Article 3: Freedom from torture and inhumane and degrading treatment or punishment

Article 3 of the European Convention on Human Rights provides that:

'No one shall be subjected to torture or to inhumane or degrading treatment or punishment'

Article 3: Freedom from torture and inhumane and degrading treatment or punishment **70**

Summary

Article 3 is an absolute right prohibiting torture, and inhumane or degrading treatment or punishment. The state must not itself engage in torture, or in inhumane or degrading treatment. It is also obliged to prevent such treatment happening, and to carry out an investigation into allegations that it has. The state must comply with its obligations within its territory and, in exceptional circumstances, in different countries where it exercises effective jurisdiction.

The prohibition on torture has been part of the British common law framework since the 18th century. Today the legal framework around torture is considerably more sophisticated. It is prohibited both by civil law and by several Acts of Parliament. The UK has also ratified several international conventions prohibiting torture and ill-treatment. This framework is supported by an institutional structure of regulators, including the Care Quality Commission (CQC), the Independent Police Complaints Commission (IPCC) and Her Majesty's Chief Inspectorate of Prisons for England and Wales (HMI Prisons).

The key issues we address in this chapter are:

People who use health and social care services may be at risk of inhumane or degrading treatment

People who use health and social care services have a right to be protected from inhumane and degrading treatment and when there are allegations of mistreatment the state has an obligation to investigate. There is evidence of mistreatment of some users of health and social care services that breaches Article 3.

The review shows that:

- People who are receiving health or social care from private and voluntary sector providers do not have the same level of direct protection under the Human Rights Act as those receiving it from public bodies.
- Local authorities do not make the most effective use of the scope that they have for protecting and promoting human rights when commissioning care from other providers.
- Better inspections of all care settings are needed.

Children and young people in custody may be at risk of inhumane or degrading treatment

Children detained in young offender institutions, secure training centres or secure children's homes are under the full control of the authorities, so the responsibilities of the state are enhanced. Because of the vulnerability of young people in these circumstances the threshold of severity for defining torture, inhumane or degrading treatment or punishment is lowered.

The review shows that:

- There is evidence that restraint is used extensively, but better data are needed.
- Authorised restraint techniques used in young offender institutions and secure training centres do not meet human rights standards.
- The use of restraint as a form of discipline, rather than in cases of absolute necessity or safety, is in breach of Article 3.
- Possible breaches of Article 3 in these settings are not always effectively investigated.

The state sometimes fails in its duty to protect vulnerable people against ill-treatment by other individuals

Under Article 3, the state is required to have both laws and systems in place to prevent people suffering ill-treatment at the hands of other individuals. This means that criminal laws must be effective and punish those who perpetrate torture, and inhumane or degrading treatment. It also means that public authorities have an obligation to act to protect vulnerable individuals from ill-treatment that reaches the level of severity of Article 3, when they know or should have known about it.

The review shows that:

- Public authorities sometimes fail to fulfil their positive obligation to intervene in cases of serious ill-treatment of children, disabled people, and women at risk of domestic violence.
- Local authority mechanisms to investigate and learn from serious cases of ill-treatment may be insufficient.
- Agencies do not always work together effectively to prevent ill-treatment of children and disabled people.
- Despite some advances, police forces still too often fail to investigate cases of rape and domestic violence.

- Despite improvements in the approach of the police and Crown Prosecution Service, hate crime against disabled people still has a low prosecution and conviction rate.
- The law regarding the defence of 'reasonable punishment' of children may be incompatible with Article 3.

The UK government has itself been accused of perpetrating and being complicit in torture and inhumane or degrading treatment

Article 3 obliges the state to refrain from subjecting anyone within its jurisdiction to treatment or punishment that meets the threshold for torture, or inhumane or degrading treatment. This includes an obligation to refrain from being complicit in these acts. When serious allegations of ill-treatment are made, the state then has an obligation to undertake an effective investigation, regardless of the identity of the alleged victim. There is also an obligation not to expel individuals to countries where there is a real risk that they may face torture.

The review shows that:

- There have been allegations that the security and intelligence services were complicit in the ill-treatment of prisoners and civilians in counter-terrorism operations overseas in the immediate aftermath of the 9/11 attacks.
- Guidance for intelligence officers on detaining and interviewing detainees abroad breaches Article 3.
- There have been allegations that British military personnel have been involved in the torture and ill-treatment of civilians and detainees in Iraq. These allegations have not been investigated thoroughly enough to meet Article 3 obligations.
- Despite concerns as to their effectiveness in preventing torture, the government continues to rely on memorandums of understanding in order to deport people to places where they are at risk of torture and degrading treatment.

The UK's obligations under Article 3

Freedom from torture and inhumane or degrading treatment or punishment is an absolute right. This right applies even during a war or in times of threats to national security. States can never, under any circumstances, suspend or derogate from this article, be it for public order purposes or in the interest of society, or due to threats to national security. Everybody has a right to protection under Article 3, regardless of their identity or actions.¹

Torture is also regarded as one of the few principles of international law that is *'jus cogens'*, or accepted by the international community as a norm which is universal and must be upheld regardless of the circumstances.²

Minimum threshold

To be considered a breach of Article 3, the conduct in question must involve a minimum level of severity. Whether the threshold of either torture or inhumane or degrading treatment or punishment has been reached will depend on all the circumstances of the case.

The more vulnerable the victim is the more likely it is that the threshold of minimum severity will be met.³ The assessment of the minimum threshold is relative and depends on all the circumstances of the case including the duration of treatment, the physical or mental effects and the sex, age and state of health of the victim.⁴ A victim's inability to complain coherently, or at all, about how he or she is being affected by any particular treatment, is also taken into account.⁵

¹ Chahal v. the United Kingdom [1996] EHRR 413 and confirmed in Saadi v. Italy [2008] BHRC 123.

² The absolute prohibition on torture is also included in other international treaties, such as the International Covenant on Civil and Political Rights (ICCPR) Article 7, the United Nations Convention Against Torture (UNCAT) and the European Convention Against Torture (ECPT) ratified by the United Kingdom.

³ *Price v. the United Kingdom* [1988] 55 DR 224.

⁴ Ireland v. the United Kingdom [1978] 2 EHRR 25, para 162; see also Selmouni v. France [1988] EHRLR 510, para 160.

⁵ *Herczegfalvy v. Austria* [1992] 15 EHRR 437, para 82; *Aerts v. Belgium* [1998] 29 EHRR 50, para 66.

Individuals in custody

When an individual, whether a child or an adult, is in custody and under full control of state agents, the responsibilities of the state are enhanced. In this case, the starting point for assessing whether any ill-treatment has taken place is a decision as to whether physical force has been used **at all** against a person deprived of their liberty.⁶ If a detainee, whether a child or an adult, shows signs of injury during detention as a result of physical force, the authorities have an obligation to show that the force 'was necessitated by the detainee's own conduct and that only such force as was absolutely necessary was used'.⁷

Different types of ill-treatment

There are differences between the various types of ill-treatment. All must, however, meet the minimum level of severity.

• Torture

For treatment to amount to torture it must be particularly severe.⁸ For example, the European Court of Human Rights found that stripping someone naked, tying their arms behind their back, and then suspending them by their arms, amounted to torture; as did rape of a detainee by an official of the state; and subjection to electric shocks, hot and cold water treatment, blows to the head and threats of ill-treatment to the applicant's children.⁹

Inhumane treatment or punishment

If treatment or punishment causes intense physical or mental suffering, but is not severe enough to amount to torture, it is defined as inhumane treatment. Physical assaults can amount to inhumane treatment if sufficiently serious. Deliberately cruel acts may also amount to inhumane treatment. *In Asker, Selçuk, Dulas and Bilgin v. Turkey* the court held 74

⁶ *Ribitsch v. Austria* [1995] 21 EHRR 573, para 34; and *Assenov and others v. Bulgaria* [1999] EHRLR 225, para 94.

⁷ Tomasi v. France [1992] 15 EHRR 1, paras 108-111; Ribitsch v. Austria ibid., para 34; Aksoy v. Turkey [1996] 23 EHRR 553.

⁸ The United Nations Convention Against Torture in Article 1 defines torture as: 'any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions'.

⁹ Akkoc v. Turkey (21987/93).

that the destruction of the applicants' homes by the security forces was an act of violence and deliberate destruction which disregarded the safety and welfare of the applicants, who were left without shelter and in circumstances which caused anguish and suffering.¹⁰

Degrading treatment or punishment

Degrading treatment or punishment arouses a feeling of fear, anguish and inferiority and humiliates and debases the victim. It includes treatment designed to break the physical or moral resistance of a victim. Whether the treatment or punishment is degrading is subjective: it is sufficient for the victim to feel humiliated, even if the state agent does not perceive the treatment as humiliating. One of the first illustrations of degrading treatment was the case *Tyrer v. the United Kingdom* about corporal punishment.

In the presence of his father and a doctor the applicant, a 15-year-old boy, was made to take down his trousers and underpants and bend over a table; he was held by two policemen while a third administered the punishment of three strokes of the birch. The Court considered that the punishment did not amount to torture but was degrading.¹¹

Article 3 imposes three different types of obligations on the state:

• **a negative obligation** which means that the state must itself refrain from subjecting anyone within its jurisdiction to treatment or punishment that meets the 'threshold' of being torture, inhumane or degrading treatment.

¹⁰ Selçuk and Asker v. Turkey, judgment of 24 April 1998, ECHR 1998-II.

¹¹ Tyrer v. the United Kingdom (5856/72) ECHR 1978. The definition of degrading treatment has also been applied to asylum seekers. In 2005 the House of Lords in the case of R. (Limbuela and Others) v. S/S for the Home Department [2005] UKHL 66 found that the removal of support from three destitute asylum-seekers under section 55 was unlawful as it breached their right not to be subjected to inhumane or degrading treatment under Article 3 ECHR. Section 55 of the Nationality, Immigration and Asylum Act 2002 denied access to asylum support to those asylum-seekers who had not applied for asylum 'as soon as reasonably practicable' after arriving in the UK. This had the effect of singling out late asylum claimants and removing them from eligibility for support, at the same time as barring them from working or accessing mainstream benefits. The judgment found that treatment is inhumane or degrading if, to a seriously detrimental extent, it denies the most basic needs of any human being. Where the inhumane or degrading treatment or punishment results from acts or omissions for which the state is directly responsible, there is an absolute obligation on the state to refrain from such conduct. The threshold test was whether 'the treatment to which the asylum-seeker was being subjected by the entire package of restrictions and deprivations that surrounded him was so severe that it could properly be described as inhumane or degrading treatment within the meaning of [Article 3]'.

