Monitoring places of detention

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

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Contents

Introduction by Nick Hardwick

Her Majesty's Chief Inspector of Prisons

This is the third annual report of the UK's National Preventive Mechanism (NPM), the group of 18 organisations designated to fulfil the UK's obligations to ensure the independent monitoring of the treatment of and conditions for people deprived of their liberty. These obligations arise from the UK's status as a party to the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The purpose of monitoring is to prevent ill-treatment in all places of detention – from prisons to children's homes to secure hospitals. Such places are typically hidden from public view and the people held there are inherently vulnerable. Through the work of the 18 members of the NPM, their rights to be held safely and with respect for their human dignity are safeguarded.

While the UK had a long history of visits to places of detention, particularly to prisons, the ratification of OPCAT by the government and designation of the NPM has re-emphasised the importance of independent monitoring and a human-rights based approach. In accordance with OPCAT, the members of the NPM make regular visits to places of detention, focusing on treatment and conditions and seeking the views of detainees. The members operate independently of one another, and the primary work of the NPM is carried out by individual members in their own inspections or visits and reported in their own annual reports. However, a coordination role is performed by HM Inspectorate of Prisons.

In previous annual reports, we have sought to summarise the activities and findings of the 18 NPM members and to identify common themes arising in places of detention in England, Wales, Scotland and Northern Ireland. This year, we have sought instead to focus on key issues arising from our work during the year, and have made several recommendations with the aim of preventing ill-treatment in detention and ensuring the effective implementation of OPCAT in the UK.

The use of force and restraint has been a key concern to all members of the NPM, regardless of the type of detention monitored or the jurisdiction in which they operate. Despite a plethora of guidelines and standards, we find that force is often not used appropriately: it is used when it is not necessary; it is applied in a disproportionate manner; staff are not sufficiently trained; and governance arrangements are limited. However, we do also find examples of good practice, demonstrating that relevant guidelines and standards are capable of being implemented even in the face of challenging behaviour. We therefore reiterate in this report the key components of a lawful, safe and effective system of force and restraint.

We also focus on the escorting of detainees, acknowledging that detainees may be particularly vulnerable while they are being escorted to, from or between places of detention. We focus, in particular, on escorts within the criminal justice system and on overseas escorts. Overseas escorts has been a new area of work for the NPM members who monitor immigration detention, and involves monitoring detainees during their removal from the UK, including during removal flights. We make recommendations to authorities responsible for escorts aimed at ensuring they strike an appropriate balance between transporting detainees securely, and doing so safely and humanely and without resorting to disproportionate security measures.

In this report, we have also highlighted the valuable work of the lay monitoring bodies within our NPM. The work of four of the 18 members is carried out by volunteers who monitor prisons and police custody in their local communities. They do so with impressive frequency and commitment. We make recommendations regarding the remit of and support for lay monitors with the aim of ensuring that OPCAT is effectively implemented in the UK.

We have also summarised the coordinated and joint activities of the NPM members and noted progress against our previous recommendations that the government identifies which places of detention are not subject to independent visits and ensures that those gaps in protection are addressed. We are pleased to report that the government has extended the remits of NPM members to cover court custody in England and Wales, as well as customs custody facilities. While progress on military detention still needs to be made, we are moving closer to the full implementation of OPCAT.

Our recommendations are directed at the UK government, the devolved administrations and those authorities responsible for places of detention.

We would like to thank the Human Rights Implementation Centre at the University of Bristol and the Association for the Prevention of Torture for their ongoing support and contribution to our work.

Nick Hardwick
Her Majesty's Chief Inspector of Prisons

Section one
Context

About OPCAT and the NPM

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

States that ratify OPCAT are required to designate a 'national preventive mechanism' (NPM), a body or group of bodies that regularly examine the treatment of detainees, make recommendations and comment on existing or draft legislation with the aim of improving treatment and conditions in detention. To carry out its monitoring role effectively, the NPM must be independent of government and the institutions it monitors. OPCAT sets out the powers which NPMs should have, including the ability to:

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

OPCAT also requires that the NPM be sufficiently resourced to perform its role. Its personnel should have the necessary expertise and be sufficiently diverse to represent the community in which it operates.

At the international level, OPCAT established the Subcommittee on Prevention of Torture (SPT). Made up of 25 experts from around the world, the role of the SPT is both operational and advisory. In its operational capacity, the SPT is able to visit places of detention in any State that has ratified OPCAT and to make recommendations to the State regarding the protection of detainees from ill-treatment. In its advisory capacity, the SPT is required to advise and assist States in the establishment of NPMs and, thereafter, to maintain direct contact with NPMs and offer them training and assistance.

Implementation of OPCAT in the UK

The UK ratified OPCAT in December 2003 and designated its NPM in March 2009. Designation of the NPM was the responsibility of the UK government and it chose to designate multiple, existing bodies as the NPM rather than create a new, single-body NPM. This took into account the fact that many types of detention in the UK were already subject to monitoring by independent bodies, as envisaged by OPCAT. In designating existing bodies as members of the NPM, the government explicitly required that they have a statutory basis and be able to make unannounced visits to places of detention.

The government concluded that 18 bodies operating in England, Wales, Scotland and Northern Ireland met those requirements. These bodies were formally designated as the UK's NPM in a statement to Parliament

on 31 March 2009 (see Appendix I). At the time, the government also noted that additional bodies may be added to the NPM in the future. The bodies making up the NPM monitor various types of detention, including prisons, police custody, court custody, customs custody facilities, secure accommodation for children, and immigration, mental health and military detention.

Given the scale and complexity of the UK's NPM – the majority of NPMs in other countries are single-body entities – it was agreed that HM Inspectorate of Prisons (HMIP) would carry out the coordination and communication function of the NPM. The purpose of coordination is to promote cohesion and a shared understanding of OPCAT among the NPM members, to encourage collaboration and the sharing of information and good practice, and to facilitate joint activities. The role is performed by an NPM coordinator, appointed by HMIP to liaise with all members of the NPM, advise members on the effective implementation of OPCAT, share information with them, and provide support on policy and human rights issues. While based at HMIP, the coordinator represents the interests of all members, liaises with the Subcommittee on Prevention of Torture, other NPMs and external stakeholders, prepares the annual report, and organises meetings and workshops.

While coordination is essential to the full and effective implementation of OPCAT in the UK, the independence of individual NPM members is respected, as is their ability to set their own priorities for detention monitoring.

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

Currently, the UK's NPM is made up of the following bodies:

England and Wales
Her Majesty's Inspectorate of Prisons (HMIP)
Independent Monitoring Boards (IMB)
Independent Custody Visiting Association (ICVA)[1]
Her Majesty's Inspectorate of Constabulary (HMIC)
Care Quality Commission (CQC)
Healthcare Inspectorate Wales (HIW)
Office of the Children's Commissioner for England (OCC)
Care and Social Services Inspectorate Wales (CSSIW)
Office for Standards in Education, Children's Services and Skills (Ofsted)

Scotland
Her Majesty's Inspectorate of Prisons for Scotland (HMIPS)
Her Majesty's Inspectorate of Constabulary for Scotland (HMICS)
Scottish Human Rights Commission (SHRC)
Mental Welfare Commission for Scotland (MWCS)
Care Inspectorate (CI)[2]

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

The table below provides a general overview of the NPM members responsible for monitoring each type of detention in each jurisdiction in the UK. It should be noted that the Office of the Children's Commissioner for England has the right to enter any premises, except a private dwelling, for the purpose of interviewing any child accommodated or cared for there. Similarly, the Scottish Human Rights Commission has a broad power to enter and inspect any place of detention in the context of an inquiry into the policies or practices of Scottish public authorities.

	England	Wales	Scotland	Northern Ireland
Prisons	HMIP with CQC & Ofsted IMB	HMIP with HIW IMB	HMIPS	CJINI & HMIP with RQIA IMBNI
Police custody	HMIC & HMIP ICVA	HMIC & HMIP ICVA	HMICS ICVS	CJINI with RQIA NIPBICVS
Court custody	HMIP	HMIP	HMIPS	CJINI
Children in secure accommodation	Ofsted (jointly with HMIP for secure training centres)	CSSIW	CI	RQIA CJINI
Detention under mental health law	CQC	HIW	MWCS	RQIA
Deprivation of liberty safeguards	CQC	HIW CSSIW	n/a	n/a
Immigration detention	HMIP IMB	HMIP IMB	HMIP IMB	HMIP IMB
Military detention[3]	HMIP	HMIP	HMIP	HMIP
Customs custody facilities	HMIC and HMIP	HMIC and HMIP	HMIC and HMIP	HMIC and HMIP

1 Although the Independent Custody Visiting Association is listed as an organisation operating in England and Wales, its membership includes independent custody visitors who operate in Scotland (ICVS).
2 The Care Inspectorate's detention monitoring role was formerly the function of the Scottish Commission for the Regulation of Care, or Care Commission. In April 2011, the Care Commission, the Social Work Inspection Agency and Directorate 6 of HM Inspectorate of Education became Social Care and Social Work Inspection Scotland (known as the 'Care Inspectorate'). It is anticipated that the Care Inspectorate will be formally designated as a member of the NPM in place of the Care Commission.
3 Inspections of military detention facilities are by invitation only – HMIP does not have a statutory right of access. Not all military detention facilities are inspected as yet.

Section two
The third year – an overview

In 2011–12, the members of the UK's NPM continued to make regular visits to places of detention, monitoring the treatment of and conditions for detainees and making recommendations to the relevant authorities. The activities of the members and their findings are described in their individual annual reports. In this NPM-wide annual report, we note the joint activities of the members, how coordination is developing and the extent to which OPCAT is being implemented in the UK. This report also addresses key issues considered by the NPM members in 2011–12:

- the use of force and restraint in detention
- the escorting of detainees
- the role of lay monitors within the NPM.

Joint activities

As in previous years, members have continued to strengthen relationships with one another and develop their identity as an NPM. As they have learned about each other's role, there has been a noticeable increase in bilateral and multilateral working among members, with information shared and duplication of work avoided.

In 2011–12, several NPM events took place, some of which are described in more detail later in this report:

- biannual NPM business meetings, attended by all members
- a workshop solely for the lay bodies in the NPM, exploring the implementation of OPCAT in the context of monitoring by unpaid members of the local community
- a thematic workshop on the use of force and restraint, a key concern of members regardless of the type of detention monitored.

Our NPM business meetings provide members with the opportunity to discuss key findings or best practice, apply learning from monitoring one type of detention to another and learn from work in other jurisdictions. At meetings in 2011–12, the members explored the definition of detention. They discussed the difference between a restriction and a deprivation of liberty, the extent to which some people who reside in, for example, hospitals and care homes, may be considered detained if they are prevented from leaving should they choose to do so, and whether there are sufficient safeguards to protect people in these situations. Given the complexity of these issues, the NPM members decided to explore these in more detail in 2012–13 and share information across jurisdictions within the UK about de facto detention. Members also identified common concerns that could be the subject of future joint work. These included solitary confinement, the searching of detainees and visitors and the taking of samples, and drug and alcohol misuse.

