



Monitoring places of detention

Second **Annual Report**
of the United Kingdom's
National Preventive Mechanism
2010-11



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

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by Command of Her Majesty
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Introduction by Nick Hardwick Her Majesty's Chief Inspector of Prisons

The United Nations adopted the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in 2002. OPCAT is unusual among international human rights instruments in that rather than setting new standards, it commits States to establishing a mechanism to prevent existing standards being violated.

For detainees removed from public scrutiny in a prison or police cell, a secure hospital ward or juvenile facility, independent preventive inspection is particularly important. The nature of those held, the imbalance of power between detainee and gaoler and the fact that the work of the institution takes place behind high walls, out of sight, creates the conditions in which it is all too easy for abuse to take place. However, in my view, the greatest risk is the normative effect those conditions create. Away from public scrutiny, it is all too easy for even well intentioned staff to become accepting of standards that in any other setting would be unacceptable.

OPCAT seeks to protect detainees and prevent their ill-treatment by providing for a system of independent monitoring by a 'national preventive mechanism' (NPM). The NPM carries out regular visits to places of detention, examining the treatment of and conditions for detainees and, where necessary, makes recommendations to the detaining authorities.

In the UK, the role of the NPM is carried out jointly by 18 organisations, which, between them, visit or inspect a range of detention settings, including prisons, police and court custody, secure accommodation for children and immigration, military and mental health detention. The NPM is coordinated by HM Inspectorate of Prisons. While the NPM structure in the UK may be complex, our purpose is clear – to prevent the ill-treatment of anyone who is deprived of their liberty, through a system of independent and regular visits to places of detention.

The primary work of the NPM is therefore carried out by its individual members in their own inspection programmes or visits and reported in their own annual reports. In this second annual report of the UK's NPM as a whole, we summarise the activities of the 18 NPM members and what they found when visiting places of detention across England, Wales, Scotland and Northern Ireland, and identify some common themes that emerged. We also report on the joint activities we have undertaken and the work done to ensure that OPCAT is fully and effectively implemented in the UK.

We are pleased to report progress on the recommendation we made in our first annual report – that the government should identify which places of detention are not subject to independent visits by the NPM and ensure that those gaps in protection are

addressed. The government has considered our recommendation and plans are being made to instigate the independent monitoring of court custody in England and Wales, and customs custody facilities. Discussions are in progress about inspection of service custody facilities operated by the British military.

Our first annual report was very much an introduction to OPCAT, the role of NPMs and the composition of our NPM in the UK. In that report, we profiled each of the NPM members, describing their role, methodology and key findings. In this year's report, we have presented our work and findings according to the type of detention visited or inspected.

In preparing this report, a recurring theme raised by almost all members of the NPM has been the current economic climate and the need for public bodies to make efficiency savings. This impacts not only on the NPM members and their capacity to carry out monitoring to the extent required by OPCAT, but also on the places of detention visited and their ability to maintain standards and to respond to recommendations. This is a challenge to be addressed by all NPM members in the coming years.

We would like to thank the Human Rights Implementation Centre at the University of Bristol for their continuing support; Sarah Green, formerly of the Mental Disability Advocacy Centre, for her advice in planning our thematic workshop on mental health in detention; and all the other individuals and organisations who assisted the NPM members in their work, including the Association for the Prevention of Torture and the Prison Reform Trust.

We direct this report to the Subcommittee for the Prevention of Torture, the UK government and devolved administrations, and those authorities responsible for places of detention.



Nick Hardwick
Her Majesty's Chief Inspector of Prisons

Section one Context



About OPCAT

The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) was adopted by the United Nations General Assembly in 2002. Its adoption 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 can best be achieved via a system of independent and regular visits to all places of detention for the purpose of monitoring the treatment of and conditions for detainees.

States which ratify OPCAT are obliged to designate a 'national preventive mechanism' (NPM), a body or group of bodies which regularly examine the treatment of people deprived of their liberty, make recommendations and comment on existing or draft legislation, all with the aim of improving the treatment and conditions of detainees. To carry out their role effectively, OPCAT requires that NPMs be, above all, independent. They should also be adequately resourced to perform their role, and their personnel should have the necessary expertise and be representative of the communities in which they operate.

OPCAT also sets out the powers which NPMs should have. These include the ability to:

- access all places of detention
- conduct interviews in private with detainees and other relevant people
- choose which places they want to visit and who they want to interview
- access information about the number of people deprived of their liberty, the number of places of detention and their location
- access information about the treatment of and conditions for detainees.

Implementation of OPCAT in the UK

The UK ratified OPCAT in December 2003 and designated its NPM in March 2009. During the designation process, the UK government took into account the fact that an NPM need not be a single entity but may be made up of several constituent parts. The government considered which bodies already existing in the UK performed functions analogous to those of an NPM and explicitly required that, to be designated as part of the UK's NPM, the bodies have a statutory basis and be able to make unannounced visits to places of detention.

The government concluded that 18 bodies operating in England, Wales, Scotland and Northern Ireland met these requirements and, in a statement to Parliament on 31 March 2009, formally designated them as the UK's NPM. The government also noted that additional bodies may be added to the NPM in the future. Currently, the UK's NPM is made up of the following bodies:

England and Wales

Her Majesty's Inspectorate of Prisons (HMIP)
 Independent Monitoring Boards (IMB)
 Independent Custody Visiting Association¹ (ICVA)
 Her Majesty's Inspectorate of Constabulary (HMIC)
 Care Quality Commission (CQC)
 Healthcare Inspectorate Wales (HIW)
 Office of the Children's Commissioner for England (OCC)
 Care and Social Services Inspectorate Wales (CSSIW)
 Office for Standards in Education, Children's Services and Skills (Ofsted)

¹ Although the Independent Custody Visiting Association is listed as an organisation operating in England and Wales, its membership includes independent custody visitors who operate in Scotland.

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)

Scottish Commission for the Regulation of Care² (CC)

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)

Given the size of the NPM and its varied membership, HM Inspectorate of Prisons (HMIP) performs a coordinating role. The purpose of coordination is to promote cohesion and a shared understanding of OPCAT among the NPM members, to encourage collaboration and the sharing of information and good practice, and to facilitate joint activities. At the same time, however, the independence of individual members is respected, as is their ability to set their own priorities for detention monitoring.

Subcommittee for the Prevention of Torture

At the international level, OPCAT created the Subcommittee for the Prevention of Torture (SPT), a group of 25 experts currently chaired by Professor Malcolm Evans of the University of Bristol. The SPT has both an operational and advisory role. Its operational role mirrors that of NPMs: the SPT is mandated to visit places of detention in any State which has ratified OPCAT and to make recommendations to the State regarding the protection of detainees from torture and other forms of ill-treatment. In its advisory capacity, the SPT is required to advise and assist States in the establishment of NPMs and, once established, to maintain direct contact with NPMs and offer them training and assistance. To this end, the SPT recently published helpful guidelines on NPMs.³ The SPT has not yet visited the UK, although the UK NPM has established contact with it and looks forward to developing this relationship.

² In April 2011, the Scottish Commission for the Regulation of Care merged with another organisation to become Social Care and Social Work Inspection Scotland ('Care Inspectorate'). The new body retains detention monitoring powers and it is anticipated that the Care Inspectorate will be formally designated as a member of the NPM in place of the Scottish Commission for the Regulation of Care.

³ Subcommittee on the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Guidelines on national preventive mechanisms* CAT/OP/12/5 (9 December 2010).

Section two

The second year – an overview

In 2010–11, the second year of designation, the 18 members of the UK's NPM continued to make regular visits to places of detention, monitoring the treatment of and conditions for detainees and making recommendations to the relevant authorities. The activities of the members and their key findings are described in Section 3 of this report and are organised by the type of detention visited. Throughout the year, members continued to build relationships with one another, increase their understanding of OPCAT and develop their identity as an NPM.

Coming together

In June 2010, members of the NPM met to discuss their roles and their recent activities and to plan future collective work. The meeting provided a forum for discussing the challenges that members face when visiting places of detention and for identifying emerging or common themes.

Members recognised that resources for collective work were limited. HMIP only has funding for a part-time NPM coordinator and individual members face pressure on the resources they have available for monitoring and inspection activities. However, members suggested that, collectively, the NPM could become a repository of information and best practice on monitoring detention. This could include:

- joint training on key issues
- at least one workshop each year focusing on a particular theme – suggested themes included the mental health of detainees, the use of force and restraint, children deprived of their liberty across all types of detention, and the escorting of detainees to and from, and between, places of detention
- sub-groups of the NPM undertaking joint work – groups could be based on the jurisdiction in which the members operate, or the type of detention visited.

Members noted uncertainty about the definition of detention. It was agreed that members would discuss this further and consider, in particular, those who may not be held under any lawful order but may be deemed to be de facto detained. This could include, for example, elderly people living in care homes.

Alongside the powers to examine the treatment of detainees and make recommendations, Article 19(c) of OPCAT states that NPMs shall be granted the power *‘to submit proposals and observations concerning existing or draft legislation.’* Members considered how best to fulfil this strategic preventive role that OPCAT envisages for NPMs and the extent to which, individually or collectively, members use their experience to comment on legislation, as well as simply visiting places of detention.

The extent to which individual members of the UK NPM exercise the power set out in Article 19(c) varies. Some members comment only on issues that arise directly from individual visits or inspections, while others produce thematic reports which may be seen as more strategic in nature. Some members regularly comment on existing or draft legislation. While some may not have an explicit power to do so, there is nothing in their mandates to prevent such comment. Members noted that Article 19(c) provides an opportunity for the 18 members of the NPM to comment collectively on issues within their remit and may even create an expectation that they do so. It was recognised that there could be great strength in the bodies coming together in this way. However, the members acknowledged that collectively commenting on issues may be challenging. There is the obvious difficulty in achieving consensus among 18 independent organisations, and some issues may not be appropriate for comment by all members (for example, where the issue relates to a type of detention visited only by some members or relates only to one jurisdiction within the UK). The members of the NPM will continue to explore how they can fulfil Article 19(c) of OPCAT, both individually and collectively.

The NPM members agreed to take collective action, for the first time, in relation to allegations that UK agencies were complicit in the torture of detainees being held abroad. While the conduct alleged may not necessarily have related to detainees within the UK’s jurisdiction or control and therefore fallen within the remit of the NPM, the allegations nonetheless involved agents of the UK and their treatment of detainees. The members of the NPM therefore wrote to the government, welcoming its intention to initiate an inquiry into the allegations and recommending that it be conducted in an independent, impartial and transparent manner, in accordance with international human rights standards. The members noted their interest in its outcome and offered advice on the safeguards necessary to prevent torture and other forms of ill-treatment in places of detention.

Following the meeting in June 2010, the NPM began to take forward the suggested future activities. In March 2011, the NPM held its first thematic workshop on mental health in detention. This theme was chosen for the first workshop because, as noted in our first annual report, the issue of detainees with mental health problems was perhaps the most significant and recurring concern among the members, across all types of detention. The purpose of the workshop was to:

- raise awareness of mental health issues affecting detainees
- raise awareness of relevant legal standards
- share information about good practice in the monitoring of detainees with mental health issues
- strengthen links between the NPM members.

The NPM is grateful to several experts who participated in our workshop, including Dr Clive Meux, the Mental Disability Advocacy Centre and the Prison Reform Trust. In particular, the NPM appreciated the opportunity to hear a service-user perspective on detention from a board member of the Care Quality Commission. The members found the workshop to be informative and helpful and valued the opportunity to share their experiences. A second thematic workshop, focusing on restraint and the use of force, is planned for 2011–12.

Also in 2010–11, a subgroup of NPM members, made up of those who visit places where people are detained under mental health law, met to share information about their work and examine recurring themes. Hosted by the Mental Welfare Commission for Scotland, the meeting was attended by the Care Quality Commission (England), Healthcare Inspectorate Wales and the Regulation and Quality Improvement Authority (Northern Ireland). While mental health and incapacity legislation varies between the jurisdictions in the UK, as do the mandates of each of the four organisations, they were nonetheless able to identify common issues and key themes across the UK. Each of the organisations has a strong basis in human rights and a focus on the experience of individual patients. Key themes included the need for authorities to do more to involve patients with mental disorders and keep them informed, particularly about their legal rights; the need to address the physical health of those detained under mental health law; and the need for further training for professionals on issues relating to consent and capacity. The four organisations agreed to meet annually to share information and good practice and to consider whether they can

work on common priorities on which they might report on a UK-wide basis.

