

# **EHRC Submission to the UN Committee Against Torture: list of issues on the UK's 5th periodic report**

**August 2012**

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## List of abbreviations

ACPO	Association of Chief Police Officers
CIDT	Cruel, Inhuman or Degrading Treatment or Punishment
CPS	Crown Prosecution Service
CQC	Care Quality Commission
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EHRC	Equality and Human Rights Commission
FGM	Female Genital Mutilation
IPCC	Independent Police Complaints Commission
IRC	Immigration Removal Centre
JCHR	(UK Parliamentary) Joint Committee on Human Rights
HRA	Human Rights Act 1998
NGO	Non-governmental organisation
NHRI	National Human Rights Institution
NOMS	National Offender Management Service
PHSO	Parliamentary and Health Services Ombudsman
PPO	Prison and Probation Ombudsman
SIAC	Special Immigration Appeals Commission
TPIM	Terrorism Prevention and Investigation Measure
UKBA	UK Borders Agency
UNCAT	the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
UNCRC	the UN Convention on the Rights of the Child

## Introduction

We are fortunate in Britain to live in a democratic country where people are generally free to live without fear. The state operates within a clear and comprehensive legal framework which protects citizens' rights and seeks to punish those who commit crimes. However, as in all societies, there is always room for improvement. In this report, the Equality and Human Rights Commission (EHRC / the Commission), as the NHRI for Great Britain and one of the three 'A' status NHRIs for the UK, sets out the issues which in our view should form the basis of the forthcoming examination of the UK by the Committee Against Torture, the international treaty monitoring body for the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT / the Convention). In doing so we necessarily focus on areas of possible non-compliance with UNCAT where the government could act to improve the situation. We do not list the far more numerous ways in which the UK does comply with the requirements of the Convention which are outside the scope of this report, and are set out in the UK's 5<sup>th</sup> periodic state report.<sup>1</sup>

The UK has ratified several international conventions that are not part of domestic law, but by ratifying them, the UK commits itself to being legally bound by their obligations, and respecting and implementing their provisions. These include the two specific conventions which prohibit torture and inhuman and degrading treatment: UNCAT and the European Convention Against Torture.

The UK has also ratified a number of international treaties that provide further protection against torture and ill-treatment. For example, it has ratified the four Geneva Conventions and their two additional protocols,<sup>2</sup> which are the international laws that define the basic rights of civil and military prisoners and civilians during war and the obligation not to torture prisoners in armed conflicts.

Importantly, the legal protections provided for by UNCAT are also supported by the provisions of the European Convention on Human Rights (ECHR) which has been incorporated into UK domestic law via the Human Rights Act 1998 (HRA). Any failure to adhere to the Articles of UNCAT will almost inevitably also breach Article 3 ECHR. This means that individuals are able to seek a remedy through the national courts for any action which may constitute torture or inhuman, cruel or degrading treatment or punishment (CIDT). They are unable to rely directly in the UK courts on the provisions of UNCAT as the Convention has not been incorporated into domestic law.

## Scope of this report

This report covers the legal framework, policies and practices in Britain (England, Scotland and Wales) that under the UK's constitutional arrangements are the

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<sup>1</sup> Available at <http://www2.ohchr.org/english/bodies/cat/docs/CAT.C.GBR.5.pdf>

<sup>2</sup> Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of the Armed Forces at Sea. Convention (III) relative to the Treatment of Prisoners of War. Convention (IV) relative to the Protection of Civilian Persons in Time of War.

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responsibility of the UK Government or have been devolved to the Welsh Assembly. This means that it includes issues that affect Britain and also issues that are specific to England and Wales. For clarity we explain in the subject headings the issues that are relevant to the Britain or are restricted to England and Wales.

The report does not cover matters that the UK Government has devolved to the Scottish Parliament. It is within the statutory remit of the Scottish Human Rights Commission (SHRC) to comment on human rights issues that, in Scotland, fall within the powers devolved to the Scottish Parliament. Therefore, the SHRC, in its submissions to the Committee, will cover issues in Scotland for which the Scottish Parliament has responsibility.

The EHRC has no remit in Northern Ireland, the Crown Dependencies or Overseas Territories so issues specific to those countries and regions are not covered in this report.

### **Structure of the report**

The main part of this report is structured thematically. Where it is not stated our concern relates to a possible violation of Article 2 in relation to torture or Article 16 for CIDT. Where our analysis raises questions about compliance with other Articles of the Convention, we specify them.

In selecting material for this report we have prioritised matters that on our analysis:

- are the most pressing torture / CIDT issues in Britain today, and /or
- where the Committee is likely to be interested in additional information on that topic (due to a previous recommendation, correspondence or general comment), and/or
- where the Commission has carried out particular work on the issue which may assist the Committee, and/or
- because the issue is unlikely to be covered in any shadow report submitted by NGOs, and/or
- the information in the state report is scant or potentially misleading.

### **Sources**

This report draws primarily on significant work the Commission has carried out in the past two years including:

- The Human Rights Review 2012<sup>3</sup>
- The Inquiry into home care of older people<sup>4</sup>
- Inquiry into disability-related harassment<sup>5</sup>
- The Human Rights Measurement Framework<sup>6</sup>.

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<sup>3</sup> <http://www.equalityhumanrights.com/human-rights/our-human-rights-work/human-rights-review/>

<sup>4</sup> <http://www.equalityhumanrights.com/legal-and-policy/inquiries-and-assessments/inquiry-into-home-care-of-older-people/>

<sup>5</sup> <http://www.equalityhumanrights.com/legal-and-policy/inquiries-and-assessments/inquiry-into-disability-related-harassment/>

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It also draws on other Commission sources, such as our legal casework, interventions and responses to consultation about proposed legislative change, and many external sources, including reports published by NGOs, Ombudsmen, inspectorates and regulators.

We have conducted consultation with civil society and received contributions, either via written responses to our consultation, or through contributions at roundtables and focus group events from a wide range of organisations. We are very grateful to everyone who has taken the time to contribute. A full list of those who have done so is at the end of this report.

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<sup>6</sup> <http://www.equalityhumanrights.com/human-rights/our-human-rights-work/human-rights-measurement-framework/>

## **Section 1: UK involvement in conflict overseas (GB)**

### **Extent of the jurisdiction**

#### **Applicability of UNCAT outside the UK**

The Equality and Human Rights Commission (EHRC) agrees with the Committee's interpretation of the extent of the jurisdiction of UNCAT as expressed in its General Comment No 2 and in its 2004 Concluding Observations:

“the Convention protections extend to all territories under the jurisdiction of a State party and considers that this principle includes all areas under the de facto effective control of the State party's authorities.”

The UK government does not accept the applicability of the Convention to the actions of its forces abroad.<sup>7</sup>

Our legal opinion is that the extent of the applicability of UNCAT will mirror that of other international treaty obligations. In particular there is guidance from the ECtHR as to the applicability of the ECHR, most recently in the *Al-Skeini* case in 2011. The ECtHR found that the UK had jurisdiction over the city of Basra in Iraq in 2003.<sup>8</sup> Therefore, the UK's human rights obligations applied to its behaviour in that territory.<sup>9</sup>

#### **The EHRC recommends that the Committee asks the UK government:**

On what basis does the government believe that the provisions of the Convention do not apply to the actions of its forces in Afghanistan or Iraq?

### **Allegations of torture and ill-treatment of civilians and detainees in Iraq**

Allegations have been made that British military personnel have been involved in the torture and ill-treatment of civilians and detainees in Iraq. The UK government accepts that some of the allegations are credible and investigations are being held into at least 169 different allegations.

Information has emerged from inquiries and court cases between 2003 and 2010. The inquiry into the death of Baha Mousa reported in 2011. In 2003, soldiers from the Queen's Lancashire Regiment arrested 10 Iraqis, including Baha Mousa, and

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<sup>7</sup> Para 29 5<sup>th</sup> report to CAT

<sup>8</sup> European Court of Human Rights, 2011. *Extra-territorial jurisdiction of ECHR States*. Available at: [http://www.echr.coe.int/NR/rdonlyres/DD99396C-3853-448C-AFB4-67240B1B48AE/0/3415038\\_Press\\_Unit\\_Factsheet\\_\\_Extraterritorial\\_Jurisdiction.pdf](http://www.echr.coe.int/NR/rdonlyres/DD99396C-3853-448C-AFB4-67240B1B48AE/0/3415038_Press_Unit_Factsheet__Extraterritorial_Jurisdiction.pdf).

<sup>9</sup> *Al-Skeini v. the United Kingdom*, European Court of Human Rights Grand Chamber (55721/07).

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took them back to a temporary detention centre run by the regiment.<sup>10</sup> The inquiry heard that prisoners in the detention centre were hooded with hessian sacks, handcuffed, forced to adopt a 'stress position' (standing up with knees bent and arms outstretched) and deprived of sleep.<sup>11</sup> Witnesses also claimed that during their detention, the Iraqis were beaten and kicked by soldiers from the regiment who had been given the task of 'conditioning' the detainees for eventual 'tactical questioning' by military intelligence officers. Baha Mousa died while he was in custody. A post-mortem examination found that he suffered at least 93 injuries, including fractured ribs and a broken nose, which were 'in part' the cause of his death. In 2007, a court martial found that Corporal Payne was guilty of inhumane treatment and sentenced him to one year in prison.<sup>12</sup>

In relation to the detention facilities, the inquiry said that they were wholly inadequate and there was no meaningful custody record, or even a log of personnel visiting the facilities. It also found that there was a: lack of clear guidance about the prohibition on the use of hessian sacks, sleep, food and water deprivation; a lack of training and clear guidance on techniques that can be used to interrogate detainees and 'tactical questioning'; and an absence of any medical policy.<sup>13</sup>

A second legal challenge heard allegations that British soldiers unlawfully killed a number of Iraqi nationals at Camp Abu Naji and ill-treated five Iraqi nationals detained at the camp and subsequently at the divisional temporary detention facility at Shaibah Logistics Base. The Al-Sweady Inquiry has been set up to establish the facts of those allegations, and is will not report for several years. Hearings were due to commence in April 2012.<sup>14</sup>

In November 2010, during proceedings brought by Ali Zaki Mousa on behalf of over 100 civilians in Iraq, the High Court considered an application for judicial review into the Secretary of State's decision not to order a public inquiry into allegations of ill-treatment of Iraqi detainees at the Divisional Temporary Facility near Basra at which the Joint Forces Interrogation Team worked. It was alleged that detainees were starved, deprived of sleep, subjected to sensory deprivation and threatened with execution; that detainees were beaten, forced to kneel in stressful positions for up to 30 hours at a time, and that some were subjected to electric shocks. Some of the prisoners also claimed they were subjected to sexual humiliation by female soldiers,

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<sup>10</sup> Rt. Hon. Sir William Gage, 2011. *The Baha Mousa Public Inquiry Report, Volume 1*. London: The Stationery Office. Para 1.24.

<sup>11</sup> Ibid. See for example, Liam Douglas Fredrick Felton Witness statement to the Baha Musa inquiry. Available at: [http://www.bahamousainquiry.org/linkedfiles/baha\\_mousa/baha\\_mousa\\_inquiry\\_evidence/evidence\\_061009/bmi00830.pdf](http://www.bahamousainquiry.org/linkedfiles/baha_mousa/baha_mousa_inquiry_evidence/evidence_061009/bmi00830.pdf) and statement from Lieutenant Colonel Gavin Davies to the Baha Mousa inquiry. Available at: [http://www.bahamousainquiry.org/linkedfiles/baha\\_mousa/hearings/transcripts/2010-29-03-day75fullday.pdf](http://www.bahamousainquiry.org/linkedfiles/baha_mousa/hearings/transcripts/2010-29-03-day75fullday.pdf).

<sup>12</sup> La Hague Justice Portal. Available at: <http://www.haguejusticeportal.net/eCache/DEF/12/136.html>. Accessed 22/11/2011. Transcript of the sentencing available at: <http://www.publications.parliament.uk/pa/ld200607/ldlwa/070327wa1.pdf>.

<sup>13</sup> W. Gage, 2011. *The Baha Mousa Public Inquiry Report, Volume 3*. London: The Stationery Office. Page 1287. Available at: [http://www.bahamousainquiry.org/f\\_report/vol%20iii/Part%20XVIII/Part%20XVIII.pdf](http://www.bahamousainquiry.org/f_report/vol%20iii/Part%20XVIII/Part%20XVIII.pdf).

<sup>14</sup> Al- Sweady Inquiry. Available at: <http://www.alsweadyinquiry.org/>.

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while others alleged that they were held for days in cells as small as one square metre.<sup>15</sup>

To investigate these allegations, the Ministry of Defence set up the Iraq Historic Allegations Team in 2010, which was originally due to complete its work in the autumn of 2012. The Ministry also established the Iraq Historic Allegations Panel to consider the results of the team's investigations and identify any wider issues to be brought to the attention of the Ministry of Defence or of ministers personally.

The Commission argued that a prompt response by the authorities in investigating allegations of ill-treatment has been regarded by the European Court of Human Rights as essential in maintaining public confidence in the state's adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts.<sup>16</sup>

The Court of Appeal has now determined that these measures do not meet the requirements of an Article 3 ECHR investigation. The Court ruled that the investigation process set up by the UK government did not have the necessary degree of independence, and as such did not meet the requirements of the investigative duty in Article 3.<sup>17</sup> The Court found that because members of the Provost Branch (part of the British Army) were part of the investigation team, it compromised the institutional independence of the team. In light of that decision, the government's 'wait and see' approach to initiating a full public inquiry "could not stand".<sup>18</sup> The UK government's response to the Court of Appeal's judgment has been to replace members of the Royal Military Police in the Iraq Historic Allegations Team with members of the Royal Navy Police.<sup>19</sup> A further legal challenge to that investigative process is pending before the courts.

In another case, *Al-Skeini*, the UK government argued that it was not obliged to carry out an investigation into the involvement of the British Armed Forces in the deaths of five civilians in Iraq in 2003. The government claimed that its activities in Iraq were outside its jurisdiction, and so Article 3 did not apply. The European Court found that the UK had effective jurisdiction in Basra in Iraq, and had failed to carry out an effective investigation into the deaths and mistreatment of Iraqi civilians between 1 May 2003 and 28 June 2004.<sup>20</sup> The court found that the UK failed to investigate all but one death, that of Baha Mousa.<sup>21</sup> In response to the court's judgment the

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<sup>15</sup> *Ali Zaki Mousa and others v. Secretary of State for Defence* [2010] EWHC 3304 (Admin).

<sup>16</sup> Equality and Human Rights intervention in *Ali Zaki Mousa and others v. Secretary of State for Defence* [2010] EWHC 3304 (Admin).

<sup>17</sup> *Mousa, R. (on the application of) v. Secretary of State for Defence & Anor* [2011] EWCA Civ 1334 (22 November 2011).

<sup>18</sup> *Ibid.*

<sup>19</sup> Written Ministerial Statement 26 March 2012 Hansard Column 87WS

<sup>20</sup> *Al-Skeini v. the United Kingdom*, European Court of Human Rights Grand Chamber (Application no. 55721/07).

<sup>21</sup> *Ibid.*

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government is now establishing a new team with the Iraq Historic Allegations Team to investigate those cases<sup>22</sup>.

In relation these allegations there is a concurrent obligation under Article 12 UNCAT for effective investigations to be carried out.

**The EHRC recommends that the Committee asks the UK government:**

When is the Iraq Historical Allegations team likely to complete its investigations? How is the Al-Sweady inquiry progressing and when is that inquiry likely to report? Are any other investigations likely to be carried out beyond those two processes?

## **Allegations of ill-treatment by UK forces in Afghanistan**

There have been reports of abuse and ill-treatment that may amount to torture or CIDT by UK armed forces in Afghanistan, some of which have been investigated by the RMP.<sup>23</sup>

**The EHRC recommends that the Committee asks the UK government:**

How many investigations have been carried out in relation to allegations of CIDT in Afghanistan? Have there been any prosecutions? Are any further investigations likely to be required?

## **Allegations of complicity in torture abroad**

Allegations have been made that the security and secret intelligence services were complicit in the ill-treatment of prisoners and civilians in counter-terrorism operations overseas in the aftermath of the 9/11 attacks. If proved, this would constitute a violation of Article 2 UNCAT.

The allegations relate to at least 25 people including three British citizens and four individuals who held legal residency in Britain who were being held in the Guantanamo Bay detention facility.<sup>24</sup> Other alleged locations include Afghanistan, Egypt, Pakistan, Libya and Uganda. Cases have been reported by non-governmental organisations, the UN and UK domestic bodies like the UK parliamentary Joint Committee on Human Rights (JCHR).<sup>25</sup> The UK government

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<sup>22</sup> Written Ministerial Statement 26 March 2012 Hansard Column 87WS

<sup>23</sup> For instance, Afghanistan: list of investigations and prosecutions of British troops. <http://www.guardian.co.uk/news/datablog/2012/mar/29/afghanistan-british-army-crimes>; 29 March 2012. See also: The Royal Military Police investigated allegations that two British soldiers sexually assaulted two ten year olds: <http://www.bbc.co.uk/news/uk-16607304>; 18 January 2012.

<sup>24</sup> For a non-exhaustive list of individuals see: Equality and Human Rights Commission. Letter to Rt. Hon. Sir Peter Gibson. 13 September 2010.

<sup>25</sup> House of Commons, 2009. *The Joint Committee on Human Rights Twenty Third Report Allegations of UK Complicity in Torture*; United Nations, 2010. *Joint study on global practices in relation to secret detention in the context of countering terrorism of the Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, the Working Group on Arbitrary Detention and the Working Group on Enforced or Involuntary Disappearance*. UN

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denies that there is evidence of security service personnel torturing anyone directly or being complicit in torture.

In August 2008 the High Court found that British security services had provided information and questions for interviews conducted in Pakistan with Binyam Mohamed, who was resident in Britain. Mohamed alleges that he was tortured in Pakistan, Morocco and Afghanistan between 2002 and 2004, being beaten and scalded and having his penis slashed with a scalpel. Evidence from investigations into security and intelligence agents showed that British officials knew of at least some of the treatment he had suffered. A US court has also found there was 'credible' evidence that he was tortured in Pakistan and Morocco.<sup>26</sup>

In November 2010 the UK government announced a settlement with 16 individuals in relation to their imprisonment in Guantanamo Bay.<sup>27</sup> Other allegations have been made around the practice of 'extraordinary rendition'.

Extraordinary rendition violates the prohibition not to expel a person to another state, or hand that person to the agents of another state, when there are substantial grounds for believing that he or she will be in danger of being subjected to torture (Article 3 UNCAT).

There is little reliable information on the number of individuals who have been subject to extraordinary rendition. When allegations of UK involvement in extraordinary renditions emerged in 2005, UK government ministers repeatedly stated that British airports and airspace were not being used for this purpose.<sup>28</sup> In 2008, the government accepted that there was a mistake in its statements and that in 2002 its airspace and territory had been used for extraordinary rendition flights. It had received information from Washington that two flights had stopped over at Diego Garcia, the British overseas territory in the Indian Ocean.<sup>29</sup> The government acknowledged that one of the detainees in question was subsequently held in Guantanamo Bay but it did not reveal the name of the individual.<sup>30</sup>

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document number A/HRC/13/42 26. Human Rights Watch, 2009. *Cruel Britannia. British Complicity in the Torture and Ill-treatment of Terror Suspects in Pakistan*. Available at: <http://www.hrw.org/en/node/86690>

<sup>26</sup> *R. (Mohamed) v. Secretary of State for Foreign and Commonwealth Affairs*, 10 February 2010 [2010] EWCA Civ 65. Available at: <http://www.bailii.org/ew/cases/EWCA/Civ/2010/65.html> Accessed 22/11/2011; CPS decision on witness B. Available at: [http://www.cps.gov.uk/news/press\\_releases/141\\_10/](http://www.cps.gov.uk/news/press_releases/141_10/)

<sup>27</sup> Hansard HC col 752 (16 November 2010). Available at: <http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm101116/debtext/101116-0001.htm>.

<sup>28</sup> House of Commons, 2006. *Joint Committee on Human Rights. Nineteenth report of Session 2005-2006*. Para 148. Available at: <http://www.publications.parliament.uk/pa/jt200506/jtselect/jtrights/185/185-i.pdf>.

<sup>29</sup> Statement made by the Secretary of State for Foreign and Commonwealth Affairs David Miliband. Hansard HC, col 547 (21 February 2008) at: <http://www.publications.parliament.uk/pa/cm200708/cmhansrd/cm080221/debtext/80221-0007.htm>.

<sup>30</sup> Campaign group Reprieve believes that this person is Mohammed Saad Iqbal Madni. Reprieve, *Secret Prisons and Renditions*. Available at: <http://www.reprieve.org.uk/cases/muhammedsaadiqbalmadni/>.

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In February 2009, the UK government said that in 2004 two individuals had been captured by British forces in and around Baghdad. They were rendered to US detention and subsequently moved to a US detention facility in Afghanistan.<sup>31</sup> This detention facility is known for its inhumane conditions.<sup>32</sup>

The High Court has recently heard allegations from three men of rendition and torture in March 2011<sup>33</sup>. They failed to persuade the court that it should order disclosure from the government of details of what the UK security service agencies knew of their treatment. The court did not say in open judgment whether UK officials were involved or not.<sup>34</sup>

The most recent allegation dates from September 2011, when Human Rights Watch reported that it had documents that appear to incriminate Britain's intelligence services in planning the 2004 capture and rendition of Abdel-Hakim Belhaj.<sup>35</sup> The UK government has announced that criminal investigations will be carried out in relation to Belhaj's case and similar allegations made by another Libyan dissident Sami al Saadi.<sup>36</sup>

To comply with the UK's obligations under UNCAT Article 12 the investigation into these allegations of complicity must be independent, impartial, subject to public scrutiny, and include effective access to the process for victims. The people conducting the inquiry must act with diligence and promptness, and the investigation must be capable of establishing the facts and identifying those who are responsible for the violations. Every effort must be made to seek and secure information regarding torture violations, including from other states that are unwilling to co-operate.

As set out in the state report<sup>37</sup> in July 2010 the Prime Minister, David Cameron, announced that an independent inquiry would examine whether, and to what extent (if at all) the UK government and its intelligence agencies were involved in improper

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<sup>31</sup> Rt. Hon. John Hutton MP, Hansard HC col 394 (26 February 2009). Available at: <http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090226/debtext/90226-0008.htm#09022651000004> (accessed 22/11/2011) and Rt. Hon. Bob Ainsworth MP, Hansard HC col 549W (06 July 2009). Available at: <http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090706/text/90706w0010.htm#09070625001975>.

<sup>32</sup> Ibid.

<sup>33</sup> R(Omar Awadh Omar and others)v The Secretary of State for Foreign and Commonwealth Affairs 2012] EWHC 1737 (Admin). See also Freedom From Torture, 2011. *Uganda – fresh allegations of MI5 involvement in torture overseas*. Available at: <http://freedomfromtorture.org/news-events/news/3484>.

<sup>34</sup> Ibid.

<sup>35</sup> Human Rights Watch, 2011. *US/UK: Documents Reveal Libya Rendition Details*. Available at: <http://www.hrw.org/news/2011/09/08/usuk-documents-reveal-libya-rendition-details>.

<sup>36</sup> Joint statement by the Director of Public Prosecutions and the Metropolitan Police Service, 12 January 2012. Available at: [http://www.cps.gov.uk/news/press\\_statements/joint\\_statement\\_by\\_the\\_director\\_of\\_public\\_prosecutions\\_and\\_the\\_metropolitan\\_police\\_service/](http://www.cps.gov.uk/news/press_statements/joint_statement_by_the_director_of_public_prosecutions_and_the_metropolitan_police_service/).

<sup>37</sup> At page 8

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treatment of detainees held by other countries in counter-terrorism operations overseas in the immediate aftermath of the attacks of 9/11, or were aware of improper treatment of detainees in operations in which Britain was involved. The inquiry was chaired by Rt. Hon. Sir Peter Gibson.

The government stated that the inquiry did not have to comply with Article 3 ECHR investigation requirements, as it had not been set up in order 'to examine allegations of torture and other ill-treatment, which give rise to particular requirements under Article 3 ECHR'. There was a delay in the inquiry getting formally underway as it had to await the outcome of criminal investigations which at that point were ongoing into some of the cases.

The proposed inquiry was criticised by human rights groups and by the Commission. The terms of reference and protocols of the inquiry set out that key hearings would be held in secret; and that the cabinet secretary would have veto over what information would be made public.<sup>38</sup>

The Commission urged the chair of the inquiry and the government that it should be an effective investigation and compliant with international human rights obligations.<sup>39</sup> Lawyers acting for former detainees and 10 non-governmental organisations<sup>40</sup> indicated that they would not participate in the inquiry, believing that the terms of reference and protocols would not establish the truth of the allegations or prevent the abuses from happening again.<sup>41</sup> As further criminal investigations into rendition of individuals to Libya had recently been commenced, the government decided to conclude the inquiry in January 2012 before the inquiry had formally launched. It has committed itself to holding an independent judge-led inquiry at some point in the future.<sup>42</sup>

The Commission has welcomed the commitment to hold an inquiry in the future, and made recommendations for its conduct.<sup>43</sup> Such an inquiry will be an important step forward towards reaffirming the UK's reputation for strict adherence to international human rights standards. The procedural safeguards mandated by human rights standards are: the power to compel witness testimony, access to all relevant documentation whether in the hands of the state or an independent party, formal status for the victims of the allegations to enable effective participation such as

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<sup>38</sup> The Detainee Inquiry, 2011. *Terms of Reference and Protocol published*. Available at: <http://www.detaineeinquiry.org.uk/2011/07/news-release-terms-of-reference-and-protocol-published/>.

<sup>39</sup> Equality and Human Rights Commission. Letter to Rt. Hon. Sir Peter Gibson. 13 September 2010.

<sup>40</sup> These organisations were: Liberty, Redress, Amnesty International, Cageprisoners, the Aire Centre, Freedom from Torture, Human Rights Watch, Justice, Reprieve, and British Irish Rights Watch.

<sup>41</sup> Liberty, Redress, Amnesty International, Cageprisoners, Address, the Aire centre, Freedom from Torture, Human Rights Watch, Justice, Reprieve and British Irish Rights Watch letter to the chair of the inquiry. Available at: [http://www.amnesty.org.uk/uploads/documents/doc\\_21711.pdf](http://www.amnesty.org.uk/uploads/documents/doc_21711.pdf).

<sup>42</sup> Statement made by the Lord Chancellor and Secretary of State for Justice (Mr Kenneth Clarke). Hansard HC, col 752 (18 January 2012). Available at: <http://www.publications.parliament.uk/pa/cm201212/cmhansrd/cm120118/debtext/120118-0001.htm..>

<sup>43</sup> Letter Mark Hammond, Chief Executive, EHRC to the Right Honourable Kenneth Clarke QC MP, Secretary of State for Justice 21 February 2012.

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cross-examination of witnesses through counsel, disclosure to the parties and to the public of as much information as possible, and decisions as to closed proceedings and confidentiality to be made by the inquiry panel rather than by government.

The Commission's hope is that the inquiry is, by the time it reports, in a good position to make recommendations to government as to ways in which guidance, policies or procedures can be improved in future so as to prevent potential human rights abuses in future.<sup>44</sup>

In his most recent correspondence with the Commission, the Secretary of State says that the UK government is mindful of the reservations that were raised by us, and by others, but that it would be premature to make decisions about the conduct of a new inquiry at this stage<sup>45</sup>.

**The EHRC recommends that the Committee asks the UK government:**

Please provide further details of the criminal investigations that are currently in progress in relation to the allegations by Abdel-Hakim Belhaj and Sami al Saadi. Are there other related criminal investigations underway? How long are they expected to take? What arrangements have been made to ensure that the delay does not prejudice the future inquiry in relation to the other allegations that were due to be within the remit of the Detainee Inquiry chaired by Sir Peter Gibson?

## **Section 2: Counter-terrorism (GB)**

### **Counter-terrorism measures**

#### **Control orders**

The Committee was very concerned at the 2004 UK examination about the indefinite detention provisions under the Anti-terrorism, Crime and Security Act 2001 (AtCSA). After they were ruled unlawful following the House of Lords judgment in the *Belmarsh* case,<sup>46</sup> the UK government brought in control orders<sup>47</sup>. Again the

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<sup>44</sup> See also A/HRC/19/61 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez on the scope and role of commissions of inquiry.

<sup>45</sup> Letter from the Right Honourable Kenneth Clarke QC MP to Mark Hammond, CEO of the EHRC 31 May 2012

<sup>46</sup> *A.(F.C.) and others (F.C.) v. Secretary of State for the Home Department* [2004] UKHL 56. The European Court of Human Rights also found that the legislation breached Articles 14 and 5 ECHR. *A v. the United Kingdom* [2009] EHR 301.

<sup>47</sup> The power to impose control orders was provided by the Prevention of Terrorism Act 2005 (PTA) which was replaced, on 15 December 2011, by the Terrorism Prevention and Investigation Measures Act 2011.

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Committee had concerns, as expressed in its 2009 response to the government's update report<sup>48</sup>.

In 2008, the United Nations Human Rights Committee highlighted how control orders placed significant restrictions on the liberty of an individual who had not been charged with a criminal offence. It also questioned the nature of the judicial process applicable to control orders.<sup>49</sup> The JCHR concluded in 2010 that the regime was no longer sustainable, in light of its impact on individuals and concerns about the compatibility of the closed evidence procedures involving special advocates with Article 6 ECHR.<sup>50</sup>

Fifty-two people were made subject to a control order. Of these, 23 were forced to relocate under the terms of the order. As of December 2011, nine people, all British citizens, were under control orders, including four who had been under the regime for between two and five years. There is evidence that control orders have been distressing for the controlled person and their families.<sup>51</sup>

### **Terrorism Prevention and Investigation Measures**

In December 2011, Terrorism Prevention Investigation Measures (TPIMs) replaced control orders, with the last orders expiring on 26 January 2012.<sup>52</sup>

The new TPIM Act 2011 replaces curfews with overnight residence requirements and removes provisions for relocation to another part of the UK. The Act allows the Home Secretary to impose restrictive measures on individuals including requirements to stay overnight at specified addresses, to report to a police station daily, not to enter specific places or areas, not to contact particular individuals and not to travel overseas. Other measures include electronic tagging, restrictions on work, and on access to property and financial services. The Act does permit individuals subject to TPIMs restricted access to the internet. There is a time limit of 2 years for TPIMs.

The TPIM regime is potentially less onerous than control orders, yet nevertheless replicates many of its predecessor's features. TPIMs continue to allow significant restrictions on individuals' liberty based on the threat they are considered to pose rather than for the purposes of investigating or punishing criminal activity.

TPIMs, like control orders, may be imposed by the Home Secretary, though only with judicial permission except where she 'reasonably considers that the urgency of the case requires terrorism prevention and investigation measures to be imposed

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<sup>48</sup> Letter from Felice D Gaer Rapporteur for Follow-up on Concluding Observations CAT to Ambassador Peter Gooderham, UK Ambassador to the UN, 29 April 2009

<sup>49</sup> ICCPR Concluding Observations – 93<sup>rd</sup> Session UK Review, 30 July 2008. Available at: <http://www2.ohchr.org/english/bodies/hrc/hrcs93.htm>.

<sup>50</sup> JCHR, Counter-Terrorism Policy and Human Rights: Annual Renewal of Control Orders Legislation 2010 (Ninth Report of 2009-10): [www.publications.parliament.uk/pa/jt/jtrights.htm](http://www.publications.parliament.uk/pa/jt/jtrights.htm).

<sup>51</sup> Control Orders in 2011: Final report of the independent reviewer on the Prevention Of Terrorism Act 2005: David Anderson Q.C. Independent Reviewer Of Terrorism Legislation; March 2012

<sup>52</sup> Terrorism Prevention and Investigation Measures Act 2011.

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without obtaining such permission'. TPIMs must be based on 'reasonable belief' in the threat posed by the individual concerned. This is slightly more onerous than the control order threshold of 'reasonable grounds for suspecting', but still well below the standard of proof required in civil or criminal matters ('on the balance of probabilities' and 'beyond reasonable doubt' respectively). Court procedures for reviewing TPIMs, like control orders, will involve the use of closed material.

As at May 2012 nine men, all British, were subject to TPIMs. All had previously been subject to control orders.

