Inspecting policing in the public interest

Report on an unannounced inspection visit to police custody suites in

Durham

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

12–15 May 2014

Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Any enquiries regarding this publication should be sent to HM Inspectorate of Prisons at Victory House, 6th floor, 30–34 Kingsway, London, WC2B 6EX, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk, or HM Inspectorate of Constabulary at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or haveyoursay@hmic.gsi.gov.uk

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons or http://www.hmic.gov.uk

Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary

Contents

Section 1. Introduction

This report is part of a programme of unannounced inspections of police custody carried out jointly by our two inspectorates and which form a key part of the joint work programme of the criminal justice inspectorates. These inspections also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention. The inspections look at strategy, treatment and conditions, individual rights and health care.

This was the second inspection of Durham police, the first one being in 2008. Since the last inspection there has been considerable change in policing: the introduction of Police and Crime Commissioners as strategic elected officials, immense financial pressures and greater expectations to work in partnership with others.

There was a clear line of accountability and an effective management structure overseeing custody arrangements. It was good to see a management drive to make use of alternatives to custody. There were good links with partners, with some positive outcomes for detainees, especially in relation to health care. We saw arresting officers take detainees to cells as a result of inadequate staffing; this practice should be avoided to protect both detainees and officers from allegations of coercion. Additionally, staff not used to working in custody, would not know to explain basic necessities for detainees, such as emergency call bells.

We saw good and respectful interactions between staff and detainees, and detainees we spoke with said they were treated well. There was a women's diversion scheme which provided targeted advice and support for women. It was being evaluated in terms of impact but anecdotally staff told us they thought it was good and well used. It was good to see a use of force form being completed for custody and analysed for learning and trends. There were mixed practices in the provision of privacy, especially if there was a sensitive offence being considered.

Initial risk assessments and risk management in custody were good. We saw staff exploring risk with sensitivity and there was some careful and considerate questioning. However by comparison, pre-release risk assessments were lacking and sometimes non-existent. Staff clearly had the competence, and understood the complexity of initial risk assessments, but did not always apply these skills when people left custody. When they did, it was in exceptional cases where the detainee leaving custody gave obvious cause for concern to the sergeant. If the sergeant failed to recognise any obvious concerns the detainee would leave without any supporting advice or information. The force needs to provide a consistent approach to people leaving custody.

Provision of meals, drinks, exercise and other detainee care was generally positive but compromised by the lack of shower facilities, especially for people attending court. Custody suites were clean and had benefitted from a recent refurbishment programme.

Out of hours adult services, provided by the local authority, were frequently poor, further compounding vulnerability in detention. Young people were generally dealt with quickly, but if they were detained, custody sergeants told us they always telephoned the local authority for alternative secure and non secure accommodation; however, in practice this was not always the case. Further work was required with the local authority to secure appropriate accommodation for young people, and officers need to ensure they record requests for alternative accommodation, if only to identify demand.

Health care in many aspects was good. However, we were very concerned that there were too many people who were mentally unwell held in police cells. We were also concerned that some mental health detainees were brought into custody under substantive offences rather than under the section 136 criteria, hence potentially criminalising mentally unwell people. We were not satisfied that the

force could confidently explain the true numbers of people with mental health problems passing through their custody suites.

We noted that of the 52 recommendations made in our previous report, after our inspection of 22 – 23 September 2008, 34 recommendations had been achieved, 14 had been partially achieved and four had not been achieved.

This report provides a number of recommendations to assist the force and the Police and Crime Commissioner to improve provision further. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

Thomas P Winsor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

December 2014

Section 2. Background and key findings

2.1 This report is one in a series relating to inspections of police custody carried out jointly by HM Inspectorates of Prisons and Constabulary. These inspections form part of the joint work programme of the criminal justice inspectorates and contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorates of Prisons and Constabulary are two of several bodies making up the NPM in the UK.

2.2 The inspections of police custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the Association of Chief Police Officers (ACPO) *Authorised Professional Practice - Detention and Custody* at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*[1] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 The last inspection of Durham police custody suites took place from 22 to 23 September 2008.

2.4 The cell capacity of each designated custody suites was as follows:

Custody suites	**Cells**
Bishop Auckland	**9**
Durham	**15**
Darlington	**15**
Peterlee	**14**
Consett (undesignated - standby by suite)	**7**
Spennymoor (undesignated standby suite)	**5**

Strategy

2.5 There was a positive management drive to make use of alternatives to custody, including restorative justice and voluntary attendance. Parts of the estate were old but it was good to see that investment had been made to keep the suites safe and clean. There was a process for collection and subsequent evaluation of the data relating to detainee care, but there were gaps – for example, detention times and monitoring of strip-searches.

2.6 The duty custody inspector was informed of all arrests and directed the escorting officers to the most appropriate custody suite. While we saw good direction and allocation of suites, we also saw some detainees stood waiting in the car park for at least an hour. In some suites

[1] http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/02/police-custody-expectations.pdf

we saw staff struggling to manage their duties and relying on non custody staff to take detainees to cells.

2.7 There were good links at the senior partnership level with some positive outcomes for detainees in terms of health care. There was also evidence of progress in respect of the provision of local authority accommodation for young people in detention, though this required further development.

2.8 Staff received specific custody training before working in custody. Staff informed us that they had recently attended mental health awareness-raising sessions and had found them useful. A circular advising of lessons learnt from adverse incidents in the custody suites was provided and staff told us they found this useful.

2.9 There was a quality assurance (QA) process which included cross referencing with CCTV recordings and person escort records, but these did not include shift handovers. Outcomes from QA processes were given as feedback to individual staff members, and used to inform themes during refresher training.

Treatment and conditions

2.10 Detainees were treated with respect and we saw a good balance of professional and friendly conduct between staff and detainees. Detainees we spoke with, some of whom had not been in custody before, said they were treated well.

2.11 Most young people were dealt with quickly, with the notable exception of a young person held for 39 hours. There was a women's diversion scheme which appeared to be effective. However, there was limited access for people with disabilities and only in some suites were people asked about their religious observances. Most staff were aware of the protocol for searching transgender detainees.

2.12 There were mixed levels of awareness and practices in respecting and protecting the privacy and dignity of detainees. The design of the suites offered privacy but some custody sergeants lacked awareness of the need to safeguard private conversations. However, we did see some sergeants clearing the area to offer privacy in relation to the booking-in of a detainee for a sensitive offence.

2.13 We observed good initial risk assessments, with careful, sensitive questions and exploration of detainees' self-harm history. However, in some cases it seemed that risk assessments were unnecessarily delayed, and this was further supported by our custody record analysis. There was good justification and rationale for observation levels, and detention officers were generally clear about what was expected when conducting checks. However, our analysis of custody records found there to be insufficient detail about detainees' response to rousing checks, and in one case we saw an officer using his mobile telephone when responsible for a constant watch. Handovers were qualitative but did not include the whole team.

