



Monitoring places of detention

First **Annual Report**
of the United Kingdom's
National Preventive Mechanism
2009-10



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

1 April 2009 – 31 March 2010

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by Command of Her Majesty
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Introduction by Nick Hardwick

Her Majesty's Chief Inspector of Prisons

People deprived of their liberty are out of sight, low priority and unpopular and therefore at particular risk of inhumane or degrading treatment. In the UK and elsewhere there has been growing recognition of detainees' vulnerability and the need for robust, independent mechanisms to protect them from ill-treatment. This view was given formal recognition by the United Nations when it adopted the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) and then by the UK when it ratified OPCAT in 2003.

The basic premise of OPCAT is that protections for those who are detained can be strengthened by a system of regular visits to all places of detention – prisons, police custody, children's secure accommodation, immigration, military and mental health

detention, and any other place where a person may be deprived of their liberty. Those States which ratify OPCAT, including the UK, are required to designate a national preventive mechanism (NPM) to carry out such visits and to monitor the treatment and conditions of detainees. The UK NPM was established in March 2009 when the government decided that the functions of the mechanism would be fulfilled by the collective action of 18 existing bodies which visit or inspect places of detention. My own inspectorate, HM Inspectorate of Prisons, was asked to coordinate the NPM.

OPCAT also requires that NPMs publish an annual report of their activities – this report is the first from the NPM in the UK. It details the individual and collective activities of the members making up the UK's NPM and covers the period 1 April 2009 to 31 March 2010. As well as providing background

information on OPCAT and the role of NPMs, it outlines the role of the individual members and their detention-related activities in the first year since designation. Already, some common themes such as concerns about the detention of those with mental health problems and the use of restraint have begun to emerge. We hope this report helps to provide an overview of the state of detention in the UK and our efforts to prevent ill-treatment. In future years, I hope we will be able to work together to build on this foundation to strengthen and develop these preventive mechanisms.

Despite the broad scope of the UK NPM, there nonetheless remain places of detention which are not covered by designated members. This has prompted us to make our first collective recommendation: that the UK government identifies any places of detention not visited by the NPM and ensures that those gaps are addressed.

On behalf of the 18 members of the UK NPM, I would like to thank my predecessor, Dame Anne Owers, who led the NPM

during its first year and who worked tirelessly to protect the rights of detainees. I would also like to thank the Human Rights Implementation Centre at the University of Bristol for their support of the NPM during its first year.

Finally, we hope that this first annual report addresses some of the complexities of our NPM in the UK. We hope it will be of interest to all those concerned with the treatment of detainees and their conditions of detention.



Nick Hardwick
Her Majesty's Chief Inspector of Prisons

Section one

Context

About OPCAT

The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is an international human rights treaty designed to strengthen the protection of people deprived of their liberty. It acknowledges that such people are particularly vulnerable to ill-treatment, and advocates that efforts to end ill-treatment focus on prevention through a system of regular visits to places of detention.

At the time of its adoption in 2002, OPCAT was the first treaty to establish a dual international and national system for the protection of human rights. At the international level, OPCAT established the Subcommittee for the Prevention of Torture (SPT). The role of the SPT is to periodically visit places of detention in each of the States which ratify the treaty (States Parties) and to make recommendations to those States concerning the prevention of ill-treatment. At the national level, OPCAT requires States Parties to have in place a 'national preventive mechanism' (NPM), the role of which is also to visit places of detention and monitor the treatment of and conditions for detainees. While the two visiting regimes – at international and national levels – may overlap, they are intended to complement each other and be mutually reinforcing.

The scope of OPCAT is deliberately broad. States Parties must allow the SPT and the NPM to carry out visits to *“any place under its jurisdiction and control where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence”*.¹

OPCAT defines deprivation of liberty as *“any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.”*²

About the SPT

Following the entry into force of OPCAT in 2006, the SPT began its work in February 2007. The role of the SPT is to visit places of detention and make recommendations to States Parties concerning the protection of detainees against torture and other ill-treatment. When they ratify OPCAT, States Parties must grant the SPT unrestricted access to all places of detention and allow it to conduct private interviews with any detainee it chooses, as well as any other relevant people. Sanctions against anyone, or any organisation, who speaks to the SPT are prohibited. States Parties are also obliged to provide the SPT with information on the number of detainees and the number of places of detention and their location, as well as information relating to treatment and conditions.

Following a visit, the SPT passes on its recommendations and observations to the State in confidence and, if relevant, to the NPM. SPT reports may be published at the request of the State Party. OPCAT emphasises co-operation between the SPT and the State Party and the need for dialogue about the implementation of the SPT's recommendations.

¹ Article 4(1). The full text of OPCAT is available on the website of the Office of the United Nations High Commissioner for Human Rights at: www2.ohchr.org/english/law/cat-one.htm

² Article 4(2).

In addition to visiting places of detention, OPCAT expects the SPT to become involved in the establishment and the ongoing work of NPMs. Article 11 of OPCAT says that the SPT must:

- advise and assist States in the establishment of NPMs
- maintain contact with NPMs, offering them training and technical assistance to strengthen their capacities
- advise and assist NPMs in evaluating the needs of and means for protecting detainees
- make recommendations and observations to States with a view to strengthening the capacity and mandate of NPMs.

The SPT is currently made up of 25 independent and impartial experts from a range of relevant professional backgrounds, including lawyers, doctors and inspection experts.³

About NPMs

Article 3 of OPCAT requires States Parties to “set up, designate or maintain at the domestic level one or several visiting bodies for the prevention of torture and other cruel, inhuman or degrading treatment or punishment”. These domestic visiting bodies are referred to as the national preventive mechanism. The form that NPMs should take is not prescribed – States can either create a new body or nominate an existing body to fulfil the functions. They can also decide whether one or more bodies should be designated. This flexibility has led to variety in the structure and composition of the NPMs so far designated under OPCAT.

The role and powers of NPMs are similar to those of the SPT. At a minimum, OPCAT requires that NPMs have the power to:

- regularly examine the treatment of people deprived of their liberty in places of detention
- make recommendations to the relevant authorities with the aim of improving the treatment and conditions of detainees
- submit proposals and observations concerning existing or draft legislation.⁴

To enable NPMs to exercise these powers, they should have:

- access to information concerning the number of people deprived of their liberty, the number of places of detention and their location
- access to information about the treatment and conditions of detainees
- access to all places of detention
- the opportunity to conduct private interviews with detainees and any other relevant person
- freedom to choose which places they want to visit and who they want to interview
- the right to have contact with the SPT, to send it information and meet with it.⁵

OPCAT also requires States Parties to examine the recommendations of NPMs and discuss possible implementation measures with them. Although NPMs are not obliged to produce annual reports, this responsibility is implied given the duty on States Parties to publish and disseminate them.

³ The independent expert from the UK is Professor Malcolm Evans from the University of Bristol.

⁴ Article 19.

⁵ Article 20.

While OPCAT does not dictate how NPMs should be structured, it does set out the criteria that they should meet. Perhaps the most important of these is that NPMs should be independent. The NPM must be adequately resourced to carry out its role and its personnel should have the necessary capabilities and expertise. There should also be a gender balance among the personnel and they should be representative of ethnic and minority groups. The SPT has expanded upon the minimum requirements set out in OPCAT. In preliminary guidelines for the development of NPMs published in 2008, the SPT recommended, for example, that the mandate and powers of the NPM be set out in law.⁶

The UK's NPM

The UK ratified OPCAT in December 2003 but did not designate its NPM until March 2009. A number of complexities may have prolonged the designation process. Firstly, a number of existing bodies already carried out roles which were similar to that of the NPM. While an initial decision was made that the functions of the NPM in the UK would be performed by the collective action of existing bodies, the government still had to consider which existing bodies were OPCAT-compliant and which should be designated. Secondly, despite the pre-existing bodies, there remained gaps in coverage of places of detention. For example, while inspection of prisons was well established, inspection of military detention and police custody, at that time, was limited. Thirdly, the UK government had to liaise with the devolved administrations in Wales, Northern Ireland

and Scotland over arrangements in those countries. Finally, the government also had to think about whether and how to coordinate the activities of the multiple bodies being considered for designation.

During 2006 and 2007, the government consulted with relevant bodies about the composition of the UK's NPM and the extent to which existing bodies complied with OPCAT. In deciding which bodies should be designated, the government applied the following criteria:

- the statutory basis upon which the bodies operate gives them unrestricted access to places of detention and to detainees, including the power to make unannounced visits, and unrestricted access to information about detainees and their conditions of detention (or at least contains nothing to prevent such access and such visits)
- bodies should possess the independence, capability and professional knowledge to carry out visits.

In a written ministerial statement made to Parliament on 31 March 2009, the government formally designated 18 bodies which would make up the UK's NPM.⁷ The government also mentioned that additional inspection bodies may be added to the NPM in future.

⁶ See *First annual report of the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (February 2007 to March 2008), CAT/C/40/2 (14 May 2008).

⁷ The written ministerial statement is included at Appendix 1.

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

England and Wales

Her Majesty's Inspectorate of Prisons
Independent Monitoring Boards
Independent Custody Visiting Association⁸
Her Majesty's Inspectorate of Constabulary
Care Quality Commission
Healthcare Inspectorate Wales
Children's Commissioner for England
Care and Social Services Inspectorate Wales
Office for Standards in Education

Scotland

Her Majesty's Inspectorate of Prisons for Scotland
Her Majesty's Inspectorate of Constabulary for Scotland
Scottish Human Rights Commission
Mental Welfare Commission for Scotland
Scottish Commission for the Regulation of Care

Northern Ireland

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

Coordination

Following designation of the NPM, it was agreed by members that Her Majesty's Inspectorate of Prisons (HMIP) would carry out the coordination and communication function of the NPM. The purpose of coordination is to promote cohesion among the NPM members, to facilitate a collective understanding of OPCAT and its requirements, and to encourage collaboration and shared learning among a wide-ranging and large group of organisations. At the same time, however, the independence of individual members is respected, as is their ability to set their own priorities for detention monitoring.

This role is performed by an NPM coordinator, a person appointed by HMIP to liaise with all members of the NPM, to share information with them and provide support on policy and human rights issues. While based at HMIP, the coordinator represents the interests of all members, liaises with the SPT, other NPMs and other external stakeholders, prepares the annual report and organises seminars and joint training. Through working with each of the NPM members, the coordinator is able to gain an overview of all detention monitoring in the UK, identifying common issues of concern or gaps in protection.

⁸ Although the Independent Custody Visiting Association is listed as an organisation operating in England and Wales, its membership includes independent custody visitors who operate in Scotland.

Section two

The first year

In the UK the visiting of most places of detention was well established prior to the ratification of OPCAT. Following designation therefore, the members of the NPM were able to continue their work, albeit under a new international framework. Section 4 of this report provides detailed information about the activities of each member in 2009–10.

In addition to the regular visits carried out by each member, most activity in the first year following designation has been focused on raising awareness among NPM members of OPCAT and their newly enhanced role. While some members of the NPM already collaborate with one another, efforts have been made to promote awareness and understanding of the role of each organisation among all NPM members and to build positive working relationships. The appointment of the NPM coordinator in October 2009 has allowed more proactive work to take place.

The impact of designation as a member of the NPM has varied according to individual members. For some, it has resulted in an expansion of their role or a greater focus on detention monitoring. For others, it has resulted in the adoption of a more human rights-based approach to their visits. The impact of designation is discussed further in the profiles of individual members below.

Coming together

In December 2009, the members met to discuss their role as the UK's NPM. The NPM is indebted to the Human Rights Implementation Centre at the University of Bristol for funding and helping to organise the meeting. At the meeting, the members discussed the impact of NPM membership on their organisation and the challenges for the NPM as a whole and for individual members. They also considered HMIP's coordination role and sought to identify ways in which the members could work together.

The members examined a number of issues, including the need to raise awareness of OPCAT and their need for clarity around basic concepts such as the definition of detention. This issue was particularly relevant for those members whose remit is broad and goes beyond visits to places where people are detained by lawful order, such as care homes for the elderly. While such places may not strictly be deemed places of detention, the residents may be under certain restrictions which some may consider amount to de facto detention. It was agreed to further explore this issue.

The members also discussed the different contexts – both political and geographical – in which they operate, including fears that some service providers are subject to over-inspection. They agreed that the existence of the NPM would facilitate the sharing of information and good practice among members and could lead to joint activities such as training for staff. However, concern was also expressed about the availability of resources for joint work. There was agreement that the NPM members should draw on common standards when monitoring places of detention but that homogenisation (for example, of methodologies) was neither necessary nor appropriate given the different types of detention visited and the different contexts in which the members operate.

Mapping the NPM

Given the size and complexity of the NPM in the UK, it was thought useful to map the mandates and methodologies of each of the members. This work was primarily undertaken by the Human Rights Implementation Centre at the University of Bristol with the assistance and input of the NPM members themselves, and is available online.⁹

External relations

Members of the UK's NPM are often invited to share their experience and expertise of visiting a range of detention settings with others. For example, Independent Monitoring Boards in England and Wales have hosted visits by delegations from a range of countries, including Japan and Russia, who are interested in the idea of visits to prisons by volunteers from the community. Similarly, representatives from the Independent Custody Visiting Association have visited China to share their expertise.

In addition, representatives of the UK NPM have participated in a project designed to strengthen the prevention of torture in Europe. Organised by the Council of Europe, it involves creating an active network of NPMs so that information and best practice on detention monitoring can be shared. Part of the project involves a series of workshops exploring themes relating to monitoring detention. In March 2009, a workshop was held in Padua, Italy to explore the role of NPMs in preventing ill-treatment of those

⁹ To view a database of the UK NPM members, visit: www.bristol.ac.uk/law/research/centres-themes/hric

detained in psychiatric institutions. The UK NPM was represented by the Care Quality Commission and the workshop was also attended by members of the SPT, as well as other international organisations with expertise in this area. In 2010–11, the UK NPM will participate in additional workshops, including one on monitoring police custody.

Compliance with OPCAT

In the UK, the ratification of OPCAT and the designation of the NPM did not result in visiting bodies being given the necessary powers to fulfil the functions of an NPM. Instead the members had pre-existing mandates that were deemed by the government to be sufficiently compliant with OPCAT to merit designation. As a result, the manner in which the members meet the OPCAT criteria is not always consistent. For example, the members have varying degrees of independence, their nature and composition differs, and the frequency of visits varies according to the type of detention visited and the member carrying out the visit. Nonetheless, for the most part the members meet the OPCAT criteria, although there are some outstanding issues, some of which are described below under

the members' individual profiles. However, the government envisaged that the functions of the UK's NPM would be fulfilled by the collective action of the members, and it may therefore be possible that where two members visit the same places of detention, any perceived deficiencies in the mandate of one member may be corrected by the other.

