national preventive mechanism

Monitoring places of detention

16th **Annual Report**
of the United Kingdom's
National Preventive Mechanism
2024/25

CP 1457

Government of the United Kingdom

UK National Preventive Mechanism

Monitoring places of detention

16th Annual Report of the United Kingdom's National Preventive Mechanism

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Presented to Parliament by the Secretary of State for Justice
by Command of His Majesty

December 2025

CP 1457

This publication is available at www.gov.uk/official-documents.

Any enquiries regarding this publication should be sent to us at **UKNPM@hmiprisons.gov.uk**

ISBN 978-1-5286-6108-9

E03490465 12/25

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office

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All artworks featured in this report were produced by those held in detention and are reproduced courtesy of Koestler Arts

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Foreword

This is the 16th Annual Report of the United Kingdom's National Preventive Mechanism (NPM).

Over the past year, NPM bodies have carried out more than 50,000 visits across every category of detention in the UK, producing over 3,000 recommendations and identifying hundreds of examples of good practice. Together, these findings represent the most comprehensive preventive scrutiny of detention anywhere in the world.

The picture they paint is one of continuing and deepening concern. In too many settings, the same systemic problems recur, year after year. Conditions that fall far short of international and domestic human rights standards have become normalised which is wholly unacceptable. Overcrowding, staff shortages, deteriorating infrastructure and prolonged isolation continue to undermine the dignity, safety and wellbeing of people deprived of their liberty across all nations and across detention types.

As in previous years, this report makes for sobering reading. In the prison estate, the capacity crisis has reached an intolerable level. Conditions in some establishments continue to breach minimum standards of human dignity. Overcrowding and decay have deepened, with staff and leaders striving against impossible odds to maintain safety and decency. The NPM has repeatedly warned that this crisis cannot be solved by stretching existing systems further, but only through structural reform, investment and a

commitment to reduce reliance on detention as a default response.

In immigration detention, the picture is equally troubling. Violence, self-harm and indefinite detention have all increased significantly, with growing evidence of poor mental health and deteriorating safety for detainees. In mental health and social care, long-term institutionalisation of people with a learning disability and autistic people remains widespread, with individuals detained for years in settings that are neither therapeutic nor appropriate.

These are not new concerns. They are the same patterns of systemic failure identified in successive NPM, United Nations (UN) and European Committee for the Prevention of Torture (CPT) reports over more than a decade. This must stop.

And yet, among these troubling challenges, causes for cautious optimism can be found. In secure children's homes, trauma informed models such as the Framework for Integrated Care (SECURE STAIRS) are showing tangible benefits for children and

staff alike. The launch of our new NPM Reporting Dashboard this year marks a leap in transparency and accountability: for the first time, every recommendation made by an NPM body can be tracked, analysed and shared, providing a clearer picture of systemic issues across all detention settings. It enables policymakers, practitioners and the public to analyse patterns, identify areas of persistent concern, and measure progress over time. It represents a step change in how the UK understands and responds to evidence from detention monitoring.

Internationally, the UK NPM has continued to play a leadership role in the global preventive community, working closely with other mechanisms and international partners to strengthen OPCAT implementation worldwide. Domestically, the NPM's collective voice has influenced key legislative consultations and inquiries across all four nations of the UK, providing evidence-based recommendations on mental health law reform, equality strategies, and children's justice and sentencing.

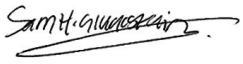
The NPM's central team, and the 21 bodies that make up the mechanism together embody the UK's commitment to preventing ill treatment, but recommendations remain unaddressed. Without action, the same words will be written again next year. As they were last year.

The NPM therefore urgently and unapologetically repeats the message that inspection and monitoring alone cannot prevent ill treatment. Prevention requires leadership, investment, and the courage to confront uncomfortable truths about the role of detention in modern society. The time for listening to our message, and for positive change, is now.

Fifteen years after the NPM's establishment, the preventive model remains as vital as ever. Our collective challenge is to turn sustained observation into sustained improvement - ensuring that the human dignity of every person deprived of their liberty is not only recognised in principle but realised in practice.

To all those working in the most challenging of environments, and to those deprived of their liberty, we extend our sincere thanks. To the more than 3,500 staff and volunteers across the NPM undertaking the essential work of visiting, observing and reporting - your efforts continue to uphold the principle at the heart of OPCAT: that no person, anywhere, should be subjected to torture or ill treatment.

Sherry Ralph,
Chair, UK NPM



Sam Gluckstein,
Head of UK NPM

Introduction: The UK National Preventive Mechanism

In 2002, the United Nations (UN) adopted the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), which created a dual national and international system of regular visits to any place where people are or might be deprived of their liberty:

1. National Preventive Mechanisms
2. The Subcommittee for the Prevention of Torture

According to OPCAT article 19, **National Preventive Mechanisms** are domestic organisations with the mandate to:

- Regularly examine the treatment of persons deprived of their liberty in places of detention, with a view to strengthening their protection against torture and other cruel, inhuman or degrading treatment or punishment.
- Make recommendations to the relevant authorities in order to improve treatment and conditions and prevent torture and other cruel, inhuman or degrading treatment or punishment.
- Submit proposals and observations concerning existing or draft legislation.

(See OPCAT articles 17-23)

The Subcommittee for the Prevention of Torture is an international system of independent and impartial experts elected by States parties to the OPCAT who will visit those states to:

- Advise and assist NPMs on protecting detainees from torture and ill treatment
- Make recommendations to states to strengthen capacity and mandates of NPMs
- Maintain contact with NPMs offering training and assistance

(See OPCAT articles 11-16)

The UK was one of the first states to ratify OPCAT in 2003, and created the National Preventive Mechanism (NPM) in March 2009.[1] While some states created a new organisation after ratifying OPCAT, the UK designated existing organisations with the role of visiting places of detention to work together as a multi-body NPM. Today, the UK NPM is made up of 21 organisations, which independently monitor different settings of detention across the UK, and a central team, which supports and leads NPM bodies in delivering their OPCAT responsibilities, undertakes collective work to prevent ill treatment of detained people in the UK, promotes awareness and understanding of OPCAT principles, and works with international mechanisms and organisations with a mandate to prevent ill treatment of detained people.

1 OPCAT has now been ratified by 92 states.

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, the Secure 16-19 Academy, 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.

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)

What is "torture"?

The UN Convention Against Torture outlines a limited definition of "torture", as any intentional act producing severe mental or physical pain or suffering by a person acting on behalf of a state, for a specific purpose, which might be to punish, intimidate, coerce, discriminate or interrogate. Broadly, torture and other cruel, inhuman and degrading treatment or punishment (CIDT) refer to severe harm, either physical or mental, sustained through environments or experiences while deprived of liberty through state authority. **Both are equally prohibited in any circumstance**. Alongside the prohibition of torture and CIDT under international law, states are obliged to treat anyone deprived of their liberty with humanity and respect for their inherent dignity.

The UK NPM uses the term "ill treatment" to cover all elements of torture and CIDT. This term is briefer and easier to use. Moreover, because the Convention Against Torture has traditionally been understood to primarily protect individuals in criminal justice settings, using the term "ill treatment" is a reminder that those deprived of their liberty in other settings such as mental health or social care facilities also need preventive based monitoring.

Role and Purpose of the UK NPM

An NPM's primary function is to prevent torture and CIDT of those deprived of their liberty, through regular, preventive visits to places where people are deprived of their liberty. OPCAT recognises that closed settings create an inherently increased risk of ill treatment due to detainees' reliance on state authorities to access everyday necessities. The treaty therefore mandates that efforts to eradicate torture should first and foremost be concentrated on prevention. Rather than investigating whether a practice or environment amounts to torture, NPMs create a regular presence that reduces risk factors that can make a torturous environment or any act of CIDT more likely. As well as recommendations made directly to prisons, secure hospitals or police custody centres, for example, the NPM compiles public reports, analyses findings to develop bespoke recommendations and training packages, contributes to legislative scrutiny to improve frameworks to protect detained people, and gives evidence to UN and Council of Europe treaty bodies and special procedures.

OPCAT article 19

This annual report is structured around the mandate outlined in OPCAT article 19, giving an overview of:

1. NPM constituent body visits to places of detention and their findings (19a)
2. Recommendations made to relevant authorities by constituent bodies and the UK NPM central team (19b)
3. Proposals and observations concerning existing or draft legislation (19c)

Visits by NPM bodies

Introduction

Optional Protocol to the Convention Against Torture, Article 19 (a)

The national preventive mechanisms shall be granted at a minimum the power:

(a) To regularly examine the treatment of the persons deprived of their liberty in places of detention as defined in article 4, with a view to strengthening, if necessary, their protection against torture and other cruel, inhuman or degrading treatment or punishment

The constituent bodies of the NPM conduct visits, mostly unannounced, to the places of detention set out in this section. For some organisations, such as the prisons inspectorates, this forms the core purpose of their work. For others, such as health and social care regulators, visits sit alongside and support their other functions. NPM bodies work collaboratively, sharing expertise to ensure settings are robustly scrutinised. For example, healthcare inspectorates join prison and police inspectors, resulting in a holistic picture of an establishment.

Many issues are identified by inspectors, monitors and visitors during the more than 50,000 individual on-site visits conducted throughout the year. This section focusses on those issues that most closely engage the UK's obligations under OPCAT identified between April 2024 and March 2025. The information in this section, unless explicitly referenced, is taken from NPM body reporting throughout the reporting year, and from minutes of NPM meetings and oral and written consultations with NPM organisation staff.

Alongside these observations are numerous examples of good practice. For example, while prisons across the UK are struggling to cope with populations over their operating capacity, CJI's joint inspections with His Majesty's Inspectorate of Prisons (HMIP) and the Regulation and Quality Improvement Authority (RQIA) of Hydebank Wood Women's Prison and Hydebank Wood Secure College noted that the prison responded well to increases in remand population and made sure that prisoners had the same opportunities as sentenced peers in education, training and work. Despite an increased population of women with more complex needs, Hydebank Wood was operating "far more successfully than most similar prisons inspected in England and Wales", following a rolling programme of refurbishment and identification of further improvement work.[2]

In police custody, custody visiting schemes in one area of England and Wales reported significant decreases in the use of anti-rip clothing, a key issue of concern in the 2023-24 NPM Annual Report. Several areas also reported good practice where staff offered additional support to women experiencing symptoms of menopause or perimenopause, which was the focus of ICVA and NPM guidance published in October 2024.[3]

In Secure Children's Homes, Ofsted reports generally good education and health provision to children, with improvements in children's learning and mental, emotional and physical health as a result. A trauma informed model known as SECURE STAIRS, commissioned by NHS England, delivers a consistent, trauma informed collaborative approach to meeting children's needs. The framework is being implemented at Oakhill Secure Training Centre, and Oasis Restore Secure School has a bespoke version of the

2 Report on an unannounced Inspection of Hydebank Wood Women's Prison - November 2024 - CJI NI

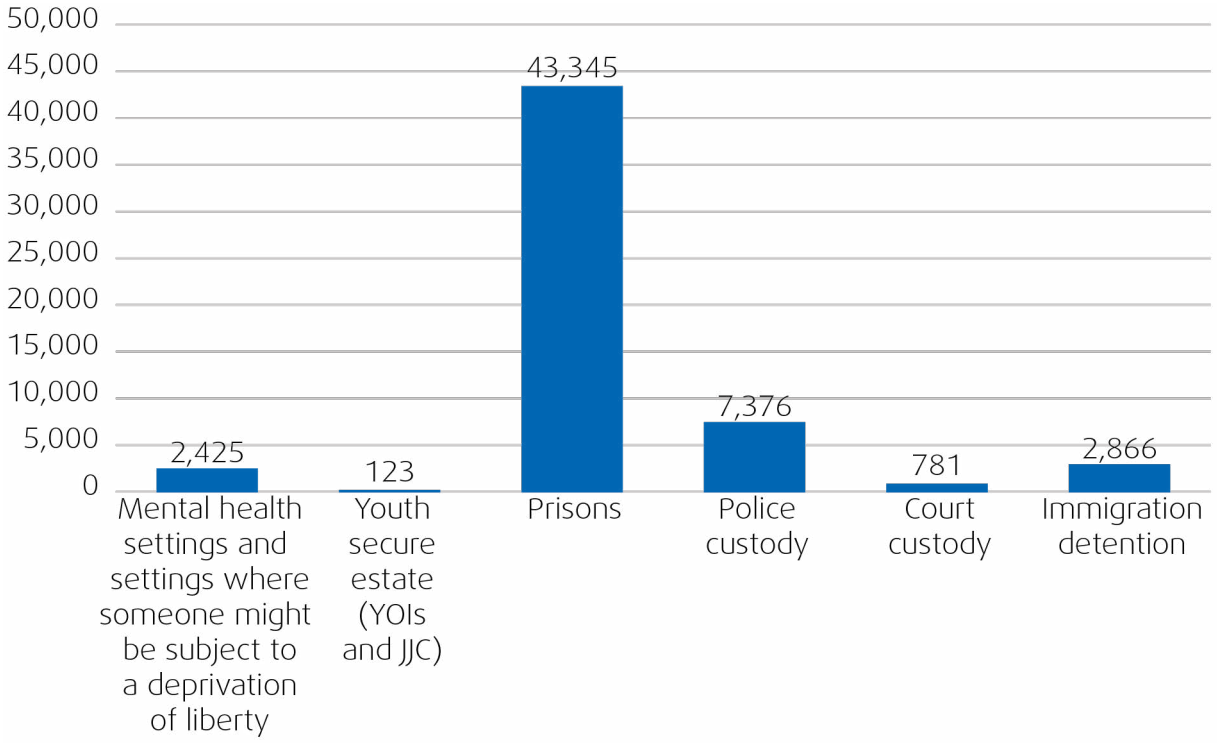
3 ICVA Quarterly stakeholder update - Q4 2024/2025 - ICVA

Framework for Integrated Care known as the RESTORE Framework. SECURE STAIRS is also being implemented in the Young Offender Institutions holding under 18s. This has had tangible benefits for children and increased the skill of staff looking after them. It also provides good support and guidance for staff working with children with very challenging behaviours and complex needs.

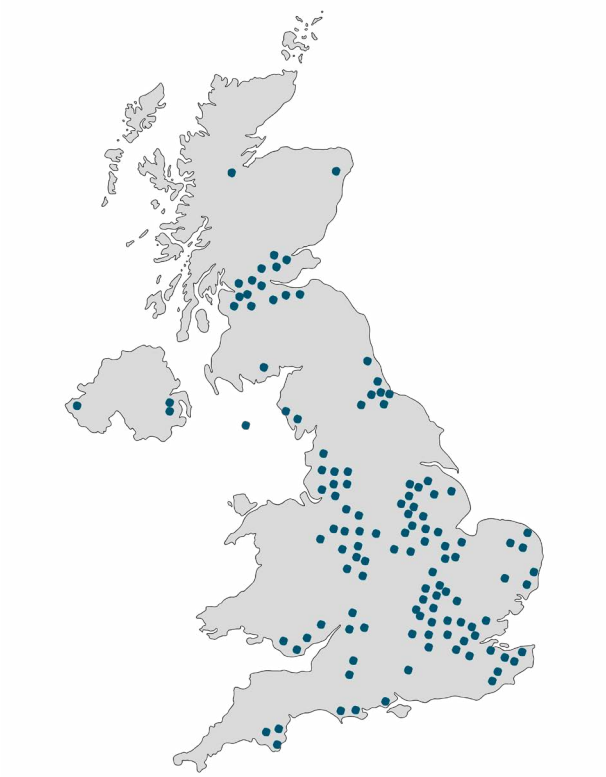
These and many other examples demonstrate the hard work, dedication and skill of thousands of staff in varied detention settings across the UK. However, reporting from the year demonstrates the challenges those staff face, and the impacts this has on those deprived of their liberty. It is impossible to record in one report every example of good practice, just as it is impractical to list every concern of each NPM body. The following summaries therefore include the issues most pertinent to article 3 of the European Convention on Human Rights (ECHR), the prohibition of torture and CIDT. Three key areas raise concerns of article 3 breaches:

- Worsening conditions in overcrowded, physically deteriorating prisons, where some prisoners continue to be detained indefinitely under public protection sentences, with no obvious path to progress.
- Increasingly crowded and violent immigration detention, where detainees can also be detained indefinitely and are increasingly held for significantly longer periods, sometimes despite vulnerabilities.
- The institutionalisation of people with a learning disability and autistic people in hospitals, where continued deprivation of liberty does not contribute to therapeutic care. Closed cultures in health and social care settings risk normalising poor treatment.

Approximate number of inspections and monitoring visits between 1 April 2024 and 31 March 2025



Prisons



Impression of prisons visited between April 2024 to March 2025. Total establishments visited: 146.

Deliberate ill-treatment was not observed during monitoring and inspection of prisons over the reporting year. However, the capacity crisis and ensuing difficulties has led to highly concerning practices and norms which breach international law. In particular, the use of indeterminate sentences, and increasingly the inability to progress through a sentence towards release, have received international attention for being inhumane. Overpopulation and overcrowding of prisons prevent governments from adequately fulfilling human rights obligations to provide treatment and conditions in detention which respect the inherent human dignity of prisoners.

