from the inspection of a secure residential children's home into this work.

HMI Prisons inspects young offender institutions (YOI) and STCs (the latter with Ofsted). Conclusions from the inspections of one YOI and one STC were included in this review.

Background

UN human rights bodies consider the imposition of solitary confinement, of any duration, on children to be cruel, inhuman or degrading treatment and consistently recommend that children should not be subjected to it.[68] In 2006, an independent inquiry headed by Lord Carlile recommended that solitary confinement should never be used as a punishment.[69]

Where isolation and solitary confinement occur

Formal segregation in YOIs in England is governed by the YOI Rules and Prison Service order (PSO) 1700.[70] These set out the possibility for a child to be removed from association for 'good order and discipline' (GOOD) or 'in his own interests' (YOI Rule 49). This should last for no more than three days, unless authorised by the Secretary of State for up to 14 days, which can be renewed. Children can also be confined temporarily for refractory or violent behaviour for up

68 United Nations Committee against Torture, *Consideration of the Reports submitted by States Parties under article 19 of the Convention, Concluding observations of the Committee against Torture, Macao Special Administrative Region*, CAT/C/MAC/CO/4, para. 8; UN Subcommittee on Prevention of Torture, *Report on the SPT visit to the Republic of Paraguay*, CAT/OP/PRY/1, para. 185; UN Committee on the Rights of the Child, *Consideration of reports submitted by States Parties under Art. 44 of the Convention, Concluding observations of the Committee, Denmark*, CRC/C/15/Add.151, para. 41; and UN Committee on the Rights of the Child, *Consideration of reports submitted by States Parties under Art. 44 of the Convention, Concluding observations of the Committee, El Salvador*, CRC/C/15/Add.232, para. 36 (a); United Nations General Assembly, Report of the Special Rapporteur on Torture, A/66/268, 5 August 2011, para77.

69 The Lord Carlile of Berriew QC, *An independent inquiry into the use of physical restraint, solitary confinement and forcible strip searching of children in prisons, STCs and local authority SCHs*, (2006) The Howard League for Penal Reform.

70 The Young Offender Institution Rules 2000, at: http://www.legislation.gov.uk/uksi/2000/3371/contents/made; HM Prison Service Prison Service Instruction 1700 *Segregation, Special Accommodation and Body Belts* at http://www.justice.gov.uk/downloads/offenders/psipso/psi-17-2006.doc (accessed 14/10/15).

to 24 hours in a special cell or room (YOI Rule 51). The YOI Rules prohibit governors from imposing cellular confinement as a punishment (YOI Rule 60 (1) (f))[71]. In YOIs, children would be held in a designated 'care and separation unit', but may also be isolated in their rooms if on basic regime or 'losses'.

Secure Training Centre Rules[72] and regulations relating to children's homes[73] govern isolation practices in STCs and SCHs in England and Wales. Some individual establishments have their own policies, which may require more detailed recording of instances of isolation that might not be recorded in other establishments.

In STCs and SCHs, NPM members found both formal and informal isolation occurring in children's own cells/rooms or other areas, including corridors, education rooms and health care units. Isolation practices in SCHs are usually defined as elected, directed or enforced, following guidance developed by the secure accommodation network[74]. Directed and enforced separation are used as part of behaviour management techniques and to prevent injury to the child or another, or to prevent significant damage.
In STCs, isolation often occurred as a consequence of restraint. Recently implemented children's homes regulations and associated quality standards have made it clear that a further restriction of liberty in secure children's homes constitutes a restraint.[75]

Specific issues identified through monitoring

Terminology

Isolation and/or solitary confinement were a main feature or defining characteristic of the following practices and 'statuses':

- YOIs: separation, care and separation, unemployed disruptive, single unlock, loss of association, 'losses', basic for violence, basic (regime), reintegration and support;
- STCs: single separation, time out, time away, removal from association;
- SCHs: group separation (where a child is separated from the rest of the group but continues to engage in one-to-one activities with staff), risk management.

Length of isolation: formal and informal practices

The majority of instances of formal isolation in STCs and SCHs are short (less than an hour), although NPM members found informal practices, where children are isolated from their peers but have some limited interaction with staff, that lasted for several days.

In one YOI, the average period of formal segregation was nine days, with the shortest recorded lasting one day and the longest 60 days. NPM members identified practices amounting to solitary confinement outside formal isolation facilities. In many cases, isolation outside the formal care and separation unit lasted for more than 22 hours a day, and could last for several weeks.

71 See also: Prison Service Order 0101, *The Young Offenders Institution (Amendment) Rules 2000*.
72 *The Secure Training Centre Rules 1998*, at: www.legislation.gov.uk/uksi/1998/472/contents/made (accessed 14/10/15).
73 *The Children's Homes (England) Regulations 2015*, at: www.legislation.gov.uk/uksi/2015/541/contents/made; *The Children (Secure Accommodation) Regulations 1991*, at: www.legislation.gov.uk/uksi/1991/1505/regulation/6/made (accessed 14/10/15).
74 See: http://www.securechildrenshomes.org.uk/secure-accommodation-network/ (accessed 14/10/15).
75 Department for Education (2015), *Guide to the children's homes regulations, including the quality standards*, paragraph 9.42.

Case study: 'unemployed disruptive'
In one YOI, an inspection by an NPM member identified that boys were being held in conditions amounting to solitary confinement under an informal regime known as 'unemployed disruptive'. As a result of disruptive behaviour, boys were isolated in their cells, in many instances for over 22 hours a day. There was no formal governance of the practice, and although a weekly review meeting considered the boys, this was only through a verbal account by wing staff, with no objective assessment. The lack of governance made it hard to identify how long some boys were held under this regime, but it was clear that it could often last several weeks. In some instances, if the perceived risk had decreased, boys would return to a normal regime. In other instances, they might be transferred out of the establishment.

Conditions and regime

The conditions under which children were isolated varied considerably. In the YOI included in this review, boys held in a separation and care unit were in a poor environment, with an inadequate regime. Although some improvements had been made, the exercise yards were bare and austere, and there was little evidence of any constructive activities. Some boys had been allowed to exercise together, but all of the boys that the NPM member spoke to said they had spent most of their time locked in their cells.

Segregation units in YOIs are small wings of single occupancy cells, often containing fixed furniture. The regime for children in these units is basic and, while some have access to televisions, there is little visual stimulation and time out of cell for most is limited to less than an hour a day. Outside of this review, NPM members have frequently criticised the conditions in dedicated segregation units in some YOIs, finding dirty cells covered in graffiti, cells with poor ventilation, dirty toilets, austere exercise yards, and limited access to showers, exercise, education and telephone calls. In several instances, boys have reported boredom or loneliness, spending most of their time sleeping or reading. Good relationships between staff and boys, and frequent visits from chaplains and advocates in some units, have been noted, and NPM members have viewed positively instances where a consistent regime meant boys knew they would always get the time out of cell and activities they were told they would get.[76]

For boys informally isolated in their cells, conditions also varied. Some cells were grubby and did not have cupboards or shelves, and not all toilets were adequately screened. Since, in most establishments, there were no procedures for monitoring or the governance of such episodes, the duration of isolation, time out of cell, access to, and reintegration to, normal regime depended on the discretion of individual staff.

STCs and SCHs do not have dedicated facilities for isolating children, so basic conditions are no different if a child is isolated. As a result, the conditions for children isolated in STCs and SCHs were generally much better than for boys in YOIs. In some instances,

76 HM Inspectorate of Prisons (2014), *Report on an announced inspection of HMPYOI Feltham (children and young people) Guys Marsh, by HM Chief Inspector of Prisons, 11-15 August 2014*; HM Inspectorate of Prisons 2014, *Report on an announced inspection of HMPYOI Cookham Wood by HM Chief Inspector of Prisons, 9-20 June 2014*; HM Inspectorate of Prisons 2013, *Report on an announced inspection of HMYOI Warren Hill by HM Chief Inspector of Prisons, 5-8 March 2013*; HM Inspectorate of Prisons (2015), *Report on an unannounced inspection of HMYOI Werrington by HM Chief Inspector of Prisons 1-12 September 2014.*

however, children isolated in their normal rooms in SCHs had their property removed and bathroom facilities locked off. In some instances, isolated children were required to wear non-rip clothes.

There was variation in the extent to which isolation in STCs and SCHs affected children's access to education. In some instances, children were unable to access education for short periods, but in others there were arrangements to ensure as much education as possible within the constraints of the isolation. In one instance, normal education was replaced by poor quality worksheets, which did not provide any meaningful educational input, and in others, children had no face-to-face contact with education staff during periods of isolation.

One STC that used a specific room for isolation ensured it was comfortable and well equipped. Interaction with staff was considerable and contact with other children promoted, as far as safety and other concerns would permit. Efforts were made to ensure as much access to education as possible, and children were allowed to return to their usual rooms to sleep at night.

Good practice in one YOI

A specialist unit in one YOI had taken steps to ensure all children were well integrated and kept occupied during the core day. Excellent case conferencing ensured that even the most withdrawn of boys were encouraged (and expected) to socialise and take part in the busy regime. These efforts were instrumental in the fact that no one had been put in the segregation unit for some months. A very small number of boys had been put in segregation on the main YOI site.

Procedures and governance

Procedures established under PSO 1700 apply to children in YOIs as they do to adults. These include the requirement for regular visits and assessments by the doctor and health care staff to ensure there is no reason why prisoners should be removed from segregation on physical or mental health grounds. An initial segregation safety screen must be completed within two hours of a child being segregated. The role of the IMB, which should be informed of decisions to segregate and be able to attend case conferences and reviews to make their views known, also applies equally.

Although one NPM member noted a general improvement in consistency of decision-making, recording and monitoring of the use of separation in STCs and SCHs over the last three years, several concerns still exist. Improvements in the recording of single separation was needed in two out of 10 SCHs, and improvement in monitoring and recording of single separation in three out of four STCs. In one STC, inspectors were not assured that all instances of single separation were recorded, but management oversight of recorded instances was considered adequate. In the YOI in this review, the NPM member considered that segregation was being used as a last resort and all instances reviewed had been appropriately authorised. It was also noted that the YOI had ceased to remove boys from their residential units as a punishment.

Whether directed, elected or enforced, all isolation practices need to be subject to governance procedures, oversight and monitoring. In practice, however, incidents of elected separation are less likely to be reported. Where isolation and solitary confinement occurred outside specific

segregation facilities, NPM members were concerned by the absence of formal procedures or oversight. In one STC, some staff saw 'time out' as a form of punishment, rather than a procedure young people could elect to follow when they wanted some private time on their own. Over a quarter of boys in YOIs surveyed by one NPM member had spent a night in segregation.

Reintegration

In some SCHs, NPM members noted phased reintegration from isolation, using the living area outside bedrooms for this purpose. In another, a 'restorative approach' was used, with all children completing a report after isolation to look at what happened and the impact on themselves and others. An NPM member found that in several SCHs, some children did not know how to return to a normal location or regime.

In one YOI, boys completing their time in a segregation unit were either returned to a normal wing or transferred out of the prison. In some instances, boys might be released from custody directly from a segregation unit. Planning for reintegration was judged to be *ad hoc* and without formal policies.

Good practice in SCHs included effective debriefing and reflection for staff and children. This, alongside an increased emphasis on de-escalation, led to a reduction in the frequency of incidents and improved behaviour of young people.

Conclusion

This review demonstrates that there is still more to be done to avoid the use of isolation. Although NPM members identified appropriate use of short periods of formal isolation in some SCHs and STCs, and authorised and justified use of formal isolation in the one YOI reviewed, evidence also shows a worrying number of instances where isolation is not subject to formal governance. In some instances, children are held for long periods in conditions that amount to solitary confinement. There is a wide variation in the conditions and regime for children who are subject to isolation across different types of detention facilities, which may lead to children with similar needs and behaviours being treated in very different ways.

As children have not fully developed cognitively, mentally or emotionally, the possibility that isolation or solitary confinement could cause lasting harm cannot be dismissed. This provides a rationale for rigorous scrutiny of practices that amount to isolation and solitary confinement by NPM members. Children should not be isolated as a punishment, and should never be held in conditions that amount to solitary confinement.

This review identified appropriate use of short periods of isolation in some SCHs and STCs and appropriate governance of formal segregation in some YOIs, but also some unacceptable informal practices that isolate and, in many cases, lead to solitary confinement.

Oversight and scrutiny of children in detention has multiple layers. NPM members (including IMBs) play a role, but there are other reporting requirements for the authorities that detain children (to the Youth Justice Board in England and Wales, through YJB monitors for example) that should ensure that all isolation practices are monitored, and inappropriate or informal practices are stopped. It is not clear whether critical incident procedures would be invoked by lengthy periods of isolation. Local Safeguarding Children Boards could provide

external scrutiny where isolation goes on for long periods or where it is informal, such as they currently do in relation to other safeguarding issues in prisons (such as use of force or complaints).