External relations

In our first annual report, we noted that we had focused on raising awareness of OPCAT among the NPM members themselves. This work continued in our second year and remains ongoing. For example, as part of a human rights training event for the Independent Monitoring Boards in Northern Ireland, the NPM coordinator made a presentation on OPCAT, the role of NPMs and the implications for the work of board members. The NPM has also recognised the need to raise awareness among our stakeholders. While the 18 members are well known for their monitoring work as individual organisations, we believe there is a need to raise awareness of OPCAT and the NPM as a whole.

With that in mind, we held our first stakeholder seminar in Northern Ireland in early 2011. Hosted by the Regulation and Quality Improvement Authority, this seminar was solely for the NPM members operating in Northern Ireland – of which there are five⁴ – and stakeholders, such as the Northern Ireland Human Rights Commission, the Prisoner Ombudsman and the Committee for the Administration of Justice. As well as raising awareness of the NPM members and their role in detention monitoring, participants heard about the international context in which they operate courtesy of the Association for the Prevention of Torture. They discussed how NPM members could work together and how they could engage with other organisations whose activities impact directly on detention. The NPM will consider whether this event could be replicated in the other jurisdictions in the UK.

4 Independent Monitoring Boards (Northern Ireland), Criminal Justice Inspection Northern Ireland, Regulation and Quality Improvement Authority, Northern Ireland Policing Board Independent Custody Visiting Scheme and HM Inspectorate of Prisons.

The UK NPM has continued to participate in the European NPM Project. Organised by the Council of Europe, this project seeks to create an active network of NPMs, so that information and best practice on detention monitoring can be shared. In 2010–11, representatives of the UK NPM attended thematic workshops on monitoring police custody, security in detention and the methodology of monitoring. Under the auspices of this project, in 2011, the UK NPM will also host and organise an inter-NPM discussion on monitoring deportations. This involves NPMs monitoring the treatment of detainees not just while they are detained in immigration removal centres, but until they are returned to their country of origin.

In 2010–11, the members of the UK NPM continued to share their expertise and experience with others. Often, a newly designated NPM in another country, an organisation about to be designated, or a government exploring how to implement OPCAT will contact the NPM members in the UK for advice. Various members have hosted delegations from many countries, including Ukraine, Japan, Peru, Ecuador, Angola, Australia and the Netherlands.

Compliance with OPCAT

In our first annual report, we noted that not all places of detention are monitored by members of the NPM, as required by Article 4 of OPCAT. In particular, we highlighted gaps relating to military detention facilities and court custody in England and Wales. We therefore recommended that:

“The UK government should explore gaps in the coverage of the NPM, identifying places of detention that are not currently monitored for the purpose of preventing

ill-treatment. Any identified gaps, such as military detention and court custody, should be addressed as soon as possible to ensure that the UK complies with its international obligations”.

We are pleased to report that the government intends to extend the mandate of HMIP, so that it may inspect court custody facilities in England and Wales. Preparatory work has already been undertaken by HMIP, with criteria for inspection being drafted. It is anticipated that a programme of inspections will commence in 2012. Furthermore, court custody facilities are currently monitored by ‘lay observers’ – volunteers from local communities who make frequent visits to courts – and the government is considering whether they should be designated in respect of this monitoring activity to become the nineteenth member of the NPM. This would result in layers of monitoring for court custody in England and Wales – by a professional inspectorate and a lay body – as is already the case for prisons and police custody.

Scope of OPCAT

The scope of OPCAT is deliberately broad and, under Article 4(1), States Parties must allow the NPM and the SPT to carry out visits to “**any** place under its jurisdiction and control where persons **are or may be** deprived of their liberty” (emphasis added).

Article 4(2) defines deprivation of liberty as “any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority”.

No progress has yet been made regarding military detention, although, as reported in our first annual report, HMIP is in discussion with the government about extending its inspection programme to service custody facilities (that is, facilities run by the British armed forces and more often known as ‘guardhouses’).

It has also come to our attention that there are several customs custody suites operated by the UK Border Agency (UKBA) which are not currently the subject of independent monitoring. These suites are used to hold people for short periods of time when they are believed to have entered the UK after ingesting large quantities of drugs for the purpose of smuggling. They are held under the Police and Criminal Evidence Act 1984, the same regulatory framework that applies to police detainees. The UKBA is aware of the government’s obligations under OPCAT and has been considering options to ensure that customs custody suites are inspected independently. The custody suites fall within the remit of HM Inspectorate of Constabulary, already an NPM member, and it is anticipated that inspections will be carried out jointly with HMIP.

Recommendation

Although some progress is being made in relation to our first annual report, we reiterate that recommendation and ask the government to ensure that all those deprived of their liberty benefit from the protection offered by independent, regular visits by the NPM.

Challenges

The NPM in the UK is distinctive because of its large size and complex structure. This presents many challenges which other single-body NPMs may not face. However, it also has benefits: the individual bodies of the UK NPM have developed considerable expertise in monitoring the places of detention in which they specialise. Another distinctive feature of the UK’s NPM is the inclusion of lay visiting bodies in addition to professional inspectorates. Their inclusion also offers benefits, as they are able to visit places of detention with impressive frequency.

Our first annual report outlined some of the challenges faced by the NPM. For example, the members may have a different understanding of OPCAT and how it can be best implemented; there may be different views about the coordination role and how extensive it should be; and there is considerable divergence in the nature and roles of the members and the contexts in which they operate. For many members, detention monitoring is just one part of a broader role, while for others it represents their core business.

Nonetheless, as relationships between the members grow stronger and they settle into their roles under OPCAT both individually and collectively, we are sure that none of the challenges faced are insurmountable. We recognise that designation as NPM members provides us with the opportunity to come together to identify systemic issues across all types of detention and to share information and good practice. To address some of the challenges faced, consideration is being given to establishing a steering group for the NPM, made up of five member organisations. This group would facilitate decision-making relating to the NPM and set the strategic direction for joint activities.

Section three

The second year – activities and key issues by type of detention

In 2010–11, the members of the NPM visited a range of places of detention across the UK. This report highlights some of their activities and key findings. We have chosen to present these according to the type of detention visited, with jurisdictional themes and organisational activities also highlighted. The table below provides a general overview of the NPM member responsible for monitoring each type of detention in each jurisdiction

in the UK.⁵ It should be noted that the Office of the Children’s Commissioner for England has the right to enter any premises, except a private dwelling, for the purpose of interviewing any child accommodated or cared for there. Similarly, the Scottish Human Rights Commission has a broad power to enter and inspect any place of detention in the context of an inquiry into the policies or practices of Scottish public authorities.

	England	Wales	Scotland	Northern Ireland
Prisons	HMIP with CQC & Ofsted IMB	HMIP with HIW IMB	HMIPS	CJINI & HMIP with RQIA IMBNI
Police custody	HMIC & HMIP ICVA	HMIC & HMIP ICVA	HMICS ICVS	CJINI with RQIA NIPBICVS
Court custody	Not yet monitored by NPM member	Not yet monitored by NPM member	HMIPS	CJINI
Children in secure accommodation	Ofsted	CSSIW	CC	RQIA CJINI
Detention under mental health law	CQC	HIW	MWCS	RQIA
Deprivation of liberty safeguards	CQC	HIW CSSIW	n/a	n/a
Immigration detention	HMIP IMB	HMIP IMB	HMIP IMB	HMIP
Military detention ⁶	HMIP	HMIP	HMIP	HMIP

⁵ See Appendix 3 for abbreviations.

⁶ Inspections of military detention facilities are by invitation only – HMIP does not have a statutory right of access. Not all military detention facilities are inspected as yet.

Prisons

There are more than 150 prisons in the UK, each subject to independent monitoring by one or more members of the NPM. The prison population rate varies significantly in

the UK: it is 153 per 100,000 of the national population in Scotland; 152 per 100,000 in England and Wales; and only 93 per 100,000 in Northern Ireland.⁷

Prison population in the UK	Total	Adult men	Adult women	Under 18s	Remand	Rate per 100,000
England & Wales ⁸	85,400	79,605	4,218	1,577	12,300	152
Scotland ⁹	7,983	7,394	432	157	1,430	153
Northern Ireland ¹⁰	1,614	1,567	47	19	587	93

England and Wales

Prisons in England and Wales are regularly inspected by HM Inspectorate of Prisons (HMIP) for the purpose of reviewing the treatment of and conditions for, prisoners. In England, Ofsted and the Care Quality Commission (CQC) participate in the HMIP-led inspections, assessing education and health care provision, respectively. In Wales, Estyn¹¹ and Healthcare Inspectorate Wales assess education and health care provision in prisons, again as part of HMIP-led inspections. In addition, each prison receives regular visits from an Independent Monitoring Board, made up of volunteers from the local community.

In 2010–11, HMIP inspected 62 prisons: 53 holding adult and young adult men; three prisons holding women; and six prisons holding children and young people under the age of 18. More than half of these inspections were unannounced. All

inspections are conducted against published standards, known as Expectations, which draw on and are referenced against human rights standards. Expectations are based on the four tests of a healthy prison:

- safety
- respect
- purposeful activity
- resettlement.

Inspections are either full inspections or follow-up inspections, in which HMIP assesses the progress made against previous recommendations. This year, HMIP inspected the outcome of 4,538 recommendations across the prison estate and found that 69% had been achieved or partially achieved.

While HMIP generally found prisons to be increasingly safe, it nonetheless identified many areas of concern across all categories of prison that compromised

⁷ International Centre for Prison Studies, World Prison Brief: www.prisonstudies.org/info/worldbrief/. Last accessed 22 August 2011.

⁸ As at 31 March 2011. Ministry of Justice Statistics Bulletin, *Offender management statistics quarterly bulletin January to March 2011, England and Wales* (July 2011).

⁹ As at 30 June 2010. Scottish Government Statistical Bulletin, *Prison statistics Scotland: 2010–11* (August 2011).

¹⁰ As at 28 March 2011. The number of under-18s in prison in Northern Ireland is given as the average population for March 2011.

¹¹ Estyn is not a member of the UK's NPM.

the safety of prisoners being held. It found the availability and use of drugs in prisons to be high, despite some prisons making efforts to tackle both the supply of and demand for drugs. In one prison, almost a fifth of prisoners told HMIP that they had developed a drug problem while incarcerated. Many incidents of violence in the same prison were drug-related. It is essential that prisons reduce the supply of drugs in their establishments, but also that they reduce demand. HMIP was encouraged by the continuing development of an integrated drug treatment system but was also concerned that some prisoners are maintained on opiate substitutes without the regular reviews necessary to reduce and end drug dependence.

HMIP also found that staff-prisoner relationships had improved, with prisoners increasingly being treated with respect for their human dignity. Most prisoners said that they were treated with respect by staff and had a member of staff they could turn to if they had a problem. However, prisoners from minority groups did not report so positively. Muslim prisoners in particular, who made up 10% of the prisoners surveyed by HMIP, had consistently more negative perceptions than the prison population as a whole. A thematic review of Muslim prisoners by HMIP warned that a sole emphasis on combating extremism, combined with wider media portrayals of Islam, encouraged staff to associate all Muslim prisoners with terrorism.¹²

The treatment of older prisoners and those with disabilities also needed to improve. HMIP noted improvements in prison health care but the care of prisoners with mental

health problems remained an issue. It found that prison staff needed more help to identify and meet the needs of prisoners with mental disorder and learning disabilities. Too many offenders with acute mental health needs were being held in prison instead of being diverted from the criminal justice system.

While the quantity and quality of purposeful activity in prisons in England and Wales had improved, further improvement was still required. Too often, work and education opportunities were not taken up and too many prisoners spent time locked in their cells during the day. Similarly, HMIP found that there was much to do in improving resettlement provision, including facilitating prisoners' contact with their families. It noted that it is often the families of prisoners who support prisoners while they are incarcerated, find them a job when they are released, house them and encourage them to stay out of trouble, and recommended that more is done to involve families in the resettlement process.