Perhaps the most significant compliance issue is whether all places of detention are covered by the NPM in the UK, as required by OPCAT. Gaps in coverage have so far been identified in relation to military detention facilities and court custody in England and Wales. While HMIP is invited to inspect some places of military detention (most notably the Military Corrective Training Centre, the main detention facility for military personnel), the right of access is not statutory. Moreover, there are other places of military detention which are not currently inspected, such as service custody facilities (sometimes known as guardhouses). HMIP is currently in discussion with the government about extending its inspection programme of military detention facilities, as well as an extension of its mandate so that it may inspect court custody.

Recommendation: The UK government should explore gaps in the coverage of the NPM, identifying places of detention that are not currently monitored for the purpose of preventing ill-treatment. Any identified gaps, such as military detention and court custody, should be addressed as soon as possible to ensure that the UK complies with its international obligations.

Challenges

As with any other newly designated NPM, the NPM in the UK faces several challenges in fulfilling its functions. Many of the challenges faced by the UK NPM relate to its structure – notably its size and complexity. The UK is not unique in having an NPM made up of several bodies, but it does appear to be unique in having quite so many. With 18 bodies (so far), it is perhaps inevitable that the members may have a different understanding of OPCAT and how best it can be implemented. They may also have different views on the coordination role performed by HMIP and how extensive this should be. The NPM in the UK is made up of a range of organisations: they visit different types of detention; they operate under different legal frameworks; and, importantly, they work in different jurisdictions within the UK, including different political contexts. Furthermore, membership of the NPM is not final and additional bodies may be added as gaps in coverage are identified and addressed.

With the views of 18 bodies to consider, coordinated activity of the NPM could prove challenging. There may be different ideas about what collective work should take place and, even where agreement is reached, plans may be tempered by more practical issues such as capacity and resources. This may be a particular issue for the lay bodies within the NPM, so thought is given to how to support them to take part in coordinated activities. On behalf of the NPM, HMIP has requested additional resources for its coordination role, but is aware that the request has been made at a time when the government faces severe financial pressures.

When the government assigned the coordination role to HMIP, little guidance was given on what this may involve. During the designation process, concern was expressed that granting the coordination role to one body could place it in a more powerful position than the other members. If the NPM members could not reach agreement about an issue, would the coordinating body be able to dictate a particular course of action? Fortunately, the members have so far been able to operate on a consensus basis, but the issue remains unresolved.

For some members, monitoring places of detention is just one part of a much wider regulatory or inspection role. They may find it difficult to sufficiently prioritise visits to places of detention when there are other calls on their resources, particularly in the current financial climate. Designation as a member of the NPM may result in a greater emphasis on monitoring detention but it should be noted that, generally, members have not been given additional resources to do this.

Many of the members of the NPM are adept at dealing with their external stakeholders and involving them in their work. Nonetheless, thought needs to be given to those outside the mechanism who are interested in the work of the NPM as a whole. The NPM should form relationships with the SPT and other international bodies, as well as civil society. A particular challenge is that the composition of the NPM in the UK is likely to be confusing to outsiders.

The criteria for designation employed by the government, while justified, have led to some apparent anomalies. For example, there are prison visiting committees in Scotland whose role is equivalent to Independent Monitoring Boards in England, Wales and Northern Ireland. While the monitoring boards have all been designated, the Scottish visiting committees have not. At first glance this may seem illogical, but visiting committees in Scotland were under review when the NPM was designated and the government decided not to include them at that time.¹⁰ To add to the confusion, there are some members of the NPM who appear to have a corresponding member in another jurisdiction – but this is not always the case. For example, it may seem that HMIP in England and Wales and HMIP in Scotland (HMIPS) have the same mandate. However, while HMIP inspects prisons, immigration and military detention and police custody, HMIPS inspects prisons, legalised police cells and prisoner escort arrangements, which includes the conditions in which prisoners are held in court cells. In short, there is much work to be done in explaining the composition of the UK NPM to stakeholders.

It is plain therefore that the NPM in the UK faces numerous challenges, many of which are common to all newly designated NPMs and some of which are particular to the circumstances in the UK. Nonetheless, the members are confident that none of these challenges are insurmountable and the experience of the first year suggests that they are more than able to overcome them. Moreover, while the NPM structure poses particular difficulties, the members feel that

the long history of visiting and inspecting places of detention in the UK means they are well placed to fulfil the functions of an NPM as set out in OPCAT.

Emerging issues

Given the number of organisations involved in visiting places of detention and the range of places visited, it is a challenge to easily identify common or recurring issues. Nonetheless, it is clear from discussions between members and from the profiles of each member included in this report that there are key issues affecting those deprived of their liberty. These issues are discussed in more detail in their profiles but a few are highlighted below.

Mental health

Perhaps the most significant and recurring concern across all types of detention relates to detainees with mental health problems. In 2009–10, many members noted the need to divert these detainees from the criminal justice system but cited the ineffective use of diversionary schemes. Members visiting prisons and police custody noted that, despite the best efforts of staff, detainees did not receive the support and treatment required. In prisons, those with mental health problems were sometimes held for long periods in segregation units, often awaiting transfers to a more appropriate environment.

¹⁰ The current arrangements for prison visiting committees in Scotland remain under review. It is possible that they will be designated as an additional member of the UK's NPM in the future.

Even where detainees were held in more appropriate settings providing care and treatment, they still experienced difficulties, including access to appropriate mental health services. In particular, children experienced inappropriate placements, such as in adult psychiatric wards, and faced difficulties when making the transition from child to adult services.

Resources

Another significant issue is that of limited resources. This is true of the places of detention visited and their capacity to deliver adequate services to detainees, but also for NPM members themselves. There is a fear that the progress that has been made in recent years in the treatment and conditions for all detainees may not only stall, but that standards may actually begin to fall. In prisons, for example, inadequate funding will impact all aspects of detention. It will adversely affect the standard of accommodation, the prisoner's time out of cell and the provision of education and rehabilitative programmes. For members of the NPM, a decrease in funding may inhibit their ability to continue to carry out visiting to the current extent and standard.

Vulnerable groups

While all those held in custody may be considered vulnerable, the vulnerability of particular groups of detainees is often heightened. All members of the NPM expressed concern about such groups, including women, children, those with physical and learning disabilities and those who misuse alcohol and drugs. The members highlighted the need for detaining authorities and service providers to pay particular attention to the rights and needs of these groups.

Restraint

Several members have reported concerns about the use of restraint on detainees across different types of detention. They have questioned whether restraint is being used safely, only when absolutely necessary and whether appropriate methods are used on children.

Prison population

Many of the members who visit prisons have expressed concerns about the rising prison population and the overcrowding of prisons. This has an adverse affect on all aspects of a prisoner's life, including safety, the prison regime, their ability to maintain sufficient contact with their family and their preparation for release. Prisons may find themselves increasingly unable to deal with problems caused by overcrowding because of decreasing resources.

Detention of children for immigration purposes

The detention of children for immigration purposes was cited as a key concern by all members of the NPM who visit the immigration estate. They were most concerned that decisions to detain children, or to continue their detention, did not fully take account of the best interests of the child. They also cited the negative impact that such detention can have on children, including on their emotional wellbeing and their mental health, and their ties with the community. The members recommended that the detention of children be ended and viable alternatives to detention be developed. The government has since announced its intention to end the detention of children for immigration purposes and the NPM is awaiting the implementation of the government's plans.

Right to dignity

Some of the NPM members, particularly those involved in visiting social care and health settings, have examined detainees' rights to dignity and privacy. Often work on these issues has been linked to taking a human rights-based approach to visiting or inspecting. Members have encouraged detaining authorities and service providers to have a greater focus on the dignity of detainees.

Service user involvement

All members of the NPM speak to detainees as part of their visits to places of detention and listen to the detainee's own experiences. Members are keen to ensure that detaining authorities and service providers also listen to the views of their service users. This is a particular issue for those held in social care or health settings. Members recommended that greater efforts be made to involve service users in decisions about their care and in planning for the future.

Health care

While the health care provided in custodial settings has improved in recent years, particularly in prisons, concerns remain. In particular, members visiting police custody noted the need for improvement in forensic medical services.

Section three

Looking ahead: year two

In the first year following designation NPM members have concentrated on familiarising themselves with their newly enhanced role and the international framework within which they now operate. They have also sought to build good working relationships with the other members and to identify priorities for year two.

In 2010–11, the members will continue to come together and share their expertise and experience of visiting places of detention. In particular, they will discuss how the members, individually and collectively, implement Article 19(c) of OPCAT which states that NPMs should have the power to submit proposals and observations concerning existing or draft legislation.

Given the widespread concern among the members about the mental health of detainees, there are plans to hold a thematic workshop for all members on this issue. The NPM will also consider holding a workshop for all members who carry out visits in a particular jurisdiction. This idea is most likely to be trialled in Northern Ireland and will involve not only NPM members but external stakeholders.

Within the NPM, some members will also meet to discuss visits to particular types of detention. For example, those who visit detention under mental health law in the four countries within the UK will explore opportunities to share information and good practice and engage in collaborative work.

Section four

National Preventive Mechanism member profiles

This section features a profile of each of the 18 members of the NPM, providing an overview of their remits and the type of detention they visit and for which they are designated. It also includes information about the extent to which they comply with OPCAT, the impact that membership of the NPM has had on their organisation, a summary of their activities in 2009-10 and some key issues that have arisen during their visits to places of detention. A nineteenth profile, of independent custody visitors in Scotland, is also included. Although they have not been separately designated as part of the UK's NPM, they have been visiting police custody for many years and it is likely they will be designated in the near future.

More detailed information about each organisation can be found on their own websites and in their individual annual reports.¹¹

¹¹ A list of websites is given at Appendix 2.

Her Majesty's Inspectorate of Prisons

Her Majesty's Inspectorate of Prisons (HMIP) is an independent, statutory organisation which carries out regular inspections of places of detention to assess the treatment of and conditions for detainees.¹² HMIP is responsible for inspecting all prisons in England and Wales, including young offender institutions; all removal centres, short-term holding facilities and escort arrangements for immigration detainees; and all police custody facilities, in association with HM Inspectorate of Constabulary. HMIP may inspect both public and private detention facilities.

HMIP is often invited to inspect prisons in other jurisdictions, including Northern Ireland (in partnership with Criminal Justice Inspection Northern Ireland), the Channel Islands, the Isle of Man and other Commonwealth territories. By invitation, HMIP inspects some military detention facilities, such as the Military Corrective Training Centre in Colchester. In association with HM Inspectorate of Probation, HMIP inspects offender management in custody.

HMIP is led by the Chief Inspector of Prisons who is supported by a Deputy Chief Inspector and six inspection teams. While some inspectors have experience of working in prisons, others have expertise in medicine, law, probation, social work, youth justice and drug treatment. The inspection teams specialise in different types of detention, including prisons for adult men, women or children and young people, immigration detention or police custody. The Chief

Inspector is further assisted by a team of researchers and editorial and programme support staff. In addition, HMIP draws on the expertise of partner inspectorates, such as the Care Quality Commission and Ofsted, and their territorial equivalents, during inspections.

Methodology¹³

HMIP's programme of inspection is based on a mixture of chronology and risk assessment. Prisons holding adults have a full inspection at least once every five years; prison and immigration removal centres holding children and young people have a full inspection every three years; and immigration removal centres holding only adults receive a full inspection every four years. In addition to these regular full inspections, all detention facilities have interim follow-up inspections which are unannounced and proportionate to risk. Thus, for example, a prison deemed to be high risk would receive a follow-up inspection within 12 to 36 months of the full inspection.

Residential short-term holding facilities are inspected on a four-year cycle while non-residential facilities are inspected on an eight-year cycle. Both types of facilities receive follow-up inspections in the interim. One inspection of immigration escorting arrangements is carried out each year.

Most full inspections are announced and last one week. Follow-up inspections assess the progress made against the previous recommendations. The length and depth of follow-up inspections is based on the risk assessment of the institution.

¹² HMIP's mandate is set out in the Prison Act 1952 as amended by the Criminal Justice Act 1982, the Immigration and Asylum Act 1999, the Immigration, Asylum and Nationality Act 2006 and the Police and Justice Act 2006.

¹³ Further information about the methodology of police custody inspections can be found under the profile of HMIC at page 30.

All inspections are conducted against published criteria known as expectations. There are separate expectations for adult prisoners, children and young people in prison, immigration detention and police custody. Expectations draw on and are referenced against international human rights standards. Expectations are also based on the concept of a healthy prison that was first set out by the World Health Organisation but which has been developed by HMIP and is now widely accepted as a definition of what ought to be achieved in any custodial environment. Findings from prison inspections are brigaded under four tests of a healthy prison – safety, respect, purposeful activity and resettlement. For immigration detention, findings are brigaded under similar tests but resettlement is replaced by preparation for release.

HMIP gathers evidence from a range of sources during inspections, including confidential surveys of randomly selected prisoners or detainees, focus groups and individual interviews with prisoners or detainees, interviews with staff, documentary analysis and observation by inspectors.

Following publication of inspection reports, inspected institutions produce an action plan addressing the recommendations made by HMIP.

Impact of NPM membership

Designation as a member of the UK's NPM has had a significant impact on the work of HMIP, not least because it has assumed the coordination role for the NPM. Designation has also resulted in increased cooperation between HMIP and other independent

inspectorates and visiting bodies, both at national and international levels. It has also led to an expansion of HMIP's remit – the introduction of joint inspections with HMIC of police custody came about as a direct result of the UK's ratification of OPCAT. HMIP's remit may expand even further in future to being involved in inspections of court custody facilities in England and Wales, as well as more extensive inspection of military detention facilities, both in the UK and overseas.

Summary of activities

In 2009–10, HMIP carried out 70 inspections of prisons and young offender institutions involving a mixture of announced and unannounced, full and follow-up inspections. It also carried out 21 inspections of immigration removal centres, short-term holding facilities and escorting arrangements, and 14 police custody inspections. In addition, HMIP was invited to inspect the Military Corrective Training Centre and prisons in Northern Ireland and Guernsey.

As well as inspecting individual institutions, HMIP carries out thematic inspections. These allow findings from across a number of institutions to be presented in one report and for recommendations to be made and good practice highlighted. In 2009–10, HMIP published thematic reports on race relations in prison, alcohol services in prison, the experiences of 15 to 18-year-olds in custody and detainee escorts and removals.¹⁴ In its report on alcohol services in prison, for example, HMIP noted that 19% of prisoners surveyed in 2008–09 reported having an alcohol problem when they entered prison. This is almost certainly an underestimate as many of those with alcohol problems

¹⁴ All thematic reports, and all inspection reports, are available on HMIP's website.

will fail to recognise or acknowledge them. Prisoners with alcohol problems are likely to be more problematic in general and to require greater support; however HMIP found that services for alcohol users were limited compared to the services available to illicit drug users. HMIP recommended that a national strategy, based on need and backed by sufficient resources, training and support, be implemented.