In his independent review of the UK government's counter terrorism laws, Lord MacDonald recommended that any replacement for control orders should aim to facilitate the prosecution and conviction of terrorist suspects.<sup>53</sup> However, critics have questioned whether TPIMs will be any more effective in achieving this goal than control orders.<sup>54</sup> The government has not adopted alternatives, such as enhanced surveillance techniques<sup>55</sup> or allowing intercept evidence to be used in court<sup>56</sup> which would allow suspects to be prosecuted under the normal criminal justice system, and either convicted or acquitted.<sup>57</sup>

The JCHR criticised the proposed TPIM regime and its compliance with human rights. It recommended that the Home Secretary should apply to the court, which should then consider whether the order should be made, rather than merely having an oversight role. The JCHR also proposed that the standard of proof for TPIMs should be raised to the 'balance of probabilities'. In addition, the committee recommended that the court should fully review the imposition of TPIMs, with guarantees to ensure that the individual concerned can properly challenge the evidence and have a fair hearing.<sup>58</sup>

The EHRC welcomed attempts to create a more proportionate regime.<sup>59</sup> However, our analysis shows that this regime still lacks the necessary safeguards to protect

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<sup>53</sup> Lord MacDonald, January 2011. *Review of Counter-terrorism and Security Powers; A Report by Lord MacDonald of River Glaven QC*, Cm 8003. Page 9. Available at: <http://www.homeoffice.gov.uk/publications/counter-terrorism/review-of-ct-security-powers/report-by-lord-mcdonald?view=Binary>.

<sup>54</sup> Ibid, see also Liberty, June 2011. Liberty's Committee Stage Briefing on the Terrorism Prevention and Investigation Measures Bill in the House of Commons. Available at: <http://www.liberty-humanrights.org.uk/pdfs/policy11/liberty-s-committee-stage-briefing-on-the-tpims-bill-june-2011-.pdf>.

<sup>55</sup> Ibid. The EHRC has suggested that the availability of intercept evidence should be considered, as well as the use of surveillance. Equality and Human Rights Commission, September 2010. *Equality and Human Rights Commission submission to Review of Counter Terrorism and Security Powers*. Available at: <http://www.equalityhumanrights.com/legal-and-policy/consultation-responses/ehrc-submission-review-of-counter-terrorism-and-security-powers/>

<sup>56</sup> Home Office, January 2011. *Review of Counter-Terrorism and Security Powers*, Cm8004. Page 37.

<sup>57</sup> Ibid.

<sup>58</sup> Joint Committee on Human Rights, October 2011. *Legislative Scrutiny: Terrorism Prevention and Investigation Measures Bill* (second report). Twentieth Report of 2010-12.

<sup>59</sup> Equality and Human Rights Commission, 7 June 2011. Parliamentary briefing: Terrorism Prevention and Investigation Measures Bill, Second Reading, House of Commons. Available at: [www.equalityhumanrights.com/uploaded.../tpimsbill2rcommons762011.doc](http://www.equalityhumanrights.com/uploaded.../tpimsbill2rcommons762011.doc).

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human rights, and that it might result in breaches of UNCAT and the ECHR. TPIMs violate long-held principles of civil liberties, including the prohibition on punishment for what people might do rather than what they have done.

**The EHRC recommends that the Committee asks the UK government:**

Please explain why it has not been possible for individuals subject to TPIMs to be prosecuted through the criminal justice system and provide details of attempts to investigate and prosecute those subject to TPIMs. Please provide details as to how the TPIMs regime meets the requirements of the Convention and how the government ensures that the closed material proceedings are fair.

**Pre-charge detention**

Extended periods of pre-charge detention for people suspected of terrorism-related offences are longer than are usually allowed to detain suspects under English<sup>60</sup> and Scots criminal law. In extreme cases this may amount to degrading treatment and constitute a violation of UNCAT Article 16.

The Criminal Justice Act 2003 increased the maximum pre-charge detention period in the UK to 14 days and the Terrorism Act 2006 further extended it to 28 days. In 2008, proposals to increase the maximum pre-charge detention period to 42 days were strongly opposed by the JCHR, EHRC,<sup>61</sup> many parliamentarians and various civil society organisations. The House of Lords rejected the proposals.

In January 2011 the statutory period of 28 days pre-charge detention lapsed and the maximum period reverted to the previous 14-day limit. The Protection of Freedoms Act retains the 14-day limit for terrorism suspects, with judicial authorisation. The EHRC welcomes this improvement on the previous regime, yet it is still significantly longer than the usual criminal process. It is also significantly longer than pre-charge detention periods in other countries, such as the US (2 days), Canada (1 day), Germany (2 days) and Spain (5 days).<sup>62</sup> The Home Secretary retains a limited power in an emergency when parliament is not sitting to extend pre-charge detention to 28 days.<sup>63</sup>

The EHRC has argued that the maximum period of pre-charge detention in terrorism cases should be four days, the same as under English criminal law<sup>64</sup>. Extended pre-

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<sup>60</sup> English law applies in England and Wales

<sup>61</sup> The EHRC obtained advice from Rabinder Singh QC that analysed how extended periods of detention risked breaching Articles 3, 5, 6 and 14 ECHR, and stated that detention for up to 42 days would be likely to breach Articles 5, 6 and 14, and might also breach Article 3. Available at: <http://www.equalityhumanrights.com/legal-and-policy/parliamentary-briefings/crime-security-policing-and-counter-terrorism-bill-briefings/counter-terrorism-bill-including-proposals-to-allow-detention-for-up-to-42-days/>.

<sup>62</sup> Liberty, July 2010. *Terrorism pre-charge detention comparative law study*. It should be noted that direct comparisons of periods of detention are difficult due to the differing criminal justice systems.

<sup>63</sup> Protection of Freedoms Act 2011

<sup>64</sup> In Scotland the initial period is 12 hours, with the possibility of extending to a maximum of 24 hours (Criminal Procedure (Legal Assistance, Detention and Appeals)(Scotland) Act 2010.

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charge detention should only be used where strictly necessary,<sup>65</sup> and should be accompanied by stringent checks and balances.<sup>66</sup> The EHRC and other organisations consider any extension to 28 days, even in an emergency, would risk breaching Article 16 UNCAT as well as Article 5 ECHR.<sup>67</sup> Both the UN Human Rights Committee and the UN Human Rights Council have expressed concerns about the extended pre-charge detention periods.<sup>68</sup> They recommend strict time limits, strengthened guarantees and that, on arrest, terrorist suspects should be promptly informed of any charge against them, and tried within a reasonable time or released.<sup>69</sup>

The UK independent reviewer of counter terrorism measures has recommended that bail be available to those detained under the Terrorism Acts.<sup>70</sup>

**The EHRC recommends that the Committee asks the UK government:**

Please explain how the power to detain people without charge for up to 14 days is compatible with the provisions of the Convention. For those detained, please provide details as to whether they were eventually charged, and convicted or acquitted, including for what offences. Will the government consider whether bail might be appropriate for those subject to detention under these provisions?

## **Closed material proceedings**

### **Reliability of evidence derived from secret intelligence sources**

In closed material procedures the concerned person is not able to see the evidence themselves. Rather a special advocate is appointed on their behalf. The person is

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<sup>65</sup> Schedule 8, paragraph 32 Terrorism Act 2006 provides that:

A judicial authority may issue a warrant of further detention only if satisfied that—

- (a) there are reasonable grounds for believing that the further detention of the person to whom the application relates is necessary and
- (b) the investigation in connection with which the person is detained is being conducted diligently and expeditiously.

<sup>66</sup> EHRC submission on the *Review of Counter Terrorism and Security Powers*, September 2010. Available at: [www.equalityhumanrights.com/legal-and-policy/consultation-responses/ehrc-submission-review-of-counter-terrorism-and-security-powers](http://www.equalityhumanrights.com/legal-and-policy/consultation-responses/ehrc-submission-review-of-counter-terrorism-and-security-powers).

<sup>67</sup> JUSTICE, December 2011. *Protection of Freedoms Bill, Briefing for the House of Lords Grand Committee Stage*. Available at: <http://www.justice.org.uk/data/files/resources/137/JUSTICE-Brief-Lords-Grand-Committee-December-2011.pdf>.

<sup>68</sup> ICCPR Concluding Observations – 93<sup>rd</sup> Session UK review, 30 July 2008. Available at: <http://www2.ohchr.org/english/bodies/hrc/hrcls93.htm>.

<sup>69</sup> UN Human Rights Council Universal Period Review, 7-18 April 2008. Available at: <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/112/65/PDF/G0811265.pdf?OpenElement>. Accessed 13/01/12. ICCPR concluding observations – 93<sup>rd</sup> Session UK review, 30 July 2008. Available at: <http://www2.ohchr.org/english/bodies/hrc/hrcls93.htm>.

<sup>70</sup> Report on the Operation of the Terrorism Act 2000 and Part 1 of the Terrorism Act 2006. David Anderson QC; June 2012

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given sufficient information as to the nature of the allegations for them to be able to instruct the special advocate.

The Committee has previously raised questions of the UK government as to how it intended to amend the special advocates procedure to ensure that fully effective legal representation can be granted. The system has been amended to enable “gisting”, that is that the person is given sufficient details of the allegations against them to instruct the special advocate.

Much of the closed evidence used in cases which concern national security is heavily reliant on information from secret intelligence sources. Such evidence may contain second- or third- hand testimony or other material which would not normally be admissible in ordinary criminal or civil proceedings.<sup>71</sup> In addition, the standard of proof in most types of cases in which closed material is used is typically much lower than in civil and criminal cases.

A number of senior judges have noted that closed material is likely to be less reliable than evidence produced in open court because it has not been tested by thorough cross-examination. In the Supreme Court case of *Al Rawi*, for example, Lord Kerr warned that: ‘Evidence which has been insulated from challenge may positively mislead’.<sup>72</sup> Although special advocates are able to cross-examine witness in closed hearing, they are prohibited from discussing their questions with the person they are representing after service of the closed material. For this reason, Lord Bingham described the task of special advocates as ‘taking blind shots at a hidden target’.<sup>73</sup> The JCHR has been highly critical of the fairness of closed material procedures, as have the Special Advocates themselves, who have identified a number of practical concerns as to the operation of closed material procedures, and conclude that closed material proceedings are inherently unfair.<sup>74</sup>

**The EHRC recommends that the Committee asks the UK government:**

How does the UK government ensure that closed material procedures comply with Convention rights and enable the person concerned to effectively challenge evidence?

**Justice and Security Bill – proposed extension of the use of closed material**

From its origins in deportation cases, the use of closed material has gradually extended across the legal systems in the UK. Legislation has been passed permitting it in new areas, including terrorist asset freezing proceedings, employment tribunals, and even planning inquiries. In recent evidence to the JCHR, the

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<sup>71</sup> See e.g. paragraph 17(4) of the Special Advocates’ response to the Green Paper on Justice and Security, referring to the use of ‘second or third hand hearsay ... or even more remote evidence; frequently with the primary source unattributed and unidentifiable, and invariably unavailable for their evidence to be tested, even in closed proceedings’.

<sup>72</sup> *Al Rawi*, para 93. See also e.g. Sedley, L.J. in *A.F. and others v. Secretary of State for the Home Department* [2008] EWCA Civ 1148 at paras 113 and 117.

<sup>73</sup> *Roberts v. Parole Board* [2005] UKHL 45 at para 18.

<sup>74</sup> Special Advocates’ memorandum on the Justice and Security Bill submitted to the Joint Committee on Human Rights

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government has identified 14 different contexts in which the special advocate system has been provided for in legislation in civil proceedings.<sup>75</sup> However, there are also a number of situations in which special advocates have been appointed on a non-statutory basis, e.g. their use before the Security Vetting Appeals Panel. Accordingly, the UK government has no accurate figures of how many special advocates have been appointed since 1997.<sup>76</sup>

For example, the House of Lords agreed that the Parole Board could use closed evidence in order to decide whether it is safe to release a prisoner on parole. This was permitted even though there was no explicit provision for the use of closed procedures in the law governing the Parole Board. More recently, the Supreme Court recently upheld the use of a closed material procedure in the employment tribunal in *Tariq v. Home Office*.<sup>77</sup>

The UK government's Justice and Security bill proposes extending the use of closed proceedings to any civil case in which a government minister certifies that it involves sensitive material that should not be disclosed in the public interest.<sup>78</sup> The Minister would apply to the Court who would then grant the application if one of the parties to the proceedings would be required to disclose material in the proceedings and the disclosure would be damaging to national security. The proposals have been widely criticised by leading QCs,<sup>79</sup> special advocates,<sup>80</sup> NGOs<sup>81</sup> and the JCHR.

The Bill also proposes to amend the '*Norwich Pharmacal*' jurisdiction. This jurisdiction enables the ordering of disclosure of information from a person who is mixed up (however innocently) in the wrongdoing of another person, of information about that wrongdoing. It is potentially an important tool in exposing wrongdoing such as allegations of complicity to torture. The bill proposes removing this jurisdiction, in certain circumstances if the information is sensitive. Sensitive information means, broadly, information which relates to, has come from or is held by the security and intelligence agencies or defence intelligence units, or whose disclosure the Secretary of State has certified would damage the interests of national security or international relations.

### **The EHRC recommends that the Committee asks the UK government:**

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<sup>75</sup> Memorandum submitted by the Ministry of Justice to the Joint Committee on Human Rights, 28 November 2011.

<sup>76</sup> See the Freedom of Information Act requests referred to in JUSTICE, 2009. Secret Evidence. Para 359.

<sup>77</sup> *Tariq v. Home Office* [2011] UKSC 35.

<sup>78</sup> Para 2.7 of the Green Paper. The Secretary of State's decision would be reviewable by the trial judge on 'judicial review principles', but any challenge to this decision would itself necessarily involve closed proceedings.

<sup>79</sup> See e.g. memorandum of Dinah Rose QC to the Joint Committee on Human Rights, 24 January 2012, at para 14: 'the Green Paper is fundamentally incompatible with our system of civil justice'.

<sup>80</sup> See Justice and Security Green Paper – Response to consultation from Special Advocates, 16 December 2011 and evidence to the Joint Committee on Human Rights June 2012.

<sup>81</sup> See e.g. responses of JUSTICE, Liberty, Amnesty International, and the Bingham Centre for the Rule of Law. Available at: <http://ukhumanrightsblog.com/2012/01/31/more-secret-trials-no-thanks/>.

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Please provide evidence as to the necessity for closed material proceedings in civil cases, and why these are not satisfactorily dealt with by current Public Interest Immunity proceedings. How will the government ensure that closed material procedures enable evidence from the security services to be effectively challenged? Please provide evidence to support the need to amend the *Norwich Pharmacal* jurisdiction.

### **Compliance with Article 15**

The Committee has previously been concerned about the use of evidence in court that may have been obtained under torture.<sup>82</sup>

The UK government has committed in the light of the decision in *A v Secretary of State for the Home Department (No.2)* [2005] not to allow evidence obtained by torture to be admissible in legal proceedings.. The Commission's assessment is that wherever secret evidence is admitted there is an enhanced risk that evidence obtained by torture will be admitted inadvertently since it cannot be challenged in open court. This is an additional reason for concern about the proposed extension of the use of closed material proceedings.

#### **The EHRC recommends that the Committee asks the UK government:**

Please explain how the government will ensure that evidence obtained by torture is not used in legal proceedings, bearing in mind restricted rights under closed material proceedings to know and challenge security service evidence?

### **Oversight of the security and intelligence services**

Effective oversight of the security and intelligence services would ensure that the risk of further allegations of complicity in torture arising in future would be minimised. There is currently a lack of comprehensive or effective independent oversight of the activities of the security and intelligence services. Oversight is split between a number of UK judicial offices, Commissions and Parliamentary bodies. The primary bodies with responsibility for oversight are the Intelligence Services Committee of the UK Parliament, and the Intelligence Services Commissioner. The effectiveness of both has been criticised.<sup>83</sup>

The Justice and Security bill proposes to reform the Intelligence Services Committee, to make it a proper Parliamentary Committee, appointed by and reporting to the UK Parliament and to widen its remit. However appointments, its reports, and its work will remain subject to approval by the Prime Minister.

The bill also provides that the Intelligence Services Commissioner should have additional oversight of investigatory functions carried out by the intelligence agencies. Additional oversight of the operation of the intelligence services through an independent commissioner is to be welcome. However the proposals to add

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<sup>82</sup> CAT 2004 concluding observations CAT/C/CR/33/310

<sup>83</sup> Freedom from Suspicion Surveillance Reform for a Digital Age. Justice 2011

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oversight to the role of the Intelligence Services Commissioner as currently framed are unlikely to provide sufficient independent oversight.

The current regime of Commissioners with responsibility for oversight of security and intelligence service activities, intrusive surveillance and other aspects of privacy is confusing and fragmented, lacking transparency and hindering public access and accountability. Rather than adding to this regime, there should be rationalisation and consolidation of the various relevant Commissioners and their powers.<sup>84</sup>

**The EHRC recommends that the Committee asks the UK government:**

How will the government ensure that the Committee is able to provide effective Parliamentary oversight of the intelligence services, independent of government? Please provide details of how the Intelligence Services Commissioner has exercised his review powers, including numbers of warrants and authorisations reviewed under each relevant section of his powers.

## Section 3: Immigration (GB)

### Refoulement

#### Memoranda of understanding

The UK government has an obligation to refrain from deporting or expelling a person to another state when there are substantial grounds for believing that they will be in danger of being subjected to torture or other ill-treatment by state authorities or private individuals in that country (Article 3 UNCAT).<sup>85</sup> That is so even when that person poses a threat to national security.<sup>86</sup>

Memoranda of understanding and diplomatic assurances (in individual cases) are government records of an agreement or understanding between states, and have been used to facilitate the transfer of people from one territory to another. The UK government uses them to try to mitigate risks of torture and other ill-treatment that would otherwise prevent the transfer of people, in particular terrorist suspects.<sup>87</sup> However, it is unclear whether such memoranda are adequate in reducing the risk of

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<sup>84</sup> Protecting Information Privacy. Raab and Goold. EHRC 2011.  
[http://www.equalityhumanrights.com/uploaded\\_files/research/rr69.pdf](http://www.equalityhumanrights.com/uploaded_files/research/rr69.pdf)

<sup>85</sup> See also *Soering v. the United Kingdom* 11 EHRR 439 (14038/38) para 88 and *Chahal v. the United Kingdom* (1996) 23 EHRR 413.

<sup>86</sup> See *Chahal v. the United Kingdom* [1996] 23 EHRR 413; *Soering v. the United Kingdom*, judgment of 7 July 1989, Series A no. 161; *Saadi v. Italy* (37201/06), 28 February 2008.

<sup>87</sup> Redress, 2008. *The United Kingdom, torture and anti-terrorism: where the problems lie*. London: Redress. Page 51. Available at:  
<http://www.redress.org/downloads/publications/Where%20the%20ProblemsLie%2010%20Dec%2008A4.pdf>. Accessed 22/11/2011.

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torture potentially faced by expelled individuals.<sup>88</sup> Concerns have also been raised, including in our domestic courts, to memoranda which govern the transfer of detainees from the UK to other state authorities during periods of armed conflict. In *R (Maya Evans) v SSD* [2010] it was held that restrictions must be placed on the transfer of detainees in Afghanistan by the UK Armed Forces to a particular Afghan-run detention facility due to allegations of abuse in that facility.<sup>89</sup>

In its state report the government has argued that this policy demonstrates the UK's commitment to upholding its human rights obligations. Memoranda of understanding always specify that the recipient government should respect the basic rights of the person deported and provide for post-return monitoring mechanisms.<sup>90</sup>

Three countries have signed memoranda of understanding with the UK and have had them tested in the Special Immigration Appeals Commission (SIAC): Jordan, Libya and Ethiopia.<sup>91</sup> In 2011 a further memorandum was agreed with Morocco, but this has not yet been tested in SIAC. The UK government has also signed an exchange of letters with the Algerian president to deport individuals on a case-by-case basis and some of those agreements have been tested in SIAC.<sup>92</sup> The agreements with Algeria and the memorandum with Jordan have been approved by the House of Lords.<sup>93</sup> The agreement with Libya was held to be invalid by the UK courts in 2008 and has not been relied on since then. Nine people have been effectively deported from Britain following the receipt of diplomatic assurances. These were all to Algeria...

In January 2012, the European Court of Human Rights approved the memorandum of understanding between the UK and Jordan, deciding that despite some room for improvement the agreement would ensure that Abu Qatada would not be exposed to a real risk of torture if he were deported. However, it held that his deportation would be in breach of Article 6 ECHR (the right to a fair trial), in that evidence obtained through the use of torture would be admitted in his retrial in Jordan.<sup>94</sup>

As well as the UN Committee Against Torture, both the UN Human Rights Committee and the Special Rapporteur have repeatedly asked the UK government

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<sup>88</sup> See for example, Manfred Nowak, ex UN special rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Torture and other cruel, inhuman or degrading treatment or punishment Note by the Secretary-General. UN document A/60/316.

<sup>89</sup> *R. (on the application of Maya Evans) v. Secretary of State for Defence* [2010] EWHC 1445 (Admin).

<sup>90</sup> UK 5th periodic state report pages 14-18

<sup>91</sup> Britain has also signed a memorandum of understanding with Lebanon, but it has not been tested in SIAC. Algeria: Case of Y, case of BB, Case of G, Case of U, Case of Y, BB and U in the Court of Appeal [2010] EWCA Civ 898; Jordan: Case of Othman, Case of VV; Libya: Cases of DD and As.

<sup>92</sup> The exchange of letters can be viewed on the FCO website. See Foreign and Commonwealth Office, 'Targeting Terrorist Activity'. Available at: <http://www.fco.gov.uk/en/global-issues/counter-terrorism-policy/deportation-with-assurances/>.

<sup>93</sup> *RB (Algeria) (FC) and another (Appellants) v. Secretary of State for the Home Department (Respondent) and OO (Jordan) (Original Respondent and Cross-appellant) v. Secretary of State for the Home Department (Original Appellant and Cross-respondent)*, [2009] UKHL 10.

<sup>94</sup> *Othman (Abu Qatada) v. the United Kingdom* (Application no. 8139/09) 17 January 2012.

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to review the memorandum of understanding procedure.<sup>95</sup> The UK government has been unwilling to abandon it, as it maintains that those measures are sufficient to protect the individuals against torture.<sup>96</sup>

The latest review on the use of these assurances took place in 2010 as part of the Home Office review of counter-terrorism and security powers. They rejected submissions from human rights organisations requesting the abolition of these assurances, and the government decided that the assurances should remain in place..

The Committee's attention is also drawn to the recent Supreme Court Case *W (Algeria) and BB (Algeria) and others v SSHD*<sup>97</sup>. The appellants in those cases were faced with the prospect of being unable to adduce evidence to demonstrate that diplomatic assurances would not protect them<sup>98</sup>. The cases are now pending in SIAC.

### **The EHRC recommends that the Committee asks the UK government:**

What monitoring has been carried out to ensure that the nine people returned to Algeria have not been subject to torture or CIDT since their return? Please give further details of the 'official visit' mentioned at para 57 of the State Report. Are there any further memoranda of understanding under negotiation? Are there plans to deport any other individuals under the existing arrangements with Jordan, Morocco or Algeria?

### **Return to a risk of torture**

Despite the UK government's acceptance of the principle that failed asylum seekers should not be returned to a risk of torture in their country of origin, numerous cases have been reported of individuals being returned to countries that are not safe for them. There is no system of post-return monitoring to ensure that those who are forcibly removed are not harmed on their return.

Justice First, a voluntary organisation working with asylum seekers in the Tees Valley, has reported on 17 Congolese asylum seekers returned to Democratic Republic of the Congo (DRC) between 2006 and 2011 and documented serious risk and actual harm to them on their return.<sup>99</sup>

On 28 September 2011 UK Border Agency (UKBA) returned 50 people, including 42 who had previously made asylum applications, to Sri Lanka. A further charter flight operation took place on 15 December 2011 when 50 Sri Lankans were removed. A further charter flight took place on 28 February 2012.

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<sup>95</sup> United Nations, 2008. *Human Rights Committee: Consideration of reports submitted by States parties under Article 40 of the Covenant*. Available at: <http://www.statewatch.org/news/2008/jul/uk-un-hr.pdf>.

<sup>96</sup> Foreign and Commonwealth Office, 2010. *Annual Report on Human Rights 2009*. Page 45.

<sup>97</sup> *W (Algeria) and BB (Algeria) and others v SSHD* [2012] UKSC 8, 7 March 2012

<sup>98</sup> [http://www.supremecourt.gov.uk/docs/UKSC\\_2010\\_0238\\_ps.pdf](http://www.supremecourt.gov.uk/docs/UKSC_2010_0238_ps.pdf)

<sup>99</sup> <http://justicefirst.org.uk/wp-content/uploads/UNSAFE-RETURN-DECEMBER-5TH-2011.pdf>

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Investigations by Human Rights Watch have found that some failed Tamil asylum seekers from the UK and other countries have been subjected to arbitrary arrest and torture upon their return to Sri Lanka. Human Rights Watch has documented 13 cases in which Tamil failed asylum seekers were subjected to torture by government security forces on return from various countries, most recently in February 2012 and have called on the UK to suspend deportation flights to Sri Lanka.<sup>100</sup> Amnesty International has also previously briefed the Committee on the dangers facing Tamils who are forced returned to Sri Lanka.<sup>101</sup>

In *MSS v Belgium and Greece* it was held that conditions for MSS in Greece violated Article 3 ECHR<sup>102</sup>. The Court of Justice of the European Union held in *NS v UK* that there can be no conclusive presumption of compliance by a country, including a European country, with fundamental rights<sup>103</sup>. Schedule 3 to the Asylum and Immigration (Treatment of Claimants etc.) Act 2004 purported to contain such conclusive presumptions, and the UK government has relied upon these in removing people, creating a risk of torture or other cruel, inhuman or degrading treatment.

We would also draw to the Committee's attention *R (Medical Justice) v SSHD*<sup>104</sup>. Prior to that case, there were categories of person whom the Home Office was removing without notice, giving them no opportunity to advance evidence of a risk on return. One example is that of John Bosco Nyombi who was removed to Uganda despite having a pending application in the UK. He was detained in Uganda because of his sexual orientation until the Administrative Court ordered that the Home Secretary should bring him back to the UK. He was subsequently recognised as a refugee in 2009 and was awarded very substantial compensation.<sup>105</sup>

Returns to Iraq, Afghanistan and Zimbabwe have also given rise to concern. Even where notice of removal is given, the UK Border Agency does not promise more than 72 hours notice. The Immigration Law Practitioner's Association (ILPA) reports difficulties in ensuring individuals have the opportunity to challenge removal directions. ILPA is supposed to receive the letters that the UKBA sends to the administrative court notifying the court that a charter flight is imminent at the same time as these are sent to the court. This does not reliably happen. The risks that a person facing refoulement to torture is unable within the time constraints to challenge the removal, or do so effectively, are high.<sup>106</sup>

### **The EHRC recommends that the Committee asks the UK government:**

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<sup>100</sup> <http://www.hrw.org/news/2012/05/29/uk-suspend-deportations-tamils-sri-lanka>

<sup>101</sup> Sri Lanka: Briefing to Committee Against Torture Amnesty International. October 2011 <http://www.amnesty.org/en/library/asset/ASA37/016/2011/en/2bb1bbe4-8ba5-4f37-82d0-70cbfec5bb2d/asa370162011en.pdf>

<sup>102</sup> *MSS v Belgium and Greece*, Application no. 30696/09, European Court of Human Rights, 21 January 2011

<sup>103</sup> Joined Cases C-411/10 and C-493/10, N. S. (C-411/10) v Secretary of State for the Home Department, CJEU, 21 December 2011

<sup>104</sup> *R (Medical Justice) v SSHD*<sup>104</sup> [2011] EWCA Civ 269

<sup>105</sup> <http://www.newint.org/features/2010/06/01/john-bosco-nyombi-persecution-uganda/>

<sup>106</sup> ILPA response to EHRC list of issues consultation, April 2012.

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What monitoring is carried out to ensure that failed asylum seekers returned to DRC and Sri Lanka have not been subject to torture or CIDT since their return? Where allegations have been substantiated how is that information communicated within government, including to Embassies and High Commissions abroad? What arrangements are in place to ensure that all countries, including European countries, are properly assessed as to safety for return?<sup>107</sup>

## Immigration detention

### Detention of victims of torture

The UKBA has detention centres in England, Scotland and Northern Ireland. The EHRC's Human Rights Review found that contrary to UK government policy, UKBA staff at detention centres do not always follow the correct procedures to safeguard vulnerable individuals and remove them from detention.

Detention can have an impact on the mental health of individuals particularly those who flee to Britain because they have been tortured, or who already have mental health conditions. The impact of detention on such individuals engages the prohibition of inhuman and degrading treatment (Article 16 UNCAT) as well as other fundamental human rights.

### **Rule 35**

The UKBA is subject to guidance intended to identify victims of torture and people with mental health conditions and to avoid their detention where it could exacerbate their distress, and where there are no exceptional factors to justify detention. Anyone detained must be examined by a qualified GP within 24 hours of arriving in a detention centre.<sup>108</sup> Rule 35 of the Detention Centre Rules 2001 requires that doctors, 'report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention'.<sup>109</sup> Such individuals would include those whose mental health condition or disability cannot be 'satisfactorily managed' in detention.<sup>110</sup> Rule 35(3) also requires doctors to report to case managers any detained persons who may have been the victims of torture, who must notify the Home Office without delay.

In *R.(D. and K.) v. S.S.H.D.* [2006], the High Court ruled that the medical examination and subsequent report on a detainee must at least provide independent evidence of torture for the Home Office to decide that further detention is necessary.<sup>111</sup> The UKBA guidance notes that independent evidence of torture should

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<sup>107</sup> For instance, what assessment has been made in relation to returns to Romania or Moldova?

<sup>108</sup> Rule 34 Detention Centre Rules 2001.'

<sup>109</sup> Detention Centre Rules 2001.

<sup>110</sup> UKBA, Enforcement Instructions and Guidance. Para 55.10.

<sup>111</sup> *R.(D. & K.) v. S.S.H.D.* [2006] EWHC 980 (Admin), 150 *Sol Jo LB* 743, cited with approval in the Supreme Court in *Kambadzi*.

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weigh strongly in favour of release.<sup>112</sup> An unsupported torture claim does not automatically prevent detention.

Evidence indicates that the UKBA often does not follow its rules when assessing whether individuals are torture victims. Her Majesty's Chief Inspector of Prisons has repeatedly found breaches of Home Office policy and Detention Centre Rules in the failure to maintain proper systems to establish whether detainees bear signs of torture, such as scarring or post-traumatic stress disorder.<sup>113</sup> Medical Justice and other organisations have emphasised that the Rule 35 safeguard is dangerously ineffective. For instance, a woman who claimed asylum on the basis of having been repeatedly raped in a West African prison, including by state officials, was detained at Yarl's Wood Immigration Removal Centre (IRC) without proper medical examination, as required by Rule 35. Instead of alerting the Home Office promptly about her claims, as required under Rule 35, the Judge said the UKBA sent a 'pathetic apology' of a report which took over a week to arrive, with.

'...no indication that anyone took it into account at all... it is difficult to imagine a breach which more closely affects somebody who has been the victim of torture and in this case the omission is quite unforgivable'.<sup>114</sup>

The detained woman was eventually released from detention and compensated.

In February 2011, the UKBA published an audit to 'address the perception among some NGOs that the UK Border Agency fails to comply with ... policy and detains thousands of torture victims every year.'<sup>115</sup> The audit found that in a two month sample, officials responded in just 35% of cases within the two working-day time limit required by the policy. NGOs in the sector were critical that this analysis only looked at timescales and failed to examine content of the reports, the quality of the detention review, the assessment of medical evidence or the reasons to maintain detention in 91% of the cases it examined.<sup>116</sup>

The UKBA has told the EHRC that 'a forthcoming audit will look at progress made in improving the administrative process, and will also examine qualitative issues

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<sup>112</sup> UKBA, DFT and DNSA – Intake Selection (AIU Instruction), para 2.3.

<sup>113</sup> See, for example, HM Chief Inspector of Prisons reports on Harmondsworth IRC (11-15 January 2010), Brook House IRC (15-19 March 2010), Colnbrook IRC and short-term holding facility (16-27 August 2010), Tinsley House IRC (7-11 February 2011), Campsfield House IRC (16-18 May 2011) and Haslar IRC (31 May- 3 June 2011).

