



UK National Preventive Mechanism Submission to Joint Committee on Human Rights Inquiry: Mental Health and Deaths in Prison

Background

1. The UK National Preventive Mechanism (NPM) was established in March 2009 as a consequence of the UK's ratification of the United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in December 2003. It is made up of 21 statutory bodies that monitor places of detention, most of whom existed before their designation as part of the UK's NPM.¹
2. The objective of OPCAT is to establish a system of regular visits, undertaken by both independent international and national bodies, to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment. In order to fulfill its obligations under OPCAT, the UK had to establish a National Preventive Mechanism, which must:
 - i) regularly examine the treatment of persons deprived of their liberty in places of detention, with a view to strengthening the protection against torture and ill-treatment;
 - ii) make recommendations to relevant authorities with the aims of improving the treatment and conditions of persons deprived of their liberty and preventing torture and ill-treatment; and
 - iii) submit proposals and observations concerning existing or draft legislation.
3. The NPM's main aim is to promote the prevention of torture and ill-treatment in all places of detention in compliance with the mandate established under OPCAT. It does this by visiting, monitoring and inspecting every place of detention in each of the four nations of the UK. Its strategic aims are to strengthen the protection of those in detention through coordinated and collaborative work on relevant issues, and to build an NPM that is effective in delivering all of the requirements of OPCAT.
4. The effective operation of the NPM is a continuing obligation on States party to OPCAT. There is an expectation that NPMs are reinforced and strengthened as necessary after their designation.²

¹ Further information about the UK NPM can be found on its website at: <http://www.nationalpreventivemechanism.org.uk/> [accessed 03/03/17].

² UN SPT, *Guidelines on national preventive mechanisms*, 9 December 2010 (CAT/OP/12/5), paragraph 15.

Inquiry scope: mental health and deaths in prison

5. Individual NPM members have raised a range of concerns relevant to the inquiry in their reports on places of detention, and HM Inspectorate of Prisons (one of the 21 NPM members) also intends to submit separate evidence to the inquiry. Rather than repeat these concerns, the NPM will focus on its coordinated work relevant to the inquiry topic, and provide views on how to strengthen approaches to mental health and deaths in prison in line with human rights standards.
6. This submission will focus on three areas in which the NPM has specific interest and shared learning:
 - The appropriateness of prison (ToR 1)
 - Segregation/solitary confinement (ToR 7)
 - Learning lessons for the future (ToR 8)

The appropriateness of prison (ToR 1)

7. The NPM is currently undertaking a joint thematic project on the transitions and pathways between different types of detention. Given that individual inspection and monitoring bodies inevitably take an establishment-specific approach to their work, this project uses the combined forces of the NPM to examine the issues that extend beyond the scope of individual NPM bodies, or fall outside NPM members' usual monitoring methodology.
8. Pathways between prisons and mental health settings are one of our focus areas, as these have been identified as an area of concern by NPM members.³ We will examine the impact on the treatment of detainees arising from their movement or inability to move between settings and are seeking to identify situations in which there is a risk that ill-treatment or inadequate/inappropriate conditions may result from such pathways and transitions.
9. We are currently gathering evidence as part of this project, so are unable to provide any conclusions at this stage, but our work to date covers the following issues:
 - Whether transfers from prisons to mental health settings are happening promptly;
 - The impact on detainees if transferred a long distance from initial placement/home;
 - Gaps in the legal framework for cross-border transfers (for example, it is not possible to transfer someone directly from a Scottish prison to an English psychiatric hospital);
 - The extent to which decisions about appropriate placements are influenced by local service availability;
 - Admission criteria into some mental health services which may exclude some people (particularly with personality disorder diagnoses), even though the individual's current placement (in prison) may not be able to provide appropriate care;

³ HM Inspectorate of Prisons has identified several cases in its inspections where transfers did not happen promptly, which would suggest that the specific recommendation for a 14-day target for transfers in the Bradley Report is not being met, and the broader recommendation made by the JCHR to address the shortage of places in high- or medium-secure units has not been achieved.

- Whether transfers to mental health services are being used inappropriately and late in sentences to ensure indefinite detention of people felt to be high risk;
 - Particular issues with the transfer of women, children or foreign nationals.
10. Human rights standards focus on treatment and conditions in given detention settings (particularly prisons) and on the legal basis for the detention (ECHR, article 5, e.g. mental health law), and focus little, if at all, on the principles or standards that should govern any movement between settings. We intend to give thought to the possibility of establishing a human rights framework that might govern NPM members' evaluation of pathways and transitions, and influence future policy.