- **a positive obligation** to require public authorities to take steps to prevent torture and ill-treatment. This requires the state to have laws in place to adequately protect vulnerable groups from ill-treatment and for public officials to act to protect vulnerable people from harm inflicted on them by others.
- **a procedural obligation** to carry out an effective investigation where there are credible allegations of serious ill-treatment. For an investigation to be considered effective, there need to be procedural safeguards in place and the investigation should be prompt and independent and it should be capable of leading to the identification and punishment of those responsible of any violation of Article 3.

Relation to other articles

Since inhumane or degrading treatment violates human dignity there is sometimes an overlap between Article 3 and Article 8 (the right to respect for private and family life). It is not uncommon where ill-treatment fails to meet the level of severity demanded by Article 3 that a violation of Article 8 may have occurred as Article 8 protects a person's physical integrity as an aspect of private life; this has also been recognised by the European Court of Human Rights.¹² Where the treatment can or has led to the death of the person, and the authorities were aware of this, the Court has recognised that Article 2 is relevant.¹³

European Court of Human Rights. *Factsheet – Violence against Women*. Available at: http://www.echr.coe.int/NR/rdonlyres/39C38938-2E29-4151-9280-D5AC063DD02E/0/FICHES_Violence_femmes_EN.pdf. Accessed 18/11/2011.

See also, General Recommendation No. 19 (1992) Violence Against Women issued by the UN Committee On the Elimination of Discrimination Against Women (CEDAW).

76

¹² E.S. and Others v. Slovakia (8227/04)15 December. See above.

¹³ In *Opuz v. Turkey* [2009] ECHR 33401/02 the applicant and her mother were assaulted and threatened over many years by the applicant's husband H.O., at various points, leaving both women with life-threatening injuries. With only one exception, no prosecution was brought against him on the grounds that both women had withdrawn their complaints, despite their explanations that H.O. had harassed them into doing so, threatening to kill them. He subsequently stabbed his wife seven times and shot dead his mother-in-law. The Court found a violation of Article 2 (right to life) concerning the murder of H.O.'s mother-in-law and a violation of Article 3 (prohibition of inhumane or degrading treatment) concerning the state's failure to protect his wife.

The development of Article 3 in Britain

The prohibition of torture has been part of the British common law framework since the 18th century. In 1709 the government passed the Treason Act – the first Act prohibiting torture of any person accused of any crime. Previously, if an individual stood mute and refused to plead guilty or not guilty for a felony, he would be tortured until he entered a plea. This Act put an end to torture as a legal means of criminal inquiry in the United Kingdom, and was the first formal abolition of torture in any European state.¹⁴

Today the legal framework satisfying the negative, positive and procedural obligations of the state in relation to torture is considerably more sophisticated. Our legal system continues to prohibit torture and other forms of ill-treatment through its criminal and civil law framework. For example, section 134 of the Criminal Justice Act 1988 prohibits torture undertaken by a public official, regardless of whether the victim is or is not a British citizen and whether or not the torture was committed in Britain.¹⁵ Criminal law also outlaws acts or omissions which might constitute torture or inhumane or degrading treatment, and allows the prosecution of perpetrators, across offences ranging from hate crimes or harassment, to rape or assault and grievous bodily harm.

Civil law gives expression to Article 3 through mechanisms such as injunctions and restraining orders to protect a victim. Protection from domestic violence, for example, is provided largely by civil law. Harassment can also be dealt with through civil law and individuals can bring tort (or personal injury) proceedings and claim damages for trespass or assault, battery or false imprisonment.¹⁶

¹⁴ J. Wade, 1839. British history, chronologically arranged; comprehending a classified analysis of events in church and state; and of the constitutional, political, commercial, intellectual and social progress of the United Kingdom, from the first invasion by the Romans to the accession of Queen Victoria. Volume: 2. London: Effingham Wilson.

¹⁵ This Act was introduced when the UK government signed up to the UN Convention Against Torture which required the government to have a law prohibiting torture.

¹⁶ See Protection of Harassment Act 1997, Section 2 – Harassment can be either a civil or criminal matter.

Lastly, in public law there are statutes, regulations, rules and codes which govern public functions and services such as the reception of a child into care to avoid harm (the Children Act 1989 and 2004); treatment and conditions of residential care; conditions of detention (the Prison Rules 1999); and discipline in detention (Criminal Justice and Public Order Act 1994).

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. Examples of these are the two specific conventions which prohibit torture and inhumane and degrading treatment: the United Nations Convention Against Torture and the European Convention Against Torture. The United Nations Convention imposes a duty on the state to submit a periodic report to the United Nations Committee Against Torture outlining how it is complying with its obligations. Both Conventions have protocols establishing a system of regular visits by an independent expert committee to all places where people are deprived of their liberty, to prevent torture and other cruel, inhumane or degrading treatment or punishment. The protocol to the UN Convention also obliges States to designate or establish a national body or bodies, called National Preventive Mechanisms, to conduct regular preventative visits to places of detention in that country.

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,¹⁷ 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.

The UK's legal framework that gives expression to Article 3 is also supported by an institutional structure of regulators. These include the 18 inspection bodies that come under the National Preventative Mechanism, like the Care Quality Commission (CQC), Her Majesty's Inspectorate of Prisons (HMI Prisons), the Independent Police Complaints Commission (IPCC) and the Office for Standards in Education, Children's Services and Skills (Ofsted).

17 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 (II) relative to the Treatment of Prisoners of War. Convention (IV) relative to the Protection of Civilian Persons in Time of War. 78

However, despite the apparent strong legal and institutional framework supporting Article 3, the evidence suggests Britain may not be fully meeting its obligations under this article in some areas.

The issues we have chosen for this chapter demonstrate a range of applications of Article 3. They show, for example, that the protection against torture and inhumane or degrading treatment is not confined to the actions of state agents in prisons or during war time; this protection extends to any individual who has been or is at risk of being seriously ill-treated at home or in the community or when accessing a public service.

We will examine each of these in turn in this chapter. In each setting we look at whether there are adequate laws to comply with Article 3; and whether there are institutions and processes in place to protect and uphold the law. We draw conclusions about the key issues which must be tackled if Britain is to fully meet its human rights obligations under Article 3.

People who use health and social care services may be at risk of inhumane or degrading

How Article 3 protects people who receive health or social care

People who use health or social care services – by definition, some of the most vulnerable people in society – have a right to be protected from inhumane or degrading treatment. For example, Article 3 should protect people from severe mistreatment such as that exposed by the BBC Panorama programme in May 2011, which showed how disabled residents of Winterbourne View hospital near Bristol were routinely slapped, kicked, teased and taunted by members of staff.

To be covered by Article 3, the treatment must be bad enough to reach the minimum level of severity, outlined above. It is not the only human right which may apply to cases of abuse or neglect in health and social care settings. There may be cases in which older people, for example, have been badly treated by a care worker but not so badly that the behaviour would constitute inhumane or degrading treatment. The treatment in this case may still breach Article 8, the right to physical integrity as an aspect of private life (see the chapter on Article 8, the right to respect for private and family life, home and correspondence).

Three institutions are in place to protect individuals who are users of health and social care services. The Care Quality Commission (CQC) was established in 2009 to regulate, register, inspect and review health and adult social care services in the public, private and voluntary sectors in England. The CQC can take legal action against providers that fail to meet the minimum requirements outlined by the CQC's essential standards.¹⁸ The Parliamentary and Health

18 Care Quality Commission, 2010. *Essential standards of quality and safety*. Available at: http://www.cqc.org.uk/sites/default/files/media/documents/essential_standards_of_quality_and_safety_march_2010_final_0.pdf. Accessed 24/11/2011.

Service Ombudsman (PHSO) investigates complaints by individuals about improper actions or poor treatment by government departments, public bodies and the National Health Service (NHS) in England. The Local Government Ombudsman also has the capacity to investigate complaints about adult social care providers, such as care homes and home care providers, across public, private, and third sector settings.

There is evidence that some people who use health and social care services are at risk of inhumane and degrading mistreatment which breaches Article 3. In February 2011, the PHSO reported on 10 investigations into the care of older people by NHS institutions, of which several revealed ill-treatment possibly serious enough to breach Article 3.¹⁹

Mrs H, 88, 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.²⁰

This was not an isolated case: 18 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 2011.²¹

In November 2011, the Equality and Human Rights Commission (the Commission) 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

¹⁹ 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. Accessed 18/11/2011.

²⁰ Ibid.

²¹ Ibid.

the commissioning and delivery of home care services, with many care workers providing excellent care under challenging circumstances. However, there 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 Article 3.²²

As people often receive health and social care services at home, behind closed doors, it is hard to say how often breaches of Article 3 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 Article 3.

Key issues

1. 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 as those receiving it from public bodies

The Human Rights Act (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 settings because most care homes are owned by private or voluntary sector organisations, as are most 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 per cent), with 17 per cent being operated by public sector bodies.²³

This mixed economy has some complex legal consequences in relation to the scope of the HRA (see Article 8 for further information). A House of Lords ruling in 2007 excluded independent providers of residential social care from the scope of the Act.²⁴ 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

²² 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/. Accessed 23/11/2011. See page 28.

²³ 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. Accessed 23/11/2011.

²⁴ Y.L. v. Birmingham City Council and others [2007] UKHL 27.

of this decision for care home residents whose places are arranged by local authorities.²⁵ However, 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.²⁶ However, there is no case law relating to other categories of patient. Private hospitals treating NHS patients may not have obligations under the HRA.²⁷

This means that a sizeable minority of people who use health and social care services may not have their human rights directly protected by the law. Their rights may, however, be protected indirectly as the public authorities that commission health and social care services from independent providers have positive obligations to promote and protect the human rights of individual service users, which may extend to services provided by independent organisations.

