national preventive mechanism

Monitoring places of detention

13th **Annual Report**
of the United Kingdom's
National Preventive Mechanism
2021/22

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Foreword by Wendy Sinclair-Gieben UK NPM Chair

In this, the 20th anniversary of the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), I am delighted to introduce the 13th annual report of the UK National Preventive Mechanism (NPM).

The UK NPM was established in 2009 with a mandate to carry out regular, independent visits to places of detention. The NPM's activities have expanded significantly since it was first established, and now include joint work focused on specific areas of OPCAT compliance, as well as on thematic detention issues.

I must place on record my most sincere thanks to outgoing NPM Chair, John Wadham. John led the NPM for six years and made a profound contribution to the work of detention monitoring and inspection in the UK. He demits office with a legacy to be proud of and leaves behind a strong foundation for us to build on.

As HM Chief Inspector of Prisons for Scotland and NPM Steering Group member, I have been designated Chair while the organisation carries out a period of internal review and governance audit. I am clear that the regular monitoring of detention makes a significant contribution to improving treatment and conditions, and I have been active in pursuing the benefit of collective and collaborative work among the NPM membership throughout my tenure.

In this report, covering the reporting period 2021 to 2022, we reflect on what has been a difficult period of recovery from the COVID-19 pandemic. OPCAT recognised 20 years ago that detainees are particularly vulnerable to ill-treatment, and therefore particularly at risk from the long-term effects of the pandemic. Our 21 expert inspection and monitoring bodies recognised the importance of continued scrutiny during the pandemic. They have carried out thousands of scrutiny visits to places of detention to examine the treatment and conditions of individuals held, based firmly in established international human rights principles.

Staff shortages were a key concern for almost all NPM members. High vacancy rates, departure of experienced staff, reliance on agency workers, changes in management and lack of supervision affected prisons, custody, and healthcare settings. These factors further reduced availability of services in partnership. This had consequential effects on the quality

of care for those detained under the Mental Health Act, for children in secure services, and for purposeful activity and rehabilitation routes in prisons. Systems are in gridlock and staff shortages are resulting in unprecedented shortfalls of provision. In prisons, people were unacceptably locked in their cells for up to 23 hours a day.

COVID-19 restrictions continued to impact services despite restrictions being gradually lifted over the course of the reporting year. Some restrictions, for example, imposed very long periods of isolation on prisoners (up to 14 days) which were misaligned to the community easing of restrictions. Ongoing recovery and budgetary pressures are likely to continue to adversely affect people in detention. Restricted access to regimes compromised purposeful activity and learning opportunities in prisons. There were backlogs in court processes and support for substance misuse, and inequitable access to health services.

In children and young people's services, bullying continued to be a problem. Overwhelming evidence was reported of placements too far from young people's families and communities, without the necessary mental health support and educational placements.

Inadequate provisions for women, particularly those with mental ill-health, was an issue for several members. Self-harm remained high, especially in women's prisons and among young adults. Women did not always have access to female staff, and were sometimes detained or transported with men, including men with a history of violence against women.

This reporting year, two of our members have been involved in a public inquiry into ill treatment. This has shone a light on our processes and encouraged us to develop training and prevention material and refine our practices. We will continue to work collectively to share best practice and learning across our membership.

I have also been pleased to link up with the network of international NPMs across the world, and we continue to engage widely with international and regional human rights bodies (the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and the Subcommittee for the Prevention Torture (SPT)) and other inter-governmental bodies. Our Head of Secretariat has represented the NPM at two international conferences and I have been pleased to support Australia as they seek to implement OPCAT into their processes. We also welcomed the CPT on a visit to England in this reporting cycle. As always, we value this close relationship with the CPT to provide an extra level of assurance to our scrutiny processes.

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

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

Wendy Sinclair-Gieben
UK NPM Chair
HM Chief Inspector of Prisons, Scotland

Executive summary

The UK NPM is made up of 21 bodies that monitor and inspect places of detention in the UK to prevent torture and ill-treatment for those deprived of their liberty. NPM members work collectively to fulfil the NPM's mandate under OPCAT.

OPCAT is designed to strengthen protections for people deprived of their liberty, as it is recognised that they are particularly vulnerable to ill-treatment. According to OPCAT, efforts to combat torture and ill-treatment should focus on its prevention, which is best achieved by setting up an NPM to visit all places of deprivation of liberty independently and on a regular basis. The UK ratified OPCAT in December 2003 and designated its NPM in March 2009.

This annual report is published in compliance with Article 23 of OPCAT. This year we have adapted the methodology to make this report more concise, summarising key findings of our members and presenting them through common themes, directing readers to their output where appropriate. The majority of our output will now fall outside of the annual reporting period to allow the organisation to respond more dynamically and across thematic priorities. To stay informed on the work of the UK NPM, visit www.nationalpreventivemechanism.org.uk and follow us on Twitter @UKNPM.

Over the reporting year, pandemic restrictions began to lift, though in places where people are deprived of their liberty this did not happen at the same pace as it did for wider society. Outbreaks of COVID-19 are still a reality, and the regimes and services offered by prisons, secure centres, and care settings are still unfit for purpose.

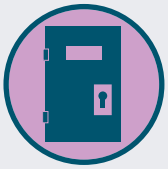
This report includes information on the situation for people deprived of their liberty in England, Wales, Scotland, and Northern Ireland, and covers the period from 29 March 2021 to 4 April 2022. The information gathered in this report is drawn from member's own reporting, inspection reports, submissions to inquiries, dialogue with members, and other publications. Summarising members' findings and concerns, the report positions them in terms of the UK's obligations under international and domestic laws and agreements.

The report first gives an overview of the state of detention in the UK, and then considers the following key themes shared by members, alongside the UK's legal obligations under OPCAT and other relevant treaty law and international agreements. The key themes are:

- reduction in provision: a perfect storm of crises in staffing, funding, and COVID
- equality and diversity in detention
- immigration detention in England and Wales
- police custody, court custody and transportation
- criminal justice procedures for people with mental-ill health
- legal frameworks for deprivation of liberty in health and social care

Our report synthesises some of the key themes and findings of our members who make regular visits to places of detention to prevent ill-treatment. It should not be viewed as exhaustive of all detention issues raised but is intended as a brief overview of the key issues across detention settings in the UK. For more detailed analysis, readers are encouraged to look to the specific membership output.

Types of detention



Prisons and young offender institutions

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

Police custody

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

Escort and court custody

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

Detention under the Terrorism Act

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

Children in secure accommodation

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

Children (all detention settings)

- CCE (England)

Detention under Mental Health Law

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

Deprivation of liberty and other safeguards in health and social care

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

Immigration detention

- HMI Prisons and IMB (England, Wales and Scotland)
- HMI Prisons with CJINI, IMB (Northern Ireland)

Military detention

- HMI Prisons (United Kingdom)

Customs custody facilities

- HMICFRS, and HMICS (United Kingdom)

Geographical coverage

national preventive mechanism

Scotland

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

England

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

United Kingdom

- Independent Reviewer of Terrorism Legislation (IRTL)

Northern Ireland

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

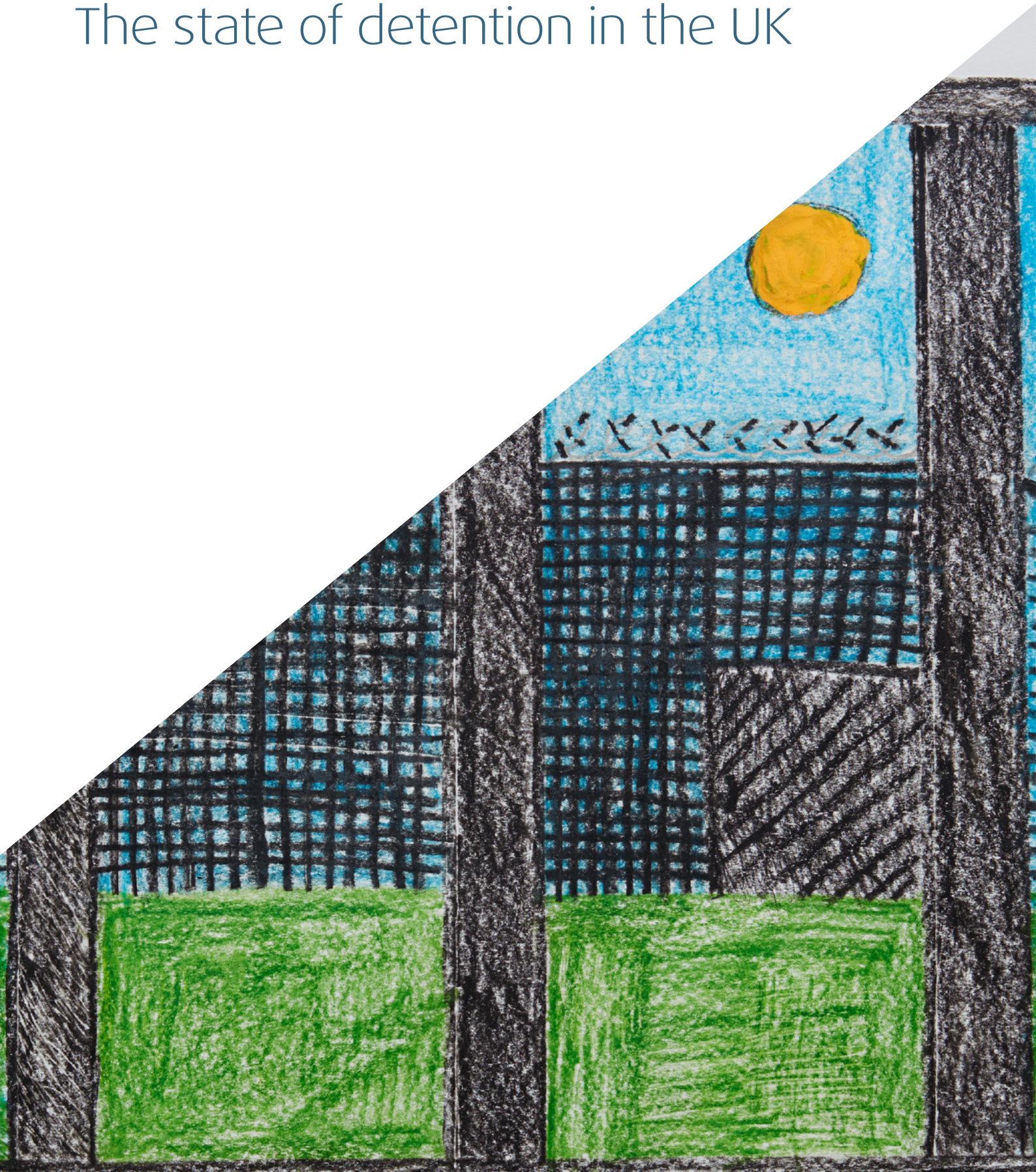
Wales

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

England and Wales

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

The state of detention in the UK



The state of detention in the UK presents as a mixed bag. We have seen some brilliant practice with professionals working in very challenging circumstances. We likewise know of entrenched issues with repeated recommendations made time after time with little effort to address them. It has been harder for people deprived of their liberty to see friends, family or advocates through in-person visits. Staff shortages, high infection risk, and implementation of social distancing regulations were key challenges for custody sites and care settings.

