national
preventive
mechanism

Monitoring places of detention

15th **Annual Report**
of the United Kingdom's
National Preventive Mechanism
2023/24

CP 1209

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15th Annual Report of the United Kingdom's National Preventive Mechanism

2023/24

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p5: **Behind the Mic,** HM Prison Brixton, Painting, 2024. Image courtesy of Koestler Arts.

p12: **If Only!**, HM Prison Wealstun, Painting, 2024. Image courtesy of Koestler Arts.

p14: **Aubergine,** HM Young Offender Institution Cookham Wood, Painting, 2024. Image courtesy of Koestler Arts.

p56: **Tag,** Vinney Green (secure children's home), Painting, 2024. Image courtesy of Koestler Arts.

p59: **Gorgeous Gargoyle**, Harmondsworth Immigration Removal Centre, Ceramics, 2024. Image courtesy of Koestler Arts.

p60: **Semi Skimmed Spilt Milk**, HM Prison High Down, Craft, 2024. Image courtesy of Koestler Arts.

p64: **Free as a Bird in Prison**, HM Prison Wormwood Scrubs, Sculpture, 2024. Image courtesy of Koestler Arts.

p69: **Bust**, HM Young Offender Centre Hydebank Wood, Craft, 2024. Image courtesy of Koestler Arts.

p70: **The Tea Towel**, HM Prison Magilligan, Pastel, 2024. Image courtesy of Koestler Arts.

Contents

Foreword: 15 years of the UK NPM

"Next year, the NPM will celebrate our 15th anniversary. I hope we are able then to report on much more significant reforms, and that my foreword can be distinctly original from Mr Hardwick, Mr Wadham and Mr Strang." Wendy Sinclair Gieben, 14th NPM Annual Report

These were the words of demitting Chair Wendy Sinclair Gieben in her final report as UK NPM Chair. In our last Annual Report, we reflected that while we consistently meet dedicated, skilled staff grappling with challenges, far too many systemic issues have remained unaddressed across our 15-year experience as an NPM. Our Annual Reports have all been far too similar. Recommendations are repeated. And, regrettably, the hopes that our 15th report would be a marked change in this regard have not come to fruition.

The UK signed and ratified OPCAT in 2003, the second country to do so. Five years later, the UK designated a National Preventive Mechanism, appointing the first 18 organisation to form the NPM in 2009. The NPM's last annual report gave a concerning retrospective of 14 years documenting similar issues which, while often taken seriously and improvements made by staff and leaders in individual institutions, had not resulted in overall national change since 2009. We acknowledge that it can be difficult to adopt recommendations caused by a lack of resources, as the setting being scrutinised cannot effectively implement recommendations without sufficient resources to do so however strong their will to might be.

Support for those with mental ill health, increasing numbers of people deprived of their liberty and unstable staffing numbers and experience remain key issues across all settings since 2009. Meanwhile, structural challenges such as the lack of legislative basis for the NPM (though most of the bodies that make up the NPM do have a statutory basis) still exist 15 years after designation and in the face of repeated recommendations by the SPT and CPT.

The UK recognises that those deprived of their liberty are in a uniquely vulnerable position to be subject to ill-treatment and that scrutiny plays a vital role in preventing this. But to what end? International human rights bodies, domestic inspection and monitoring bodies, and government appointed commissions continue to make recommendations to improve outcomes for detainees. This report evidences that governments have failed to make meaningful progress against the extremely worrying findings of the bodies they have appointed to independently scrutinise places of detention.

That said, preventive based scrutiny is focussed not just on what we find on visits, but what we don't find. I am confident that without such a strong model of an NPM – experiences of detainees would be significantly worse. Over the last 15 years, the NPM, made up of 21 organisations with multiple purposes, has developed a cohesive voice on specific issues and created a network for inter-body questioning and discussion. Strong connections between organisations allow joint working for change based on evidence from across different settings.

A multibody NPM such as the UK's has challenges. But as we enter our 16th year and reflect on 15 years of operation, it is clear that one of the great successes is the ability to step back and look at systemic issues across detention settings and jurisdictions. The wide breadth of the UK NPM – comprising over 3,500 people carrying out tens of thousands of visits every year – gives enormous scope to fulfil our preventive mandate.

The following report identifies and reflects on the systemic issues affecting all detention settings, whether people held there are held for health, criminal justice, or administrative reasons. The NPM hopes that over the next 15 years, we will see greater focus from policymakers and sector-leaders on addressing these issues through engagement with recommendations, investment in staffing and infrastructure, and ensuring any statutory changes promote the rights of people deprived of their liberty.

While outside the reporting window of this report, it would be remiss not to highlight the first change in UK Government in fourteen years. This new government has come to power at a complex and challenging time for this sector. We note announcements of an upcoming review on sentencing and Mental Health Bill – the UK NPM will continue to fulfil its mandate doing all within our power to ensure the rights of detainees are kept firmly in the spotlight.

It is most disappointing, if not somewhat predictable, that this foreword has not met with the hopes of the last, to reflect on great strides in improvements in treatment and conditions for those deprived of their liberty.

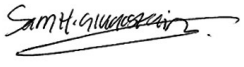
In 2025, the UK NPM Central Team will come to the end of a two-year business plan which brought focus to our four strategic objectives. Over this two-year period, the NPM has been transformed into a more credible, influential and healthy organisation. We will build on this growth in the years to come. The central team exist to support and lead OPCAT compliance in the UK, and we would like to thank them for their endeavours in this reporting window.

This year the NPM has made meaningful contributions to the international space, with Sam supporting NPMs across the globe in their fulfilment of OPCAT. We have published preventive guidance for monitors, which is the first articulation since we began on what prevention means in context.

And we continue to offer support and advice to our 3,500 individuals carrying out the NPM mandate.

I must place on record our most sincere thanks to Wendy Sinclair Gieben, who was Chair during much of the reporting period of this report. She demits office with a legacy to be proud of, and her support in the detention space is hard to overstate.

We would also like to thank all our partners, members and stakeholders for their commitment and support to this organisation in upholding the rights of those detained. To individuals deprived of liberty, to staff working in the sector, and to interested stakeholders – I commit every resource of this office to that aim as we move forward – ultimately – to prevent ill-treatment in places of deprivation of liberty.



Sherry Ralph,
Chair, UK NPM

Sam Gluckstein,
Head of UK NPM

Geographical coverage

Scotland

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

Northern Ireland

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

England

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

United Kingdom

- Independent Reviewer of Terrorism Legislation (IRTL)

Wales

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

England and Wales

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

Types of detention scrutiny

Care Inspectorate

Principle body which inspects Secure Accommodation Services and Social Care in Scotland.

Care Quality Commission

Principal body which inspects Forensic Mental Health Facilities, Detention under the Mental Health Act, and Deprivation of Liberty Safeguards (DoLS) in England.

Care Inspectorate Wales

Principal body which inspects Secure Children Homes, and DoLS Social Care in Wales.

The Children's Commissioner for England (CCE)

The CCE have the statutory power to enter any setting where a child is detained.

Criminal Justice Inspection Northern Ireland

Principal body which inspects prisons, police custody, court custody and juvenile detention in Northern Ireland.

Healthcare Inspectorate Wales

Principal body which inspects mental health detention in Wales.

HM Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS)

Principal body which inspects police custody in England and Wales.

HM Inspectorate of Constabulary in Scotland

Principal body which inspects police custody in Scotland.

HM Inspectorate of Prisons (E&W)

Principal body which inspects prisons and court custody in England and Wales and Immigration detention UK wide.

HM Inspectorate of Prisons for Scotland

Principal body which inspects and monitors prison and court custody in Scotland.

Independent Custody Visiting Association

Principal body representing monitoring of police custody in England and Wales.

Independent Custody Visiting Scotland

Principal body which monitors police custody in Scotland.

Independent Monitoring Board

Principal body which monitors prisons in England and Wales and Immigration detention UK wide.

Independent Monitoring Board (NI)

Principal body which monitors prisons in Northern Ireland.

Independent Reviewer of Terrorism Legislation (IRTL)

The IRTL has the right of entry to custody.

Lay Observers

Principal body which monitors court custody and escort provision in England and Wales.

Mental Welfare Commission for Scotland

Principal body which inspects mental health detention in Scotland.

Northern Ireland Policing Board Independent Custody Visiting Scheme

Principal body which monitors police custody in Northern Ireland.

Ofsted

Principal Body which inspects Secure Children Homes and Secure Training Centres in England.

Regulation and Quality Improvement Authority

Principal body which inspects places where people are detained under Mental Health Law, and children's secure accommodation in Northern Ireland.

Scottish Human Rights Commission

Can work collectively on issues of joint concern and have statutory powers of entry in Scotland.

Introduction

The 21 constituent bodies of the UK National Preventive Mechanism (NPM) publish more than 100 reports each year of scrutiny visits, inspections, continuous monitoring observations and thematic research. This report outlines the commonalities between them to point to systemic issues in settings of deprivation of liberty across the UK. While the legislative, economic and social circumstances in England, Northern Ireland, Scotland and Wales are different, and while no setting where someone is deprived of their liberty will be exactly the same as another, there are clear similarities between reports that demonstrate UK-wide concerns about conditions and treatment, which need national and collective solutions.

The professional and lay bodies that make up the NPM have deep expertise in the institutions and settings they scrutinise, the often very high quality of care and support in some, and the problems faced by each. The role of the NPM annual report is to pull together findings to identify systemic problems that may risk violating article 3 of the European Convention on Human Rights, currently or in the future.[1] The majority of sources used are NPM organisations' publications from the reporting year. Where these are not available, organisations have fed directly into the report through written contributions.

Over the year, the NPM has engaged in international processes aimed at preventing ill-treatment and improving standards in detention. One of these, the UN Human Rights Committee, concluded with the following concerns about UK detention settings, echoed in reports and statements by the Subcommittee on Prevention of Torture (SPT), European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and Special Rapporteur on Torture:

- high-risk conditions such as:
  - chronic overcrowding
  - poor living conditions
  - lack of purposeful regimes
  - information management
- solitary confinement of children
- the psychological impact of indeterminate sentences or indefinite detention
- mental health, self-harm, and self-inflicted deaths in detention

These concerns have been used as the main headings for the analytical part of this report, 'the state of detention in the UK', which presents NPM bodies' findings from 1 April 2023 to 31 March 2024. This reflects how findings from the work of the 3,500 individuals who carry out the OPCAT mandate in the UK inform the evidence submitted to international human rights mechanisms. These then set expectations of the Westminster and devolved governments to make changes that ensure the prevention of torture and ill treatment in the UK. While international attention this year has focused mainly on prisons, youth offender institutions and immigration detention, this report also discusses these concerns in other settings where people are deprived of their liberty, such as inpatient mental health settings, secure accommodation services for children and young people, or police and court custody. The joint work of the UK's NPM is then described to outline how the NPM can amplify and develop the preventive work carried out by each individual organisation. Throughout, the lead experts on scrutiny offer their insights on the settings they monitor, visit and inspect, to give a joint reflection on the key issues across the country.

1 Alongside other international law, the United Nations Convention against Torture, and the International Covenant of Civil and Political Rights (ICCPR) article 7.

The state of detention in the UK: NPM bodies' findings and analysis

High-risk conditions

Chronic overpopulation in criminal justice detention received much attention domestically and internationally and will be discussed in the next sub-section. However, looking at this only from the perspective of space – i.e. having enough buildings and rooms to detain people in – does not go far enough to prevent the long-term negative impacts of stretching services rather than changing them, re-assessing who needs them, and if something new is needed instead. It is not only the number of people in a space that affects crowding; the physical quality of that space, the capacity of staff to support them and a preparedness for the increasingly complex needs of individuals deprived of their liberty are all essential to ensure the fulfilment of the right not only to be free of ill treatment, but all the component rights such as rights to privacy, to an adequate standard of health and the inherent dignity of the human being.

In prisons, the continued rise in population led to various early release schemes throughout or shortly following the reporting year in England, Wales and Scotland and the reopening of previously decommissioned accommodation in Northern Ireland. The Scottish Parliament voted to approve Emergency Early Release for prisoners on short-term sentences who were already due for release in the near future.[2] In England and Wales, in October 2023 the Ministry of Justice began allowing prisoners to be released up to 18 days before their automatic release date, which increased to 70 days.[3]

This follows the launching of Operation Safeguard the previous year to use police custody cells in England and Wales to accommodate the prison population.[4] The incoming Westminster Government has extended the approach to early release, introducing a new early release initiative that will see some standard determinate sentences reduce from 50% to 40% of the original sentence. Unfortunately, these emergency schemes do not address recommendations about long-term impacts of a ballooning population across different settings and are only a short-term solution. Initiatives which help to prevent people entering prisons in the first place will do far more to address this problem in a way that supports individuals, employees and the public.

To take an example from secure care services for children and young people in England, overcrowding is not an issue in Secure Children's Homes (SCHs) as such settings are regulated and have a specific number of children they can look after according to their registration. However, homes in England cannot always use all placements and are overall at approximately 65% to 70% capacity, according to Ofsted, due to a range of factors. In England, there has been an increase over the last five years of children with highly complex needs, including mental ill-health, meaning they require higher ratios of staff, and cannot always live with other children due to risk.

2 **Emergency Early Release – Scottish Prison Service (sps.gov.uk)**

3 **What is the Government doing to reduce pressure on prison capacity? (parliament.uk)**

4 **PR 240: OPERATION SAFEGUARD – The POA (poauk.org.uk)**

In Scotland, an interim report by the Children and Young People's Centre for Justice and Dartington Service Design Lab reported that most children in secure care "felt a separate provision was needed for children requiring care and protection on mental health grounds, as secure care was deemed inappropriate and insufficient for the support they needed".[5] The Care Inspectorate's Secure Pathway Review, published in September 2023 further reflected that "almost half of young people in the sample had additional support needs such as neurodiversity, mental health conditions or learning disabilities".[6] In addition, difficulties in recruitment and retention of staff continue to challenge secure care services in England and in Scotland, making it harder for existing staff to provide continuous support. Old and no longer fit for purpose buildings are a problem cited by Ofsted in England, which mirrors reports from scrutiny bodies of other detention settings, particularly prisons.

In police custody, staffing has been the most reported thematic area of concern for independent custody visitors (ICVs), with reports that ineffective staffing particularly in terms of healthcare means some detainees are unable to access healthcare in a timely manner. The lack of female staff in custody settings, a topic of ongoing reports by ICVs, means some female detainees cannot be allocated a female member of staff as a point of contact. There are also impacts from lack of custody staff, impacting on detainee treatment, specifically access to showers and fresh air. Where healthcare practitioners are not fully embedded in custody units, detainees' continuity of care is disrupted and referrals are missed. Alongside this, there are significant delays in mental health assessments and transfers.[7] A lack of staff with the right training meant that in some cases children in custody were not supported by appropriately trained staff, and there were gaps in training on human rights, life support and resuscitation.

In health and social care settings in England, the number of Deprivation of Liberty Safeguards (DoLS) applications has continued to rise, far beyond the levels expected when the safeguards were designed. This means people in vulnerable circumstances are waiting for far too long without the right safeguards in place or being left without legal protections.

5 Reimagining Secure Care Interim Report – **Children and Young People's Centre for Justice (cycj.org.uk)**

6 **Secure Care Pathway Review – Care Inspectorate (careinspectorate.com)**

7 **Report on an inspection visit to police custody suites in West Midlands Police – His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (justiceinspectorates.gov.uk)**

Scrutiny statement: prisons

Across the prison estates in England and Wales, Northern Ireland and Scotland, rising prison populations and overcrowding, staff shortages and inexperience, and deteriorating infrastructure continue to create a strained environment. We have seen buildings that are not fit for purpose brought back into use, or two people being squeezed into single cells, to cope with more prisoners, without enough staff or wider infrastructure to adequately prepare them for release and manage risks of reoffending. The NPM recognises that responding to a surge in the prison population is challenging and resource intensive but it is not a reason to pause human rights and standards of care and treatment. It requires a sustainable response that provides reasonable alternatives to custody while providing safe custody that meets standards for those who need it.

A lack of staff to deliver or facilitate access to purposeful activity and education, as well as a shortage of activity spaces, restricted time out of cell, and increasing difficulties paying for basic items paints a picture of an impoverished regime. With lack of alternative activities, we see continued availability and demand for drugs, which does nothing to improve mental health or safety in prisons and prevents vital rehabilitative work. In addition, the lack of access to purposeful activity and an equitable regime is a growing problem for people held on remand, as the number of people on remand for long periods is growing.