Key issues¹⁵

The seriousness with which inspections are regarded was evidenced in 2009 by the decision of some managers in two prisons – Wandsworth and Pentonville – to swap difficult prisoners for the duration of their respective inspections. This was both unacceptable and pointless, overshadowing the undoubted progress made in both prisons. By making the welfare of prisoners subordinate to the desire to impress inspectors, it fundamentally misunderstood, and indeed undermined, the purpose of inspection. As a consequence, HMIP was asked by the government to carry out more unannounced inspections in future.

In relation to prisons, another key issue in 2009–10 was the rising population and overcrowding. This is particularly important at a time when prisons have decreased resources. Despite the efforts of prisons and prison staff, overcrowding has an adverse impact on the treatment of and conditions for prisoners, and it compromises successful rehabilitation.

In relation to immigration detention, HMIP yet again expressed concern in 2009–10 about the detention of children in immigration removal centres. HMIP found little evidence that decisions to detain children, or to maintain their detention, fully take account of the best interests of the child.

Looking forward

In 2010–11, HMIP will continue its programme of inspections of prisons, immigration detention and police custody. In addition, it will publish thematic reports on the experiences of Muslim prisoners, women in prison and the management of gang issues among children and young people in prison custody and the community.¹⁶ HMIP will also explore the effectiveness of training plans for children and young people. Such plans should underpin and guide the management of a young person's time in custody and his or her transition back into the community.

¹⁵ For a discussion of key issues arising in police custody, see page 30.

¹⁶ The thematic inspection relating to gangs is being carried out in conjunction with HMIC and HM Inspectorate of Probation.

Independent Monitoring Boards

Independent Monitoring Boards have a statutory duty to satisfy themselves as to the state of the prisons or immigration detention facilities they visit, their administration and the treatment of prisoners or detainees.¹⁷ The boards are made up of unpaid public appointees from the community and they fulfil their duties by carrying out regular visits to the establishments concerned. There is a board for every prison in England and Wales and every immigration removal centre in England, Wales and Scotland, as well as boards for short-term holding facilities for immigration detainees. Depending on the size of the establishment visited, boards are made up of between 10 and 20 members. Each board includes a chairman and vice chairman. In practice, boards also include a board development officer who has responsibility for the training of board members. Members of boards are appointed by the Secretary of State and are independent of the establishment they visit. They are initially appointed for a three-year term but may be reappointed.

Independent Monitoring Boards for both prisons and immigration detention facilities are supported by a central secretariat. In addition, a National Council for Independent Monitoring Boards provides them with a national voice. Members of the Council are elected by board members.

Methodology

Board members may access the prison or immigration detention facility at any time and may have access to any prisoner or detainee and any records. They may interview any prisoner or detainee out of the sight and hearing of staff. The board is

obliged to meet at the establishment at least once a month. Generally, at least one board member makes a visit each week, although more regular visits are often made. Board members will often monitor meetings held in the establishment and will be notified of serious incidents so that they may attend and monitor how they are handled. During their visits, board members may receive 'applications' from prisoners or detainees who have issues that they have not been able to resolve with staff.

Boards may raise any concerns with the governor or manager of the establishment as well as the Secretary of State. In addition, boards submit an annual report to the Secretary of State providing an overview of the treatment of and conditions for prisoners or detainees.

OPCAT compliance

Historically, magistrates in England and Wales were required to monitor the sentences they imposed on offenders and thus were the precursor to modern day Independent Monitoring Boards. Many boards still include magistrates as members. Some concern has been expressed that the independence of boards, as required by OPCAT, is undermined by the presence of magistrates. There is a feeling that it is inappropriate for those involved in the sentencing of offenders to also be involved in monitoring their treatment and conditions. While it is accepted that conflicts of interest must be avoided, currently neither the government nor boards themselves feel that a blanket prohibition on magistrates acting as board members is needed.

¹⁷ Independent Monitoring Boards for prisons are governed by s.6 of the Prison Act 1952 and the Prison Rules 1999. Boards for the immigration detention estate are governed by s.152 of the Immigration and Asylum Act 1999 and the Detention Centre Rules 2001.

Summary of activities

In 2009–10, Independent Monitoring Boards made approximately 50,000 visits to prisons and immigration detention facilities and the annual reports of 137 boards were published. Two thematic reports were also published. One report concerned the availability and range of learning and skills training in prisons¹⁸ while the other reviewed conditions in 25 segregation units within prisons.¹⁹ This latter report noted that boards are not always informed when a prisoner is segregated, despite a mandatory requirement to do so within 24 hours. It also expressed concern at the number of prisoners with mental health issues held in segregation units, often for prolonged periods.

The National Council for Independent Monitoring Boards also published an annual report providing a national picture of treatment and conditions in prisons and immigration detention facilities.²⁰ It highlighted recurring issues, some of which are outlined below.

Key issues

In relation to the prison estate, Independent Monitoring Boards have identified several recurring issues that are of concern. Like HMIP, boards are concerned about the rising prison population and the adverse impact overcrowding has on safety and the prison regime. There are insufficient prison places in certain parts of the country, resulting in prisoners being held far from home and inhibiting family and legal visits. Boards are also concerned about the number of prisoners with mental illness. Despite the best efforts of staff, these prisoners do not receive the support and treatment they require and more should be done to divert them to more appropriate environments and services.

Around a fifth of all applications received by boards relate to the loss of or damage to prisoner property. The loss of personal possessions, such as family correspondence

and photographs, can have a dramatic effect on a prisoner's morale. However, there seems to be little acknowledgement of this longstanding problem given the failure of the authorities to effectively tackle it.

The use of indeterminate sentences for public protection (IPP) has been a key issue for boards.²¹ They are concerned at the number of those with IPP sentences who are serving terms well in excess of their tariffs (sometimes years). Often prisoners are unable to take courses which would improve their suitability for release because the courses are not offered at their prison. In recent years, boards have repeatedly expressed concern about foreign national prisoners whose sentences have expired but whose detention in prison nonetheless continues pending deportation.

In relation to the immigration estate, boards have expressed concern about the detention of children and the length of time some detainees spend in immigration removal centres. Some are detained for years and boards are concerned at the impact of such long-term, indefinite detention on their mental health. Boards are also concerned about the building or refurbishment of the immigration detention estate using criteria that would normally apply to prisons.

Looking forward

During their visits to prisons in the coming year, Independent Monitoring Boards will pay close attention to the use and management of segregation and the provision of health care. They will also monitor the impact of prison budget cuts amid fears that reduced funding will result in a general decline in standards for prisoners. In relation to immigration detention, boards will closely monitor the resolution of age-disputed cases and the length of time detainees spend travelling between places of detention and waiting at airports prior to their removal from the UK.

18 Independent Monitoring Boards, *Opportunity or not* (2009).

19 Independent Monitoring Boards, *A prison within a prison* (2009).

20 National Council for Independent Monitoring Boards, *Behind closed doors* (2010).

21 Indeterminate sentences for public protection may be imposed on those who have committed specified offences and who are deemed to pose a significant risk of serious harm in the future. Offenders are given a 'tariff' (the minimum period of imprisonment) but may only be released following expiration of the tariff if they can show the Parole Board that they have reduced their risk to the public.

Independent Custody Visiting Association

Independent custody visitors are volunteers from the community who visit all police stations where detainees are held to check on their welfare. Custody visiting is statutory by virtue of the Police Reform Act 2002 which places a duty on each police authority in England and Wales to organise and oversee the delivery of custody visiting in its area.²² The 2002 Act grants custody visitors the power to access police stations, examine records relating to detention, meet detainees for the purpose of a discussion about their treatment and conditions, and inspect facilities, including cell accommodation, washing and toilet facilities and the facilities for the provision of food.

Each police authority is responsible for recruiting visitors in its area and must ensure there is an adequate number of trained visitors available at all times. Recruitment is done through an open, non-discriminatory and well-publicised process. In making appointments, the police authority must ensure that visitors have no direct involvement in the criminal justice system and are independent of both the authority and the police force for that area. The police authority must also ensure that visitors are representative of the local community and that there is a balance in terms of age, gender and ethnicity.

The police authority is responsible for administering the visiting scheme in its area. However, the vast majority of custody visiting schemes are also members of the Independent Custody Visiting Association (ICVA), a voluntary organisation which seeks

to promote and support effective custody visiting. ICVA provides advocacy, training and support for visitors. It also supports police authorities in administering their visiting schemes by, for example, advising on best practice.²³

Methodology

Visits to police stations must be undertaken by custody visitors in pairs. Visits are unannounced and are usually not less than once a week. A decision about the frequency of visits is made locally by the police authority in consultation with the police force. Visits should be sufficiently regular to monitor detainees' welfare, but should not be so frequent as to unreasonably interfere with the work of the police.

When visiting police stations, visitors monitor the way in which detainees are treated and the conditions in which they are held, as well as their general health and wellbeing. Visitors also check that detainees' rights and entitlements are being observed. These rights and entitlements are set out in the Police and Criminal Evidence Act 1984 (PACE) and its associated Codes of Practice.

During visits, custody visitors may speak to detainees to discuss detainees' health and wellbeing, to establish whether detainees have been offered their rights and entitlements under PACE and to confirm that their conditions of detention are adequate. Subject to the detainee's consent, the visitor may examine the detainee's custody record as well as other relevant documentation. At the end of each visit, and while they are

²² There is a police authority for each local police force in England and Wales. The authority is independent of the police force and exists to secure the maintenance of an efficient and effective police force for its area. The authority holds the chief police officer to account for the services delivered by the police force.

²³ The custody visiting schemes in Northern Ireland and Scotland are also members of ICVA and benefit from its support.

still in the police station, custody visitors complete a report of their findings. One copy remains at the station for the attention of the officer in charge while additional copies are sent to the police authority and other interested parties. Arrangements for publishing reports and addressing the concerns of visitors are different in each local area. However, each police authority must report annually on the activities of its custody visiting scheme. In addition, ICVA produces an annual report of custody visiting generally and of its own activities.

Impact of NPM membership

The joint inspections of police detention carried out by HMIP and HMIC, which were initiated following the ratification of OPCAT by the UK, have helped custody visitors to focus on monitoring the human rights of detainees as well as ensuring their detention is PACE-compliant. Much of ICVA's work in 2009–10 has involved raising awareness of human rights among custody visitors and scheme administrators. New training programmes are being piloted to reflect this increased focus on human rights and upcoming events will focus on the rights and welfare of particularly vulnerable detainees.

Although custody visiting schemes in England and Wales have always worked with their counterparts in Scotland and Northern Ireland, membership of the NPM has reinforced their relationship with other members of the NPM, including other lay bodies. NPM membership has also helped ICVA to collaborate with other bodies responsible for monitoring police detention.

Summary of activities

In 2009–10, custody visitors carried out thousands of visits to police stations across England and Wales. At the national level, ICVA took the lead in redrafting the code of practice which underpins custody visiting. The majority of the work was completed in 2009–10 with the revised code being published in April 2010.²⁴ The code of practice covers the function, organisation and recruitment of custody visitors and their working arrangements.

In 2009–10 ICVA also produced new training materials for custody visitors which include a reference to their new role as members of the UK's NPM.

Looking forward

For some time, custody visitors have been concerned about detainees with mental health problems. In the next year, ICVA will continue working to address these concerns. ICVA will also be working with the government to develop a protocol for visiting suspected terrorists who are detained in police custody.

Currently, there is uncertainty over the future of the police authorities, which have statutory responsibility for overseeing custody visiting schemes. The impact on custody visiting of any changes to police authorities is as yet unknown. As with many other members of the UK NPM, resources for custody visiting and for ICVA are likely to come under pressure.

²⁴ Home Office, *Revised Code of Practice on Independent Custody Visiting* (2010).

Her Majesty's Inspectorate of Constabulary

The role of HM Inspectorate of Constabulary (HMIC), set out in the Police Act 1996, is to inspect and report on the efficiency and effectiveness of policing. This involves inspecting individual local police forces and police authorities as well as national police forces and policing agencies. Following the UK's ratification of OPCAT, HMIC's role has included carrying out inspections of police custody facilities in England and Wales in partnership with HM Inspectorate of Prisons.

HMIC is currently led by a Chief Inspector and four Inspectors of Constabulary, and is staffed by a team of assistant inspectors. Until recently, members of HMIC were appointed exclusively from the ranks of senior police officers. It is now customary, however, that some inspectors are appointed from non-police backgrounds, underlining HMIC's commitment to objectivity and broadening its professional base.

Methodology

The inspection programme devised by HMIC and HMIP seeks to ensure that every designated police custody suite in England and Wales is inspected at least once in a six-year period. By the end of March 2010, the inspection programme was a third of the way through its projected cycle. During the six-year cycle, some police custody suites will be subject to follow-up inspections based on an assessment of risk. Around one-third of inspections are unannounced.

As well as visiting custody suites and speaking to detainees and staff, evidence is drawn from surveys of prisoners at a nearby prison who have previously been detained in the relevant custody suite. After each inspection, a detailed report is sent to the relevant chief constable and

the chair of the police authority. The police authority responds within three months by producing an action plan to address any recommendations made.

HMIC and HMIP have devised detailed inspection criteria, known as expectations, against which the treatment and conditions for detainees in police custody are assessed. The expectations also act as a guide to senior police officers and police authorities on the standards that the two inspectorates expect to find in police custody and the sources of information and evidence upon which they will rely. The expectations are informed by the Police and Criminal Evidence Act 1984 (PACE) and its associated codes of practice and government guidance on the safer detention and handling of people in custody. In addition, the expectations are informed by, and referenced against, international human rights standards. The four key areas covered by the expectations are strategy, treatment and conditions, individual rights and health care. The final expectations were published in 2010 after being trialled in several inspections and following consultation with key stakeholders.

Summary of activities and key issues

In 2009–10, HMIC and HMIP carried out 14 police custody inspections. These inspections brought to light some good practice in individual police forces and custody suites, but also identified some general and systemic concerns. At a strategic level, some police forces paid insufficient attention to custodial issues. Where this was the case, it led to inconsistency in provision and conditions as well as a failure to recognise the importance of a safe custodial environment. Another emerging concern

related to the lack of governance and monitoring of the use of force on detainees in custody. This precluded any analysis of trends in the extent, type or circumstances of the use of force.

In relation to treatment and conditions, in most police custody suites, custody staff were found to be respectful in their daily interactions with detainees. However, the standard of accommodation for detainees was highly variable. While some variation was due to age and the design standards at the time of construction, there were also examples of more modern buildings where a lack of ongoing investment and maintenance had allowed avoidable deterioration. A key concern was the widespread presence of ligature points in cells.

Inspections found that the provision of rights under PACE, such as access to legal advice, was virtually universal and was embedded in the culture and practice of custody staff. Nevertheless, it was found that detainees were often not told how they could make a complaint about their care and treatment and were not enabled to do so. In some cases, detainees were actively discouraged from making complaints.

Inspections also revealed concerns about the consistency and governance of health care services in police custody. There was significant variation in arrangements for the provision of forensic medical and health care services and concerns were raised about response times, the administration of medication, the suitability of examination facilities and the handling of drug dependencies. Mental health provision was of particular concern. While there were some examples of good practice, inspections

also found examples of poor protocols with mental health support services and secure facilities, and ineffective use of schemes to divert appropriate cases from unnecessarily entering the criminal justice system.