The members discussed best practice in monitoring detention and the attributes an NPM should have to carry out its role effectively. In particular, members discussed the concept of independence, examining whether they are sufficiently independent to meet the requirements of OPCAT. While OPCAT itself sets out some basic requirements, the SPT has provided further guidelines on the form and operation of NPMs.[4] Taking these into account, the UK NPM decided to formulate 'expectations' – a set of powers and practices expected of any member of our NPM and which are essential to effective monitoring.

4 SPT, Guidelines on national preventive mechanisms CAT/OP/12/5 (09/12/10) ('SPT Guidelines'); SPT, The approach of the SPT to the concept of prevention of torture and other cruel, inhuman or degrading treatment or punishment under OPCAT CAT/OP/12/6 (30/12/10) ('SPT on Prevention').

Expectations

1 Monitoring bodies should be independent of the authorities visited/inspected and of the government.
OPCAT Articles 17, 18(1)

2 Monitoring bodies should be impartial.
SPT Guidelines 18, 19, 30

3 Monitoring bodies should have the right to publish their findings and to make recommendations for the purpose of preventing ill-treatment and improving standards in detention.
OPCAT Articles 19(b), (c); SPT Guidelines 36

4 Monitoring bodies should have unfettered access to places of detention. Access should be granted even where monitoring bodies arrive unannounced.
OPCAT Articles 20(c), (e); SPT Guidelines 25

5 Monitoring bodies should have unfettered access to all detainees and to information about them.
OPCAT Article 20

6 The voice of the detainee is an essential component of any monitoring of places of detention.
OPCAT Article 20(d)

7 There must be a focus on the prevention of ill-treatment.
OPCAT Articles 1, 3

8 All places of detention should be monitored regularly.
OPCAT Articles 1, 19(a)

9 Monitoring bodies should set their own criteria against which they monitor the treatment of and conditions for detainees.
SPT Guidelines 12

10 Criteria for monitoring should be firmly grounded in human rights standards and should be transparent.
OPCAT Article 19(b)

11 Monitoring bodies should be sufficiently resourced to perform their role.
OPCAT Article 18(3)

12 The remit of monitoring bodies should be set out in statute.
SPT Guidelines 7

13 The staff of monitoring bodies should be recruited and appointed in an open and fair manner.
SPT Guidelines 16

14 Monitoring bodies should promote and encourage respect for diversity, both in their own workforce and when monitoring places of detention.
OPCAT Article 18(2); SPT on Prevention 5(j)

Article 19(c)

In addition to regular visits to places of detention, OPCAT requires NPMs to have the power 'to submit proposals and observations concerning existing or draft legislation'. Article 19(c) is interpreted as envisaging a more strategic role for NPMs under which they may seek to improve the treatment of and conditions for detainees at a national level. The members of the UK NPM carry out this role on both an individual and collective basis. Individual members often comment on policy proposals or draft legislation. In 2011–12, this included:

- the Scottish Human Rights Commission (SHRC) responded to a government consultation on the detention and questioning of suspects in police custody and their right to legal assistance
- SHRC and HM Chief Inspector of Prisons for Scotland each gave evidence to a Commission on Women Offenders established by the Scottish government to explore ways to improve outcomes for women in the criminal justice system
- the Children's Commissioner for England and HMIP each submitted evidence to an inquiry by the Justice Select Committee into the youth justice system
- HMIP responded to a European Union green paper on detention, and supported the responses of both the French and Spanish NPMs.

The NPM members have also commented on policy and legislation on a collective basis. For example, the NPM responded to Scottish government proposals to reform policing, successfully calling on the government to use this reform as an opportunity to strengthen custody visiting arrangements.

Developing coordination

Although HMIP was appointed as the coordinating body, it is not 'in charge' of the NPM: it does not take decisions on behalf of the members without first consulting with them and securing consensus. Coordinating such a large and disparate group of organisations can be challenging and securing agreement on particular issues can be difficult, particularly when decisions are needed quickly. These challenges are only likely to increase as the government considers expanding the NPM membership.

To address some of these challenges, the members agreed to establish a steering group. The role of the steering group is to facilitate decision making, set the strategic direction for coordinated or joint work, monitor the outcome and value of such work, and support HMIP and the NPM coordinator in their roles. The steering group is made up of five members, including HMIP (as the coordinating body) and one member from each of the four nations. It began its work in January 2011 and meets three times a year.

The creation of a steering group has been a positive step in developing the coordination of the NPM, and has led to the NPM having, for the first time, a business plan for its coordinated activities for 2012–13.[5] Its purpose is to maximise efforts to prevent ill-treatment in all places of detention by providing effective coordination of the NPM. The plan features three key objectives, against which progress will be monitored by the steering group:

- to support the NPM members and promote collaboration between them and the sharing of information and good practice.

5 The business plan is available from the NPM coordinator.

- to promote compliance with OPCAT in the UK.
- to raise awareness of the NPM in the UK and internationally.

It is important to note that the business plan addresses the coordination of the NPM, not the day-to-day monitoring activities of all members, which will be addressed in the individual plans of each organisation.

Compliance with OPCAT

While independent monitoring arrangements are firmly embedded for many places of detention in the UK, the process of implementing OPCAT is ongoing. In previous annual reports, we identified some places of detention that were not regularly and independently monitored by the NPM. These included court custody in England and Wales, some places of military detention, and customs custody suites operated by UK Border Force. Such gaps in coverage meant that the UK was not yet fully compliant with OPCAT, Article 4 of which requires that all places of detention be subject to regular and independent monitoring. In each of our previous annual reports, we have recommended that the UK government addresses any gaps in coverage. We are pleased to report significant progress in these areas.

Court custody

The government invited HMIP to carry out regular inspections of court custody. In 2011–12, HMIP developed and piloted inspection criteria and an inspection methodology for court custody in England and Wales, and an inspection programme commenced in 2012–13. Initially, access to courts was granted under a memorandum of understanding between HMIP and the government, but this moved to a statutory footing in late 2012.[6]

While HMIP was given the statutory power to inspect the vast majority of court custody facilities, including those at Crown, county and magistrates' courts, some facilities remain outside its remit, including, for example, those at the Royal Courts of Justice. Some gaps, therefore, remain.

Court custody facilities, including the escorting of detainees to and from courts, are monitored by lay observers – volunteers from the local community. Lay observers were not included in the NPM when the members were designated in 2009, despite performing a similar role to other lay monitoring bodies that were designated (including independent police custody visitors and independent monitoring boards for prisons). The NPM has supported the lay observers' request to be added to the NPM, and we hope that this will be agreed by the government soon. If agreed, this will result in layers of monitoring for court custody in England and Wales – by a professional inspectorate and a lay body – as is already the case for prisons and police custody.

Customs custody

Customs custody facilities are operated by the UK Border Force. They are located at ports of entry to the UK and are used to hold people for short periods when, for example, they are believed to have entered the UK after ingesting drugs for the purpose of smuggling. Such people are held under the same regulatory framework that applies to police detainees. Border Force has been keen to ensure these custodial facilities are subject to monitoring in accordance with OPCAT. HM Inspectorate of Constabulary, an NPM member, was granted the statutory power to inspect the facilities and carried out its first inspection in late 2012, in association with HMIP.

6 The Public Bodies (Abolition of Her Majesty's Inspectorate of Courts Administration and the Public Guardian Board) Order 2012.

Military detention

Progress has also been made for the service custody facilities operated by the British Armed Forces. These facilities are used to hold military personnel who have offended against military or criminal law for up to 14 days. The government has indicated that it will invite HMIP to inspect these facilities with a regular programme of inspection commencing in 2013–14. This inspection programme will be limited to service custody facilities within the UK but, in the longer term, the NPM will be seeking to ensure that all such facilities, including those on UK military bases around the world, are monitored.

Crown Dependencies and Overseas Territories

We welcome the government's proposal to extend OPCAT to the Isle of Man, a British Crown Dependency. Detention monitoring already takes place on the Isle of Man and the government is looking to designate the organisations responsible as additional members of the NPM. The government should now consider what role it should play in implementing OPCAT in respect of other Crown Dependencies or British Overseas Territories.

Progress is being made towards the full and effective implementation of OPCAT in the UK. We urge the government to recognise that implementing OPCAT is an ongoing process and one that should be kept under review, particularly for places of detention not subject to regular monitoring by an independent body with statutory rights of access.

Detention monitoring in Scotland

There has also been a significant and positive development with independent custody visitors in Scotland, who visit detainees held in police custody. Custody visitors in Scotland were not designated separately as members of the UK NPM but instead were involved in the NPM's work through their membership of the Independent Custody Visiting Association, an NPM member that operates primarily in England and Wales. Although operating with government support, Scottish custody visitors did not have a statutory basis for their work. This changed with the passing of the Police and Fire Reform (Scotland) Act 2012 by the Scottish Parliament. This placed custody visiting in Scotland on a statutory footing and set out visitors' rights of access to detainees in police custody. The 2012 Act also explicitly stated that the purpose of custody visiting is to meet:

> 'the objective of OPCAT, that is, the objective of establishing a system of visits … to places where people are deprived of their liberty in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.'

This is the first time that any monitoring body in the UK has had OPCAT referenced in its statutory framework. The 2012 Act also provides for visits to police custody by the SPT, another first. The NPM contributed to government and parliamentary discussions about the custody visitors and had recommended that they be placed on a statutory footing. We are, therefore, pleased at these legislative developments and hope that custody visitors in Scotland will be designated as a member of the NPM in their own right.

The NPM has also contributed to discussions in Scotland about the monitoring of prisons and the role of prison visiting committees. In Scotland, each prison is monitored by a visiting committee made up of volunteers. These committees were not designated as members

of the NPM in 2009 because, at that time, they were undergoing review. This was despite the fact that the committees were performing a similar role to independent monitoring boards in England and Wales and Northern Ireland, all of which are part of the NPM.

In 2011–12, the Scottish government announced its intention to abolish prison visiting committees and proposed that their monitoring role be taken up by HM Inspectorate of Prisons for Scotland. A final decision has not yet been reached, but the NPM has asked that the Scottish government take account of OPCAT in its decision making, and that any new monitoring arrangements are OPCAT-compliant.

External relations

Interest from abroad in the work of the UK NPM members remains high and this year we have hosted visiting delegations from a range of nations, including China, Japan, South Korea and Uganda. These delegations often comprise government officials looking to ratify or implement OPCAT, non-governmental organisations campaigning for ratification in their home nation, or newly designated NPMs seeking information about how we monitor detention in the UK. In July 2011, we hosted a visit from the Independent Police Conduct Authority (IPCA), one of five organisations making up the New Zealand NPM. Given that multi-body NPMs such as those in the UK and New Zealand are rare, this was a useful opportunity to discuss the challenges of coordination and the benefits of having member organisations with expertise in monitoring particular types of detention. IPCA was also able to shadow an inspection of police custody in London by HMIC and HMIP, as well as observe the work of custody visitors in Northern Ireland.