We see a mixed picture on access to healthcare, especially mental health support. The long and often under-documented waits for prisoners requiring transfer to forensic mental health beds affects both individual well-being and overall prison safety. Segregation units are over-used to cope with serious mental health problems, leaving vulnerable prisoners at risk of irreversible harm and revolving through an untherapeutic environment, and prison officers and nurses struggling to care for some of the most unwell individuals.

The mental health consequences of Indeterminate Sentences for Public Protection (IPP) are well-documented, yet we must also consider the overlap with other similar sentences such as Orders for Lifelong Restriction (OLR) in Scotland and Indeterminate Custodial Sentences (ICS) in Northern Ireland. The prolonged uncertainty and lack of clarity surrounding release dates for those serving these sentences exacerbate mental health challenges and leaves prisoners feeling hopeless and in despair, which contributes to the unrest within our prisons.

It is clear that addressing these challenges requires more than isolated efforts; it necessitates effective joint working with key partner organisations. Effective collaboration between healthcare services, prison authorities, education and skills providers, the third sector and other relevant bodies was always important but is now essential to ensure that prisons have a chance of fulfilling their rehabilitative purpose.

Elisabeth Davies,
National Chair, Indepedent Monitoring Boards (IMB)

John Denvir,
Chair, Independent Monitoring Boards Northern Ireland (IMBNI)

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Chief Inspector, Criminal Justice Inspection (CJI)

Stephen Sandham,
Interim Chief Inspector, His Majesty's Inspectorate of Prisons for Scotland (HMIPS)

Charlie Taylor,
His Majesty's Chief Inspector of Prisons

Chronic overcrowding

Prisons

NPM reports throughout the year, including evidence to the UN Human Rights Committee, documented "cumulative deleterious effects" of chronic overcrowding, poor living conditions and lack of purposeful regimes in prisons.[8] The UK NPM's first annual report, published 15 years ago, already raised "concerns about the rising prison population and the overcrowding of prisons", and the adverse effect this had on all aspects of a prisoner's life.[9] The committee's concluding remarks include recommendations that the UK continue efforts to reduce over-population, particularly through application of non-custodial measures according to the Tokyo Rules. In October, the IMB provided written evidence to the Justice Select Committee inquiry into the future prison population and estate capacity, remarking on the negative impacts on decency, privacy, safety, progression and resettlement of crowding in prisons.[10] The UN Special Rapporteur on Torture made an international recommendation this year to improve the information available to policy and decision makers, monitoring bodies, prosecutors and judges on measures to improve conditions and measure capacity, as well as available alternatives to detention.[11]

In Scotland, the "stubbornly entrenched issue of overcrowding… reached a crisis point with a prison population far in excess of the ability…to provide a humane, rehabilitative experience".[12] One inspection saw small cells housing two prisoners in cramped conditions despite HMIPS repeating this concern throughout the last 10 years, with some shared cells well below the CPT's recommended minimum space.[13] Then Chief Inspector Wendy Sinclair-Gieben wrote to the Cabinet Secretary for Justice and Home Affairs on the issue of overcrowding in September 2023, and remarks in August 2024 that "the crisis has deepened". A review of conditions in Segregation and Reintegration Units (SRUs) found the physical environment to be dark, unstimulating and non-therapeutic – not fit for purpose given the very complex needs of many of the prisoners there.[14]

8 **Concluding observations on the eighth periodic report of the United Kingdom of Great Britain and Northern Ireland – International Covenant on Civil and Political Rights Human Rights Committee (tbinternet.ohchr.org)**

9 **First Annual Report 2009-10 – National Preventive Mechanism (nationalpreventivemechanism.org.uk)**

10 **Written evidence submitted by the National Chair of Independent Monitoring Boards for the Justice Select Committee inquiry into the future prison population and estate capacity** – IBM (committees.parliament.uk)

11 **Current issues and good practices in prison management – UN Human Rights Council (undocs.org)**

12 **Forward by HM Chief Inspector of Prisons for Scotland – HM Chief Inspector's Annual Report 2023-24 (prisonsinspectoratescotland.gov.uk)**

13 **HM Chief Inspector's Annual Report 2023-24 – HM Chief Inspector's Prisons for Scotland (prisonsinspectoratescotland.gov.uk)**

14 **A Thematic Review Of Segregation In Scottish Prisons – HM Inspectorate of Prisons for Scotland (prisonsinspectoratescotland.gov.uk)**

SRU cells and shared areas lack access to sensory, cognitive, physical or social stimulation – better access to natural light, bigger windows, improved air circulation, access to nature, and facilities for creative expression are all needed to facilitate improved mental health through sensory stimulation.

In Northern Ireland, a report of an unannounced inspection of Maghaberry Prison, published in June 2023, noted that a significant increase in the prison population in 2022 resulted in 376 prisoners sharing cells, with the first-night centre frequently close to overcrowding and that a rising prisoner population would "continue to hamper progress" at the prison.[15] A significant driver of the increased population in Northern Ireland was the proportion of people held on remand which was much higher than in other jurisdictions in the United Kingdom.[16] A significant increase in the population had undermined progress in personal development as dedicated staff had to be redeployed to work on residential wings, and the recruitment of new staff could not keep up with the increase.[17] An independent review of progress found that there were 200 more prisoners than at the full inspection, 100 of whom were held on remand. Almost 400 men continued to share cells, and older accommodation criticised by inspectors had been brought back into use to cope with the growing population. Resources had been redirected to provide additional psychology resource and interventions, but the service remained under-resourced and did not meet the many and varied needs of the increased prison population. Despite these challenges, the review found that time out of cell had increased from one hour to two, allowing for time outdoors, exercise, and eating outside of cells. However, there was no accurate method of recording time out of cell, which will be essential to ensure improvements are continuing and that men are not spending too long without meaningful interaction, access to the outdoors and minimum available exercise. At Magilligan Prison, an independent review of progress also noted an ongoing increase in the prison population alongside the legacy of the COVID-19 pandemic and a difficult financial climate as challenges to the delivery of prisoner development.[18] The significant increase in the female population at Hydebank Wood Women's Prison was also a concern.

Court custody

In some courts in England and Wales, Lay Observers report that people in custody are kept in overcrowded conditions with far too many detainees in a single cell.

Secure Training Centres

Oakhill Secure Training Centre (STC) is currently looking after around 70 children, which makes the living conditions cramped and poses challenges for the provider to meet the often-complex needs of children there, according to Ofsted.

15 **An unannounced inspection of Maghaberry Prison 20 September – 6 October 2022 – Criminal Inspection Northern Ireland (cjini.org)**

16 **The operation of Bail and Remand in Northern Ireland – Criminal Inspection Northern Ireland (cjini.org)**

17 **Report of an Independent Review of Progress at Maghaberry Prison – Criminal Inspection Northern Ireland (cjini.org)**

18 **Report of an independent review of progress at Magilligan Prison – Criminal Inspection Northern Ireland (cjini.org)**

Due to a lack of staffing on occasions to support this cohort, children have been restricted to their rooms for longer periods of time than necessary. Solitary confinement of juveniles is strictly prohibited by the United Nations Rules for the Protection of Juveniles Deprived of their Liberty when used as a punishment as it may compromise the physical or mental health of the juvenile concerned (Rule 67). Though not used as punishment in this case, the impacts of restricting children to their room must be taken seriously. Rule 32 requires the design of detention facilities for juveniles to be in keeping with the rehabilitative aim of residential institutions, with due regard for sensory stimuli, opportunities for association and participation in sports, exercise and leisure activities.

Secure 16 to 19 academies

The first of this new type of provision was registered by Ofsted on 8 August 2024 and has not yet been inspected. Secure 16 to 19 academies have dual status. They are registered with and inspected and regulated by Ofsted as secure children's homes and regulated by the Ministry of Justice as 16 to 19 academies. Secure 16 to 19 academies accommodate children who are remanded by the courts to custody or who are serving a custodial sentence.

Poor living conditions

Prisons

Living conditions had deteriorated in many prisons in England and Wales, with overcrowding exacerbating poor conditions.[19] HMI Prisons issued four urgent notifications, for example at HMP Bedford which was very dirty and overcrowded.[20] Bristol and Bedford had both previously received urgent notifications in 2018 and 2019, respectively. Two-thirds of IMBs criticised the physical disrepair of establishments with some described as "inhumane, without access to basic sanitations", while routine maintenance was made more difficult or impossible by population pressures.[21] Broken heating systems meant some prisoners were left in intolerably hot or cold temperatures, with poor ventilation, flooding and vermin posing additional problems.[22] Single cells are oversubscribed to the point that even people needing a single cell for health reasons are not guaranteed one. Older prisoners and those with physical disabilities could not always access cell doors and beds and sometimes resorted to unsafe means of moving around.

19 **HM Chief Inspector of Prisons for England and Wales Annual Report 2023-24 (cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

20 **HM Chief Inspector of Prisons for England and Wales Annual Report 2023-24 (cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

21 **Written evidence submitted by the National Chair of Independent Monitoring Boards for the Justice Select Committee inquiry into the future prison population and estate capacity** (committees.parliament.uk); **Independent Monitoring Board highlights significant concerns across places of detention in 2023 National Annual Report – Independent Monitoring Boards (imb.org.uk)**

22 **HM Chief Inspector of Prisons for England and Wales Annual Report 2023-24 (cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**; **Written evidence submitted by the National Chair of Independent Monitoring Boards for the Justice Select Committee inquiry into the future prison population and estate capacity** (committees.parliament.uk)

Older prisoners were accommodated in segregation units if there was no other appropriate accommodation.[23] Segregation units were frequently used for extended periods for prisoners needing to be separated due to conflict or while waiting for transfer in England and Wales.[24] According to the Nelson Mandela Rules, solitary confinement, which refers to confinement without meaningful human contact for 22 hours or more a day, should only be used in exceptional cases as a last resort, for as short a time as possible. It should be prohibited in cases of prisoners with mental disabilities if it would exacerbate these conditions (Rule 45). Prolonged solitary confinement refers to solitary confinement for a time period in excess of 15 consecutive days, beyond which time it may constitute inhuman and degrading treatment. The CPT notes that "solitary confinement can, in certain circumstances, amount to inhuman and degrading treatment; in any event, all forms of solitary confinement should be as short as possible".[25]

In Scotland, HMIPS report that "Scotland still has antiquated Victorian prison establishments" which have led to the decommissioning of cells and failing roof structures (at HMP Greenock) because of water leaks.[26] Independent Prison Monitors (IPMs) reported significant concerns arising from the long-term inadequacy of the building. While the reception area was renovated and holding cells previously described as "cupboard like" were replaced, there was limited ventilation and natural lighting due to the Victorian architecture of the building, and the infrastructure, combined with population constraints, meant daily showers were not possible for everyone (in fact only for those with physical jobs or gym sessions).Though the prison was generally clean, there was evidence of water run marks and mould and mildew.[27] All of this demonstrates the potential for negative impacts of outdated buildings and disrepair on health, hygiene and human dignity. The provision of adequate living standards also extends to health, nutrition and the cost of living. HMIPS found prisoners struggling with rising prices while there was no corresponding increase in wages for their work.[28] At HMP YOI Polmont, the daily food budget per prisoner meant it was increasingly difficult for the prison to provide fresh and nutritional meals, and HMIPS does not consider the budget for food across prisons in Scotland to be suitable to provide the nutrition necessary for a healthy life, recommending that the Scottish Prison Service and the Scottish Government review the food budget for all prisons in Scotland.[29]

23 **Written evidence submitted by the National Chair of Independent Monitoring Boards for the Justice Select Committee inquiry into the future prison population and estate capacity** (committees.parliament.uk)

24 **Independent Monitoring Board highlights significant concerns across places of detention in 2023 National Annual Report – Independent Monitoring Boards (imb.org.uk)**

25 CPT, 2nd General Report on the CPT's Activities, paragraph 56.

26 **HM Chief Inspector's Annual Report 2023-24 – HM Inspectorate of Prisons for Scotland (prisonsinspectoratescotland.gov.uk)**

27 **Independent Prison Monitoring (IPM) Findings Annual Report – HM Inspectorate of Prisons for Scotland (prisonsinspectoratescotland.gov.uk)**

28 Independent **Prison Monitoring (IPM) Findings Annual Report – HM Inspectorate of Prisons for Scotland (prisonsinspectoratescotland.gov.uk)**

29 **HMP YOI Polmont Full Inspection 2023 – August 2023** – HM Inspectorate of Prisons for Scotland (prisonsinspectoratescotland.gov.uk)

In Northern Ireland, improvements were visible at Magilligan Prison in cleanliness, with brighter and more welcoming communal areas. Perceptions of staff victimisation had not been addressed and no concerted action by leaders taken in this regard, despite having accepted the recommendation at two previous inspections.

Court custody

In England, though some conditions had improved in court custody previously inspected by HMIP, lack of accessible facilities in Surrey and Sussex courts meant people with mobility impairments were transferred a long way from home, with inadequate arrangements made to support them travelling home, while there were examples of cells not being clean enough and needing more regular maintenance.[30] Availability of activities also needed improvement in some court custody units (CCUs).[31] Routine handcuffing and searching occurred at all CCUs inspected by HMIP (England and Wales); though the position on handcuffing had improved at Surrey and Sussex, HMIP had concerns about whether its use was proportionate.[32]

Disproportionate or unnecessary use of handcuffs or searching can compromise detainee dignity. In Scotland, one CCU was underground and only accessible by a narrow staircase, which meant disabled detainees had to be held in witness rooms in the court.

Police custody

In England and Wales, inspections by HMICFRS identified ligature points; at one setting these had been identified at a previous inspection, with little done to mitigate risks as staff had not been briefed.[33] In Scotland, a police custody inspection found the design of the building and poor air conditions made interview rooms uncomfortable in warm weather, and though cells had natural light, their dual light setting was only controlled remotely at the charge bar.[34] Too hot or too cold temperatures can impact the ability to think clearly and complete everyday tasks which could also affect outcomes of interviews. This raises concerns over the right to autonomy and dignity, as well as the more direct impacts on the interview.

30 Report on an inspection visit to court custody facilities in **Surrey and Sussex July 2023 – HMI Prisons (hmiprisons.justiceinspectorates.gov.uk)**

31 Report on an inspection visit to court custody facilities in **Humber and South Yorkshire December 2023 – HMI Prisons (hmiprisons.justiceinspectorates.gov.uk)**

32 Report on an inspection visit to court custody facilities in **Bedfordshire, Hertfordshire and Cambridgeshire April 2023 – HMI Prisons (hmiprisons.justiceinspectorates.gov.uk)**; Report on an inspection visit to court custody facilities in **Surrey and Sussex July 2023 – HMI Prisons (hmiprisons.justiceinspectorates.gov.uk);** Report on an inspection visit to court custody facilities in **Humber and South Yorkshire December 2023 – HMI Prisons (hmiprisons.justiceinspectorates.gov.uk)**

33 **Report on an inspection visit to police custody suites in West Yorkshire Police – His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (justiceinspectorates.gov.uk)**

34 **HMICS Custody Inspection Report – Fife – HM Inspectorate of Constabulary in Scotland (hmics.scot)**

While temperature related discomfort can be a problem for all detainees, work by the Independent Custody Visiting Association on support for women going through menopause suggests this will have a disproportionate effect on this group, who should have access to cooler, temperature controlled cells if needed.[35]

Custody visitors in Scotland identified there is a lack of offering or making available suitable washing and shower facilities throughout the custody estate. This presents a concern about detainee hygiene and dignity.[36] When a person is detained in police custody for more than a day, they must be offered facilities to wash and/or shave at least once a day.[37] They also raised the issue of request culture in police custody, with detainees not always receiving their letter of rights, contacting a named person, or being told that reading material is available.[38] Custody visitors in Scotland note that healthcare provision is a particular challenge, as not all facilities have onsite medical provision which can lead to delays in accessing medication. Sometimes detainees are not informed how long they will wait which "can add to the anxiety and stress that detainees may already experience while in custody".[39]

The Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules) and the European Prison Rules both require that health standards be met with due regard for climatic conditions, air quality, minimum floor space, lighting and ventilation (Nelson Mandela Rule 13), and with adequate sanitary installations for all to use in a clean and decent manner whenever required (Rule 15, 16). All parts of a prison used by prisoners should be properly maintained and kept "scrupulously clean at all times" (Rule 17). Though the Nelson Mandela Rules and European Prison Rules apply to prisons, they are an example of expectations in other detention settings where OPCAT applies, such as police custody.