<sup>114</sup> *E v Home Office*, Central London County Court, 10 June 2010. Reported on Channel 4 News, 24 September 2010. Judge condemns treatment of torture victim. Available at: <http://www.channel4.com/news/judge-condemns-treatment-of-torture-victim>.

<sup>115</sup> UK Border Agency, Detention Centre Rule 35 Audit, 4 February 2011. Available at: <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/reports/detention-centre-rule-35-audit/>.

<sup>116</sup> See, for example, Freedom from Torture, 'UKBA review of safeguard to release torture victims from detention fails to deliver' (1 March 2012) available at: <http://www.freedomfromtorture.org/news-blogs/3436>. Medical Justice, March 2011. *Ignored detention centre medical reports means torture survivors left to rot*. Page 4. Available at: <http://www.medicaljustice.org.uk/mj-reports,-submissions,-etc./responses/1716-ignored-detention-centre-medical-reports-means-torture-survivors-left-to-rot-040311.html>.

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relating to Rule 35 report issuances and consideration'.<sup>117</sup> The UK government also notes that it implemented measures in early 2011 to improve important administrative aspects of the Rule 35 process. At the same time, work began to improve qualitative elements which the Commission has been told would be introduced in 2012.

In May 2012 a study found that victims of torture are routinely being held in immigration detention<sup>118</sup>. The charity Medical Justice reported on the cases of 50 people who have medical evidence of the torture they sustained, 14 of whom now have been granted leave to remain in the UK. In only one case did Rule 35 trigger a detainee's release. All but two of the 50 have now been released. Those surveyed were in detention for an average of 226 days. The impact of detention can be severe: of the medical notes examined, 23% went on hunger strike; 34% experienced suicidal intent/ideation or actual self-harm; 16% attempted suicide; 11 were transferred to hospital as acute emergencies; and there was one near death event.

### ***Fast track detention***

Routing asylum seekers who claim to be survivors of torture into fast track detention is inappropriate, because the process is designed to deal with cases that can be resolved quickly.<sup>119</sup> However, torture survivors may enter the system because the information needed to assess suitability for fast track is usually only available at the asylum interview which takes place once the person is in detention. Prior to this, asylum seekers undergo an initial screening process to assess whether they are suitable for the fast track process. At this screening, asylum seekers are not initially asked whether they have been tortured, but whether they have any medical conditions or disabilities, which torture survivors may not equate with their experience. Torture survivors are unlikely to realise that they will need to produce 'independent evidence of torture' at the screening interview to avoid being routed into the fast track process, or in order to establish their protection claim. The majority will have arrived in Britain following a long journey and will not have received legal advice, or sought independent evidence of torture before the interview.

The screening process itself has been criticised as not being conducive for applicants to provide personal and potentially sensitive information, such as providing information about torture. The Independent Chief Inspector of Borders and Immigration observed interviews taking place in an open plan environment, with applicants in the queue being able to hear interviews taking place and thus compromising confidentiality. In addition, an applicant may not mention that they have been tortured in a brief interview when they may have feelings of shame about what they have experienced and when they need time to build some level of trust.

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<sup>117</sup> Government comments on the Equality and Human Rights Commission draft report of the Human Rights Review. 2011.

<sup>118</sup> "The Second Torture": The Immigration Detention of Torture Survivors', Medical Justice 22 May 2012; available from <http://www.ein.org.uk/news/medical-justice-report-second-torture-immigration-detention-torture-survivors>

<sup>119</sup> Human Rights Watch, 2010. Fast-Tracked Unfairness Detention and Denial of Women Asylum Seekers in the UK. Page 34.

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Some will also have been tortured by authority figures, which can make it difficult for a UKBA officer to elicit such information, even if they were trained to do so.<sup>120</sup>

Human Rights Watch conducted research on the detention of women in the fast-track process which included interviews with women with direct experience of the fast track process and with solicitors, barristers who provide legal advice and assistance to women on the fast track process.<sup>121</sup> The screening process can fail to prevent a vulnerable individual from entering the system. For instance, in June 2009 'Laura', an asylum seeker from Sierra Leone, was placed in the fast-track detention system despite having witnessed her father's beheading, been raped several times, imprisoned, forced to have an abortion by having her stomach cut open, and trafficked into Britain. The screening interview was not designed to elicit such information, and did not do so. 'Laura' was only released from detention and granted refugee status after interventions by NGOs.<sup>122</sup>

In 2006, the Home Office acknowledged that the fast track procedure was not sufficiently robust to identify complex claims.<sup>123</sup> In 2008, the UN Refugee Agency reported that many unsuitable cases were fast tracked due to a lack of clear guidance about which cases could be 'decided quickly'.<sup>124</sup> The Council of Europe's Commissioner for Human Rights has suggested that these problems could be mitigated through precise legislation that ensures no complex cases or vulnerable groups, including victims of torture, are routed through the fast track system.<sup>125</sup> Such clarification would help to protect vulnerable individuals from inappropriate detention, as well as provide greater transparency about the process for all detainees and decision-makers. It would also help reduce the risk of arbitrary and unlawful detention.

The UN Refugee Agency has long held that the detention of asylum seekers is undesirable, should only be considered as a last resort, and that accelerated procedures should only be used where adequate safeguards guarantee fairness of procedure and quality of decision-making.<sup>126</sup> The speed of the fast track process is to resolve asylum applications quickly to the benefit of both the asylum applicant and the UKBA. Yet its rapidity risks making the process unfair. In 2010, the UNHCR

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<sup>120</sup> For more info: [http://icinspector.independent.gov.uk/wp-content/uploads/2012/02/Asylum\\_A-thematic-inspection-of-Detained-Fast-Track.pdf](http://icinspector.independent.gov.uk/wp-content/uploads/2012/02/Asylum_A-thematic-inspection-of-Detained-Fast-Track.pdf)

<sup>121</sup> Human Rights Watch, 2010. *Fast-Tracked Unfairness Detention and Denial of Women Asylum Seekers in the UK*.

<sup>122</sup> Ibid. Page 35 Cases documented by Freedom from Torture of torture survivors in detention and in isolation.

<sup>123</sup> Ibid. Page 2.

. Ibid. Page 39 quoting from UNHCR, 'Quality Initiative Project, Fifth Report to the Minister', March 2008. Pp. 22-23.

<sup>125</sup> Council of Europe, 18 September 2008. Memorandum by Thomas Hammarberg, Commissioner for *Human Rights of the Council of Europe*, following his visits to the United Kingdom on 5-8 February and 31 March–2 April 2008, CommDH (2008) 23 Strasbourg.

<sup>126</sup> UNHCR, August 2010. *Quality Integration Project, Key Observations and Recommendations*. Page 1. Available at: [http://www.unhcr.org.uk/fileadmin/user\\_upload/pdf/First\\_Quality\\_Integration\\_Project\\_Report\\_Key\\_Findings\\_and\\_Rec\\_01.pdf](http://www.unhcr.org.uk/fileadmin/user_upload/pdf/First_Quality_Integration_Project_Report_Key_Findings_and_Rec_01.pdf).

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found that there are inadequate screening processes which lead to complex cases and vulnerable applicants entering the fast track system.<sup>127</sup> It found that the UKBA did not always follow the appropriate methodology for assessing each element of an asylum applicant's case.<sup>128</sup> In particular, there were inadequate safeguards to ensure that asylum seekers were able to present their case sufficiently, and inappropriate burdens were placed on applicants to prove their claims when they were detained.

**The EHRC recommends that the Committee asks the UK government:**

Has the audit of administrative processes and examination of substantive issues in relation to rule 35 been carried out? Are improvements are being made to the rule 35 procedure to ensure that it is effectively implemented?

What action has the government taken following the UNHCR's 2010 recommendations to a) improve the design and function of screening and routing include, as a primary aim, the need to ensure that unsuitable claims and vulnerable individuals are not routed in to the Detained Fast Track detention; b) to provide clearer and more substantive guidance to UKBA staff involved in referring to and selecting cases for the DFT so that they can better identify both cases that cannot be 'decided quickly' and claimants who may be vulnerable?

**Care of detainees with mental health conditions**

Since 2004, the Prison and Probation Ombudsman (PPO) has investigated six self-inflicted deaths in immigration detention.<sup>129</sup> In 2011 there were three deaths in immigration removal centres, one of which was self-inflicted. These deaths are currently being investigated. The Institute of Race Relations has, since 1989, been recording the deaths of asylum seekers and undocumented migrants as a result of attempting to enter the UK, self-harm, denial of medical treatment, destitution, hazardous working conditions or racist attacks.<sup>130</sup>

The UK government do not routinely publish the figures on self-harm in immigration removal centres, and there is no data available on self-harm in short-term holding facilities.

The UKBA's Enforcement Instructions and Guidance for 2008 provided that people suffering from mental illness could be detained in only very exceptional circumstances: there was a 'presumption in favour of release' for those people in immigration detention who were suffering serious medical conditions or mental illnesses.<sup>131</sup> The current 2010 Enforcement Instructions and Guidance allows for the

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<sup>127</sup> Ibid, Page 4.

<sup>128</sup> Ibid. Page 2.

<sup>129</sup> Prisons and Probation Ombudsman Investigation reports available at: <http://www.ppo.gov.uk/immigration-removal-centre-investigations.html>.

<sup>130</sup> Available at <http://www.irr.org.uk/news/roll-call-of-deaths-of-asylum-seekers-and-undocumented-migrants-2005-onwards/>

<sup>131</sup> UKBA Enforcement Instructions and Guidance for 2008.

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detention of people with mental illness unless their mental illness is so serious it cannot be managed in detention. In such cases, exceptional reasons will be needed to justify their detention. This appears to reverse the presumption in the previous guidance.<sup>132</sup>

The UK government argues that there has been no change in policy, but that this clarifies the 2008 policy.<sup>133</sup> That argument appears to have been rejected by the court in *R(HA (Nigeria)) v SSHD* [2012] in which the court held that the detention of a mentally ill person in an Immigration Removal Centre amounted to inhuman and degrading treatment and false imprisonment, and that the change of policy had been introduced in breach of the Public Sector Equality Duty<sup>134</sup>.

Other cases prove that this is a repeated problem. For instance, in *R.(S.) v. S.S.H.D.* [2011], the High Court found that the detention of a seriously mentally ill man at Harmondsworth detention centre in 2010 amounted to inhuman or degrading treatment.<sup>135</sup> A similar finding was made a few months later in *R.(B.A.) v. S.S.H.D.* in relation to the detention of another man at Harmondsworth in 2011.<sup>136</sup> In BA's case the judge speaks of the "callous indifference" to his suffering. Rather than one case being a wake-up call and leading to changes in the treatment of mentally ill detainees, these cases form a pattern and may be indicative of shortcomings in the UK government's treatment of immigration detainees.

People in immigration removal centres have varying degrees of access to mental health care (including access to psychiatrists and counselling, and mental health nurses), as provision is managed by different contractors in different centres.<sup>137</sup> Research by the charity Mind has found that people with significant and complex mental health conditions are being detained, and that mental health service providers do not feel that the provision is always adequate to deal with the high levels of mental distress experienced by detainees.<sup>138</sup>

HM Chief Inspector of Prisons has commented on the unsuitable facilities for vulnerable detainees, a lack of access to counselling, poor use of interpreting services and a lack of training for healthcare staff in identifying signs of torture or trauma. It concluded in its 2010-11 annual report that:

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<sup>132</sup> Ibid. See *R.(B.A.) v. S.S.H.D.* [2011] EWHC 2748 (Admin), [2011] All ER (D) 219 para 179.

<sup>133</sup> Government comments on the Equality and Human Rights Commission's draft Human Rights Review, December 2011.

<sup>134</sup> *R(HA (Nigeria)) v SSHD* [2012] EWHC 979 (Admin)

<sup>135</sup> *R.(S.) v. S.S.H.D.* [2011] EWHC 2120 (Admin), [2011] EWHC 2120 (Admin), 175 CL&J 551.

<sup>136</sup> *R.(B.A.) v. S.S.H.D.* [2011] EWHC 2748 (Admin), [2011] All ER (D) 219.

<sup>137</sup> AVID, 2011. *Vulnerable groups in Immigration Detention: Mental Health*. Page 3. Available at: <http://www.aviddetention.org.uk/images/avid%20mental%20health%20briefing%20310311%20for%20det%20forum%20work.pdf>. Accessed 01/02/2012.

<sup>138</sup> Mind, 2009. *A Civilised Society: Mental health provision for refugees and asylum seekers in England and Wales*. Page 21. Available at: [http://www.mind.org.uk/assets/0000/5695/refugee\\_report\\_2.pdf](http://www.mind.org.uk/assets/0000/5695/refugee_report_2.pdf). Accessed 01/02/2012.

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‘Mental health problems were evident for detainees in many centres, and some had reported significant trauma or torture. However the process intended to provide safeguards to detainees who were not fit to be detained, or had experiences of torture, did not appear to be effective.’<sup>139</sup>

HMI Prisons has highlighted both good and poor practice in suicide prevention and self-harm management in immigration removal centres. It found that staff had an adequate understanding of suicide and self-harm intervention, but that safeguarding policies were ineffective.<sup>140</sup> The inspectorate found no equivalent to the Samaritans and Samaritan-supported ‘listeners’ who play such an important role across the prison system.

The inspectorate also emphasised the importance of keeping ‘at risk’ individuals in the company of others. Evidence shows that vulnerable detainees have been segregated while waiting for referral to secondary mental health services, although this is likely to have a detrimental effect on their condition.<sup>141</sup> The report also notes that staff in immigration detention centres do not carry anti-ligature knives, which is standard practice in prisons. This could delay attempts to save the life of a suicidal detainee.

In all of the centres it inspected, HMI Prisons found that official letters written by doctors to advise the UKBA of concerns about detainees’ health often received cursory replies or no replies at all. For example, in Colnbrook immigration removal centre, of 125 such letters, 61 had received replies.<sup>142</sup>

The report noted that:

‘Colnbrook had an especially high demand for mental health services. It managed this reasonably well but had little space for mental health nurse clinics and many patients had left the centre before they could be seen. Counselling services were limited across the inspected establishments.’<sup>143</sup>

### **The EHRC recommends that the Committee asks the UK government:**

Given the evidence that people with significant mental health issues are being detained, in breach of the government's existing guidelines, what steps can be

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<sup>139</sup> HMI Prisons, 2011. *Annual Report 2010-11*. London: The Stationery Office. Page 68.

<sup>140</sup> HMI Prisons, 2011. *Annual Report 2010-11*. London: The Stationery Office. Page 68.

<sup>141</sup> AVID, 2011. *Vulnerable groups in Immigration Detention: Mental Health*. Page 5. Available at: <http://www.aviddetention.org.uk/images/avid%20mental%20health%20briefing%20310311%20for%20det%20forum%20work.pdf>. Accessed 01/02/2012; and HMI Prisons, 2010. *Annual Report 2008-09*. London: The Stationery Office. Page 22.

<sup>142</sup> HMI Prisons, 2010. Report on an unannounced full follow-up inspection of Colnbrook Immigration Removal Centre and short-term holding facility 16–27 August 2010. London: HMI Prisons. Page 32.

<sup>143</sup> HMI Prisons, 2011. HM Chief Inspector of Prisons for England and Wales Annual Report 2010-11. London: The Stationery Office. Page 69.

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taken to prevent further detentions taking place, and to ensure that any detainee wrongly held is released as soon as credible concerns are raised?

### Care of detainees with physical health problems

Concerns have also been raised in relation to other health care issues for detainees particularly disabled people and people with long-term health conditions. The charity Medical Justice has investigated health care for detainees living with HIV. They reported a lack of access to HIV medication and several instances of the disruption to treatment regimes. For example they reported that UKBA tried to deport an HIV+ pregnant mother who had been given less than a month's medication even though it is critical that treatment is not interrupted during pregnancy, to avoid a newborn child becoming infected<sup>144</sup>.

#### **The EHRC recommends that the Committee asks the UK government:**

Please give details of the government's policy on health care for immigration detainees, particularly those with HIV or other serious and life-threatening conditions.

### Detention of children

Section 55 of the Borders, Citizenship and Immigration Act 2009, and the UKBA's associated Enforcement and Instructions Guidance require the UKBA to carry out its functions while having regard to safeguarding and promoting the welfare of children. Nonetheless, detaining children for immigration purposes has been widely criticised for appearing to punish and imprison children who have not been accused – let alone convicted – of any crime.<sup>145</sup> In 2010, 405 children entered immigration detention, of whom 74% were asylum detainees.<sup>146</sup> The medical profession has also highlighted the potentially harmful impact of detention on children's mental and physical wellbeing<sup>147</sup> and the Children's Commissioner for England has stated:

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<sup>144</sup> "Detained & Denied: The clinical care of immigration detainees living with HIV" - 22/03/11. Available at <http://www.medicaljustice.org.uk/mj-reports,-submissions,-etc./reports/1723-qdetained-a-denied-the-clinical-care-of-immigration-detainees-living-with-hivq-220311.html>

<sup>145</sup> See, for example, the speech by the Deputy Prime Minister, June 2010: 'We are setting out, for the first time, how we are ending the detention of children for immigration purposes in the UK. How we are ending the shameful practice that last year alone saw over 1000 children – 1000 innocent children imprisoned.' Available at: <http://www.dpm.cabinetoffice.gov.uk/news/child-detention-speech>.

<sup>146</sup> Home Office, February 2011. Control of Immigration: Quarterly Statistical Summary, Quarter 4 (October–December). Page 27. Available at: <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/immigration-asylum-research/control-immigration-q4-2010/control-immigration-q4-2010?view=Binary>. Accessed 13/02/12.

<sup>147</sup> See, for example, Medical Justice's written response to the government's *Review into ending the detention of children for immigration purposes*, December 2010. Available at: <http://www.ukba.homeoffice.gov.uk/policyandlaw/consultations/closed/>. Accessed 10/02/12. See also Home Affairs Select Committee, *The detention of children in the immigration system* (First Report of 2009-10, HC 73). Para 11: 'it must be remembered that Yarl's Wood remains essentially a prison. There is a limit to how family-friendly such a facility can be; and while we accept that conditions have improved, we still regret that such a facility is needed in the first place.'

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'While I fully acknowledge the Government's right to determine who is allowed to stay in this country, my contention remains that detention is harmful to children and therefore never likely to be in their best interests.'<sup>148</sup>

The charity Medical Justice has documented many cases of harm done to children detained between 2004 and April 2010<sup>149</sup>. These children spent a mean average of 26 days each in immigration detention. One child had spent 166 days in detention, over numerous separate periods, before her third birthday. 48% of the children in the report were born in the UK<sup>150</sup>.

In June 2010, the government announced it would end the detention of children for immigration purposes<sup>151</sup> and in December 2010 published its review on the subject, as it closed the family unit at Yarl's Wood IRC.<sup>152</sup> This was an important and significant step in reducing the number of children in detention and the length of time they spend there. Yet there are still circumstances in which children and families are held in immigration detention. The government's review set out a new family returns process where, 'as a last resort', families with children could be referred to new 'pre-departure accommodation' for up to 72 hours, or up to one week with ministerial approval.<sup>153</sup> The UK government considers this facility more family-friendly than an IRC.<sup>154</sup> In Scotland, children can be detained for up to 72 hours at Dungavel IRC which is not new 'pre-departure accommodation'. It has also set up an independent

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<sup>148</sup> Children's Commissioner for England, 2010. The Children's Commissioner for England's follow up report to: The arrest and detention of children subject to immigration control. Page 2.

<sup>149</sup> Medical Justice : "'State Sponsored Cruelty': Children in immigration detention" - 09/09/10. Available at <http://www.medicaljustice.org.uk/mj-reports,-submissions,-etc./reports/1420-medical-justice--qstate-sponsored-cruelty-children-in-immigration-detention-090910.html>

<sup>150</sup> Ibid. The report found that of the 141 cases featured :

- 74 children were psychologically harmed. Symptoms included bed wetting and loss of bowel control, heightened anxiety, and food refusal. 34 children exhibited signs of developmental regression, and six children expressed suicidal ideation either whilst in or after they were detained. Three girls attempted to end their own lives.
- 23 children would not eat food for a period of time. UKBA have admitted that some detainees were being offered food beyond its 'best before' date. Some children lost significant amounts of weight.
- 48 children were reported to have witnessed violence, mostly during attempts to remove them from the UK, and 13 were physically harmed as a result of violence in detention.

92 children had physical health problems which were exacerbated, or caused by immigration detention, including fever, vomiting, abdominal pains, diarrhoea, musculoskeletal pain, and coughing up blood. 50 of these children were reported to have received inadequate healthcare in detention including failures to recognise medical needs, failures to make appropriate referrals, and delays in treating. Some children were left in severe pain.

<sup>151</sup> Deputy PM's speech on children and families, June 2010. Available at: <http://www.dpm.cabinetoffice.gov.uk/news/deputy-pms-speech-children-and-families>.

<sup>152</sup> Home Office, December 2010. Review into Ending the Detention of Children for Immigration Purposes.

<sup>153</sup> Ibid. Page 21.

<sup>154</sup> Children can also be held with their families in Tinsley House on arrival in the UK. The Refugee Consortium has questioned why they cannot be held in the new family returns facility which ought to be more appropriate. ( Refugee Consortium, Briefing on Immigration Detention of Children, September 2011).

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family returns panel to advise the UKBA on methods of deportation which take into account the need to protect and promote child welfare.<sup>155</sup>

Meanwhile, the UK government has contracted the children's charity Barnardo's to work with children and families held at the pre-departure accommodation. Barnardo's recognises the criticisms surrounding the continued practice of placing children in immigration-related detention<sup>156</sup> and has stated that 'if policy and practice fall short of safeguarding the welfare, dignity and respect of families, then Barnardo's will raise concerns, will speak out and ultimately, if we have to, we will withdraw our services'.<sup>157</sup>

Children can also be detained when they arrive in the UK. In response to a freedom of information request by the Children's Society, the UK government reported that 697 children were held at Greater London and South East ports between May and the end of August 2011, one-third of whom were unaccompanied.<sup>158</sup> The Children's Commissioner for England found that contrary to government policy, unaccompanied children arriving at Dover were not being held for the 'shortest appropriate period of time'. Instead, they were 'detained whilst significant interviews took place that will inevitably bear on their prospects of being granted permission to stay in the UK'.<sup>159</sup> In the cases she considered, the Commissioner found that the local authority was informed several hours after the child's arrival and well into the interview process. She concluded that interviewing a child in depth, immediately after a long journey, was unnecessary and unlikely to be in their best interest.<sup>160</sup>

Some unaccompanied children are also detained with adults because their age is disputed either by the UKBA officials or by social services. This means that they are inappropriately detained without the increased safety provisions that a children's setting affords. This is incompatible with their rights under the UN Convention on the Rights of the Child (UNCRC). This may happen either because they have had insufficient opportunity to confirm their age before detention, or because they have

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<sup>155</sup> UKBA, March 2011. Family Returns Fact Sheets: Fact Sheet: Independent Family Returns Panel. Page 1. Available at: <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithus/296503/family-returns-fact-sheets..>

<sup>156</sup> See, for example, Gentleman, A., 18 October 2011. 'Child detention: has the government broken its promise to end it?' The Guardian. Available at: <http://www.guardian.co.uk/uk/2011/oct/17/child-detention-government-broken-promise>.

<sup>157</sup> Morris, N., 1 August 2011. *Barnardo's gives ultimatum to Coalition over asylum-seeker deal*, The Independent, 1 August 2011, quoting Anne Marie Carrie, Barnardo's Chief Executive. Available at: <http://www.independent.co.uk/news/uk/politics/barnardos-gives-ultimatum-to-coalition-over-asylumseeker-deal-2329701.html..>

<sup>158</sup> The Children's Society. Press release: *Almost 700 children detained in four months*. Available at: <http://www.childrensociety.org.uk/news-views/press-release/almost-700-children-detained-three-months>.

<sup>159</sup> Matthew A., January 2012. Landing in Dover: The immigration process undergone by unaccompanied children arriving in Kent. Children's Commissioner for England. Page 7.

<sup>160</sup> Ibid. Pp. 5 and 7.

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been wrongly assessed as adults.<sup>161</sup> Between October 2009 and March 2011, 24 children were held as adults and later released due to doubts about their age.<sup>162</sup>

**The EHRC recommends that the Committee asks the UK government:**

Please provide details of how many children have been detained for immigration-related purposes, including prior to deportation, and on arrival in the UK, since the closure of the family unit at Yarl's Wood, including at detention centres in Scotland, Wales and Northern Ireland. Please confirm for how long each child was detained and for what purpose.

## Destitution

### Failed asylum seekers

It has long been recognised that destitution may give rise to torture or other cruel, inhuman or degrading treatment or punishment, see *R(Limbuella) v SSHD* [2005]<sup>163</sup>. The House of Lords established that refusal to give financial support (including practice of refusing accommodation or food) to asylum seekers may lead to CIDT where the individuals involved would otherwise be destitute: “.. there was an imminent prospect that the way they were being treated by the Secretary of State, in the context of the entire regime to which they were being subjected by the state, would lead to a condition that was inhuman or degrading.”

If a person is refused asylum and has no further opportunities to appeal, they lose their right to accommodation and support 21 days later. The main exceptions to this are refused asylum seeking families with children who should continue to receive support under Section 95 of the Asylum and Immigration Act 1999, and refused asylum seekers who are destitute and qualify for support under Section 4 of the 1999 Act by showing that they are taking steps to leave the UK or are unable to do so through no fault of their own (e.g. they are too sick to travel, there is no viable return route to their country, they have a judicial review pending).

In 2010, it was estimated that around 70% of destitute asylum seekers in the UK came from just eight countries, all of which were either in conflict or had serious and widespread human rights violations (Zimbabwe, Iran, Iraq, Sudan, Afghanistan, Somalia, the Democratic Republic of Congo and Eritrea)<sup>164</sup>.

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<sup>161</sup> Immigration Law Practitioners Association (ILPA), 2010. Written response to Home Office Review into ending the detention of children for immigration purposes. Available at: <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/consultations/26-end-child-detention/>.

<sup>162</sup> 10 October 2011, HC Repts, Col 82W. Available at: [www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111010/text/111010w0003.htm#1110114002099](http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111010/text/111010w0003.htm#1110114002099). On 17 February 2012, the *Guardian* reported that over £1 million had been paid in compensation to 40 children who had been unlawfully detained as adults.

<sup>163</sup> *R(Limbuella) v SSHD* [2005] UKHL 66. See also *D v U.K.* [1997] 24 EHRR 423.

<sup>164</sup> Still Human Still Here, At the end of the line, 2010, page 38.

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The Still Human Still coalition of more than 50 organisations which are campaigning to end the destitution of refused asylum seekers in the UK claims that as a result of the policies outlined above, thousands of asylum seekers are living in destitution with either inadequate support or no support at all, and with no opportunity to work to support themselves<sup>165</sup>.

It also reports evidence of an increased incidence of mental and physical health problems amongst asylum seekers in recent years. The Royal College of Psychiatrists noted in 2007 that: "The psychological health of refugees and asylum seekers currently worsens on contact with the UK asylum system" and concluded that the full range of social and medical care services "should be available at all times throughout the asylum process, including (for) those whose claims have failed, whilst they remain legally in the UK."<sup>166</sup>

### **People who are unable to make an asylum claim**

It has been reported that during the spring and summer of 2011 it was particularly difficult for individuals to make an appointment at the Asylum Screening Unit or lodge their applications on a 'walk-in' basis (i.e. without an appointment); the telephone appointment system lacked the capacity to deal with the number of individuals who wished to lodge an asylum application. In addition, those who attended the Unit in person were often not seen and not given a date on which to return. Since the vast majority of these persons did not have permission to work in the UK and until their asylum applications were lodged, they were unable to access those forms of welfare support that are made available to persons seeking asylum many would-be asylum applicants were left destitute<sup>167</sup>.

#### **The EHRC recommends that the Committee asks the UK government:**

Are improvements needed to the asylum system to ensure that people who wish to make an asylum claim are able to do so within a reasonable time, particularly in cases where they have no accommodation or money to buy food, so as to ensure that those who need it are able to access asylum support? What further arrangements can be made to ensure that failed asylum seekers are not left destitute?

### **Use of force in immigration detention / removals**

An independent review commissioned by the UK government in 2010 to investigate alleged abuse of detainees by contractors of the UKBA found that:

'There should be a review of the training provided for the use of force, and of the annual retraining, to ensure that, in any case in which force is used, officers are

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<sup>165</sup> Ibid

<sup>166</sup> The Royal College of Psychiatrists (RCP), Improving services for refugees and asylum seekers: position statement, Summer 2007.

<sup>167</sup> ILPA letter to the Commission of the European Communities, 13 January 2011

trained to consider constantly the legality, necessity and proportionality of that use of force'.<sup>168</sup>

In October 2010, Jimmy Mubenga died while being deported to Angola. It was reported in the media that he died 'while being heavily restrained by security guards'<sup>169</sup> employed by G4 Security, a private firm, and that 'he complained of breathing difficulties before he collapsed'.<sup>170</sup> On 17 July 2012 the CPS announced that none of the security guards would be prosecuted. The most recent press release from the Prisons and Probation Ombudsman states that they are still exploring the events leading up to Jimmy Mubenga's death to establish if there are any lessons that can be learnt to avoid similar deaths, and that the report will be published after the forthcoming inquest.<sup>171</sup>

In response to Mubenga's death the National Offender Management Service (NOMS) conducted a review of how restraint was used by UKBA escorts and concluded that the techniques were not fundamentally dangerous. The review has not been made public.<sup>172</sup> In October 2010 Detention Services requested that the NOMS assess the feasibility of reviewing all restraint techniques and mechanical restraints used by the UK Border Agency. This is still ongoing.<sup>173</sup>

The charity Inquest published a briefing on Jimmy Mubenga's death, and called for a UK parliamentary committee inquiry into the use of restraint and force in deportation

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<sup>168</sup> N. O'Loan, 2010. *Report to the United Kingdom Border Agency on "Outsourcing Abuse."* Available at: [http://www.gla.ac.uk/media/media\\_147177\\_en.pdf](http://www.gla.ac.uk/media/media_147177_en.pdf).

<sup>169</sup> Investigations are also ongoing against G4S security guards involved in the violent restraint of Cameroonian Ludovic Paykong on a flight in March 2010, and of Colombian Jose Gutierrez, just days before Jimmy Mubenga's death. See *The Guardian*, 29 October 2010. *G4S security company loses bid to renew deportee contract*. Available at: <http://www.guardian.co.uk/uk/2010/oct/29/g4s-security-loses-deportee-contract>. Also, *The Guardian*, 21 October 2010. *G4S security guards accused over restraint of Colombian deportee*. Available at: <http://www.guardian.co.uk/uk/2010/oct/21/g4s-jose-gutierrez-deportee-alleged-mistreatment>.

<sup>170</sup> See *The Guardian*, 16 March 2011. *Jimmy Mubenga: security firm G4S may face charges over death*. Available at: <http://www.guardian.co.uk/uk/2011/mar/16/mubenga-g4s-face-charges-death>.

<sup>171</sup> Prisons and Probation Ombudsman, 2010. *Prison and Probation Ombudsman (PPO) Official Statement Death of Mr Mubenga on 12/10/2010*. Available at: <http://www.ppo.gov.uk/news-and-press-releases.htm>. See also *The Guardian* 27 October 2010. *Chaos over restraint rule for deportees*. reported that three days after Mubenga's death, the Home Office instructed 'all private security firms to halt using force while they checked that the techniques used to restrain deportees (which are the same as used in prisons), were safe'. According to the article, the Home Office lifted the ban soon after and issued new written instructions to all private security firms. *The Guardian* claims that the Home Office has refused to release the new guidance on the grounds that it is 'operational and sensitive', Available at: <http://www.guardian.co.uk/uk/2010/oct/27/deportation-restraint-rules-chaos>.

<sup>172</sup> UKBA respond to IAP request for information about restraint review. Available at: <http://iapdeathsincustody.independent.gov.uk/news/ukba-respond-to-iap-request-for-information-about-restraint-review/>. Accessed 01/02/2012. Inquest states that without that report it is not possible to scrutinise the current restraint process or to be satisfied that the current process is in fact any different to that employed at the time of Mr Mubenga's death without access to the full un-redacted document.

<sup>173</sup> Ministry of Justice comments provided to the EHRC's Human Rights Review.