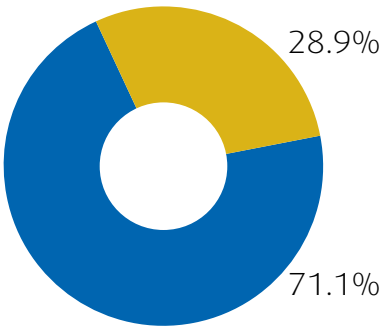
According to the European Court of Human Rights (ECtHR), violations of article 3 ECHR (prohibition of inhuman or degrading treatment or punishment) may arise not only by positive acts of ill treatment by State authorities over prisoners, but also through the imposition of degrading detention conditions, or through lack of action in the face of allegations of ill treatment. For example, the situation of prisoners held in overcrowded, dilapidated prison facilities, with too little living space and insufficient privacy, have been considered a violation of article 3, despite the fact that authorities did not **intend** to humiliate the prisoners. Social isolation, lack of meaningful activity, and continuous segregation amounting to solitary confinement contribute to inhuman and degrading treatment, despite the efforts of staff to provide for an increasingly complex population with acute needs.

Capacity crisis

Prison capacity in Northern Ireland

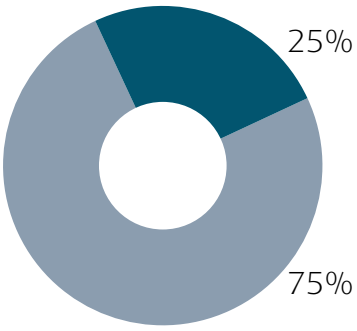
Total number of prisoners: 1,964

- Prisoners sharing cells: 28.9%
- Prisoners in single cell accommodation: 71.1%



Prison capacity in England and Wales

- Prisoners in crowded conditions*: 25%
- Prisoners in single cell accommodation: 75%

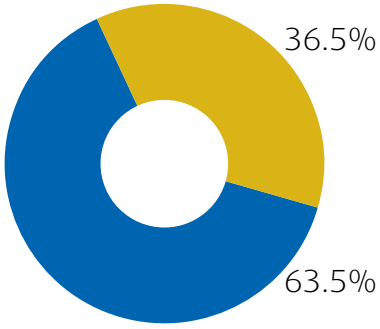


*measured by the number of prisoners on the last day of the month in a cell where the number of occupants exceeds the baseline normal accommodation of the cell.

Prison capacity in Scotland

At March 2025

- Prisoners sharing cells: 36.5%
- Prisoners in single cell accommodation: 63.5%



Prison capacity across UK jurisdictions in the year 2024-2025, according to: Northern Ireland Prison Service Annual Reports and Accounts 2024 to 2025, HMPPS Annual Digest 2024 to 2025, SPS Prison by Numbers Quarter 4 (2025). CPT standards, which the UK NPM supports, requires a minimum 4 metres squared per prisoner not including a partitioned toilet. Reporting on capacity from prison services across the UK uses mixed standards, so is unreliable to give a national picture of overcrowding.

NPM reports since its formation in 2009 cite concerns about overcrowding in prisons, lack of appropriately qualified staff to deal with the number of prisoners and their highly complex mental health needs, deteriorating physical conditions of prisons, and an overly restricted regime. Inspectors and monitors have reported a crumbling estate, with delays in refurbishment leading to unacceptable living conditions in too many prisons. Measures were introduced over the last year to manage prison capacity, and in some prisons these have allowed overdue maintenance to be completed as populations dropped temporarily. However, prison building and expansion cannot keep up with the growth in population and does not go far enough to prevent long-term negative impacts of stretching services rather than changing them.

These effects compromise the fulfilment of the right not only to be free of ill treatment, but component rights to privacy, to an adequate standard of health and the inherent dignity of the human being.

In England and Wales, population pressures meant that cells and other facilities could often not be taken out of use for routine maintenance, preventing necessary upkeep of buildings and causing issues with ventilation, broken flooring, insecure windows, unusable showers, flooding and frequent sightings of rats and cockroaches. In Scotland, several prisons have significant long-standing infrastructural issues and are in such poor state of repair that, though they continue to house prisoners, they do not provide conditions that are acceptable in the 21st century. HMIP issued four urgent notifications over the 2024-25 reporting year, including to HMP Winchester (October 2024) and HMP Rochester (August 2024), citing dilapidated accommodation in "some of the worst conditions [...] seen in recent years"; the inspectorate raised concerns about living conditions in 24 of the 38 adult prisons inspected over the year.[4] Doubling up in cramped cells can erode prisoners' mental wellbeing, especially when many spent up to 23 hours a day in their cells. Conditions tended to be better in women's prisons and the more modern men's prisons such as HMP Five Wells (where cells include a shower).

HMIPS reported of an inspection at HMP Barlinnie that "the prison infrastructure represents a barrier to safety and acceptable living standards", and that despite reporting disrepair in 2019, one unit "remained in a wretchedly poor state".[5] Barlinnie's population was more than 30% above its design capacity, and almost two thirds of prisoners were doubling up in single cells. This overpopulation meant the prison could not offer daily showers, and services and relationships were strained. At HMP YOI Grampian (June 2024), some prisoners had to temporarily sleep on mattresses on the floor, which is utterly unacceptable. Despite longstanding and consistent concerns about prison overcrowding being raised by the UK NPM, UN Committees, and the CPT, no clear plan to tackle prison overcrowding had been developed by duty bearers.

An increasing prison population is also a concern in Northern Ireland, though the population at Hydebank Wood Secure College for young adult men had reduced since the last inspection and prisoners all had single cells. At Maghaberry, older accommodation previously deemed unsuitable was re-opened to keep up with the increasing number of committals through emergency measures to increase available spaces. Despite commenting in March 2025 that "much of the prison estate is nearing the end of its useful economic life", with the ageing infrastructure, particularly at Magilligan prison, leaving prisoners housed in huts with "deteriorating walls, roofs and flooring plus aging plumbing, electrical and heating systems", the Department of Justice continues to send prisoners to these conditions.[6]

At Hydebank Wood Women's Prison, the increase in population had increased demand for healthcare, and too many appointments were missed. However, barriers to attending appointments had been identified and work to improve access had begun, with some improvement in numbers attending. Living conditions were reported as excellent, with all women having their own room.

4 HM Chief Inspector of Prisons for England and Wales Annual Report 2024–25 – July 2025 - HMIP

5 Report on HMP Barlinnie Full Inspection - 18-22 November 2024 - HMIPS

6 Long visits new build kitchen and café at Magilligan Prison – March 2025 – Department of Justice

Barriers to progression

Prison rules are clear that conditions and treatment within prison must not exacerbate the penal nature of imprisonment.[7] A core element of rehabilitation is a functioning regime providing opportunity to develop interests, skills and education. However, the NPM is concerned that there are not enough qualified staff to deliver this individualised and purposeful regime for enough prisoners, particularly for a prison population with increasingly complex needs.

In Northern Ireland, prisoner numbers had compromised preparation for release and support for prisoners leaving custody with staff abstracted from usual duties, and Prisoner Development Units (PDUs) were unable to keep up. PDUs' performance at Maghaberry and Magilligan had declined, with ongoing issues with staffing and programme delivery. Though a lot of offence-focussed work was undertaken at Hydebank Wood Secure College and Women's Prison, there was no trained psychologist to run accredited programmes.

For prisoners on life sentences, indeterminate custodial sentences (ICS) or extended custodial sentences (ECS), possibility of release is an ever-moving target. Once a set term has been served, prisoners are referred to parole commissioners to consider suitability for release. However, at this point staffing and access issues mean they have rarely been able to access programmes needed to address, and show they have addressed, offending behaviour. Increasing frustrations about this process can then lead to a more volatile prison environment and increased adjudications, which also affects eligibility for release. An October 2024 CJI inspection of the governance and operation of Parole Commissioners found that 28% of the released population is then recalled, describing significant issues with delivery of the PDU process, meaning Commissioners consider far lower proportion for release than in other jurisdictions.

In Scotland, prison regimes were rarely consistent or predictable and more needed to be done to promote wellbeing and rehabilitation Prisoners have access to little or no meaningful or purposeful activity, locked in their (often overcrowded) cells for most of the day. While the progression system was designed to enable prisoners to progress to more open conditions, the pressures of the overpopulated prison estate have left staff with insufficient training on the progression system and a lack of time to support prisoners' progression activities. This, along with delays accessing offending behaviour problems, has led to longstanding under-utilisation of the Open Estate, with 100-120 unused prisoner places in 2024-25 despite the prison estate's chronic overpopulation. This was also an issue in England and Wales open estate; some open prisons remained full, while some had a lot of empty spaces over the year, and others saw a high churn. SDS 40, an early release scheme to reduce some standard determinate sentences from 50% to 40% of the original sentence, created places predominantly in the open estate and category C training prisons, with some Independent Monitoring Boards (IMBs) concerned about the potentially destabilising effect of large numbers of new arrivals.

In England and Wales, population pressures undermined prisoners' opportunities for progression and resettlement, with a lack of accredited interventions despite NPM expectations that all prisoners will receive timely accredited programmes.

7 For example, the Standard Minimum Rules for the Treatment of Prisoners (The Nelson Mandela Rules) and the European Prison Rules.

Prisoners struggled to access offending behaviour programmes, which for a significant number will have a direct impact on the length of time they will spend in prison, as it is considered key to demonstrating reduced risk.

Across the UK, lack of access to courses and programmes is compounded by the high need for individualised support and shortage of adequately qualified psychologists. Indeterminate sentences continue to operate in all jurisdictions. In England and Wales, IPP sentences were removed from judicial options in 2012, but this change was not retrospective, leaving 1,180 prisoners still serving Imprisonment for Public Protection (IPP) sentences. In Scotland and Northern Ireland, Orders for Lifelong Restriction (OLRs) and Indeterminate Custodial Sentences (ICSs) are still available for courts to impose on individuals. Concerns in Scotland relate to the use of OLRs for crimes other than murder.

Many of the people subject to an IPP have "high levels of psychological challenge, including neurodivergence, and complex childhood trauma" that need specialist attention.[8] In the NPM's judgement, similar risks apply to individuals subject to ICS and OLR.[9] Once the original tariff is spent, it is common for prisoners to experience heightened stress because the subsequent continued detention is of unknown length, made harder to gauge or shorten through the difficulty in proving rehabilitation or safety for release. In Northern Ireland, there remain shortages of psychologists to support progression. Being under an ICS, IPP or OLR both reduces a prisoner's opportunity to access rehabilitative programmes and also reduces their capacity to engage in them or to progress. This has a profound impact on all prisoners.

The UN definition of torture clarifies that the imposition of "lawful sanctions", i.e. the deprivation of liberty, is not considered torture. However, in order to be "lawful" sanctions "cannot be open-ended, indefinite or grossly excessive to their purpose, but must be clearly defined, circumscribed and proportionate."[10] As detailed by the ECtHR, a sanction which provides no possibility of ever gaining release violates the article 3 prohibition.[11] The UN Special Rapporteur on Torture and Committee on Human Rights have both voiced concern for prisoners under IPP sentences. The Gauke sentencing review has proposed a new model of recall for prisoners serving standard determinate sentences which it hopes will improve capacity for the Parole Board to determine whether prisoners serving indeterminate sentences continue to represent a risk to the public.[12] To comply with article 5 ECHR, lifelong sentences must be causally connected to a conviction, authorised by national law, continue only for as long as the conditions that required its intervention remain, and there must be opportunities for rehabilitation, education and training to reduce these conditions or risks.[13] While the UK provides for those opportunities in law, they are not always delivered in practice.

8 **IPP sentences: Government and Parole Board Responses to the Committee's Third Report – Ninth Special Report of Session 2022-23 – February 2023 – House of Commons - Justice Committee**

9 **UK NPM briefing - indeterminate detention - July 2025 - UK NPM**

10 **Torture and other cruel, inhuman or degrading treatment or punishment; Report of the Special Rapporteur – March 2020 – UN General Assembly – Human Rights Council**

11 Case of James, Wells and Lee v. The United Kingdom (Applications nos. 25119/09, 57715/09 and 57877/09)

12 **Independent Sentencing Review - Final report and proposals for reform - May 2025 - Independent Sentencing Review**

13 Johnstone v HM Advocate – May 1993 – High Court of Justiciary Scotland

Long-term isolation

In Scotland, too many prisoners continue to suffer long-term isolation in Separation and Reintegration Units (SRUs). While the staff in most SRUs were reported to be knowledgeable and supportive of those in their care, a concern for independent prison monitors (IPMs) was that prisoners were spending too long in SRUs, raising questions of whether prison is the right place for prisoners with complex mental health problems that cannot be addressed by the prison. More prisoners are also held in isolation in the main halls due to the lack of available space in SRUs, making the regime more complicated to manage.

In England and Wales, too much time locked in cell continues to be a problem for many prisons. This limited time spent in fresh air, and opportunities to shower or have a hot meal. Alongside prisoners with mental health needs being held for prolonged periods (including up to 800 days) in Care and Separation Units (CSUs), men were often locked in-cell for up to 23 hours a day, with poor regime offer. Some segregation units were "bleak", with little access to meaningful regime or therapeutic support.[14] Self-isolation of vulnerable prisoners in the main population was also a concern, as a lack of available cells in vulnerable prisoner units left many feeling unsafe.

Women with severe mental health conditions are often found in solitary confinement units in not-suitable settings. Although these units are used as a last resort for safety and protection, findings across the NPM show women with very high mental health needs, acutely unwell and who should be in hospital, held in solitary confinement. There are still long delays in transfers to adult forensic mental health inpatient services and psychiatric intensive care units (PICU).

The high level of non-disciplinary segregation was an acute and national issue, with knock-on effects to hygiene, health, and dignity.

Mental health

Mental health issues are extremely prevalent in prisons across the UK and exacerbated by overcrowding, staff shortages, obstacles to progression, restricted regime and/or widespread drug use. Prisons lack the appropriate care and support for complex needs like severe mental illness, dementia or other age-related mental healthcare needs. Prison rules and international standards require the safeguarding of all prisoners, who must have access to the health services available in the country without discrimination on the grounds of their legal situation. Across the prison estate (for men and women) low prison staffing levels and limited regimes contribute to poor mental health and increasing risk of self-harm. All prison inspectorates and monitoring bodies recorded deep concern for mentally unwell prisoners (both men and women) waiting unacceptably long times to transfer to specialist mental health inpatient facilities for treatment under Mental Health Acts. Often, these people in mental health crisis were held in segregation or prison in-patient units, which were detrimental to their health. Prisons are not an appropriate or therapeutic environment for people who should be receiving proper medical treatment for mental health.

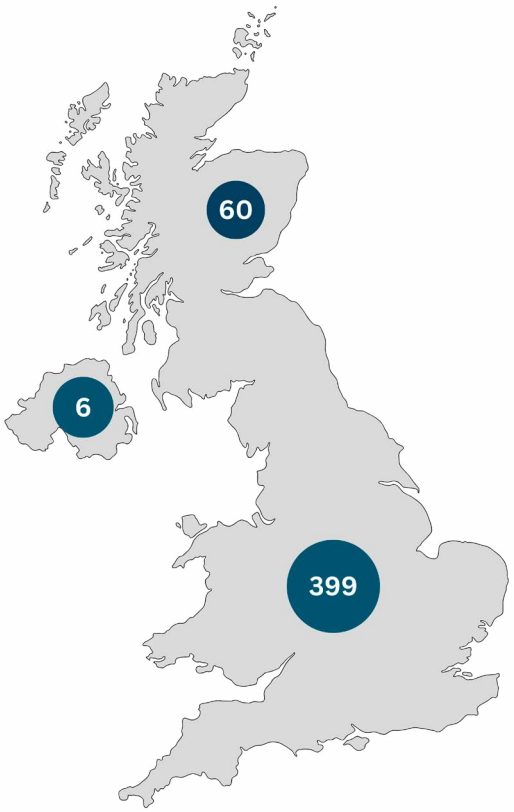
14 National Annual Report 2024; Adult prisons, young offender institutions and immigration detention – June 2025 - IMB

In Northern Ireland, a major concern is the lack of specific personality disorder services, or training for staff on personality disorders, in prisons. Progress has been slow to achieve recommendations made in the **Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons.** The current approach to safeguarding and investigation of complaints is inadequate. There is not enough evidence of safeguarding procedures to protect people who make complaints, or of consideration of external scrutiny.

In Scotland, the Mental Welfare Commission for Scotland's (MWCS) final closure report on its 2021 publication, **Mental Health in Scotland's Prisons 2021: under-served and under-resourced,** noted that its recommendations highlighting the needs of those who experience poor mental health and are moved to an SRU, continue to require MWCS oversight. Ongoing challenges include timely transfers to a mental health service that can meet prisoners' needs, while those prisoners' mental health deteriorates while they are in prison. Work by Scottish Government on the development of a Forensic Mental Health Board for Scotland is pending.

