

## Submission to JCHR inquiry on the use of restraint and isolation on detained children

### Background: Children's Commissioner for England & UK National Preventive Mechanism

1. The UK National Preventive Mechanism (NPM) was established in March 2009 following 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 and inspect places of detention.<sup>1</sup>
2. The objective of the OPCAT is 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 independent and regular visits to all places of detention<sup>2</sup>. Effective monitoring of the use of restraint and isolation is essential to preventing the ill-treatment of children in detention and to safe-guarding their rights and well-being. The NPM – both through our central coordination work and individual members – has conducted significant work to evaluate and strengthen approaches to monitoring the use of force, restraint and isolation and to share best practice across detention settings and the different jurisdictions of the UK.
3. This submission has been contributed to by members of the NPM's children and young people's sub-group, chaired by Anne Longfield, Children's Commissioner for England. The Children's Commissioner's role was created by the Children Act 2004 and was strengthened by the Children and Families Act 2014. The Children's Commissioner promotes and protects the rights, views and interests of children. As a member of the NPM, she has a key role in monitoring conditions of detention for children in order to prevent torture, cruel or inhuman or degrading treatment or punishment. The Children's Commissioner for Wales also contributed to the paper.

### Questions 1 and 2: human rights standards, restraint and isolation

4. Restraint and isolation are a focus of NPM members' regular inspection and monitoring activities. Evidence taken from recent reports – and concerns expressed about the impact of these practices on children's human rights and well-being – are set out below.

#### ***Restraint - police custody***

5. NPM members, Her Majesty's Inspectorate of Prisons (HMI Prisons) and Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) jointly conduct inspections of police custody in England and Wales.
6. New inspection standards were introduced in April 2016 with a greater focus on monitoring the use of force, safeguarding and the treatment of children and vulnerable adults<sup>3</sup>. The expectation on the use of force, developed with reference to international human rights standards, details the outcome that inspectors expect police forces to achieve: "*any force used from first point of contact is strictly necessary, proportionate and lawful, used as a last resort and subject to robust accountability. Any force used is*

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<sup>1</sup> A full list of the designated members of the NPM and further information about the UK NPM can be found on its website at:

<http://www.nationalpreventivemechanism.org.uk/>

<sup>2</sup> According to OPCAT, the role of the NPM is to:

- i) regularly examine the treatment of people deprived of their liberty with a view to strengthening their protection against torture and other forms of ill-treatment;
- ii) make recommendations to the relevant authorities with the aim of improving the treatment and conditions of detainees;
- iii) submit proposals and observations on existing or draft legislation

<sup>3</sup> See HMIP and HMICFRS *Expectations for Police Custody: criteria for assessing the treatment of and conditions for detainees in police custody* (Version 3, 2016)

*proportionate and is carried out by trained staff using approved techniques.”*

7. In inspections since the new expectations were introduced, inspectors have raised a number of concerns about the use of force on children detained in police custody including:
  - i) In Thames Valley<sup>4</sup> inspectors noted that handcuffs were not always removed quickly enough from compliant detainees. They commented on a child's case, which they reviewed on CCTV, involving a boy with ADHD who was handcuffed for over 30 minutes during a close proximity cell watch. They saw no attempts to de-escalate the situation before the handcuffs were applied.
  - ii) In Humberside<sup>5</sup> they commented on an incident that occurred during their inspection, which involved the use of a spit guard on a 17-year-old. Inspectors referred this case to the force for further investigation on several grounds, including concerns about the proportionality and governance of the use of spit guards in the custody environment and, in particular, on a child.
  - iii) In West Yorkshire<sup>6</sup> where the inspectors asked the force to refer two cases of use of force involving children to the local safeguarding children board. One case involved a self-harming young person who was restrained to remove his clothing, and who was subsequently left naked for a period of time. The second involved a girl with identified mental health issues who was heavily restrained on two occasions in a short period.