2.14 It was apparent from initial risk assessments that staff had an awareness and general understanding of risk, but pre-release assessments were lacking by comparison. There was a good, informative leaflet about support agencies, which was given to some detainees. We were pleased to see that staff completed a use of force form, and these were used to identify themes and learning in training. However, the force needs to analyse the use of strip-search across the custody suites.

2.15 Detainee care was positive overall but was compromised by a lack of privacy in the shower facilities, which were either located next to a busy drug worker's office or easily viewable

from cell corridors. Our custody analysis suggested that overnight detainees were not routinely offered a shower before an appearance in court. The suites were generally clean and satisfactory due to a recent refurbishment programme, and staff told us that repairs were dealt with promptly.

Individual rights

2.16 Staff told us they rarely needed to question the need for arrest as officers sought advice before detention and were prompted to consider alternatives if appropriate. There was an increase in the use of voluntary attendance and restorative justice approaches, and several officers stated that as a result of this process they were more aware of alternatives to arrest. We saw officers progressing cases and we were satisfied that generally, detention lasted no longer than necessary.

2.17 Appropriate adult services were available during the day, but out of office hours, when the local authority provided an appropriate adult service, provision was restricted and frequently poor. Custody sergeants told us they always telephoned the local authority if accommodation was required for young people who were in police custody; however the data provided by the force contradicted this.

2.18 Access to translation and interpretation services and materials was available and offered to detainees. Staff were positive about the overall provision.

2.19 PACE reviews were frequently conducted by telephone. Detainees had access to legal services and private interview rooms for legal consultations. There were current PACE booklets available in all suites, but in some suites the rights and entitlements leaflet was out of date.

2.20 Court cut off times were satisfactory, and staff reported that detainees were not delayed in custody suites. Detainees were told of their right to make a complaint and some were given the Independent Police Complaints Commission leaflet.

Health care

2.21 Primary health care was provided by Total Healthcare who employed nurses and forensic medical examiners. A good level of health care was delivered across the range of services and there was an excellent level of contract monitoring. Regular reviews took place at bi-monthly meetings and were attended by relevant senior partners. There was a strong strategic overview of health care delivery; however, more attention needs to be given to people who were detained and mentally unwell.

2.22 Patient care was good and clinical records reflected this with relevant information transcribed to the custody database. We observed the respectful treatment of detainees, and female detainees could be seen by someone of their own gender. Custody staff were positive about the health care provided at custody suites. Clinical suites were clean and well equipped, and medicine management and stock management was good. Custody staff made efforts to retrieve medicine from the detainee's home or chemist. There was good provision and maintenance of resuscitation equipment at all suites.

2.23 Substance misuse services were integrated into both drug and alcohol misuse with good links to the criminal justice liaison service and mental health facilities. Two section 136[2] suites were available across the force. The data revealed that there were too many section 136 detainees held in custody. Police officers were careful not to leave vulnerable people on the street and sometimes brought people into custody who committed low-level, or non-notifiable offences and who were mentally unwell. While this was done with the best of intentions, it had the potential outcome of criminalising people with mental health concerns and concealed overall demand for mental health services.

Main recommendations

2.24 Levels of custody- trained staff should be sufficient to ensure the safety and wellbeing of detainees, staff and visitors.

2.25 Pre release risk assessments (PRRA) should be detailed, meaningful and based on an ongoing assessment of the detainees' needs while in custody; the custody record should reflect the needs of the detainees on release and any action that needs to be taken, including information leaflets about support agencies. Custody sergeants should be further briefed about the purpose and procedures for PRRAs.

2.26 Section 136 detainees should not come into custody as a place of safety. Durham police should engage with partners to ensure better access to section 136 facilities, in line with the expectations of the national Mental Health Crisis Care Concordat.

2.27 Durham police should ensure people arrested with mental health concerns are diverted to the correct medical or clinical services at the earliest opportunity and mentally ill people should not be unnecessarily subjected to the criminal justice process.

[2] Section 136 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a hospital, or a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker, and for the making of any necessary arrangements for treatment or care.

Section 3. Strategy

Expected outcomes:
There is a strategic focus on custody that drives the development and application of custody-specific policies and procedures to protect the well-being of detainees.

Strategic management

3.1 There was an effective governance structure in place that supported the management of custody. The deputy chief constable (DCC) provided strategic leadership on custody issues. There was a centralised custody function, which was delivered through the custody and justice department. The head of custody was a chief inspector.

3.2 Although some parts of the current estate were old, there had been investment to improve the safety of suites, and they were generally clean, with limited graffiti.

3.3 Staffing levels were barely adequate, with some staff struggling to manage their duties when suites were busy. Custody staff often had to rely on using arresting or processing officers for certain tasks, such as taking and placing detainees in cells. Custody staff included permanent custody sergeants and detention officers employed by Durham Constabulary, who were responsible for the care and welfare of detainees. They provided a good standard of care for detainees, and were professional and positive in their role. The staffing model was not self-sufficient and there was regular use of sergeants from other custody suites or operational response teams to provide resilience. At the time of the inspection some custody staff were on training and reliance on 'backfill' of custody duties was greater, however many staff told us this 'backfilling' was not an uncommon occurrence.

3.4 There were dedicated custody inspectors on each shift. They had responsibility for the force's custody suites and when on duty, between them, they provided round the clock cover, which included line management responsibility for the custody staff on their shift, as well as Police and Criminal Evidence Act (PACE) issues. Line management arrangements for custody staff were clear. Custody inspectors were informed of all arrests and directed escorting officers to the most appropriate custody suite. While we saw efficient use of custody suites through this allocation, we also saw some detainees being directed to busy custody suites. This meant that some detainees were left waiting outside in the car park at Bishop Auckland as there was no holding area in the custody suite. In one case we saw a detainee waiting for an hour in a van.

3.5 There were a number of systematic governance meetings where custody was discussed, including a custody management meeting chaired by the DCC, and a weekly custody meeting chaired by the head of custody. A summary of the key issues from these meetings was circulated to all custody staff. The head of custody held monthly bilateral meetings with custody inspectors. Custody inspectors met with staff at a local level. This overall structure provided a forum to raise and disseminate custody issues.

3.6 There was a structured process for the collection and evaluation of basic data relating to the treatment of those in custody, including monitoring the number of young people coming into custody, the use of voluntary attendance and use of force data. However, strip-search data, detention times or waiting times between arrival at the custody suite and authorisation of detention by the custody sergeant were not monitored.

3.7 There was a positive strategic drive to make use of alternatives to custody, including restorative approaches and voluntary attendance.

3.8 The force had procedures on custody but these had not been reviewed against the College of Policing's Authorised Professional Practice on detention and custody.

Partnerships

3.9 The Police and Crime Commissioner's (PCC) office coordinated an independent custody visitor (ICV) scheme for the force. This arrangement worked well: the ICV and the PCC coordinator reported a good relationship between the two, and issues which were identified during visits were promptly resolved. There was regular police representation at ICV panel meetings.