In its 2021 response to a CPT visit report, the UK Government put forward a 28-day timeframe to complete transfers from prisons to hospital for prisoners with severe mental health need warranting detention under the Mental Health Act in England and Wales. However, bespoke research by NPM bodies in 2024 found that this 28-day timeframe is too-often missed and poorly recorded across the country. The incorporation of the 28-day timeframe in the Mental Health Bill, and the need for effective recording to facilitate scrutiny, is detailed under **Draft and existing legislation**.

Deaths in prison



The number of prisoners who died in prison in Northern Ireland, Scotland and England and Wales, according to:

1. **The Prisoner Ombudsman for Northern Ireland**
2. **The Scottish Prison Service**
3. **Ministry of Justice and HM Prison and Probation Service**

In Scotland, the number of people who died in prison more than doubled between 2015 and 2024 from 24 deaths in 2015 to 64 in 2024, while the overall increase in population was 6.48%.[15] The NPM Scotland subgroup has followed the implementation of recommendations of the

15 Statistics from the Scottish Prison Service show that the average prison population in 2015 was 7,622, while the average prison population in 2024 was 8,116, an increase of 6.48%; **Prison Population - Data, Research and Evidence - Scottish Prison Service**

Independent Review of the Response to Deaths in Prison Custody closely, considering the Scottish Government's obligations to protect the right to life.[16] Of the 20 recommendations and six advisory points of the review, all accepted, 15 have been implemented. However, more individuals died in Scottish prisons in the last three months of 2024 than ever before. The three recorded primary causes of death are medical causes, suicide, and substance use, with numbers of those dying from substance use and medical causes in particular increasing.

In England and Wales, there were 399 deaths in prison custody in the twelve months to March 2025, a 37% increase from the year before. The number of self-inflicted deaths was the same as the previous year, with 91 men and women sadly dying by suicide.[17] IMBs found that, despite increased scrutiny at prisons recognised as "cluster sites" for self-inflicted deaths, further deaths were not prevented, while HMIP also highlighted insufficient learning across the estate from previous Prisons and Probation Ombudsman recommendations. The Assessment, Care in Custody and Teamwork process, to support those at risk of self-harm or suicide, was not fit for purpose at some sites, with incomplete observations, reviews or notes, and some absent supervision checks.

Following an information collecting exercise by the NPM Northern Ireland Subgroup, keys gaps were identified in the proactive sharing of information by establishments with inspectorates and monitoring bodies on deaths and serious adverse incidents in custody. Some data sharing agreements are in development, while some key gaps remain. Filling these gaps will improve intelligence within the NPM Northern Ireland Subgroup, allowing consolidated recommendations, more direct monitoring of recommendation implementation and identification of any serious systemic issues.

Use of force

Force must be proportionate to the threat posed and to the aim in which it was intended. To ensure sufficient oversight of use of force, staff can use body worn cameras to record incidents, and there should be a medical check of the prisoner after any instance of force, as well as a debrief with staff involved. Increased violence in prisons, with increased risk of weapons entering prisons via drones and recent attacks on prison officers, compromise prisoner and officer safety and have been met with a "sustained increase" in use of force incidents since the end of 2022-23. Assaults against other prisoners and against prison staff have both increased since 2020-21, now almost matching the highest numbers recorded in 2019 before the pandemic following steady increase since 2012-13.[18]

16 Independent Review of the Response to Deaths in Prison Custody – November 2021 – HMIPS, SHRC, Families Outside

17 Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to March 2025 Assaults and Self-harm to December 2024 - GOV.UK

18 Safety and order - Prisons data - Justice Data

This year, the amount of force used against prisoners had risen in more than 40% of adult male prisons inspected by HMIP, due to rising levels of violence. The use of PAVA (Pelargonic Acid Vanillylamide, a synthetic incapacitant spray) was unjustified on many occasions, according to HMIP, and was more frequent than in 2023-24. Young adults were more likely to be the subject of use of force in the male estate and work to support them was limited. Neurodivergent prisoners were also overrepresented in use of force incidents, and at some prisons there were "obvious and concerning" racial disproportionalities.[19] Women in crisis were met with a "concerning reliance on using physical force, in some cases without good reason", creating a punitive approach to a mental health issue. The NPM is concerned about the high frequency with which staff use force to stop women self-harming, with low use of body-worn cameras to allow for adequate monitoring, learning and improving practice.

Oversight of use of force was not adequate to be sure that every use of force was justified and proportionate, as there were still a large proportion of incidents not recorded, or recording starting too late to show whether force was necessary and reasonable (though use of the cameras did improve over the year).

Impact of drugs

In England and Wales, HMIP reported the destabilising impact of an "overwhelming amount of drugs".[20] The high availability and demand – fed by lack of purposeful activity and long hours in cell - led to an increase in violence over the year, eroding relationships between prisoners and staff and compromising the potential of rehabilitative regimes. 11% of men and 19% of women surveyed said they had developed a problem with drugs, alcohol or diverted medication after arriving in prison, with drug and alcohol problems affecting a higher proportion of women than men.

In Northern Ireland, IMBs at Maghaberry Prison expressed concern about high numbers of prisoners continuing to fail X-ray body scans. While positive scans have reduced since the scanners were introduced, a concerning number of prisoners still leave for accompanied hospital visits and fail a scan on their return. IMBs raised this issue with the Northern Ireland Prison Service, who instigated an independent report, which has not yet been made available to NPM bodies.

The number of prisoners found to be under the influence of drugs and the number of drug related deaths continued to be a concern in Scotland as well.

19 National Annual Report 2024; Adult prisons, young offender institutions and immigration detention – June 2025 - IMB

20 HM Chief Inspector of Prisons for England and Wales Annual Report 2024–25 – July 2025 - HMIP

Immigration detention

Impression of immigration detention settings visited between April 2024 to March 2025. Total establishments visited: 13

More people are being detained for immigration purposes, and despite some positive improvements, conditions in some detentions centres this year were the worst seen by inspectors in these settings. The population has increased and people continued to be held indefinitely, some for over a year. Only about a third of detainees at sites inspected by HMIP were deported, and more than half released.[21] Administrative detention, to process arrivals or if necessary to affect deportation, is not a punishment. The purpose of detention centres is to provide "secure but humane accommodation…in a relaxed regime with as much freedom of movement and association as possible".[22] However, in some cases, immigration detention in the UK resembles penal environments.

Indefinite detention

The UK is the only country in Europe not to have a statutory time limit to pre-deportation detention, which the UN Human Rights Committee has repeatedly recommended it introduce.[23] Pre-deportation detention should only be used exceptionally, for the shortest time possible, and as a measure of last resort where it is both necessary in the individual case and proportionate to the ends sought; there must be a reasonable possibility of deportation. Detention is deemed arbitrary if it is applied automatically to a broad category of persons or solely because their presence in a country is undocumented.[24] However, despite safeguards to detention decision making such as the Detention Gatekeeper and Case Progression Panels, the lack of a statutory time limit for detention means it is possible for detainees to spend years in detention, not knowing how long they will be there.[25] This has

21 HM Chief Inspector of Prisons for England and Wales Annual Report 2024–25 – July 2025 - HMIP

22 **The Detention Centre Rules 2001**

23 Human Rights Committee, Concluding observations on the eighth periodic report of the United Kingdom of Great Britain and Northern Ireland, CCPR/C/GBR/CO/8. 42-43

24 HRC, General Comment No. 35: Liberty and Security of Person, CCPR/C/GC/35, (December 16, 2014), para. 18; WGAD, Revised Deliberation No. 5 on deprivation of liberty of migrants, para. 19; WGAD, Revised Deliberation No. 5 on deprivation of liberty of migrants, para 12 and 14; SRHRM, Detention of migrants in an irregular situation, para. 68

25 **Duration of detention; United Kingdom – April 2025 - Asylum Information Database - European Council on Refugees and Exiles** N.b. the longest periods of detention are usually of people awaiting deportation after serving a criminal sentence.

significant negative impacts on health and wellbeing, contributing to violence, depression and self-harm. As of March 2025, 1,102 detainees had spent more than 28 days in detention.[26] 28 days is the UN Human Right's Committee's recommended limit, to avoid "distress and anxiety and [...] exacerbate[d] mental health conditions".[27] Of the 1,102, 150 had been detained for four to six months, 105 for more than six months.

Increasingly unsafe male detention estate

More time-served foreign national offenders were transferred from prisons to IRCs under Operation Safeguard, under which the Home Office accepted those convicted of violent or sexual offences, as well as people with a broadly higher risk profile.[28] Double occupancy in rooms previously occupied by one person increased. Healthcare and safeguarding processes were further stretched by an expanding population, and Brook House and Harmondsworth IRCs were holding more people than they could effectively manage. Substance misuse increased significantly and became commonplace, indicating instability, poor staff control and weak security. An increase in violence, including improvised weapons being noted by IMBs, were a particular problem at Harmondsworth and Colnbrook. Inspectors described conditions and treatment at Harmondsworth as the worst they had seen at an IRC. Violence had doubled since the last inspection. An independent review of progress, published after the reporting window, found very positive progress on concerns.

The UK has implemented safeguards through Detention Centre Rules and the Short-term Holding Facilities Rules.[29] Detainees must receive or be offered a healthcare screening within a set time period after their arrival in detention. If the medical practitioner considers that ongoing detention will be injurious to their health – in most cases this is due to previous experiences of torture, but should also be for suicidal ideation and other health conditions – the Home Office must consider their report and weigh the risks against considerations of immigration control.[30] In May 2024, IMBs at Gatwick and Heathrow IRCs wrote to the Home Office to discuss failings in the Home Office's statutory duty to protect vulnerable people from harm, citing systemic failings in safeguards for the higher number of vulnerable people now detained. Many people were in detention several months after a doctor's assessment that ongoing detention posed a serious risk of harm, even where the Home Office had agreed that they should be released. Processes to identify risk in reception interviews were ineffective, including asking sensitive questions in non-private areas, making disclosure riskier, and therefore less likely. Occasionally, under-use of available interpretation and translation services meant reception interviews could not capture vulnerabilities or risks.

Population increase added further challenges to ongoing failure to uphold maintenance. At Tinsley House, major investment was needed to resolve issues with drainage which was affecting air quality and hygiene at the centre. Detainees complained to

26 How many people are detained under immigration powers in the UK? – February 2025 – Home Office

27 Home Office rejects Human Rights Committee's call for a time limit to immigration detention – July 2029 - Committees - UK Parliament

28 Foreign National offenders with the most serious offences are not transferred to an IRC under Home Office checks and balances, see Detention General Instructions for risk assessment considerations.

29 The Detention Centre Rules 2001 – gov.uk; The Short-term Holding Facility Rules 2018 – gov.uk

30 Detention Services Order 08/2016 Management of adults at risk in immigration detention - August 2022

the IMB about lack of toilet paper, lack of soap, and lack of shower curtains. The Board described conditions after escalating complaints as continuing to be "grubby, smelly and messy".[31] HMIP noted that while one wing at Harmondsworth was closed for refurbishment, an "equally decrepit" wing was still in use.[32]

Increase in self-harm and suicide

IRCs are not equipped to provide the care required, or with appropriate spaces to care for a rising number of people with increasingly complex mental health needs. Staff were not adequately trained to support detainees, some of whom were sectioned under the Mental Health Act, and healthcare teams were inconsistently staffed and overloaded. There was a distressing rise in self-harm and the number of suicide attempts in the male IRC estate in 2024-2025 rose.[33] Many other detainees discussed struggling with poor mental health and feelings of depression after arriving in IRCs, which was so common IMBs saw it become normalised for staff, with not enough done to address and prevent mental health risk factors and reduce rates of self-harm. IMBs observed people "unable to cope", causing "serious and life-altering harm to themselves".[34]

According to IMBs, more people were held in Care and Separation Units (CSUs), and for longer periods. Individuals can be moved, under removal from association (Rule 40) or temporary confinement (Rule 42), into a CSU for no more than 24 hours, extendable to a maximum of 14 days by the Secretary of State. However, some detainees were isolated in CSUs for several weeks at a time, as the 14-day authorisation was repeatedly renewed. For those with mental ill health, this was often due to a lack of more appropriate care and the challenges of living in the everyday IRC setting. The long-term isolation appeared to cause deterioration in mental health for some people seen by IMBs.

Use of force

Alongside increased population under Operation Safeguard and the rising levels of violence, use of force in immigration detention settings rose in 2024-25. The NPM is concerned that principles of safe use of force were not consistently followed. Staff resorted to use of force during deportations, sometimes for long periods and on vulnerable people. It was not always recorded why force was used. Use of force should only be used as a last resort and when necessary in pursuit of legitimate aims, with no other alternative available. At UK-run Short-term Holding Facilities (STHFs) in France, there was poor oversight of use of force by Border Force staff, with some footage or reporting not reviewed at all, and insufficient knowledge of safeguarding. Almost everyone taken to hospitals from Gatwick IRCs were taken in handcuffs as routine, which discouraged further hospital visits due to stigma. The blanket approach was based on stricter Home Office guidance, which was interpreted, incorrectly, as requiring universal use of handcuffs.

31 National Annual Report 2024; Adult prisons, young offender institutions and immigration detention – June 2025 - IMB

32 HM Chief Inspector of Prisons for England and Wales Annual Report 2024–25 – July 2025 - HMIP

33 National Annual Report 2024; Adult prisons, young offender institutions and immigration detention – June 2025 - IMB

34 National Annual Report 2024; Adult prisons, young offender institutions and immigration detention – June 2025 - IMB

Separation in CSUs is allowed when necessary for security or safety and these measures should never be used as a punishment. However, IMBs observed separation implemented frequently either when someone refused to share a room or to prepare for a deportation and avoid predicted disruption.

Concerns in Short-term Holding Facilities

There were delays in repairs in some STHFs, which were extended by lengthy decision-making procedures involving the numerous agencies working at sites. Sometimes this resulted in temperature extremes, with holding rooms sinking to 10.9 degrees in one case (meanwhile, in Heathrow IRC a ventilation failure led to detainees being held at extremely high temperatures, without fans). There was inadequate provision of basic necessities, at certain locations, which included food, and blankets for those detained overnight at port facilities. IMBs described it as "common for people to be left without bedding and many sat through the night on hard plastic chairs or slept on the floor" in those settings.[35] Inspectors found some STHFs "barely fit for purpose", despite improvements in some others.[36] Hot food was withdrawn at Border Force directly managed facilities in 2023 after failing to meet local authority food standards, but throughout 2024 some holding rooms continued to be unable to offer hot food or drink, and where hot food was available it was not always suitable for detainees, for example not including a halal option.

People detained at the majority of STHFs continue to be denied access to prescription medication under Home Office policy, placing their health at significant risk. Policy requires confiscation of all medication, and without specific healthcare or pharmaceutical provision at STHFs, the process of obtaining new medical advice and prescriptions via phone or emergency facilities incurs long and unnecessary waits. This has been raised by IMBs since 2017, and the Home Office has reported a new contract award for medication to be made in 2026. However, for the rest of this year it is likely that those detained in STHFs will continue to miss essential medication windows.

There was regular detention in holding rooms past the 24-hour time limit, which should only be exceeded in exceptional circumstances under Secretary of State authorisation. Most concerning, IMBs observed detention for more than 24 hours in small, windowless rooms, meaning individuals had no access to fresh air or sunlight. In non-residential airport STHFs, designed to hold people for only a few hours, a quarter of detainees – including many children – were detained for more than 12 hours, and almost 600 were detained for more than 24 hours in the six months before HMIP's January 2024 inspection (published in April 2024). At Luton airport, children were detained in crowded holding rooms with unrelated adults, raising significant safeguarding concerns.

Staffing shortages and, in some STHFs at the Kent coast, space limitations, meant that people had to be held in vans, in aiting areas without adequate facilities, or in areas

35 National Annual Report 2024; Adult prisons, young offender institutions and immigration detention – June 2025 - IMB

36 HM Chief Inspector of Prisons for England and Wales Annual Report 2024–25 – July 2025 - HMIP

exposed to public view for several hours, compromising privacy and dignity. Two of the UK-run STHFs in France, inspected in November 2024, held people in small, dingy rooms with very little natural light, without access to the open air or comfortable sleeping facilities. Though Border Force were efficiently processing cases, some people – including children – were held in these rooms for more than 10 hours and there was no analysis of why detention was lasting so long.

Detention and deprivation of liberty in health and adult social care settings

Impression of high secure mental health settings visited between April 2024 to March 2025. Total establishments visited: 21. Please note that low and medium secure settings are not recorded, and nor are non-secure mental health or social care settings where people may be deprived of their liberty.
High secure settings are indicated only by county or commissioning area.

Mental health and mental capacity legislation in the UK allows for the deprivation of liberty of people in certain circumstances. In some health settings such as Secure Mental Health hospitals, most or all people receiving care would be deprived of their liberty, in other settings such as care homes or acute hospitals this may only be the case for some of the people receiving care.