We also continued to participate in the European NPM project. Sponsored by the Council of Europe, this project has created an active network of NPMs allowing information and best practice on detention monitoring to be shared. Representatives of the NPM have attended thematic workshops on how best to gather evidence during visits, and monitoring the treatment of vulnerable detainees. This year, the project has had a particular focus on monitoring detainees during deportations, with European NPMs sharing information about how best to monitor deportations given that this is an emerging area of work for many of us. Discussions on this issue began at an event hosted by HMIP in London in July 2011 and attended by representatives of the NPMs of France, Germany, Spain and Switzerland, as well as by members of the European Committee for the Prevention of Torture (CPT) and non-governmental organisations. Discussions continued at two further workshops in 2012 (for further information, see section 4).

Also under the auspices of the European NPM project, representatives of the UK NPM were asked to participate in a workshop in Ukraine designed to support the implementation of OPCAT and the designation of a Ukrainian NPM. There was considerable interest in the multi-body model adopted in the UK, and our representatives described the benefits and challenges of such a model.

NPM members have also undertaken ad hoc projects to promote ratification of OPCAT and share information about best practice in detention monitoring. For example, at the request of the Ministry of Justice and Foreign and Commonwealth Office, HMIP agreed to promote the concept of independent prison inspection to officials in Russia, sharing information about inspection methodology and human rights-based criteria.

The European CPT, a Council of Europe body with a similar role to that of the SPT, announced its intention to visit places of detention in the UK in 2012. While the CPT had visited the UK on several previous occasions, this was the first such visit since the NPM was designated in 2009. The NPM members began a dialogue with the CPT, highlighting key areas of concern, such as the situation of women in prison.

The NPM is grateful for the continued support it has received from the Human Rights Implementation Centre (HRIC) at the University of Bristol. HRIC maintains a database providing information about the remits and work of each of the 18 NPM members – a valuable resource given the size and complexity of the NPM. HRIC also provided support to some NPM seminars in 2011–12, including briefing papers on OPCAT-related issues, as well as administrative support.

Recommendation

To the UK government

1 The government should consider what role it should play in implementing OPCAT in British Crown Dependencies and Overseas Territories.

Section three

The use of force and restraint

The European Court of Human Rights has often said that recourse to physical force against a detainee that has not been made strictly necessary by their own conduct diminishes human dignity. It is therefore essential that the use of force against a detainee, or the application of restraints, be done with great caution and in limited circumstances. Force or restraint must only be used when it is necessary, proportionate, as a last resort and in accordance with the law. While the use of force or the application of restraints may vary from one type of detention to another, monitoring force and restraint forms a key component of visits to all places of detention by members of the NPM. Discussions between NPM members have regularly identified force and restraint as an area of concern. As a result, the NPM members participated in a workshop in March 2012 to identify common concerns, share information about how best to monitor force and restraint and what to look for during visits, and highlight good practice in managing detainees and their behaviour.[7]

Definition

Various definitions of force or restraint have been suggested but what is clear is that the terms cover a wide range of actions or equipment that restrict a detainee's freedom of movement or exercise of free will. In some types of detention, the use of a 'guiding hand' may be considered force (for example, where a member of staff places a hand on the detainee's elbow to guide them to, or remove them from, a particular location). At the other end of the spectrum, force may include the use of incapacitant spray or an electroshock weapon. The following categories of force or restraint illustrate the broad range of actions covered (some actions may fall within more than one category):

- physical – using physical force without equipment
- mechanical – using equipment such as handcuffs or leg restraints
- chemical – using medication to restrain a detainee
- environmental – for example, using seclusion to restrict a detainee's movement
- technological – for example, using electronic tagging, pressure pads or alarms to alert staff to a detainee's movements
- psychological – for example, repeatedly telling someone, especially a vulnerable person, that they are not allowed to do something or that it is dangerous, or depriving a detainee of something that is necessary for what they want to do, such as a walking aid.[8]

7 The NPM is grateful to the Human Rights Implementation Centre at the University of Bristol for its assistance in hosting and funding this workshop.
8 These categories were adapted in part from Royal College of Nursing, *'Let's talk about restraint' Rights, risks and responsibility* (2008).

Monitoring use of force and restraint

When monitoring the use of force and restraint, members of the NPM expect to find that these are only used when necessary, proportionate, as a last resort and in accordance with the law. Members may apply slightly different monitoring or inspection criteria during their visits but there are some widely accepted standards relating to force and restraint that should be implemented. The relevance of these standards may vary depending on the type of restraint used. For example, it would not be expected that a qualified medical practitioner sees a police detainee following every application of handcuffs by a police officer. Nonetheless, the following standards form the basis of what NPM members generally expect to find when monitoring the use of force and restraint.

- Every effort should be made to de-escalate the situation or manage the detainee using the least restrictive means possible.
- Restraint techniques should be safe and accredited.
- Institutions and services should have clear and accessible policies on the use of force or restraint.
- Staff should be trained in appropriate restraint techniques and training should be updated regularly.
- Detainees should be seen by a qualified medical practitioner following the use of force or restraint. Injuries should be recorded and treatment provided.
- Detainees should be debriefed following incidents of force or restraint and should be able to make a complaint if they wish to.
- All incidents of force or restraint should be recorded. Records should be scrutinised by senior managers to ensure force or restraint is used lawfully.
- Incidents should be monitored (for example, at an institutional level) to identify trends. Trends should be acted upon.
- There should be special arrangements for the use of force or restraint against detainees who may be particularly vulnerable, including children, women (particularly pregnant women), those with disabilities and older detainees.

Despite these standards representing good practice in the use of force and restraint, the members of the NPM often find they are not met. The findings of the NPM members described below illustrate the range of actions constituting force and restraint encountered during monitoring visits, and highlight examples of good and poor practice. We have presented their findings according to the type of custody visited. Although we have highlighted the work of only some NPM members during 2011–12, the use of force and the application of restraints have been, and will remain, a key interest to all members of the NPM. Monitoring force and restraint is essential to preventing the ill-treatment of detainees and safeguarding their rights and well-being.

Children and young people in secure accommodation

For several years, the physical restraint of children and young people in secure accommodation has been a high profile issue, particularly in England and Wales, following two restraint-related deaths of children in 2004. Gareth Myatt, aged 15, died while being restrained by staff at Rainsbrook Secure Training Centre (STC). Adam Rickwood, aged 14, was found hanging in his cell at Hassockfield STC a few hours after he had been subject to restraint. An inquest held that an unlawful use of force had contributed to Adam's decision to take his own life.

Eight years later, the physical restraint of children in secure accommodation remains a contentious issue and one closely monitored by members of the NPM. In particular, the Office of the Children's Commissioner (OCC), which has a broad power to enter any premises where children are cared for, has sought to promote a children's rights-based approach to restraint.

In 2011–12, OCC published a report on the emotional well-being and mental health of children and young people in the youth justice system.[9] This report was partly based on a series of visits to establishments where children are detained (including STCs, young offender institutions (YOIs), children's homes and secure mental health facilities). During those visits, OCC found a tendency by staff to rely on physical controls to manage risk and deal with challenging behaviour rather than focusing on the development of positive relationships with children. OCC also noted inconsistencies between establishments on procedures and practice on restraint, with variation in the frequency with which it was used. In only two of the 11 establishments visited did children indicate that restraint was rare; in all others, children referred to restraint as an everyday experience. In one STC, OCC noted that a spike in the number of restraints had been driven by a change in staff rotas that resulted in young people being locked in their cells for longer.

> 'It happens every day, three or four times. Sometimes they deserve it but some [staff] just do it 'cos they can't be bothered to sort things out.'
> 15-year-old boy in a secure training centre

Restraint was used less frequently in small establishments with high staff-child ratios and where staff were well-trained and supported. In these establishments, children said they felt cared for.

In 2011–12, OCC also submitted evidence to the UN Human Rights Council in advance of the Council's review of the extent to which the UK has implemented its human rights obligations. OCC recommended that the law should provide that restraint may only be used to prevent harm to the child or others. It also recommended that the deliberate use of pain as a restraint technique be prohibited. This recommendation has been echoed by HMIP and follows comments by the UN Committee on the Rights of the Child that authorities should:

> '... minimise the necessity to use restraint and to ensure that any methods used are safe and proportionate to the situation and do not involve the deliberate infliction of pain as a form of control.' [10]

In July 2012, the Ministry of Justice published details of a new system of physical restraint for use in STCs and YOIs in England and Wales. Although it does not prohibit pain-compliance techniques, OCC has welcomed the new system's focus on de-escalation and using restraint as a last resort. The relevant NPM members will monitor the implementation of the new system of restraint in the coming year.

9 OCC, *'I think I must have been born bad'. Emotional wellbeing and mental health of children and young people in the youth justice system* (June 2011).
10 Committee on the Rights of the Child, General Comment No. 8: The right of the child to protection from corporal punishment and other cruel or degrading forms of punishment (arts. 19; 28, para. 2; and 37, inter alia) (2006) at paragraph 15.

Although the use of force and restraint in the children's secure estate has been most contentious in England and Wales, it is also closely monitored by relevant NPM members operating in Northern Ireland and Scotland. In a joint inspection of the Woodlands Juvenile Justice Centre in 2011, for example, Criminal Justice Inspection Northern Ireland (CJINI) and the Regulation and Quality Improvement Authority (RQIA) noted a significant reduction in the use of force and found effective systems to record, analyse and learn from restraint incidents. RQIA also found a significant reduction in restraint incidents during its inspection of Lakewood Secure Care Centre (a secure children's home). This reduction resulted from action to address previous recommendations by RQIA, including the setting up of a weekly behaviour management group to analyse each incident of restraint, address any issues arising from the incidents and learn from them. Additional training for staff had also been provided.

Health and social care settings

In some health and social care settings where residents are not legally detained, the restrictions of liberty applied to residents are such that they may constitute de facto detention. This is an issue the NPM members will explore further in 2012–13. The findings from work in 2011–12 described below include instances of force and restraint in places of detention, as well as restrictions of liberty in non-secure residential settings which, when taken together, may constitute a deprivation of liberty.

In Scotland, the Mental Welfare Commission for Scotland (MWCS) safeguards the rights and welfare of everyone with a mental illness, learning disability or related condition. This includes making regular visits to monitor the treatment of those detained under mental health law. It also includes visiting other residential settings in which people's liberty may be restricted through the use of force or restraint.