3.10 There were good links with partners at a strategic level, including police representation at the Cleveland and Durham local criminal justice board, and the Chief Constable attended the local strategic partnership. Police did not usually attend the local health and wellbeing board. The head of custody regularly met with partners including the youth offending service, health care provider and social services, which had produced some good outcomes in health care. Partnership work with the local authority in respect of provision for young people needed further development. We were told the out of office hours and weekend appropriate adult (AA) provision, which was provided through the local authority, was frequently poor (see paragraph 5.4).

Learning and development

3.11 All custody staff had undergone specific training before taking on custody duties. The custody sergeant's course was linked to the national custody officer learning programme (NCOLP) produced by the College of Policing.

3.12 Custody staff received regular refresher training, which was available for custody inspectors, custody sergeants and detention officers. Staff told us they valued this training, which had recently included an input on mental health awareness.

3.13 Custody inspectors were responsible for quality assurance of custody records and dip-sampled a number of records each week. This process included cross referencing entries against CCTV recordings and person escort records (PER), but it did not include shift handovers. Custody inspectors gave feedback directly to staff. The outcomes from the quality assurance process were reviewed by the head of custody, with outcomes discussed at the weekly custody meeting chaired by the head of custody. Any themes or issues identified from the dip-sampling were delivered to staff during refresher training days.

3.14 A process was in place for recording adverse incidents, overseen by the head of custody and professional standards department. Adverse incidents were also discussed at the custody management meeting chaired by the DCC. Learning from these adverse incidents was disseminated to staff along with other relevant custody information via a weekly circular from the custody and justice department. Staff told us that they found this useful.

3.15 There was an informative and accessible custody intranet site, which included information relating to adverse incidents and Independent Police Complaints Commission (IPCC) 'learning the lessons' bulletins. Staff said they found it useful and used it regularly.

Recommendations

3.16 Through partnership working at a strategic level, action should be taken to address the lack of local authority accommodation for children and young people refused bail at police stations.

3.17 Relevant and appropriate management information should be collected and used to plan, monitor and identify trends and interventions in custody, and to improve outcomes for the force and detainees.

Housekeeping points

3.18 The force should review custody procedures against the College of Policing Authorised Professional Practice (APP) custody policy.

3.19 Shift handovers should be included within the quality assurance process.

Section 4. Treatment and conditions

Expected outcomes:
Detainees are held in a clean and decent environment in which their safety is protected and their multiple and diverse needs are met.

Respect

4.1 Staff were friendly and considerate to detainees, using their first names or titles as appropriate, and detainees said they felt well looked after. During the inspection there were good examples of custody staff managing some vulnerable detainees. We also observed violent detainees being brought into custody and officers using restraining techniques appropriately, and subsequently providing good levels of care.

4.2 With the exception of Durham, which had a booking-in room, booking-in areas were small and could only provide adequate privacy by staff booking in one detainee at a time and by closing the door between them and the corridor. On occasion, detainees looked confused by the questions they were asked and would have benefited from some clarification. At Darlington and Peterlee, we heard conversations about detainees and investigations taking place in a back office within earshot of detainees at the nearby booking-in desk. There were discrete booking-in areas at Durham, Darlington and Peterlee, though they were rarely used, at Bishop Auckland staff prevented non-custody staff coming into the custody suite while a detainee was booked in for an alleged sensitive offence.

4.3 Toilets in cells were obscured on CCTV monitors, except at Darlington, where there was an additional monitor in a back office, and any member of staff entering the office could see detainees using the toilet.

4.4 At Peterlee, there was a well-used women's diversion scheme that supported women by addressing issues that might otherwise result in them being taken into custody. We were told the force was using a university to professionally evaluate the impact of the scheme. Women detainees were asked if they might be pregnant but not if they wished to speak to a female officer; our custody record analysis (CRA) showed that only one of the eight female detainees in the sample was offered a female member of staff to speak to. Girls aged 16 or under were not allocated a named female officer responsible for their care at any of the suites.

4.5 Young people brought into custody were mostly dealt with quickly, but in our sample of 30, of which seven were young people, there was one case where a young person was held in custody for 39 hours. He was also recorded as suffering from attention deficient hyperactivity disorder (ADHD) and was autistic. He was offered food on seven occasions, but refused it all seven times, and there was no record to confirm if alternative food was offered or if the officers offered to call his parents. The records made were basic and brief, and did not reflect any extra care needs due to his ADHD or autism.

4.6 Detention officers (DOs) informed us that they had received some computer-based training on safeguarding vulnerable detainees and diversity. There were no adapted cells for disabled detainees, although Darlington and Peterlee had a suitable toilet and shower. All the bed plinths were low, which made it difficult for disabled or frail detainees to be suitably accommodated. There were no hearing loops.

4.7 At some suites, detainees were asked about religious observance. All suites had a reasonable supply of prayer mats and religious texts, but staff could not always easily find them. Detainees were not routinely told that religious books were available.

4.8 Most staff knew the importance of offering transgender detainees a choice about the gender of officer who searched them.

Recommendations

4.9 Booking-in desks should allow effective and private communication between detainees, staff and their legal representatives.

4.10 Durham Constabulary should develop procedures that ensure custody staff consider and respond to the distinct needs of women, children and young people, and disabled people in custody. (Repeated recommendation 4.127)

4.11 Every suite should have some cells with bed plinths that are of conventional bed height and a hearing loop should be available in all custody suites.

Housekeeping points

4.12 Girls aged 16 or under should be allocated a named female member of staff who is responsible for their care.

4.13 Custody staff should ensure that confidential conversations cannot be overheard by detainees or visitors in the booking-in areas.

4.14 Toilet areas should be obscured on all CCTV screens.

Safety

4.15 On most occasions, on arrival at the police station we saw detainees being promptly booked in by the custody sergeant. However, we noted that some detainees waited a long time to be booked in and on one occasion as long as an hour. We were informed that at Durham and Darlington there were, supposedly, two custody sergeants allocated to the booking-in desk. However, throughout the inspection we saw only one custody sergeant per suite, and staff told us that having two custody sergeants was a rare occurrence.

4.16 Initial risk assessment procedures were generally good. Custody sergeants booked in detainees and asked a standard set of questions about health and self-harm. All custody sergeants asked appropriate supplementary questions when necessary to explore areas of potential concern. Some custody sergeants checked that detainees could read; in one instance this revealed that a detainee who said he could read was actually unable to. Custody records contained useful supplementary information about health, addictions, and risk. We saw assessments particularly well conducted at Darlington: the custody sergeant probed sensitively, uncovering mental health problems and some recent self-harm that one detainee was initially reticent about disclosing.

4.17 At Bishop Auckland a detainee divulged to a DO that she had serious feelings about harming herself. The DO spent a long time with the detainee in her cell and a referral was made to the mental health nurse. Good support was offered to the detainee while she was in custody and staff made plans to ensure her safety on release. At Peterlee a risk assessment was

carried out at the earliest opportunity with a violent detainee as soon as he calmed down and, until the risk assessment was carried out, he was subject to 15 minute checks. However, we observed some risk assessments being unacceptably delayed, including one in which an intoxicated detainee was booked in at 8.16pm, but was not risk assessed until 4.20pm the next day. Our CRA found similar examples of unacceptably long delays.