Prisons

Pandemic restrictions continued to disrupt every aspect of prison life across the UK, including safety, humane treatment, wellbeing, and purposeful and rehabilitative activities. More staff leave than join prisons each month, and there is a deficit in staff experience.[1] The number of unsentenced prisoners had increased substantially, and the new Probation Services structure in England and Wales meant many prisoners, especially those on remand, did not have adequate support before and after release.[2]

One prison in Northern Ireland was inspected in the reporting period, where although there was a safe environment with very little violence, the high number of illegal drugs entering and being consumed in the prison was a concern.[3] Scotland has a high rate of imprisonment and a rising rate of deaths in prisons. Remand, overcrowding, and social isolation were also growing problems.[4]

There are fewer women than men in the criminal justice system, but they continue to be underserved. Mental health issues are still much more prevalent for women in prison, with some sent there due to non-availability of mental health facilities in hospitals, and there were long waiting times to be transferred to a psychiatric ward for those with severe mental ill-health in prisons.[5] In Scotland, women are "at the extreme end of the waiting times and if requiring high secure in-patient treatment

1 Independent Monitoring Boards, 'National Annual Report 21-22', 6 October 2022, available at: **https://imb.org.uk/document/national-annual-report-2021-22/**

2 HM Chief Inspector of Prisons for England and Wales, 'Annual Report 2021–22', HMI Prisons Annual Report 2021–22, 13 July 2022, available at: **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2022/07/HMIP-Annual-Report-web-2021-22.pdf**

3 Criminal Justice Inspection Northern Ireland, HM Inspectorate of Prisons, the Regulation and Quality Improvement Authority, 'Report of an Unannounced Inspection of Magilligan Prison 21 May-10 June 2021' February 2022, available at: **https://www.cjini.org/getattachment/4ae6bd06-979d-4b1e-a724-c2ab6ee5ac09/report.aspx**

4 HM Chief Inspector of Prisons for Scotland, 'Annual Report 2021-22', November 2022, available at: **https://www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/HMIPS - HM Chief Inspectors Annual Report - 2021-22 - Final Version_0.pdf**

5 HM Chief Inspector of Prisons for England and Wales, 'Annual Report 2021–22', HMI Prisons Annual Report 2021–22, 13 July 2022, available at: **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2022/07/HMIP-Annual-Report-web-2021-22.pdf**

are transferred to England".[6] Criminal Justice Inspection Northern Ireland were concerned that male and female prisoners shared a Care and Supervision Unit at Hydebank Wood College and Women's Prison, where there was high instance of mental ill-health. Lack of entirely separate facilities for men and women is contrary to the Mandela Rules on the minimum treatment of prisoners.

Health and social care

Overstretched mental health services compromise safety and often place people very far from their communities. Outstanding points of concern are that staff shortages mean that patients are not getting the level or quality of care we expect, and the safety of patients and staff is being put at risk. The quality of ward environments was concerning, with many inpatient environments in need of immediate update and repair.[7]

In England, Wales, and Scotland, people from ethnic minority groups are disproportionately likely to be detained under Mental Health Acts. We are aware that reviews and reforms are ongoing, and we hope to see this discriminatory practice addressed. Access to advocacy for people deprived of their liberty was an issue across all regions.[8]

In Scotland, England and Wales, there are concerns at rising numbers of detention. Members in Scotland suggest that the pressure on services means people only receive treatment once they become so unwell they are detained.[9] Members in England suggest that rising detention rates depend on many factors, but include lack of adequate earlier intervention due to gaps in community service provision.

Across the UK, different pieces of legislation cover deprivation of liberty for mental ill-health. Members in England and Wales continue to engage with government over the eventual replacement of Deprivation of Liberty Safeguards (DoLS) with Liberty Protection Safeguards (LPS) to ensure that these principles are grounded in human rights principles.[10]

Children

COVID-19 is still a very present issue in the children's secure estate, with outbreaks at secure training centres and secure children's homes. There are also issues with the recruitment and retention of staff. As noted by the Care Inspectorate (Scotland), the resulting unpredictable shift patterns, inconsistent training and recorded supervision create a destabilising influence

6 HM Chief Inspector of Prisons for Scotland, 'Annual Report 2021-22', November 2022, available at: **https://www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/HMIPS - HM Chief Inspectors Annual Report - 2021-22 - Final Version_0.pdf**

7 Care Quality Commission, 'Monitoring the Mental Health Act in 2020/21', 2022, available at: **https://www.cqc.org.uk/sites/default/files/20210127_mhareport_printer.pdf**

8 Ibid.

9 Mental Welfare Commission for Scotland, 'Mental Health Act Monitoring Report 2020-21: Statistical Monitoring', September 2021, available at: **https://www.mwcscot.org.uk/search?keys=deprivation+of+liberty&op=submit&type=0&leg=54&theme=0**

10 Care Inspectorate Wales, 'Chief Inspector's Annual Report 2021-22', 2022, **https://www.careinspectorate.wales/sites/default/files/2022-10/221020-annual-Report-2021-22-EN.pdf**

on children in secure homes.[11] Pandemic restrictions and being placed far from families limited children's ability to maintain contact with family and friends.

According to the Children's Commissioner for England, around 1,000 children are deprived of their liberty in England at any given time in mental health wards and secure children's homes. There are few children in prison in Scotland, and a survey by His Majesty's Inspectorate of Prisons for Scotland (HMIPS) resulted in a proposal to the Scottish government to remove all under-18s from prison custody.[12] The proportion of children held on remand in Scotland's Young Offender Institution increased.

In November 2022, Police Scotland and the Scottish Police Authority hosted a well-attended roundtable: 'Places of safety for children in conflict with the law'. This was attended by key stakeholders and chief officers from local authorities across Scotland and focussed on working in partnership to identify future alternatives to custody for children.

Shortage of key information

In Scotland, The Care Inspectorate found instances in a secure setting where improvements were needed in risk assessments. It is a requirement for services to inform the Care Inspectorate about significant instances, including accidents, instances where children are restrained, harm themselves or others, allegations of abuse relating to a child, and any allegations of staff misconduct. The Care Inspectorate found examples where services failed to notify of incidents as they should.[13] In Welsh prisons, inspectors also found some weaknesses in the monitoring of performance data, reducing the ability to plan and improve provision.[14] In terms of mental health, an outstanding issue was that the Ministry of Justice, HM Prisons and Probation Service and NHS England do not know the extent of the need for mental healthcare provision in prisons, leaving a need unmet.[15] Data from prisons on equality monitoring were out of date and on a local level not even gathered, let alone analysed fully to address equalities issues.[16]

11 Care Inspectorate, 'Welcome to the Care Inspectorate'**, available at: https://www.careinspectorate.com/**

12 HM Chief Inspector of Prisons for Scotland, 'Annual Report 2021-22', November 2022, available at: **https://www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/HMIPS - HM Chief Inspectors Annual Report - 2021-22 - Final Version_0.pdf**

13 Care Inspectorate, 'Welcome to the Care Inspectorate', available at: **https://www.careinspectorate.com/**

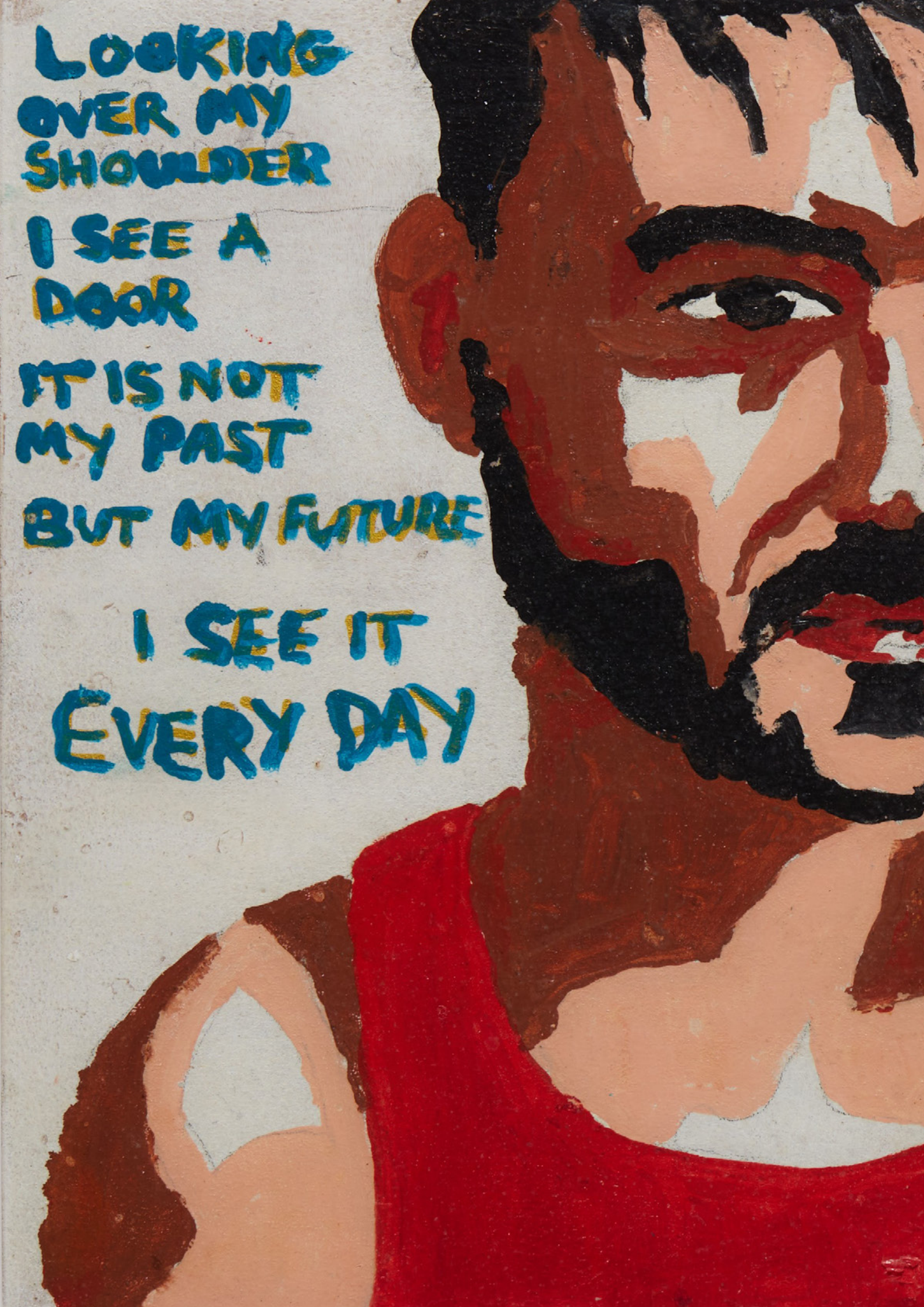
14 His Majesty's Chief Inspector of Prisons, 'Submission to the Health, Social Care and Sport Committee consultation on the provision of health and social care in the adult prison estate', September 2019, available at: **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/06/HMI-Prisons-Submission-to-HSCS-Committee-Wales_FINAL.pdf**

