Inspecting policing in the public interest

Report on an unannounced inspection visit to police custody suites in

Warwickshire and West Mercia

by HM Inspectorate of Prisons

and HM Inspectorate of Constabulary

21–30 October 2014

Glossary of terms

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Contents

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.

In January 2014, the Home Secretary asked HM Inspectorate of Constabulary (HMIC) to undertake a thematic inspection in 2014/15 on the welfare of vulnerable people in police custody. It was decided by HMIC and HM Inspectorate of Prisons to use the existing rolling programme of police custody inspections to facilitate the principal fieldwork. The inspection of police custody suites in this fieldwork, and the findings will inform the final thematic report which is to be published in 2015

Warwickshire and West Mercia police forces formed a strategic alliance in 2013 that included streamlining their custody suites into one operation. This was managed by an assistant chief constable and a head of custody. At the time of this inspection the alliance between the two forces was still embedding; senior managers recognised differences in practice, potentially offering good opportunities to learn from each other.

In our inspection we found there were some weaknesses in the overall management of custody. There were no dedicated custody inspectors to line manage the custody sergeants, which created a void in accountability and oversight. Inspectors had other duties and openly admitted a lack of time to focus on custody matters. This gap between the custody sergeants and head of custody weakened accountability, consistency and oversight of actions and decisions taken in custody. Most inspectors did not report to the head of custody, and sergeants were, understandably, unclear about their line management structure.

Quality assurance processes had been recently introduced but the lack of management oversight reduced their effectiveness. There was no feedback to individual staff and no link to organisational learning from previous incidents. Existing data was not used to analyse custody records, use of force or complaints to improve organisational policies and individual actions. Despite this lack of management oversight, custody sergeants and detention officers provided an adequate level of care that was, in our observation, generally better in Warwickshire.

Partnership arrangements to ensure that children were not held in custody overnight were not effective. In the twelve months before the inspection, thirty-six children had been detained in police cells overnight. Custody staff knew the importance of ensuring children were not detained in custody overnight and made strenuous efforts to avoid this but had been unsuccessful too often. Although in some cases considerate and sensitive care was given to children who were detained, in other cases insufficient attention was given to their individual needs.

Custody staff also reported significant difficulties in obtaining appropriate adults for support for both children and vulnerable adults. In most cases there was no appropriate adults provision overnight which contributed to unnecessarily prolonged detention compounding the vulnerability and distress for children and vulnerable adults.

The quality of risk assessments was variable particularly in West Mercia. Risk management was not sufficiently related to the initial risk assessment or kept under review. As a result it was too formulaic and disproportionate in some cases but not sufficiently robust in the case of some very vulnerable detainees. Risk assessments did not reflect the actual risk, and in one case, a 14-year-old boy was identified as not being at risk despite his disclosure of very recent self-harm, he self-harmed within 15 minutes of being placed in a cell.

We also observed disproportionate use of anti-rip clothing and expressed specific concern about the use of the emergency restraint belt. Two out of the three cases we reviewed were referred to the Professional Standards Department for investigation into their use. There was no use of force policy specific to custody, and so none of these incidents were monitored, analysed or subject to any oversight. It was concerning that sergeants decided to use this level of force without any guidance or supervision.

In contrast, health care was a very good picture; health care practitioners were available in the suites 24 hours, although temporary staff shortages resulted in some delays. Detainees spoke very highly of their health treatment and care, and staff were also complimentary of the service.

There were monthly operational meetings between a custody inspector and custody health care staff, and regular strategic meetings involving senior managers representing NHS, ambulance services, local authorities and the police. These meetings were a forum for resolving emerging problems in custody and health care.

Nearly all of those detained under section 136 of the Mental Health Act[1] were taken to an NHS place of safety in accord with national policy. The use of section 136 was treated as a medical emergency, and the multi-agency approach was exemplary.

Overall, the creation of the custody alliance between West Mercia and Warwickshire was a sensible strategy. However, at the time of this inspection, these new arrangements were still bedding in. There were significant gaps in the management structure and despite adequate care overall, weak oversight and partnerships had led to poor management of some vulnerable detainees, in some cases including children, and the much too regular use of inappropriate and disproportionate restraint techniques. Healthcare and arrangements for detainees with severe mental health problems were generally much better and provided a model that other aspects of the custody arrangements could follow.