Health and social care detention

NPM members monitoring health and social care settings examined isolation practices in adult mental health and intellectual disability hospital wards. Evidence was contributed by MWCS, CSSIW, HIW and CQC.[77]

MWCS can review all records of incidents of seclusion and policies and procedures, and has its own guidance for staff on use of seclusion.[78]

CSSIW reviews a random selection of files on annual inspections of care homes, looking at all incidents occurring in the previous 12 months for each file, including isolation. CSSIW may also become aware of isolation occurring in complaints about other issues, or in relation to applications for deprivation of liberty safeguards under its regulatory powers.

HIW reviews seclusion rooms as part of regulatory inspections in independent hospitals and looks at seclusion rooms as part of inspection visits to NHS services.

CQC looks at isolation practices on visits conducted under the Mental Health Act and as part of its regulatory inspections. It has undertaken monitoring visits with a specific focus on isolation, and can also investigate and receive complaints related to these practices.

Background

Health and social care detention is not punitive in nature, so practices within detention such as isolation should not have a punitive purpose. Isolation should not be used as a punishment, threat or active behaviour modification tool, or solely as a means of managing self-harming behaviour, but rather as a reactive, last resort measure to contain actually dangerous behaviour. It can only be justified for as long as it necessary to contain such behaviour.

Where isolation and solitary confinement occur

Case study: isolation on a ward

In one instance a detained patient was kept in a locked area of a secure ward on a continuous basis for over five years. The hospital defined this practice as 'low stimulus'. Although the patient was isolated, efforts had been made to ensure regular contact with staff who attended to his personal care and meals, and encouraged him to leave the area and join other patients on the ward. The NPM member was satisfied that the patient was able to do this on request, and noted that his case was subject to regular review by multidisciplinary teams and regular risk assessments. The nature of the person and the situation and oversight meant that the seclusion was deemed appropriate and considered to be used as a last resort.

Isolation in health and social care settings is more commonly known as 'seclusion'. In their monitoring, NPM members found detainees isolated in a range of ways, both formal and informal.

77 The Care Inspectorate has begun monitoring in 2015.
78 Mental Welfare Commission for Scotland (2014), *Good practice guide, the use of seclusion*. At: http://www.mwcscot.org.uk/media/191573/final_use_of_seclusion.pdf (accessed 14/10/15).

In England, two distinct categories are recognised: 'seclusion' and 'long-term segregation' (LTS).[79] Secure hospitals in Scotland use 'seclusion rooms', usually monitored via a window. Patients are normally allowed out of the room for personal care, using the toilet, and exercise where appropriate.

In some settings, patients are given 'time out' in their rooms when their behaviour has escalated. This essentially isolates the patient, and is more common in places where there is no seclusion room, or as a step before formal seclusion.

NPM members also come across cases where an area is separated off in a ward as a self-contained area for an individual patient.

Voluntary isolation or isolation 'at own request' also occurs, as a way to reduce stimuli on wards that could provoke aggressive behaviour. Such isolation must also be subject to frequent review.

In care homes, NPM members identified residents who had become isolated as a result of disproportionate measures taken to address perceived risks (for example, falling from their wheelchair).

Specific issues identified through monitoring

Terminology

Isolation and/or solitary confinement were a main feature or defining characteristic of the following practices: seclusion; long-term segregation; low stimulus; time out; intensive care suite; therapeutic isolation; single-person wards; enforced segregation.

Length and frequency of isolation: formal and informal practices

Isolation defined as seclusion can last several hours or even days. Where practices are identified as LTS as defined in the Mental Health Act (MHA) Code of Practice,[80] which applies in England, these will usually meet the NPM definition of solitary confinement.

One NPM member has expressed concern at the routine isolation of patients in high security hospitals as they are locked in their bedrooms at night. Specific powers to do this have been set out in policy.[81] Although the practice would meet the criteria for seclusion under the MHA Code of Practice, the Department of Health has stated that such practices are not to be deemed as such and therefore are not subject to the same review requirements.[82] Concerns were raised by the NPM member that this effectively introduced a new category of seclusion.

79 Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In some instances, LTS may constitute solitary confinement. LTS introduced into Mental Health Act Code of Practice (Department of Health) 2008 and 2015 since 2005 ruling *Regina v. Ashworth Hospital Authority (now Mersey Care National Health Service Trust) ex parte Munjaz [2005]* UKHL 58.

80 Department of Health (2015), *Mental Health Act 1983: Code of Practice*. London, The Stationery Office.

81 National Health Service England (2013), *The High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013*.

82 See Department of Health (2015), *op. cit.*, para 26.105.

Conditions

Special seclusion rooms are designed to be 'low stimulus', which might mean they only contain a bed/mattress, toilet and wash basin, or sometimes a bed with separate access to a toilet. NPM members have identified many cases where there have been no attempts to make isolation spaces more 'homely', which is particularly important where isolation is long-term.

NPM members have identified situations in which patients are denied normal clothing, which should only be as a last resort. One member found instances where female patients were secluded without access to sanitary products for reasons of 'safety'. Several visits identified patients who did not have sight of a clock.

Concerns about conditions

Critical comments about infrastructure had been made by one NPM member in 52 out of 126 visits. These included: lack of privacy; lack of ventilation; rooms too hot or too cold; dirty rooms; unrepaired damage; dangerous sharp corners/raised screws in fittings; inadequate furnishing or bedding; lack of call point. In one case, a female patient had been secluded on a men's ward because the female ward facility was already in use, and in another case, a female patient had been secluded unclothed, and then been observed by male staff. A previously criticised practice of passing food through a hatch in a door facing the seclusion room toilet area had recurred.

Procedures and governance

One NPM member found that continuing episodes of solitary confinement were designated variously as seclusion or LTS. There is a risk that detaining authorities may redefine extended periods of seclusion as LTS, to justify relaxing the regularity of formal reviews, although the increasing prescriptiveness of the MHA Code of Practice might discourage this.

In many instances, there was regular review of isolation by multidisciplinary teams, but in one case where a detained patient with intellectual disabilities had been segregated from the main population of the ward in a 'flat-like' facility continuously for two weeks, records did not provide evidence of any consultation or agreement with the multidisciplinary team for this, and there was no evidence of a 'restrictive practice care plan' that could have provided a rationale for the isolation.

In around one-fifth of its visits, one NPM member identified concerns about the review of seclusion, including many instances where medical and other reviews did not take place as often as required, and inadequacies in record keeping.

In some instances, internal oversight of seclusion was found to be deficient. In one visit, an NPM member found no overarching system to monitor seclusion, and staff were unable to say when it had last been used. In another visit, a clinical governance group tasked with the oversight of seclusion and LTS had not discussed the matter for over a year.

Good practice in a low secure hospital

A patient with a history of violent assault was held in a secluded area of a low secure hospital with a permanently activated alarm on the door, rather than referring him to a medium secure facility, which was considered a more restrictive measure. Agreement of the patient's family was sought and obtained, and safeguards included continuous review, care planning, independent advocacy, and regular contact with the NPM member regarding any further changes. An independent consultant psychiatrist and consultant nurse from a medium secure hospital elsewhere in the UK were asked to review the treatment plan to ensure it met the patient's needs and rights, and implemented appropriate safeguards. The patient had access to therapeutic and activity interventions and regular observations. After improvement in the patient's behaviour, nursing staff facilitated his contact with other patients, under close supervision.

Legitimacy of isolation

During their visits, NPM members identified concerns about the legitimacy of the use of isolation. For example, patients on a forensic child and adolescent ward claimed that seclusion was used as a punishment, a patient on an acute ward stated that seclusion was not used as a last resort as other options had not been considered, and other patients said that they might be secluded if they refused to take medication.

In one case, a resident in a care home in Wales was isolated as she was restricted to using only her bedroom because of being urine incontinent. This case led to a criminal investigation.

NPM members are aware that where isolation is not used, alternative means of managing disturbed behaviour might include increased use of medication (chemical restraint), prolonged manual restraint or mechanical restraint (the use of restraining garments). One NPM member noted that in a learning disabilities unit the lack of a seclusion facility led to prolonged manual restraint on many occasions. Positive efforts by some services to look at their restraint practices more broadly, and attempts to move to a 'no restraint' position, by focusing on the root causes of behaviour disturbance (boredom, lack of staff contact, lack of quiet or private spaces), are to be welcomed.

Reintegration

The Mental Health Act Code of Practice 2015 (England) includes the enhanced requirements that debriefing and support should follow all episodes of seclusion, and an acknowledgement that they are likely to cause some degree of distress to patients. Such debriefing, or post-incident review, should provide an opportunity for organisational learning. Where patients are able to and agree to discuss the incident that led to the use of a restrictive intervention, they should have the opportunity, through an empathetic therapeutic relationship, to explore aspects of the intervention that helped, did not help and might be done differently, as well as to record in an advance statement their wishes for future restrictive interventions.[83]

83 Department of Health (2015), *op. cit.*, paras 26.148, 26.167-171.

As part of their monitoring, the NPM expects mental health services in England to have implemented the new guidance in the Code of Practice, but in a number of visits NPM members have already found no evidence that post-incident debriefings have been held.

Conclusion

Isolation can cause distress to detained patients and those in care settings. The practices identified by NPM members illustrate that, in many cases, procedures designed to ensure appropriate use and oversight of isolation are not followed or evidenced. All detained patients are vulnerable as a result of suffering from severe mental disorder, which makes safeguards of extreme importance.

Focus by health inspectorates on the physical and mental health consequences of seclusion has led to more specific scrutiny of the environment and regime where it occurs. It is welcome that the new MHA Code of Practice strengthens the protections of patients in England who are isolated in the short-or long-term, and raises standards for the conditions for such isolation. The acknowledgment in the Code that seclusion always has the potential to be traumatising, so that patients need support after it, and that seclusion rooms need to have a visible clock, are a direct result of observations from NPM monitoring. At the same time, the routine introduction of isolation through night-time confinement, without the possibility for the review requirements of other forms of isolation, is of concern.

The NPM mental health forum will consider ways to strengthen the monitoring of isolation and solitary confinement – including through full implementation of the MHA Code of Practice in England – through their monitoring and regulatory powers. Some positive developments in standards and awareness have undoubtedly been achieved, and NPM members can play an important role in ensuring these are sustained, and introduced in areas they have not been.

Immigration detention

Immigration detention across the four nations of the UK is monitored by HMI Prisons and the IMBs, with other NPM members providing specific monitoring of health and education provision. Evidence was contributed to this review from three inspections of immigration removal centres (IRCs).

Background

The differentiation of immigration detention (a form of administrative detention) from punitive forms of detention should be clear in the conditions in which detainees are held.[84] The non-punitive purpose of IRCs in the UK is clearly set out in the Detention Centre Rules (2001), which emphasise that there should be a relaxed regime with as much freedom of movement and association as possible, consistent with maintaining a safe and secure environment.[85] This principle should govern the use of any practices amounting to isolation in IRCs.

84 UN Special Rapporteur on the human rights of migrants, *Report to the UN Human Rights Council* A/HRC/20/24, 2 April 2012, para 31.
85 The Detention Centre Rules 2001, 3(1), at: http://www.legislation.gov.uk/uksi/2001/238/made (accessed 14/10/15).

Where isolation and solitary confinement occur

Under the Detention Centre Rules, detainees can be isolated as a result of removal from association (Rule 40) or temporary confinement (Rule 42).[86] Removal from association should be justified by the interests of security or safety. According to the Detention Centre Rules, for the first 24 hours it may be authorised by a detention centre manager, acting under the responsibility of the Secretary of State, who should be notified. Detainees should not be removed for a period of longer than 24 hours without the authority of the Secretary of State, though in practice this is delegated to a senior manager of Home Office immigration enforcement. Temporary confinement in special accommodation can be used to contain or control refractory or violent behaviour, but for no longer than such behaviour lasts. It should not last for more than 24 hours without higher approval, and should not exceed three days.

Two of the IRCs visited had 'separation units' where detainees were held under Rule 40 or Rule 42, one of which had eight cells. In the third IRC, a room off the main corridor was used. No evidence was found of informal isolation or solitary confinement in the main areas of these establishments.

Children were not isolated in any instances in the one IRC that held them (as part of a family unit).

Specific issues identified through monitoring

Length and type of isolation

Isolation arising from Rule 40 is much more common than Rule 42. One IRC visited had high use of isolation, but for comparatively short periods. In one IRC, with capacity for 575 detainees, inspectors calculated that around 131 detainees had been separated in the six months prior to the inspection. Of these, 128 had been separated under Rule 40 and three under Rule 42. In many instances they had been kept in cells for over 22 hours a day, although they could use mobile phones while there. It was rare for anyone to remain in the separation unit for longer than six days.

In another IRC, although the total number of detainees isolated was lower than the average, the time spent in isolation was higher, often due to delays by the escorting contractor because their vans did not always arrive at the centre when expected. In some instances, the isolation constituted solitary confinement.

Justification for isolation

In most cases, inspectors considered that Rule 40 and Rule 42 separation was used appropriately. However, in one of the IRCs, inspectors found evidence that detainees with mental health needs had been separated because of a lack of more suitable accommodation for them.

