

UK NPM Submission Human Rights Committee 140th session

February 2024



The UK National Preventive Mechanism (NPM) is made up of 21 bodies that monitor and inspect places of detention in the UK to prevent torture and ill-treatment for those deprived of their liberty. The UK's multi-body NPM allows for deep expertise and a broad reach across detention settings; approximately 3,500 individuals across these 21 organisations collectively fulfil the NPM's mandate under the Optional Protocol to the Convention Against Torture (OPCAT) through inspections, monitoring and visits to places where people are deprived of their liberty.

NPM member organisations are:

- Care Inspectorate
- Care Quality Commission
- Care Inspectorate Wales
- The Children's Commissioner for England
- Criminal Justice Inspection Northern Ireland
- Healthcare Inspectorate Wales
- His Majesty's Inspectorate of Constabulary and Fire & Rescue Services
- His Majesty's Inspectorate of Constabulary in Scotland
- His Majesty's Inspectorate of Prisons
- His Majesty's Inspectorate of Prisons for Scotland
- Independent Custody Visiting Association
- Independent Custody Visitors Scotland
- Independent Monitoring Board
- Independent Monitoring Boards (Northern Ireland)
- Independent Reviewer of Terrorism Legislation
- Lay Observers
- Mental Welfare Commission for Scotland
- Northern Ireland Policing Board Independent Custody Visiting Scheme
- Ofsted (Office for Standards in Education, Children's Services and Skills)
- The Regulation and Quality Improvement Authority
- Scottish Human Rights Commission

OPCAT is designed to strengthen protections for people deprived of their liberty, as it is recognised that they are particularly vulnerable to ill-treatment. The UK ratified OPCAT in December 2003 and designated its NPM in March 2009. At the heart of OPCAT is the idea that a system of regular, independent visits to places of detention can serve as an important safeguard against abuses and prevent torture and ill-treatment in places that by their very nature fall outside the public gaze.

The UK was one of the early proponents of the treaty and was actively involved in the drafting process. It was one of the first countries to notify the United Nations of the designation of its NPM. This submission provides scrutiny of the UK State Report to the list of issues and gives additional context and information to drive improvement in the conditions and treatment of those deprived of their liberty in the UK.

The NPM submission responds the UK's report where it relates to the conditions and treatment of those in detention. In particular, it covers:

- Immigration detention
- Modern slavery
- Suicide in prison
- Self-harm

In addition, there are significant human rights concerns not covered by the list of issues or in the UK's response, including:

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

The UK NPM notes the absence of references to detention in Northern Ireland in the ICCPR's list of issues or the UK Government's report. To address this, we have incorporated information about Northern Ireland where relevant in the sections below and have also included a supplementary section on Northern Ireland.

Immigration detention

While findings show that standards, treatment and conditions in immigration removal centres range from satisfactory to good, there is broader concern around the pace of the Home Office to make decisions in many cases, and some detainees with very complex needs are held for far too long (not least because of the challenge of finding suitable provision in the community). This response confines itself to the issues raised by the UK Government in its state report, over which NPM members have raised concern, the full picture of conditions in immigration detention is more complex, and we direct the Committee to reporting by NPM members HM Inspectorate of Prisons and the Independent Monitoring Board.¹

The UK State response to the List of Issues emphasises that despite the absence of a formal time limit on the detention of individuals, there is no **indefinite detention**. Though the UK does not pursue a practice of indefinite detention, over-long and in

¹ For example: Immigration Detention Estate National Annual Report 2022, IMB (imb.org.uk); Report on an unannounced inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons 30 May - 16 June 2022 – HMIP (justiceinspectorates.gov.uk); Report on an unannounced inspection of Yarl's Wood Immigration Removal Centre by HM Chief Inspector of Prisons 12-14 June, 3-6 July 2023 – HMIP (justiceinspectorates.gov.uk); Report on an unannounced inspection of Tinsley House Immigration Removal Centre by HM Chief Inspector of Prisons 17 April - 5 May 2023 – HMIP (justiceinspectorates.gov.uk).

practice indefinite detention does occur in UK immigration detention. In addition, the UK's response to the ICCPR List of Issues was submitted before the passage of the Illegal Migration Act and therefore refers to laws, procedures and practices before the implementation of this Act. Under the Illegal Migration Act, migrants who travel irregularly to the UK can be detained at the discretion of the Home Secretary with no statutory time limit, even when there is no realistic prospect of removal. NPM member the Children's Commissioner for England issued several briefings to MPs on the Illegal Migration Bill (now Act), including on her concern for children detained at the Kent Intake Unit and at Manston, given the living conditions.²

The lack of a statutory time limit for immigration detention in the UK can lead to periods of indefinite detention; detainees do not know how long they will be held for, and for many this can amount to months in detention. Administrative detention must be proportionate, for as short a time as necessary, and without causing additional harm to the detainee. Indefinite detention can cause high levels of mental and physical ill-health, and the lack of a time limit is cited by detainees as affecting their wellbeing.³ At Yarl's Wood IRC in 2023, lengthy and indefinite detention, as well as the lack of information about immigration case progression, were found to be causes of distress for many detainees, contributing to 84% of detainees reporting feeling depressed and 44% reporting suicidal feelings.⁴ At Tinsley House IRC, average cumulative time spent in detention (ongoing detention, including at centres prior to Tinsley) was 79 days in May 2023, with the longest at 444 days, which was "unacceptably long".⁵ At Heathrow IRC, NPM members repeatedly report that "too many detainees are held for unacceptably long periods of time with no chance of imminent removal".⁶ Monitoring visits find that indefinite periods of detention, alongside a lack of information on the progress of individual cases, has significant negative impacts on health and wellbeing of those effected.⁷

Section 12(1)(b) of the Illegal Migration Act disapplies the principle that detention can only lawfully be exercised where there is a realistic prospect of removal, within a reasonable time period,⁸ which opens a legal route to indefinite detention. Human Rights standards are clear that migrants should only be detained as an absolute last resort and for the shortest possible time.