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cases.<sup>174</sup> There was subsequently an inquiry into the treatment of people being deported, conducted by the House of Commons Home Affairs Select Committee. In its report published on 26 January 2012, the Committee found that potentially lethal head-down restraints may still be used, even though they are not authorised. The Committee recommends urgent guidance be given by the Home Office to all staff in enforced removals about the dangers of seated restraint techniques in which the subject is bent forward. It also recommends that the Home Office commission research into control and restraint techniques which are suitable for use on aircraft.<sup>175</sup>

Reports of abuses since the change of contractor continue.<sup>176</sup> Amnesty International has reported numerous allegations of abuse during enforced removals from the UK both before and after the change of contractor. They argue that there are widespread and fundamental problems.<sup>177</sup>

**The EHRC recommends that the Committee asks the UK government:**

Does the government intend to accept the recommendations of the Home Affairs Select Committee in relation to a review of the use of seated restraint techniques? What further steps are being taken to ensure that dangerous techniques are not used?

Will the government consider ending the use of private contractors to enforce removals?

How many detainees have sustained injuries in the last 3 years as a result of the use of force or restraint by UKBA's employees or private contractors both in immigration detention and during removal or attempted removal? Why in each case was the injury sustained? How many of those were taken to hospital and how were the injuries documented? What investigations take place following injury to ensure the any assault is prosecuted and that lessons are learnt?

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<sup>174</sup> Inquest produced briefing on death of Mr Jimmy Mubenga. Available at: <http://iapdeathsincustody.independent.gov.uk/news/inquest-produce-briefing-on-death-of-mr-jimmy-mubenga/>.

<sup>175</sup> House of Commons, 2012. Home Affairs Committee Rules governing enforced removals from the UK – Eighteenth Report of Session 2010-12. London: The Stationery Office. Available online <http://www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/inquiries/parliament-2010/rules-governing-enforced-removals-from-the-uk/>

<sup>176</sup> See also See the House of Commons Home Affairs Committee Eighteenth Report of Session 2010-2012 *Rules governing enforced removals from the UK* (17 January 2012) and House of Commons Home Affairs Committee, *The Work of the UK Border Agency*, 4th Report of Session 2010-11, 21 December 2010, for evidence of the Independent Police Complaints Committee about Reliance, the company that now holds the contract.

<sup>177</sup> Amnesty International: *Out of Control: The case for a complete overhaul of enforced removals by private contractors*; 7 July 2011 [http://www.amnesty.org.uk/uploads/documents/doc\\_21634.pdf](http://www.amnesty.org.uk/uploads/documents/doc_21634.pdf) See also 13 April 2012 *Deportation contractor Reliance faces litany of abuse claims against staff* The Guardian, available at <http://www.guardian.co.uk/uk/2012/apr/13/deportation-contractor-reliance-abuse-claims>.

## Section 4: Police and Prisons (England and Wales)

### Policing

#### Policing protests

In its Human Rights Review 2012, the Commission found that the police do not always use the minimum level of force when policing protests.

During large scale protests in London between 2009 and 2011, police used significant levels of force against protesters. One of the most controversial incidents occurred in April 2009, during the course of the G20 protests, when Ian Tomlinson, a 47-year-old bystander, collapsed and died after he was hit by a baton and pushed to the ground. The inquest jury decided in May 2011 that Mr Tomlinson's death was caused by 'excessive and unreasonable force' in striking him.<sup>178</sup>

The inquest returned a verdict of unlawful killing, and in May 2011, the Crown Prosecution Service decided the police officer should be charged with manslaughter. The trial is currently underway (June 2012); PC Simon Harwood is pleading not guilty.<sup>179</sup> Following the G20 protests the Independent Police Complaints Commission (IPCC) received 136 complaints alleging the use of excessive force by the police.<sup>180</sup>

Another incident occurred in December 2010 during protests in London against education cuts and higher tuition fees.<sup>181</sup> Jody McIntyre, a 20-year-old disabled wheelchair user and student activist, complained that the police assaulted him with a baton, tipped him out of his wheelchair and dragged him across the road. An internal Metropolitan Police Service investigation, supervised by the IPCC, concluded that Mr McIntyre had been inadvertently hit with a baton and then tipped out of his wheelchair and pulled across the road for his own safety. It said that the officers' actions were justifiable given their risk assessment, and the fact that violent disorder was taking place.<sup>182</sup>

In its March 2011 report on facilitating peaceful protest,<sup>183</sup> the JCHR welcomed police training on the use of force, but expressed concern that there was no specific

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<sup>178</sup> BBC, 3 May 2011. Ian Tomlinson unlawfully killed by PC at G20 protests. Available at: <http://www.telegraph.co.uk/news/uknews/1561096/Parliament-war-protester-jailed-over-600-fine.html>. Accessed 21/02/2012.

<sup>179</sup> See <http://www.iantomlinsonfamilycampaign.org.uk/> for more information.

<sup>180</sup> HMI Constabulary, 2009. *Adapting to protest – nurturing the British model of policing*. Page 110. Available at: <http://www.hmic.gov.uk/media/adapting-to-protest-nurturing-the-british-model-of-policing-20091125.pdf>.

<sup>181</sup> Joint Committee on Human Rights, 2011. *Facilitating Peaceful Protest. Tenth Report of Session 2010-11*. London: The Stationery Office.

<sup>182</sup> Metropolitan Police, 2011. *Investigation into police involvement with Jody McIntyre*. Available at: <http://content.met.police.uk/News/Investigation-into-police-involvement-with-Jody-McIntyre/1260268989354/1257246745756>.

<sup>183</sup> Joint Committee on Human Rights, 2011. *Facilitating Peaceful Protest. Tenth Report of Session 2010-11*. London: The Stationery Office.

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guidance on when a baton might be used to strike the head. The JCHR recommended specific guidance on the use of batons.

Against this background, the evidence in England indicates that there is a risk that police planning of operations, use of tactics, and officer training on the use of force are not always adequate to ensure the minimum level of force is used when required to maintain public order and protect people from harm, or prevent damage to property.<sup>184</sup>

**The EHRC recommends that the Committee asks the UK government:**

In the light of the incidents described that took place in 2009 and 2010 what further guidance and training has been given to police officers to ensure they comply with the law when policing protests?

**Meaning of ‘reasonable force’**

In its national review of policing protest in England and Wales, published in 2009, HMI Constabulary concluded that ‘there is no consistent doctrine articulating the core principles around the police use of force’.<sup>185</sup> Among other recommendations, HMI Constabulary proposed that the Home Office, Association of Chief Police Officers and the National Policing Improvement Agency adopt an overarching set of principles on the use of force which should inform every area of policing and are fully integrated into all policing codes of practice, policy documents, guidance manuals and training programmes. They entrench the fundamental legal concepts of necessity, proportionality and the minimum use of force, in particular:

- In carrying out their duties, police officers should as far as possible apply non-violent methods before resorting to any use of force.
- Police officers should use force only when strictly necessary and where other means remain ineffective or have no realistic chance of achieving the lawful objective.
- Any use of force by police officers should be the minimum appropriate in the circumstances.
- Police officers should use lethal or potentially lethal force only when absolutely necessary to protect life.
- Police officers should plan and control operations to minimize, to the greatest extent possible, recourse to lethal force.
- Individual officers are accountable and responsible for any use of force and must be able to justify their actions in law.<sup>186</sup>

However, this recommendation has still to be fully implemented.<sup>187</sup>

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<sup>184</sup> See, for example, HMI Constabulary, 2009. *Adapting to protest – nurturing the British model of policing*. Chapter 6. Available at: <http://www.hmic.gov.uk/media/adapting-to-protest-nurturing-the-british-model-of-policing-20091125.pdf>.

<sup>185</sup> HMI Constabulary, 2009. *Adapting to protest – nurturing the British model of policing*. Pp. 116-117. Available at: <http://www.hmic.gov.uk/media/adapting-to-protest-nurturing-the-british-model-of-policing-20091125.pdf>.

<sup>186</sup> Ibid.

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**The EHRC recommends that the Committee asks the UK government:**

What steps are being taken to comply with the recommendations of HMI Constabulary to adopt overarching standards for the use of force?

## **Police use of electroshock weapons (Tasers)**

The Committee has indicated on several occasions that it does not consider the use of Tasers to be compatible with the Convention. For instance, in this recommendation to the New Zealand government in 2009:

“The State party should consider relinquishing the use of electric taser weapons, the impact of which on the physical and mental state of targeted persons would appear to violate articles 2 and 16 of the Convention.”<sup>188</sup>

The committee has made similar recommendations to other state parties including France and Spain.

The Commission, in agreement with Amnesty International and other human rights organisations, considers that the use of Tasers can be lawful in some individual circumstances if strict conditions are met<sup>189</sup>. However, serious safety concerns have been documented, particularly where they have been used on children<sup>190</sup> and this reinforces the need for very strict controls on their use<sup>191</sup>.

The Association of Chief Police Officers has issued guidance<sup>192</sup> for England and Wales, which seeks to limit the use of Tasers to situations where there is a threat of violence and its use is “proportionate, lawful, appropriate, necessary and non-discriminate”. The decision to deploy the Taser is made by the individual officer, not, as for firearm use, by an officer further up the chain of command.

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<sup>187</sup> HMI Constabulary, 2011. *Policing Public Order: An overview and review of progress against the recommendations of Adapting to Protest and Nurturing the British Model of Policing*. Available at: <http://www.hmic.gov.uk/media/policing-public-order-20110208.pdf>. Accessed 21/02/2012.

<sup>188</sup> Para 9 of the concluding observations on New Zealand’s fifth periodic report (CAT/C/NZL/CO/5).

<sup>189</sup> The Deployment of Taser Weapons to UK Law Enforcement Officials: An Amnesty International Perspective. Oliver Sprague; *Policing*, a Journal of Policy and Practice, Oxford Journals, Volume 1 Issue 3, pp 309-315 <http://policing.oxfordjournals.org/content/1/3/309.extract>

<sup>190</sup> Tasers were used on children aged between 13 and 17 years 252 times by police forces in England between July 2007 and December 2009 (latest available statistics), Statistics obtained by CRAE via FOI requests.

<sup>191</sup> ‘Less than Lethal’ Amnesty International 2008. <http://www.amnesty.org/en/library/asset/AMR51/010/2008/en/530be6d6-437e-4c77-851b-9e581197ccf6/amr510102008en.pdf>

<sup>192</sup> Extended operational Deployment of Taser for Specially Trained Units Policy and Operational Use of Taser by Authorised Firearms Officers, 2008, both available from <http://www.acpo.police.uk/ProfessionalPractice/UniformedOperations.aspx>

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Concerns have been expressed that Tasers have been used in recent policing operations where their deployment may not have been justified. For instance, during the eviction of travellers from Dale Farm three people were tasered.<sup>193</sup>

**The EHRC recommends that the Committee asks the UK government:**

Are further safeguards needed to prevent the unnecessary use of Taser weapons? Why does the protocol for discharge of a potentially lethal weapon allow an individual officer to make the decision in the case of a Taser, where for firearm use an order from a commanding officer is required?

## Prison conditions

### Overcrowding

In twenty years the prison population in England and Wales has nearly doubled. This is largely due to increased sentence lengths, the introduction of mandatory penalties and an earlier recourse to custody for those who, in the past, would have been required to pay a fine or do community service. Now, 83 of 134 prisons in England and Wales are overcrowded. On 22 June 2012, the prison population was 85,697. In 1992-93, the average prison population was 44,628.<sup>194</sup>

Between 2001 and 2011, the prison population grew by 19,650 or 30%. A rise in the number of people sentenced to immediate custody accounts for 65% of the increase.<sup>195</sup>

Average sentence length has been increasing, it is now 2.9 months longer than in the same period in 2001. The average sentence length is 14.7 months. The proportion of the sentenced prison population serving indeterminate sentences (life sentences and Indeterminate Sentences for Public Protection) increased from 9% in 1995 to 19% in 2011.<sup>196</sup>

In 2010-11 an average of 20,211 prisoners were held in overcrowded accommodation, accounting for 24% of the total prison population. Within this total the number of prisoners doubling up in cells designed for one occupant was 19,268 (22.7% of the total prison population) and there were on average 829 prisoners held three to a cell in cells designed for two (1% of population).

The rate of overcrowding in male local establishments is still almost twice the national rate. Private prisons have held a higher percentage of their prisoners in overcrowded accommodation than public sector prisons every year for the past thirteen years. In 2010-11 the private prisons average was 31.8%, compared to an average of 22.8% in the public sector. Forest Bank, Doncaster and Altcourse have

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<sup>193</sup> [http://www.publicinterestlawyers.co.uk/news\\_details.php?id=179](http://www.publicinterestlawyers.co.uk/news_details.php?id=179)

<sup>194</sup> Prison Reform Trust. *Bromley Briefings Prison Factfile* June 2012. Available at [http://www.prisonreformtrust.org.uk/Portals/0/Documents/FactfileJune2012.pdf?dm\\_i=47L,UJV5,U407X,2IEO2,1](http://www.prisonreformtrust.org.uk/Portals/0/Documents/FactfileJune2012.pdf?dm_i=47L,UJV5,U407X,2IEO2,1)

<sup>195</sup> Ibid. The statistics are derived from Ministry of Justice Offender Management Caseload Statistics.

<sup>196</sup> Ibid.

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particularly high rates of overcrowding, with 48.9%, 61.7%, and 72.9% of prisoners held in overcrowded accommodation respectively.<sup>197</sup>

**The EHRC recommends that the Committee asks the UK government:**

What steps are being taken to reduce the size of the prison population and to reduce overcrowding? Why is overcrowding particularly acute in privately-run prisons?

**Women prisoners**

In 2007 a review of women with particular vulnerabilities in the criminal justice system, the Corston Report<sup>198</sup> made detailed recommendations about fundamental reform that was needed to improve the conditions for women in prison and in the criminal justice system as a whole. The many recommendations included that women's prisons should be replaced with smaller suitable and geographically dispersed multi-functional custody suites within 10 years, that in the meantime improvements to sanitation arrangements were urgently required and that strip-searching should be reduced to the absolute minimum necessary<sup>199</sup>.

Baroness Corston published a second report in 2011.<sup>200</sup> The end of automatic strip searches for women upon reception to prison is a significant step. The most important recommendation which had still not been implemented is that there remain 13 women's prisons in England (and none in Wales). Women are still more likely than men to be incarcerated for non-violent offences: 68% of women are in prison for non-violent offences, compared with 47% of men.<sup>201</sup>

The number of women in prison has increased by 85% over the past 15 years (1996-2011). On 22 June 2012, the women's prison population stood at 4,116. Of all the women who are sent to prison, 37% say they have attempted suicide at some time in their life. 51% have severe and enduring mental illness, 47% a major depressive disorder, 6% psychosis and 3% schizophrenia.<sup>202</sup>

The UK government has stated its intention to reduce the number of women in custody due to the impact that often has on the well being of children, and on the women themselves, and to increase the use of community sentences. It has

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<sup>197</sup> Ibid. page 17

<sup>198</sup> Available from <http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf/>

<sup>199</sup> Ibid. page 5.

<sup>200</sup> Women in the penal system. Second report on women with particular vulnerabilities in the criminal justice system. All Party Parliamentary Group on Women in the Penal System. Available at [http://d19ylpo4aovc7m.cloudfront.net/fileadmin/howard\\_league/user/pdf/Publications/Women\\_in\\_the\\_penal\\_system.pdf](http://d19ylpo4aovc7m.cloudfront.net/fileadmin/howard_league/user/pdf/Publications/Women_in_the_penal_system.pdf)

<sup>201</sup> Ibid

<sup>202</sup> Prison Reform Trust. *Bromley Briefings Prison Factfile* June 2012. Available at [http://www.prisonreformtrust.org.uk/Portals/0/Documents/FactfileJune2012.pdf?dm\\_i=47L,UJV5,U407X,2IEO2,1](http://www.prisonreformtrust.org.uk/Portals/0/Documents/FactfileJune2012.pdf?dm_i=47L,UJV5,U407X,2IEO2,1)

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embarked on a process of closing women's prisons<sup>203</sup>. However, there is evidence that prison closures lead to women being incarcerated further from their home and family ties and calls are now being made for further urgent reform<sup>204</sup>.

In February 2012 the Chief Inspector of Prisons, Nick Hardwick gave a lecture highlighting the very shocking and distressing conditions found by the Inspectorate at Styal Prison in 2011.<sup>205</sup> He said, " I have seen a lot of pretty grim things in my working life but what I saw at the Keller Unit kept me awake at night. The levels of self mutilation and despair were just terrible. Men who are as repeatedly violent to others in prison as these women are to themselves are treated as a national responsibility and managed with resources and attention from the centre. These women, whose disturbance is turned inwards, are left to a local prison to manage as best they can."

In 2010, there were a total of 26,983 incidents of self-harm in prisons, with 6,639 prisoners recorded as having injured themselves. Women accounted for 47% of all incidents of self harm despite representing just 5% of the total prison population.<sup>206</sup>

**The EHRC recommends that the Committee asks the UK government:**

How has the government responded to the HMI Prisons inspection of Styal Prison? What further steps are being taken to implement the recommendations of the Causton report? What steps are being taken to improve mental health services for women in prison and to divert women with mental health problems away from custody into therapeutic care?

**Older prisoners**

People aged 60 and over are now the fastest growing age group in the prison estate. The number of sentenced prisoners aged 60 and over rose by 103% between 2002 and 2011. On 31 March 2011 there were 42 people in prison aged 81 and over. The oldest prisoner in June 2011 was 92 years of age<sup>207</sup>.

The increase in the elderly prison population is not explained by demographic changes, nor can it be explained by a so-called 'elderly crime wave'. The increases are due to harsher sentencing policies which have resulted in the courts sending a larger proportion of criminals aged over 60 to prison to serve longer sentences<sup>208</sup>.

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<sup>203</sup> Ministry of Justice (2009) *A Report on the Government's Strategy for Diverting Women Away from Crime*

<sup>204</sup> <http://www.guardian.co.uk/society/2012/feb/11/women-prisons-urgent-reform-needed>

<sup>205</sup> *Women In Prison: Corston Five Years On*, Nick Hardwick, HM Chief Inspector of Prisons, 29 February 2012 Available at [http://www.womeninprison.org.uk/news\\_show.php?id=70](http://www.womeninprison.org.uk/news_show.php?id=70)

<sup>206</sup> Ministry of Justice (2011) *Safety in Custody 2010 England and Wales*,

<sup>207</sup> Prison Reform Trust. *Bromley Briefings Prison Factfile* June 2012. Available at [http://www.prisonreformtrust.org.uk/Portals/0/Documents/FactfileJune2012.pdf?dm\\_i=47L,UJV5,U407X,2IEO2,1](http://www.prisonreformtrust.org.uk/Portals/0/Documents/FactfileJune2012.pdf?dm_i=47L,UJV5,U407X,2IEO2,1)

<sup>208</sup> HM Inspectorate of Prisons (2004) 'No problems – old and quiet': Older prisoners in England and Wales, a thematic review by HM Chief Inspector of Prisons

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A report by the Prisons Inspectorate has indicated “little evidence of multidisciplinary working” and found it “disappointing that the social care needs of older and disabled prisoners were still considered the responsibility of health services only.”<sup>209</sup> Prison Reform Trust research has found that services for older people in prison did not meet those that would be available for the elderly in the community<sup>210</sup>. The report expresses concern that some older people entering prison had the medication they were receiving in the community stopped.

More than half of all elderly prisoners suffer from a mental disorder. The most common disorder is depression which often emerges as a result of imprisonment.

Four years after a thematic review of older prisons, HM Chief Inspector of Prisons stated that “eight of [their] key recommendations have not been implemented.” This is while “the issues older prisoners pose are likely to become more acute, as an increasing number of long-sentenced prisoners grow old and frail in prison.”

These issues are important because a prison system designed primarily for fit young men has already proved ill-suited to meeting the needs of women, disabled prisoners and others with vulnerabilities. Age-related illnesses such as dementia are not well catered for in the prison system, and ill-treatment is likely to result.

**The EHRC recommends that the Committee asks the UK government:**

How does the government intend to deal with the aging prison population? Why are social services not usually involved in assessing and providing for the care needs of prisoners? What steps are being taken to ensure that older prisoners are treated with dignity and that their age-related needs are met?

**Prisoners with mental health conditions**

Research by the Prisons and Probation Ombudsman (PPO) indicates that people with mental health conditions are more likely to self-harm and commit suicide,<sup>211</sup> as are people undergoing drug and/or alcohol withdrawal.<sup>212</sup> It also shows that individuals with a history of self-harm are more likely to commit suicide. The PPO review of fatal incidents reports since 2004 noted that in over half (38 of 65) of all self-inflicted deaths, the person had a history of self-harm, with the majority having self-harmed in the previous 12 months.<sup>213</sup>

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<sup>209</sup> Ibid.

<sup>210</sup> Prison Reform Trust (2008) *Doing Time: the experiences and needs of older people in prison*

<sup>211</sup> Prisons and Probation Ombudsman for England and Wales, 2011. *Learning from PPO Investigations: Self-inflicted deaths in prison custody, 2007-2009*. Pp. 11-12. Available at: <http://www.ppo.gov.uk/docs/self-inflicted-deaths-in-prison.pdf>. Accessed 01/02/2012.

<sup>212</sup> Her Majesty's Prison Service, 2007. *Prison Service Order 2700: Suicide Prevention and Self-Harm Management*. Para 6.3.1. Available at: [http://pso.hmprisonservice.gov.uk/pso2700/pso%202700\\_-\\_front\\_index\\_and\\_pso\\_itself.htm](http://pso.hmprisonservice.gov.uk/pso2700/pso%202700_-_front_index_and_pso_itself.htm). Accessed 01/02/2012.

<sup>213</sup> D. Ryan-Mills, 2010. *Review: fatal incidents report: from September 2008 to August 2009*. London: Prison and Probation Ombudsman. Available at: <http://www.ppo.gov.uk/docs/PPO-FII-Report-March-2010.pdf>. Accessed 01/02/2012. Prisoners harm themselves for a variety of reasons, not always with suicidal intent. It can be a way of managing distress and anxiety (PSO 2700).

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The UK government has recognised that prison is not always the most appropriate place for offenders with mental health conditions.<sup>214</sup> However, currently an estimated 90% of the prison population suffers from a mental health condition.<sup>215</sup> 10% of men and 30% of women have had a previous psychiatric admission before entered prison. Prisoners with severe mental health problems are often not diverted to more appropriate secure provision. The Chief Inspector of Prisons has estimated, based on visits to local prisons, that 41% of prisoners being held in health care centres should have been in secure NHS accommodation. In 2010, there were a total of 26,983 incidents of self-harm in prisons, with 6,639 prisoners recorded as having injured themselves.<sup>216</sup>

Neurotic and personality disorders are particularly prevalent - 40% of male and 63% of female sentenced prisoners have a neurotic disorder, over three times the level in the general population. 62% of male and 57% of female sentenced prisoners have a personality disorder.<sup>217</sup>

Imprisonment brings its own pressures, increasing feelings of isolation, and prompting worries about maintaining relationships, homes and jobs.<sup>218</sup>

Many women contend with particularly difficult issues when they enter prison. They may have lost children to the care system; 66% of women offenders have dependent children under the age of 18. Imprisonment, usually far from the family home, will have a detrimental impact on family ties. Over half of female prisoners say they have suffered domestic violence, one in three has experienced sexual abuse, and one quarter have spent time in local authority care.<sup>219</sup> The following example, taken from the 2010-11 HMI Prisons report, illustrates some of these challenges:

'Bronzefield Women's Prison, for instance, has to cope with distressingly high levels of self-harm. Because of their mental distress, some women repeatedly self-harmed – one woman had harmed herself more than 90 times in one month. This degree of self-harm led to a high level of the use of force as officers intervened to remove ligatures. The prison did its best to manage these women and keep them safe, but prison was clearly not a suitable environment for many with acute and complex mental health needs'.<sup>220</sup>

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<sup>214</sup> Ministry of Justice, 2010. *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing for Offenders*. London: The Stationery Office. Page 36. Also see, HM Government, 2009. *Healthy Children, Safer Communities*.

<sup>215</sup> These include personality disorders and/or substance misuse.

<sup>216</sup> Prison Reform Trust *Bromley Briefing Prison Factfile* June 2012.

<sup>217</sup> *Ibid.*

<sup>218</sup> For isolation, see HM Government, 2011. *Consultation on preventing suicide in England, A cross government outcomes strategy to save lives*. Page 20. Available at: [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_128463.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128463.pdf).

<sup>219</sup> Prison Reform Trust, 2010. *Bromley Briefings Prison Factfile*. Page 3. Available at: <http://www.prisonreformtrust.org.uk/Portals/0/Documents/FactfileDec10small.pdf>.

<sup>220</sup> HMI Prisons, 2011. *HM Chief Inspector of Prisons for England and Wales Annual Report 2010-11*. London: The Stationery Office. Page 9.

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Prisons have taken steps to cope with the high level of need, both in terms of mental health and drug and alcohol misuse. Between 2004 and 2007 there was a 20% increase in the size of mental health in-reach teams across the prison system, but they have since become over-stretched.<sup>221</sup> In his review of the treatment of people with mental health conditions or learning disabilities in the criminal justice system, Lord Bradley found that 85% of in-reach team leaders said they were not sufficiently staffed to meet the needs of prisoners who were referred to them.<sup>222</sup>

HM Chief Inspector of Prisons has highlighted both good and poor practice in suicide prevention and self-harm management in prisons. Samaritan-supported 'listeners' (prisoners who have been trained by the Samaritans) were found to have an important role in working with offenders who may need confidential support. However, the inspectorate still found that 'the care of prisoners with mental health problems remains one of the most troubling aspects of the prison system'. It stated:

'The high levels of mental health need are obvious as you walk around most prisons. I sometimes found prisoners with learning difficulties or moderate mental health needs – "poor copers" in prison jargon – seeking refuge from the pressures on the wings in segregation units or health care.'<sup>223</sup>

HM Chief Inspector of Prisons concluded that prisons in England and Wales still hold too many prisoners with acute mental health needs, for whom this is a completely unsuitable environment. The report welcomed the UK government's commitment to divert more of those with mental health problems away from the criminal justice system altogether.<sup>224</sup>

The UK government is proposing to roll out liaison and diversion services for mentally ill offenders nationally by 2014. It also intends to increase the treatment capacity for high risk, sexual or violent offenders whose offending is linked to severe forms of personality disorder, as these offenders 'pose challenging behavioural or control problems in prison, and high risk of reoffending if in the community'.<sup>225</sup>

### **The EHRC recommends that the Committee asks the UK government:**

What steps have been taken to implement the recommendations of the 2009 Bradley Report? What further measures can be taken to reduce the numbers of people with mental health problems in the prison system? In the meantime how will levels of support to mentally ill offenders be increased?

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<sup>221</sup> The Offender Health Research Network, 2009. *A National Evaluation of Prison Mental Health In-Reach Services*. Available at <http://www.ohrn.nhs.uk/resource/research/Inreach.pdf>.

<sup>222</sup> Department of Health, 2009. *The Bradley Report – Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. Page 104. Available at: [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_098698.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf). Accessed 01/02/2012.

<sup>223</sup> HMI Prisons, 2011. *HM Chief Inspector of Prisons for England and Wales Annual Report 2010-11*. London: The Stationery Office. Page 8.

<sup>224</sup> HMI Prisons, 2011. *HM Chief Inspector of Prisons for England and Wales Annual Report 2010-11*. London: The Stationery Office. Page 8.

<sup>225</sup> Ministry of Justice, 2010. *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing for Offenders*. London: The Stationery Office. Page 36.

## Accessibility and services for disabled prisoners

There is a large variation in the current estimates of the prevalence of disability amongst prisoners, from 5% on the prison database to 34% of surveyed prisoners self-reporting disability.<sup>226</sup> However, people with mental health problems and learning disabilities often do not self-report as disabled. If those people were included it is likely that the figure would be nearer 80%: 20 – 30% of offenders have learning disabilities or difficulties that interfere with their ability to cope with the criminal justice system<sup>227</sup> and 40% of male and 63% of female sentenced prisoners have a neurotic disorder, over three times the level in the general population. 62% of male and 57% of female sentenced prisoners have a personality disorder.<sup>228</sup>

HM Inspectorate of Prisons published a thematic report on the care and support of prisoners with a disability in March 2009, which identified a number of areas of serious concern<sup>229</sup>. These include the following:

- The serious under-recording of the number of prisoners with disabilities in the prison system;
- Insufficient screening on arrival to allow or encourage prisoners to declare disabilities;
- Prisoners with disabilities feeling significantly more unsafe in prison than other prisoners;
- Limited or non-existent monitoring of prisoners with disabilities, including a failure to monitor their access to activities, their complaints, and potential bullying of these prisoners;
- Many disability liaison officers (DLOs) feeling that they lacked training, funding or support, and had insufficient time to fulfil their role;
- Prisoners with disabilities having less access to activities, including association and time outside the cell;
- Prisoners with disabilities being less likely to have a sentence plan, or to be involved in its development.

It is clear from the many cases that have been referred to the EHRC's helpline<sup>230</sup> that disabled prisoners are not having their needs met. Our analysis shows that the most helpful improvement would be a much better system of screening on reception for learning disabilities, mental health needs, other medical needs and physical

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<sup>226</sup> Ministry of Justice (2012) Estimating the prevalence of disability amongst prisoners: results from the Surveying Prisoner Crime Reduction (SPCR) survey

<sup>227</sup> Loucks, N. (2007) No One Knows: Offenders with Learning Difficulties and Learning Disabilities. Review of prevalence and associated needs, London: Prison Reform Trust

<sup>228</sup> Stewart, D. (2008) The problems and needs of newly sentenced prisoners: results from a national survey, London: Ministry of Justice

<sup>229</sup> Thematic review by HM Inspectorate of Prisons on the care and support of prisoners with a disability – March 2009 (“the Anne Owers report”). For more recent examples see also Disability Now, February 2012, *Double time: stories from behind bars*. The report claims that it has uncovered evidence which suggests that the treatment which some disabled prisoners receive inside is tantamount to neglect, discrimination and in some cases, abuse.

<sup>230</sup> Since the opening of the Commission, the helpline has logged 400 calls relating to all discrimination within Prisons (01.10.07 to 22.09.11). Just under a third (30.55%) of those calls are related specifically to disability.

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disabilities, including a full assessment of what services might be needed to meet those needs and what reasonable adjustments to the prison regime might be appropriate. Training of prison officers to carry out this kind of screening is urgently needed.

**The EHRC recommends that the Committee asks the UK government:**

What steps are being taken to ensure that prisons adhere to the standards outlined in the relevant prison service order and instruction in relation to the identification and treatment of disabled prisoners? What evaluation and monitoring or oversight is there of the training given to prison officers to ensure that they understand their duties to disabled prisoners and its effectiveness? What evaluation and/or monitoring is there of the systems which are in place to ensure that prisons meet the relevant standards in relation to identification and meeting of needs? How are needs communicated from one part of the system to another - for instance from sentencing reports to prison, from remand to incarceration, on prison transfer, and from prison to probation?

## **Transgender prisoners**

In March 2011 the Ministry of Justice published new guidelines on the treatment of transgender and transsexual prisoners.<sup>231</sup> The guidelines now provide a comprehensive system for the treatment of trans prisoners which should prevent ill-treatment. Nevertheless, the Commission has received complaints including a case of a male to female prisoner held at male prison permitted only strip-wash facilities, with no access to shower or bath<sup>232</sup>.

**The EHRC recommends that the Committee asks the UK government:**

How many complaints have been received from transgender prisoners since March 2011 about access to facilities appropriate for their acquired gender? What training has been given to prison officers to enable them to implement PSI 07/2011 effectively? What monitoring mechanism is in place to ensure that the relevant PSI and its standards are being put into practice?

## **Restraint**

### **Restraint techniques**

The Commission's Human Rights Review found that dangerous restraint techniques, or techniques used without sufficient training, continue to put police, prison, mentally ill, and immigration detainees' lives at risk.

'Prone restraint', which involves holding an individual face down on the floor, is one example of a potentially dangerous restraint technique. In 1998 David Bennett died in a mental health facility after he was restrained in this way for a prolonged period.

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<sup>231</sup> PSI 07/2011 The Care and Management of Transsexual Prisoners.

<sup>232</sup> EHRC Focus group, consultation on CAT list of issues, February 2012.