In England and Wales, lack of adequate risk assessment in police custody settings before strip searching or use of anti-rip clothing continues to raise concerns over detainee dignity, a building block of mental safety and integrity, and compliance with article 3. Some centres continued to use anti-rip clothing to manage risk, without good enough justification for its use. In Lancashire, anti-rip suits were used too often, without adequate justification, sometimes in response to behaviour rather than to manage risk. According to HMICFRS, "sometimes it is solely because the detainee won't answer the risk assessment questions".[40] In some cases force was used to remove clothing; where the removal of clothing is not justified in the first place this is an unnecessary and therefore unjustified use of force.

35 **The Menopause Transition Report from the Betterment (Healthcare) Working Group – ICVA (icva.org.uk)**

36 Police Performance Committee 12 September 2023 – Scottish Police Authority **(spa.police.uk)**

37 The Care and Welfare SOP section 35.

38 **Independent Custody Visiting Scotland (ICVS): Key activity for Q3 2023 (October – December) – Scottish Police Authority (spa.police.uk)**

39 Independent Custody Visiting Scotland Annual Report 2023-24 – Scottish Police Authority **(spa.police.uk)**

40 **Report on an inspection visit to police custody suites in Lancashire – HM Inspectorate of Constabulary and Fire & Rescue Services and Care Quality Commission (justiceinspectorates.gov.uk)**

As an area for improvement at a previous inspection, the lack of action taken has made it a cause for concern to HMICFRS. Elsewhere, dignity was not always ensured when a detainee's clothing was removed, and in general the management of risk was a problem.

ICVs in Scotland also raised concerns about the use of anti-ligature clothing, with a one-size approach meaning it was unfit for purpose for smaller and female detainees.[41] However, HMIC has noted that the Police Service of Scotland has resolved the issue of anti-ligature clothing and it has not seen evidence that this is an ongoing issue at the close of the reporting period. ICVA's work on anti-rip clothing has recommended that its default use in the absence of risk information should be stopped.[42]

In Northern Ireland, the Policing Board found that strip searches of young people and children were conducted according to "long standing custom and practice" instead of PACE Codes and guidance, with no challenges by senor staff despite questioning from Policing Board members, NGOs or public media.[43] This attests to the strong influence of workplace culture and leadership on practices and their impacts on detainee's treatment and dignity. It also demonstrates that the role of scrutiny does not end with publication of findings – real engagement from places of detention is needed to ensure human-rights safeguards are maintained in all settings. In June 2023, the Boards Human Rights Advisor published a report on the strip searching of children and young people in police custody, which report included a number of recommendations for PSNI to consider, including recommendation 8:

> **"PSNI should reconsider its oversight and governance arrangements for the strip searching of children in custody. In doing so it should consider the recent Custody Detention Scrutiny Panels guidance from the National Police Chiefs Council and the establishment of a Custody Scrutiny Panel, such as the one in place in Suffolk Constabulary to ensure that all strip searches are considered by external 'experts' such as Independent Custody Visitors and the NI Appropriate Adult Scheme provider, specially trained in the role."**

This recommendation was implemented and PSNI worked with the board to establish a Strip Searching of Juveniles Scrutiny Panel. This panel is chaired by a PSNI representative and consist of two representatives from the board's Independent Custody Visiting (ICV) Scheme and a member from the Northern Ireland Appropriate Adult Scheme. The first official panel was held on 28 February 2024 and examined the records in relation to all juvenile strip searches conducted between August 2023 and January 2024.

Health and social care

Under the Standards of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), patients have a right to a suitable standard of environment.

41 Police Performance Committee 12 September 2023 – Scottish Police Authority **(spa.police.uk)**

42 **Anti-Rip Clothing Update Report – ICVA (icva.org.uk)**

43 **Children and Young People: Strip Searching in Police Custody – Human Rights Review (nipolicingboard.org.uk)**

However, during inspections in England, CQC found some wards that were not clean, with food on floors, ripped furniture and a failure to ensure appropriate hygiene in food preparation areas, in one inspection the ward was infested by mice. In some cases, wards have closed due to the environments being unsafe.[44]

CQC's work so far this year on monitoring the MHA has shown that the unsuitable environment of inpatient wards continues to be a concern and mixed sex ward breaches continue to rise, which has safety implications for patients. People affected by mental ill health can at times act in disinhibited ways or may lack the mental capacity to make sound decisions about relationships. They may also have experienced abuse in the past, which might have contributed to their mental ill-health and which might leave them at risk of being exploited by others.

Lack of meaningful activity

Prisons

IMBs' overriding concerns in England and Wales, repeatedly put to ministers, relate to purposeful activity, time out of cell, staff shortages and material conditions.[45] This was also the area HMIP found to be the worst performing, out of four healthy prisons test areas, across England and Wales.[46] Though some individual establishments made improvements over the year, particularly open prisons which tended to provide better access to purposeful activity,[47] leadership priorities, national shortfalls in staffing and capacity for repairs, and the growing prison population, resulted in prisoners spending up to 23 hours a day in their cells in some prisons and inadequate purposeful activity, which heightened feelings of hopelessness and boredom, risk factors in self-harming behaviour.[48] Weekends in prison were particularly poor in England and Wales, with 60% of prisoners having less than 2.5 hours a day out of cell each day, some only leaving their cells for 45 minutes and in one prison only able to leave their cells to collect meals.[49] This makes it impossible to complete essential tasks like showering, cleaning their living space, submitting paperwork, contacting friends and family, and going outdoors. IMBs reported mouldy, poorly ventilated shower areas resulting from lack of time to complete cleaning duties.[50]

44 **The state of health care and adult social care in England 2023/24 – Care Quality Commission (cqc.org.uk)**

45 **Independent Monitoring Board highlights significant concerns across places of detention in 2023 National Annual Report – Independent Monitoring Boards (imb.org.uk)**

46 **HM Chief Inspector of Prisons for England and Wales Annual Report 2023-24 (cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

47 HMIP open estate inspections.

48 **Written evidence submitted by the National Chair of Independent Monitoring Boards for the Justice Select Committee inquiry into the future prison population and estate capacity** (committees.parliament.uk)

49 **A thematic review of weekends in prison by HM Chief Inspector of Prisons March 2023 (justiceinspectorates.gov.uk)**

50 **HM Chief Inspector of Prisons for England and Wales Annual Report 2023-24 (cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

The Nelson Mandela Rules require a minimum of one hour of suitable exercise in open air daily.[51] The UK government states prisoners "should be able to spend between 30 minutes and an hour outside in the open air each day".[52]

The interpretation of the prison rules in Scotland leaves remand prisoners with too few options to engage in meaningful activity. The IPM annual reports raised concerns that the regime was inadequate at several prisons, for example the Edinburgh report stated:

> **"One of the most significant issues for HMP Edinburgh during the year was the regime, or lack of it. All prisoners and staff raised concerns about the lack of evening activity. For too many prisoners the reality was they spent the majority of their day locked in their cell, particularly those on remand."**

At Maghaberry Prison in Northern Ireland, while body scanners and mandatory drug testing had begun to address the issue of drugs supply, the ongoing trading of medication in the prison suggests that demand has not changed.[53] There were more staff to support development but they were unable to fulfil their specialist function consistently due to being redeployed to residential units opened to facilitate an increase in population. The report emphasises that "efforts were being thwarted by staff shortfalls".[54]

Health and social care

Patients in hospital under DoLS in England continue to raise concerns about how staffing issues lead to a lack of therapeutic activities and a lack of one-to-one sessions with staff. Activities such as music, art or physical activity that are tailored to people's individual needs give people a sense of purpose and structure to each day and aid their recovery. Patients have described to CQC that a lack of these leads to boredom and could lead to patient-on-staff violence, patient-on-patient aggression or self-harm.[55]

Information management

Across the four nations of the UK and different detention settings, patterns of failure to record, share and use information compromises privacy, mental health, safety and scrutiny.

Police custody

For police custody, a Northern Ireland review of strip searching children and young people found PSNI responded to questions with inaccurate data (PSNI have promised to robustly address this issue to ensure no recurrence), while across the UK there is no nationally held data on the number of strip searches conducted in custody, who is searched and why, where they are searched or who is present.[56]

51 **Standard Minimum Rules for the Treatment of Prisoners – United Nations (unodc.org)**

52 **Prison life: Prisoner privileges and rights – GOV.UK (www.gov.uk)**

53 **Report of an Independent Review of Progress at Maghaberry Prison – Criminal Justice Inspection Northern Ireland (cjini.org)**

54 **Report of an Independent Review of Progress at Maghaberry Prison – Criminal Justice Inspection Northern Ireland (cjini.org)**

55 **State of Care 2023/24 – Care Quality Commission (cqc.org.uk)**

56 **Children and Young People: Strip Searching in Police Custody – Human Rights Review (nipolicingboard.org.uk)**

It is now mandatory for police forces to provide this data to the Home Office for England and Wales, but a lack of complete and disaggregated data prevents effective understanding and improvement of practices.

In England and Wales, some police custody centres did not collect key information on how many detainees needed assessment under section 2 of the Mental Health Act, or how long they waited. In police custody in Dorset, detainees wait too long for a Mental Health Act assessment when required, and then longer waits to be transferred to a mental health facility.[57] A lack of available data means there is no clear picture of how well the needs of people with mental ill health are met, and little joint work undertaken to improve outcomes. This obscured understanding of how custody services affect outcomes for detainees, or how to improve them.[58] Limited review of incidents on CCTV in some sites, and frequent use of PAVA in cells and corridors in others, meant that governance and oversight of use of force was unsatisfactory and forces could not always demonstrate that force and restraint were only used when necessarily justified or proportionate. The use of force must always be necessary and proportionate. Effective record-keeping is needed to interrogate why and how much force is used to hold officers to account, to prevent the possibility of wanton or arbitrary force.

Record keeping and observations also caused concern in some Scottish police custody inspections. At one, omissions in records of searches, cell visits, provision of food and drink and medicines, and washing facilities were a concern, and it was not clear if the problem lay in service provision or in record keeping.[59] CCTV observation in some sites was "not fit for purpose", being close to the charge bar and raising concerns about the privacy of vulnerable people subject to observation.[60] Elsewhere, written information regarding care plans and healthcare interventions and secondary mental health assessments was not well-shared between the healthcare provider and the custody centre.[61] At this inspection, separate IT systems meant updates on care plans were mainly delivered orally, leaving gaps in essential information. This means that staff in different settings along an individual's journey to or from court custody might not know relevant risk factors that might affect their health, safety, or treatment.

57 **Report on an inspection visit to police custody suites in Dorset – His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (justiceinspectorates.gov.uk)**

58 **Report on an inspection visit to police custody suites in West Yorkshire Police – His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (justiceinspectorates.gov.uk); Report on an inspection visit to police custody suites in South Wales Police – His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (justiceinspectorates.gov.uk)**

59 **HMICS Custody Inspection Report – Fife – HM Inspectorate of Constabulary in Scotland (hmics.scot)**

60 **HMICS Custody Progress Inspection report – Dumfries and Galloway – HM Inspectorate of Constabulary in Scotland (hmics.scot)**

61 **HMICS Custody Inspection Report – Tayside – HM Inspectorate of Constabulary in Scotland (hmics.scot)**

Court custody

In the small number of court custody units (CCUs) inspected this year in Scotland, inspectors found concerns regarding CCTV and information use in three inspections leaving areas of CCUs uncovered and preventing constant observation of anyone needing it.[62] In one location, failure to use information meant that two detainees were placed in the same cell despite recorded information of religious bias and sexual orientation bias of one of them, placing the other at risk.[63] There were other empty cells available. States have a proactive duty to ensure the safety of those under their care and such avoidable risks to individual safety raises concerns around measures to ensure all UK authorities and their staff are aware of measures to safeguard individuals from discrimination, physical or mental harm. Important questions regarding risk were not asked or documented by the staff on the arrival of people into custody and they were not read their rights or ensured to have understood their rights on arrival. Though staff were particularly good at spending time with detainees and identifying their needs, physical and mental condition, this information was not updated on the GEOAmey IT system for hours after initial interactions.

In England and Wales, digital person escort records were not always thorough and staff were not always consistently briefed on risks in court custody.[64] Individual staff statements justifying use of force were not sufficient enough, and quality assurance not sufficiently rigorous. However, leaders had set up an email service which allowed custody, escort and HM Court and Tribunals service staff to communicate effectively, allowing real-time exchange of information which reduced delays.

Mental health detention

The Mental Welfare commission for Scotland conducted a review of repeated uses of police place of safety powers under the Mental Health Act, finding that some people are repeatedly brought to mental health services by police services under section 297 of this Act.[65] Around 35% of people who are repeatedly detained under this provision did not have a recorded care plan, which raises concerns that important information which would support wellbeing or recovery is lacking. The review recommended that all people who are subject to repeated section 297 detention have a trauma-informed, person-centred care plan that includes a crisis plan. Further, it recommended a review of Standard Operating Procedure by Police Scotland to ensure that no patients are subject to unnecessary detention if they are willing and have capacity to be assessed voluntarily. Health boards should ensure that their psychiatric emergency plans do not create an inadvertent expectation that patients be detained by police services in order to access an urgent mental health assessment.

62 **Report on Inspection of the court Custody Provision, Selkirk Sheriff Court 18 May 2023 – HM Inspectorate of Prisons for Scotland (prisonsinspectoratescotland.gov.uk); Report on Inspection of the court Custody Provision, Forfard Sheriff Court 26 April 2023 – HM Inspectorate of Prisons for Scotland (prisonsinspectoratescotland.gov.uk)**

63 **Report on Inspection of the court Custody Provision, Forfard Sheriff Court 26 April 2023 – HM Inspectorate of Prisons for Scotland (prisonsinspectoratescotland.gov.uk)**

64 Report on an inspection visit to court custody facilities in **Surrey and Sussex July 2023 – HMI Prisons (hmiprisons.justiceinspectorates.gov.uk)**

65 The role of police officers in mental health support – **Mental Welfare Commission for Scotland (mwcscot.org.uk)**

Scrutiny statement: forensic mental health and inpatient mental health

As the UK NPM, we are entrusted with scrutinising the conditions and treatment experienced by individuals detained in mental health settings across the United Kingdom. The most pressing issues we see are staffing challenges such as high vacancies of qualified staff, increased staff absence and a growing reliance on agency personnel. A consistent and well-supported team who feel able to raise concerns when needed is essential to the safety and effectiveness of mental health wards. However, too often, staff are left under-supported, and a culture of blame leads to a workforce that feels isolated rather than empowered. This does not provide a consistent, predictable and person-centred quality of care which those deprived of their liberty in these situations need and deserve to facilitate recovery and rehabilitation.

Furthermore, compliance with mandatory training remains inconsistent, particularly in areas such as conflict de-escalation and the use of force. It is vital that all staff in mental health and social care settings are equipped with the skills and knowledge required to manage challenging situations safely and effectively. Otherwise, both staff and patients are placed at greater risk, undermining safety and the overall quality of care while patients are detained.

Resource shortages are contributing to unacceptable delays in transferring individuals from prison to appropriate mental health care facilities. These delays, which are not well-enough documented, compromise the treatment and recovery of some of the most vulnerable individuals in our society while they wait in often untherapeutic settings which cannot meet their mental health needs. In Northern Ireland, the current Mental Health Order legislation – which does not allow for the deprivation of liberty of individuals with a working diagnosis of personality disorder, leading to a high and increasing number ending up in prison, where they cannot be adequately supported.

The resourcing issues across health and social care are well known and are not limited to forensic or high-secure settings. Continuous over-occupancy of inpatient mental health services leads to significant issues for individuals with mental ill health or learning disabilities requiring admission for assessment and treatment. However, the impacts they have on those deprived of their liberty tend to be hidden from public awareness due to their closed nature. It is where gaps in services create the highest risk of poor conditions and ill-treatment, preventing an adequate service to support those acutely in need of support, and to promote patient and public safety. Alongside the sometimes poor condition of the mental health hospitals estate and lack of beds and community provision, these risks are magnified.

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Chris Dzikiti,
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Wendy McGregor,
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John Powell,
Director of Mental Health, Healthcare Inspectorate Wales (HIW)

Solitary confinement of children

HMIPS reported on the relative lack of access to one hour a day in fresh air in Scotland's YOI Polmont, with children spending long periods locked in their rooms. 46% of children in the YOI setting did not report being able to spend more than two hours outside their cell each day, 38% of young people in the adults estate, compared to 29% of adults from other age brackets.[66] In England, all IMBs monitoring YOIs noted staffing shortages leading to additional limits on time out of cell, particularly at weekends.[67] Across YOIs many children reported spending "most of their sentence locked up alone in their cell with very little human contact".