Looking forward

In 2010–11, HMIC and HMIP will continue their programme of joint inspections and will further develop the methodology for the inspection of police custody. In addition to publishing individual inspection reports, they plan to produce a report highlighting recurring themes and issues from all inspections undertaken between 2008 and 2010.

Even though joint inspections by HMIC and HMIP have only fairly recently been introduced, it is already clear that inspections are focusing attention on the safe and humane treatment of those in police custody, not just in those suites already inspected, but across England and Wales.

Care Quality Commission

The Care Quality Commission (CQC) is an independent, statutory organisation responsible for the registration, review and inspection of health and adult social care services in England.²⁵ A key part of this role involves monitoring the operation of the Mental Health Act 1983, including visiting those who are detained under mental health law. Such visits are carried out by Mental Health Act (MHA) commissioners, people appointed by CQC on the basis of their expertise and experience. MHA commissioners come from a range of professional backgrounds, including law and medicine, but all must have knowledge of the MHA and mental health services. Commissioners visit services where people are detained under mental health legislation to find out about their experiences and to check that their rights are being protected. Commissioners may also visit patients who are subject to community treatment orders.

In line with its wider role of regulating and inspecting all health services, CQC participates in inspections of prisons and immigration detention by HMIP, and inspections of police custody by HMIP and HMIC.

Methodology

CQC makes announced visits at short notice and unannounced visits to psychiatric wards where patients are detained under mental health law. Currently, psychiatric wards are visited at no more than 18-month intervals, although many wards are visited more frequently according to perceived need. MHA commissioners are afforded free access to patients, premises and records, including medical records. CQC is committed to involving service users in its work and, on

some occasions, a specially trained person with experience of being detained will help the commissioner to plan and carry out a visit. Following each visit, a summary report is sent to the manager of the ward and overall findings are collated into an annual report for the NHS trust or independent hospital. These annual reports are also published on the CQC website.

OPCAT compliance

As with some other members of the UK's NPM, CQC's founding legislation enables the government to direct it to examine certain areas of the government's choosing. There are concerns that this compromises CQC's independence and has the potential to distort CQC's own priorities, particularly at a time of scarce resources. For example, regulations made under the Health and Social Care Act 2008 require CQC to be notified of the unauthorised absence of a detainee from hospital. This has turned into a considerably bureaucratic task and takes resources away from work CQC itself has prioritised.

Summary of activities

In 2009–10, CQC carried out visits to 1,733 wards in 701 hospitals where patients were detained under the MHA. On these visits, it met in private with 4,943 patients, checked 5,673 detention documents, and met 113 patients in groups.

Key issues

CQC has identified a number of key issues arising from its visits to places of detention. In particular, it is concerned at the safety and security of child and adolescent patients admitted to adult mental health facilities, although this practice is becoming less

²⁵ CQC was created by the Health and Social Care Act 2008. It became fully operational on 1 April 2009 when it took over the activities of the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission.

common. At the same time, there are also concerns that the safety, privacy and dignity of those admitted to dedicated child and adolescent services may be compromised given that gender separation in such services is less observed than in adult services.

A recurring issue relates to the application of mental health law by the police. Section 136 of the MHA authorises any police officer to remove a person to a place of safety if they find that person in a public place, apparently suffering from mental disorder and in immediate need of care or control. Once at the place of safety, the person can be detained for up to 72 hours to determine whether hospital admission or another form of help is required. There has been a significant increase in the availability of hospital-based places of safety leading to the less frequent use of police cells. However, CQC is concerned at the lack of consistency in the use of section 136 powers, with detention sometimes appearing to be unlawful (such as the initial detention taking place in a person's home rather than a public place). It is also concerned that patients are being inadequately assessed prior to being transferred or discharged from the place of safety.

Other issues identified by CQC include:

- the failure of some services to involve the patient in their own assessments and care planning
- the lack of independent advocates for detained patients and those subject to compulsory treatment in the community
- the increasing emphasis on security within hospitals and the blanket application of rules which risk infringing the rights of detainees
- insufficient trained staff in psychiatric wards resulting in reduced staff-patient interaction and unnecessarily restrictive conditions of detention
- the inappropriate use of seclusion.

As part of its wider role in monitoring health and adult social services in England, CQC has identified concerns around the 'deprivation of liberty safeguards'. These safeguards were recently introduced to protect those who are not detained under mental health law but who lack capacity to consent to care or treatment that is deemed by others to be in their best interest. Such care or treatment may involve depriving a person of their liberty in either a hospital or a care home. The safeguards seek to ensure that any decision to deprive someone of their liberty is made following defined processes and in consultation with specific authorities.²⁶ CQC is concerned that limited use is being made by services of the deprivation of liberty safeguards. While reasons for the low uptake are not yet known, there is a fear that there may be patients who are de facto detained, without legal recognition and without the added protection that the safeguards are intended to provide. CQC will continue to monitor this issue in 2010-11.

Looking forward

In an organisation of CQC's size and broad scope, there will always be a tension between the different functions it performs. In 2010-11, an internal restructuring of CQC threatens some roles dedicated to the monitoring of the MHA. A review of visits to those detained under mental health law is also underway, although this is designed to enhance effectiveness. As CQC's overall budget comes under pressure it will be a challenge to maintain its focus on its OPCAT-related work. Nonetheless, in 2010-11, CQC will continue to visit places of detention and will publish a report focusing on its monitoring of the MHA. In the next year, it also intends to focus on the care and treatment of forensic patients, that is, those patients who fall within both the criminal justice and mental health systems. CQC will also continue to make available its own experts to deliver training to other NPMs in Europe.

²⁶ The deprivation of liberty safeguards are set out in the Mental Capacity Act 2005.

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) regulates and inspects all health care in Wales. It assesses the quality and safety of health care commissioned or provided by organisations in the NHS and the independent sector against a range of standards, policies, guidance and regulations, and highlights areas requiring improvement. HIW also undertakes special reviews where there may be systemic failures in delivering health care so that improvement and learning are able to take place. In April 2009, HIW took on the functions of the former Mental Health Act Commission and is now responsible for monitoring compliance with mental health legislation and ensuring that health care organisations observe the safeguards relating to deprivation of liberty under the Mental Health Capacity Act 2005.²⁷ HIW has appointed a Review Service for Mental Health to carry out this work which involves making visits to health care settings where people are detained under mental health law. HIW works closely with Care and Social Services Inspectorate Wales (CSSIW) which monitors the use of deprivation of liberty safeguards in social care settings in Wales.

HIW also participates in HMIP-led inspections of prisons in Wales, assessing the health care provided to prisoners and ensuring it is equivalent to that provided in the community. In addition, HIW carries out two further functions which are relevant to its membership of the UK's NPM:

- it participates in investigations into deaths in Welsh prisons
- in circumstances where a patient known to mental health services is involved

in a homicide, HIW may conduct an independent review of the case to ensure that any lessons that may be learned are identified and acted on.

HIW carries out its functions on behalf of Welsh Ministers and is part of the Welsh Assembly Government. However, its operational independence is protected by a number of safeguards that enable HIW to provide an objective view of health care in Wales.

Methodology

HIW's Review Service for Mental Health seeks to ensure that all those receiving care and treatment in Wales and who are subject to mental health legislation are treated with dignity and respect; have the right to ethical and lawful treatment; receive the care and treatment that is appropriate to their needs; and are enabled to lead as fulfilling lives as possible. The Review Service makes announced and unannounced visits to services where people are detained under mental health law. All facilities are visited at least once a year with the timing and nature of visits being determined on the basis of risk.

Following each visit, feedback letters are sent to the detaining authorities identifying good practice and any issues of concern. These letters are not published as they contain information that could identify individual detainees. However, annual reports of visits to individual detaining authorities are published. HIW also intends to publish an overview report of the findings of its Review Service each year. The first such report, relating to work in 2009–10, will be published in late 2010.

²⁷ For further information about the deprivation of liberty safeguards, see the profile of CQC at page 33.

To safeguard patients, certain treatments (such as electro-convulsive therapy) provided under mental health legislation require a patient's consent, or the agreement of an independent doctor that the treatment proposed is appropriate for the patient's specific needs. HIW provides these independent doctors through its 'second opinion appointed doctors' service. In 2009–10, HIW received 836 requests for second opinions.

Summary of activities and key issues

In 2009–10, HIW carried out 91 visits to 51 hospitals where patients were detained under mental health legislation. It spoke to more than 200 patients, either informally in private interviews or as part of group meetings. It also examined the documents of around 200 patients to monitor whether detaining authorities were following statutory procedures and national guidelines. HIW has identified recurring issues as a result of its visits, many of which relate to the quality and environment of care rather than the legalities of detention. Several concerns related to consent and capacity such as a lack of understanding by staff of capacity issues, failure to make clear assessments of capacity, difficulties in managing fluctuating capacity and difficulties in adhering to legal processes.

In 2009, HIW commenced a special programme of visits to mental health services where people may be detained, the purpose of which was to assess the dignity and respect afforded to patients. Thirteen hospitals were visited and HIW interviewed

patients, carers and staff, examined patient records and observed the environment and the care and treatment provided. A key finding arising from these reviews was the lack of therapeutic input on many of the wards visited.

Also in 2009, HIW published a report on child and adolescent mental health services in partnership with other regulatory and inspecting bodies in Wales, including CSSIW. The report detailed findings of a review of inpatient provision for those under the age of 18, including those detained under mental health legislation. It also touched on mental health services for young people in prison or secure accommodation. The report identified several concerns, including inconsistency in provision across Wales, the inappropriate placement of children in paediatric or adult mental health wards, a lack of specialist mental health services, inadequate arrangements for the transition to adult services and a failure to involve children in planning their care.

Looking forward

Like the CQC in England, HIW has found that health services in Wales are making lower than expected use of the deprivation of liberty safeguards. HIW will explore the reasons for this and will undertake a more systematic data gathering exercise in 2010–11. It will also undertake a number of special reviews which will include looking at the care and treatment of detained patients. One review concerns the use of physical restraint and whether it is used safely and only when absolutely necessary. Another will examine how mental health service providers manage the risk of suicide.

Children's Commissioner

Established by the Children Act 2004, the role of the Children's Commissioner is to promote awareness of the views and interests of children in England²⁸ among, for example, those working with children and the government. The Commissioner's remit covers all children up to the age of 18, or those up to the age of 21 if they have a learning disability or if they have been in the care of the state at any time since the age of 16. Within this broad remit, the Commissioner is to have particular regard to those children who do not have other adequate means by which they can make their views known.

The Commissioner is supported by a Deputy Commissioner who is also the chief executive of the Office of the Children's Commissioner (OCC), an office comprising 25 staff, many of whom use the Commissioner's delegated powers to carry out their work.

These powers include the right to enter any premises, except a private dwelling, for the purpose of interviewing any child accommodated or cared for there. With the child's consent, the Commissioner may interview the child in private. Those exercising statutory duties, such as a secure accommodation facility, young offender's institution or immigration detention centre, must also supply the Commissioner with any information that she may reasonably request. In addition, where the OCC publishes a report with recommendations relating to those exercising statutory duties, they are required to respond in writing, stating what action is being or will be taken to address the recommendations made.

OPCAT compliance

The OCC does not carry out a regular programme of visits as required by OPCAT, but instead benefits from a very broad power to enter premises where children may be detained. This remit and accompanying set of powers is used on a regular basis to inform the OCC's work. The OCC's focus on the views and interests of children is useful given that they are potentially a particularly vulnerable group of detainees. OCC reports may therefore highlight or uncover issues that may otherwise not be noted by other organisations. Of particular note is the Commissioner's duty to have regard to the United Nations Convention on the Rights of the Child in her work, in line with Article 19(b) of OPCAT.²⁹

Summary of activities and key issues

A key issue for the OCC is the detention of children for the purpose of immigration control. The majority of such children are detained in Yar's Wood Immigration Removal Centre in England, a facility visited by the OCC three times in four years due to concerns about their treatment. In May 2009, the OCC published a report following one such visit,³⁰ the purpose of which was to examine the provision and conditions at the centre and to hear from children and their families about their experiences of the detention process.

The OCC identified several areas of concern during the visit, not least the fact of detention itself. It felt that depriving children of their liberty for administrative purposes was never likely to be in their best interests

²⁸ The Commissioner also has a role in promoting the awareness of the views and interests of children in the rest of the UK in relation to non-devolved matters (such as immigration issues or, in relation to Wales only, youth justice).

²⁹ Article 19(b) requires NPMs to take into consideration "the relevant norms of the United Nations."

³⁰ Children's Commissioner, *The arrest and detention of children subject to immigration control: a report following the Children's Commissioner for England's visit to Yar's Wood Immigration Removal Centre* (2009).

and it recommended that detention be ended and alternatives developed. The OCC also expressed concern about the care and treatment received by children in detention, including:

- the process of arrest and conditions during transportation to the detention facility, which the majority of children found upsetting and frightening
- evidence from children that control and restraint were sometimes used on them
- the need for improved emotional support or counselling
- the need to ensure health care received within the facility is of the same standard as that received in the community
- the need for improved services for pregnant and nursing women.

The report made multiple recommendations and these were followed up in another visit to Yarl's Wood, a report of which was published in February 2010.³¹ While welcoming significant changes to policy and practice and an improvement in the physical environment of the facility, the OCC nonetheless reiterated the view that detention is never likely to be in children's best interests and cited growing evidence that detention has a profound and negative impact on them.

As well as publishing reports of visits, the OCC has commented on law and policy affecting children in detention, in line with Article 19(c) of OPCAT. For example, in 2009, the OCC commented on statutory guidance which would supplement a new duty on the government agency responsible for enforcing immigration law to safeguard and promote the welfare of children.

In 2009–10, the OCC also undertook work into the conditions of young offenders detained in custody. It visited a number of secure establishments to interview young people about the conditions and treatment they experienced. More detailed work has begun on examining the provision of mental health services to ensure the needs of very vulnerable young people in custody are addressed.

Looking forward

Following an announcement by the government that it intends to end the detention of children and young people for immigration purposes, the OCC will work to ensure that this commitment is realised and that the immigration system better reflects human rights standards.

The treatment of those young people detained in the youth justice system will continue to be a priority over the coming year as the OCC visits establishments. It will complete a detailed review of the mental health needs of young people in custody and how these are being addressed. The complaints processes available for young people in custody will also be monitored.

³¹ Children's Commissioner, *The Children's Commissioner for England's follow up report to the arrest and detention of children subject to immigration control* (2010).

Care and Social Services Inspectorate Wales

The Care and Social Services Inspectorate Wales (CSSIW) is responsible for the regulation and inspection of all social care services in Wales. This broad remit includes, for example, the inspection of local authority social services, care homes for adults, children's homes, day care services for children, adoption and fostering services and residential schools.³² CSSIW has been designated as a member of the UK's NPM due to its inspections of secure accommodation for children. There is only one such facility for children in Wales (Hillside Secure Children's Centre) and children are placed there either because of their offending behaviour or because they pose a significant risk to themselves or others.