This year, HMIP inspected three women's prisons and published a thematic report on women in prison.¹³ It found that the decision to reduce the number of women's prisons had meant that the remaining closed women's prisons were now more complex, and that more women were being held further from their homes. It noted that outcomes for women were much better in open or semi-open conditions. There had been improvements in most women's prisons, particularly in regard to safety, owing to the better treatment and management of women with substance use problems.

¹² HMIP, *Muslim prisoners' experiences* (June 2010).

¹³ HMIP, *Women in prison* (July 2010).

Nonetheless, HMIP reported that the extent and seriousness of self-harm among women prisoners remained a major concern. Health care, and particularly secondary mental health care, had improved but there was insufficient primary mental health care provision. Resettlement services were not always aligned to the specific needs of women prisoners. Overall, HMIP noted commendable work in most women's prisons but a prison environment simply could not meet the needs of many of the women being held.

Children and young people under the age of 18 may be held in young offender institutions (YOIs) run by the Prison Service.¹⁴ In recent years, there has been concern that custody is not always being used as a last resort for under-18s; however, HMIP was pleased to note that there had been a large reduction in the number of young people being held in prison. While the fall in the number of young people in custody was welcome, one inevitable consequence was that some establishments had been closed and young people were being held even further from home than before.

In 2010–11, HMIP inspected six YOIs holding those under the age of 18. Three of these inspections were unannounced follow-ups, in which HMIP found that more than three-quarters of its previous recommendations had been achieved or partially achieved. While noting improvements in many areas, HMIP nonetheless had concerns about a number of areas, including searching, staffing and a lack of purposeful activity.

HMIP noted that, while the majority of reception staff dealt sensitively with young people, arriving in custody remained a daunting experience. At some YOIs, routine strip-searching marred efforts by staff to reassure new arrivals; at others, strip-searching was intelligence led. A stable and experienced staff team has a vital role to play in ensuring that an establishment is safe and HMIP found that one YOI with a history of violence between young people and towards staff had been badly affected by a recruitment freeze. This had resulted in a number of posts being filled on a temporary basis, and bullying and the use of force by staff were high. HMIP also found that young people did not have enough time out of cell and had limited access to the open air. More positively, however, it found that the majority of young people undertook some form of accredited education and training, and for many, this was their first experience of educational achievement.

HMIP also conducts thematic inspections. In 2010–11, it published several thematic reports, including reports on:

- training planning for children and young people
- the management of gang issues among children and young people in custody and in the community, in conjunction with HM Inspectorates of Constabulary and Probation
- offender management, jointly with HM Inspectorate of Probation
- commissioning health care in prisons, jointly with CQC.

¹⁴ Children and young people under the age of 18 may also be detained in secure training centres or secure children's homes. These detention facilities are not run by the Prison Service and instead are described below in the section on 'Children in secure accommodation' (page 32).

Many of the concerns raised by HMIP were echoed by Independent Monitoring Boards (IMBs). There is one board for every prison in England and Wales, and board members make regular, often weekly, visits to the prison. In 2010–11, boards made more than 46,000 visits and each board published its own annual report.

IMBs across England and Wales reported concerns about:

- the increase in the number of deaths in custody from natural causes and, linked to this, the lack of progress on the care and management of older prisoners
- overcrowding, which has resulted in prisoners being transferred from London prisons to other establishments, making family contact and effective rehabilitation work more difficult
- young adults aged 18–21 being held throughout the prison estate without specific provision for them
- the number of foreign national prisoners held in prisons beyond their sentence expiry date and the impact of this continued detention on their mental health
- the number of prisoners serving indeterminate sentences for public protection. These sentences are imposed on those who have committed specified offences and who are deemed to pose a serious risk of serious harm in the future. Offenders are given a ‘tariff’, which is the minimum period of imprisonment, but may only be released following expiration of the tariff if they can show the parole board that they have reduced their risk to the public. IMBs regularly meet prisoners whose tariff has expired but who are

unable to access the programmes required for them to be considered for parole.

Similarly to HMIP, IMBs have welcomed the fall in the number of under-18s in prison. They too recognise that this brings its own challenges: young people will be held further from home, and this has implications for how often families visit. IMBs have other concerns in relation to young people in custody, including the lack of post-custody accommodation for those who are not able to return home; the lack of social workers in prisons; and the limited number of alcohol and drug interventions that are appropriate to the age group. IMBs too are concerned about the strip-searching of young people, believing that the inherent decency of strip-searching must be questioned, no matter how carefully the search is executed.

In 2010, the National Council for Independent Monitoring Boards published a report on the lack of in-cell sanitation in prisons in England and Wales.¹⁵ The report noted that 2,000 cells across 10 prisons lack in-cell sanitation. While electronic unlocking systems exist in these prisons, there is often excessive queuing and limited access, and the unlocking systems often break down. Prisoners resort to using buckets in their cells at night, which means that slopping out continues, despite the formal ending of this practice 14 years ago. IMBs were particularly concerned about older prisoners and those with disabilities who lived in such conditions. They found the lack of in-cell sanitation to be unacceptable and encouraged the government to address this problem and to ensure that prisoners are treated humanely.

¹⁵ National Council for Independent Monitoring Boards, *‘Slopping Out?’ A report on the lack of in-cell sanitation in Her Majesty’s Prisons in England and Wales* (August 2010).

In the coming year, IMBs will closely monitor a number of key areas, including the implications of National Health Service reform for prison health care and the impact of contractual difficulties between prisons and education providers on prisoners' access to education.

The Office of the Children's Commissioner for England (OCC) also has a statutory power to visit YOIs. As part of a study on the emotional wellbeing and mental health of children and young people in the youth justice system, OCC staff visited five YOIs in 2010–11.¹⁶ While a report of this study is to be published later in 2011, the OCC identified a number of issues which it sought to address immediately following the visits. It noted degrading practices relating to strip-searching, serious concerns about the frequency of restraint and the methods used, the poor condition of accommodation in some settings, the quality and quantity of food, arrangements for visits and the credibility and accessibility of complaints systems. As a result of these concerns, OCC carried out further visits to YOIs, as well as other establishments in the children's secure estate, to examine safeguarding arrangements and the use of separation and restraint.¹⁷

Scotland

Scotland's 15 prisons are inspected by HM Chief Inspector of Prisons for Scotland (HMCIPS). Each prison also has a prison visiting committee, made up of volunteers from the local community whose role is analogous to that of Independent Monitoring Boards in the rest of the UK. The visiting committees are, however, not currently members of the NPM.

In 2010–11, HMCIPS published inspection reports on three prisons – Glenochil, Peterhead and Addiewell – as well as a thematic review of arrangements for progressing prisoners from closed to open conditions. In the course of its inspections, HMCIPS assesses conditions, safety, respect, prisoners' contact with the outside world, entitlements, activities, health care and reintegration.

In relation to the conditions in which prisoners were being held, HMCIPS praised the physical environment at the newly built Addiewell but described the conditions at Peterhead as degrading. Peterhead is the only prison in Scotland where cells have no running water: prisoners use chemical toilets and wash their hands with water from pump-action flasks. HMCIPS found these arrangements to be clearly inadequate and was concerned about hygiene and infection control. Peterhead is an old prison and plans to replace it have long been discussed. While there is an intention to build a new prison on the same site, the current prison will remain for at least four more years. HMCIPS was concerned that the conditions

¹⁶ This study also involved visits to secure children's homes and secure training centres, which are reported at page 32.

¹⁷ For additional information, see the section on children in secure accommodation at page 32.

should not be allowed to deteriorate further. Uncertainty about the future of the prison and the poor conditions had had a negative impact on staff: HMCIPS found the staff to be understandably weary of ‘making do’. Despite this, staff-prisoner relationships at Peterhead were found to be excellent.

Glenochil was undergoing a much-needed modernisation and redevelopment programme but this was inevitably having an impact on prisoners’ access to regime opportunities. HMCIPS noted that many prisoners remained in the halls during the day instead of being involved in gainful activity; on one afternoon during the inspection, 483 prisoners were in the halls and only 181 were involved in activities or attending visits or other appointments. While it is hoped that this situation will improve once the prison’s redevelopment is complete, HMCIPS will continue to monitor this area. HMCIPS was similarly concerned about the 40% of prisoners at Addiewell found locked in their cells during the day and not taking part in work, learning or physical activity. This was despite Addiewell providing each prisoner with a personalised timetable and making efforts to ensure that prisoners were engaged in purposeful activity. In contrast to Glenochil and Addiewell, there was adequate access to activities for prisoners at Peterhead.

HMCIPS identified several areas of special interest which are fundamental to offender management. One such area is staff training and development. HMCIPS found shortfalls in role-specific staff training at both Glenochil and Peterhead. At Glenochil, this had resulted in some staff lacking the confidence and

competence to perform their role effectively. HMCIPS was encouraged by a thorough staff training programme at Addiewell.

Another area of special interest is prisoners’ families. HMCIPS has regularly stressed the importance of visitor centres at prisons, particularly those prisons which are national facilities or which have poor transport links. Visitor centres should be an essential requirement, providing refreshments and a place to wait in decent conditions and for families to gather themselves in advance of a visit or to regroup afterwards. Staff at visitor centres can provide essential support and advice. However, there was no visitor centre at either Glenochil or Addiewell.

At Glenochil and Peterhead, HMCIPS was concerned at the lack of programmes to address offending behaviour. At Glenochil, there was a long list of prisoners waiting to be assessed for programmes to address behaviour, in particular the violence prevention programme.

In its thematic review of arrangements for progressing prisoners from closed to open conditions, HMCIPS noted that risk assessment, risk mitigation and prisoner case management processes had been evolving over a number of years. Piecemeal changes to Scottish Prison Service policies and practices had, however, resulted in increasing disjointedness within the progression system. While the constituent parts of the system were themselves generally appropriate, the inter-relationship between them had become unclear and a review of the progression system as a whole should be undertaken.¹⁸

¹⁸ HMCIPS, *Review of the arrangements for progressing prisoners from closed to open conditions* (2011).

Northern Ireland

There are three prisons in Northern Ireland: Maghaberry and Magilligan hold adult male prisoners, and Hydebank Wood holds adult female prisoners, young men up to the age of 21 (although, in some cases, a prisoner may remain at Hydebank Wood until the day before his 24th birthday), and boys under the age of 18. Each prison is inspected jointly by Criminal Justice Inspection Northern Ireland (CJINI) and HMIP. The Regulation and Quality Improvement Authority (RQIA) contributes to these inspections by assessing the health care provided to prisoners, while education provision is assessed by the Education and Training Inspectorate.¹⁹ CJINI also undertakes its own inspections of specific issues in relation to prisons. For example, in 2010, it published reports on the corporate governance of the Northern Ireland Prison Service and on mistaken prisoner releases.²⁰

Each prison in Northern Ireland also has its own IMB. The boards operate in much the same way as those in England and Wales, making regular, unannounced visits to the prisons and monitoring the treatment of and conditions for prisoners.

In 2010–11, CJINI, HMIP and RQIA inspected Magilligan and found that outcomes for prisoners were reasonably good across all four healthy prison tests. The inspection found that safety had improved, with few reported incidents of violence and most prisoners reporting that they felt safe. Security were more proportionate but further improvements were required, including a need to combat drug use more effectively. While improvements to the fabric of the prison had

been made since the previous inspection, the physical environment remained marred by oppressive fencing and the continued use of accommodation which was difficult to supervise and had poor sanitary facilities. Relationships between staff and prisoners were generally positive. Health services at the prison were good, although there was insufficient primary mental health provision to meet the needs of prisoners. At the time of the inspection, industrial action by the Northern Ireland Prison Officers' Association was seriously limiting prisoners' time out of cell and access to purposeful activity. Records suggested, however, that provision was usually reasonable. Resettlement work was found to need better strategic direction, to ensure that some impressive constituent parts were welded into a more integrated whole. To sustain the progress made at Magilligan, CJINI and HMIP noted that there needs to be solid support from Northern Ireland Prison Service headquarters, not least to deal with the poor industrial relations.