2. Local authorities do not make the most effective use of the scope that they have for protecting and promoting human rights when commissioning care from other providers

Local authorities and primary care trusts are currently responsible for commissioning health and social care services from private and third sector organisations. Local authorities have positive obligations to carry out their powers and duties in a way that promotes and protects the rights contained in the HRA. This applies to every aspect of their day-to-day work. At a strategic level, commissioners can identify the needs of the local population and plan how these should be met, in ways that fit with equality and human rights legislation and meet their positive obligations to promote and protect human rights. During the procurement and contract management processes, local authorities can actively manage and monitor how well social care protects and promotes human rights in practice, and take action if any risks to human rights become apparent. If local authorities and primary care trusts included human rights as part of the commissioning criteria around the quality and delivery of care, this would help to raise standards across the board.²⁸

²⁵ Health and Social Care Act 2008.

²⁶ R. (A.) v. Partnerships in Care Ltd [2002] EWHC 529 (Admin).

²⁷ Private hospitals are subject to inspections from the Care Quality Commission.

²⁸ 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/. Accessed 23/11/2011.

However, evidence from the Commission's inquiry into older people and human rights in home care suggests that commissioning bodies have a poor understanding of their positive obligations and so do not make the most effective use of the scope they have for protecting and promoting human rights. The inquiry found that local authorities believe they take account of human rights in their commissioning plans and procurement processes, but it was clear from interviews with them and analysis of their commissioning and procurement documentation that they had a patchy understanding of human rights and their own obligations in protecting and promoting these rights for older people.

The Commission found that commissioning bodies usually addressed human rights superficially in their commissioning documents. If mentioned at all, the HRA and related legislation was usually listed in the standard terms of the document, often in the legal appendices, without setting out substantive requirements of how providers should address human rights when delivering a service. Commissioning documents might also refer to principles of dignity, respect and independence but did not necessarily mention human rights, the HRA and the public authorities' positive human rights obligations.

The inquiry also found that practice on commissioning varied a great deal between local authorities – some local authorities adopted a qualitydriven approach, incorporating human rights principles at all stages of the commissioning process, while others appeared to focus on price above all other considerations – an approach which is likely to reduce the quality of services. However, very few are consistently adopting commissioning principles that are firmly underpinned by an understanding of human rights.²⁹

²⁹ 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/. Accessed 23/11/2011.

3. Better inspections of all care settings are needed

The state is under an obligation to investigate well-founded allegations of inhumane 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 CQC stopped conducting routine inspections of all providers. Instead, they now take a risk-based approach, trying to identify through selfassessment from providers where a potential need for regulatory action exists. There are fears that this has made scrutiny of human rights issues less effective, as it pays 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.³⁰

As from October 2010, the CQC ceased monitoring the commissioning practices of local authorities. This means that the CQC cannot comment on poor commissioning, but only on the quality of care services that result from those commissioning practices. The Commission's inquiry into older people and human rights in home care received evidence of serious concerns about this gap in the regulatory system.³¹

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.³² It has also recently announced plans for a programme of random, unannounced inspections of hospitals providing care for people with learning disabilities. Acting in response to the

³⁰ 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. Accessed 18/11/2011.

³¹ 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/. Accessed 07/12/2011.

³² 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. Accessed 24/11/2011.

Commission's inquiry, the CQC has made plans to carry out a themed inspection programme of around 250 care home providers starting in April 2012.³³

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.³⁴ 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.³⁵

³³ Care Quality Commission, 2011. *CQC to target care home services*. Available at: http://www.cqc.org. uk/node/386875. Accessed 07/12/2011.

³⁴ 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. Accessed 18/11/2011.

³⁵ 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/. Accessed 18/11/2011.

Children and young people in custody may be at risk of inhumane or degrading treatment

How Article 3 protects children and young people in custody³⁶

Children and young people who have been convicted of crimes 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.

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.³⁷

All children and young people in custody are vulnerable due to their age and immaturity. Many will have experienced neglect, abuse, domestic violence, poor parenting³⁸ and poverty.³⁹ They are also more likely to have poor educational experiences and have learning disabilities.⁴⁰

- 36 Children in these settings are also protected by the Children Act 1989 and Children Act 2004 Section 11. This imposes a general duty on young offenders institutions and secure training centres and secure children's homes to safeguard and promote the welfare of children.
- 37 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.
- 38 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. Accessed 18/11/2011.
- 39 Youth Justice Board, 2007. Accommodation needs and experiences. London: Youth Justice Board.
- 40 Youth Justice Board, 2006. *Barriers to engaging in education, training and employment*. London: Youth Justice Board.

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 3.⁴¹

The UN 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.⁴² The Convention on the Rights of the Child 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.⁴³

In 2007, the government introduced the Secure Training Centre (Amendment) Rules. The rules allowed officers working in these institutions 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 'inhumane 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. The rules were quashed, and secure training centres are no longer allowed to restrain young offenders on these grounds.⁴⁴ 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.

⁴¹ 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 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, paras 52 and 53; and *Assenov and others v. Bulgaria*, judgment of 28 October 1998, Reports 1998 - VIII, para 94.

⁴² 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.

⁴³ Article 19 and 37 Convention on the Rights of the Child.

⁴⁴ 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.

The government has put in place regulations and processes to safeguard children and young people in its care. To ensure young offender institutions, secure training centres and secure children's homes meet the requirements on safeguarding and the use of restraint, the Youth Justice Board uses a monitoring team which visits and reports on all secure establishments, and directs resources to where risks exist. The Criminal Justice and Public Order Act 1994 provides for the appointment of an independent monitor to every secure training centre who is required to investigate and report on allegations made against custody officers. Under Rule 38 (3) of the Secure Training Centre Rules 1998 the monitor should be notified within 12 hours of a child being physically restrained and each incident report is reviewed to understand what led up to it and how it was handled. Measures to mitigate any risks or issues of concern are reviewed monthly. If a young person dies, becomes seriously ill or sustains any serious injury, then secure training centres must comply with a Serious and Significant Incident Reporting Protocol. Independent monitors also ensure that the secure training centre uses external agencies to provide additional independent scrutiny and investigation where necessary.

The monitors also visit young offender institutions. Young offender institutions are required to have a safeguarding children manager to ensure safeguarding is part of policies and practices in the institution. Young offender institutions are required to inform a young person's family or appropriate adult if control and restraint is used on the young person, and all uses of force should be recorded, and serious injuries reported to the Youth Justice Board.

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.⁴⁵ The Children's Act 1989 requires local authorities to implement a complaints procedure for children in its care, including those in secure children's homes.

Local safeguarding children's boards have oversight of safeguarding arrangements within the youth secure estate in their area. Government guidance requires that there are protocols between local authorities, young

45 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.

offender institutions, secure training centres and local safeguarding children's boards which set out how they will work together and share information to safeguard and promote the welfare of children and young people in secure establishments.⁴⁶

Key issues

1. There is evidence that restraint is used extensively, but better data are needed

Restraint statistics are likely to be an underestimate and it remains unclear from the available literature whether all incidents across detention centres are captured.⁴⁷ 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]'.⁴⁸ 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 review, that 'the current system ... distorts figures and does not present an accurate account of real events'.⁴⁹

⁴⁶ Department for Children, Schools and Families, 2010. *Working together to safeguard children*. DCSF. Available at: https://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN.pdf. Accessed 18/11/2011.

⁴⁷ 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. 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.

⁴⁸ 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. Accessed 18/11/2011.

⁴⁹ 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. Accessed 21/11/2011.

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.⁵⁰ On average, this means 575 restraints per month. In one establishment, nearly half of the children had been restrained.⁵¹ 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.⁵²

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.⁵³ 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.

2. Authorised restraint techniques used in young offender institutions and secure training centres do not meet human rights standards

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,⁵⁴ 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)'.⁵⁵

⁵⁰ 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. Accessed 22/11/2011.

⁵¹ Ibid.

⁵² Ibid.

⁵³ Youth Justice Board. Briefing note for Equality and Human Rights Commission. September 2011.

⁵⁴ 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 Inhumane or Degrading Treatment or Punishment (CPT) from 18 November to 1 December 2008.

⁵⁵ 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.

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.⁵⁶ '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.⁵⁷

'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 government is currently considering authorising a new system of restraint to be used across young offender institutions and secure training centres. Formal approval is not likely to be announced until the beginning of 2012.⁵⁸ The new system of restraint will introduce new strategies and policies on the use of force. However, it is believed that some of these methods will also rely on the use of pain, as pain-compliant techniques are being considered as part of the new restraint system.⁵⁹ 92

⁵⁶ 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. Accessed 22/11/2011.

⁵⁷ Ibid.

⁵⁸ Since March 2011 the Restraint Advisory Board and the National Offender Management Service (NOMS) have developed the restraint methods to be presented to Ministers. The roll out of this new technique is set out in P. Smallridge and A. Williamson, 2011. *Report on implementing the independent review of restraint in juvenile secure settings*. Page 7. Available at: http://www.justice.gov.uk/downloads/publications/policy/moj/report-implement-review-restraint-juvenile-secure-settings.pdf. Accessed 22/11/2011.

⁵⁹ *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. 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.

3. The use of restraint as a form of discipline, rather than in cases of absolute necessity or safety, is in breach of Article 3

In 2008, the Court of Appeal established that the use of restraint in secure training centres for the purpose of good order and discipline, rather than for safety, was a breach of Article 3.⁶⁰ Additionally, Article 3 when applied to children should be interpreted in light of international conventions. In particular, interpretation must take into account Article 37(c) of the Convention on the Rights of the Child, which provides that every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her own age.⁶¹

The Committee on the Rights of the Child has urged the UK 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.⁶²

The evidence suggests that restraint is being used unlawfully or inappropriately. Unlawful use 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, numerous reports have consistently 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.⁶³

⁶⁰ The Commission intervened in the case of R. (C.) v. Secretary of State for Justice [2008] EWCA Civ 882.