15 Criminal Justice Joint Inspection, Care Quality Commission, Healthcare Inspectorate Wales, 'A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders', November 2021, available at: **https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2021/11/Mental-health-joint-thematic-report.pdf**

16 HM Chief Inspector of Prisons for England and Wales, 'Annual Report 2021–22', 13 July 2022, available at: **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2022/07/HMIP-Annual-Report-web-2021-22.pdf**

In all of these cases, the information available to NPM members to use in order to inspect and monitor places of detention is restricted. OPCAT requires states to ensure that NPMs have access to all information referring to the treatment and conditions of people in detention, on top of the ability to access sites to enable the fulfilment of their mandates.[17] This requires the bodies that make up the UK's detention estate to keep accurate, thorough, and up-to-date standards of record keeping and scrutiny.

17 United Nations Human Rights Office of the High Commissioner, 'Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Article 20', 18 December 2002, available at: **https://www.ohchr.org/en/instruments-mechanisms/instruments/optional-protocol-convention-against-torture-and-other-cruel**


LOOKING
OVER MY
SHOULDER
I SEE A
DOOR
IT IS NOT
MY PAST
BUT MY FUTURE
I SEE IT
EVERY DAY

Reduction in provision: a perfect storm of crises in staffing, funding, and COVID-19

In prisons, custody, and health and social care settings, NPM members observed some severely reduced services due to ongoing COVID-19 recovery, resource limitations, staffing crisis, and struggles to maintain consistent training, supervision and partnership work.

Health and social care

Care Quality Commission (CQC) found that the health and social care system is gridlocked.[18] A systemic shortage of qualified mental health nurses, shortages of beds, other staff, reliance on agency and bank staff, inconsistent training and lack of supervision put patient and staff safety at risk across the UK. The shortage of available spaces means many patients are detained very far from their communities for prolonged periods of time. This increases the risk of closed cultures developing, where ill-treatment is much harder to identify and prevent. CQC defines closed cultures as "a poor culture that can lead to harm, including human rights breaches such as abuse", where people are more likely to be at risk of deliberate or unintentional harm.[19]

Children

In England, Ofsted found that taking into account staffing crises, ongoing COVID-19 recovery, and the increasingly complex needs of children entering the estate, secure children's homes generally performed well. However, there are not enough places – every day an average of 48 children who are a serious risk to themselves are waiting for a welfare placement.

Ofsted has commented about the gap in provision between secure children's homes and mental health provision for children with complex needs. Despite not meeting the criteria for admission to SCHs or for detention in Tier 4 provision under the Mental Health Act, children often end up in SCHs because there is no other option or provision that can provide the appropriate care and keep these children safe. In the secure children's estate, some buildings are old and have not kept up with the changing and more complex needs of children. Investment is needed to ensure that the needs of children can be met and sufficient places are available to meet the increasing demand for provision for very vulnerable children.

There is currently one operational secure training centre in England, following the closure of Rainsbrook in summer 2021 after a decision by the Secretary of State for Justice. Oakhill secure training centre provides for children between 12 and 18 years of age who are remanded to custody or serving a custodial sentence. The overall provision for children in secure training centres is not good enough, as reflected in the joint inspectorates' reports, and the environment does not meet the needs of vulnerable children.

18 Care Quality Commission, 'The state of health care and adult social care in England 2021/22', 20 October 2022, available at: **https://www.cqc.org.uk/sites/default/files/2022-10/20221024_stateofcare2122_print.pdf**

19 Care Quality Commission, 'How CQC identifies and responds to closed cultures' 12 May 2022, available at: **https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures#:~:text=Our%20definition%20of%20a%20closed,of%20deliberate%20or%20unintentional%20harm**

At the start of 2022, difficulties providing education on-ward and in youth custody services in England still had a consequential effect on children's time out of their room. In-person visits were limited, and the time children spent alone in their rooms was a primary concern. Delays are ongoing to deliver the first 'secure school' that intends to "place education at the heart of a secure setting" under new integrated care systems.[20] The Children's Commissioner for England found overwhelming evidence of placements too far from home and communities, without the right educational placements or the correct mental health support for children. The Commissioner is deeply concerned about the standard of care in Young Offender Institutions and the safety of children within them. Children deprived of their liberty outside registered accommodation was a growing concern.

There has been an increased use of deprivation of liberty authorisations under the inherent jurisdiction of the High Court for Children where no appropriate welfare placement in any secure setting can be found – this is of serious concern and must be urgently addressed. It is incumbent on the state to fulfil their human rights obligations by ensuring children, who are at particular risk of ill treatment, are accommodated in suitable facilities. Data must also be collected on the number of children in this situation and where they are living once the current deprivation of liberty court comes to an end.

In Scottish secure care, staff shortages and changes impacted on children with histories of trauma, while some staff lacked a trauma-informed perspective. High vacancy rates in care teams lead to inconsistencies and uncertainties among staff, unpredictable shift patterns, incomplete or inconsistent recorded supervision, and inconsistent completion of key training. This, in turn, acts as a destabilising influence on children in secure settings. Mental Welfare Commission for Scotland (MWCS) noted on their ward visits that while patients often speak of how supportive and professional the staff are, it is clear that care and treatment can be negatively affected by staff shortages.[21]

Prisons

Staffing shortages are now one of the key barriers to humane and rehabilitative regimes. Experienced staff are leaving the service and recruitment and retention of staff does not keep up, while COVID-19 can cause further staff absence. Most prisons, including training prisons, still run a restricted regime with prisoners spending up to 23 hours a day in cells. Most prisoners held in segregation had a too-limited regime.

The handover of resettlement work to the national Probation Service in England and Wales created significant gaps in support, especially for remand prisoners. Libraries were closed in most prisons, and offending behaviour, violence reduction and purposeful activity are considerably reduced. This negatively impacts on health and wellbeing, with prolonged confinement to cell exacerbating a high level of mental health need.

Restrictions to rehabilitative and offender management work inhibit prisoners' progression through a prison journey designed to reintegrate them into society

20 Children's Commissioner, 'Children deprived of liberty', 26 July 2022, available at: **https://www.childrenscommissioner.gov.uk/2022/07/26/children-deprived-of-liberty/**

21 Mental Welfare Commission for Scotland, 'Annual Report 2021-22', October 2022, available at: **https://www.mwcscot.org.uk/sites/default/files/2022-10/MentalWelfareCommission_AnnualReport_2021-22.pdf**

upon release. In Scotland, for example, frustration with progression opportunities was one of the biggest issues raised by prisoners with HMIPS, despite the consistent availability of places in Scotland's Open Estate. Strict regimes restricted face-to-face visits but led to greater use of technology for virtual visits. Monitors and inspectors in Scotland and Northern Ireland noted this might have positive impacts for prisoners whose families live far away.

In Wales, HMIP and Healthcare Inspectorate Wales found that prisoners often faced unacceptably long waits to access primary care clinics. They recommend that delays and cancellations of escorts to external healthcare appointments should be monitored against national waiting times to identify the delays to treatment access.[22] However, at HMP Usk, HMP Prescoed, HMP Cardiff and HMP Berwyn, prisoners' hospital appointments were rarely cancelled, which was "commendable".[23]

In the male estate in England and Wales, excessive use of force, swearing and abusive language during restraint, and inadequate attempts to de-escalate were noted by HMIP. If the use of force is justified, it must be no more than is strictly necessary.[24]

Where in England the continuation of a national 'command' regime meant that individual prisons could not adapt service provision to their level of risk, it was pleasing to observe during a Criminal Justice Inspection Northern Ireland inspection of Magilligan prison in Northern Ireland. Here, unlike prisons elsewhere in the UK, prisoners were unlocked for much of the day during the pandemic.[25] However, there was still a restricted regime and few opportunities for learning and skills development. Elsewhere, complaints by prisoners indicated that access to their rights did not mirror the relaxation of restrictions outside the prison. There were also concerns about the amount of time prisoners spend in their cells each day in Scotland, not wholly related to COVID-19.[26]

The Committee for the Prevention of Torture reminds authorities that "protective measures must never result in inhuman or

22 His Majesty's Chief Inspector of Prisons, 'Submission to the Health, Social Care and Sport Committee consultation on the provision of health and social care in the adult prison estate', September 2019, available at: **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/06/HMI-Prisons-Submission-to-HSCS-Committee-Wales_FINAL.pdf**

23 His Majesty's Chief Inspector of Prisons, 'Submission to the Health, Social Care and Sport Committee consultation on the provision of health and social care in the adult prison estate', September 2019, available at: **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/06/HMI-Prisons-Submission-to-HSCS-Committee-Wales_FINAL.pdf**

24 United Nations General Assembly, 'The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)', Rule 82.1, 8 January 2016, available at: **https://www.un.org/en/events/mandeladay/mandela_rules.shtml**

25 Criminal Justice Inspection Northern Ireland, HM Inspectorate of Prisons, the Regulation and Quality Improvement Authority, 'Report of an unannounced inspection of Magilligan Prison 21 May-10 June 2021', February 2022, available at: **https://www.cjini.org/getattachment/4ae6bd06-979d-4b1e-a724-c2ab6ee5ac09/report.aspx**

26 HM Chief Inspector of Prisons for Scotland, 'Annual Report 2021-22', November 2022, available at: **https://www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/HMIPS - HM Chief Inspectors Annual Report - 2021-22 - Final Version_0.pdf**

degrading treatment of persons deprived of their liberty".[27] States must ensure all measures taken in response to COVID-19 in detention settings are lawful, proportionate and necessary. Alternatives to in-person visits should be frequent and free.[28]

Limited Care and Supervision Units facilities were a cause for concern. A CJI review of Care and Supervision Units within Northern Ireland prisons found that the regime experienced by a number of prisoners did not meet UN Standards Minimum Rules. Prisoners were spending too long in their cell without meaningful human contact, and the need for staff training and supervision was also identified. In Scotland, prisoners were isolating for disproportionately long periods of time, sometimes being kept in cell for most of the day for at least 10 days. There was some improvement as regimes gradually opened access to education and gymnasia.