Segregation/solitary confinement (ToR 7)

11. From 2014–15 the NPM conducted a joint project on isolation and solitary confinement, using human rights-based criteria to examine practices across detention settings including prisons.⁴
12. Human rights standards are clear that the practice of isolating prisoners can be justified as a disciplinary sanction, for the purposes of protection, or as an administrative decision for preventive purposes. However, there should be strong procedural safeguards in place and solitary confinement should only be used as a last resort, in exceptional circumstances, and for the shortest possible time.
13. In many instances, we found regimes in segregation units that amounted to solitary confinement in practice. This meant that prisoners were confined to their cells for more than 22 hours a day and had limited meaningful contact with others.⁵ NPM members found wide variation in the conditions in segregation units, and identified particular concerns with cage-like exercise yards and the variable provision of activities and facilities that might help to mitigate the effects of isolation. We identified good practice in a prison where communal areas in a segregation unit had been decorated brightly and had 'normalising' features such as murals and posters, and where efforts were made to ensure prisoners could eat outside of their cells if they posed no risk to others, and could associate with others for short periods following risk assessment.
14. We also found varying levels of oversight of prisoners in segregation. In some prisons, segregation monitoring and review groups (SMARG) conducted sophisticated monitoring that identified the individuals who repeatedly ended up in segregation; in others monitoring had lapsed and only the personal knowledge of staff could guide actions and understanding. We welcomed the instances where mental health staff led on the health care role in reviewing segregation. In one prison the Independent Monitoring Board reported difficulties in attending the first reviews of segregation as per their role.
15. We identified widespread informal isolation or solitary confinement of prisoners arising from the regimes they were on or particular practices or measures in place. Examples included

⁴ The findings from this project were published in the Sixth Annual Report of the UK NPM: <http://www.nationalpreventivemechanism.org.uk/wp-content/uploads/2015/12/NPM-Annual-Report-2014-15-web.pdf> [accessed 03/03/17].

⁵ United Nations, Standard Minimum Rules for the Treatment of Prisoners, (the Mandela Rules), Rule 43–44.

prisoners being held on a restricted regime known as 'duty of care', which aimed to protect individuals at risk of retaliatory violence but led to them spending only 30 minutes a day out of their cells on the main wing. Another example was at a prison where 600 out of 1,600 men were unemployed and as a result of this, and of a regime severely affected by staff shortages, these 600 men only received between half an hour to an hour of exercise and association per day. In one young offender institution (YOI) we found a number of boys held under an informal regime known as 'unemployed disruptive', which meant they were often isolated in their cells for over 22 hours a day.

16. Although many of these regimes or practices did not have isolation as a main purpose, the fact that they resulted in solitary confinement, and that this was not recognised, was of great concern. We were particularly worried that the use of a wide range of terminology to describe regimes or practices which had isolation as a main feature or defining characteristic could deflect attention from their severity. This included terms such as 'duty of care', 'removal from association', 'confined to room' and 'accommodation in specified conditions'.
17. The informality of this isolation, with no adequate governance processes or oversight, meant that the potential harm to prisoners – including those who were vulnerable (and already identified as such through the assessment, care in custody and teamwork (ACCT) process) – was not properly considered or acted upon. It also meant that prisons were unable to monitor how long prisoners had actually been in solitary confinement.
18. We were also concerned about the limited governance of isolation that failed to identify or address any disproportionate representation of prisoners with protected characteristics (including mental health issues) in formal isolation.
19. The joint NPM project gave us the opportunity to examine practices in different detention settings, and to identify lessons that could be applied in prisons. We were struck by the inconsistency of practice, which could lead to two men with identical mental health needs, disruptive behaviour and self-harm risks being held in very different conditions, depending on where they happened to end up being detained.
20. In particular, we found that there was a greater understanding of the need to help detainees reintegrate after a period of isolation in mental health detention than in prisons, where reintegration planning was rarely more than *ad hoc*. We concluded that prisons should do more to ensure prisoners knew what they needed to do for their segregation to end, and that they could learn from practices that included staggered reintegration, post-isolation debriefs and reviews, focusing on the detainee's successful reintegration and preventing future episodes.
21. Following on from this work, members of the UK NPM worked together to develop comprehensive guidance on monitoring isolation in detention.⁶ This guidance provides a framework that NPM members will apply when monitoring isolation and making recommendations, and aims to improve consistency of approach. It allows NPM members to identify and promote good and improved practice. We hope the document will also inform detention practice and policy.

⁶ <http://www.nationalpreventivemechanism.org.uk/wp-content/uploads/2017/02/NPM-Isolation-Guidance-FINAL.pdf> [accessed 03/03/17].