Institutionalisation of people with a learning disability and autistic people

People with a learning disability and autistic people can spend many years in mental health hospitals or units specifically for people with a learning disability across the UK. Detention in the absence of individualised, therapeutic need risks violating the right to liberty (article 5 ECHR) and risks treatment violating article 3 ECHR.[37] Spending years in an institution (e.g. a hospital) can erode a person's ability to see friends and family, and their freedoms to make everyday choices, or decide about medication or treatment, impacting their rights to a private and family life and to legal capacity. The ongoing possibility of restraint and seclusion risks creating traumatic responses challenging the prohibition of torture and other cruel and inhuman treatment and punishment.

In Scotland, both the Scottish Human Rights Commission (SHRC) and MWCS undertook specific reviews into causes or effects of institutionalisation on long-term inpatients. MWCS examined the conditions for 55 people with learning disability and complex needs who have been in hospital in Scotland for 10 years or more, and found that people are staying in hospital for too long – an average of 18 years and two months. This violates their rights to live independently and be included in the community, despite various policies in the last ten years to support realisation of this right.[38] As well as people on the Dynamic Support Register in Scotland and delayed discharge list, other patients were considered to live at the hospital with no discharge plan, who were not on either list and therefore without the same legal safeguards. The Dynamic Support Register exists to ensure that "people are only in hospital for as long as they require assessment and treatment" but has not achieved this aim. Ten out of 18 people were recorded as delayed discharges. For nine of these it was not clear how long they had been in delayed discharge, while some had been deemed clinically well enough to leave hospital as long ago as 2013. After spending more than 10 years in hospital, 14 of the 18 patients MWCS visited were subject to restrictive interventions. Care plans and environments were not always fit for purpose. People had lost independent living skills, had lost confidence, and experienced distress in a group ward situation. However, MWCS found some good, collaborative practice implementing inclusive and active discharge planning despite concerns about the capacity of community care resources to safeguard the person and meet their needs.

The Coming Home Implementation Plan was designed to remedy serious human rights concerns about people with a learning disability and autistic people in hospitals. However, the target to greatly reduce numbers of people in institutional, rather than community, care by March 2024 was not met, and there has been little follow-up on using a Community Living Fund to facilitate moves into community care. SHRC reports no significant reduction in the number of people living in institutions, and no meaningful reduction in the amount of time they spend there. Staff working with this cohort remain under-trained in the United Nations Convention on the Rights

37 Legislative Scrutiny: Mental Health Bill – Third Report of Session 2024-25 – May 2025 – UK Parliament

38 The keys to life: Improving quality of life for people with learning disabilities – June 2013 – Scottish Government; Coming Home: A Report on Out-of-Area Placements and Delayed Discharge for People with Learning Disabilities and Complex Needs – November 2018 – Scottish Government; Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge – February 2022 – Scottish Government

of Persons with Disabilities (UNCRPD). SHRC recommends urgent law reform to remove lawful detention because of a lack of state-provided community-based support, rather than a clinical need.

In October 2024, a closure report by MWCS on compulsory treatment for mental illness in the community noted that the Mental Health Tribunal for Scotland will now log two-year reviews where a person has been on a Compulsory Treatment Order in the Community for more than five years. This is based on MWCS findings that almost three quarters of these orders had been in place for over two years, with some people subject to a compulsory community treatment order for 17 years. A meeting was held with the Law Society Mental Health and Disability Sub-Committee in September 2024 about the Commission's views on the benefits, or not, of long-term compulsory community treatment orders.

In Northern Ireland, lack of community placements for people with a learning disability led to delays in discharge from acute settings. Slow progress has been made to resettle patients in Muckamore Abbey, though there have been successful discharges into the community. There is continued over-occupancy of mental health services, which impacts on patient safety, as well as the capacity to admit new patients (including those to be transferred from prison).

In England, too many autistic people or people with a learning disability continue to be detained in mental health wards under the Mental Health Act.[39] They are detained for far too long; in June 2024, the majority of these patients had been in hospital for more than two years, and almost one in six had stayed in hospital for more than 10 years. Delays in discharge are often related to a lack of available placements in residential care, a lack of appropriate social care support, or lack of suitable housing. Most hospital wards do not provide therapeutic environments for autistic people and people with a learning disability. They are brightly lit, and mental health wards can be noisy and chaotic, which contributes to distress, which can lead to restraint, seclusion and segregation, themselves causing distress and trauma.

In Wales, a lack of effective discharge planning and lack of enough suitably trained staff to ensure effective pathways through services also contributes to extended stays, impacting the number of available beds.

39 Written evidence by Care Quality Commission (MHB00026) – January 2025 – Parliament.uk

Closed cultures

CQC commissioned the Patient Experience Library to analyse warning signals from avoidable harm inquiries in health and social care.[40] The report finds harmful patterns in behaviour and cultures, and the red flags that can help to identify them. The outcome of the analysis includes a Red Flag Tracker tool, which can help anyone who feels something is "not quite right" to check their initial concerns against evidence.

In early 2024, CQC commenced engagement with external subject matter experts in organisational abuse and supported the development of an Expert Reference Group (ERG), hosted by Partners in Care and Health. The group has collaborated to collate and publish resources on organisational abuse, delivered a public webinar and commissioned research to inform national work on preventing, identifying and responding to organisational abuse. The ERG has raised awareness of closed cultures that can develop within health and social care services.[41]

In adult social care, CQC has taken enforcement action in some of their assessments of care homes and supported living services where a closed culture and poor application of the Mental Capacity Act mean that people are unlawfully deprived of their liberty.

Restrictive interventions, seclusion and restraint

Following Baroness Hollins' independent review and 2023 report on care for autistic people and people with a learning disability in long-term segregation in inpatient settings, the Department of Health and Social Care in England (DHSC) asked CQC to lead a programme of Independent Care (Education) and Treatment Reviews for a two-year period with reviews starting in May 2024. By March 2025, CQC had completed 47 reviews of the care of people, resulting in some important positive changes, including the 11 people who left long-term segregation either to a ward or a new home in the community. The approach has a focus on ensuring people's human rights are protected, improving people's lives and wellbeing, and working together to address barriers to the individual's care. The wider aim of the programme is to reduce the use of long-term segregation nationally.

CQC completed 702 Mental Health Act monitoring visits in the reporting year, to a wide range of hospital settings, including 123 in forensic mental health. Mental Health Act monitoring visits include a focus (through engaging with people receiving care) on whether people's rights are upheld and restrictions are appropriate. Through their monitoring activity, CQC have seen patients held in overly restrictive environments as a result of bed shortages. Blanket restrictions on wards, and access to fresh air and outdoor spaces were also a key area of concern for Mental Health Act reviewers.

In December 2024, CQC noted increasing concerns about the use of chemical restraint, particularly the use of intubation. Regulatory activity had identified examples of this being used in hospital settings to control autistic people or people with a learning disability when they were communicating distress. This was a particular concern relating to cases of heavy sedation in acute settings and affected people of all ages. CQC highlighted that restrictive practices like chemical restraint are inappropriate when they could have been prevented through better person-centred

40 **Responding to challenge – April 2025 - Care Quality Commission**

41 **How CQC identifies and responds to closed cultures – May 2022 – Care Quality Commission; Closed cultures in social care: Guidance and questions to ask – April 2024 – Local Government Association**

planning, listening, understanding, skills, support, and system partner collaboration and that they impact on people's human rights. Workforce shortages are a challenge in building a skilled workforce that is able to take preventive approaches. CQC's policy position on reducing restrictive practices covers 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.

In one hospital in Scotland visited by MWCS, records for individuals subject to soft restraints were not as detailed as MWCS expected. There were daily reviews of individuals subject to soft restraints, but they appeared tokenistic as staff did not have the authority to make clinical decisions or recommendations to stop use of soft restriction kits. The only person with authority to remove the kits was a responsible medical officer at a weekly care and treatment meeting. A weekly decision is not proportionate or reasonable. MWCS recommended meaningful review at least once a day.

In Wales, staff at Llanarth Court were supportive and respectful and compliance with mandatory training and strong leadership were strengths, though there were still staff vacancies. For some patients, en-suite bedrooms provided a good standard of privacy and dignity. Least restrictive practices in care planning and in ward practices supported individualised patient care, and a model of least restrictive care was effectively leading staff to focus on therapeutic engagement, building a relaxed atmosphere. When restraints took place, there was thorough recording and supervision allowing for all-staff learning from incidents. Redirection and de-escalation were respectful and supportive. When patients were placed in intensive care suites to manage aggressive or disturbed behaviour, exit strategies were used to reintegrate back into the main ward, allowing patients to set their own goals to support this.

In Northern Ireland, RQIA identified inconsistent approaches to recognising and reporting incidents in accordance with regional procedures. Challenges in care settings and issues with seclusion and restraint risk breaching human rights and the Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings, as well as the Regional Operational Procedure for the Use of Seclusion in Northern Ireland, 2023.

Systemic difficulties and delays

In England, CQC inspects and monitors hospitals and care homes, in any of which people may be subject to a Deprivation of Liberty Safeguards (DoLS) authorisation under the Mental Capacity Act. In Wales, scrutiny of hospitals is undertaken by Health Inspectorate Wales (HIW), and care homes with or without nursing provision are inspected by Care Inspectorate Wales (CIW). The total number of DoLS applications received each year across England and Wales is far beyond the levels expected when the safeguards were designed, often resulting in lengthy delays. This means people in vulnerable circumstances are waiting for far too long without the right safeguards and legal protections in place.

In England, issues with the DoLS system continue to disproportionately affect certain groups of people. CQC's survey of Mental Capacity Act leads in hospitals highlighted concerns around older people, including those with dementia. CQC still see wide variation in how local authorities manage DoLS applications. While some local authorities report not having any backlogs, others struggle to meet demand.

The policy landscape in health and social care is changing, and this will likely have implications for the DoLS system. The Liberty Protection Safeguards (LPS) were due to replace DoLS, but their implementation was delayed multiple times. In light of the chronic and longstanding issues impacting the DoLS system, CQC has continued to highlight the need for substantial intervention and reform. The government's recent announcement that it intends to consult on LPS in 2026 has been welcomed by CQC. Another pending area for change arises from the reforms to the Mental Health Act. Despite the Bill's ambition to prevent long-term hospital detentions of autistic people and people with a learning disability, CQC is concerned that a lack of suitable community-based alternatives could lead to people being detained under other legal frameworks, such as DoLS. This would place additional pressure on an already struggling system that is not always effectively protecting people's rights.

Delays in DoLS assessments being completed and authorised in Wales has also led to periods of unlawful deprivation. In Scotland, mental health officers were not always consulted on emergency detention, which also weakens the safeguards in place to ensure that any deprivation of liberty is absolutely necessary and in the individual's best interests.

Other systemic issues

In England, system pressures mean people (including young people) can be detained far from home or in environments that do not meet their needs. CQC has flagged concerns around workforce retention, training and support for staff, with evidence of staff not having the specialist training required, particularly in caring for autistic people and people with a learning disability. In healthcare settings in some areas of Wales, difficulties with staffing, recruitment and retention have caused similar issues, with a lack of suitably trained staff to ensure effective care pathway and effective medicine management and lack of hospital beds.

In secure hospitals in Scotland, positive findings included access to secure garden areas and walking trails, person-centred care and treatment records which incorporated patients' views, well-lit and spacious wards. Enhanced observation, nursing in bedrooms, side rooms or ward day rooms supported patients' safety and were all delivered in line with good practice. Some nursing staff did not understand their responsibilities towards specified persons under the Mental Health Act (which includes anyone

detained in a high secure environment). While security measures such as locked door policies or enhanced observations were mostly in line with good practice, some patients were under excessive security, in part due to the wait for a space in a lower security ward. Some had appealed to the Supreme Court. MWCS was concerned that individuals' rights to move were not met and are following up individual cases.

Over 25 inspections of NHS and independent hospitals, and community mental health teams across Wales, HIW found that both mental health and learning disability services in Wales continue to face recurring and systemic challenges. Safe, person-centred care is hampered by staffing shortages, physical deterioration of settings, and weaknesses in governance. While most services demonstrated compliance with the Mental Health Act 1983 and Mental Health (Wales) Measure 2010, HIW noted areas for improvement in documentation, consent to treatment and discharge planning.

The quality and consistency of care in mental health and learning disability services continues to be compromised by persistent difficulties recruiting and retaining skilled staff in nursing, psychology and occupational therapy. Some settings suffered from low morale, with difficulty filling specialist roles and high reliance on bank and agency staff. These staffing constraints, added to high bed occupancy, meant that inpatient services were under pressure, despite a clear commitment to delivering compassionate care. HIW observed positive examples of multidisciplinary working and legal compliance with the Mental Health Act 1983.

A large number of both NHS and independent services were found to have poor maintenance, damaged fixtures and inadequate infection prevention and control, with some NHS hospitals requiring urgent improvement plans, having deteriorated since the last HIW inspection. Despite previous and repeated recommendations, HIW found gaps in documentation, poor storage practices and inconsistent oversight of medication management. The lack of sustained improvement poses risks to patient safety.

Several services had inadequate risk management practices, and inconsistent audit processes. Patients had limited access to secure personal space, few gender-specific areas and inconsistent access to advocacy and information.

Anti-racist approaches to prevention

CQC highlight that more is needed to address the over-representation of Black people who are detained under the Mental Health Act and placed on community treatment orders in England and have welcomed the introduction of the Patient Carer Race Equality Framework (PCREF), the first anti-racism framework for mental health trusts and mental health service providers. CQC recognises that PCREF is an important part of advancing rights-respecting care and have included a 'question of the moment' for their Mental Health Act Reviewers to explore the adoption of PCREF in their visits this year. In September 2024, CQC committed to becoming an anti-racist organisation and introduced enhanced training for staff.

Police custody

Impression of police custody settings visited between April 2024 to March 2025, represented by county or commissioning area. Total establishments visited: 21

In Northern Ireland, while the findings about the treatment of detainees and their safety were positive, the pace of legislative reform to ensure alternative accommodation to custody for children was not fast enough. One person has died following a period of time where they were held in police custody in Northern Ireland during the reporting year, which is being investigated by the Police Ombudsman for Northern Ireland. Healthcare remains a challenge. In England and Wales, detainees' treatment or assessment for transfer to hospital is frequently delayed due to low numbers of healthcare practitioners covering multiple custody suites, high caseload demand, and issues bedding in new contracts. Police custody in the north east of Scotland has faced recurring instances with detainees not being provided access to prescriptions and not being informed of how long it will take to see a doctor or a nurse. The police custody estate needs modernisation, with 46% of maintenance issues reported relating to cells out of use because of broken toilets, leaks or damaged walls.

Observation and risk assessment

In Scotland, risk assessment observations are not being used effectively. 42% of individuals in custody in Scotland declared mental health vulnerabilities over 2024-25, broadly consistent with the 43% of detainees who self-declared a mental health vulnerability in 2023-24. Police Scotland collaborate with NHS 24 to provide mental health support when required to detainees. However, sufficient improvements have not been made to address incongruence between risk assessment and observations following His Majesty's Inspectorate of Constabulary in Scotland (HMICS) recommendations. Some custody centres had a concerning lack of health service, so a proportion of the large number of people with mental health and substance misuse challenges could pass through custody and leave without any service or referral.

In England and Wales, children and vulnerable adults on constant observation were sometimes seen by custody visitors to be placed in handcuffs while waiting for an appropriate adult for strip searching, which suggests arbitrary, and possibly distressing for children, use of a restraint that should only be used when deemed necessary and proportionate following an individualised risk assessment. A national letter from the National Police Chiefs' Council advising that these arrangements should only be utilised in extreme circumstances only, was issued in February

2025 following action by the Independent Custody Visiting Association (ICVA) and the National Appropriate Adult Network.[42]

His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) found that although some forces had good governance and oversight of custody services, improvements were needed in others. While some forces collect and analyse a good range of performance information, not all forces use data effectively to understand and improve performance. The governance and scrutiny of use of force was not always good enough, and more could be done generally, though there were good quality assurance processes in some forces. There were some good examples of monitoring data on wait times for mental health assessments, but some forces needed to do more to understand outcomes for detainees. Detainees can face long waits for assessments and transfers to mental health facilities. However, support in custody is generally good, with access to healthcare and liaison and diversion services. Forces focus on the safety of detainees but do not always complete pre-release risk assessments in enough detail to reflect all the risks they identify. Some detainees have faced delays in police custody due to problems with the capacity of courts. Though HMICFRS found some good examples of reviews of detention, inspectors also found that forces did not always comply with PACE and its codes of practice, and the standard of recording needed to improve. Forces generally take account of detainee welfare during reviews, including the specific needs of children.

In Northern Ireland, detainees were more likely to be placed on the appropriate observation level, but recorded risk assessments and care plans lacked detailed risk analysis and did not specify the need to rouse detainees who were under the influence of alcohol and drugs. In some custody records, there was no written evidence that detainees had been roused and pre-release risk assessments also lacked sufficient detail or actions to address all identified risks. Risk assessment, planning and recording all needed improvements, with recommendations made in 2020 to the Police Service of Northern Ireland only partially or not achieved.