> **"Despite employing hundreds of staff and dozens of managers, most sites were unable to deliver one meaningful conversation with each child a week."[68]**

Insufficient progress in behaviour management measures was a leading factor in time spent in cell across the UK, as violence remained high and children were kept in their cells to minimise contact with other children. This further limited access to education and activities. The Children's Commissioner for England's (CCE) visits to YOIs found that "the great majority of children in custody are being detained in unacceptable and unsafe conditions".[69] Children at HMYOI Cookham Wood were worried about safety, weapons, education and a "chaotic regime".[70]

National Chair of the IMBs Elisabeth Davies wrote to the Minister for Justice in July 2023 as long-standing concerns about restricted and unpredictable regimes, limited time out of room, lack of purposeful activity and spikes in violence had heightened to an "endemic" rate in England.[71] Separated children could spend more than 23 hours a day inside their rooms, and some establishments struggled to keep up with the increasing cohort of children with complex needs. IMBs have described the two hours out of cell over a whole weekend at Wetherby as "inhumane".

66 **Young People's Experiences of the Scottish Prison System – HM Inspectorate of Prisons for Scotland (prisonsinspectoratescotland.gov.uk)**

67 **Written evidence submitted by the National Chair of Independent Monitoring Boards for the Justice Select Committee inquiry into the future prison population and estate capacity (committees.parliament.uk)**

68 **Children in custody 2022-23: An analysis of 12-18-year-olds' perceptions of their experiences in secure training centres and young offender institutions, November 2023 (cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

69 **Children's Commissioner raises concern about the possible introduction of incapacitant spray into Young Offenders Institutions – Children's Commissioner for England (childrenscommissioner.gov.uk)**

70 **Children's Commissioner's concerns about Cookham Wood and children in custody – Children's Commissioner for England (childrenscommissioner.gov.uk)**

71 Safety and Regime in the Youth Estate – IMB **(cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

HMYOI Cookham Wood was closed in 2024 (with plans to re-open as an adult male prison), and children were due to be released to secure training centres, other YOIs, or to adult prisons upon turning 18.[72]

An independent review of progress carried out in March 2024 noted that the key weakness of very limited time out of cell remained a problem, with children able to spend an average of less than three hours outside their room a day, with many seeing much less than this. With such limited activity children had less motivation to behave well which increased risks to safety. Though published outside the reporting period, HMIP issued Cookham Wood with an urgent notification, the fifth issued to an establishment in the youth estate since the process was introduced. The Inspectorate had found acceptance of very low standards of behaviour, a lack of activity and widespread use of solitary confinement, and stated "over a quarter of the children were completely segregated from the main population, and at the time of our inspection, 90% were subject to 'keep apart' arrangements, with staff managing 583 individual conflicts in a population of 77".[73]

In secure children's homes (England), there are regulations governing the use of 'single separation' (where children are locked into an area, usually their bedroom) and 'managing away' (where children are locked into an area but with staff present). English Regulations define that these measures of control must be used proportionately and only when there is a significant risk to the child or others or serious damage to property that cannot be managed any other way. In the last year, Ofsted found that in two SCHs, there was inappropriate use of single separation and managing away during the reporting year.

This led to Ofsted taking enforcement action by serving compliance notices. These are legal notices that set out clearly what the home is expected to do and by when to reduce harm and improve children's experiences. Both homes responded fully to the notices and ceased the poor practice. All other SCHs were applying the practice appropriately. In general terms, Ofsted found most SCHs help to keep children safe and providing a good environment for children to be looked after. At Oakhill STC, single separation and managing away are being used appropriately.

Outside of secure care provision, Lay Observers in England and Wales are concerned about the way children are kept in locked cells for long periods when they are in court custody.[74] Despite a tacit agreement that children should be in non-cellular accommodation, very few court custody suites have any facilities other than cells in which to keep children. LOs have sometimes observed children in cells but with the door open and trained staff communicating with the child. This is rare, with the majority of children still placed in locked cells.

72 **Report on an independent review of progress at HMYOI Cookham Wood by HM Chief Inspector of Prisons 9-17 April 2024 (cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

73 **HMYOI Cookham Wood Urgent Notification – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)**

74 **Lay Observers Annual Report 2022-2023 (cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

The Human Rights Committee echoed concerns over children detained in their rooms up to 23 hours a day, recommending effective limits to administrative or disciplinary segregation, that it be used only as a measure of last resort, for as short a time as possible, with use of measures such as judicial review. The Nelson Mandela Rules (45) require the above considerations and emphasise that isolation should never be used for children in criminal justice. The committee expressed particular concern about the use of segregation, solitary confinement, restraints and strip searches in young offenders' institutions in Scotland.

The United Nations Committee on the Rights of the Child published concluding observations on the UK in June 2023, including deep concern about "the draconian and punitive nature of [the UK's] child justice system" and the "continued use of solitary confinement on children, and segregation and isolation in child detention facilities".[75] Scotland incorporated the United Nations Convention on the Rights of the Child in 2024.[76]

NPM reports from the reporting year suggest that either through lack of resourcing (inadequate staffing, unsuccessful behaviour management programmes), lack of effective use of resources, or lack of knowledge (of relevant codes of practice, of best-interests principles), children are isolated in not only YOIs and secure care services, but at any stage of the criminal justice system. As children are still developing socially, psychologically and cognitively, they are particularly vulnerable to the negative effects of isolation and lack of meaningful contact.[77] This can amount to a breach of ECHR article 3 and the UK's Human Rights Act, as was acknowledged by the UK in December this year when it accepted that a 15-year-old boy with serious mental health problems was subjected to "inhuman and degrading treatment" through solitary confinement, when he was locked alone in his cell for more than 23 hours a day for 55 days at Feltham Prison.[78]

75 **Concluding observations on the combined sixth and seventh periodic reports of the United Kingdom of Great Britain and Northern Ireland – United Nations Committee on the Rights of the Child (tbinternet.ohchr.org)**\

76 **United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act (legislation.gov.uk)**

77 **The use of solitary confinement in the youth secure estate – BMA (bma.org.uk)**

78 **Government agrees that treatment of 15-year-old boy in solitary confinement breached Article 3 of European Convention on Human Rights – The Howard League (hoardleagure.org)**

Scrutiny statement: children deprived of their liberty

As the organisations responsible for the oversight of conditions and treatment for children deprived of their liberty across the United Kingdom, our shared expectation is that every child within these services receives the care, support, and opportunities they need to thrive.

One of the most concerning practices observed in young offenders institutions is the excessive time children spend in their rooms without meaningful human contact. In some cases, this amounts to solitary confinement, which is deeply damaging to a child's mental and emotional wellbeing. Secure environments must be places where children feel supported, not isolated. The practice of confining children in their rooms for extended periods must be addressed as a matter of priority. Compounding this issue are challenges with recruitment and staffing. The shortage of qualified staff has led to additional limits on children's time out of their rooms, particularly during weekends when staffing levels are often lower. This situation further restricts children's access to activities, education and social interaction, all of which are critical to their development and rehabilitation. Under-provision of appropriate mental health provision for children means that children are sometimes held in secure accommodation when these are not best placed to meet their needs.

Another critical area of concern is the need for better inter-agency collaboration to ensure that children are moved to a registered service that meets their individual needs. If children are left in secure settings longer than necessary due to lack of a suitable placement, this delay can have serious consequences for their development and wellbeing. Co-ordinated efforts between agencies to find appropriate, timely placements is essential.

Finally, there is a significant drop-off in support for children when they turn 18. As children transition out of secure care, many young people find themselves without the necessary support structures in place, leaving them vulnerable to further challenges. It is essential that these young adults are given the support they need to successfully reintegrate into society and continue their journey towards independence.

Despite these challenges, there are examples of good practice where committed staff and effective leadership are making a positive difference in the lives of the children in their care. In Wales, a consistent, child-centred, trauma-informed practice provides good experiences and wellbeing for the children in the secure unit. While material improvements are needed to facilitate individualised care, children have access to education, clinical support, and opportunities to be healthy and enjoy themselves. This is thanks to the efforts made by staff and managers. In England, most Secure Children's Homes keep children safe in a good environment, while in Scotland, four secure accommodation services demonstrated good outcomes for children with strong leadership, where staff were confident raising concerns, with robust support plans and strong relationships with families outside. These examples show what is possible when the right approaches and working culture are in place and can flourish. As we move forward, it is vital that these positive practices are shared, resourced and implemented more widely across the sector.

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Care Inspectorate Wales (CIW)

Jackie Irvine,
Chief Executive,
Care Inspectorate (CI)

Sir Martyn Oliver,
His Majesty's Chief Inspector at Ofsted

Additional issues for children deprived of their liberty in the UK

The loss of support in place for children once a young person reaches 18 years of age was a concern explored at the 2024 NPM conference. In Scotland, where the majority of people under 25 are held in the adult estate, HMIPS found that young people were not accessing opportunities to gain qualifications, education, work experience or rehabilitation.[79] Young people reported "mental stress caused by the extensive periods they were forced to spend locked in their cells rather than engaging in productive and meaningful activity".[80] This concern also related to children moving on from secure provision in England – Ofsted has emphasised the importance of multi-disciplinary and multi-agency collaboration in proper planning, noting that this should begin from the moment children arrive at a SCH or STC.[81] Local authorities are responsible to find the next place for a child that meets their individual needs, and some authorities leave it too late to plan.

This can lead to children placed for welfare reasons under section 25 of the Children Act 1989 being deprived of their liberty for more than the minimum time necessary, as some authorities have asked courts to extend welfare orders until they can find a suitable next place. This can also undermine the support provided to children in secure care through the uncertainty and anxiety caused.

In Scotland, Care Inspectorate inspections of four secure accommodation services found good outcomes for children and young people where there was strong leadership and staff were confident to raise concerns, deliver robust support plans and maintain strong relationships with families outside the service.[82] Where services worked collaboratively with external bodies such as the NHS, outcomes for children and young people were improved by thorough individual care plans on admission, a range of organisations to champion young people's needs and effective work of specialist staff alongside care and education staff.[83] On the other hand, services that had gaps in communication with external stakeholders and less management oversight faced increased risks of ineffective child protection investigations.[84]

79 **Young People's Experiences of the Scottish Prison System – HMIPS (prisonsinspectoratescotland.gov.uk)**

80 **Young People's Experiences of the Scottish Prison System – HMIPS (prisonsinspectoratescotland.gov.uk)**

81 **The importance of good planning for children moving on from the secure estate – Ofsted: social care (blog.gov.uk)**

82 Rossie Secure Accommodation Service Inspection Report – Care Inspectorate **(careinspectorate.com)**

83 Rossie Secure Accommodation Service Inspection Report – Care Inspectorate **(careinspectorate.com)**; Kibble Safe Centre Secure Accommodation Service Inspection Report – Care Inspectorate **(careinspectorate.com)**

84 St. Mary's Kenmure Secure Accommodation Service Inspection Report – Care Inspectorate **(careinspectorate.com)**

The sector wide challenges with recruitment and staffing meant there were significant challenges in two services which, despite certain robust mitigating actions, still had an impact on young people.[85] Where services had higher retention of staff and less reliance on agency staff, children were more confident knowing who was providing their support to build positive relationships.[86]

In England, CQC notes concerns that some children subject to deprivation of liberty orders issued by the courts fall outside of CQC's regulation if they are not receiving a regulated activity, such as personal care. For children deprived of their liberty further to applications made under the Children Act 1989 or the inherent jurisdiction of the High Court, CQC is also unable to comprehensively capture accurate numbers, locations or conditions imposed by the courts even if these children are in receipt of regulated activities. Without adequate information about who is deprived of their liberty and where, NPMs are unable to effectively scrutinise their conditions and treatment.

In Northern Ireland, the Regulation and Quality Improvement Authority's (RQIA) inspection of the Regional Secure Centre for children found good outcomes for children and young people. Improvements were found in admission and discharge pathways and the use of restrictive practices. Staff working in the centre had access to therapeutic support provided professionals which informed and strengthened their therapeutic approach to the children and young people.

A Care Inspectorate Wales (CIW) inspection of the Secure Accommodation Service in Wales found good outcomes and wellbeing for children, who felt safe, secure and well supported by staff who worked in a well-embedded child-centred culture. Staffing levels were adequate and training was available, though the service still faced challenges with staff retention. Safeguarding care planning and behaviour support and management were all effective and supported by a clear management structure.

85 Good Shepherd Centre Bishopton Secure Accommodation Service Inspection Report – Care Inspectorate **(careinspectorate.com)**

86 St. Mary's Kenmure Secure Accommodation Service Inspection Report – Care Inspectorate **(careinspectorate.com)**

Scrutiny statement: court custody

Our shared concerns in court custody across the UK are mirrored in other detention settings: the impact of staff shortages and the lack of arrangements for people following release. These highlight how investment in those working both within and around detention settings is crucial to ensure the safety of the public and those journeying through criminal justice systems in the UK.

Staff shortages have been a pervasive issue in courts, contributing to extended times in custody, late arrivals at court, and delays in transferring detainees to prison after hearings. These delays not only cause unnecessary stress and anxiety for detainees but also impact the overall efficiency and fairness of the justice process. Insufficient arrangements for detainees following their release leaves many released without means to get home or experiencing long waits for approval of their release by prison governors.

The physical condition of court custody cells is also a problem, where cells are often not sufficiently cleaned or maintained, particularly over weekends. In England and Wales, poor quality food is often a problem as well.

Troubling circumstances for children and young people in court custody in Northern Ireland have also been noted by Lay Observers in England and Wales. These include a lack of consistent suitable accommodation, and not always being accompanied by or receiving support from appropriately trained or specialist officers. This gap in care and protection is unacceptable and must be addressed to ensure the safety and well-being of young people in the custody system.

Finally, monitors have observed high numbers of detained persons with significant mental health issues, as well as an increase in the number of detainees with physical disabilities. The material conditions of cells are particularly important in terms of accessibility and physical safety, while the rising number of detainees with such conditions underscores the need for more tailored care and accommodation within court custody units.

However, it is important to recognise areas of good practice where multi-agency relationships work well, leading to visible improvements in conditions, more prompt processing of detainees, and proactive leadership in addressing issues that compromise detainee treatment. These examples provide a model for how court custody can and should operate, offering a standard to which all facilities should aspire.

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Stephen Sandham,
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David Whalley,
Lay Observers

The psychological impact of indeterminate sentences or indefinite detention

Immigration detention

Following the NPM's evidence to the UN Human Rights Committee's examination of the UK (March 2024), the committee's questioning of UK representatives and concluding observations included ongoing concerns over the length of time migrants are held in UK immigration detention and the expansion of application of detention under the Illegal Migration Act 2023.[87] The committee recommended that the UK establish a statutory time limit on immigration detention and ensure detention is only used as a measure of last resort and for the shortest possible period of time, increasing use of alternatives to detention, especially for children and pregnant women.