86 Detention Centre Rules 2001, Rules 40 and 42 respectively.

Conditions and regime

The conditions of separation in two of the IRCs – one with a dedicated separation unit, and one with a single room used for separation – were found to be stark and poor. The third IRC had good conditions in its separation unit, including an association room that was used regularly. Rule 40 cells were sparsely furnished. Cells were clean and had properly screened toilets and showers.

Case study: poor conditions during separation

The separation unit in one IRC consisted of eight cells, including a gated constant watch cell. The environment was generally poor. Although the two communal corridors were reasonably clean, they were narrow and had little natural light, which created an oppressive environment. Most cells were dirty and some toilets were filthy. Some cells had televisions and all had electricity. The exercise yard was stark and cage-like.

A basic daily regime included showers and exercise, but in many instances detainees were kept in their cells, separated from others for over 22 hours a day. Detainees were allowed to use their mobile phones while locked in their cells.

Rule 40 detainees could in theory attend activities such as education, library and gym after a risk assessment, but in reality this rarely happened.

Procedures and governance

In two of the IRCs, the NPM member found problems with the documentation applying to the separation of detainees. In one, it did not always clearly justify the reasons for separation, and Home Office and health care staff did not always record their visits to the unit, although they did make regular visits. In another, Home Office signatures were missing on some documents and in one instance, Home Office staff had not seen a detainee before he was taken off Rule 40.

Good practice in one IRC

A segregation monitoring and review group met monthly to monitor the number of those held in segregation and the reasons behind this. A strategy document had been published that described working practices and management arrangements. All cases were reviewed every day by a senior manager and detainees were usually seen by a member of the IMB, a chaplain and a doctor.

Conclusion

These accounts show a wide variation in the conditions of isolation in the immigration detention estate. There was inconsistent application of the safeguards that should be in place for all instances of isolation, some of which amounted to solitary confinement.

Given this, it is essential that all NPM members with a role in monitoring immigration detention pay close attention to isolation practices.

Police and border force custody

Police custody facilities in the UK are inspected regularly by HMIC, HMI Prisons, HMICS and CJINI, and independent custody visitors (members of ICVA, ICVS and NIPBICVS) visit routinely to check that the rights and entitlements of detainees are granted and their welfare is cared for.

Evidence from two police custody inspections in England and Wales and one inspection of Border Force customs custody (at airports and ports), as well as comments from two visiting bodies were included in this review.

Background

Detention in police custody in England and Wales is governed through Code C of the Police and Criminal Evidence Act 1984. Some detainees in police custody are held under immigration powers ('IS91' detainees) awaiting transfer to an IRC, or under section 136 of the Mental Health Act and the Children Act 1989 as a 'place of safety'. Police custody, including specially designated suites, is also used to hold detainees under the Terrorism Act 2000 (TACT).[87]

- Under PACE, detainees can be detained for a maximum of 24 hours before a charge or an extension of detention is sought from a police superintendent for a further 12 hours. In serious cases, detention can be further extended by a magistrate. Detention can be further extended once a detainee is charged if bail is refused and they are awaiting a court appearance.
- In Scotland, detainees held for court are detained until the next lawful (court sitting) day, which could extend to four days in custody during a holiday period.
- Under the Terrorism Act, detainees can be held before charge for up to 14 days, subject to regular reviews.
- There is no time limit on detention under IS91 in police custody.
- There is no specific time limit on the detention of children in police stations as a place of safety, but this should be 'only [...] until such time as alternative suitable accommodation can be found'.[88]
- Under the Mental Health Act 1983, the maximum period a person can be detained by the police is 72 hours.

Border Force customs custody is similar to police custody but has a small throughput (approximately 750 in 2013–14). Individuals passing through ports or airports suspected of having ingested drugs in sealed packages to conceal them while entering the country may be held here to await any drugs passing through their bodies.

Where isolation and solitary confinement occur

Isolation is the norm in police custody, justified by the fact that detainees need to be held alone while questioned about offences they might have committed, or while other evidence is being gathered, before charge. Policy sets out single cell occupancy for all detainees, regardless of their offences or the duration of their detention.[89] On rare occasions, detainees in England and Wales have been found 'doubled up' in cells.

NPM members considered cases of longer than normal periods of detention without 'meaningful interaction', some of which could amount to solitary confinement.

Specific issues identified through monitoring

Length of isolation

The maximum time that a detainee in police or border force custody will be isolated should be determined by the time limits of the specific detaining power under which they are held, as above.

87 Unlike PACE detainees, under TACT section 41, individuals can be arrested for 'reasonable suspicion' of being concerned in the commission, preparation or instigation of acts of terrorism even when no specific offence is in mind. The treatment of TACT detainees is governed by specific rules contained in Part I of TACT Schedule 8 and PACE Code H.
88 The Children Act 1989.
89 Police Scotland; PACE section 8 Code C.

NPM members have noted cases where immigration detainees held under IS91 powers have been isolated for three to four days awaiting transfer to an IRC. Police detainees, if arrested over weekends, might be detained for longer than normal periods while waiting for a court appearance.

Case study: 45 hours isolation during pre-trial detention

A 19-year-old man was arrested at 11.58am on Tuesday and charged the following morning. He was ready for court at 12.45pm on Wednesday, and papers were faxed to the court at 13.23pm. He was eventually taken to court at 10.10am on Thursday, after 45 hours in custody. During this 45-hour period he had a 45-minute police interview, a 20-minute interview with his solicitor and had been brought out to the custody desk to be charged. Apart from this he had spent the entire time in his cell, with no exercise or shower (although the latter was offered). There was an old magazine in his cell which he had been given to pass the time. The detainee would have been visited every 60 minutes (a look through the hatch and maybe a few words).

Case study: 28 hours isolation under immigration powers

This timeline illustrates the time that one IS91 detainee spent in police custody.

09.12: arrested
10.10: authorised and rights and entitlements explained to detainee in Arabic via telephone interpreting service
10.18: health care requested
10.50: detainee waited at the 'bridge' to see health care, rather than being placed in cell
10.57: detainee given food and drink
11.49: detainee taken to medical room for approximately 15 minutes before returning to cell
12.32: removed from cell to speak to solicitor on telephone (with interpreter) in the consultation room
12.56: following advice from solicitor claimed political asylum
14.00: detainee provided with meal in his cell
17.12: IS91 served at booking-in desk via telephone interpreting service
22.44: detainee allowed of out his cell to wash his hands and face
05:30: woken up and given hot drink, halal food and biscuits, a copy of the Qur'an and a prayer mat
08.32: given a hot drink but refused food
14.00 (approx): transferred to IRC

Total time: circa 28 hours.

Justification and governance of isolation

There are no separate procedures, documentation or permissions required for isolation or solitary confinement in police custody, as it is inherent in this type of detention.

NPM monitors have seen little evidence of specific consideration given to the impact of isolation in police custody on a child or a person with mental health issues. However, detained children are often kept in cells or rooms closer to a booking-in desk where custody staff can provide additional visits.

For immigration detainees, as police authorities charge immigration authorities for the costs of detention once reported and until collected, this creates an audit trail and an economic incentive to limit their time in detention.

Case study: a case for cell sharing?

Eight detainees arrested after a 'lorry drop' on a motorway were taken to two police custody suites. There was at least one father and son in the group, and two brothers. None of the group claimed to be able to speak English, and stated their nationalities as Iraqi or Syrian. They had been held for over 22 hours when NPM inspectors encountered them. As a result of inspectors' interventions, the two brothers were given access to the exercise yard so they could speak to each other. Inspectors felt that, given the likelihood these men had travelled together and their family connections, there could have been some consideration of 'doubling up' cells for a while. There would also have been an opportunity to place the group in a secure gated area together.

Conditions and facilities

As isolation is the norm in police custody, it is important that the effects of this on the detainee can be offset or negated by a regime that facilitates good staff-detainee interaction, as well as access to showers, exercise, reading materials and visits.

NPM members find that facilities for detainees are often provided only in response to a request from them and not offered systematically. While all custody suites have shower facilities and toiletries, and most have an area for fresh air or outside exercise and some limited reading material, detainees often do not know that these facilities are available to them.

Case study: meaningful contact?

An immigration detainee had approached 24 hours in custody when an NPM inspector spoke to him. He was awaiting transfer to an IRC and had been out of his cell for just five minutes to make a telephone call to his solicitor. He had been 'visited' every 30 minutes by detention staff, which usually meant opening the cell hatch or a quick word '*everything alright?*', and had received microwave meals at standard meal times. The detention officer responsible thought the detainee spoke limited English, but he was in fact fluent. The detainee said he would have liked a shower and some fresh air, but neither of these had been offered, nor did he know they were available. After the NPM inspector's suggestion, he eventually got five minutes outside for fresh air, but was not given a shower. He was eventually transferred after approximately 36 hours.

In the cases we identified where detainees had been held for longer than usual periods, the conditions of detention were the same as they would have been for any other detainee. Police cells are unfurnished and have a simple bench in them. They usually have a mattress, pillow and blanket (but often only on request or at night). Most cells have in-cell toilets but only a minority have handwashing facilities. Detainees held for long periods may have to remain in the clothing that they arrived in, although families are sometimes allowed to bring fresh clothes for those detained for longer periods, subject to risk assessment. NPM members find that although alternative clothing is sometimes provided, changes of underwear are only stocked by a minority of suites.

One NPM member noted that of eight Border Force custody suites inspected, only two had an outside exercise area. They noted that detainees were often held alone, and that interaction between detainees and staff was mixed. In one case, a detainee had been held for 20 days in a suite with no outside exercise facilities, but staff had made efforts to facilitate telephone calls, obtain books and clothing, and were considerate.

Conclusion

Policies governing detention in police custody indicate that detainees should be held alone in cells, which mostly has a specific rationale arising from their detention before charging while evidence might be gathered.

However, as identified above, in some cases detainees are held for longer than usual periods and ways of offsetting the isolating conditions should be explored. This should include encouraging meaningful interaction between staff and detainees, and facilitating access to showers and exercise yards, visits and reading materials.

NPM monitoring also shows that there might be cases where individuals held in police custody could safely interact with others, such as the case involving detainees from the same family held under immigration powers.

The possibility that detainees can be held for up to 14 days under terrorism legislation warrants particular attention, given the likelihood of longer than usual periods of isolation, and will be considered by NPM members in future work.

Key themes

Some themes emerge from the review of practice by NPM members, allowing us to identify broad areas of concern across different types of detention.

The evidence provided by NPM members shows that there is inconsistent practice across detention settings. Areas of good practice have been identified, including valuable efforts to reduce the use of isolation and address complex individual cases.

The findings show the extent to which practices or regimes in places of detention amount to solitary confinement. Although many of these do not have the main purpose of isolation (e.g. 'basic' regimes), the fact that they result in solitary confinement is of concern. The use of diverse terminology to describe practices that isolate detainees could deflect attention from the severe nature of these practices.

The conditions in which detainees were isolated varied considerably, as did their access to education, visits, telephone calls, and other aspects of a regime that would offset the effects of isolation. In a few places, considerable efforts were made to engage detainees or mitigate the sense of isolation, but in others facilities were only provided on request or inconsistently.

While efforts have been made to strengthen the procedures and safeguards for formal isolation across many forms of detention, NPM members' monitoring identified too many instances in which governance was poor and further efforts to avoid isolation were warranted. It was of particular concern that the governance of isolation for children was still not robust enough, and that oversight processes did not shed light on the reasons for or address any disproportionate representation of detainees from certain 'protected characteristics' in isolation. The role that NPM members play in scrutinising these procedures and safeguards is crucial and could be further strengthened.

All NPM members found informal isolation and solitary confinement that arose from restrictive regimes or temporary measures, and the decreasing staffing levels in many places of detention contributed directly to this. The informality of isolation, with no governance processes or oversight, means that the potential for harm to detainees, including vulnerable detainees, is not fully considered and could affect their ability to reintegrate into life in the main establishment.

The importance of reintegration processes was highlighted by many NPM members. Many examples from the health sector demonstrate a better understanding of approaches to integrating detainees back on to normal regimes, including by preparing advance statements and holding post-incident debriefs. In all instances of isolation, detainees should know what is required for isolation to end, and it was worrying to find many examples where this was not the case.

Where isolation is the norm, such as in police custody, there may be instances in which it is unwarranted and potentially harmful. Further attention to mitigating the effects of isolation in these situations as well as in non-punitive settings is warranted, especially through encouraging meaningful interaction between staff and detainees.

Next steps

This initial review of practice will feed into future work to strengthen the consistency and rigour of the NPM's monitoring, and into proposals for strengthening policy and practice across detention settings in the UK. Some NPM members have already set out steps for taking this work forward, including:

- the NPM children and young people's sub-group will focus during 2015–16 on its members' findings and ways to strengthen monitoring and appropriate use of isolation;
- the Care Inspectorate will report on its findings on solitary confinement and isolation in forthcoming reports on each of the five secure units for young people in Scotland;
- the Children's Commissioner for England will publish the findings from its project on isolation in 2015;
- inspectorates will focus on the isolation or solitary confinement of TACT detainees in future inspection work;
- HMICS will take account of isolation and solitary confinement, as well as regimes that offset their effects, during the

custody inspections in its Local Policing+ inspection programme;[90]
- HMI Prisons inspected the close supervision centres, looking at the CSCs as a discrete system for the first time. It consulted a group of experts to inform the development of specific *Expectations* (inspection standards) that focused attention on the safeguards and efforts to offset the effects of isolation.

