Monitoring places of detention

Eleventh **Annual Report**
of the United Kingdom's
National Preventive Mechanism
1 April 2019 – 31 March 2020

CP 366

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Introduction by John Wadham, NPM Chair

In the National Preventive Mechanism's (NPM) 11th Annual Report, covering the reporting year 2019 to 2020, we present an overview of the political, policy and legislative developments regarding places of detention and deprivation of liberty. We bring together NPM members' findings from the year on the different areas of detention that they monitor. We also document key developments for NPM members and the NPM Secretariat, and highlight important international events that have taken place, such as the first ever visit from the UN's Subcommittee for Prevention of Torture and Committee Against Torture's periodic review of the UK.

Members' findings on places of detention from the year show a mixed picture. With regard to prisons, NPM members in Scotland identified a number of human rights issues, including levels of overcrowding and understaffing, that caused significant concern. Criminal Justice Inspection Northern Ireland (CJINI) and the Regulation and Quality Improvement Authority (RQIA) this year published a thematic review on the safety of prisoners, which identified some important improvements in how vulnerable prisoners are treated. Drugs remained a problem across the Northern Ireland prison estate. In England and Wales, NPM members found poor levels of safety in many prisons. I am especially concerned about the rate of self-harm among prisoners: incidents reached yet another record high in England and Wales of 64,552 in the 12 months to March 2020, up 11% (57,968 incidents) from the 12 months to March 2019.[1]

NPM members also raised concerns about the detention of people with a mental health problem, a learning disability and/or autism. The Care Quality Commission's (CQC) interim report on the subject found that many services were unable to meet the needs of patients as staff lacked the necessary training and skills. Worryingly, a high proportion of the patients CQC visited were held in segregation. Healthcare Inspectorate Wales (HIW) also found that some secure mental health facilities in Wales had serious maintenance issues which had not been addressed, resulting in patients living in unsafe and undignified conditions.

Our Annual Report also notes positive developments that have occurred across the detention estate. In particular, the NPM welcomes the announcement of an independent public inquiry into the allegations of abuse at Brook House Immigration Removal Centre. Similarly, the NPM supports the Scottish Government's commitment to conduct an inquiry into the

1 Ministry of Justice (MoJ), July 2020, Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2020 Assaults and Self-harm to March 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/905064/safety-in-custody-q1-2020.pdf [accessed 10/11/2020]; MoJ, July 2019, Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2019 Assaults and Self-harm to March 2019, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/820627/safety-in-custody-q1-2019.pdf [accessed 10/11/2020]

death of Sheku Bayoh, who died in police custody in Scotland in May 2015. I hope these investigations provide lessons to prevent the same cases happening again.

Another significant event from the reporting year was the first ever visit to the UK by the UN's Subcommittee on the Prevention of Torture (SPT). The SPT is a UN treaty body, made up of Independent Experts on protecting the rights of people in detention. It plays an important role in advising and assisting NPMs and governments around the world in carrying out the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) mandate.

A delegation from the SPT conducted the visit to the UK in September 2019. I was delighted when the SPT announced this visit, and it was a privilege to have them work with the UK NPM. During the visit, we were able to discuss some of our pressing concerns with the SPT, related to both the treatment of people in detention and the lack of legislation for the NPM. The committee shadowed NPM members on various inspections and visits, conducted their own visits to places of detention and held meetings with government officials, national human rights institutions and third sector organisations with expertise in detention-related issues. This year's Annual Report outlines where the SPT visited and discusses the importance of this international scrutiny for the NPM and UK. As members of the UK NPM work together on how best to respond to the SPT report published after the UN's visit, we look forward to developing the ways in which we carry out our preventive mandate.

The end of the reporting year was dominated by the coronavirus (COVID-19) pandemic. Since then, people across the UK have been in various levels of 'lockdown'. As noted by the NPM and international human rights organisations, people in detention and deprived of their liberty were, and still are, one of the groups most vulnerable to the virus and the associated severe restrictions in places of detention. Although much of the work NPM members have done to monitor the situation for people in detention during this difficult time has taken place outside of the reporting year, occurring after March 2020, our Annual Report touches on how we responded to COVID-19. The NPM will publish a comprehensive report on the impact of the virus across all types of detention settings in the UK in due course.

Evidently, 2019–20 was an important year for the UK NPM. In the year since we celebrated our 10th anniversary, we have continued to exercise our preventive role in a busy and difficult context, which involved scrutiny from a UN torture prevention body and unprecedented challenges related to COVID-19. As Chair of the NPM, I feel proud of the difference made by the NPM and its 21 members, the details of which are set out in this year's Annual Report.

John Wadham
Chair
UK National Preventive Mechanism

Section one
Context

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

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

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

To carry out its monitoring role effectively, the NPM must:

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

Additionally, the NPM must have the power to:

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

The NPM must also liaise with the Subcommittee on Prevention of Torture (SPT), an international body established by OPCAT with both operational functions (visiting places of detention in states parties and making recommendations regarding the protection of detainees from ill-treatment) and advisory functions (providing assistance and training to states parties and NPMs). The SPT comprises 25 independent and impartial experts from around the world and publishes an annual report on its activities.[2] As of November 2020, there were 90 states parties to OPCAT and 76 designated NPMs.[3]

2 All annual reports, including the most recent Annual Report which covers the work carried out by the SPT in 2016, are available on the website of the Office of the High Commissioner for Human Rights: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=12&DocTypeID=27 [accessed 08/01/2020].

3 United Nations Treaty Collection, 'Chapter IV: 9. b Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment', status as at 08/01/2020, https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9-b&chapter=4&clang=_en [accessed 08/01/2020]; Association for the Prevention of Torture, OPCAT database, available at: http://www.apt.ch/en/opcat-database/ [accessed 01/12/2019].

The UK's National Preventive Mechanism

The UK ratified OPCAT in December 2003 and designated a number of organisations to form the UK NPM in March 2009. Designation was the sole responsibility of the UK government and it chose to designate multiple existing bodies rather than create a new, single-body NPM. This decision took into account the fact that many types of detention in the UK were already subject to monitoring by independent bodies, as envisaged by OPCAT, and the different political, legal and administrative systems in place in the four nations that make up the UK. The members of the NPM were designated by ministerial statement to Parliament but without any specific legislative underpinning, a fact which has been strongly criticised by the United Nations.[4] There are now 21 bodies designated to the NPM; the most recent designation was for the Independent Reviewer of Terrorism Legislation on 12 January 2017.[5]

Scotland

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

Northern Ireland

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

England and Wales

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

United Kingdom

Independent Reviewer of Terrorism Legislation (IRTL)

4 Letter to John Wadham from Head of SPT European Regional Team, January 2018, https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2019/01/2.-2018.01.29-reply-to-the-NPM-of-UK-copy-002.pdf [accessed 14/01/2019]

5 Further information on the process of designation and a link to the Written Ministerial Statement can be found on the website of the NPM at https://www.nationalpreventivemechanism.org.uk/about/background/ [accessed 08/01/2020].

The bodies which make up the UK NPM monitor different types of detention across the jurisdictions, including prisons, young offender institutions (YOIs), police custody, court custody, customs custody facilities, secure accommodation for children, immigration detention facilities, mental health and military detention, as follows:[6]

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

6 Deprivation of liberty legal safeguards apply only to England and Wales as part of the Mental Capacity Act 2005, but organisations in Scotland and Northern Ireland visit and inspect health and social care facilities where people may be deprived of liberty.

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

UK NPM members do not have provisions in their legislation to inspect or visit extraterritorial places of detention or the Overseas Territories (OTs) or Crown Dependencies (CDs) of the UK. No members of the UK NPM have powers to inspect military detention overseas. The NPM does not have access to any information about places of detention overseas, either under control of the military or otherwise.

The NPM's twice-yearly business meetings are its main forum for members to share findings, best practice, experiences and lessons from monitoring different types of detention and different jurisdictions. The NPM business plan is agreed and monitored at these meetings and other decisions which require the input of all members are made. This reporting year, business meetings were held in November 2019 in Edinburgh and in March 2020 in Belfast.

NPM Chair

The NPM's independent Chair is appointed by NPM members. John Wadham took up the role in 2014, having been appointed for a four-year term. He was appointed for a second four-year term in April 2018. The role of the Chair is to advise and support the NPM in fulfilling its mandate, including:

- chairing the NPM steering group meetings three to four times a year and NPM business meetings twice a year;
- supporting NPM members in developing and implementing NPM work and in fulfilling their NPM responsibilities; and
- speaking publicly on behalf of the NPM and representing the NPM at meetings with external stakeholders.

The Chair also supports the NPM Secretariat in carrying out its role.

NPM Secretariat

The NPM's Secretariat is based at HMI Prisons and coordinates the UK NPM to help achieve the full and effective implementation of OPCAT in the UK. It comprises three employees who coordinate the NPM with the purpose of:

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

NPM steering group

The NPM steering group oversees the overall strategy and activities of the NPM. Its five members meet regularly and are representative of members in all four nations of the UK and, as far as possible, of the different remits of organisations that make up the NPM.

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

In the reporting year, the steering group met three times. As of March 2020, the membership was as follows:

- Peter Clarke, HM Chief Inspector of Prisons, HMI Prisons;
- Rachel Lindsay, Inspector, CJINI;
- John Powell, Head of Regulations and Mental Health, HIW;
- Judith Robertson, Chair, SHRC; and
- Dame Anne Owers, National Chair, IMB.

NPM sub-groups

Since the NPM was designated, its members have taken the initiative to establish thematic sub-groups which allow them to strengthen collaboration, share information and prioritise topics of particular relevance to their NPM mandate. The NPM has four sub-groups which worked throughout the year.

The NPM's newest sub-group is the police sub-group, which examines cross-cutting issues in police custody across the four nations. The sub-group was established because NPM members who visit police custody recognised that the issues faced by people in short-term detention are often different from those held in longer-term detention. Members decided that a dedicated forum in which custody visitors and inspectors could discuss detention in police custody, including detention under terrorism legislation, would be beneficial. The police sub-group shares good practice and identifies areas of concern in police custody units. The police sub-group met in June 2019 and January 2020. The sub-group is organised and chaired by ICVA.

The Scottish sub-group met twice during the year, in October 2019 and February 2020. The group coordinates NPM activities in Scotland, provides support to NPM members, raises the profile of the work of the NPM and improves liaison with the Scottish Government. During the reporting year the group was chaired by the then Scottish member of the NPM steering group, Colin McKay, Chief Executive of the MWCS. The Scottish sub-group is supported by a part-time NPM Scottish Assistant Coordinator. As of March 2020, Judith Robertson, Chair of the SHRC, took over as Chair of the Scottish sub-group.

The mental health sub-group, which brings together the NPM members that have responsibility for monitoring mental health detention in the UK, met twice during the year, in April and November 2019. This sub-group provides an opportunity for organisations with responsibilities for the monitoring and protection of people in health and social care detention settings to work collaboratively on issues with specific mental health impacts. The group is chaired by Mat Kinton, a National Mental Health Act Policy Advisor at CQC.

In 2019–20, the NPM sub-group which focuses on children and young people in detention continued to serve as a way for NPM members to exchange information and intelligence, and to consider joint work on issues affecting detained children. The group is chaired by staff from the CCE and met in April and October 2019.

COVID-19

In March 2020, at the end of the reporting year, the UK government imposed lockdown measures to manage the outbreak of coronavirus (COVID-19).

The COVID-19 pandemic poses a significant threat to the rights of people in detention. People in detention and deprived of their liberty are more vulnerable to infection because of the inherent risks in places of detention, such as the difficulty of maintaining physical distancing in close confinement. People in detention are also wholly reliant on the state for care and are likely to be severely impacted by restrictions in place to stop the spread of COVID-19. The role of visiting bodies is crucial during COVID-19, as detainees are placed under more restrictions that may undermine their human rights.

In February 2020, the NPM wrote to the SPT for advice on monitoring places of quarantine (also referred to as supported isolation facilities). We received helpful advice from the SPT which made it clear that places of quarantine used to prevent the spread of COVID-19 fall within the scope of OPCAT.[7] Later advice from the SPT also indicated that NPMs must continue their visits to places of detention during COVID-19, recognising that there will be necessary limitations to the scope of visits, to keep people living and working in detention, and those carrying out visits, safe.[8]

In March 2020, the NPM wrote to the Secretary of State for Justice Robert Buckland QC MP to outline our concerns for people in detention.[9] We also wrote to Cabinet Secretary for Justice Humza Yousaf MSP and Justice Minister Naomi Long MLA.[10] Our letters to government emphasised key human rights concerns for people in detention, such as increased isolation and potential solitary confinement, the inherent challenge of physical distancing in places of detention and the loss of in-person social visits.

At the beginning of April 2020, we published a short factsheet detailing the work NPM members quickly developed to ensure independent oversight and scrutiny continued in places of detention.[11] In the factsheet, we outlined our commitment to the principle of 'do no harm': NPM members must not put detainees or staff in places of detention at risk by spreading the virus through inspection or monitoring visits; equally we should not put our own staff or volunteers at risk of exposure.

7 UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, February 2020, Advice of the Subcommittee on Prevention of Torture to the National Preventive Mechanism of the United Kingdom of Great Britain and Northern Ireland regarding compulsory quarantine for Coronavirus, adopted at its 40th session (10 to 14 February 2020), https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2020/02/2020.02.25-Annexed-Advice.pdf-V2.pdf [accessed 27/08/2020]

8 UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, March 2020, Advice of the Subcommittee on Prevention of Torture to States Parties and National Preventive Mechanisms relating to the Coronavirus Pandemic (adopted on 25 March 2020), https://www.ohchr.org/Documents/HRBodies/OPCAT/AdviceStatePartiesCoronavirusPandemic2020.pdf [accessed 27/08/2020]

9 UK NPM, March 2020, Letter from NPM Chair John Wadham to Robert Buckland QC MP regarding the rights of people in detention during COVID-19, https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2020/03/NPM-letter-to-Robert-Buckland-re-COVID19-300320.docx-WEB-2.pdf [accessed 27/08/2020]

10 UK NPM, April 2020, Letter from NPM Chair John Wadham and NPM Scottish sub-group Chair Judith Robertson to Humza Yousaf MSP regarding the rights of people in detention during COVID-19 https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2020/04/NPM-letter-to-Cabinet-Secretary-for-Justice-re.-COVID-19.pdf [accessed 27/08/2020]; UK NPM, April 2020, Letter from NPM Chair John Wadham to Justice Minister Naomi Long MLA regarding the rights of people in detention during COVID-19 https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2020/04/NPM-letter-to-Naomi-Long-re-COVID-160420.pdf [accessed 27/08/2020]

11 UK NPM, April 2020, Factsheet: The UK National Preventive Mechanism – preventing ill-treatment in the context of COVID-19, https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2020/04/WEB-NPM-member-approaches-for-website-.pdf [accessed 27/08/2020]

Since the outbreak of COVID-19, the NPM has made significant efforts to continue monitoring places of detention. Some approaches to monitoring places of detention across the NPM in the context of the COVID-19 pandemic include:

- carrying out on-site visits to places of detention. Some members have adapted their methodology to perform shorter and more focused visits. In many cases, these visits will be based on data from a range of sources and focus on a smaller number of themes, such as safety in places of detention;
- using confidential phone hotlines, as well as video and online services and technology, to enable direct independent contact with people in detention;
- monitoring data on detention requested at a national level and from individual detention establishments;
- working with non-governmental organisations (NGOs), advocacy groups and other members of civil society to gather information about the situation in detention, and to contact people in detention; and
- issuing regular reports on findings from on-site visits and remote monitoring, which includes virtual visits and data collection.

The NPM began collating members' evidence on the impact of COVID-19 in April 2020. We aim to produce a comprehensive report on the impact of the virus on people in all types of detention in the UK in the next reporting year.

Political context, policy and legislative developments

The political context in 2019–2020

Prior to the COVID-19 pandemic, political discourse in the UK continued to be largely focused on the UK's departure from the European Union. While the Conservative Party remained in power after the general election in December 2019, there were some notable shifts in policy. The Queen's Speech in December 2019 included government commitments to: reform the Mental Health Act 1983 in England and Wales; increase time served under custodial sentences for the most serious offences in England and Wales; and reform the immigration system across the UK.[12]

The new government also pledged to establish a Royal Commission to review and improve the efficiency and effectiveness of the criminal justice process and establish a Constitution, Democracy and Rights Commission as part of a process of potentially amending the Human Rights Act and examining the relationship between the government, Parliament and the courts.[13]

In January 2020, the British and Northern Irish governments reached an agreement to restore devolved government in Northern Ireland after a three-year hiatus. The New Decade, New Approach deal included commitments for the Executive to publish a Mental Health Action Plan by March 2020, along with a Mental Health Strategy by December 2020, and to address the findings in recently published reports from CJINI (see 'Deprivation of Liberty Safeguards', p.15).[14]

12 HM Government, December 2019, *Speech: Queen's Speech December 2019*, https://www.gov.uk/government/speeches/queens-speech-december-2019 [accessed 24/08/2020]

13 House of Lords Library, March 2020, *Constitution, Democracy and Rights Commission*, https://lordslibrary.parliament.uk/research-briefings/lln-2020-0089/ [accessed 24/08/2020]

14 UK Government and Irish Government, January 2020, *New Decade, New Approach*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856998/2020-01-08_a_new_decade__a_new_approach.pdf, [accessed 21/10/2020]

The Commission on Justice in Wales released its landmark report, *Justice in Wales for the People of Wales*, in October 2019. The Commission recommended full legislative devolution for the justice system. The report argued that guidance for the inspection of police, prisons and probation services should be determined in Wales. The report concluded that the people of Wales are being let down by the system in its current state, and that they do not have the benefit which the people of Scotland, Northern Ireland and England have of justice being an integral part of overall policy making, particularly those which are already devolved to Wales such as health, education and social welfare.[15]

The Counter-Terrorism and Border Security Act 2019 received Royal Assent on 12 February 2019. The IRTL, Jonathan Hall QC, noted in his latest Annual Report (published in March 2020) that this is a major piece of updating legislation, amending both Terrorism Acts (2000 and 2006), which were introduced in the immediate aftermath of the London Bridge attack of 2017.[16] Some detention-related provisions in the 2019 Act include increasing the maximum penalty for certain preparatory terrorism offences to 15 years imprisonment.

The Counter-Terrorism and Border Security Act also suspends the detention clock for those arrested under section 41 of the Terrorism Act 2000 where they are admitted to hospital.[17]

Towards the end of the reporting period, the COVID-19 pandemic began to significantly impact both detention settings and the scrutiny practices of NPM members. The Coronavirus Act 2020 received Royal Assent in the UK Parliament on 25 March 2020.[18] Following this, various regulations were passed which implemented lockdown rules. The Act made temporary changes to the way in which local authorities provide care and support and to mental health legislation, although the latter were never put into practice and as of September 2020 were agreed to be withdrawn.[19] The Act also encouraged the use of video technology in court hearings.

Prison regimes were severely restricted and social visits were stopped temporarily.[20] In late March, fears around safety and well-being during the pandemic, particularly for those in prisons and immigration detention, led to calls from civil society for the release of large numbers of

15 The Commission on Justice in Wales, October 2019, *Commission on Justice in Wales report*, https://gov.wales/commission-justice-wales-report, [accessed 24/08/2020]

16 The Independent Reviewer of Terrorism Legislation, *The Terrorism Acts in 2018*, https://terrorismlegislationreviewer.independent.gov.uk/wp-content/uploads/2020/03/Terrorism-Acts-in-2018-Report-1.pdf [accessed 10/11/2020]

17 UK Government, February 2019, *Counter-Terrorism and Border Security Act 2019*, https://www.legislation.gov.uk/ukpga/2019/3/section/18/enacted, [accessed 01/12/2020]

18 UK Government, March 2020, *Coronavirus Act 2020*, https://services.parliament.uk/bills/2019-21/coronavirus.html, [accessed 24/08/2020]

19 Hansard, 30 September 2020, Volume 681, col 393; Coronavirus Act 2020 (Review of Temporary Provisions)

20 In England and Wales *The Prison and Young Offender Institution (Coronavirus) (Amendment) Rules 2020* came into force 6 April 2020, available: https://www.legislation.gov.uk/uksi/2020/400/introduction/made [accessed 07/08/2020]. In Scotland *The Prisons and Young Offenders Institutions (Coronavirus) (Scotland)* Amendment Rules 2020 came into force on 15 June 2020, available: https://www.legislation.gov.uk/ssi/2020/175/introduction/made [accessed 07/08/2020]. In Northern Ireland, T*he Social Security (Coronavirus) (Prisoners) Regulations (Northern Ireland) 2020* came into force 8 April 2020, available: https://www.legislation.gov.uk/nisr/2020/63/introduction/made [accessed 07/08/2020].

prisoners and detainees.[21] Across the four nations, some early release schemes were established. The NPM will soon publish a report on detention during COVID-19 (see 'COVID-19', p.12 and 'Looking ahead to 2020–21', p.78).

A public inquiry into the death of Sheku Bayoh, who died in police custody in Scotland on 3 May 2015, was announced in November 2019. The public inquiry into Sheku Bayoh's death (see 'Deaths in police custody', p.36) will consider the role of race in the treatment he received from the police. In England and Wales, the findings of the Lammy Review on the treatment of, and outcomes for, black and minority ethnic individuals in the criminal justice system (2017), as well as those of the Angiolini Review into deaths and serious incidents in police custody (2017), remain relevant, with recommendations on racial disparities in the criminal justice system and on the processes surrounding deaths and serious incidents in police custody still in progress. In February 2020, the UK government provided an overview of the work undertaken to address the Lammy Review and the over-representation of those from black and minority ethnic backgrounds in the criminal justice system.[22] The review of the Mental Health Act 1983, published in December 2018, also highlighted the need for action on racial disparities in the mental health system. We await a white paper on a new Mental Health Act.

Mental health and social care

Mental health law, policy and practice were rapidly evolving issues in the reporting year in the UK. There was a particular focus on the legislative framework and oversight of the detention of people with learning disabilities and autism, as well as on other secure care.

Deprivation of Liberty Safeguards

In December 2019, Northern Ireland commenced the phased implementation of a new statutory framework for Deprivation of Liberty Safeguards (DoLS) created under the Mental Capacity Act (NI) 2016. DoLS are accompanied by interim codes of practice.[23] To manage the first phase of the commencement of the Act, the Mental Health (NI) Order 1986 remains in place with a system that uses both the 1986 Order and the 2016 Act providing statutory frameworks for DoLS. The new Act fuses mental health and mental capacity legislation in Northern Ireland, creating a single legislative framework for deprivation of liberty. RQIA has updated its inspection processes to provide assurances that safeguards are in place for service users and patients who lack capacity and who are deprived of their liberty.

The Mental Capacity (Amendment) Act 2019, which covers England and Wales, received Royal Assent in May 2019, but the enactment of its provisions has been delayed and the date for full implementation is currently timetabled for April 2022.

21 For example: INQUEST, March 2020, *NEWS: Powerful coalition call on government to immediately reduce number of people in detention settings*, available: https://www.inquest.org.uk/covid-19-letter [accessed 24/08/2020]; Prison Reform Trust, April 2020, *News: PRT and Howard League call for further early release to protect prisoners, staff and wider public*, available: http://www.prisonreformtrust.org.uk/PressPolicy/News/vw/1/ItemID/838 [accessed 24/08/2020]; Detention Action, March 2020, *Letter to MPs: COVID-19 set to cause human tragedy in immigration detention*, available: https://detentionaction.org.uk/2020/03/21/letter-to-mps-covid-19-set-to-cause-human-tragedy-in-immigration-detention/ [accessed 24/08/2020]; Council of Europe, March 2020, *Statement: Commissioner calls for release of immigration detainees while Covid-19 crisis continues*, available: https://www.coe.int/en/web/commissioner/-/commissioner-calls-for-release-of-immigration-detainees-while-covid-19-crisis-continues [accessed 24/08/2020]

22 UK Government, February 2020, Tackling Racial Disparity in the Criminal Justice System, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881317/tackling-racial-disparity-cjs-2020.pdf, [accessed 14/10/2020]

23 Northern Ireland Department of Health, November 2019, Mental Capacity (NI) Act Codes of Practice, https://www.health-ni.gov.uk/mca-codes-practice [accessed 30/10/2020]

The Mental Capacity (Amendment) Act 2019 replaces the current Deprivation of Liberty Safeguards (DoLS) with a new scheme known as Liberty Protection Safeguards (LPS), and a public consultation on the draft regulations and Code of Practice for LPS is planned. The Act reforms the process for authorising arrangements for a person's care or treatment which amount to a deprivation of their liberty, where the person does not have the capacity to consent to these arrangements, amending the Mental Capacity Act 2005.