⁶¹ Convention on the Rights of the Child Article 37.

⁶² 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. Accessed 22/11/2011.

⁶³ 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. Accessed 22/11/2011.

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.⁶⁴ For example, the inspection in 2010 of 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.' 65

The 2009 inspection of Hindley young offender institution found that restraint was sometimes used inappropriately.⁶⁶

In 2008, when the Joint Committee on Human Rights (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.⁶⁷

In 2011, the UK National Preventive Mechanisms (NPMs) also questioned the extent to which restraint is being used safely and only when absolutely necessary and whether appropriate methods are used on children.⁶⁸

⁶⁴ 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/. Accessed 22/11/2011.

⁶⁵ 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. Accessed 22/11/2011.

⁶⁶ 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. Accessed 22/11/2011.

⁶⁷ 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. Accessed 22/11/2011.

⁶⁸ 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. Accessed 22/11/2011. The UK NPMs is a collective of 18 bodies set up following Britain's ratification of the Optional Protocol to the Prevention Against Torture, and its role is to visit all places of detention and monitor the treatment of and conditions for detainees.

4. Possible breaches of Article 3 in these settings are not always effectively investigated

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'.⁶⁹ 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.⁷⁰ 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 2011.⁷¹ 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.

There is also evidence that children and young people are unlikely to report incidents, and as a consequence cases of use of restraint are going unaddressed: 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.⁷² 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.⁷³ This point is backed up by an investigation by the Children's Commissioner for England, who 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

⁶⁹ *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.

⁷⁰ Since recorded instances are also partial statistics, it is likely that many incidents are not recorded and not investigated.

⁷¹ Hansard HL, col WA72 (09 November 2011). Available at: http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/111109w0001.htm. Accessed 24/01/2012.

⁷² 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%200f%20childrens%20rights%20 Nov%202010.pdf. Accessed 23/11/2011.

⁷³ The Howard League for Penal Reform, 2011. *Twisted: the use of force on children in custody*. Available at: http://www.howardleague.org/restraint/. Accessed 22/11/2011.

the procedures to be slow and impersonal. Some feared reprisals if they complained.⁷⁴ This 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.⁷⁵

⁷⁴ 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. Accessed 22/11/2011.

⁷⁵ 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%200f%20the%20Complaints%20System%20-%20Summary%20 and%20Action%20Plan.pdf. Accessed 30/11/2011.

The state sometimes fails in its duty to protect vulnerable people against ill-treatment by other individuals

How Article 3 protects people from ill-treatment at the hands of individuals

The state has a positive obligation to take effective protective measures to prevent inhumane and degrading treatment.⁷⁶ 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 for Article 3, then they should take adequate steps to prevent the aggressor carrying out this threat or committing further acts of violence.⁷⁷

The idea that Article 3 protects people from ill-treatment caused not only by agents of the state but also by other individuals is fairly new. It was not until 1994 that the European Court of Human Rights (the Court) found, for example, that a state had breached its Article 3 obligations by allowing guardians to physically punish children. The Court considered that children and other vulnerable individuals, in particular, were entitled to protection in the form of effective deterrence: 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 inhumane 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.⁷⁸

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 3.⁷⁹ 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.⁸⁰

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.⁸¹

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.⁸² This section looks at examples of Article 3 breaches arising from the failure to intervene effectively to safeguard abused children, disabled people who are ill-treated and women experiencing domestic violence. It focuses on violence against women, children and disabled people because there have been several cases in which individuals from these groups have been subjected to ill-treatment that reached the level of severity of Article 3. There is also evidence that the authorities may have failed in their obligations to protect them. The same duty would apply to any other individuals subject to treatment of the necessary severity to breach Article 3.

79 Z. and Others v. the United Kingdom [2001] 29392/95 2 F.L.R. 612.

80 *Opuz v. Turkey* [2009] ECHR 33401/02.

98

⁸¹ E.S. and Others v. Slovakia (8227/04). M.C. v. Bulgaria [2003] ECHR 646. 82 Satik v. Turkey (31866/96).

Key issues

1. Public authorities sometimes fail to fulfil their positive obligation to intervene in cases of serious 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 Article 3 obligations to protect people from ill-treatment where possible.

The case of Peter Connelly, or Baby P, is an example of ill-treatment that reached the level of severity of Article 3. The authorities failed to act effectively despite knowing that the child was at risk of ill-treatment.

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'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'.⁸³

83 Local Safeguarding Children's Board Haringey, 2009. *Serious Case Review: Baby Peter*. Available at: http://www.haringeylscb.org/executive_summary_peter_final.pdf. Accessed 22/11/2011.

Serious case reviews investigate the death or serious injury of a child where abuse or neglect is known or suspected to be a factor. These reviews show that in over 70 per cent 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.⁸⁴

Of the 194 cases evaluated by Ofsted, 90 had resulted in the death of a child, of which 31 were receiving services as 'children in need'.⁸⁵ 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.⁸⁶

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 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 harrassment 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.⁸⁷

⁸⁴ 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. Accessed 22/11/2011.

⁸⁵ 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.

⁸⁶ 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-typassed 22/11/2011.

⁸⁷ Equality and Human Rights Commission, 2011. Hidden in Plain Sight. Inquiry into disabilityrelated harassment. Pp. 11, 53. Available at: http://www.equalityhumanrights.com/uploaded_files/ disabilityfi/ehrc_hidden_in_plain_sight_3.pdf. Accessed 22/11/2011.

Michael Gilbert, who had an undiagnosed mental health condition, had lived with the Watt family for more than 10 years. During this time, the court heard that 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.88

As in the case of children, local authorities should conduct serious case reviews when the death or harm of a 'vulnerable adult' has occurred.⁸⁹ 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'.⁹⁰

89 The Law Commission, 2011. Adult Social Care. London: The Stationery Office. Para 9.3.

90 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: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4074540.pdf. Accessed 22/11/2011.

⁸⁸ Equality and Human Rights Commission, 2011. *Hidden in Plain Sight. Inquiry into disabilityrelated harassment.* Pp. 45. Available at: http://www.equalityhumanrights.com/uploaded_files/ disabilityfi/ehrc_hidden_in_plain_sight_3.pdf. Accessed 22/11/2011.

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.⁹¹

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.⁹²

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 where the victim was in prior contact with the police.⁹³ 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.

⁹¹ 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. Accessed 22/11/2011.

⁹² Equality and Human Rights Commission, 2011. *Hidden in plain sight: Inquiry into disabilityrelated harassment*. Available at: http://www.equalityhumanrights.com/uploaded_files/disabilityfi/ ehrc_hidden_in_plain_sight_3.pdf. Accessed 22/11/2011.

⁹³ Independent Police Complaints Commission, 2010. *Annual Report 2009/2010*. Available at: http://www.ipcc.gov.uk/en/Pages/corp_reports-plans.aspx. Accessed 22/11/2011.

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 IPPC'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.⁹⁴

2. Local authority mechanisms to investigate and learn from serious cases of ill-treatment may be insufficient

Local Safeguarding Children's Boards are the statutory mechanism 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.

94 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. Accessed 22/11/2011. 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. Accessed 22/11/2011. This is of course not the only mechanism in place, 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.⁹⁵

However, according to the Munro Review, a 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'.⁹⁶

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'.⁹⁷

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.⁹⁸

⁹⁵ 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 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.

⁹⁶ 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/. Accessed 22/11/2011.

⁹⁷ 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-lessonstaking-action-ofsteds-evaluations-of-serious-case-reviews-1-april-2007-31-march-200. Accessed 22/11/2011.

⁹⁸ 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/. Accessed 22/11/2011.
For serious case reviews of vulnerable adults the situation is worse. Reviews are not compulsory for local authorities 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.⁹⁹ 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.¹⁰⁰ 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 yet to be introduced.¹⁰¹ The Law Commission has also set out its recommendations in relation to adult safeguarding and law reform.

The 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.¹⁰²

⁹⁹ 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. Accessed 22/11/2011.

¹⁰⁰ 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. Accessed 22/11/2011.

¹⁰¹ Department of Health, 2011. Statement of Government policy on adult safeguarding. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/ PublicationsPolicyAndGuidance/DH_126748. Accessed 22/11/2011.

¹⁰² Ibid.

3. Agencies do not always work together effectively to prevent ill-treatment of children and disabled people

In cases involving the ill-treatment of disabled people, there are often blurred lines of responsibility between the criminal justice system, social care, and other relevant agencies.¹⁰³ A review of 22 serious case reviews of vulnerable adults found that the most common cause of failure to protect an individual was the lack of inter-agency communication. Of the 22 case reviews, 17 cited a poor relationship between care staff, police, hospital staff and the system of safeguarding within the local authority as the cause of failure.¹⁰⁴

Some local authorities and their social care agencies have failed to intervene in cases of abuse of vulnerable adults, and have argued that there is no duty for them to do so. However, the 'No Secrets Guidance' on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse, makes it clear that the local authority is expected to take on this role.¹⁰⁵

The police also appear to be failing to intervene in cases of ill-treatment of disabled individuals because they find it difficult to identify the 'needs' of the disabled individuals and their families or to recognise when the problem might escalate. A report by Her Majesty's Inspectorate of Constabulary (HMI Constabulary) found that only half (22 out of 43) of police forces in England and Wales are able to identify and prioritise repeat callers at the time when the call is made and less than a third (13 out of 43) can effectively identify the most at risk callers.¹⁰⁶ The Commission's inquiry into the harassment of disabled people also found that control room operators may not be aware of the history or impact of harassment when grading the call. As a result the police may not visit at all or may take some days to respond. Individual officers may also deprioritise low-level harassment in order to focus on 'criminal behaviour'.¹⁰⁷

¹⁰³ J. Perry, 2004. 'Is Justice Taking a Beating?', Community Care.

 ¹⁰⁴ 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. Accessed 22/11/2011.
105 Ibid.