In addition, CSSIW monitors the use of the deprivation of liberty safeguards during its regular inspections of adult care homes. As noted previously, these safeguards were introduced to protect those who lack capacity to consent to care or treatment that is deemed by others to be in their best interest. Such care or treatment may involve depriving a person of their liberty in either a hospital or a care home.³³

CSSIW carries out its functions on behalf of Welsh Ministers and is part of the Welsh Assembly Government. However, CSSIW is functionally independent of the government and has extensive operational autonomy. It is able to set its own programme of work and has full editorial control over its reports.

Methodology

CSSIW undertakes announced and unannounced inspections. Both Hillside and adult care homes are inspected annually. CSSIW has the right of entry to premises, the right to inspect and remove documents and to require information, and the right to interview staff and service users in private. All inspection reports are published except where the care home inspected is so small that publication may allow the identification of individual residents. CSSIW is committed to putting the experiences of service users at the heart of its work, encouraging services to treat people with dignity and respect and promoting equality, diversity and human rights.

As well as inspecting social care services, CSSIW provides professional advice to the Welsh Assembly Government to inform the development of policy, legislation and practice.

Summary of activities and key issues

In its annual inspection of Hillside in 2009, CSSIW identified no outstanding requirements from the previous inspection and no new requirements were made.³⁴ Given that Hillside is the only secure children's home in Wales, some children placed there are a considerable distance from their homes. In addition, children from Wales may be placed elsewhere in the secure estate in the UK. For both groups,

32 The mandate of CSSIW is set out in several pieces of legislation including the Health and Social Care (Community Health and Standards) Act 2003, the Care Standards Act 2000, the Children Act 1989 and the Adoption and Children Act 2002.

33 For more information about deprivation of liberty safeguards, see the profile of CQC at page 33. The use of the safeguards in health services in Wales is monitored by HIW while in England, CQC monitors the safeguards in both health and social care services.

34 The service provider is responsible for ensuring that the service operates in a way which complies with the regulations. Those regulations which CSSIW believes to be key in bringing about change in the particular service will be separately and clearly identified in the 'requirement' section of an inspection report.

this may result in reduced contact with their families, adding to the children's sense of isolation and vulnerability. Welsh children detained in other parts of the UK may also experience language difficulties as many have Welsh as their first language, rather than English. Placement far from home can also adversely affect the effectiveness of care planning and resettlement.

CSSIW has noted that many children require access to mental health or substance misuse services while in secure accommodation and on their return to the community. It highlights the need to ensure continuity in the planning and delivery of these services. CSSIW has recommended that children leaving Hillside receive more effective support for their return to the community. Such support may involve a range of services, including housing. Children accommodated in any part of the secure estate are particularly vulnerable and robust safeguarding systems are required to promote their welfare.

In relation to its monitoring of the deprivation of liberty safeguards, CSSIW has noted considerable variation in their use across Wales. Intelligence gathered by CSSIW suggests a need to raise awareness of the legislation underpinning the safeguards. Nonetheless, CSSIW has also found examples of good practice where those delivering care home services have demonstrated good understanding of the safeguards and how to use them.

Best interests assessors consider the interests of the service user and make recommendations about any proposed deprivation of liberty. Although in England such assessors require accreditation, there is no such requirement in Wales. CSSIW intends to monitor this issue as it may pose problems for assessors from Wales who wish to evaluate the needs of Welsh service users placed in care homes in England. This, and other issues, will be raised by CSSIW in its first annual report on the implementation of the deprivation of liberty safeguards to be published in 2010.

Looking forward

As with most other members of the UK's NPM, CSSIW must fulfil its regulation and inspection mandate while facing increasing financial pressures. This is particularly challenging as social care is currently undergoing significant changes to which CSSIW must adapt. There is greater emphasis than ever before on the independence and autonomy of service users which is, of course, welcome. Nonetheless, these developments potentially provide more scope for the ill-treatment of vulnerable people. The challenge for CSSIW and others will be to promote this independence for service users while also safeguarding their safety and welfare.

Ofsted

The Office for Standards in Education, Children’s Services and Skills (Ofsted) is a regulatory and inspection body which seeks to promote excellence in the care of children and young people, and in education and skills for learners of all ages. Its remit includes the regulation and inspection of childcare and children’s social care, and the inspection of schools, colleges and adult and community learning, among other services. In the context of detention, Ofsted inspects the care and educational provision for children in secure accommodation, and assesses the provision of education and training in prisons, young offender institutions and immigration removal centres as part of HMIP-led inspections.

Children are placed in secure accommodation either because their behaviour poses a significant risk to themselves or others, or because they are on remand or serving a sentence. Secure accommodation is provided in two settings: secure children’s homes and secure training centres. There are 16 secure children’s homes providing care and support for children aged 10 to 17. There are four secure training centres providing places for 12 to 17-year-olds who have been remanded or sentenced by the courts.

Ofsted is led by Her Majesty’s Chief Inspector and is staffed by inspectors with expertise and experience in relevant areas, including, for example, education and social care.

Methodology³⁵

Ofsted carries out inspections of secure accommodation twice a year, with one unannounced inspection each year. Inspections may be full or interim. Full

inspections assess compliance with regulations and nationally prescribed minimum standards, as well as the extent to which the provider achieves positive outcomes for children. An interim inspection predominantly involves following up on findings and recommendations from the previous full inspection.

Summary of activities and key issues

In 2009–10, inspections of secure accommodation by Ofsted found that the quality of care is predominantly good. Particular strengths were seen in the relationships between children and young people, the individual care they receive to meet their needs and the use of external partners to provide activities which they enjoy and from which they learn. As one child told the inspectors, “They are good at keeping us safe and allow us to do things we are interested in.”

The number of secure establishments judged ‘outstanding’ increased from the previous year. These facilities were characterised by a calm and purposeful atmosphere and positive, professional relationships between staff and young people. Clear boundaries and consistent routines underpinned effective behaviour management and staff were skilled at diffusing difficult situations. These providers had strong systems for consulting with the young people in their care and engaged successfully with the local authority and other agencies to ensure their ongoing safety. Nonetheless, inspections of some secure establishments identified several weaknesses. These included the inadequate management of complaints,

³⁵ For further information about methodology in relation to Ofsted’s inspections of education and training in prisons, young offender institutions and immigration removal centres, see HMIP profile at page 23.

poor arrangements for self-medication and insufficient action taken to assess the risk of bullying and counteract it.

In many of the secure establishments, Ofsted found that the use of physical restraint was decreasing as a result of good training for staff, the effective use of de-escalation techniques, and the robust review of individual incidents that required restraint. However, in some poorly performing establishments, the recording of physical restraint remained a common weakness.

In relation to the education provided in secure training centres, Ofsted found improvements during its inspections. The achievements of young people were generally good and many gained useful qualifications in literacy and numeracy and their first experience of educational success. In a few establishments though, there were insufficient opportunities for young people to gain meaningful and substantial qualifications, even when their length of stay would allow them to do so. Instead they gained large numbers of certificates which were of little value.

In addition, Ofsted published thematic reports on secure accommodation for children. One report described what life is like within a secure children's home, based on the experiences of children themselves.³⁶ Another evaluated the effectiveness of arrangements for education and training while children and young people are moving through the youth justice system or serving their sentence in the community.³⁷ Ofsted also evaluated the provision of mental health services for children over the age of 16 in residential settings, including those in secure children's homes.³⁸ It found inconsistent mental health provision, noting poor arrangements for transfers from child to adult mental health services, a lack of

services in rural areas, difficulties in sharing information and an unwillingness on the part of the young people to engage with specialist workers because of prejudices linked to mental health. In its evaluation report, Ofsted emphasised the importance of different agencies working together to improve and develop mental health services for young people, and clear local service level agreements for child and adolescent mental health services.

Ofsted's inspections of the education and training provision in the prison estate found that in comparison to the previous year, there were a higher number of prisons where the provision was judged to be inadequate. The most common finding was that there was simply too little activity to engage the number of prisoners held: there were too few education and work places and there were too many waiting lists for vocational training. While there were good examples of extensive vocational training and employability skills training, there was often a lack of good quality literacy and numeracy provision to support training.

In the immigration detention estate, Ofsted found that the management and planning of education were often weak. Education was not promoted sufficiently and the take-up was low. The education offered was often too narrow.

Looking forward

As well as continuing its programme of regular inspections in places of detention, Ofsted plans to consult stakeholders in 2010–11 as part of a review of its methodology for inspecting all children's homes, including secure homes. It will also publish a thematic report on admission, discharge and resettlement arrangements for children in secure accommodation.

³⁶ Ofsted, *Life in secure care* (2009).

³⁷ Ofsted, *Transition through detention and custody* (2010).

³⁸ Ofsted, *An evaluation of the provision of mental health services for looked after young people over the age of 16 accommodated in residential settings* (2010).

Her Majesty's Inspectorate of Prisons for Scotland

The post of Her Majesty's Chief Inspector of Prisons for Scotland (HMCIPS) has existed since 1981 and was made statutory by virtue of section 7 of the Prison (Scotland) Act 1989. The 1989 Act requires HMCIPS to inspect prisons, including young offenders institutions, paying particular attention to the treatment of prisoners and conditions in prison. In addition, HMCIPS has a duty to inspect legalised police cells. In Scotland, legalised police cells are used to hold prisoners awaiting trial in their local area, rather than transfer them to distant prisons. Eight police stations have legalised cells and all are located in outlying areas. Prisoners are not held in legalised police cells for longer than 30 days.

The Criminal Justice and Public Order Act 1994 introduced a duty on HMCIPS to inspect prisoner escort arrangements. Prisoner escort arrangements include the conditions in which prisoners are transported from one place to another, as well as court custody facilities or any other place where prisoners are temporarily held outside a prison.

HMCIPS publishes a report of every inspection as well as thematic inspections and an annual report of its activities. All are submitted to the Scottish Government, although HMCIPS operates independently from the Scottish Government and the Scottish Prison Service. The Chief Inspector is assisted by three inspection staff and a personal secretary. This core team is augmented by experts in education and social work, and any other experts as required.

Methodology

HMCIPS carries out regular announced and unannounced inspections. Inspections may either be full or follow-up. Full inspections typically last one week while follow-up inspections last one or two days. The purpose of a follow-up inspection is to monitor issues raised during previous inspections and to examine any significant changes. HMCIPS is moving away from three-year cyclical inspections of prisons and will instead carry out inspections as required. Inspection of legalised police cells currently takes place every three years. When inspecting a prison, HMCIPS also inspects the custody facilities of courts serving that prison and related prisoner escorting arrangements.³⁹ HMCIPS is able to access any part of an establishment, view any relevant papers and speak to prisoners and staff privately and in confidence.

HMCIPS has developed standards for use in inspection. Based in part on international human rights law, these standards provide a consistent and transparent framework for inspection. The standards are grouped into three key areas:

- safety
- decency, humanity and respect for legal rights
- opportunities for self-improvement and access to services and activities.

³⁹ A full inspection, focused solely on prisoner escorting, was carried out in 2006.

Summary of activities and key issues

During 2009–10, HMCIPS carried out three full inspections of HMP & YOI Cornton Vale, HMP Greenock and HMP Perth.⁴⁰ Cornton Vale holds all categories of women, including young offenders, women on remand and convicted prisoners. While HMCIPS found Cornton Vale to be a safe prison, it was concerned about the increasing number of women held there. It found the conditions in which most of the women lived to be unacceptable, noting that many spent long periods 'locked up' because of insufficient opportunities for work and education. HMCIPS also expressed concern that there was inadequate access to sanitation facilities, that food was of poor quality, and that the health centre was not fit for purpose.

The inspection reports for both Greenock and Perth prisons were generally positive. However, at Greenock, HMCIPS found living conditions for most prisoners were not good and commented on the lack of privacy for prisoners using in-cell toilets. At Perth, HMCIPS expressed concern at the high number of prisoners testing positive for illegal substances on release and also recommended that arrangements for prisoners' first nights in custody should be more structured.

As well as inspecting individual places of detention, HMCIPS carries out thematic inspections. Previous themes have included prisoners with severe and enduring mental health problems and conditions for remand prisoners. In 2009, HMCIPS published a report of a thematic inspection carried

out in conjunction with Her Majesty's Inspectorate of Constabulary for Scotland and the Social Work Inspection Agency. This inspection focused on the assessment and management of offenders who present a high risk of serious harm. The report made a number of recommendations, including greater coordination between agencies so that prisons receive information more quickly when an offender begins a sentence for a serious violent or sexual offence. It also recommended that all staff working with offenders who present a high risk of serious harm, including prison staff, receive appropriate training and support.⁴¹

Looking forward

During the course of the year, a new Chief Inspector of Prisons was appointed. He has identified six areas of special interest which will provide an additional focus for inspections in the future. These areas are the training and development of prison staff; prisoners' families; community partnerships; preparation for release; addictions; and the smuggling of illicit and unauthorised items into prison.

40 All inspection reports are available on the HMCIPS website.

41 SWIA, HMIC & HMIP, *Assessing and managing offenders who present a high risk of serious harm* (2009) available at: www.swia.gov.uk

Her Majesty's Inspectorate of Constabulary for Scotland

The role of HM Inspectorate of Constabulary for Scotland (HMICS) is to monitor and improve police services in Scotland.⁴² It scrutinises the work of Scotland's eight police forces as well as the Scottish Police Services Authority, a national body responsible for, among other things, the training of all police officers. HMICS inspects all aspects of policing, including police custody.

HMICS is led by the Inspector of Constabulary for Scotland and is staffed by a team of inspectors, all of whom are senior police officers or staff on secondment from police forces around the UK. Further support, such as research and administrative services, is provided by a team of civil servants. Where necessary, HMICS will seek additional experts to provide specialist advice during inspections. Although HMICS is an independent organisation, the Scottish government may call upon it to undertake particular pieces of work.

Methodology

HMICS carries out inspections of individual police forces in Scotland as well as inspections covering particular themes. It has recently reviewed its methodology, introducing a more risk-based and proportionate approach to inspection activity. In deciding which forces or which themes to review, HMICS consults with stakeholders and considers assessments carried out by police forces themselves to identify any difficulties or concerns.

Following an inspection, HMICS publishes a report, including any necessary recommendations, and subsequently monitors their implementation. Recommendations arising from thematic inspections, for example, are followed up during inspections of individual police forces to ensure that good practice is being embedded throughout Scotland. In addition to its inspection reports, HMICS publishes an annual report on the state and efficiency of all police forces.

HMICS also provides advice to the Scottish government on policing matters. Such advice may ultimately result in changes to legislation.