Isolation practices must only be used when absolutely necessary, for the shortest time possible, and must be proportionate to the legitimate objective for which they are imposed. Because of the harm that can be caused by isolation, specific and additional safeguards must also be in place, and justification for measures and their severity must be examined carefully by monitoring bodies. The table opposite breaks down relevant prison standards, highlighting relevant rules by which NPM members measure compliance with obligations relating to the prevention of torture.

27 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 'Statement of principles relating to the treatment of persons deprived of their liberty in the context of the coronavirus disease (COVID-19) pandemic', March 2020, available at: **https://rm.coe.int/16809cfa4b**

28 UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), '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)', March 2020, part II paragraph 11, available at: **https://www.ohchr.org/Documents/HRBodies/OPCAT/AdviceStatePartiesCoronavirusPandemic2020.pdf**

United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)	
Rule 4.1 Rule 4.2	The purposes of a sentence of imprisonment or similar measures deprivative of a person's liberty are primarily to protect society against crime and to reduce recidivism. Those purposes can be achieved only if the period of imprisonment is used to ensure, so far as possible, the reintegration of such persons into society upon release so that they can lead a law-abiding and self-supporting life. To this end, prison administrations and other competent authorities should offer education, vocational training and work, as well as other forms of assistance that are appropriate and available, including those of a remedial, moral, spiritual, social and health and sports-based in nature. All such programmes, activities and services should be delivered in line with the individual treatment needs of prisoners.
Rule 43	In no circumstances may restrictions or disciplinary sanctions amount to torture or other cruel, inhuman or degrading treatment or punishment. The following practices, in particular, shall be prohibited: (a) Indefinite solitary confinement, (b) Prolonged solitary confinement
Rule 44	For the purpose of these rules, solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days.
Rule 45.1 Rule 45.2	Solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review, and only pursuant to the authorization by a competent authority. It shall not be imposed by virtue of a prisoner's sentence. The imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures. The prohibition of the use of solitary confinement and similar measures in cases involving women and children, as referred to in other United Nations standards and norms in crime prevention and criminal justice, continues to apply.
Rule 74.3	To secure the foregoing ends, personnel shall be appointed on a full-time basis as professional prison staff and have civil service status with security of tenure subject only to good conduct, efficiency and physical fitness. Salaries shall be adequate to attract and retain suitable men and women, and employment benefits and conditions of service shall be favourable in view of the exacting nature of the work.

United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)	
Rule 75.2	Before entering on duty, all prison staff shall be provided with training tailored to their general and specific duties, which shall be reflective of contemporary evidence-based best practice in penal sciences. Only those candidates who successfully pass the theoretical and practical tests at the end of such training shall be allowed to enter the prison service
Rule 88.1	The treatment of prisoners should emphasize not their exclusion from the community but their continuing part in it. Community agencies should therefore be enlisted wherever possible to assist the prison staff in the task of social rehabilitation of the prisoners.
Rule 105	Recreational and cultural activities shall be provided in all prisons for the benefit of the mental and physical health of prisoners.

United Nations Standard Minimum Rules for the Administration of Juvenile Justice ("The Beijing Rules")	
Rule 1.2	Member States shall endeavour to develop conditions that will ensure for the juvenile a meaningful life in the community, which, during that period in life when she or he is most susceptible to deviant behaviour, will foster a process of personal development and education that is as free from crime and delinquency as possible.
Rule 1.3	Sufficient attention shall be given to positive measures that involve the full mobilisation of all possible resources, including the family, volunteers and other community groups, as well as schools and other community institutions, for the purpose of promoting the well-being of the juvenile, with a view to reducing the need for intervention under the law, and of effectively, fairly and humanely dealing with the juvenile in conflict with the law.
Rule 1.6	Juvenile justice services shall be systematically developed and co-ordinated with a view to improving and sustaining the competence of personnel involved in the services, including their methods, approaches and attitudes.

Equality and diversity in detention

In prisons, equality and diversity work had been neglected and was slow to recover post COVID-19. In HMIP surveys, ethnic minority prisoners had more negative perceptions than white prisoners in some key aspects of treatment and conditions. IMBs in England and Wales noted disproportionate treatment of black and minority ethnic prisoners, use of disciplinary measures, and use of force and incapacity spray on black, minority ethnic and Muslim prisoners in the men's estate.[29]

In hospital settings in England, CQC notes that ethnic minorities continue to be overrepresented among people subject to Mental Health Act powers. Mental Welfare Commission for Scotland (MWCS) noted that staff were requesting training for working with prisoners with complex mental health needs, as well as a need and desire for ethnicity and diversity training.[30] Most concerningly, MWCS also found differences in the ways the Mental Health Act is applied when people from ethnic minorities are detained for care and treatment compared to white Scottish people. This is particularly the case between black women and white Scottish women. International rules on the treatment of prisoners are clear that they must be applied impartially, with no discrimination on grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or any other status.[31]

A thematic review of outcomes for detained girls identified a "dysfunctional custody system failing girls" in England and Wales.[32] Where "many dedicated frontline staff [were] doing their best in extremely difficult circumstances", the estate did not function effectively, leaving girls with the highest need placed in establishments with least resource. Girls were 83% more likely to use violence than boys, more likely to be directed at staff than other children, and were 12 times more likely to self-harm. Too often staff used restraint as a preventive measure in a cycle of restraint and self-harm.[33] At Hydebank Wood Women's prison in Northern Ireland, concerns were raised about the male and female prisoners sharing a Care and Supervision Unit. As a result, immediate action was taken, and they are now held in separate units. In secure children's services in Scotland, the Care Inspectorate reported bullying, which at one site was particularly related to gender.

29 Independent Monitoring Boards, 'National Annual Report 21-22', 6 October 2022, available at: **https://imb.org.uk/document/national-annual-report-2021-22/**

30 See: Mental Welfare Commission for Scotland, available at: **https://www.mwcscot.org.uk/**

31 United Nations General Assembly, 'United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)', Rule 2.1, 8 January 2016, available at: https://www.un.org/en/events/mandeladay/mandela_rules.shtml

32 His Majesty's Inspectorate of Prisons, 'Dysfunctional custody system failing girls', 21 September 2022, available at: **https://www.justiceinspectorates.gov.uk/hmiprisons/media/press-releases/2022/09/dysfunctional-custody-system-failing-girls/**

33 Ibid.

Services should have procedures in place to actively counter discrimination for all service users. While contracts with secure care providers include a clause relating to appropriate safeguarding policies and procedures to ensure children are safe and free from all forms of abuse, harassment, and discrimination, members' findings suggest these are not working effectively in practice.

Immigration detention in England and Wales

At the time of writing, the immigration detention estate is under unprecedented scrutiny following the hearings into mistreatment by staff at Brook House and the later exposure of alleged inhuman conditions at Manston short-term holding facility (STHF). Independent monitors and HMIP have visited and inspected different immigration settings, as well as foreign nationals held in prisons, over the reporting year. A key concern for the Independent Reviewer of Terrorism Legislation is designated detention facilities in ports. Under OPCAT Article 4, inspection visits must be allowed to any place where persons are, or may be, deprived of their liberty – but it is not clear that this is currently the case.

Some prisons had high numbers of foreign nationals, who had limited access to legal advice about their immigration status. Free legal advice must be made available to immigration detainees held in prisons.[34] In immigration detention as well, detainees were often uninformed for days about the reason for their detention and had not been given a Home Office screening interview or risk assessment on or before arrival. Too many detainees were held for lengthy periods with little prospect of removal, including many considered to be vulnerable under the Home Office's own adults at risk in immigration detention policy.[35]

Protracted detention and a refusal to provide information and procedural rights to detainees can cumulatively inflict serious psychological harm, potentially becoming cruel or inhuman treatment.[36] The Council of Europe's Committee for the Prevention of Torture considers that "the prolonged detention of persons under aliens legislation, without a time limit and with unclear prospects for release, could easily be considered as amounting to inhuman treatment".[37]

Where the physical environment of some residential STHFs were good, those on the South Coast were unfit for purpose, conditions remained unacceptably poor and progress on opening new, larger facilities had been too slow. Other elements such as safeguarding and procedural safeguards were weak. Improvements in the physical environment followed significant investment

34 The High Court of Justice Queen's Bench Division Administrative Court, 'SM, R (On the Application Of) v Bail for Immigration Detainees [2021] EWHC 418 (Admin) (25 February 2021)', 25 February 2021, available at: **https://www.bailii.org/ew/cases/EWHC/Admin/2021/418.html**

35 HM Chief Inspector of Prisons for England and Wales, 'Annual Report 2021–22', 13 July 2022, available at: **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2022/07/HMIP-Annual-Report-web-2021-22.pdf**

36 Human Rights Council, 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment – 37th session', 26 February 2018, available at: **https://www.ohchr.org/sites/default/files/Documents/Issues/Torture/A_HRC_37_50_EN.pdf**

37 CPT, 'Factsheet on Immigration detention (CPT/Inf(2017)3', March 2017, available at: **https://rm.coe.int/16806fbf12**

at Dungavel. Harmondsworth was still prison-like, with run-down living areas and detainees locked in their cells for long periods. There was no investment for clearly needed refurbishment. In several cases, detention exceeded the legal limit for residential STHFs of five days.

Immigration detention facilities should provide adequately furnished and clean accommodation in a good state of repair, offering sufficient space for detainees.[38] Various facilities had little private space, and people were sometimes held overnight in wet clothes, having to sleep on the ground in cramped conditions. Detainees, including families and unaccompanied children, spent several days without access to washing facilities, beds, or time in the open air. At Kent Intake Unite, detainees were confined to a permanently lit room without access to fresh air or even the chance to look outside because of the frosted windows. 40 people were in the holding room, barely able to move and unable to rest properly after exhausting journeys. Under prison rules, in all places where detainees are required to live, windows must allow access to adequate natural light and fresh air, and an hour of suitable exercise in the open air is considered the minimum.[39]

38 CPT, The former Yugoslav Republic of Macedonia: Visit 2014', 25 March 2015, available at: **http://hudoc.cpt.coe.int/eng?i=p-mkd-20141007-en-38**

39 United Nations General Assembly, 'United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)', Rule 14 and 23, 8 January 2016, available at: **https://www.un.org/en/events/mandeladay/mandela_rules.shtml**

Police custody, court custody and transportation

In all jurisdictions, overall improvements have been made in custody and transportation contexts. Improvements in terms of preservation of rights and conditions of custody suites in Northern Ireland received particular note, given the challenges and restrictions presented by the COVID-19 pandemic.[40] In England and Wales, national organisations proactively responded to independent custody visitors' feedback, and His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) inspections found improved custody service provision. Staff and custody officers were generally found to treat people with respect and recognise diverse needs.[41] In Scotland, visitors found that many issues were addressed immediately by custody authorities.[42]

However, challenges remained in each region, particularly in the areas of health and hygiene, advocacy, record keeping, and the treatment of children. Services that are overall positive and respectful are far too often hampered by low staffing levels which mean they cannot deliver full normal services.[43] Demand in services greatly exceeds capacity and services are under considerable pressure.