4.18 We were informed that some custody sergeants were unable to conduct police national computer (PNC) checks, although they ensured the DO checked the PNC; this was sometimes not done until after the risk assessment was completed. PNC checks should be completed at the same time as the booking-in process to ensure knowledge and consideration of all risks to the detainee's welfare and safety

4.19 Care plans specified a range of observations from hourly to constant and custody records confirmed that these were reviewed and amended appropriately. Children and young people were automatically placed on 30 minute observations due to their vulnerability, as were detainees who were in custody for the first time. Intoxicated detainees were subject to rousing checks and DOs were able to explain the importance of obtaining a response that demonstrated a normal level of consciousness. However, the CRA found that insufficient detail was recorded about detainees' response to rousing.

4.20 Officers undertaking constant observations were briefed and would, subject to risk assessment, sit in the cell with the detainee rather than outside it. However, we saw an officer using his mobile phone when he should have been undertaking constant observations of a vulnerable detainee. It was only after we pointed this out to the custody sergeant that the officer was instructed to give the detainee his full attention. At each suite there was a stock of rip-proof clothing, but we did not see it in use and risk management methods were proportionate. Staff carried anti-ligature knives.

4.21 Not all cells were monitored by CCTV but we were informed that CCTV cells were used for those detainees who were vulnerable but did not require continual monitoring. At Bishop Auckland the CCTV monitor was in the back office and when the suite was busy there was no one intermittently checking the detainees located in these cells, although there was a multi-screen monitor at the booking-in desk. However this was insufficient for higher risk detainees.

4.22 There was no shift overlap for handovers. The information that was exchanged during the handover process was good and was relevant to the detainees' risks and care planning. However detention officers conducted their own handover separately, despite having relevant information that would have contributed to the sergeant's handover. Custody staff did not routinely go and introduce themselves to detainees after the handover.

4.23 At most suites, we saw cell call bells responded to promptly. The exception was at Durham, where the cell call bells sounded in a back office, where staff were not always present.

4.24 While the initial risk assessment was well done, pre-release risk assessments (PRRAs) were mostly lacking by comparison. Staff clearly had the competence and understood the complexity of risk assessments but did not always apply them to people leaving custody. Although we saw some excellent pre-release risk assessments, with community support aftercare in place before detainees left custody, and some detainees were given money for bus fares, whereas others were taken home by officers, we also saw custody sergeants releasing many detainees without discussing PRRA at all.

4.25 There was a good, informative leaflet about support agencies (albeit only in English), but few detainees were given it. It seemed that unless there were strong concerns about a detainee being released, custody sergeants did not understand the purpose of conducting a PRRA.

They expressed little awareness of the benefits of encouraging detainees to seek help with the issues that may have led to their arrest (see main recommendation 2.25).

Recommendations

4.26 Risk assessments should be completed at the earliest possible opportunity and include warning markers on the PNC before the risk assessment is completed.

4.27 Custody sergeants and detention officers should receive their handovers together, in an area cleared of other staff and detainees.

4.28 Custody staff conducting constant supervision via closed-circuit television should not be engaged in other tasks and significant events and interactions should be recorded.

Use of force

4.29 Not all detainees were brought into the suites in handcuffs and many officers clearly understood that handcuffing should be justifiable, necessary and appropriate. However, at Durham, a very troubled detainee was in handcuffs for over 24 hours in his cell. He was under constant observation to prevent him retrieving sharp items, which he had told staff were hidden inside his body, as custody sergeants considered that to be the only way of ensuring his safety. Nevertheless we were concerned about him spending such a prolonged period in handcuffs. Elsewhere, we also saw a detainee arrive in custody in a very agitated state, whom staff believed had secreted items for self-harm. He declined to produce the items and was forcibly strip-searched. He was taken to a cell and professionally searched with consideration for both his and the officer's safety.

4.30 The force was unable to provide data on strip-searching across the custody suites.

4.31 A use of force form was available and staff were conversant with its use. The professional standards department had access to this information, which was a good mechanism for identifying any concerning trends or conduct. It was positive that these forms were analysed and that trends were communicated to managers and staff. An example of this was that the analysis of the form revealed a potential overuse of pepper spray; this was then addressed with the officer concerned. All custody staff received annual personal safety training.

Recommendation

4.32 Detainees should not be handcuffed in cells.

Physical conditions

4.33 There was an ongoing refurbishment programme and it was clear that some custody suites had been recently repainted, deep cleaned and partially refurbished, which had improved the general condition of the suites. However, the suite at Durham, which had been recently refurbished, was already looking tired: graffiti which had been carved into the walls had merely been painted over and could still be seen; the floors remained bare; and ingrained dirt was building up in the corners of the cell walls and floors. Darlington was mainly clean and almost entirely free of graffiti as was Peterlee, although some cells were very cold.

4.34 At Bishop Auckland, the suite was old, and while the booking area was light and bright, the cell area offered little natural light. During the inspection we observed a high turnover of detainees, which clearly contributed to the overall tired appearance of the cells.

4.35 There was a record sheet of daily maintenance checks at all suites, though we found that there were several days when no checks had been recorded. There was no record of emergency evacuation drills taking place, but staff knew of the procedure and had access to the fire evacuation kit. At Darlington, a practise fire evacuation took place during our inspection.

4.36 Staff at all suites told us that repairs and deep cleaning took place promptly and that cells were rarely out of use for more than 24 hours. Independent custody visitor (ICV) records showed that few concerns about physical conditions had been raised.

4.37 We were concerned that as the property lockers at Durham were very small, detainees' outer clothing was stored on the floor outside their cell doors. This was unhygienic, insecure and disrespectful. We did not see this happen elsewhere.

Housekeeping points

4.38 Cell maintenance and cleanliness checks should take place every day and be recorded.

4.39 Floors at Durham should be kept clean, and there should be suitable provision for the storage of detainees' property.

4.40 Emergency evacuations should be practised at every suite and records kept.

Detainee care

4.41 Night shifts were expected to offer detainees the opportunity to shower prior to going to court, but there was little evidence in the custody records to confirm this. Our CRA revealed that just four detainees were either offered or used washing facilities while in custody.

4.42 The showers at Durham were inadequate. They did not provide anywhere private to dress, and the female detainees' shower was next to the busy drug workers' office. At Peterlee the female shower could easily be seen by detainees passing through the corridor, and it was difficult to envisage a detainee wanting to shower there. There were no hand basins in cells and, with the exception of Peterlee, the sinks in the corridor had no towels, though DOs told us they would fetch towels on request. At all suites toilet paper was usually given by request only, although at Peterlee we saw some already placed in cells awaiting the next detainee. At Darlington there was a walk in shower, adapted for disabled detainees. However, it offered insufficient privacy because the door was too small.