Summary of activities and key issues

While HMICS carried out no thematic inspections relating to police custody in 2009–10, it continued to monitor the implementation of recommendations made in three custody-related inspection reports published in the previous year. The first of these concerned the design of police custody facilities. HMICS noted that custody facilities differed across Scotland and found that there was scope for reducing the risks associated with detaining people. It recommended that police forces adopt a common approach to the design of custody facilities, taking into account relevant standards and best practice.⁴³

⁴² See section 33 of the Police (Scotland) Act 1967.

⁴³ HMICS, *Thematic inspection: Custody facilities* (2008).

In the second thematic inspection, HMICS examined the care of detained and arrested children. One of the main issues which arose during its inspection related to the inappropriate retention of children in custody without relevant legislation and guidance. In its report, HMICS highlighted the need for police forces to provide care for children that meets their specific needs. It noted scope for improvement within police forces in terms of their understanding and implementation of policies, procedures and practices concerning the care of detained children.⁴⁴

In its third thematic inspection, HMICS examined the provision of medical services for people in police custody. It found that such provision has developed in an ad-hoc manner and is no longer suitable to meet the needs of detainees and police forces. As a result, HMICS made a number of recommendations based on identified good practice and sought to contribute to a wider discussion about how and by whom medical services should be provided.⁴⁵

When inspecting individual police forces and their corresponding police authorities,⁴⁶ HMICS examines the extent to which they facilitate independent custody visiting.⁴⁷ When inspecting Northern Constabulary and Northern Joint Police Board, HMICS noted that custody visitors had operated in that police area since 2000. However, while

mainland custody facilities received visits, those located on islands did not, despite the island facilities processing a significant number of detainees. HMICS recommended that the police board ensure all facilities in its area receive visits. It also recommended that the police board inform all custody visitors of recommendations made by HMICS in its custody-themed inspection reports.

Looking forward

In the next year, HMICS will continue to monitor the implementation of recommendations made in its custody-themed inspection reports. It will also examine the provision of and safeguards for police custody in its inspections of individual police forces.

44 HMICS, *Thematic inspection: Care of detained and arrested children* (2008).

45 HMICS, *Thematic inspection: Medical services for people in police custody* (2008).

46 Police authorities (sometimes called police boards) in Scotland are independent of the police force and are not responsible for the day-to-day delivery of policing. Instead, each police authority is responsible for setting, monitoring and scrutinising the budget of its local police force and for holding the Chief Constable to account for the force's performance.

47 For further information about independent custody visiting in Scotland, see page 52.

Scottish Human Rights Commission

The Scottish Human Rights Commission is an independent, statutory body with the power to enter places of detention and report on the rights of detainees. Established by the Scottish Commission for Human Rights Act 2006, the general duty of the Commission is to promote awareness, understanding and respect for human rights and, in particular, to encourage best practice in relation to them. The Commission fulfils this duty through education, training, awareness-raising and research, as well as by influencing the development of law, policy and practice in Scotland. In carrying out its role, the Commission must have regard to the human rights of those groups in society whose entitlements are not otherwise being sufficiently promoted, such as detainees.

The Commission consists of a Chair and up to four other members. Currently, the Commission has three part-time members and is supported by 10 members of staff. As required by OPCAT, the Commission is independent. It is not subject to the direction or control of the Scottish government or the Scottish Parliament. The Chair of the Commission is appointed by Her Majesty on the nomination of Parliament. The other members of the Commission are appointed by a body made up of members of the Scottish Parliament from across the political spectrum, while staff are engaged through an open recruitment campaign.

Methodology

The Commission has the power to conduct inquiries into the policies or practices of Scottish public authorities where such an

inquiry would be relevant to the promotion of awareness, understanding and respect for human rights. In the course of an inquiry, the Commission may enter and inspect any place of detention and may conduct interviews with any detainee in private, with the detainee's consent. 'Place of detention' is defined by the 2006 Act as *"any premises, vehicle or other place in or at which an individual is or may be detained by, or with the authority or consent of, a Scottish public authority."*⁴⁸ For the purpose of its inquiry, the Commission may also require a Scottish public authority or its staff to provide it with relevant information, including documentation and oral evidence. Any visit to a place of detention would be carried out within a human rights framework, with special regard to international human rights standards.

Prior to conducting an inquiry, the Commission must give notice of and publicise the terms of reference for the proposed inquiry and a summary of the procedure to be followed. Once completed, the Commission must lay a report of the inquiry, including any findings and recommendations, before the Scottish Parliament. In addition to these reports, the Commission must also lay before the Parliament an annual report of its activities.

Article 19(c) of OPCAT envisages a strategic role for NPMs in addition to their regular visiting of places of detention.⁴⁹ This is reflected in the 2006 Act which empowers the Commission to review and recommend changes to the law of Scotland or any policies or practices of any Scottish public authorities.

⁴⁸ Section 11(2), Scottish Commission for Human Rights Act 2006.

⁴⁹ Article 19(c) states that NPMs should be granted the power *"to submit proposals and observations concerning existing or draft legislation."*

OPCAT compliance

As Scotland's national human rights institution, the Commission has been accredited by the UN and is considered by it to be compliant with the Paris Principles. This is relevant to the Commission's role as a member of the NPM as Article 18(4) of OPCAT requires that when designating NPMs, States Parties should give due consideration to the Paris Principles.⁵⁰

Although the Commission does not carry out 'regular' visiting of places of detention as required by OPCAT, the broad scope of its powers to enter any place of detention are potentially useful to the UK's NPM. Whereas most other NPM members are able to enter only specified places of detention (for example, a prison or a police custody facility), the Commission is able to enter any place where a person is or may be detained. Thus, where there are gaps in the coverage of the other NPM members in Scotland, the Commission is able to step in and ensure the human rights of detainees are respected.

Summary of activities

The Commission is only a recently established body and has not as yet conducted a formal inquiry and used its power to enter a place of detention. Nevertheless, the Commission has sought to promote the human rights of detainees. In 2009, the Commission published an independent evaluation of the experience of The State Hospital which had sought to adopt a human rights culture. The State Hospital provides psychiatric care in conditions of high security for persons

with mental illness who are detained under mental health or criminal law. The evaluation found that, by adopting a human rights-based approach to its work, The State Hospital increased satisfaction among patients over their care and treatment. There was a reduction in 'blanket' policies and an increased focus on risk assessment of individual patients. Procedures to manage violence and aggression were now seen as proportionate, seclusion was not routinely used as a punishment and patients actively engaged in decisions affecting them. Applying a human rights-based approach also led to increased work-related satisfaction among staff, a fairer environment and improved relations between staff and patients.⁵¹ The Commission's evaluation provides lessons for other public authorities and the Scottish Prison Service is now considering the possibility of adopting a human rights-based approach.

This year, the Commission also published a human rights framework for the design and implementation of remedies for cases of historic child abuse in Scotland. This framework includes recommendations relating to the right to dignified and appropriate conditions of detention for children held in residential care.⁵²

Looking forward

In the coming year, the Commission will continue its work on human dignity in care settings as well as justice and remedies for adults who were abused in residential care as children.

⁵⁰ The Principles relating to the status of national institutions for the promotion and protection of human rights (The Paris Principles) are a series of recommendations on the role, status and functions of national human rights institutions, with a focus on independence, adopted by the UN General Assembly in 1993.

⁵¹ SHRC, *Human rights in a health care setting: making it work for everyone, an evaluation of a human rights-based approach at The State Hospital* (2009).

⁵² SHRC, *A human rights framework for the design and implementation of the proposed "Acknowledgement and Accountability Forum" and other remedies for historic child abuse in Scotland* (2010).

Mental Welfare Commission for Scotland

The Mental Welfare Commission for Scotland (MWCS) is an independent, statutory organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder.⁵³ It ensures that the care and treatment of individuals are compliant with mental health and incapacity law in Scotland. MWCS focuses primarily on people rather than places, and has the authority to visit people in a prescribed list of establishments including hospitals, prisons and care homes. However, it also visits people being cared for under mental health or incapacity law wherever they may be, including their own homes. Thus, MWCS seeks to safeguard the rights and welfare of both detained and non-detained persons. The mandate of MWCS is broad and includes, for example:

- visits to monitor the care and treatment of persons subject to mental health or incapacity legislation
- investigations and inquiries into situations where a person may have suffered abuse, neglect, improper detention or deficiency of care and treatment.

The Commission and its staff are made up of experts in mental health, nursing, social work and other relevant fields, as well as service users and their carers.

Methodology

MWCS has the power to enter premises where a person may receive care or treatment, access any relevant information, including medical information, and carry out private interviews with patients and staff. Visits may be announced or unannounced. To

facilitate its visiting of persons with mental disorders who are detained, MWCS is formally notified of all episodes of compulsory care and treatment under mental health law.

MWCS carries out visits to individuals who are cared for under mental health or incapacity legislation. It conducts 'focused' visits to people receiving care in a particular setting if it has concerns that they may not be having their needs met or their rights respected. 'Themed' visits are used to compare care and treatment across Scotland. MWCS decides which themes to explore based on consultation with stakeholders and findings from other visits. Focused and themed visits also include patients who are not subject to compulsory care or treatment.

Following visits, MWCS will make recommendations regarding the care and treatment of patients. If recommendations are not implemented, the MWCS may escalate concerns. This has involved undertaking further visits with an invitation to NHS Board Chief Executives to attend so that the MWCS can discuss concerns with them in person. It publishes reports of its focused and themed visits and its investigations, as well as an annual report which summarises its monitoring activities and findings.

OPCAT compliance and impact of NPM membership

In addition to visiting people deprived of their liberty, MWCS seeks to prevent ill-treatment in places of detention by promoting best practice in the implementation of mental health and incapacity law. It regularly publishes guidance on good practice when

⁵³ Its remit and powers are set out primarily in the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000.

dealing with practical or ethical difficulties, such as guidance on the use of restraint in residential care settings.⁵⁴ All guidance is developed in consultation with stakeholders, including patients and carers. In keeping with its preventive role under OPCAT, MWCS operates a telephone advice service for patients, carers and professionals. This offers advice on the care and treatment of those subject to mental health or incapacity law, including those who are deprived of their liberty.

In recent years, there have been efforts in Scotland to reduce the burden on public services caused by external scrutiny bodies. As part of these efforts, it was at one stage proposed that MWCS be merged with a governmental organisation. However, membership of the UK's NPM and OPCAT's emphasis on the need for independent inspection helped MWCS to resist the proposed merger. Instead, some structural changes to MWCS, to be made in April 2011, will allow it to retain its independent status and will strengthen its focus on the rights and welfare of the individual.⁵⁵ More generally, designation as part of the UK's NPM has given MWCS the impetus to take an increasingly human-rights based approach to its work.

Summary of activities and key issues

In 2009–10, MWCS carried out visits to 770 individuals subject to mental health and incapacity legislation. It saw an additional 1,089 individuals, not all of whom were subject to compulsory care or treatment, as part of its focused and themed visits. During one visit to a hospital, MWCS found that patients were being restrained unlawfully and their rights were being infringed by strict behavioural regimes. MWCS reported its concerns and intervened to ensure that the patients were informed of their rights and that staff understood the rights of patients. Since then, the culture and practice of the hospital has changed significantly.

MWCS identified a number of key issues in the course of its work. It noted several interferences with the rights to privacy and dignity, including the use of searches, taking samples for drug or alcohol testing and restrictions on communications. These interferences were often applied in an arbitrary manner. MWCS has since published good practice guidance on using restrictions appropriately.⁵⁶

MWCS published themed reports on older people's care, intensive psychiatric care and secure facilities. In a themed report on people subject to short-term detention, MWCS found that their rights were generally well respected. It found evidence that individuals were involved in decisions about their care and that the care provided met their needs and was frequently reviewed. However, it also found that not all individuals were aware of their right to appeal against their detention.⁵⁷

In conjunction with the Care Commission, MWCS published a themed report on people with dementia in care homes.⁵⁸ This work had a significant influence on the development of a national strategy on dementia.

Looking forward

Over the next year, MWCS will continue to monitor the care and treatment received by people subject to mental health and incapacity legislation. In particular, it will look at the care and treatment of patients subject to community compulsory treatment, patients in adult acute care and persons with learning disabilities in residential care. MWCS will also monitor the care and treatment of patients with dementia in general hospitals. These patients may not be formally detained, but they have no choice about where they reside and may be de facto detained. MWCS will also look at compliance with safeguards for medical treatment under mental health legislation.

54 MWCS, *Rights, risks and limits to freedom* (2006).

55 These changes will be made when relevant provisions of the Public Services Reform (Scotland) Act 2010 come into force.

56 MWCS, *Specified persons guidance* (2010).

57 MWCS, *Short-term detention* (2010).

58 MWCS & Care Commission, *Remember I'm still me* (2009).

Scottish Commission for the Regulation of Care (Care Commission)

The Care Commission was designated as a member of the UK's NPM in respect of its inspections of secure accommodation services for children in Scotland. In Scotland, children may be placed in secure accommodation where they pose a significant risk to either themselves or others and are likely to run away or abscond from a more open care setting. In addition, the Care Commission may inspect care services in psychiatric hospitals where some patients may be detained.

Inspecting such places of detention is just one aspect of the Care Commission's role. Under the Regulation of Care (Scotland) Act 2001, the Care Commission has a broad remit to regulate and improve care services in Scotland. This involves registering new services, inspecting services, investigating complaints and taking enforcement action where necessary to improve services. Other care services within the Care Commission's remit include children's day care services, childminding, care homes for older people and independent hospitals. The Care Commission regulates around 15,000 services each year, only seven of which are secure accommodation services.⁵⁹

The 2001 Act empowers the Care Commission to inspect any care service within its remit and to enter, at any time, any premises used for providing the service. The Care Commission may examine the state and management of the service and the treatment of persons cared for. It may conduct private interviews with any person cared for by the service as well as the manager and provider of the service and any other employee. The Care Commission may

also require the care service provider to supply it with any information it considers necessary.

The Care Commission is a non-departmental public body. It is independent in its day-to-day running, but is ultimately accountable to the Scottish government. The Care Commission is made up of a convenor and other members appointed by the Scottish government. They are supported by staff, one of whom – the chief officer – is appointed subject to the approval of the Scottish government. When making appointments, the government must encourage equal opportunities and a requisite number of appointees must use, or have used, care services, or be the carer of such a person.

Methodology

The Care Commission inspects each of the seven secure accommodation services for children and eight private psychiatric hospital services no less than twice a year. At least one of these inspections must be unannounced. Inspections are targeted so that the Commission spends less time with services which it considers are working hard to provide consistently high standards of care. Services about which there is more concern receive more intense inspections.

Inspections are carried out against the 2001 Act, associated regulations and National Care Standards. These standards were developed by the Scottish government following wide consultation, including with groups representing service users. The standards are rights-based and set out the quality of care people using the services can expect. Where necessary, the Care Commission can take

⁵⁹ While some of the other services within the Commission's remit may involve some restriction of freedom, they are not considered places of detention. For example, the Commission inspects offender accommodation services for those who are released from prison but who are required to reside in specified accommodation during the resettlement process.

enforcement action to ensure the regulations and the standards are met. In extreme cases, enforcement action may include closing down a service.