Engaging the right to liberty and security of person, Lay Observers report on detainees brought from a prison and released by a court while in custody being retained in cells until the sending prison provides a document confirming they are not wanted on other charges.[44] This can take "up to four hours during which an innocent person can be held in custody".[45]

40 Northern Ireland Policing Board and the Custody Visiting Scheme, 'Annual Custody Visitors Report April 2021-March 2022', available at: **https://www.nipolicingboard.org.uk/files/nipolicingboard/2022-09/annual-custody-visitors-annual-report-april-2021-march-2022.pdf**

41 His Majesty's Chief Inspector of Constabulary and Fire and Rescue Services, 'State of Policing: the annual assessment of policing in England and Wales', 6 April 2022, available at: **https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/State-of-policing-2021-1-single-page.pdf**

42 Scottish Police Authority, 'Independent Custody Visiting Scheme Scotland Annual Report 2021-22', available at: **https://www.spa.police.uk/spa-media/2bclpjjw/icvs-annual-report-2021_22-final.pdf**

43 As noted by Lay Observers.

44 European Convention of Human Rights, Article 5 (implemented in UK law through the Human Rights Act); International Covenant on Civil and Political Rights, Article 9

45 As noted by Lay Observers.

Health

While detainees' health needs were generally well-met by professionals in police custody in England and Wales, HMICFRS noted that showers and exercise should have been offered more, while independent custody visitors noted insufficient access to hygiene.[46] In Northern Ireland, custody visitors found various issues of cleanliness and hygiene.[47] Following pandemic restrictions to facilities, Independent Custody Visiting Scotland (ICVS) recommends that Police Scotland closely monitors access to washing and showering facilities. It is the view of Independent Custody Visitors (ICVs) that detainees' wellbeing and treatment would be improved if they were offered access to washing facilities at the first opportunity after being processed in custody, where capacity and facilities allow. In particular, this is where the detainee is due for court the next lawful day, regardless of time spent in custody.[48] Some cell toilets were not functioning, cells were cold, and some handwashing facilities were not working. A 5-Year Vision and Direction now sets out plans to embrace a public health response.[49] Despite this, His Majesty's Inspectorate of Constabulary in Scotland (HMICS) has found that the provision of healthcare services to police custody, for which NHS boards have responsibility, remains inconsistent across the country.

There is a significant lack of psychological support for people with a history of personality disorder and trauma. Since the COVID-19 pandemic there is a significant increase in the severity of presentations of acute mental ill-health in Northern Ireland. Higher levels of acuity and increasingly complex mental health problems have higher associated risks.[50] There are long waiting times for mental health appointments, for addiction appointments and for transfer to acute mental health beds within hospital.[51] More than 40% of detainees in Scotland self-declared as having a mental health condition or vulnerability in their lives.[52]

46 Independent Custody Visiting Association (ICVA), 'Annual Report 2021/22', July 2022, available at: **https://icva.org.uk/wp-content/uploads/2022/07/02-ICVA-annual-report-2122.pdf**

47 Northern Ireland Policing Board and the Custody Visiting Scheme, 'Annual Custody Visitors Report April 2021-March 2022', available at: **https://www.nipolicingboard.org.uk/files/nipolicingboard/2022-09/annual-custody-visitors-annual-report-april-2021-march-2022.pdf**

48 Scottish Police Authority, 'Independent Custody Visiting Scheme Scotland Annual Report 2021-22', available at: **https://www.spa.police.uk/spa-media/2bclpjjw/icvs-annual-report-2021_22-final.pdf**

49 Police Scotland Criminal Justice Services Division, '5 Year Vision and Direction', 7 June 2022, available at: **https://www.spa.police.uk/spa-media/hyldjuql/rep-c-20220531-item-2-1-criminal-justice-services-division-5-year-vision-and-direction.pdf**

50 Regulation and Quality Improvement Authority, 'RQIA Annual Report and Accounts 1 April 2021-31 March 2022', 27 July 2022, available at: **https://www.rqia.org.uk/RQIA/files/5c/5cdeca2e-797b-4a01-8364-d243b1e71f5f.pdf**

51 Regulation and Quality Improvement Authority, 'Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons', October 2021, available at: **https://www.rqia.org.uk/RQIA/files/95/955cfa4a-5199-4be7-9f1a-801e1369ce84.pdf**

52 Scottish Police Authority, 'Independent Custody Visiting Scheme Scotland Annual Report 2021-22', available at: **https://www.spa.police.uk/spa-media/2bclpjjw/icvs-annual-report-2021_22-final.pdf**

Children

In England and Wales, HMICFRS did find good work on keeping children and vulnerable people out of custody, while Lay Observers concluded that the custody regime to manage children and young people introduced in the new agreement with contractors in 2020 has been a positive improvement. However, limited staffing levels restricted this service, leaving vulnerable children and young people without full support and spending long periods alone, locked in cell. Where they were detained in custody, they were rarely moved to accommodation arranged by local authority, and there were some unacceptably long waits for an appropriate adult to arrive.[53] Young people in police custody waited longer in detention and ICVA found this correlated with a lower understanding of their rights and entitlements where they did not have access to an appropriate adult.[54]

4,201 children were held in custody in Scotland, continuing a decrease since 2020 due to continual progress by Police Scotland through partnership agencies to reduce the need for children to be held in police custody.[55] Where children continue to be held in custody, this is due to a lack of alternative suitable places of safety. Staffing shortages affected Escort Custody Services, with poor performance by contractor GEOAmey since 2019, continuing with failure to meet contractual requirements, missed hospital appointments, and late arrival of children to prisons.[56]

Once children and young people have completed their appearances at court and have returned to their cells, they often have to wait again for a placement to be arranged. This may result in them not getting back to their residence in time for a meal. While the majority are treated well, the number of these incidents is too high for this age group of detainees. Lay Observers are also concerned about the long distances that children and young people travel to court, making appearances long, tiring and distressing. CJI also identified improvements required in the care of children in court custody in Northern Ireland.[57]

Record keeping

Record keeping and information sharing were key issues in custody and transport contexts in England and Wales. HMICFRS found that custody records information was not detailed enough, and information on the use of restraint or force on detainees was

53 His Majesty's Chief Inspector of Constabulary, 'State of Policing; the annual assessment of policing in England and Wales 2021', 10 March 2022, **https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/State-of-policing-2021-1-single-page.pdf**

54 Independent Custody Visiting Association (ICVA), 'Annual Report 2021/22', available at: **https://icva.org.uk/wp-content/uploads/2022/07/02-ICVA-annual-report-2122.pdf**

55 Scottish Police Authority Independent Custody Visiting Scheme Scotland, 'Annual Report 2021-22', available at: **https://www.spa.police.uk/spa-media/2bclpjjw/icvs-annual-report-2021_22-final.pdf**

56 HM Chief Inspector of Prisons for Scotland, 'Annual Report 2021-22', November 2022, available at: **https://www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/HMIPS - HM Chief Inspectors Annual Report - 2021-22 - Final Version_0.pdf**

57 Criminal Justice Inspection Northern Ireland, 'Court Custody: The detention of persons in the custody of the court in Northern Ireland', March 2022, available at: **https://www.cjini.org/getattachment/793e1720-6235-44fb-be9c-bfee98af9cf1/Court-Custody-2022.aspx**

often limited and frequently inaccurate.[58] Information siloes also have harmful impacts on individuals deprived of their liberty. In October 2022, though outside the reporting period, Lay Observers found that delays to appearance in court and poor treatment of a 15-year-old male were not recorded officially. This withheld crucial context to his subsequent behaviour, for which he may now face a conviction. Another major concern is the quality and completeness of the Person Escort Records that should accompany all detainees. Far too often detainees arrive at a court and the Person Escort Record does not provide the relevant information and risk factors to assist the custody staff in effectively managing detainees.[59] In Northern Ireland, the risk information provided for transfer from prison to court also needed to be improved.[60]

Recommendations by HMICS included:

- improvements to the information process during cell checks
- a review into potential risks and benefits of utilising local police to cover shifts and custody operations
- engaging with responsible health boards and health and social care partnerships to ensure consistent, accessible and quality healthcare

Advocacy

In custody settings, good practice was found by criminal justice liaison and diversion services, which identify people who have mental ill-health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system. [61] However, observations by Lay Observers have highlighted a serious concern regarding the number of agencies involved in dealing with detainees, and a serious lack of cohesion and interconnection between them, adversely impacting on their treatment.

Meanwhile, HMICFRS noted that The Police and Criminal Evidence Act 1984 and codes of practice were not always met. At the same time, the use of Section 136 of the Mental Health Act to detain those with mental ill-health while in custody as a place of safety continued and was potentially increasing – this is of high concern.