Staffing and healthcare

A follow up review by CJI and RQIA observed the advantages of a nurse-led healthcare model in police custody, noting delays in the roll out of consistent, nurse-led and high-quality healthcare across all suites. In the custody suites that did not have nurse-led provision, challenges in ensuring the delivery of an effective Forensic Medical Officer service meant custody healthcare could not be provided consistently. Despite custody staff concerns about the risks to detainees and themselves without access to effective health or medical care, and escalation to the Assistant Chief Constable and Departmental Risk Management Group, there had been little observable action to address the risk, leaving staff and detainees exposed.

In some custody centres in Scotland, there was a lack of custody staff per shift to meet detainee needs and facilitate visits by independent custody visitors – a requirement under OPCAT. Where ICVs do have access, they have been able to work with Police Scotland on proposals to improve provisions for detainees. For example, after highlighting that some reading material might be inaccessible to detainees with dyslexia and autism, ICVS proposed sourcing specific books for these readers, which are

42 **Re: Use of handcuffs on children and vulnerable adults awaiting an appropriate adult for a strip search – February 2025 – NPCC**

now being used and given to detainees on request. Increasingly, local policing officers are needed to backfill shifts, as there are gaps within core custody teams and staff on modified duties often have limitations on what they can do to support detainees.

This has negatively impacted staff morale, which in turn affects detainees' welfare, particularly in larger centres with specialist facilities. This had direct impacts on detainee dignity.

In England and Wales, low staff numbers meant that detainee needs could not always be accommodated, negatively impacting their welfare. Nor were there always enough staff to facilitate independent custody visits. Problems embedding healthcare contracts led to inconsistent healthcare provision, and high demands on short-staffed teams meant that healthcare could not be proactive, and detainees' requests for assessment or treatment faced delays.

Children

Police cells are not a suitable place for children, especially overnight, and prolonged stays in these environments, designed for adults, can be harmful.

In Northern Ireland, though the number of children entering police custody had decreased since 2020, there remained delays in obtaining an Appropriate Adult for children resident in children's homes, which meant their progress through custody was slower, release happened later, and children were held overnight. However, inspectors also saw good practice where Custody Sergeants did not authorise detention when children were brought into custody and gave directions to avoid placing children in a cell or expedited children's cases. In 2020, CJI made recommendations to the Department of Justice to pursue legislative reform to facilitate children and young people's right to bail, to provide for alternative accommodation for children, and enhance information to officers on detaining children and young people. CJI noted welcome progress in September's tabling of the Justice Bill 2024, to address remand, bail and custody arrangements for children and young people, but remain concerned about delays in delivering alternative arrangements.

The NPM's 2023-24 Annual Report referred to recommendations made in the Northern Ireland Policing Board's 2023 human rights review, on the strip searching of children in police custody. Following the recommendations, there were fewer strip searches of children in the year to March 2024, and very few conducted without an Appropriate Adult present. Several issues raised are still outstanding, including underreporting leading to appropriate adults not always being present when they should be.[43]

In England and Wales, not all forces have effective processes to prioritise booking in children or to support their needs when they first arrive to custody. While forces contact local authorities to request secure accommodation for children remanded in custody overnight, there is a lack of suitable accommodation. This is a national issue. In London, the available accommodation was unsuitable for children as it was too far away, so children remanded to custody will always stay overnight in a police cell. Despite forces making requests to local authorities, HMICFRS still find a poor outcome for children remanded to custody due to a lack of alternative local authority accommodation. As a result, children charged with offences are routinely detained overnight in police custody. Following anti-immigration public disorder in July and August 2024,

43 Human Rights Review of Children and Young People and Policing – December 2024 – NI Policing Board

the Children's Commissioner for England undertook a review of the experiences of children who spent time in custody following their participation. Some children described spending between 48 and 72 hours in police custody, with many spending at least a night there in order to appear in court the next day. Of the two forces formally inspected during this period, neither were adversely affected by the disorders in July and August 2024. HMICFRS found that some forces do attempt to prioritise booking-in according to age, risk and vulnerability, but there is room for improvement.

Independent Custody Visiting Scotland report that Police Scotland continue to try to minimise the number of children held in police custody; 4,056 children were held in custody this year, compared with 4,083 last year and 4,261 the year before. This follows the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024, under which provisions in the Criminal Justice (Scotland) Act 2016 will be amended to ensure that all young people under 18 are treated as children while in police custody. Amendments contained in the Children (Care and Justice) (Scotland) Act 2024 were not in force during the reporting year. However, custody visitors observed children being appropriately cared for, with staff appropriately informed about welfare needs of children in police custody. However, recent custody inspections by HMICS and Healthcare Improvement Scotland found incidents in custody records of children being detained for longer than necessary with potentially detrimental impacts for them. This often related to care experienced children, where delays in them being picked up by care staff contributed to the extended time spent in custody.

NPM impact: menopause in police custody

In 2024, ICVA produced guidance on custody conditions for people experiencing menopause and perimenopause. The NPM followed up with guidance for monitors and inspectors in all places of detention to consider menopause and its impacts in their scrutiny.

In April 2024, ICVA sent a survey to all custody visiting scheme managers on suites' adoption of the new menopause referral pathway.

Before the National Police Chiefs' Council recommended the menopause pathway's introduction, only 2 scheme managers were aware of arrangements for those coping with symptoms of menopause. The 2024 survey demonstrated a boom in awareness with 38% of custody officers undergoing training, and 46% of respondents informing of changes implemented as a result, including implementation of menopause packs, training, and a single menopause point of contact. Packs were offered on arrival to any detainees that may require them.

Amendments to the Authorised Professional Practice were introduced in June 2024, including a bespoke section on the menopause referral pathway, under which all female detainees over the age of 40 should be offered the opportunity to discuss perimenopause or menopausal symptoms and produce a care plan for their time in custody. These might include memory aids, paper fans, or access to water, among other measures.

Improvements are still needed in some forces, but there has been an overall increase in awareness of menopause and provisions in police custody.

Court custody and transport

Impression of court custody settings visited between April 2024 to March 2025, indicated by county or commissioning area. Total establishments visited: 19

Inspectors and monitors did not witness treatment or conditions amounting to torture, cruel or inhuman treatment or punishment in court custody. The NPM is assured by reports of staff supportiveness and of initiatives to reduce detainees' stress. However, obstacles to providing safe and fit court custody sites and transport services need concerted attention, particularly where funding or clarification of contracts could facilitate repairs. Transport contractors should review practice and outline where and how to complete these. Though CJI did not conduct an inspection of court custody in the reporting year, court cell conditions in Northern Ireland were a concern.

In England and Wales, inspections of courts and escort providers in West Mercia & Staffordshire, Wales, and West Midlands and Warwickshire – all areas where court custody and transport is delivered by GeoAmey - found that detainee transport to court was often delayed, due to the volume of people going through courts, insufficient contracted staff or vehicles, population pressures in prisons and distances between prison and court.

The lack of transportation staff across the whole court custody process means that existing staff are diverted from transport to custody, and there are not enough transport staff to provide a reliable service. This results in very long journeys (to cover multiple sites) in uncomfortable conditions. Delays cause distress and can extend time in detention unnecessarily, particularly when they mean a detainee cannot see a solicitor before their court appointment or arrive too late for their appointment altogether. This undermines their right to legal counsel and a fair trial. Alternatives such as video link are now provided by prisons, and the use of these to minimise prisoner transfers for court hearings had increased by 17% from the previous year, according to HMPPS. However, video links were rarely used for detainees travelling from police custody. Hearings could also be delayed because of incomplete preparation, lack of legal representatives or interpreters. Lack of interpretation was most frequent at remand courts, on Saturdays and public holidays. For detainees, these delays meant longer in court custody or a higher likelihood of remand in prison. Delays leaving courts meant people being detained in vans not designed for long-term detention, in a physically uncomfortable space and no distraction. Those returning late at night to prison may then also miss out on a hot meal or shower.

Across England and Wales, HMIP and Lay Observers found that women and children often had to share vehicles with adult men, with partition screens providing some protection. Particularly concerning were instances of women being transported in the same vehicle as men charged or convicted with sexual offences or violence against women. This is a regular occurrence, especially in transport from police custody, and risks exposing women to verbal abuse and of re-traumatisation for women who have experienced sexual or gender-based violence. Separation screens were not always used, and in any case do not block sound, while their presence indicates that a woman or child is on board. The principle of separation, outlined in international and domestic rules, requires women to be detained separately to men, children to be detained separately to adults, and immigration detainees to be detained separately to those imprisoned for criminal offences.[44] Units in the same facility should be completely separate.[45] Children should be transported in non-cellular vehicles and kept completely separate from detained adults to protect their safety, dignity and wellbeing.

The long journeys and long waits for vans to fill up pose an unavoidable physical challenge, which has not been addressed in a dignified way. Those in the van are not always allowed to disembark at stops to other courts to use the toilet and are provided with "specialised liquid bags" to use in their van cell. There is nothing to cover sounds, and cells are covered by CCTV. Detainees report significant discomfort, i.e. pain, to avoid having to use the bags. The waits also cause additional risks for individuals waiting to access medication, or when warmer clothes or air conditioning are needed.

Routine use of handcuffs in unsecure vehicle bays when moving detainees into court buildings was also a problem across England and Wales. Restraint should be used only when necessary and proportionate to individual risk. However, Lay Observers frequently reported blanket use of handcuffs without reference to individual circumstances, including on pregnant women and children. Rather than being due to resource constraints, Lay Observers found that this was often the result of lack of consideration of detainees' dignity. Detainees were sometimes moved in handcuffs in full view of the public, which sometimes resulted in videos appearing on social media, undermining their rights to a private life and the principle of presumed innocence.

In court custody itself, there were improvements in meeting detainee needs, including better provision of distraction activities, though distraction materials were limited and not always suitable. Custody staff were reassuring and able to diffuse tension. The use of force was only deployed as a last resort, and inspectors saw improved proportionality in use of handcuffs and searching.

Relatively few children were detained in court custody, and when they were transferred to courts from a secure setting they were usually accompanied by specially trained staff and held in legal consultation rooms, rather than cells. However, some children were locked in cells in West Midlands and Warwickshire.

44 International Covenant on Civil and Political Rights Article 10; Convention on the Rights of the Child Article 37; International Convention on the Rights of Migrants and their Families Article 17; UN Standard Minimum Rules for the Treatment of Prisoners Rules 11, 89, 93; UN Rules for the Treatment of Women and Non-custodial Measures for Women Rules 40, 41; United Nations Rules for the Protection of Juveniles Deprived of their Liberty Rules 27, 28, 29, 30; European Prison Rules 18, 34.5, 51, 52, 53.

45 **Separation of detainees - APT**

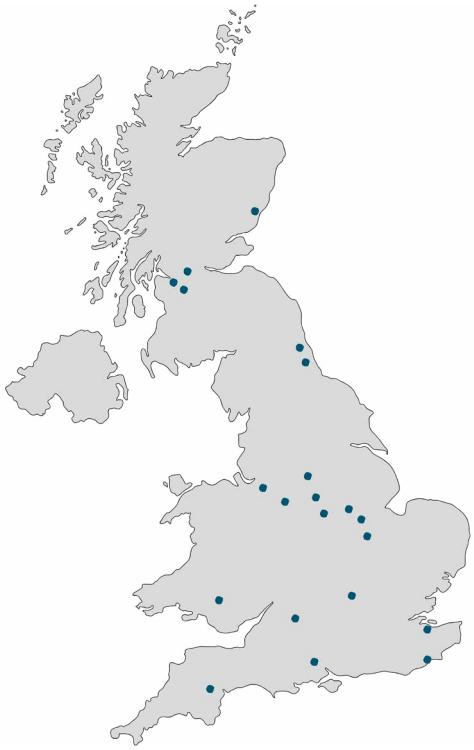
Where children arrive at court custody from police custody, they are rarely accompanied by trained staff, which often means they are placed in a locked cell.

Too few custody settings could meet needs of detainees with mobility issues or a disability, and detainees with physical disabilities or mobility difficulties were sometimes sent to inaccessible courts, where they could not access the court appointment they had travelled, sometimes long distances, to attend. Some buildings were run down, with very small cells barely fit for use. Complex contracts and too little funding prevented necessary repairs, according to HMIP.

In Scotland, His Majesty's Inspectorate of Prisons for Scotland (HMIPS) published a thematic review of prisoner transport: **"Planned Failure" – A Thematic Review of Prisoner Transport in Scotland**. The review found that GeoAmey, the prisoner transport provider, frequently alerts the Scottish Prison Service (SPS) that they are unable to deliver booked escorts to hospital appointments or court hearings. HMIPS described the impact of this failure as unacceptable, with hundreds of prisoners missing important hospital appointments, or missing opportunities to participate in activities that would contribute to their progression to open conditions.

HMIPS found cleanliness, graffiti and the need for structural repairs to be an issue in several court custody units, but human rights were actively considered by staff. In six out of eight court custody inspections, there was limited or no direct accessibility to the Court Custody Unit for people in wheelchairs or with limited mobility but there was access to seating and toilets elsewhere. In most, such as Ayr and Stranraer Sheriff Courts, this was due to the age of the buildings. At Ayr and Jedburgh Sheriff and Justice of the Peace Courts, this also meant there was no disabled toilet, while at Stranraer and Stornoway Sheriff and Justice of the Peace Courts, disabled toilets were only located in or through public areas.

Children and young adults



Impression of secure children's accommodation visited between April 2024 to March 2025. Total establishments visited: 21

The introduction of new legislation and policy has changed practice in the deprivation of children's liberty, and Secure Children's Homes, Secure Accommodation Services, Secure Training Centres and Young Offender Institutions (YOIs) have adapted to new provisions. The Children (Care and Justice) (Scotland) Act 2024 ended the placement of under 18s in YOIs in August 2024, though the option for young people to remain in secure placements beyond their 18th birthday is yet to be implemented. In England, the report "Delivering the Best for Girls in Custody" prompted the decision to stop detaining girls in YOIs.
Oasis Restore Secure School was opened

during the reporting year and temporarily closed shortly after the year ended, with no date for re-opening yet set. The NPM has ongoing concerns about safeguarding, especially in the growing number of unregistered homes in England and Wales, and self-harm, violence and time in room in YOIs. YOIs in England and Wales saw a concerning rise in levels of self-harm, violence and use of weapons, undermining their capacity to rehabilitate children. Children spent too long in their rooms with limited activity or socialisation, especially for those being separated from others, and experienced poor and disrupted education.

Restrictive practice

In 2024, the Care Inspectorate published a statistical bulletin on restrictive practices, in order to enhance transparency on progress made by Scottish Government on its commitment to Keeping the Promise by reducing use, and eliminating misuse, of restraint in children's care in Scotland. In Secure Accommodation Services, the Care Inspectorate observed strong, compassionate relationships and a thoughtful approach to risk. A good understanding of young people's rights and efforts to support young people without using restraints reduced the likelihood of restraint and restrictive practice. There was impressive commitment to, and continued progress on, the reduction of restraint, informed at Rossie Secure Accommodation Service by in-depth analysis and reflection from incidents, and regular staff training. However, at St. Mary's Kenmure, the Care Inspectorate observed unnecessarily high levels of restraint and restrictive practice, often finding the use of restraint to be disproportionate to the level of risk. This affected children's physical and emotional safety and built a reactive culture that escalated restraints. There was no recording of learning from significant incidents, despite some children being harmed through use of restraint. Though staff wanted to protect young people, they didn't have crucial information to manage risks and deliver safe support, and their capacity to build positive relationships was compromised by frequent staff moves and rota changes, as well as overreliance on agency staff. Despite staffs' compassion and support, their lack of induction and unfamiliarity with the children in their care led to unsafe practice.

In March 2024 there were 11 girls in secure services in England and Wales, compared to 519 boys. The lack of a specific service model for girls has meant outcomes for the very few girls in custody are poor. In March 2025, the UK government announced it would stop placing girls sentenced to youth custody in Young Offender Institutions in England and Wales, following the independent review "Delivering the Best for Girls in Custody" and following several months of not placing girls in HMYOI Wetherby.[46] Girls often had complex physical and mental health issues, and spent long hours locked in their cells because of an inflexible daily routine. The frequency and severity of self-harm associated with this time in cell was highly concerning. Restraints were used very frequently – sometimes more than once in the same night – and all-male teams had been used to remove girls' clothes under restraint to stop self-harm, which was clearly traumatic for the girls. Girls can still be placed in Secure Children's Homes, Oakhill Secure Training Centre, and, until its temporary closure, the new Oasis Secure School.