¹⁰⁶ Her Majesty's Inspectorate for Constabulary, 2010. Anti-social Behaviour: Stop the rot. Page 11. Available at: http://www.hmic.gov.uk/SiteCollectionDocuments Anti-social_behaviour_2010 ASB_SPE_20100923.pdf. Accessed 22/11/2011.

¹⁰⁷ Equality and Human Rights Commission, 2011. *Hidden in plain sight: Inquiry into disabilityrelated harassment*. Page 143. Available at: http://www.equalityhumanrights.com/legal-andpolicy/inquiries-and-assessments/inquiry-into-disability-related-harassment/hidden-in-plainsight-the-inquiry-final-report/. Accessed 23/11/2011.

In child protection cases there is often a lack of accountability within services, and a blurring of boundaries between different agencies, that make it very difficult for authorities to identify who should be doing what.¹⁰⁸ Ofsted reports have commented on poor communication either within agencies, for example between different parts of the health service, between different agencies, or from one local authority to another.¹⁰⁹ When serious incidents occur, weaknesses have been found in the systems used by agencies to communicate information at key points in children's lives. For example, the transfer of information from a GP to a midwifery service and then to the health visiting service was not sufficiently reliable. There were also concerns about poor communication between specialist children's services, such as child and adolescent mental health services, and universal services such as individual schools.¹¹⁰ This lack of communication means that at-risk children can fall through the net.

4. Despite some advances, police forces still too often fail to investigate 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.

¹⁰⁸ The Social Work Task Force, 2009. *Building a safe, confident future – The final report of the Social Work Task Force*. London, Department for Education. Available at : https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-01114-2009. Accessed 22/11/2011.

¹⁰⁹ Ofsted, 2010. *Learning lessons from serious case reviews 2009-2010*. Available at: http://www.ofsted.gov.uk/resources/learning-lessons-serious-case-reviews-2009-2010. Accessed 22/11/2011.

While the policies are laudable, there are serious problems with their implementation. The Stern Review (2010) into the handling of rape allegations exposed areas in which criminal law is not being enforced by the police. It noted that although 58 per cent of people charged with rape are convicted, only 6 per cent of rapes initially reported to police get to the point of conviction.¹¹¹ In 2006 statutory charging was introduced. 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 CPS. This still suggests that a large proportion of cases reported to the police do not progress any further.¹¹²

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).

Several 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.¹¹³ One rape victim reported:

¹¹¹ 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. Accessed 22/11/2011.

¹¹² Equality and Human Rights Commission, 2010. *Triennial Review: How fair is Britain?* Page 139.

¹¹³ 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. Accessed 22/11/2011.

'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.'¹¹⁴

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.¹¹⁵ 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 Independent Police Complaints Commission (IPCC) investigation noted that:

'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.'¹¹⁶

Advances have been made to protect women from domestic abuse. Rape in marriage was recognised as a crime 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. The IPCC's investigation into domestic abuse cases where the woman has been seriously injured or killed shows

114 Ibid.

¹¹⁵ 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. Accessed 22/11/2011.

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.¹¹⁷ The IPCC has made useful recommendations to improve policing, but again there is evidence that some local forces have failed to implement them.¹¹⁸

5. Despite improvements in the approach of the police and Crown Prosecution Service, hate crime against disabled people still has a low prosecution and conviction rate

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 3.¹¹⁹ The Crown Prosecution Service (CPS) subsequently reviewed its policies and took a number of steps to 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.¹²⁰

¹¹⁷ 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. Accessed 24/01/2012.

¹¹⁸ 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%20 press&l2link=news%2FPages%2Fdefault.aspx&l2title=Press%20Releases. Accessed 24/01/2012.

^{119 (}B.) v. Director of Public Prosecutions (Equality and Human Rights Commission intervening)[2009] EWHC 106 (Admin) [2009] WLR (D) 25 QBD.

¹²⁰ 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. Accessed 22/11/2011.

'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.¹²¹

Nevertheless, disability harassment and disability hate crimes still have unacceptably low prosecution and conviction rates.¹²² 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 as 'just too complicated' because 'applying for special measures is almost like a series of tripwires for a prosecutor'.¹²³ 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 are a matter for the CPS (England and Wales) 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.

Disabled people face many barriers in making allegations of ill-treatment. Many cases are reported to third parties, such as GPs.¹²⁴ 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.¹²⁵

- 121 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.
- 122 Equality and Human Rights Commission, 2010. *Triennial Review: How fair is Britain*? Chapter 8, Physical Security.
- 123 Equality and Human Rights Commission, 2011. *Hidden in plain sight: Inquiry into disabilityrelated harassment*. Page 150. Available at: http://www.equalityhumanrights.com/legal-andpolicy/inquiries-and-assessments/inquiry-into-disability-related-harassment/hidden-in-plainsight-the-inquiry-final-report/. Accessed 22/11/2011.
- 124 Mencap, 1999. *Living in Fear. The need to combat bullying of people with a learning disability.* London: Mencap.
- 125 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. Accessed 22/11/2011.

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.¹²⁶ 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.¹²⁷ Incidents of sexual violence against disabled people, especially people with mental health conditions, are frequently not treated as crimes.¹²⁸

6. The law regarding the defence of 'reasonable punishment' of children may be incompatible with Article 3

In 1998 the European Court of Human Rights found that UK domestic law did not provide adequate protection for children from 'inhumane 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.¹²⁹

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 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 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 Convention.¹³⁰ This has been accepted by the Court.

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. 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.

¹²⁶ 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.

¹²⁷ D. Gillard, and C. Wallace, 2003. *No Way to Handle Assault, Community Care* (1499) 20 Nov 2003-26 Nov 2003. Pp. 46-47.

¹²⁸ Equality and Human Rights Commission, 2010. *Triennial Review How fair is Britain*? Chapter 7. 129 *A. v. the United Kingdom* [1998] ECHR 100/1997/884/1096.

¹³⁰ UK statement to Council of Europe Committee of Ministers, June 2005.

However, sometimes in practice it can be difficult to distinguish between common assault and actual bodily harm.¹³¹ 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.¹³² The review concluded that the legal position was clear and appropriate but that the law was difficult to understand.

The Joint Committee on Human Rights considered the issue of legal certainty in its nineteenth report in 2004, concluding that prohibiting corporal punishment would make the law clearer.¹³³ 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 change its law.¹³⁴

¹³¹ 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/. Accessed 24/01/2012.

¹³² Department for Children, Schools and Families, 2007. *Review of Section 58 of the Children Act 2004.* Paras 21-26.

¹³³ Joint Committee on Human Rights Nineteenth Report September 2004.

¹³⁴ UN Committee on the Rights of the Child Concluding observations CRC/C/GBR/CO/4 20 October 2008.

The UK government has itself been accused of perpetrating and being complicit in torture and inhumane or degrading treatment

Terrorism and Article 3

Since the 9/11 attacks, governments around the world have taken additional measures to protect their citizens from the threat of terrorism. While it is crucial for the state to protect public safety, it must also meet its human rights obligations. Article 3 applies even in times of conflict, and regardless of the identity or actions of the person.

Article 3 imposes a negative obligation on the state to refrain from subjecting anyone within its jurisdiction to treatment or punishment that meets the threshold for torture, or inhumane or degrading treatment. This includes an obligation to refrain from being complicit in these acts. Neither the European Court of Human Rights nor the domestic courts have defined the concept of complicity. The Joint Committee on Human Rights (JCHR), after hearing evidence from a number of academics and experts, concluded that complicity has different meanings depending on whether the context is individual criminal responsibility or state responsibility.¹³⁵

¹³⁵ For a complete discussion see: Joint Committee on Human Rights, 2009. *Allegations of UK Complicity in Torture. Twenty-third Report of Session 2008-09.* London: House of Commons.

- For the purposes of individual criminal responsibility for complicity in torture, complicity requires proof of three elements: (1) knowledge that torture is taking place, (2) a direct contribution by way of assistance that (3) has a substantial effect on the perpetration of the crime.
- For the purposes of state responsibility for complicity in torture, however, complicity means simply one state giving assistance to another state in the commission of torture, or acquiescing in such torture, in the knowledge, including constructive knowledge, of the circumstances of the torture which is or has been taking place.

An additional obligation of the state is to carry out an effective investigation if there are credible allegations of ill-treatment. An effective investigation must be independent, impartial, subject to public scrutiny, and include access to the investigative process for the victims. The investigation should also be prompt and capable of establishing the facts and identifying those who were responsible for the violations.¹³⁶

One of the principal legal challenges posed by the government's response to terrorism is the extent to which UK jurisdiction extends into areas beyond the country's borders, and particularly whether it extends to territories such as Iraq and Afghanistan. If so, the rights contained in the European Convention would also apply in these areas. According to Article 1 of the Convention, the state is only responsible for securing the rights of the Convention in places where the state is exercising its jurisdiction. The definition of what falls under the jurisdiction of the state has evolved over time. Initially it was thought that the

¹³⁶ Letter from Liberty, The AIRE Centre, Amnesty International, British Irish Rights Watch, Cageprisoners, Justice, The Medical Foundation for the Care of Victims of Torture, Redress and Reprieve. To Rt. Hon. Sir Peter Gibson (Chair of the Inquiry) on 8 February 2010. Available at: http://www.justice.org.uk/data/files/resources/161/Submission_to_Detainee_Inquiry_NGOletter_8feb11.pdf. Accessed 22/11/2011/ Quoting: *Aksoy v. Turkey* (21987/93), para 98 (1996) 23 E.H.R.R. 553; *Aydin v. Turkey*, para 103 (1999) 28 E.H.R.R. 25; *Kurt v. Turkey* (24276/94), para 140 (1999) 27 E.H.R.R. 373; *Ergi v. Turkey* (23818/94), para 98 (2001) 32; E.H.R.R. 18, 28 July 1998; *Akkoç v. Turkey* (22947/93) and (22948/93), para 118, 10 October 2000; *Mikheyev v. Russia* (77617/01), para 107-110; *Jordan v. the United Kingdom*, para 109.

jurisdiction was limited to the physical territory of the state. However, the Court has widened this interpretation in some exceptional cases. States have been held to be responsible for securing the rights of the Convention over territories outside their physical borders, where they have 'effective jurisdiction'.¹³⁷

For example, in 2011 the European Court of Human Rights found that the UK had jurisdiction over the city of Basra in Iraq in 2003.¹³⁸ Therefore, the UK's human rights obligations applied to its behaviour in that territory.