58 His Majesty's Chief Inspector of Constabulary and Fire and Rescue Services, 'State of Policing; the annual assessment of policing in England and Wales', 10 March 2022, available at: **https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/State-of-policing-2021-1-single-page.pdf**

59 As noted by Lay Observers.

60 Criminal Justice Inspection Northern Ireland, 'Court Custody: The detention of persons in the custody of the court in Northern Ireland', March 2022, available at: **https://www.cjini.org/getattachment/793e1720-6235-44fb-be9c-bfee98af9cf1/Court-Custody-2022.aspx**

61 His Majesty's Chief Inspector of Constabulary and Fire and Rescue Services, 'State of Policing; the annual assessment of policing in England and Wales', 10 March 2022, available at: **https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/State-of-policing-2021-1-single-page.pdf**

Custody visitors' concerns continued over a pervasive request culture, and issues with access to solicitors continued in England and Wales.[62] Women detainees did not always have access to women staff members, and vulnerable female detainees, as well as children and young persons, were not given priority in court appearance which led to them waiting up to five hours to be heard in court. Women often shared transport to court with men and were not always adequately protected from verbal abuse.[63]

Video-enabled justice was introduced in many custody suites. Sometimes this was successful. However, there are many concerns around detainees spending longer in custody as they wait to attend court and await escort to prison. An increase in virtual remand hearings held in police custody imposed new demands on custody staff. ICVA found this impacted on detainee welfare and led to longer stays in custody.[64]

In Scotland, independent monitors found numerous issues in transportation, for example women being brought to prison late at night. In custody suites, 70 visits identified issues of detainees not being told or understanding why they were detained. Others did not understand or were not told that their named person or legal support had been notified. Many instances were addressed immediately.[65]

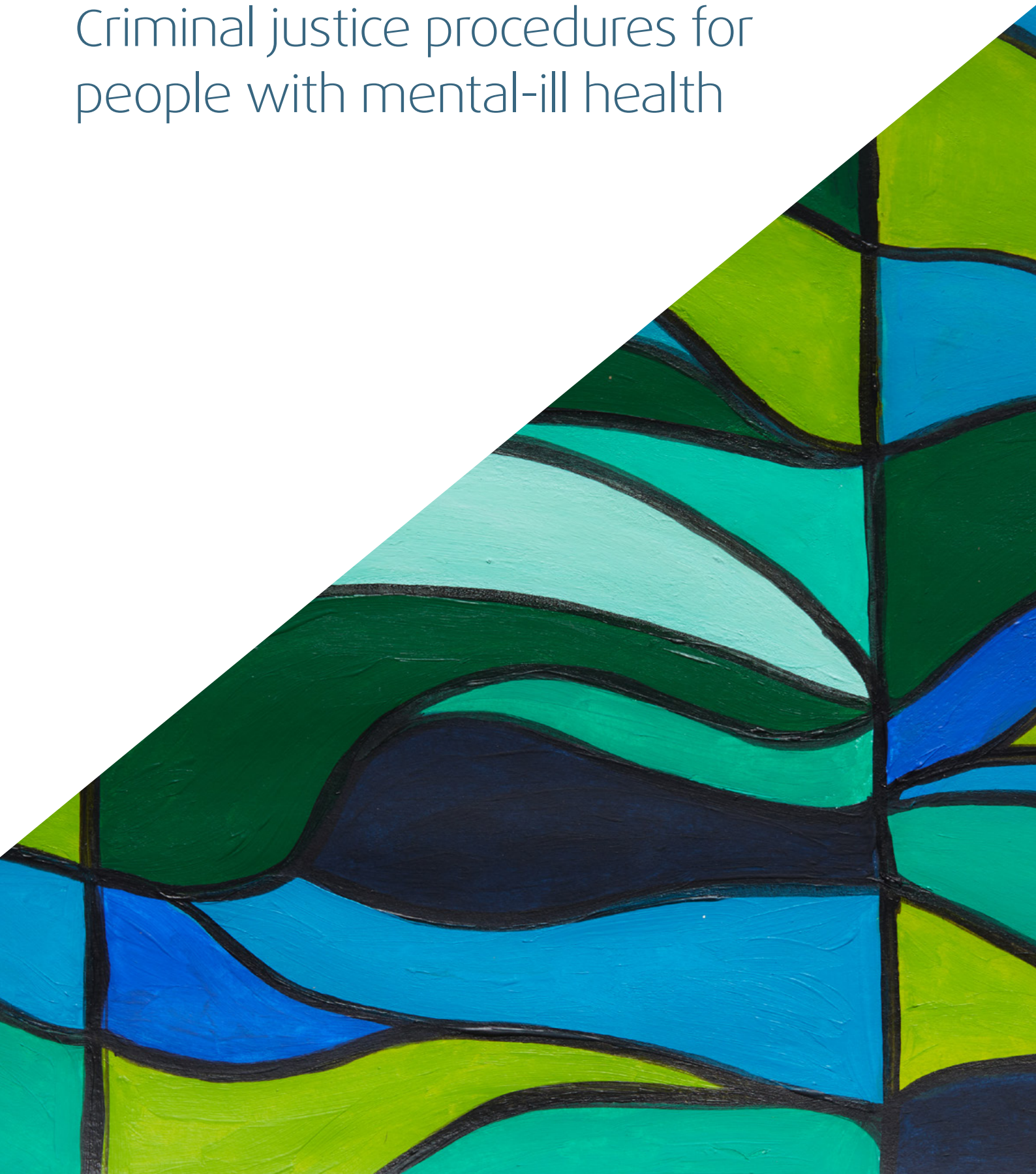
62 Independent Custody Visiting Association (ICVA), 'Annual Report 2021/22', available at: **https://icva.org.uk/wp-content/uploads/2022/07/02-ICVA-annual-report-2122.pdf**

63 HM Chief Inspector of Prisons for England and Wales, 'Annual Report 2021–22', 13 July 2022, available at: **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2022/07/HMIP-Annual-Report-web-2021-22.pdf**

64 Independent Custody Visiting Association (ICVA), 'Annual Report 2021/22', available at: **https://icva.org.uk/wp-content/uploads/2022/07/02-ICVA-annual-report-2122.pdf**

65 Scottish Police Authority, 'Independent Custody Visiting Scheme Scotland: Annual Report 2021-22', available at: **https://www.spa.police.uk/spa-media/2bclpjjw/icvs-annual-report-2021_22-final.pdff**

Criminal justice procedures for people with mental-ill health



Improvements have been made to mental health provisions in English and Welsh prisons since 2005, when the NHS took over responsibility for healthcare in prisons. However, a lack of a common definition of mental health across the criminal justice system led to inconsistencies in identification at different stages of a person's criminal justice journey.[66] This led to poorer assessments, needs not being met, and no accurate picture of how many people have mental health needs and disorders.

In custody settings, good practice was found by criminal justice liaison and diversion services, which identify people who have mental ill-health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system.[67] Outstanding issues included the need for action to prevent mentally ill people being sent to or kept in prison, due to a shortage of mental health services in the community. The use of prison for severe mental health problems is a chronic problem – IMBs identified an urgent need for joint action with the Department of Health so that prison is not the default setting for people whose primary problem is mental disorder. [68] IMBs found that those with the most severe mental health disorders are found in segregation units, with long delays in transfer to mental health units. Additionally, support for disabled and neurodiverse prisoners was problematic.

Almost half of women responding to HMIP surveys said they had a disability, but only 39% of those said they were getting the support they needed. Prison administrations should take into account the individual needs of all prisoners in order to apply the principle of non-discrimination. In particular, they should protect and promote the rights of the most vulnerable prisoners.[69]

Good practice was identified in men's prisons in Wales, where all prisoners at HMP Cardiff, HMP Usk and HMP Prescoed were seen by social care staff on arrival.[70] Extensively trained 'buddies' were allocated to prisoners at HMP Usk, following an agreed care plan. Over half the population in some women's prisons was on mental health caseload.

66 Criminal Justice Joint Inspection, Care Quality Commission, Healthcare Inspectorate Wales, 'A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders' November 2021**, available at: https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2021/11/Mental-health-joint-thematic-report.pdf**

67 His Majesty's Chief Inspector of Constabulary and Fire and Rescue Services, 'State of Policing: the annual assessment of policing in England and Wales', 6 April 2022, available at: **https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/State-of-policing-2021-1-single-page.pdf**

68 Independent Monitoring Boards, 'National Annual Report 21-22', 6 October 2022, available at: **https://imb.org.uk/document/national-annual-report-2021-22/**

69 United Nations General Assembly, 'United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)', Rule 2.2, 8 January 2016, available at: https://www.un.org/en/events/mandeladay/mandela_rules.shtml

70 His Majesty's Chief Inspector of Prisons, 'Submission to the Health, Social Care and Sport Committee consultation on the provision of health and social care in the adult prison estate', September 2019, available at: **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/06/HMI-Prisons-Submission-to-HSCS-Committee-Wales_FINAL.pdf**

Some with acute mental illness are still sent to prison by the courts as an alleged 'place of safety' or for their 'own protection'. Self-harm remained high, especially in women's prisons and among young adults. Girls in custody in England and Wales had complex needs including self-harm, substance misuse, neurodivergence and mental ill-health. Some had been remanded to custody because there were no placements available in hospital or community settings, but the environment in custody cannot provide the correct therapeutic environment.[71] This is an increasing trend, and for some children there was no availability at all nationwide. At the same time, inspectors also observed good relationships between staff members and girls.

The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) require that those with mental health needs are housed at the lowest possible security level, receiving appropriate treatment, rather than being placed in higher security level facilities purely due to their mental health problems.[72] Individualised, gender sensitive, trauma informed and comprehensive mental health care and rehabilitation programmes should be made available for women, and staff should be trained to detect mental health care needs and risk of self-harm and suicide.[73]

Healthcare Inspectorate Wales also identified the need for stronger partnership working between health boards and prisons to raise the profile of prison healthcare.[74] Mental health teams were responsive but lacked capacity to assist all prisoners with mild to moderate emotional problems. HMP Berwyn Prison was the exception, as it had a wide range of interventions, agreed care plans and reviews. Severe and enduring mental health needs were quickly and regularly reviewed by a mental health team at Swansea. [75]

MWCS stated that there had been little improvement in mental health services in prisons in the ten years between visits to all 15 of Scotland's prisons, which were

71 His Majesty's Inspectorate of Prisons, 'Dysfunctional custody system failing girls', **21 September 2022, available at: https://www.justiceinspectorates.gov.uk/hmiprisons/media/press-releases/2022/09/dysfunctional-custody-system-failing-girls/**

72 United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), Rule 41.4.

73 His Majesty's Chief Inspector of Prisons, 'Submission to the Health, Social Care and Sport Committee: consultation on the provision of health and social care in the adult prison estate', September 2019, available at: **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/06/HMI-Prisons-Submission-to-HSCS-Committee-Wales_FINAL.pdf**

74 Health Inspectorate Wales, 'HIW urges Swansea Bay University Health Board to strengthen oversight of healthcare services to HMP Swansea', 30 June 2022, available at: **https://www.hiw.org.uk/hiw-urges-swansea-bay-university-health-board-strengthen-oversight-healthcare-services-hmp-swansea**

75 His Majesty's Chief Inspector of Prisons, 'Submission to the Health, Social Care and Sport Committee: consultation on the provision of health and social care in the adult prison estate', September 2019, available at: **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/06/HMI-Prisons-Submission-to-HSCS-Committee-Wales_FINAL.pdf**

"under-served and under-resourced".[76] The Mental Welfare Commission recommends an urgent audit of the use of segregation for prisoners "so mentally unwell that there is no alternative to safely manage their care in custody".[77] In particular, resources should be guaranteed for better outcomes for people with mental health related conditions in prisons.