Learning lessons for the future (ToR 8)

22. It is clear that the worrying rise in self-inflicted deaths and mental health needs in prisons warrants a clear and determined response, and we welcome this Committee's attention to the issue.
23. The NPM can play an important role in efforts to address the issues of synthesising evidence, raising concerns about compliance with the UK's human rights obligations, and in identifying and promoting good practice that is in line with those human rights standards. However, the NPM has a limited ability to carry this out because of its informal status and lack of resources.
24. We recently raised with the Justice Committee our concern that the UK NPM itself is not specifically provided for in legislation and has no separate corporate or legal existence.⁷ This results in there being no guarantee of independence, no system of accountability, and Parliament having no role in agreeing either its mandate or its objectives. It is difficult to see how this is in compliance with OPCAT or the requirement for NPMs, as set out by the United Nations Subcommittee on Prevention of Torture.⁸ The lack of legislation undermines our legitimacy nationally and internationally, fails to protect our independence and functions from interference, and does not assist us to deliver on our day-to-day tasks. We are also concerned that the absence of legislation might suggest that the NPM is not regarded by the government as being particularly important. We believe legislation for the NPM and its members would be an opportunity to establish a proper system of accountability to Parliament.
25. Members of the NPM also wish to see their own responsibilities under OPCAT incorporated into their own statutes. Currently, the legislation of only two of the members of the NPM (both in Scotland) refers to OPCAT.⁹ Acknowledging NPM members' responsibilities in law would formalise the requirements of the NPM and make sure both the NPM and its members can be held to account for delivering them. It would also be useful to include in legislation a duty to ensure that NPM members co-operate with each other and with the NPM itself, which we believe would be of great practical benefit in our attempts to prevent ill-treatment through coordinated activities.
26. We welcome the recognition of OPCAT insofar as it relates to the work of HM Chief Inspector of Prisons in the Prisons and Courts Bill. We hope that it will be possible to make suggestions

⁷ <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/justice-committee/prison-reform/written/45906.html> [accessed 03/03/17].

⁸ 'The mandate and powers of the NPM should be clearly set out in a constitutional or legislative text', UN SPT, *Guidelines on national preventive mechanisms*, 9 December 2010 (CAT/OP/12/5); see also UN SPT, *Analytical self-assessment tool for NPMs*, 6 February 2012 (CAT/OP/1). See also: UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Visit to the Netherlands for the purpose of providing advisory assistance to the national preventive mechanism: recommendations and observations addressed to the State party*. Report of the Subcommittee. (CAT/OP/NLD/1).

⁹ The Police and Fire Reform (Scotland) Act 2012 (<http://www.legislation.gov.uk/asp/2012/8/contents/enacted> [accessed 03/03/17]) refers explicitly to the SPT and OPCAT (s. 93-96). The Public Services Reform (Inspection and Monitoring of Prisons) (Scotland) Order 2015 which introduces reference to the SPT and OPCAT into the Prisons (Scotland) Act 1989 (<http://www.legislation.gov.uk/ssi/2015/39/contents/made?article-3-2-c> [accessed 03/03/17]).

during the passage of the Bill that might strengthen the recognition of, and accountability to, Parliament.

27. We welcome the inclusion in the Prisons and Courts Bill of an explicit requirement on the Secretary of State for Justice to respond to the reports of HM Inspectorate of Prisons, and of a procedure for escalating significant concerns, both of which we think will help drive standards upwards and increase accountability for the actions of those responsible for the treatment and conditions of prisoners.
28. We are aware that many of the existing policies governing procedures in prisons are in the process of being discarded in favour of increased devolution of powers to governors to develop local policies. We would hope that there would be clear criteria for the decisions to withdraw policies or enter into new, local policies and that any new policies aspire to improved treatment and outcomes for prisoners.¹⁰
29. There have been calls for the NPM as a body to play a more active role in ensuring wider lessons are learned from deaths in custody, in line with the intention behind the recommendations in the JCHR's 2004 report. With the above measures in place, and sufficient resourcing to allow the coordination of these efforts, the NPM could indeed play a more active role in future by driving consistency between the work of its members, advising on monitoring standards and approaches that are consistent with human rights standards, and ensuring all inspection and monitoring upholds the approach set out in OPCAT to *prevent* ill-treatment in detention, which is necessarily different from approaches that investigate or provide redress for violations that have already happened.
30. We hope that you find this information useful. Please do not hesitate to contact us if you require any further information.

UK National Preventive Mechanism

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¹⁰ The EHRC Human Rights Framework for Adults in Detention (https://www.equalityhumanrights.com/sites/default/files/human_rights_framework_2.pdf [accessed 03/03/17]) could be used to support this, as could the Expectations developed by HMI Prisons for their inspections, which are underpinned by human rights standards.