In 2011–12, MWCS made a series of visits to people with learning disabilities in hospital care and assessed the use of restraint over a six-month period. Of the 113 people whose care and treatment were assessed, 20 had required some level of physical intervention. Three had required floor restraint while the remainder had required seated restraint or minimal guidance from one area to another. Six of the 20 were restrained regularly (from fortnightly to daily restraint). MWCS found that all staff had appropriate training but was concerned about one incident in which inappropriate restraint techniques were used, and one unit that was unable to find its record of restraints. In those cases, MWCS has undertaken follow-up action.[11]

In a review of people with severe and enduring mental illness, MWCS was concerned about people with different security needs placed on the same ward. This resulted in unnecessarily secure environments for some of the patients. MWCS made several recommendations aimed at the minimum use of force to ensure individual safety.[12]

During an investigation into the care and treatment of a woman with dementia, MWCS found that chemical restraint was used inappropriately. While staying at a hospital over a 12-day period, the woman was given fluids by a drip but no nutrition. This increased her agitation and distress, and the hospital responded by sedating her over 100 times with injections or rectal medication. MWCS considered that this could amount to degrading treatment.[13]

Another investigation highlighted that it can also be inhuman not to use force. A woman with alcohol-related brain damage refused medical interventions despite being suspected of having cervical cancer. When she became terminally ill and had a large bloody vaginal discharge, staff in her care home allowed her to refuse to be cleaned and given pain relief. MWCS considered that this left the woman in considerable indignity and distress – it was content that her decision not to receive medical treatment was respected, but felt that care home staff should have overruled her later refusal of care in order to preserve her dignity.[14] To address risks of staff using excessive force, or omitting to use reasonable force, MWCS published a good practice guide on the use of force to provide physical health care.[15]

In Northern Ireland, RQIA monitors health and social care settings, including those where people are, or may be, detained. During inspections, RQIA found a range of restraints being used, including inappropriate use of rapid tranquilisation, bedrails, lap straps on specialist seating, arm splints and specialist sleepwear. It was evident to RQIA that, in some settings, staff used restraint without adequate training and policies governing the use of physical interventions were inadequate, out of date or simply absent. Several patients interviewed by RQIA said that they had sustained injuries while being restrained.

In several non-secure health or social care settings that RQIA visited, it found environmental restrictions that could amount to de facto detention. These included locked internal doors, locked external doors and gates, and the use of seclusion as a method of behaviour management. RQIA was concerned about:

- a lack of understanding among service providers that the practices were restrictive
- failures to assess the impact of service-wide restrictions on individual service users
- few services were able to describe the assessment processes and agreements with service users and/or their representatives in relation to these restrictions
- the absence of safeguards to monitor the appropriateness of restrictions.

As a result of these inspections, RQIA took enforcement action against several care providers. In each case, this has resulted in improvements in the quality of care.

Case study

RQIA found a voluntary patient in a long-stay ward for adults with learning disabilities wearing arm splints. The splints were used to minimise the risk that he would harm himself. RQIA was concerned that the patient's care records did not indicate any consideration of less restrictive measures to prevent self-harm. The patient was found to be wearing the splints at all times, despite an occupational therapist recommending that this should not occur.

11 MWCS, *Themed visit to hospital units for the assessment and treatment of people with learning disabilities* (July 2012).
12 MWCS, *Left Behind* (January 2012).

13 MWCS, *Starved of Care: Investigation into the care and treatment of 'Mrs V'* (May 2011).
14 MWCS, *Ms R Report: Challenges in providing healthcare for an individual who cannot understand or consent* (May 2012).
15 MWCS, *Right to Treat?* (July 2011).

During one inspection, RQIA found that voluntary patients with learning disabilities were deprived of their liberty because their ward was kept locked. In addition, staff were regularly restraining patients and doing so without training or adequate procedural guidance. The patients experienced infrequent family contact and there was minimal input from independent advocacy services. RQIA found there were few safeguards to promote the rights of patients: their rights to liberty, protection, autonomy and dignity were significantly compromised.

In contrast, RQIA identified good practice in a regional intensive care unit for adults with learning disabilities. It found evidence of regular accredited training for staff, and a commitment to detailed recording and auditing of each incident involving the use of force and restraint.

Police custody

Police custody throughout the UK is monitored at two levels – by a professional inspectorate and by independent custody visitors. In 2011–12, HMIC and HMIP continued their joint inspection programme of police custody facilities in England and Wales. These inspections include an assessment of the use and governance of restraint. Generally, HMIC/HMIP observed good use of de-escalation techniques, which minimised the need to use restraint. Where restraint was used, it was done so proportionately, and staff continued to communicate with detainees to explain what was happening with the aim of de-escalating the situation as quickly as possible.

However, there were variations in practice. In Nottinghamshire, inspectors met police officers who said they would only use handcuffs when it was proportionate and necessary. This was borne out by an analysis of custody records, which showed few detainees arriving at custody suites in handcuffs. In contrast, in Northumbria, staff told inspectors that it was the police force's policy that everyone arrested should be handcuffed. Many police officers said they would do this regardless of the alleged offence or the extent to which the arrested person was compliant. This approach resulted in children, pregnant women and compliant detainees being handcuffed.

While individual uses of force were noted in detainees' custody records, a repeated recommendation was that the police force should collate use of force data. Without data, the force was prevented from identifying trends in the use of force to help inform future policy, practice and training. This failure to collate data follows on from the removal of a Home Office requirement for police forces to submit monthly use of force returns. It is, therefore, difficult to make comparisons between police forces or to construct a national picture of how force is used in police custody.

In light of this, the Ministerial Board on Deaths in Custody invited the Independent Custody Visiting Association (ICVA) to monitor the use of force in police custody by examining individual custody records. Custody visitors were due to carry out this work in 2012–13 and present their findings to the Ministerial Board in 2013. They will look at the type of force used, its duration and the point at which it was used during the detention process, the provision of medical treatment following the use of force, and the recording of the incident.

Prisons

In Northern Ireland, both CJINI and the Independent Monitoring Boards (IMBNI) made restraint-related recommendations this year. For the women and young male offenders held at Hydebank Wood, CJINI found that previous recommendations that all staff should receive refresher training in control and restraint techniques had not been achieved. Only just under half the staff had received refresher training in the previous 12 months. The failure to train sufficient female staff had resulted in an unacceptable situation where a male officer was involved in the strip search of a woman under restraint. However, other previous CJINI recommendations had been achieved, and governance arrangements had improved.

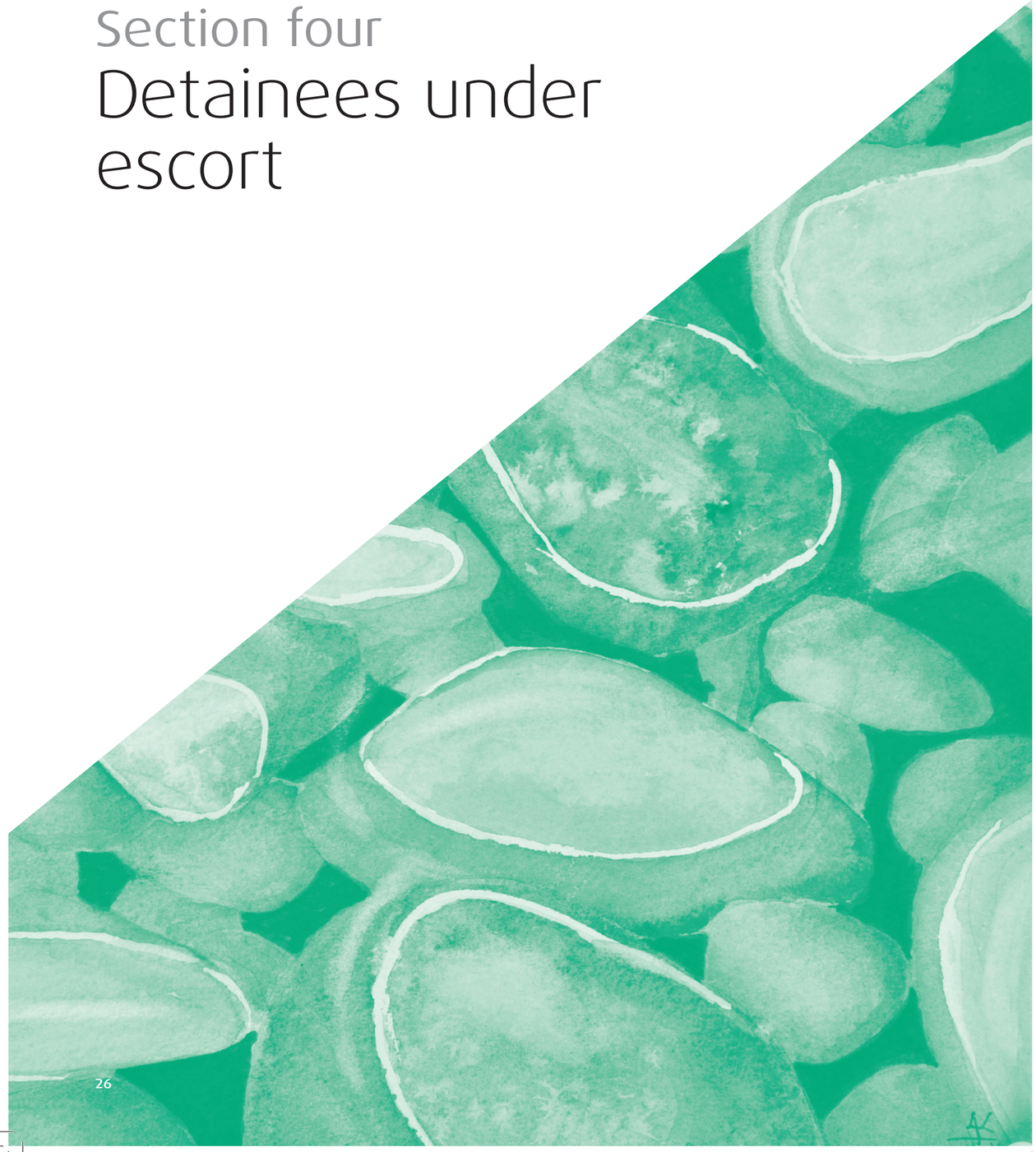
The IMB for Hydebank Wood Young Offenders Centre has expressed concern about the inappropriate use of restraint on young prisoners deemed to be at risk of self-harm. The IMB felt that the use of restraint on such prisoners could exacerbate their situation, and recommended that restraint only be used on at-risk prisoners in very exceptional circumstances.

In England and Wales, HMIP made 58 restraint-related recommendations in its full inspections of 32 adult prisons in 2011–12. In its follow-up inspections during the same period, over a quarter of previous restraint-related recommendations had not yet been achieved. The majority of recommendations related to the governance of restraint, rather than its application in practice. Prisons were encouraged to improve recording practices and to make better use of data, including analysing trends to assess, for example, whether force was used disproportionately against prisoners from particular backgrounds. There was also a need for senior managers to quality assure restraint documentation.