NPM members will also use these findings to develop a set of common standards for monitoring isolation and solitary confinement that can be used across all detention settings.

De facto detention

Across all the jurisdictions, NPM members continue to identify individuals using health and social care services who are subject to *de facto* detention – deprived of their liberty with a lack of access to proper processes for review of the legality and necessity for the deprivation of their liberty.

The 2014 Supreme Court judgment in the cases of *P v Cheshire West* and *P&Q v Surrey County Council*[91] provides some greater clarity on some circumstances that constitute deprivation of liberty under Article 5 of the European Court of Human Rights (ECHR). People are deprived of their liberty if they:

- lack the capacity to make decisions about their care and residence;
- are subject to continuous supervision and control under the responsibility of the state; and,
- lack the option to leave their care setting. (The Cheshire West test)

Previous NPM annual reports described the prevalence of *de facto* detention. The greatest challenges identified were in health and social care settings. In 2014–15, the UK NPM *de facto* detention working group sought to focus on how NPM members detect *de facto* detention in these settings, evaluate the effectiveness of the safeguards to protect these individuals, and identify possible gaps in policy or legislation.

For the purposes of the work undertaken in 2014–15, anyone deprived of their liberty according to the Cheshire West test would be considered *de facto* detained, if that had been done without due process. There are also other cases that amount to *de facto* detention, including situations where people have capacity to make decisions about their care and residence but are not able to leave the care setting, or have expressed unhappiness about aspects of the care regime, such as restraint.

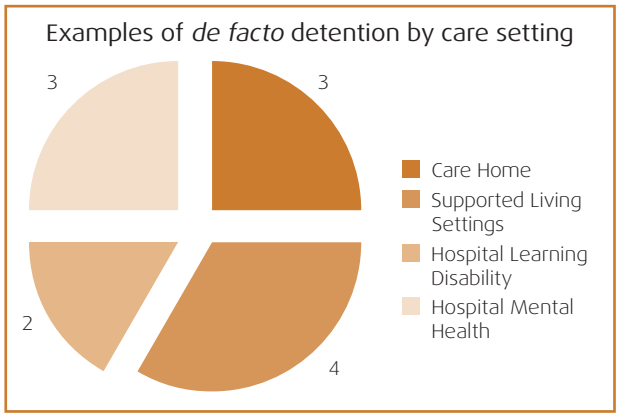
De facto detention by care setting

The working group sought examples of *de facto* detention practice from care settings in each UK jurisdiction. NPM members from two countries responded to the request for information. Responses were received from RQIA, MWCS and CI, with 12 examples of *de facto* detention evenly spread across care homes, mental health hospitals, mental health hospitals for people with a learning disability, and supported

90 The first such inspection, of the custody centre at Kittybrewster in Aberdeen, again highlighted the lack of access to showers and exercise for detainees. This inspection took place in March 2015 and the report was published in May 2015 (HMICS [2015], *Local Policing+ Inspection Programme, Inspection of custody centre located in Aberdeen City Division*) at: http://www.hmics.org/publications/local-policing-inspection-programme-inspection-custody-centre-located-aberdeen-city (accessed 14/10/15).

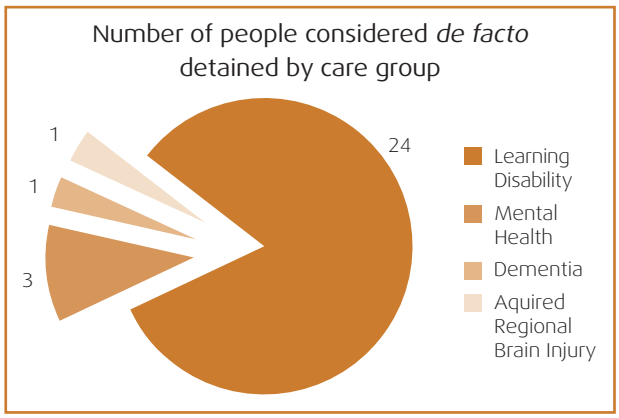
91 The Supreme Court Hilary Term [2014] UKSC 19, at: http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf (accessed 14/10/15).

living settings. The findings presented here do not provide an exhaustive account nor comprehensive piece of research, but give a picture of the types of situations and cases identified through NPM monitoring.



De facto detention by care group

Seven of the 12 examples (58%) related to services for people with a learning disability (adults and younger people), receiving inpatient hospital treatment, residing in a health or social care setting, or receiving a health or social care service.



It should be noted, however, that three of these examples described situations of *de facto* detention for 20 people in total; two examples related to hospital wards providing care and treatment for a total of 18 people across both wards, and another referred to two people living in shared accommodation in the community. Therefore, of the 29 people referred to in the examples provided by NPM members, it is concerning that 24 (83%) considered to be *de facto* detained had a learning disability.

The remaining examples related to people with dementia (one), alcohol-related brain injury (one), and mental ill health (two adults and one younger person).

Legislative frameworks

There are legislative frameworks in Scotland to provide safeguards for individuals who lack the capacity to make decisions regarding their care, treatment or living arrangements independently. Currently in Northern Ireland there are less robust safeguards in place although new legislation (the Mental Capacity Bill), anticipated to be enacted in spring 2016, aims to address the gaps in legislation relating to an individual's capacity to make decisions. In the interim, the Deprivation of Liberty Safeguards guidance issued by the Department of Health, Social Services and Public Safety provides the framework for which any practice amounting to deprivation of liberty should be considered and implemented.

The examples provided by NPM members indicated a gap in the knowledge and understanding of staff providing services about what they should consider about deprivation of liberty/restrictive practices in their practice. Staff often practise in a manner that could be considered as lacking legal validity, when the safeguards of the legislative frameworks have not been applied. Only two of the examples provided demonstrated that staff were aware of the implications of their practice. These staff had tried to ensure that the circumstances and appropriate authorisations were considered

in accordance with the legislative framework. Seven of the examples clearly demonstrated that staff were not aware that aspects of their practice could be considered as lacking a legal basis. The remaining three cases were less clear; while some aspects of staff practice were authorised, the changing legal landscape post-Cheshire West might mean that new areas need to be considered and practical guidance provided for staff.

The proposed Northern Ireland legislation, as currently envisaged, will provide safeguards for people assessed as lacking capacity to make decisions about their health, welfare and/or finance, and guide staff in lawful practice. In Scotland, in some cases there is a lack of clarity about who should be the person or body responsible for applying for the appropriate authorisations, although this is considered on a case-by-case basis.

Common themes

The most clearly defined areas of commonality in the health and social care examples provided included:

- a lack of clarity or understanding in staff practice;
- a failure to engage a multidisciplinary team in risk assessments and care planning;
- a failure to review risk assessments and care plans, including review of the person's capacity to consent to care, treatment and/or interventions;
- ineffective governance in terms of identification of cases of *de facto* detention.

These findings are not significantly different from those detailed in previous NPM annual reports. NPM members will continue to make recommendations for improvement where incidences of *de facto* detention are identified. NPM members will also consider if the development of guidance for staff would be beneficial.

De facto detention outside of health or social care settings

De facto detention was also identified in 2014–15 by HMI Prisons (England and Wales). An inspection of a building used by immigration services identified a 'secondary search area', a single locked room with seating for nine people, who could not freely leave. On the day of the inspection visit, 31 adults and one child were held in this area for an average of one hour and 56 minutes, with seven of these detainees held for more than four hours.[92] Other concerns noted included:

- failure to complete the required documentation to validate the detention;
- a lack of training or accreditation for the guard taking custody of the detainees;
- a lack of child protection training for the Home Office security guard;
- men and women could not be held separately;
- the area was unsuitable for children, and deemed an inappropriate place to hold people;
- detainees had to request exit from the locked secondary search area to use the toilet;
- detainees had no access to fresh air;
- unclear governance arrangements;
- poor record keeping.

A recommendation was made to the Home Office addressing these concerns. This was the first example of *de facto* detention identified by HMI Prisons, and considered likely to be an isolated incident.

92 HM Inspectorate of Prisons (2015), *Report on an unannounced inspection of the short term holding facility at Becket House by HM Chief Inspector of Prisons, 6 January 2015.*

Case studies

Case study 1

Mr K has his own tenancy with day support and on-call night staff. Mr K doesn't respond well to change, and when anxious he can be aggressive to others. His behaviour at times includes banging his head on doors and windows, throwing objects and hitting out at others. When his behaviour indicates that he is becoming agitated he can often be redirected to go back to his flat; at other times he seeks out the safety of his flat independently.

There are times, however, when he needs to be restrained to maintain his safety and the safety of others. Protocols are in place to manage his distressed behaviour, which includes staff taking him to his flat, then withdrawing quickly. Actions taken at these times include locking the kitchen door and talking to him through his front door.

Although all agree that this is the safest way to monitor Mr K at these times, neither the restraint nor seclusion have been legally authorised. There are times when Mr K seeks his own flat and self-selects to be on his own. At other times, by banging on the door he is clearly stating that he does not want this. The use of restraint is not 'one-off' but part of a plan of care, and not legally authorised.

Staff involved in this case have not recognised the implementation of these actions as a practice lacking legal validity. In this jurisdiction there is a legal framework which could consider the legal authorisation of the deprivation of liberty in these circumstances. In this case, either Mr K's parents or the local authority should apply for a welfare guardianship order.

Case study 2

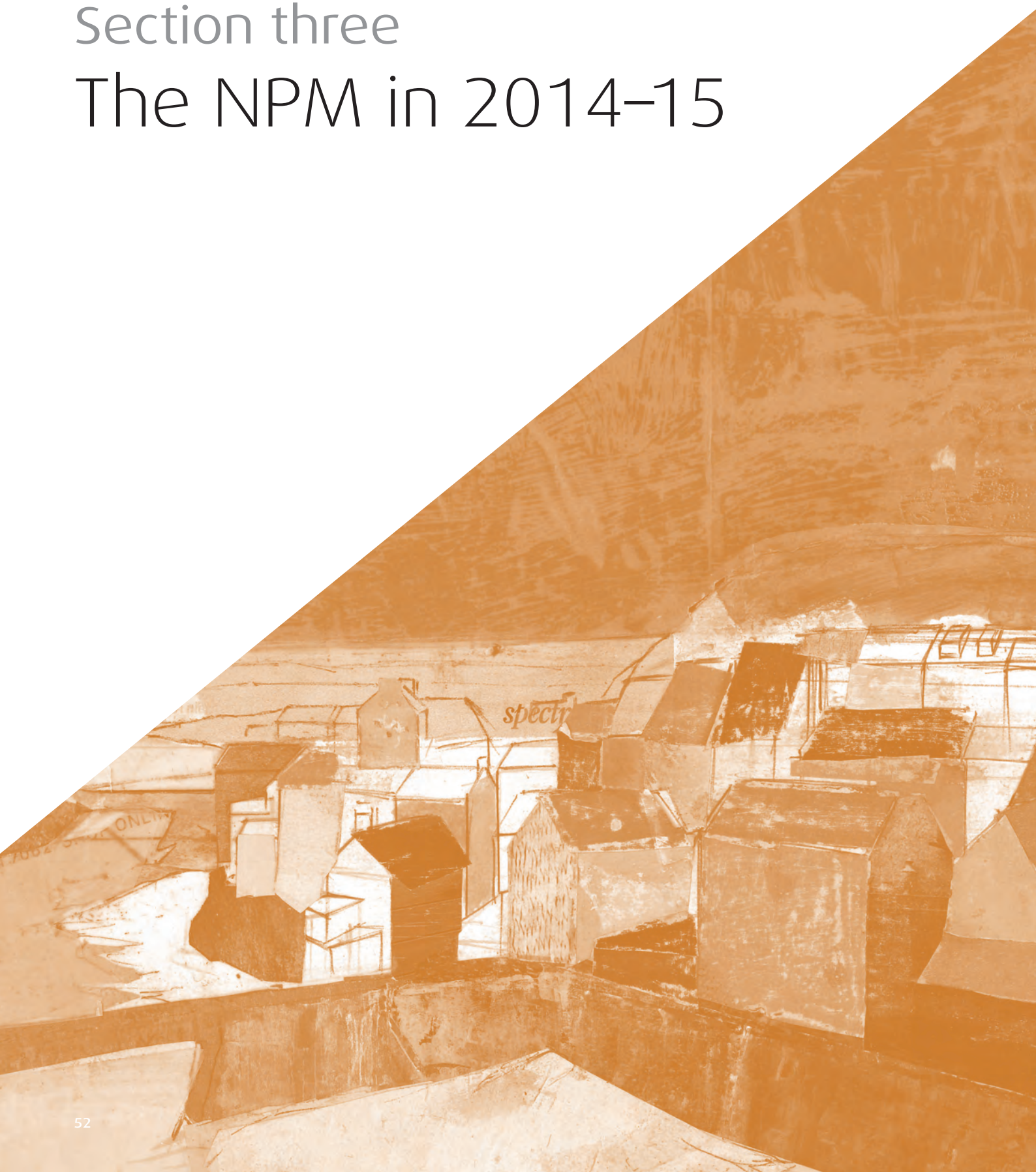
A ward in a mental health hospital for people with a learning disability had 10 patients waiting to move to suitable community settings. None of the patients were formally detained in accordance with the Mental Health (NI) Order 1986. All of the patients lacked the capacity to make decisions about their care and treatment independently. Exit from the ward was locked; internal doors were also locked, restricting the movement of patients within the ward.