NPM findings show that detainees are being held for too long, particularly detainees for whom there do not appear to be realistic chances of deportation taking place.⁹ Without a definitive time limit for detention, these individuals are in practice held in indefinite detention, which can have profound effects on

² Illegal Migration Bill – priorities for Amendment drafting, Children's Commissioner for England (childrenscommissioner.gov.uk); Briefings to MPs on Illegal Migration Bill, Children's Commissioner for England (childrenscommissioner.gov.uk); Illegal Migration Bill – Unaccompanied Children Seeking Asylum, Children's Commissioner for England (childrenscommissioner.gov.uk)

³ Report on an unannounced inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons 30 May - 16 June 2022 – HMIP (justiceinspectorates.gov.uk)

⁴ Report on an unannounced inspection of Yarl's Wood Immigration Removal Centre by HM Chief Inspector of Prisons 12-14 June, 3-6 July 2023 – HMIP (justiceinspectorates.gov.uk)

⁵ Report on an unannounced inspection of Tinsley House Immigration Removal Centre by HM Chief Inspector of Prisons 17 April - 5 May 2023 – HMIP (justiceinspectorates.gov.uk)

⁶ Report on an unannounced inspection of Tinsley House Immigration Removal Centre by HM Chief Inspector of Prisons 17 April - 5 May 2023 – HMIP (justiceinspectorates.gov.uk)

⁷ Immigration Detention Estate National Annual Report 2022, IMB (imb.org.uk)

⁸ Detention: General instructions Version 3.0 – Home Office (publishing.service.gov.uk)

⁹ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23 – HMIP (justiceinspectorates.gov.uk)

their wellbeing. In addition to existing findings, the NPM notes that the legal framework has changed since the UK Government submitted its report, with legislation now in place to allow for detention without realistic prospects of removal. The impacts of Illegal Migration Act are yet to be assessed in future scrutiny visits.

The UK response detailed that the UK immigration detention system operates with a **presumption of liberty**, meaning a presumption to grant Immigration Bail, with particular risk to vulnerable detainees. Despite a presumption to grant immigration bail, NPM members have noted that in practice detainees continue to be held in detention due to shortages of suitable accommodation provision in the community, including highly vulnerable detainees who were granted bail in principle, and detainees who were held in this situation for five months.¹⁰ A joined-up, multi-organisation approach is still lacking to implement the presumption of liberty in the UK's immigration detention systems, leaving people in detention for weeks or months while waiting for accommodation decisions.¹¹ This has also impacted highly vulnerable detainees, for whom ongoing detention risks further deterioration and violations of the prohibition of torture and ill-treatment.

At Yarl's Wood, no tangible progress had been made by the Home Office or HMPPS leaders to resolve the longstanding issues in probation accommodation checks which might resolve this issue.¹² At Tinsley House, poor communication between the Home office and the probation services contributed to long waits for bail accommodation, with one detainee held in detention despite being bailed almost a year prior.¹³ Across IRCs at Gatwick, a lack of ownership and accountability caused substantial delays.¹⁴ Statements in the UK ICCPR response therefore do not match findings from inspections, visits and monitoring.

Section 13 of the Illegal Migration Act adds limits to powers to grant immigration bail, including preventing the First-tier Tribunal from granting immigration bail until after 28 days on detention in many cases.¹⁵ This is contrary to the UK's statement of abiding by a presumption of liberty, and in fact introduces a "minimum term" to immigration detention. For vulnerable detainees, this risks missing opportunities to remove them from detention where their health is likely to be worsened by continued detention, who have suicidal ideation, or who have been victims of torture. UK Detention Centre Rule 35, and Short-term holding facility rule 32, are in place to alert authorities when this is the case.

The UK response notes that work on amending the **Detention Centre Rules 2001** has been paused, and points to its intention to proceed with work on rationalising the policy on the detention of victims of modern slavery and on putting in place

¹⁰ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23 – HMIP ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk)); Report on an unannounced inspection of Yarl's Wood Immigration Removal Centre by HM Chief Inspector of Prisons 12-14 June, 3-6 July 2023 – HMIP ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk)); Report on an unannounced inspection of Tinsley House Immigration Removal Centre by HM Chief Inspector of Prisons 17 April - 5 May 2023 – HMIP ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk))

¹¹ Annual Report of the Independent Monitoring Board at Heathrow Immigration Removal Centre for reporting year 1 January 2022- 31 December 2022, IMB ([imb.org.uk](https://www.imb.org.uk))

¹² Report on an unannounced inspection of Yarl's Wood Immigration Removal Centre by HM Chief Inspector of Prisons 12-14 June, 3-6 July 2023 – HMIP ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk))

¹³ Report on an unannounced inspection of Tinsley House Immigration Removal Centre by HM Chief Inspector of Prisons 17 April - 5 May 2023 – HMIP ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk))

¹⁴ Annual Report of the Independent Monitoring Board at Gatwick IRC / RSTHF for reporting year 1 January – 31 December 2022 ([imb.org.uk](https://www.imb.org.uk))

¹⁵ Illegal Migration Act 2023, UK Public General Acts ([legislation.gov.uk](https://www.legislation.gov.uk)) Section 13(b)

standards in respect of the submission of external medical reports. The UK NPM notes that the issue with the Detention Centre Rules 2001 is not their content but their implementation. For example, while most cases of removal of association under Rules 40 and 42 at Heathrow IRC adhered to the rules, with most detainees held in segregation for a limited period of no more than 24 hours, there were examples of the CSU being used for reasons outside the Rules, such as for detainees who said they did not want to share a room for physical or mental health reasons, or detainees who were taken to CSU in advance of their removal directions (over one third of detainees held in CSU in 2022).¹⁶ The IRC was not near capacity, so it is unlikely that in these instances Rule 40 accommodation was felt to be “unnecessary, a last resort, justified and proportionate to the risk presented”. Use of segregation for detainees exhibiting behaviour which appeared to be rooted in ongoing mental health issues is also a concern.

The UK NPM is concerned that since publication of the Shaw follow-up review of the **welfare of vulnerable people in immigration detention** in 2018, action on improving standards has not materialised. The recommendations are grounded in human rights obligations, and despite the UK Government having accepted in principle all recommendations, there is disappointingly little progress. The reforms to the immigration system mentioned in the UK response refer to the Nationality and Borders Act (2021), Illegal Migration Act (2023) and would now apply to the Safety of Rwanda (Asylum and Immigration) Bill, introduced in December 2023. During attempts to prepare individuals for deportation to Rwanda in 2022, there were acutely negative impacts on detainees’ mental health, exacerbated by a lack of information sharing by the Home Office.¹⁷ More migrants are likely to be detained under the Illegal Migration Act, with fewer safeguards for vulnerable detainees and survivors of torture.

Modern Slavery

As noted in the section above, the UK Government’s response details how it has paused implementation of recommendations in the Shaw Review in light of reforms to the immigration system. Provisions in the Illegal Migration Act 2023 prevent those people the Home Secretary has made arrangements to remove from making human rights or modern slavery claims at all while in the UK. Currently, where such claims are successful, they result in a person’s release from detention. Therefore, vulnerable people who would have been released will potentially remain in detention; this includes torture victims, people who have been trafficked, and victims of modern slavery.