In 2003 the UK was an occupying power in Basra. It was alleged that during an operation the military killed five individuals and arrested a sixth. The UK refused to conduct an independent investigation into the circumstances of the deaths. It argued that the five individuals were shot outside its territory and therefore outside its jurisdiction and so the Convention did not apply.¹³⁹

The Court found that because the UK was exercising public powers on the territory, as it had assumed authority and responsibility for the maintenance of security in southeast Iraq, it had assumed jurisdiction. Therefore it was required to carry out an independent and effective investigation into these deaths.¹⁴⁰

The Court has also recognised that no-one can be deported or expelled to a country where there is a real risk that the person may face torture or illtreatment, even when that person poses a threat to national security.¹⁴¹

139 Britain did investigate the death of the 6th person, Baha Mousa: this is explained later in the chapter.

¹³⁷ The Court has held that whenever the state has an 'effective jurisdiction' over a territory, it then has an obligation to secure the rights of the Convention. For example, in the case of *Loizidou v*. *Turkey* (1995), which relates to access to private property in occupied territory (in this case northern Cyprus) the Court made two significant decisions: 1) that the concept of jurisdiction under Article 1 ECHR is not restricted to the national territory of the High Contracting Parties; and 2) that responsibility may also arise as a consequence of military action a Contracting Party exercises effective control of an area outside its national territory.

¹³⁸ 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. Accessed 06/12/2011.

¹⁴⁰ *Al-Skeini v. the United Kingdom*, European Court of Human Rights Grand Chamber (55721/07). 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.

¹⁴¹ This is in line with the principle of non-refoulement set out in the 1951 Convention Relating to the Status of Refugees and its Protocol as well as in Article 3 of the UN Convention Against Torture Convention, that protects refugees from being returned to places where their lives or freedoms may be threatened. For domestic cases see UK House of Lords decision in *Islam v. Secretary of State for the Home Department* and *R. v. IAT*, ex parte Shah (1999) 2 all ER 545 (1999) 2 WLR 1015.

The government has stated that it unreservedly condemns the use of torture and cruel, inhumane or degrading treatment or punishment as a matter of fundamental principle, and that it does not condone it, nor ask others to do it on its behalf. In parliament, the Prime Minister has stated 'we have signed countless prohibitions against it [torture], we do not condone it anywhere in the world, and we should be clear that information derived from it is useless. We should also be clear that we should not deport people to be tortured elsewhere, but we should redouble our efforts... to ensure that we can have guarantees from other countries so that we can deport people to them knowing that they will not be tortured.'¹⁴²

Key issues

1. There have been allegations that the security and intelligence services were complicit in the ill-treatment of prisoners and civilians in counter-terrorism operations overseas in the immediate aftermath of the 9/11 attacks

There have been allegations that security and intelligence officials have been complicit in the torture and ill-treatment of more than 20 people in various countries including in Afghanistan, Egypt, Pakistan, Libya, Uganda and Guantanamo Bay in Cuba. The government denies that there is evidence of security service personnel torturing anyone directly or being complicit in torture. Cases have been reported by non-governmental organisations, the UN and UK domestic bodies like the JCHR.¹⁴³ There are allegations of officials being complicit in the torture or ill-treatment of at least 25 people, including three

¹⁴² Hansard HC col 180 (6 July 2010). Available at: http://www.publications.parliament.uk/pa/ cm201011/cmhansrd/cm100706/debtext/100706-0001.htm

¹⁴³ See Human Rights Watch, 2009. *Cruel Britannia. British Complicity in the Torture and Illtreatment of Terror Suspects in Pakistan*. Available at: http://www.hrw.org/en/node/86690; The Joint Committee on Human Rights 20th report session 2008-09 Allegations of UK Complicity in Torture; and Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism, the Special Rapporteur on torture and other cruel, inhumane or degrading treatment or punishment, the Working Group on Arbitrary Detention and the Working Group on Enforced or Involuntary Disappearance. UN document number A/ HRC/13/42 26 January 2010.

British citizens and four individuals who held legal residency in Britain who were being held in the Guantanamo Bay detention facility.¹⁴⁴

For example, 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.¹⁴⁵

144 For a non-exhaustive list of individuals see: Equality and Human Rights Commission. Letter to Rt. Hon. Sir Peter Gibson. 13 September 2010. See also: 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 Accessed 22/11/2011; 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, inhumane or degrading treatment or punishment, the Working Group on Arbitrary Detention and the Working Group on Enforced or Involuntary Disappearance.* UN document number A/HRC/13/42 26.

The Human Rights Watch report provides accounts of five UK citizens of Pakistani origin who alleged that they were tortured in Pakistan between 2004 and 2007 and that the UK government agencies knew about this treatment. The names of the individuals are: Salahuddin Amin, Zeeshan Siddiqui, Rangzieb Ahmed, Rashid Rauf and a fifth individual who wished to remain anonymous. The Joint Committee on Human Rights report discussed the following cases: in Pakistan: MSS, Rangzieb Ahmed, Zeeshan Siddiqui, Salahuddin Amin, Tariq Mahmood, Tahir Shah and Rashid Rauf; in Egypt: Azhar Khan, plus 3 possible others and Binyam Mohamed. The UN report looked at the allegations of Bisher Al-Rawi, Moazzam Begg, Omar Deghayes, Mohamed Ezzoueck, Maryam Kallis, Azhar Khan, Mohammed Saad Iqbal Madni, Binyam Mohamed, Abu Omar (alias).

¹⁴⁵ 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/ Accessed 22/11/2011.

In November 2010 the UK government announced a settlement with 16 individuals in relation to their imprisonment in Guantanamo Bay, but this settlement is not an admission of culpability.¹⁴⁶ Other allegations have been made around the practice of 'extraordinary rendition'. The terms rendition and extraordinary rendition are not legally defined in UK or in international law. According to the UK government:

'Rendition has been used to describe informal transfers of individuals in a wide range of circumstances, including the transfer of terrorist suspects between countries. Extraordinary rendition has been used to describe "renditions" where it is alleged that there is a risk of torture or mistreatment.'¹⁴⁷

Article 3 is relevant to extraordinary rendition because it 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.

¹⁴⁶ Hansard HC col 752 (16 November 2010). Available at: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm101116/debtext/101116-0001.htm. Accessed 22/11/2011.

¹⁴⁷ Foreign Commonwealth Office, 2006. *Human Rights Annual Report*. London. Page 181. Available at: http://collections.europarchive.org/tna/20080205132101/fco.gov.uk/Files/kfile/ hr_report2006.pdf. Accessed 22/11/2011. 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. For domestic cases see: UK House of Lords decision in *Islam v. Secretary of State for the Home Department* and *R. v. IAT*, ex parte Shah [1999] 2 AC 629 [1999] 2 All ER 545 [1999] 2 WLR 1015. Furthermore, extraordinary rendition involves a transfer outside the transferor's jurisdiction without lawful authority, and third states may become complicit in, and in turn also be in breach of their obligations under international law, either in assisting rendition or in being responsible for the ill-treatment of the transferees. Chatham House International Law Discussion Group meeting held on 27 March 2008. http://www.chathamhouse.org/sites/default/ files/public/Research/International%20Law/il270308.pdf. Accessed 22/11/2011.

There is little reliable information on the number of individuals who have been subject to extraordinary rendition. When allegations of British involvement in extraordinary renditions emerged in 2005, government ministers repeatedly stated that British airports and airspace were not being used for this purpose.¹⁴⁸ 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.¹⁴⁹ 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.¹⁵⁰

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.¹⁵¹ This detention facility is well known for its inhumanee conditions.¹⁵² The UK government did not reveal their names. Reprieve found that the two people were Amanatullah Ali and Yunus Rahmatullah also known as 'Salae Huddin'.¹⁵³

152 Ibid.

¹⁴⁸ 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. Accessed 22/11/2011.

¹⁴⁹ 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. Accessed 22/11/2011.

¹⁵⁰ 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/. Accessed 22/11/2011.

¹⁵¹ 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. Accessed 22/11/2011.

¹⁵³ Reprieve. Available at: http://www.reprieve.org.uk/cases/yunusrahmatullah/. Accessed 22/11/2011.

The *Guardian* reported more allegations of rendition and torture in March 2011. Omar Awadh alleged he was abducted in Nairobi before being illegally rendered to Uganda and handed over to the Rapid Response Unit, which has been criticised by Human Rights Watch for its methods of interrogation and detention, including torture. Mr Awadh said that he was beaten and threatened with further rendition to Guantanamo Bay, before being interrogated by American and British individuals who identified themselves as FBI and security service officials.¹⁵⁴

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.¹⁵⁵ The government has since 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.¹⁵⁶

There is evidence that the government's investigation of these alleged breaches has not been thorough enough to meet its Article 3 obligations. An Article 3 investigation 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.¹⁵⁷ Every effort must be made to seek and secure information

¹⁵⁴ Freedom From Torture, 2011. *Uganda – fresh allegations of MI5 involvement in torture overseas*. Available at: http://freedomfromtorture.org/news-events/news/3484. Accessed 22/11/2011.

¹⁵⁵ 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. Accessed 22/11/2011.

¹⁵⁶ 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/. Accessed 24/01/12.