A key change is that LPS may be authorised in any setting in which the criteria are met (as opposed to DoLS applying to care homes and hospitals only). This includes settings like supported living or domiciliary care, which are currently regulated by CQC. It also includes some settings that are not within the scope of CQC's regulation and oversight, such as private residences where a person may need to be deprived of their liberty in order to enable arrangements for their care and treatment, yet not be in receipt of services regulated by CQC. Once LPS are in place, NHS hospitals, Clinical Commissioning Groups and local authorities may be authorisers of them. As well as this, 16–17-year-olds will be in scope of LPS, bringing the age range covered by LPS in line with other provisions in the Mental Capacity Act 2005. The CCE and Ofsted have engaged with the Department of Health and Social Care (DHSC) on this particular development. CQC worked with the DHSC and key stakeholders throughout the reporting year to discuss how it might adapt its monitoring and regulation to include the increased range and number of detention settings under LPS.

In the meantime, the DoLS scheme continues to operate. Now over 10 years old, the current DoLS code of practice does not reflect impacting case law, such as the 2014 Supreme Court ruling on the case of *P v. Cheshire West* which prompted the creation of the Mental Capacity (amendment) Act.[24] More recently, in September 2019 the Supreme Court issued a judgement on detention and parental consent, *In the matter of D (A Child)*, ruling that parental responsibility is not sufficient for lawful authority for the deprivation of liberty of a 16- or 17-year-old child who lacks capacity to consent.[25] Lawful deprivation of liberty would therefore need to come through other means, and parental consent is not an option to consider before using detention under the Mental Health Act 1983 as current guidance implies.

Secure hospitals for people with a learning disability and autistic people

In May 2019, a BBC *Panorama* documentary exposed a culture of abuse at Whorlton Hall, a secure hospital for people with a learning disability and autistic people in County Durham, causing widespread concern both about the treatment and why it had not been uncovered in previous inspections. Following the broadcast of the documentary, CQC took steps to look at how it could improve its inspection and monitoring in 'closed cultures'.[26] CQC commissioned two independent reviews considering the situation at Whorlton Hall. In January 2020, the first independent review, by David Noble, was published, considering actions taken by CQC following an inspection of Whorlton Hall in 2015. The review found CQC's decisions to

24 In *P v Cheshire West* three individuals with severe learning disabilities were living in arrangements deemed by the court to represent a deprivation of liberty. The ruling placed increasing burdens on local authorities and health and social care practitioners administering the DoLS. The Law Commission subsequently recommended that DoLS be abolished and proposed a replacement scheme set out in a draft Bill.

25 UK Supreme Court, September 2019, *In the matter of D (A Child)*, https://www.supremecourt.uk/cases/docs/uksc-2018-0064-judgment.pdf [accessed 24/08/2020]

26 For more information see: CQC (webpage), Our work on closed cultures, available: https://www.cqc.org.uk/publications/themes-care/our-work-closed-cultures [accessed 24/08/2020]

not publish the 2015 inspection report prior to the 2016 reinspection, and to not follow its own internal investigation, were wrong. The review made seven recommendations around processes for CQC inspections, quality assurance, legal policies and internal whistleblowing.[27]

The second independent review commissioned by CQC, by Professor Glynis Murphy, was published in March 2020. It considered CQC's regulation of Whorlton Hall between 2015 and 2019. The review identified several reasons why CQC did not detect the abusive behaviour of staff and found that while CQC followed its procedures over this period, several improvements are needed to strengthen its approach to inspection and regulation. These include changes to inspection methodology, more unannounced and evening inspections, swifter publication of reports, improved response to abuse allegations and whistleblowing and a more flexible inspection approach where intelligence indicates there is a risk.[28] In response, CQC has set up a dedicated team responsible for incorporating these recommendations into CQC policy. This team includes external stakeholders as well as people who use CQC services and their families.

Also responding to the Whorlton Hall documentary and wider public concern, the Joint Committee on Human Rights (JCHR) undertook an inquiry into the detention of young people with a learning disability and autistic people, published on 1 November 2019. The Committee called for changes to the Mental Health Act 1983 to protect those detained from the 'horrific reality' found in some mental health hospitals. The Committee described the 'grim' and predictable pathway to inappropriate detention in potentially 'brutal' circumstances for children and young people. It also recommended substantive reforms to CQC's inspection methodology.[29] The government's response to the JCHR reports on the detention of young people with a learning disability and autistic people and the implications of the government's COVID-19 response (from 12 June 2020) was published on 22 October 2020.[30]

In February 2020, the Equality and Human Rights Commission (EHRC) sent a pre-action protocol letter for judicial review against the Secretary of State for Health and Social Care over the repeated failure to move people with a learning disability and autistic people into appropriate accommodation. EHRC voiced concerns about the rights of more than 2,000 people with a learning disability and autistic people being detained in secure hospitals, often far away from home and for many years. The pre-action letter argued that the department has breached the European Convention of Human Rights (ECHR) for failing to meet the targets set in the Transforming Care programme and the Building the Right Support programme.

27 CQC, January 2020, News: CQC publishes independent review into its regulation of Whorlton Hall, https://www.cqc.org.uk/news/stories/cqc-publishes-independent-review-its-regulation-whorlton-hall [accessed 24/08/2020]

28 CQC, March 2020, *Press release: CQC publishes independent review into its regulation of Whorlton Hall between 2015 and 2019,* https://cqc.org.uk/news/stories/cqc-publishes-independent-review-its-regulation-whorlton-hall-between-2015-2019 [accessed 24/08/2020]

29 Joint Committee on Human Rights, November 2019, News: Human rights of many people with a learning disability and/or autism are being breached in mental health hospitals, available: https://committees.parliament.uk/committee/93/human-rights-joint-committee/news/91540/human-rights-of-many-people-with-a-learning-disability-andor-autism-are-being-breached-in-mental-health-hospitals/ [accessed 24/08/2020]

30 UK Government, October 2020, The Government Response to the Joint Committee on Human Rights reports on the Detention of Young People with Learning Disabilities and/or Autism and the implications of the Government's COVID-19 response, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/928520/Final_Web_accessible_Government_Response_to_the_JCHR_reports_on_the_Detention_of_Young_People_with_LDA.pdf [accessed 01/12/2020]

These targets included moving patients from inappropriate inpatient care to community-based settings and reducing the reliance on inpatient care for people with a learning disability and autistic people. EHRC also called for the immediate implementation of recommendations made by the JCHR and Rightful Lives' Eight Point plan.[31]

CQC published the interim report of its review of restraint, seclusion and segregation for adults and children, commissioned by the Secretary of State for the Department of Health and Social Care (DHSC), in May 2019.[32] It examined the experiences of people cared for in segregation on a mental health ward for children and young people or on a ward for people with a learning disability and/or autism. In response to CQC recommendations made in its interim report on restraint, seclusion and segregation in May 2019, DHSC agreed that there would be an immediate in-depth review of the care provided and the discharge plan for people with a learning disability and autistic people who are being nursed in segregation in specialist mental health and learning disability inpatient settings. DHSC is leading on this work with NHS England and NHS Improvement and has established a programme of Independent Care Education and Treatment Reviews (ICETRs). ICETRs provide a platform in which an independently chaired panel can raise key issues associated with individual care plans. Where serious concerns are identified, CQC can escalate issues to a local inspection team, make a safeguarding referral or conduct a targeted visit. From November 2019 to September 2020, 77 ICETRs took place.[33]

Reviews into mental health legislation

The government commissioned an independent review of the Mental Health Act 1983 in October 2017. The review was chaired by Professor Sir Simon Wessely. An interim report on the review was published in May 2018.[34] The review recommended wide-ranging legislative change. However, the publication of a white paper by the government is awaited. This has been delayed during COVID-19 and by the process of exiting the European Union. Guidance on the Mental Health Units (Use of Force) Act in England, known as Seni's Law and enacted in November 2018, is also awaited. This Act will increase protections and oversight of use of force in mental health settings in England. Civil society organisations and the family of Seni Lewis, who died in 2010 following prolonged restraint while a voluntary inpatient in a mental health unit, have criticised the ongoing delay in the enforcement of the Act.[35]

31 EHRC, February 2020, *Health Secretary faces legal challenge for failing patients with learning disabilities and autism*, https://www.equalityhumanrights.com/en/our-work/news/health-secretary-faces-legal-challenge-failing-patients-learning-disabilities-and [accessed 24/08/2020]

32 CQC, May 2020, *Interim report: Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism*, https://www.cqc.org.uk/publications/themed-work/interim-report-review-restraint-prolonged-seclusion-segregation-people [accessed 24/08/2020]

33 ICETR reviews are undertaken by a panel comprising of an independent chair, Expert by Experience, clinical expert, commissioner and Mental Health Act Reviewer (MHAR). The focus of the ICETR is to make recommendations to improve the quality of care and treatment for a patient and to identify any barriers to discharge. Following the ICETR, the independent chair is responsible for producing a report, which is sent to the provider and to its oversight panel, chaired by Baroness Hollins. This process also provides information to CQC, and where serious concerns are identified these are escalated to a local inspection team.

34 Independent Review of the Mental Health Act, May 2018, Interim Report: The Independent Review of the Mental Health Act, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/703919/The_independent_Mental_Health_Act_review__interim_report_01_05_2018.pdf [accessed 10/11/2020]

35 The Guardian, July 2020, *Parents of man who died after police restraint challenge delay over Seni's law*, https://www.theguardian.com/society/2020/jul/20/parents-of-man-who-died-after-police-restraint-challenge-delay-over-senis-law [accessed 24/08/2020]

A wide-ranging independent review of mental health law in Scotland, announced in March 2019, is ongoing, having opened with a public consultation in February 2020.[36] One particular area of interest is how legislation, including the Mental Health (Care and Treatment) (Scotland) Act 2003 and Mental Health (Scotland) Act 2015, meets modern human rights standards.

The *Independent review of learning disability and autism in the Mental Health Act in Scotland* was published in December 2019 and recommended major changes to improve compliance with human rights law. These include the recommendations that learning disability and autism should be removed from the definition of 'mental disorder' in the Act, and that the law include the description of disability from the UN Convention on the Rights of Persons with Disabilities. The review also recommends working towards a law that removes discrimination in detention and the introduction of a disability model to the criminal justice system to ensure fairness.[37]

The Scottish Government has also continued to coordinate work on the recommendations of the *Review of the arrangements for investigating the deaths of patients being treated for mental disorder*, published in December 2018, and the actions of its Suicide Prevention Action Plan from August 2018. As part of this work, MWCS continues to develop a system for investigating all deaths of patients who, at the time of death, were subject to an order either under the Mental Health (Care and Treatment) (Scotland) Act 2003 or part VI of the Criminal Procedure (Scotland) Act 1995, whether in hospital or in the community. MWCS has commenced detailed scoping and plans to consult on options for the revised system, before developing a business case and implementation plan for submission in June 2021.[38]

Another important review in Scotland during the year was an independent review of forensic mental health services, looking at how services are provided to people in secure hospitals and people who are not in hospital but are at risk of offending or have offended, including those in prisons.[39]

In April 2019, the Sentencing Council for England and Wales commenced a consultation on draft overarching principles for sentencing people with mental ill health, developmental disorders and neurological impairments. The resulting guidance was published in July 2020 and came into force on 1 October 2020.

36 For more information see the Scottish Mental Health Law Review website: https://www.mentalhealthlawreview.scot/ [accessed 24/08/2020]

37 Scottish Government, December 2019, *Independent review of learning disability and autism in the Mental Health Act* https://webarchive.nrscotland.gov.uk/20200313205853/https://www.irmha.scot/ [accessed 24/08/20]

38 MWCS Deaths in Detention Reviews webpage, https://www.mwcscot.org.uk/policy-and-research/deaths-detention-reviews [accessed 24/08/2020]

39 Scottish Government, September 2019, *Forensic mental health services independent review: terms of reference*, https://www.gov.scot/publications/forensic-mental-health-services-independent-review-terms-of-reference/ [accessed 24/08/2020]

Prisons

Significant concerns around safety, overcrowding and deaths in prisons across the UK remain. A range of reviews, policies and plans were published in 2019–20, while new legislation has focused on sentencing changes, with some developments around prisoner voting rights.

In our 10th Annual Report we noted that in February 2019 the then Secretary of State for Justice for England and Wales, David Gauke, acknowledged the high rate of imprisonment and proposed that caution be exercised in continuing to increase sentences. He also accepted there was a very strong case for abolishing short prison sentences (with some exceptions) and making greater use of community orders, though no commitment was made to legislate.[40] Since then there has been a shift in the rhetoric around sentencing and crime, with a move away from discouraging short sentences in England and Wales.

New legislation concerning prisoners

In February 2020, further terror legislation came into force following the terrorist attacks at Fishmongers Hall, London and in Streatham which were committed by individuals who had previously been convicted of terror offences and released automatically at the halfway point of their sentence on licence. Emergency legislation was introduced under the Terrorist Offenders (Restriction of Early Release) Act 2020. This legislation retrospectively ended automatic early release for terrorist offenders in the UK serving standard determinate sentences, requiring them to spend a minimum of two-thirds of their term in prison before being considered for release by the Parole Board.

The UK government intends to increase further the length of prison sentences for those convicted of terrorist offences under the Counter-Terrorism and Sentencing Bill 2020. This includes the creation of a new 'Serious Terrorist Sentence, with a minimum 14-year jail term,' for dangerous offenders who risked multiple lives as a result of their offending. The IRTL called for the publication of statistics on the success rate of applications for warrants of further detention under Schedule 8 to the Terrorism Act 2020. The government accepted this recommendation in its formal response published in October 2020.[41] The IRTL also undertook an independent review of multi-agency public protection arrangements (MAPPA), which was published in May 2020.[42]

As well as the changes to sentencing and parole brought in by terror legislation, the Release of Prisoners (Alteration of Relevant Proportion of Sentence) Order 2019 moves the release point in England and Wales from halfway through a custodial sentence to two-thirds of the way through, for those convicted of relevant violent and sexual offences. This Order was part of the current government's election manifesto and follows the significant controversy around the release on licence of a taxi driver, found guilty of 19 sexual offences, who had served the minimum term of a (now repealed) indeterminate 'Imprisonment for Public Protection' sentence. The Order came into force on 1 April 2020 and its provisions have the effect of modifying the application of relevant sentences of imprisonment (under s. 237(1) of the Criminal Justice Act 2003)

40 MoJ, February 2019, 'Beyond prison, redefining punishment': David Gauke speech, https://www.gov.uk/government/speeches/beyond-prison-redefining-punishment-david-gauke-speech [accessed 24/08/2020]

41 UK Government, October 2020, Response to the operation of the Terrorism Acts in 2018 Report, https://www.gov.uk/government/publications/response-to-the-operation-of-the-terrorism-acts-in-2018-report, [accessed 01/12/2020]

42 This review was published May 2020, available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/913983/supervision-terrorism-and-terrorism-risk-offenders-review.pdf [accessed 14/10/2020]

where they are fixed-term sentences of seven years or more in length.[43]

The Management of Offenders (Scotland) Act 2019 received Royal Assent in July 2019, creating changes in the management of people serving sentences outside of prison. The Act strengthens powers of recall from home detention curfew (HDC) by introducing a new offence (of remaining unlawfully at large) and granting police greater powers to help apprehend anyone who absconds. It also enables courts to add electronic monitoring to a Community Payback Order, enabling the use of GPS and remote substance monitoring technology, in addition to the radio frequency technology currently used with curfew tags.[44] The new Act followed the publication of reviews of HDC by HMIPS and HMICS in 2018. There were further changes to the guidance on HDC in Scotland, published in December 2019. In May 2019, HMICS published *Strategic Review – an independent assessment of Police Scotland's response to a breach of Home Detention Curfew – progress review*, having conducted fieldwork in April and May 2019, testing the progress of the 16 recommendations.

Reviews into prison conditions in England and Wales

The House of Commons Justice Committee's report of its inquiry, *Prison Population 2022: planning for the future*, was published in April 2019. It found that over the past 25 years, the prison population in England and Wales has almost doubled in size, but that capacity has not kept pace with demand. The inquiry heard that staffing shortages and other disruptions have severely undermined the delivery of rehabilitative services in prisons. The Committee concluded that this creates immeasurable wasted costs and recommended an overarching strategy for reoffending with significant additional resources for cross-departmental provision.[45] Following this, in October 2019 the Justice Committee published the report of its inquiry on prison governance. Recommendations included a repeated recommendation that the Prisons and Probation Ombudsman (PPO), the national structure of Independent Monitoring Boards and the NPM should be put on a proper statutory footing.[46]

The Prison Performance Support Programme, a new intensive support programme which aims to help 'challenging' prisons to improve safety and rehabilitation, was introduced in February 2020. The Ministry of Justice (MoJ) reports that more staff, new technology and maintenance improvements will play a key role.[47] The initiative sits alongside the government's £2.75 billion investment plans, which focus on prison security, creating additional prison places and tackling pressing maintenance issues in existing

43 UK Government, The Release of Prisoners (Alteration of Relevant Proportion of Sentence) Order 2019, https://www.legislation.gov.uk/ukdsi/2019/9780111190524 [accessed 24/08/2020]

44 UK Government, Management of Offenders (Scotland) Act 2019, https://www.legislation.gov.uk/asp/2019/14/notes/division/4/1/1 [accessed 24/08/2020]

45 Justice Committee, April 2019, Prisons crisis: Government's current approach inefficient, ineffective and unsustainable, https://committees.parliament.uk/committee/102/justice-committee/news/99437/prisons-crisis-governments-current-approach-inefficient-ineffective-and-unsustainable/ [accessed 24/08/2020]

46 House of Commons Justice Committee, October 2019, *Prison Governance: First Report of Session 2019*, https://publications.parliament.uk/pa/cm201919/cmselect/cmjust/191/191.pdf [accessed 30/10/2020]

47 MoJ, February 2020, *Press release: New support plan to improve jails*, https://www.gov.uk/government/news/new-support-plan-to-improve-jails [accessed 24/08/2020]

prisons. The Prison Performance Support Programme follows on from the learning arising from the 10 Prisons Project, which invested over £10 million in 'challenging' prisons and focused on reducing violence and the availability of drugs. Statistics about the project published in August 2019 showed an overall reduction in assaults by 16% and a 50% reduction in positive drug tests.[48] However, four of the 10 prisons showed little or no improvement, and in one, HMP Wormwood Scrubs, violence had significantly increased. There was criticism of the project after an analysis of official data by the charity INQUEST highlighted that the number of deaths in the 10 prisons had increased by 20% (from 34 in the previous year to 41 during the first 11 months of the project).[49]

Since 2016, the MoJ has committed to creating 10,000 new prison places in England and Wales, to replace old accommodation. In March 2017, a number of projects were announced to meet this target, including the building of new prisons and expansion of existing ones across seven sites. To date there have been varying levels of progress. Construction began in Wellingborough in September 2019 for a new prison (HMP Five Wells) and a new houseblock at HMP Stocken was completed in 2019, yet plans for a prison in Port Talbot were withdrawn in January 2019 following strong community objections and the temporary closure and redevelopment of HMP Rochester and HMP Hindley have been delayed.[50] Further plans to close old prisons in poor condition are now on hold. In August 2019 the government made a further announcement that it would spend up to £2.5 billion to create the 10,000 prison places.[51] These 10,000 places, it said, would be in addition to the approximately 3,500 places created since the initial commitment was made in 2016.[52] The Justice Secretary said in October 2019 that the MoJ was aiming to reach the 10,000 figure by 2025.[53]

48 MoJ, August 2019, Press release: 10 Prisons Project sees drops in violence and drugs, https://www.gov.uk/government/news/10-prisons-project-sees-drops-in-violence-and-drugs [accessed 24/08/2020]

49 The Guardian, August 2019, *Deaths on the rise in 10 of toughest prisons in England and Wales*, https://www.theguardian.com/society/2019/aug/22/deaths-on-the-rise-in-10-of-britains-toughest-prisons [accessed 24/08/2020]

50 House of Commons Library, November 2019, *Briefing Paper: The Prison Estate*, http://researchbriefings.files.parliament.uk/documents/SN05646/SN05646.pdf [accessed 24/08/2020]

51 MoJ, August 2019, *10,000 extra prison places to keep the public safe*, https://www.gov.uk/government/news/10-000-extra-prison-places-to-keep-the-public-safe [accessed 24/08/2020]

52 House of Commons Justice Committee, September 2019, Letter from Justice Secretary, Robert Buckland to Chair of the Justice Committee, Bob Neil, https://old.parliament.uk/documents/commons-committees/Justice/correspondence/Letter-from-Robert-Buckland-Lord-Chancellor-on%20Settlement-for-2020-21.pdf [accessed 24/08/2020]

53 House of Commons Library, November 2019, *Briefing Paper: The Prison Estate*, http://researchbriefings.files.parliament.uk/documents/SN05646/SN05646.pdf [accessed 24/08/2020]

PAVA

Following a six-month pilot in 2017–18, a £2 million national rollout of PAVA spray to all prison officers in the closed adult male estate in England and Wales went ahead in 2019–20. PAVA is an incapacitant spray similar to pepper spray. Civil society organisations were concerned about the lack of public debate and consultation on this development, and had concerns around the disproportionate impact on black and minority ethnic people and those with disabilities in particular.[54] In August 2019, the EHRC funded a disabled prisoner's application for judicial review of the decision to make PAVA spray available to prison officers in the adult male prison estate. The EHRC stated that the MoJ had not adequately considered the potential impact on people who have mental health conditions or learning disabilities and was concerned that the pilot scheme exposed significant risks of unlawful use of the spray. Following the launch of the legal action, the MoJ carried out a more detailed equality impact assessment on the pilot which showed disproportionate use of force against younger people, black people and Muslim people. The MoJ subsequently made changes to the way it intends to roll out the spray, including strengthened safeguards and more robust training and guidance. In light of these commitments, the claimant in this case discontinued legal action.[55]

Reviews on women prisoners in England and Wales

The Female Offender Strategy for England and Wales was published in 2018 and its progress was reported to Parliament in June 2019. A key part of the strategy was the government's commitment to developing a 'residential women's centre' pilot in at least five sites across England and Wales, which it said offered a robust alternative to short custodial sentences. The MoJ has since concluded the first phase of consultation with local voluntary and statutory agencies, partners and providers to inform the scoping of the project. It also invested £5 million in community services for women in 2018–19 and 2019–20 and made a commitment to develop and publish a 'National Concordat on Female Offenders' by autumn 2019 (though this is still awaited).[56]

A review by Lord Farmer of the importance of strengthening female offenders' family and other relationships to prevent reoffending and reduce intergenerational crime was published in June 2019. The review examined practice in England and Wales and was a follow-up to a similar review of men's prisons. It found family and other relationships are 'utterly indispensable' and that supporting women to build and maintain healthy relationships is key to rehabilitation and reducing intergenerational crime. Lord Farmer noted that the focus on adverse childhood experiences, which runs through social policy in Wales, Scotland and Northern Ireland, needs to be given more salience in England. The review called for action across government departments to prevent adverse childhood experiences and

54 Prison Reform Trust, August 2019, Letter: Peter Dawson to Jo Farrar on PAVA, http://www.prisonreformtrust.org.uk/Portals/0/Documents/PAVA/Correspondence/2019.08.05%20-%20PD%20to%20Jo%20Farrar%20-%20PAVA.pdf [accessed 10/11/2020]

55 EHRC, August 2019, *Ministry of Justice to give prisoners greater protection during rollout of PAVA spray*, https://www.equalityhumanrights.com/en/our-work/news/ministry-justice-give-prisoners-greater-protection-during-rollout-pava-spray [accessed 24/08/2020]

56 House of Commons Library, July 2019, *Female Offender Strategy One Year On: Commons Debate Pack*, https://commonslibrary.parliament.uk/research-briefings/cdp-2019-0204/ [accessed 24/08/2020]

support early interventions which should not depend on the criminal justice system. He also recommended that the MoJ deploy prison-based social workers as part of a multidisciplinary custodial team and make improvements to visiting and the use of communications technology.[57]

Probation reforms in England and Wales

There have been major changes to the controversial Transforming Rehabilitation (TR) agenda in England and Wales, a model introduced in 2013 which overhauled the system for the resettlement of prisoners and handed the management of these contracts to community rehabilitation companies, largely in the private sector, leaving only the most serious offenders to be supervised by the National Probation Service. This decision followed a series of deeply critical reports, including from Dame Glenys Stacey, the then Chief Inspector of Probation, who described TR as 'irredeemably flawed'. HM Inspectorate of Probation reported in March 2019 that the TR model had led to 'a deplorable diminution of the probation profession and a widespread move away from good probation practice'.[58] In May 2019, the Justice Secretary announced major changes, including that all offender management work would be returned to the National Probation Service. Development of a new model is ongoing.