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The report into his death recommended that detainees should not be subjected to prone restraint for more than three minutes.<sup>233</sup> The UK government responded that patients should only be held in the prone position as a last resort, and only for as long as necessary.<sup>234</sup>

An inquest into the death of Roger Sylvester in 2003 after he was restrained by eight police officers using this technique also said that a time limit should be set.<sup>235</sup> In 2005 the JCHR added their concern:

'restraint in the prone position was particularly controversial because of the dangers it carried, and its implications in a number of deaths in custody ... there is a case for guidance prescribing time-limits for prone restraint, departure from which would have to be justified by individual circumstances'.<sup>236</sup>

Subsequently Godfrey Moyo died at London's Belmarsh prison in 2005 after he was restrained for approximately 30 minutes in the prone position. The inquest found that the use of restraint was a contributing factor in his death.<sup>237</sup> Nevertheless, so far the UK government has not introduced any guidance on how long detainees should be held in the prone position.

The nose distraction technique, in which the detainee is given a sharp upward jab under the nose, also continues to be used. It was prohibited in secure training centres after 14-year-old Adam Rickwood hanged himself in 2004 after being subjected to this technique, and the jury identified it as a factor which contributed to his death.<sup>238</sup> There is evidence that it continued to be used in young offender institutions for prisoners under 18 until January 2011.<sup>239</sup> The nose control technique, which is very similar to the nose distraction technique, was also banned in under-18 young offender institutions in January 2011. It continues to be used in adult prisons and in young offender institutions holding 18-20-year-olds.

The risk of death may be higher when restraint techniques are used by individuals who are not properly trained or used on disabled people with certain impairments,

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<sup>233</sup> Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003. *Independent Inquiry into the death of David Bennett*. Page 52.

<sup>234</sup> Department of Health, 2005. *Delivering Race Equality in Mental Health Care*. Page 26.

<sup>235</sup> Rule 43 Roger Sylvester. Available at: <http://4wardeveruk.org/wp-content/uploads/2010/05/Roger-Sylvester-Rule-43-Recommendations.pdf>.

<sup>236</sup> House of Lords, 2004. Joint Committee on Human Rights. *Deaths in Custody Third Report of session 2004-05*. London: The Stationery Office.

<sup>237</sup> Garden Court Chambers, 2009. *Positional Asphyxia and Restraint Death at HMP Belmarsh – Jury Find Healthcare Guilty of Neglect*. Available at: [http://www.gardencourtchambers.co.uk/news/news\\_detail.cfm?iNewsID=504](http://www.gardencourtchambers.co.uk/news/news_detail.cfm?iNewsID=504).

<sup>238</sup> In the second inquest into his death the jury found that '[amongst other factors] the use of the Nose Distraction Technique more than minimally contributed to Adam taking his own life'.

<sup>239</sup> Youth Justice Board communication with the Equality and Human Rights Commission, received on 17 October 2011. Department for Children, Schools and Families, 2008. *The Government's Response to the Report by Peter Smallridge and Andrew Williamson of a Review of the Use of Restraint in Juvenile Secure Settings*. Available at: <http://www.justice.gov.uk/publications/docs/govt-response-restraint-review.pdf>.

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e.g. spinal injury, or heart condition. This has been highlighted as a concern in a number of reports. A review commissioned by the government in 2008 into the use of restraint in juvenile secure settings recommended that, 'All staff in the secure estate should have consistent and comprehensive training in the awareness of risk factors in restraint.'

**The EHRC recommends that the Committee asks the UK government:**

What steps are being taken to prevent the use of prone and seated restraint techniques either at all, or for prolonged periods? What further measures are needed to ensure there are no further preventable serious injuries or deaths resulting from restraint?

**Recording and reporting on deaths in custody due to the use of restraint**

It is clear from the available evidence that the unsafe use of restraint remains a problem across all forms of detention in England and Wales.<sup>240</sup> The Independent Advisory Panel has noted that there is 'an inconsistent approach to recording and reporting on the use of force across the custodial sectors'.<sup>241</sup>

There is no record kept of deaths in which restraint may have been a contributory factor, as opposed to the primary cause. This means that it is impossible to assess how far the UK government is meeting its obligation not to deprive an individual in its care of his or her life.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report collects information on sudden unexplained deaths of mental health inpatients. Between 1999 and 2007 there were 371 such deaths in England and Wales, 15 of which directly followed restraint. However it is not known whether restraint caused those deaths.<sup>242</sup> The JCHR has argued that without a national database of figures for how many such deaths were connected to the use of restraint, some deaths recorded as being from natural causes may in fact be attributable to restraint.<sup>243</sup>

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<sup>240</sup> House of Lords, 2004. Joint Committee on Human Rights. *Deaths in Custody* Third Report of session 2004-05. London: The Stationery Office. Para 227; P. Smallridge and A. Williamson, 2008. Independent Review of restraint in juvenile settings. Available at: [http://www.justice.gov.uk/publications/docs/restraint\\_review.pdf](http://www.justice.gov.uk/publications/docs/restraint_review.pdf). Accessed 01/02/2012. See also, C. Berriew, 2006. *An independent inquiry into the use of physical restraint, solitary confinement and forcible strip searching of children in prisons, secure training centres and local authority secure children's homes*. London: Howard League for Penal Reform. Available at: [http://www.howardleague.org/fileadmin/howard\\_league/user/pdf/Publications/Carlile\\_Report\\_pdf.pdf](http://www.howardleague.org/fileadmin/howard_league/user/pdf/Publications/Carlile_Report_pdf.pdf).

<sup>241</sup> Independent Advisory Panel on Deaths in Custody, 2011. Statistical Analysis of all recorded deaths of individuals detained in state custody between 1 January 2000 and 31 December 2010. Available at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/10/IAP-Statistical-Analysis-of-All-Recorded-Deaths-in-State-Custody-Between-2000-and-2010.pdf>.

<sup>242</sup> See: [http://www.medicine.manchester.ac.uk/mentalhealth/research/suicide/prevention/nci/inquiryannualreports/Annual\\_Report\\_July\\_2011.pdf](http://www.medicine.manchester.ac.uk/mentalhealth/research/suicide/prevention/nci/inquiryannualreports/Annual_Report_July_2011.pdf).

<sup>243</sup> House of Lords, 2004. Joint Committee on Human Rights. *Deaths in Custody* Third Report of session 2004-05. London: The Stationery Office. Para 224.

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Specifically in relation to psychiatric deaths in detention, the charity Inquest states that: 'the existing internal systems for examining and reporting these deaths are so poor that we believe some contentious deaths could escape any public scrutiny'.<sup>244</sup>

**The EHRC recommends that the Committee asks the UK government:**

What steps will be taken to improve the recording and reporting on deaths in all forms of detention following restraint?

## **Investigations of deaths in custody and deaths by lethal force (Article 12)**

### ***Inquests***

Inquests in England and Wales are not as effective as they could be. There are often long delays particularly in complex cases.<sup>245</sup> The Coroners and Justice Act 2009 introduced a number of changes to the inquest system to make it more consistent and effective. The Act established the office of chief coroner, with powers to drive up standards at inquests and tackle delays. The proposed right of appeal to the chief coroner, which organisations on behalf of bereaved families considered would reduce the need for expensive litigation, has been removed.<sup>246</sup>

### ***The Independent Police Complaints Commission (IPCC)***

The IPCC oversees the police complaints system in England and Wales. In 2010 the House of Commons Home Affairs Select Committee heard evidence from a range of witnesses to assess the general progress of the IPCC since its inception, and to consider lack of trust and confidence in and the independence of the IPCC.<sup>247</sup> Some witnesses questioned the IPCC's independence, given that some former police officers are among its investigative staff. Others also felt that the IPCC sided with the police.<sup>248</sup> As the Home Affairs Select Committee commented,

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<sup>244</sup> Inquest, 2004. Submission to the Joint Committee on Human Rights – Inquiry into deaths in custody, Page 12. Available at: <http://inquest.gn.apc.org/pdf/INQUESTs%20Submission%20to%20the%20Joint%20Committee%20on%20Human%20Rights.pdf> .

<sup>245</sup> Independent Advisory Panel on deaths in custody. *Independent Advisory Panel on Deaths in Custody report on delays to inquests into deaths in custody*. Available at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/11/Delays-in-DiC-Inquests-IAP-Cross-Sector-Learning.pdf>.

<sup>246</sup> Royal British Legion , Inquest briefing on the Public Bodies bill. Available at: [http://inquest.org.uk/pdf/briefings/INQUEST\\_RBL\\_joint\\_briefing\\_Lords\\_on\\_Commons\\_amendments\\_Public\\_Bodies\\_Bill\\_Nov11.pdf](http://inquest.org.uk/pdf/briefings/INQUEST_RBL_joint_briefing_Lords_on_Commons_amendments_Public_Bodies_Bill_Nov11.pdf).

<sup>247</sup> House of Commons, 2010. *The Home Affairs Committee – The work of the Independent Police Complaints Commission Eleventh Report*. London: The Stationery Office. Available at: <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhaff/366/366.pdf>.

<sup>248</sup> See for example Case: *R.(on the application of Saunders) v. Independent Police Complaints Commission* [2008] EWHC 2372 (Admin); [2009] P.T.S.R. 1192 (QBD (Admin) where the applicants sought a judicial review of the failure of the IPCC to give directions to the police to prevent officers from collaborating or conferring when making their statements.

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'The IPCC thus often presents an impression to the public of being an arm's length police investigation unit rather than a public complaints/ombudsman service.'<sup>249</sup>

The committee concluded that:

'Whether or not the IPCC is failing in its duty of objectivity and impartiality, it is clearly failing to convey such qualities to many of its users.'<sup>250</sup>

It recommended that steps were taken to improve trust and confidence in the IPCC, to place the complainants at the heart of the process.<sup>251</sup> In response to these concerns the UK government has acknowledged the work the IPCC has done to put complainants' needs first and to make the complaints system more accessible. The IPCC has stated that there are processes in place to ensure that former police officers are not involved in investigations involving their former colleagues.<sup>252</sup>

In 2011, the IPCC was criticised for its investigation into the death of Mark Duggan. At the opening of the inquest, counsel on behalf of the family of Mark Duggan stated that the family had 'a complete breakdown in confidence for this investigation'.<sup>253</sup> He pointed out errors the IPCC had made in providing misinformation about the shooting shortly after Mark Duggan's death, including incorrect suggestions that he had been involved in a shoot-out with the police. At the inquest opening the IPCC accepted that it had made a mistake and provided inaccurate information. The inquest into Mark Duggan's death is listed for January 2013 but it was reported in June 2012 that the Coroner has warned that it may not take place even then as the IPCC are refusing or unable to disclose documents relating to its investigation which has not yet concluded<sup>254</sup>.

### ***The Prison and Probation Ombudsman (PPO)***

The PPO investigates complaints from prisoners and those on probation in England and Wales and those held in immigration removal centres in the UK. The PPO lacks formal statutory independence. Unlike the IPCC, the PPO's remit is not laid out in any statute; rather it is an arm's length body sponsored by the Ministry of Justice. This led the JCHR in 2004 to state that

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<sup>249</sup> House of Commons, 2010. *The Home Affairs Committee – The work of the Independent Police Complaints Commission Eleventh Report*. London: The Stationery Office. Available at: <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhaff/366/366.pdf>.

<sup>250</sup> Ibid.

<sup>251</sup> Ibid.

<sup>252</sup> The Government Reply To The Eleventh Report From The Home Affairs Committee Session 2009-10 HC 366: The Work of the Independent Police Complaints Commission Cm 8056. Available at: <http://www.official-documents.gov.uk/document/cm80/8056/8056.pdf>.

<sup>253</sup> BBC, 12 December 2011. *Duggan family's 'breakdown in confidence' in IPCC*. Available at: <http://www.bbc.co.uk/news/uk-england-london-16141820>.

<sup>254</sup> <http://www.guardian.co.uk/uk/2012/jun/28/mark-duggan-coroner-police-watchdog?newsfeed=true>

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'...until such a statutory basis is provided, investigations by the Ombudsman are unlikely to meet the obligation to investigate under Article 2 ECHR'.<sup>255</sup>

In April 2011 the government reiterated its commitment to the independence of the PPO, and said it was continuing to review whether this should be placed on a statutory basis.<sup>256</sup>

Clinical reviews form a key part of the investigations undertaken by the PPO. In some circumstances these reviews are commissioned by the same primary care trust that provided healthcare to the custodial setting. In these cases the level of independence has been questioned.<sup>257</sup>

**The EHRC recommends that the Committee asks the UK government:**

What improvements have been made to inquest system since the appointment of the Chief Coroner? Please provide figures for the delay in inquests being held from 2009 to date.

Given the lack of public confidence in the IPCC, are there any plans to reform it?

Will the government consider putting the independence of PPO on a statutory footing?

**Prosecutions following deaths in custody**

There are very few prosecutions and convictions following deaths in custody in England and Wales. An investigation must be capable of identifying and punishing those responsible for deaths which occur in custody, where appropriate.<sup>258</sup> There is evidence to show that this is not the case under the current system.

Although deaths in police custody are rare, they do happen. Between 1998/99 and 2008/09 there were 333 deaths in or following police custody. Of these, the IPCC recommended misconduct or disciplinary proceedings against 78 police officers. Prosecutions were recommended in 13 cases.

Even where misconduct has been identified as a possible contributory factor to a death in custody, police officers are very rarely tried and found guilty. In the 13 cases which were prosecuted between 1998/99 and 2008/09, none resulted in a guilty

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<sup>255</sup> House of Lords, 2004. Joint Committee on Human Rights. Deaths in Custody Third Report of session 2004-05. London: The Stationery Office. Para 332.

<sup>256</sup> See letter from the secretary of state for justice to the IAP, 7 April 2011. Available at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/05/Forum-for-Preventing-Deaths-in-Custody-Report-on-Article-2-Compliant-Investigations.pdf>.

<sup>257</sup> Report of the IAP's workstream considering investigations of deaths in custody – compliance with Article 2 ECHR MBDC 36.

<sup>258</sup> *Öğur v. Turkey* [1999] ECHR 21594/93.

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verdict.<sup>259</sup> In the last 42 years there has only been one police officer convicted for the death of a person in custody, and that was in 1969.<sup>260</sup>

Since 1990 eight inquests into cases of death in custody have returned verdicts of unlawful killing. Despite this, none of the police officers involved have been successfully prosecuted.<sup>261</sup>

In relation to its own research, the IPCC commented:

‘The acquittal rate of police officers and staff members is ... very high despite, in some cases, there appearing to be relatively strong evidence of misconduct or neglect.’<sup>262</sup>

The EHRC has argued that the criminal law provisions of England and Wales fail to meet Article 2 ECHR obligations.<sup>263</sup> This is firstly because the CPS imposes an inappropriately high evidential threshold when deciding whether or not to prosecute. Secondly, the law of self defence in English law is very wide, and is inconsistent with the requirements of Article 2(2) ECHR. The practical result is that, in cases involving killing by state officials, those responsible are rarely prosecuted or punished.

### **The EHRC recommends that the Committee asks the UK government:**

Why are prosecution and conviction rates of police officers following deaths in custody so low? What steps are being taken to improve the rates of prosecution and conviction?

### **Promptness of investigations**

To assemble the necessary evidence for an inquest it is essential that an independent investigation is carried out immediately after a death. The passage of time may erode the amount and quality of the evidence available. If there is a long delay before an inquest is concluded, poor practice which contributed to the death may remain unaddressed by the relevant authorities. Delays are also clearly of concern to the family of the deceased.

According to Ministry of Justice data, the estimated average time taken to process an inquest in 2010 – from the date the death was reported until the conclusion of the inquest – was 27 weeks. However, this data does not distinguish between relatively straightforward non-jury cases, and cases of death in custody, which require a jury and may be considerably more complex.

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<sup>259</sup> M. Hannan et al., 2010. *Deaths in or Following Police Custody: An examination of the cases 1998/99–2008/09*. London: Independent Police Complaints Commission.

<sup>260</sup> *The Guardian*, 28 October 2011. *Let there be justice for those who have died in custody*. Available at: [www.guardian.co.uk/commentisfree/2011/oct/28/deaths-in-police-custody](http://www.guardian.co.uk/commentisfree/2011/oct/28/deaths-in-police-custody).

<sup>261</sup> Inquest. *Unlawful Killing Verdicts and Prosecutions*. Available at: <http://inquest.gn.apc.org/website/statistics/unlawful-killing-verdicts>.

<sup>262</sup> M. Hannan et al., 2010. *Deaths in or Following Police Custody: An examination of the cases 1998/99–2008/09*. London: Independent Police Complaints Commission.

<sup>263</sup> *De Silva v. the United Kingdom* ECHR Application No. 5828/08. Third party intervention from the Equality and Human Rights Commission.

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The charity Inquest has analysed the progress of 500 complex cases in which it has been involved. In 48% of these cases the process took two years or more to conclude, 24% took three years or more, and 9% took four years or more. Recent inquests have been held into deaths in prison which had been outstanding for more than five years.<sup>264</sup> The Independent Advisory Panel on Deaths in Custody, assisted by the Coroners' Society for England and Wales, conducted a survey in early 2011 which indicated that approximately 25% of inquests into deaths in custody take more than two years to complete.<sup>265</sup>

There are a number of reasons why cases take this long. Delays tend to be concentrated in geographical areas with high numbers of prisons and other custodial settings, where coroners are disproportionately burdened with complex cases.<sup>266</sup> Inquest's research cites the lack of resources available to coroners, a shortage of experts and the difficulty of obtaining timely clinical reviews.

The length of IPCC,<sup>267</sup> PPO and other investigations can also contribute to inquest delays, as inquests are not usually finalised until other proceedings are completed. In 2010-11 the PPO reduced the time it took to investigate deaths, but still only published 15% of reports within its target of 20-26 weeks.<sup>268</sup>

Some cases are particularly complex and there will be an inevitable delay in order to conduct thorough investigations, but these cases should be the exception. As the Independent Advisory Panel notes:

'Whilst some delays are unavoidable, the panel does not believe that delays over 18 months are reasonable'.<sup>269</sup>

**The EHRC recommends that the Committee asks the UK government:**

What measures are being taken to ensure that investigations into deaths in custody are carried out promptly and expeditiously?

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<sup>264</sup> Inquest, 2011. Briefing on delays in the inquest system and coronial reform. Available at: [http://inquest.gn.apc.org/pdf/briefings/INQUEST\\_briefing\\_on\\_delays\\_and\\_coronial\\_reform\\_July\\_2011\\_Lords.pdf](http://inquest.gn.apc.org/pdf/briefings/INQUEST_briefing_on_delays_and_coronial_reform_July_2011_Lords.pdf).

<sup>265</sup> Independent Advisory Panel on deaths in custody. *Independent Advisory Panel on Deaths in Custody report on delays to inquests into deaths in custody*. Available at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/11/Delays-in-DiC-Inquests-IAP-Cross-Sector-Learning.pdf>.

<sup>266</sup> Ibid.

<sup>267</sup> 60% of IPCC independent investigations are completed within 157 working days. Publication of investigations reports may be delayed pending the conclusion of inquest or criminal justice proceedings.

<sup>268</sup> Prisons and Probation Ombudsman for England and Wales, 2011. *Annual Report 2010-2011*. Available at: [http://www.ppo.gov.uk/docs/ppo-annual-report\\_2010-11\\_web.pdf](http://www.ppo.gov.uk/docs/ppo-annual-report_2010-11_web.pdf).

<sup>269</sup> See: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/11/IAP-on-Deaths-in-Custody-Newsletter-November-2011.pdf>.

## Section 5: Children (England and Wales)

### Children in custody

#### Restraint of children and young people in custody

The EHRC's Human Rights Review 2012 found that children and young people in custody are at risk of CIDT.

Children and young people who have been convicted of crimes in England and Wales may be detained in the youth secure estate (made up of young offender institutions, secure training centres and secure children's homes). Young offender institutions are for young offenders between the ages of 15 and 21, although those over 18 are held separately. Secure training centres house vulnerable young people for whom a young offender institution would not be suitable. Secure children's homes are for the youngest or otherwise most vulnerable young offenders, as well as children in local authority care.

In June 2012 there were 1919 children in custody. The average custody population across the secure estate (not including 18 year olds) has decreased from over 3000 in 2002/2003 to around 2000 in 2011/2012.<sup>270</sup>

Children and young people detained in these institutions are under the control and care of the authorities, so the responsibilities of the state are enhanced.<sup>271</sup>

All children and young people in custody are vulnerable due to their age and immaturity. Many will have experienced neglect, abuse, domestic violence, poor parenting<sup>272</sup> and poverty.<sup>273</sup> They are also more likely to have poor educational experiences and have learning disabilities.<sup>274</sup> Such children are likely to have behavioural difficulties and may come into conflict with other children or staff in the youth secure estate. In extreme situations, staff can rely on restraint of children to prevent harm to either the child or to others.

The use of physical force for chastisement is unlawful and any use of physical force that is not strictly necessary to protect the safety of an individual, whether children or staff, is in principle a breach of Article 3 ECHR<sup>275</sup> and Article 16 UNCAT. The UN

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<sup>270</sup> Youth Justice Board presentation, John Drew Chief Executive YJB, 26/6/12

<sup>271</sup> See: Convention on the Rights of the Child: Article 40, and General Comment No 10. See also United Nations Standard Minimum Rules for the Administration of Juvenile Justice, para 19.1.

<sup>272</sup> Office of the Children's Commissioner in England, 2011. 'I think I must have been born bad': Emotional wellbeing and mental health of children and young people in the youth justice system. Available at: [http://www.childrenscommissioner.gov.uk/content/publications/content\\_503](http://www.childrenscommissioner.gov.uk/content/publications/content_503).

<sup>273</sup> Youth Justice Board, 2007. *Accommodation needs and experiences*. London: Youth Justice Board.

<sup>274</sup> Youth Justice Board, 2006 *Barriers to engaging in education, training and employment*. London: Youth Justice Board.

<sup>275</sup> *Keenan v. the United Kingdom* [2001] 33 EHRR 38.

In 2008 the Court of Appeal established that the use of restraint for the purpose of good order and discipline, rather than for safety, was a breach of Article 3 the case of *R.(C.) v. Secretary of State for*

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Committee on the Rights of the Child has stressed that any restraint against children should be used only as a last resort and exclusively to prevent harm to the child and others around the child.<sup>276</sup> The UNCRC also provides that children have the right to be protected from being hurt and mistreated, either physically or mentally, that no-one is allowed to punish children in a cruel or harmful way when they are in custody, and that children who break the law should not be treated cruelly.<sup>277</sup>

In 2007, the UK government introduced the Secure Training Centre (Amendment) Rules. The rules allowed officers working in these institutions in England and Wales to physically restrain young offenders to ensure 'good order and discipline'. The Commission and other children's rights organisations challenged these rules arguing that they amounted to inhuman and degrading treatment. The High Court ruled that because the Secretary of State could not establish that physical restraint was necessary to establish good order and discipline, the Amendment Rules were in breach of Article 3 ECHR<sup>278</sup>. The rules were quashed, and secure training centres are no longer allowed to restrain young offenders on these grounds.<sup>279</sup> This ruling did not apply to young offender institutions where restraint may be used to maintain good order and discipline. Restraint may not be used for good order and discipline in secure children's homes.

Secure children's homes are required to comply with the regulatory framework for children's homes which is explicit about the use of restraint, namely that it should only be used when there is a real risk of injury, serious damage to property or to prevent escape, and that children must not be restrained for good order and discipline, or to intend to inflict pain.<sup>280</sup>

The UN Committee on the Rights of the Child has urged the UK Government to ensure that restraint against children is used only as a last resort and exclusively to prevent harm to the child or others and that all methods of physical restraint for disciplinary purposes be abolished.<sup>281</sup>

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*Justice* [2008] EWCA Civ 882. See also European Court on Human Rights: *Ribitsch v. Austria*, judgment of 4 December 1995, Reports of judgments and decisions 1996, p. 26, para 34; *Tekin*, pp. 1517-1518, para 52 and 53; and *Assenov and others v. Bulgaria*, judgment of 28 October 1998, Reports 1998 - VIII, para 94.

<sup>276</sup> UN Committee on the Rights of the Child, 2008. *Concluding Observations*. UNCRC. Available at: <http://www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/CRC.C.GBR.CO.4.pdf>. Accessed 18/11/2011.

<sup>277</sup> Article 19 and 37 Convention on the Rights of the Child.

<sup>278</sup> The Commission intervened in the case of *R.(C.) v. Secretary of State for Justice* [2008] EWCA Civ 882.

<sup>279</sup> This judgment does not apply to young offender institutions or secure children's homes. See *R. (C.) v. Secretary of State for Justice* [2008] EWCA 882.

<sup>280</sup> Department for Children, Schools and Families, 2006. *Getting the Best from Complaints; Social Care Complaints and Representations for Children, Young People and Others*. Nottingham: DCSF publications. Paras 2.29-2.32.

<sup>281</sup> Committee on the rights of the child. Forty-ninth session. *Concluding observations: United Kingdom of Great Britain and Northern Ireland* (2008) UN document: CRC/C/GBR/CO/4. Available at: <http://www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/CRC.C.GBR.CO.4.pdf>.

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Unlawful use of restraint occurs where restraint is used for reasons other than those stated in the rules. For example restraint cannot be used as a punishment or, in secure training centres, to force compliance with an instruction. Even where restraint is used lawfully, it may still be an inappropriate response to an incident because it is not the last resort and alternative measures are available. Inappropriate use may be inferred from the evidence of high use and frequency.

Since 2006, reports have drawn attention to restraint used for purposes other than safety. For example, the Howard League for Penal Reform convened an independent inquiry into young offender institutions, secure training centres and secure children's homes in 2006 and found that restraint was used both as a punishment and to secure compliance.<sup>282</sup>

Evidence submitted by Her Majesty's Inspectorate of Prisons to the Carlile Inquiry into children in custody states that in 2011, restraint is still being used to secure compliance with instructions in all young offender institutions, and only two institutions report a proportionate but slow decrease in the use of restraint.<sup>283</sup> For example, the inspection in 2010 to Ashfield young offender institution stated:

'The use of force was slowly decreasing, but there were examples of force being used to secure compliance, which was inappropriate.'<sup>284</sup>

The 2009 inspection of Hindley young offender institution found that restraint was sometimes used inappropriately.<sup>285</sup> In 2008, when the JCHR carried out an inquiry into the use of restraint in secure training centres they found that the high use of restraint suggested that it was being used more frequently than absolutely necessary.<sup>286</sup>

In 2011, the UK National Preventive Mechanisms also questioned the extent to which restraint is being used safely and only when absolutely necessary and whether appropriate methods are used on children.<sup>287</sup>

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<sup>282</sup> The Lord Carlile of Berriew QC, 2006. An independent inquiry into the use of physical restraint, solitary confinement and forcible strip searching of children in prisons, secure training centres and local authority secure children's homes. Page 43. Available at: [http://www.howardleague.org/fileadmin/howard\\_league/user/pdf/Publications/Carlile\\_Report\\_pdf.pdf](http://www.howardleague.org/fileadmin/howard_league/user/pdf/Publications/Carlile_Report_pdf.pdf).

<sup>283</sup> HM Inspectorate of Prisons. Evidence submitted to The Howard League for Penal Reform for the Carlile inquiry: five years on. Para 19. Available at: [http://www.howardleague.org/carlile-inquiry/..](http://www.howardleague.org/carlile-inquiry/)

<sup>284</sup> Report on a full unannounced inspection of HMYOI Ashfield 10-14 May 2010 by HM Chief Inspector of Prisons. Available at: <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/ashfield-2010-rps.pdf>.

<sup>285</sup> Report on an announced inspection of HMYOI Hindley 19-23 October 2009 by HM Chief Inspector of Prisons. Available at: [http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/Hindley\\_2009\\_rps\(1\).pdf](http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/Hindley_2009_rps(1).pdf).

<sup>286</sup> Joint Committee on Human Rights, 2008. *The Use of Restraint in Secure Training Centres. Eleventh Report of Session 2007-08*. London: House of Commons. Available at: <http://www.publications.parliament.uk/pa/jt200708/jtselect/jtrights/65/65.pdf>.

<sup>287</sup> Ministry of Justice, 2011. *Monitoring places of detention, First Annual Report of the United Kingdom's National Preventive Mechanism 2009-10*, London. Available at: [http://www.justice.gov.uk/downloads/guidance/inspection-monitoring/National\\_Preventive\\_Mechanism\\_Annual\\_report\\_2009-2010\(web\).pdf](http://www.justice.gov.uk/downloads/guidance/inspection-monitoring/National_Preventive_Mechanism_Annual_report_2009-2010(web).pdf).

**The EHRC recommends that the Committee asks the UK government:**

The use of restraint for the purposes of maintaining good order and discipline is unlawful in Secure Training Centres and Secure Children's Homes. Why is the same rule not applied in Young Offenders Institutions? When will the use of restraint in YOIs be reviewed? What measures have been taken to ensure that restraint is only used as a last resort and where absolutely necessary to prevent injury to the child or to others?

**Authorised restraint techniques**

The approved methods of restraint in young offender institutions and secure training centres do not meet internationally agreed standards, which prohibit the use of intentional pain. The European Committee for the Prevention of Torture recommended the discontinuation of the use of manual restraint based upon pain compliant methods,<sup>288</sup> and the Commissioner for Human Rights of the Council of Europe has urged:

'...the immediate discontinuation of all methods of restraint that aim to inflict deliberate pain on children (among which physical restraints, forcible strip-searching and solitary confinement)'.<sup>289</sup>

Currently, the two authorised methods of restraint used in young offender institutions and secure training centres in England and Wales are called 'control and restraint' and 'physical control in care'. 'Control and restraint' is a system that uses holds which can be intensified to cause pain. One of the techniques is the intentional infliction of pain by immobilising the arms, employing joint locks using wrist flexion.<sup>290</sup> 'Physical control in care' authorises the use of distraction techniques such as the thumb technique, where fingers are used to bend the upper joint of the thumb forwards and down towards the palm of the hand, and a rib technique, which involves the inward and upward motion of the knuckles into the back of the child, exerting pressure on the lower rib.<sup>291</sup>

'Control and restraint' is used in young offender institutions holding young people between 15 and 21. 'Physical control in care' is used in secure training centres holding boys and girls aged between 14 and 17.

The UK government is currently considering authorising a new system of restraint to be used across young offender institutions and secure training centres. The Restraint Advisory Board has recently completed its task of assessing the new system of restraint for use in secure training centres and young offender institutions -

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<sup>288</sup> Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 18 November to 1 December 2008.

<sup>289</sup> Memorandum by Thomas Hammarberg, Commissioner for Human Rights of the Council of Europe following his visits to the United Kingdom (5-8 February and 31 March-2 April 2008). Issue reviewed: Rights of the child with focus on juvenile justice.

<sup>290</sup> Howard League for Penal Reform, 2011. *Twisted: the use of force in children's custody*. Available at: [http://www.howardleague.org/fileadmin/howard\\_league/user/pdf/Publications/Restraint.pdf](http://www.howardleague.org/fileadmin/howard_league/user/pdf/Publications/Restraint.pdf).

<sup>291</sup> *Ibid.*

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minimising and managing physical restraint (MMPR) and its report on MMPR has just been published.<sup>292</sup> The new system of restraint will introduce new strategies and policies on the use of force. However, pain-compliant techniques remain part of the new restraint system.<sup>293</sup>

**The EHRC recommends that the Committee asks the UK government:**

Please provide a full update on the work of the Restraint Advisory Board and the new MMPR system of restraint. Will the government consider banning the use of any technique designed to inflict pain on children? Why has the new mandibular angle technique been introduced?

**Extent of the use of restraint**

Restraint statistics are likely to be an underestimate and it remains unclear from the available literature whether all incidents across detention centres are captured.<sup>294</sup> In 2008 the government's independent review of restraint in juvenile secure settings concluded that: 'There is a need for better, more consistent reporting, monitoring and analysis of information on restraint by units across the estate [young offender institutions, secure training centres, and secure children's homes]'.<sup>295</sup> The follow up report in 2011 observed that information systems in young offender institutions had improved and were more accurate, but the process of data collection was in need of change. Several stakeholders expressed their 'serious concern' to the Commission's Human Rights Review, that 'the current system ... distorts figures and does not present an accurate account of real events'.<sup>296</sup>

With these caveats, Youth Justice Board statistics in 2009/10 revealed that there were a total of 6,904 incidents of reported use of restraint in England and Wales in young offender institutions, secure training centres and secure children's homes.<sup>297</sup> On average, this means 575 restraints per month. In one establishment, nearly half

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<sup>292</sup> <http://www.justice.gov.uk/youth-justice/custody/behaviour-management>.