The patients in this ward presented with a range of complex needs; all had been in hospital for more than 10 years. However, none of the staff recognised the deprivation of liberty nor considered the interim safeguards set out by local government in the absence of a more robust legislative framework. None of the documentation available for individual patients recorded any identified risks or rationale for this level of restriction, or indicated that it was proportionate and the least restrictive option.

The staff in this situation were asked to complete comprehensive multidisciplinary risk assessments and management plans for each patient to ensure that any deprivation of liberty/restrictive practice was proportionate to the assessed level of risk, and the least restrictive option that could be used.

Section three

The NPM in 2014–15



Strengthening the NPM

Plans for strengthening governance

In 2014–15, its sixth year, the NPM began to take forward suggestions arising from the internal and external scrutiny of its work (through the first NPM self-assessment, the 'UK NPM: Five years on' event, and direct feedback from the UN Subcommittee on Prevention of Torture) in the previous year. In June 2014, a meeting was held with the then Minister for Justice and Civil Liberties, the Rt Hon Simon Hughes MP, to set out the NPM's intentions to strengthen its OPCAT compliance and seek commitment from the government to support this process. The Minister expressed his support for these efforts.

Subsequent to this meeting, NPM members agreed specific measures they would pursue to strengthen the governance of the NPM: to appoint a chair to the NPM, from outside the NPM membership; to seek a legislative basis for the NPM through explicit reference to NPM and OPCAT responsibilities in members' own statutes where these are under review; and through specific legislation setting out the duties and powers of the NPM.

These proposals have been discussed with Ministry of Justice officials through the year. Discussion about the role of chair and its relationship to NPM members and government ministers that would ensure appropriate leadership and independence were continuing at year end.

The NPM responded to a November 2013 letter from the UN SPT, setting out its plans to address the concerns and suggestions identified by the SPT, which covered issues relating to the possibility of there being 'mixed messages' across the NPM, the need to improve information sharing and take a more 'preventive' approach, and to have a coordinated plan for the promotion of its activities.

Strengthening NPM activity and membership

The establishment of two new NPM sub-groups – on mental health detention, and in Scotland – has strengthened the NPM's ability to share experience and articulate its findings. It is envisaged that these sub-groups will take forward joint work to further areas of the NPM business plan.

Further discussions were held about the possible inclusion of the Independent Reviewer of Terrorism Legislation (IRTL) in the NPM and in March 2015, David Anderson, the current Independent Reviewer, presented an overview of his role and shared views about possible links with NPM members' monitoring at the March 2015 business meeting. At the year end, the case for including the IRTL was being considered by the Ministry of Justice.[93]

In November 2014, NPM members agreed to make a modest financial contribution to the central costs of the NPM.

With a view to strengthening the capacity of all members to build knowledge of their NPM responsibilities among colleagues, senior managers, boards, external stakeholders and others, the NPM coordination prepared new training materials. Work to establish an independent website for the NPM was started, with support from the Ministry of Justice.[94] Short factsheets

93 See also Independent Reviewer of Terrorism Legislation (2015), *The Terrorism Acts in 2014*. September 2015. Paragraphs 7.25-7.27.

94 This website was launched in July 2015, see: www.nationalpreventivemechanism.org.uk.

setting out the NPM's work to reflect on its first five years, and its self-assessment methodology and process were published during the year and have been disseminated widely among the NPM's stakeholders, including NPMs around the world.[95]

Independence of NPM personnel

In May 2014, the UK NPM agreed guidance - *Ensuring the independence of NPM personnel* (see Appendix III) - which sets out members' intention to work progressively towards a reduction in reliance on seconded staff for NPM work, among other measures. The guidance addresses the 2013 recommendation of the UN Committee against Torture, which called on the UK to 'end the practice of seconding individuals working in places of deprivation of liberty to NPM bodies'.

Under this guidance, NPM members agreed to report annually on their progress in reducing their reliance on secondees. Four out of 20 members reported using secondees in 2014–15. All 10 of the NPM members who had no secondees in 2013–14 remained in the same position. Four NPM members had reduced the overall number of secondees involved in NPM work. Two NPM members had increased the number of secondees by one, but had plans to address any potential conflicts of interest. Figures provided by four NPM members were not comparable to the previous year.

Preventing sanctions

Taking forward the NPM's obligation to prevent any punishment or prejudice resulting from a person or organisation's contact with its monitors (OPCAT Art.21), NPM members worked to develop specific policies and protocols:

- HMI Prisons led work to draft a protocol aimed at preventing sanctions from arising during joint HMIC/HMI Prisons police custody inspections; this protocol will be completed in 2015–16;
- HMI Prisons and the IMB National Council worked with the Prisons and Probation Ombudsman to implement their 2013 protocol on preventing sanctions in prisons;
- HMICS began work to develop a policy on preventing sanctions and reprisals;
- CJINI led the development of a protocol to prevent sanctions and reprisals for inspections in prisons with the IMB NI and the Prisoner Ombudsman NI, due to be completed in June 2015;
- HMIPS developed a protocol on preventing sanctions and reprisals, and included the topic in training for new inspectors.

Member-specific developments

The Care Inspectorate reflected the requirements of OPCAT in its new three-year corporate plan, which sets out to provide robust inspection, support local and national policy, and contribute to a rights-based care system in Scotland. A review and consultation on its methodology and approach have provided further opportunities to integrate its NPM role into its work. During the year, the Care Inspectorate was asked to lead (with Health Improvement Scotland) on the development of Scottish National Care Standards, which will be underpinned by human rights and refer to the work of the NPM.

Further efforts to take forward specific issues relating to the NPM mandate include those to raise awareness of *de facto* detention and child sexual exploitation and the need

95 See: http://www.nationalpreventivemechanism.org.uk/publications-resources/.

for coordinated responses across services. The Care Inspectorate has also looked at how its inspections of care homes for adults with learning disabilities can better focus on people's experiences and outcomes, and how their rights are promoted and protected.

The National Council of the Independent Monitoring Boards has included the NPM role within its development plan, and a training and development working group will include the requirements of the NPM in all relevant training programmes for IMB members. The IMBs' new national monitoring framework references OPCAT and provides guidelines to monitoring boards on how they should meet its requirements.

The Independent Custody Visiting Association (ICVA) continued to take forward recommendations made during the development of the national standards. A working group commissioned to look at the feasibility of a national ICV report form has issued guidance to schemes on the recommended minimum information custody visits should be seeking to gather, and training modules.

ICVA is exploring the possibility of reissuing its national standards every two years with the Home Office, as a way of ensuring the standards evolve in line with local practice.

ICVA requested that a review be carried out to establish custody visiting schemes' compliance with the codes of practice issued by the Home Office, as a result of concerns about the governance arrangements of some schemes nationally.

In June 2014, the Care Quality Commission's (CQC) executive team and board received a paper on CQC's NPM duties, to ensure that these were understood at the organisation's senior level.

After proposing the creation of an NPM mental health forum to NPM members, CQC organised the first two meetings of the forum and agreed to take on the role of chair.

In March 2015, CQC held an NPM workshop for staff working within CQC policy, inspection and equality teams as well as NPM members, at which the Human Rights Implementation Centre at Bristol University presented its findings on comparative research reviewing international monitoring mechanisms, commissioned by CQC in 2013.

The Scottish Human Rights Commission (SHRC) and HMIPS started a joint programme of prison visits in Scotland. SHRC delivered a joint statement with the English and Northern Ireland National Human Rights Institutions (NHRIs) to the UN Human Rights Council on the human rights of people with mental health issues detained by the state.[96] SHRC also worked with the Scottish Government, civil society and HIMPS in the implementation of the new system for independent monitoring of prisons. SHRC and MWCS worked together to progress a commitment in the mental health strategy for Scotland to improving human rights in mental health care, including considering ways to improve mental health services in places of detention.[97]

96 Scottish Human Rights Commission (2015), *Joint statement on mental health detention to UN Human Rights Council* at: http://www.scottishhumanrights.com/resources/policysubmissions/hrcdetmar15 (accessed 14/10/15).
97 The Scottish Government, *Mental Health Strategy for Scotland: 2012-15*. At: http://www.gov.scot/resource/0039/00398762.pdf (accessed 14/10/15).

The Children's Commissioner for England (CCE) commissioned an evidence review of where children are placed in detention and care settings in England, and the legal and regulatory/inspection frameworks that govern their placement in each setting, to identify any gaps. CCE also developed a project looking at isolation in the secure estate for children and young people, and conducted a data collection exercise to inform fieldwork in the following year.

As part of its visit function, CCE made unannounced visits to eight establishments in the children's custodial estate, one unannounced visit to a secure children's home providing welfare accommodation only, and one announced visit to a secure mental health inpatient unit for children.

The Care and Social Services Inspectorate Wales (CSSIW) continued to work in partnership with colleagues from HIW to monitor, inspect and improve the operation of the deprivation of liberty safeguards in Wales. Training was delivered to existing and new inspectors to reinforce their understanding of their responsibilities in monitoring the operation of the safeguards, with a particular focus on awareness of *de facto* detention. CSSIW was invited to join the 'Leadership Group' established by the Welsh Government to consider the implications of the Cheshire West judgment. CSSIW is actively raising the importance of the NPM role in this group, as well as more broadly through internal and external communications.

CSSIW developed new inspection frameworks for its inspections of regulated services and local authority social services. These include quality judgement frameworks and are focused on an assessment of the effectiveness of social services and social care in supporting good outcomes for people. They include explicit consideration of the extent to which the care and support provided helps to secure rights and entitlements for people.

Her Majesty's Inspectorate of Prisons for Scotland (HMIPS) revised the standards it had used for its inspections since 2006, which it considered no longer adequately reflected the requirements of prison inspections. Practitioners (including other NPM members), academics and others with an interest in human rights and how prisons are run, were consulted and the new standards were published in March 2015.[98] The standards place greater emphasis on engaging prisoners in decision-making, improving evaluation of the clarity of purpose and priorities of the prison, and assessing relationships both within the prison and with external agencies and communities, and include specific human rights indicators.

New legislation gave HMIPS the responsibility for the monitoring of prisons in Scotland (the role previously carried out by Visiting Committees), and HMIPS made preparations for the implementation of this role (from September 2015) by recruiting volunteer Independent Prison Monitors.

During the year, Her Majesty's Inspectorate of Constabulary in Scotland (HMICS) embarked on a new inspection programme, which will contribute to the implementation of OPCAT in police custody in Scotland. This followed a thematic inspection of police

98 HM Inspectorate of Prisons for Scotland (2015), *Standards for inspecting and monitoring prisons in Scotland*, at: http://www.gov.scot/Publications/2015/03/8256/0 (accessed 14/10/15).

custody arrangements in Scotland in 2014. The new inspection programme, 'Local Policing+', will see HMICS inspect policing in each of Police Scotland's 14 territorial divisions, with inspections of approximately three divisions, and all of the custody centres within them, each year. The first local policing inspection to include custody centres took place in Aberdeen in March 2015. The rolling programme will ensure HMICS inspects all custody centres in Scotland, as required by OPCAT, and monitors progress and, where appropriate, discharge recommendations from its 2014 thematic inspection of custody.

HMICS is also committed to ensuring that its custody inspection team does not include any police officers seconded to the organisation. HMICS nominated an individual staff member from a non-policing background to lead on custody matters as a further guarantee of independence. Information about the steps taken has been publicised on the HMICS website.

The Mental Welfare Commission for Scotland (MWCS) continued its programme of national themed visits in 2014–15. During its visits to monitor the use of enhanced observation in adult acute admission wards, the MWCS paid attention to whether, in practice, deprivation of liberty issues and the possibility of *de facto* detention were being considered.[99]

The MWCS started to build its focus on NPM thematic issues into visit work. Visits to all the intensive psychiatric care units started, and will include a focus on restrictive practices, specifically the use of restraint and seclusion. Visits to all learning disability assessment units are also planned and, again, specific information will be gathered about restrictions/restraints and the use of seclusion, or other practices that isolate individuals.