The Council of Europe Committee for the Prevention of Torture (CPT) published a report on its 2023 visit to UK immigration detention sites in February. NPM findings from the last year are reflected in the CPT's recommendations concerning delays and poor communication regarding provision of bail accommodation in the community, leaving people in detention for weeks or months while waiting for accommodation decisions (not least because of the challenge of finding suitable provision in the community).[88] The CPT was concerned about the application of Detention Centre Rule 35 concerning identification of vulnerable detainees, following NPM observation of poor implementation of the Detention Centre Rules, including ineffective safeguarding processes and ongoing detention despite identification of vulnerabilities or a history of torture.[89] HMIP reported a "worrying rise" in disturbances in immigration detention caused by the growth in population and "desperately slow decision-making from the Home Office"; a large proportion of detainees are released into the community with "no reasonable possibility of deportation".[90]

The CPT found that good practice is undermined by uncertainty of length of detention and the use of prison-like centres in some cases.[91] The UK government of February 2024 responded that the introduction of a time limit would "seriously constrain [their] ability to maintain the right balance and uphold the integrity of the immigration system". The prohibition on torture is absolute; if conditions amount to ill-treatment, there can be no justification. Indefinite detention and lack of information on individual case progress has significant negative impacts on health and wellbeing.[92]

87 **Concluding observations on the eighth periodic report of the United Kingdom of Great Britain and Northern Ireland – United Nations Human Rights Committee** (tbinternet.ohchr.org)

88 **Council of Europe anti-torture Committee (CPT) publishes report on its 2023 ad hoc visit to the United Kingdom on immigration detention – CPT (coe.int)**

89 **Independent Monitoring Board highlights significant concerns across places of detention in 2023 National Annual Report – Independent Monitoring Boards (imb.org.uk)**

90 **HM Chief Inspector of Prisons for England and Wales Annual Report 2023-24 (cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

91 **UK NPM response to the CPT report and UK Government Response – National Preventive Mechanism (nationalpreventivemechanism.org.uk)**

92 **Independent Monitoring Board highlights significant concerns across places of detention in 2023 National Annual Report – Independent Monitoring Boards (imb.org.uk)**

Indeterminate sentences in prisons

Imprisonment for public protection (IPP) sentences were indeterminate sentences given to serious offenders in England and Wales who posed a significant risk of serious harm to the public. IPP sentences were abolished in 2012 but not retrospectively, meaning 1,180 prisoners in England and Wales are still subject to an ongoing indefinite sentence under IPP.[93] In December, the UK's House of Commons adopted partial reforms to the system, which halved the amount of time those released were subject to recall but did not change the sentences of any IPP prisoners still in prison.[94] In a written submission to the Justice Committee Inquiry on future prison and estate capacity, HMIP outlined that prisoners serving long or indeterminate sentences are unable to progress where accredited programmes aimed to reduce reoffending are unavailable.[95] Where such programmes have not been completed, the parole board is less likely to recommend release, which can increase prisoners' feelings of hopelessness, contributing to a heightened risk of suicide and self-harm.

IMBs note that the "ongoing hardship" of IPP sentences is likely to contribute to the increased display of behaviours' associated with serious mental ill health or personality disorder in care and separation units (CSUs), as well as with regularly repeated and prolonged stays in isolated conditions.[96] IMBs observe IPP prisoners at increased risk of suicide and self-harm and have also identified the frustration and hopelessness of an indefinite sentence as a contributor to violent incidents, posing serious safety implications.[97] The UN Special Rapporteur on Torture has called throughout the year for an urgent review of IPP sentences, outlining concerns that ongoing indefinite sentences amount to psychological torture.[98] The NPM considers ongoing indeterminate sentences to have visible and measurable negative impacts on the mental health of individuals in prison. The UK has a responsibility to those under its authority to respect, protect and fulfil their rights, including to the highest attainable standard of mental health. However, despite knowing the impacts of these sentences, it has not amended them.

93 Written evidence submitted by His Majesty's Inspectorate of Prisons **(committees.parliament.uk)**

94 **MoJ reforms on IPPs, parole and the Independent Public Advocate welcome, but IPP changes do not go far enough, Justice Committee warns – UK Parliament (committees.parliament.uk)**

95 Written evidence submitted by His Majesty's Inspectorate of Prisons **(committees.parliament.uk)**

96 **Segregation of men with mental health needs – Independent Monitoring Boards (imb.org.uk)**

97 The impact of IPP sentences on prisoner's wellbeing – Independent Monitoring Boards (imb.org.uk)

98 UK: UN torture expert calls for urgent review of over 2,000 prison tariffs under discredited IPP sentencing scheme – OHCHR (ohchr.org); **Reform of problematic UK sentencing system welcome but bolder action needed says UN Special Rapporteur on torture – OHCHR** (ohchr.org)

Though IPP sentences are no longer issued in England and Wales, an Order of Lifelong Restriction (OLR) in Scotland (introduced in 2006) and Indeterminate Custodial Sentences (ICS) (2008) in Northern Ireland, are still active. Under an OLR there is no fixed release date, and when the 'punishment' element of the sentence is served, the Parole Board decides whether an individual can be released.[99] If released, those with an OLR are subject to supervision by the Risk Management Authority (RMA) for the rest of their life. Similarly, the ICS has no release date and prisoners will remain in custody until they demonstrate to the Parole Commissioners for Northern Ireland (PCNI) that they can be released safely.[100] However, where ICS prisoners are not released, they must be referred again to the PCNI within two years. Once released, standard and bespoke licence conditions apply for at least 10 years, and potentially for the rest of the individual's life. The same concerns exist about the possible impact of these indeterminate sentences, though they do not currently receive the same public scrutiny.

99 **About the OLR – Risk Management Authority (rma.scot)**

100 **Indeterminate Custodial Sentences (ICS) – Parole Commissioners for Northern Ireland (parolecomni.org.uk)**

Scrutiny statement: immigration detention

As the appointed bodies responsible for the inspection and monitoring of immigration detention facilities in the United Kingdom, we have observed growing challenges over the last year. Jail-like settings, coupled with an increasing population, a significant proportion of whom are vulnerable or have complex needs, are driving unrest and self-harm among detainees. Such conditions do not support dignity and well-being.

One of the most urgent issues Independent Monitoring Boards have identified is that detained people in Short-Term Holding Facilities are not able to access their prescribed medication. This places individuals at risk of medical deterioration, exacerbating any vulnerabilities and undermining health. Access to necessary medical care is a fundamental right that detention settings have a responsibility to fulfil.

Another shared concern is the uncertainty surrounding the length of detention. Many individuals experience prolonged and indefinite periods of detention due to slow Home Office decision-making processes and a lack of timely updates on their cases. This uncertainty causes distress and anxiety, contributing to a growing sense of hopelessness among those detained. In too many cases, people are detained despite no realistic prospect of deportation, raising questions about the justification of their continued confinement. In other cases, people continue to be detained despite having been granted bail, due to a lack of suitable accommodation in the community. This ongoing, unnecessary detention casts doubt on the principle that detention is used only as a last resort, in line with the principles of fairness and justice.

We are also deeply concerned about the poor use and application of Rule 35 assessments, which are intended to ensure that vulnerable individuals, such as those who have been tortured or are otherwise at risk, are not inappropriately detained. The shortcomings in the implementation of these vital protections are leaving some of the most vulnerable people at continued risk. Administrative detention (deprivation of liberty to process arrivals or to ensure removal from the UK) must only ever be used lawfully and as a last resort. While people are detained by UK authorities, it is the authorities' responsibility to maintain their safety and dignity. This year, it has not been evident that the UK is always fulfilling this responsibility.

Elisabeth Davies,
National Chair, Indepedent Monitoring Boards (IMB)

Charlie Taylor,
His Majesty's Chief Inspector of Prisons

Mental health, self-harm, and self-inflicted deaths in detention

The Human Rights Committee's examination of the UK concluded with concern over the increase in self-inflicted deaths and self-harm in custody and recommended increasing preventive efforts and thorough, independent investigations into all cases.

Prisons

NPM bodies report poor and deteriorating mental health in criminal justice detention. In England and Wales it is estimated that half of people entering prison are neurodivergent.[101] HMIP and IMBs in England and Wales continue to be concerned that women are sent to prisons solely based on mental-health.[102] An HMICS thematic review of policing mental health considered it unsustainable for Police Scotland to continue without a mental health strategy, as a basis for staff training and understanding.[103]

Concerns have been raised repeatedly by IMBs and HMIP in England, HMIPS and IPMs in Scotland, and by CJI in Northern Ireland that Care and Separation units (in England), Care and Supervision Units (in Northern Ireland) (CSUs) and Separation and Reintegration Units (in Scotland, SRUs), all also referred to here as segregation units, are not the appropriate place to hold prisoners with mental health needs. Mental wellbeing and behaviour often deteriorated through prolonged segregation, while rotation between different segregation units, healthcare units (where applicable) and short periods on wings posed challenges in tracking total time spent in isolation.[104] Solitary confinement refers to the confinement of prisoners for 22 or more hours a day without meaningful human contact, while prolonged solitary confinement begins once a person has been held in such conditions for 15 days (Nelson Mandela Rule 44). It is absolutely prohibited for solitary confinement to become prolonged or indefinite, which equates to torture, cruel, inhuman or degrading treatment or punishment (Nelson Mandela Rule 43a), and accurate measurement is essential to ensuring this is not occurring.

In Scotland, HMIPS found that due to systemic issues, segregation is overused across the prison estate and used for too long for many individual prisoners, and that segregated prisoners were not able to access two hours meaningful human contact a day.[105] There was not enough availability of purposeful activity or regime for those in SRUs, and staff needed better training in mental health, therapeutic and trauma-informed approaches to prisoner management.

101 **Current issues and good practices in prison management – United Nations Human Rights Council (undocs.org)**; Her Majesty's Inspectorate of Prisons and Her Majesty's Inspectorate of Probation, Neurodiversity in the Criminal Justice System: A Review of Evidence (2021), page 8.

102 **Independent Monitoring Board highlights significant concerns across places of detention in 2023 National Annual Report – IMB (imb.org.uk); Community Sentences: response to the Justice and Home Affairs Committee inquiry from His Majesty's Inspectorate of Prisons – HMI Prisons (hmiprisons.justiceinspectorates.gov.uk)**

103 **HMICS Thematic review of policing mental health in Scotland** – HM Inspectorate of Constabulary in Scotland (hmics.scot)

104 **Segregation of men with mental health needs: A thematic monitoring report** – IMB (imb.org.uk)

105 **A Thematic Review Of Segregation In Scottish Prisons – HM Inspectorate of Prisons for Scotland (prisonsinspectoratescotland.gov.uk)**

Key findings of HMIPS' Thematic Review of Segregation in Scottish Prisons included over-use of SRUs across the estate, and "too many prisoners spending detrimentally long periods in SRUs".[106] Prisoners in SRUs could not generally access a minimum of two-hours meaningful human contact a day as outlined in the Nelson Mandela Rules. There was increasing and inappropriate use of SRUs to keep extremely mentally unwell prisoners safe where they had not been assigned beds in secure psychiatric facilities, and not enough was done in prisons to address individual problems that could lead to relocation to SRU and prevent reintegration. The physical environment of SRUs is generally not fitforpurpose and especially detrimental to the people often held there with complex needs.

CSUs in England are too often used as a default for men with severe or challenging mental health needs.[107] Long delays in transfers to more appropriate settings (in-patient units or mental health beds) mean that CSUs become the only option for governors and staff working without sufficient training or resources, while making extensive efforts to keep prisoners at risk of self-harm and suicide safe. Again, provision outside prisons is essential to ensuring decent treatment inside them – more appropriate mental health provision in the community, with more mental health hospital beds with appropriate security are needed.[108]

In Women's prisons in England and Wales, IMBs find that despite commitments to remove courts' power to use prison as a 'place of safety' (under the Mental Health Act 1983) or to remand people to prison for their own protection under mental health grounds (under the Bail Act 1976), the number of women deprived of their liberty under these provisions has actually increased in some prisons.[109] A lack of secure mental health beds leads to women being detained for their safety on an inappropriate environment for their mental health needs, with some women held in segregation or on wings without adequate treatment and support. Due to the high level of need, inpatient and specialist units in women's prisons – where they exist – are often full, and women needing admission to secure mental health hospitals are not transferred quickly enough – a matter under observation by the NPM's task and finish group on mental health transfers. The high level of care and supervision needed to support women with particularly complex needs who account for many of the increasing incidents of self-harm in prisons,[110] is exacerbating staff shortages. In Northern Ireland, a follow up of implementation of recommendations made in CJI's review into the operation of CSUs found impressive actions taken in partnership by the Northern Ireland Prison Service (NIPS), the South Eastern Health and Social Care Trust, and Belfast Metropolitan College.[111]

106 **A Thematic Review Of Segregation In Scottish Prisons – HM Inspectorate of Prisons for Scotland (prisonsinspectoratescotland.gov.uk)**

107 **Segregation of men with mental health needs: A thematic monitoring report** – IMB (imb.org.uk)

108 **Segregation of men with mental health needs: A thematic monitoring report** – IMB (imb.org.uk)

109 **Mental health concerns in women's prisons – IMB (imb.org.uk)**

110 **Safety in custody: quarterly update to December 2022 – GOV.UK (www.gov.uk)**

111 **A review into the operation of Care and Supervision Units in the Northern Ireland Prison Service – Criminal Justice Inspection Northern Ireland (cjini.org)**

A CSU Operational Framework provided clear messages about the vital role of monitoring segregation, transparency and consistent governance arrangements in discharging human rights obligations. Appointment of a project manager and support from staff and operational managers drove innovative use of technology for monitoring time out of cell and engagement with purposeful activity, using data to provide effective oversight and generate information to improve service delivery in CSUs. However, individuals with very complex needs were still managed in CSUs, while a challenging operational environment includes increased prisoner population, staff shortages, court backlogs, funding pressures. The IRP at Maghaberry Prison followed up on concerns identified during the 2022 inspection and found there were still weaknesses in adult safeguarding and procedures to support prisoners at risk of self-harm and suicide.[112] Steps taken to improve safeguarding were undermined by ineffective collaboration with partner agencies and stakeholders to deliver an effective policy and strategy to protect prisoners at risk.

Immigration detention

Deaths in immigration detention have been extremely rare but there were two apparent self-inflicted deaths across the estate.[113] These self-inflicted deaths, the prevalence of self-harm and IMBs' findings that people's mental health deteriorated (in some cases to the point of needing to be sectioned) all present the picture that immigration detention is an environment that fails to keep people safe.[114]

The number of people in immigration detention was 54% higher in 2023 than 2022.[115] The growing population and growing unrest, added to poor identification of vulnerable detainees, poses risks to mental health and safety.[116] Longer periods of cumulative detention, no release or removal date, and slow case progress were problems at both IRCs inspected and reported by HMIP over the year (Yarl's Wood and Tinsley House – where three people were detained for more than a year at the time of inspection), culminating in a disturbance involving more than 50 detainees at Yarl's Wood which led to 13 escaping.

"Far too many were detained despite being granted bail, because of a lack of approved accommodation."

112 **Report of an Independent Review of Progress at Maghaberry Prison – Criminal Justice Inspection Northern Ireland (cjini.org)**

113 National Annual Report 2023 – IMB **(cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

114 National Annual Report 2023 – IMB **(cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

115 **Independent Monitoring Board highlights significant concerns across places of detention in 2023 National Annual Report – IMB (imb.org.uk)**

116 **HM Chief Inspector of Prisons for England and Wales Annual Report 2023-24 (cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

Despite the increased number of people at risk of suicide or self-harm and the high levels of disorder and security breaches,[117] the Home Office could not provide contractor Serco with accurate safeguarding data to show risk levels or the outcome of doctors' reports identifying those whose health would be worsened by detention, who are at risk of suicide or who have been victims of torture (Rule 35 reports).[118] As a result, staff were unable to plan or deliver suitable care at Yarl's Wood or Tinsley House. While welfare work for women at Yarl's Wood was effective, leaders had not identified that more consistent provision was needed in the women's unit, where women were intimidated when using an outdoor yard overlooked by men's accommodation.[119] International standards are clear that in institutions that receive both men and women, premises allocated to women should be kept "entirely separate" from men, a measure to protect physical and mental integrity of detainees.[120] Ahead of charter removals, many detainees were locked in separation conditions, not based on individual risk assessment or subject to proper oversight. These were not consistent with Immigration Centre Rule 40 – removal from association in interests of security or safety.[121] In a report published in June 2023, The IMB Charter Flight Monitoring Team questioned the length of time for which a restraint or use of force was used during journeys, as well as the use of force on some individuals who had been identified as at risk of suicide or self-harm.[122] While monitors observed generally respectful treatment of detainees throughout removals, they also documented people being confined to parked vehicles for long periods of time, unnecessary crowding by escorts, lack of information and failure to consistently use interpreting facilities when needed.

Their report states:

> **"HOIE's insistence on removing or trying to remove vulnerable people, some perhaps with mental health problems, may accord with policy but is morally questionable".[123]**

The UK is obliged to follow internationally agreed standards and domestic policy should be interpreted in line with international law.

117 **Independent Monitoring Board highlights significant concerns across places of detention in 2023 National Annual Report – IMB (imb.org.uk);** Gatwick IMB found that the overall level of self-harm incidents increased throughout the year. By October, the Board reported that acts of self-harm had become more frequent, at approximately twice the level of incidents than in July.