<sup>293</sup> *The Carlile Inquiry: five years on: A public hearing on the use of force on children in custody*. Joint written evidence from the Ministry of Justice and the Youth Justice Board for England and Wales, Page 5. Available at:

[http://www.howardleague.org/fileadmin/howard\\_league/user/pdf/Events/MoJ\\_ans\\_YJB\\_joint\\_Written\\_Evidence\\_for\\_Carlile\\_Inquiry\\_Five\\_Years\\_On\\_sent\\_to\\_Howard\\_League\\_09-05-2011.doc](http://www.howardleague.org/fileadmin/howard_league/user/pdf/Events/MoJ_ans_YJB_joint_Written_Evidence_for_Carlile_Inquiry_Five_Years_On_sent_to_Howard_League_09-05-2011.doc). Accessed 22/11/2011. See also P. Smallridge and A. Williamson, 2011. *Report on implementing the independent review of restraint in juvenile secure settings*. Ministry of Justice.

<sup>294</sup> See: The Howard League for Penal Reform, 2011. *Twisted: the use of force on children in custody*. Available at:

[http://www.howardleague.org/fileadmin/howard\\_league/user/pdf/Publications/Restraint.pdf](http://www.howardleague.org/fileadmin/howard_league/user/pdf/Publications/Restraint.pdf). Accessed 18/11/2011. See: Children's Commissioner for England. Memorandum of Lord Carlile's public hearing on the use of restraint, Evidence submitted by the Office of the Children's Commissioner April 2011.

<sup>295</sup> P. Smallridge and A. Williamson, 2008. *Independent Review Of Restraint In Juvenile Secure Settings*. Available at: [http://www.justice.gov.uk/publications/docs/restraint\\_review.pdf](http://www.justice.gov.uk/publications/docs/restraint_review.pdf).

<sup>296</sup> P. Smallridge and A. Williamson, 2011. *Report On Implementing The Independent Review Of Restraint In Juvenile Secure Settings*. Available at: <http://www.justice.gov.uk/publications/docs/report-implement-review-restraint-juvenile-secure-settings.pdf>.

<sup>297</sup> Ministry of Justice, 2011. *Youth Justice Statistics 2009/10 for England and Wales*. Available at: <http://www.justice.gov.uk/publications/docs/yjb-annual-workload-data-0910.pdf>.

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of the children had been restrained.<sup>298</sup> Of these 6,904 incidents, 257 resulted in the injury of a child, of which 249 were a minor injury requiring medical treatment, which could include cuts, scratches, grazes, bloody noses, concussion, serious bruising and sprains. The remaining eight were classified as a serious injury requiring hospital treatment and could include serious cuts, fractures, loss of consciousness and damage to internal organs.<sup>299</sup>

Statistics supplied by the Youth Justice Board stated that 134 of the minor injuries occurred in young offender institutions, 111 in secure training centres and 4 in secure children's homes. Of the major injuries 7 occurred in a young offender institution and 1 in a secure children's home.<sup>300</sup> However, statistics on the number of injuries by establishment are not published, so it is difficult to identify whether there are systemic problems in particular institutions.

**The EHRC recommends that the Committee asks the UK government:**

In order for there to be a better understanding of the use of restraint on children and young people more data needs to be collected, including in particular statistics on injuries incurred broken down by institution.

**Investigations of incidents of alleged mistreatment**

If a child in custody shows signs of injury after restraint has been employed, the authorities have an obligation to prove that the force used 'was necessitated by the detainee's own conduct and that only such force as was absolutely necessary was used'.<sup>301</sup> The state also has an obligation to carry out an effective investigation that is capable of identifying and punishing the individual or individuals responsible for any acts of ill-treatment.

There is no national database that records the number of times physical restraint was used, whether injuries were caused, or links this to whether an investigation was conducted. Neither is there a record of the outcome of any such investigation.<sup>302</sup> Data provided by the Youth Justice Board shows that there were 285 cases of serious injuries reported in secure training centres between 2006 and November 2011.<sup>303</sup> The Youth Justice Board could not provide details about the outcome of investigations into the use of restraint in young offender institutions or secure children's homes because it is not collected centrally.

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<sup>298</sup> Ibid.

<sup>299</sup> Ibid

<sup>300</sup> Youth Justice Board. Briefing note for Equality and Human Rights Commission. September 2011.

<sup>301</sup> *Tomasi v. France*, judgment of 27 August 1992, Series A no. 241-A, pp. 40-41, 108-111; *Ribitsch v. Austria*, judgment of 4 December 1995, Reports of judgments and decisions 1996, pp. 26, 34; *Aksoy v. Turkey*, judgment of 18 December 1996, pp. 17, 61.

<sup>302</sup> Since recorded instances are also partial statistics, it is likely that many incidents are not recorded and not investigated.

<sup>303</sup> Hansard HL, col WA72 (09 November 2011). Available at: <http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/111109w0001.htm>.

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Reports from non-governmental organisations that provide advice to children in these settings suggest that children and young people are reluctant to pursue complaints about their treatment in custody; as a consequence cases of use of restraint are going unaddressed.<sup>304</sup> In some cases where young people do complain about their treatment, the institutions involved are reluctant to disclose evidence or provide a detailed formal response.<sup>305</sup> The Children's Commissioner for England found that the vast majority of children interviewed knew how to use the complaints system, but that they rarely did so because they had little or no faith that it would be effective for them. The system was felt to be selective, with complaints that were inconvenient to staff often ignored. Children considered the procedures to be slow and impersonal. Some feared reprisals if they complained.<sup>306</sup> The 2010-11 HMI Prisons survey found that fewer than a quarter (24%) of 15-18 year old ethnic minorities in custody believed that a staff member would take it seriously if they reported that they were being victimised (compared to 36% of their white counterparts). The failure to complain does not, however, excuse the lack of investigations because the state has a duty to investigate whenever there is a reasonable suspicion of ill-treatment, regardless of how it comes to their attention.

In response to the criticisms of the complaints system, the Youth Justice Board commissioned an independent review of complaints mechanisms in young offender institutions, secure training centres, and secure children's homes in 2011. In March 2011, it published an action plan for its improvement. The action plan identified principles that all establishments should consider putting in place a system of complaints. This included recommendations that the complaints system should be easy to use, that written responses should be timely and of a high quality, and that responses to complaints should be discussed with the young person involved.<sup>307</sup>

### **The EHRC recommends that the Committee asks the UK government:**

What progress has been made in ensuring that investigations of all allegations of abuse or mistreatment in the secure children's estate that may amount to CIDT are effectively investigated? Has the Youth Justice Board action plan been implemented? How are improvements in the system monitored and assessed?

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<sup>304</sup> Children's Rights Alliance for England, 2010. *State of Children's Rights in England* 2010. Page 65. Available at: <http://www.crae.org.uk/assets/files/CRAE%20State%20of%20childrens%20rights%20Nov%202010.pdf>.

<sup>305</sup> The Howard League for Penal Reform, 2011. *Twisted: the use of force on children in custody*. Available at: <http://www.howardleague.org/restraint/>.

<sup>306</sup> Children's Commissioner for England, 2011. Memorandum of Lord Carlile's public hearing on the use of restraint. Evidence submitted by the Office of the Children's Commissioner. Available at: [http://www.howardleague.org/fileadmin/howard\\_league/user/pdf/Events/Office\\_of\\_the\\_Children\\_s\\_Commissioner\\_Submission\\_to\\_Lord\\_Carlile\\_s\\_public\\_hearing\\_on\\_the\\_use\\_of\\_restraint\\_April\\_2011\\_.pdf](http://www.howardleague.org/fileadmin/howard_league/user/pdf/Events/Office_of_the_Children_s_Commissioner_Submission_to_Lord_Carlile_s_public_hearing_on_the_use_of_restraint_April_2011_.pdf).

<sup>307</sup> Youth Justice Board, 2011. *Review of the Complaints System in the Secure Estate for Children and Young People*. Ministry of Justice: London. Available at: <http://www.yjb.gov.uk/publications/Resources/Downloads/Review%20of%20the%20Complaints%20System%20-%20Summary%20and%20Action%20Plan.pdf>.

## Investigations into deaths of children in secure children's homes

Since 1990, in England and Wales there have been 31 deaths in custody of young people aged 14-17.<sup>308</sup> When a child or young person dies in the youth justice system the obligation to carry out an Article 2 ECHR compliant investigation is mainly met through the inquest procedure, as it is with adults.

When a young person dies in a young offender institution or a secure training centre, an investigation is carried out by the PPO. However, its remit does not extend to children and young people in custody in secure children's homes. When a child dies in a secure children's home, Ofsted inspects the establishment to ensure that it is safe for other residents. The local safeguarding children boards are obliged to carry out a child death review, and a serious case review.<sup>309</sup>

The Independent Advisory Panel on Deaths in Custody reported that regarding this process 'there is a gap in terms of Article 2 compliance'.<sup>310</sup> It found that neither Ofsted investigations, nor the local safeguarding children boards and serious case reviews focus on establishing the facts around the cause of death. They may not involve the family and are not carried out in public. The local safeguarding children board is unlikely to be sufficiently institutionally independent as it is comprised of organisations that report to the same local authority that has responsibility for running the secure children's home.<sup>311</sup>

The UK government argues that these processes, while important, are not intended to meet the Article 2 requirements, which are primarily met through the inquest.<sup>312</sup> However, the Independent Advisory Panel has responded that it may be difficult for inquests to comply with Article 2 without information provided by an independent investigation. It recommends that this should be done by the PPO.<sup>313</sup> The government is currently considering this recommendation.<sup>314</sup>

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<sup>308</sup> Inquest, ongoing. *Child Deaths in penal custody (England & Wales) 1990-date*. Available at: [http://inquest.gn.apc.org/pdf/Deaths\\_of\\_Children\\_in\\_Penal\\_Custody\\_1990-date.pdf](http://inquest.gn.apc.org/pdf/Deaths_of_Children_in_Penal_Custody_1990-date.pdf).

<sup>309</sup> Department for Children, Schools and Families, 2010. *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*. Para 8.4. Available at: <https://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN.pdf>.

<sup>310</sup> Report of the IAP's workstream considering investigations of deaths in custody – compliance with Article 2 ECHR MBDC 36.

<sup>311</sup> A. Barty, 2009. *Will a death in custody always be subject to independent investigation?* Forum for preventing deaths in custody: Report on Article 2-Compliant Investigation of Deaths in Custody. Page 15. Available at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/05/Forum-for-Preventing-Deaths-in-Custody-Report-on-Article-2-Compliant-Investigations.pdf>.

<sup>312</sup> See Letter from the Secretary of State for Justice to the IAP, 7 April 2011. Available at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/05/Forum-for-Preventing-Deaths-in-Custody-Report-on-Article-2-Compliant-Investigations.pdf>.

<sup>313</sup> Report of the IAP's workstream considering investigations of deaths in custody – compliance with Article 2 ECHR MBDC 36.

<sup>314</sup> Independent Advisory Panel on deaths in Custody E bulletin July 2011 issue 5. Available at: <http://www.ohrn.nhs.uk/resource/policy/IAP5thNewsletter.pdf>.

**The EHRC recommends that the Committee asks the UK government:**

What is the government's response to the Independent Advisory Panel's recommendation that there should be an independent PPO led investigation into deaths in secure children's homes?

## **Age of criminal responsibility**

The Committee has frequently criticised states for setting the age of criminal responsibility lower than internationally recognised standards.

In England and Wales the age of criminal responsibility is set at 10 years old. This is the age at which a person can be charged, and be found guilty, of committing a criminal offence. Any child below the age of 10 is not considered to have the capacity to distinguish right from wrong and be held liable for a criminal act.

The age of criminal responsibility in England and Wales is lower than many countries: in Scotland it is 12 years, in China, Russia and Germany it is 14 years, and in France and Brazil it is 18 years.<sup>315</sup> The UN Committee on the Rights of the Child has stated that setting the age of criminal responsibility below 12 is 'not acceptable'.<sup>316</sup> In its concluding observations in 2008, it urged the UK to raise the age limit in England and Wales accordingly.<sup>317</sup> The Council of Europe Commissioner for Human Rights has also recommended that the UK government should increase the age 'to bring it in line with the rest of Europe, where the average age of criminal responsibility is 14 or 15'.<sup>318</sup>

Some other jurisdictions respond to offences committed by children by adopting a welfare-based approach which regards children in trouble with the law as children first and foremost. This approach seeks to address the causes of their crime, which are likely to stem from neglect and abuse, rather than prioritising an adversarial system of proving guilt and innocence.<sup>319</sup> As a 2009 study of vulnerable defendants observed:

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<sup>315</sup> Prison Reform Trust, June 2011. Bromley Briefings Factfile. Page 34. Ten years old is also the age of criminal responsibility in Northern Ireland, Australia, and New Zealand. Only Switzerland, Nigeria, South Africa, and Sri Lanka have a lower age of criminal responsibility.

<sup>316</sup> CRC Committee, 2007. General Comment No. 10: children's rights in juvenile justice, UN document CRC/C/GC/10. Para 32.

<sup>317</sup> UNCRC, October 2008. Committee on the rights of the Child, Concluding Observations, CRC/C/GBR/CO/420. Para 78.

<sup>318</sup> Memorandum by Thomas Hammarberg, Commissioner for Human Rights of the Council of Europe, following his visits to the United Kingdom (5-8 February and 31 March-2 April 2008), *Rights of the child with focus on juvenile justice*, CommDH (2008) 27, Strasbourg, 17 October 2008.

<sup>319</sup> Scotland Children's Hearing System take most of the responsibility from courts for dealing with children and young people under 16, and in some cases under 18, who commit offences or who are in need of care and protection. This is based on the principle that children who commit offences and children who need care and protection are often the same children. This system seeks ways to support the child and move them away from re-offending. Where a decision is made to prosecute a child in a court, the hearing system can advise the court on how best to support the child in the process. This offers additional safeguards to support the child.

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'A welfare-based approach to offending by children does not imply that the harms caused by the offending should be overlooked, but seeks to address harmful behaviour by responding to the child's welfare needs – on the assumption that these needs are likely to be at the heart of the offending behaviour.'<sup>320</sup>

The JCHR has also criticized the government's approach, noting:

'We are not persuaded by the Minister's response [to not increasing the age of criminal responsibility] ... Whilst we do not underestimate the effects on communities of the offending of some very young children, we do not believe that the UK's current response is consistent with its international obligations to children. Indeed, we consider that resort to the criminal law for very young children can be detrimental to those communities and counter-productive.'<sup>321</sup>

In December 2011 the Royal Society published a report that looked at the legal applications of neuroscience. One issue the report considered was the role of neuroscience in determining an appropriate age of criminal responsibility. The report drew the following conclusion:

"...it is clear that at the age of ten the brain is developmentally immature, and continues to undergo important changes linked to regulating one's own behaviour. There is concern among some professionals in this field that the age of criminal responsibility in the UK is unreasonably low..."<sup>322</sup>

In January 2012 the Centre for Social Justice, a think tank established in 2004 by Conservative MP Iain Duncan Smith, published a policy report on youth justice. The report called for the age of criminal responsibility to be raised from 10 to 12, arguing that "robust responses ... delivered outside of the youth justice system would better serve justice and be a more effective means of addressing criminality".<sup>323</sup>

In March 2012 the All Party Parliamentary Group on Women in the Penal System published the results of a year-long inquiry it had conducted into girls in the penal system. It recommended that the age of criminal responsibility in England and Wales be raised in line with the European average age of 14 years.<sup>324</sup>

**The EHRC recommends that the Committee asks the UK government:**

Will the UK government consider raising the age of criminal responsibility to at least 12 years old in line with international standards? What evidence does the government rely on in support of its view that a younger age than the accepted minimum is acceptable?

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<sup>320</sup> Jacobson, J. and Talbot, J., 2009. Vulnerable Defendants in the Criminal Courts: a review of provision for adults and children. Page 61.

<sup>321</sup> Joint Committee on Human Rights, 20 November 2009. *Children's Rights*, Twenty-fifth Report of Session 2008–09, HL Paper 157 HC 318. Para 66.

<sup>322</sup> Royal Society, *Brain Waves Module 4: Neuroscience and the law*, December 2011, p13

<sup>323</sup> Centre for Social Justice, *Rules of Engagement: Changing the heart of youth justice*, January 2012, p22

<sup>324</sup> Hansard, HL Deb 20 December 2010 cc815-7, HC Deb 20 July 2011 c1107-8W and HC Deb 11 August 2011 c1086

## Corporal punishment

### Reasonable punishment

In 1998 the European Court of Human Rights found that UK domestic law did not provide adequate protection for children from inhuman or degrading treatment or punishment to satisfy Article 3. At the time, the law permitted parents and others who had care and control of a child under 16 to use the defence of 'reasonable punishment' when they were charged with wounding or causing grievous bodily harm, assault, occasioning actual bodily harm or cruelty.<sup>325</sup>

Section 58 of the Children Act 2004 limits the use of the defence of reasonable punishment so that it can no longer be used when people are charged in England and Wales with offences against a child, such as causing actual bodily harm or cruelty to a child. However, the reasonable punishment defence remains available when parents or guardians are charged with common assault under section 39 Criminal Justice Act 1988 and in civil proceedings for trespass to the person.

The UK government has argued that conduct charged as common assault does not achieve the level of severity of Article 3 and therefore the law does not violate the European Convention.<sup>326</sup> This has been accepted by the European Court of Human Rights.

The CPS has, as a result of section 58, amended its charging standard so that only the most minor of injuries sustained by a child and inflicted by an adult can be charged as common assault under English law. The injuries must be 'transient or trifling' and no more than a 'temporary reddening of the skin', otherwise they will be charged as actual bodily harm for which the reasonable punishment defence is not available.

However, sometimes in practice it can be difficult to distinguish between common assault and actual bodily harm.<sup>327</sup> In 2007 the Department for Children, Schools and Families carried out a review of section 58 of the Children Act 2004. The analysis of responses showed that health and social services professionals considered that section 58 made it difficult to give consistent advice to parents and that the lack of understanding of the law made it difficult for practitioners to work with parents. According to the professionals, giving advice on positive parenting was difficult because parents responded by citing the law allowing smacking.<sup>328</sup> The review concluded that the legal position was clear and appropriate but that the law was difficult to understand.

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<sup>325</sup> *A v. the United Kingdom* [1998] ECHR 100/1997/884/1096.

<sup>326</sup> UK statement to Council of Europe Committee of Ministers, June 2005.

<sup>327</sup> For definition in levels of severity required for common assault, actual bodily harm, and grievous bodily harm, see Crown Prosecution Service, *Offences against the Person*, incorporating the Charging Standard. Available at: [http://www.cps.gov.uk/legal/l\\_to\\_o/offences\\_against\\_the\\_person/](http://www.cps.gov.uk/legal/l_to_o/offences_against_the_person/).

<sup>328</sup> Department for Children, Schools and Families, 2007. *Review of Section 58 of the Children Act 2004*. Para 21 – 26.

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The JCHR considered the issue of legal certainty in its nineteenth report in 2004, concluding that prohibiting corporal punishment would make the law clearer.<sup>329</sup> In addition, the UN Committee on the Rights of the Child (General Comment No. 8) expressly prohibits the use of physical punishment on children and urges all States to move quickly to prohibit and eliminate all corporal punishment and other cruel or degrading forms of punishment. The Committee has also recommended three times that the UK Government change its law.<sup>330</sup>

Research carried out by the National Society for the Prevention of Cruelty to Children (NSPCC) in 2009 and published in 2011, found that 41.6% of the parents/guardians interviewed said they had physically punished or “smacked” their child in the past year.<sup>331</sup>

**The EHRC recommends that the Committee asks the UK government:**

Does the government accept the criticisms of the JCHR and the DCSF review that the current law on reasonable punishment is difficult for parents to understand? Why does the UK continue to ignore calls from the UN treaty bodies to abolish the defence of reasonable punishment?

**Corporal punishment in schools**

At present any parent or anyone *in loco parentis* – in place of the parent – has a legal right in England and Wales to use the defence of “reasonable punishment” under section 58 of the Children Act if they inflict a common assault on a child.

Teachers are *in loco parentis* to their pupils. Most teachers are prohibited in law from using corporal punishment, but the prohibition does not apply to teachers providing under 12½ hours education a week – for example sports coaches, Sunday school or madrassah teachers, youth workers, music teachers or home tutors<sup>332</sup>.

Concerns were first expressed in 2006 by the Muslim Parliament of Great Britain about the physical abuse of children in madrassahs, part-time weekend or evening Islamic schools<sup>333</sup>. There are estimated to be nearly 1,600 madrassahs in the UK, teaching as many as 200,000 children overall.<sup>334</sup> Dr Siddiqui, the Muslim Parliament’s leader, estimated that at least 40% of madrassahs permit the hitting of children, sometimes very violently, and criticised the fact that they were unregulated: “In our view this is simply not acceptable. It is also not acceptable for the local

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<sup>329</sup> Joint Committee on Human Rights Nineteenth Report September 2004.

<sup>330</sup> UN Committee on the Rights of the Child. Concluding observations CRC/C/GBR/CO/4. 20 October 2008.

<sup>331</sup> Radford, L. et al (2011), *Child abuse and neglect in the UK today*, London: NSPCC

<sup>332</sup> Children Are Unbeatable! Alliance, Briefing: Extending prohibition of corporal punishment to madrasas, Sunday schools, youth clubs and others *in loco parentis*. 2009

<sup>333</sup> *Child Protection in Faith-Based Environments*, Muslim Parliament of Great Britain, 2006

<sup>334</sup> *The Times* December 10 2008

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authorities and police not to take this challenge seriously for fear of being accused of cultural insensitivities.<sup>335</sup>

In March 2010 the UK government Chief Adviser on the Safety of Children, Sir Roger Singleton recommended that

" The current ban on physical punishment in schools and other children's settings should be extended to include any form of advice, guidance, teaching, training, instruction, worship, treatment or therapy and to any form of care or supervision which is carried out other than by a parent or member of the child's own family or household."<sup>336</sup>

The consultation carried out by Sir Roger Singleton in 2010 also clearly indicated that physical punishment of children was an issue in some Christian settings as well as in madrassahs<sup>337</sup>.

**The EHRC recommends that the Committee asks the UK government:**

Will the government consider banning the use of all physical punishment of children by another other than the child's parents and implement the recommendation made in March 2010 by Sir Roger Singleton?

## Mosquitos

On 22 June 2011 the Commission wrote to the UK Government Minister for Children expressing concern about the legality of the use of a noise-emitting deterrent device used to prevent teenagers congregating in certain places.

The 'Mosquito' is a deterrent device marketed as the most effective tool for dispersing groups of teenagers behaving in an antisocial manner<sup>338</sup>. The device is widely used by police and local authorities, chain stores, independent shops and private individuals to protect their property from the effects of teenage antisocial behaviour.

The device emits a high frequency a noise; the frequency emitted can be set at either 8 KHz or 17 KHz. The higher frequency is generally only detected by people under about 25. Above that age the ability to hear higher frequencies diminishes

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<sup>335</sup> Ibid. There have been reports of many cases including successful prosecutions: A BBC investigation in October 2011 found that more than 400 allegations of physical abuse in madrassahs had been made in the past three years: <http://www.bbc.co.uk/news/education-15256764>. In November 2011 a teacher was jailed for 10 weeks: <http://www.bbc.co.uk/news/uk-england-leeds-15857748>

<sup>336</sup> *Physical punishment: improving consistency and protection; An independent Report* by Sir Roger Singleton, Chief Adviser on the Safety of Children. March 2010

<sup>337</sup> *Physical punishment: improving consistency and protection; An independent Report* by Sir Roger Singleton, Chief Adviser on the Safety of Children. March 2010. See also *R (Williamson and others) v Secretary of State for Education and Employment and others* [2005] UKHL 15. Physical punishment is likely to be used by some minority fundamentalist groups because of the fierce legal battles fought and lost by these groups to retain corporal punishment in their independent schools in England and Wales.

<sup>338</sup> <http://www.compoundsecurity.co.uk/security-information/mosquito-devices>

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such that older people would not hear the noise. In simple terms, young people find the noise very unpleasant and tend to leave the area. There is no evidence that the Mosquito causes permanent hearing damage,.

There are currently no specific controls on the manufacture, marketing or use of Mosquitos and no plans to ban them in the UK<sup>339</sup>.

Over the past few years several organisations including Liberty<sup>340</sup>, the Office of the Children's Commissioner for England,<sup>341</sup> Scotland's Commissioner for Children and Young People<sup>342</sup>, and the JCHR have expressed concerns that Mosquitos discriminate against young people in a way which makes them potentially unlawful. The concerns centre around the fact that they impact only on children and young people and that they target all young people regardless of whether they are committing or have been guilty of any offence.

On 22 March 2010, the Parliamentary Assembly of the Council of Europe voted in support of a report calling for a European ban on Mosquitos<sup>343</sup>.

Having taken legal advice, the Commission considers that the use of mosquito devices (at the higher frequency which can only be heard by children and young people) will be unlawful in most instances as they discriminate against young people in violation of their rights under the ECHR. They may also violate Article 16 UNCAT.. The purported justification for the interference with the rights of children and young people will only be proportionate if the use of Mosquitos is restricted solely to particular situations where there is evidence that they will prevent actual behaviour that has occurred in the past recurring and where the use is a proportionate response to the behaviour it is intended to prevent.

**The EHRC recommends that the Committee asks the UK government:**

In its response to the Commission<sup>344</sup> the Minister said that the Mosquito device embodies a negative attitude towards young people; that it is a discriminatory device and that it serves only to further alienate a section of our society that should be valued. In the light of that does the government now intend to introduce regulation to limit their use to the narrow circumstances in which their use is lawful?

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<sup>339</sup> In Scotland if the ban was because of detrimental effects on children's health it would be within devolved power of the Scottish Parliament. Also, local authorities in England, Scotland and Wales have power to introduce bye-laws to ban Mosquitos. But, an overall ban in terms of manufacturing, marketing etc would be reserved to the UK Government.

<sup>340</sup> <http://www.liberty-human-rights.org.uk/campaigns/buzz-off/index.php>

<sup>341</sup> [http://www.childrenscommissioner.gov.uk/content/press\\_release/content\\_376](http://www.childrenscommissioner.gov.uk/content/press_release/content_376)

<sup>342</sup> <http://www.publications.parliament.uk/pa/jt200809/jtselect/jtrights/157/157we47.htm>

<sup>343</sup> <http://assembly.coe.int/Mainf.asp?link=/Documents/AdoptedText/ta10/EREC1930.htm>

<sup>344</sup> Tim Loughton MP, Parliamentary Under Secretary of State for Children and Families, 19 August 2011

## Section 6: Health and Social Care (England and Wales)

### Ill-treatment amounting to cruel, inhuman or degrading treatment in health and social care settings (Article 16)

The EHRC notes with some concern that the UK's periodic state report makes no reference to instances – some well publicised – of cruel, inhuman or degrading treatment (CIDT) in the context of health and social care. Article 16 UNCAT and Article 3 ECHR should protect people from severe mistreatment. However there is evidence that some people who use health and social care services are at risk of abusive treatment by care workers. They may also be subject to abusive treatment by other residents or service users. People living in residential care settings are particularly vulnerable. For example, in May 2011 a BBC Panorama programme exposed through secret filming how disabled residents of Winterbourne View hospital near Bristol were routinely slapped, kicked, teased and taunted by members of staff. One particularly harrowing example captured on film was that of an eighteen year old woman being verbally abused and doused with cold water while fully clothed, as a 'punishment'. The privately owned purpose built hospital was home to 24 adults with learning disabilities and autism, whose places had been commissioned by local authorities and NHS trusts. As a result of the scandal, four people were arrested, several more staff were suspended and shortly afterwards the hospital was closed down. The scandal prompted the Care Quality Commission (CQC) to undertake 150 unannounced inspections of similar services in England (see below).

In February 2011, the Parliamentary and Health Services Ombudsman (PHSO) reported on 10 investigations into the care of older people by NHS institutions in England, of which several revealed ill-treatment possibly serious enough to breach Article 16.<sup>345</sup>

Eighteen per cent of the 9,000 complaints made to the PHSO in 2010 were about the care of people over 65 and the organisation accepted 226 cases about older people for investigation, twice as many as all other age groups put together in 2011.<sup>346</sup>

In November 2011, the EHRC published the report of its formal inquiry into older people and human rights in home care. The inquiry found some evidence of good practice in the commissioning and delivery of home care services, with many care workers providing excellent care under challenging circumstances. However, there

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<sup>345</sup> Parliamentary and Health Service Ombudsman, 2011. *Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people*. Available at: [http://www.ombudsman.org.uk/\\_\\_data/assets/pdf\\_file/0016/7216/Care-and-Compassion-PHSO-0114web.pdf](http://www.ombudsman.org.uk/__data/assets/pdf_file/0016/7216/Care-and-Compassion-PHSO-0114web.pdf). One example in the PHSO report is that of Mrs H, 88, who was deaf and partially sighted. After a fall at home, she was hospitalised for four months suffering from acute confusion. While in hospital, she experienced poor standards of care and had several further falls, one of which broke her collarbone. She was transferred to a care home by ambulance while strapped to a stretcher in a state of agitation and distress. On her arrival the manager noticed that she had numerous unexplained injuries, was soaked with urine and was dressed in clothing held up with large paper clips. She was bruised, dishevelled and confused. The following day she had to be readmitted to a local hospital. She died before the PHSO could conclude its investigation.

<sup>346</sup> Ibid.

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were also worrying examples of poor treatment. In a few cases this treatment appears to have been serious enough to approach or exceed the threshold for a breach of UNCAT. For example, many concerns were raised about older people not being given support they needed to eat and drink. In one case, an older woman with Huntingdon's disease suffered dramatic weight loss because care workers simply left food and drink next to her, even though she was physically unable to feed herself. In another case, an older man with dementia lost so much weight due to not being given support to eat by home care workers that he was admitted to hospital and died three days later. <sup>347</sup>

As people often receive health and social care services at home, behind closed doors, it is hard to say how often CIDT may be happening. The frequency of serious abuse and neglect in these settings should not be exaggerated, but the fact that such incidents happen at all underlines a number of serious issues relating to Britain's compliance with its duty to protect individuals from abuses by others.

The EHRC's inquiry into home care services highlighted weaknesses in the system of adult safeguarding, a system based on non-statutory guidance requiring local authority social services departments to lead a multi-agency approach to the protection of vulnerable adults. The EHRC's inquiry into disability-related harassment, also published in 2011, <sup>348</sup> demonstrated even more starkly the failings in adult safeguarding. This inquiry describes several cases where serious and repeated harassment of disabled people, eventually leading to their death, involved missed opportunities by statutory agencies to make safeguarding referrals. In the current climate of public spending cuts, there are concerns that public authorities commissioning care service are prioritising low cost above quality, so risking driving down standards of care. This is illustrated by evidence from the EHRC's home care inquiry, which found that some providers are being forced to cut corners as a result of local authority commissioning practices – for example by care packages limiting the amount of time that care workers can spend on each visit to as little as 15 minutes<sup>349</sup>. If public authorities reduce the quality of care owing to budget restraints, increasing human rights breaches are likely to follow.

## **Private health and social care provision**

People who are receiving health and social care from private and voluntary sector providers do not have the same level of direct protection under the Human Rights Act (HRA) as those receiving it from public providers.

The HRA applies to both public authorities and to other organisations when they are performing functions of a public nature. This is important in health and social care

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<sup>347</sup> Equality and Human Rights Commission, 2011. *Close to home: An inquiry into older people and human rights in home care*. Available at: <http://www.equalityhumanrights.com/legal-and-policy/inquiries-and-assessments/inquiry-into-home-care-of-older-people/>. See page 28.

<sup>348</sup> Equality and Human Rights Commission, 2011. *Hidden in plain sight – inquiry into disability-related harassment*

<sup>349</sup> Other examples of potential inhuman and degrading treatment that may arise include where care packages only provide for incontinence pads instead of assistance with toileting. Note the case Application No 4241/12 Ms Elaine McDonald v UK currently pending before the ECHR which addresses this issue.

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settings because most care homes are owned by private or voluntary sector organisations, as are the majority of home-based care services. Most care homes in England are privately owned (two-thirds), and the remaining are operated by the public sector and voluntary sectors. Private ownership also predominates for domiciliary agencies (at over 70%), with 17% being operated by public sector bodies.<sup>350</sup>

This mixed economy has some complex legal consequences in relation to the scope of the HRA the statute which provides the mechanism through which individuals can enforce their human rights in the domestic courts. A House of Lords ruling in 2007 excluded independent providers of residential social care from the scope of the Act.<sup>351</sup> The court did not expressly discuss home care but its reasoning almost certainly applies to independent providers in this sector too. The following year, legislation was put in place to reverse the effects of this decision, but only for care home residents whose places are arranged by local authorities.<sup>352</sup> People who pay for their own residential care are not entitled to the same protection.