4.43 All cells had good thick mattresses, but no pillows. Mattresses were not routinely sanitised between uses. There were plenty of blankets and safety blankets. There were ample stocks of replacement clothing, including spare underwear, but despite this, staff informed us that they had recently been instructed to restrict its use and to issue paper suits instead. We saw paper suits given to detainees who would have been better off in tracksuit bottoms, for example a 14-year-old boy. Clothing with cords or laces was removed from all detainees with no regard to the individual level of risk. This was a disproportionate response, particularly for those detainees who were assessed as low risk. We observed several detainees moving around the custody suites without any shoes on.

4.44 There were feminine hygiene packs, although female detainees were not routinely offered them, and plenty of soap, toothpaste, razors, and cotton towels.

4.45 There were good stocks of microwave meals at all suites, offering options for a range of dietary needs, including halal, vegetarian and gluten-free. Staff told us they would provide more than one meal on reasonable request and we observed this being done. Tea, coffee, hot chocolate and water was available and regularly offered. Custody staff said they allowed relatives to bring in food in factory-sealed containers, and in one case our CRA showed evidence that a family member was permitted to bring in such a meal.

4.46 All suites had exercise yards and we saw detainees using them. There were a few newspapers, magazines and books available in all suites but none of these were in languages other than English, and there was little that was suitable for young people. Social visits were rarely facilitated, despite there being a closed visits room at Durham.

Recommendations

4.47 **All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private.** (repeated recommendation 4.133)

4.48 **Pillows should be provided to all detainees.**

4.49 **Unless there is a forensic reason to do so, replacement clothes rather than paper suits should be given to detainees to wear when their own clothes are removed.** (repeated recommendation 4.137)

4.50 **A range of reading materials should be available and routinely offered, including books and magazines suitable for young people and for those whose first language is not English.**

Housekeeping points

4.51 Female detainees should routinely be offered hygiene packs.

4.52 Mattresses should be wiped down between uses.

4.53 Social visits should be facilitated for those detained for long periods or for young people and other vulnerable adults.

Section 5. Individual rights

Expected outcomes:
Detainees are informed of their individual rights on arrival and can freely exercise those rights while in custody.

Rights relating to detention

5.1 Custody officers stated that they would rarely need to question the necessity of an arrest or refuse detention. Often, police officers would seek advice from custody officers prior to undertaking planned operations and we also observed custody inspectors taking radio messages from officers who contemplated making spontaneous street arrests and were prompted to consider alternatives if appropriate. Several police officers stated that they had been made more aware of Code G of Police and Criminal Evidence Act (PACE), which emphasises the importance of ensuring an arrest is necessary, and that consequently there had been an increase in the use of voluntary attendance by suspects at the police station (see section on strategy).

5.2 Although Durham Constabulary had a prisoner handling team, custody officers were not over-reliant on this team and arresting officers would, where appropriate, progress the case. We saw many cases being progressed promptly and were satisfied that detention generally lasted no longer than was necessary.

5.3 Custody staff assured us that the custody suite was never used as a place of safety for children under section 46 of the Children Act 1989. Staff said they contacted social services to check the availability of 'safe beds' for detained young people who were held overnight and who could not be bailed, even if they thought beds would not be available. Custody officers told us that wherever possible they would prefer to bail a child or young person to return at a later date rather than keep them overnight (see section on strategy).

5.4 All detainees under the age of 18, and those adults deemed to be vulnerable, such as those with learning difficulties, would be interviewed in the presence of an appropriate adult (AA). Staff told us that in the first instance they tried to find relatives to act as AAs. However, when this was not possible, during normal office hours (9am to 5pm Monday to Friday) the local authority social services were contacted. For those under 18 an AA was provided through the local Youth Offending Service, and adult social services provided an AA for vulnerable adults. We were informed that this arrangement worked well during normal hours, but out of hours and at weekends all AA provision was provided through the local authority social service's Emergency Duty Team, where response was frequently poor.

Recommendation

5.5 **Appropriate Adults should be available for vulnerable people out of normal office hours so they are not further disadvantaged by delays or prolonged stays in custody.** (repeated recommendation 5.163)

Rights relating to PACE

5.6 Criminal Defence Service posters advising detainees on arrival that they had the right to legal representation were only displayed at Peterlee. However, all custody officers told detainees

about their right to free representation. Those who refused the offer were asked why and reminded that they could change their minds at any time. In our custody record analysis (CRA), all detainees were offered legal advice, and 50% (15 detainees) accepted the offer. Legal advisors were contacted promptly and attended when required. Legal advice for those detained for immigration matters was available through the duty solicitor scheme.

5.7 Detainees could speak to legal advisors in private, both on the telephone and in interview rooms. However, despite cordless telephones being available, we occasionally saw detainees using the desk telephone or using cordless phones in the presence of others.

5.8 All detainees at the booking-in desk were told that someone could be informed of their whereabouts. In our CRA 73% of the sample (22 detainees) declined the offer. For those who accepted, the CRA clearly showed that the nominated person had been informed of the arrest in all but one case, and on that occasion several attempts had been made to contact them.

5.9 Detainees were given a notice of rights and entitlements, which was available in many different languages and in an easy to read format. However, not all custody staff knew of the easy to read format and suites had different stocks of the rights and entitlement leaflets, some of which were out of date. Detainees could also consult PACE codes of practice and several up-to-date copies were available.

5.10 PACE reviews were undertaken by the custody manager who was responsible for all custody suites in the force, and he/she visited each suite regularly. Wherever possible reviews were undertaken in person, but due to delays caused by travelling there was a reliance on telephone reviews. We did not observe any face-to-face reviews taking place, only telephone reviews. However, these were robust and informative. In our CRA, 17 detainees required a review and it was only clear on three occasions that these were done face-to-face. Four were carried out when the detainee was asleep and therefore not disturbed. It was not clear if detainees whose reviews took place while they were asleep were later informed that this had taken place or reminded of their rights and entitlements.

5.11 The management of DNA was good, samples were frequently collected from the suite and we did not find old DNA samples. Very few custody staff understood the policy for the retention and disposal of DNA samples in line with the Protection of Freedoms Act 2012, despite there being posters on the wall.

5.12 Custody staff were mostly positive about court cut-off times. We were informed that, with some exceptions, it was possible to get someone to court by 3pm. During the inspection we did not see detainees kept unnecessarily in police detention due to any early court cut-off time.

Housekeeping points

5.13 Detainees should always be offered the opportunity to speak to their legal representative privately on the telephone.

5.14 Criminal Defence Service posters should be displayed in all suites.

5.15 The force should satisfy itself that there is no over-reliance on telephone PACE reviews

5.16 Custody staff should be made aware of the DNA retention and disposal policy.

5.17 The rights and entitlements leaflets offered should be up-to-date and consistent at all suites.

Rights relating to treatment

5.18 Information on how to make a complaint was included in one version of the rights and entitlements leaflet, but not all detainees received this version. We were informed that if a detainee wanted to make a complaint then they would be issued with a form and advised to make a complaint once they left custody. This would not be the case if the complaint was of a criminal nature, where an inspector would be informed and, where possible, take the complaint. It was unclear what the procedure was for detainees who were not released, for example, if they were taken directly to court.