### ***Restraint – youth secure estate***

8. In 2012–13, NPM members HMI Prisons, Ofsted and the Care Quality Commission (CQC) began jointly inspecting STCs; each centre is inspected annually on an unannounced basis. HMIP also inspects Young Offender Institutions (YOIs) with CQC and sets out, in *Expectations: criteria for assessing the treatment of children and young people* that: “when children and young people are physically restrained, the minimum degree of force is used for the shortest amount of time necessary, by trained staff using approved techniques. Following restraint, children and young people are appropriately monitored and supported.”<sup>7</sup> This expectation was developed with reference to international human rights standards and is underpinned by specific criteria linked to these standards.
9. In addition, the Children's Commissioner has powers to enter and visit institutions in the youth justice secure estate. During these regular visits, the Children's Commissioner requests data on restraints, views CCTV footage of restraints and raises any concerns subsequently with the detaining institution and the Youth Justice Board.
10. Since the *Panorama* documentary in early 2016 about mistreatment of children at Medway Secure Training Centre (STC), there has been an intense focus on the use of force in the youth secure estate.
11. A visit to the UK by the European Committee for the Prevention of Torture (CPT) during March and April 2016 raised concerns about the action taken to implement the recommendations for improvement made by the Medway Improvement Board (and by NPM members HMIP and Ofsted). The CPT also criticised some of the treatment of children and young people in Cookham Wood YOI and recommended “the United Kingdom authorities take steps to ensure that co-ordination between the different bodies involved in investigating allegations of staff ill treatment against juveniles in detention is more effective, and the management of the prison should take steps itself to address the matter.”<sup>8</sup>
12. NPM members have commented the new system of ‘*Minimising and Managing Physical Restraint*’ (MMPR) has brought some improvements in the framework governing the use of restraint on children, however:
  - a) MMPR includes techniques which involve the deliberate infliction of pain on children – contrary to human rights standards and the clear recommendations of international bodies including the UN Committee on the Rights of the Child<sup>9</sup>;
  - b) The rules on when staff are permitted to use force on children in custody are still broad and in YOIs staff are able to restrain children in order to maintain “good order and discipline”. Again, the UN Committee on the Rights of the Child has been clear

<sup>4</sup> HMIP and HMI CFRS *Report on an unannounced inspection visit to police custody suites in Thames Valley, 5-16 February 2018* (June 2018)

<sup>5</sup> HMIP and HMI CFRS *Report on an unannounced inspection visit to police custody suites in Humberside, 2-13 October 2017* (March 2018)

<sup>6</sup> HMIP and HMI CFRS *Report on an unannounced inspection visit to police custody suites in West Yorkshire, 8-22 July 2016* (December 2016)

<sup>7</sup> HMIP, *Expectations: criteria for assessing the treatment of children and young people and conditions in prison* (Version 2, 2012). NB HMIP has consulted on a revised, updated version of these Expectations which will be published imminently.

<sup>8</sup> European Committee for the Prevention of Torture, *Report to the Government of the United Kingdom on the visit to the United Kingdom from 30 March to 12 April 2016*

<sup>9</sup> UN Committee on the Rights of the Child (2016) *Concluding Observations on the United Kingdom of Great Britain and Northern Ireland*

that 'restraint or force can be used only when the child poses an imminent threat of injury to him or herself or others, and only when all other means of control have been exhausted' and recommended the UK 'abolish all methods of restraint against children for disciplinary purposes in all institutional settings'

13. HMI Prisons and the CQC have both submitted separate evidence to the Joint Committee which highlight their concerns about the use of restraint in STCs and YOIs following recent inspections.
14. In 2016-17, the Children's Commissioner conducted a series of visits to five out of the 15 Secure Children's Homes (SCHs) in England and Wales and, as part of an analysis of culture and practice, focused on the use of restraint and restrictive interventions.
15. In contrast to some of the findings from NPM members in relation to inspections of STCs and YOIs, evidence from the Children's Commissioner's visits indicated a positive culture across SCHs including policies and procedures that gave greater priority to children's safety and recovery at the heart of the institutions. The facilities presented good staff ratios, a small number of beds per unit, and warm and supportive interactions were observed between staff and young people by Children's Commissioner staff. Generally, the SCHs visited were arranged into small units that were well laid out, spacious and provided a range of suitable space e.g. outdoor/gardening provision, good sports and educational facilities. Against that backdrop, restraint policies and data showed a general approach focused on de-escalation and minimising interventions, good levels of staff training and transparency about monitoring interventions and good practice in terms of reporting incidents according to safeguarding procedures. Where restraint data showed particularly high rates, the SCH in question was able to explain this trend and what they were doing to provide support. Overall, use of restraint was generally of short duration - particularly when compared to the mental health settings (see below).