118 **HM Chief Inspector of Prisons for England and Wales Annual Report 2023-24 (cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

119 **HM Chief Inspector of Prisons for England and Wales Annual Report 2023-24 (cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

120 Nelson Mandela Rule 11(a); **Separation of detainees – APT (apt.ch)**

121 **Annual Report of the Independent Monitoring Boards' Charter Flight Monitoring Team For reporting year 1 January 2022 – 31 December 2022 – IMG (img.org.uk)**

122 Annual Report of the Independent Monitoring Boards' Charter Flight Monitoring Team – IMB (imb.org.uk)

123 **Annual Report of the Independent Monitoring Boards' Charter Flight Monitoring Team For reporting year 1 January 2022 to 31 December 2022 – IMG (img.org.uk)**

Court custody

Lay Observers in England and Wales are concerned by the number of individuals brought to court with serious mental health concerns. In magistrates' courts, there are far too many defendants who have serious diagnosed mental health conditions and many of these are remanded to prison. Of the detainees with mental health conditions, a significant proportion are autistic or have personality disorders. There is little awareness of the impact of autism for individuals in court custody. As an example, one man who is severely autistic was brought to a court from one prison, where he had been remanded. On the completion of his day's court hearing, he was transferred to another prison. The man had just managed to settle into the environment of the first prison but no account was taken of the difficulty he would then face with adjusting to a different prison.

Children

According to Ofsted, there is a lack of appropriate mental health provision for children across England. This means that at times, children with significant mental health needs are being looked after in SCHs and STCs when these provisions are not best placed to meet these children's needs. SCHs have at times become a default position as there is a lack of appropriate types of provision that can look after these children. The level of self-harm varies, but self-harm and serious self-harm are increasing due to the complexity of need of the children being looked after in secure provision.

Mental Health Act (MHA) Reviewers in England found that lack of staff also impacted on one service's ability to open all of the Child and Adolescent Mental Health Services (CAMHS) beds on site, thus reducing capacity. Concerns around staffing were mostly raised in regard to agency staff. Agency staff were said to lack the knowledge and skills required for the specialist services they were working in. The appropriateness of the ward environment received mixed feedback from MHA Reviewers. In some cases, they thought the ward was age-appropriate and designed to meet the needs of patients. However, in others, the ward was not age-appropriate, was described as 'too clinical' and did not offer the relaxed and comfortable environment patients were said to need. Similarly, a young person being cared for within an adult ward, was deemed to be in an unsuitable environment, partially due to being segregated in a 'pod' on an adult ward.[124]

In Scotland, measures were taken during the reporting year so that by September 2024, children are no longer held in prison custody, implementing a CRC recommendation and longstanding recommendations by HMIPS and the HMCIPS.

Mental health detention

Significant structural problems persist in the mental health sector – ageing estate, understaffing, and insufficient beds. There is a lack of community interventions to prevent hospital admissions and detentions and this means that people receive their first treatment in hospital when they have become more unwell. Lack of inpatient beds, combined with a lack of capacity across the system, including community care, can lead to people being sent to a hospital miles away from home. Out-of-area placements can be hugely detrimental to patients' recovery and can lead to people feeling isolated because friends and family are often not able to visit.

124 **Publications – Care Quality Commission (cqc.org.uk)**

In England, problems with staffing and skill mix was a key concern identified through the CQC's special review of services at Nottinghamshire Healthcare NHS Foundation Trust. This review shows that services across the country are currently facing many of the same challenges in recruiting psychologists, occupational therapists and consultant psychiatrists – all of which are having an impact on capacity to deliver services. Many services are now reliant on bank staff. Heavy reliance on agency staff increases the risk of people receiving inconsistent care as agency staff were not always familiar with patient's care plans or routines. Though agency staff are also relied on in Northern Ireland, this does not seem to pose the same problems. An RQIA inspection noted that challenges relating to high staff absence were mitigated against by the block booking of experienced agency staff who contributed to an improved work environment and provided consistency in care to patients.[125]

CQC published guidance in November 2023 on reducing harm from ligatures in mental health wards and wards for people with a learning disability, outlining five key factors to reduce harm – therapeutic engagement, the built environment, staffing and skills, technology and procurement.[126] The quality of interaction between staff and patients and person-centred safety plans created with the patient (therapeutic engagement) relies on having enough of the right staff with the right skills, training and support, with time to spend building trust and rapport. High use of agency staff, low levels of qualified staff and increases in staff absence are all linked to self-harming behaviour. A supported workforce is essential to manage and reduce self-harm on mental health wards, but CQC note that "a culture of blame and fear is still prevalent in far too many healthcare organisations".[127]

Compliance with mandatory training, including on conflict de-escalation and on use-of-force only as a last resort, was a concern at mental health wards in Wales, and HIW also remarked on high number of staff vacancies (though overall standards of care were good and significant improvements had been made since the last inspection at one hospital).[128] Staff reported insufficient resources to meet patient demand, and potential risks to patient safety included lack of onsite night manager and only one qualified nurse per-ward.[129] One hospital faced difficulties providing safe staffing levels when staff were moved to the Section 136 Unit, a suite which acts as a place of safety for people detained under the Act, while the suite itself was afflicted by long-term problems in its physical layout and location, which compromised safety for those detained there.[130]

125 **Inspection Report Western Health and Social Care Trust Lakeview Hospital – The Regulation and Quality Improvement Authority (rqia.org.uk)**

126 **Reducing harm from ligatures in mental health wards and wards for people with a learning disability – Care Quality Commission (cqc.org.uk)**

127 **Therapeutic engagement – Care Quality Commission (cqc.org.uk)**

128 **Significant Improvements made to Mental Health Services at Royal Glamorgan Hospital in Llantrisant – Healthcare Inspectorate Wales (hiw.org.uk)**

129 **Independent Mental Health Service Inspection Report (Unannounced) – Healthcare Inspectorate Wales (hiw.org.uk)**

130 **Hospital Inspection Report (Unannounced) – Healthcare Inspectorate Wales (hiw.org.uk)**

Elsewhere, non-compliance of documentation with the MHA led to high risks for detained patients, differences between doses and medication prescribed and those in the statutory certificate of consent form, administration of medication without checking for consent or authorisation by a Second Opinion Authorised Doctor, and ineffective clinical audits to identify discrepancies.[131] Some hospitals presented issues with recording the legal status of MHA detentions, which led to staff being held up when administering medication, as consent certificates and medication records were not consistent. In one hospital, there was no information available on the Mental Health Act, meaning patients were not informed of how to make a complaint.[132]

This was also the case in England – for example, at one provider staff had failed to follow the Mental Health Act Code of Practice when caring for a patient in long term segregation. Staff had not recognised this as segregation despite the patient not being able to freely mix with other patients on the ward for five months.[133] CQC published a policy position on reducing restrictive practices in August 2023, and is now asking the UK government to make it law for mental health providers to notify the CQC each time the use the most harmful types of restraint on patients, as well as seclusion or segregation.

In 2023, the Department of Health and Social Care asked CQC to lead Independent Care Education and Treatment Reviews for the next two years, firstly in partnership with NHS England then independently. This followed one of the recommendations made in Baroness Hollins' report, published in autumn 2023. The review panels started in May 2024 and review the care of people who are autistic or who have a learning disability to support them to move out of long-term segregation.

CQC continues to note concerns about the operation of the Deprivation of Liberty Safeguards (DoLS) in England.[134] The DoLS system has needed reform for over 10 years. The number of applications to deprive individuals of their liberty in care homes and hospitals has continued to rise far beyond the levels expected when the safeguards were designed, yet local authorities have shared that they often do not have sufficient resources to cope with such demand. This leads to large ongoing backlogs, with over 123,000 people waiting for an assessment as of March 2024 despite efforts from authorities to adopt prioritisation tools to process applications and make use of additional resources where available. The number of applications processed within the statutory 21-day timeframe is still too low, as only 19% of standard applications were completed within this timeframe in the last reporting year.

131 **Independent Mental Health Service Inspection Report (Unannounced) – Healthcare Inspectorate Wales (hiw.org.uk)**

132 **Hospital Inspection Report (Unannounced) – Healthcare Inspectorate Wales (hiw.org.uk)**

133 Burton Park **inspection report – Care Quality Commission (cqc.org.uk)**

134 **The state of health care and adult social care in England 2023/24 – Care Quality Commission (cqc.org.uk)**

This means people in vulnerable circumstances are waiting for far too long without the right safeguards or legal protections in place. This can result in them being unlawfully deprived of their liberty or being deprived of their liberty longer than necessary, potentially in unsuitable care arrangements. It may affect people's human rights if they are unable to challenge the deprivation of liberty, as legal aid is only available if an authorisation is in place.

Some groups of people with protected characteristics under the Equality Act 2010, including people with a disability and older people, are more likely than others to require the safeguards offered by DoLS and will therefore be disproportionately affected by the delays to the implementation of reforms. In addition to this, the findings from CQC's survey of National DoLS Leads suggested that the ongoing use of prioritisation tools by some local authorities may further exacerbate inequalities for some groups, such as people with a learning disability or dementia, as they may not always meet the threshold for prioritisation and could be left waiting for extended periods. Aside from the impacts of the backlogs, CQC is particularly concerned about communication around DoLS for people who do not speak English as a first language or who use alternative ways of communicating. CQC's external stakeholder group have spoken of concerns around language barriers and inadequate interpretation services, which caused distress to people using services and their family members. One stakeholder felt these issues can be compounded by poor cultural competency among staff, which can lead to poorer care, less effective interventions, and reduced engagement with services.

In Scotland, the Care Inspectorate's 'Secure care pathway review' found that access to adequate and appropriate educational, legal and health support in the community is vital to preventing young people entering a secure care setting.[135] Regular changes of staff caring for young people or being moved around the care system correlates with fewer signs of improvement in safety.

135 **Secure care pathway review 2023 – Care Inspectorate (careinspectorate.com)**

Scrutiny statement: police custody

Across England and Wales, Scotland and Northern Ireland, visitors and inspectors see variations or inconsistencies in practices that leave detainees vulnerable to higher risks of poor conditions or disproportionate treatment.

A major shared concern among NPM scrutiny bodies is the disparity we see between levels of risk assessment and observation levels set in police custody. In England and Wales, custody visitors have observed vulnerable detainees either not assessed for vulnerability or being assessed as not vulnerable enough to require an appropriate adult. Evidence from the Home Office Custody Statistics and the National Appropriate Adult Network suggests that the identification of vulnerability varies significantly from one force to another. In Scotland, the gap between risk level ascribed, and observation levels provided to people in custody is poorly recognised and rarely audited. These disparities present a significant risk to detainee safety. In Northern Ireland, invasive searches of juveniles, although rare, tended to follow a long-standing custom and practice approach by the police, rather than that of the guidance provided by the PACE Codes. This exposes children deprived of their liberty to potentially unnecessary, potentially traumatising procedures when they enter police custody.

Inconsistencies in healthcare are another common observation. In Scotland, healthcare providers across the country provide highly varying levels of service with striking difference in type and style of delivery. In England and Wales, struggles to effectively staff healthcare units have led to detainees unable to access healthcare in a timely manner and long waits for medical attention. Long waits for children and vulnerable adults in custody can lead to spending a longer time in custody than necessary – detention should be for as short a time as necessary. In Northern Ireland, delays in the roll-out of a nurse-led healthcare model in custody has led to inconsistencies in how quickly and effectively detainees are able to access healthcare services.

Staffing issues have affected other areas of detainee wellbeing; there are sometimes not enough custody staff in English and Welsh custody suites to facilitate access to showers or to an outdoor space – these are essential entitlements and lack of access is an unacceptable compromise of detainee health, hygiene, and dignity. Custody visitors' own scrutiny role is compromised when there are not sufficient staff to facilitate a visit.

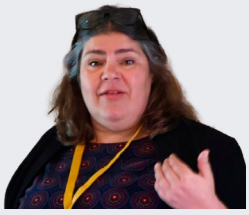
Finally, the physical condition of police custody suites poses its own risks. In Scotland, barely adequate buildings require capital investment which hamper's Police Scotland's strategy to continually improve facilities for those held in police custody.

Andy Cooke,
HM Chief Inspector of Constabulary and HM Chief Inspector of Fire & Rescue Services

Rachel Lindsay,
Lead Inspector,
Criminal Justice Inspection Northern Ireland (CJI)

Matthew Magrath,
Scheme manager,
Independent Custody Visiting Northern Ireland (ICVNI)

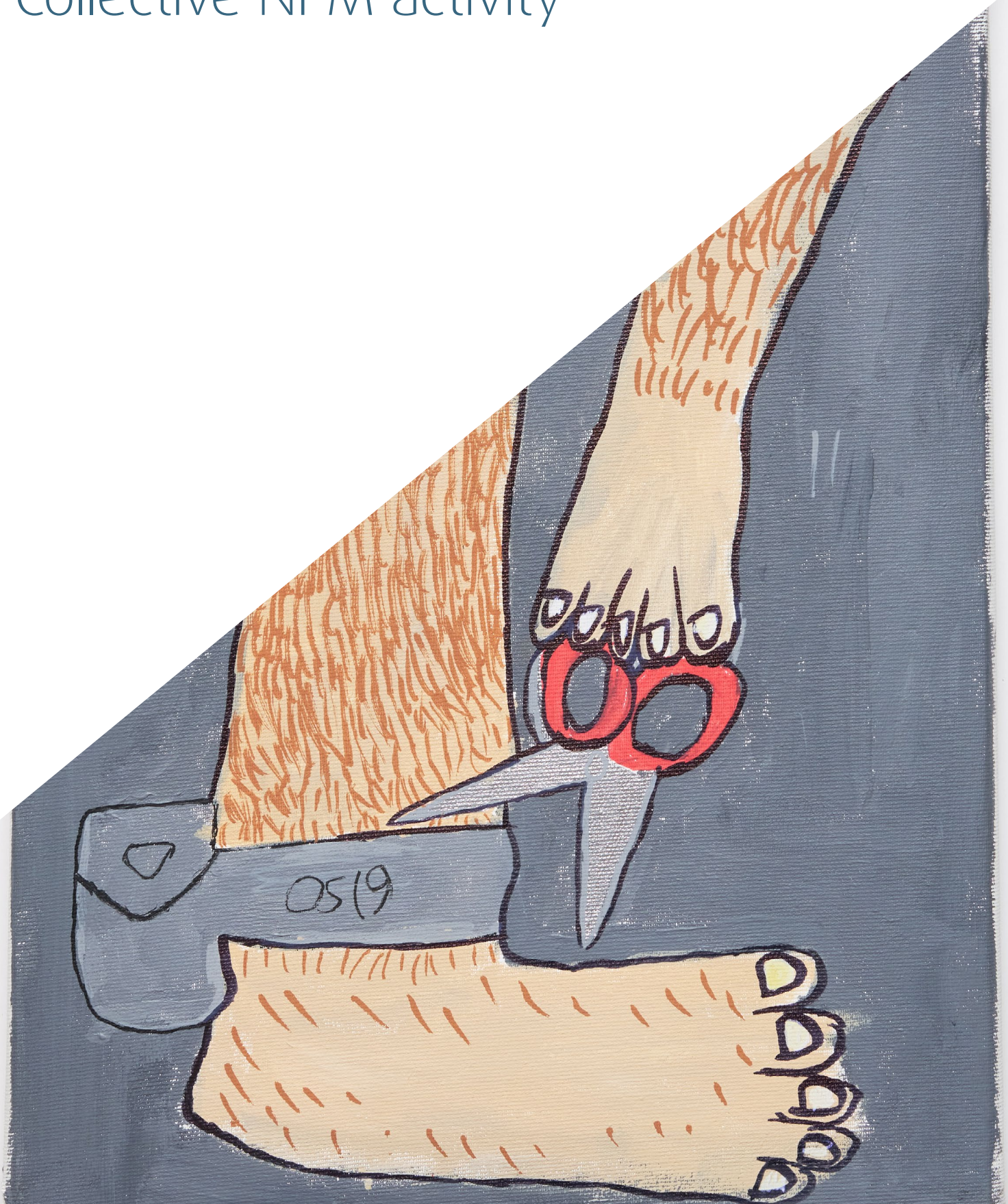
Craig Naylor,
His Majesty's Chief Inspector of Constabulary in Scotland



Sherry Ralph,
Chief Executive Officer,
INdependent Custody Visiting Association (ICVA)

Kirsty Scott,
National Scheme Manager,
Independent Custody Visiting Scotland (ICVS)

Collective NPM activity



A business plan for 2023-25 was launched in April 2023 with four strategic objectives:

1. Support members in delivering their own responsibilities under OPCAT.
2. Undertake collective work and joint actions with a view to preventing ill treatment of detained people in the UK.
3. Promote awareness and understanding of OPCAT principles and the work of the NPM in the UK.
4. Liaise and work with international mechanisms and organisations with a mandate to prevent ill-treatment.