Recommendation

5.19 Complaints should be taken while detainees are still in custody, unless there is a good reason not to do so.

Section 6. Health care

Expected outcomes:
Detainees have access to competent health care professionals who meet their physical health, mental health and substance use needs in a timely way.

Governance

6.1 Primary health care was provided by Total Healthcare who employed nurses and forensic medical examiners. Adult substance misuse services were provided by Addaction and North East Council on Alcoholism (NECA)[3]. These two drug and alcohol services covered the four custody suites, with Addaction being the substantive operator. A mental health Criminal Justice Liaison and Diversion Service (CJLDS) was available to the force, and mental health nurses were available during weekdays in all the suites.

6.2 Total Healthcare worked well with frontline police staff and the service was managed by County Durham and Darlington Foundation Trust. The contract was monitored effectively and there was a multi-agency approach. Regular reviews took place at bi-monthly meetings and were attended by senior police officers, the lead local provider, lead forensic medical examiner (FME) and NHS England representatives. A health check assessment had been completed in 2012 and was used to inform the delivery of services. A recent external evaluation and health assessment demonstrated that the issues raised in our 2008 report had successfully been addressed. We found that there was a strong strategic overview of all elements of health care delivery.

6.3 Custody staff were complementary about the health care staff at the suites. The force had assessed the effectiveness and efficiency of the service and had taken action to ensure that staff took appropriate steps to divert people from custody. Senior management were aware of repeat offenders and had initiated work with the Integrated Offender Management Service (IOM) to support these offenders to change their behaviour. They also worked with offender community health providers and probation officers to identify actions that could be taken to reduce prolific offending behaviour. Senior managers also worked with the local Mental Health Trust to ensure people with mental health needs could be taken to alternative places of safety instead of police cells.

6.4 The health care staff we saw were professional, but they did fail to follow their provider's uniform policy. They were caring and respectful with the detainees and used language interpretation services when required. Mechanisms were in place to ensure that female detainees could be seen by health care staff of their own gender. County Durham and Darlington Foundation Trust had not provided Total Healthcare staff with an accessible office base in their estate, nor had they negotiated an office space to be provided in the police estate; therefore staff were completing their handover in the University of Durham car park. Health care staff could not access their hospital database from the custody suites; this limited their ability to promptly identify if detainees had existing health conditions or were involved with community health care providers.

---

[3] Regional registered charity working in the area of substance use/misuse.

6.5 There were more female FMEs and Total Healthcare was in the process of recruiting more male FMEs. Total Healthcare employed eight FMEs and six nurses. In our survey 17% of detainees said they were seen by a nurse.

6.6 Total Healthcare and the lead Chief Inspector had established clear lines of management and accountability. The health care provider had systems for checking staff member's professional credentials and there were good opportunities for professional development. An induction programme was available which allowed new staff to shadow experienced staff. Mandatory training was well managed and there were opportunities for staff to receive regular clinical supervision. Detainee complaints about the level and quality of health care were extremely rare.

6.7 The clinical rooms at all four suites were clean, well equipped and in good order. The flooring at Bishop Auckland needed replacing. All sinks and examination couches were suited to the care and treatment of detainees. The examinations of detainees that we observed were all carried out professionally while maintaining privacy for the detainees. The suites did not contain evidence of health care screening or health promotion materials.

6.8 Medicine management was good with all medicines administered by health care staff or self-administered under the supervision of custody staff. Nurses had access to a wide range of patient group directions. Stock was well managed and we did not find any out of date supplies.

6.9 Eleven of the detainees (37%) in our sample reported being on medication on arrival in custody, and three of them required this medication while in custody. Of these three detainees, two received their medication. Efforts were made by custody staff to retrieve medicines from the detainee's home or chemist when required and this included methadone. Symptomatic relief was available for custody staff to administer but would not be given until six hours of detention had passed and health care staff had been consulted. Paracetamol and Ibuprofen were not secured suitably at Durham and Bishop Auckland.

6.10 An excellent range of emergency resuscitation equipment was available and accessible in each of the suites. The equipment sets were all the same with the same layout and included oxygen, suction apparatus and automated external defibrillators. Well stocked first aid kits were also available. Equipment was well maintained with good records kept of daily checks. A good level of first aid and resuscitation training was provided for all staff.

Recommendations

6.11 IT systems should be available to allow health care staff access to the local hospital database.

6.12 Clinical staff should perform shift handovers in suitable work premises.

6.13 Clinical examination rooms should comply with the infection control standards.

Housekeeping points

6.14 All staff should comply with the providers' uniform policy.

6.15 Patient information leaflets and health promotion literature should be accessible in all clinical rooms.

Patient care

6.16 Health care was provided over 24 hours with nurses working 12-hour shifts. One nurse provided cover for all four suites. FMEs provided an on call service for each 12-hour shift.

6.17 All detainees were offered the opportunity to see a member of the health care team or referred if the custody staff had concerns for their physical or mental health. The provider monitored attendance and response times. Response times were recorded in the custody record. Response time targets were set at 90 minutes and the health care contract included credit penalties if these were not achieved. In our sample of records the longest waiting time was two hours 29 minutes and the shortest 16 minutes. The average waiting time was one hour 35 minutes. Annual records indicated that the targets were usually met.

6.18 Custody staff were generally happy with the availability of nursing staff and noted longer delays with the response from FMEs. In our custody record analysis we found some concerning instances of poor recording in the custody record but the samples of clinical records we observed included a good level of detail. Health care information was shared appropriately and detainees had their care managed professionally. All records were stored in locked cabinets at each suite.

Recommendation

6.19 All instances of care that would be relevant to custody staff should be reflected in the custody record.

Substance misuse

6.20 Substance misuse services were provided at each of the suites during weekdays with one worker from Addaction covering Durham, Bishop Auckland and Peterlee, and another worker from NECA attending Darlington. At all other times detainees with substance misuse problems were given appointments or signposted to the relevant service. In our CRA, six detainees (20%) came into custody with alcohol or drug dependencies. Substance misuse workers saw detainees with drug and alcohol problems and referred juveniles to the Youth Offending Teams in the community. There were good links with health care staff and the CJLDS, and the workers were valued by the custody staff. Needle exchange services were not available for detainees.

Recommendation

6.21 Injecting drug users released into the community should be offered clean needles by drug workers.

Mental health

6.22 Mental health services were provided by Tees, Esk and Wear Valley NHS Trust. The team were well established as a criminal justice liaison and diversion service with two mental health nurses based at Durham, and one for each of the remaining suites. The service was provided each weekday with out-of-hours access to the crisis teams and secondary care facilities. A child and adolescent mental health service was about to commence. Custody staff spoke highly of the mental health support offered to detainees.

6.23 Mental health nurses provided a useful contact with the community mental health services, but were unable to access NHS records at the custody suites. The team provided mental health awareness training for custody and general nursing staff (see paragraph 6.11).