### ***Restraint – mental health settings***

16. As part of a series of visits in 2016-17, the Children's Commissioner's staff also visited all six medium secure and forensic in-patient Child and Adolescent Mental Health Services (CAMHS) units in England. This enabled a cross-sector comparison of care and treatment of children in youth justice and mental health settings.
17. The Children's Commissioner's research found that in mental health settings (including those where children with learning disabilities are detained):
  - iv) Restraint was used more frequently than in SCHs, was often combined with chemical restraint, and was of far longer duration compared to practice in the SCH sector;
  - v) Restraint practice was not standardised across the sector with units using different models (including those incorporating the use of prone (face down) restraint);
  - vi) There were differences in the way information and data about restraint was recorded across the medium secure units. The data that was provided showed very lengthy restraints had taken place – including in the prone position (in contrast to SCHs where any restraint was generally very brief (under a minute));
  - vii) Lack of unit-wide CCTV meant it was impossible to review incidents of restraints to determine if they had been conducted properly (in contrast to the SCHs where this is possible).
18. NPM member the Care Quality Commission (CQC) also inspects CAMHS units and pays particular attention to practices of control and restraint, including segregation and seclusion practices. CQC has submitted evidence to the Joint Committee's inquiry.

### ***Isolation***

19. At their most severe, isolation practices can amount to solitary confinement.<sup>10</sup> When an individual is confined to a cell or room for 22 hours or more a day and, where this lasts for a period in excess of 15 consecutive days, this can amount to prolonged solitary confinement. UN human rights bodies consider the imposition of solitary confinement, of any duration, on children to be cruel, inhuman or degrading treatment and have consistently recommended that children should not be subjected to it: for example, in his 2011 report to the UN General Assembly, the UN Special Rapporteur on Torture set out his authoritative view that solitary confinement should not be used on children.<sup>11</sup>
20. The CPT, following a 2016 visit to the UK, also noted "*an increasing trend at the international level to promote the abolition of*

<sup>10</sup> As set out in the *Istanbul Statement on the Use and Effects of Solitary Confinement* (9 December 2007)

<sup>11</sup> United Nations General Assembly, report of the Special Rapporteur on Torture A/66/268 (5 August 2011)

*solitary confinement as a disciplinary sanction in respect of juveniles. Particular reference should be made to the United Nations Standard Minimum Rules on the Treatment of Prisoners (Nelson Mandela Rules) which have recently been revised by a unanimous resolution of the General Assembly and which explicitly stipulate in Rule 45 (1) that solitary confinement shall not be imposed on juveniles.*" The CPT was critical of the UK's record and highlighted children in Cookham Wood YOI being on a 'separation list' where they were found to be locked up, alone in their cells for 23 and a half hours a day. They concluded: *'holding juvenile inmates in such conditions amounts to inhuman and degrading treatment.'* The CPT recommended the UK *'take urgent steps to provide all juvenile prisoners – especially those on 'separation' or 'protection' lists with a purposeful regime, including physical activities and considerably more time out of cells...'*

21. While isolation of children can occur in a range of detention settings, inspection and monitoring reports from NPM members have raised particular concerns about the use of isolation in the youth secure estate.
22. Separately, HMI Prisons and CQC have set out findings from some of their most recent inspections in their evidence to the Joint Committee.
23. Visits to the youth secure estate by the Children's Commissioner have highlighted concerns about the amount of time spent in isolation by some children – in some cases amounting to solitary confinement. Such concerns led to the commissioning of research to assess the nature, prevalence, causes and impact of isolation and solitary confinement. Key findings of *Unlocking Potential: a study of the isolation of children in custody in England*<sup>12</sup> included:
  - i) On average, one in three children in the youth justice secure estate in England are isolated at some point. Children who experience isolation are likely to do so more than once.
  - ii) A child who experiences isolation in a YOI is likely, over a seven month period, to spend eight to nine times as long separated from their peers as a child in a secure children's home.
  - iii) Factors influencing higher uses of isolation included: a lower staff to child ratio; building structure (some units had a geography that facilitated separation of particular children without being removed from the normal routine of the establishment); larger units with higher density populations may be more difficult to manage without resorting to isolation; more rigid regimes associated with YOIs which can lead to a default presumption of longer periods of isolation.
  - iv) Variations between the different sectors of the secure estate. For example, SCHs and STCs using isolation as a 'cooling off' mechanism, working towards reintegration at the earliest point possible compared with YOIs where there was more a sense of isolation used as a punishment and less emphasis on ensuring its use for the minimum necessary period.
24. The Children's Commissioner's research also found that children with the following characteristics were at increased risk of isolation:
  - i) Black and mixed heritage children were three times as likely to experience isolation;
  - ii) Children with a recorded disability are two-thirds more likely to experience isolation;
  - iii) Looked after children are almost two-thirds more likely to experience isolation;
  - iv) Children assessed as a suicide risk (or having comparable markers of vulnerability) are nearly 50% more likely to experience isolation.
25. Children interviewed for the research described how the experience of isolation generated feelings of boredom, stress, apathy, anxiety, anger, depression and hopelessness. Staff confirmed that even short periods of isolation could trigger self-harm, exacerbate the impact of trauma experienced in the past and cause psychotic episodes.
26. Partly because of the psychological and physiological impact, any use of isolation involving children and young people requires increased scrutiny through monitoring and inspection. From 2014-15, members of the NPM carried out joint, thematic work focused on isolation and solitary confinement in detention settings, using human rights-based criteria to identify current practices across the detention settings that they monitor. As part of this joint, thematic work, NPM members shared details from their inspection and monitoring work which involved isolation or solitary confinement. The evidence from members in relation to children and young people was summarised in the NPM's *Sixth Annual Report*<sup>13</sup>.
27. Some of the specific issues identified in relation to the youth secure estate through the NPM's thematic work included:

<sup>12</sup> Children's Commissioner for England, *Unlocking Potential: A study of the isolation of children in custody in England* (2015)

<sup>13</sup> *Monitoring places of detention: Sixth annual report of the United Kingdom's National Preventive Mechanism* 1 April 2014-31 March 2015

### *Terminology*

28. Isolation and/or solitary confinement were part of number of practices or statuses for example, separation, loss of association, time out etc. Although many of these do not have the main purpose of isolation, the fact that they result in solitary confinement is of concern. The use of diverse terminology to describe practices that isolate detainees could deflect attention from the severe nature of these practices.

### *Length of isolation*

29. NPM members found that the majority of instances of formal isolation in STCs and SCHs were short (less than an hour) but that there were a number of informal practices, where children were isolated from their peers but had some limited interaction with staff, that lasted several days. NPM members identified practices amounting to solitary confinement outside formal isolation facilities. In many cases, isolation outside the formal care and separation unit lasted for more than 22 hours a day and could last for several weeks.

### *Conditions and regime*

30. The conditions under which children were isolated varied considerably. For example, in YOIs:
- i) boys held formally in separation and care units were often held in poor environments with an inadequate regime. NPM members' inspection reports have frequently commented on the poor conditions in dedicated segregation units finding dirty cells covered in graffiti, cells with poor ventilation, dirty toilets, austere exercise yards, limited access to showers, exercise, education and telephone calls. Often exercise yards were bare and austere and NPM members found little evidence of any constructive activities with boys spending most of their time locked in cells which were basic, with little stimulation;
  - ii) for boys informally isolated in their cells, conditions also varied. Most worryingly, since there were no procedures for monitoring or the governance of such episodes, the duration of isolation, time out of cell, access to and re-integration to the normal regime depended on the discretion of individual staff. Informal isolation and solitary confinement that arises from restrictive regimes or temporary measures, and the impact of decreasing staffing levels, is an increasing feature of life in YOIs. The informality of this isolation, with no governance processes or oversight, means that the potential for harm to detainees, including vulnerable children, is not fully considered and could affect their ability to reintegrate into life in the main establishment.
31. STCs and SCHs do not have dedicated facilities for isolating children so basic conditions are no different if a child is isolated. However, children reported having property removed, bathroom facilities locked off and, in some instances, being required to wear anti-rip clothing. NPM members reported variations in the extent to which isolation in STCs and SCHs affected children's access to education. In some instances, children were unable to access education for short periods but in others the normal education was replaced by poor quality worksheets or children had no face-to-face contact with education staff during periods of isolation. The conditions in which detainees were isolated are important as they can help offset the effects of isolation so, in institutions where there was good practice, considerable efforts were made to engage detainees or mitigate the sense of isolation, but in others, facilities were only provided on request or inconsistently.