Ofsted's inspections – a minimum of two per year - of Secure Children's Homes in England observed mostly good practice using relationship-based care. Improvements could be made at several homes in the

46 Government no longer places girls in Young Offender Institutions - GOV.UK

management oversight of use of force and accuracy of recording. Where physical interventions were infrequent, this was because leaders developed and led child centred practices and staff had very good relationships with children. Children made remarkable progress at Lincolnshire Secure Unit. Ofsted observed an inclusive, positive and child-centred culture that is led and role modelled by leaders and implemented day-to-day by all staff. Children are able to discuss and explore their identities and have a trusted adult who they can talk to and confide in. Children take active roles in the home, which teaches them independence and skills for adulthood. All staff strongly advocate for the children, and leaders actively challenge other services when actions and decisions taken are not in children's best interests. Staff's professional development is a strength and sits alongside a needs analysis that informs the support they need to meet children's ongoing needs. The trauma-informed model of care is embedded in practice.

At Oasis Restore Trust, the first secure 16-19 academy, the first monitoring visit to the education provision judged it as making "reasonable progress". The first full inspection judged all areas as "requires improvement to be good". Despite leaders training staff on best practice in single separation (where children are locked alone in an area) and managing away (where children are locked in an area, with staff present), the use of these measures, albeit for reasonably short periods, was not recognised and recorded by staff or managers and therefore could not be scrutinised by senior leaders. On the other hand, sensitive de-escalation meant that any physical restraint was proportionate, and children were always

seen afterwards by healthcare staff. Debriefs with children and staff were held, that considered how recurrence could be avoided and any development areas for staff.

HMIP, Ofsted and CQC inspectors found the YOIs inspected, reviewed and monitored to be troubled by violence, limited education, poor relationships with staff and "unmanageable" keep apart lists. High levels of violence disrupted access to education and activities. This improved after inspections at HMYOI Parc and HMYOI Wetherby.

At Hydebank Wood Secure College in Northern Ireland, which holds young men aged between 18 and 21 years old, inspectors found that outcomes were good in all four inspection areas (safety, respect, purposeful activity, preparation for release). There was a prison-wide approach to mental health and neurodiversity awareness, good time out of cell and availability of a wide range of interventions, events and activities, and workshops focussed on positive choices and rehabilitation. Use of force was lower than at the last inspection, though governance arrangements needed strengthening. The segregation environment had improved, care for prisoners in crisis was good, and levels of self-harm were lower than in similar.

Excessive isolation

In England, Ofsted served a compliance notice on one secure children's home and raised a recommendation in the inspection of the Secure Training Centre regarding inappropriate ongoing use of locking children into areas or their rooms after the legal criteria for such action has ended. Improvements were quickly made.

All YOIs were "dominated by violence and disorder and weak education provision", with sites trapped in a cycle of conflict and isolation, with children locked in their cells for a long time, leading to higher frustration and violence.[47] Outcomes for children declined and only HMYOI Parc was considered safe. No YOI provided good enough education. The Ministry of Justice announced the conversion of Cookham Wood into an adult prison because it could not deliver the improvements needed quickly enough.[48]

HMIP reviewed the separation of children in YOIs in October 2024. Use of single separation remained very high. With an average population of 440 children and young people, there were 1,038 instances of separation involving 480 children. 64% reported being locked up or prevented from mixing with other children as a punishment. 179 instances involved a child being separated for between 21 and 100 days, and 21 children were separated for over 100 days.

The Care Inspectorate focussed closely on how secure accommodation services in Scotland maintain and promote young people's safety and rights where seclusion is used. At Rossie Secure Accommodation Services, Care Inspectorate found support for young people's rights and wellbeing to be very good, with staff having a good understanding of seclusion and, more importantly, proactive strategies which could be used to prevent it.

Lack of appropriate accommodation

The proportion of children held on remand due to lack of alternative accommodation, especially looked after children, was a key

47 **Children in custody 2023-24. An analysis of 12-18-year-olds' perceptions of their experiences in secure training centres and young offender institutions – November 2024 – HMIP**

48 **Young offender's institution to be repurposed – March 2024 – Gov.uk**

concern in Northern Ireland. Woodlands Juvenile Justice Centre remains the only accommodation available when Health and Social Care Trusts advise that no other accommodation for children in their care is available. This, along with practicalities such as the time of arrest and distance to travel, has led to children held in police cells overnight under PACE and transfers between Woodlands Juvenile Justice Centre and Lakewood Secure Care Centre are common. While children have been granted bail by the Court, their release is frequently delayed until a suitable address is identified. There remains therefore an acute need to develop alternative accommodation options. Meanwhile, overoccupancy and pressures in Northern Ireland CAMHS inpatient settings have led to under-18s being accommodated in adult wards, which themselves are already stretched.

In England and Wales, Secure Children's Homes are very good at quickly developing positive relationships with children, addressing the reasons why children have ended up in secure care and preparing children for their next steps. However, insufficient provision of mental health beds or settings that can meet the needs of children with the most complex needs delay discharge from secure care. Children can end up in provisions that are not suitable or cannot meet their needs and they can end up being placed back into secure provision. Ofsted is also aware from inspections that some responsible authorities for children leaving secure care are planning poorly, and there is a shortage of appropriate places for these children. This means some children do not know where they are moving to in the weeks and sometimes days leading up to them moving on, which causes them anxiety and distress. Limited placement availability means that children sometimes go to where their needs cannot always be met. Placements then breakdown and they sometimes end up back in secure care. This situation has not improved since the NPM's last annual report.

Unregistered children's homes

In December 2024 Ofsted published a new analysis of the concerning rise in unregistered children's homes in England. Ofsted investigated more than 1,000 cases of potential unregistered settings, finding that 900 were unregistered, compared to 700 in 2023. 12% of children in unregistered homes were subject to a Deprivation of Liberty order. Unregistered homes are illegal, and do not have the safeguards and scrutiny mechanisms of homes registered with Ofsted, including annual inspections and monthly visits by an independent person to check that children are well looked after and safe. Children are placed in these settings by local authorities because there is often no alternative when a placement is required and the needs of the child are significant and complex.

Children are usually placed alone, leaving them isolated and without inspection and/or regulatory oversight. CQC does not receive notifications when children are deprived of their liberty under the Children Act 1989 or the inherent jurisdiction of the High Court. This means that CQC does not have access to data such as accurate numbers, locations or conditions imposed by the courts, even if these children are in receipt of CQC regulated activities. In Wales, children in unregistered homes do not benefit from the oversight of formal inspection by CIW as they fall outside of CIW's regulatory remit. However, assurances of safety are sought from local authorities and CIW consider its enforcement powers when necessary.

Recommendations

Optional Protocol to the Convention Against Torture, Article 19 (b).

The national preventive mechanisms shall be granted at a minimum the power:

(b) To make recommendations to the relevant authorities with the aim of improving the treatment and the conditions of the persons deprived of their liberty and to prevent torture and other cruel, inhuman or degrading treatment or punishment, taking into consideration the relevant norms of the United Nations;

The UK NPM makes recommendations under various formats. During individual inspections and monitoring visits, NPM bodies will discuss key concerns and areas for improvement directly with the establishment, which will then also feature in the inspection report, thematic reports or annual reports. These reports also feature recommendations to the relevant government department or ministry. The NPM as a whole can also make recommendations through its publications, briefings and training resources published throughout the year, represented by its central coordinating team, by the Northern Ireland and Scotland Subgroups, as well as by individual NPM bodies, in evidence made to government reviews and inquiries.

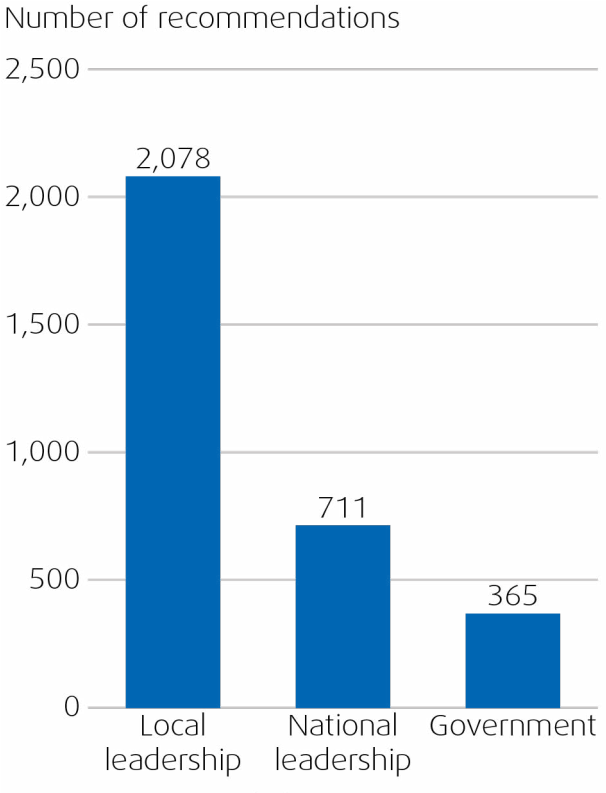
Over more than 50,000 visits, thousands of individual recommendations are made to institutions, national authorities (for example, the prison services of each nation) and to government. This section focusses on collective NPM activity and on engagement with government reviews and inquiries, to reflect systemic and UK-wide concerns and recommendations for improvement.

The NPM reporting dashboard

In August 2025, the UK NPM launched the first-ever reporting dashboard, capturing all reports, recommendations and good practice from each of the 21 NPM Bodies. Of course, the value of recommendations is in duty-bearers' response to them and their implementation. The dashboard represents a first step towards addressing concerns about a lack of response to many recommendations, by systematically logging them in one location. In the future, the NPM plans to develop functionality to highlight where recommendations have been implemented.

Over the reporting year, The UK NPM collectively conducted more than 50,000 visits, and published a total of 3,882 recommendations in 296 public reports. Most recommendations were made directly to the place of deprivation of liberty (2,779), with 733 made to national authorities and 370 to UK or national governments. 715 examples of good practice were captured.

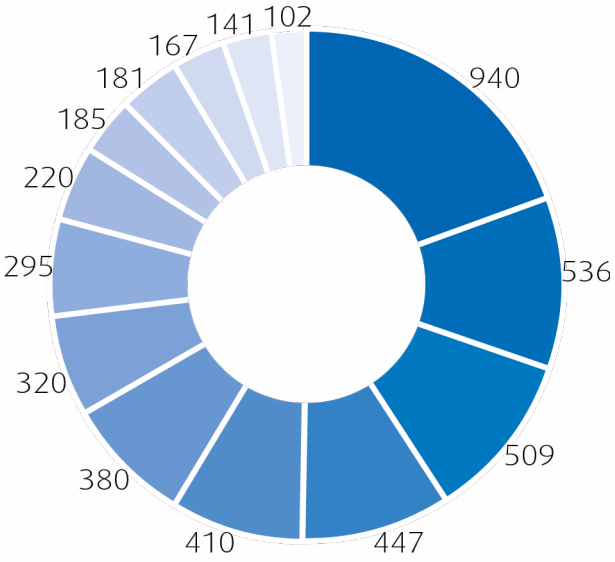
Recommendations by target



Recommendations are divided by category, and within each category are further details about what a recommendation relates to. For example, within "management, oversight and procedures", the most common category of recommendation with 940 made across all NPM bodies, 413 recommendations relate to "governance", the day-to-day running of an establishment. The most common categories of recommendation made over 2024-2025 were:

- Management, oversight and procedures
- Conditions and environment
- Safety and security
- Treatment

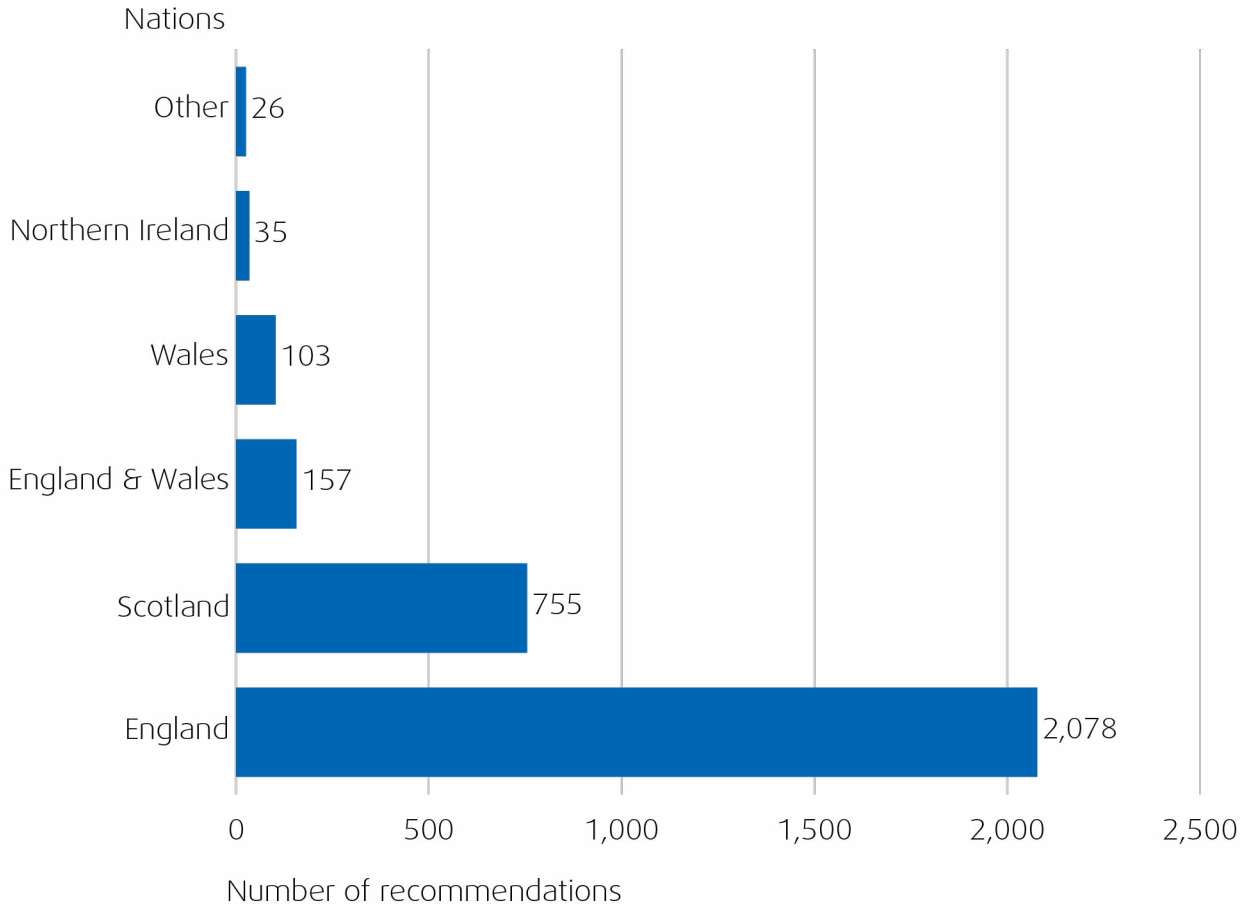
Recommendations by category



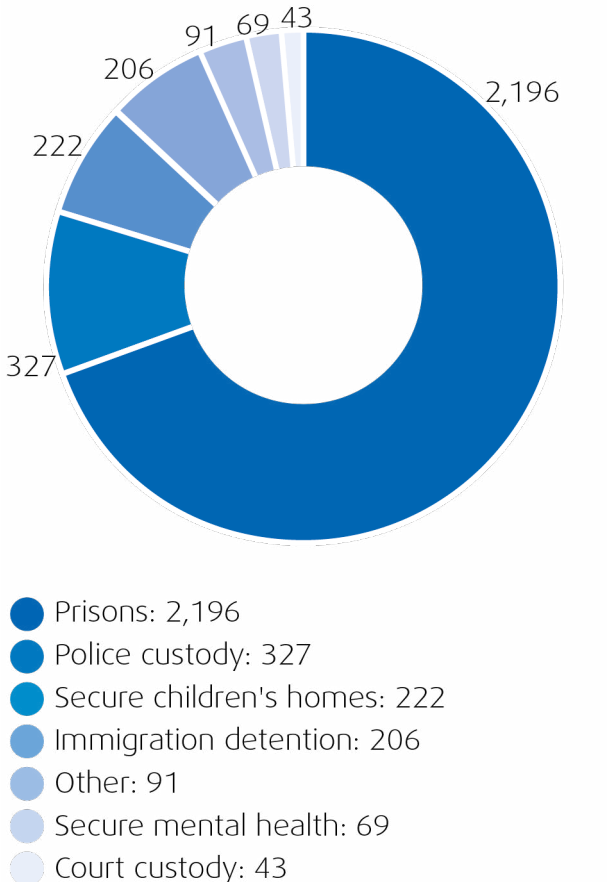
- Management, oversight and procedures: 940
- Conditions and environment: 536
- Safety and security: 509
- Treatment: 447
- Education and purposeful activity: 410
- Staffing: 380
- Healthcare: 320
- Data: 295
- Mental health: 220
- DEI: 185
- Progression and rehabilitation: 181
- Daily regime and experience in detention: 167
- Social connection: 141
- Transfers and escorts: 102

380 recommendations were made specifically about staffing or staff training, which remained a crucial issue across different settings as recruitment, retention and training of staff proved challenging, compromising other areas of detainees' lives and in some case their safety.