6.24 Some detainees who came into custody should have been diverted to a hospital or other place of safety for mental health care. Section 136 of the Mental Health Act allows police officers to move a person from a public place to a place of safety. In Durham there were two hospital based places of safety (section 136 suites). Nevertheless, we found that a high number of people detained under section 136, were held in custody and not in section 136 suites. We were told that this occurred as the assessment criteria for admission to section 136 suites were overly restrictive.

6.25 We were also concerned about the numbers of detainees brought into custody who had mental health concerns, and were arrested for minor offences such as trespassing. As the force did not collect this data, it was unclear how many people were brought into custody who had been arrested for minor offences, and then, required a mental health assessment. This practice unjustly criminalised people with mental health problems.

Section 7. Summary of recommendations and housekeeping points

Main recommendations

7.1 Levels of custody- trained staff should be sufficient to ensure the safety and wellbeing of detainees, staff and visitors. (2.24)

7.2 Pre release risk assessments (PRRA) should be detailed, meaningful and based on an ongoing assessment of the detainees' needs while in custody; the custody record should reflect the needs of the detainees on release and any action that needs to be taken, including information leaflets about support agencies. Custody sergeants should be further briefed about the purpose and procedures for PRRAs. (2.25)

7.3 Section 136 detainees should not come into custody as a place of safety. Durham police should engage with partners to ensure better access to section 136 facilities, in line with the expectations of the national Mental Health Crisis Care Concordat. (2.26)

7.4 Durham police should ensure people arrested with mental health concerns are diverted to the correct medical or clinical services at the earliest opportunity and mentally ill people should not be unnecessarily subjected to the criminal justice process. (2.27)

Recommendations

Strategy

7.5 Through partnership working at a strategic level, action should be taken to address the lack of local authority accommodation for children and young people refused bail at police stations. (3.16)

7.6 Relevant and appropriate management information should be collected and used to plan, monitor and identify trends and interventions in custody, and to improve outcomes for the force and detainees. (3.17)

Treatment and conditions

7.7 Booking-in desks should allow effective and private communication between detainees, staff and their legal representatives. (4.9)

7.8 Durham Constabulary should develop procedures that ensure custody staff consider and respond to the distinct needs of women, children and young people, and disabled people in custody. (4.10, repeated recommendation 4.127)

7.9 Every suite should have some cells with bed plinths that are of conventional bed height and a hearing loop should be available in all custody suites. (4.11)

7.10 Risk assessments should be completed at the earliest possible opportunity and include warning markers on the PNC before the risk assessment is completed. (4.26)

7.11 Custody sergeants and detention officers should receive their handovers together, in an area cleared of other staff and detainees. (4.27)

7.12 Custody staff conducting constant supervision via closed-circuit television should not be engaged in other tasks and significant events and interactions should be recorded. (4.28)

7.13 Detainees should not be handcuffed in cells. (4.32)

7.14 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.47, repeated recommendation 4.133)

7.15 Pillows should be provided to all detainees. (4.48)

7.16 Unless there is a forensic reason to do so, replacement clothes rather than paper suits should be given to detainees to wear when their own clothes are removed. (4.49, repeated recommendation 4.137)

7.17 A range of reading materials should be available and routinely offered, including books and magazines suitable for young people and for those whose first language is not English. (4.50)

Individual rights

7.18 Appropriate Adults should be available for vulnerable people out of normal office hours so they are not further disadvantaged by delays or prolonged stays in custody. (5.5, repeated recommendation 5.163)

7.19 Complaints should be taken while detainees are still in custody, unless there is a good reason not to do so. (5.19)

Health care

7.20 IT systems should be available to allow health care staff access to the local hospital database. (6.11)

7.21 Clinical staff should perform shift handovers in suitable work premises. (6.12)

7.22 Clinical examination rooms should comply with the infection control standards. (6.13)

7.23 All instances of care that would be relevant to custody staff should be reflected in the custody record. (6.19)

7.24 Injecting drug users released into the community should be offered clean needles by drug workers. (6.21)

Housekeeping points

Strategy

7.25 The force should review custody procedures against the College of Policing Authorised Professional Practice (APP) custody policy. (3.18)

7.26 Shift handovers should be included within the quality assurance process. (3.19)

Treatment and conditions

7.27 Girls aged 16 or under should be allocated a named female member of staff who is responsible for their care. (4.12)

7.28 Custody staff should ensure that confidential conversations cannot be overheard by detainees or visitors in the booking-in areas. (4.13)

7.29 Toilet areas should be obscured on all CCTV screens. (4.14)

7.30 Cell maintenance and cleanliness checks should take place every day and be recorded. (4.38)

7.31 Floors at Durham should be kept clean, and there should be suitable provision for the storage of detainees' property. (4.39)

7.32 Emergency evacuations should be practiced at every suite and records kept. (4.40)

7.33 Female detainees should routinely be offered hygiene packs. (4.51)

7.34 Mattresses should be wiped down between uses. (4.52)

7.35 Social visits should be facilitated for those detained for long periods or for young people and other vulnerable adults. (4.53)

Individual rights

7.36 Detainees should always be offered the opportunity to speak to their legal representative privately on the telephone. (5.13)

7.37 Criminal Defence Service posters should be displayed in all suites. (5.14)

7.38 The force should satisfy itself that there is no over-reliance on telephone PACE reviews (5.15)

7.39 Custody staff should be made aware of the DNA retention and disposal policy. (5.16)

7.40 The rights and entitlements leaflets offered should be up-to-date and consistent at all suites. (5.17)

Health care

7.41 All staff should comply with the providers' uniform policy. (6.14)

7.42 Patient information leaflets and health promotion literature should be accessible in all clinical rooms. (6.15)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	HMIP team leader
Gary Boughen	HMIP inspector
Peter Dunn	HMIP inspector
Robert Bowles	HMIC staff officer
Mark Ewan	HMIC staff officer
Vinnett Pearcy	HMIP Inspector
Michael Bowen	HMIP health services inspector
Katie Tucker	Care Quality Commission
Joe Simmonds	HMIP researcher

Appendix II: Progress on recommendations from the last report

The following is a summary of the main findings from the last report and a list of all the recommendations made. The reference numbers at the end of each recommendation refer to the paragraph location in the previous report. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Strategy

There is a strategic focus on custody that drives the development and application of custody-specific policies and procedures to protect the well-being of detainees.