NPM members have expressed concern in reports on immigration detentions settings about the adequate use of interpretation, and sufficient confidentiality in reception interviews.¹⁸ In some settings arrival interviews are not always conducted in private, raising concerns about thorough screening for exploitation, modern slavery, and possible triggering of the national referral mechanism.¹⁹ As a human

¹⁶ Annual Report of the Independent Monitoring Board at Heathrow Immigration Removal Centre for reporting year 1 January 2022- 31 December 2022, IMB ([imb.org.uk](https://www.imb.org.uk))

¹⁷ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk))

¹⁸ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk))

¹⁹ Concern that Home Office policy is preventing people in immigration detention taking prescribed medicines - Independent Monitoring Boards ([imb.org.uk](https://www.imb.org.uk))

rights standard, interviews must take place in a confidential setting to allow individuals to safely disclose vulnerabilities, including experiences of torture, trafficking and modern slavery. This is a key step in preventing ill treatment in detention. Recent member reports have flagged concerns around staff training on adult safeguarding, modern slavery and the policy on adults at risk, with outstanding recommendations in this regard recently found at Tinsley House IRC.²⁰ Staff training is a vital component of preventing ill-treatment and is a requirement under the Nelson Mandela Rules, European Prison Rules, CPT standards and other international guidance.

Suicide in prison

England and Wales

The UK Government report emphasises **safety in prisons** as a top priority and notes new training initiatives (Introduction to Suicide and Self-Harm Prevention training), additional prison officers, and the rollout of the key worker scheme since 2016 as efforts to reduce incidents of self-harm and suicide in the prison estate. The Listener Scheme and increased financial support to the Samaritans' service are also highlighted. However, rates of suicide in the male estate in England and Wales remain high (78 in the year ending March 2023, 77 in the year ending March 2020), and are increasing in the female estate.²¹ There remained weaknesses in measures to prevent suicide and self-harm in more than half of prisons inspected in England and Wales in the year 2022-2023.²²

Women being sent to prison solely on mental health grounds, under remand for "own protection" under the Bail Act 1976, or to prison as a "place of safety" under the Mental Health Act 1983, is very concerning.²³ Prisons are not an appropriate or therapeutic environment for people who should be receiving proper medical treatment for mental health. The probability of stillbirth suffered in prison has increased from five-times higher than in the public, to seven-times higher, and babies born to women in prison are almost twice as likely to need time in neo-natal units. Prison rules and international standards require the safeguarding of all prisoners in their care, and prisoners must have access to the health services available in the country without discrimination on the grounds of their legal situation.

The UK report refers to changes to the case management system used to support prisoners thought to be at risk of self-harm and suicide (ACCT), with training and guidance for staff, to account for diverse risks, triggers and other protective factors, which were rolled out in 2021. However, members found poor use of the ACCT process for people at risk of suicide and self-harm in prisons. Failure to identify risks and triggers, gaps in care plans, and a lack of useful recorded observations led to a system that was "not always effective in providing adequate support for prisoners in

²⁰ Report on an unannounced inspection of Tinsley House Immigration Removal Centre by HM Chief Inspector of Prisons 17 April - 5 May 2023 – HMIP ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk))

²¹ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk))

²² HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk))

²³ Mental health concerns in women's prisons May, 2023, IMB ([imb.org.uk](https://www.imb.org.uk))

crisis”.²⁴ NPM members in England and Wales find that delivery of healthcare provision in prisons is often undermined by a general shortage of staff and a lack of suitably qualified staff.²⁵ Staff shortages acutely impacted on time out of cell which further exacerbated poor mental health.²⁶

Scotland

While the State response in regard to Scotland indicated strong aspiration to address the rate of suicides in prisons, findings from inspection and monitoring do not indicate that this is translating into improved outcomes for people in prison. **The Suicide Prevention Action Plan** mentioned in the Scottish Government’s response makes very little reference to prisons, and the national statistics on suicide cited within it were irrelevant to the prison environment, which appears to have followed a very different pattern from the decreases in suicide in the national population.²⁷ In the general population, the Scottish Government has stated that “[b]etween 2002-2006 and 2013-2017, the rate of death by suicide in Scotland fell by 20%,” and (as mentioned in the response) has set a target to decrease deaths by suicide by another 20% by 2022.²⁸²⁹ A recent review of suicides in prisons in Scotland found, “[t]here is no clear trend in the number of deaths attributed to ‘intentional self-harm’...which has fluctuated between 4 and 14 per year between 2012 and 2022.”³⁰

With regards to the **National Suicide Prevention Leadership Group (NSPLG)** referenced in the state response, having reviewed all 44 documents produced by the now defunct group during their existence from 2018-2022, including minutes from their 30 meetings, four annual reports and several research papers, there is no evidence of direct actions to prevent suicide in Scottish prisons.³¹ Further, and possibly offering an explanation for the lack of attention to prisons, there was no representation in the group from the Scottish Prison Service or any other prison or criminal justice related organisation.

With regards to the provision of additional guidance to prison and NHS staff on “**how to identify those who may be struggling whilst in isolation,**” the NPM would bring to the attention of the committee the 2023 Thematic Review Of Segregation In Scottish Prisons, which found what the NPM considers to be very serious torture and ill-treatment concerns, including and up to direct mistreatment and abuse by prison staff.³² Mental health decline, lack of meaningful activity and time outside of cells are just some of the specific issues of concern. The NPM Scotland Subgroup has written to the Cabinet Secretary for Justice and Home Affairs regarding our concerns in December 2023, but have yet to receive a response.

²⁴ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk))

²⁵ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk))

²⁶ Report on an independent review of progress on HMP Isle of Wight by HM Chief Inspector of Prisons 5-7 June 2023, HMI Prisons ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk))

²⁷ Deaths in Prison Custody in Scotland 2012-2022, Scottish Government ([gov.scot](https://www.gov.scot))

²⁸ Suicide prevention action plan: every life matters, Scottish Government ([gov.scot](https://www.gov.scot))

²⁹ The United Kingdom’s Response to the United Nations Human Rights Committee’s List of Issues on the Covenant on Civil and Political Rights (ICCPR) dated May 2020 ([gov.uk](https://www.gov.uk))

³⁰ Deaths in Prison Custody in Scotland 2012-2022, Scottish Government ([gov.scot](https://www.gov.scot))

³¹ The word “prison” appeared fewer than a dozen times, often referencing future meetings with the Scottish Prison Service or His Majesty’s Chief Inspector of Prisons, but with no follow-up. Other references included recommendations for research or establishing processes for prison-leavers. No references related to supporting the prevention of suicides in prisons.