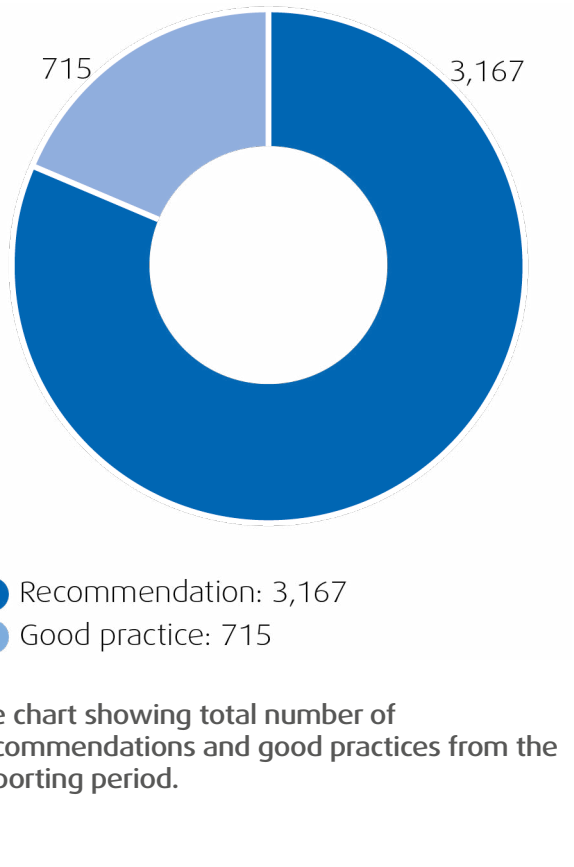
Total recommendations by nation



Total recommendations by setting



Total recommendations by recommendation type



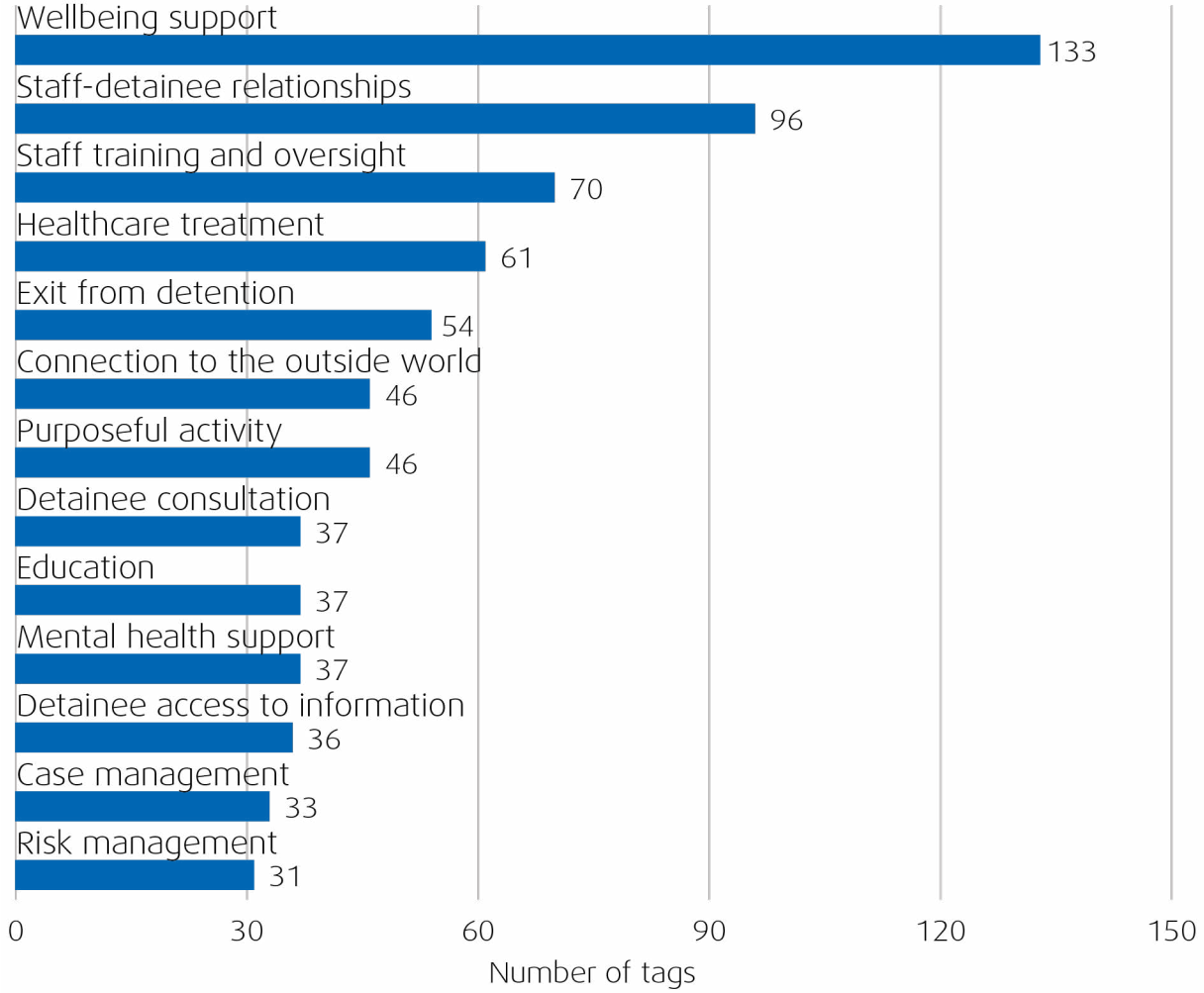
Pie chart showing total number of recommendations and good practices from the reporting period.

Good Practice: Insights from 2024-25

The UK NPM's core mandate is to identify and prevent ill treatment and torture in places of deprivation of liberty. One meaningful way to do this is to spotlight and share examples of good practice observed in the scrutiny visits that NPM bodies undertake across all detention settings, in order to identify and replicate what works well. This section gives an overview of emerging themes of good practice across all detention settings inspected or monitored in the UK between April 2024 and March 2025. The NPM encourages authorities to better utilise good practice to allow improvements to become systemic.

Of 3,882 records collected in the reporting period, 715 of these are records of good practice. Most common tags in these records are **Wellbeing support, Staff/detainee relationships and Staff training and oversight**.

Total reports by tag



Top tags from good practice records in the reporting period.

Wellbeing support:

The Hamlet Project at HMP YOI Drake Hall, the first facility of its type in the women's estate, provides additional support to women who struggle to engage fully with activities on offer before release or may struggle to relate positively to peers. A dedicated staff team provides tailored support.

Custody personnel in the Gwent police force show a good level of care towards children, offering food and drink regularly, as well as distraction materials for those who may benefit from them. These include Game Boys, fidget spinners and foam balls. Children can spend time outside their cell in the exercise yard, and visits from family members can be accommodated.

At Hydebank Wood Women's Prison and Secure College, a range of interventions and engagement opportunities are facilitated, including impressive animal therapy and regular one-to-one check-ins or group work activities such as arts and crafts. A thoughtfully created space known as the 'cosy corner' has been created to provide a safe space for this support to be delivered.

Staff/detainee relationships:

Relationships are professional at the Bella Centre community Custody Units, with a person-centred focus which recognises people as individuals who are encouraged and supported to be involved in plans for their future, and informed about decisions that affect them.

At Rampton Hospital, all patients say that staff are respectful, patient, kind and know their likes and dislikes. Staff also describe patients in a positive manner, and know individual strengths and vulnerable areas, working with patients to develop support plans.

Staff training and oversight:

In the Argyll and Dumbartonshire policing team, training opportunities are available to ensure staff competencies, including access to mental health first aid, skills training in self-harm, suicide intervention and prevention.

HMP Cardiff was a pilot site for an HMPPS-funded project to provide frontline officers with structured supervision from a peer. This aims to support wellbeing and increase officers' confidence in dealing with prisoners. Those who took part spoke positively about the additional support and guidance.

At Rossie Secure Accommodation Services, aspirational developments have taken place to support the reduction of restrictive practices, informed by in-depth analysis, reflection from incidents and regular training.

Concluding remarks:

While each setting operates within distinct legal and operational contexts, these recurring themes highlight how respectful interaction and skilled, supportive staff can create safer and more dignified environments.

The inclusion of good practice in inspection and monitoring reporting reflects an increasing emphasis on improvement and shared learning across detention settings.

Government reviews and inquiries

Over the year, the NPM central team and NPM organisations responded to a range of consultations and policy reviews, making recommendations to government committees, independent reviews, and All Party Parliamentary Groups. These outlined areas impacted by ongoing problems with, for example, prison estate capacity, and outlining what should be done to meaningfully address pressures.

May 2024

Care Inspectorate and MWCS make written submissions to Scottish Government's consultation on the UN Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024: Statutory Guidance on Part 2 and 3, Section 18.

September 2024

HMIP submits written evidence to the Public Services Committee inquiry about Interpreting and Translating Services in the Courts.

October 2024

Care Inspectorate and MWCS make written submissions to Scottish Government's the Adults with Incapacity Amendment Act consultation.

Care Inspectorate makes written submission to Scottish Government's "moving on" from care into adulthood consultation.

November 2024

HMIP submits written evidence to the Public Accounts Committee on Tackling Homelessness.

December 2024

IMB submits a response to the consultation on the NHS 10-year-plan.

January 2025

HMIP submits written evidence to:

- The Public Accounts Committee on prison estate capacity.
- The Crown Courts backlog inquiry.
- The Justice Committee inquiry about Rehabilitation and Resettlement: ending the cycle of reoffending.
- The Justice and Home Affairs Committee inquiry about Prison culture: governance, leadership and staffing (HMIP later provides oral evidence).
- The Independent Sentencing Review

IMB submits written evidence to:

- The Justice Committee's inquiry into tackling drugs in prison.
- The Independent Sentencing Review.
- The Justice and Home Affairs Committee's inquiry on prison culture: governance, leadership and staffing.

HMICFRS submits written response to the Independent Sentencing Review.

Care Inspectorate makes written submission to Scottish Government consultation on developing a universal definition of "care experience".

RQIA at implementation workshops to progress the Regional Mental Health Strategy for Northern Ireland to implementation stage. Discussed delivery of mental health services. set priorities and aligned key strategic initiatives.

February 2025

Care Inspectorate made written submission to Scottish Government's Equality and Human Rights Mainstreaming Strategy.

SHRC made written submission to Scottish Government's Equality and Human Rights Mainstreaming Strategy.

HMIP submits written response to the Justice Committee's inquiry into tackling drugs in prison and later provides oral evidence.

IMB delivers oral evidence to the Justice Committee's inquiry into tackling drugs in prison.

Ongoing

Care Inspectorate and HMIPS input regarding the ending of the placement of under-18s in YOIs under provisions of the Children (Care and Justice) (Scotland) Act 2024.

RQIA consultation on acts of restraint, in support of the commencement of the Mental Capacity (Northern Ireland) Act.

In England, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9a commenced in April 2024. This has ensured people staying in a care home, hospital or hospice can receive visits from people they wish to see, people living in a care home are not discouraged from taking outside visits and people attending appointments can be accompanied by a family member, friend or advocate. DHSC announced a review of Regulation 9A in January 2025, and CQC have engaged closely throughout.

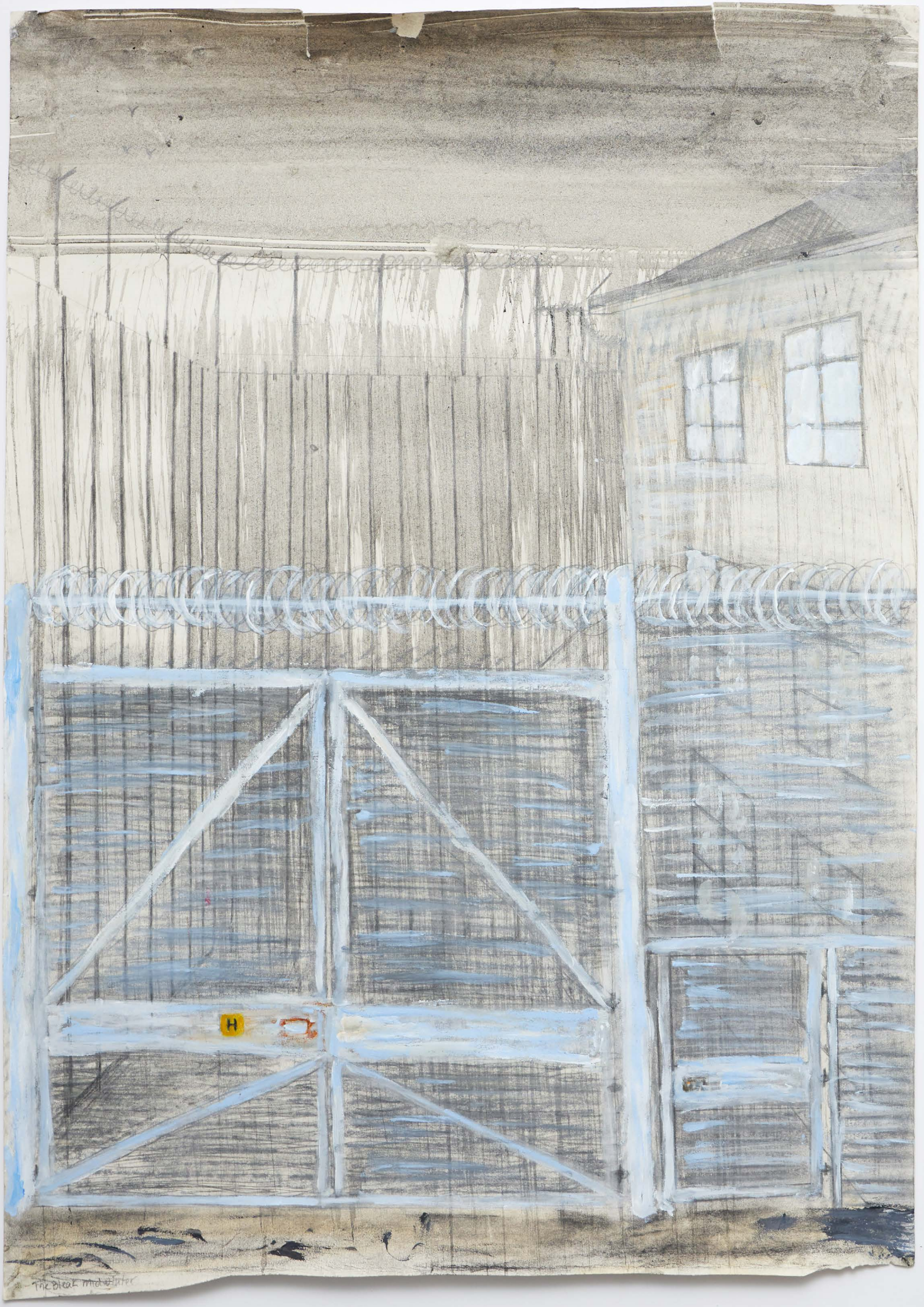
March 2025

HMIP submits evidence to the Welsh Affairs Committee inquiry about Prisons, Probation and Rehabilitation in Wales.

HMIP presents the Time to Care thematic report to the APPG for women in contact with the justice system.

HMIP presents findings to the APPG for immigration detention.

IMB submits written evidence to the Welsh Affairs Committee on Prisons, Probation and Rehabilitation in Wales.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UK NPM recommendations

June 2024: publication of the NPM Preventive Guidance

The NPM published two detailed and accessible guidebooks for inspectors and monitors, and leaders and managers, on preventive approaches to and qualities of inspection and monitoring activities. The NPM Preventive Guidance identifies five risk factors: Organisational culture within the detaining environment, policies and procedures operating within the detaining organisation, characteristics and life experiences, practices, and moments. The guidance has informed ongoing work on a training package for all NPM volunteer organisations, which is delivered in 2025-26.

October 2024: Publication of NPM Menopause toolkit

The menopause toolkit supports NPM inspectors, monitors, and visitors in all settings of deprivation of liberty to monitor risk factors and impacts of perimenopause, menopause, and post menopause. It includes a guidance document and awareness training video. The toolkit includes human rights standards and international detention rules to outline minimum expectations for establishments to meet when supporting people experiencing symptoms of perimenopause and menopause.

October 2024: NPM Recommended Standard on tracking mental health bed waiting times

The UK NPM published a recommended standard on monitoring the time taken to complete transfers from prisons to secure mental health settings. The recommendation prompted targeted work with Scottish Government by the NPM Scotland Subgroup, and with detention settings and Ombudspersons in Northern Ireland by the NPM Northern Ireland Subgroup.

November 2024: NPM definition of deprivation of liberty

In 2024, the UN Subcommittee on the Prevention of Torture published its first General Comment on OPCAT Article 4, places of deprivation of liberty.[49] In November 2024, the UK NPM Steering Group agreed a definition of deprivation of liberty as:

> **Confinement – physical, legal or administrative – of a person by or with the knowledge of a state or delegated authority to a specific location or area, from which they are unable to leave at will.**

NPM bodies can use the definition to guide approaches to monitoring and inspection, and to recommend that governments or institutions facilitate access.