In addition to its regular prison inspection programme, CJINI and the RQIA made unannounced visits to Maghaberry during a dirty protest by separated republican prisoners. The visits were carried out in response to concerns about hygiene and the impact of the dirty protest on prisoners' health. A report of the visits was submitted to the Minister of Justice and the Minister of Health and included recommendations for action.

The IMBs for the three prisons in Northern Ireland noted that progress had been made in 2010–11 but key issues remain

¹⁹ The Education and Training Inspectorate is not a member of the NPM.

²⁰ CJINI, *Northern Ireland Prison Service Corporate Governance Arrangements* (December 2010); CJINI, *Northern Ireland Prison Service Mistaken Prisoner Releases* (November 2010).

to be addressed. For example, the board at Hydebank Wood welcomed efforts to increase the length of time that prisoners spend out of their cell but noted that this could be increased even further. It also welcomed a newly extended visiting facility, where mothers and their children can spend quality, private time together. Nonetheless, the board recommended fundamental changes at Hydebank Wood:

- the board believes the prison is unsuitable for under-18s and that they should be held separately from older prisoners. It recommends under-18s be held in the Juvenile Justice Centre rather than in prison
- there should be a stand-alone women's prison. Women prisoners require different approaches, facilities and staff trained to deal with them but the current provision at Hydebank Wood is inadequate.

The protest by separated republican prisoners at Maghaberry was closely monitored by the IMB. It welcomed a new search facility and a revised searching policy which sought to address some of the prisoners' concerns.

The boards at all three prisons expressed concerns which mirror those identified in inspections by CJINI and HMIP. These included concerns about those prisoners with mental health problems who required admission to a secure hospital but were instead being cared for in prison; the availability of drugs; limited time out of cell; an insufficient quantity and range of purposeful activity; a lack of adequate educational provision, particularly for young prisoners; and overcrowding.

Police custody

In each jurisdiction within the UK, police custody is subject to two layers of monitoring by members of the NPM. At one level, volunteers from the local community, known as independent custody visitors, make short unannounced but very frequent visits to police custody suites. There are independent custody visiting schemes in operation throughout the UK. At another level, less frequent but more in-depth inspections of police custody suites are undertaken by professional inspectorates. In England and Wales, inspections are carried out jointly by HM Inspectorate of Constabulary (HMIC) and HMIP; in Scotland, HM Inspectorate of Constabulary for Scotland (HMICS) is able to inspect police custody; and in Northern Ireland, police custody is inspected by CJINI and RQIA. Together, these layers ensure that police custody is monitored regularly and by those with the necessary experience and expertise, as required by OPCAT.

England

In the wake of the UK's ratification of OPCAT, HMIC and HMIP commenced a joint programme of inspection of police custody throughout England and Wales. The Care Quality Commission, also an NPM member, contributes health care expertise to these inspections. In 2010–11, 16 police custody suites were inspected. Nearly half of provincial forces and Metropolitan Police Service boroughs have been visited since the inspection programme began in 2008. This year saw a greater number of unannounced inspections and it is intended that, in the future, all police custody inspections will be unannounced.

Inspections are carried out against criteria, known as Expectations, which are informed by and referenced against human rights standards. Expectations are also informed by the Police and Criminal Evidence Act 1984 (PACE) and its associated codes of practice, as well as national guidance on the safer detention and handling of people in police custody. The Expectations cover four key areas: strategy; treatment and conditions; individual rights; and health care.

In previous years, inspections have found that police forces lacked effective attention to custodial issues at a strategic level. This picture changed in 2010–11, with HMIC and HMIP finding a clear strategic focus on the safety of detainees and decent treatment in the majority of forces visited, although there were exceptions.

Inspectors continued to see staff take a professional and respectful approach to detainees, although there was insufficient focus on diversity and privacy issues. Safety was a major focus in all the places inspected, although many cells contained ligature points and governance of the use of force was lacking. Elements of basic care and welfare were still too reliant on detainees making requests. Police forces and boroughs were balancing the rights and entitlements of individuals with expediting investigations effectively, although arrangements for providing appropriate adults suffered from a lack of central guidance about who was responsible.²¹ Police continued to adhere to the PACE definition of a juvenile, which meant that 17-year-olds were not automatically provided with an appropriate

²¹ An appropriate adult must be called to the police station for any person under the age of 17 or any person who has mental health difficulties or is otherwise deemed vulnerable. The role of the appropriate adult is independently to support and assist the detainee to ensure that they understand what is happening during the interview and investigative process.

adult. HMIC and HMIP found this to be out of line with international standards and other domestic legislation, which treats all those under the age of 18 as a child or young person in need of additional protection and support.

Arrangements for primary health care and support for substance users were extremely mixed, as were the outcomes achieved for detainees. In some areas, there was ineffective use of schemes to divert those with mental health problems from police custody, and police cells were used inappropriately to detain those subject to section 136 of the Mental Health Act 1983.²²

HMIC and HMIP have been pleased by the positive way in which most police forces have responded to their inspection findings and by the improvements which frequently result. This clearly demonstrates the positive impact of the UK's ratification of OPCAT and the role of NPMs in raising standards in places of detention.

In addition to inspections by HMIC and HMIP, all police custody suites in England and Wales are monitored by independent custody visiting schemes. Custody visitors are members of the local community who make very frequent – often weekly – unannounced visits to police custody. This year, custody visitors have expressed concern at the use of police cells as a place of safety under section 136 of the Mental Health Act 1983 and at the length of time that police cells are used to hold

immigration detainees. Visitors have also begun to monitor the action plans put in place by police authorities in response to recommendations arising from the joint HMIC/HMIP inspections.

Most custody visiting schemes are members of the Independent Custody Visiting Association (ICVA), a voluntary organisation which seeks to promote and support effective custody visiting. ICVA led on redrafting a code of practice for custody visiting, which was published in April 2010, and has also been involved in an extensive consultation on national standards for custody visiting.²³ ICVA has also sought to promote human rights awareness among custody visitors via training programmes and checklists for visitors. It will continue to play a crucial role in the coming year as policing structures in England and Wales face significant reform, resulting in uncertainty for those managing custody visiting schemes, as well as custody visitors themselves.

Scotland

In 2010–11, HMICS continued to monitor the implementation of recommendations made in previous thematic reports on police detention. These reports had focused on the design of detention facilities, the care of detained children and the provision of medical services for people in police custody.

During its regular inspections of policing in Scotland, HMICS monitors the extent to which individual police forces and their corresponding police boards facilitate independent custody visiting.²⁴ Unlike other jurisdictions in the UK,

²² Section 136 authorises any police officer to remove a person to a place of safety if they find that person in a public place, apparently suffering from a mental disorder and in immediate need of care or control. Once at the place of safety, the person can be detained for up to 72 hours to determine whether hospital admission or another form of help is required. There has been a shift towards hospital-based places of safety rather than using police cells.

²³ Home Office, *Code of practice on independent custody visiting* (April 2010).

²⁴ Police boards (also known as police authorities) in Scotland are independent of the police force and are not responsible for the day-to-day delivery of policing. Instead, each police board is responsible for setting, monitoring and scrutinising the budget of its local police force and for holding the chief constable to account for the force's performance.

custody visiting in Scotland is not a statutory requirement.²⁵ Instead, it is up to each police board to decide for itself whether to establish and maintain a custody visiting scheme in their area. In a best-value audit and inspection of Grampian Police and Grampian Joint Police Board, published in February 2011, HMICS noted that Grampian was the only area in the UK not to have an operational custody visiting scheme. Acknowledging the vital role that custody visitors play in raising standards in custody and ensuring the fair treatment of detainees, HMICS recommended that Grampian implement a custody visiting scheme as a matter of priority. A custody visiting scheme has since been established.

In 2010–11, independent custody visitors regularly monitored the treatment of and conditions for detainees, reporting concerns to the police board. A key issue of concern to custody visitors is the length of time that detainees may be held. In exceptional circumstances – where there are public holidays on a Friday and the following Monday – it is possible that detainees may be held in police custody from Friday until Tuesday. Police custodial facilities are not generally appropriate for detention of this duration. As a result of concerns raised, consideration is now being given to opening courts at weekends, to reduce the length of time that detainees spend in custody.

At a strategic level, custody visitors have been considering the potential impact of proposals to reform policing across Scotland. The Scottish government recently announced its intention to replace the eight police forces with a single Scottish force. As custody

visiting schemes are currently organised according to police force areas, any reforms will have an impact on them. However, reform also offers an opportunity for the Scottish government to consider all aspects of policing, including police custody, and to place independent custody visiting on a statutory footing.

Another important national development of interest to HMICS and the independent custody visitors, as well as the Scottish Human Rights Commission, was the ruling in *Cadder v Her Majesty's Advocate* and its impact on detainees in police custody. In this case, the Supreme Court held that the law in Scotland which allowed suspects to be detained and questioned by police for up to six hours without access to legal advice was incompatible with Article 6 of the European Convention on Human Rights (right to a fair trial).²⁶ In response to this ruling, the Criminal Procedure (Legal Assistance, Detention and Appeals) Scotland Act 2010 was introduced. The 2010 Act grants suspects a statutory right to legal advice while being questioned by police but also extends the six-hour period during which a suspect may be detained for questioning.

While welcoming this legislative recognition of a suspect's right to have effective legal assistance, the Scottish Human Rights Commission has nonetheless expressed concern that the 2010 Act has extended the period for which a suspect may be detained without charge from six to 12 hours and, in some cases, to 24 hours. The Commission was also concerned at the emergency nature of the legislation; the 2010 Act was introduced to the Scottish Parliament and

²⁵ Although not statutory, custody visiting is supported by the Scottish government, both financially and through published guidance.

²⁶ *Cadder (Appellant) v Her Majesty's Advocate (Respondent) (Scotland)* [2010] UKSC 43.

enacted within a matter of days, allowing little time for consultation with stakeholders or for the implications of the changes to be fully considered.

The extended length of time for which suspects may be detained is likely to have an impact on both the custody process and facilities, and will present new challenges to police forces. These legal and practical developments will now be taken into account by both HMICS and the independent custody visitors during their monitoring of police custody in Scotland.

Northern Ireland

CJINI inspects all aspects of the criminal justice system, including places of detention such as prisons, court and police custody, and secure facilities for children. Custody inspections are carried out in conjunction with RQIA, which assesses the health and social care provision in these settings. CJINI's programme for 2010–11 did not include police custody, as this had been inspected in the previous year, but a follow-up inspection will be undertaken in 2011–12.

In 2010–11, the Northern Ireland Policing Board's independent custody visitors made 1,047 unannounced visits to the 21 designated custody suites in Northern Ireland. There were 1,963 detainees held in custody at the time of the visits, and custody visitors spoke to 918 of them. Of the remainder, 358 detainees refused to be seen, while the others were not seen for other reasons, such as being asleep or being with their solicitor. The consent of detainees is required before custody visitors may speak to them or view their custody record. Previously,

custody visitors were introduced to detainees by custody officers. However, in October 2010, custody visitors began to introduce themselves to detainees. This has had a large impact – 26% of detainees declined to speak to custody visitors from April to September 2010 but this fell to 9% from October 2010 to March 2011. This year, custody visitors have also increased the number of visits carried out at weekends and at unsocial hours (between midnight and 6am).

Of the 1,047 visits made by custody visitors, 82% were deemed to be satisfactory. A total of 227 issues were raised in the unsatisfactory visits. The most common concerns related to safety and security hazards, sanitation, oxygen checks, faulty equipment and cleanliness of accommodation. Other issues included lighting, ventilation and detainees not being told their rights. As reported last year, custody visitors remain concerned about the number of immigration detainees being held in police custody – this was due to there being no dedicated immigration detention facility in Northern Ireland in 2010–11. Such a facility opened in late in 2011, however, and custody visitors hope that this will provide more appropriate accommodation.

Custody visitors in Northern Ireland work with their counterparts in the rest of the UK to develop national standards for visiting and to raise awareness of their work. Such joint working makes good use of limited resources at a time when custody visitors, as with many other monitoring bodies, are being asked to make considerable efficiency savings. There are fears that a reduction in funding will result in fewer visits being made to police custody.