¹⁵⁷ Letter from Liberty, The AIRE Centre, Amnesty International, British Irish Rights Watch, Cageprisoners, Justice, The Medical Foundation for the Care of Victims of Torture, Redress and Reprieve. To Rt. Hon. Sir Peter Gibson (Chair of the Inquiry) on 8 February 2010. Available at: http://www.justice.org.uk/data/files/resources/161/Submission_to_Detainee_Inquiry_ NGOletter_8feb11.pdf. Accessed 22/11/2011/ Quoting: *Aksoy v. Turkey* (21987/93), para 98 (1996) 23 E.H.R.R. 553; *Aydin v. Turkey*, para 103 (1999) 28 E.H.R.R. 25; *Kurt v. Turkey* (24276/94), para 140 (1999) 27 E.H.R.R. 373; *Ergi v. Turkey* (23818/94), para 98 (2001) 32; E.H.R.R. 18, 28 July 1998; Akkoç v. Turkey (22947/93) and (22948/93), para 118, 10 October 2000; *Mikheyev v. Russia* (77617/01), paras 107-110; *Jordan v. the United Kingdom*, para 109.

regarding torture violations, including from other states that are unwilling to co-operate. $^{\scriptscriptstyle 158}$

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 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 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'. The proposed inquiry was widely criticised by human rights groups and by the Commission.

There were concerns that 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.¹⁵⁹

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.¹⁶⁰ Lawyers acting for former detainees and 10 nongovernmental organisations¹⁶¹ 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.¹⁶²

160 Equality and Human Rights Commission. Letter to Rt. Hon. Sir Peter Gibson. 13 September 2010.

¹⁵⁸ For a complete reference to the discussion please see the letters from NGOs and responses from the chair of the inquiry. Available at: http://www.justice.org.uk/resources.php/161/detainee-inquiry-justice-submission. Accessed 22/11/2011.

¹⁵⁹ 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/. Accessed 22/11/2011.

¹⁶¹ These organisations were: Liberty, Redress, Amnesty International, Cageprisoners, the AIRE Centre, Freedom from Torture, Human Rights Watch, Justice, Reprieve, and British Irish Rights Watch.

¹⁶² 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. Accessed 22/11/2011.

As further criminal investigations into rendition of individuals to Libya had recently been commenced, the government decided to conclude the inquiry in January 2012, but has committed itself to holding an independent judge-led inquiry at some point in the future.¹⁶³

2. Guidance for intelligence officers on detaining and interviewing detainees abroad breaches Article 3

Following the allegations detailed in the previous section, the UK government published guidance setting out the approach that British intelligence officers should take to obtaining information from individuals detained overseas.¹⁶⁴

The guidance sets out the steps which must be taken by intelligence officers before they interview detainees held by other states, seek intelligence from detainees in the custody of foreign countries or solicit the detention of a person by a foreign country.

The Commission and a victim of hooding in Iraq, Alaa' Nassif Jassim Al-Bazzouni, brought legal challenges against the guidance. In Al-Bazzouni's case the courts found that this guidance did not properly reflect international legal obligations. The Commission argued that to determine whether an individual officer or the state could be responsible for a breach of Article 3, the correct legal test is whether officers were aware or had reason to believe that there was a 'real risk' of torture. This would be the case according to both domestic criminal law and international human rights law. The guidance prohibits officers to act when there is a 'serious risk', which the Commission argued was a higher threshold and therefore legally incorrect. The judges found that the distinction between the two terms was 'elusive' and dismissed the claim. Mr Al-Bazzouni's claim was based on the contention that the guidance permitted hooding of detainees in certain circumstances when the UK's law and policy prohibit hooding at all times. His claim succeeded and the guidance will have to be amended.¹⁶⁵

¹⁶³ 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. Accessed 20/01/2012.

¹⁶⁴ HM Government, 2010. Consolidated guidance to Intelligence Officers and Service Personnel on the Detention and Interviewing of Detainees Overseas, and on the Passing and Receipt of Intelligence Relating to Detainees. London: Cabinet Office. Available at: http://www.parliament. uk/deposits/depositedpapers/2011/DEP2011-1796.pdf. Accessed 22/11/2011.

¹⁶⁵ Equality and Human Rights Commission v. the Prime Minister & Ors and Alaa' Nassif Jassim Al Bazzouni v. the Prime Minister [2011] EWHC 2401 (Admin).

3. There have been allegations that British military personnel have been involved in the torture and ill-treatment of civilians and detainees in Iraq. Some of these allegations have not been investigated thoroughly enough to meet Article 3 obligations

There have been numerous allegations that British military personnel have been involved in the torture and ill-treatment of civilians and detainees in Iraq.

There are no figures available on how many allegations of torture against civilians have been made. However, information has emerged from several inquiries and court cases between 2003 and 2010. One source of such information was the inquiry into the death of Baha Mousa which was reported in 2011. In 2003, soldiers from the Queen's Lancashire Regiment arrested 10 Iragis, including Baha Mousa, and took them back to a temporary detention centre run by the regiment.¹⁶⁶ 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.¹⁶⁷ 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 inhumanee treatment and sentenced him to one year in prison.¹⁶⁸

¹⁶⁶ Rt. Hon. Sir William Gage, 2011. *The Baha Mousa Public Inquiry Report, Volume 1*. London: The Stationery Office. Para 1.24.

¹⁶⁷ 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 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. Accessed 22/11/2011.

¹⁶⁸ 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. Accessed 22/11/2011.

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.¹⁶⁹

After the Baha Mousa case 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 likely to take years to report. Hearings are due to commence in April 2012.¹⁷⁰

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 that they were subjected to sexual humiliation by female soldiers, while others alleged that they were held for days in cells as small as one square metre.¹⁷¹

To investigate these allegations, the Ministry of Defence set up the Iraq Historic Allegations Team in 2010, which was 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.

¹⁶⁹ 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. Accessed 22/11/2011.

¹⁷⁰ Al- Sweady Inquiry. Available at: http://www.alsweadyinquiry.org/. Accessed 22/11/2011.

¹⁷¹ Ali Zaki Mousa and others v. Secretary of State for Defence [2010] EWHC 3304 (Admin).

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.¹⁷² The Secretary of State had planned to wait until the Iraq Historic Allegations Team's investigation was concluded in 2012 before deciding whether an investigation into systematic abuses was necessary.¹⁷³ In practice, this would have meant that if systematic failures were found, allegations of ill-treatment that occurred in 2003 might only have been investigated nine years after their occurrence.¹⁷⁴

The Court of Appeal has now determined that these measures do not meet the requirements of an Article 3 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 3.¹⁷⁵ 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.¹⁷⁶ It is now for the government to decide how to meet the Article 3 investigative duty.

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 2004.¹⁷⁷

173 Ali Zaki Mousa and others v. Secretary of State for Defence [2010] EWHC 3304 (Admin) para 117.

¹⁷² See for example *Indelicato v. Italy* (31143/96) Judgment 18.10.2001.

¹⁷⁴ Equality and Human Rights intervention in *Ali Zaki Mousa and others v. Secretary of State for Defence* [2010] EWHC 3304 (Admin).

¹⁷⁵ *Mousa, R. (on the application of) v. Secretary of State for Defence & Anor* [2011] EWCA Civ 1334 (22 November 2011).

¹⁷⁶ *Mousa, R. (on the application of) v. Secretary of State for Defence & Anor* [2011] EWCA Civ 1334 (22 November 2011).

¹⁷⁷ The European Court resolved in July 2011, in the case of *Al-Skeini v. the United Kingdom*, that Britain had effective jurisdiction over Basra and therefore it had an obligation to secure the rights of the people in this part of the Iraqi territory.

The court found that the UK failed to investigate all but one death, that of Baha Mousa.¹⁷⁸ It is still unknown how the government is planning to fulfil its investigative obligation under Article 3 in that case.

4. Despite concerns as to their effectiveness in preventing torture, the government continues to rely on memoranda of understanding in order to deport people to places where they are at risk of torture and degrading treatment

The UK 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.¹⁷⁹

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. States use them to try to mitigate risks of torture and other ill-treatment that would otherwise prevent the transfer of people, in particular terrorist suspects.¹⁸⁰ However, it is unclear whether such memoranda are adequate in reducing the risk of torture potentially faced by expelled individuals.¹⁸¹ Similar concerns have 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.¹⁸²

¹⁷⁸ Al-Skeini v. the United Kingdom, European Court of Human Rights Grand Chamber (Application no. 55721/07).

¹⁷⁹ Soering v. the United Kingdom 11 EHRR 439 (14038/38) para 88 and Chahal v. the United Kingdom (1996) 23 EHRR 413.

¹⁸⁰ 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%20 the%20ProblemsLie%2010%20Dec%2008A4.pdf. Accessed 22/11/2011.

¹⁸¹ See for example, Manfred Nowak, ex UN special rapporteur on torture and other cruel, inhumane or degrading treatment or punishment. Torture and other cruel, inhumane or degrading treatment or punishment Note by the Secretary-General. UN document A/60/316.

¹⁸² *R.* (*on the application of Maya Evans*) *v. Secretary of State for Defence* [2010] EWHC 1445 (Admin) which 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.

In 2006, the Joint Committee on Human Rights (JCHR) raised serious concerns about the UK's use of diplomatic assurances. According to the report,

'those deported may face a real risk of torture or inhumane and degrading treatment, without any reliable means of address'.¹⁸³

The JCHR also found that the government's reliance on such memoranda undermined the absolute prohibition to abstain from deporting or expelling a person when there is a real risk that they may face torture, and threatened to place the UK in violation of its binding international obligations.¹⁸⁴

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.¹⁸⁵

Three countries have signed memoranda of understanding and have had them tested in the Special Immigration Appeals Commission (SIAC): Jordan, Libya and Ethiopia.¹⁸⁶ In 2011 a further memorandum was agreed with Morocco, but this has not yet been tested in SIAC.¹⁸⁷ 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. The agreements with Algeria and the memorandum with Jordan have been approved by the House of Lords.¹⁸⁸ The agreement with Libya was held to be invalid by

¹⁸³ House of Commons, 2006. *Joint Committee on Human Rights – Nineteenth Report, Session 2005-*06. Available at: http://www.publications.parliament.uk/pa/jt200506/jtselect/jtrights/185/18502. htm. Accessed 22/11/2011.

¹⁸⁴ Ibid.

¹⁸⁵ Ministry of Justice, 2011. United Nations Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment: 5th Report by the United Kingdom of Great Britain and Northern Ireland. Available at: http://www.parliament.uk/deposits/depositedpapers/2011/DEP2011-1420. pdf. Accessed 22/11/2011.