³² A Thematic Review Of Segregation In Scottish Prisons, HMIPS ([prisoninspectorscotland.gov.uk](https://www.prisoninspectorscotland.gov.uk))

The state response highlights two independent reviews which have been commissioned following the deaths of a 16-year-old boy and a 21-year-old young woman by suicide at HMPYOI Polmont just months apart in 2018. The November **2021 Independent Review of the Response to Deaths in Prison Custody** made 20 recommendations, as well as one key recommendation, to reduce the risk of deaths in custody.³³ The key recommendation was that a separate independent investigation should be undertaken as soon as possible into each death in prison custody.³⁴ Currently, fewer than a quarter of the recommendations have been implemented.³⁵ The NPM is concerned that significant time is being spent on process-related activities which have thus far not led to concrete outcomes. One of the secondary recommendations was to establish a group to look at preventing deaths in custody with significant family involvement. The number of deaths in prison custody has not diminished since the report was published.

The state response also highlighted the commissioning of the May 2019 **Report on Expert Review of Provision of Mental Health Services** at HMP YOI Polmont, which made 7 key recommendations and several additional recommendations to support the mental health of young people at Polmont.³⁶ Since this report, we are pleased to see that inspection and monitoring reports have noted significant improvements at Polmont, with the most recent inspection report stating that the “senior management team had clearly brought vision, purpose, energy and direction to the prison,” and the IPM Annual Report commending the reduction in the population held in the segregation and reintegration unit (SRU).³⁷ Research conducted in 2019-20 (and published in 2023) by the University of Glasgow found that 85.5% of young men at Polmont suffered from a current mental health condition, but only 3% had received mental health assessments in prison.³⁸ Although the August 2023 inspection report found that mental health staffing issues persisted, health and wellbeing was rated as “satisfactory” compared to the 2018 report which rated this standard as “poor”,³⁹ demonstrating meaningful progress.

Despite **funding commitments** described by the state response to help hire more **mental health staff**, there are shortages of healthcare staff in most prisons.⁴⁰ In 2022-23 75% of prisoners in Scotland said it was quite difficult or very difficult to

³³ Independent Review of the Response to Deaths in Prison Custody, Families Outside, SHRC, HMIPS (prisonsinspectoratescotland.gov.uk)

³⁴ According to the report the purpose of these reviews would be “to establish the circumstances surrounding the death, examine whether any operational methods, policy, practice, or management arrangements would help prevent a recurrence, examine relevant health issues and assess clinical care, provide explanations and insight for bereaved relatives, and help fulfil the procedural requirements of Article 2 of the ECHR” (p. 6)

³⁵ Independent Review of the Response to Deaths in Prison Custody: progress report - follow up – Scottish Government (gov.scot)

³⁶ Report on Expert Review of Provision of Mental Health Services at HMP YOI Polmont, HMIPS (prisonsinspectoratescotland.gov.uk)

³⁷ Independent Prison Monitoring (IPM) Findings Annual Report HMP YOI Polmont 2022-23, HMIPS (prisonsinspectoratescotland.gov.uk)

³⁸ Reactive Attachment Disorder, Disinhibited Social Engagement Disorder, adverse childhood experiences, and mental health in an imprisoned young offender population, Enlighten Publications (gla.ac.uk)

³⁹ Report on Full Inspection of HMP YOI Polmont - 29 October to 2 November 2018, HMIPS (prisonsinspectoratescotland.gov.uk)

⁴⁰ IPM - National Mid-Year Report April - September 2023, HMIPS (prisonsinspectoratescotland.gov.uk)

access mental healthcare, which is a top concern.⁴¹⁴²

Self-harm

As cited above, the UK Government's response details additional training to address self-harm and suicide prevention and enhance mental health training, alongside the recruitment of additional staff. A whole-system approach is described to address the poorer mental and physical health typically found in prisons compared to the general UK population. However, across the detention estate low staffing levels and limited regimes contribute to poor mental health, increasing risk of self-harm.

There remained weaknesses in measures to prevent suicide and self-harm in more than half of **male prisons** in England and Wales inspected in the year 2022-2023, though in the year ending December 2022 recorded self-harm incidents had reduced by 9% in the male estate compared to the previous year.⁴³ Over half of adult men's prisons had weak measures in self-harm prevention, including poor oversight and lack of planning to improve mental health outcomes. Insufficient data analysis inhibited a proper understanding of the main causes of self-harm, and there was inadequate investigation of serious incidents. Excessive time locked in cell, lack of purposeful activity and interventions, and a poor regime were reported by prisoners to contribute to their frustration and anxiety, and limited the quality of staff-prisoner relations, all contributing to higher risk of self-harm.

In Scotland, a number of initiatives on self-harm have been undertaken by the Scottish Prison Service, both based on NPM member recommendations and independently. Recommendations have been made to the Scottish Prison Service to prioritise suicide and self-harm prevention, in part by ensuring that continued work on this is included in the SPS Annual Delivery Plans. The 'Talk To Me', 'Management of Offender at Risk' (MORS), and Self Harm policies" will be reviewed during the 2023-24 period.⁴⁴ Additionally, in-cell telephony with mobile phones was introduced during the COVID pandemic and these are gradually being replaced with hard wired in cell telephony. This has been a priority area for SPS, and is being rolled out across all sites and listed as an action in their 2023-24 Annual Delivery Plan. In-cell telephony has shown to reduce self-harm by allowing individuals to contact family and friends, or self-help services such as Samaritans, when needed.⁴⁵ We note however, that it is important that prisons not rely exclusively on this technology to provide individuals with meaningful human contact, which could lead to further isolation.