Reviews into prison conditions in Scotland

In Scotland, the visit by the Council of Europe's Committee for the Prevention of Torture (CPT) in 2018 raised serious concerns about the mental health care and treatment of women in prison in HMP & YOI Cornton Vale. In response, the MWCS conducted an investigation into the number of female prisoners who experienced delays in transfer from prison to hospital for mental health care and treatment. The report of this research will consider what changes are required to improve pathways from prison to mental health care for women across in the Scottish estate. In March 2020, Morrison Construction was announced as the contractor for the £54 million contract to build the replacement prison at Cornton Vale, with a smaller prison planned for around 80 women. This rebuild is part of a move towards community-based custody units for women.[59]

57 Lord Farmer, June 2019, *The Importance of Strengthening Female Offenders' Family and other Relationships to Prevent Reoffending and Reduce Intergenerational Crime*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/809467/farmer-review-women.PDF [accessed 24/08/2020]

58 HMI Probation, March 2019, Report of the Chief Inspector of Probation, https://www.justiceinspectorates.gov.uk/hmiprobation/inspections/report-of-the-chief-inspector-of-probation/ [accessed 10/11/2020]

59 BBC, March 2020, Contract awarded for £54m Cornton Vale women's prison rebuild, https://www.bbc.co.uk/news/uk-scotland-tayside-central-51835727 [30/10/2020]

Deaths in prisons in Scotland

In August 2019, the conclusion of the Fatal Accident Inquiry (FAI) into the death of Mr Marshall following an incident at HMP Edinburgh was published. Allan Marshall, who was 30 years old, died on 28 March 2015 following continual physical restraint by multiple prison officers over a period of 40 minutes. The Sheriff presiding over the FAI found Mr Marshall had suffered from an episode of Excited Delirium Syndrome that resulted from him forcefully resisting the restraint, with the cause of death recorded as hypoxic-ischaemic brain injury due to out-of-hospital cardiac arrest during physical restraint on a man with coronary artery atheroma. The Sheriff concluded that the death was 'entirely preventable', with a number of missed opportunities in the days prior to and during the restraint, when prison officers could have made a decision to seek medical support from NHS Prison Medical Care Staff.[60] Scotland's Justice Secretary Humza Yousaf met with the family of Mr Marshall and told the media 'they deserve an apology'.[61] The conclusion of the FAI, four years on from the death, led to serious concern across the sector and brought further focus to the systems for responding to deaths in prison in Scotland.

The SHRC supported the Chief Inspector of Prisons in Scotland in her ongoing review into deaths in custody in Scotland, following an announcement made by the Cabinet Secretary for Justice in November 2019. The review will identify and make recommendations about areas of improvement to ensure that appropriate and transparent arrangements are in place in response to deaths in custody in Scottish prisons, including deaths of prisoners while in NHS care. Judith Robertson, Chair of the SHRC, is co-Chair of the review along with Wendy Sinclair-Gieben of HMIPS and Nancy Loucks from Families Outside (a charity which works on behalf of families affected by imprisonment). The review is examining the operational policies, practice and training in place within the Scottish Prison Service and NHS which are relevant to deaths of prisoners. It is intended to complement current arrangements for the investigation of deaths in custody and the holding of FAI, which are the responsibility of the Lord Advocate acting independently of any other person. The review follows the campaigning around failures of the current system from bereaved families. The final report of the review is expected to be published in 2021.

In August 2019, *Fatal Accident Inquiries: Follow up review* was published by HM Inspectorate of Prosecution in Scotland.[62] It looked at the progress three years on from the previous review (published in August 2016), and highlighted continued delays in hearings, which often take a number of years to be completed. The review made three new recommendations, including one about the prioritisation of FAIs on the deaths of young people in legal custody.

60 Scottish Courts and Tribunals, August 2019, Fatal Accident Inquiry: Determination by Sheriff Gordon Liddle under the Inquiries Into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 into the death of Allan Stewart Marshall, https://scotcourts.gov.uk/docs/default-source/cos-general-docs/pdf-docs-for-opinions/2019fai35.pdf?sfvrsn=0, [accessed 10/11/2020]

61 BBC, September 2019, Justice secretary to apologise over Allan Marshall's custody death, https://www.bbc.co.uk/news/uk-scotland-edinburgh-east-fife-49608267 [accessed 10/11/2020]

62 Scottish Government, August 2019, *Fatal Accident Inquiries: follow up review*, https://www.gov.scot/publications/follow-up-review-fatal-accident-inquiries/ [accessed 24/08/2020]

An HMIPS report on an expert review of the provision of mental health services for young people entering and in custody at HMP YOI Polmont was published in May 2019.[63] Recommendations included enhanced and more consistent Death in Prison Learning Audit and Review processes, by the Scottish Prison Service, to maximise learning from previous incidents, and further consideration by the Scottish Government of how the justice system can better respond to international evidence about maturation and alternative models of secure care.

Reviews into prison conditions in Northern Ireland

In November 2016, the Ministers of Justice and Health in Northern Ireland announced a joint review of vulnerable people in custody. This followed five consecutive deaths in prison in Northern Ireland, four relating to mental health issues, and incidents of prisoners committing acts of serious self-harm. Publication of the report has been paused, partly due to the delay in establishing the Executive in Northern Ireland. In December 2018, RQIA was commissioned to complete the report, which is now expected in June 2021.

Prisoner voting rights

In Scotland, the Scottish Elections (Franchise and Representation) Act 2020 will allow prisoners to vote in local and Scottish elections when they are serving a sentence of less than 12 months. The passing of this legislation was significant, as it was the first to require a super majority (two-thirds of all Members of Scottish Parliaments (MSPs)) to back it. It was voted through in February 2020 and received Royal Assent on 1 April 2020. Amendments to the Local Government and Elections (Wales) Bill, brought forward by the Welsh Government in March 2020, would, if passed, allow prisoners sentenced to less than four years to register to vote in Assembly and local government elections. Similarly, in 2018 guidance was issued to the Northern Ireland Prison Service that prisoners were allowed to vote if they were on unaccompanied temporary release or were released early on licence during the custodial element of their sentence on Conditional Early Release. There are no further plans to introduce voting for prisoners in England, though proposals were made in 2017 to allow prisoners on release on temporary licence (ROTL) to vote. This is despite a judgment made in 2005 (*Hirst v United Kingdom (No 2)*) which found the blanket ban on UK prisoners exercising the right to vote is contrary to the European Convention on Human Rights.[64]

Children in detention

Significant attention has been paid to children in custody and secure care nationally and internationally over the period. There have also been legislative and policy developments on the care and treatment of children across the UK.

63 HMIPS, May 2019, *Report on Expert Review of Provision of Mental Health Services at HMP YOI Polmont*, available: https://www.prisonsinspectoratescotland.gov.uk/publications/report-expert-review-provision-mental-health-services-hmp-yoi-polmont [accessed 24/08/2020]

64 House of Commons Library, August 2020, *Research Briefing: Prisoners' voting rights: developments since May 2015*, https://commonslibrary.parliament.uk/research-briefings/cbp-7461/ [accessed 24/08/2020]

New legislation concerning children in the criminal justice system

The Age of Criminal Responsibility (Scotland) Act 2019, which came into force in autumn 2019, raised the age of criminal responsibility from eight to 12 in Scotland.[65] The Act also provides certain safeguards to ensure that harmful behaviour by children under 12 can be responded to in an appropriate and meaningful way, which will not criminalise them and should reduce the possibility of children under 12 being placed in a secure setting. The Minister for Children and Young People established an advisory group to review the Act's operation and to consider whether the age of criminal responsibility should be increased further.[66] At the time, 12 was the lowest minimum age for criminal responsibility considered acceptable by the UN Committee on the Rights of the Child (CRC), which later recommend a higher minimum age of at least 14 years.[67]

International standards on children in detention

In September 2019, the CRC issued a new general comment to the UN Convention on the Rights of the Child on children in the justice system, which replaces its previous comment in this area from 2007. The new comment reflects developments that have occurred since 2007, the Committee's jurisprudence, new knowledge about child and adolescent development and evidence of effective practices, including those relating to restorative justice. It also reflects concerns such as the trends relating to the minimum age of criminal responsibility and the persistent use of deprivation of liberty. It clarifies the UN position that countries should raise the minimum age of criminal responsibility to at least 14 years.[68]

These developments to the Convention on the Rights of the Child followed evidence from the report by the Independent Expert leading the global study on children deprived of liberty, Manfred Nowak, published in July 2019.[69] In Northern Ireland, England and Wales the current minimum age of criminal responsibility is 10 years old. In its latest periodic review of the UK, the United Nations Convention against Torture (UNCAT) reiterated its previous recommendation that countries in the UK, including Scotland, raise the minimum age of criminal responsibility in line with international standards and ensure the full implementation of juvenile justice standards.[70]

65 UK Government, Age of Criminal Responsibility (Scotland) Act 2019, https://www.legislation.gov.uk/asp/2019/7/contents/enacted [accessed 30/10/2020]

66 Scottish Government, *Age of Criminal Responsibility Advisory Group* webpage, https://www.gov.scot/groups/age-of-criminal-responsibility-advisory-group/ [accessed 10/08/2020]

67 *'In the original General Comment No. 10 (2007), the CRC [UN Committee on the Rights of the Child] considered 12 years to be the absolute minimum age. It now states that this age is still low and calls on States to increase their minimum age to at least 14 years. The CRC has also been concerned that States had been misinterpreting the General Comment and viewing 12 as an acceptable MACR and the target aim.' Children and Young People's Commissioner Scotland, January 2019, Submission of the Children and Young People's Commissioner Scotland: Age of Criminal Responsibility (Scotland) Bill,* https://www.cypcs.org.uk/ufiles/ACR-evidence-Jan-19.pdf [accessed 24/08/2020]

68 Committee on the Rights of the Child, September 2019, *General comment No. 24 (2019) on children's rights in the child justice system,* https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fGC%2f24&Lang=en [accessed 24/08/2020]

69 UN General Assembly, July 2019, *Global study on children deprived of liberty,* https://reliefweb.int/sites/reliefweb.int/files/resources/A_74_136_E.pdf [accessed 24/08/2020]

70 UNCAT, June 2019, *Concluding observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland,* page 5.

Reviews into secure care for children and young people in England and Wales

The JCHR concluded its inquiry, Youth Detention: Solitary confinement and restraint, in April 2019.[71] The Committee considered the use of restraint and separation in a range of settings in England and Wales where children are detained, including for care, treatment or welfare reasons, or because of criminal offences. The inquiry found that restraint and separation of children is occurring too often, with rates even higher for black and minority ethnic children. The JCHR concluded that: the use of restraint for the purposes of 'discipline and good order' in young offender institutions (YOIs) must be prohibited in all but the most exceptional of circumstances; the use of prone (face-down) restraint as anything but a last resort is not compliant with human rights standards for children; and the use of separation from normal human contact is harmful to children if used for more than a few hours at a time, and beyond that can amount to inhumane or degrading treatment. The JCHR also found that incidents of separation can lead to children ending up in what amounts to solitary confinement, and that it is within the power of the government to prevent such unlawful conditions. The UK NPM and CCE provided joint evidence to the JCHR's inquiry, which was cited in the final report.

The government responded to the inquiry in July 2019 and was broadly supportive of the recommendations, highlighting a number of policy plans and further reviews.[72] These included the review on the use of pain-inducing restraint techniques in the youth secure estate in England and Wales by former Chair of the Youth Justice Board, Charlie Taylor, published on 18 June 2020.[73] The review followed legal action and public pressure by children's rights organisation Article 39 and other supporters of a ban of the practice.[74] UNCAT's latest review of the UK noted an increase in the use of restraints in the youth custodial estate, and reiterated that (in accordance with rules 63 and 64 of the UN Rules for the Protection of Juveniles Deprived of their Liberty) instruments of restraint and force can only be used in exceptional cases, where all other control methods have been exhausted and failed.[75]

CQC published its final report on its review on the use of restraint, seclusion and segregation in October 2020.[76] The interim report, published in May 2019, examined the experiences of those people cared for in segregation on a mental health ward for children and young people or on a ward for people with a learning disability or autism.[77] The findings of the interim report are referred to in 'Mental health and social care', p.15.

71 Joint Committee on Human Rights, Youth Detention: Solitary confinement and restraint inquiry, https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/994/99402.htm [accessed 11/10/2020]

72 Joint Committee on Human Rights, July 2019, *Youth detention: solitary confinement and restraint: Government Response to the Committee's Nineteenth Report of Session 2017-19*, https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/2547/2547.pdf [accessed 24/08/2020]

73 UK Government, June 2020, Independent review of the use of pain-inducing techniques in the youth secure estate, https://www.gov.uk/government/publications/independent-review-of-the-use-of-pain-inducing-techniques-in-the-youth-secure-estate [accessed 30/10/2020]

74 Article 39, March 2020, *Article 39 challenges Ministry of Justice over pain-inducing restraint*, https://article39.org.uk/2020/03/07/article-39-challenges-ministry-of-justice-over-pain-inducing-restraint/ [accessed 24/08/2020]

75 UNCAT, June 2019, *Concluding observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland*, page 5.

76 CQC, October 2020, Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people and people with a learning disability and/or mental health condition, https://www.cqc.org.uk/sites/default/files/20201023_rssreview_report.pdf [accessed 01/12/2020]

77 CQC, May 2019, *Interim report: Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism*, https://www.cqc.org.uk/publications/themed-work/interim-report-review-restraint-prolonged-seclusion-segregation-people [accessed 24/08/2020]

In July 2019, the House of Commons Justice Select Committee commenced an inquiry on Children and Young People in Custody in England and Wales, considering the progress the government has made in implementing the recommendations of the 2016 Taylor Review and reforming the approach to youth justice. Several NPM members contributed evidence, though this inquiry was closed due to the General Election in December 2019 and was only recently re-established in the new parliament.[78]

Secure schools

In the previous reporting period, the NPM noted that in England and Wales plans were made to change the nature of secure accommodation for children in different respects, including through the opening of a pilot 'secure school' at the site of the highly criticised and now closed Medway Secure Training Centre. In July 2019 it was announced that the Oasis Charitable Trust had been chosen as the UK's first secure school operator, and would be taken forward to the pre-opening stage.[79] However in November 2019 it was reported that this pilot school, which had been due to launch in autumn 2020, had been delayed and would not be open until 2022 at the earliest.[80]

Reviews into secure care for children and young people in Scotland

Following the deaths in custody at HMP YOI Polmont of William Lindsay, aged 16, and Katie Allan, aged 21, the Justice Committee of the Scottish Parliament opened an inquiry into secure care places for children and young people in Scotland. Several NPM members gave evidence. The final report was published November 2019 and made a number of recommendations around mental health assessments and guaranteed access to appropriate care and education services, as well as around improvements in the model of provision and placement to ensure no child or young person is sent to HMP YOI Polmont when a secure unit would be more appropriate to their needs.

The Committee called on the Scottish Government to review the current legislative and policy framework regarding transition between secure care and prison, with a view to making the relevant changes to the law and current policy.[81] It also endorsed the recommendations of the HMIPS report on an expert review of the provision of mental health services for young people entering and in custody at HMP YOI Polmont, and noted its upcoming review on deaths in prison (see 'Deaths in prison in Scotland', p.25).

78 House of Commons Justice Committee, October 2019, *Children and young people in custody inquiry - publications,* https://old.parliament.uk/business/committees/committees-a-z/commons-select/justice-committee/inquiries/parliament-2017/children-young-people-custody-inquiry-17-19/publications/ [accessed 10/11/2020]

79 MoJ, July 2019, Secure schools: Setting up the first Secure School in the UK, https://www.gov.uk/government/publications/secure-schools-how-to-apply [accessed 24/08/2020]

80 Children and Young People Now, November 2019, *MoJ confirms delay to secure school opening,* https://www.cypnow.co.uk/news/article/moj-confirms-delay-to-secure-school-opening [accessed 24/08/2020]. In a Justice Select Committee, 14 July 2020, oral evidence session on an inquiry into children and young people in custody, Lucy Frazer MP also stated that one of the challenges causing a delay was ensuring the site was satisfactory to Ofsted. Transcript available https://committees.parliament.uk/oralevidence/703/pdf/ [accessed 15/10/2020]

81 Scottish Parliament Justice Committee, November 2019, *Secure care and prison places for children and young people in Scotland,* https://sp-bpr-en-prod-cdnep.azureedge.net/published/J/2019/11/26/Secure-care-and-prison-places-for-children-and-young-people-in-Scotland/JS052019R22.pdf [accessed 24/08/2020]

The Justice Committee also looked forward to the findings of the Independent Care Review, commissioned by the Scottish Government. A large-scale 'root and branch' review, it aimed to stimulate fundamental and long-lasting changes in the culture of the care and criminal justice system for children in Scotland. After three years, the review published its final reports in February 2020, which called for a radical overhaul of the system and detailed the human and economic cost of the current provision and its failures. The review concluded that YOIs are not appropriate places for children and recommended that, where liberty must be restricted, it must only be done when other options have been fully explored, for the shortest time possible and in small, secure, safe and trauma-informed environments.

The review called for diversion of children from the criminal justice system through a further raising of the minimum age of criminal responsibility. It also highlighted the disproportionate criminalisation of children in care, despite no evidence that care-experienced children engage in more offending behaviour than their peers, and recommended that Scotland reduce this disproportionality by supporting the workforce to behave and treat children in a way that is relational rather than procedural and process driven.[82] The Scottish Government has made a commitment to progress the recommendations of the review, and the review team and supporters continue to campaign for change under the banner *#KeepThePromise*. The Care Inspectorate took part in the review and is now considering its own contribution to such change, including implementing new standards for secure care and scrutinising the decisions and transitions that lead children in and out of secure care (which is currently beyond its remit).

Further key reports on children and young people in Scotland included the recommendations of the Children and Young People's Mental Health Task Force, published in July 2019, and the *Youth Commission on Mental Health Services* report, published in May 2019.[83]

Reviews into secure care for children and young people in Northern Ireland

Work on the integration of care and justice settings providing secure accommodation for children in Northern Ireland continues. In 2018 a report was published by the Department of Health which recommended establishing a joint care and justice campus on the Lakewood and Woodlands sites, as well as broader reforms.[84] A trigger for the review was growing concern that children and young people in care, often with the most complex needs, were spending periods of time within each of the facilities, sometimes experiencing repeat admissions and moving from one to the other. A single therapeutic framework model will also be adopted across the campuses.

82 Independent Care Review, February 2020, *The Promise*, https://www.carereview.scot/wp-content/uploads/2020/03/The-Promise_v7.pdf [accessed 24/08/2020]

83 Scottish Government, (webpage) *Mental Health: Children and Young People*, https://www.gov.scot/policies/mental-health/children-and-young-people/ [accessed 24/08/2020]

84 Northern Ireland Executive, December 2018, *Proposals for new specialist children's campus to be developed*, https://www.northernireland.gov.uk/node/36325 [accessed 24/08/2020]

Immigration detention

Throughout the reporting year, parliamentarians and civil society organisations continued to raise concerns around the lack of a time limit in immigration detention. Other concerns raised during the year relate to ongoing issues with the safety of vulnerable detainees and the performance of privately contracted immigration services.

Planned legislative changes to immigration policy by the previous government stalled in March 2019 and were discontinued when Parliament was prorogued for the General Election in September 2019. The current Immigration and Social Security Co-ordination (EU Withdrawal) Bill, introduced in March 2020, received mention in the Queen's Speech of December 2019. The speech stated that '[A] modern, fair, points-based immigration system' would be introduced which 'will welcome skilled workers from across the world to contribute to the United Kingdom's economy, communities and public services'.[85]

Brook House investigation

In November 2019, it was announced that the PPO investigation of events in Brook House Immigration Removal Centre (IRC) would be converted to a statutory inquiry. The investigation had been delayed pending legal action.[86] The original announcement followed a *Panorama* documentary ('Undercover: Britain's Immigration Secrets') broadcast on 4 September 2017, which revealed shocking levels of abuse of detainees at Brook House IRC.

A National Audit Office (NAO) investigation of the Home Office's management of its contract with private contractor G4S to run Brook House IRC, conducted for the Home Affairs Committee, was published in July 2019. NAO found that G4S made £14.3 million in profit from Brook House between 2012 and 2018. NAO also found that until 2018 the Home Office had insufficient staff in place to properly verify or validate G4S's reported level of performance. Since the documentary was broadcast, the Home Office has increased the size and role of its contract monitoring team.[87] The contract has now been awarded to Serco.

Significantly, NAO found that 84 incidents of physical and verbal abuse identified from the BBC *Panorama* footage were not classified as a contractual breach and did not lead to any significant penalties. After the programme was broadcast, the Home Office fined G4S £2,768 for eight incidents, four of which should have been previously reported. The Home Office subsequently announced that the G4S contract, which was extended for two years in August 2018 after the programme was broadcast, was 'not fit for purpose'.

Dungavel House Immigration Removal Centre

In May 2019, BBC Scotland reported concerns about the operation of the Adults at Risk policy in Dungavel House IRC, the only IRC in Scotland, and at short-term holding facilities at Glasgow and Edinburgh airports, all of which are administered by the UK Home Office. BBC Scotland highlighted figures from the Home Office from 31 December 2018 showing that

85 UK Government, December 2019, Queen's Speech December 2019, https://www.gov.uk/government/speeches/queens-speech-december-2019, [accessed 10/11/2020]

86 Prisons and Probation Ombudsman, November 2019, *PPO's Brook House investigation converted into statutory inquiry*, https://www.ppo.gov.uk/news/ppos-brook-house-investigation-converted-into-statutory-inquiry/ [accessed 31/08/2020]

87 Home Affairs Select Committee, July 2019, *News: G4S make £14.3m profit from Brook House contract despite serious failings*, https://committees.parliament.uk/committee/83/home-affairs-committee/news/100641/g4s-make-143m-profit-from-brook-house-contract-despite-serious-failings/ [accessed 31/08/2020]

39% of people detained at the centre were classed as adults at risk.[88] The Scottish Government has repeatedly pressed the UK Government to implement more humane asylum and immigration detention systems. On 15 May 2019, the Cabinet Secretary for Communities and Local Government wrote to the UK immigration minister to express the Scottish Government's deep concerns following reports about the detention of children and pregnant women at Dungavel House IRC. On 1 April 2019, the Cabinet Secretary wrote to support calls for a time limit on immigration detention.[89]

Deaths in immigration detention

Over the reporting period there was a series of critical inquests examining the circumstances of deaths of immigration detainees which took place between 2016 and 2017. These included both self-inflicted deaths and those involving issues with physical health care.[90] In March 2020, an inquest was concluded into the death of Prince Kwabena Fosu who died in Harmondsworth IRC on 30 October 2012.

Prince Kwabena Fosu, 31, was a Ghanaian national who entered the UK on a valid business visitor visa. He was then refused leave on entry but appealed. The inquest into his death heard evidence that, shortly after that appeal concluded, police encountered Mr Fosu running naked down the street. Despite concerns of officers, a mental health assessment in the police station concluded he was fit to be detained and transferred to immigration detention. Shortly after arriving at Harmondsworth IRC, Mr Fosu was restrained and put into segregation where he remained until his death six days later, on 30 October 2012. The bedding had been removed, and records of checks by health and detention staff showed no positive evidence that Mr Fosu had eaten, drunk or slept, and that he was naked throughout this time. The cell was contaminated with smeared faeces, urine and food debris, but Mr Fosu was not referred for a mental health assessment at any point, although an IMB member raised concerns about his mental health. The inquest concluded that neglect contributed to his death, and the jury identified several serious failures by the Home Office, detention staff, health care teams and the police, as well as other agencies. The jury was also critical of the IMB, finding its monitoring of Mr Fosu was ineffective and inadequate. The medical cause of death was found to be a 'sudden death following hypothermia, dehydration and malnourishment in a man with psychotic illness'.

88 BBC Scotland, May 2019, *'At risk' adults held at Dungavel immigration centre*, https://www.bbc.co.uk/news/uk-scotland-48367896 [accessed 31/08/2020]. The Home Office reported to the NPM that their interpretation of this data would instead make this 28% of people detained.

89 TheyWorkForYou, June 2019, Scottish Parliament written questions: Dungavel House (Children), https://www.theyworkforyou.com/sp/?id=2019-06-06.21.0 [accessed 31/08/2020]

90 See notes section: INQUEST, March 2020, Press release: *Jury concludes neglect and gross failures contributed to the death of Prince Fosu in immigration detention*, https://www.inquest.org.uk/prince-fosu-inquest-conclusion [accessed 31/08/2020]

Reviews into conditions in immigration detention

In March 2019, the House of Commons Home Affairs Committee published the report of an inquiry into immigration detention, which found 'serious problems with almost every element of the immigration detention system'.[91] The Committee called for more transparency in collating information about the number of people who are wrongfully detained, identifying a weak administrative process and a lack of judicial oversight of the decision to detain. It asked that the Home Office do much more to ensure that all reasonable alternatives to detention are considered. It also highlighted a rapidly growing consensus among medical professionals, independent inspectorate bodies and other key stakeholders on the need for a maximum time limit. It called for an end to indefinite immigration detention and implementation of a maximum 28-day time limit with regular checks and safeguards.