In Northern Ireland, demand in services greatly exceeds capacity.[78] There is a significant lack of psychological support for people with a history of personality disorder and trauma. Since the COVID-19 pandemic there is a significant increase in the severity of presentations of acute mental ill-health, with higher levels of acuity and increasingly complex mental health problems, with higher associated risks. Concerns were raised about the segregation of people with severe mental illness in Care and Supervision Units at Northern Ireland prisons, and timely access to appropriate hospital beds was required. The IMB raised the lack of information about times that prisoners had meaningful contact. Digital recordings of each interaction with prisoners are now compiled to allow for analysis and scrutiny. In 2021, RQIA published its review of services for vulnerable persons detained in Northern Ireland prisons.[79] The review made recommendations for the planning, commissioning and delivery of services to support people with mental ill-health who are at risk of self-harm or suicide.

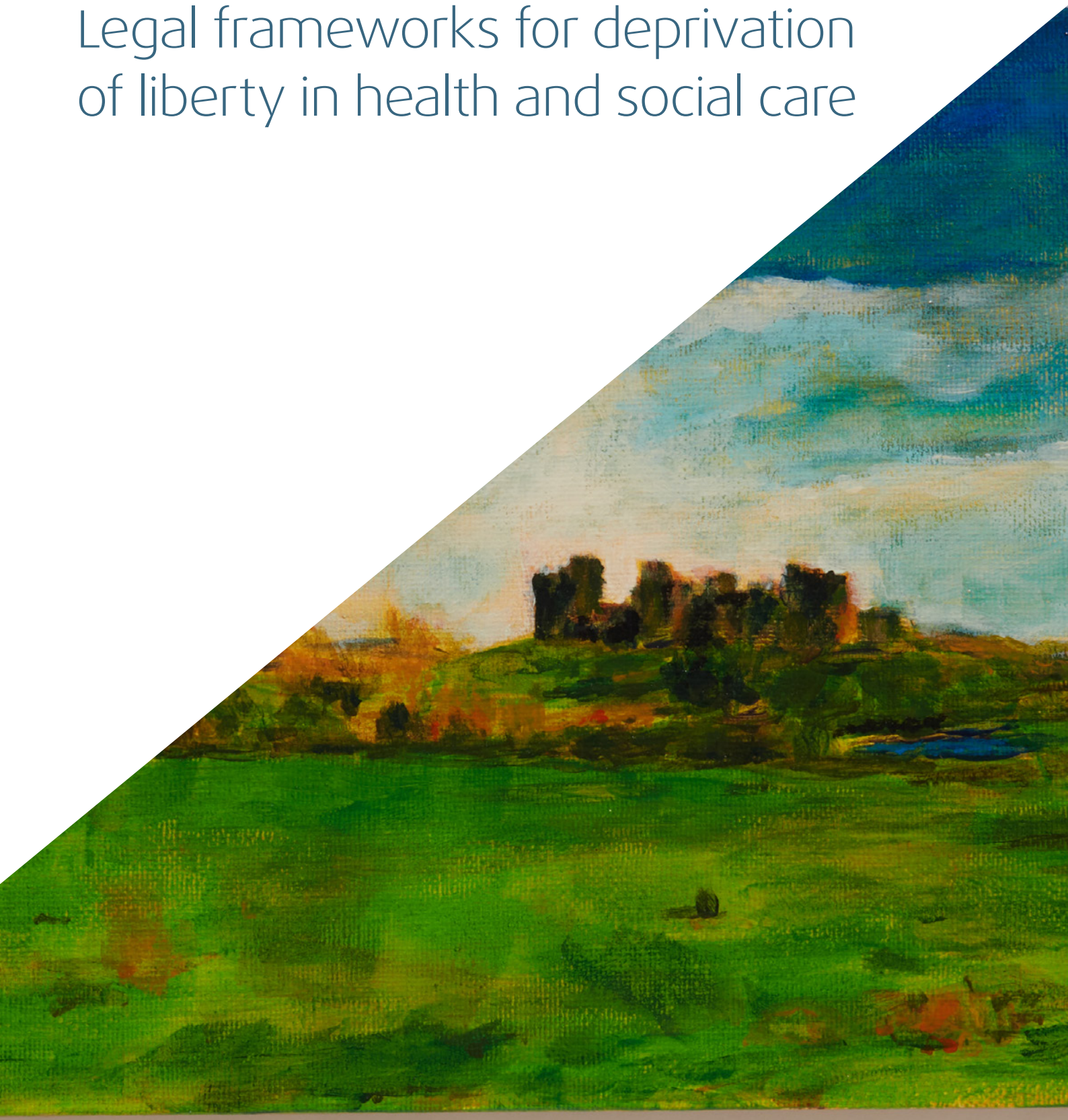
76 Mental Welfare Commission for Scotland, 'Mental health support in Scotland's prisons 2021: under-served and under-resourced, Themed visit report', April 2022, available at: **https://www.mwcscot.org.uk/sites/default/files/2022-04/PrisonReport-April2022.pdf**

77 Ibid.

78 Regulation and Quality Improvement Authority, 'RQIA Annual Report and Accounts 1 April 2021-31 March 2022', 27 July 2022, available at: **https://www.rqia.org.uk/RQIA/files/5c/5cdeca2e-797b-4a01-8364-d243b1e71f5f.pdf**

79 Regulation and Quality Improvement Authority, 'Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons', October 2021, available at: **https://www.rqia.org.uk/RQIA/files/95/955cfa4a-5199-4be7-9f1a-801e1369ce84.pdf**

Legal frameworks for deprivation of liberty in health and social care



Deprivation of Liberty Safeguards (DoLS) is a procedure in England and Wales to lawfully and temporarily deprive a patient or resident of a care service of their liberty in order to keep them safe, where they lack the capacity to consent to this care or treatment. Under UK law, a person can only be deprived of their liberty where this is in specific circumstances and "in accordance with a procedure prescribed in law".[80] In Wales, Care Inspectorate Wales and Healthcare Inspectorate Wales have joint responsibility for the monitoring and reporting of DoLS. The most recent annual monitoring report, published in March 2021, notes that where applications from care homes decreased, urgent applications in hospitals increased. Urgent applications allow a hospital or care home to grant itself temporary authorisation before standard authorisation to deprive someone of liberty can be obtained.

In 2018, the Mental Capacity (Amendment) Bill was published. When implemented, this will replace DoLS with Liberty Protection Safeguards (LPS), which will allow a more streamlined process to authorise deprivations of liberty. LPS will apply to a wider range of settings than DoLS, lowering the applicable age to 16, and applying also to home-care and supported living.

In England, the government is currently considering responses to its consultation on the Mental Capacity Act (MCA) and LPS code of practice and regulations.[81] The original date for entry into force of LPS cannot be met due to the same workforce and pandemic pressures affecting the rest of the sector. The Children's Commissioner for England is working to ensure 16-18 year olds' rights are safeguarded and their views respected under the new framework in England.[82] Currently, confusion over DoLS means that adults' and children's legal rights, and the capacity to consent are not well understood. Additionally, some are at risk of being unlawfully deprived of their liberty.

The Westminster government has published a Draft Mental Health Bill policy paper to reform the Mental Health Act and "improve the way that people with a learning disability and autistic people are treated in law".[83] A Joint Committee questioned mental health leaders at CQC in November 2022. In Scotland, the Scottish Mental Health Law Review made multiple recommendations to Scottish government, including expanding the Mental Health Tribunal for Scotland's jurisdiction to include capacity cases, and emphasising the principle of least restrictive alternatives for any treatment without consent.[84] On situations of deprivation of liberty, the report recognises "a human rights gap in Scots law around the Deprivation of Liberty for persons who lack capacity to consent to this voluntarily", exposed by the European Court of Human Rights

80 European Convention of Human Rights, 'Article 5, in UK law by virtue of the Human Rights Act 1998', 9 November 1998, available at: **https://www.legislation.gov.uk/ukpga/1998/42/data.pdf**

81 Care Quality Commission, 'The state of health care and adult social care in England 2021/22', 20 October 2022, **https://www.cqc.org.uk/sites/default/files/2022-10/20221024_stateofcare2122_print.pdf**

82 Children's Commissioner, 'Children deprived of liberty', 26 July 2022, available at: **https://www.childrenscommissioner.gov.uk/2022/07/26/children-deprived-of-liberty/**

83 Draft Mental Health Bill 2022, **https://www.gov.uk/government/publications/draft-mental-health-bill-2022**

84 Ibid.

in HL v UK (2004).[85] It recommends that the Scottish Government establish a legislative framework for situations where a person may be deprived of their liberty, to incorporate human rights enablement, supported decision making, and autonomous decision making.[86]

In Northern Ireland, partial implementation of the Mental Capacity Act (Northern Ireland 2016), and the Mental Capacity (Deprivation of Liberty) Regulations 2019 came into effect in December 2019. These conferred new responsibilities on the Regulation and Quality Improvement Authority (RQIA). Work on repurposing RQIA to implement this role was delayed by the pandemic. Due to the current capacity and resources within RQIA there is a risk that it fails to meet its statutory functions in respect of this legislation.[87] In Scotland, resource constraints could continue to be a barrier to the correct operation of Deprivation of Liberty orders if not increased.[88] The Adults with Incapacity Act 2000 is an important safeguard for people who are unable to make some or all decisions in Scotland. It is vital that plans to introduce emergency powers ensure this does not mean a reduction of proper scrutiny where intervention amounts to deprivation of liberty.

85 Ibid.

86 Ibid.

87 Regulation and Quality Improvement Authority, 'RQIA Annual Report and Accounts: 1 April 2021-31 March 2022', 27 July 2022, available at: **https://www.rqia.org.uk/RQIA/files/5c/5cdeca2e-797b-4a01-8364-d243b1e71f5f.pdf**

88 Mental Welfare Commission for Scotland, 'Scottish Mental Health Law review – consultation response,' June 2022, available at: **https://www.mwcscot.org.uk/sites/default/files/2022-06/SMHLR-Response_May2022.pdf**

List of NPM members and ongoing work

The Care Inspectorate

In July 2022, Care Inspectorate launched a review into the impact of the Secure Care Pathway and Standards published in 2020. The review will be conducted up to August 2023 and will focus on people under 18 who have been, or are, at risk of being placed in secure accommodation by Scottish local authorities. A national report will be published in autumn 2023. The Care Inspectorate continues its routine inspection of secure care for children, in accordance with regulations. It contributes guest inspectors to collaborate with HMIPS in its inspections of prisons in Scotland.