HMIP found during its inspection of Send that one woman had remained handcuffed to a female officer during a hospital appointment. The cuffing continued throughout an intimate examination and while the woman was getting undressed. She said being handcuffed had made the whole procedure very distressing and difficult. HMIP found this to be disproportionate as it was not based on an assessment of individual risk and compromised the woman's rights to privacy and dignity.

However, HMIP did identify some examples of good practice on restraint in prisons. For example, at Onley, prisoners were formally debriefed following any incident in which force was used against them. At Lowdham Grange, managers carried small portable video recorders to record spontaneous incidents of the use of force (HMIP expects that all planned use of force is video recorded).

Section four
Detainees under escort



During a period of detention, a detainee may be moved from one place of detention to another. For example, a person may first be detained in police custody, before appearing in court and then being remanded to prison; they may be moved from one prison to another; or they may be transferred from prison to hospital to attend an appointment. While escorted from one place to another, the person remains deprived of their liberty and under the control of the state. Article 4 of OPCAT requires that NPMs should visit any place where people are, or may be, deprived of their liberty. A deprivation of liberty is described as 'any form of detention' and is not restricted to a fixed place of detention, such as a prison or secure psychiatric facility. The periods during which a detainee is escorted should, therefore, be subject to independent and regular monitoring.

Several members of the NPM carry out such monitoring, with some having a specific statutory duty to do so. For example, HMIPS, whose primary role is to inspect prisons in Scotland, also has a duty to 'inspect the conditions in which prisoners are transported or held in pursuance of prisoner escort arrangements'.[16] HMIP, whose role includes monitoring detainees held under immigration law, has a specific duty to monitor the treatment and conditions of such detainees when they are under escort.

Detainees may be particularly vulnerable while they are being escorted to, from or between places of detention. The escorting authorities must strike a balance between transporting detainees securely, and doing so safely and humanely and without resorting to disproportionate security measures.

Taking into account monitoring activities carried out by the NPM members in 2011–12, we have chosen to highlight two key escorting issues:

- the escorting of prisoners between places of detention in the criminal justice system in Scotland and in England and Wales[17]
- the escorting of detainees being removed from the UK ('overseas escorts').

Escorts in the criminal justice system

The escorting of the majority of detainees in the criminal justice system is carried out on behalf of the state by private contractors in both Scotland, and in England and Wales. In both jurisdictions, escorting contracts were re-tendered and allocated to new providers during 2011–12.

Scotland

During 2011–12, HMIPS carried out an inspection of the conditions in which prisoners were transported and held in sheriff and justice of the peace courts throughout Scotland. This followed a previous inspection of the conditions under which prisoners were escorted, published in 2007. The escorts subject to inspection were moves from court to prison, and from prison to court.

During its inspections of prisoner escorts, HMIPS was guided by inspection criteria relating to safety and to decency, humanity and respect for legal rights:

- **Safety**: The individual prisoner should be safe from harm by others, safe from self-harm and, as far as is possible, be managed in such a way that any risk that they pose to others is assessed and appropriate interventions are put in place to respond to those risks.

16 Section 7(2) of the Prisons (Scotland) Act 1989 as amended by section 103(2)(b) of the Criminal Justice and Public Order Act 1994.

17 Escorts in the criminal justice system in Northern Ireland are inspected by CJINI. Its most recent inspection report was published in October 2010 and was cited in the NPM's second annual report covering 2010–11.

- **Decency, humanity and respect for legal rights**: The individual prisoner should be treated in such a manner as to preserve their human rights, preserve human dignity, respect individuality and support family ties. Treatment of the prisoner should be fair and consistent, and the prisoner should not be treated outside the law and the Prison Rules. The prisoner should be held in clean and hygienic conditions, which promote self-respect.

During the inspection, one source of evidence was a survey in which prisoners were asked how well they got on with escort staff. The survey results indicated that relationships between staff and prisoners were generally good: 80% of prisoners said they got on 'okay', 'fairly well' or 'very well' with staff, while 12% said they got on with them either 'fairly badly' or 'very badly'.

HMIPS noted that its inspection was conducted during a period when escort services were in a state of transition. From 11 January 2012, escorts were provided by G4S (which took over from Reliance Custodial Services, the previous provider). This re-tendering process had an impact on conditions for prisoners. Reliance had kept older vehicles in service instead of replacing them, and the risk of breakdown was significant. New vehicles have been brought into service since the new contract was awarded.

HMIPS praised the regular first aid training for escort staff and noted that they had a standardised induction, which was good practice but had not yet been adopted across Scotland.

HMIPS found that the providers managed the high number of escorts in Scotland's central belt well, but that escorts to and from remote courts in the Highlands and Islands were more challenging. Nonetheless, this was managed without significant adverse effect on prisoners.

In its inspection of escorts, as well as its regular prison inspections, HMIPS noted the extraordinary distances some prisoners travelled to appear in court. This was particularly the case for women prisoners, most of whom were held in Cornton Vale in Stirling but who may be required to appear at courts across Scotland. HMIPS recommended that the Scottish Prison Service and the Scottish Court Service work together to introduce video conference links between prisons and courts, particularly remote courts. Video links will reduce the need for prisoners to travel long distances for what can often be very short court appearances, or appearances that can be cancelled at short notice.

There was concern about the possibility of exposing prisoners to public scrutiny when they arrived at some courts or en route from their cell to the courtroom. While this tended to be well managed, risks to the safety of prisoners and escort staff arising from public interference remained. HMIPS recommended that there should be urgent action to address these risks at courts in Arbroath and Tain in particular.

England and Wales

As in Scotland, arrangements for escorting prisoners to and from court and on inter-prison transfer in England and Wales underwent significant changes in 2011–12. From 29 August 2011, prison escort contracts were awarded to two new providers – Serco Wincanton supplies escorts for London and the east of England, while GEOAmey supplies the rest of England and Wales. These contracts provide for the escort of around 80,000 prisoners to court a month.[18] Three members of the NPM – HMIP, IMBs and the Children's Commissioner – have reported difficulties with the implementation of the new contracts, as well as general concerns about escorts.

In the early days of the new contracts, both contractors experienced difficulties with staffing, the scheduling of vehicles and their technology. This resulted in late arrivals to prison from court and prisoners, particularly in London, being 'locked out' and diverted to other prisons or police custody suites. Even where late arriving prisoners were admitted to a prison, there were additional pressures on the establishment's reception and first night procedures. These concerns were highlighted by HMIP but also by the IMBs at, for example, Wormwood Scrubs, Nottingham and Norwich. Under the new contracts, escort vehicles picked up prisoners from a number of points before taking them to court or prison, meaning that the prisoner picked up first often had a protracted journey. Despite long journeys, prisoners were not always routinely offered toilet breaks. The IMB at Wormwood Scrubs also noted that while prisoners were given drinking water, they were left without food for too long during very lengthy journeys.

Although most prisoners reported a reasonable experience of escort arrangements, they also said they spent long periods in court cells or in transit before arriving at their prison. During inspections of local prisons, HMIP found delays in moving prisoners through reception caused by large groups arriving together late in the afternoon.

HMIP also found disproportionate security procedures during escorts and on arrival at prisons. For example, prisoners transferring to Hatfield, an open prison, were nonetheless transported in secure vans. Some prisoners were handcuffed while disembarking from vehicles and walking the short distance to reception: this was disproportionate to the risk presented.

The IMB at Wormwood Scrubs was concerned by last-minute cancellations of inter-prison transfers by the contractor. Prisoners were held in reception, ready for transfer, early in the morning only to be returned to their cells in the afternoon. This was clearly unsettling for prisoners and staff. The prisoner escort service was described by the local IMB as 'unpredictable' at Norwich and 'extremely poor' at Lewes.

Of particular concern were children and young people arriving at their establishment late in the evening when induction processes could not be carried out properly and hot meals were often not available. Late arrivals may have been caused by late collections from court, or by vehicles dropping adults off first and leaving children with longer journeys. The IMBs criticised such late arrivals, particularly for children experiencing prison for the first time.

The NPM members monitoring escorts were concerned that the new contracts permitted women and children under 18 to be transported in the same vehicles as adult men. While there were protocols to separate the different groups within vehicles, HMIP found that they were underdeveloped. Even escort staff reported that mixing men and women on the same van was problematic. Removable partitions to divide vehicles into separate compartments for men, women and

18 Category A prisoners are escorted by the Prison Service itself rather than by a private provider.

children were not effective and hampered the ability of staff to supervise all prisoners. These concerns about the transport of children, women and men together in the same vehicle echo concerns by CJINI about the escorting of prisoners in Northern Ireland.

The NPM members believe that children under the age of 18, women and men should be transported separately. This is in line with international human rights standards and is also based on our own monitoring experience that the separation of women and children from adult males is essential to ensure the safety and well-being of all prisoners.[19]

Person escort records

When a prisoner is escorted between police stations, courts, prisons and hospitals, it is essential that those responsible for the prisoner are aware of any risks or vulnerabilities. Risks and vulnerabilities are assessed before any escort and should be recorded on a person escort record (PER). The PER travels with the prisoner throughout movements and can contain key information about them, including the risk of self-harm and suicide. It is, therefore, one element in a range of processes by which the state fulfils its duty of care to those at risk of self-harm and suicide.

In August 2011, HMIP was asked by the Ministerial Board on Deaths in Custody[20] to inspect the use of PERs following concerns that the forms were not used effectively. HMIP carried out this work in three stages by:

1 Exploring the extent to which information about the risk of self-harm obtained during detention in police custody was accurately recorded and likely to be useful in subsequent care planning. A total of 181 PERs in five police forces were inspected. HMIP found that many PERs were only partially complete or illegible. In some police forces, the forms were discarded while in others they were stored untidily with pages from one detainee's form mixed with pages from another detainee's PER. Staff using PERs did not fully understand the importance of the information they contained. They saw the forms as bureaucratic rather than an important tool in planning and delivering detainee care. Where self-harm was identified, this information was often too vague to be useful. This could mask the potential seriousness of a detainee's recent behaviour in custody. However, HMIP did note good practice in one police force. In South Wales, staff were trained how to complete PERs and quality assurance checks were carried out. As a result, the quality of PER information in South Wales was considerably better than in other police forces.

2 Reviewing the extent to which information in PERs was helpful in managing the care of prisoners and young people vulnerable to self-harm in prisons and young offender institutions. Fieldwork was conducted at five prisons and included observation at reception, interviews with staff and prisoners, and records analysis. Prison staff said PERs were a useful means of flagging self-harm as an issue, but were not always sufficiently detailed and often did not include an indication of the level and immediacy of risk. This made care planning difficult.

19 See, for example, Article 37(c) of the United Nations Convention on the Rights of the Child, Article 10 of the International Covenant on Civil and Political Rights, and Rule 8 of the Standard Minimum Rules for the Treatment of Prisoners.
20 The Ministerial Board on Deaths in Custody is part of a three-tier structure aiming to bring about a continuing and shared reduction in the number and rate of deaths in all forms of state custody in England and Wales.