¹⁸⁶ 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; Jordan: Case of Othman, Case of VV; Libya: Cases of DD and AS.

¹⁸⁷ 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/counterterrorism-policy/deportation-with-assurances/. Accessed 22/11/2011.

¹⁸⁸ 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.

the UK courts in 2008 and has not been relied on since then. According to the report submitted by the UK to the United Nations Committee Against Torture in 2011, nine people have been effectively deported from Britain following the receipt of diplomatic assurances. These were all to Algeria, a country with poor a human rights record.¹⁸⁹

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 of the Convention (the right to a fair trial), in that evidence obtained through the use of torture would be admitted in his retrial in Jordan.¹⁹⁰

The UN Human Rights Committee, the Special Rapporteur and the UN Committee Against Torture have repeatedly asked the UK government to review the memorandum of understanding procedure.¹⁹¹ In spite of concerns related to the practice, the UK government has been unwilling to change the practice, as it maintains that those measures are sufficient to protect the individuals against torture.¹⁹²

The latest review on the use of these assurances took place in 2010 as part of the Home Office review of six key counter-terrorism and security powers. Once again, they rejected submissions from human rights organisations requesting the abolition of these assurances, and the government decided that the assurances should remain in place. Furthermore, in the annual report of the Foreign and Commonwealth Office, issued in March 2010, the UK government states that it will 'continue to negotiate new memoranda of understanding in 2010'.¹⁹³

190 *Case of Othman (Abu Qatada) v. the United Kingdom* (Application no. 8139/09) 17 January 2012.

192 Foreign and Commonwealth Office, 2010. *Annual Report on Human Rights 2009*. Page 45. 193 Ibid.

¹⁸⁹ Ministry of Justice, 2011. United Nations Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment: 5th Report by the United Kingdom of Great Britain and Northern Ireland. Available at: http://www.parliament.uk/deposits/depositedpapers/2011/DEP2011-1420 pdf. Accessed 22/11/2011.

¹⁹¹ 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. Accessed 22/11/2011.

Case study: Catherine's story

In 2005, Catherine was raped by a stranger who she had invited into her home.

She has bipolar disorder, and on the day she was raped, she was experiencing a psychotic episode. "I thought it was the last judgement day and everyone had to look after each other. I made him a hot chocolate. He was asking me to kiss him and I said no. And then he moved me forcibly into the bedroom and I knew I was going to be raped," she says.

The day after the rape, Catherine was detained by the police when she was found stopping traffic, and sectioned under the Mental Health Act. It was from the hospital two months later, in December 2005, that she first reported the rape to police in her home town of Cambridge. In February 2006, she contacted the police to find out how the investigation was progressing. She discovered that nothing at all had been done, and that her allegation had not been recorded as a crime. Catherine believes her mental illness played a part in the police's failure to investigate.

"The officers thought that they could act with impunity, and considered the mentally ill as a lower class of citizen," she says. "The investigating officer herself treated me with contempt. She wanted an easy job, and was willing to lie about the evidence, rather than perform a proper investigation."

Potential leads were not pursued in time. Catherine had described how after the rape, her attacker had walked her to a bank and forced her to withdraw money. But, by the time detectives contacted the bank, the CCTV footage from that day had been wiped. The man who raped Catherine has never been caught.

Catherine said an officer had told her the cameras at the bank were 'dummy' and did not have film in them. When she discovered the footage had been lost, she decided to launch a formal complaint against the Cambridgeshire force. An internal investigation began. The sergeant who let paperwork lie on his desk denied that he had ignored the case because the woman making the complaint had mental health problems. He was given a superintendent's written warning. The female officer who had initially dealt with Catherine received words of advice.

"The officers thought they could act with impunity and viewed mentally ill people as lower class citizens"

Catherine was still not satisfied with the police response. She said: "The superintending officer failed in two regards. Not only did he fail to allocate a crime number and put an investigating officer on the case, but he left the paperwork on his desk, untouched. I would describe his professional behaviour as characterised by neglect."

Catherine found a solicitor who argued that there had been a breach of human rights law. Under Article 3, the state has a duty to investigate all cases where an individual has been subject to inhumane or degrading treatment. After legal action began, Cambridgeshire Police settled out of court and paid Catherine £3,500 in compensation. The force admitted no liability but issued a letter of apology.

"This victory is important, since it can begin to address this attitude that the police have towards the vulnerable," Catherine says. "The Human Rights Act holds the police to account. I see my legal victory not as an end, but as a beginning, and I want it to be a message to both women and men who are disadvantaged, whether it is in terms of ethnicity, poverty, illness, or disability, that they have legal rights, and the state has obligations to fulfil these rights."

Case study: Northumbria Police and domestic violence

Andrea Gartland is an independent domestic violence advisor based in a police station in Newcastle.

Human rights legislation has had a direct impact on the women she advises, as she recalls in relation to one case, that of Mary (not her real name).

In 2008, Mary separated from her partner. He began stalking her and she was bombarded with threatening phone calls and text messages. He would turn up at her home uninvited. Paint was thrown at her door, and her car and garage door were damaged. Photographs and a kitchen knife were left on her front doorstep. Mary went to court but despite obtaining protective orders the harassment continued. On one occasion, she called the police in a highly distressed state after receiving a picture message on her mobile phone of two shot guns laid out on a bed. The image was accompanied by a caption that read, 'spoilt for choice ha-ha'.

"Mary was very scared," says Andrea. "This man was not going to give up and he had no fear of the police. She was having panic attacks as he lived nearby and she was scared to be alone in the house."

Fortunately, Mary was a beneficiary of a new, human rights-based approach by Northumbria Police to tackling domestic violence. There was a robust response involving the police and other agencies, which looked at increasing her safety, protecting her child and managing the behaviour of the offender. Mary was also provided with practical support by Andrea and her team who, for example, arranged for security measures including a burglar alarm and intercom system to be installed at her home.

The new approach taken by Northumbria Police was influenced by the Human Rights Act, as Detective Chief Inspector Max Black explains. "During the early 2000s, the force reviewed how it dealt with domestic violence, with respect to human rights legislation. We found that although policy was well intentioned it was not adequate ... after the review we realised we had a positive obligation to intervene to protect those at risk of inhumane or degrading treatment with regards to domestic violence." "after the review we realised we had a positive obligation to intervene to protect those at risk of inhumane or degrading treatment with regards to domestic violence"

As a result, all officers are now trained in human rights so that they avoid dealing with domestic violence incidents as breaches of the peace and actively consider the need to protect the victim and their children from harm. A sophisticated new computer system collates and shares intelligence about perpetrators and all incidents are graded by specialist police officers using a risk assessment tool.

A 'high' risk assessment automatically triggers a conference involving several agencies, which put together a co-ordinated community response. An allocated domestic violence officer will continue to support 'high risk' victims until the risk is reduced or removed, even when the victim chooses to return to a relationship with the perpetrator or decides not to appear in court proceedings.

This has been complemented by training for officials in magistrates' courts, and specialist domestic violence courts are available throughout the Northumbria force area. Independent domestic violence advisers are now located in some police stations.

According to DCI Black, "the Human Rights Act reinforces our duty to protect the public. As a police force, this approach means we get reassurance that victims are safe and it reduces the risk of re-offending. For victims, it means multi-agency support is available even if they do not want to bring charges against their alleged abuser, which often happens because of their personal circumstances."

Three years later Mary is safe, and building a new life. Her housing provider helped by awarding Mary priority status which allowed her to move to another area unknown to her abuser. Her former partner was found guilty at trial and as part of the sentence he was made subject to an indefinite restraining order. There have been no further reported incidents.

"The last time I saw her, she was very relieved and moving forward," says Gartland.

Case study: Adele's story

"I was unable to use the toilet or sleep in the bed," says Adele Matthews. "I try not to think about what happened because if I do I get very upset."

Adele is a disabled woman who used Article 3 of the Human Rights Act in a landmark case regarding her treatment in police custody and in prison.

Adele uses a wheelchair; due to damage by the drug Thalidomide she was born with shortened arms and legs. She also suffers from kidney problems. She was sent to prison in 1995, after she was taken to county court over a minor debt issue. During the case, she refused to answer questions about her financial position, and was sentenced to seven days in custody for contempt of court.

As it was not possible to take Adele to prison until the next day, she spent the night in a cell at Lincoln Police Station. The cell contained a wooden bed and a mattress but was not specially adapted for a disabled person. As a result, she was forced to sleep in her wheelchair and was unable to use the toilet. The emergency buttons and light switches in the cell were also out of her reach.

The police custody record showed that during the night, Adele complained of the cold every half hour, a serious problem for someone with recurring kidney problems. After she made several complaints, a doctor was called who noted Adele could not use the bed and could not leave her wheelchair. The doctor also said the cell was too cold and officers were told the facilities were not adapted to the needs of a disabled person. Despite the doctor's comments, no action was taken and Adele remained in the cell overnight.

The following day, Adele was moved to New Hall Women's Prison, Wakefield, where she was detained in the prison's Health Care Centre until the afternoon of 23 January 1995. Once again she had difficulty when using the toilet in her cell and felt humiliated when male prison officers were required to lift her on and off the toilet.

"I was sitting in my own faeces and urine in a wheelchair. No-one should be made to go through that experience"

"I was sitting in my own faeces and urine in a wheelchair. No-one should be made to go through that experience," she says.

By the time of her release, Adele was suffering from health problems which continued for 10 weeks after she was released. On 30 January 1995, she consulted solicitors with a view to bringing an action in negligence against the Home Office.

On 10 July 2001, The European Court of Human Rights found in Adele's favour and said there had been a violation of Article 3. The court said that to detain a severely disabled person in conditions where she is dangerously cold, risks developing sores because her bed is too hard or unreachable, and is unable to go to the toilet or keep clean without the greatest of difficulty, constitutes degrading treatment.

Adele says: "I was very pleased at the decision but I should not have been sent to prison for such a minor offence ... The Human Rights Act helped me and I hope it makes a huge difference for other disabled people."