The courts have ruled that for patients who are detained under the Mental Health Act (1983) a private hospital is performing a 'public function' under the HRA.<sup>353</sup> However, there is no case law relating to other categories of patient. Private hospitals treating NHS patients may not have obligations under the HRA.<sup>354</sup> It should be noted that, with the introduction of reforms under the Health and Social Care Act 2012, a much greater proportion of NHS healthcare will be commissioned from independent providers.

All this means that a sizeable but growing minority of people who use health and social care services may not have their human rights directly protected by the law. In practice, this means that they do not have direct redress for any human rights breaches by the service provider or its employees. An amendment to the UK Government's Health and Social Care Bill (now Act), debated by the House of Lords on 13 March 2012, would have ensured clarity on the application of the HRA to home care and healthcare services commissioned from private and third sector organisations. Although the amendment was rejected, the government made a commitment to ensuring that human rights was part of the underpinning framework in adult social care law, and that anticipated reforms to the law would ensure consistency with the obligations placed on local authorities by the Human Rights Act.

**The EHRC recommends that the Committee asks the UK government:**

Will the government consider clarifying the law to place beyond doubt that all private and third sector providers of health and social care commissioned by a

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<sup>350</sup> Department of Health, 2010. *How social care is delivered* [Archived internet page]. Available at: <http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Aboutthedirectorate/Howsocialcareisdelivered/index.htm..>

<sup>351</sup> *Y.L. v. Birmingham City Council and others* [2007] UKHL 27.

<sup>352</sup> Health and Social Care Act. 2008.

<sup>353</sup> *R (A) v. Partnerships in Care Ltd* [2002] EWHC 529 (Admin).

<sup>354</sup> Private hospitals are subject to inspections from the Care Quality Commission.

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public authority are performing a 'public function' within the meaning of the Human Rights Act?

In reforming adult social care legislation, will the government also consider using human rights principles as a foundation for statutory, over-arching principles underpinning the new law?

### **Better inspection of care settings**

The state is under an obligation to investigate well-founded allegations of inhuman or degrading treatment in the health and social care system, even when it has occurred in services provided by a private or third sector organisation.

In June 2010, the Care Quality Commission (CQC) stopped conducting routine inspections of all providers in England. Instead, they decided to take a risk-based approach, trying to identify primarily through self-assessment from providers where a potential need for regulatory action exists. There were fears that this made scrutiny of human rights issues less effective, as it paid insufficient attention to qualitative and anecdotal evidence that may reveal abuse, for example from members of the public and whistleblowing employees. In the Winterbourne View case, the CQC's last routine inspection in 2009 did not give rise to any significant concerns. The CQC relied on the provider to notify it of any serious incidents, and the hospital did not comply with this legal duty.<sup>355</sup>

Acting in response to the Commission's inquiry the CQC has made plans to carry out a themed programme of unannounced inspections of around 250 care home providers starting in April 2012.<sup>356</sup>

In response to criticisms arising from the Winterbourne View case, the CQC has amended its whistleblowers policy and now provides clearer information on its website explaining how members of the public can give feedback, whether good or bad, about health and social care services.<sup>357</sup> It has also recently completed a programme of random, unannounced inspections of hospitals and care homes providing care for people with learning disabilities. The report revealed that nearly half the hospitals and care homes that were inspected did not meet statutory standards. Adult safeguarding concerns were identified in 27 of the providers, which included concerns about injuries received following the use of restraint. The inspections found a generally poor staff understanding of restraint, and a lack of monitoring of its usage leading to increased risks of inappropriate use.<sup>358</sup>

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<sup>355</sup> House of Commons Health Committee, 2011. Annual accountability hearing with the Care Quality Commission Ninth report of session, 2010-2012, September 2011. Available at: <http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1430/1430.pdf..>

<sup>356</sup> Care Quality Commission, 2011. *CQC to target care home services*. Available at: <http://www.cqc.org.uk/node/386875>.

<sup>357</sup> Care Quality Commission, 2010. *Whistleblowing: Guidance for providers who are registered with the Care Quality Commission and who employ workers*. Available at: [http://www.cqc.org.uk/sites/default/files/media/documents/20110616\\_ext\\_gdce\\_wblowing\\_reg\\_persons\\_v0\\_04\\_cb\\_collated\\_\\_no\\_tracks\\_for\\_external\\_publication.pdf](http://www.cqc.org.uk/sites/default/files/media/documents/20110616_ext_gdce_wblowing_reg_persons_v0_04_cb_collated__no_tracks_for_external_publication.pdf).

<sup>358</sup> Care Quality Commission, June 2012. Learning disability services inspection programme

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More generally, the CQC is now piloting a new inspection approach that incorporates the views and experiences of service users, and is considering a move away from generic inspection models to more specialist inspection approaches aimed at particular types of provider. It has launched a consultation on proposals to review its judgement framework and enforcement policy.<sup>359</sup> The CQC's aims are to simplify and strengthen its regulatory model of monitoring and inspecting providers and to build on what it has learned over the last 18 months. The proposals include looking at the frequency with which the CQC carries out inspections of providers and how these inspections are targeted.

As the regulator for the health and social care sector, the CQC has a central role in protecting the human rights of disabled and older people in regulated care settings. Building on a previous memorandum of understanding between the CQC and the Commission, the two bodies have recently published joint guidance for CQC inspectors on equality and human rights.<sup>360</sup>

**The EHRC recommends that the Committee asks the UK government:**

Please explain why the issues of safeguarding of vulnerable adults and instances of CIDT in health and social care settings are absent from the state report. Please update the Committee on the activities of the health and social care regulators so far as inspections of health and care settings are concerned, including plans to protect adults at risk from harm with unannounced, targeted inspections.

## Deaths in mental health settings

### Investigations

There is no single person or agency automatically responsible for investigating deaths of patients in mental health settings in England. Such deaths may be investigated by an inquest, an internal hospital inquiry, the Strategic Health Authority, a commissioned independent body, or a combination of some or all of them.<sup>361</sup> The CQC is notified of all deaths, and has a discretionary role in reviewing them. Though it aims to share the lessons learnt from each case across organisations, there is no formal mechanism for doing this.

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<sup>359</sup> Care Quality Commission, 2011. *Our proposals for our judgement framework and Enforcement policy consultation*. Available at: [http://www.cqc.org.uk/sites/default/files/media/documents/20110916\\_consultation\\_document\\_judgement\\_framework\\_and\\_enforcement\\_policy\\_consultation.pdf](http://www.cqc.org.uk/sites/default/files/media/documents/20110916_consultation_document_judgement_framework_and_enforcement_policy_consultation.pdf).

<sup>360</sup> Equality and Human Rights Commission and CQC. *Guidance for Care Quality Commission Inspectors*. Available at: <http://www.equalityhumanrights.com/key-projects/care-and-support/guidance-for-care-quality-commission-inspectors/>.

<sup>361</sup> In Wales the Health Inspectorate of Wales reviews deaths of mental health patients. This is not a statutory requirement, and the process is currently under review. See Health Inspectorate of Wales, 2011. *Monitoring the use of the Mental Health Act in 2009-2010*. Available at: <http://www.hiw.org.uk/Documents/477/Monitoring%20Mental%20Health%20Act%2009%2010%20MP%203.pdf>.

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The inquest may need information that is obtained from an independent investigation immediately after the death. The Forum for Preventing Deaths in Custody criticised Strategic Health Authority investigations, specifically questioning their independence, and recommended that for all deaths involving people with mental health conditions that engage Article 2 ECHR, an independent investigator should be immediately appointed.<sup>362</sup>

The Independent Advisory Panel on Deaths in Custody has followed up the work of the Forum. It pointed out that the coronial system is not sufficiently responsive or properly resourced to undertake effective investigation into all deaths of all detained mental health patients. The lack of a system for independent investigation may mean that learning will be missed.

The Independent Advisory Panel has made a number of recommendations. It has called for a review of the quality of independent investigations carried out by Strategic Health Authorities and for revision of guidance. It also recommended that NHS Commissioning Board should provide guidance to clarify when independent investigations should be commissioned, and that the Care Quality Commission should take a role in conducting or commissioning independent investigations.<sup>363</sup>

**The EHRC recommends that the Committee asks the UK government:**

Why is there no automatic independent investigation into all deaths of people who die in mental health settings? How does the current system ensure that systemic issues comes to light and that lessons are learned for the future?

## **Section 7: Protection from abuse (England and Wales)**

### **Failure to protect**

The Committee has noted that state parties are under an obligation to take preventative measures to protect individuals who may be at risk of attack or abuse amounting to torture or CIDT.<sup>364</sup>

This is mirrored by a binding positive obligation in English law under Article 3 ECHR incorporated into domestic law in the HRA.<sup>365</sup> In practical terms, this obligation means that once the authorities – for example, the police or social services – have been made aware that someone has been threatened or harmed by another person to the level of severity that qualifies as a possible breach of Article 3 ECHR, then

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<sup>362</sup> A. Barty, 2009. *Will a death in custody always be subject to independent investigation?* Forum for preventing deaths in custody: Report on Article 2-Compliant Investigation of Deaths in Custody. Available at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/05/Forum-for-Preventing-Deaths-in-Custody-Report-on-Article-2-Compliant-Investigations.pdf>.

<sup>363</sup> Report of the IAP's workstream considering investigations of deaths in custody – compliance with Article 2 ECHR MBDC 36.

<sup>364</sup> For instance, CAT/C/IRL/CO/1 para 21 with regard to Ireland's failure to protect girls and women from abuse in the Magdalene Laundries.

<sup>365</sup> See para 176 *Opuz v. Turkey* [2009] ECHR 33401/02.

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they should take adequate steps to prevent the aggressor carrying out this threat or committing further acts of violence.<sup>366</sup> In the cases mentioned below the Commission's view is that any conduct found by the courts to violate Article 3 ECHR will also by definition constitute a breach of UNCAT.

In *A. v. the United Kingdom* the European Court of Human Rights found a violation of Article 3 when a step-father was acquitted of assault, after beating his step-son to such an extent that the treatment amounted to inhuman and degrading treatment. At that time UK law permitted a defence of lawful chastisement. The Court held that, even though the treatment was perpetrated by one private person against another, the state was still responsible because there was not an adequate system of law in place to protect against such treatment.<sup>367</sup>

In 1995 the Court found that a failure of a local authority to intervene to stop ill-treatment to which children were subjected by their parents was a breach of the UK's obligations under Article 3.<sup>368</sup> More recently, it also found a breach of Article 3 in domestic violence cases where the authorities knew that serious assaults were occurring, and failed to prevent them.<sup>369</sup>

The Court has also found breaches of Article 3 where authorities have failed to properly investigate and prosecute any non-consensual sexual act, even where the victim had not resisted physically.<sup>370</sup>

The state's positive obligations include a requirement to intervene where it is clear that there has been an Article 3 breach in order to stop it.<sup>371</sup>

### **Ill-treatment of children, disabled people, and women at risk of domestic violence**

In recent years many cases have emerged in which public authorities have failed to act to protect a vulnerable person – a child, a disabled person, or a woman experiencing domestic abuse, for example – despite the fact that the ill-treatment has been brought to their attention. These cases indicate that the authorities in question are failing to fulfil their international treaty obligations to protect people from ill-treatment where possible.

#### ***Children***

The case of Peter Connelly, or Baby P, is an example of ill-treatment that reached the level of severity to engage UNCAT. The authorities failed to act effectively despite knowing that the child was at risk of ill-treatment.

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<sup>366</sup> Ibid., paras 200-2.

<sup>367</sup> *A. v. UK* [1998] EHRLR 82.

<sup>368</sup> *Z. and Others v. the United Kingdom* [2001] 29392/95 2 F.L.R. 612.

<sup>369</sup> *Opuz v. Turkey* [2009] ECHR 33401/02.

<sup>370</sup> *E.S. and Others v. Slovakia* (8227/04). *M.C. v. Bulgaria* [2003] ECHR 646.

<sup>371</sup> *Satik v. Turkey* (31866/96).

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In 2007 Peter Connelly's mother called an ambulance but, despite efforts of hospital and ambulance staff, the 17-month-old boy was pronounced dead 48 minutes after her call. A post-mortem examination revealed that he had eight fractured ribs on the left side and a fractured spine. Peter had been on Haringey Council's child protection register under the category of physical abuse and neglect since December 2006 – he had suffered over 50 injuries in the eight months before his death – and was the subject of a child protection plan. Over this period his family was seen 60 times by different agencies including the local authority, a hospital, and the police service. The serious case review concluded that – despite the fact that all the staff involved in this case were well motivated and concerned to play their part in safeguarding Peter – his death could have been prevented if authorities had identified the severity of the abuse and intervened. It concluded that 'the culture of safeguarding and child protection at the time, was completely inadequate to meet the challenges presented by the case'.<sup>372</sup>

Serious case reviews investigate the death or serious injury of a child in England and Wales where abuse or neglect is known or suspected to be a factor. These reviews show that in over 70% of cases evaluated by Ofsted in which a child has been seriously injured or died due to abuse or neglect, social services were aware of the risk but failed to act to protect the child, or their actions were inadequate and failed to protect the child. In 119 of 194 serious case reviews evaluated by Ofsted in 2009/10, social care services knew that children were vulnerable to abuse due to past incidents of domestic violence, mental ill-health, and drug and alcohol misuse. In many cases the parents were also receiving support from agencies in their own right.<sup>373</sup>

Of the 194 cases evaluated by Ofsted, 90 had resulted in the death of a child, of whom 31 were receiving services as 'children in need'.<sup>374</sup> The other 104 cases involved physical abuse or long-term neglect causing serious harm, and in each case the family had a history of contact with the agencies involved.<sup>375</sup>

Beliefs that children can be witches or possessed by evil spirits and need to be physically punished are present in some African Christian churches within the UK, as well as in other minority faiths. Victoria Climbié is perhaps the most notorious example: a result of her and other similar cases Scotland Yard set up "Project Violet" to investigate ritual abuse in churches. The final report in 2006 analysed the cases of 47 children, mostly between eight and fourteen, who were hit, punched, burned,

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<sup>372</sup> Local Safeguarding Children's Board Haringey, 2009. *Serious Case Review: Baby Peter*. Available at: [http://www.haringeylscb.org/executive\\_summary\\_peter\\_final.pdf](http://www.haringeylscb.org/executive_summary_peter_final.pdf).

<sup>373</sup> Ofsted, 2010. *Learning lessons from serious case reviews 2009-2010*. Available at: <http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Documents-by-type/Statistics/Other-statistics/Learning-lessons-from-serious-case-reviews-2009-2010>.

<sup>374</sup> Children in need are those who are believed to need local authority services to achieve or maintain a reasonable standard of health or development or need local authority services to prevent significant or further harm to health or development or are disabled and they are defined under section 17 of the Children Act 1989. Some children are in need because they are suffering, or likely to suffer, significant harm.

<sup>375</sup> Ofsted, 2010. *Learning lessons from serious case reviews 2009-2010*. Available at: <http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Documents-by-type/Statistics/Other-statistics/Learning-lessons-from-serious-case-reviews-2009-2010>.

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stabbed, half-strangled, starved, tied up, placed in cold baths or had chilli pepper, salt or ginger applied to their eyes and genitals.<sup>376</sup>

### ***Disabled people and adults at risk of harm***

Similar failures are evident in cases of disabled people suffering persistent harassment. In 2011 the Commission published the report of its formal inquiry into disability-related harassment. It found that public authorities do not take the complaints of disabled people seriously or respond with sufficient urgency because there is a culture of disbelief about the issue. For this reason, the inquiry described disability harassment as a problem which is 'hidden in plain sight'. It highlighted examples of ill-treatment of disabled people, and police and social workers' failure to recognise it.<sup>377</sup>

Michael Gilbert, who had an undiagnosed mental health condition, had lived with the Watt family for more than 10 years. During this time, he was seriously assaulted and abused, including beatings and scolding, for entertainment on a regular basis. Michael ran away several times and was abducted and brought back to the family. Despite police knowledge of these abductions, no one was charged or prosecuted. Michael also visited GPs and hospitals several times but none of them recognised the abuse. The assaults got worse towards the end of his life: one of the members of the family did press-ups on a piece of wood placed in his mouth and jumped on his stomach, making him doubly incontinent and leaving his stomach so swollen he could hardly walk. On the last day of his life he 'suffered beating upon beating and was gravely ill' and was found by two members of the family lying on a deflated blow-up bed, where he had defecated and urinated. At this point, 'he requested and was given medication but he could only just about speak. He was left there and died that evening'. Four members of the Watt family, and two of their girlfriends, were sentenced to a total of 93 years in prison for offences connected with Michael Gilbert's death in January 2009, including causing or allowing the death of a vulnerable adult.<sup>378</sup>

As in the case of children, local authorities in England should conduct serious case reviews when the death or harm of a 'vulnerable adult' has occurred.<sup>379</sup> A vulnerable adult is a person over 18 years of age 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'.<sup>380</sup>

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<sup>376</sup> *Child Abuse Linked to Accusations of "Possession" and "Witchcraft"* Eileen Stobart, DCSF 2006 Research Report RR750.

<sup>377</sup> Equality and Human Rights Commission, 2011. *Hidden in Plain Sight. Inquiry into disability-related harassment*. Pp. 11, 53. Available at: [http://www.equalityhumanrights.com/uploaded\\_files/disabilityfi/ehrc\\_hidden\\_in\\_plain\\_sight\\_3.pdf..](http://www.equalityhumanrights.com/uploaded_files/disabilityfi/ehrc_hidden_in_plain_sight_3.pdf..)

<sup>378</sup> Equality and Human Rights Commission, 2011. *Hidden in Plain Sight. Inquiry into disability-related harassment*. Pp. 45. Available at: [http://www.equalityhumanrights.com/uploaded\\_files/disabilityfi/ehrc\\_hidden\\_in\\_plain\\_sight\\_3.pdf..](http://www.equalityhumanrights.com/uploaded_files/disabilityfi/ehrc_hidden_in_plain_sight_3.pdf..)

<sup>379</sup> The Law Commission, 2011. *Adult Social Care*. London: The Stationery Office. Para 9.3.

<sup>380</sup> Department of Health, 2000. No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. Pp. 8-9. Available at:

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Serious case reviews of 'vulnerable adults' are not compulsory, not collected centrally, and local authorities do not have the obligation to publish them. There has only been one study into serious case reviews of vulnerable adults. As it looked at only 22 reviews, its findings are indicative rather than representative of all adult serious case reviews. Nevertheless, in all the cases when the victim died or was seriously injured it was found that the victim was in contact with at least one agency and that concerns about the victims' vulnerability and harm existed.<sup>381</sup>

The Commission's inquiry into the harassment of disabled people found a systemic failure by public authorities to recognise the extent and impact of harassment and abuse and to intervene effectively when it had been identified.<sup>382</sup>

### **Domestic violence**

In cases of domestic violence, too, there is evidence to suggest that authorities do not act effectively to protect women they know to be vulnerable. The 2009/10 annual report of the Independent Police Complaints Commission (IPCC) noted an increasing number of deaths in domestic violence cases in England and Wales where the victim was in prior contact with the police.<sup>383</sup> Since the IPCC was created in 2004, it has recorded 26 cases of women who had prior contact with the police about domestic violence incidents, who were subsequently killed by their partners or ex-partners.

In 2010, the IPCC carried out an investigation into the way Lancashire Constabulary failed to respond to calls from Ms A, a woman that the police knew was a repeat victim of domestic violence. Early in the morning she went to the police to report that her ex-partner had attacked her the evening before; she had a black eye and swollen face. An arrest request was issued, but not carried out due to the lack of police patrols. She called six times through the day to report that her ex-partner was harassing her and sending text messages saying that he was going to hurt her. A phone call was also made by the nursery staff where her children were placed, because they feared she was in danger. No patrols were sent to Ms A's house and the police arrest warrant was not followed through. By the end of the day her ex-partner had stabbed her and poured boiling water over her. The IPCC's investigation concluded that the police failed to identify the vulnerability of the victim and opportunities were missed to give her the protection she needed.<sup>384</sup>

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[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4074540.pdf..](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4074540.pdf..)

<sup>381</sup> J. Manthorpe and S. Martineau, 2010. Serious Case Reviews in Adult Safeguarding in England: An analysis of Sample reports. *British Journal of Social Work* 1-18. Available at: <http://www.yhip.org.uk/silo/files/serious-case-reviews-in-adult-safeguarding-in-england.pdf>.

<sup>382</sup> Equality and Human Rights Commission, 2011. *Hidden in plain sight: Inquiry into disability-related harassment*. Available at: [http://www.equalityhumanrights.com/uploaded\\_files/disabilityfi/ehrc\\_hidden\\_in\\_plain\\_sight\\_3.pdf..](http://www.equalityhumanrights.com/uploaded_files/disabilityfi/ehrc_hidden_in_plain_sight_3.pdf..)

<sup>383</sup> Independent Police Complaints Commission, 2010. *Annual Report 2009/2010*. Available at: [http://www.ipcc.gov.uk/en/Pages/corp\\_reports-plans.aspx](http://www.ipcc.gov.uk/en/Pages/corp_reports-plans.aspx).

<sup>384</sup> Independent Police Complaints Commission, 2010. *Investigation into contact with Lancashire Constabulary regarding the safety of Ms A on September 2010*. Available at: [http://www.ipcc.gov.uk/en/Pages/investigation\\_reports.aspx..](http://www.ipcc.gov.uk/en/Pages/investigation_reports.aspx..)

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There have also been cases of so-called 'honour' killings reported where the police knew of threats to the victim but did not respond adequately. The most well-known of those cases is that of Banaz Mahmud who was gang-raped and killed in a brutal 'honour' killing in January 2006. Five men including her father and uncle were convicted of the killing. However, the IPCC investigation into the way the police handled her complaints identified that opportunities may have been missed to prevent the tragedy and that Banaz Mahmud was let down badly by the service she received from the police.<sup>385</sup>

**The EHRC recommends that the Committee asks the UK government:**

In the light of the evidence in recent years of very serious cases of failure to protect individuals - including children, vulnerable adults and women at risk of domestic violence - from very serious harm and cruelty and, in some cases, torture, what further actions are being taken to ensure that statutory services, including the police, social services and NHS, understand their duty to protect people they know to be at risk, and to prevent abuse?

**Local authority mechanisms to investigate and learn from serious cases of ill-treatment**

Local Safeguarding Children's Boards are the statutory mechanism in England through which, for the purposes of safeguarding and promoting the welfare of children, the local authority and other relevant organisations within the area co-ordinate and monitor the service they provide. They are uniquely positioned to monitor how professionals and services are working together to safeguard and promote the welfare of children. They are also well placed to identify emerging problems by learning from good practice, and to oversee efforts to improve services in response.

Serious case reviews are one of the mechanisms available to these boards after a child dies or is seriously injured. When conducting a serious case review, the board looks at how local professionals and services worked together to safeguard the child and what may have gone wrong. It also identifies good practice and lessons learned.

The police will also investigate cases that come to their attention and when the child dies a coroner may also open an investigation. But serious case reviews are uniquely positioned to understand the causes of safeguarding failures and can help all agencies involved learn lessons and reduce the risk of ill-treatment of children in their local area.<sup>386</sup>

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Another IPCC Commissioner's Report Investigation was conducted into the police management of reports of domestic abuse made in relation to Casey Brittle (2011). Available at: [http://www.ipcc.gov.uk/en/Pages/investigation\\_reports.aspx](http://www.ipcc.gov.uk/en/Pages/investigation_reports.aspx).

<sup>385</sup>

[http://www.ipcc.gov.uk/news/Pages/10122008\\_mahmoddisciplineoutcome.aspx?auto=True&l1link=pages%2Fnews.aspx&l1title=News%20and%20press&l2link=news%2FPages%2Fdefault.aspx&l2title=Press%20Releases](http://www.ipcc.gov.uk/news/Pages/10122008_mahmoddisciplineoutcome.aspx?auto=True&l1link=pages%2Fnews.aspx&l1title=News%20and%20press&l2link=news%2FPages%2Fdefault.aspx&l2title=Press%20Releases)

<sup>386</sup> HM Government, 2010. *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*. Nottingham: DCSF (Department for Children, Schools and Families) Publications. Working together to safeguard children is the guidance that sets out the situations when a review should take place, it requires Local Safeguarding Boards to consider

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However, according to the Munro Review, a UK government review of the child protection system published in 2010, serious case reviews are failing to identify the core issues that prevent child protection professionals from protecting children. Munro recommended that in serious case reviews there 'should be a stronger focus on understanding the underlying issues that made professionals behave in the way they did and what prevented them from being able to properly help and protect children'.<sup>387</sup>

Supporting this finding Ofsted noted: 'Serious case reviews were generally successful at identifying what had happened to the children concerned, but were less effective at addressing why'.<sup>388</sup>

The Munro Review also highlighted the tendency of serious case reviews to find that human error is the reason for safeguarding failure rather than taking a broader view when drawing lessons. As a result, the response of the authorities in question has often been to control staff more closely. This has created increasing pressure on staff to comply with procedures, leading to a 'heavily bureaucratised system' that is unable to respond to the needs of the child.<sup>389</sup>

For serious case reviews of vulnerable adults the situation is worse. Reviews are not compulsory for local authorities in England and they are not obliged to publish the findings. Unlike serious case reviews relating to the death or harm of a child, no central institution has the obligation to collect and analyse serious case review findings to identify the failures of the system.<sup>390</sup> At present, therefore, public authorities are not able to learn lessons from previous cases where vulnerable adults have been seriously ill-treated.

In addition, there is no legislation making adult safeguarding boards mandatory (although they are referenced in statutory guidance). The Law Commission has recently recommended that they should become statutory bodies in order to strengthen their role and clarify the responsibilities of their member agencies.<sup>391</sup> In a statement of policy on 16 May 2011, the government confirmed its intention to legislate for statutory safeguarding adult boards, although legislative proposals are

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conducting a serious case review when a child has died or the child has been seriously harmed and there is concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child's welfare.

<sup>387</sup> E. Munro, 2011. *The Munro Review of Child Protection: Final Report. A child-centred system*. London: Department for Education. Available at: [http://www.education.gov.uk/munroreview/..](http://www.education.gov.uk/munroreview/)

<sup>388</sup> Ofsted, 2008. *Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008*. Available at: <http://www.ofsted.gov.uk/resources/learning-lessons-taking-action-ofsteds-evaluations-of-serious-case-reviews-1-april-2007-31-march-2008..>

<sup>389</sup> E. Munro, 2011. *The Munro Review of Child Protection: Final Report. A child-centred system*. London: Department for Education. Available at: <http://www.education.gov.uk/munroreview/..>

<sup>390</sup> J. Manthorpe and S. Martineau, 2010. Serious Case Reviews in Adult Safeguarding in England: An analysis of Sample reports. *British Journal of Social Work* 1-18. Available at: <http://www.yhip.org.uk/silo/files/serious-case-reviews-in-adult-safeguarding-in-england.pdf..>

<sup>391</sup> Law Commission, 2011. Law Commission recommendations bring adult protection into the 21st century, say two leading organisations that challenge elder abuse. Available at: [http://www.safeguardingdurhamadults.info/SiteCollectionDocuments/NEWS\\_RELEASE\\_Law\\_Commission\\_11.05.11.pdf..](http://www.safeguardingdurhamadults.info/SiteCollectionDocuments/NEWS_RELEASE_Law_Commission_11.05.11.pdf..)

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yet to be introduced.<sup>392</sup> The Law Commission has also set out its recommendations in relation to adult safeguarding and law reform<sup>393</sup>. The UK government is starting to recognise the shortcomings of the system. It has acknowledged that it must provide appropriate legislative powers and duties, ensuring that the law on keeping people safe is clear, proportionate and effective. The Department of Health published, in May 2011, a Statement of Government Policy on Adult Safeguarding, which begins to set out a new framework for safeguarding, and the intention to legislate for safeguarding adults boards.<sup>394</sup>

**The EHRC recommends that the Committee asks the UK government:**

What is the delay in implementing the proposal to make Adult Safeguarding Boards statutory? What further powers and duties are needed to ensure that adults are adequately protected from abuse? Are the Law Commission's recommendations in relation to adult safeguarding and law reform going to be implemented? What is the timeframe for this?

**Police investigations in cases of rape and domestic violence**

People who have been victims of ill-treatment should be able to have their case heard in the criminal justice system and perpetrators should face the consequences of their actions.

The Crown Prosecution Service (CPS) has a good record in responding to issues relating to violence against women, including rape. Attitudes, policies and practices around dealing with rape allegations have changed for the better in recent years, in response to sustained campaigns by women's organisations. In England and Wales there is a specialised system for dealing with rape at the police, prosecution and judicial levels. Measures in the courtroom to minimise the trauma of the trial for the complainant have been introduced and there is a programme to provide state-of-the-art medical centres in every police force area, where victims of rape can be examined and assisted.

While the policies are laudable, there are problems with their implementation. The Stern Review (2010) into the handling of rape allegations in England and Wales exposed areas in which criminal law is not being enforced by the police. It noted that although 58% of people charged with rape are convicted, only 6% of rapes initially reported to the police get to the point of conviction.<sup>395</sup> In 2006 statutory charging was introduced in England and Wales. Under this scheme, police officers are provided with access to CPS prosecutors for advice and charging decisions. Since its introduction, around half of all cases reported to the police have been referred to the

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<sup>392</sup> Department of Health, 2011. *Statement of Government policy on adult safeguarding*. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_126748..](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126748..)

<sup>393</sup> <http://lawcommission.justice.gov.uk/news/1461.htm>

<sup>394</sup> Department of Health, 2011. *Statement of Government policy on adult safeguarding*.

<sup>395</sup> Government Equalities Office, 2010. *The Stern Review: a report by Baroness Vivien Stern CBE of an independent review into how rape complaints are handled by public authorities in England and Wales*. Available at: [http://beneaththewig.com/wp-content/uploads/2011/08/Stern\\_Review\\_acc\\_FINAL4.pdf..](http://beneaththewig.com/wp-content/uploads/2011/08/Stern_Review_acc_FINAL4.pdf..)

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CPS. This still suggests that a large proportion of cases reported to the police do not progress any further.<sup>396</sup>

The Stern Review highlighted that despite special efforts to improve the way the police respond when a rape is reported, 'there is a long history of disbelief, disrespect, blaming the victim, not seeing rape as a serious violation, and therefore deciding not to record it as a crime'. The Review also noted that the police have a series of arrangements for getting access to forensic physicians, who can take appropriate samples, assess any injuries, reassure and provide care for victims. However, there are problems with the quality of the physicians involved and the police sometimes experience delays in finding one, and in particular obtaining the services of female physicians (who are preferred by both male and female victims).

Independent reports have criticised the police for their insensitive and dismissive approach to victims of sexual violence. The Home Office review on the criminal justice system's response to rape victims was heavily critical of the way police handled and prosecuted rape complaints. For example, it found that several women believed that the police had not properly investigated their cases; and many women reported that the police did not believe them, particularly if they had previous criminal convictions or had been drinking.<sup>397</sup> One rape victim reported:

'The police did a cursory drive around, they knocked on two doors, and then said they were never going to find them. Their attitude is: it's a university town, if we worked on all on these things we would never stop working on suspected rape cases.'<sup>398</sup>

The Stern Review also argued that the CPS's current policies are the right ones, but that the policies have not been fully implemented. The CPS's target for reducing 'unsuccessful outcomes,' influences their decisions to take forward to trial only cases with the strongest evidence. The Review found that cases were not properly prepared, as prosecution lawyers were often not ready for what might be disclosed about the complainant, and did not respond effectively to material presented by the defence.

The case of John Worboys demonstrated the impact of the police's reluctance to believe rape victims and the lack of proactive investigation.<sup>399</sup> Worboys was a taxi driver who picked up women late at night, drugged them, and then sexually assaulted or raped them. The first victims contacted the police in 2006 but their allegations were not investigated. Worboys was identified as a suspect following an allegation of sexual assault in July 2007, when he was arrested but not charged with any offence. He went on to attack a further seven women before he was finally charged in February 2008 and convicted in 2009. The IPCC investigation noted that:

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<sup>396</sup> Equality and Human Rights Commission, 2010. *Triennial Review: How fair is Britain?* Page 139.