⁴¹ HM Chief Inspector's Annual Report 2022-23, HMIPS (prisonsinspectoratescotland.gov.uk)

⁴² The full passage, highlighting several serious concerns, reads: "Feedback from prisoners via our pre-inspection prisoner survey painted a deeply troubling picture about safety, staff attitudes and access to crucial services. Only 29% of prisoners said they felt safe all or most of the time. Sixty per cent of prisoners said they had witnessed staff abusing, threatening, bullying, or assaulting another prisoner and 40% of prisoners said they had been abused, threatened, bullied, or assaulted by staff themselves. Eighty four per cent of prisoners said it was quite difficult or very difficult to access the prison GP and 69% said it was difficult to access a nurse. Similarly, 75% said it was quite difficult or very difficult to access mental healthcare. Almost half of all prisoners said it was difficult to access education"

⁴³ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022-23, HMIP (justiceinspectorates.gov.uk)

⁴⁴ Annual Delivery Plan 2023 – 24, Scottish Prison Service (sps.gov.uk)

⁴⁵ HMP YOI Polmont Full Inspection 14 to 18 August 2023, HMIPS (prisonsinspectoratescotland.gov.uk)

Notwithstanding the mental health and healthcare staffing shortages posing systemic challenges in places of detention across Scotland, prison intake screening processes to assess individuals' risk of suicide or self-harm appear to be increasing in standardisation and consistency, according to recent inspection reports.⁴⁶ Work remains to be done in some prisons to ensure records are consistently kept up-to-date with regards to suicide and self-harm risk, and to improve the above-mentioned standardisation of intake risk assessment.⁴⁷

Poor mental health is a particularly prominent issue in the **women's estate**, where self-harm is considerably higher than in the men's estate. Self-harm rates in the women's estate rose every quarter between Q4 2021 and Q1 2023; in June in 2023 the rate was 65% higher than it had been a year before.⁴⁸ NPM members found concerning treatment of women in prison with extreme mental health difficulties, for whom prison was not the appropriate facility, and who were subject to excessively long transfer times to hospital.⁴⁹ Staff in women's prisons were found not to have the requisite expertise to care for women with complex needs; there was not enough active care to prevent women entering a crisis, and some women who prolifically self-harmed were not cared for appropriately. Low availability of purposeful activity, education, or work led to declining mental health standards, and women continued to be locked in their cells for far too long. The NPM is concerned about the high frequency with which staff resort to use of force to stop women self-harming, with low use of body-worn cameras. It is essential that any use of force is necessary, appropriate and proportionate.

NPM members have, over the last year, generally found good access to mental health support for children who self-harmed in **youth custody**, with self-harm prevention measures considered helpful.⁵⁰ Nonetheless, the rate of self-harm among children in custody rose by 37% in the year 2022-23.⁵¹

While self-harm across the **immigration detention estate** is generally low level, NPM members are concerned about the variable quality of assessment, care in detention and teamwork (ACDT) case management documentation. For detainees who cannot speak English, there is not enough use of professional interpreters in reception interviews and case reviews of detainees at risk of self-harm.⁵² In light of the Illegal Migration Act and the Safety of Rwanda Bill, the NPM also notes with concern shortcomings in deportation procedure. During the first attempted removals to Rwanda in 2022, several of those planned to be removed to Rwanda were classed as adults at risk or had open ACDT documentation for self-harm concerns.⁵³

⁴⁶ E.g. HMP YOI Polmont Full Inspection Report August 2023, HMIPS (prisonsinspectoratescotland.gov.uk); HMP Greenock Full Inspection Report February 2023, HMIPS (prisonsinspectoratescotland.gov.uk); HMP Addiewell Full Inspection Report November 2022, HMIPS (prisonsinspectoratescotland.gov.uk)

⁴⁷ E.g. HMP Inverness Full Inspection August 2022, HMIPS (prisonsinspectoratescotland.gov.uk)

⁴⁸ Mental health concerns in women's prisons May, 2023, IMB (imb.org.uk)

⁴⁹ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP (justiceinspectorates.gov.uk)

⁵⁰ A joint thematic inspection of work with children subject to remand in youth detention, HM Inspectorate of Probation, HMIP, Ofsted (justiceinspectorates.gov.uk); Oakhill Secure Training Centre Full Inspection 2 to 6 October 2023, CQC, HMIP, Ofsted (ofsted.gov.uk)

⁵¹ Children in custody 2022-23: An analysis of 12-18-year-olds' perceptions of their experiences in secure training centres and young offender institutions November 2023, HMIP (justiceinspectorates.gov.uk)

⁵² HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP (justiceinspectorates.gov.uk)

⁵³ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP (justiceinspectorates.gov.uk)

In **police custody** in England and Wales, there are consistent issues with the use of anti-rip clothing being used in the absence of risk information, often by force, and potentially as a punitive measure. The proportionality and justification of this practice was not adequately recorded, and the clothing was reported as being used unnecessarily for detainees on Level 4 observations. Crucially, serious concerns were raised about detainee dignity, particularly when clothes were removed by force. In some cases, detainees were left naked in order to manage behaviour, both in custody suites which used anti-rip clothing and those that did not. Where there are alternative methods available to monitor detainee likelihood of harming behaviours, this practice is likely to be unlawful, raising serious concerns of ill-treatment.⁵⁴

The lack of scrutiny of use of force and restraint in police custody is a concern in police custody across England and Wales.⁵⁵ Inaccurate data, lack of completed forms for use-of-force incidents, incomplete custody records, and limited quality assurances prevented forces from demonstrating that when force was used it was necessary, justified, and proportionate.

Overcrowding, overcapacity, and time out of cell

The issues described throughout this submission are inseparable from the general shortage of staff across detention settings, which are acting at or above capacity. Overcrowding is an ongoing and entrenched issue, risking “more deprivation, squalor and the risk of further violence”.⁵⁶ In England and Wales, the prison population is at its highest ever in 2023,⁵⁷ and is projected to increase.⁵⁸ Overpopulation of Scottish prisons has been a key concern for over a decade, with many prisons still regularly operating above their design capacity.⁵⁹ In Northern Ireland, overcrowding in HMP Maghaberry has led to prisoners with extreme behaviours spending lengthy periods segregated from the general prison population.⁶⁰ Half of prisoners reported spending less than two hours out of their cell on a typical weekday, and often less on weekends.

Mental health issues are extremely prevalent in prisons across the UK and exacerbated by overcrowding, obstacles to progression, restricted regime and/or widespread drug use found at their prisons. It is difficult for prisons to adequately meet this level of need, as mental healthcare teams are particularly understaffed. NPM members found an over-reliance on pharmacological treatments, which prevented patients addressing underlying trauma and improving health outcomes. Mental health training for prison officers continued to be very fragmented and non-existent in some establishments. Though three prisons had improved provision of in-cell learning support by education staff, most prisoners had no opportunity to engage

⁵⁴ Anti-rip clothing in custody: Interim evaluation, Independent Custody Visiting Association, Dyfed-Powys Police, Dyfed Powys OPCC (icva.org.uk)

⁵⁵ Custody suites archives, His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (justiceinspectors.gov.uk)

⁵⁶ Chief Inspector's blog: Why the prison population crisis is everyone's concern, HMIP (justiceinspectors.gov.uk)

⁵⁷ Prison population figures: 2023, Ministry of Justice (gov.uk); What is the Government doing to reduce pressure on prison capacity? House of Commons Library (commonslibrary.parliament.uk)