Court custody

At present, not all court custody facilities in the UK are monitored by a member of the NPM. While there are monitoring arrangements in Northern Ireland and Scotland, court custody in England and Wales remains a gap in the NPM's coverage. The UK government has acknowledged this gap and the need for independent monitoring arrangements to be put in place, so that the UK complies with its international obligations under OPCAT. The government has therefore indicated that HMIP will soon be granted powers to inspect the treatment of and conditions for detainees held in court cells. Preparatory work has already been undertaken by HMIP. It is anticipated that two pilot inspections will take place in early 2012 before a formal inspection programme begins.

However, court custody facilities in England and Wales are not without scrutiny; they are currently monitored by 'lay observers', volunteers from local communities who make regular visits to courts in much the same way that Independent Monitoring Boards visit prisons or independent custody visitors monitor police cells. Lay observers are not members of the NPM but the UK government has been asked to consider whether they should be added as a nineteenth member. This would result in layers of monitoring for court custody in England and Wales – by a professional inspectorate and a lay body – as is already the case for other types of detention, such as prisons.

Scotland

In Scotland, HMCIPS has a duty to inspect prisoner escort arrangements. This includes the conditions in which prisoners are transported from one place to another, as well as court custody facilities or any other place where prisoners are temporarily held outside a prison. HMCIPS fulfils this duty as part of its regular inspections of prisons; when inspecting a particular prison, HMCIPS will also inspect the custody facilities of courts serving that prison, and related prisoner escorting arrangements.

In 2010–11, HMCIPS published reports of three prison inspections.²⁷ These inspections included a review of custody facilities at six courts. In two courts, conditions in the cells were found to be poor, in two they were adequate and in two they were acceptable.

Generally, the physical condition of cells was found to be inadequate, with cells being dirty or covered in graffiti and with no cells having natural light. While toilets were available, often there were no hand-washing or drying facilities. In some courts, it was difficult to separate men, women and young people, although special arrangements could sometimes be made. Facilities for legal visits were generally good, although in one court it was found to be difficult for detainees to speak to their solicitor in private. At all courts, there were arrangements for medical support, and all escort staff were first-aid trained. Concern was expressed that, at one court, the courtroom was inaccessible to detainees with disabilities. Instead, the sheriff and lawyers conducted the hearing in the cell of detainees who used a wheelchair. Generally, detainees were treated well by

²⁷ HMIPS, *Report on HMP Glenochil* (2010); HMIPS, *Report on HMP Peterhead* (2010); HMIPS, *Report on HMP Addiewell* (2011).

staff and, at one court, each detainee was asked during the reception process whether he or she needed the services of a drug or alcohol support worker. This was described by HMCIPS as good practice.

Northern Ireland

In Northern Ireland, CJINI is mandated to inspect court custody. In 2010, it published the report of an inspection which reviewed the provision of court custody and transport services to determine whether the treatment and conditions experienced by prisoners and other court users in court custody were decent, respectful, safe and secure.²⁸

Generally, CJINI found that prisoners were treated in a safe and humane manner and that staff had a respectful attitude towards them. However, CJINI also found that the quality of court facilities was extremely variable. The disparity between the best and worst facility was high, with four court custody facilities barely being deemed fit for purpose. Major failings included the lack of secure vehicle docks at some courts, increasing the risk that prisoners might escape, and poor facilities for prisoners with disabilities. Prisoners were escorted through public areas and there was limited room to ensure appropriate segregation of prisoners. CJINI also identified the need for a more consistent approach to the handcuffing of prisoners. It recommended that prisoners should not be routinely handcuffed when being transported in secure vehicles; handcuffs should be used only when an individual risk assessment indicates a high level of risk. CJINI also recommended that male and female prisoners be transported separately.

²⁸ CJINI, *An inspection of prisoner escort and court custody arrangements in Northern Ireland* (2010).

Children in secure accommodation

Generally in the UK, children and young people are placed in secure accommodation because they are on remand or serving a sentence, or because their behaviour poses a serious risk to themselves or others. The law varies between jurisdictions in the UK, as does practice, but all secure settings for young people are monitored by members of the NPM.

England and Wales

In England and Wales, young people under the age of 18 may be placed in secure training centres (STCs) or secure children's homes. STCs are only used for young people who are on remand or are sentenced, whereas secure children's homes also accommodate young people whose behaviour poses a serious risk to themselves or others. There are currently four STCs, all of which are located in England, although young people from Wales may be placed in them. There are 16 secure children's homes in England and one in Wales. Run by the private sector, STCs hold between 50 and 80 young people aged between 12 and 17. Generally, secure children's homes hold those aged between 10 and 14 and are smaller than STCs, holding between eight and 40 young people.

STCs and the secure children's homes in England are monitored by Ofsted, while health care provided to children in these settings is monitored by CQC. The secure children's home in Wales is monitored by Care and Social Services Inspectorate Wales (CSSIW).

In 2010–11, Ofsted inspected the care and educational provision for young people in each of the four STCs. It found that the STCs were performing well: three STCs were judged to be outstanding and the fourth was satisfactory, an improvement on the previous year.

Following the tragic deaths of two young people following the use of restraint in STCs, the use of restraint has been the subject of much discussion and criticism. Several restraint holds have been withdrawn from use, and centres have sought to minimise the use of restraint through the development of positive relationships between staff and young people, an increased use of mediation and individual work with young people to resolve issues. Ofsted reported that these approaches have enabled staff to manage challenging behaviour successfully. There has been a downward trend in the use of restraint over the past two years and one centre has recorded large reductions in the use of sanctions and separation.

Ofsted reported that three of the centres had outstanding arrangements to protect and safely manage young people. Each centre had close professional relationships with the local authority, including child protection services. Any use of restraint that resulted in an injury to a young person, and all allegations or complaints that might suggest abusive treatment of young people, were routinely discussed with the local authority.

Ofsted found that children were positive about their relationships with individual staff members and felt able to complain without fear of repercussion if they had any concerns. Children were well supported in centres through regular access to independent advocates and external child care agencies.

Children were also encouraged to retain contact with their families; however, arrangements to enable telephone contact with families and others were not adequate in two centres.

In 2010–11, Ofsted also inspected each secure children’s home twice. Because there are so few secure homes in England, it can be difficult to place young people near their homes and families. This makes it more difficult to maintain family contact and presents challenges when supporting young people to make the transition from the home to the community. These issues were highlighted in a thematic review published by Ofsted in 2010.²⁹

In the review, Ofsted evaluated the quality of admission and discharge processes for young people in secure accommodation and their resettlement into the community. It examined factors that helped or constrained effective practice and made recommendations for improvement. Ofsted found that many young people were placed a long distance from their home, with some parents making journeys of hundreds of miles to visit their children. These young people were unlikely to have the same level of support as those placed locally, either on admission or discharge. This adversely affected plans for successful reintegration into the community. Ofsted found that secure establishments used assessment, planning and review effectively, which included involving other organisations, as well as the young people and their families. While young people generally received good emotional support, it was common for discharge arrangements not to be agreed until the last few days of the placement. Ofsted also

noted that staff from other agencies did not participate sufficiently in plans for young people to return to the community.

The OCC has a statutory remit to promote children’s views and interests and to have regard to the United Nations Convention on the Rights of the Child. While it is not an inspectorate as such, the OCC visits places of detention. It has the power to enter any premises where children are cared for, other than a private home, to interview children with their consent, and reports on issues from a child’s perspective.

A large part of the OCC’s work during 2010–11 was linked to its study of the emotional wellbeing and mental health of children and young people in the youth justice system, particularly those in detention. Eleven institutions in the children’s secure estate were visited and the OCC examined the support provided to young people. It published a report in June 2011 which included recommendations directed to the Ministry of Justice, the Youth Justice Board, the Department of Health and local authorities.

In 2011, the OCC also published research on young people’s views on restraint in the secure estate.³⁰ The use of restraint generated a strong emotional response from most of the participants in the research, but the way that girls experienced restraint varied dramatically from that of the boys. Many of the girls felt that restraint had a negative impact on their mental health and wellbeing and they disliked it intensely. By contrast, boys reported feelings of anger, indifference or of acceptance that restraint was a necessary element of the custodial

²⁹ Ofsted, *Admission and discharge from secure accommodation* (August 2010).

³⁰ Office of the Children’s Commissioner, *Young people’s views on restraint in the secure estate* (March 2011). This research included the views of young people held in young offender institutions, as well as STCs and secure children’s homes.

regime. The most cited reason for young people's dislike of restraint was that they thought that too much force was being used; young people wanted to move from a culture of coercion to one of cooperation. As a result of this research, the OCC made several recommendations, including that:

- young people with experience of custody be actively involved in reviewing and evaluating policy and practice
- the deliberate use of pain to enforce order and control be prohibited
- international human rights standards should inform how and when restraint is used on young people and that these standards should be applied consistently between institutions.

The OCC also published research on safeguarding in the secure estate.³¹ This focused on accessible and effective complaint processes, helplines for young people, searches and the use of separation.

The majority of young people participating in the research knew how to use complaint systems but rarely did so. Generally, they did not feel that the secure estate attached importance to their complaints, although young people in STCs and secure children's homes were more positive than those in young offender institutions. The young people's views on helplines were mixed: some reported a high level of satisfaction but others viewed them as ineffective. Full searches were viewed by the young people as a necessary part of the regime, to ensure safety. Girls were likely to feel intimidated by searches and reported feeling anxious, powerless and embarrassed. Boys were less concerned by full searches but still

felt that they were a breach of dignity. The young people suggested using screens for undressing or dressing gowns, or electronic equipment such as scanners or wands. Young people also understood why separation was necessary, although disliked the experience. Some saw it as punishment, rather than a management technique, and were unhappy at being cut off from normally supportive relationships.

The OCC will continue to visit institutions where young people are detained and, in 2011-12, will focus on seeking the implementation of the recommendations made as a result of its work on the emotional wellbeing and mental health of young people in the youth justice system. It will also carry out more detailed work on complaint systems in the children's secure estate.

Wales

Hillside Secure Children's Centre, the secure children's home in Wales, is inspected every year by CSSIW. Its inspections cover a range of themes, including quality of care and treatment, the physical environment, quality of life and planning for individual needs and preferences. This year, CSSIW found no significant concerns about the care being given to young people at Hillside.

In its assessment of the quality of care and treatment, for example, CSSIW noted that since its previous inspection, a psychologist had been employed at the centre full-time, which was beneficial for the young people. However, it also noted that some of the work undertaken by the psychologist was limited because of the short period that some of the young people spent at Hillside.

³¹ Office of the Children's Commissioner, *Young people's views on safeguarding in the secure estate* (March 2011). This research also included the views of young people held in young offender institutions, as well as STCs and secure children's homes.

CSSIW found that the young people's views were listened to and taken into account through weekly meetings. These meetings were recorded, although one unit in the centre did not always record actions, and that should be rectified. CSSIW noted that, while the young people's opportunities to make everyday choices were necessarily restricted by the nature of the centre, within the boundaries set, the young people were encouraged to make as many choices as they could.

As the only secure children's home in Wales, many of the residents at Hillside are placed far from their families. With this in mind, CSSIW was pleased to note that a residential visitor suite was available for families who travelled long distances for visits.

Scotland

In Scotland, children and young people may be placed in secure accommodation when they pose a serious risk to either themselves or others and are likely to run away or abscond from a more open setting. There are seven secure accommodation services in Scotland and all were monitored in 2010–11 by the Care Commission. On 1 April 2011, the Care Commission merged with another organisation, to become Social Care and Social Work Improvement Scotland ('Care Inspectorate'). The Care Inspectorate has since taken on the Care Commission's monitoring role.

The Care Commission visited each service twice a year, with one visit being unannounced. It monitored the quality of care and support, the environment, the staffing and management, and leadership, although each area was not assessed at every inspection. In 2010–11, the

Commission was mostly positive about secure accommodation services. One service, for example, had struck a good balance between security and care, with young people feeling safe and valued. The service was effective at involving young people and their parents or carers; staff were highly skilled; and young people's health and wellbeing had a high profile. The Care Commission made several recommendations on areas for improvement in relation to other services, including:

- services should develop their participative approach and should involve young people and their carers in evaluating the service
- services should ensure that complaints are followed up appropriately and that young people receive feedback
- staff should be regularly trained in safe methods of restraint
- staffing levels should be adequate to meet the needs of young people.