Care Inspectorate Wales

Care Inspectorate Wales inspected two secure accommodation services, and joint inspections with Estyn resumed in January. The DoLS report for 2020-2021 was published in March 2022. Care Inspectorate Wales is working with the Welsh Government, Estyn, and Healthcare Inspectorate Wales on the implementation of LPS in Wales. Care Inspectorate Wales is developing a draft monitoring and reporting strategy, describing the discharge of responsibilities for monitoring and reporting on LPS. This is to ensure people are not deprived of their liberty unlawfully, and to promote improvement through recommendations and sharing effective practice.[89]

Care Quality Commission

In May 2022, CQC published a factsheet on identifying and responding to closed cultures, including a list of warning signs to look for in preventive work. This work is being used as a springboard for future collective NPM work on preventive inspection and monitoring practice.

Adaptations to visits to ensure safety during the pandemic resulted in some compromises and some improvements to practice. Remote visits were found to facilitate improved contact with carers and families of detained patients, as well as with Mental Health Act advocates. CQC has included the need for better access to advocacy support, including culturally appropriate advocacy, in its written evidence for the Mental Health Act reform bill.

The Children's Commissioner for England

The commissioner's ultimate aim is for no child to be living in an institution. The commissioner continues to work to ensure that LPS, which will replace DoLS under reforms to the Mental Capacity Act, will take into account children's views and safeguard their rights. The Children's Commissioner has carried out a series of visits to youth custody settings and inpatient mental health wards. The commissioner will be publishing her findings and recommendations for service improvements in the new year.

89 Care Inspectorate Wales, Healthcare Inspectorate Wales, Estyn, 'Liberty Protection Safeguards, DRAFT Monitoring and Reporting Strategy for Wales', available at: **https://www.careinspectorate.wales/sites/default/files/2022-05/2205122-LPS-draft-Monitoring-Reporting-Strategy-en.pdf**

Criminal Justice Inspection Northern Ireland

Criminal Justice Inspection Northern Ireland published an inspection of Magilligan Prison, a review into the Operation of Care and Supervision Units in the NIPS, and an inspection of court custody arrangements through the reporting year. Inspectors undertook fieldwork at Woodlands JJC to inform an inspection to be published 2022-23.

Healthcare Inspectorate Wales (HIW)

In March 2022, Healthcare Inspectorate Wales published a joint report with Care Inspectorate Wales into the use of DoLS in Wales for the previous year. HIW supported the Prisons and Probation Ombudsman's investigations of deaths in custody via clinical review.

Between 28 June and 2 July 2021, Care Inspectorate Wales, HMICFRS, HIW, His Majesty's Inspectorate of Probation and Estyn carried out a joint inspection of the multi-agency response to abuse and neglect in Neath Port Talbot.

HIW have been working on "Mental Health hospitals, Learning Disability, hospitals and Mental Health Act monitoring report for 2021-2022", which will be published in due course, making recommendations and highlighting good practice.

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

Custody inspections restarted in May 2021. Where visits used to be unannounced, HMICFRS now gave notice to mitigate any infection risks. Activities such as examining custody records, conducting interviews and focus groups were conducted remotely. HMICFRS hopes to retain some remote methods for their effectiveness and efficiency.

Five inspections to November 2021 found improved provision in custody services, with staff and custody officers generally treating people with respect and recognising diverse needs. Showers and exercise should have been offered more.

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

HMICS is working with Healthcare Improvement Scotland on a baseline review of the provision of healthcare services to police custody centres. A report on the outcome will be published in January 2023. This will inform subsequent onsite joint inspections of custody centres, the first of which took place in November 2022. Joint inspections of adult support and protection services incorporated digital arrangements following the COVID-19 pandemic.

His Majesty's Inspectorate of Prisons

The reporting year began under ongoing COVID-19 restrictions, meaning scrutiny visits continued in place of full inspections. However, full inspections of the adult prison estate, young offender institutions and secure training centres for children, police custody suites and court custody areas resumed throughout the year.

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

Full inspections resumed in October 2021, with full CCU inspections planned for 2022. The HMIPS Independent Review of the Response to Deaths in Custody was published in November 2021. The review recommended wide-ranging systemic changes and independent investigations into every death in prison custody, and the direct involvement of families in a review into preventing deaths in custody.

HMIPS proposed to the Scottish Government to expedite the removal of all under-18s from prison custody. Independent Prison Monitors raised concerns that restrictions imposed on under-18s were as extreme as for adult prisoners. HMIPS launched a progression review in 2022 to examine the convicted prisoner journey through the Scottish estate towards liberation and a thematic review into Separation and Reintegration Units.

Independent Custody Visiting Association (ICVA)

ICVA provided the newly elected Police and Crime Commissioners in May 2021 with information and support to meet their statutory duty to run independent custody visiting schemes.

ICVA collaborated with the Criminal Justice Alliance in 2021 on a report on race and gender inequalities in police custody. The findings formed the basis of ICVA's new anti-racism action plan, and 2022-2023's thematic of tackling discrimination in custody.

ICVA's website hosted 15 training videos throughout the year, presented findings on anti-rip suites to the lead of the National Custody Forum, and attended the Ministerial Board on Deaths in Custody to present the ICOP project. Schemes with Terrorism Act 2000 detention implemented remote visiting as a matter of priority and ensured that ICVs were speaking to detainees, either via telephone or video conferencing.

Independent Custody Visiting Scotland (ICVS)

Face to face visits were resumed in August 2021, and temporarily suspended in December to the end of January 2022. Telephone visits, while a good compromise during pandemic restrictions, missed important observations of body language and a person's health or wellbeing. Sometimes reception was poor, and it was hard to hear detainees. Visiting patterns were further changed by measures to accommodate the COP26 event. 300 arrests a day were predicted, necessitating increased custody visits. Three virtual training sessions were held as well as a COP26 live exercise. Visits were planned every other day, but ultimately daily visits were conducted during the event. There were 97 arrests during COP26, and arrested persons spent very little time in police custody.

Considerations to improve custody visits include strengthening the ICVS operating model and improving guidance on data collection processes, providing additional training to visitors and staff, digitising the ICVS service, and developing a vision and improvement plan.

ICVS are investigating the impact of age and sex on those in detention, particularly the inclusion of menopause in vulnerability assessments, and how this may impact treatment and conditions in police custody.

Independent Monitoring Board (IMB)

The IMB National Chair and members of the management board gave oral and written evidence to Parliamentary committees and groups on topics including improving outcomes for women in the criminal justice system, Imprisonment for public protection sentences, and mental health in prison.

Consultation responses included responses to the Prison Strategy White Paper, the Youth Custody Service Behaviour Management and Physical Restraint framework consultation, Home Office detention Services Order, and the Youth Custody Service separation.

Independent Monitoring Boards (Northern Ireland) (IMB)

The IMB welcomed the review by the Criminal Justice Inspection Northern Ireland of Care and Supervision Units, finding that significant improvements were required at strategic and operational levels. IMB will continue to monitor progress on recommendations and improvements outlined in the report.

The IMB Northern Ireland sought to clarify the reasons why the appointment of IMB board members in Northern Ireland is different to colleagues across the remainder of the United Kingdom. There is a potential that this could be detrimental to the monitoring of those in custody across Northern Ireland. IMB Northern Ireland has received rationale from the Department of Justice, which has not amended the term of tenure

Independent Reviewer of Terrorism Legislation

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

Lay Observers

21 new lay observers were appointed this year, following a major recruitment campaign. Observations by Lay Observers have highlighted a serious concern regarding the number of agencies involved in dealing with detainees and a serious lack of cohesion and interconnection between them, adversely impacting on the treatment of detainees.

Mental Welfare Commission for Scotland (MWCS)

In person visits were reintroduced in the reporting period. Their focus was on units where there is a major deprivation of liberty, where the MWCS gathered information from themed visits, previous visits, patients' concerns and other sources about care and treatment, or where it had been some time since the last MWCS visit.

Over the year, MWCS supported the Scottish Mental Health Law review, and examined racial inequality across mental health services. MWCS developed proposals for reviews into deaths of people detained for mental health treatment and mental health homicides, and gave evidence on the pandemic and mental health detention in Scotland before Holyrood parliamentary committees. MWCS developed three research briefs for the review of Scotland's mental health and incapacity legislation. A good practice guide was also developed in relation to excessive security appeals and the rights of individuals.

Ofsted

Ofsted leads inspections of STCs supported by HMI Prisons and the CQC. They inspect and regulate SCH, supported by the CQC. Ofsted also supports HMI Prisons inspections of Young Offender Institutions assessing education provision. Progress monitoring visits to prisons began in May 2021, and full inspections resumed in October 2021. A joint thematic publication on girls in custody published with HMI Prisons, HMI Probation, the CQC and Care Inspectorate Wales identified good partnership work between health, education and care staff that aimed to meet the needs of the girls. However, a lack of effective planning for health care and education after release was also identified.[90]

Northern Ireland Policing Board Independent Custody Visiting Scheme (ICV)

There are currently 23 active ICVs with a further six ICVs about to join the scheme from the reserve list, after having completed their induction training on 10th June 2022. 24,178 detained persons were processed through custody during the reporting year. ICVs made 514 visits. 33 were not completed and were classed as invalid. Seven of the valid visits were classified as unsatisfactory.

42 visits were made to detainees held under the Terrorism Act 2000 (TACT). Seven were invalid. No visits were classified as unsatisfactory.

The Regulation and Quality Improvement Authority (RQIA)

An expert review team found improvement in partnership working and governance arrangements. Good practice included health and wellbeing engagement during COVID-19, the Towards Zero Suicide Initiative, the Forensic Managed Care Network, and the Supporting People at Risk 'evolution' approach to supporting people in crisis. RQIA's expert review team found need for improvement in commissioning, planning, and delivery.

Scottish Human Rights Commission

In its 'report card' for Scotland's Universal Periodic Review, The Scottish Human Rights Commission urged the Scottish Government to take urgent action to meet human rights standards in places of detention and deprivation of liberty. SHRC completed its work on the Independent Review of the Response to Deaths in Prison Custody in November 2021, with a key recommendation that an independent body carry out a separate independent investigation into all deaths in custody.

The Commission submitted 14 recommendations to an inquiry investigating the handling of COVID-19 in Scotland, noting disproportionate impacts on the prison population.[91]

90 HM Inspectorate of Prisons, 'A thematic review of outcomes for girls in custody' September 2022, available at: **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2022/09/Outcomes-for-girls-in-custody-web-2022.pdf**

91 Scottish Human Rights Commission, 'Consultation Response: Terms of Reference for COVID-19 Inquiry' September 2021, available at: **https://pdf.browsealoud.com/PDFViewer/_Desktop/viewer.aspx?file=https://pdf.browsealoud.com/StreamingProxy.ashx?url=https://www.scottishhumanrights.com/media/2229/reponse-covid-public-inquiry-consultation-final-300921.pdf&opts=pdf.browsealoud.com#langidsrc=en-gb&locale=en-gb&langiddest=en-gb&dom=pdf.browsealoud.com**

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