### *Procedures and governance*

32. Procedures established under PSO 1700 (on segregation) apply to children in YOIs as they do to adults – including the requirement for an initial segregation safety screen within two hours of a child being segregated and that the IMB (who are members of the NPM) should be informed of decisions to segregate and be able to attend case conferences and reviews to make their views known. The provisions for children are identical in all key respects to those for adults, except that the respective timescales are halved. This presupposes treatment of children as smaller adults and the NPM believes, in line with international human rights standards, a separate approach to the treatment of children would be appropriate so that any policies around the removal from association of children draw on professional perspectives on the specific risks and needs in relation to children. Principles of good practice could be drawn, for example, from better practice in some STCs and SCHs.
33. In relation to STCs and SCHs, although NPM members noted a general improvement in consistency of decision-making, recording and monitoring of the use of separation in these settings, some concerns still existed. Where isolation occurs outside segregation processes, NPM members were concerned by the absence of formal procedures or oversight. It is of particular concern that the governance of isolation for children is not more robust and that oversight processes do not shed light on the reasons for or address any disproportionate representation of detainees from BAME backgrounds in isolation.

### *Reintegration*

34. Processes for re-integrating children and young people back into normal conditions are important. In all instances of isolation, detainees should know what is required for isolation to end and what will happen next. However, NPM members found that in several settings, planning and processes for re-integration of children into a normal location or regime was ad hoc and without formal policies. However, good practice in SCHs included the application of a 'restorative approach' with all children completing a report after isolation to look at what happened and the impact on themselves and others. Debriefing and reflection by staff and an emphasis on de-escalation led to a reduction in the frequency of incidents and improved behavior of children and young people.
35. The NPM review demonstrated that there is work to be done to avoid the use of isolation for children and young people and a worrying number of instances where isolation is not subject to formal governance. In some instances, children are held for long periods in conditions that amount to solitary confinement. There is a wide variation in the conditions and regime for children who are subject to isolation across different types of detention facilities which may lead to children with similar needs and behaviours being treated in very different ways. This needs to change.

### **Question 3: ensuring rights compliant standards are applied across detention settings**

36. Oversight and scrutiny of the treatment of children in detention is vital. NPM members play an important role in monitoring treatment and conditions, publicising findings and making recommendations for change to ensure children do not experience ill treatment in detention. Through their individual and joint inspections, NPM members continue to assess practices in detention involving the restraint and isolation of children against international human rights standards.
37. In addition, the NPM has developed joint, overarching guidance on isolation in detention which draws on international best practice<sup>14</sup>. It provides a comprehensive framework that NPM members are applying when examining isolation in detention. The guidance aims to improve the consistency with which NPM members monitor the use of isolation and allow them to identify and promote good and improved practice. We would encourage the Joint Committee to consider the specific section on children.
38. Other bodies and reporting requirements (for example to the Youth Justice Board and through YJB monitors in England and Wales) could be harnessed to ensure that all restraint and isolation practices are monitored and stopped where inappropriate:
  - a) NPM members have previously suggested that, in relation to children in YOIs subject to isolation under PSO 1700, consideration should be given to requiring authorisation from a senior manager external to the establishment such as a Deputy Director of Custody at the National Offender Management Service, under the Ministry of Justice, after 10 days rather than 21 days.
  - b) It is not clear whether critical incident procedures would be invoked by lengthy periods of isolation. Local Safeguarding Children Boards could provide external scrutiny where isolation goes on for longer periods or where it is informal, such as they currently do in relation to other safeguarding issues in prisons (such as the use of force or complaints).
39. As well as amending legislation and policies on the use of force and isolation to ensure they are compliant with international standards (as flagged in the evidence above), a crucial way to ensure rights compliant standards are applied across detention settings would be to make sure the recommendations (and examples of good practice) from NPM members are implemented following inspection and monitoring visits. We would like to see Government to take the lead in ensuring recommendations are acted on and supporting institutions to make operational changes and improvements.
40. In April 2019, the UN Committee against Torture will examine the UK's track record on the prevention of torture and ill treatment. The Committee has already flagged that it would like to receive information about the use of isolation and solitary confinement in detention settings and the use of restraint (particularly in healthcare settings). The NPM will be submitting a report to the Committee that shares our members' evidence of current practice and our concerns. Alongside the Joint Committee's inquiry, the UN Committee's examination presents an opportunity for Government to robustly examine current practice and put in place an action plan to implement changes to prevent any further ill treatment of children in detention.

September 2018

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<sup>14</sup> UK National Preventive Mechanism, *Guidance: isolation in detention* (2017). Available from: <http://www.nationalpreventivemechanism.org.uk/app/uploads/2017/02/NPM-Isolation-Guidance-FINAL.pdf>