The government responded to the Home Affairs Committee in September 2019, agreeing with the principle of a fair and humane immigration system but rejecting more than half of the recommendations, including the call for a time limit. The government said it believed that an immigration detention time limit of 28 days would severely constrain the ability to maintain balanced and effective immigration control, potentially incentivise significant abuse of the system and put the public at risk. It did accept the need for more openness and public reporting on data.[92] In a letter to the Committee, the Home Office also gave an update on its work reforming immigration detention, detailing a two-year pilot scheme to provide alternative arrangements for a number of women in detention or at risk of being detained at Yarl's Wood IRC, and plans for further pilots to test different models of support. The Home Office also said that the recently introduced Detention Gatekeeper function was improving the quality and consistency of initial decisions to detain, with judgements made independently of the referring team or caseworker.[93]

The Home Office consulted on changes to the Detention Services Order policy on mental incapacity/disability in immigration detention (with an update to the 2019 policy published in July 2020). In our last Annual Report, we noted that the Adults at Risk in Immigration Detention policy had failed on multiple occasions to protect people considered vulnerable from being detained. Since the follow up *Shaw Review*, which reports on the welfare of vulnerable people in immigration detention (published in 2018), the Independent Chief Inspector of Borders and Immigration now reports annually on the implementation of this policy.[94] The Home Office publishes data annually on deaths in immigration detention, to increase transparency.

91 House of Commons Home Affairs Committee, March 2019, *Immigration detention: Fourteenth report of session 2017-18*, https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/913/913.pdf [accessed 31/08/2020]

92 *The Government rejected 17 of 33 recommendations, partially accepted four and accepted (including accepting the principles but not the action) of 12 recommendations by the committee. See House of Commons Home Affairs Committee, September 2019, Immigration detention: Government Response to the Committee's Fourteenth Report of Session 2017-19*, https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/2602/2602.pdf [accessed 31/08/2020]

93 Parliament UK (webpage), *Appendix 1: Letter from the Minister of State for Immigration to the Chair of the Committee, 23 July 2019*, https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/2602/260602.htm [accessed 31/08/2020]

94 Independent Chief Inspector of Borders and Immigration, September 2020, *News story Chief Inspector publishes 2019-20 Annual Report*, https://www.gov.uk/government/news/chief-inspector-publishes-2019-20-annual-report, [accessed 30/10/2020]

Windrush

There were a series of further developments around the Windrush scandal. HM Inspector at HMICFRS, Wendy Williams, who had been asked by the then Home Secretary Rt Hon Sajid Javid MP to provide an independent assessment of the events leading up to the Windrush scandal and to identify the key lessons for the Home Office, published her report in March 2020.[95] The report provided updates on the work of the Windrush Taskforce (a dedicated team working to resolve applications under the Scheme as quickly as possible) and the Windrush Historical Cases Review unit (established to examine the immigration records of 11,800 British residents of Caribbean Commonwealth nationality who were born before 1973 and who had been held in immigration detention or removed from the UK since 2002). The unit found that 122 members of the Windrush generation had been detained and 83 had faced removal, with 31 facing both removal and detention. A series of updates provided by the Home Office to the Home Affairs Committee illustrated that a backlog in cases which were yet to be considered by the Taskforce had reduced over the year but that in April 2020 there remained over 1,000 outstanding cases.[96]

Immigration detention during COVID-19

Proceedings for Judicial Review against the Home Office were issued on 18 March 2020 by the NGO Detention Action and an Estonian national subject to a deportation order. It challenged the lawfulness and safety of continued immigration detention during the COVID-19 pandemic (as many escort flights were cancelled, making detention in IRCs unlawful) and called for the release of all immigration detainees. While the case was dismissed by the High Court seven days later, the Home Office undertook to review the cases of all people detained.[97] During the pandemic some 350 detainees were released on bail and there was a significant reduction in removals, with those to some countries suspended entirely.[98]

95 Wendy Williams, March 2020, *Windrush Lessons Learned*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874022/6.5577_HO_Windrush_Lessons_Learned_Review_WEB_v2.pdf [accessed 31/08/2020]

96 The Independent, April 2020, *Windrush scandal: More than 1,000 cases yet to be considered by Home Office, figures show*, https://www.independent.co.uk/news/uk/home-news/windrush-scandal-home-office-scheme-taskforce-immigration-a9489871.html [accessed 31/08/2020]

97 Royal Courts of Justice, March 2020, *Detention Action & Anor, R (On the Application Of) v Secretary of State for the Home Department [2020] EWHC 732 (Admin)*, https://www.bailii.org/ew/cases/EWHC/Admin/2020/732.html [accessed 31/08/2020]

98 Detention Action, March 2020, *Press Release: Over 350 released from immigration detention and all cases to be urgently reviewed*, https://detentionaction.org.uk/2020/03/26/press-release-over-350-released-from-immigration-detention-and-all-cases-to-be-urgently-reviewed/ [accessed 31/08/2020]

Police custody

While there have been no relevant legislative developments, there have been a number of changes in policy and practice in policing, and developments in two public inquiries into deaths in police custody.

Reviews into police custody in Scotland

The Scottish Government consulted on new Strategic Police Priorities, which were published in December 2019. They reflect key NPM principles including equality and human rights to support positive criminal justice outcomes, being ethical, open and transparent and working collaboratively with partners to improve outcomes for individuals and the vulnerable.[99] In October 2019, a three-month consultation commenced on the Letter of Rights provided to suspects and accused persons held in police custody. Although the analysis of consultation responses has not yet been published, the government has indicated that it plans to revise the Letter.[100]

The Independent Review of Complaints Handling, Investigations and Misconduct Issues in relation to Policing submitted its preliminary report to the Scottish Parliament in June 2019. The review, by Dame Elish Angiolini QC, who previously conducted a review looking at similar systems in England and Wales, made 30 immediate recommendations including to the Police Investigations and Review Commissioner (PIRC), Police Scotland, Scottish Police Authority (SPA) and the Crown Office and Procurator Fiscal Service. She reported evidence that 'the current arrangements for handling complaints about the police are overly complex, lack clarity and can be open to a range of different interpretations'. She recommended that PIRC, which investigates complaints and deaths in custody, should adopt a similar policy to its equivalent in England and Wales by recruiting non-police officers to the most senior posts. Following serious incidents, she recommended that officers of Police Scotland give every assistance, and that the current assumption of cooperation between key agencies should be strengthened and put into primary legislation. The final report was published on 11 November 2020.[101]

Reviews into police custody in Northern Ireland

The Police Service of Northern Ireland is implementing a Custody Pathfinder Programme for custody health care. The programme will shift health care in police custody towards a principally nurse-led service, with specially trained custody nurse practitioners working as part of the custody team, and mental health nurses also being recruited. The aim is to improve the quality of the health care service and outcomes for patients in custody and reduce emergency department visits. Prior to this, custody health care had been physician-led and was delivered by forensic medical officers only, who will remain in place on

99 Scottish Government, December 2019, *Review of Strategic Police Priorities: Consultation*, https://consult.gov.scot/safer-communities/review-of-strategic-police-priorities/ [accessed 31/08/2020]

100 Scottish Government, October 2019, *Letter of rights: consultation*, https://www.gov.scot/publications/consultation-letter-rights-scotland/ [accessed 31/08/2020]

101 Dame Elish Angiolini QC, June 2019, *Independent review of complaints handling, investigations and misconduct issues in relation to policing: preliminary report*, https://www.gov.scot/publications/preliminary-report-independent-review-complaints-handling-investigations-misconduct-issues-relation-policing/pages/19/ [accessed 31/08/2020]; Dame Elish Angiolini QC, November 2020, Independent Review of Complaints Handling, Investigations and Misconduct Issues in Relation to Policing: Final report, https://www.gov.scot/binaries/content/documents/govscot/publications/independent-report/2020/11/independent-review-complaints-handling-investigations-misconduct-issues-relation-policing/documents/independent-review-complaints-handling-investigations-misconduct-issues-relation-policing-final-report/independent-review-complaints-handling-investigations-misconduct-issues-relation-policing-final-report/govscot%3Adocument/independent-review-complaints-handling-investigations-misconduct-issues-relation-policing-final-report.pdf?forceDownload=true [accessed 01/12/2020]

an on-call basis to attend where a doctor is required.[102] Although it was hoped that the programme would be extended to all custody suites in Northern Ireland by September 2020, due to COVID-19 the programme will now be implemented in two additional suites outside Belfast by early 2021.

Deaths in police custody

In November 2019, the Cabinet Secretary for Justice in Scotland announced a public inquiry into the death of Sheku Bayoh.[103] This announcement followed a decision by the Lord Advocate not to charge Police Scotland or the officers involved in the death with criminal, corporate or health and safety offences. Sheku Bayoh, a black man born in Sierra Leone, was 31 years old when he died after being restrained by up to five police officers on 3 May 2015.[104] The Justice Secretary has asked that the inquiry address the question of whether Sheku Bayoh's race played a part in how the incident was approached and dealt with by the police, and look at the circumstances leading up to and following his death.[105]

Policy changes concerning police custody in England and Wales

In March 2020 the National Police Chief's Council published its National Strategy on Policing and Mental Health. This sets out the strategic principles underpinning the police response to those who experience mental ill health. In relation to custody, the strategy sets a strategic objective that 'the police service should work to completely eliminate reliance upon the use of police custody as a 'Place of Safety' under the Mental Health Act 1983'. The strategy points out that this has already been achieved in some police force areas.[106]

Revisions made to Codes C and H in the Police and Criminal Evidence Act (PACE) 1984 came into force in England and Wales in August 2019. ICVA, HMICFRS and HMI Prisons fed into the consultation regarding these changes. The revisions were made to ensure access to necessary menstrual care products, and ensure the broader health, hygiene and welfare needs of those in police custody are met. Detainees must now be given the opportunity to speak to someone of the same gender about their personal hygiene needs. Female and transgender detainees must be proactively offered menstrual care products, and detainees must be told toilets are private. The changes also strengthened dignity in strip searches.[107]

102 Police Service of Northern Ireland, June 2019, *News: New nurse-led custody service on justice system's frontline*, https://www.psni.police.uk/news/Latest-News/040619-new-nurse-led-custody-service-on-justice-systems-frontline/ [accessed 31/08/2020]

103 Scottish Government, November 2019, *Ministerial statement on Sheku Bayoh*, https://www.gov.scot/publications/ministerial-statement-humza-yousaf-statement-sheku-bayoh-next-steps/ [accessed 31/08/2020]

104 INQUEST, November 2019, *Media release: Scottish Government announce public inquiry into the death of Sheku Bayoh*, https://www.inquest.org.uk/sheku-bayoh-inquiry [accessed 31/08/2020]

105 Scottish Government, November 2019, *Ministerial statement on Sheku Bayoh*, https://www.gov.scot/publications/ministerial-statement-humza-yousaf-statement-sheku-bayoh-next-steps/ [accessed 31/08/2020]

106 National Police Chiefs' Council, February 2020, National Strategy on Policing and Mental Health, https://www.npcc.police.uk/Mental%20Health/Nat%20Strat%20Final%20v2%2026%20Feb%202020.pdf#:~:text=National%20Strategy%20on%20Policing%20and%20Mental%20Health%20Foreword,the%20police%20service%20as%20a%20whole.%20The%20challenge [accessed 10/11/2020]

107 ICVA, July 2020, *Blog: Reflecting back on a year*, https://icva.org.uk/reflecting-back-on-a-year/ [accessed 31/08/2020]

The situation in detention during the year

Prisons

Prisons remain a key area of concern for NPM members, with a range of persistent issues identified over the reporting period, including poor safety and high levels of self-harm. In England and Wales, the population across the prison estate on 27 March 2020 was 83,189, up 546 from 2019. Within the population, MoJ reports that 79,548 prisoners were male and 3,641 were female.[108] The population also rose in Scotland during 2019, with monthly averages for the reporting period consistently above 8,000 and at one point over 8,300, before falling at the end of March 2020 as court activity slowed in line with COVID-19-related restrictions.[109] In Northern Ireland, in the week ending 20 March 2020 the total population had risen by 136 from the previous year to 1,593, of whom 88 were female.[110] According to analysis of data by the World Prison Brief, Northern Ireland has the lowest rate of imprisonment in the UK. England and Wales jointly have the third highest prison population on the continent of Europe, and the 20th highest rate of imprisonment (with Scotland the 21st highest).[111]

In November 2019, a report on the safety of prisoners held by the Northern Ireland Prison Service was published by RQIA and CJINI. RQIA and CJINI inspectors noted progress in the management of vulnerable prisoners with the piloting of a new strategy specifically designed to address their needs. However, inspectors also stated that further work was needed to respond to the quantity and availability of drugs in prisons in Northern Ireland, with the publication of a new strategy on this considered positive. Bullying also remained a significant issue.[112] In this joint inspection report, the Chief Inspector of CJINI expressed frustration at repeating key recommendations made in 2014. Inspectors remained concerned that prisons did not provide the therapeutic environment required for people with complex needs and recommended courts be made aware of these limitations when committing people to prison for mental health assessments. RQIA and CJINI called for much closer working between the prison service and local health and social care trusts on the joint delivery of the strategies on suicide and self-harm and the management of substance abuse, which are crucial to prisoner safety. The report also called for the implementation of inspection and Death in Custody report recommendations, and the delivery of safer custody at establishment level.

108 MoJ, March 2020, *Population bulletin: weekly 27 March 2020*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876296/prison-pop-27-mar-2020.ods [accessed 24/08/2020]

109 Scottish Parliament, March 2020, *Scotland's Prison Population to Feb 2020*, https://sp-bpr-en-prod-cdnep.azureedge.net/published/2020/3/9/Scotland-s-prison-population-to-Feb-2020/SB%2020-21i.pdf [accessed 24/08/2020]

110 NI Department of Justice (webpage), *Weekly Situation Reports 2019/2020*, https://www.justice-ni.gov.uk/articles/weekly-situation-reports-october-2015#toc-22 [accessed 24/08/2020]

111 World Prison Brief (webpage), *World Prison Brief Data*, https://www.prisonstudies.org/world-prison-brief-data [accessed 24/08/2020]

112 CJINI, November 2019, *The Safety Of Prisoners Held by the Northern Ireland Prison Service: A joint inspection by CJINI and RQIA*, http://www.cjini.org/getattachment/3a70dd41-7bb3-430d-9901-3ed7a191cf94/The-Safety-of-Prisoners.aspx [accessed 24/08/2020]

IMBNI reported serious concerns about HMP Magilligan in 2019–20. IMBNI raised concerns over the staff shortages during the 2019 festive period which resulted in prisoners, including those who normally receive medication via supervised swallow, receiving a two-week supply of medication in cell. This led to bullying and violence, with numerous prisoners then deprived of necessary medication. Staff were unable to manage the situation and were subsequently ordered to enter each cell to account for medication, which caused disquiet among prisoners and potentially breached medical confidentiality. This incident reflects broader concerns about the illicit availability of prescription drugs in HMP Magilligan, with the Board reporting a shift towards more prescription drugs, such as opioid painkillers, being detected (rather than the psychoactive substances seen previously).[113] In March 2020, the Prisoner Ombudsman published an investigation into the death of 27-year-old Paul Johnston at HMP Magilligan whose death was caused by an accidental overdose of Fentanyl and Alprazolam on 4 August 2017. Neither drug was prescribed to him.[114]

NPM members completed a multidisciplinary inspection of Ash House and Hydebank Wood Secure College in 2019. RQIA, CJINI, HMI Prisons and the Education and Training Inspectorate found 'remarkable' progress. The areas of safety, respect and rehabilitation were good, and purposeful activity was reasonably good at both facilities. Significant improvements had been made to the environment and the care and support of prisoners who required periods of time in the Hydebank Wood's Care and Supervision Unit. Inspectors found a high number of previous recommendations had been achieved, and levels of violence and self-harm at Ash House were lower than rates found at the previous inspection, and lower than in comparative prisons in England. However, there were concerns about the absence of a systematic approach to the identification of women eligible for public health screening programmes while in prison. Concerns regarding access to care and treatment of patients with substance misuse needs were also identified.[115] There had been an increase in the number of women detained at Ash House which led to doubling up in some cells, relocation of some women and the opening of a separate committal landing for women.

While the IMBNI at Hydebank Wood welcomed the introduction of a new committal landing, they were concerned about the lack of progress in developing a separate women's prison, with a regime and culture suited to the needs of female prisoners. The IMBNI at Hydebank Wood also praised the new learning and skills centre which was opened in September 2019. However, the IMBNI also reported concerns about the length of time some young men have been held in segregation. In some instances, the reason for segregation was suspected possession of drugs as indicated by a drugs dog. IMBNI has called for alternative reliable equipment for testing of prisoners for drugs and mobile phones to be made available to prisons in Northern Ireland. The IMBNI at Hydebank Wood also reported concerns about the use of restraint in prisons, with one particularly serious incident where five prison officers restrained a female prisoner. IMBNI also reported a lack of confidence in the

113 IMB Northern Ireland, February 2020, *Independent Monitoring Board Annual Report 2018-19: Magilligan Prison*, http://www.imb-ni.org.uk/publications/feb-20/Magilligan_Annual_Report_18-19.pdf [accessed 24/08/2020]

114 NI Prisoner Ombudsman, March 2020, *Investigation Report into the Circumstances Surrounding the Death of Mr Paul Johnston*, https://niprisonerombudsman.gov.uk/publications/download/121 [accessed 24/08/2020]

115 CJINI, July 2020, *Report on an Unannounced Inspection of Hydebank Wood Secure College*, http://cjini.org/TheInspections/Inspection-Reports/2020/April-June/Unannounced-Inspection-of-Hydebank-Wood-Secure-Col [accessed 24/08/2020]

Official Complaints process among prisoners, although the regular attendance by Prison Ombudsman staff has encouraged dialogue, and there was progress with the introduction of regular forums, including separate forums for foreign nationals.

IMBNI also noted positive developments following the introduction of the Supporting Prisoners at Risk procedures (part of the Suicide and Self-Harm Prevention Strategy) across the Northern Ireland prison estate. IMBNI found that the procedures have led to more effective triaging with staff taking an individualised approach to the prisoner and diffusing situations which, formerly, would have resulted in use of the special accommodation and anti-ligature clothing.

HMI Prisons reported that in adult male prisons in England and Wales, safety outcomes remained poor or not sufficiently good in just over half of their inspections, especially in local prisons.[116] Self-harm incidents reached yet another record high of 64,552 incidents in the 12 months to March 2020, up 11% from the previous 12 months.[117] In over two-thirds of prisons, HMI Prisons found managers had not done enough to understand and respond to the causes of self-harm. Similarly, levels of violence had continued to rise across most of the estate. Inspectors found that prisons often failed to collate and analyse data well enough to inform effective violence reduction strategies. The use of force had increased since the previous year in just over half the adult male prisons visited.

In approximately one-third of prisons, use of force documentation was incomplete or of poor quality. At HMP Hewell, for example, 350 reports were missing. However, a few prisons had improved scrutiny in their use of force, and good practice was found at HMP Wormwood Scrubs, HMP Parc and HMYOI Aylesbury.

Safety was a key issue at HMP Bristol, which contributed to HMI Prisons invoking an Urgent Notification. At HMP Bristol, inspectors found 'chronic and seemingly intractable failings', which had been evident for the best part of a decade. This was despite improved staffing levels and some new investment. The rate of self-harm was high and there had been two self-inflicted deaths since the last inspection, with one in 10 prisoners monitored for risk of suicide and/or self-harm.[118] Yet the recommendations of the PPO, who investigates all deaths in custody in England and Wales, had not been implemented.

The PPO reported that around 40% of all prisons had not adequately implemented the recommendations from their investigations. In the 12 months to March 2020, there were 286 deaths in prison custody, a decrease of 10% from 317 deaths in the previous 12 months. Of these, 80 deaths were self-inflicted, an 8% decrease from the 87 self-inflicted deaths in the previous 12 months.[119]

116 HMI Prisons, October 2020, Her Majesty's Chief Inspector of Prisons 2019-20 Annual Report, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf [accessed 30/10/2020]

117 MoJ, July 2020, *Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2020 Assaults and Self-harm to March 2020*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/905064/safety-in-custody-q1-2020.pdf [accessed 24/08/2020]

118 HMI Prisons, June 2019, *HMCIP Peter Clarke Letter to Secretary of State for Justice RE: Urgent Notification: HM Prison Bristol*, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/06/11jun-UN-letter-and-debrief-final.pdf [accessed 24/08/2020]

119 MoJ, April 2020, *Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to March 2020 Assaults and Self-harm to December 2019*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/893374/safety-in-custody-q4-2019.pdf [accessed 24/08/2020]

There continued to be significant concerns about safety raised by IMBs with rises in both self-harm and violence in many prisons, often caused by drugs and debt. Prisons holding young adults remained particularly volatile. The HMYOI Feltham IMB reported an increase in prisoner on prisoner assaults and at HMYOI Deerbolt, though violence had reduced by the third quarter of the year, the IMB reported that the HM Prison and Probation Service (HMPPS) challenge, support and intervention process was being used punitively and for those who were vulnerable and bullied. Many young people were said to be transgressing so they could go into the relative safety of segregation.[120] At HMYOI Aylesbury, self-harm had increased by over 50% and assaults by over 100%. At HMP/YOI Swinfen Hall, the Board noted that violence was twice as high as in 2015, though there had been a notable increase in self-harm, with the under-21 population accounting for over 70% of self-harm incidents and 87% of resulting hospital admissions. The IMB also noted the connection between violence and a poor regime: as the regime stabilised, violent incidents decreased.[121]

Some IMBs reported on new approaches to reduce the use, and length, of segregation in prisons in England and Wales. However, concerns remain that too many prisoners with serious mental ill health issues were being segregated, often in extreme conditions for lengthy periods. Boards reported that four prisoners at HMP Woodhill were segregated for over 200 days, awaiting transfer either to the close supervision centres or to a mental health setting, while at HMP Lowdham Grange stays in segregation of over 100 days were recorded, with one prisoner still awaiting a mental health placement after 191 days. Boards also reported the segregation of prisoners at risk of suicide and self-harm and on assessment, care in custody and teamwork case management for prisoners at risk of suicide or self-harm (ACCT) reviews. More positively, at HMP Erlestoke the Board noted a decrease in the number of segregated prisoners on ACCTs and a 60% decrease in the use of segregation. The Board at HMP Littlehey also reported an overall reduction in the use of segregation.[122]

120 IMB, September 2020, Independent Monitoring Boards National Annual Report, 2019-20 https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IMB-national-annual-report-201920-amended-FINAL-.pdf [accessed 30/10/2020]

121 IMB, September 2020, Independent Monitoring Boards National Annual Report, 2019-20 https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IMB-national-annual-report-201920-amended-FINAL-.pdf [accessed 30/10/2020]

122 IMB, September 2020, Independent Monitoring Boards National Annual Report, 2019-20 https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IMB-national-annual-report-201920-amended-FINAL-.pdf [accessed 30/10/2020]

HMI Prisons found there were some improvements in prisoners' relationships with staff and in health care. The key worker scheme, which was introduced as part of the Offender Management in Custody model in 2018, was having some positive impact, but the lack of staff enforcement of some basic rules was often still a problem. However, many IMBs found that the aims of the scheme were not being met in many prisons, with a significant decline in officer engagement with prisoners.[123]

Overcrowding persisted and living conditions in some prisons remained poor during the reporting period. In both HMP Brixton and HMP Forest Bank, for example, 60% of prisoners shared a cell designed for one.[124] Some living conditions were unhygienic, with some sites affected by vermin, and overall prisoners continued to live in inadequate conditions even when issues had been raised at previous inspections. During an Independent Review of Progress (IRP) visit at HMP Exeter, for example, inspectors again found prisoners in cells without windows (as they had done during the full inspection) and identified one prisoner living in a dirty segregation cell which was not fit for purpose. However, some prisons had made improvements to living conditions. For example, at HMP Stocken, inspectors found that there was a prisoner-led audit to ensure decent living conditions.[125]

A number of IMBs, such as Lancaster Farms, Preston, Bure, Ranby and Buckley Hall, noted the lack of decency when two prisoners had to share a single cell: at HMP Bullingdon about 80% of single cells were 'doubled' in this way, and the Board there and at HMP Bure and HMP Preston considered that this was inhumane. In some cases, as at HMP Whatton and HMP Lancaster Farms, some prisoners were eating meals alongside unscreened toilets. The Board at HMP Brixton referred to the 'cramped and undignified conditions' for most men there 'sharing small cells, with bunk beds within arm's reach of a toilet shielded only by a flimsy curtain'.[126]

In 2019–20, HMI Prisons found processes for promoting equality and diversity remained underdeveloped or too recently implemented to demonstrate sustained improved outcomes in many prisons. The same findings were reported by IMBs.[127] Outcomes around purposeful activity for prisoners remained poor, and few prisons showed signs of improvement. Most prisoners still spent too much time locked in their cells, with an average of only 13% of prisoners reporting they received the expected 10 hours out of their cell per day. Time out of cell was even more restricted at weekends. At HMP Leeds and HMYOI Feltham B, over 80% of prisoners surveyed told HMI Prisons that they spent 22 hours a day locked up. The situation was generally better in training prisons, but even there

123 IMB, September 2020, Independent Monitoring Boards National Annual Report, 2019-20 https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IMB-national-annual-report-201920-amended-FINAL-.pdf [accessed 30/10/2020]

124 HMI Prisons, October 2020, Her Majesty's Chief Inspector of Prisons 2019-20 Annual Report, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf [accessed 30/10/2020]

125 HMI Prisons, October 2020, Her Majesty's Chief Inspector of Prisons 2019-20 Annual Report, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf [accessed 30/10/2020]

126 IMB, September 2020, Independent Monitoring Boards National Annual Report, 2019-20 https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IMB-national-annual-report-201920-amended-FINAL-.pdf [accessed 30/10/2020]

127 IMB, September 2020, Independent Monitoring Boards National Annual Report, 2019-20 https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IMB-national-annual-report-201920-amended-FINAL-.pdf [accessed 30/10/2020]

less than a quarter of prisoners said they received 10 hours a day out of cell.[128]

Of the adult male establishments inspected by HMI Prisons during the year, fewer than half had rehabilitation and release planning which was judged to be good or reasonably good. In 2019–20, local and category C training prisons performed more poorly than other types of establishment inspected by HMI Prisons. Most open prisons performed well, but homelessness or unstable accommodation on release continued to be a serious problem across the estate, with some local resettlement prisons releasing nearly half of all prisoners to homelessness or temporary accommodation.[129] HMP Liverpool, however, had worked hard to develop a meaningful relationship with the local authority and 85% of its prisoners were released into settled accommodation.