In the last NPM report, the MWCS reported that it had reviewed the operation of restrictions in hospitals, which can be authorised under mental health law in relation to correspondence, the use of telephones, and certain security measures. To follow this up, MWCS published revised and updated guidance on principles and best practice in implementing specific restrictions.[100]

The MWCS visits a significant number of people each year who are subject to guardianship orders under incapacity legislation, and this year began to screen systematically all applications and orders granted to identify potential deprivation of liberty issues, and ensure that visits target people whose care and support might raise issues about deprivation of liberty.

The MWCS started work to develop a patient's rights care pathway, to identify how people can be given information about their rights at key stages in their care.

The Independent Custody Visitors Scotland (ICVS) continued to disseminate NPM materials and provide training on NPM responsibilities as part of its training programme for current and new volunteers; 32 new custody visitors joined the scheme during the year. A Scottish code of practice for independent custody visiting was produced and ratified by the Scottish Government, Ministry of Justice and the Scottish Police Authority Board.

99 Mental Welfare Commission for Scotland (2015), *Visiting and monitoring report: Enhanced observation 2014/15.*
100 Mental Welfare Commission for Scotland (2015), *Specified persons guidance: Principles and best practice in implementing specified persons regulations under the Mental Health (Care and Treatment) (Scotland) Act 20013.*

Criminal Justice Inspection Northern Ireland (CJINI) published a report of its inspection of Magilligan Prison (February 2015) as well as thematic reports on the safety of prisoners held by the Northern Ireland Prison Service (October 2014), and a follow-up review of prisoner escort and court custody arrangements (April 2014). Inspection fieldwork was conducted in the Juvenile Justice Centre.[101]

The Northern Ireland Policing Board Independent Custody Visiting Scheme (NIPBICVS) delivered training and development activities to encourage and promote continuous improvement on the scheme, including training on vulnerable adults and equality and diversity. Five new custody visitors joined in August 2014.

Ofsted (Office for Standards in Education, Children's Services and Skills) developed and published a revised framework for children's homes during 2014–15. The methodology for inspecting England's secure children's homes (SCHs) is incorporated within this wider framework, making it clear that such establishments are primarily homes for children, regardless of their secure nature. The framework incorporates strengthened guidance on the inspections of SCHs and, specifically, guidance on inspectors' evaluation of the use of restraint and single separation, in line with a key NPM priority. The framework now references its many links to OPCAT more explicitly.

Respect for children's rights and entitlements are central to the framework, which sets out the benchmark of 'good' as the minimum acceptable standard of care and help for children and young people, wherever they are living.

It was agreed that a revised framework should explain more clearly that inspectors' judgements of STCs are underpinned by OPCAT values and principles. Greater clarity was required on inspections' examination of the use of single separation and restraint.[102]

Between April 2014 and March 2015, Her Majesty's Inspectorate of Prisons (England and Wales) (HMI Prisons) published 94 inspection reports, including reports on 49 adult prisons, nine children's secure establishments, 10 police forces' custody facilities and three immigration detention facilities. It also produced thematic research on transfers and escorts in the criminal justice system, and a review of release on temporary licence (ROTL) failures.

In line with NPM guidance, HMI Prisons reduced the number of seconded staff from nine in 2013–14 to seven in 2014–15. The findings from its NPM self-assessment fed directly into the organisation's corporate plan, with all areas identified as 'partially compliant' or 'not currently compliant' included as action points. HMI Prisons published its self-assessment response on its website.

In June 2014, after consultation with a wide range of stakeholders, HMI Prisons published its *Expectations: Criteria for assessing the treatment of and conditions for women in prison*, which draws from the UN Bangkok Rules on the treatment of women offenders.[103] HMI Prisons is revising its police

101 Report to be published in 2015.
102 Proposals for change have since been consulted upon widely and the new framework was published in July 2015. See: https://www.gov.uk/government/publications/inspecting-secure-training-centres-framework (accessed 14/10/15).
103 United Nations General Assembly, *United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders* (the Bangkok Rules), A/C.3/65/L.5., 6 October 2010.

custody, court custody and immigration *Expectations*, and drafted new *Expectations* for the close supervision centres (CSC) system, informed by an analysis of applicable human rights standards. These *Expectations* were piloted during an inspection of CSCs in March 2015 – HMI Prisons' first inspection of the system as a whole. They are being revised in light of the inspection and will be published in 2015–16.

Her Majesty's Inspectorate of Constabulary (England and Wales) (HMIC) conducted a thematic inspection, commissioned by the Home Secretary, focusing on the welfare of vulnerable people in police custody. The scope of this inspection included the decision to arrest, alternatives to arrest considered and/or available, and treatment of detainees before their arrival at the police custody suite. The thematic report, published in March 2015, found that in many instances custody for vulnerable people could have been avoided if alternatives had been explored. The lack of suitable alternative accommodation or health care arrangements led to people with mental health problems and children spending long periods in custody. Police custody provision had a significant role as a function of the health and social care system. The report also found that people from black and minority ethnic groups were overrepresented in the number of people detained.[104] The report made several recommendations, and a national group chaired by the Home Office is now overseeing their implementation.

HMIC conducted 11 police custody inspections jointly with HMI Prisons during the year. Using the NPM self-assessment, learning from the vulnerability thematic inspection and other sources, HMIC and HMI Prisons identified a number of areas for improvement, which are being developed into a change programme for delivery in the next reporting year. This will take a more robust and effective approach to inspection and OPCAT requirements

In 2014–15, HMIC introduced a new approach to its inspections of the police service – 'PEEL' (police effectiveness, efficiency and legitimacy). This programme is being developed to provide a rounded assessment of every aspect of what police forces do, using criteria that allow graded judgments to be made. The PEEL programme could have implications for the way HMIC approaches inspections of custody, and this is being addressed in the scope of the change programme for custody inspection referred to above.

The Regulation and Quality Improvement Authority (RQIA) monitored almost 11,000 forms received by health and social care trusts to establish the appropriateness of detention and guardianship orders and treatment plans, advising trusts to address any concerns it identified. Over the year, RQIA noted and informed the trusts of 29 errors/omissions that led to improper detentions.

RQIA conducted 66 primary inspections of mental health and learning disability wards, as part of a planned programme and in response to concerns raised through complaints and whistleblowing. Inspections

104 HM Inspectorate of Constabulary (2015), *op. cit.*

focused on the theme of autonomy. Lay assessors were introduced to the inspection process as well as easy-to-read patient questionnaires and observation tools. A further 66 patient experience inspections were undertaken to meet with and offer interviews to patients in mental health wards, including wards for people with dementia, children and adolescent mental health wards and to patients in learning disability wards.

More than 75% of wards demonstrated compliance or substantial compliance with expectations related to therapeutic and recreational activity, information about rights and discharge planning. Inspection findings showed lower levels of compliance with respect to capacity and consent, individualised assessment and management of need and risk, and restriction and deprivation of liberty.

RQIA also conducted joint inspections of Magilligan Prison, Woodlands Juvenile Justice Centre and monitoring visits in relation to the Prison Review Team's work.

NPM sub-groups

NPM children and young people's sub-group

The children and young people's sub-group, hosted by CCE, continued to meet quarterly as a forum for coordinating action and sharing intelligence and information on issues concerning the work of NPM members on children in detention across the UK.

During the year, the sub-group focused on *de facto* detention (discussing possible gaps and overlaps in the inspection regime across settings, the different legal framework for children, the possibility that it arises in non-detention settings), vulnerable people in police custody (based on the findings from a thematic inspection led by HMIC), isolation and solitary confinement, the proposed new framework for Ofsted/HMI Prisons inspections of secure training centres (STCs), and the results of the HMI Prisons/YJB survey of young people in custody.

Following an evaluation of the children and young people's sub-group in 2014, it was recommended that it focus on agreeing action points where value can be added, as well as joint work on the strategic priority issues agreed by the NPM as a whole, with specific reference to children.

NPM Scottish sub-group

The first meetings of the Scottish sub-group were held in October 2014 and February 2015, with a Director of the Scottish Government invited to attend each. Members of the sub-group conducted peer reviews of each other's NPM self-assessments. Plans for the sub-group's work in 2015–16 include increasing the impact of the work of the NPM in Scotland.

NPM mental health network

The first two meetings of the mental health network focused on the ways its members will work together, and established a clear purpose and set of common objectives for the group. The group will coordinate approaches, enable peer reviews and share resources for research, training and development. In March 2015, members of the mental health network attended a human rights workshop convened by CQC, discussing research on the strategy and practices for keeping mental health detention settings under review.

Joint working between NPM members

Scottish NPM members' joint working arrangements developed over the year, with the Care Inspectorate joining HMIPS on its inspection of HMPs Glenochil, Greenock and Perth. The Scottish Human Rights Commission joined the HMIPS inspection of HMP Glenochil, using the new HMIPS inspection standards. The MWCS and HMIPS have begun work to coordinate prison visits by both organisations, and SHRC and MWCS have been working to progress Commitment 5 of the Mental Health Strategy for Scotland,[105] with the Scottish Government.

A joint report by the MWCS and Care Inspectorate on the mental health needs of young people in secure care identified several areas for improvement, including around transition arrangements for young people moving into and out of secure care.[106] Following this, further joint work in secure care settings is also planned.

Ofsted worked closely with partner inspectorates HMI Prisons and CQC, as well as other stakeholders, to develop its revised framework for the inspection of STCs, which are commissioned by the Youth Justice Board.

HMIC and HMI Prisons worked to develop revised *Expectations* (assessment criteria) for the joint programme of police custody inspection. The document, which will be published in the next reporting year, has been extended to include the treatment of detainees from the first point of contact with the police and places a stronger focus on equality and diversity, and leadership and accountability.

ICVA is currently working with the Lay Observers nationally to produce protocols that will safeguard the rights and entitlements of people dealt with by pilot 'virtual court' initiatives. Discussions have included specific monitoring arrangements by the separate organisations, and the distribution of a first night leaflet to detainees who have received custodial sentences.

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

Across the NPM, members submitted comments and responded to consultations on draft legislation and policy, as part of its remit to strengthen the protections of those in detention. Some of the main policy consultations and legislative processes to which NPM members have submitted proposals and observations include the following.

- The Care Inspectorate responded to Scottish Government consultations on proposals for an offence of wilful neglect or ill-treatment in health and social care settings,[107] to reform fatal accident inquiries legislation,[108] and to the Public Petitions Committee call for evidence on national guidance on restraint and seclusion in schools.[109]

105 The Scottish Government, *Mental Health Strategy for Scotland: 2012-15.*
106 Mental Welfare Commission for Scotland, *Visiting and monitoring report: Visits to young people in secure care settings* at: http://www.mwcscot.org.uk/media/203241/visits_to_young_people_in_secure_care_settings_final.pdf (accessed 14/10/15).
107 See: http://www.gov.scot/Resource/0046/00469698.pdf (accessed 14/10/15).
108 See: http://hub.careinspectorate.com/media/200552/care-inspectorate-response-to-fai-consultation-september-2014.pdf (accessed 14/10/15).
109 See: https://www.scottish.parliament.uk/S4_PublicPetitionsCommittee/General%20Documents/PE1548_E_Care_Inspectorate_20.04.15.pdf (accessed 14/10/15).

- The IMBs gave evidence to the Justice Select Committee inquiry into prisons: policy and planning, the Harris Review into deaths in custody, and the review into the welfare in detention of vulnerable persons.
- CQC has a statutory role in providing proposals to government on the content of the Mental Health Act Code of Practice and in 2014 provided a detailed submission to a review of the Code. Many of CQC's suggestions and subsequent observations, including those arising from its monitoring activities, were accepted and the Code has strengthened its advice on restraint, seclusion, involvement of patients in decisions about their care, and (for the first time) the avoidance of 'blanket restrictions' on liberty and rights. The revised Code also describes, for the first time, CQC's NPM role. CQC will monitor the implementation of this Code in its NPM visiting work.[110]
- CCE submitted several briefings during the passage of the Criminal Justice and Courts Bill through parliament. These focused on the proposed secure college, including the proposed detention of girls, and boys under 15 within it. CCE also responded to a Ministry of Justice consultation on proposals for secure college rules, raising concerns in particular about the use of force.
- CSSIW worked with the Welsh Government to inform and influence the shape of the Regulation and Inspection of Social Care (Wales) Bill.
- HMIPS submitted evidence to the Justice Committee of the Scottish Parliament on the Public Services Reform (Inspection and Monitoring of Prisons) (Scotland) Order 2015. HMCIPS gave evidence in person to the Justice Committee of the Scottish Parliament on 2 December 2014.[111]
- The MWCS took an active role in responding to draft legislation, in particular highlighting concerns about Scotland's Mental Health Bill. MWCS put forward amendments to challenge some aspects of the Bill, particularly the timescales for review of detention, and to strengthen the right of access to independent advocacy.
- ICVS and HMICS provided evidence on the progress and status of the custody visiting scheme in Scotland to the Justice Sub-committee of the Scottish Parliament in October 2014.
- As well as commenting on a number of draft Prison Service Instructions and draft Detention Services Orders throughout the year, HMI Prisons gave evidence to the Public Administration Select Committee inquiry on accountability of quangos and public bodies (April 2014), the Welsh Affairs Committee inquiry on Welsh prisons and offenders (June 2014), the independent review into self-inflicted deaths in National Offender Management (NOMS) custody of 18–24-year-olds, the Harris Review (July 2014), the parliamentary inquiry into the use of immigration detention in the UK, hosted by the All-Party Parliamentary Group on Refugees and the All-Party Parliamentary Group on Migration (October 2014), the National Assembly for Wales Health and Social Care Committee inquiries into new psychoactive substances (October 2014) and alcohol and substance misuse (January 2015), and the Ministry of Justice consultation on plans for secure college rules (December 2014).