The collective work outlined in the below sections on national subgroups and task and finish groups has developed the NPM's work on objectives one to three during the reporting year. Under objective four, in February 2024 the NPM central team submitted evidence to the UN Human Rights Committee's 140th Session, in which it examined the UK's fulfilment of objectives under the International Covenant on Civil and Political Rights. The NPM's submission, drawing from NPM body inspection and monitoring reports, provided scrutiny of the UK State Report to the committee's list of issues, giving additional context to drive improvement in the conditions and treatment of those deprived of their liberty in the UK. It also outlined concerns not covered in the UN's list of issues, including:

- overcrowding, overcapacity, and time out of cell
- use of prison for people with acute mental ill-health, including over representation in segregation units
- Imprisonment for Public Protection (IPP) sentences in England and Wales
- outstanding matters of concern

The submission highlighted the concerning lack of any reference to detention in Northern Ireland in either the committee's list of issues, or the UK's State response, and provided supplementary information. The submission also raised the ongoing lack of legislative basis for the NPM, incomplete criminalisation of torture in UK legislation, and extraterritorial responsibility for torture and other cruel, inhuman or degrading treatment or punishment. The UK government's position is that the NPM complies with the requirements of the OPCAT, however, UN committees, the Special Rapporteur on Torture and the Council of Europe hold continuing concerns about the lack of a clear legislative basis of the NPM in the UK and the resultant lack of statutory guarantee of independence. The lack of a clear legislative basis for the NPM has long been a matter of concern to the SPT.[136] There is still British law undermining the absolute prohibition of torture: The UK has repeatedly refused to repeal a provision in the Criminal Justice Act 1988 which provides a defence for alleged perpetrators of torture if there is "lawful authority, justification or excuse". However, the prohibition on torture is absolute and there can be no justification. Finally, some areas of detention that are under UK state control are only scrutinised by invitation, without the power to attend unannounced, meaning the preventive function served within the UK is not extended here.

136 Monitoring places of detention; Ninth Annual Report of the United Kingdom's National Preventive Mechanism 1 April 2017 – 31 March 2018, NPM (**npm.org.uk**)

The UN Special Rapporteur on Torture also issued a report on current issues and good practices in prison management this year.[137] The NPM contributed findings from the UK, including a recommendation to introduce initiatives to increase staff awareness of neurodivergence, including identification of conditions, individualised care plans, and one-to-one support for prisoners with learning needs.

In July 2023, the UK NPM was invited to contribute to the Association for the Prevention of Torture (APT)'s Global Report on Women in Prisons, aimed at promoting an evidence-based debate on the impact of prison on women, and to enhance the use of gender-responsive alternatives to detention. The UK NPM's contribution outlined concerns over the rising self-harm in women's prisons, where some women were acutely unwell and should have been in hospital, the lack of active and preventive care to prevent women getting into crisis, leading to staff using physical force to stop self-harming behaviour. It also raised continued limits to adequate time out of cell, exacerbated by staff shortages. In some women's prisons, over half the population was on a mental health caseload in 2021, and mental health services in prisons struggled to cope.

Many of those with the most severe mental disorders are to be found in segregation units, and the more severe or complex the condition, the longer the stay, as there are still long delays in transfers to mental health units. Others self-harm often and dangerously by ligature. Some with acute mental illness are still sent to prison by the courts as an alleged 'place of safety' or for their 'own protection'. There is an urgent need for joint action with the Department of Health so that prison is not the default setting for people whose primary problem is mental disorder.

To promote understanding of OPCAT principles and the work of the NPM, the central team launched a new website incorporating key thematic publications and produced two guidance documents and a training page under a preventive project, outlining practical considerations for monitors, visitors, and organisation leadership to strengthen the prevention of torture and other cruel, inhuman or degrading treatment or punishment.[138]

137 **A/HRC/55/52: Current issues and good practices in prison management – Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment – OHCHR (ohchr.org)**

138 **Training resources – National Preventive Mechanism (nationalpreventivemechanism.org.uk)**

NPM national subgroups

NPM Northern Ireland Subgroup

The NPM Northern Ireland Subgroup was officially launched in April 2023 and meets quarterly, addressing an ongoing workplan which identifies key priorities:

Deaths in custody and after release

Currently, the NPM Northern Ireland Subgroup is undertaking a follow-up project from the NPM's roundtable on deaths in detention, held in September 2023, to outline the data that each member organisations receives from the settings they monitor following a death or serious incident. The resulting report will allow the group to identify gaps in information provided and how to fill those gaps to ensure comprehensive scrutiny.

Adult safeguarding in places of detention

As adult safeguarding is an increasing issue in prisons, CJI has reviewed procedures for identifying and escalating and is currently finalising a safeguarding and escalation procedure to inform future monitoring and inspections. The purpose of this work strand was to monitor progress and maintain a focus on work to address the shortcomings in adult safeguarding approaches identified in recent inspection reports.

Prevalence of personality disorder in places of detention

The current mental health legislation in Northern Ireland, Mental Health (Northern Ireland) Order 1986, has an impact on the delivery of care and treatment to people with a personality disorder. People with a personality disorder who are not considered to be presenting with any co-existing mental disorders cannot be compulsorily admitted to a mental health hospital. However, they can be offered hospital admission on a voluntary basis. There is a significant reliance on community mental health services to deliver treatment and support to people with a personality disorder. Across Northern Ireland there are variations in the availability of these services and care pathways used.

Currently in Northern Ireland there is no specialist inpatient, residential or intensive therapeutic day treatment service for people with personality disorder. The lack of this service has resulted in referrals to specialist services outside of Northern Ireland.

Evidence indicates the prevalence of people with personality disorder is much higher in the prison population than the general population. There is no specialist personality disorder service available in the Northern Ireland prisons resulting in a reliance on the mental health team and existing psychology resource to provide support and interventions. The lack of a specialist personality disorder service in Northern Ireland prisons and the lack of a regional specialist personality disorder inpatient service has had a negative impact on people with a personality disorder in prison. Some people have experienced long delays in accessing psychological support with some requiring the additional restrictions imposed in the prisons care and support units (CSU).

This is an ongoing focus for both the Northern Ireland Prison Service and the Prison Health Care team. Updates will be provided to this group on progress.

Training for members

Northern Ireland IMB members do not have access to sufficient training to fulfil their role, essential to guaranteeing the functional independence of NPM personnel. Article 18 of OPCAT requires states to guarantee the functional independence of NPMs and personnel, and to take necessary measures to ensure that they have the required capabilities and knowledge. A small working group is working collaboratively on additional training resources and has proposed topics, contributors and timescales for training. Meanwhile, wider work on preventive guidance for monitors has been undertaken by the NPM central team, producing training materials that can be adapted by individual NPM bodies.[139]

Resourcing of NPM bodies

All NPM members face challenges relating to budgetary constraints, which impact their ability to ensure sufficient resources and staffing to fulfil their OPCAT and NPM mandate. All states that have ratified OPCAT accept the obligation to provide adequate resources for the NPM to function (OPCAT article 18). NPM Northern Ireland Subgroup members face increasing difficulties in ensuring sufficient staffing to undertake all aspects of their monitoring role. A meeting has been arranged with the Department of Health and Department of Justice to present the group's priority concerns, approaching these as connected issues between the two departments.

NPM Scotland Subgroup

The NPM Scotland Subgroup has identified a range of key issues in places of detention:

- prison overpopulation
- long waits to be transferred from prison to a mental health facility
- no high secure mental health facilities for women in Scotland
- transportation issues, affecting multiple detention settings and access to urgent healthcare
- outstanding recommendations from the deaths in custody review
- segregation in Scotland's prisons
- inadequate complaints systems in detention settings
- inadequate human rights training for staff
- problems with electronic prescription services and access to medication in custody
- mitigating the effects of the Illegal Migration Act
- inconsistent processes for mental health assessments across different settings
- persistently outstanding recommendations from all subgroup members

139 **Training resources – National Preventive Mechanism (nationalpreventivemechanism.org.uk)**

In October 2023, the NPM Scotland Subgroup submitted a response to the Scottish Government's Human Rights Bill consultation.[140] Broadly, the subgroup welcomed the Bill and its incorporation proposal but advocated for the inclusion of the UN Convention Against Torture (UNCAT) and of OPCAT in the Bill, as well as a more ambitious programme of delivery including provision of adequate resources and guidance to support human rights scrutiny bodies to fulfil their requirements. Incorporation of the UNCAT and OPCAT would enshrine the NPM mandate in legislation, taking proactive steps to prevent torture and ill-treatment through the duties and obligations set out in OPCAT. Incorporation of UNCAT would protect the right to rehabilitation, not only bolstering rights of those deprived of their liberty in Scotland but improving mental and physical health outcomes following detention.

Also in October, the subgroup issued a statement expressing concerns about the lack of progress in implementing recommendations to address deaths in prisons in Scotland.[141] At this point, four years since the Independent Review of the Response to Deaths in Prison Custody was commissioned and two years since recommendations were published, only five of 26 recommendations and advisory points had been completed. In November, the subgroup met with Cabinet Secretary for Justice and Home Affairs, Angela Constance to discuss prison overpopulation, mental health transfers, improving the journey through and out of custody, and systemic lack of action on recommendations from scrutiny bodies.

In December, the group followed up with a letter of concern regarding human rights violation relating to the use of segregation and reintegration units in Scottish prisons.[142] In March 2024, Gillian Imery, external chair to provide independent oversight and leadership to the implementation of the recommendations of the independent review, confirmed that 12 recommendations/advisory points had been implemented.

Healthcare Improvement Scotland (HIS) was invited to attend subgroup meetings as an observer this year and worked with the NPM to secure funding to enable joint inspections with HMICS. A programme of joint inspections between HIS and HMICS was launched this year to ensure inspections and recommendations incorporate a thorough assessment of issues affecting detainees. Joint inspections were completed in Fife, Dumfries and Galloway, Tayside and Lanarkshire.

In March 2024, the NPM Scotland Subgroup selected two key issues for the next year:

- Progress on the recommendations from the Independent Review of the Response to Deaths in Prison Custody.
- Monitoring of mental health transfers, including the creation of guidance around mental health transfers, and collection of data on how long people deprived of their liberty are waiting to be transferred to mental health beds.

140 **NPM responds to Scottish Human Rights Bill consultation – National Preventive Mechanism (nationalpreventivemechanism.org.uk)**

141 **Concern expressed about lack of progress to address deaths in prisons in Scotland – National Preventive Mechanism (nationalpreventivemechanism.org.uk)**

142 **A Thematic Review Of Segregation In Scottish Prisons – HMIPS (prisonsinspectoratescotland.gov.uk)**

NPM initiatives

Deaths in detention

In September 2023, The UK NPM hosted a roundtable on deaths in detention. A range of stakeholders participated, including NPM organisations, ombudspersons, NGOs and other independent experts across the UK. Deaths in, and on release from, all forms of custody are a global and increasing concern, and there is no comprehensive, UK-wide analysis of why deaths in custody are increasing. The roundtable aimed to gather perspectives and shared learning in order to identify opportunities to strengthen preventive methodology, to contribute to efforts to prevent deaths in detention. A series of problem areas to address were identified during the roundtable:

- prison population increases and capacity
- access to and use of information/data by monitoring and investigative bodies
- notification of serious incidents
- working with families
- detainee voices
- effective recommendations
- training and education

Based on the day's presentations and discussions, participants agreed that better co-operation to prevent deaths in detention was a priority and resolved to work together.

Menopause

Identifying that women experiencing menopause and perimenopause are less likely to have physical and emotional needs met in custody, NPM representatives agreed to produce a toolkit and training video for monitors of all detention settings to measure effective support in this area. Building on work by the Independent Custody Visiting Association and Sussex OPCC, the group set out human rights principles and good practice indicators relevant to all settings and has produced an awareness raising video and training resources for monitors.[143]

Mental health transfers

The overreliance on the criminal justice system to cope with NHS shortfalls is an issue across the UK in prisons, police custody, health and mental health settings. Issues within places of detention include lack of appropriate training on mental health conditions and behaviours, excessively long waiting times for transfer from custody to a secure mental health facility, and over-use of isolation units.

A review undertaken by the mental health task and finish group revealed similar concerns from NPM members across the UK about the provision of mental health support in prisons and between prison and health services. People with a mental illness are overrepresented in prisons compared with the general population, and rates of suicide and self-harm are also higher, with strong evidence of psychotic illness, major depressive illness, and problems with substance misuse.

143 Female Detainee Care and Dignity – The Menopause Transition Report from the Betterment (Healthcare) Working Group – ICVA (icva.org.uk)**; Menopause toolkit – National Preventive Mechanism (nationalpreventivemechanism.org.uk)**

An overarching strategic approach is lacking to meet the needs of people experiencing mental ill health, learning disability and autistic spectrum disorder in prisons. Major concerns were information gaps on mental health support needs before, during and after custody, transfer times and a lack of monitoring of transfer times, the over-use of segregation, under-resourcing, and a lack of mandatory training for non-specialist staff. Everyone has the right to the highest attainable standard of health and mental health, and in detention settings the state has an additional responsibility to facilitate this right.[144] However, conditions, regimes and treatment in some settings has been detrimental to some individuals' mental health.

The analysis also considered current law reforms which might improve this situation, including the draft Bill to reform the Mental Health Act 1983 in England and Wales, the Scottish Mental Health Law Review and Vision for Justice in Scotland. It was encouraging that the Joint Committee on the Draft Mental Health Bill engaged with NPM members on the harms of detention and its unequal impacts on black and minority ethnic people, the availability of community alternatives (particularly for people with learning disabilities and autistic people), and the resourcing required for implementation of reforms.[145]

However, it was dismaying that plans to reform the MHA, including changes to DoLS as well as introduction of a time limit for transfers, were indefinitely suspended by the government in November 2023.[146]

The draft Bill to reform the Mental Health Act 1983 proposed a 28-day statutory time limit for transfer of patients from prison to hospital, independent monitoring of this process, and the removal of prisons and police stations as 'places of safety' from the Act. NHS guidance recommends a 28-day timeframe in England and Wales.[147] In Northern Ireland, the Mental Health (Northern Ireland) Order 1986 and Code of Practice require admission to hospital within 14 days of recommendation for detention in a hospital.[148] In Scotland, there is currently no guidance or requirement on transfer times following a clinical referral. However, transfers to a secure mental health facility are required within seven days if ordered by a court.

Following the group's qualitative review, the NPM conducted a quantitative exercise across all four nations, gathering available data from clinical commissioning authorities on the length of time taken to complete transfers from prisons to secure mental health beds throughout 2023.

144 **Mental health: Promoting and protecting human rights – WHO (who.int)**

145 **Draft Mental Health Bill 2022 –** CQC and MWCS **(parliament.uk)**

146 **The King's Speech 2023 – GOV.UK (www.gov.uk)**

147 National Good Practice Guidelines.

148 Mental Health (Northern Ireland) Order 1986; The Department of Health and Social Services Mental Health (Northern Ireland) Order 1986 Code of Practice, 2.22 (Admissions directed by the Secretary of State).

A study by HMIP and CQC of a sample of prisons in England and Wales found just 15% of transfers were made within 28 days from the point it was identified that their mental health needs could not be treated in prison.[149] In Northern Ireland, 31 people in prison were referred for an access assessment (though 59 assessments were carried out by Healthcare in Prison psychiatrists or Host Trust medical practitioner in this time). In 13 of the 31 cases, the initial assessment itself did not take place within the 14 day time limit for completed transfer. Twenty-four of the 31 assessments recommended transfer to hospital, 19 of which were completed. Eight transfers were complete within the 14 day time limit. In Scotland, MWCS found that the Forensic Network, a non-departmental body, currently seeks to collate data on the number of transfers, and returned information that over 2023, it received 49 referrals to forensic mental health services, all of which were accepted. If the time limit were 28 days, 53.3% of transfers in 2023 would have taken place within the limit. While the minimum transfer time was 0 days, the maximum stood at a long 150 day wait.

Data analysis also identified that there is no consistent independent oversight of transfer timelines in England and Wales or in Scotland, and data is not publicly available. In Northern Ireland, RQIA can request transfer information from health trusts, but there is no arrangement for routine data sharing.

A comparison of the figures collected by MWCS on the number of individuals transferred from prisons, and the information submitted to the Forensic Network, indicates that the data available via Forensic Network is not accurate, and that wait time data is likely to be incomplete.