HMI Prisons was concerned that systemic problems with the offender assessment system (OASys) continued to hinder the prompt completion of assessments by HMPPS which manage a prisoner's risk, impeding all subsequent aspects of prisoner progression and risk management. Inspections identified large numbers of prisoners without an up-to-date OASys, affecting as many as 50% of eligible prisoners at HMP Pentonville and 60% at HMP Bullingdon.[130]

In March 2019, the opening of a new separate unit designated for transgender women assessed as high risk was announced at HMP & YOI Downview. The unit had been earmarked for development as a community health and well-being centre, but these plans were paused. The local IMB was highly critical of the short notice re-designation of the wing, leading to continued issues with health care. There were high levels of self-harm in the first three months of the unit opening.[131] In July 2019, the guidance for the care and management of individuals who are transgender was updated.[132]

HMI Prisons reported that, overall, the outcomes in the five women's prisons inspected during the year were good or reasonably good in the areas of safety, respect and purposeful activity. Levels of self-harm remained high in the closed prisons inspected, which was often attributed to a small number of women with very complex needs. Significantly more prisoners in women's than men's prisons (39% compared to 19%) reported being subject to ACCT case management. ACCT case management was found to be good overall, but the quality of some entries in the records was inadequate. Staff-prisoner relationships remained a strength in women's prisons.[133]

128 HMI Prisons, October 2020, Her Majesty's Chief Inspector of Prisons 2019-20 Annual Report, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf [accessed 30/10/2020]

129 HMI Prisons, October 2020, Her Majesty's Chief Inspector of Prisons 2019-20 Annual Report, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf [accessed 30/10/2020]

130 HMI Prisons, October 2020, Her Majesty's Chief Inspector of Prisons 2019-20 Annual Report, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf [accessed 30/10/2020]

131 IMB, December 2019, *Annual report of the IMB at HMP/YOI Downview*, https://www.imb.org.uk/downview-2018-19-annual-report-published/ [accessed 24/08/2020]

132 Gov.uk (webpage last updated 27 January 2020), *Guidance: The care and management of individuals who are transgender* https://www.gov.uk/government/publications/the-care-and-management-of-individuals-who-are-transgender [accessed 30/10/2020]

133 HMI Prisons, October 2020, Her Majesty's Chief Inspector of Prisons 2019-20 Annual Report, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf [accessed 30/10/2020]

Women's prisons in England and Wales, like men's prisons, also had issues with resettlement and had some gaps in providing accommodation on release. Too many women were released homeless or to very short-term accommodation, and none of the prisons inspected measured the sustainability of the accommodation into which prisoners were released. For example, at HMP Eastwood Park, almost half of prisoners discharged in the recent months prior to the inspection had been released either homeless or to very temporary or emergency accommodation. In February 2020, 10 of the 12 IMBs in women's prisons carried out a joint resettlement survey. They found that nearly 60% of the women surveyed did not have settled accommodation on release, yet this overall finding did not seem to be reflected in figures provided by the prisons themselves.[134]

In September 2019, the death of a newborn baby at HMP & YOI Bronzefield gave rise to serious public concern. The mother was detained at the prison and gave birth alone in her cell. Ten reviews are due to take place or are already underway. These include two internal reviews by the prison and by Sodexo (the contractor), a joint investigation by HMPPS and HMP Bronzefield, an NHS clinical review, two police reviews, two social service reviews and the local Child Death Overview Panel and a future coroner's report. Alongside these, the prisons minister Lucy Frazer commissioned the PPO to carry out an ongoing overarching investigation into the death, which will be made public. In a letter responding to the JCHR, she also outlined further actions, including expediting the ongoing review of mother and baby units in prisons to improve data collection on pregnancy in prison.[135] There is no public data on the number of pregnancies, stillbirths or deaths of newborn babies in prison. Research by the health think tank the Nuffield Trust identified 56 prisoners in England who gave birth during their prison stay in 2017–18. Published in February 2020, the research found that six prisoners gave birth either in prison or on their way to hospital. Their research also found that nearly four in 10 hospital appointments made for prisoners are cancelled or missed, they had 24% fewer inpatient admissions and outpatient appointments than the general population and there are signs of lapses of care within prison for certain groups of prisoners.[136]

In Scotland, NPM members identified a number of human rights issues in prisons. Key issues identified included overcrowding, resulting in situations where two prisoners were sharing cells intended for one, and understaffing, resulting in long periods of time locked in cells (in some cases 22–23 hours per day) with inadequate access to exercise, education, employment or other rehabilitative activities. HMIPS also found inconsistencies in the administration, recording and handling of complaints, and a lack of trust in accountability systems among prisoners. Other human rights issues identified related to the isolation of foreign national prisoners, who were often not provided with appropriate translated materials about key processes in prison.

134 IMB, August 2020, Resettlement: A survey by Independent Monitoring Boards of women being released from prison, https://www.imb.org.uk/more-than-half-of-women-prisoners-have-no-settled-home-on-release-reveals-new-report-from-independent-prison-monitors/ [accessed 30/10/2020]

135 Lucy Frazer QC MP, October 2019, *Letter RE: Information on the number of pregnant women in prison*, https://old.parliament.uk/documents/joint-committees/human-rights/correspondence/2019-20/191031%20Response%20from%20Lucy%20Frazer%20QC%20MP%20on%20the%20tragic%20death%20of%20a%20baby%20at%20HMP%20Bronzefield.pdf [accessed 10/11/2020]

136 Nuffield Trust, February 2020, *Locked out? Prisoners' use of hospital care*, https://www.nuffieldtrust.org.uk/research/locked-out-prisoners-use-of-hospital-care [accessed 24/08/2020]

Similarly, HMIPS found that prisons failed to facilitate contact between foreign national prisoners and their families via video link. Inspectors found some prisoners on non-offence and offence protection were unable to access the prison regime and spent a disproportionate amount of time in cells, effectively amounting to conditions of solitary confinement. Continued use of psychoactive substances by prisoners impacted on prisoner behaviour and staff morale. There was a lack of access to advocacy services and some barriers to accessing mental health services. Inspectors were concerned that progression was not being managed sufficiently by the Scottish prison service and that the introduction of the national model had not addressed the issues. For example, HMP Dumfries had no offender management programme available, meaning some prisoners were unable to complete programmes required for parole or rehabilitation progress without moving location. HMIPS continued to raise inconsistencies in health and social care provision by the different health boards as an ongoing issue.

An inspection of HMP Barlinnie in August 2019 was deeply critical and found the prison to be wholly unsuitable for many prisoners. The lack of accessible cells for those with a disability was particularly concerning. Inspectors also commented on the poor overall living conditions and fragile infrastructure in HMP Barlinnie, Scotland's largest prison. HMIPS' report led to a special visit to the prison from the Scottish Parliament Justice Committee. The Committee subsequently echoed serious concerns about conditions in the prison. It has since been announced that a site and funding for a 'new Barlinnie', HMP Glasgow, has been secured. The new prison is not expected to be opened until 2024. In the meantime, funding has also been provided to HMP Barlinnie to remodel the reception area and to rectify the issue of the inadequate holding cells in the reception area, colloquially termed 'dog boxes'. The use of these has been repeatedly highlighted by HMIPS and the CPT as amounting to ill-treatment.[137]

The SHRC continues to report concerns about the high number of outstanding FAIs into deaths in prison in Scotland, as well as in police custody, and a lack of sufficient public scrutiny in the process. There were 37 deaths in Scottish prisons from January to December 2019, including two women, and a further five deaths of men by the end of March 2020.[138] NPM members SHRC and HMIPS did note some positive trends in some of the Scottish prisons inspected in the period, including respectful and helpful staff-prisoner relationships and good, comprehensive information provided in induction (though this was not consistently available in alternative formats and languages). For example, HMP Edinburgh had a well-documented equality and diversity programme and good evidence of participation in it, and was compliant with the Scottish Prison Service Gender Identity and Gender Reassignment policy. There were also positive findings in respect to participation in cultural activities and celebrations and religious observance in HMP YOI Polmont.

Mental health detentions and social care

As of September 2020, data for Wales showed that the number of formal admissions under the Mental Health Act and

137 HMIPS, May 2020, HMP Barlinnie: Full Inspection – 26 August – 6 September 2019, https://www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/Report%20on%20HMP%20Barlinnie%20-%2026-August-6%20September%202019%20-%20Final.pdf [accessed 10/11/2020]

138 Scottish Prison Service, *Prisoner Deaths,* https://www.sps.gov.uk/Corporate/Information/PrisonerDeaths.aspx [accessed 24/08/2020]

other legislation during the year 2017–18 increased to 1,891, of whom 843 were female.[139] CIW reports the total volume of DoLS applications received by local authorities in Wales increased by 6% in 2018–2019. The majority of DoLS applications were for individuals aged 65 or older. The vast majority of applications that were refused were on the grounds of mental incapacity: the authoriser required further evidence that the person lacked the mental capacity to make the decision in question before the DoLS was accepted. Most standard applications were not completed in 28 days. Very few people were referred to Independent Mental Capacity Advocates (IMCAs) or to the Court of Protection. As such, supervisory bodies were unable to assure themselves that people's human rights are not being breached by being deprived of their liberty unlawfully.

During the reporting period, HIW undertook 13 inspections to NHS hospitals including a Children and Adolescent Mental Health Services (CAMHS) unit, a medium secure unit, a learning disability service, a psychiatric intensive care unit and elderly care services across Wales. Generally, HIW reported positive findings. It also undertook 15 independent health care inspections, including to one learning disability hospital, medium secure units and CAMHS units. HIW identified positive findings including respectful staff interactions and engagement with patients from dedicated and motivated staff. It also found that patients were provided with a good range of therapies and activities, and it saw some good examples of care and treatment planning. In some instances, there was good progress on recommendations since previous inspections, less restrictive models of care and effective governance which had a positive impact.

However, HIW also identified issues within these settings relating to failings in the maintenance and refurbishment of often-outdated wards, in some cases impacting on patient safety and dignity, some inappropriate interactions with patients and issues with physical health and inadequate personal alarm systems. Quality of care planning across Wales varied considerably, with some very concerning examples. Staff training in a range of vital areas was also lacking, as was the effective management of medication. HIW identified many good practices in its monitoring of the Mental Health Act, including in implementation and documentation, and a good level of governance and audit. However, there were some recurring issues with unclear or out-of-date records, and significant improvements were required around the admissions processes to ensure detention was appropriate.

In Scotland, MWCS reported that over the past 10 years the total number of compulsory treatment orders (CTOs) in existence in Scotland has risen steadily: by 22 percentage points from 54% to 66% per 100,000 population. In 2018–19, Scotland saw the highest number of episodes of compulsory treatment since new mental health legislation came into effect in 2005, with a 41% increase in longer-term orders over the past 10 years. The rise in rates in community-based detention orders also reached new levels in the last reporting year: nearly half of all CTO detentions are now in the community.[140]

139 Stats Wales, *Admissions to mental health facilities by local health board,* https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Admissions-to-Mental-Health-Facilities/admissionstomentalhealthfacilitiesbylhb [accessed 24/08/2020]

140 MWCS, October 2019, *Mental Health Act Monitoring Report 2018-19,* https://www.mwcscot.org.uk/publications?type=44&leg=54 [accessed 24/08/2020]

MWCS published a themed visit report, *Autism and complex care needs*, in October 2019. This was based on visits undertaken in the previous year. The report made a number of recommendations including: reducing the use of medication for managing behaviours seen as challenging; addressing issues about the use of restraint and seclusion; and addressing the issue of delayed discharges which in many cases compromised human rights as enshrined in Article 19 of the United Nations Convention on the rights of Persons with Disabilities (UNCRPD).[141] MWCS completed an investigation and published a report in September 2019 which examined a case in which a woman with learning disabilities and other care needs, who had been admitted to hospital following a neck fracture, was not discharged from hospital until 18 months after she had been deemed fit to leave. The Commission felt this delay impacted on her human rights. The dispute arose primarily because the health and social care partnership believed the woman should move to a care home, while the family wanted her to return home (where she eventually returned and now lives successfully with the support of her family and social care). The report contains recommendations for the specific organisation involved, and for similar organisations across Scotland.[142]

In England, NHS data shows that in 2019-20 there were more than 50,893 new detentions under the Mental Health Act, with an estimated overall increase of 0.8% from last year. Among the five ethnic groups, known rates of detention for the 'Black or Black British' group were over four times those of the 'White' group. Among age groups, the detention rates for the 18-34 group were 40% higher than those in the 50-56 group.[143]

In May 2019, CQC published its interim report of the review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and/or autism.[144] This report shares findings from visits to 35 wards where it assessed the care of 39 people. It focuses on the experience of those people cared for in segregation on a mental health ward for children and young people or on a ward for people with a learning disability or autism. Findings showed that: many of the people visited had, since childhood, been communicating their distress and needs in a way that neurotypical people may find hard to understand, and services were unable to meet their needs; a high proportion of people in segregation had autism; some of the wards did not have a built environment that was suitable for people with autism; and many staff lacked the necessary training and skills. CQC also found that several people visited were not receiving high quality care and treatment, while some were experiencing delayed discharge from hospital, and therefore prolonged time in segregation, due to there being no suitable package of care available in a non-hospital

141 MWCS, October 2019, *Autism and complex care needs*, https://www.mwcscot.org.uk/news/more-support-needed-people-autism-and-complex-needs [accessed 30/10/2020]

142 MWCS, September 2019, *Investigation into a delayed discharge - Ms ST*, https://www.mwcscot.org.uk/news/investigation-delayed-discharge-ms-st [accessed 24/08/2020]

143 NHS Digital, October 2020, Mental Health Act Statistics, Annual Figures 2019-20, https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2019-20-annual-figures [accessed 01/12/2020]

144 CQC, May 2020, Interim report: Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism, https://www.cqc.org.uk/publications/themed-work/interim-report-review-restraint-prolonged-seclusion-segregation-people [accessed 24/08/2020]

setting.[145] CQC published its final report on restraint, seclusion and segregation on 22 October 2020.[146]

In Northern Ireland, data for 2018–19 shows 1,106 total compulsory admissions under the Mental Health (NI) Order 1986 for mental illness. This was an increase of 12% since 2014. Of the detained patients, 518 (47%) were female. Additionally, there were 35 compulsory admissions under the Order for people with a learning disability, a decrease of 40% since 2014.[147]

RQIA raised concerns about the management of adult safeguarding incidents, serious adverse incidents and near misses which impacted on the safe delivery of care and treatment for patients who were detained across mental health and learning disability inpatient facilities inspected in Northern Ireland. RQIA was concerned about: increased pressures across mental health services impacting on patient safety and care and treatment in inpatient facilities; significant staffing shortages; frequent over-occupancy on wards across inpatient facilities; reduced capacity to receive new admissions; inappropriate admissions to psychiatric intensive care units; and increased environmental risks to patient safety. These concerns resulted in RQIA taking escalation action with three of the five health and social care trusts. Three of the five trusts in Northern Ireland have inpatient facilities which require environmental improvements, with RQIA identifying potential risks associated with old hospital wards such as a high number of ligature points.

In August 2019, RQIA took enforcement action against the Belfast Health and Social Care Trust in respect to serious concerns about staffing, safeguarding and the management of patients' finances and property (Article 116 Mental Health (NI) Order 1986) in Muckamore Abbey Hospital. The hospital provides inpatient assessment and treatment facilities for people with severe learning disabilities and mental health needs.[148] The action followed reports of abuse of patients and the suspension of 20 nurses in 2018, with police investigations ongoing.[149] In particular, CCTV footage from the hospital revealed approximately 1,500 crimes against patients in the hospital's psychiatric intensive care unit over a six-month period in 2017 to 2018. A February 2019 review into the treatment of patients by Dr Margaret Flynn said there were 'catastrophic failings' in the hospital.[150] Throughout 2019–2020, RQIA completed a series of inspections of the hospital and supported the Trust to address the improvements required to comply with the actions as set out in the Improvement Notices. At the beginning of 2020, significant improvements had been made and all three Improvement Notices were removed.

145 CQC, May 2019, Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability or autism Interim report, https://www.cqc.org.uk/sites/default/files/20191118_rssinterimreport_full.pdf [accessed 16/12/2020]

146 CQC, October 2020, Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people and people with a learning disability and/or mental health condition, https://www.cqc.org.uk/sites/default/files/20201023_rssreview_report.pdf [accessed 01/12/2020]

147 Department of Health, August 2019, *Mental health and learning disability inpatients 2018/19*, https://www.health-ni.gov.uk/publications/mental-health-and-learning-disability-inpatients-201819 [accessed 24/08/2020]

148 BBC News, September 2020, Muckamore Abbey Hospital: Timeline of abuse allegations, available: https://www.bbc.co.uk/news/uk-northern-ireland-49498971 [accessed 16/09/2020]

149 BBC News, August 2019, Muckamore Abbey: RQIA takes action after abuse claims, https://www.bbc.co.uk/news/uk-northern-ireland-49372659 [accessed 24/08/2020]

150 Belfast Trust, February 2019, *Summary of Muckamore Abbey Hospital – A Way to Go*, https://belfasttrust.hscni.net/wpfd_file/summary-of-mah-safeguarding-review/ [accessed 16/09/2020]

At this time, RQIA was also concerned about some deficits in the quality of the information recording mental health detention. This followed an audit of the forms that were submitted to detain patients in hospital for treatment for a period of up to six months, in accordance with the Mental Health (NI) Order 1986. RQIA is working with health and social care trusts, the Department of Health and the Royal College of Psychiatrists to improve the process, and will complete a further audit to ensure progress is being made.

Children in detention

While some developments in children's secure care have been found by NPM members to be positive, national challenges remain. NPM members have identified significant issues across secure settings for children more broadly, particularly in YOIs.

MWCS reported rising rates of detention among children and young people in Scotland, with its figures indicating that about 100 young people were admitted (not necessarily detained) in the wrong setting (in adult wards) last year.[151] MWCs' submission to the ongoing review of the Mental Health Act in Scotland also highlighted its concern that keeping the need for continued detention under review is not well realised in practice, and it will be doing more work in this area in the year ahead.

As part of the move towards integrating care and justice settings which provide secure accommodation for children in Northern Ireland, the referral and admission process into Lakewood Regional Secure Care Centre has now been revised, with beds allocated through a regional multi-agency panel. The panel also monitors the care and services a young person is receiving, as well as discharge planning. Broader work on the integration, which will organise placement on a young person's individual needs and risk management factors rather than the reason for detention, continues. It is hoped that this new approach will also feature an improved approach for reintegration into the community. Lakewood is the only Regional Secure Care Centre for children in Northern Ireland. RQIA was concerned about a rising number of incidents involving illicit drug use, self-harm, absconding and other concerning behaviours at Lakewood. It saw potential for young people's safety and liberty to be impacted by poorly delivered care and has scrutinised the host health and social care trust which is now reviewing its arrangements for safeguarding children in residential care.

The Beechcroft Child and Adolescent Mental Health unit, in Belfast, closed one ward for 15 weeks in 2019 due to risks arising from unsafe staffing levels (indicative of nursing recruitment challenges across Northern Ireland). Belfast Health and Social Care Trust, which manages the site, recruited a number of agency staff to fill essential gaps, but this was a temporary solution. RQIA found the psychiatric intensive care unit in Beechcroft needed improvement. RQIA called for a review of the use of blanket restrictions at the facility, which are aimed to prevent absconding but may also hinder young people in gaining confidence or

151 MWCS, March 2020, Young people monitoring report 2018/19 https://www.mwcscot.org.uk/sites/default/files/2020-05/YoungPeopleMonitoringReport_2018-19.pdf [accessed 30/10/2020]

self-management skills, particularly when preparing for discharge. An inspection of the Iveagh unit, a hospital inpatient facility for young people with a learning disability and additional mental health problems, revealed ongoing delays in the discharge of children to suitable alternatives in the community. This has been raised as an area for improvement with the host trust and is also being monitored by the Northern Ireland Commissioner for Children and Young People.

CQC found a number of serious failings in its ICETRs regarding appropriate and suitable care for children and adolescents who have a learning disability and/or autism who are admitted to hospital. CQC found: overly restrictive conditions; unsuitable environments and inappropriate placements with inadequate specialist involvement; poor discharge and/or transition planning; and failures of communication with patients, their families and/or their carers.[152]

The CCE is concerned about informal admissions to mental health hospitals, with evidence that children are being asked to agree to be 'informal' patients and not to be sectioned. In particular, the CCE is concerned that children only agree to be 'informal' patients because they think they will be sectioned if they do not, which in effect removes the element of 'choice'.[153]

Ofsted reported the closure of one secure children's home (SCH) in England in the reporting year, which further reduced the capacity of the service to 13 homes (compared to the 29 operational in 2002). The National Secure Welfare Commissioning Unit reported that high numbers of children (around 25) are waiting for places every day, while around 20 children are placed in Scottish SCHs at any time due to the lack of provision in England. Ofsted, the CCE and local authorities remain concerned about England's insufficient capacity to ensure very vulnerable children with complex needs have placements.

During this reporting period, Ofsted found a decline in the performance of SCHs compared to previous years, which have generally seen positive inspection judgements. Of the 13 SCHs, three were 'inadequate', two were 'requires improvement to be good', six were 'good' and two were 'outstanding'. Those judged as less than good generally had issues with weaknesses in leadership, management and monitoring activity. Other areas of concern included SCHs regularly having to challenge placing authorities so that plans are in place for suitable accommodation and support for when children leave the home. Four settings were served with compliance notices, and one was also served with a notice restricting new placements.[154]

152 CQC, May 2020, Interim report: Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism, https://www.cqc.org.uk/publications/themed-work/interim-report-review-restraint-prolonged-seclusion-segregation-people [accessed 24/08/2020]

153 CCE, May 2019, Far less than they deserve: Children with learning disabilities or autism living in mental health hospitals, https://www.childrenscommissioner.gov.uk/wp-content/uploads/2019/05/CCO-far-less-than-they-deserve-2019.pdf, [accessed 10/11/2020]

154 The aim of compliance notices is to clarify to the provider that they must remedy a specific matter. An offence is committed if they do not complete the step(s) set out in a compliance notice by the date specified. A restriction notice prevents a provision from accepting any new placements, while allowing the children residing at the home to remain.

In its subsequent visits, Ofsted noted improvement in all four settings, which complied fully with the notices. A follow-up inspection to the home where a restriction notice was served noted significant improvement and the restriction was lifted. Across SCHs in England, physical and emotional health provision has been further strengthened through commissioning with NHS England and the embedding of the 'secure stairs' model (an integrated care framework that addresses the needs of children in the secure estate).

CIW reported improvements to the management of Wales' only SCH, while CI noted that four of the five secure accommodation services for children and young people in Scotland continued to be of a good quality and achieve high evaluations. However, CI was particularly concerned about children who are not in a registered secure setting but whose liberty or rights may be restricted. This includes services, many of which are small, set up as 'alternatives to secure' accommodation which provide placements some distance from a child's home, including placements for children from other parts of the UK. CI has identified issues around potential isolation, the challenges these services face in properly understanding and meeting children's' needs and the availability of appropriate education and timely and informed access to health provision, including provision of mental health services.