Northern Ireland

In Northern Ireland, young people aged 13 years and over may be placed in a regional secure care centre if they meet the required legal criteria: the young person poses a risk to himself and/or others or is likely to abscond if placed in a more open setting. The centre for Northern Ireland accommodates 16 young people in two eight-bed units. The centre was inspected twice during the year by RQIA; one inspection was announced and one was unannounced.

The inspections covered specific standards which examined the individual therapeutic work carried out by staff with the young people; education in the centre; and statutory records, as well as the day-to-day functioning

of the staff and management team. RQIA was satisfied with the overall quality of care being delivered and the centre met the standards under inspection. Requirements were made in the following areas:

- improving the quality of recording of physical restraint
- the need to strengthen the links between education in the centre and education in the community
- ensuring that staffing levels were always commensurate with the needs of the facility.

This year, RQIA also examined the pathways through care of 10 young people who met the criteria for secure accommodation. The purpose of the work was to trace the pathways through care for the identified group and examine the key milestones/factors that influenced the outcomes they experienced. The research group was divided into two sections: one group who met the criteria and were placed in secure care, and a second group who also met the criteria but did not receive a placement. RQIA examined the young people's case records and completed interviews with the young people, social work staff and chairpersons for the restriction of liberty panels. The findings will be published in 2011-12.

In addition to this secure care centre, children and young people may also be referred by the courts to Woodlands Juvenile Justice Centre. Woodlands can accommodate up to 48 young people in secure conditions. In March 2011, CJINI, RQIA and the Education and Training Inspectorate jointly inspected Woodlands. Their findings will be published later in 2011. CJINI also undertook two unannounced monitoring visits to Woodlands in conjunction with the Office of Social Services.

Detention under mental health law

In the UK, people with mental disorders may be detained under mental health law to ensure that they receive the care and treatment necessary for their own health and safety or for the protection of others. This is subject to strict criteria and safeguards set out in mental health legislation. The precise legal provisions and processes vary between jurisdictions in the UK, as do the independent monitoring arrangements. However, the four NPM members responsible for monitoring detention under mental health law in the UK communicate regularly with one another, sharing information and experience.³² This communication is particularly important, as cross-border placements sometimes take place.

England

In England, CQC regulates health and adult social care. It has a statutory duty to monitor the operation of the Mental Health Act 1983 (MHA) and to carry out visits to those whose rights are restricted under it. Visits are carried out by MHA commissioners who are separate from compliance inspectors carrying out the regulatory activities of CQC. During their visits to services where people are detained, MHA commissioners check that detained patients' rights are being safeguarded and meet patients to find out more about their individual experience of detention.

In 2010–11, MHA commissioners carried out 1,565 visits in more than 670 hospitals in England. They met in private with more than 4,700 detained patients. Reports of individual visits are submitted to hospital managers but are not published. Instead, CQC publishes annual statements on each mental health trust or independent provider. CQC also publishes an

annual report to Parliament of its monitoring of the use of the MHA.

The MHA Code of Practice includes a statement of principles to guide those who have responsibilities under the Act and to which all those involved in the operation of the Act should adhere. In monitoring the MHA, CQC checks that any restrictions imposed on a patient's liberty are the least restrictive and that MHA powers are exercised with respect for the patient's wishes and feelings and within a wider approach that focuses on promoting recovery and autonomy.

Patients and, where appropriate, carers or families should be involved in planning, developing and reviewing their own treatment. This can help lessen the perception of coercion in psychiatric care. CQC's monitoring shows that there continue to be variations in the extent to which patients are involved in assessments and care planning. While it has observed excellent examples of patient participation, CQC has also visited many services where practice is deficient. Some patients have been excluded from care planning and decision making and report feeling intimidated or patronised by staff. Some patients are presented with care plans which are not personalised to them and in which they have had no input. CQC recommends that service providers ensure that staff are appropriately skilled and encourage patient participation.

Through its 'Acting Together' programme, the CQC itself promotes the participation of service users in its monitoring work. A panel of service users, comprising people who are currently subject to detention or who have been previously detained, informs CQC's approach to monitoring the operation of the MHA.

³² See page 13.

CQC uses its regulatory powers under the Health and Social Care Act 2008 to ensure that all those who provide services to patients detained under the MHA comply with its 'Essential Standards of Quality and Safety'. These standards cover all aspects of service provision including staffing, training, consent and appropriate use of control and restraint.

Wales

In 2010–11, around 50 hospitals in which patients are detained under mental health law were visited by Healthcare Inspectorate Wales (HIW), with some hospitals being visited more than once. Many of the issues highlighted by HIW in last year's annual report remained a concern this year.

HIW is concerned that the capacity of patients (for example, to consent to treatment) is not being appropriately assessed, recorded or reviewed. In addition, patients are not being adequately informed of their rights. Often, their rights are explained in a perfunctory manner and this important safeguard is treated as a 'tick box' exercise. There is often no record of how a patient was informed of their rights or whether efforts were made to tailor explanations about rights to the patient's individual communication needs. HIW found that patients do not demonstrate a strong understanding of their rights.

As a result of efforts to support patients in the community wherever possible, patients are increasingly admitted to hospital only when they are acutely ill. This has led to a more volatile patient mix and has heightened pressure on staff. Staffing has not always been reviewed to take account of this change in patient profile.

Mirroring the concerns of the CQC about mental health detention in England, HIW is concerned about whether appropriate control and restraint methods are being used in Wales. While it wishes to encourage approaches focused on de-escalation, it nevertheless recognises that staff dealing with aggressive patients should have the skills to manage them physically when required. In particular, staff working with children and young people should be trained in age-appropriate control and restraint. In relation to children and young people more generally, HIW is concerned about whether they are able to access suitable services, particularly when crises occur at evenings or weekends.

This year, patients have told HIW about a lack of stimulating activities appropriate to their age, needs and skills. HIW is also concerned about a lack of psychological therapies, whether provided by psychologists or suitably trained nursing staff.

Sometimes, patients are not legally detained but may agree to stay in hospital 'informally'. Some services argue that these informal patients agree, as part of their care plan, to reside on a hospital ward except when granted leave by their doctor. HIW has noted that it is difficult to evidence whether such patients are made aware of their rights. HIW fears that many stay in hospital under coercion or due to actual or implicit threats that they will be legally detained if they are not compliant. It recommends that an informal patient's right to freedom of movement must be respected.

Scotland

In Scotland, the Mental Welfare Commission for Scotland (MWCS) is mandated to visit and monitor the treatment of anyone detained under mental health law. In 2010–11, it visited 1,925 people with mental disorder in a variety of settings, most of whom were subject to compulsory mental health treatment or welfare guardianship. MWCS also conducted 98 focused visits to mental health or learning disability facilities where it had identified a greater risk that people were not having their needs met or their rights respected. Of these visits, 21 were unannounced. The visits resulted in 301 recommendations for improvement.

In addition to its regular visits to places of detention, MWCS conducts thematic reviews, which often include information about people who are detained. This year, MWCS published reports on people with dementia in hospital; people receiving compulsory treatment after committing an offence; people in learning disability facilities; people in adult acute mental health wards; and people with acquired brain injury and alcohol-related brain damage. MWCS also publishes good practice guides. This year, it published a guide on supporting the right of people with mental disorder to have sexual relationships while being free from abuse or exploitation.³³

As well as its general monitoring function, MWCS may also carry out investigations. In 2010, it published a report of an investigation of the case of a woman who died by suicide while detained in hospital. It found that nobody had got to grips with her mixture of mental illness, alcohol use and social problems.

MWCS has identified a number of key issues in the course of its work. It is concerned about young people being admitted to adult wards and a lack of attention to regulations on searches, the taking of samples and restricting communications. It has also highlighted the lack of attention to the physical health of people with severe and enduring mental illness. People detained in hospitals often gain weight due to medication and inactivity. MWCS recommends that access to exercise, dietary advice and regular screening for health risks must improve.

MWCS is concerned about variations in the use of compulsory treatment:

- a person is twice as likely to be treated under compulsion in Fife than in the Borders
- there is some evidence of a disproportionately high use of compulsion for black African and Caribbean people
- women are more likely to be detained under emergency orders, while men are more likely to be subject to long-term orders.

Despite its numerous concerns about mental health detention, MWCS has noted that progress was made in 2010–11. It believes that care for people with dementia is improving and is positive about a fall in the use of emergency detention. Its report on visits to people receiving compulsory treatment after committing an offence was largely positive, in that it found good attention to individual needs and rights; that levels of security were not excessive; and that the people visited were generally appreciative of the care they received.

³³ All MWCS publications are available online at www.mwscot.org.uk/newpublications/mwc_publications.asp.

MWCS also adopts a more strategic approach to its work, frequently responding to government and Scottish Parliament consultations. One such response concerned a proposal to extend the scope of fatal accident inquiries to include automatically anyone who dies in mental health detention. MWCS rejected this proposal in favour of a two-stage process under which cases can first be screened to avoid the need for an inquiry into a death from natural causes.

MWCS has also highlighted to the Scottish government and others where it considers that mental health and incapacity legislation are incompatible with human rights law. For example, it noted that when a person detained under a long-term order is transferred into Scotland, he is unable to appeal against his detention until three months have passed since the granting of the order.

Northern Ireland

In Northern Ireland, mental health detention is monitored by RQIA. More than 1,300 people were detained under mental health law in 2010–11 and RQIA carried out 46 inspections of mental health and learning disability services where people may be detained. RQIA's inspection programme is supplemented by a programme of 'patient experience reviews'. This is aimed at keeping under review the care and treatment provided to detained patients and involves offering each detained patient the opportunity to be interviewed privately by an inspector. This year, RQIA met 133 patients as part of this programme.

A number of key themes arose from these inspections, many of which were similar to those identified in the rest of the UK, including

concerns about how patients are informed of their rights; issues relating to informed consent; and effective engagement with patients in care planning and treatment. RQIA was also concerned about patients' limited access to independent advocacy and a lack of patient-focused information on admission and discharge leading to continuity of care being compromised. RQIA also identified several instances of poor patient assessment.

Patient experience reviews highlighted additional issues, such as patient privacy and dignity; limits on patients' time out of the ward, whether accompanied or unaccompanied; and limited access to smoking facilities.

In 2011, RQIA published a review of child and adolescent mental health services. This review looked specifically at the care of under-18s on adult wards, a number of whom are detained under mental health law. The RQIA considers that admission of a young person to an adult ward constitutes admission to an inappropriate environment. Nonetheless, it noted that, in recent years, significant safeguards have been developed and implemented regarding the way in which young people on adult wards are accommodated and managed.

Next year, as part of its inspections of mental health and learning disability services, RQIA will focus on the human rights theme of protection, which will include an assessment of the use of seclusion, restrictive practices and physical restraint. It will also consider the safeguarding of vulnerable adults and children in hospitals and will conduct a review of risk assessment and management in mental health services. This latter activity will include a specific focus on those patients with a dual diagnosis of mental disorder and substance misuse.

Deprivation of liberty safeguards

Deprivation of liberty safeguards were introduced in recent years to protect those who are not detained under mental health law but who lack capacity to consent to care or treatment that is deemed by others to be in their best interest. Such care or treatment may involve depriving someone of their liberty in either a hospital or care home. The safeguards seek to ensure that any decision to deprive someone of their liberty is made following defined processes and in consultation with specific authorities. Applying only in England and Wales, deprivation of liberty safeguards are monitored by three members of the NPM – CQC in England, and HIW and CSSIW in Wales.

The deprivation of liberty safeguards were introduced following the decision of the European Court of Human Rights in *HL v United Kingdom*.³⁴ This case concerned an autistic man with a learning disability who lacked the capacity to decide whether he should be admitted to hospital for specific treatment. He was admitted informally but this decision was challenged by his carers. The Court found that his admission amounted to an unlawful deprivation of liberty under Article 5 of the European Convention on Human Rights.

England

CQC's main approach to monitoring the use of deprivation of liberty safeguards is through its process of monitoring compliance with its essential standards of safety and quality by regulated health and adult social care providers, including care homes. In some instances, CQC's MHA commissioners also report on issues relating to the use of

the deprivation of liberty safeguards which are identified in the course of their visits to detained patients.