In 2008, the Care Commission introduced a grading system to its inspections. Services are graded on a scale of 1 (unsatisfactory) to 6 (excellent) across five themes. The themes are quality of care and support; environment; staffing; management and leadership; and information. A report of each inspection is published. Before the report is finalised, the provider of the service is given the opportunity to comment on the draft. The Care Commission also publishes an annual report of all its activities.

Summary of activities

During 2009–10, the Care Commission carried out 14 inspections of the seven secure accommodation services for children and 15 inspections of the eight private psychiatric hospitals in Scotland. It also investigated seven complaints relating to four of the services. A further investigation was carried out in relation to the suicide of a young man in secure accommodation. Although OPCAT does not require complaints handling to be part of an NPM's mandate, the Care Commission is nevertheless able to use its complaints handling function to contribute to its preventive mandate. Investigations of complaints often raise issues that are relevant not just to the individual complainant, but to other people in secure care.

This year, the Care Commission also published guidance for care service providers to help them actively involve people who use their services, as well as their carers.⁶⁰

The involvement of service users is seen as a central element of service delivery and service improvement. The extent to which users are involved informs the Care Commission's grading of a service.

Following publication of a government strategy for looked after children, the Care Commission published a series of bulletins which considered the quality of through care and after care, and the mental and physical health and wellbeing of young people living in residential settings, including secure accommodation.⁶¹

Key issues

In 2008, the Care Commission published a report which, in part, reviewed the use of physical restraint against young people in secure accommodation, as well as other residential settings.⁶² Since then, the Care Commission has continued to work with service providers and others, including non-governmental organisations and the Scottish government, to improve guidance on and practice of the use of physical restraint.

Looking forward

In the coming year, the Care Commission will maintain its inspection programme and will continue its work on suicide prevention and promoting the use of appropriate methods of physical restraint for children. In April 2011, the Care Commission will cease to exist and its functions will be transferred to a new organisation – Social Care and Social Work Improvement Scotland. It is anticipated that the new organisation will be OPCAT-compliant and will be designated as a member of the UK's NPM in place of the Care Commission.

60 Care Commission, *Involving people who use care services and their families, friends and supporters: guidance for care service providers* (2009).

61 These bulletins are available on the Care Commission website.

62 Care Commission, *Protecting children and young people in residential care: are we doing enough?* (2008).

Independent Custody Visitors Scotland

Although visiting of police custody takes place in Scotland as it does in the rest of the UK, the Scottish custody visiting schemes have not been separately designated as part of the UK's NPM. Instead they are members of the Independent Custody Visiting Association (ICVA) albeit that they retain their own funding and management framework. For the sake of clarity, custody visitors in Scotland would prefer that they be designated separately from ICVA as is the case in Northern Ireland.⁶³

As in the rest of the UK, independent custody visitors in Scotland carry out regular, unannounced visits to police stations to monitor the treatment of and conditions for detainees. However, in Scotland, custody visiting is not a statutory requirement. Instead, it is up to Scotland's eight police authorities to decide for themselves whether to establish and maintain a custody visiting scheme for their area.⁶⁴ Although not statutory, custody visiting is supported by the Scottish government. In 2004, it published guidance setting out its commitment to custody visiting and suggesting national standards to assist in the introduction of visiting schemes across Scotland.⁶⁵

Each of the eight police authorities has chosen to establish a custody visiting scheme, although one is not yet operational. Of the seven operational schemes, the majority are well-established while other schemes are still in the process of being rolled out across the police authority area.

Where schemes are in place, they operate in substantially the same way as custody visiting schemes in England and Wales.⁶⁶ Visitors are recruited by police authorities and should be independent people of good character, who are able to make informed judgments about detention in which the community can have confidence, and which the police will accept as fair. Visitors carry out visits in pairs to police stations, examining the conditions in which detainees are held and speaking with detainees and custodial staff.

Visiting schemes in Scotland are members of ICVA, itself a member of the UK's NPM. The Scottish government makes a financial contribution to ICVA so that its Scottish members may benefit from its support and expertise.

OPCAT compliance and impact of NPM membership

Although custody visitors in Scotland carry out their visits in line with the requirements of OPCAT, the overall visiting scheme is not yet fully OPCAT-compliant. For example, police stations in all areas of Scotland are not yet covered by visiting schemes, although progress is being made. The lack of a statutory basis for custody visiting in Scotland is also cause for concern.⁶⁷ Nonetheless, the inclusion of custody visitors in Scotland as part of the UK's NPM has already had a positive impact by sharpening their focus on monitoring the human rights of those detained in police custody.

⁶³ Custody visitors in Northern Ireland are also members of ICVA but were nonetheless designated separately as an NPM member by the government.

⁶⁴ Police authorities (sometimes called police boards) in Scotland are independent of the police force and are not responsible for the day-to-day delivery of policing. Instead, each police authority is responsible for setting, monitoring and scrutinising the budget of its local police force and for holding the Chief Constable to account for the force's performance.

⁶⁵ Police Circular 14/2004, *Independent Custody Visiting National Standards*.

⁶⁶ For further information, see the profile of ICVA above at page 28. It should be noted however that custody visitors in Scotland assess the rights and entitlements of detainees against the Criminal Procedure (Scotland) Act 1995, rather than PACE.

⁶⁷ See Article 18(4) of OPCAT citing the Paris Principles, Principle 2 of which recommends that institutions should have a constitutional or legislative basis. See also SPT, *Preliminary guidelines for the on-going development of national preventive mechanisms* (2008) at 1(i).

Summary of activities and key issues

Over 1,400 visits are made by custody visitors to police stations each year in Scotland. The majority of concerns raised by visitors relate to conditions of detention, including temperature (with detainees generally being too cold), availability of food and water, sanitation facilities and opportunities to shower. These concerns are normally resolved at the police station but are also addressed during local meetings of custody visitors and police representatives. Such meetings allow custody visitors to share concerns and examples of good practice. One key issue raised by visitors concerns the right of the detainee to exercise. This issue is now being considered at a national level by the Association of Chief Police Officers in Scotland.

As a result of visitors' concerns about the level of staffing in police custody, Central Scotland Police has instigated a review of custody facilities including staff-detainee ratios. It is anticipated that this review will result in a greater strategic focus by the police force on the custody environment.

Looking forward

The right of detainees to access a solicitor while in police custody has been a key issue in Scotland and has recently been the subject of legislative change.⁶⁸ This change is likely to impact on the custody visiting process.

Given the current economic climate, all police authorities in Scotland are likely to be subject to budget cuts for the foreseeable future. This may impact on their funding of custody visiting and their ability to efficiently manage visiting schemes. While budget cuts are expected to affect all NPM members in the coming months and years, custody visiting in Scotland is particularly vulnerable because of its lack of a statutory basis.

Although custody visiting in Scotland is likely to be subject to continuous review and improvement, visitors are nonetheless performing their role effectively. This is due to the dedication and hard work of the volunteers who undertake visits on behalf of their communities.

⁶⁸ See *Cadder (Appellant) v Her Majesty's Advocate (Respondent) (Scotland)* [2010] UKSC 43 and the Criminal Procedure (Legal Assistance, Detention and Appeals) (Scotland) Act 2010.

Independent Monitoring Boards (Northern Ireland)

The Independent Monitoring Boards in Northern Ireland are statutory bodies whose role is to monitor the treatment of prisoners and the conditions of their imprisonment. Established and governed by the Prison Act Northern Ireland 1953 and the Prison and Young Offender Centre Rules (Northern Ireland) 1995, there are three boards in Northern Ireland. Each board is appointed to monitor one of the following establishments:

- Maghaberry, a high security prison for adult males, which also provides separated accommodation for paramilitary prisoners from loyalist and republican backgrounds
- Magilligan, a medium security prison for adult males, which also offers low security accommodation for prisoners nearing the end of their sentence
- Hydebank Wood, a site offering accommodation for young men aged 17 to 21, boys aged 15 to 17 and adult female prisoners.

As indicated by their name, Independent Monitoring Boards are independent of government, the Prison Service and the civil service. Board members are unpaid volunteers drawn from the general public and appointed by the Secretary of State for Northern Ireland following an open recruitment process.⁶⁹ To further guarantee independence, the 1995 Rules prohibit any person interested in any contract for the supply of goods and services to a prison from being a member of the board. Board members are appointed for an initial three-year term, with current policy allowing appointments to be renewed up to a

maximum of nine years. There should be around 15 members on each board, although this can vary due to resignations and delays in appointments. At 31 March 2010, there were 12 board members for Maghaberry, 14 for Magilligan and six for Hydebank Wood. The 1953 Act states that any board visiting a women's prison must contain at least two female members. The work of the boards is supported and administered by a small secretariat.

Methodology

By law, Independent Monitoring Boards are required to meet at the prison each month and must ensure that at least two members visit the prison between meetings. They must also ensure that all parts of the prison are visited at reasonable intervals. In practice, the boards make unannounced visits at least every week. The board is obliged to monitor:

- the treatment of prisoners including provision for their health care and other welfare while in prison
- the facilities available to prisoners to allow them to make purposeful use of their time
- the cleanliness and adequacy of prison premises.

When carrying out their visits, board members also deal with requests or complaints from prisoners.

Independent Monitoring Boards have free access at any time to all parts of the prison and to all prisoners. They may interview any prisoner out of the sight and hearing of prison staff. Prison governors are obliged to grant them reasonable access to any records

⁶⁹ From 12 April 2010, members will be appointed by the Justice Minister for Northern Ireland following the devolution of policing and justice.

of the prison, except those which governors are obliged to keep confidential. Each member who visits the prison reports on his visit to the board. The board reports any matters of concern to the prison governor or, in serious cases, to the Secretary of State. In addition, the board makes an annual report to the Secretary of State detailing its work and any advice or suggestions the board may have.⁷⁰

Summary of activities

During 2009–10, each of the three Independent Monitoring Boards in Northern Ireland published reports of their activities the previous year. The annual report of the board for Hydebank Wood, for example, included a detailed overview of members' observations as well as 54 recommendations.

In line with Article 19(c) of OPCAT, boards also have the opportunity to comment on Prison Service policy. For example, in 2009, the three boards collectively commented on a draft Prison Service strategy for working with and supporting the families of prisoners.

Key issues

The three boards identified many issues affecting prisoners in Northern Ireland, some of which were common to all three establishments. For example, all three boards commented on the lack of specialist provision for offenders with severe mental health problems. They noted that prison tends not to be the most appropriate setting for such offenders. The boards for both Maghaberry and Magilligan recommended that more should be done to tackle drug use in prison and both noted the lack of accessible facilities for disabled prisoners.

The board for Hydebank Wood noted the challenges that the establishment faces when trying to meet the needs of the various categories of prisoners accommodated there. For example, it described the lack of daily access to fresh air as being a particular problem for the 15 to 17-year-olds who must be kept separate from the adult population. In addition, it expressed concern at the use of force to manage the behaviour of juveniles. The board for Hydebank Wood also voiced disquiet at the amount of time prisoners spend in their cells due to unscheduled 'lockdowns' caused by industrial action and a high level of staff sickness. Such lockdowns result in prisoners eating meals in cells with in-cell sanitation.

Looking forward

A key challenge facing Independent Monitoring Boards in the next year will be performing their role in the face of budget cuts. This will not only impact on the work of the boards themselves, but also on the prisons which they visit. For example, the board for Magilligan is concerned that much of the accommodation there is old but is unlikely to be replaced given funding constraints.

⁷⁰ From 12 April 2010, concerns will be reported, and annual reports will be made, to the Justice Minister rather than the Secretary of State.

Criminal Justice Inspection Northern Ireland

Criminal Justice Inspection Northern Ireland (CJINI) was established by the Justice (Northern Ireland) Act 2002 for the purpose of inspecting all aspects of the criminal justice system.⁷¹ Its role is not just to inspect places of detention, but also to inspect, for example, prosecution and probation services. CJINI describes one of its objectives as being 'to provide independent scrutiny of the outcomes for, and treatment of, users of the criminal justice system'.

The 2002 Act lists the organisations which CJINI must inspect and states that any inspection may cover any institution provided or managed by the organisation. The list is comprehensive and includes, for example, the Northern Ireland Prison Service and the Police Service of Northern Ireland. CJINI therefore has the power to inspect a wide range of places of detention, including prisons, a juvenile justice centre, police custody, court custody and secure care facilities for children.

CJINI also carries out inspections of hostels for offenders who are released from prison but who are required to reside in 'approved premises' where they continue to take part in resettlement activities. While these premises may not strictly be considered places of detention, residents are required to abide by certain rules and to be present in keeping with curfew or license conditions.

CJINI is not part of government and its staff do not form part of the civil service in Northern Ireland. Its Chief Inspector is appointed for a term of five years by the Secretary of State for Northern Ireland following an open recruitment process. He is supported by a Deputy Chief Inspector, seven inspectors, an inspection support officer and a small business support team.

Methodology

CJINI carries out both unannounced and announced inspections of places of detention and often does so in conjunction with other organisations, including other members of the NPM. For example, CJINI inspects prisons in association with HMIP and the Regulation and Quality Improvement Authority (RQIA). In the course of an inspection, CJINI has the power to enter places of detention within its remit and to require that documents and other information be provided. In practice, CJINI also carries out private interviews with detainees. Given the range of places of detention inspected, CJINI has no set frequency with which it inspects institutions, but does so on a regular basis taking into account the significance of, and risks associated with, the institution and its role within the criminal justice system. All inspections are underpinned by human rights standards.

CJINI is required to report to the Northern Ireland Justice Minister on each inspection it carries out. CJINI lays its inspection reports before the Northern Ireland Assembly and is legally required to make all its reports publicly available. It also produces an annual report which covers its inspections of places of detention as well as its non detention-related work.

OPCAT compliance and impact of NPM membership

CJINI benefits from being a single inspectorate responsible for the whole of the justice system in Northern Ireland. Not only can it inspect individual places of detention, it can consider the interfaces between places of detention and the organisations that operate them. This facilitates, for example, the inspection of prisoner escorting which involves police, prison and private agencies. Nonetheless, CJINI

⁷¹ The inspection of courts was initially omitted from its mandate but was later added by the Justice and Security (Northern Ireland) Act 2007.

is concerned at potential gaps in the NPM's coverage in Northern Ireland, including those detained by the military and those detained by HM Revenues & Custom.

Given the breadth of CJINI's remit, designation as an NPM member has prompted it to increase its focus on inspecting places of detention, leading to its first inspections of police custody, prisoner escorting and court custody. Although CJINI was engaging in collaborative work prior to designation as a member of the UK's NPM, designation has strengthened its collaborative working arrangements and encouraged the sharing of information with its fellow NPM members.