In May 2019, the CCE published a report on the detention of children in England across all settings. As there are various methods of reporting on the detention of children, the CCE combined data from a range of sources and found that 1,465 children in England were securely detained in March 2018. Of these, 873 were detained in youth justice settings, 505 were detained under the Mental Health Act and 87 were placed in SCHs for their own safety. In total, the CCE estimated that it costs over £300 million a year to look after these children. They also found that there are at least 200 children deprived of their liberty in other settings that are unknown to the public due to a lack of data. The CCE is concerned that there is no proper oversight for these vulnerable children.[155]

The IMB continued to report severe problems and delays in transferring seriously mentally ill young people from the youth justice estate into mental health and secure care, due to a lack of sufficient alternative provision (particularly for those approaching 18 years of age).[156]

Also in May 2019, the CCE published a report on children with learning disabilities or autism living in mental health hospitals. They found that many children were being unnecessarily admitted to secure hospitals. In some cases children were spending months and even years in institutions. The average time children with autism and/or a learning disability had spent in their current hospital was six months. One in four did not appear to have had a formal review of their care plan in over six months. Of 250 children in these settings, 95 were staying at sites known to be more than 31 miles

155 CCE, May 2019, *Who are they? Where are they?*, https://www.childrenscommissioner.gov.uk/report/who-are-they-where-are-they/ [accessed 24/08/2020]

156 IMB, September 2020, Independent Monitoring Boards National Annual Report, 2019-20 https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IMB-national-annual-report-201920-amended-FINAL-.pdf [accessed 30/10/2020]

from home. The CCE stated that the current system in place to support those with learning disabilities and/or autism is letting down vulnerable children in England. They also highlighted evidence of restrictive practices and the use of sedation. The CCE stated that some children described how their stays in mental health hospitals had been traumatic. The CCE recommended a cross-government plan to provide community support for children and new funding for the right support in the community to enable children to stay with their families.[157]

The CCE was also concerned about the number of children remanded into custody. As of October 2020, youth justice monthly statistics show that children on remand now account for 33% of the entire youth custody population.[158] The proportion of children on remand has been steadily increasing over the last four years. Of the children remanded to youth detention accommodation, using all courts data in 2019, 34% received a non-custodial sentence, 32% were acquitted and 34% were sentenced to immediate custody.[159] In 2018–19, a higher proportion of children from all ethnic groups other than white compared to white children in custody were there on remand (33% compared to 24%), raising serious concerns about a particularly stark disproportionality.[160]

HMICFRS began to identify some small improvements to be made for the welfare of children in police custody in England and Wales, and has continued to focus on how quickly children are moved through custody. However, when children are charged and refused bail they continue to remain in custody for too long and are rarely moved to local authority accommodation as they should be.

HMI Prisons found varied progress during seven inspections of five YOIs across England and Wales in the reporting period. Standards of care for children at risk of self-harm had improved in all YOIs except HMYOI Feltham A, where self-harm had risen dramatically. However, inspectors found good practice at HMYOI Werrington, where a database recorded significant triggers for self-harm, such as bereavements, and staff were sent reminders to enhance their observations and awareness of any concerning behaviour. While children had reasonably good time out of cell on weekdays at HMYOI Parc and HMYOI Werrington, elsewhere they did not have enough time outside their cells to access everyday basics, including association, showers and telephone calls and, in many cases, education. At HMYOI Feltham A, children were unlocked on average for only 4.2 hours on a weekday and much less at weekends.

157 CCE, May 2019, *Far less than they deserve*, https://www.childrenscommissioner.gov.uk/report/far-less-than-they-deserve/ [accessed 24/08/2020]

158 UK Government, October 2020, Youth custody data, https://www.gov.uk/government/statistics/youth-custody-data#history [accessed 30/10/2020]

159 UK Government, January 2020, Youth justice statistics: 2018-19, https://www.gov.uk/government/statistics/youth-justice-statistics-2018-to-2019 [accessed 01/12/2020]

160 UK Government, May 2020, Ethnicity facts and figures: Young people in custody, https://www.ethnicity-facts-figures.service.gov.uk/crime-justice-and-the-law/courts-sentencing-and-tribunals/young-people-in-custody/latest [accessed 10/11/2020]

In July 2019, HMI Prisons issued an Urgent Notification to the Secretary of State for Justice highlighting concerns about HMYOI Feltham A. This was the first use of the process for an establishment which detains children, and the Urgent Notification was issued after inspectors found unacceptable treatment and conditions and 'overwhelming' problems with safety. Issues included: ungoverned use of force; a lack of access to proper education or reliable access to health care; and children subject to behaviour management that was almost exclusively focused on punishment. Levels of self-harm were 14 times higher than in 2017, and a poor and unpredictable regime was dominated by the 'keep-apart' policy to separate children from rival gangs, which disrupted daily life. Ofsted, which took part in the joint inspection, judged the provision of and attendance at education as 'inadequate'. Many children were released without stable accommodation, education, training or employment or support from families.[161] In order to make improvements at Feltham, children were diverted to other YOIs, but this created new challenges at, for example, HMYOI Cookham Wood, which had staffing shortages at the same time as it received more children.

HMI Prisons published a thematic review on the separation of children aged 15–18 in YOIs in England and Wales, finding that most children separated from their peers experienced a regime that amounted to the widely-accepted definition of solitary confinement, with little human contact and in conditions which risked damaging their mental health. There were dramatic variations in childrens' experiences of separation across the five YOIs reported on and between different units in the same establishment, which was 'inexplicable' in a small custodial estate holding just over 600 children.[162] Around one in 10 children were found to be separated at the time of inspection. Checks by managers, nurses and chaplains gave an illusion of oversight, but were cursory, often took place though a locked door and sometimes did not happen at all. The report noted some areas of better practice, particularly at HMYOI Parc, but generally identified 'multiple and widespread failings'.

The IMB also reported concerns about segregation in YOIs, with some children being segregated for many weeks even when they had serious mental health conditions. Cookham Wood IMB reported two incidences of children being segregated for over 90 days, and two others for more than six weeks. More widely, all IMBs in the under-18s estate expressed concerns about the high and often growing level of self-harm, particularly among young people with severe behavioural difficulties and mental health concerns.[163]

161 HMI Prisons, August 2019, *Urgent Notification: HMYOI Feltham A*, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/08/LC-to-Peter-Clarke-HMYOI-Feltham-A.pdf [accessed 24/08/2020]

162 HMI Prisons, January 2020, *Separation of children in young offender institutions*, https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/separation-of-children-in-young-offender-institutions/ [accessed 24/08/2020]

163 IMB, September 2020, Independent Monitoring Boards National Annual Report, 2019-20 https://www.imb.org.uk/prisons-remained-tightly-stretched-pre-covid-says-independent-national-monitoring-report-2019-20/ [accessed 30/10/2020]

The CCE also highlighted issues with the continued restrictions to regimes in YOIs and secure training centres. This reporting year, a series of unannounced visits to establishments on weekend days by the CCE uncovered the common practice in some YOIs for children to spend more than 22 hours in their cells over the weekend. The CCE continued to state concern about the increasing use of restrictive physical interventions (RPIs). The number of RPIs increased by 16% in the last year, to around 6,300 incidents.[164]

HMI Prisons found children in YOIs in England and Wales were more negative about their treatment by staff, time out of cell and access to everyday essentials than those held in secure training centres (STCs), according to an analysis of the perceptions of their experiences in 2018–19. In the latest annual *Children in Custody* report, published in February 2020, HMI Prisons reported on an analysis of 12–18-year-olds' perceptions of their experiences in custody. Nearly 80% of all children aged 12 to 18 who are held in custody are in YOIs: 712 out of a total of 920 at the end of March 2019. YOIs are designed to hold 15–18-year-olds and the majority are 16 and 17. However, as in previous years, the most pressing issues for children were the increasing levels of bullying and violence across both YOIs and STCs. Forty-eight per cent of children reported having experienced victimisation by other children in their current establishment. The rising levels of violence led to increasing use of restraint and separation. Nearly two-thirds of children reported being subject to restraint and 59% reported having been kept locked up and stopped from mixing with other children as a punishment.[165]

Three STCs were operational during 2019–20 in England, with inspections led by Ofsted alongside HMI Prisons and CQC. Inspections of Oakhill and Rainsbrook delivered judgements of 'requires improvement to be good'. Medway was judged 'inadequate' in October 2019. Following this judgement, Ofsted, on behalf of the joint inspectorates, wrote to the Secretary of State for Justice to raise concerns about significant failures leaving children unsafe. Ofsted and partner inspectorates carried out a further visit to Medway in December 2019 to assess what action it had taken to ensure children were safer. The inspection found that some progress had been made in some areas to improve practice; however, little progress had been made in those areas that significantly impact on children's experiences, well-being and safety, and senior managers were too slow to accept this and respond. Medway was closed on 31 March 2020 as part of the government's plans to develop the first secure school (see 'Secure schools', p.29). Medway was run by G4S until June 2016, from which point it was then managed by HMPPS until its closure.

Inspections of STCs continue to reflect concerns about levels of violence, use of force and physical restraint, the safety of children and staff and the levels of staff skill and knowledge to care appropriately for children. However, emotional health provision is being strengthened through commissioning with NHS England and the introduction of the 'secure stairs' model.

164 MoJ, January 2020, Youth Justice Statistics 2018/19, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/862078/youth-justice-statistics-bulletin-march-2019.pdf [accessed 30/10/2020]

165 HMI Prisons, February 2020, *Children in Custody 2018–19*, https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/children-in-custody-2018-19/ [accessed 24/08/2020]

Immigration detention

Around 24,400 people entered immigration detention in the UK in the 12 months ending December 2019, the lowest number since 2009. The Home Office detained 73 children for immigration-related purposes in that period. In 2019, detainees who had sought asylum accounted for 58% (14,086) of people entering detention. Analysis by Migration Observatory found that around half of those entering immigration detention have claimed asylum in the UK since 2009.[166]

During the reporting year, HMI Prisons inspected three of the seven immigration removal centres (IRCs) around the UK. Outcomes at Morton Hall and Brook House IRCs had improved to at least reasonably good. While inspectors found Colnbrook IRC to be a reasonably respectful centre during their 2018 inspection, safety outcomes had declined and were not sufficiently good. Inspectors found that anxiety about immigration status and removal led to many detainees feeling unsafe.[167]

Self-harm had risen at all three of the IRCs inspected during the reporting year. A notable percentage of detainees said they had felt suicidal while in detention (46% in Colnbrook, 40% in Brook House and 29% in Morton Hall), reflecting a high level of distress among the population. The number of self-harm incidents had risen substantially in every centre and was particularly high in Morton Hall. Procedures to monitor and care for detainees at risk of self-harm were generally good in Morton Hall and Colnbrook, but at Brook House assessment, care in detention and teamwork case management was not implemented well enough. At all centres, there was insufficient attendance at reviews by Home Office staff, even though the stress of uncertain immigration status, removal and detention without time limit were the most common risk factors.[168]

IMBs reported a trend for shorter periods of detention, which the NPM welcomes. However, the 2% of detainees who stay more than six months still represent appreciable numbers of people who remain in detention: as of 31 December 2019, 26 detainees at Harmondsworth IRC had been held for over six months, and the longest stay there during 2019 was two years and eight months. At Brook House, as of 31 December 2019, two men had been in detention for more than a year; at Dungavel, one detainee had.[169]

166 Migration Observatory, May 2020, *Immigration Detention in the UK*, https://migrationobservatory.ox.ac.uk/resources/briefings/immigration-detention-in-the-uk/ [accessed 24/08/2020]

167 HMI Prisons, October 2020, Her Majesty's Chief Inspector of Prisons 2019-20 Annual Report, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf [accessed 30/10/2020]

168 HMI Prisons, October 2020, Her Majesty's Chief Inspector of Prisons 2019-20 Annual Report, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf [accessed 30/10/2020]

169 IMB, October 2020, Immigration Detention Estate: Annual Report 2019, https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IDE-National-Annual-Report-for-publication.pdf [accessed 10/11/2020]

All IMBs acknowledged improvements in health care over the years, but concern, particularly about the mental health of detainees, remained. One of the most serious indicators of vulnerability by virtue of mental ill-health is the number of detainees who are sectioned under the Mental Health Act. In 2019, seven detainees at Harmondsworth were sectioned; at Yarl's Wood, five were. The figure for Yarl's Wood includes a woman who had previously been sectioned in 2014. She was immediately identified as an Adult at Risk and was subsequently sectioned again, but because of administrative problems in the area where she had previously been registered, there was a delay of 49 days from sectioning before she was transferred to a mental health bed.[170]

A second indicator of vulnerability and harm in detention is self-harm, which IMBs reported as still being a worrying feature of life in detention. At Yarl's Wood, there were 54 cases of self-harm during 2019, which is more than the total for 2018, even though there were fewer detainees. At Harmondsworth, there was an average of two to three incidents of serious self-harm, requiring external medical attention, per month. At Morton Hall, there were 202 incidents of self-harm in 2019, which equated to a similar rate to 2018.[171]

There were also examples of detainees with other vulnerabilities, such as physical or other disabilities, being detained, with inadequate provision for their needs. At Harmondsworth, the IMB reported that detainees included those who use wheelchairs as well as those who are partially sighted or have learning difficulties. The Board did not consider the IRC to be suitable for these detainees, particularly as there is no provision for social care, and cited a continuing problem with an unreliable main lift.[172]

At Tinsley House, Yarl's Wood and Dungavel, IMBs reported that levels of violence were low during 2019. The Tinsley House Board in particular described the atmosphere in the IRC as being very safe. At Harmondsworth, Morton Hall and Brook House, however, IMBs were concerned about levels of violence. The Brook House Board reported 20 detainee-on-detainee assaults, 260 threats of violence, 24 fights and 82 assaults on staff during 2019.[173]

HMI Prisons found that physical security arrangements remained disproportionate in IRCs which were inspected during the reporting year. Detainees were often confined to their rooms for prolonged periods, and handcuffs were also used excessively for some detainees attending outside appointments.[174] In 2018, IMBs at Harmondsworth, Campsfield House (now closed) and Brook House IRCs had reported unacceptably high rates of handcuffing of detainees on external visits – for example 92% of detainees were handcuffed on

170 IMB, October 2020, Immigration Detention Estate: Annual Report 2019, https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IDE-National-Annual-Report-for-publication.pdf [accessed 10/11/2020]

171 IMB, October 2020, Immigration Detention Estate: Annual Report 2019, https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IDE-National-Annual-Report-for-publication.pdf [accessed 10/11/2020]

172 IMB, October 2020, Immigration Detention Estate: Annual Report 2019, https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IDE-National-Annual-Report-for-publication.pdf [accessed 10/11/2020]

173 IMB, October 2020, Immigration Detention Estate: Annual Report 2019, https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IDE-National-Annual-Report-for-publication.pdf [accessed 10/11/2020]

174 HMI Prisons, October 2020, Her Majesty's Chief Inspector of Prisons 2019-20 Annual Report, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf [accessed 30/10/2020]

external visits at Harmondsworth. After concerns were raised with Immigration Enforcement and with the then Immigration Minister, the rate for December 2018 fell to 59%. This level was not maintained across all sites during 2019: at Harmondsworth the rate for the six months to December 2019 was 75%, while at Brook House the rate over 2019 was 66%.[175]

There was some refurbishment in short-term holding facilities (STHFs) at ports and airports but at Heathrow Airport Terminal 5 STHF, there were still no showers in the holding room. The problems with legionella bacteria, causing the showers in the other holding rooms to be out of use for months at a time, persisted during 2019. There were also no showers in the holding rooms at either Glasgow or Edinburgh airports. The lack of privacy for the toilets in Festival Court reporting centre continued to be a matter of concern.[176]

In addition to IRCs and STHFs, HMI Prisons inspected two detainee removal flights. During these overseas escorts, inspectors continued to identify a disproportionate approach to risk and excessive use of restraints.[177]

The IMB Charter Flight Monitoring Team (CFMT) considered the use of restraint necessary, reasonable and proportionate in many, but not all, cases. According to its observations, restraint has, on occasion, been used in response to a simple statement of reluctance to leave, not accompanied by verbal threats or physical resistance on the part of the detainee. Furthermore, the CFMT raised concerns that people removed under the provisions of the Dublin Convention, who were being removed to the European country where their asylum claims were to be determined, were subject to greater levels of restraint than other returnees. One in 10 detainees on the flight to West Africa in September were restrained; five in eight detainees on the flights to Germany and Kosovo in November were restrained. While monitoring a flight to Germany in July 2019, the IMB CFMT witnessed an extremely distressing incident. Two men who had self-harmed shortly before being handed over to escorts were presented without having had their injuries medically treated, and, in one case, semi-naked. IMB monitors considered that the treatment of these two men was degrading and inhumane.[178]

175 IMB, October 2020, Immigration Detention Estate: Annual Report 2019, https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IDE-National-Annual-Report-for-publication.pdf [accessed 10/11/2020]

176 IMB, October 2020, Immigration Detention Estate: Annual Report 2019, https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IDE-National-Annual-Report-for-publication.pdf [accessed 10/11/2020]

177 HMI Prisons, October 2020, Her Majesty's Chief Inspector of Prisons 2019-20 Annual Report, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf [accessed 30/10/2020]

178 IMB, October 2020, Immigration Detention Estate: Annual Report 2019, https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/10/IDE-National-Annual-Report-for-publication.pdf [accessed 10/11/2020]

Police and court custody

The Police Service of Northern Ireland recorded 26,284 detained persons through custody in the 2019–20. During this time, NIPBICVS reported that Independent Custody Visitors (ICV) in Northern Ireland were able to complete 503 custody visits, 49 of which were to the Serious Crime Suite to visit detainees arrested under the Terrorism Act 2000. At the time of the visits a total of 1,139 detainees were in custody and ICVs interviewed 42% of them. Visitors also inspected 814 (72%) custody records to check on the rights, health and well-being of detainees and conditions of detention.

After initial increases following the establishment of self-introduction (where ICVs are visible and introduce themselves to detainees) by ICVs in 2018, NIPBICVS reported a downward trend in the uptake of interviews by detainees in the Serious Crime Suite, with a refusal rate of 27%. It plans to do more work to improve this issue, including with the IRTL and its human rights team. ICVs report that in 90% of visits to custody the conditions for detainees were satisfactory, with the 10% of unsatisfactory visits recorded for a range of reasons, including most often the detainee requiring an appropriate adult or interpreter, or medical attention.[179] Since the COVID-19 pandemic, police in Northern Ireland have introduced 'spit and bite guards' (an item designed to reduce the risk of diseases and injuries associated with spitting and biting), which NIPBICVS continues to monitor.

In Scotland, in over 1,308 unannounced visits, ICVS reported no significant issues regarding care or ill-treatment. The material conditions of the custody estate were found to vary across Scotland and monitors sometimes found poor quality cells. For example, ICVs reported that not all cells had hand washing facilities in them and individuals were unable to wash their hands unless they requested to and were escorted out of cell. Throughout the custody estate, ICVs were concerned at the length of time it took police authorities to address issues associated with material repairs once raised by ICVs. This was echoed by HMIPS inspectors who, in their inspections of court custody units, found similar variations in conditions, with some units having offensive graffiti.[180]

HMICS focused on the strategic arrangements for the delivery of police custody across Scotland in 2019–20.[181] It found many positive developments including: the recruitment of 150 custody staff; benefits arising from remodelling suites; extensive efforts made to involve statutory and voluntary sector partners in promoting better outcomes for detainees and communities; and a reduction in custody-related complaints. However, a lack of capital investment in the custody estate continued to impede efforts to deliver as efficient and effective custody service as possible, and there was an ongoing lack of publicly available information about custody. HMICS also found that the ongoing introduction of constable-led custody centres needed further work on safeguards. During the inspection period, HMICS was able to close 11 outstanding recommendations and 18 improvement actions on custody in

179 NIPB, July 2020, *Annual Custody Visitors Annual Report April 2019 - March 2020*, https://www.nipolicingboard.org.uk/publication/annual-custody-visitors-annual-report-april-2019-march-2020 [accessed 24/08/2020]

180 HMIPS, February 2020, Report on the inspection of Court Custody Provision at Glasgow Sheriff Court, 24 February 2020, https://www.prisonsinspectoratescotland.gov.uk/publications/report-inspection-court-custody-provision-glasgow-sheriff-court-24-february-2020 [accessed 30/10/2020]

181 HMICS, June 2019, *Inspection of the strategic arrangements for the delivery of police custody*. https://www.hmics.scot/sites/default/files/publications/HMICS20190606PUB.pdf [accessed 22/10/2020]

Scotland. HMICS also recommended that SPA improve visibility of the work of the ICVS in Scotland, which SPA maintains and manages, and review governance functions as they relate to independent custody visiting. HMICS specifically queried whether it is appropriate that ICVS is managed by the SPA given the inherent conflict of interest in their roles.[182]

HMICS also completed an inspection of custody centres in Greater Glasgow.[183] The findings reflected concerns raised in the nationwide inspections completed in 2018.[184] The report, published in June 2019, found issues with: queueing and processing times; delays with a new policy allowing lower-risk detainees a period of continuous rest or sleep for three hours (rather than a blanket policy of hourly rousing); and a lack of observation and accessible cells across the region (though following inspection the number of observation cells has increased). Inspectors also found a reduced number of full-time custody centres in the division was increasing the time some officers spent travelling with detainees.

Inspectors were concerned that a much greater use of constant observations in the region than elsewhere in Scotland was impacting on resources for local policing and required further analysis. HMICS also highlighted that detainees across Greater Glasgow benefitted from full-time nurse-led health care provision, based at Govan custody centre, and that a number of improvements had been made to physical conditions. Nationally, HMICS continues to be concerned about ongoing deficiencies in the oversight of health care in custody, due to a lack of independent scrutiny by Healthcare Improvement Scotland. However, a bid for resourcing this has now been submitted to the Scottish Government for consideration, which would allow a joint programme of inspection to be developed and delivered.

In England and Wales, NPM members found most police forces were not good enough at collating and monitoring important custody performance data, with gaps in important information or poor data quality, including the length of time detainees spent in custody and the level of care received. Detainees requiring mental health assessment frequently waited for excessive periods. In some instances, people were detained under section 136 of the Mental Health Act to be sent to a health-based place of safety at the end of their police detention because an assessment had not been carried out in custody, and it was not deemed safe to release them. ICVs reported unacceptable delays in transferring prisoners out of police custody, including those waiting for mental health beds or awaiting transport to prison.

182 HMIPS, September 2019, *Thematic Inspection of the Scottish Police Authority*, https://www.hmics.scot/publications/thematic-inspection-scottish-police-authority [accessed 31/08/2020]

183 HMICS, June 2019, *Inspection of custody centres in Greater Glasgow Division*, https://www.hmics.scot/sites/default/files/publications/HMICS20190612PUB.pdf [accessed 22/10/2020]

184 HMICS, October 2018, *Inspection of custody centres across Scotland*, https://www.hmics.scot/sites/default/files/publications/HMICS20181019PUB.pdf [accessed 24/08/2020]

HMI Prisons, HMICFRS and ICVs reported that detainees who needed them did not always receive the support of Appropriate Adults or had to wait too long for this support. ICVs additionally reported delays in accessing mental health support in the custody suite and incomplete detainee risk assessments. HMI Prisons and HMICFRS reported that governance of use of force was weak in all forces inspected in England and Wales.[185] Data were often not readily available and were unreliable or inaccurate, and not all staff involved in using force against detainees routinely completed the individual forms required to justify its use. There was too little quality assurance of incidents where force was used. This was an ongoing concern or area for improvement in all police custody inspection reports. Despite these weaknesses in governance, custody staff generally managed challenging detainees well and de-escalated many situations effectively without resorting to using force. HMICFRS also stated that review of detention (as required by PACE) to decide whether a further period of detention for the detainee should be authorised were often not carried out well enough.

HMI Prisons, HMICFRS and ICVs reported that there were some improvements to the police's approach to managing the welfare needs of women in custody, with more being offered the opportunity to speak with a female officer and provision of suitable menstrual care products, though this was not universal and concerns remain in some areas. ICVs reported seeing no female members of staff in the suites, and problems with women in custody accessing showers.

ICVs in England and Wales made some positive reports of detainee care in the period. This included specific cases where staff have supported vulnerable detainees. In addition to this, several schemes reported effective working between the custody staff and the ICVs, with time being taken to explain processes, offering of shadowing opportunities and engaging with ICVs during busy periods in custody. However, there were staffing issues in police custody over the period, including being short-staffed, which ICVs reported as having unacceptable impacts on detainee care, and issues with ICVs themselves attaining access to custody and detainees.