CQC reports annually on its monitoring of deprivation of liberty safeguards. The first such report was published in March 2011.³⁵ This report noted that there was clear variation in organisations' understanding and practice of the safeguards and in staff training. CQC found too many examples of managers and staff in hospitals and care homes who were unaware of the safeguards or who had received no training on them. It also found too many examples of staff in hospitals and care homes using restraint or restricting people's movement where they failed to consider that these practices could deprive a person of their liberty. Furthermore, CQC's inspections of hospitals and care homes highlighted some confusion over the wider Mental Capacity Act. Care providers may not know when they are exceeding the powers that this Act gives them and therefore may not be aware when they need to apply for an authorisation to deprive a person of their liberty. Indeed, some inspections found that certain care homes were failing to carry out any assessment of mental capacity on any service users. However, CQC also found some hospitals and care homes demonstrating good practice in using the safeguards to protect people's rights.

One issue raised by CQC in its annual report on the use of the deprivation of liberty safeguards was the perception that the safeguards are overly bureaucratic. It therefore encouraged the Department of Health to consider whether it could reduce the amount of paperwork needed to use the safeguards.

³⁴ Application No. 45508/99 (October 2004).

³⁵ CQC, *The operation of the deprivation of liberty safeguards in England, 2009/10* (March 2011).

Wales

HIW and CSSIW monitor the use of the deprivation of liberty safeguards in Wales in the course of their regular visits to health and social care settings, respectively. Similarly to CQC, HIW and CSSIW publish an annual report of their deprivation of liberty safeguards monitoring activities. Their inspection reports of individual services may also include findings regarding the use of the safeguards.

The first annual reports from both HIW and CSSIW on the use of the safeguards were published in March 2011.³⁶ They found that this was much lower than expected and varied widely between regions. Their use in urgent circumstances was much higher than expected, suggesting that the rights of patients and service users were not being considered as part of forward care planning. HIW and CSSIW expressed concern that a continued low-level use of the safeguards will mean that those involved in managing the process will do so infrequently and that this may compromise the development of expertise. They note that if people's rights are to be protected adequately, the safeguards must be well known, understood and embedded into practice in both health and social care settings.

³⁶ HIW, *Mental Capacity Act 2005, Deprivation of liberty safeguards annual monitoring report for health, 1 April 2009 to 31 March 2010* (March 2011); CSSIW, *Mental Capacity Act 2005, Deprivation of liberty safeguards monitoring report on the first year of operation, 1 April 2009 to 31 March 2010* (March 2011).

Immigration detention

Throughout the UK, immigration detention facilities are monitored by HMIP and IMBs. HMIP regularly inspects all immigration removal centres (IRCs) and short-term holding facilities (STHFs), as well as escorting arrangements for immigration detainees. Each IRC, of which there are 11, also has its own IMB, made up of volunteers from the local community, who regularly visit the centre and assess the treatment of detainees. In addition, there are three IMBs for some STHFs at airports and reporting centres.³⁷ However, not all STHFs are monitored by IMBs. Due to budget cuts, the previously agreed rollout of new boards for the remaining STHFs in the UK has been halted.

Other NPM members involved in monitoring immigration detention include Ofsted, MWCS and the OCC. Ofsted participates in HMIP-led inspections of IRCs by assessing the learning and skills provision for detainees, while MWCS may visit people with mental disorder who are detained at Dungavel IRC, in Scotland. The OCC has undertaken periodic visits to facilities where families may be detained, with the aim of promoting and protecting children's rights. Its reports have a strong focus on the experience and welfare of children and young people.

In 2010–11, HMIP published reports of inspections at six IRCs and nine STHFs. It also published two inspection reports on immigration escorting arrangements.³⁸ HMIP noted uneven progress and much inconsistency across IRCs, publishing both its best inspection report and one of its worst. Dungavel became the first centre where

outcomes for detainees were assessed as good across all four of HMIP's tests of a healthy establishment (safety, respect, purposeful activity and preparation for release). In relation to safety, for example, HMIP found that detainees felt extremely safe, there were positive staff-detainee relationships and there was minimal use of force. By contrast, safety at the newly opened Brook House IRC was poor; there was a high level of bullying and violence, and the use of force by staff was frequent. Detainees there lacked confidence in staff's ability to protect them or manage difficult situations.

In the first annual report of the NPM, IMBs noted their concern about the building or refurbishment of the immigration detention estate using criteria that would normally apply to prisons. This concern was borne out in HMIP inspections. Indeed, HMIP noted that the design of some IRCs was more austere and restrictive than in many prisons. The physical environment of many facilities was a particular concern.

More positively, HMIP found that the range of activities available had improved in response to detainees being held for longer periods. It also found that most detainees had reasonable freedom of movement; however, this varied between centres: detainees could move around for 19.5 hours a day at one centre but less than 10 hours at another.

HMIP expects that those held in detention centres are able to keep in contact with the outside world and are prepared for their release, transfer or removal from the UK.

³⁷ One of these boards monitors holding facilities at Heathrow Airport; another monitors the airports and reporting centre in Glasgow and Edinburgh; and the third covers the North and Midlands area, which includes the airports and reporting centres in Manchester, Birmingham and Leeds.

³⁸ All reports are available at: www.justice.gov.uk/publications/inspectorate-reports/hmi-prisons/index.htm

However, detainees in most centres were not offered systematic pre-removal support. By contrast, at Dungavel, a welfare officer met every detainee who had been served with removal directions, to ensure that their needs were being met. Overall, detainees had good access to the outside world and were able to retain their mobile telephones to facilitate this.

HMIP's inspections of STHFs and escort arrangements found that progress had been made, although some problems remained. For example, the routine handcuffing of detainees through security checkpoints at Manchester Airport was thought to be unnecessary.

In 2010-11, the 14 IMBs carried out approximately 2,000 visits to immigration detention facilities and each board published its own annual report. The most serious issue they raised was the length of time that detainees were held in IRCs. Of the 2,655 people being detained under immigration law on 31 March 2011, 225 had been detained for more than one year.³⁹ One person had been detained for 1,975 days (5.4 years).⁴⁰ IMBs are particularly concerned about the deterioration in the mental health of detainees in long-term, indefinite detention.

The following issues are also of concern to IMBs and will be closely monitored in the coming year:

- detainees arriving at detention facilities with inadequately completed documentation, compromising the risk assessments necessary to allocate them to their accommodation

- delays in the resolution of age-disputed cases
- detainees being subjected to unnecessarily long travel and waiting times before their arrival at airports for removal
- inadequate handling of detainee complaints against non-immigration agencies, such as the police.

Longest periods of detention

At 31 March 2011, of the 2,655 people detained solely under Immigration Act powers, the 19 longest recorded periods of detention were:

Period of detention (years/(days))	Nº of people
5.4 (1,975)	1
4.3 (1,577)	1
3.8 (1,420)	1
3.8 (1,396)	1
3.7 (1,357)	1
3.6 (1,322)	1
3.5 (1,297)	1
3.5 (1,291)	1
3.3 (1,231)	1
3.3 (1,213)	1
3.3 (1,205)	2
3.2 (1,193)	1
3.1 (1,163)	1
3.1 (1,141)	1
3.0 (1,125)	1
3.0 (1,123)	1
3.0 (1,115)	1
3.0 (1,114)	1
3.0 (1,107)	1

³⁹ Home Office, *Control of immigration: quarterly statistical summary, United Kingdom Quarter 1 2011 (January - March)* (2011).

⁴⁰ Information about the longest periods of detention was published by the government following a freedom of information request - see www.medicaljustice.org.uk/information-gathering/foi-requests.html.

Detention of children

HMIP, IMBs and the OCC have all expressed deep concern at the detention of children for immigration purposes and welcomed the announcement by the UK government in 2010 that such detention would end. Despite the government's announcement, children will continue to be detained with their families in some circumstances. Families may be held for short periods in new pre-departure accommodation and at Tinsley House IRC. Given concerns about the effect of detention on children's health and welfare, the NPM members will continue to monitor their treatment closely. In addition, the OCC has led child rights-based training sessions to staff employed in the pre-departure accommodation.

Unaccompanied children seeking asylum

During 2010–11, the OCC also undertook visits to a centre for accommodating unaccompanied children who are seeking asylum in Kent, and screening facilities at the port of Dover.⁴¹ It sought to establish what happens to children between their first contact with UK authorities and being placed into local authority care. While impressed at the level of care provided by the local authority-run centre, the OCC made 15 recommendations regarding their concerns about the treatment of children at key stages in the screening process. It has since undertaken further work to assess the arrangements relating to children's first interview with immigration authorities and the period they are held by port authorities. It will publish findings and recommendations later in 2011–12.

Overseas escorts

Until recently, both HMIP and IMBs monitored escorting arrangements for detainees being deported, up to the point where the aircraft was about to take off. Following the death of a detainee on board an aircraft in October 2010, HMIP has begun to inspect overseas escorts, monitoring the treatment of detainees throughout the deportation process and until detainees reach their country of origin. The first such inspection, of detainees being deported to Jamaica, took place in March 2011. In addition, IMBs have been invited by the Home Secretary to monitor charter flights. The feasibility of extending their remit in this way is currently being assessed. This has involved monitoring two flights so far, to Nigeria and Afghanistan. The outcome of this assessment will be known in 2011–12.

Northern Ireland

Until recently, there has been no dedicated immigration detention facility in Northern Ireland. Instead, immigration detainees are held in police custody before being transferred to England or Scotland. Independent custody visitors in Northern Ireland have encountered such detainees during their regular visits to police custody and have expressed concern about this practice. However, in 2011 an STHF will be established in Northern Ireland, potentially offering more appropriate accommodation for immigration detainees. It will fall within the mandate of HMIP and it is anticipated that arrangements for monitoring by a lay body will also be put in place.

⁴¹ Office of the Children's Commissioner, *Landing in Kent* (February 2011).

Military detention

While none of the NPM members in the UK has a specific statutory mandate to monitor places of military detention, HMIP is regularly invited by the Provost Marshal (Army) to inspect the Military Corrective Training Centre (MCTC). This is the UK armed forces' single central custodial facility, holding mainly servicemen and women who have been sentenced to periods of detention from 14 days to two years. Most such detainees have offended against military law rather than criminal law, and few are detained for offences that would have resulted in custody if they had been civilians. The MCTC is staffed by service personnel.

In June 2010, HMIP conducted an unannounced follow-up inspection of the MCTC, in which it assessed the extent to which progress had been made against recommendations made during a previous inspection. It found that, while a number of areas remained to be addressed, considerable progress had been made. Ofsted, another NPM member, contributes to HMIP's inspections of the MCTC by assessing the learning and skills provision for detainees.

Arrangements to ensure the safety of detainees had greatly improved: efforts had been made to tackle bullying and good support was given to those at risk of self-harm. There was greater attention to the particular vulnerabilities of young people under the age of 18 but further work was required. While detainees reported mixed relationships with staff, inspectors observed a generally supportive approach by staff towards those in their care. However, despite previous recommendations, the approach to diversity remained underdeveloped. Progress on the resettlement needs of detainees

had been considerable. Accommodation, employment and financial advisory services had all improved, as had support with maintaining family ties.

The MCTC also has its own IMB, which operates in much the same way as other IMBs in England and Wales, except that members are appointed by the Secretary of State for Defence rather than the Secretary of State for Justice. In preparing this report, the NPM has noted that the MCTC IMB is not part of the same operational framework as other IMBs and therefore has not yet engaged with the NPM; the NPM will engage with the IMB at the MCTC in the future.

Military detainees may also be held for short periods in service custody facilities (sometimes referred to as 'guardhouses'). There are several such facilities in the UK and overseas. They do not currently receive independent monitoring but consideration has been given in the past to allowing HMIP to inspect them. In line with Article 4 of OPCAT, and as previously noted at page 14, the NPM has recommended to the UK government that all places of detention be monitored, including service custody facilities. Ideally, all independent monitoring of military detention should be placed on a statutory footing, in accordance with guidelines issued by the Subcommittee on the Prevention of Torture.⁴²

In recent years, HMIP has been in discussions with the Ministry of Defence regarding the possibility of carrying out independent inspections of UK-run detention facilities in Afghanistan. While the government does not believe that OPCAT applies extra-territorially, it is nonetheless considering the value of independent monitoring and the safeguards and public assurance it offers.