Summary of activities

In 2009–10, CJINI inspected several places and types of detention and reviewed certain themes relating to detention. It carried out two unannounced inspections of the juvenile justice centre as well as fieldwork for the inspection of Magilligan, one of two prisons for adult males in Northern Ireland. In conjunction with HMIP, CJINI published a report of an inspection of Maghaberry, the other male prison. This inspection identified concerns in all four tests of a 'healthy prison': safety, respect, purposeful activity, and resettlement. The inspection found immediate attention was required to improve governance and accountability arrangements, to improve the relationship between the prison and Prison HQ, and to make changes to established working practices. During the year, the Chief Inspector of CJINI also conducted an unannounced visit to Maghaberry to observe a major search operation.

In June 2009, CJINI published its first inspection of police custody. Overall, custody services performed to an acceptable standard but some concerns were identified. For example, CJINI noted the high cost of delivering forensic medical services in police custody and expressed concern about the inappropriate use of police custody as a place of safety for individuals with mental health problems.

CJINI also carried out fieldwork for its first inspection of prisoner escorting arrangements

and court custody. This involved visiting courthouses across Northern Ireland and monitoring escort vans, as well as interviews with detainees, staff and other stakeholders.

During the year, CJINI published thematic reviews on prison staff training and development; life sentence prisoners making the transition to living in the community; mental health and the criminal justice system; and vulnerable prisoners.⁷²

Key issues

A number of key issues have arisen during the course of CJINI's inspections of places of detention. One recurring area of concern is the mental health of detainees. In 2010, CJINI published a thematic report on this issue. It recommended that those with mental disorders be diverted from custody as prisons are not therapeutic environments and generally have a negative impact on mental health. For those who are imprisoned, the quality of care must be improved.

Another key issue arising from CJINI's work relates to the care of vulnerable prisoners. CJINI's thematic review of vulnerable prisoners was carried out following the suicide of a prisoner in Maghaberry. The review noted significant concerns. The day-to-day regime for vulnerable prisoners was inadequate for their ongoing care and they spent too long in their cells. The assessment and monitoring of prisoners at risk was also found to be inconsistent.

Looking forward

In the next year, CJINI will continue its inspection programme and will carry out a thematic review of how prisoners are prepared for their release from prison. CJINI will also continue to monitor issues identified this year, including recommendations made as a result of its inspection of Maghaberry. That inspection found that conditions for prisoners were an ongoing cause for concern: only 54% of recommendations made during the previous inspection had been achieved. CJINI will continue to press for implementation of the recommendations and to monitor the treatment and conditions of prisoners held there.

⁷² CJINI, *Prison Service staff training and development: an inspection of the training and development of operational staff in the Northern Ireland Prison Service* (2009), CJINI, *A review of transition to community arrangements for life sentence prisoners in Northern Ireland* (2009), CJINI, *Not a marginal issue: mental health and the criminal justice system in Northern Ireland* (2010), CJINI, *Vulnerable prisoners: an inspection of the treatment of vulnerable prisoners by the Northern Ireland Prison Service* (2009).

Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) was established by statute in 2005 to monitor the availability and accessibility of health and social care services in Northern Ireland and to promote improvement in the quality of those services.⁷³ The RQIA's remit is broad but a key element of its role is to inspect the provision of health and social care in places of detention. RQIA may visit prisons, children in secure accommodation or people detained on the basis of their mental health or learning disability. RQIA also inspects a range of residential accommodation where people are cared for but are not deprived of their liberty, such as hospitals, children's homes or nursing homes.

RQIA may enter and inspect the premises of any service within its remit at any time, with a view to examining the state and management of the premises and the treatment of people accommodated or cared for there. It may interview in private the manager, staff or service user and require the service provider or manager to make available any information it deems necessary.

RQIA is a non-departmental public body reporting to the Department for Health, Social Services and Public Safety. It is independent and is staffed by experts from a wide range of health and social care disciplines.

Methodology

RQIA carries out announced and unannounced inspections of places of detention with the frequency and nature of the inspection determined by the type of detention and any intelligence received, such as complaints or evidence of serious incidents. In carrying out its work, RQIA emphasises the importance of listening to the detainee. As well as individual or group interviews with detainees during inspections themselves, RQIA engages with former detainees and detainee representatives, as well as members of civil society, including non-governmental organisations and academics.

Except for inspections carried out jointly with CJINI or HMIP, RQIA does not produce reports of individual inspections. However, findings from individual inspections are shared with service providers and users, with recommendations being monitored through the ongoing inspection programme. RQIA produces an overview of all its activities on a quarterly basis, as well as an annual report.

As well as carrying out inspections, RQIA seeks to improve health and social care services by influencing law and policy. It comments on draft legislation and advises on any necessary changes to current law. RQIA's recent efforts in this area have mainly focused on the development of new mental health legislation in Northern Ireland.

⁷³ Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. RQIA's role was extended as a result of the Health and Social Care (Reform) Act (Northern Ireland) 2009 when it assumed the functions previously carried out by the Mental Health Commission.

Impact of NPM membership

Since being designated as a member of the UK's NPM, RQIA has adopted a human rights-based approach to its work. As a result, international human rights law and jurisprudence are considered in the inspection of health and social care services in Northern Ireland and training on OPCAT has been delivered to its staff. RQIA has worked with leading international human rights experts to develop expectation statements and indicators for inspection which are focused on outcomes for detainees and other service users. The use of these indicators during inspections has already resulted in changes such as the introduction of locks on toilet doors for some patients, increased access to fresh air and improved legal rights.

Summary of activities and key issues

In 2009–10, RQIA visited 28 mental health facilities across Northern Ireland, including all such facilities providing services to children. These mental health facilities hold a mixture of detained and non-detained patients. Key requirements identified during these visits included:

- more accessible information for patients on their rights
- improved access to advocacy services
- a greater involvement of patients in their care plans
- a greater emphasis on patient privacy, for example, during showering or visits.

RQIA also visited a number of institutions providing residential care to people with learning disabilities. The majority of people cared for in these institutions are not detained under any lawful order, yet RQIA noted during some visits that entrances and exits were locked.

RQIA visited all 53 children's homes in Northern Ireland, including one providing secure accommodation for young people aged 13 to 17. As a result of this visit, RQIA expressed concerns about the use of physical restraint and the failure to record routinely the duration of restraint or any resulting injuries. RQIA also noted that some records indicated a lack of clarity over what constitutes restraint, why such physical intervention was necessary and whether it had been effective.

During 2009–10, RQIA carried out fieldwork for the inspection of Magilligan prison in association with CJINI and HMIP. It also contributed to CJINI's first inspection of police custody in Northern Ireland.

Looking forward

In the coming year, RQIA will roll out an inspection programme for inpatient mental health and learning disability facilities. It will continue work begun in 2009–10 on examining the experiences of children in secure accommodation and will develop a strategy for monitoring health and social care in prisons. Like most other members of the NPM, RQIA will continue its work while facing a reduction in its funding.

Northern Ireland Policing Board Independent Custody Visiting Scheme

The Independent Custody Visiting Scheme in Northern Ireland is made up of volunteers from the community who carry out regular, unannounced visits to custody suites in police stations. The volunteers, known as custody visitors, monitor the rights, health and wellbeing and the conditions of detention of those held in police custody. The Custody Visiting Scheme was first established in Northern Ireland in 1991 and was made statutory by the Police (Northern Ireland) Act 2000. Visits are made to detainees held under Code C of the Police and Criminal Evidence (Northern Ireland) Order 1989, the Terrorism Act 2000 and the Immigration Act 1971.

Custody visitors are recruited through open advertising and are appointed to serve a maximum of six years. During the recruitment process, attempts are made to ensure that visitors are as representative of the community as possible. While the Custody Visiting Scheme as a whole is independent of the Police Service of Northern Ireland (PSNI), individual volunteers themselves must also be independent of the criminal justice system (for example, police officers or magistrates are not permitted to volunteer). Custody visitors receive training which is supported by a custody visiting handbook, detailing how visits should be carried out and setting out a code of practice for visitors. Specialist training, with particular emphasis on human rights, is provided for those visiting detained terrorist suspects.

The Custody Visiting Scheme is administered and supported by the Northern Ireland Policing Board, an independent, statutory body whose role is to hold the PSNI to account for the delivery of police services in Northern Ireland. The Policing Board itself is made up of members from the four largest political parties in Northern Ireland, as well as independent members appointed by the Department of Justice.

Methodology

At 31 March 2010, there were 57 custody visitors carrying out visits to 21 designated police custody suites across Northern Ireland. The visitors are divided into four teams, each covering a specific geographical area:

- Belfast/Antrim – responsible for nine custody suites
- Down/Armagh – responsible for four custody suites
- North West – responsible for four custody suites
- Tyrone/Fermanagh – responsible for four custody suites.

Pairs of visitors make unannounced visits on any day of the week and at any time of day or night. Visitors will only speak to detainees or view their custody record if the detainee consents. A report is made of every visit and is shared with the Chief Constable of the PSNI and the Policing Board. Any issues of concern identified by the custody visitors and which remain unresolved within a reasonable timeframe will be followed up by the Policing Board. In addition, quarterly statistics relating to custody visits, and an annual report based on the visits of all four teams, are published.

OPCAT compliance and impact of NPM membership

The ability of custody visitors to carry out very regular visiting of police detention facilities enables them to fulfil the preventive role envisaged by OPCAT. Over the years, custody visitors have identified hundreds of issues which, without resolution, may have had significantly adverse outcomes for detainees.

Custody visitors in Northern Ireland enjoy a close relationship with fellow custody visiting schemes within the UK's NPM, even undertaking joint training with custody

visitors in Scotland. Membership of the NPM has raised the profile of custody visitors among others working in this field and has contributed to custody visitors having an increased focus on the human rights of detainees, as well as looking at the conditions in which they are held.

Summary of activities

Between 1 April 2009 and 31 March 2010, the custody visitors made 1,066 visits. Of those visits, 1,025 were deemed to be 'valid visits'. The 41 outstanding visits could not be completed due to factors such as the custody suite being closed or the unavailability of a custody visitor. There were 1,475 detainees held in police custody at the time of the visits in 2009–2010. Visitors spoke to 673 of these detainees. Some 408 (29%) detainees refused to be seen by a visitor while 394 were not seen for other reasons (such as being asleep or being with their solicitor).

Of the 1,025 valid visits, 786 (77%) were found to be entirely satisfactory. In the remaining 239 (23%) visits, issues of concern were identified and the visits were deemed unsatisfactory. A total of 268 issues were identified by custody visitors during the course of the year. The majority of issues related to the safety or security of the detainee (such as ligature points), sanitation, cleanliness and faulty equipment. Other issues of concern related to bedding, lighting and ventilation.⁷⁴

Key issues

As noted above, the main issues arising from custody visits in 2009–10 relate to safety and security hazards. More generally, custody visitors have become concerned about the amount of time that immigration detainees spend in police custody suites. There is currently no dedicated detention facility for immigration detainees in Northern Ireland and detainees are often held in police

custody pending removal to a detention centre in Scotland or England. In response to these concerns, raised by custody visitors and others such as the Northern Ireland Human Rights Commission, the UK government has announced its intention to open a dedicated immigration detention centre, although it is unlikely to become operational until 2011.

Custody visitors are only mandated to visit designated custody suites. In limited circumstances, however, the police may detain a person in a non-designated police station, although such detention is unlikely to be for longer than six hours. Nevertheless, custody visitors have become concerned at the increasing number of detainees being held in non-designated police stations to which they have no access. This concern is being raised with the PSNI.

Despite their many concerns, custody visitors believe that the PSNI has improved its provision for detainees in recent years. The percentage of unsatisfactory visits has dropped from 36% in 2007–08 to 23% in 2009–10.

Looking forward

As with several other members of the UK's NPM, the Custody Visiting Scheme in Northern Ireland is faced with carrying out its important role with decreasing resources. The Scheme faces year-on-year budget cuts over the next four financial years. This will undoubtedly mean that the number of visits will have to be reduced, together with more limited training for visitors. The recruitment of new custody visitors may also be adversely affected. The funding situation makes it all the more challenging for custody visitors to make their visiting even more effective and may affect their plans to, for example, increase the number of detainees spoken to during visits.

⁷⁴ Further information on custody visits is available at: www.nipolicingboard.org.uk

Section five

Appendices

Appendix one

Written ministerial statement – 31 March 2009⁷⁵

Optional Protocol to the Convention Against Torture (OPCAT)

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

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

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

England and Wales

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

Scotland

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

Northern Ireland

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

⁷⁵ HC Col 56WS, 31 March 2009.

Appendix two

Further information about the UK's NPM

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

Laura Paton
National Preventive Mechanism Coordinator
HM Inspectorate of Prisons
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London SW1P 2BQ
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England and Wales

HM Inspectorate of Prisons
www.justice.gov.uk/inspectorates/hmi-prisons

Independent Monitoring Boards
www.imb.gov.uk

Independent Custody Visiting Association
www.icva.org.uk

HM Inspectorate of Constabulary
www.hmic.gov.uk

Care Quality Commission
www.cqc.gov.uk

Healthcare Inspectorate Wales
www.hiw.org.uk

Children's Commissioner for England
www.childrenscommissioner.gov.uk

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

Office for Standards in Education
www.ofsted.gov.uk

Scotland

HM Inspectorate of Prisons for Scotland
www.scotland.gov.uk/Topics/Justice/public-safety/offender-management/offender-custody/Prisons/17208

HM Inspectorate of Constabulary for Scotland
www.scotland.gov.uk/Topics/Justice/public-safety/Police/local/15403

Scottish Human Rights Commission
www.scottishhumanrights.com

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

Scottish Commission for the Regulation of Care
www.carecommission.com

Northern Ireland

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

Criminal Justice Inspection Northern Ireland
www.cjini.org

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

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

Appendix three

List of abbreviations

CC	Care Commission
CJINI	Criminal Justice Inspection Northern Ireland
CQC	Care Quality Commission
CSSIW	Care and Social Services Inspectorate Wales
HIW	Healthcare Inspectorate Wales
HMCIPS	Her Majesty's Chief Inspector of Prisons for Scotland
HMIC	Her Majesty's Inspectorate of Constabulary
HMICS	Her Majesty's Inspectorate of Constabulary for Scotland
HMIP	Her Majesty's Inspectorate of Prisons
HMIPS	Her Majesty's Inspectorate of Prisons for Scotland
HMP	Her Majesty's Prison
ICVA	Independent Custody Visiting Association
ICVS	Independent Custody Visitors Scotland
IMB	Independent Monitoring Boards
IMBNI	Independent Monitoring Boards (Northern Ireland)
MWCS	Mental Welfare Commission for Scotland
NHS	National Health Service
NIPBICVS	Northern Ireland Policing Board Independent Custody Visiting Scheme
NPM	National Preventive Mechanism
OCC	Office of the Children's Commissioner
Ofsted	Office for Standards in Education, Children's Services and Skills
OPCAT	Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
RQIA	Regulation and Quality Improvement Authority
SHRC	Scottish Human Rights Commission
SPT	Subcommittee for the Prevention of Torture
YOI	Young offender institution



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