HMI Prisons and HMICFRS jointly carried out the first inspections of the five custody suites used for holding suspects arrested for terrorism or terrorist-related offences. Overall, inspectors found many positive features and good outcomes for detainees. Custody staff provided good care for detainees, and the conditions in which detainees were held were generally of a good standard. However, there was a lack of integration between counter terrorism policing and custody services in the host police forces. The main areas identified for improvement related to governance, oversight and consistency of approaches and procedures across the facilities.

185 HMI Prisons, October 2020, Her Majesty's Chief Inspector of Prisons Annual Report 2019-20, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf [accessed 30/10/2020]

HMI Prisons carried out three inspections of court custody facilities in England and Wales during the reporting year, which covered five crown courts, 16 magistrates' courts, eight combined courts and one immigration and asylum chamber. In all the court custody facilities, inspectors found that generally good attention was paid to ensuring detainees' legal rights were met. Detainees were mostly kept in reasonable conditions and were treated well during their time in court custody. Inspectors were concerned that some detainees continued to be held in custody for longer than necessary. Force was used relatively infrequently, and when it was, it seemed generally proportionate and reasonable. However, it was of continued concern that in all the courts inspected, detainees (including children) were subjected to routine and excessive handcuffing in the absence of individual risk assessments and despite the secure environment.

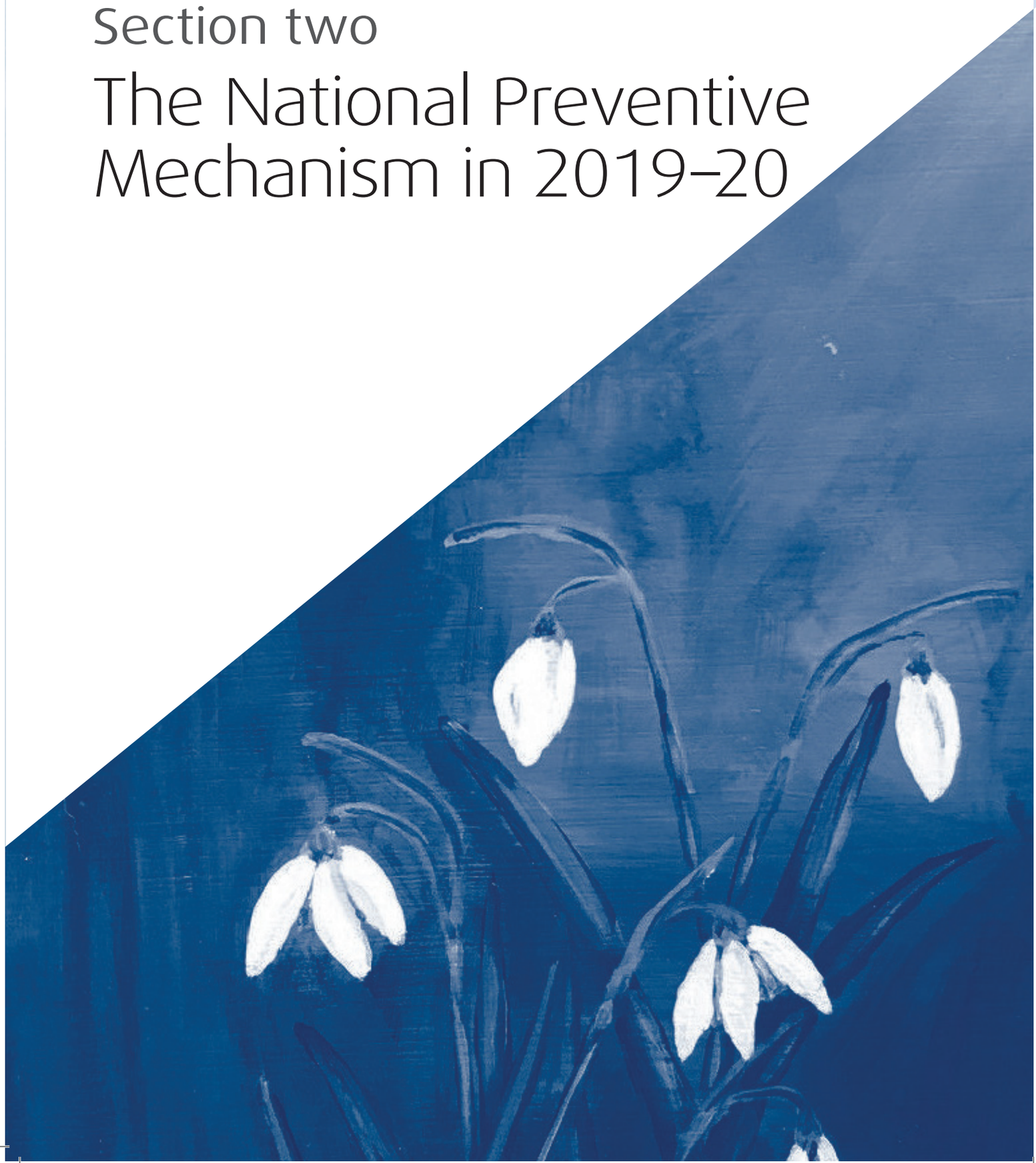
HMI Prisons inspections took place alongside regular oversight from the Lay Observers (LO), who reported that incomplete and poor-quality Person Escort Records (PERs) were preventing escort and custody officers from undertaking vital risk assessments. There were also ineffectively and improperly implemented health care procedures; poor conditions in a number of custody suites; issues with the escort, court custody arrangements and treatment of children and young people; and long delays in the release or transfer of detained people. For example, an LO report from Bradford Magistrates' Court recorded that a 14-year-old child arrived in the custody suite at 8.46am. He was then kept in his cell until his court appearance at 3.08pm which finished at 4.05pm. He eventually left the custody suite for his onward journey to a YOI at 8pm. That meant he had been held in the cells for over 11 hours and he did not arrive at his destination until late at night. This does not happen with adults as most prisons have a deadline for receiving detainees from court. Frequently children and young people are transported on vans with adults in contravention of the Beijing expectations 'that Juveniles under detention pending trial shall be kept separate from adults.'[186] As a result, children and young people are held on vans until all adults have been returned to their establishments and then transported to theirs last. LOs regarded this is as a lack of respect and decency for such young, vulnerable people.

LOs also undertook a detailed analysis of the location of observers and courts, to provide information for the restructure of the regions to be more effective in terms of time and access. Three surveys were conducted to establish the impact of developments introduced by the Prisoner and Escort Custody Service (PECS). They focused on: the publication of a guidance document on the management of medication for detained persons produced by NHS England; the publication of guidance with two flowcharts for control of extreme temperatures; and the introduction of commercially-produced distraction packs for people in detention.

186 United Nations, 1985, United Nations Standard Minimum Rules for the Administration of Juvenile Justice ("The Beijing Rules"), https://www.ohchr.org/Documents/ProfessionalInterest/beijingrules.pdf [accessed 10/11/2020]

Section two

The National Preventive Mechanism in 2019–20



National Preventive Mechanism objectives

Each year, the NPM agrees a business plan to guide the work we do and ensure we meet the requirements of OPCAT. In 2019–20, we had four objectives. We aimed to:

- work together as members of the NPM to strengthen the protection of those in detention in the UK;
- ensure every NPM member delivers its own responsibilities under OPCAT;
- build an NPM that is effective in delivering all the requirements of OPCAT; and
- increase the visibility and awareness of the NPM's role in prevention, OPCAT, the prohibition of ill-treatment in detention and the Convention Against Torture.

Strengthening the National Preventive Mechanism

In early March 2020, the NPM members based in Northern Ireland (CJINI, IMBNI, RQIA and NIPBICVS) met to discuss the possibility of setting up a Northern Irish sub-group to improve the collaborative working between the NPM bodies in the region. At this meeting, members highlighted the need to work together to ensure ministers and executive departments in Northern Ireland with responsibility for places of detention were delivering quality services and were compliant with human rights obligations. NPM members in Northern Ireland will continue to explore the best forum for collaborative working in the region.

Wider engagement and visibility

In February 2020, the NPM appeared on an episode of *Better Human*, a podcast which documents positive human rights stories. IMB National Chair Dame Anne Owers and IMB member Anne Finlayson spoke about the work that monitoring boards do on a voluntary basis to monitor the treatment of people in detention. Alison Thomson from MWCS discussed the important work done to monitor the treatment and conditions in places of mental health detention. The then Head of the UK NPM Secretariat, Louise Finer, spoke about the wider international human rights framework that underpins the work of professional inspectors and volunteer monitors.

In March 2020, we published our anniversary report, *Ten years of the NPM: Working together to prevent torture and ill-treatment.*[187] This special report looks back at the history of the NPM and the invaluable contribution it has made to the prevention of torture. *Ten years of the NPM* provides examples of the work done to strengthen the human rights focus of inspection and monitoring work. The report also highlights how the NPM works together effectively and engages with international efforts to prevent torture.

Member-specific developments

In 2019–20, the **Children's Commissioner for England (CCE)** engaged in research on the situation for children who are deprived of their liberty without appropriate legal authorisation. The CCE published a report on the topic: *Who are they? Where are they?*[188] For this research, the CCE expanded their visiting programme and worked with secure children's homes (SCHs), local authorities and social workers to find out more about this complex area where children are deprived of their liberty without proper legal authorisation in place (for more on the CCE's findings on this issue, see 'Children in detention', p.48).

The CCE also published research on the excessive lengths of stay for children in secure hospitals in England.[189] As a result of the CCE's work on this issue, the NHS announced a taskforce with the aim of changing the situation for children. Anne Longfield, the Children's Commissioner, chairs the Independent Oversight Group attached to the taskforce and throughout the reporting year worked to amplify the voices of children who are detained for extensive periods in secure hospitals.

187 UK NPM, 2020, Ten year of the UK National Preventive Mechanism: Working together to prevent torture and ill-treatment, https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2020/03/6.6303_NPM_10-Years-Report_V7_WEB.pdf [accessed 10/11/2020]

188 CCE, May 2019, *Who are they? Where are they?: Children locked up,* https://www.childrenscommissioner.gov.uk/wp-content/uploads/2019/05/cco-who-are-they-where-are-they-may-2019.pdf [accessed 27/08/2020]

189 CCE, May 2019, *Far less than they deserve: Children with learning disabilities or autism living in mental health hospitals,* https://www.childrenscommissioner.gov.uk/wp-content/uploads/2019/05/CCO-far-less-than-they-deserve-2019.pdf [accessed 27/08/2020]

The CCE continued to work with the Children's Commissioners for Wales, Scotland and Northern Ireland to consult on emerging issues and concerns regarding children in detention or deprived of their liberty across the four nations. The CCE has also engaged with officials from the UK government's Justice and Health and Social Care departments to represent the experiences of children in detention.

The **Care Inspectorate (CI)** for Scotland continued to conduct unannounced inspections of secure accommodation for children throughout the year. This included inspecting detention settings and non-traditional detention settings such as care homes. In line with the introduction of new human rights-based health and social care standards, the CI has developed new quality frameworks for all service types, including services for children. CI's new quality assurance framework will be used by inspectors when monitoring care homes for children and young people. The new framework has a greater focus on the human rights of people in detention.

Criminal Justice Inspection Northern Ireland (CJINI) developed its police custody inspection methodology in 2019–20. It worked with other NPM members to develop the new methodology, which aims to examine the treatment of detainees in police custody more thoroughly by looking more closely at detainees' police custody records.

Together with RQIA, CJINI released its report on the safety of prisoners in Northern Ireland.[190] The report highlighted areas for the Northern Ireland Prison Service (NIPS) to focus on to ensure better safety of people in prison.

In November 2019, Jacqui Durkin was appointed as the new Chief Inspector for criminal justice in Northern Ireland.

In 2019–2020, the **Care Quality Commission (CQC)** engaged in Independent Care Education and Treatment Reviews (ICETRs), following recommendations made in its interim review of restraint, seclusion and segregation (see 'Secure hospitals for people with learning disabilities and/or autism', p.16). CQC Mental Health Act reviewers provide expert input to these reviews, which are independently chaired, with work led by the Department for Health and Social Care.

Healthcare Inspectorate Wales (HIW) began planning a national review of mental health crisis units across Wales. In previous HIW inspection reports, mental health crisis units were identified as settings requiring improvement. The purpose of HIW's national review will be to identify themes, trends and concerns across these units. The fieldwork for this review will resume once COVID-19 restrictions have lifted.

190 CJINI and RQIA, November 2019, The *Safety or Prisoners Held by the Northern Ireland Prison Service: A Joint Inspection by Criminal Justice Inspection Northern Ireland and the Regulation and Quality Improvement Authority* http://www.cjini.org/getattachment/3a70dd41-7bb3-430d-9901-3ed7a191cf94/The-Safety-of-Prisoners.aspx [accessed 27/08/2020]

Between 1 April 2019 and 31 March 2020, **Her Majesty's Inspectorate of Prisons (HMI Prisons)** published inspection reports on 37 prisons holding adult men and five prisons holding adult women, and published 16 independent reviews of progress (IRPs) in adult male prisons. IRPs provide an independent assessment of the progress a prison has made in implementing recommendations from the previous full inspection. IRPs are not inspections and do not result in scores. HMI Prisons published five inspection reports of young offender institutions (YOIs) holding children under the age of 18, and two inspection reports of STCs holding children aged 12 to 18, jointly with Ofsted.

In relation to immigration detention, HMI Prisons inspected three immigration removal centres, 13 short-term holding facilities and two charter flight removals. In addition, it inspected police custody suites in six force areas, as well as TACT (Terrorism Act) suites holding detainees arrested on suspicion of terrorism or terrorism-related offences, jointly with HMICFRS. HMI Prisons also inspected three court custody areas. During the year, HM Chief Inspector of Prisons issued two Urgent Notification letters to the Justice Secretary expressing serious concerns, following the inspections of HMP Bristol (June 2019) and HMYOI Feltham A (July 2019).

HMI Prisons revised two sets of its *Expectations*, the human rights-based criteria used for assessing the treatment of detainees and conditions of detention. It worked with HMICFRS on the second edition of *Expectations* for Border Force custody suites and also published a second version of *Expectations* for court custody, following wide consultation. HMI Prisons published several thematic reports during the reporting year on: the separation of children in YOIs; youth resettlement (together with HM Inspectorate of Probation); and an analysis report on the experiences of children held in STCs and YOIs.

HMI Prisons' full inspection programme was suspended on 17 March 2020 due to COVID-19. HMI Prisons developed the short scrutiny visits (SSVs) model to continue to fulfil its duty to scrutinise and report independently on treatment and conditions. SSVs were announced on 8 April 2020 and the visits commenced on 21 April 2020.[191]

Her Majesty's Inspectorate of the Constabulary and Fire & Rescue Services (HMICFRS) continued to contribute to the NPM's police sub-group during the reporting year. It has also engaged with police forces across England and Wales to share information on its inspection reports.

191 HMI Prisons, Short Scrutiny Visits (webpage), https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/short-scrutiny-visits/ [accessed 10/11/2020]. HMI Prisons launched the Scrutiny Visits (SVs) methodology in August 2020, more information here: https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/scrutiny-visits/ [accessed 10/11/2020]

Positively, HMICFRS reports that Code C of the PACE Codes of Practice changed in part as a result of the thematic findings from both HMICFRS and Independent Custody Visiting Association (ICVA). Code C sets out the requirements for the detention, treatment and questioning of subjects. HMICFRS reported that its findings from the police custody inspection programme were influential, alongside the work of ICVA which campaigned to highlight concerns, in informing the changes to the PACE Code of Practice in relation to detainee care, specifically meeting the needs of women and girls held in police custody.

In August 2019, HMICFRS published its inaugural inspection of nationwide TACT facilities, in collaboration with HMI Prisons and ICVA (see 'Police and court custody', p.57, for more detail).

Her Majesty's Inspectorate of the Constabulary in Scotland (HMICS) carried out a focused inspection on the strategic arrangements for police custody during the reporting year.[192] In 2019, HMICS updated its inspection framework and custody inspection framework, incorporating changes that strengthened its commitment to prevent torture and ill-treatment for people in detention. HMICS continued to contribute to the NPM's Scottish sub-group and police sub-group.

In the reporting year, **Her Majesty's Inspectorate for Prisons in Scotland (HMIPS)** carried out three court custody unit (CCU) inspections which also scrutinised the vans used to transport detainees to and from prison. HMIPS recently increased the frequency with which it carries out CCU visits and developed new quality indicators for transport inspections.

HMIPS also carried out four prison inspections and a return inspection to HMP Grampian. One inspection was to HMP Barlinnie, which was criticised by the CPT during its 2018 visit. In particular, the CPT stated that keeping prisoners in HMP Barlinnie's reception holding cells – colloquially termed 'dog boxes' – could amount to ill-treatment. In the report to its follow-up inspection, HMIPS called on the Scottish Government to urgently re-model the reception area in the prison.[193]

A key part of HMIPS is its Independent Prison Monitoring team. Independent Prison Monitors (IPMs) are volunteers from the community who visit each prison in Scotland every week. In the reporting year, IPMs conducted 948 monitoring visits and handled 1,047 prisoner requests. In total, volunteers dedicated 4,636 hours of their time to monitoring prisons in Scotland. In 2020, HMIPS conducted a survey of prisoners to review the ways in which prisoners can contact IPMs and improve IPM information sharing processes.

192 HMIPS, June 2019, *Inspection of the strategic arrangements for the delivery of police custody*, https://www.hmics.scot/sites/default/files/publications/HMICS20190606PUB.pdf [accessed 27/08/2020]

193 HMICS, May 2020, *HMP Barlinnie: Full inspection – 26 August – 6 September 2019*, https://www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/Report%20on%20HMP%20Barlinnie%20-%2026-August-6%20September%202019%20-%20Final.pdf [accessed 27/08/2020]

During the year, HMIPS recruited someone to their team who had lived experience of detention, to help support its inspections.

In 2019–20, the **Independent Custody Visiting Association (ICVA)** prepared Independent Custody Visitors (ICVs) for amendments to the PACE Code of Practice, which made changes to the menstrual care that should be offered to women and girls in custody. In the previous year, ICVA led a successful campaign to change the Code of Practice to ensure women were offered menstrual care products and that their privacy would be respected while in police custody.

ICVA also planned to launch its second quality assurance framework for visiting schemes across England and Wales during the year. The new framework includes reference to OPCAT and international human rights standards for monitoring police custody. The launch of the framework has been delayed due to COVID-19.

In addition, ICVA piloted a new monitoring methodology. The new methodology aims to reinforce the preventive focus of ICVA's work by setting out an approach for greater scrutiny of detainees' custody records. An external evaluation of the pilot is scheduled to be published in summer 2020.

Independent Custody Visitors Scotland worked with Police Scotland on new training materials on the NPM and OPCAT for staff. ICVS report that there were many changes to the custody estate in Scotland during the reporting year. As a result, ICVS has worked with ICVs on how to monitor the new Criminal Justice Hubs set up by Police Scotland. The ICVS team has developed a new process for monitoring more vulnerable detainees in these hubs. ICVs will also focus more on the general maintenance of the new hubs to identify and report on areas in need of improvement.

Throughout 2019–20, the **Independent Monitoring Boards (IMB)** for England and Wales developed a new national monitoring framework. This monitoring framework also includes guidance on how Boards can draft their annual reports to enable consistency in reporting on the conditions in places of detention: this will ensure thematic issues can be easily identified. The IMB also delivered training courses for over 300 of their members. This training had a specific focus on monitoring separation within the immigration estate. In addition, the IMB have reviewed their online monitoring guidance for members to improve remote monitoring methods.

Significantly, in 2019–20, new Monitoring Boards were set up in Gatwick, Stansted and Luton short-term holding facilities. The IMB also held discussions with the Ministry of Defence regarding the monitoring of military detention facilities in the UK.

During the reporting year, the IMB made a successful bid for an increased budget allocation for the year 2020–21. These additional resources will allow the organisation to increase visits across the prison and immigration removal estate.

In the reporting year, the **Independent Monitoring Boards Northern Ireland (IMBNI)** carried out a recruitment campaign in 2018–19, and in April 2019 10 new members were appointed to join the three Boards monitoring prisons in Northern Ireland.

Jonathan Hall QC was appointed to be the new **Independent Reviewer of Terrorism Legislation (IRTL)** in April 2019. He published his Annual Report which expressly considers the conditions of TACT detainees in March 2020 (for more information on the findings from this report, see 'Political context, policy and legislative developments', p.13).[194]

In 2019–20, **Lay Observers (LO)** developed their National Development Plan, which aims to improve their governance structure, recruitment processes, monitoring, training, quality assurance and communications. They introduced a new 'Visits Protocol' in November 2019 to develop their systems of monitoring and reporting on the conditions for people detained in court custody and transport.

In the year, the LO also held their second volunteers conference, which set out the LO's vision for improving the role of LOs in accordance with OPCAT and international human rights standards. Several workshops were held which focused on the treatment of women, children and young people in court custody, as well as on specific medical issues LOs should be aware of. The LO highlighted three key standards for volunteers to work to: respect, decency and welfare. New monitoring guidance is now being produced to bring these standards in line with HMI Prisons' most recent court custody *Expectations*.

The LO have also been working on new models for introducing prison visits to their methodology. Prison visits would allow monitors to assess the treatment of detainees who had recently been involved in journeys to and from prison.

In 2019–20, the **Mental Welfare Commission for Scotland (MWCS)** continued work on the Deaths in Detention Review, which was announced by the Scottish Government in 2018. The review is looking into investigations into the deaths of people who were subject to mental health legislation or being treated for mental illness (and some neurological conditions such as dementia) or a learning disability. MWCs aims to present the review to the Scottish Government by June 2021.

194 IRTL, *The Terrorism Acts in 2018*, https://terrorismlegislationreviewer.independent.gov.uk/wp-content/uploads/2020/03/Terrorism-Acts-in-2018-Report-1.pdf [accessed 10/11/2020]

MWCS completed two themed visits during 2019–20, including to older persons mental health wards. MWCS also conducted a series of visits to examine the ways in which restrictions on patients in mental health detention respected the rights of the individual detained. In October 2019, it also published a themed visit report on autism and complex care needs.[195]

In October 2019, MWCS published a good practice guide to the use of seclusion in mental health institutions, which was influenced by the NPM's Isolation Guidance.[196] MWCS' good practice guide to restraint will be published in the next reporting year. In addition, MWCS visited services supporting people with an eating disorder, and the information from these visits is currently being collated for the forthcoming final report.

The MWCS had also completed all the preparatory work for a themed visit to all prisons in Scotland by the beginning of March 2020. Consultations and stakeholder meetings had been held and dates for all the visits were arranged with visits about to start when COVID-19 restrictions were introduced. These prison visits will now be rescheduled.

The **Northern Ireland Policing Board Independent Custody Visiting Scheme** participated in the Public Health Agency's review of the Custody Pathfinder Programme, which is a custody health care reform initiative, and has kept ICVs aware of changes to the police custody estate in Northern Ireland as it begins a new nurse-led approach.

NIPBICVS held a PACE refresher course for ICVs in September 2019. NIPBICVS also organised a volunteer recognition event in June 2019 to celebrate Volunteers' Week. Throughout the year, NIPBICVS ran a recruitment campaign for new volunteers. Fourteen new ICVs were selected, although their induction has been postponed due to COVID-19.

Following extensive consultation with stakeholders, the **Office for Standards in Education, Children's Services and Skills (Ofsted)** published a revised joint inspection framework for inspections of secure training centres in March 2019.[197] The new inspection guidance was in use from 1 April 2019. Ofsted also published newly enhanced guidance for inspections of secure children's homes (SCHs) as part of the Social Care Common Inspection Framework.[198] SCHs were previously inspected under the children's homes guidance. The new SCH guidance aims to reflect the specialist nature of secure provision and came into use from April 2019.

195 MWCS, October 2019, Autism and complex care needs: Visiting and monitoring reports, https://www.mwcscot.org.uk/sites/default/files/2019-10/ASD_ThemeVisitReport-20191030.pdf [accessed 27/08/2020]

196 MWCS, October 2019, Good practice guide; use of seclusion. https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010.pdf [accessed 27/08/2020]

197 Ofsted, March 2019, Joint inspection framework: secure training centres, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859706/Secure_training_centres__Ofsted_inspection_framework.pdf [accessed 27/08/2020]

198 Ofsted, November 2019, Social care common inspection framework (SCCIF): children's home, https://assets.publishing.service.gov.uk/media/5c9b837040f0b633fc95f7a9/SCCIF_children_s_homes.pdf [accessed 27/08/2020]

In 2019–20 the **Regulation and Quality Improvement Authority (RQIA)** organised multiple staff training events on the Mental Capacity Act (NI) 2016. As a result, RQIA has identified members of staff to support and guide inspection staff on the Act so that they can monitor its implementation in relation to Deprivation of Liberty Safeguards across all facilities in Northern Ireland.