Based on the task and finish group's review, the lack of progress on the draft Bill, and findings that the recommended, provisional and required time limits for transfer from prison to a secure hospital are missed across all four nations, the task and finish group will now engage with the new government on new reforms to the Mental Health Act.

Definition of detention or deprivation of liberty

Over the reporting year, the SPT consulted on a General Comment on OPCAT Article 4 to address the definition of 'places of detention'.[150] The General Comment was finalised in July 2024. This will be a key document in guiding NPMs and States in ensuring adequate monitoring of all places where someone might be deprived of their liberty. To compliment the General Comment, the NPM established a Task and Finish Group to agree a succinct definition and implementation guide for reference by NPM organisations and individuals working and volunteering for them.

149 **The long wait: A thematic review of delays in the transfer of mentally unwell prisoners by HM Chief Inspector of Prisons February 2024 – HMIP (cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com)**

150 Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment – United Nations **(un.org)**

In addition to the working group's outputs, guidance by Ofsted and the Care Inspectorate interrogates the question of when conditions in care settings are restrictions of liberty, and when restrictions become deprivation of liberty. Ofsted's 'Positive environments where children can flourish' outlines that when children cannot easily leave facilities such as sensory room or tents independently, or if staff discourage them from leaving, this can be a restriction.[151] A Care Inspectorate position paper from June 2023 outlines that the intensity of measures used to restrict a child's liberty indicates whether this has become deprivation of liberty.[152] Any care practice that restricts a young person's liberty should be time limited, recorded and communicated, with regular formal review. Usually, only a registered secure accommodation service can lawfully apply restrictions that amount to a deprivation of liberty.[153]

In Northern Ireland, on occasion RQIA have identified unlawful restrictive practices in a registered care service which have amounted to an unauthorised Deprivation of Liberty or de facto detention. RQIA have used its regulatory powers to ensure action is taken to address the matters immediately.

In January, the NPM Task and Finish Group appointed an external researcher to stress-test three potential definitions. This work concluded that a definition that looks beyond the physical setting to take into account whether an individual is able to leave at will, their individual vulnerabilities, as well as the nature and extent of the controls could apply. The working group will consider the findings alongside the SPT General Comment.

151 **Positive environments where children can flourish – GOV.UK (www.gov.uk)**

152 **Depriving and restricting liberty for children and young people in care home, school care and secure accommodation services – Care Inspectorate (careinspectorate.com)**

153 **Depriving and restricting liberty for children and young people in care home, school care and secure accommodation services – Care Inspectorate (careinspectorate.com)**

NPM bodies' ongoing work and thematic priorities

Key thematic reports by NPM bodies can be found on the UK NPM's website.[154]

Care Inspectorate

The Care Inspectorate conducted unannounced inspections of four registered secure accommodation services this year; Rossie Secure Accommodation Services, Kibble Safe Centre, St Marys Kenmure and Good Shepherd Centre Bishopston. In September, the Care Inspectorate published recommendations on 'Safer Recruitment Through Better Recruitment' which respond to systemic problems in recruitment and retention in health and social care.[155] The Bairn's House Final standards, which the Care Inspectorate consulted on in the last reporting year, were published in May.[156] In June 2023, Care Inspectorate published a position paper – 'Depriving and restricting liberty for children and young people in care home, school care and secure accommodation services', which details examples of restrictions of liberty and outlines when a restriction of liberty may amount to a deprivation of liberty through environmental design or care practices.[157] 'A quality framework for justice accommodation (offender accommodation) services' was published in March this year.

Care Inspectorate Wales

With Healthcare Inspectorate Wales, Care Inspectorate Wales monitors Deprivation of Liberty Safeguards in Wales, producing the annual monitoring report for health and social care. Care Inspectorate Wales has called for continued investment in play and progression, a relentless focus on staff wellbeing, compassionate leadership and early intervention. CIW also adheres to the Welsh Government framework on reducing restrictive practices. CIW inspected Wales's Secure Accommodation Service this year.

Care Quality Commission

CQC publishes the 'Monitoring the Mental Health Act' and 'State of Care' reports every year, reporting on the protection and treatment of those detained under the Mental Health Act and those subject to a Deprivation of Liberty Safeguards authorisation in health and social care settings. CQC regulates registered providers, including training requirements for staff which under the Health and Care Act 2022 includes a requirement on learning disability and autism.[158] In August 2023, CQC published its new restrictive practice policy position, covering expectations that providers promote positive cultures where staff listen to and understand people in their care, promote trust, support recovery, and protect safety and wellbeing.[159]

154 **Key reports from NPM bodies – National Preventive Mechanism (nationalpreventivemechanism.org.uk)**

155 **Safer recruitment guidance 2023 – Care Inspectorate (careinspectorate.com)**

156 **Bairns' Hoose (Barnahus) Standards – Care Inspectorate (careinspectorate.com)**

157 **Depriving and restricting liberty for children and young people in care home, school care and secure accommodation services – Care Inspectorate (careinspectorate.com)**

158 **Training staff to support autistic people and people with a learning disability – Care Quality Commission (cqc.org.uk)**

159 **Restrictive practice — a failure of person-centred care planning? – Care Quality Commission (cqc.org.uk)**

With HMIP, CQC published 'The Long Wait: A thematic review of delays in the transfer of mentally unwell prisoners' in February.[160] CQC recommitted to human rights this year with the publication of an updated human rights approach in December 2023.[161] This specifies that good care is rights-respecting care and must be built on rights-respecting cultures in health and care services. CQC integrated the Patient and Carer Race Equality Framework into its assessment structure, which supports the rights and equitable treatment and outcomes of racialised communities. This hopes to tackle the dehumanisation and racism faced by racialised communities and ethnically diverse groups.

The Children's Commissioner for England

Among many reports published throughout the reporting year, the Children's Commissioner has advocated against the possible introduction of incapacitant spray in youth offenders' institutions, issued a report on concerns following a visit to Cookham Wood, a YOI in Kent, and wrote a letter to the Youth Custody Service about children in custody. The commissioner's office had regular engagement with ministers and officials in Ministry of Justice and the Youth Custody Service on children held on secure settings, and conducted frequent visits to settings where children are detained, including all YOIs.

Criminal Justice Inspection Northern Ireland

CJI published the report of an unannounced inspection of Maghaberry Prison in June 2023 and conducted two IRPs during the reporting year at Maghaberry Prison and Magilligan Prison, disrupting the traditional cycle of prison inspections to interrogate how establishments implement recommendations between inspections. In September 2023, CJI published a follow-up review of recommendations from last year's review into Care and Supervision Units, noting that action taken between services has been impressive, including fast development of an operational framework, innovative use of technology and effective oversight through data.[162] However, some individuals with very challenging needs continue to be managed in CSUs, and the increased prisoner population, staff shortages, court backlogs and funding pressures have created a continued challenging operational environment. CJI conducted a follow-up review of Probation Practice and the care and treatment of victims and witnesses by the criminal justice system as well as publishing a report of an inspection of the criminal justice systems approach to vulnerable older people.

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales monitors how health boards and independent providers discharge their powers and duties under the Mental Health Act 1983, amended in 2007, on behalf of Welsh ministers.

160 **The long wait: A thematic review of delays in the transfer of mentally unwell prisoners by HM Chief Inspector of Prisons February 2024 (justiceinspectorates.gov.uk)**

161 **Our updated human rights approach – Care Quality Commission (cqc.org.uk)**

162 **A review into the operation of Care and Supervision Units in the Northern Ireland Prison Service – Criminal Justice Inspection Northern Ireland (cjini.org)**

In addition, they operate the second opinion appointed doctor (SOAD) service for Wales. This service safeguards the rights of people who, while detained under the Mental Health Act, have refused prescribed treatment or have been assessed as unable to consent to the treatment. Under a review of treatment under section 61 of the Mental Health Act, when a SOAD has authorised a treatment plan, the doctor responsible for the patient's care and treatment (the Responsible Clinician) must provide a report on the patient's condition and treatment to HIW for review. HIW, alongside CIW and Estyn, launched a joint review into how healthcare, education, and children's services support the mental health of children and young people in Wales. Responding to long waiting times for support and the high demand above service capacity, a joint national report will be published in the autumn.[163]

His Majesty's Inspectorate of Constabulary and Fire & Rescue Services

HMICFRS inspected five police forces' custody suites: Dorset, Lancashire, South Wales, West Midlands and West Yorkshire. While no incidents were recorded, all reports refer to possible ligature points in cells, some of which were raised at previous inspections and remain unaddressed.

His Majesty's Inspectorate of Constabulary in Scotland

HMICS conducted four joint inspections with Health Improvement Scotland (HIS) this year, adapting a joined-up approach to issues in detention. As well as inspections of police custody, HMICS published a thematic review of policing Mental Health in Scotland. While custody procedures were not part of the review's scope, the report recommends a wider, more strategic review of the whole-system approach to mental health in Scotland. HMICS' 'Thematic Inspection of Organisational Culture in Police Scotland', published in December, made 11 recommendations to improve culture, address inequalities, define and measure values, and improve communication, training and guidance.[164]

His Majesty's Inspectorate of Prisons

HMIP published 79 inspection, independent review of progress and thematic reports of prisons, YOIs and STCs, immigration detention, court custody, and extra-jurisdiction inspections (Northern Ireland and Isle of Man). HMIP issued four urgent notifications on HMPs Bristol, Woodhill, Bedford, and Cookham Wood YOI. Thematic reviews were published on weekends in prison, restricted status women and children, the quality of reading education, children subject to remand, the impact of recruitment and retention, children's experiences in STCs and YOIs, and delays in the transfer of mentally unwell prisoners. HMIP made submissions to the Public Accounts Committee, Justice and Home Affairs Committee, Justice Select Committee, Sentencing Council and Brook House inquiry.

163 **Joint Review: How are healthcare, education, and children's services supporting the mental health needs of children and young people in Wales? – Healthcare Inspectorate Wales (hiw.org.uk)**

164 **HMICS Thematic Inspection of Organisational Culture in Police Scotland – HM Inspectorate of Constabulary in Scotland (hmics.scot)**

His Majesty's Inspectorate of Prisons for Scotland

Throughout the reporting year, HMIPS conducted two court custody unit inspections, four full prison inspections, and six thematic reviews in collaboration with key stakeholders. Independent Prison Monitors (IPMs) conducted 1,059 visits to prisons over 4,149 monitoring hours, actioning 1,202 requests from prisoners. Independent Prison Monitors published their prison specific annual reports. Thematic reports included an analytical review of young people's experiences of the Scottish Prison Estate, and a thematic review of segregation in Scottish Prisons. In April 2024, HMIPS and Care Inspectorate published the joint report 'Prison-based social work thematic review', which recognises the positive impact of meaningful staff-prisoner relationships on welfare and motivation in prisons, and that many people in prisons do not have sufficient contact with prison-based social workers.[165] Service delivery is impacted by resource pressures and a lack of national strategic vision of the aims of prison-based social work.

Independent Custody Visiting Association

ICVA's campaigns and interventions have produced tangible progress in three key thematic areas over the reporting year. The National Police Chief's Council lead for Custody supports two of ICVA's three recommendations and agreed to explore the final recommendation to end the use of anti-rip clothing, in a letter to colleagues in January 2024.[166] Since ICVA's work on lux-levels in cells, an agreement was reached to amend the Custody Design Guide to significantly lower lux levels in new-build sites and for major refurbishments.[167] Recommendations were made in the NPCC to make amendments to the College of Policing APP to offer enhanced support and care to women going through menopause in custody.[168]

Independent Custody Visiting Scotland

Independent custody visitors ensure that police custody provision in Scotland upholds the international standards set by the United Nations to prevent torture, and the cruel, inhuman or degrading treatment of people in custody. Independent custody visitors undertook more than 1,000 visits during the reporting year and spoke to over 1,600 people in custody.

165 **Prison-based social work: thematic review – Care Inspectorate** (careinspectorate.com)

166 **Anti-Rip Clothing, Update Report – ICVA (icva.org.uk)**

167 **Lux Lighting in Custody: An Impact Report – ICVA (icva.org.uk)**

168 **The Menopause Transition Report from the Betterment (Healthcare) Working Group – ICVA (icva.org.uk)**

Independent Monitoring Board

Independent Monitoring Boards undertook 37,715 visits in 2023, publishing 128 annual reports on adult prisons, YOIs and immigration detention. The national IMB published four thematic national reports, on annual findings across immigration detention, the impact of IPP sentences on prisoners' wellbeing, mental health concerns in women's prisons, and safety and regime in the youth estate. The IMB responded to consultations by the MOJ, HMPPS and the Home Office, on segregation, drug treatment, the safety of children and young people, women in prison and immigration detention, welfare and family provision in immigration detention, and technology. IMBs also gave evidence to the Joint Committee on Human Rights, the Home Affairs Committee, Welsh Affairs Committee, Justice Committee and All Party Parliamentary Group for Penal Affairs.

Independent Monitoring Boards (Northern Ireland)

Maghaberry Prison, Magilligan Prison, and Hydebank Wood Secure College and Women's Prison each have an IMB, which continued to monitor progress on recommendations and improvements.

Independent Reviewer of Terrorism Legislation

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

Lay Observers

Lay Observers are independent volunteers who check that prisoners escorted by private companies in England and Wales are treated decently. Lay Observers inspect court custody areas and the cellular vehicles used by contractors to transport detainees to and from court. They also visit police stations to observe the handover of prisoners from the police to the contractors and visit prisons to observe the handover of prisoners from the prison to the contractors and vice versa. Lay Observers play a vital role in ensuring standards of decency are maintained.

Mental Welfare Commission for Scotland

The commission is an independent statutory organisation working to protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions.

Its activities include checking if individual care and treatment are lawful and in line with good practice, empowering people and their families or carers through advice, guidance and information; promoting best practice in applying mental health and incapacity law, and influencing policy, legislation and service development.

Northern Ireland Policing Board Independent Custody Visiting Scheme

Twenty-three custody visitors made 470 visits in the reporting year, interviewing 1,048 detainees and checking 918 custody records. The most frequent issues relating to detainee wellbeing involved provision of medical attention, detainees requiring an appropriate adult, or needing to inform someone of their arrest. Twenty-five issues of material conditions in detention were raised, most of which related to faulty equipment or general maintenance. Thirteen safety/security hazards were reported during the year.

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

Ofsted leads inspections of secure training centres supported by HMIP and CQC, and of Secure 16-19 Academies supported by CQC. Ofsted also supports HMIP inspections of YOIs in England assessing education provision. Ofsted published two joint thematic inspection reports with HMIP this year: the quality of reading education in prisons, and work with children subject to remand in youth detention (with HMI Probation).

Ofsted published a blog on the importance of good planning for children moving on from the secure estate, and on principles of registering children's homes.[169]

The Regulation and Quality Improvement Authority

RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services. It is RQIA's general duty under the Mental Health (Northern Ireland) Order 1986 to keep under review the care and treatment of people suffering or appearing to be suffering from mental disorder. It has specific responsibilities to assess the health and social care services (whether in an acute or a community setting) provided to people with mental ill health or a learning disability, and to inquire into any case where there may be ill-treatment, deficiency in care or treatment, improper detention in a hospital or guardianship, or risk of loss or damage to a patient's property due to their mental disorder. RQIA undertakes inspections across 56 mental health and learning disability wards, including Child and Adolescent Mental Health inpatient services, the regional children's secure unit, and registered care settings for adults and children. RQIA scrutinises over 8,000 mental health order assessment forms every year to ensure the detention of patients is in accordance with the required legislation. Any identified improper detentions are addressed. RQIA also oversees requests for the provision of second opinions in relation to Part IV of the Mental Health (Northern Ireland) Order 1986.

169 **The importance of good planning for children moving on from the secure estate – Ofsted: social care (blog.gov.uk)**; **Registering children's homes – principles and hints and tips – Ofsted: social care (blog.gov.uk)**

These second opinions include medication reviews and providing second opinions for the administration of electroconvulsive therapy to patients who lack capacity to consent. It also assesses the quality of health care in prisons though joint inspections with Criminal Justice Inspection Northern Ireland, and the Education and Training Inspectorate.

Scottish Human Rights Commission

The Scottish Human Rights Commission is the National Human Rights Institution for Scotland with a mandate to promote and protect human rights. In March, the commission reported concerns regarding detention to UN monitoring bodies, submitting evidence to the Human Rights Committee on issues such as overcrowding in prisons and lack of access to appropriate mental healthcare. SHRC gave briefings and evidence to Scottish and UK parliamentary committees on legislation and the recommendations of the Independent Review of the Response to Deaths in Custody.

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