⁵⁸ Prison population projections: 2022 to 2027, UK Government, (gov.uk)

⁵⁹ HM Chief Inspector's Annual Report 2022-23, HMIPS (prisonsinspectorscotland.gov.uk)

⁶⁰ Report on an unannounced inspection of Maghaberry Prison 20 September – 6 October 2022, Criminal Justice Inspection Northern Ireland (cjini.org)

in activities. Long periods locked in cell contributed to frustrations and anxiety, leading to high levels of violence in over two thirds of inspected prisons in 2022-23.⁶¹ There are plans to increase prison capacity to manage overcrowding – however the estate plan cannot keep up with the growth in population. In September 2023, 66% of establishments reported overcrowding in England and Wales. There is variable provision for older prisoners despite MoJ analysis indicating for some time that prisoners over 50 will continue to rise. The surge in prison population has meant the Prison Service has struggled to accommodate prisoners safely and decently. The practice of doubling up cells originally designed for single occupation is widespread – and cell sizes regularly fall short of internationally accepted standards. Doubling up in cramped cells (often with unscreened toilets) also takes a toll on prisoners’ mental health – spending 23 hours or more locked in close proximity with no privacy.

The physical condition of the estate and its suitability for purpose has been widely criticised. These problems were particularly acute in Victorian prisons (which make up a third of the current prison estate), but they were also reported in prisons built as recently as the 1990s. Significant issues with ventilation, intolerably hot or cold temperatures, unusable showers, flooding and frequent sightings of rats and cockroaches have all been reported. In addition, the population pressures mean that cells could often not be taken out of use for routine maintenance, such as window or plumbing repairs, as there was nowhere to move the occupant.

In Scotland, Neurodiversity in prisons is an increasing challenge where we have not seen particularly innovative practice. There is also an overreliance by courts and the NHS on prisons as a ‘safe place’ for assessment and containment until a bed becomes available in health or community settings. The high percentage of women with ABI and significant prior trauma in prison argues against the effectiveness of diversion using community based preventive practices.

Overall, we see a picture in prison where too many individuals are held in settings not suited to their needs, where their health deteriorates, and they may be isolated for prolonged periods of time. Population continues to rise in Scotland and overcrowding is a chronic issue that affects almost every outcome of an establishment. The Scottish Prison Service are reviewing population management arrangements to better align accommodation to the changing demographics with the aim of optimising capacity and in so doing establish a maximum threshold. This has led to some improved use of spare capacity at HMPYOI Polmont, for example. Implementation is still ongoing and so it is too early to judge success. Issues of overcrowding are not solely a prison service issue and decades of scrutiny have highlighted the dangers of sustained overcrowding. There have not been any visible successful outcomes to date that would indicate a coordinated justice agency and parliamentary commitment.

Overcrowding continues to be a significant issue in Northern Ireland. Increasingly prisoners are doubled up in cells designed for one person. Accommodation which had previously been found to be unsuitable and earmarked for closure have been reopened to accommodate the increasing population size, leading to prisoners being held in poor conditions. The increase in pre-trial detention has placed pressures across the system, 37% of the prison population in Northern Ireland were unsentenced detainees – higher than comparable jurisdictions.

⁶¹ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP ([justiceinspectors.gov.uk](https://www.justiceinspectors.gov.uk))

There has been a lack of adequate management information on assessing prison population and the length of time individuals were spending on bail and remand. The upward population trend is a significant concern.

In **immigration detention**, while staff made efforts to keep marquees at Manston clean and tidy, the state of the site was “squalid”, and noted that “the cleanliness of the facility, overcrowding, close contact and sharing of blankets also raise[d] serious concerns for the risk of cross contamination of diseases”.⁶² These observations and the outbreaks of disease and the death of one detainee from diphtheria raise serious questions about dignity, inhuman and degrading treatment, and the state’s positive obligation to protect the right to life. Based on reports of dangerous conditions in UK immigration detention, the CPT conducted an ad-hoc visit to the UK in 2022 noting that “the cumulation of prolonged detention in very poor conditions may have resulted in many persons held at Manston Short-Term Holding Facility having been subjected to inhuman and degrading treatment”.⁶³

NPM members were pleased to see that the population in **children’s detention settings** continues to reduce, which should lead to improved relationships between children and staff.⁶⁴

Prolonged use of segregation units

In early 2023, a German court rejected the extradition of an Albanian man to the UK on human rights grounds, citing concerns about British prison conditions. In June 2023, an Irish court similarly refused to extradite a man to Scotland, based on the likelihood that he would face 22 hours a day confined to a small cell.⁶⁵ Poor conditions and limited regime, despite good relationships between prisoners and staff, were reported in segregation units in prisons across the UK. While basic requirements were met – most prisoners in segregation were allowed a shower, 30 minutes of exercise and one telephone call a day – this is below the minimum of what the NPM would expect.⁶⁶ Where possible further provision, including the expectation of more meaningful contact, must be made. All prison inspectorates and monitoring bodies recorded deep concern for mentally unwell prisoners waiting unacceptably long times to transfer to specialist mental health inpatient facilities for treatment under Mental Health Acts. Often, these people in mental health crisis were held in segregation or prison in-patient units, which were detrimental to their health.⁶⁷

In England and Wales, some segregation units were “bleak”, with little access to meaningful regime or therapeutic support.⁶⁸ Social isolation, lack of meaningful activity, and continuous segregation amounting to solitary confinement contribute to inhuman and degrading treatment or punishment.⁶⁹ There have been repeated

⁶² Letter to Select Committee Chairs from IMB National Chair regarding IMB observations of conditions at Manston Short-Term Holding Facility, Independent Monitoring Boards (imb.org.uk)

⁶³ Report to the United Kingdom government on the ad hoc visit to United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 25 to 28 November 2022, Council of Europe (coe.int)

⁶⁴ Children in custody 2022-23: An analysis of 12-18-year-olds' perceptions of their experiences in secure training centres and young offender institutions November 2023, HMIP (justiceinspectorates.gov.uk)

⁶⁵ Germany refuses man’s extradition to UK over jail concerns, Scottish Legal News (scottishlegal.com)

⁶⁶ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP (justiceinspectorates.gov.uk)

⁶⁷ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP (justiceinspectorates.gov.uk)

⁶⁸ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP (justiceinspectorates.gov.uk)