110 See: https://www.cqc.org.uk/sites/default/files/20140911_mental_health_act_code_of_practice_detailed_consultation_return_1.pdf (accessed 14/10/15).
111 See: http://www.scottish.parliament.uk/parliamentarybusiness/report.aspx?r=9665 (accessed 14/10/15).

International collaboration

Several members of the NPM met with the UN Special Rapporteur on Violence Against Women and Girls, Rashida Manjoo, during her official visit to the UK in April 2013. A report of the visit, published in June 2014, raised the Special Rapporteur's concerns about the increase in women in prison, and the overrepresentation of black and minority ethnic women in prisons and immigration detention, as well as the fact that female prisoners are more likely to repeatedly self-harm. She expressed regret at being denied entry to Yarl's Wood IRC, despite repeated requests from the start of her visit. Among her recommendations, she called for the full implementation of recommendations from the 2007 Corston report on women with particular vulnerabilities in the criminal justice system, as well as an independent examination of allegations of abuse against women detainees in Yarl's Wood and to ensure all complaints are thoroughly investigated and alleged perpetrators held accountable.[112]

Members of the UK NPM received visits from several delegations interested in their experience of independent detention monitoring. The IMBs hosted delegations from Kosovo and Russia, and a delegation from Georgia met the IMBs, CQC and HMI Prisons. HMI Prisons received visits from Australia, Georgia, Ghana, India, Kenya, Libya, Netherlands, Norway, Spain, Switzerland, Turkey and Turkmenistan. HMI Prisons' staff provided training to assist or develop local inspection and monitoring organisations in Bahrain, Bosnia-Herzegovina, Japan, Lebanon and Morocco, funding all its international work separately from its core domestic inspection business. CQC shared experiences from the UK NPM in Ukraine, at a regional (Western Balkans) conference in Kosovo and in Shanghai (although China is not a signatory to OPCAT, its new mental health legislation does provide for monitoring visits to hospitals). CQC also hosted a visit from the clinician responsible for legal reform of mental health law in Brunei Darussalam.

The UK NPM was invited to international meetings focusing on detention and monitoring. CCE spoke about detention monitoring at the World Congress on Juvenile Justice (January 2015) and on children in conflict with the law deprived of their liberty at an expert symposium organised by the Association for the Prevention of Torture (July 2014).[113] HMI Prisons and HMIPS attended the 25th anniversary conference of the CPT at the Council of Europe in Strasbourg, France in March 2015.

Members of the NPM provided detailed input into a project led by the Ludwig Boltzmann Institute of Human Rights and the Bristol University Human Rights Implementation Centre on 'Strengthening the effective implementation and follow-up of NPM recommendations'.[114]

The NPM coordinator and HMIC attended a meeting of NPMs in April 2014 to prepare input for the Organization for Security and Co-operation in Europe (OSCE) supplementary human rights dimension meeting, where the issue of torture prevention had been put

112 United Nations General Assembly (2015), *Report of the Special Rapporteur on Violence against Women, Mission to the United Kingdom of Great Britain and Northern Ireland,* A/HRC/29/27/Add.2, 19 May 2015.
113 See: http://www.apt.ch/en/2014-children-s-vulnerabilities-in-detention/ for more information (accessed 14/10/15).
114 Ludwig Boltzmann Institute and University of Bristol (2015), *Enhancing impact of NPMs: Strengthening the follow-up on NPM recommendations in the EU.* At: http://www.bristol.ac.uk/media-library/sites/law/hric/2015-documents/NPM%20Study_final.pdf (accessed 14/10/15).

on the agenda under the Swiss presidency of the OSCE. The UK NPM supported the drafting of recommendations to OSCE states that they take steps to strengthen NPMs' independence, powers and other measures aimed at preventing torture (see Appendix IV).

NPM self-assessment

In November 2013, the UN SPT recommended to the UK NPM that it use its 'analytical self-assessment tool for NPMs' to examine its effectiveness and efficiency. Since then, the UK NPM has developed its own methodology for applying the SPT's tool across the 20-body NPM.[115] In this reporting year, NPM members conducted their second self-assessment, and members peer reviewed their responses as a way of strengthening the process and encouraging learning across the NPM. The Ministry of Justice was invited to respond to questions relating to the government's role and the NPM's constitution.

The findings of this second self-assessment will feed into members' own efforts to strengthen their OPCAT compliance, as well as inform NPM business planning.

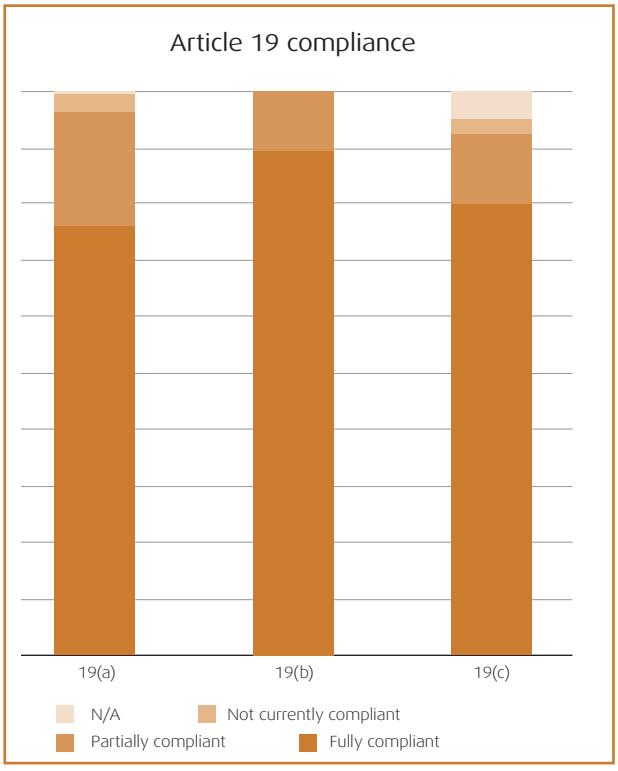
General findings

All 20 NPM members responded to the self-assessment questionnaire, and the responses from 17 of them had been peer reviewed – mostly by other NPM members.

Overall findings were more positive this year, with members reporting full compliance with 83% of the self-assessment questions, an increase of 4%. Non-compliance fell from 4% to 2%.

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

Number of people considered *de facto* detained by care group



As in 2013-14, the highest levels of compliance reported were with the power to make recommendations. Members reported higher levels of compliance with the powers to examine the treatment of those deprived

115 The UK NPM's self-assessment questionnaire can be found in Appendix 8 of the Fifth Annual Report at: http://www.nationalpreventivemechanism.org.uk/wp-content/uploads/2015/05/NPM-5th-Annual-Report-2013-14.pdf. A full write-up of the self-assessment methodology can be found at: http://www.nationalpreventivemechanism.org.uk/wp-content/uploads/2015/08/UK-NPM-self-assessment-write-up.pdf.

of their liberty, with full compliance on 76% of questions (an increase of 3%) and a decrease in non-compliance to 3% (a decrease of 5%).

Specific findings

- All members continued to report full compliance on self-assessment questions relating to their work to make recommendations with the aim of improving the treatment and conditions of persons deprived of their liberty and to prevent torture and ill-treatment (Q1.2), and to ensure that any confidential information acquired during their work is fully protected (Q1.56).
- Lowest levels of compliance continued to be in the areas of gender balance and representation of ethnic and minority groups in visiting teams (Q1.17), strategies for preventing reprisals or threats (Q1.36), as well as information collected in group interviews (Q1.37), and follow up on cases of suspected or documented ill-treatment or torture (Q1.50).
- Progress was reported in addressing two areas of low compliance identified last year – the training that NPM staff receive to carry out their NPM role effectively (Q1.11), and cooperating with others to follow up on cases of suspected or documented ill-treatment or torture (Q1.50).
- As in 2013–14, lay bodies self-assessed more positively than professional bodies, stating that they were fully complaint with 88% of the questions, compared with 81% for professional bodies.
- As in 2013–14, members from Northern Ireland were the most positive about their compliance with OPCAT, assessing full compliance with 90% of the questions. The least positive self-assessment was from members who inspect or monitor both England and Wales, with full compliance on 79% of the questions.

Conclusions

The findings from the self-assessment exercise will be presented at a future NPM business meeting to identify actions that should be taken in the areas needing progress.

The UK NPM has shared its methodology with other NPMs around the world and with the UN SPT, and has been invited to provide comments on a new draft of the SPT's self-assessment document.

Section four

Looking ahead to 2015–16

The NPM has agreed three main objectives for its work during 2015–16.

1. To strengthen the protection of those in detention through coordinated and collaborative work on relevant issues.
2. To comply with the NPM mandate established by OPCAT.
3. To raise awareness of the NPM – institutionally, in the UK and internationally.

To deliver these objectives, NPM members have agreed to continue to focus both on thematic work that brings a common approach to a specific detention issue, and efforts to strengthen the way the NPM and its members conduct their work. The following work has been agreed.

- Continue coordinated NPM work on isolation and solitary confinement, and *de facto* detention.
- Submit proposals and observations on existing and draft policy and legislation, in coordination and individually.
- Strengthen work on children and young people in detention, mental health detention, and issues specifically relating to Scotland through its three sub-groups.
- An annual peer-reviewed self-assessment of members' compliance with specific OPCAT requirements, to feed into planning by members and across the NPM.
- Propose actions to strengthen the NPM's governance.
- Adopt policies to prevent sanctions arising from NPM work.
- Implement the NPM policy on ensuring the independence of its staff.
- Strengthen relationships between devolved governments and the NPM.
- Proactive engagement with the UN Subcommittee on Prevention of Torture.
- Engagement with other UN and European bodies and NPMs on matters of mutual interest.
- Raise awareness of the NPM through European networks, with NGOs and in relation to specific NPM work.
- Provide training resources and information resources to NPM members.
- Create a stand-alone NPM website.
- Produce the annual NPM report, to be laid before Parliament.

In 2015–16, the UK's progress in implementing the International Covenant on Civil and Political Rights and the Convention on the Rights of the Child will be reviewed by official UN treaty monitoring bodies, and a periodic visit by the European Committee for Prevention of Torture has been announced for 2016.

Section five
Appendices

Appendix I

Terms of reference for the Scottish sub-group

NPM – Scottish sub-group terms of reference

Purpose

The Scottish NPM sub-group and its members represent the interests of Scottish members of the UK NPM.

The group aims to:

- share information on the work of the NPM bodies in Scotland;
- identify common issues and interests;
- coordinate NPM activities in Scotland;
- explore possibilities for joint activity;
- raise the profile of the work of the NPM;
- improve liaison with the Scottish Government;
- provide support to the NPM members in Scotland;
- make use of self-assessment and peer evaluation tools to measure continued improvement.

Membership/representation

Membership of the group is open to those who have a lead role in monitoring and inspecting places of detention across Scotland:

- HM Inspectorate of Prisons for Scotland
- The Mental Welfare Commission for Scotland
- Scottish Human Rights Commission
- Care Inspectorate
- UK NPM Coordinator
- Independent Custody Visitors Scotland
- HM Inspectorate of Constabulary for Scotland.

Working methods of the group

The group will adopt a shared learning approach. This involves:

Group meetings

- At least two meetings will be held each year prior to planned UK NPM business meetings.
- Meetings will be chaired by the Scottish member of the UK NPM steering group.
- Meeting topics will be generated by members of the group, and meeting agendas and papers circulated in advance.
- Meetings will include small group discussions to share experiences and learning.
- Other people may be invited to join group meetings on a one-off basis to aid discussion on particular topics.
- Minutes will be taken and circulated among all sub-group members.

Sharing of information and resources

- Information will be shared at sub-group meetings and via electronic communications.
- It is each member's responsibility to make clear where a matter shall remain confidential and not for discussion outside the group.
- When sharing documents, members should make clear if there is a restriction to circulation and/or use of documents.

Reporting

- The chair of the sub-group will be responsible for providing updates on the work of the group to the UK NPM at least twice yearly.

- Where actions are recommended by the sub-group, these will be recorded and submitted to the UK NPM for inclusion in the UK business plan/annual report, where relevant.

Review of terms of reference

This will be undertaken after the first six months initially, then annually thereafter, to ensure continuing relevance and ongoing development of the Scottish sub-group of the UK NPM. The next review is due in April 2015.