<sup>397</sup> S. Payne, 2009. *Rape: The Victim Experience Review*, London: Home Office. Available at: <http://webarchive.nationalarchives.gov.uk/+/http://www.homeoffice.gov.uk/documents/vawg-rape-review/rape-victim-experience2835.pdf?view=Binary..>

<sup>398</sup> Ibid.

<sup>399</sup> Independent Police Complaints Commission, 2010. *IPCC independent investigation into the Metropolitan Police Service's inquiry into allegations against John Worboys*. Available at: [http://www.ipcc.gov.uk/Documents/worboys\\_commissioners\\_report.pdf](http://www.ipcc.gov.uk/Documents/worboys_commissioners_report.pdf). Accessed 22/11/2011.

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'The overwhelming themes in these cases are of an actual or perceived sceptical or insensitive police response to victims of sexual violence, investigations that lack rigour and during which the victims feel they are not being kept informed.'<sup>400</sup>

Advances have been made to protect women from domestic abuse. Rape in marriage was recognised as a crime in English criminal law by abolition of the historic marital rape exemption in 1991. Sentencing guidelines recognising the seriousness of domestic violence were issued in 2006, and the law on murder was reformed to limit the scope of the 'provocation defence' as an excuse for domestic homicide in 2009. The key problems seem to lie not in the law or the policies themselves, but in their implementation. There is a perception at least amongst some women's groups that there is a reluctance to prosecute in domestic violence cases on public interest grounds.

The IPCC's investigation into domestic abuse cases where the woman has been seriously injured or killed shows that the failure to prevent deaths and serious injuries is in part explained by police attitudes. In some cases police did not listen to or believe victims who asked for help. In other cases, police appeared not to understand domestic violence, did not identify risks or appreciate how these might escalate. Calls were wrongly prioritised with fatal consequences.<sup>401</sup> The IPCC has made useful recommendations to improve policing, but again there is evidence that some local forces have failed to implement them.<sup>402</sup>

### **The EHRC recommends that the Committee asks the UK government:**

What steps are being taken to improve the rates of prosecution and conviction in cases of rape and domestic violence? There is evidence that the police do not handle rape cases appropriately and that this leads to a failure to obtain evidence and to prosecute. What training and other measures have been implemented since the Stern Review to address the shortcomings it identified?

### **Hate crime against disabled people**

In 2009, the High Court of Justice found that if a witness with a mental health condition is treated as unreliable because of stereotyping and false assumptions, and not given appropriate support, then this may amount to a breach of Article 3 ECHR.<sup>403</sup> The CPS subsequently reviewed its policies and took a number of steps to

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<sup>400</sup> Ibid.

<sup>401</sup> Independent Police Complaints Commission, *Learning the lessons, Bulletin 11: Gender and domestic abuse*. Available at: <http://www.learningthelessons.org.uk/Pages/Bulletin11.aspx>. Accessed 22/11/2011 ; see also the most recent IPCC report into police failures contributing to a woman's murder by her husband: [http://www.ipcc.gov.uk/news/Pages/pr\\_200112\\_merseysidemott.aspx](http://www.ipcc.gov.uk/news/Pages/pr_200112_merseysidemott.aspx). Accessed 24/01/2012.

<sup>402</sup> IPCC find individual and systemic failures in Nottinghamshire Police's handling of domestic incidents involving Casey Brittle, 18 October 2011. Available at: [http://www.ipcc.gov.uk/news/Pages/pr\\_181011\\_brittle.aspx?auto=True&l1link=pages%2Fnews.aspx&l1title=News%20and%20press&l2link=news%2FPages%2Fdefault.aspx&l2title=Press%20Releases](http://www.ipcc.gov.uk/news/Pages/pr_181011_brittle.aspx?auto=True&l1link=pages%2Fnews.aspx&l1title=News%20and%20press&l2link=news%2FPages%2Fdefault.aspx&l2title=Press%20Releases). Accessed 24/01/2012.

<sup>403</sup> *(B.) v. Director of Public Prosecutions* (Equality and Human Rights Commission intervening) [2009] EWHC 106 (Admin) [2009] WLR (D) 25 QBD.

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improve its understanding of disability hate crime and its performance in dealing with it. In 2009 it published a 'public policy statement' to explain how it would deal with cases involving victims and witnesses with mental health issues.

In 2010 the CPS worked in partnership with Mind, the mental health charity, to produce a prosecutors' toolkit for dealing with cases involving people with mental health issues as victims or witnesses. This aimed to help victims with mental health conditions by improving understanding of how mental distress affects a victim's evidence.<sup>404</sup>

'Special Measures' also exist to help vulnerable and intimidated witnesses give their best evidence in court and help to relieve some of the stress associated with giving evidence.<sup>405</sup>

Nevertheless, disability harassment and disability hate crimes still have unacceptably low prosecution and conviction rates.<sup>406</sup> Keir Starmer, Director of Public Prosecutions, giving evidence to the Commission's inquiry into the harassment of disabled people, criticised the system of special measures in the English legal system as 'just too complicated' because 'applying for special measures is almost like a series of tripwires for a prosecutor'.<sup>407</sup> He also suggested that these improvements may be insufficient because of continuing risk that a witness's impairment may be used to discredit their evidence in court. The fear of such an ordeal can lead disabled victims to withdraw their complaints or not to come forward in the first place.

The Commission's inquiry also found that the police often do not recognise hostility and prejudice to disability as a potential motivating factor for either antisocial behaviour or crime. Although prosecution decisions in England and Wales are a matter for the CPS they depend on the evidence gathered by the police. If the police do not adequately consider the possibility that a crime against a disabled person was motivated by hostility to disability, then they are unlikely to investigate it. Without evidence of any such motivation, prosecutors cannot argue for an extended sentence, which would apply in the case of a hate crime.

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<sup>404</sup> Mind, 2010. *Achieving justice for victims and witnesses with mental distress*. London. Available at: [http://www.mind.org.uk/assets/0000/9950/Prosecutors\\_\\_toolkit.pdf](http://www.mind.org.uk/assets/0000/9950/Prosecutors__toolkit.pdf). Accessed 22/11/2011.

<sup>405</sup> The Youth Justice and Criminal Evidence Act 1999 (YJCEA) defines vulnerable witnesses as:

- All child witnesses (under 18); and
- Any witness whose quality of evidence is likely to be diminished because they:
  - are suffering from a mental disorder (as defined by the Mental Health Act 1983);
  - have a significant impairment of intelligence and social functioning; or
  - have a physical disability or are suffering from a physical disorder.

<sup>406</sup> Equality and Human Rights Commission, 2010. *Triennial Review: How fair is Britain?* Chapter 8, Physical Security.

<sup>407</sup> Equality and Human Rights Commission, 2011. *Hidden in plain sight: Inquiry into disability-related harassment*. Page 150. Available at: <http://www.equalityhumanrights.com/legal-and-policy/inquiries-and-assessments/inquiry-into-disability-related-harassment/hidden-in-plain-sight-the-inquiry-final-report/>.

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Disabled people face many barriers in making allegations of ill-treatment. Many cases are reported to third parties, such as GPs.<sup>408</sup> Disabled people who approach the police may find it difficult to get an advocate as police do not always appoint one, despite the fact that they are obliged to do so for vulnerable victims.<sup>409</sup>

Police may also attribute health problems to a person's disability and as a result, not follow standard procedures to collect evidence and build a case.<sup>410</sup> For example, people with learning disabilities who are victims of sexual violence may not have medical checks carried out, resulting in a lack of medical evidence to prosecute the case later.<sup>411</sup> Incidents of sexual violence against disabled people, especially people with mental health conditions, are frequently not treated as crimes.<sup>412</sup>

**The EHRC recommends that the Committee asks the UK government:**

What preventative measures are being taken to reduce the rate of disability hate crime? What training and other measures are being taken to ensure access to justice and improve the rates of prosecution and conviction? What steps are taken to rehabilitate and educate perpetrators so that they understand the impact of their actions? What measures are being taken to ensure fully accessible, joined-up and effective support services for those who experience harassment?

## **Female Genital Mutilation**

In the UK, it is estimated that up to 24,000 girls under the age of 15 are at risk of female genital mutilation (FGM)<sup>413</sup>. FGM includes procedures that intentionally alter or injure female genital organs for non-medical reasons. The procedure has no health benefits for girls and women.

FGM is internationally recognised as a violation of the human rights of girls and women. Procedures can cause severe bleeding and problems urinating, and later potential childbirth complications and newborn deaths.

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<sup>408</sup> Mencap, 1999. *Living in Fear. The need to combat bullying of people with a learning disability.* London: Mencap.

<sup>409</sup> C. H. Sin, A. Hedges, C. Cook, N. Mguni and N. Comber, 2009. *Disabled people's experiences of targeted violence and hostility.* Manchester: Equality and Human Rights Commission. Available at: [http://www.equalityhumanrights.com/uploaded\\_files/research/disabled\\_people\\_s\\_experiences\\_of\\_targeted\\_violence\\_and\\_hostility.pdf](http://www.equalityhumanrights.com/uploaded_files/research/disabled_people_s_experiences_of_targeted_violence_and_hostility.pdf).

<sup>410</sup> Disability Rights Commission, 2006. *Equal Treatment: Closing the Gap – a formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems.* London: DRC.

<sup>411</sup> D. Gillard, and C. Wallace, 2003, *No Way to Handle Assault, Community Care* (1499) 20 Nov 2003-26 Nov 2003. Pp. 46-47.

<sup>412</sup> Equality and Human Rights Commission, 2010. *Triennial Review How fair is Britain?* Chapter 7.

<sup>413</sup> <http://www.homeoffice.gov.uk/crime/violence-against-women-girls/female-genital-mutilation/>

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The Female Genital Mutilation Act was introduced in 2003, came into effect in March 2004 and applies in England, Wales and Northern Ireland.<sup>414</sup> The Act:

- makes it illegal to practice FGM
- makes it illegal to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in that country
- makes it illegal to aid, abet, counsel or procure the carrying out of FGM abroad
- has a penalty of up to 14 years in prison and, or, a fine.

UK communities that are most at risk of FGM include Kenyans, Somalis, Sudanese, Sierra Leoneans, Egyptians, Nigerians and Eritreans. Women from non-African communities that are at risk of FGM include Yemeni, Kurdish, Indonesian and Pakistani women<sup>415</sup>.

In 2007 research revealed that over 20,000 girls could be at risk of FGM in the UK. The study reveals that nearly 66,000 women with FGM are living in England and Wales (2001) and that there are nearly 16,000 girls under the age of 15 at high risk of World Health Organisation (WHO) Type III FGM and over 5,000 at high risk of WHO Type I or Type II.<sup>416</sup>

Despite the evidence of the extent of the practice<sup>417</sup> which in each case necessarily involves a breach of the criminal law as set out in the FGM Act 2003, there have been no prosecutions in England and Wales<sup>418</sup>.

**The EHRC recommends that the Committee asks the UK government:**

The passing of the law criminalising FGM in 2003 suggests concern about prevalence, but no prosecutions have been brought. What concrete steps is

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<sup>414</sup> The Prohibition of Female Genital Mutilation (Scotland) Act 2005 makes FGM a criminal offence in Scotland.

<sup>415</sup> <http://www.homeoffice.gov.uk/crime/violence-against-women-girls/female-genital-mutilation/>

<sup>416</sup> October 2007, FORWARD: 'A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales'. Available from <http://www.forwarduk.org.uk/key-issues/fgm/research>. In April 2012 journalists investigating the practice for the Sunday Times secretly filmed a doctor, dentist and alternative medicine practitioner who were allegedly willing to perform FGM or arrange for the operation to be carried out. The investigators claimed that as many as 100,000 women in Britain have undergone FGM with medical practitioners in the UK, some of who have performed the extremely illegal procedure on girls as young as 10.

<sup>417</sup> See for instance the London Evening Standard, 16 February 2012; more than 2,100 women and girls in London have sought hospital treatment for genital mutilation over the past six years. The figures were obtained by Freedom of Information Act requests to London NHS hospitals. The figures showed that 2,167 women accessed hospital treatment for female genital mutilation since 2006, with 708 of those needing to be admitted or have surgery.

<sup>418</sup> The Child Protection System in England. Written Evidence Submitted by Jane Ellison MP to the Education Select Committee 11/11/11. Available from <http://www.publications.parliament.uk/pa/cm201213/cmselect/cmeduc/writev/1514/cp60.htm>. Contrast the situation in France where there have been about 100 convictions relating to FGM, many of them resulting in parents and FGM practitioners being sent to prison. Report available from <http://www.bbc.co.uk/news/world-18976217>.

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the government taking to encourage prosecutions? How are communities supported to abandon the practice? How do you measure the effectiveness of this support?

## **Section 8: Legislative framework (GB)**

### **The threat of repeal of the Human Rights Act 1998**

Since there is no direct remedy for a violation of UNCAT under domestic law in the UK, victims need to rely on their Article 3 ECHR rights in order to gain compensation for a violation. They are also able, in areas of law within European Union competence, to rely on their rights under the EU Charter of Fundamental Rights. If the HRA were to be repealed the availability of a remedy in relation to some types of violation of the right to be protected from and not subjected to torture and CIDT would be compromised.

The EHRC submitted its views to the consultations on the Green Paper on a Bill of Rights and Responsibilities<sup>419</sup> and the Commission on a Bill of Rights.<sup>420</sup> We have argued that we already have a Bill of Rights embodied in the HRA and should therefore keep the HRA. We believe the HRA preserves parliamentary sovereignty, and allows our domestic courts to interpret European Convention rights in a way that takes into account European Court judgments, but is in keeping with domestic law and traditions. Judges at the European Court similarly apply a 'margin of appreciation' to take into account the cultural, historic and philosophic differences in different countries. This flexibility allows judges in Britain to suggest a way forward in keeping with the law in Britain. The HRA also requires all public authorities to comply with the Convention which has improved transparency and accountability of government. The HRA has allowed people the chance to have their cases heard in British courts and is speedier and more cost effective. The Commission believes the HRA is essential for the protection of human rights and is well crafted to balance Britain's international obligations with our constitutional conventions. . The Commission is concerned to ensure not only that the incorporation of the ECHR into domestic law is not repealed but also that the mechanisms for its enforcement are not watered down.

#### **The EHRC recommends that the Committee asks the UK government:**

The Commission on a Bill of Rights is due to report by the end of 2012. Please could the government update the Committee on its outcome and on the government's proposed response to it. Please confirm whether the

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<sup>419</sup> Equality and Human Rights Commission, 2010. *HRA Plus: Human Rights for 21<sup>st</sup>-century Britain*. Equality and Human Rights Commission. Available at: [http://www.equalityhumanrights.com/uploaded\\_files/pdfs/hra\\_plus\\_main\\_report.pdf](http://www.equalityhumanrights.com/uploaded_files/pdfs/hra_plus_main_report.pdf).

<sup>420</sup> Equality and Human Rights Commission, 2011. *The case for the Human Rights Act*. Available at: [http://www.equalityhumanrights.com/uploaded\\_files/humanrights/bor\\_full.pdf](http://www.equalityhumanrights.com/uploaded_files/humanrights/bor_full.pdf). Accessed 20/12/2011. The Commission suggests retaining the HRA. However, should a Bill of Rights be introduced to replace the HRA, it should contain at least the same levels of protection of rights and the same system of balance and dialogue between government, parliament and the judiciary, and should comply with the UK's international obligations.

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government intends to weaken the protections covered by Article 3 ECHR or the mechanisms in section 2-6 of the HRA.

## **Legislative change needed to fully incorporate UN CAT**

### **s.134 Criminal Justice Act 1988**

In the most recent Concluding Observations to the UK the Committee was concerned that the 'lawful authority excuse' in section 134(4) of the Criminal Justice Act 1988 leaves a gap between the requirements of the Convention and UK domestic law.

The Commission notes the government's position that it believes s.134 is compatible with the Convention, but that it will reconsider the issue following the conclusions of the Detainee Inquiry.<sup>421</sup> So far as we are aware neither a consideration of whether UNCAT has been effectively incorporated into domestic law nor any question about s. 134 was ever part of Sir Peter Gibson's remit. In any event the Inquiry has been halted.

In the Commission's view there can never be a "lawful authority, justification or excuse" to any charge of intentional infliction of severe pain or suffering and we cannot envisage any situation in which the defence is intended to operate. The Commission's view is that s.134(4) should be repealed. Should any action be taken in response to an immediate threat the common law defence of 'self-defence' would be available in any event.

#### **The EHRC recommends that the Committee asks the UK government:**

In what circumstances is it envisaged that the s.134 CJA 1988 defence could ever be used? Why is it necessary and what would the effect be of repeal?

### **Article 22**

The Commission believes that the right to individual petition is an important feature of all the international human rights treaties the UK has ratified whether codified either through an article of a treaty requiring that states make a declaration that they recognise the competence of a committee to receive complaints, or through an optional protocol requiring state ratification. The Commission believes that the UK government should sign up to all the optional protocols and other individual complaints mechanisms.<sup>422</sup>

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<sup>421</sup> State report para 28.

<sup>422</sup> Letter from Geraldine van Bueren, Commission lead commissioner on human rights to Lord McNally, 9 August 2011; Equality and Human Rights Commission, 'Rights to bring complaints under UN human rights treaties: accountability of the UK government for international obligations', 9 August 2011. The UK has not signed the optional protocol for the ICCPR, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and has not yet indicated whether it will do so for the Convention on the Rights of the Child (CRC). It has not made a declaration for the International Convention on the Elimination of All Forms of Racial Discrimination (CERD). The UK has acceded to the optional protocol for the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of Persons with Disabilities (CRPD).

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The Commission also agrees with the JCHR that “the UK's slow progress in accepting individual petition, as compared with other European and Commonwealth states, undermines its credibility in the promotion and protection of human rights internationally”<sup>423</sup>.

The Commission does not accept the position set out in the state report that the complaints mechanisms are not beneficial since those the UK has ratified in relation to CEDAW and CRPD have been little used to date<sup>424</sup>. Article 22 should be ratified regardless of the amount of complaints that are likely to be raised with the Committee by people from the UK.

**The EHRC recommends that the Committee asks the UK government:**

Will the government reconsider as a matter of principle making a declaration under Article 22 that it recognises the competence of the Committee to receive and consider communications from or on behalf of individuals subject to its jurisdiction who claim to be victims of a violation of the provisions of the Convention?

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<sup>423</sup> Joint Committee on Human Rights 17<sup>th</sup> Report, session 2004-2005, para 27

<sup>424</sup> UK state report paras 9 and 10.

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Amnesty International Solihull Group	Humanitarian Action and Youth
Amnesty International Taunton Group	Independent Complaints Advocacy Service
Amnesty UK	Immigration Lawyers Practitioners Association
Bail for Immigration Detainees	JCF consultants
BCY Solutions	JUSTICE
Bournemouth Borough Council	Justice First
brap	Leeds Diocese Justice and Peace Commission
Bristol City Council	Leeds Metropolitan University
British Institute for Human Rights	Leeds Refugee Forum
British Irish RIGHTS WATCH	Mencap
Calla	Midlands Human Rights Group
Cambridge Community Ethnic Forum/ Cambridgeshire Human Rights & Equality Support Services	Nash Dom CIC
Children Are Unbeatable! Alliance	New Directions
Children's Commissioner for England	Nishkam Centre
Children's Rights Alliance for England	Office of the Children's Commissioner
ECCA and Social Care Institute for Excellence	Prison Reform Trust
Encompass/SexYOUality	Regional Action West Midlands
Equality South West	REDRESS
Freedom from Torture	Savana
Future East – Older people's forum	

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Solace Surviving Exile and  
Persecution

St Vincent De Paul Society – St  
Monica's Housing

The Relatives & Residents Association  
for Quality of Life of Older People in  
Care

TLT Solicitors

Unity in the Community

West Midlands Faiths Forum

West Midlands Strategic Migration  
Partnership

Women's Resource Centre

## Summary of recommendations

### Section 1: UK involvement in conflict overseas

1. On what basis does the government believe that the provisions of the Convention do not apply to the actions of its forces in Afghanistan or Iraq?
2. When is the Iraq Historical Allegations team likely to complete its investigations? How is the Al-Sweady inquiry progressing and when is that inquiry likely to report? Are any other investigations likely to be carried out beyond those two processes?
3. How many investigations have been carried out in relation to allegations of CIDT in Afghanistan? Have there been any prosecutions? Are any further investigations likely to be required?
4. Please provide further details of the criminal investigations that are currently in progress in relation to the allegations by Abdel-Hakim Belhaj and Sami al Saadi. Are there other related criminal investigations underway? How long are they expected to take? What arrangements have been made to ensure that the delay does not prejudice the future inquiry in relation to the other allegations that were due to be within the remit of the Detainee Inquiry chaired by Sir Peter Gibson?

### Section 2: Counter-terrorism

5. Please explain why it has not been possible for individuals subject to TPIMs to be prosecuted through the criminal justice system and provide details of attempts to investigate and prosecute those subject to TPIMs. Please provide details as to how the TPIMs regime meets the requirements of the Convention and how the government ensures that the closed material proceedings are fair.
6. Please explain how the power to detain people without charge for up to 14 days is compatible with the provisions of the Convention. For those detained, please provide details as to whether they were eventually charged, and convicted or acquitted, including for what offences. Will the government consider whether bail might be appropriate for those subject to detention under these provisions?
7. How does the UK government ensure that closed material procedures comply with Convention rights and enable the person concerned to effectively challenge evidence?
8. Please provide evidence as to the necessity for closed material proceedings in civil cases, and why these are not satisfactorily dealt with by current Public Interest Immunity proceedings. How will the government ensure that closed material procedures enable evidence from the security services to be effectively challenged? Please provide evidence to support the need to amend the *Norwich Pharmacal* jurisdiction.

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9. Please explain how the government will ensure that evidence obtained by torture is not used in legal proceedings, bearing in mind restricted rights under closed material proceedings to know and challenge security service evidence?
10. How will the government ensure that the Committee is able to provide effective Parliamentary oversight of the intelligence services, independent of government? Please provide details of how the Intelligence Services Commissioner has exercised his review powers, including numbers of warrants and authorisations reviewed under each relevant section of his powers.

### Section 3: Immigration

11. What monitoring has been carried out to ensure that the nine people returned to Algeria have not been subject to torture or CIDT since their return? Please give further details of the 'official visit' mentioned at para 57 of the State Report. Are there any further memoranda of understanding under negotiation? Are there plans to deport any other individuals under the existing arrangements with Jordan, Morocco or Algeria?
12. What monitoring is carried out to ensure that failed asylum seekers returned to DRC and Sri Lanka have not been subject to torture or CIDT since their return? Where allegations have been substantiated how is that information communicated within government, including to Embassies and High Commissions abroad? What arrangements are in place to ensure that all countries, including European countries, are properly assessed as to safety for return?<sup>425</sup>
13. Has the audit of administrative processes and examination of substantive issues in relation to rule 35 been carried out? Are improvements are being made to the rule 35 procedure to ensure that it is effectively implemented?
14. What action has the government taken following the UNHCR's 2010 recommendations to a) improve the design and function of screening and routing include, as a primary aim, the need to ensure that unsuitable claims and vulnerable individuals are not routed in to the Detained Fast Track detention; b) to provide clearer and more substantive guidance to UKBA staff involved in referring to and selecting cases for the DFT so that they can better identify both cases that cannot be 'decided quickly' and claimants who may be vulnerable?
15. Given the evidence that people with significant mental health issues are being detained, in breach of the government's existing guidelines, what steps can be taken to prevent further detentions taking place, and to ensure that any detainee wrongly held is released as soon as credible concerns are raised?
16. Please give details of the government's policy on health care for immigration detainees, particularly those with HIV or other serious and life-threatening conditions.

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<sup>425</sup> For instance, what assessment has been made in relation to returns to Romania or Moldova?

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17. Please provide details of how many children have been detained for immigration-related purposes, including prior to deportation, and on arrival in the UK, since the closure of the family unit at Yarl's Wood, including at detention centres in Scotland, Wales and Northern Ireland. Please confirm for how long each child was detained and for what purpose.
18. Are improvements needed to the asylum system to ensure that people who wish to make an asylum claim are able to do so within a reasonable time, particularly in cases where they have no accommodation or money to buy food, so as to ensure that those who need it are able to access asylum support? What further arrangements can be made to ensure that failed asylum seekers are not left destitute?
19. Does the government intend to accept the recommendations of the Home Affairs Select Committee in relation to a review of the use of seated restraint techniques? What further steps are being taken to ensure that dangerous techniques are not used?
20. Will the government consider ending the use of private contractors to enforce removals?
21. How many detainees have sustained injuries in the last 3 years as a result of the use of force or restraint by UKBA's employees or private contractors both in immigration detention and during removal or attempted removal? Why in each case was the injury sustained? How many of those were taken to hospital and how were the injuries documented? What investigations take place following injury to ensure the any assault is prosecuted and that lessons are learnt?

### **Section 4: Police and Prisons**

22. In the light of the incidents described that took place in 2009 and 2010 what further guidance and training has been given to police officers to ensure they comply with the law when policing protests?
23. What steps are being taken to comply with the recommendations of HMI Constabulary to adopt overarching standards for the use of force?
24. Are further safeguards needed to prevent the unnecessary use of Taser weapons? Why does the protocol for discharge of a potentially lethal weapon allow an individual officer to make the decision in the case of a Taser, where for firearm use an order from a commanding officer is required?
25. What steps are being taken to reduce the size of the prison population and to reduce overcrowding? Why is overcrowding particularly acute in privately-run prisons?
26. How has the government responded to the HMI Prisons inspection of Styal Prison? What further steps are being taken to implement the recommendations of the Causton report? What steps are being taken to improve mental health services for women in prison and to divert women with mental health problems away from custody into therapeutic care?

27. How does the government intend to deal with the aging prison population? Why are social services not usually involved in assessing and providing for the care needs of prisoners? What steps are being taken to ensure that older prisoners are treated with dignity and that their age-related needs are met?
28. What steps have been taken to implement the recommendations of the 2009 Bradley Report? What further measures can be taken to reduce the numbers of people with mental health problems in the prison system? In the meantime how will levels of support to mentally ill offenders be increased?
29. What steps are being taken to ensure that prisons adhere to the standards outlined in the relevant prison service order and instruction in relation to the identification and treatment of disabled prisoners? What evaluation and monitoring or oversight is there of the training given to prison officers to ensure that they understand their duties to disabled prisoners and its effectiveness? What evaluation and/or monitoring is there of the systems which are in place to ensure that prisons meet the relevant standards in relation to identification and meeting of needs? How are needs communicated from one part of the system to another - for instance from sentencing reports to prison, from remand to incarceration, on prison transfer, and from prison to probation?
30. How many complaints have been received from transgender prisoners since March 2011 about access to facilities appropriate for their acquired gender? What training has been given to prison officers to enable them to implement PSI 07/2011 effectively? What monitoring mechanism is in place to ensure that the relevant PSI and its standards are being put into practice?
31. What steps are being taken to prevent the use of prone and seated restraint techniques either at all, or for prolonged periods? What further measures are needed to ensure there are no further preventable serious injuries or deaths resulting from restraint?
32. What steps will be taken to improve the recording and reporting on deaths in all forms of detention following restraint?
33. What improvements have been made to inquest system since the appointment of the Chief Coroner? Please provide figures for the delay in inquests being held from 2009 to date.
34. Given the lack of public confidence in the IPCC, are there any plans to reform it?
35. Will the government consider putting the independence of PPO on a statutory footing?
36. Why are prosecution and conviction rates of police officers following deaths in custody so low? What steps are being taken to improve the rates of prosecution and conviction?
37. What measures are being taken to ensure that investigations into deaths in custody are carried out promptly and expeditiously?

## Section 5: Children

38. The use of restraint for the purposes of maintaining good order and discipline is unlawful in Secure Training Centres and Secure Children's Homes. Why is the same rule not applied in Young Offenders Institutions? When will the use of restraint in YOIs be reviewed? What measures have been taken to ensure that restraint is only used as a last resort and where absolutely necessary to prevent injury to the child or to others?
39. Please provide a full update on the work of the Restraint Advisory Board and the new MMPR system of restraint. Will the government consider banning the use of any technique designed to inflict pain on children? Why has the new mandibular angle technique been introduced?
40. In order for there to be a better understanding of the use of restraint on children and young people more data needs to be collected, including in particular statistics on injuries incurred broken down by institution.
41. What progress has been made in ensuring that investigations of all allegations of abuse or mistreatment in the secure children's estate that may amount to CIDT are effectively investigated? Has the Youth Justice Board action plan been implemented? How are improvements in the system monitored and assessed?
42. What is the government's response to the Independent Advisory Panel's recommendation that there should be an independent PPO led investigation into deaths in secure children's homes?
43. Will the UK government consider raising the age of criminal responsibility to at least 12 years old in line with international standards? What evidence does the government rely on in support of its view that a younger age than the accepted minimum is acceptable?
44. Does the government accept the criticisms of the JCHR and the DCSF review that the current law on reasonable punishment is difficult for parents to understand? Why does the UK continue to ignore calls from the UN treaty bodies to abolish the defence of reasonable punishment?
45. Will the government consider banning the use of all physical punishment of children by another other than the child's parents and implement the recommendation made in March 2010 by Sir Roger Singleton?
46. In its response to the Commission<sup>426</sup> the Minister said that the Mosquito device embodies a negative attitude towards young people; that it is a discriminatory device and that it serves only to further alienate a section of our society that should be valued. In the light of that does the government now intend to introduce regulation to limit their use to the narrow circumstances in which their use is lawful?

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<sup>426</sup> Tim Loughton MP, Parliamentary Under Secretary of State for Children and Families, 19 August 2011

## **Section 6: Health and Social Care**

47. Will the government consider clarifying the law to place beyond doubt that all private and third sector providers of health and social care commissioned by a public authority are performing a 'public function' within the meaning of the Human Rights Act?
48. In reforming adult social care legislation, will the government also consider using human rights principles as a foundation for statutory, over-arching principles underpinning the new law?
49. Please explain why the issues of safeguarding of vulnerable adults and instances of CIDT in health and social care settings are absent from the state report. Please update the Committee on the activities of the health and social care regulators so far as inspections of health and care settings are concerned, including plans to protect adults at risk from harm with unannounced, targeted inspections.
50. Why is there no automatic independent investigation into all deaths of people who die in mental health settings? How does the current system ensure that systemic issues comes to light and that lessons are learned for the future?

## **Section 7: Protection from abuse**

51. In the light of the evidence in recent years of very serious cases of failure to protect individuals - including children, vulnerable adults and women at risk of domestic violence - from very serious harm and cruelty and, in some cases, torture, what further actions are being taken to ensure that statutory services, including the police, social services and NHS, understand their duty to protect people they know to be at risk, and to prevent abuse?
52. What is the delay in implementing the proposal to make Adult Safeguarding Boards statutory? What further powers and duties are needed to ensure that adults are adequately protected from abuse? Are the Law Commission's recommendations in relation to adult safeguarding and law reform going to be implemented? What is the timeframe for this?
53. What steps are being taken to improve the rates of prosecution and conviction in cases of rape and domestic violence? There is evidence that the police do not handle rape cases appropriately and that this leads to a failure to obtain evidence and to prosecute. What training and other measures have been implemented since the Stern Review to address the shortcomings it identified?
54. What preventative measures are being taken to reduce the rate of disability hate crime? What training and other measures are being taken to ensure access to justice and improve the rates of prosecution and conviction? What steps are taken to rehabilitate and educate perpetrators so that they understanding the impact of their actions? What measures are being taken to ensure fully accessible, joined-up and effective support services for those who experience harassment?
55. The passing of the law criminalising FGM in 2003 suggests concern about prevalence, but no prosecutions have been brought. What concrete steps is

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the government taking to encourage prosecutions? How are communities supported to abandon the practice? How do you measure the effectiveness of this support?

### **Section 8: Legislative framework**

56. The Commission on a Bill of Rights is due to report by the end of 2012. Please could the government update the Committee on its outcome and on the government's proposed response to it. Please confirm whether the government intends to weaken the protections covered by Article 3 ECHR or the mechanisms in section 2-6 of the HRA.
57. In what circumstances is it envisaged that the s.134 CJA 1988 defence could ever be used? Why is it necessary and what would the effect be of repeal?
58. Will the government reconsider as a matter of principle making a declaration under Article 22 that it recognises the competence of the Committee to receive and consider communications from or on behalf of individuals subject to its jurisdiction who claim to be victims of a violation of the provisions of the Convention?