⁶⁹ The right to be free from torture or cruel, inhuman or degrading treatment or punishment: for ombudsman schemes, Equality and Human Rights Commission (equalityhumanrights.com)

findings of concern around inadequate conditions and limited regimes in segregation units. For most prisoners in segregation, their day consisted of a shower, 30 minutes of exercise and a telephone call. The high level of non-disciplinary segregation was an acute and national issue. Many units are full, or nearly full, and some prisons reported that prisoners were being segregated on wings because of this. It is far too common for mentally ill prisoners to be held in segregation units for extended periods of time while awaiting transfers to secure mental health units. At some prisons it was usual for prisoners to be held beyond 42 days; stays of over 100 days were not uncommon, and at one prison a seriously unwell prisoner was segregated for over 550 days before transfer. The picture is similar in women's prisons where segregation units are often used to hold those in mental health crisis, which is clearly detrimental to their health and wellbeing. Weak oversight and monitoring at some women's prisons meant we were not always able to see justification for the prolonged segregation of a small number of women, some of whom were at risk of self-harm.⁷⁰

In Scottish prisons, a review found deep concerns including the over-use of segregation for mental health across the prison estate. Too many prisoners faced detrimentally long periods in segregation known as Separation and Reintegration Units. They were unable to access a minimum of two hours of meaningful human contact per day in line with the Nelson Mandela Rules, and too little was done to tackle individual problems that lead to Separation and Reintegration Unit stays and to support reintegration.⁷¹ We have identified some serious concerns about the use of segregation in Scottish prisons and potential breaches of the prohibition of torture and ill-treatment.

In Northern Ireland, the use of segregation for individuals experiencing mental distress when they should be accommodated in a mental health unit has been a repeated concern, as has the time it takes to transfer an individual from prison to a mental health unit once the decision has been made to move them. A 2022 review into the operation of segregation concluded that a number of prisoners in these units had experienced conditions amounting to solitary confinement.⁷² Personality disorders are not recognised in legislation under the Mental Health (NI) Order 1986 which leads to a lack of services in prison custody. While steps have been made to improve this, funding is a constraint. Some identified good practice would include the increased use of technology to support enhanced governance and oversight of those held in Care and Supervision Units. There has been some encouraging development of a reintegration programme on exit from a CSU, and improvements in staff training and supervision. In Woodlands Juvenile Justice Centre, NPM members have identified the need for improved governance and rationale for use of single separation.

Some people **deprived of their liberty in hospitals** did not have good quality independent reviews, and without recognition under the definition of long-term segregation, there were further obstacles to their adequate monitoring and scrutiny. Health and social care services are “gridlocked” in England, with staff shortages affecting all health and social care, as staff were drawn to sectors with less stressful

⁷⁰ HMI Chief Inspector of Prisons for England and Wales Annual Report 2022–23, HMIP ([justiceinspectorates.gov.uk](https://www.justiceinspectorates.gov.uk))

⁷¹ A Thematic Review Of Segregation In Scottish Prisons, HMIPS ([prisoninspectorscotland.gov.uk](https://www.prisoninspectorscotland.gov.uk))

⁷² A review into the operation of Care and Supervision Units in the Northern Ireland Prison Service, Criminal Justice Inspection Northern Ireland ([cjini.org](https://www.cjini.org))

conditions and higher pay.⁷³ One of the biggest problems is DoLS assessments not being carried out in a timely manner. In England, ongoing problems with the DoLS process lead to a risk of unlawful deprivations of liberty, with patients being potentially left without safeguards, rights or protections in place.⁷⁴

Indeterminate sentences

The UK recently introduced a partial reform of Imprisonment for Public Protection (IPP) sentencing. Abolished in 2012 but not retroactively removed, these sentences placed indeterminate custodial sentences on those deemed to pose a significant risk of harm to the public. After release, people subject to IPP can be recalled to prison at any point for the next ten years. In 2023, there were 1,312 IPP prisoners who had never been released, and 1,597 who had been recalled to prison.⁷⁵

The partial reforms will reduce the length of time after release during which a person can be recalled to prison from ten to three years.⁷⁶ However, those still in prison continue to be subject to indefinite detention. Due to their lack of release date, IPP prisoners do not enjoy adequate access to rehabilitation, while the “feelings of hopelessness and despair” resulting from a lack of release date contributed to high levels of self-harm and to suicides.⁷⁷ The Government rejected Justice Committee recommendations to re-sentence all prisoners on IPP sentences.⁷⁸ Following this decision, IPP prisoners reported increased hopelessness and frustration, and ACCT documents were opened for several IPP prisoners, demonstrating its rapid impact on their mental health. Three apparently self-inflicted deaths of IPP prisoners occurred in three prisons in the four weeks following the announcement.⁷⁹

Outstanding matters of concern

Extraterritorial responsibility for torture, cruel, inhuman or degrading treatment and punishment

The UK report notes that the UK’s human rights obligations are primarily territorial and the ICCPR can only have effect outside the territory of the UK in exceptional circumstances. It notes that the UK is committed to complying with its human rights obligations in relation to all persons detained by its Armed Forces. The ICCPR engages state responsibility where it has *de facto* jurisdiction according to Article 2 on states undertaking to ensure all individuals both within its territory and subject to its jurisdiction enjoy the rights recognised by the Covenant. This includes military bases overseas and crown dependencies. In 2014 the Minister of the Armed Forces announced that the UK Government would not extend the remit of HM Inspectorate of Prisons (HMIP), the UK’s prison inspectorate, to include the inspection of military

⁷³ The state of health care and adult social care in England 2021/22, Care Quality Commission ([cqc.org.uk](https://www.cqc.org.uk))

⁷⁴ The state of health care and adult social care in England 2021/22, Care Quality Commission ([cqc.org.uk](https://www.cqc.org.uk))

⁷⁵ Offender management statistics quarterly: January to March 2023, HM Prisons & Probation Service, Ministry of Justice ([gov.uk](https://www.gov.uk))

⁷⁶ Reforms bring hope to rehabilitated people still serving abolished indefinite sentences, Ministry of Justice, HM Prison & Probation Service, The Rt Hon Alex Chalk KC MP ([gov.uk](https://www.gov.uk))

⁷⁷ IPP sentences, third report of Session 2022-23, House of Commons Justice Committee (committees.parliament.uk)

⁷⁸ IPP sentences: Government and Parole Board responses to the Committee’s third report, House of Commons Justice Committee (committees.parliament.uk)

⁷⁹ Segregation of men with mental health needs a thematic monitoring report, IMB (imb.org.uk)

detention facilities overseas. This was a recommendation of the Baha Mousa Public Inquiry into the death of an Iraqi hotel receptionist while in British Army custody in Iraq in 2003.⁸⁰ There is currently no independent NPM visiting, monitoring or inspection of overseas military detention facilities, meaning the preventive function served within the UK is not extended here.