Appendix II

Terms of reference for the mental health network

Terms of reference for the National Preventive Mechanism - mental health network

1. Introduction

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

Preventing the ill-treatment of people who are detained as a result of mental illness constitutes a large part of the NPM's work. To allow additional specialist discussion, the NPM members who inspect, regulate and/or visit mental health detention have established a sub-group to offer a forum for additional detailed consideration of the aspects of the NPM business plan relevant to mental health detention in the UK.

The sub-group offers organisations with responsibilities for the monitoring and protection of people in health and social care detention settings to work collaboratively on issues with specific mental health impacts.

2. Chairing, governance, reporting and membership

The NPM sub-group chair will rotate between network members every 12 months. The organisation chairing the sub-group will provide secretariat support.

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

The sub-group will be open to NPM members with an interest in people in places of mental health detention.

Meeting topics will be generated by members of the group and meeting agendas and papers circulated in advance. The sub-group agenda will be set by the chair who will liaise with the NPM coordinator. Other people may be invited to join group meetings on a one-off basis to aid discussion on particular topics.

The sub-group will not have any delegated sign-off processes from the NPM business meeting or steering group. All discussion and actions will need to be agreed in accordance with each organisation's own governance processes, including information governance procedures.

Information will be shared at sub-group meetings and via electronic communications. It is each member's responsibility to make clear where a matter shall remain confidential and not for discussion outside the group. When sharing documents, members should make clear if there is a restriction to circulation and/or use of documents

3. Purpose and objectives

The objective of the sub-group is to provide a forum for discussion and debate on topics affecting people in health and social care detention.

The group aims to:

- seek a coordinated approach to mental health issues and contributions to the NPM agenda and business plan;
- enable a peer-review approach to identification of development areas and improvement processes;
- share information on the work of the NPM bodies and increase transparency of each other's organisational approach to mental health monitoring;
- offer members access to specialist knowledge;
- provide an opportunity to discuss cross-border issues and implications for members;
- identify possibilities for sharing resources for research, training and development, such as conferences, seminars, e-learning;
- identify common issues and interests;
- discuss benchmarking possibilities to support the available evidence-base for local policy and intelligence.

4. Term and review procedures

The NPM steering group will review the effectiveness and purpose of the sub-group after the initial three meetings, then annually thereafter, to ensure continuing relevance and ongoing development of the mental health network sub-group of the UK NPM.

The next review is due in March 2016.

Approved by the MH network members:
10 March 2015

Appendix III

Guidance on ensuring the independence of NPM personnel

Ensuring the independence of NPM personnel

Guidance for members of the UK National Preventive Mechanism

Background

1. The Optional Protocol to the United Nations Convention against Torture (OPCAT), under which the UK National Preventive Mechanism (NPM) is established, sets out the requirement:

> States parties shall guarantee the functional independence of the national preventive mechanisms as well as the independence of their personnel. (Art.18)

2. This requirement has been further elaborated on by the UN Subcommittee on Prevention of Torture in its 2010 *Guidelines on national preventive mechanisms* (CAT/OP/12/5):

> 18. The State should ensure the independence of the NPM by not appointing to it members who hold positions which could raise questions of conflicts of interest.
> 19. Members of NPMs should likewise ensure that they do not hold or acquire positions which raise questions of conflicts of interest.
> 30. The NPM should carry out all aspects of its mandate in a manner which avoids actual or perceived conflicts of interest.

3. In 2013, the UN Committee against Torture, the official UN body that oversees states parties' progress in implementing the UN Convention against Torture and the Optional Protocol, reviewed the UK. During this review it raised the following concern and recommendation:

> 14. The Committee, fully cognisant of the State party's willingness to promote experience sharing, notes that the practice of seconding State officials working in places of deprivation of liberty to National Preventive Mechanism' bodies raises concerns as to the guarantee of full independence to be expected from such body (art. 2).
> **The Committee recommends that the State party end the practice of seconding individuals working in places of deprivation of liberty to National Preventive Mechanism' bodies. [...]**

4. The UK NPM comprises 20 different bodies, each with different practices on the use of secondees. A survey by NPM

members in May 2013 identified that eight NPM members used secondees in fulfilling their NPM mandate. It should be noted that the powers and scope of some NPM members are much broader than their OPCAT functions, and so they may employ secondees for work that is not related to their NPM activities.

5. At the same time as ensuring that their staff are fully independent, OPCAT also requires that the NPM ensures that its staff hold sufficient technical expertise, capabilities and professional knowledge to fulfil their mandate (*SPT Guidelines para.20*).

6. The NPM business meeting in October 2013 agreed the broad outline of a response to the UN Committee against Torture, and that the steering group should draft a response reflecting members' comments and circulate that for agreement. This was done and the NPM letter sent to the UN Committee against Torture in March 2014 (Annex B). Based on this agreed position, which also received broad support from those attending the NPM 'Five years on' conference in April 2014, the steering group agreed at its meeting in May 2014 that the guidance below should be recommended to the June 2014 business meeting for adoption.

The guidance

7. Noting the recommendation of the UN Committee against Torture and the unique composition of the UK NPM, NPM members have agreed to work progressively towards a reduction in their reliance on seconded staff for NPM work. Until this is achieved, and in the cases where it is ultimately not possible, NPM members will implement procedures to avoid conflicts of interest as a safeguard to preserve the independence of the NPM. To achieve this, they will work to establish a clearer delineation of staff assigned to NPM work, particularly among members whose work extends beyond the NPM mandate.

8. This guidance applies to all NPM members and guides their practice in relation to seconded staff, preventing conflicts of interest, and safeguarding the independence of personnel. Its provisions should be incorporated as appropriate into staff handbooks and other internal policies.

9. NPM members will aim to clearly identify which of their staff are involved in NPM work, and will consider locating them within a separate unit or department (*SPT Guidelines para.32*). The identification of NPM staff will encompass a broad understanding of how the NPM mandate is fulfilled, to include both frontline and support staff.

10. The NPM as a whole commits to reducing its reliance on seconded staff for NPM activities, and to tracking and accounting for progress over time.

11. The hiring of any new secondees for NPM work will be avoided where possible, unless the knowledge and expertise the individual brings to the NPM member cannot be found elsewhere. Where this is the case, all recruitment processes will be open, transparent and inclusive, and in accordance with published criteria (*SPT Guidelines para. 16*).

12. A full assessment of possible areas of conflict of interest will be conducted by appropriate managers of existing and new secondees.

13. On the basis of this assessment, NPM members will assign work in such a manner as to ensure the secondee is not put at risk of a conflict of interest. Regular support and supervision from managers should ensure that any issues of concern are identified and addressed at the earliest possible opportunity.

14. On no occasion will seconded staff be involved in the inspection of an establishment from which they are seconded, are likely to return to or have an otherwise close affiliation.

15. Where seconded staff are involved in NPM work, they will be made aware of their responsibility to act with real and perceived independence.

16. NPM members will report on their progress in implementing this guidance as part of the annual reporting process on their NPM activities.

Appendix IV

NPM recommendations to the OSCE Supplementary Human Rights Dimension Meeting

National Preventive Mechanisms recommendations to the OSCE Supplementary Human Rights Dimension Meeting, Vienna, 10-11 April 2014

National Preventive Mechanisms (NPMs) welcome Switzerland's decision to place the issue of torture prevention back at the top of the OSCE's political agenda and devote a Supplementary Human Dimension Meeting to this crucial human rights issue.

The following recommendations to OSCE participating States, the OSCE/ODIHR and the Swiss Chairpersonship-in-Office were developed by NPMs from 17 countries within the OSCE region during a pre-meeting, 9-10 April in Vienna.

NPMs recommendations to OSCE participating States:

All OSCE participating States should:

1. Ratify the Optional Protocol to the UN Convention against Torture (OPCAT) and establish a NPM, in accordance with the OPCAT requirements. All NPMs should have their mandate, powers and independence enshrined in national law.

2. Ensure full on-going government cooperation and dialogue with NPMs and the UN Subcommittee on Prevention of Torture (SPT) to achieve progressive improvements in detention policy and practice and the NPMs' ability to carry out their preventive mandate.

3. Ensure unimpeded and immediate access to all places of detention, including those outside of their territorial jurisdiction but under their effective control, where people are or may be deprived of their liberty, whether managed by public or private institutions. Information on NPMs' members and their mandate should be made available to all detaining authorities.

4. Ensure financial independence of NPMs to operate effectively, including providing them with adequate financial resources and ring-fencing their budgets if they are part of another larger budget.

5. Improve knowledge of detaining authorities and persons deprived of their liberty of the NPMs' preventive mandate and torture prevention in general, including through seminars or training.

6. Systematically publish NPMs annual reports, and SPT and European Committee for the Prevention of Torture (CPT) visits reports and make all efforts to translate and make them available in the main national language(s) as soon as possible.

7. Ensure that national legislation requires authorities to respond to NPMs recommendations and establish an effective

mechanism, composed of relevant State agencies, international organisations, civil society experts and the NPM, to follow up on NPMs' and other monitoring bodies' recommendations.

8. Ensure that **persons deprived of their liberty are aware of their rights**, including access to legal and medical assistance, freedom from torture, not to be forced to make confessions and their right to redress for any violations they may suffer.

9. Ensure that the **health care** of persons deprived of their liberty is overseen by relevant public health authorities.

10. Use detention as a measure of last resort, and when **persons with special needs** are detained, ensure that they have access to appropriate facilities and services. Detaining authorities should be trained on how to recognize the need of persons in situations of vulnerability, including victims of human trafficking.

11. Ensure that the rights of persons accused or convicted of national security and terrorism-related offences are fully respected.

12. **Collect and publish** data on the composition of the detained population, including those with special needs and characteristics, in order to inform action to reduce risk of torture and other ill-treatment.

13. Prioritise **changing the culture of policing**, through on-going training of police regarding evidence-based investigations and control of use of force. States should ensure the **accountability** of all ranks of law enforcement officials, including by taking actions in response to allegations and convictions of torture and ill-treatment.

Recommendations to OSCE/ODIHR:

OSCE/ODIHR should:

14. Support networks and regular peer-to-peer **exchange of experiences, information and practices between NPMs** in the OSCE region, with involvement of the SPT, and relevant regional bodies when appropriate.

15. Support training programmes for NPMs, with the involvement of SPT and regional bodies, to ensure **minimum standards and common methodology** in detention monitoring, including on thematic issues and specific places of deprivation of liberty, such as psychiatric institutions.

16. **Highlight torture prevention**, including NPMs' recommendations, in OSCE/ODHIR reports on country situations and other activities.

17. Conduct a survey on the **impact of NPMs' recommendations** in the OSCE region on national and regional jurisprudence.

18. Facilitate **continuous training** and review of curricula for law enforcement officials regarding evidence-based investigations and control of use of force. Training should include modules on how to recognize and respond to the needs of persons in situations of vulnerability.

19. Support States in ensuring **accountability** for all ranks of law enforcement officials, including by monitoring the functioning of complaint mechanisms.

Appendix V

Glossary

CAT	Convention against Torture
CCE	Office of the Children's Commissioner for England
CI	Care Inspectorate
CJINI	Criminal Justice Inspection Northern Ireland
CPT	Committee for the Prevention of Torture (Council of Europe)
CQC	Care Quality Commission
CSC	Close supervision centre'
CSSIW	Care and Social Services Inspectorate Wales
GOOD	Good order and discipline
HIW	Healthcare Inspectorate Wales
HMIC	Her Majesty's Inspectorate of Constabulary
HMICS	Her Majesty's Inspectorate of Constabulary for Scotland
HMI Prisons	Her Majesty's Inspectorate of Prisons
HMIPS	Her Majesty's Inspectorate of Prisons for Scotland
HMP	Her Majesty's Prison
ICRC	International Committee of the Red Cross
ICVA	Independent Custody Visiting Association
ICVS	Independent Custody Visitors Scotland
IMB	Independent Monitoring Board
IMBNI	Independent Monitoring Boards (Northern Ireland)
IRC	Immigration removal centre
IRTL	Independent Reviewer of Terrorism Legislation
LO	Lay Observers
LTS	Long-term segregation
MWCS	Mental Welfare Commission for Scotland
NIPBICVS	Northern Ireland Policing Board Independent Custody Visiting Scheme
NOMS	National Offender Management Service
NPM	National Preventive Mechanism
OSCE	Organization for Security and Co-operation in Europe
Ofsted	Office for Standards in Education, Children's Services and Skills
OPCAT	Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
PACE	Police and Criminal Evidence Act 1984
Protected characteristics	The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010)
PSO	Prison Service order
RQIA	Regulation and Quality Improvement Authority

SHRC	Scottish Human Rights Commission
SPT	United Nations Subcommittee on Prevention of Torture
SCH	Secure children's home
STC	Secure training centre
TACT	Terrorism Act 2000
YJB	Youth Justice Board
YOI	Young offender institution

Appendix VI

Further information about the UK NPM

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

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The image used in this report is a detail from *Whitby Bay*, by a prisoner at HMP Hull, which won a Silver Award for Mixed Media at the 2015 Koestler Awards. The Koestler Trust is a prison arts charity, inspiring offenders, secure patients and detainees to take part in the arts, work for achievement and transform their lives.
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