3 Holding focus groups with PER users (including police custody, court custody, escort and prison reception staff) to test recommendations about changes to the PER and its accompanying documentation.

As a result of its review, HMIP made several recommendations on PERs. These included: the possibility of investigating a move from a paper-based PER to an electronic record, to address practical difficulties with PERs; that PERs should be quality assured to improve standards; staff across the custodial estate should be trained in their purpose and completion; the quality of information included on PERs should improve; and self-harm warning forms should be completed where there is a significant concern about self-harm. A report of HMIP's review of PERs was published in October 2012 and the implementation of its recommendations will be monitored.[21]

Overseas escorts

The monitoring of overseas escorts has been a new area of work for two members of the NPM – IMBs and HMIP. Monitoring overseas escorts covers detainees throughout their removal from the UK, including during the removal flight. The need for independent monitoring was evidenced by the tragic death of an adult male detainee while being deported from the UK to Angola in October 2010. The man died while he was being restrained by escort staff on board an aircraft.

All immigration removal centres (IRCs) and some short-term holding facilities (STHFs) for immigration detainees are monitored by an IMB made up of volunteers from the local community. Following a request by the Home Secretary in January 2011 to monitor overseas escorts, the IMBs agreed to assess the feasibility of this new area. The IMBs have monitored six overseas escort flights to date, three of which took place during 2011–12. They included two flights organised by the British government to Kabul, Afghanistan and Islamabad, Pakistan and one Frontex-operated flight to Lahore, Pakistan.[22] Two board members monitored the escort process from the point at which the detainees were collected from the IRC until disembarkation in the destination country.

While escorting staff were initially suspicious of their presence, the board members soon found that staff were keen to facilitate monitoring as best they could. On the whole, board members were impressed by the care taken to make the detainees feel at ease and to defuse or de-escalate potentially volatile situations. However, they were concerned about the long periods detainees spent waiting during the removal process. This included long waits on coaches when leaving the IRC, as well as waiting at the airport before embarkation. These long waiting periods had the potential to increase detainees' anxiety significantly.

The board members considered it good practice that a chief immigration officer on board each flight held surgeries and met all detainees who had issues to discuss. On one flight, the board members were also able to take up complaints and concerns on behalf of the detainees, which were followed up on their return to the UK. As a result of concerns raised by board members, a formal complaints system was introduced for detainees during overseas escorts.

21 HMIP, *The Use of Person Escort Records with Detainees at Risk of Self-Harm: A thematic review* (October 2012).
22 Frontex is an agency of the European Union that promotes, coordinates and develops European border management. One of its roles is to assist EU Member States coordinate their efforts to return foreign nationals to their country of origin, including through coordinating joint return flights.

Monitoring of Frontex flights has caused particular concern among IMBs. On a Frontex flight, detainees from several EU Member States may be returned to their country of origin at the same time. One Member State is responsible for organising the flight while Frontex coordinates with the authorities from other participating States. Although the flight is coordinated by Frontex, detainees are escorted by staff of the country from which they are being returned. The IMBs have found that this results in variable standards of treatment on board flights in relation to, for example:

- the manner in which detainees are managed by escort staff – board members have noted that staff from some countries appear to be more confrontational and prone to use force than others
- the nature and extent of force used against detainees – for example, unlike the UK, some countries use chemical restraint and restraint appears to be more routinely used
- certification of fitness to fly
- health care provision during the flight
- appropriate provision of escorts of both sexes where women are removed.

The variation in treatment experienced by detainees on the same flight raises jurisdictional concerns about who is ultimately responsible for the safety and well-being of detainees while they are being removed. Standards of treatment acceptable to one participating State may not be acceptable to another.

In assessing the feasibility of continued monitoring of overseas escorts, the IMBs have recognised the important role they can play and have been reassured by the positive impact of their work. They have concluded that they will continue to monitor overseas escorts in the future.

HMIP has a statutory duty to monitor IRCs, STHFs and escort arrangements for immigration detainees. While it has been monitoring the escorting of detainees within the UK for several years, HMIP carried out its first two inspections of overseas escorts in 2011. In future, overseas escorts will form a regular part of HMIP's inspection programme.

The escorted overseas removals inspected were to Jamaica and Nigeria. The inspections involved accompanying the escorts from when they collected detainees from an IRC to the point that detainees disembarked from the aircraft in the destination country. Like the IMBs, HMIP found that both flights were orderly and, in most respects, reasonably well managed. Most escorts performed their duties well and dealt sensitively with the needs of individual detainees. However, HMIP was concerned about the lax and unprofessional approach of a minority of escort staff on one flight who, within hearing of detainees, swore freely, used offensive and racist language, and made sweeping generalisations about national characteristics. They were not challenged by colleagues or managers.

Overseas escorts are inevitably stressful events and the vulnerability of detainees during the process of removal was taken too lightly. Staff numbers were excessive, with more than three times as many escorts as detainees on one flight. There was no accredited training for the use of force on aircraft. In one case, a detainee continued to have his head restrained when he had become compliant. Handcuffs and force should only be used as a last resort and for the minimum time necessary, but HMIP found shortcomings in the application of both requirements. In one case, a detainee was kept in handcuffs for more than two hours, even though detention staff acknowledged that she was upset rather than 'kicking off'.

HMIP described as inhumane the use of 'reserve' detainees for charter flight removals. This involved overbooking flights with detainees who had said last goodbyes in the UK or were looking forward to returning home and, at the last minute, telling some that they were not flying after all. Detainees were not aware they were on this reserve list. HMIP recommended that this practice should cease, a recommendation supported by the Home Affairs Select Committee.[23]

Further monitoring and inspecting of overseas escorts by IMBs and HMIP will enable a broader picture of the treatment of and conditions for detainees during removals to be established. This will contribute to ensuring the safe and humane treatment of detainees during difficult conditions and at an incredibly stressful moment in their lives.

The importance of this emerging area of work has been recognised by the Council of Europe's European NPM project. Designed to create an active network of NPMs and facilitate the sharing of information and best practice, this project had a particular focus on overseas escorts in 2011–12. This began with a seminar in London, hosted by HMIP, and attended by representatives of the NPMs in France, Germany, Spain and Switzerland, as well as members of the European Committee for the Prevention of Torture and non-governmental organisations, such as the Association for the Prevention of Torture.

The purpose of the seminar was to discuss specific issues arising from the monitoring of removals. During the seminar, it became clear that there may be scope for cooperation between European NPMs when monitoring flights operated by Frontex or those organised jointly by European states deporting detainees to the same country. Given the complexity of the issues and the level of interest from other NPMs in Europe, the project organised further workshops on overseas escorts in March and June 2012, both of which were attended by representatives of the UK NPM.

Recommendations

To escort commissioners and providers throughout the UK

2 Children and young people under the age of 18, women and adult men should be transported separately during escorts of detainees.

3 There should be effective mechanisms to transfer information about a detainee during moves between places of detention. In England and Wales, the design, format and use of the person escort record should provide for the consistent, effective and prompt exchange of information between all those responsible for a detainee moving location.

4 Security measures taken during the escorting of detainees should be proportionate to the risk posed and based on an assessment of individual detainees.

To court services across the UK

5 There should be greater use of video conference links to minimise the need for detainees to travel long distances for short court appearances.

To the UK Border Agency

6 An accredited system of restraint should be developed for use on board aircraft. All escorting staff should receive accredited training in the approved restraint techniques.

23 Home Affairs Select Committee, Rules governing enforced removals from the UK – Eighteenth Report of Session 2010–12 (January 2012).

Section five
Lay monitoring

Monitoring of places of detention by unpaid volunteers from the local community is a key feature of the UK's NPM. Such lay monitoring takes place throughout the UK and for different types of detention. The lay monitoring of prisons, in particular, has a long history. Boards of visitors, as IMBs were previously known, were first established in the 19th century, while previous incarnations can be traced as far back as the reign of Queen Elizabeth I (1558–1603). Police custody visiting was introduced in 1984 following Lord Scarman's report into the Brixton riots in 1981. While lay monitoring was therefore well established before the adoption of OPCAT in 2002, it nonetheless fits well with the OPCAT framework.

There are currently four NPM members who monitor detention solely through the use of lay monitors. In addition, some of the professional inspectorates monitoring detention in the health and social care context use lay monitors as well as paid inspectors. It is likely that the number of lay bodies in the NPM will increase in the future. For example, the NPM anticipates that lay observers of court custody in England and Wales will be designated by the government as an additional member of the NPM, although the timing of this designation is not certain.

Lay monitoring by the NPM

1. Each prison and young offender institution in England, Wales and Northern Ireland is monitored by an IMB made up of members from the local community.
2. Similarly, immigration removal centres and short-term holding facilities throughout the UK are monitored by IMBs.
3. Police custody suites throughout the UK are monitored by independent custody visitors.
4. Some of the professional inspectorates monitoring detention in the health and social care context, such as the Care Inspectorate in Scotland, use lay monitors in addition to paid inspectors.

In implementing OPCAT effectively, the use of lay monitors offers particular benefits while also presenting some challenges. These issues were discussed at a workshop in October 2011. The NPM is grateful to the Human Rights Implementation Centre at the University of Bristol for its support of this event. The purpose of the workshop was to give the lay bodies in the NPM the opportunity to discuss the implementation of OPCAT in more depth, taking into account the nature of their organisations.

Layered monitoring

The existence of lay monitors of detention highlights another key feature of the UK's NPM – some places of detention, including prisons, police custody and immigration detention, receive 'layered' monitoring by both a professional inspectorate and by volunteers from the community. The professional inspectorate provides cyclical, in-depth professional inspection against published criteria, which include the use of, for example, health care experts as recommended by the

SPT. The lay monitoring body provides a frequency of visiting that cannot be achieved by a professional inspectorate without a significant increase in resources or changes to its methodology. The regular monitoring of detention is, of course, a key requirement of OPCAT. Lay monitors publish an annual report which, rather than being a snapshot of a place of detention at the time of an inspection, paints a picture of the establishment over the course of a year. It is these layers of monitoring that, in total, allow the UK to meet its obligations under OPCAT.

Regular monitoring

Article 1 of OPCAT states that its purpose is to establish a system of regular visits to places where people are deprived of their liberty. A key benefit of lay monitoring is the frequency with which custody visitors or board members visit places of detention, which is unmatched by professional inspectorates. In England and Wales, and in Northern Ireland, IMBs are obliged to meet at the establishment at least once a month. In practice, at least one board member makes a visit each week, but more regular visits are also made. In Northern Ireland, custody visitors made 1,037 visits to 19 police custody suites in 2011–12. Visits are made at various times of the day and at various points during the week. To encourage visitors to monitor detention at unsociable hours, custody visitors in Northern Ireland have a guideline number of weekend and late night or early morning visits.

Such frequent visiting by the lay members of the NPM is in keeping with their preventive role under OPCAT – regular visiting allows concerns about the treatment and conditions of detainees to be identified and addressed at the earliest opportunity.