Criminalisation of torture

There is still British law undermining the absolute prohibition of torture. The UK has repeatedly refused to repeal a provision in the Criminal Justice Act 1988 which provides a defence for alleged perpetrators of torture if there is “lawful authority, justification or excuse”.

UK NPM Statutory basis

The UK Government’s position is that the NPM complies with the requirements of the OPCAT, however, there are continuing concerns about the lack of a clear legislative basis of the NPM in the UK and the resultant lack of statutory guarantee of independence. Placing the NPM on a statutory footing would increase our authority and would mean that only Parliament could change our role. The lack of a clear legislative basis for the NPM has long been a matter of concern to the SPT.⁸¹

UK NPM Annual report publication

States party to OPCAT undertake to publish and disseminate the annual reports of their country’s NPM. In the UK, the last NPM annual report was delayed unnecessarily by the government’s publication process and communication around this. Despite assurance that this would not be repeated, the same problems are arising in the publication of this year’s annual report. The NPM can publish its annual report independently on its website, which it ultimately did last year. However, in these instances the UK government is apparently failing its commitment to disseminate the report, which is usually achieved through the Parliamentary publication process. The resultant delays prevent pertinent information being public in a timely manner and create unnecessary work for an under-resourced team. This goes on to reduce the resource available to coordinate members’ preventive outputs and improve outcomes for people deprived of their liberty.

Northern Ireland

We are concerned that the ICCPR list of issues and subsequent UK government response left Northern Ireland unscrutinised on several issues which relate to the NPM mandate:

- Prohibition of torture and cruel, inhuman or degrading treatment or punishment, right to liberty and security of person, counter-terrorism measures
- Right to life and conditions of detention.

⁸⁰ The Report of the Baha Mousa Inquiry Volume III, The Rt Hon Sir William Gage (Chairman) Recommendation 44 (gov.uk)

⁸¹ Monitoring places of detention; Ninth Annual Report of the United Kingdom’s National Preventive Mechanism 1 April 2017 – 31 March 2018, NPM (npm.org.uk)

As in England, Wales and Scotland, NPM members have raised concerns in places of detention in Northern Ireland. We have raised many of these issues in the above-mentioned sections and bring additional issues to the attention of the ICCPR here.

In prisons, NPM members have raised concerns in Northern Ireland about the systemic availability of illicit drugs, with approximately 30% of prisoners saying they had “developed a problem with drugs or medication not prescribed to them” while in Magilligan and Maghaberry prisons.⁸²⁸³ Care quality between the two adult prisons in Northern Ireland appears to be inconsistent, with Magilligan prison only receiving a score of “not sufficiently good” in one out of four healthy prison areas, while Maghaberry prison received a score of “not sufficiently good” or “poor” on three out of four areas (safety, purposeful activity, and rehabilitation and release planning) in recent inspection reports.

At Magilligan prison, substance misuse, standards of cleanliness and a lack of purposeful and meaningful activity are the main issues to be addressed. NPM member CJINI noted that although their recommendation to implement a drug and alcohol strategy had now been completed, it was “yet to be effective in addressing the supply of illicit drugs within the prison” as of the most recent inspection.⁸⁴ Several notable positive practices have also been recognised at Magilligan prison, including the use of a therapeutic garden, a strong culture of care among staff members, a pilot video scheme where prisoners could help their children with their homework, and more.

At Maghaberry prison, several key issues were highlighted at the most recent inspection, including:⁸⁵

- lack of an internal investigation to identify immediate learning following deaths in custody
- inconsistency in the investigation of safeguarding incidents
- absence of critical mental health support, including personality disorder services
- staffing shortages, which have led to insufficiencies in education and training, and sentence management and progression, leaving many prisoners being released without adequate plans
- discrimination by staff members against some Catholic prisoners, with staff reluctant to report poor behaviour of their colleagues
- unsuitable induction accommodations, which were dilapidated and with graffiti covered furniture, and often housed two people in cells designed for one
- frustrated and bored prisoners, with considerable reduction in education, skills and work activities since the previous inspection

⁸² Report of an unannounced inspection of Magilligan Prison 21 May – 10 June 2021, Criminal Justice Inspection Northern Ireland ([cjini.org](https://www.cjini.org))

⁸³ Report on an unannounced inspection of Maghaberry Prison 20 September – 6 October 2022, Criminal Justice Inspection Northern Ireland ([cjini.org](https://www.cjini.org))

⁸⁴ Report of an unannounced inspection of Magilligan Prison 21 May – 10 June 2021, Criminal Justice Inspection Northern Ireland ([cjini.org](https://www.cjini.org))

⁸⁵ Report on an unannounced inspection of Maghaberry Prison 20 September – 6 October 2022, Criminal Justice Inspection Northern Ireland ([cjini.org](https://www.cjini.org))

- concerns around disproportionate use of anti-ligature clothing, including cases where its use was not appropriately authorised or recorded
- prisoners not attending all of their prison health care and hospital appointments

Independent custody visitors escalated serious concerns around use of force and alleged criminal activity **in police custody** in 2022-23, which they continue to monitor.⁸⁶

Concerning secure children's care, RQIA inspections found a continued increase in the complexity of needs within the children and young people requiring admission to the service, leading to an increase in the use of restrictive practices, to support the safety of the individual children and young people and staff. They have raised concerns regarding the severity of the conditions suffered by the children and young people and the availability of resources in the regional secure centre. The NPM is concerned children are remaining in secure settings and are subject to restrictions for longer than is necessary. RQIA have identified that regional co-ordination is required to agree on processes for admission to and discharge from the regional secure centre.⁸⁷

Conclusion

In addition to the key OPCAT principles engaged by the UK state response, the NPM's submission raises significant findings of concern from scrutiny reports over the last reporting year. Overcrowding, overcapacity, little time out of cell, prolonged use of segregation units and indeterminate sentences continue to prevent full compliance with UNCAT and the ICCPR. While we have deliberately limited our submission to focus primarily on the UK state report, we have consulted with peers at the Equality and Human Rights Commission and the Scottish Human Rights Commission, and will be happy to assist the Committee with any further information they require.

⁸⁶ Independent Custody Visiting Report 2022-23, Northern Ireland Policing Board, Northern Ireland Statistics and Research Agency (nipolicingboard.org.uk)

⁸⁷ RQIA Annual Report and Accounts 1 April 2022 - 31 March 2023, the Regulation and Quality Improvement Authority (rqia.org.uk)