In March 2020, Judith Robertson, Chair of the **Scottish Human Rights Commission**, was elected as the Chair of the NPM's Scottish sub-group. During the reporting year, SHRC and the NPM's Scottish Assistant Coordinator worked to organise the activities of the Scottish sub-group. SHRC also led a series of training sessions for Members of Scottish Parliament on international human rights standards, including on the UN Human Rights Treaties to which the UK is a party.

Joint working across the National Preventive Mechanism

Working together as members of the NPM to strengthen the protection of those in detention in the UK is one of the NPM's strategic goals. As well as collaborating during inspections and on joint NPM thematic projects, members of the NPM work together on a wide range of initiatives aimed at strengthening their OPCAT compliance and detention monitoring. Some notable examples from the year include:

- CJINI conducted an inspection of police custody units in Northern Ireland with RQIA. CJINI consulted with NIPBICVS to gather information on volunteers' findings from their regular police custody visits. In preparation for this police custody inspection, a lead inspector at CJINI shadowed police custody inspections led by HMICS in Glasgow and HMICFRS and HMI Prisons in Exeter. HMICS, HMICFRS and HMI Prisons shared their inspection methodologies with CJINI to assist in developing CJINI's methodology for police custody inspections.
- ICVA continued to coordinate the TACT network, which holds regular meetings for bodies who monitor facilities holding detainees sentenced under terrorism legislation. The TACT network includes NPM members such as the IRTL, ICVS and NIPBICVS. The network helps to ensure effective communication and joint working is in place across schemes visiting TACT facilities across the UK.
- During the year, LO maintained a positive relationship with HMI Prisons. LO continued to provide HMI Prisons with custody suite reports for upcoming inspections. HMI Prisons and LO worked together during court custody inspections, and volunteers shared their feedback

with inspectors at the end of a court custody inspection.

- HMI Prisons and HMICFRS jointly carried out the first inspections of the five custody suites that are used for holding suspects arrested for terrorism or terrorist-related offences.
- MWCS participated in the Sharing Intelligence for Health and Care Group, which brings together organisations in Scotland, including NPM member CI, with responsibility for inspecting or monitoring health and social care services. The group was used to share information between organisations. Members also used the forum to share their concerns and where necessary coordinate action to deal with issues.
- SHRC are supporting the Chief Inspector of Prisons in Scotland in her ongoing review into deaths in custody in Scotland. The review will identify and make recommendations about areas of improvement to ensure that appropriate and transparent arrangements are in place in the immediate aftermath of deaths in custody in Scottish prisons, including deaths of prisoners while in NHS care. Judith Robertson, Chair of the Scottish Human Rights Commission, is working with HMIPS to ensure a human rights perspective is incorporated into the review.
- Ofsted carried out joint inspections of STCs with CQC and HMI Prisons. The inspectorates worked closely to share information and develop their inspection methodologies to prevent ill-treatment in secure settings for children and adults. CQC continued to support Ofsted's inspections of SCHs during the year. CQC inspectors offer expertise during inspections in assessing the health provision for children.

Submitting proposals and observations on legislation

OPCAT requires NPMs to submit proposals and observations to existing or draft legislation to support the prevention of torture and ill-treatment in places of detention. There are a number of ways NPM members are consulted on, or seek to influence, the development of detention policy and legislation using the evidence from their monitoring of the treatment of and conditions for detainees. Most commonly, NPM members contribute to formal policy consultations, parliamentary inquiries and draft legislation, as well as direct discussions with policy makers and politicians. For example:

- The CCE submitted evidence to the Justice Select Committee's inquiry into the youth justice population. In their submission, they highlighted the unacceptably restrictive practices used in secure establishments for children, the harshest forms of which are disproportionately used against children from black and minority ethnic backgrounds. The CCE's work on the situation for children deprived of their liberty outside the secure estate (both illegally and with High Court authorisation) was cited in a High Court judgement in April 2020. The judgement raised concerns about the legitimacy of judges to authorise a child's deprivation of liberty. The CCE's report on this topic has also been submitted to the Supreme Court on a related case. The CCE has also convened several roundtables with officials from the MoJ and Department of Health and Social Care to push for improved and integrated secure care.

- CQC responded to the Joint Committee on Human Rights (JCHR) investigation into the detention of young people with learning disabilities and/or autism. The final report from the inquiry made important recommendations relating to CQC. In its response to the JCHR, CQC noted the need to improve the way in which mental health, learning disability and/or autism services are regulated to protect the human rights of those in detention.
- HIW contributed to work on the Code of Practice for the new LPS.
- RQIA submitted observations on the Mental Capacity (NI) Act 2016, Deprivation of Liberty Safeguards Code of Practice.
- CI contributed to the Scottish Government's consultation on raising the criminal age of responsibility from eight to 12. It is hoped that the new laws will reduce the possibility of children under the age of 12 being placed in secure settings.
- CJINI's new Chief Inspector, Jacqui Durkin, appeared before the Northern Ireland Justice Committee in March 2020 to provide an introductory briefing on the work of the Inspectorate and summarise the findings of inspection reports published since January 2017.
- HMICS responded to a Scottish Government consultation on the Letter of Rights (the documentation given to people detained in police custody with information on their legal rights). HMICS also contributed to the Scottish Government's consultation on Strategic Police Priorities, which were published in December 2019. The new priorities reflect key NPM principles, including equality and human rights to support positive criminal justice outcomes, and emphasise the importance of collaborative work to improve outcomes for individuals.
- HMI Prisons made written submissions to a range of consultations and inquiries, commented on the draft Detention Services Orders and gave oral evidence to Parliamentary committees, including the Justice Select Committee inquiry into prison governance and the Health, Social Care and Sport Committee (National Assembly for Wales) inquiry into provision of health and social care in the adult prison estate.
- HMIPS gave evidence to the Equalities and Human Rights Committee on its inquiry into prisoner voting in Scotland, supporting the extension of voting rights to all prisoners. HMIPS also provided written evidence to the Justice Committee on the Management of Offenders (Scotland) Bill where it supported the greater use of electronic monitoring as an alternative to custodial sentencing. Her Majesty's Chief Inspector presented evidence to the Justice, Public Audit and post-legislative Scrutiny parliamentary committees on the 2018–19 audit of the Scottish Prison Service. Following this, the Justice Committee visited HMP Barlinnie and found the conditions there gravely concerning, and paid tribute to the hard work of staff. HMIPS continued to participate in the parliamentary cross-party group for Women and Justice and the First Ministers' National Advisory Council on women and girls.
- As a result of the IMB evidence given to the Justice Select Committee inquiry on prison governance, the Committee recommended that the national IMB structure be given statutory underpinning by the MoJ to safeguard IMB independence at a national level. IMBs also contributed to HM Prison and Probation Service's (HMPPS) consultations on use of force, raising concerns about

the implications for prisoners with autism and revised assessment, care in custody and teamwork (ACCT) processes. In early 2020, IMBs also gave evidence at the inquest of Prince Fosu, a 31-year-old man who died at Harmondsworth immigration removal centre in 2012. The jury was critical of all the agencies involved, including the then IMB. Training, guidance and support for Boards has been strengthened in the eight years since Mr Fosu's death and the learning from the inquest has been fed into further training and guidance for IMBs.

- ICVA responded to the Home Office consultation regarding changes to PACE Codes C and H on menstrual care. In May 2019, ICVA's CEO gave evidence to the All-Party Parliamentary Group on women in the penal system where she shared information on the treatment of women in police custody.
- The IRTL recommended that the practice of waking TACT detainees to check on their condition is revisited. He also recommended that any time during which an individual is detained under PACE should be taken into account when calculating the maximum time for detention under Schedule 8 of the Terrorism Act 2000.
- LO responded to the Justice Select Committee consultation on children and young people in the justice system, highlighting their areas of serious concern including: poor quality and incompleteness of PERs; failures to prioritise children and young people for court appearances; excessive length of time spent in isolation in custody suites; and inappropriate use of handcuffing.
- MWCS entered legal proceedings as an Interested Party in two actions concerning excessive levels of security. MWCS was also involved in a court case in Scotland regarding patients being transferred from hospital to care home placements without consent or legal authority. The recent procedural hearing at which matters were due to have been concluded has been postponed. In January 2020 MWCS submitted evidence to an independent review of forensic mental health services in Scotland. MWCS also submitted evidence to the final consultation stage of a review into the place of learning disability and autism in the Mental Health Act. MWCS emphasised the need to focus on human rights in applying the act to comply with the European Convention on Human Rights.
- Ofsted submitted evidence to the Justice Select Committee's Children and Young People in Custody inquiry.[199] Ofsted stated in its submission that although the number of children in custody in England has decreased, those in STCs and SCHs have increasingly complex needs.

199 Ofsted, October 2019, Written Evidence from Ofsted to the Justice Select Committee, http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/justice-committee/children-and-young-people-in-custody/written/105995.html [accessed 27/08/2020]

- In September 2019, SHRC provided a written and oral submission to the Standards, Procedures and Public Appointments Committee on the Scottish Elections (Franchise and Representation) Bill consultation. The Bill, which was passed in April 2020, gives prisoners serving sentences of less than 12 months the right to vote. SHRC also sent a submission in September 2019 to the Justice Committee's pre-budget scrutiny 2020–21 consultation. In this submission, SHRC stated that consideration should be given to recent UN treaty body conclusions and recommendations relating to prison conditions when developing budget allocation recommendations. SHRC also participated in the Independent Review of Learning Disability and Autism in the Mental Health Act as a member of the law and policy advisory group and made a Stage 3 submission in October 2019, which engaged with the issue of detention and other restrictions on liberty in context of proposed changes.[200] SHRC also provided oral evidence to an ongoing independent review into complaints handling, investigations and misconduct in relation to policing and produced a briefing in response to the Coronavirus (Scotland) Act 2020, highlighting issues relating to prisons, policing and adults with incapacity.[201]

Visit from the UN Subcommittee on Prevention of Torture

In 2018, the UN Subcommittee for Prevention of Torture (SPT) announced that it would be carrying out its first ever country visit to the UK. The SPT has a mandate to visit states that have ratified OPCAT and developed NPMs to advise and assist them in exercising their mandate to prevent torture and ill-treatment. The SPT carried out its visit to the UK between 8 and 19 September 2019.

Throughout 2019, the NPM worked hard to prepare for this visit. We held a series of workshops around the UK to discuss the visit with members. These workshops were facilitated by colleagues at Bristol University, who also provided the NPM with useful background papers on SPT country visits and what we might expect to happen during the visit. The NPM Chair and Secretariat also travelled to Geneva in June 2019 to meet with the SPT delegation. On this trip, we explained the NPM's complex organisational structure to the delegation and heard more detail about the structure of the SPT's visit.

Between 8 and 19 September, the SPT accompanied NPM members on visits to:

- Bracton mental health centre, Kent, with the CQC on a Mental Health Act review visit;
- Heathrow immigration removal centre (also known as Harmondsworth and Colnbrook), accompanying the IMB;
- HMYOI Cookham Wood Young Offenders' Institution, accompanying HMI Prisons; and
- St Leonards police station in Edinburgh with HM Inspectorate of Constabulary in Scotland.

200 Independent Review of Learning Disability and Autism in the Mental Health Act, webpage, https://webarchive.nrscotland.gov.uk/20200313205853/https://www.irmha.scot/ [accessed 10/11/2020]

201 Scottish Human Rights Commission, Human Rights and COVID-19 webpage, https://www.scottishhumanrights.com/covid-19/ [accessed 10/11/2020]

The SPT delegation also accompanied ICVs in police custody and court custody visitors on their visits to check on the welfare of detainees, and undertook confidential, unannounced visits to other places of detention around England and Scotland. The SPT met with various government departments involved in managing places of detention and persons deprived of their liberty. The delegation also held meetings with civil society organisations, including non-governmental organisations, the Equality and Human Rights Commission and academic researchers.

While the SPT's report to the UK NPM and government has not yet been published, the head of the delegation has said: 'The visiting bodies (NPM members) do an impressive amount of good work, but a more robust legislative framework is needed to achieve full compliance with the Optional Protocol'.[202] The UK NPM welcomed the SPT's visit to the UK, and the additional scrutiny they provided to places of detention and to the UK NPM to help us improve our efforts to prevent torture and ill-treatment.

Committee Against Torture

The United Nations Committee Against Torture held its 66th session from 23 April to 17 May 2019, where it publicly reviewed the reports of different nations, including the United Kingdom of Great Britain and Northern Ireland. The Committee Against Torture is the official UN body – made up of Independent Experts from around the world – that evaluates States' progress in implementing the Convention against Torture. The NPM Secretariat and Chair travelled to Geneva for the UK's evidence sessions on 7 and 8 May 2019.

Using the first-hand reports and evidence from the monitoring and inspections carried out by each of our members, the NPM Chair made an oral intervention to present a comprehensive picture of detention in the UK and the challenges in preventing ill-treatment, and answered questions from the Committee. We were pleased to see so many civil society organisations at these sessions. The NPM also attended a report launch event held by the non-governmental organisation Redress, which worked on a shadow report to the Committee Against Torture from civil society organisations.

The Committee released its concluding observations on the UK's implementation of the Convention on 7 June 2019. The concluding observations outlined the Committee's concerns on places of detention which were also raised by the NPM in our submission. The Committee also noted its concerns regarding the NPM's lack of legal status.

Committee for the Prevention of Torture

The CPT made two visits to the UK in the reporting year. In October, the CPT made a follow-up visit to Scotland, where it visited HMP & YOI Cornton Vale to assess the treatment of women with acute mental illness after reporting on alarming treatment in 2018.

The CPT also made a targeted follow-up visit to England in May 2019. It visited HMP Doncaster, HMP Liverpool and HMP Wormwood Scrubs, as well as HMYOIs Feltham and Cookham Wood, and Rainsbrook STC. The NPM released a short statement on the visit, welcoming the report and noting the concerns the committee raised in relation to the

202 UN Subcommittee on Prevention of Torture, September 2019, UN torture prevention body concludes visit to the United Kingdom of Great Britain and Northern Ireland, https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25023&LangID=E [accessed 10/11/2020]

inadequate accountability procedures in place at the three prisons visited.[203]

In November, the Association for the Prevention of Torture (APT) organised a meeting between NPMs in Europe to discuss safeguards in police custody. The event also celebrated 50 years of the CPT.

As in previous years, the NPM and its members collaborated actively with a range of international actors, including monitoring bodies and inspectorates from other countries, academics and non-governmental organisations. The NPM and its members provided input to other NPMs, expert forums and new detention monitoring initiatives over the year, as follows:

- The CCE organised a trip for a delegation of English officials to visit secure accommodation for children in Norway. The trip allowed officials to see first-hand examples of best practice in regard to the detention of children.
- CQC took part in a Doughty Street Chambers event on psychosocial disability rights with the Japan Federation of Bar Associations. CQC discussed its NPM role, the UN Convention on the Rights of Persons with Disabilities and the transition to community-based mental health services. CQC also took part in a meeting with the UN Special Rapporteur on the Right to Health, Dainius Pūras, organised by the University of Essex.
- In April 2019, CJINI hosted a Churchill Fellow from Australia's Northern Territory who visited to learn more about detention monitoring bodies. CJINI also hosted a senior inspector from the Office of the Ombudsman New Zealand (one of the New Zealand NPM bodies) for a week-long study visit in July 2019. This was an opportunity for the inspector to learn more about the UK NPM, the NPM bodies in Northern Ireland and CJINI's inspection methodologies. The inspector shadowed an IMBNI meeting in Hydebank Wood Secure College and accompanied CJINI on fieldwork for the inspection of police custody and on a visit to the Juvenile Justice Centre to meet young people who had recent experience of police custody.
- SHRC submitted a shadow report to the UN Committee Against Torture in March 2019, which was considered as part of the periodic review of the UK in May 2019. Representatives of the Commission attended the review to give evidence and supported the NPM oral session. SHRC also submitted a shadow report to International Covenant on Civil and Political Rights in January 2020.[204]

203 UK NPM, April 2020, Statement from the UK NPM in response to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) Report to the United Kingdom on their 2019 visit to England, https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2020/04/NPM-Short-response-note-CPT-report-England-2019.pdf [accessed 27/08/2020]

204 United Nations Treat Body Database, Submission to the United Nations Human Rights Committee (The Committee): NHRI Report to Inform List of Issues Prior to Reporting on the United Kingdom's 8th periodic report under the International Covenant on Civil and Political Rights, https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCCPR%2fIFR%2fGBR%2f40930&Lang=en [accessed 10/11/2020]

Section three
Looking ahead to 2020–21

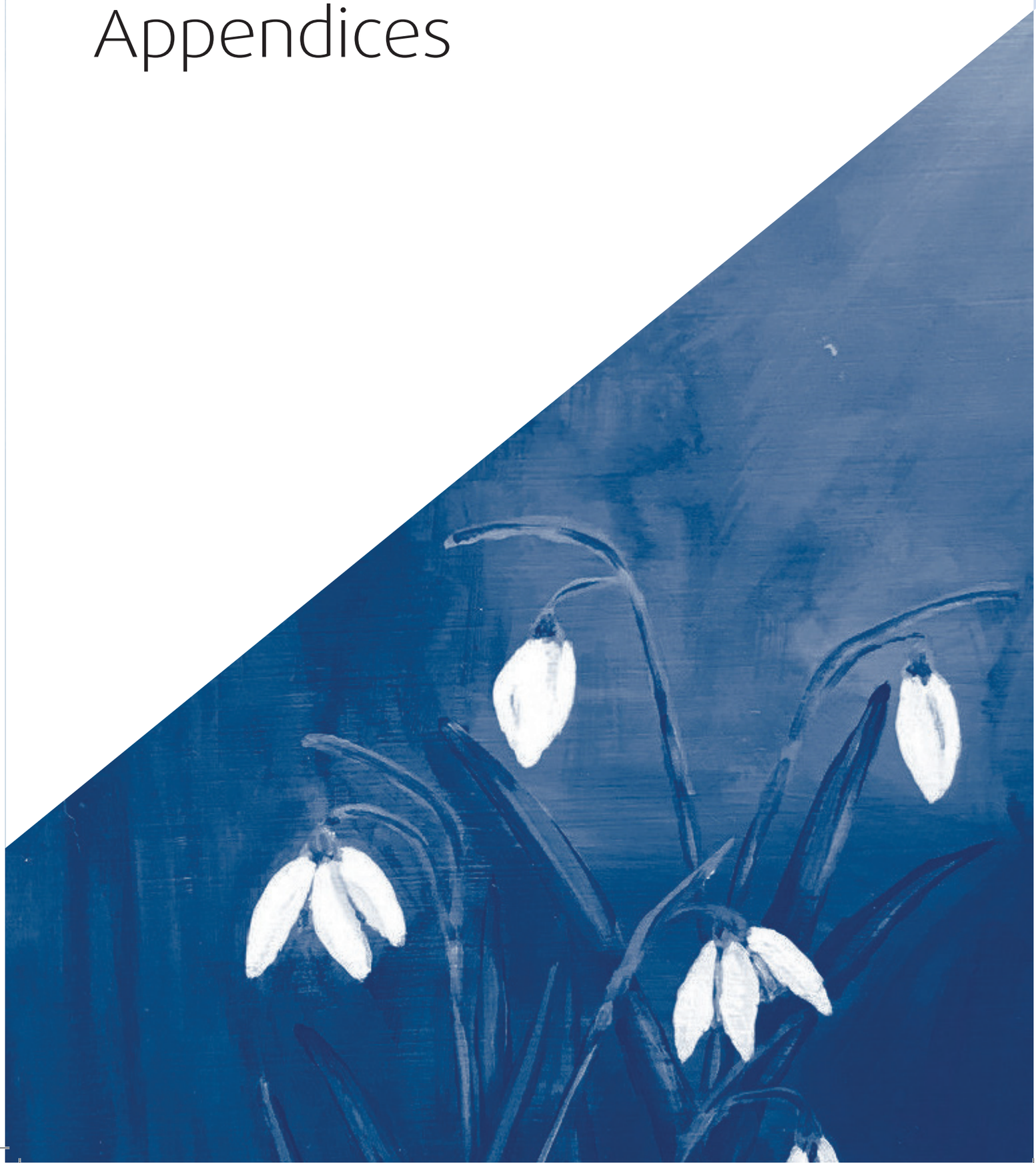
At the end of the 2019–20 reporting year, the UK went into 'lockdown' in response to the COVID-19 pandemic. Citizens were told to stay at home and work from home where possible. Visits to closed detention facilities were also suspended. Lockdown measures created difficulties for NPM members' monitoring activities and posed significant risks to detainees. The NPM engaged in multiple pieces of joint work in the first few weeks of the outbreak (see 'COVID-19', p.12). Much of our cross-member work focused on how the NPM could continue to carry out its mandate to prevent torture and ill-treatment in the context of COVID-19. Indeed, the NPM recognises that the need for independent monitoring and oversight is of crucial importance at a time when restrictive measures are enacted in places of detention, which have the potential to greatly impact the human rights of detainees.

In 2020–21, the NPM will take forward its work on COVID-19 as a priority. In particular, we hope to produce a comprehensive report on the impact of COVID-19 across places of detention in the UK later in the year. We envisage that this report will capture the key human rights concerns for people in detention, which have been gathered through members' on-site visits, inspections and remote monitoring methods. The report may also showcase some of the good practice in places of detention to manage and mitigate the risk of COVID-19 for detainees.

To reinforce the preventive focus and ensure a human rights-based approach is fully integrated into its monitoring work, the NPM will also carry out a thematic project on prevention in 2020–21. For this project, the NPM will incorporate authoritative written materials on prevention from human rights bodies, such as the SPT, relevant stakeholders and experts into advisory guidance and training for NPM members to use.

The NPM will also respond to the UN Subcommittee on Prevention of Torture's report to the UK NPM. We will do this in collaboration with the NPM membership and examine the areas of the report that will be a useful basis for future work. We will continue to engage with the SPT Secretariat on this work, to help us improve in our work to prevent torture and ill-treatment.

Appendices



Appendix I

Glossary

ACCT	Assessment, care in custody and teamwork
APT	Association for the Prevention of Torture
CAMHS	Child and Adolescent Mental Health Services
CCE	Children's Commissioner for England
CCU	Court Custody Unit
CDs	Crown Dependencies
CFMT	Charter Flight Monitoring Team
CI	Care Inspectorate
CJINI	Criminal Justice Inspection Northern Ireland
CPT	Committee for the Prevention of Torture (Council of Europe)
CQC	Care Quality Commission
CRC	Committee on the Rights of the Child (United Nations)
CIW	Care Inspectorate Wales
DHSC	Department of Health and Social Care
DoLS	Deprivation of Liberty Safeguards
ECHR	European Court of Human Rights
EHRC	Equality and Human Rights Commission
FAI	Fatal Accident Inquiry
HIW	Healthcare Inspectorate Wales
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services
HMICS	Her Majesty's Inspectorate of Constabulary in Scotland
HMI Prisons	Her Majesty's Inspectorate of Prisons
HMIPS	Her Majesty's Inspectorate of Prisons for Scotland
HMP	Her Majesty's Prison
HMPPS	Her Majesty's Prison and Probation Service
ICETRs	Independent Care Education and Treatment Reviews
ICVs	Independent Custody Visitors
ICVA	Independent Custody Visiting Association
ICVS	Independent Custody Visitors Scotland
IMB	Independent Monitoring Board
IMBNI	Independent Monitoring Boards (Northern Ireland)

IRC	Immigration removal centre
IRP	Independent Review of Progress
IRTL	Independent Reviewer of Terrorism Legislation
IPMs	Independent Prison Monitors
JCHR	Joint Committee on Human Rights
LO	Lay Observers
LPS	Liberty Protection Safeguards
MAPPA	Multi-agency public protection arrangements
MoJ	Ministry of Justice
MWCS	Mental Welfare Commission for Scotland
NAO	National Audit Office
NGO	Non-governmental organisation
NIPBICVS	Northern Ireland Policing Board Independent Custody Visiting Scheme
NIPS	Northern Ireland Prison Service
NPM	National Preventive Mechanism
OASys	Offender Assessment System
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
OTs	Overseas Territories
PACE	Police and Criminal Evidence Act 1984
PERs	Person Escort Records
PECS	Prisoner Escorting and Custody Services
PIRC	Police Investigations and Review Commissioner
PPO	Prisons and Probation Ombudsman
RQIA	Regulation and Quality Improvement Authority
RPI	Restrictive Physical Intervention
SCH	Secure children's home
SHRC	Scottish Human Rights Commission
SPA	Scottish Police Authority
SPT	United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
SSV	Short scrutiny visit
STC	Secure training centre

STHF	Short-term holding facility
TACT	Terrorism Act
TR	Transforming Rehabilitation
YOI	Young offender institution
UNCAT	United Nations Convention Against Torture
UNCRPD	United Nations Convention of the Rights of Persons with Disabilities

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