Places of detention

OPCAT requires that all places of detention receive independent and regular monitoring. At our workshop, some gaps were noted. For example, custody visitors in England and Wales visit facilities operated by the British Transport Police but said this was by invitation only. They have no statutory right of access to such facilities, as recommended by the SPT.[24] The UK government itself has highlighted the importance of monitors having a statutory right of access – this was one of the government's criteria in 2009 when deciding which organisations to designate as members of the NPM.

In Northern Ireland, the Chief Constable designates police stations to be used for detaining arrested persons. Stations that have not been designated are not currently within the remit of the custody visitors. While a person can be detained in a non-designated police station in only limited circumstances and for limited periods, OPCAT requires that all places of detention be monitored. During 2011–12, for example, 39 people were detained in non-designated police stations where custody visitors were unable to monitor their treatment and conditions. The Northern Ireland Policing Board Independent Custody Visiting Scheme, and the NPM as a whole, recommend that non-designated police stations be included in the remit of the custody visitors.

Making recommendations

The role of an NPM is to make recommendations to the relevant authorities with the aim of improving the treatment and the conditions of detainees and to prevent ill-treatment. The lay monitoring bodies in the UK's NPM make recommendations as a result of their visits to places of detention, but fear that their recommendations are not always implemented. They can make the same recommendation year after year without seeing evidence of change or an explanation about why the recommendation is not being delivered. This runs counter to Article 22 of OPCAT, which requires authorities to examine the recommendations of an NPM and enter into a dialogue with it on possible implementation measures. In England and Wales, action plans are prepared on behalf of the government in response to recommendations in each IMB's annual report. This is good practice and helps board members follow up their recommendations. In Northern Ireland, the IMBs direct their recommendations to the Justice Minister in order to have them taken seriously and to ensure they are effectively implemented. The Northern Ireland Prison Service then has to publish its response to each recommendation.

Lay monitors also fear that their recommendations are accorded a lower status than those of the professional inspectorates. In particular, they may lack the capacity to follow up strategic recommendations that are a matter of national law or policy, rather than an issue that can be resolved locally or by an individual establishment. However, by individual organisations coming together under the NPM framework, there is an opportunity for improved communication between the lay bodies and the professional inspectorates and the possibility of working together more closely to monitor the implementation of each others' recommendations. Indeed, designation as members of the NPM has already facilitated contact between the lay monitoring bodies themselves, as well as between the lay bodies and professional inspectorates, allowing them to discuss common concerns and identify areas for joint action.

Independence

The lay members of the NPM value their independence from the government and the authorities they monitor. Designation as members of the NPM has reinforced the independent nature of their work and encouraged them to assess whether they are sufficiently independent. This has had implications for their practice. For example, in the past, custody visitors in England and Wales and in Northern Ireland were introduced to detainees by the custody officer. To foster independence, custody visitors have begun a policy of self-introduction. This encourages detainees to see visitors as independent from custodial staff and is proving successful. In Northern Ireland, the proportion of detainees who refused to speak to custody visitors dropped from 18% to 7% following the implementation of self-introduction.

The SPT has noted that the independent functioning of NPMs can be fostered by specifying the periods of office for which members serve. This has been a contentious issue for some lay members of the NPM. While some already have term-limited appointments, others do not. IMBs in England and Wales are currently introducing a fixed term policy. This has prompted some fears that boards will struggle to recruit volunteers to replace term-limited members and that a significant amount of experience and expertise will be lost. Others believe that recruitment difficulties will be offset by the benefits of new board members providing a fresh perspective. In contrast, the independent custody visitors in Northern Ireland, for example, have term-limited appointments for a maximum of six years. They feel this approach has not inhibited recruitment but has, in fact, encouraged diversity among volunteers while maintaining a good level of experience and expertise.

24 SPT, Guidelines on national preventive mechanisms CAT/OP/12/5 (09/12/10) ('SPT Guidelines') at paragraph 7.

Professional knowledge

Article 18(2) of OPCAT requires that, 'the experts of the national preventive mechanism have the required capabilities and professional knowledge'. The SPT has expanded on this provision, suggesting that NPMs should include staff with relevant legal and health care expertise.[25] This requirement is at odds with the nature of lay bodies. Lay monitors are selected on the basis of their qualities and skills rather than any professional background or qualification. Often, those with work experience of a particular type of custody are specifically prohibited from becoming a lay monitor, as this would represent a conflict of interest (for example, a serving or former police officer may not serve as a custody visitor). Once appointed, they receive training in detention monitoring. A key strength of lay bodies is that they are made up of people who represent the local community and come from all walks of life, thereby providing a range of perspectives when monitoring treatment and conditions for detainees.

The lay members of the NPM do not feel that they should change their composition in response to OPCAT as, due to the layered nature of detention monitoring, professional expertise (such as health care expertise) is provided by the inspectorates during their visits to places of detention.

Diversity

Article 18(2) of OPCAT also requires that NPMs have a gender balance and an adequate representation of ethnic and minority groups. IMB members and custody visitors are recruited in an open and fair manner. Given that they are recruited from a range of backgrounds and not on the basis of their professional expertise, coupled with the sheer number of lay monitors (there are around 1,750 IMB members in England and Wales), there is scope for a broad cross-section of the community to be involved in detention monitoring. However, because of the voluntary nature of the work, lay monitors tend to be retired and therefore older. Lay bodies can struggle to recruit younger volunteers, as well as those from minority ethnic groups. Lay bodies acknowledge that this issue must be addressed given that younger people and those from black and minority ethnic groups are over-represented in the detainee population. The workshop gave the lay members of the NPM the opportunity to share information about how they target minority groups in recruitment and what can be done to retain volunteers.

Adequate resources

Despite the many advantages of lay monitoring, there are also some challenges. Although it is a cost-effective method of monitoring detainees' treatment and conditions, even lay monitoring has faced budget cuts in recent years. To maintain monitoring levels, savings must be found in already lean budgets. There are concerns that training for volunteers may be affected. Given that it can be difficult to ensure consistency in approach across monitoring boards or custody visiting schemes, initial and ongoing training remains essential.

Custody visiting in Scotland

In England and Wales, and in Northern Ireland, police custody visiting schemes were established by statute. Although custody visiting schemes also operate in Scotland, they had no statutory basis and, as a result, were not designated as a member of the NPM by the government. At the time of designation in 2009, the government required all NPM members to have a statutory right of unrestricted access to places of detention and to detainees. However, since then the status of custody visiting in Scotland has changed significantly in the context of wider policing reform.

In 2011, the Scottish government consulted on the future of policing, resulting in proposals to merge Scotland's eight police forces into one national service. The NPM collectively, as well as individual members and custody visitors in Scotland, responded to this consultation and encouraged the government to use the restructuring of policing as an opportunity to place independent custody visiting on a statutory footing. This recommendation was accepted and custody visiting was included in the Police and Fire Reform (Scotland) Bill. The NPM welcomed this initiative and was particularly pleased that the Scottish government had explicitly referenced OPCAT and its requirements in the Bill. Indeed, custody visitors in Scotland are the first of the NPM members to have OPCAT mentioned in their founding legislation. The Bill was also the first legislation in the UK to provide explicitly for visits to detention by the UN's Subcommittee on Prevention of Torture (SPT).

The Bill was passed by the Scottish Parliament in 2012 and its provisions come into force on 1 April 2013. While the NPM commends the Scottish government's commitment to OPCAT in the context of police custody, consideration should now be given to how the independent visiting of police custody in one national police service can best be supported and administered.

In light of the new statutory basis for custody visiting in Scotland, we also call on the UK government to designate Scottish custody visitors separately as a member of the NPM.

Police and Fire Reform (Scotland) Act 2012 – relevant extracts

93 Purpose of custody visiting

The provisions in this chapter are in pursuance of the objective of OPCAT, that is, the objective of establishing a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

94 Independent custody visiting

(1) The authority must make arrangements to ensure that independent custody visitors may —
  (a) visit detainees
  (b) access information relevant to the treatment of detainees and the conditions in which they are detained, and
  (c) monitor the treatment of detainees and the conditions in which they are detained.

(2) The arrangements must —
  (a) provide for the appointment as independent custody visitors of suitable persons who are independent of both the authority and the police service
  (b) authorise independent custody visitors to do anything which the authority considers necessary to enable them to visit detainees and monitor the treatment of detainees and the conditions in which they are detained, and
  (c) provide for reporting on each visit.

25 SPT, Guidelines paragraph 20.

(3) The arrangements may, in particular, authorise independent custody visitors to —
- (a) access, without prior notice, any place in which a detainee is held
- (b) examine records relating to the detention of persons there
- (c) meet any detainees there (in private) to discuss their treatment while detained and the conditions in which they are detained
- (d) inspect the conditions in which persons are detained there (including cell accommodation, washing and toilet facilities and facilities for the provision of food), and
- (e) meet such other persons that the visitors think may have information relevant to the treatment of detainees and the conditions in which they are detained.

95 SPT visits

(1) The authority must make arrangements to ensure that members of the SPT [Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment established under Article 2 of OPCAT] may —
- (a) visit detainees
- (b) access information relevant to the treatment of detainees and the conditions in which they are detained, and
- (c) monitor the treatment of detainees and the conditions in which they are detained.

Prison visiting committees in Scotland

In Scotland, each prison has a visiting committee that performs a role similar to that of an IMB in England, Wales and Northern Ireland. At the time the NPM was designated, visiting committees were not included as they were undergoing review and there were concerns about the extent to which they were OPCAT-compliant. For example, the committees received their funding directly from the Scottish Prison Service, which could compromise their independence. Pending the outcome of the review, it was anticipated that visiting committees may be designated as an NPM member in the future.

However, in 2011, the Scottish government announced that it had concluded its review and would abolish prison visiting committees. While acknowledging that prisons in Scotland are also independently inspected by HMIPS, the NPM expressed concern about this proposal, particularly:

- the loss of such frequent visits to prisons
- the reduced protection available to prisoners in Scotland compared with those in the rest of the UK
- the benefits of 'layered' prison monitoring by both a professional inspectorate, such as HMIPS, and lay monitors, such as visiting committees
- the need to ensure that decisions on prison monitoring should take OPCAT into account.

The Scottish government responded to concerns expressed by the NPM and others by proposing that HMIPS take on a prison monitoring role in addition to its inspection function. The NPM will continue to engage with the Scottish government and other relevant parties about the future of prison monitoring in Scotland. The NPM seeks to ensure that any future arrangements are OPCAT-compliant and has welcomed a review of proposals for prison monitoring against OPCAT by Professor Andrew Coyle, commissioned by the Scottish government.