Recommendations

A clear strategy for the future of custodial provision should be agreed and custody matters should be routinely included in relevant force planning documents. (3.22)
Achieved

A health strategy based on a needs analysis should be agreed utilising National Health Service (NHS) support. The strategy should ensure that sufficient health services, including forensic medical examiner (FME) cover, are provided and outline an effective working framework for FMEs and emergency care practitioners (ECP). (3.23)
Achieved

Staffing of custody suites should be managed to ensure consistent working practices across all custody suites in the north and south of the force and to reflect the pressures faced by busier custody suites. (3.24)
Partially achieved

An effective system of intrusive supervision into custodial matters should be introduced at inspector rank, with consistent audit trails detailing their findings, observations and follow-up action. (3.25)
Achieved

A formal force-wide policy should be developed which deals with cell bell usage and staff responses. (3.26)
Achieved

Greater effort should be made to utilise management information within the National Strategy for Police Information Systems (NSPIS) custody system to achieve a better understanding of the profile of detainees. (3.27)
Partially achieved

Specific policies in relation to the treatment of young people, women and immigration detainees should be introduced. (3.28)
Partially achieved

The force should develop a custody intranet site, which should included all relevant policies and be linked to the 'Lessons Learned' newsletters from the Independent Police Complaints Commission. (3.29)
Achieved

A clear complaints policy should be advertised in custody suites and the number and nature of complaints should be analysed centrally so that underlying causes of complaints can be identified with a view to solving any problems. (3.30)
Partially achieved

The force should urgently review how it stores, tracks and submits all DNA and forensic samples taken from detainees. A robust series of control mechanisms should be introduced which facilitate intrusive monitoring of performance in this area. Performance should be reviewed by a senior officer who has responsibility for ensuring its delivery. (3.31)
Achieved

Treatment and conditions

Detainees are held in a clean and decent environment in which their safety is protected and their multiple and diverse needs are met.

Booking-in and discharge arrangements should be improved so that detainees are dealt with at a desk of an appropriate height and which allows sufficient privacy for confidential information to be passed. (4.124)
Not achieved

Appropriate supervised seating areas should be provided for detainees waiting to be booked in, who should not have to wait for prolonged periods in vans. (4.125)
Partially achieved

Holding facilities, interview rooms and the exercise yard area should be made less austere and all cell areas kept clean. (4.126)
Achieved

Risk assessments should be based on individual risk and take into account the needs of specific groups such as women and children. (4.127)
Partially achieved (recommendation repeated 4.10)

All custody staff should carry personal cell keys and anti-ligature knives. (4.128)
Achieved

An entry in the custody record should be kept of all occasions and the reasons when a member of staff has access to a detainee held in the custody suite. (4.129)
Achieved

All staff working in custody suites should be up to date with training which includes the management of detainees, risk assessment, mental health awareness training and gender- and child-specific issues. (4.130)
Achieved

Basic information about what to expect in custody and what facilities can be requested should be explained to detainees and available in booklets and/or posters. (4.131)
Partially achieved

Detainees should be offered meals at appropriate intervals and this should be recorded in custody records. (4.132)
Achieved

All showers should provide appropriate privacy. (4.133)
Not achieved (recommendation repeated 4.49)

Items to meet basic needs, such as pillows, toilet paper, sanitary products, and reading materials should be routinely available unless their removal can be justified by an individual risk assessment. (4.134)
Partially achieved

Staff should explain the use of the call bell to detainees and this should be recorded. (4.135)
Partially achieved

Detainees should be held in suitable ventilated and heated cells with natural light, sanitation and washing facilities which can be used independently and in suitable privacy. (4.136)
Achieved

When required, detainees should be provided with appropriate alternative clothing and paper suits used only when absolutely necessary. (4.137)
Not achieved (recommendation repeated 4.51)

Young people under 18 should be held in well supervised accommodation and dealt with taking into account their legal status and vulnerabilities as children, including an awareness of child protection issues. (4.138)
Partially achieved

Fire evacuation plans should be practised regularly. (4.139)
Partially achieved

Individual rights

Detainees are informed of their individual rights on arrival and can freely exercise those rights while in custody.

On admission, detainees should be routinely asked if they need to see a doctor, asked about any childcare issues and offered the opportunity to make a personal telephone call to inform someone of their whereabouts unless there are clear contrary indications. (5.161)
Achieved

Custody staff should receive training on the differential impact of custody on different groups of detainees, particularly juveniles (including child protection awareness), women and carers. (5.162)
Achieved

The availability of appropriate adults out of normal office hours should be improved. (5.163)
Not Achieved (recommendation repeated 5.5)

Subject to individual risk assessment, relatives, guardians or appropriate adults should be allowed to remain with juveniles in detention rooms. (5.164)
Achieved

Discussions should be held with the Court Services to ensure that cut-off points for accepting detainees are not too early and thus result in people spending too long in police custody. (5.165)
Achieved
Detainees should be given information about how to complain about treatment in custody. (5.166)
Partially achieved

A specific procedure for handling racist incidents and complaints should be introduced. (5.167)
Achieved

A strategy should be introduced to ensure the consistency of exit plans, which should recognise the vulnerability of children. (5.168)
Partially achieved

Health care

Detainees have access to competent health care professionals who meet their physical health, mental health and substance use needs in a timely way.

Police and Criminal Evidence (PACE) regulations should be reviewed to allow registered nurses to administer prescribed controlled drugs to detainees. (6.50)
Achieved

The force should commission a health-focused organisation, such as the primary care trust, to provide the expertise to identify, equip and manage medical facilities within custody suites. This should include an infection control audit. (6.41)
Achieved

Sharps bins should be managed appropriately and exchanged regularly. They should not be used for general waste. (6.42)
Achieved

Clinical governance arrangements should be established, to include the management, training, supervision and accountability of clinical staff. These arrangements should be informed by robust risk assessment, audit and monitoring systems, with appropriate learning from findings, action planning and timely implementation. (6.43)
Achieved

There should be sufficient health services professionals to provide timely, consistent and competent healthcare services. (6.44)
Achieved

Clinical examinations should be conducted with due regard for decency, privacy and dignity. (6.45)
Achieved

Protocols for sharing information with all appropriate partner agencies should be developed. (6.46)
Achieved

Health services staff should receive ongoing training, supervision and support to maintain their professional registration and development, and this should be evidenced. (6.47)
Achieved

Appropriate resuscitation equipment in a 'grab bag' or similar should be easily accessible by all staff (health services and custody), who should know where it is and how to use it effectively. There should be weekly documented checks of all resuscitation equipment. (6.48)
Achieved

All clinical records should be held in accordance with Caldicott guidelines, be contemporaneous and conform to professional guidance from the relevant regulatory body, such as the General Medical Council or Nurse/Midwifery Council. (6.49)
Achieved

Nurses should only accept verbal orders from FMEs for medicines in exceptional circumstances. Any verbal orders must be supported by the completed prescription in fax, text message or email format at the time of the administration. (6.51)
Achieved

All medications on site should be stored safely and securely, and unused medication disposed of safely. (6.52)
Partially achieved

The force should identify a robust system to ensure the safe management and use of all pharmaceutical items. This should include stock levels of all medicines held at all police stations. (6.53)
Achieved

Custody suites should provide appropriate accommodation for health services professionals to interview detainees in a confidential setting. (6.54)
Achieved

The emergency call bell in the FME room in the Bishop Auckland custody suite should be moved to a more appropriate site – for example, under the desk top. (6.55)
Achieved

The force should review the mental health support given to detainees held at Peterlee to ensure that they receive appropriate specialist care during detention. (6.56)
Achieved

The FME rooms should be fit for purpose. This should include a daily cleaning schedule and removal of waste. (6.57)
Achieved

All police stations should keep a detailed central register of the occasions when the station is used as a place of safety. (6.58)
Achieved