⁴² Subcommittee on the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Guidelines on national preventive mechanisms* CAT/OP/12/5 (9 December 2010).

Other types of detention

As noted above at page 11, the UK NPM members have been considering the definition of detention and whether all places of detention receive regular visits, as required by OPCAT. There has been some debate over places where people may not be detained under any lawful order, but where they may be considered de facto detained. This would include some care homes for elderly people. Whether people cared for in such places are in fact detained is still being discussed by the members, and the outcome of these discussions, and any monitoring activities, will be noted in future reports.

Section four Looking ahead – year three

In its second year following designation, the NPM members have continued to make regular visits to places of detention and examine the treatment of and conditions for detainees. They have established good working relationships with one another, sharing their expertise, and have participated in joint training. The members have sought to raise awareness of the OPCAT framework within which they operate among their own personnel and with stakeholders.

This work will continue in 2011–12. The NPM as a whole will seek the full implementation of OPCAT in the UK, with its coverage being extended to more places of detention. Through their visits and inspections of places of detention, the individual members will continue to drive up standards for detainees, to ensure that they are treated with respect and in accordance with international human rights norms.

There are plans to hold a thematic workshop for all members, focusing on the use of force and restraint in detention, and to encourage the lay bodies within the NPM to meet as a subgroup, so that they may discuss issues particular to their role as volunteer monitors within the OPCAT framework. The NPM members will also continue to benefit from their participation in the Council of Europe's NPM Project. Representatives of the UK NPM will participate in workshops on the methodology of monitoring, particularly of vulnerable detainees. Such workshops offer the opportunity for NPM members to engage with NPMs in other countries, to discover new methods of working and to discuss how best to implement OPCAT.

Section five

Member overview

In the first annual report of the UK NPM, we profiled each of the NPM members, setting out detailed information relating to their mandate, structure and methodology. Rather than replicate that information in this report, we have set out below a short description of each member, as a reminder. We have also included details of any significant changes to the members that occurred during 2010–11. Detailed information about each member can be found in our first annual report, the online database of UK NPM members, or the annual reports or websites of the individual members.⁴³

As in our first annual report, information about 19 organisations is included below, even though only 18 are designated as members of the NPM. The nineteenth organisation, Independent Custody Visitors Scotland, has not been designated separately but is a member of the designated ICVA.

Care and Social Services Inspectorate Wales

CSSIW regulates and inspects all social care services in Wales. This includes secure accommodation where children are placed either for their offending behaviour or because they pose a significant risk to themselves or others. CSSIW also monitors the deprivation of liberty safeguards during its regular inspections of adult care homes.

Care Quality Commission

CQC is an independent statutory organisation responsible for registering health and adult social care services in England if they meet essential standards of quality and safety, and monitoring providers to check they continue to meet those standards. CQC also monitors

the operation of the MHA, including those who are detained under mental health law. CQC carries out inspections of health care in prisons and immigration detention alongside HMIP, and participates in inspections of police custody by HMIP and HMIC.

Criminal Justice Inspection Northern Ireland

CJINI is a statutory body with responsibility for inspecting all aspects of the criminal justice system. CJINI's mandate is broad and it may inspect a range of places of detention, including prisons, a juvenile justice centre, police custody, court custody and secure care facilities for children.

Healthcare Inspectorate Wales

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

Her Majesty's Inspectorate of Constabulary

HMIC has a statutory duty to inspect and report on the efficiency and effectiveness of policing. Following the ratification of OPCAT, HMIC's role has included carrying out inspections of police custody facilities in England and Wales in partnership with HMIP.

⁴³ The online database of UK NPM members, compiled by the Human Rights Implementation Centre at the University of Bristol in association with the members themselves, is available at www.bristol.ac.uk/law/research/centres-themes/hric/hricnmpukdatabase/index.html. The website of each member of the NPM is provided at Appendix 2.

Her Majesty's Inspectorate of Constabulary for Scotland

The role of HMICS is to monitor and improve police services in Scotland. It scrutinises the work of Scotland's eight police forces, as well as the Scottish Police Services Authority, a national body responsible for, among other things, the training of police officers. HMICS inspects all aspects of policing, including police custody.

Her Majesty's Inspectorate of Prisons

HMIP is an independent statutory organisation which carries out regular inspections of places of detention, to assess the treatment of and conditions for detainees. HMIP inspects all prisons in England and Wales, including YOIs; all IRCs, STHFs and escort arrangements for immigration detainees; and all police custody facilities in association with HMIC. By invitation, HMIP also participates in inspections of prisons in Northern Ireland (in partnership with CJINI) and inspects some military detention facilities. It is anticipated that HMIP will soon be granted powers to inspect court custody facilities.

Her Majesty's Inspectorate of Prisons for Scotland

HMIPS inspects prisons, including YOIs, paying particular attention to the treatment of and conditions for prisoners. The Inspectorate also has a duty to inspect legalised police cells. These cells are used to hold prisoners awaiting trial in their local area, rather than transfer them to distant prisons. It also inspects prisoner escort arrangements – this includes the conditions in which prisoners are transported from one place to another, as well as court custody facilities or other places where prisoners are temporarily held outside a prison.

Independent Custody Visiting Association

Independent custody visitors are volunteers from the community who visit all police stations where detainees are held, to check on their welfare. Custody visiting is statutory and visitors have the power to access police stations, examine records relating to detention, meet detainees for the purpose of discussing their treatment and conditions, and inspect facilities, including cells, washing and toilet facilities, and facilities for the provision of food.

Independent Custody Visitors (Scotland)

Independent custody visitors in Scotland carry out regular, unannounced visits to police stations to monitor the treatment of and conditions for detainees. Custody visitors in Scotland have not been designated separately as a member of the UK NPM but are members of ICVA, although they retain their own funding and management framework.

Independent Monitoring Boards

IMBs have a statutory duty to satisfy themselves as to the state of the prisons or immigration detention facilities they visit, their administration and the treatment of prisoners or detainees. The boards are made up of unpaid members of the community and fulfil their duties by carrying out regular visits to establishments. There is a board for every prison in England and Wales and every IRC in England, Wales and Scotland, as well as for STHFs for immigration detainees. Board members are appointed by the Secretary of State.

Independent Monitoring Boards (Northern Ireland)

IMBs in Northern Ireland are statutory bodies whose role is to monitor the treatment of prisoners and the conditions of their imprisonment. There are three boards in Northern Ireland, one for each prison.

Mental Welfare Commission for Scotland

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

Northern Ireland Policing Board Independent Custody Visiting Scheme

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

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

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

Office of the Children's Commissioner for England

The role of the Children's Commissioner is to promote awareness of the views and interests of children in England. The Commissioner has the power to enter any premises for the purpose of interviewing any child accommodated or cared for there. While the Commissioner does not carry out a regular programme of visits or inspections, she has a broad power to enter premises where children may be detained.

Regulation and Quality Improvement Authority

RQIA is empowered to monitor the availability and accessibility of health and social care services in Northern Ireland and to promote improvement in the quality of these services. A key element of its role is to inspect the provision of health and social care in places of detention, including prisons, secure accommodation for children or places where people are detained under mental health law.

Scottish Commission for the Regulation of Care (Care Commission)

The Care Commission had a broad remit to regulate and improve care services in Scotland. It was designated as a member of the NPM in respect of its inspections of secure accommodation services for children. The Commission was also able to inspect care services in psychiatric hospitals where some patients may have been detained. On 1 April 2011, the Care Commission was merged with another organisation, to become Social Care and Social Work Improvement Scotland ('Care Inspectorate'). The Care Inspectorate retains the Care Commission's detention monitoring functions and it is therefore anticipated that it will be formally designated by the government in place of the Care Commission as a member of the NPM.

Scottish Human Rights Commission

The Scottish Human Rights Commission is an independent statutory body with the power to enter places of detention and report on the rights of detainees. The Commission's general duty is to promote awareness, understanding and respect for human rights and, in particular, to encourage best practice in relation to them.

Section five Appendices

Appendix one

Written ministerial statement – 31 March 2009⁴⁴

Optional Protocol to the Convention Against Torture (OPCAT)

The Minister of State, Ministry of Justice (Mr. Michael Wills): The Optional Protocol to the Convention Against Torture (OPCAT), which the UK ratified in December 2003, requires states party to establish a “national preventative mechanism” to carry out a system of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

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

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

England and Wales

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

Scotland

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

Northern Ireland

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

⁴⁴ HC Col 56WS, 31 March 2009.

Appendix two

Further information about the UK's NPM

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

Laura Paton
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HM Inspectorate of Prisons
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Information about the role of each member may also be found in an online database of the UK NPM members, compiled and hosted by the Human Rights Implementation Centre at the University of Bristol. Visit www.bristol.ac.uk/law/research/centres-themes/hric/hricnmpmukdatabase/index.html

England and Wales

HM Inspectorate of Prisons
www.justice.gov.uk/about/hmi-prisons/index.htm

Independent Monitoring Boards
www.imb.gov.uk

Independent Custody Visiting Association
www.icva.org.uk

HM Inspectorate of Constabulary
www.hmic.gov.uk

Care Quality Commission
www.cqc.org.uk

Healthcare Inspectorate Wales
www.hiw.org.uk

Children's Commissioner for England
www.childrenscommissioner.gov.uk

Care and Social Services Inspectorate Wales
www.cssiw.org.uk

Office for Standards in Education
www.ofsted.gov.uk

Scotland

HM Inspectorate of Prisons for Scotland
www.scotland.gov.uk/Topics/Justice/public-safety/offender-management/offender-custody/Prisons/hmip

HM Inspectorate of Constabulary for Scotland
www.scotland.gov.uk/Topics/Justice/public-safety/Police/local/15403

Scottish Human Rights Commission
www.scottishhumanrights.com

Mental Welfare Commission for Scotland
www.mwscot.org.uk

Scottish Commission for the Regulation of Care
www.scswis.com

Northern Ireland

Independent Monitoring Boards (Northern Ireland)
www.imb-ni.org.uk

Criminal Justice Inspection Northern Ireland
www.cjini.org

Regulation and Quality Improvement Authority
www.rqia.org.uk

Northern Ireland Policing Board Independent Custody Visiting Scheme
www.nipolicingboard.org.uk/index/publications/custody-visitors.htm

Appendix three

List of abbreviations

CC	Care Commission
CJINI	Criminal Justice Inspection Northern Ireland
CQC	Care Quality Commission
CSSIW	Care and Social Services Inspectorate Wales
HIW	Healthcare Inspectorate Wales
HMCIPS	Her Majesty's Chief Inspector of Prisons for Scotland
HMIC	Her Majesty's Inspectorate of Constabulary
HMICS	Her Majesty's Inspectorate of Constabulary for Scotland
HMIP	Her Majesty's Inspectorate of Prisons
HMIPS	Her Majesty's Inspectorate of Prisons for Scotland
ICVA	Independent Custody Visiting Association
ICVS	Independent Custody Visitors Scotland
IMB	Independent Monitoring Boards
IMBNI	Independent Monitoring Boards (Northern Ireland)
MWCS	Mental Welfare Commission for Scotland
NHS	National Health Service
NIPBICVS	Northern Ireland Policing Board Independent Custody Visiting Scheme
NPM	National Preventive Mechanism
OCC	Office of the Children's Commissioner
Ofsted	Office for Standards in Education, Children's Services and Skills
OPCAT	Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
RQIA	Regulation and Quality Improvement Authority
SHRC	Scottish Human Rights Commission
SPT	Subcommittee for the Prevention of Torture
UKBA	United Kingdom Border Agency
YOI	Young offender institution



The image used on pages 6, 10, 16, 48, 50 and 54 is a detail from Portension on Prison Sheet, winner of the Antigone Foundation Bronze Award for Drawing at the 2011 Koestler Awards. The Koestler Trust is a prison arts charity, inspiring offenders, secure patients and detainees to take part in the arts, work for achievement and transform their lives. For more information visit: www.koestlertrust.org.uk

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