Lay monitors within inspectorates

In addition to monitoring by lay bodies, some of the professional inspectorate members of the NPM also use lay monitors in their work. For example, the Care Inspectorate in Scotland, which monitors secure children's homes as well as other residential care settings, uses 'lay assessors'. Lay assessors are people that use, or have used, services, or their carers, who volunteer to take part in inspections. The assessors talk to those who use the care services and their carers and make observations based on their own personal experience. This information is then used by an inspector to report on the service and make an assessment. Lay assessors are supported and trained by a dedicated team in the Care Inspectorate. The involvement of lay assessors in inspections demonstrates the Care Inspectorate's commitment to developing the participation of service users in monitoring services. Other NPM members, including Healthcare Inspectorate Wales, involve lay monitors in a similar way.

Recommendations

To the Minister for Justice in Northern Ireland

7 Non-designated police cells in Northern Ireland should be brought within the remit of the Northern Ireland Policing Board Independent Custody Visiting Scheme.

To the Cabinet Secretary for Justice in Scotland

8 Future arrangements for prison monitoring in Scotland should be OPCAT-compliant.

To the Scottish Police Authority

9 The Scottish Police Authority should consider how the independent visiting of police custody in one national police service can best be supported and administered, taking into account the requirements of OPCAT.

To the Secretary of State for Justice

10 Custody visitors in Scotland should be separately designated as an additional member of the NPM.

Section six
Looking ahead – year four

In 2012–13, the NPM members have continued to monitor the treatment and conditions of detainees and contribute to the effective implementation of OPCAT in the UK. They will continue to monitor the implementation of their recommendations, including those made in this report, with a view to preventing ill-treatment in all places of detention.

In addition, the members will continue to develop the coordination of the NPM, as outlined in the business plan for 2012–13. This will include:

- facilitating discussions between NPM members operating in different jurisdictions about de facto detention, and exploring the distinction between a restriction and a deprivation of liberty. These discussions will take place primarily between NPM members that monitor health and social care settings
- examining key issues of relevance to monitoring detention, such as the use of solitary confinement and the searching of detainees
- assessing the extent to which recommendations by NPM members are implemented and reviewing how to make effective recommendations
- developing the role and work of the steering group
- developing the relationship between the NPM members and external stakeholders, including the SPT and the Committee for the Prevention of Torture (CPT). This will include inviting a member of the SPT to visit representatives of the IMBs in England and Wales to learn more about the lay monitoring aspect of the UK's NPM. The NPM members also liaised with the CPT during its visit to the UK in 2012, providing it with information about concerns in places of detention across the UK.

Section seven
Member overview

In the first annual report of the UK NPM, we profiled each of the NPM members, setting out detailed information on their mandate, structure and methodology. Rather than replicate that information in subsequent annual reports, we have set out below a short description of each member, as a reminder. We have also included details of any significant changes to the members during 2011–12. Detailed information about each member can be found in our first annual report, the online database of UK NPM members, or the annual reports or websites of the individual members.[26]

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

Care and Social Services Inspectorate Wales

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

Care Inspectorate

Established by the Public Services Reform (Scotland) Act 2010, the Care Inspectorate is the independent scrutiny and improvement body for social work and social care and support services for people of all ages. As part of this role, the Inspectorate monitors secure children's homes as well as other residential services. The Care Inspectorate has not yet been formally designated as a member of the UK's NPM but is the successor to a previously designated member (the Care Commission).

Care Quality Commission

CQC is an independent statutory organisation responsible for registering health and adult social care services in England if they meet essential standards of quality and safety, and monitoring providers to check they continue to meet those standards. CQC also monitors the operation of the Mental Health Act 1983, including those who are detained under mental health law. CQC carries out inspections of health care in prisons and immigration detention alongside HMIP, and participates in inspections of police custody by HMIP and HMIC.

Criminal Justice Inspection Northern Ireland

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

Healthcare Inspectorate Wales

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

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

Her Majesty's Inspectorate of Constabulary

HMIC has a statutory duty to inspect and report on the efficiency and effectiveness of policing. Following the ratification of OPCAT, HMIC's role has included carrying out inspections of police custody facilities in England and Wales in partnership with HMIP. From 2012, HMIC has the statutory power to inspect customs custody facilities operated by UK Border Force.

Her Majesty's Inspectorate of Constabulary for Scotland

In 2011–12, the role of HMICS was to monitor and improve police services in Scotland. It scrutinised the work of Scotland's eight police forces, as well as the operational policing aspects of the Scottish Crime and Drugs Enforcement Agency. HMICS inspects all aspects of policing, including police custody. Following the merging of Scotland's eight police forces into one national service on 1 April 2013, the role of HMICS will be to monitor the state, efficiency and effectiveness of the Scottish Police Authority and the police service.

Her Majesty's Inspectorate of Prisons

HMIP is an independent statutory organisation that carries out regular inspections of places of detention to assess the treatment of and conditions for detainees. HMIP inspects all prisons in England and Wales, including YOIs, all immigration removal centres, short-term holding facilities and escort arrangements for immigration detainees, and all police custody facilities in association with HMIC. By invitation, HMIP also participates in inspections of prisons in Northern Ireland (in partnership with CJINI) and inspects some military detention facilities. In 2012, HMIP was granted powers to inspect court custody facilities and also began inspecting secure training centres in partnership with Ofsted, and customs custody facilities with HMIC.

Her Majesty's Inspectorate of Prisons for Scotland

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

Independent Custody Visiting Association

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

Independent Custody Visitors (Scotland)

Independent custody visitors in Scotland carry out regular, unannounced visits to police stations to monitor the treatment of and conditions for detainees. Custody visitors in Scotland have not been designated separately as a member of the UK NPM but are members of the ICVA, although they retain their own funding and management framework. By virtue of the Police and Fire Reform (Scotland) Act 2012, custody visiting in Scotland was given a statutory basis.

Independent Monitoring Boards

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

Independent Monitoring Boards (Northern Ireland)

IMBs in Northern Ireland are statutory bodies whose role is to monitor the treatment of prisoners and the conditions of their imprisonment. The boards are made up of unpaid members of the community and fulfil their duties by carrying out regular visits to establishments. There are three boards in Northern Ireland, one for each prison. Board members are appointed by the Northern Ireland Justice Minister.

Mental Welfare Commission for Scotland

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

Northern Ireland Policing Board Independent Custody Visiting Scheme

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

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

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

Office of the Children's Commissioner for England

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

Regulation and Quality Improvement Authority

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

Scottish Human Rights Commission

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

Section eight

Summary of recommendations

To the UK government

1 The government should consider what role it should play in implementing OPCAT in respect of British Crown Dependencies and Overseas Territories.

To escort commissioners and providers throughout the UK

2 Children and young people under the age of 18, women and adult men should be transported separately during escorts of detainees.

3 There should be effective mechanisms to transfer information about a detainee during moves between places of detention. In England and Wales, the design, format and use of the person escort record should provide for the consistent, effective and prompt exchange of information between all those responsible for a detainee moving location.

4 Security measures taken during the escorting of detainees should be proportionate to the risk posed and based on an assessment of individual detainees.

To court services across the UK

5 There should be greater use of video conference links to minimise the need for detainees to travel long distances for short court appearances.

To the UK Border Agency

6 An accredited system of restraint should be developed for use on board aircraft. All escorting staff should receive accredited training in the approved restraint techniques.

To the Minister for Justice in Northern Ireland

7 Non-designated police cells in Northern Ireland should be brought within the remit of the Northern Ireland Policing Board Independent Custody Visiting Scheme.

To the Cabinet Secretary for Justice in Scotland

8 Future arrangements for prison monitoring in Scotland should be OPCAT-compliant.

To the Scottish Police Authority

9 The Scottish Police Authority should consider how the independent visiting of police custody in one national police service can best be supported and administered, taking into account the requirements of OPCAT.

To the Secretary of State for Justice

10 Custody visitors in Scotland should be separately designated as an additional member of the NPM.

Section nine
Appendices

Appendix one

Written ministerial statement – 31 March 2009[27]

Optional Protocol to the Convention Against Torture (OPCAT)

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

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

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

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

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

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

27 HC Col 56WS, 31 March 2009.

Appendix two

Further information about the UK's NPM

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

National Preventive Mechanism coordinator
HM Inspectorate of Prisons
First Floor, Ashley House
2 Monck Street
London SW1P 2BQ
Email:
hmiprisons.enquiries@hmiprisons.gsi.gov.uk

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

England and Wales

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

Independent Monitoring Boards
www.justice.gov.uk/about/imb.htm

Independent Custody Visiting Association
www.icva.org.uk

HM Inspectorate of Constabulary
www.hmic.gov.uk

Care Quality Commission
www.cqc.org.uk

Healthcare Inspectorate Wales
www.hiw.org.uk

Office of the Children's Commissioner for England
www.childrenscommissioner.gov.uk

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

Office for Standards in Education, Children's Services and Skills
www.ofsted.gov.uk

Scotland

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

HM Inspectorate of Constabulary for Scotland
www.hmics.org

Scottish Human Rights Commission
www.scottishhumanrights.com

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

Care Inspectorate
www.scswis.com

Northern Ireland

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

Criminal Justice Inspection Northern Ireland
www.cjini.org

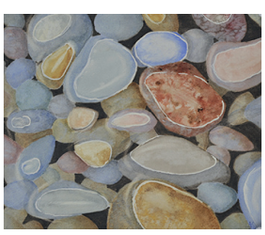
Regulation and Quality Improvement Authority
www.rqia.org.uk

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

Appendix three

List of abbreviations

CI	Care Inspectorate
CJINI	Criminal Justice Inspection Northern Ireland
CPT	Committee for the Prevention of Torture
CQC	Care Quality Commission
CSSIW	Care and Social Services Inspectorate Wales
HIW	Healthcare Inspectorate Wales
HMCIPS	Her Majesty's Chief Inspector of Prisons for Scotland
HMIC	Her Majesty's Inspectorate of Constabulary
HMICS	Her Majesty's Inspectorate of Constabulary for Scotland
HMIP	Her Majesty's Inspectorate of Prisons
HMIPS	Her Majesty's Inspectorate of Prisons for Scotland
HRIC	Human Rights Implementation Centre
ICVA	Independent Custody Visiting Association
ICVS	Independent Custody Visitors Scotland
IMB	Independent Monitoring Boards
IMBNI	Independent Monitoring Boards (Northern Ireland)
IPCA	Independent Police Conduct Authority (New Zealand)
IRC	Immigration removal centre
MWCS	Mental Welfare Commission for Scotland
NHS	National Health Service
NIPBICVS	Northern Ireland Policing Board Independent Custody Visiting Scheme
NPM	National Preventive Mechanism
OCC	Office of the Children's Commissioner for England
Ofsted	Office for Standards in Education, Children's Services and Skills
OPCAT	Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
RQIA	Regulation and Quality Improvement Authority
SHRC	Scottish Human Rights Commission
SPT	Subcommittee on Prevention of Torture
STC	Secure training centre
STHF	Short-term holding facility
UKBA	United Kingdom Border Agency
YOI	Young offender institution



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