49 CAT/OP/GC/1: General comment No. 1 (2024) on article 4 of the Optional Protocol (places of deprivation of liberty) | OHCHR

January 2025: submission to the Independent Sentencing Review

The UK NPM's submission to the Independent Sentencing Review outlined concerns about contemporary sentencing practice, encouraging the Independent Sentencing Review to consider the impact of sentence inflation, overpopulation, decreased financial and staffing resources, delayed maintenance, on the rehabilitative function of prisons. The submission emphasised:

> **The NPM notes that looking at the issue of overcrowding only from the perspective of space (i.e. not taking into account the Committee's recommendation on sentencing policy and practice) will not solve the problem. 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.**

- A reduced prison population would allow for rotational closing of facilities to repair and renovate, enabling the UK to ensure a dignified standard of living for prisoners and to provide a functioning rehabilitative service.
- In approaching sustainable reduction of the prison population, the Independent Sentencing Review should consider cohorts who require a therapeutic setting to facilitate their rehabilitation, for whom prison will never be the appropriate setting.
- A reduced population allows staff more time to engage with complex prisoners which will allow the UK to better fulfil the standard of individualised support.
- Current sentencing practices and lengths mean there are not enough qualified staff to deliver this individualised and purposeful regime for prisoners. The sentencing of many prisoners who would be more effectively rehabilitated in other settings means that there are many prisoners that most prison officers are inadequately trained to support.

February 2025: Guidance on the environmental conditions of detention

The NPM produced a briefing in partnership produced with the University of Edinburgh, outlining the importance of the sensory environment in places of detention through sound, temperature, air and light, explaining why they warrant further consideration under international rules of detention. The guidance recommends key considerations to monitor places of detention.

The NPM Northern Ireland Subgroup

The NPM Northern Ireland Subgroup met three times during the reporting year, adopting a new workplan and selecting two key issues:

- Data collection on deaths and serious adverse incidents in detention
- Personality disorder

We also agreed to add the issue of prisoners held over tariff to our workplan in March 2025.

Data collection: deaths and serious adverse incidents in detention:

Following an information collection exercise, the Subgroup identified gaps in information received when serious incidents occur from court custody, the Juvenile Justice Centre, police custody and prisons. There is a lack of definition across justice settings and therefore inconsistencies with health settings where such a definition exists. Regional Procedures provide hospitals and care homes with a definition and thresholds, whereas for prisons, police custody or court custody there was not the same formal guidance. Filling these gaps will improve intelligence, allowing for consolidated recommendations and more direct monitoring of recommendation implementation, as well as identification of any serious systemic issues.

The Subgroup has established dialogue with authorities in all detention settings and with the Prisoner Ombudsman for Northern Ireland and the Police Ombudsman for Northern Ireland, to identify the cause of gaps in information received. This will enable standardised definitions or agreed parameters to be developed for the provision of information relating to serious adverse incidents. The NIPB ICVS set up quarterly updates with the Police Ombudsman.

By March 2025, a system was established to receive information from the Northern Ireland Prison Service. Ongoing information sharing with the Prisoner Ombudsman exposed continuing differences between the information shared by each. Work continued to establish a similar system of information sharing for police custody, court custody and the Juvenile Justice Centre.

Personality disorder:

In Northern Ireland The Mental Health (Northern Ireland) Order 1986 does not recognise personality disorder as a mental disorder and a qualifying condition for compulsory admission. There are limited services in Northern Ireland prisons to support those with personality disorders and, unlike England and Wales, Psychologically Informed Planned Environments (PIPEs) are not available in Northern Ireland. There is no high secure mental health setting in Northern Ireland (only medium secure). There is overoccupancy of mental health wards, and at times people with a personality disorder may require to be transferred to a justice setting in Great Britain due to lack of availability. In the long term, a review of mental health legislation will be necessary. In the shorter term, the Subgroup agreed to pursue the improvement of conditions and treatment of people with personality disorder in detention, and to raise the profile of the issue with reform as the long-term goal. Research was commenced on information gathering on best practice and concerns relating to provisions for people with personality disorder in prison.

Prisoners held over tariff

Prisoners still in prison after their tariff expiry was raised as a key issue in March 2025. Barriers to accessing interventions and programmes to support, and show evidence of, their rehabilitation leads to some prisoners held significantly over tariff. The Parole Commissioners for Northern Ireland consider a far lower proportion of prisoners for release than in other jurisdictions. Prisoners' frustration about the lack of opportunities to progress towards release in turn leads to more adjudications, which will also count against someone's future release. A CJI inspection of the Parole Commissioners for Northern Ireland found that 28% of the released population is then recalled, and described significant issues with delivery of the Prisoner Development Unit process within Northern Ireland prisons. The Subgroup agreed to keep this under review and contribute to ongoing work across the NPM.

Ongoing work

In February 2025, the Chair and members of the Subgroup met with representatives of the Department of Justice and the Department of Health, introducing the NPM and the role of the Subgroup. The meetings covered:

1. The role of the Departments in upholding OPCAT obligations regarding resourcing, independence, and responding to reports.
2. The Subgroup's key issues of concern.
3. The NPM's independence. We raised the limitations to the Subgroup due to not having funding for a dedicated Coordinator.
4. The duty of the Departments to provide information to the NPM.
5. The importance of joint work by both Departments on early intervention.

The Subgroup also invited new organisations to join its membership in line with the model agreed across the UK following a review of membership: the Northern Ireland Human Rights Commission (NIHRC) as a standing member and Northern Ireland Commissioner for Children and Young People (NICCY) as an Associate Member. The NIHRC joined our meetings from March 2025 and have added a valuable perspective to our work.

Rachel Lindsay, Chair of the NPM Northern Ireland Subgroup

The NPM Scotland Subgroup

I am pleased to share the activities and concerns of the UK NPM Scotland Subgroup in the 2024-25 Annual Report. I began chairing the UK NPM Scotland Subgroup meeting in November 2024, after becoming Chair of the Scottish Human Rights Commission in September 2024.

The NPM Scotland Subgroup meets quarterly, and comprises six Scottish scrutiny bodies:

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

The subgroup also has two Associate Members: Healthcare Improvement Scotland (HIS) and the Children and Young People's Commissioner for Scotland (CYPCS). CYPCS was invited to join the NPM Scotland Subgroup as an associate member in March 2024 and has been actively participating in the subgroup since then.

In 2024-25, key issues for the NPM Scotland Subgroup included deaths in prison custody and mental health transfer time data. Subgroup members engaged in several activities related to the prevention of deaths in prison custody, including participation in a working group to create a National Oversight Mechanism of deaths in custody as well as the Ministerial Accountability Board to hold ministers accountable for the prevention of further deaths. In July 2024, the subgroup wrote to the Scottish Government asking whether they continue to accept in principle all recommendations and advisory points from the Independent Review of the Response to Deaths in Prison Custody (2021), as many recommendations remain unimplemented. In August 2024 we received a response confirming that the Scottish Government still accepts all recommendations in principle. With the support of the subgroup, the NPM Central Team also established a database tracking all deaths in prison custody and dedicated resources to reviewing all available Fatal Accident Inquiries related to prison custody from 2015 onwards, to understand how long they have been taking and whether recommendations are being made.

In 2024-25, the subgroup also had concerns about the lack of data on the time taken to transfer prisoners to mental health beds. Subgroup members helped develop the NPM recommended standard about the of statutory collection of this data, and engaged with a wide range of stakeholders to understand the current situation in Scotland, and what could be done to ensure this data be collected consistently to inform decision-making.

Additional issues of concern in Scotland in 2024-25 included the lack of mandatory investigation of deaths in mental health settings, extended periods in police custody, children under 18 being held in police custody centres, lack of capacity in secure accommodation services for children under 18, chronic prison overpopulation, and substance misuse and drug-related deaths in prisons. Additional concerns that spanned across all settings included the reliability of secure transport, use of force, isolation and restraint, and staffing shortages.

Collaborative work between NPM bodies produced powerful results in 2024-25. In July 2024, the NPM and SHRC published a joint report, Review...Recommend...Repeat... An assessment of where human rights have stalled in places of detention, highlighting the lack of action by duty bearers in Scotland to implement recommendations made by international human rights bodies. Since the report's publication, engagement on this issue with The Cabinet Secretary for Justice and Home Affairs Angela Constance and her team has been ongoing, as we have urged further action to deliver and demonstrate long-awaited meaningful outcome improvements for people deprived of their liberty in Scotland.

The joint inspection programme between HMICS and HIS was granted an additional year of funding in mid-2024, enabling the continued joint scrutiny of police custody centres. In 2024-25, CYPCS used their statutory investigatory powers to investigate police use of force against children under 18, with support from the UK NPM central team.

In August 2024 we welcomed legislation coming into force which prohibited children under 18 from being held in prisons or young offender institutions. However, the subgroup remains concerned about young people being transferred to HMPYOI Polmont upon turning 18 when they have only a few weeks left on their sentence, as this transition can be difficult for young people, risking causing disproportionate levels of distress. In April 2025 the subgroup wrote to the Minister for Children and Young People, Natalie Don-Innes to raise our concerns on this topic.

In 2024-25, subgroup members also individually and jointly delivered important work, including more than 50 inspection and thematic reports and investigations related to the OPCAT mandate, such as:

- **A Thematic review of prison-based social work**, Care Inspectorate and HMIPS, April 2024
- **'Planned Failure' - A Thematic Review of Prisoner Transport Services in Scotland**, HMIPS, December 2024
- **Tick Tock: A human rights assessment of progress from institutionalisation to independent living in Scotland**, SHRC, January 2025.

It has been a pleasure to chair the NPM Scotland Subgroup during this time. We remain committed to holding duty bearers to account for their responsibility to protect the rights of individuals deprived of their liberty in Scotland.

Angela O'Hagan,
NPM Scotland Subgroup Chair

Draft and existing legislation

Optional Protocol to the Convention Against Torture, Article 19 (c):

> **The national preventive mechanisms shall be granted at a minimum the power:**
>
> **To submit proposals and observations concerning existing or draft legislation.**

The capacity to comment on how existing laws do, and new laws might, impact on people deprived of their liberty is an important way for NPMs to prevent ill treatment through actions or conditions in places of detention. While specific bills before the UK's parliaments raise direct implications for people deprived of their liberty, the reporting year overall had a backdrop of political conversations to change the application of the ECHR and the Human Rights Act. While most conversations have related to article 8, the right to enjoy a private and family life, increasingly they have turned to article 3, the prohibition of torture and other cruel, inhuman or degrading treatment or punishment.

Mental health legislation: need for reform across the UK

The NPM central team, CQC, IMBs and HIW participated in the Joint Committee for Human Rights (JCHR) legislative scrutiny of the Mental Health Bill, or the Public Bill Committee call for evidence. The Bill was introduced to the House of Lords in November 2024, and the Committee began its review on 14 January 2025. The UK NPM made its submission on 25 January, focussing on questions two, three and four:

- Deprivation of liberty applied as part of conditional discharge
- Interaction between the Mental Health Act 1983 and Mental Capacity Act 2005
- Any other issues under the ECHR or Human Rights Act 1998.

The NPM submission detailed concerns about monitoring transfers, conditional discharge, equity, and protections for people with a learning disability and autistic people. Women are still sent to prison solely on mental health grounds, under remand for "own protection" under the Bail Act 1976, or to prison as a "place of safety" under the Mental Health Act 1983. Prisons are not an appropriate or therapeutic environment for people who should be receiving proper medical treatment for mental health. The Mental Health Bill proposes removing prison as a place of safety and ending remand for own protection solely for mental health reasons under the Bail Act, which the NPM supports.

CQC have played a key role in providing input and comment on proposals in the Bill, and have heavily engaged DHSC officials, Ministers and Parliamentarians as the Bill has been progressing through Parliament. CQC will continue to have an important role in the implementation of the revised Mental Health Act as CQC will be responsible for delivering some of the revised legislation. This will include the changes to the second opinion safeguards, and CQC will also monitor the implementation of the reforms as part of the section 120 Mental Health Act monitoring duties.

In Scotland, the pace of implementation of 202 recommendations made in the 2022 Scottish Mental Health Law Review (SMHLR) has been slow, with change still needed to align the law with international human rights standards, as explored in the preceding sections. The NPM expected reform under the SMHLR to the Adults with Incapacity (Scotland) Act 2000, which provides a framework to safeguard the welfare of adults who lack capacity to make some or all decisions due to mental illness, learning disability, dementia or related condition, or inability to communicate. However, the reform has been delayed

until the next Scottish Parliament. Over the year, MWCS worked with NHS Education for Scotland to improve understanding of the Adults with Incapacity Act for health, social work and social care staff across Scotland, and contributed to two priorities for the Scottish Government in response to the SMHLR: Adults with Incapacity Act reform, and the definition of a mental disorder.

In Northern Ireland, work is ongoing on the Commencement of Provisions Under the Mental Capacity Act (Northern Ireland (2016). RQIA contributed to a consultation on the commencements of sections 9(4) (a) and 12, relating to acts of restraint and the accompanying code of practice.[50] When fully commenced, the Act will fuse together mental capacity and mental health law for those aged 16 years and over within a single piece of legislation, as recommended by the Bamford Review of Mental Health and Learning Disability. However, the phased implementation has created challenges for Health and Social Care Trusts and Emergency Services such as the Northern Ireland Ambulance Service and the Police Service of Northern Ireland.

The Health and Social Care (Wales) Act 2025 became law on 24 March 2025, aiming to eliminate private profit from the care of children looked after. It will also make amendments to ensure that the Regulation and Inspection of Social Care (Wales) Act 2016 and Social Services and Well-being (Wales) Act 2014 are able to operate fully and effectively.[51] Progress with this ambitious initiative will need to be closely monitored.

Sentencing changes

The Sentencing Bill was introduced to the House of commons on 2 September 2025. Though outside the reporting window, the Bill was informed by the independent Sentencing Review 2024 to 2025 and follows a number of shorter-term changes to sentencing practice across the UK. In June 2024, the Scottish Parliament approved the Emergency Early Release of individuals due to the "rapid rise in prison population, which was already very high and complex".[52] In July 2024, the UK Government introduced a new early release initiative known as SDS 40, that allows prisoners serving an eligible standard determinate sentence (SDS) to be released into the community after serving 40% rather than 50% of that sentence in custody. 3,112 prisoners were released across two separate tranche dates in September and October 2024, but the prison population continued to grow. The activation of Operations Safeguard and Early Dawn, and the formation of the Women's Justice Board, also pursued changes in sentencing approaches. However, the total prison population in England and Wales remained virtually unchanged in January to March 2025, compared to the same period in 2024. First receptions increased by 3%.

In its submission to the Independent Sentencing Review in January 2025, the UK NPM outlined concerns about the impacts of sentencing inflation including overpopulation, unaddressed mental health issues, isolation, and compromised regime.

50 **Consultation on the Commencement of Provisions under the Mental Capacity Act (Northern Ireland) 2016 relating to "Acts of Restraint" – December 2024 - NI Direct - Citizen Space**

51 **Health and Social Care (Wales) Act 2025**

52 **Emergency Early Release – June 2024 - Scottish Prison Service**

The NPM submission noted that looking at the issue of overcrowding only from the perspective of space (i.e. not taking into account the Committee's recommendation on sentencing policy and practice) will not solve the problem. 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.

Public figures on overpopulation are artificially low because they do not take account of establishments that are not fit for purpose and should be closed. If these were decommissioned, as international standards on dignified treatment might require, the figures would be much higher. A reduced prison population would allow for rotational closing of facilities to repair and renovate, enabling the UK to ensure a dignified standard of living for prisoners and to provide a functioning rehabilitative service.

Proposed amendments to the Justice Bill in Northern Ireland incorporate some changes that could impact the custody environment.[53] The new legislation is hoped to offer improved protection to children and young people by ensuring they are only held in a youth custodial facility, rather than police or prison custody.[54] Reforms to legislation/PACE about rights of children to bail/alternative accommodation, were a key issue for CJI and RQIA.

An independent review of children's services in Northern Ireland also scrutinised the use of the Juvenile Justice Centre and the Regional Secure Care Centre.[55] The Bill strengthens the presumption of bail and includes unconditional bail for children as standard, introducing specific conditions under which a child can be remanded in custody. The final content and implementation of the new Act will hopefully improve current provision for 'Looked After' children, who make up nearly half of all children held in police custody this year, but the Bill is unlikely to receive Royal Assent before late 2026. Those parts relating to bail and accommodation will commence by Order.

53 Committee for Justice - Primary Legislation; Justice Bill – October 2024 – Northern Ireland Assembly

54 Justice Bill takes first steps in Assembly | Department of Justice

55 Children's Social Care Services in Northern Ireland; An Independent Review – June 2023 – CSCS NI Review

ISBN 978-1-5286-6108-9
E03490465