Sir Thomas P Winsor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

May 2015

[1] Section 136 enables a police officer to remove someone from a public place and take them to a place of safety – for example, 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 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*[2] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 This inspection was of West Mercia and Warwickshire police services delivering collaborative custody management and facilities. We inspected a total of seven custody suites. The last inspection for West Mercia took place 7-11 December 2009 and for Warwickshire on 12-15 October 2009.

2.4 The initial inspection considered only West Mercia but, as the custody arrangements were central to both, the inspection was extended to include Warwickshire. However, our custody record analysis refers to West Mercia only.

Custody suites	**Cells**
West Mercia	
Worcester	23
Telford	15
Hereford	16
Shrewsbury	16
Kidderminster	11
Warwickshire	
Leamington Spa	14
Nuneaton	24

Strategy

2.5 The custody alliance between West Mercia and Warwickshire had been introduced in 2013 with joint facilities and centralised management.

[2] http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria

2.6 The strategic oversight of the joint Custody arrangement was proved by an Assistant Chief Constable supported by a Chief Superintendent, Superintendent, Chief Inspector and Inspector. This area of business sat within Operations Support under the umbrella of the Local Policing Directorate across both Police areas.

2.7 The custody estate was generally in a good condition, but Kidderminster and Worcester were showing signs of deterioration.

2.8 There were no dedicated custody inspectors to oversee operational aspects of custody staff and operations. This gap in management was a risk to custody operations. Some custody staff were unclear about their line management, and whether it was to the local management team or the head of overall custody operations.

2.9 Staffing comprised custody sergeants and detention officers (DOs) provided by Tascor. DOs undertook the care and welfare aspects of detainee care, which was generally done to a satisfactory standard. On one occasion in Warwickshire we observed only one DO on duty in each suite. Arresting officers had to undertake some aspects of the DO's work, which meant that detainees, including a child on one occasion we observed, did not always receive vital information, such as the use of call bells in an emergency.

2.10 Custody matters were discussed through a monthly meeting, chaired by the head of custody; however, relief inspectors did not always attend because of other commitments. Monthly performance data were discussed but there was no quality assurance – such as analysis of custody records, complaints and use of force.

2.11 There were notable challenges for the two forces in working across a number of different local authorities. The PVP detective superintendent attended external original justice meetings, focusing on matters such as local safeguarding boards. However, it was not clear if there were tangible outcomes from these partnerships, especially in relation to children. Thirty-six children had been detained overnight in the twelve months before the inspection because custody staff had been unable to access suitable local authority accommodation. The forces had good links with the Independent Custody Visitors, who reported a positive relationship with generally prompt access and responses to issues raised.

2.12 All custody staff underwent a three week custody specific training course and DOs completed a four and a half week course before commencing custody duties to ensure they were fully trained. Custody sergeants received annual custody specific refresher training, but there was no similar provision for DOs.

2.13 Under new quality assurance arrangements, custody sergeants conducted peer reviews of custody records, with no inspector management or oversight. Custody sergeants told us they received no feedback on their performance. The custody alliance could not evidence any auditable organisational learning, and there was no evidence the performance data were used to analyse the quality of custody records, use of force or complaints.

2.14 Adverse incidents were recorded through the health and safety process rather than the Association of Chief Police Officers (ACPO) and College of Policing authorised professional practice, the accepted standard operating protocol.

2.15 There was a range of materials on both force intranet sites. However, custody managers could not update learning and development material, and a separate computer resource had had to be created to overcome and cater for the basic and necessary learning materials for delivering safe custody.

Treatment and conditions

2.16 Detainees told us they felt well treated and respected. We observed that staff were polite to detainees.

2.17 Data from custody operations showed an average waiting time ranging from 30 minutes to over an hour between arrival and detention. Waiting times of over an hour were too long. All custody suites had limited privacy for booking in vulnerable detainees, such as children or those held for sensitive offences, potentially inhibiting disclosure of information needed for a full risk assessment.

2.18 Staff knew the importance of not detaining in custody overnight and made efforts to ensure that did not happen. West Mercia staff described the scarcity of local authority secure and non-secure accommodation for children refused bail.

2.19 Detainees were usually asked if others might be affected by their detention, but this was not always the case in West Mercia. There were some facilities for detainees with disabilities, but they were limited. Custody staff understood the need to accommodate religious diversity, and could supply religious books and materials easily for detainees. Staff did not always ask detainees to describe their own ethnicity for monitoring purposes and sometimes made assumptions about it.

2.20 We saw staff undertake risk assessments that ranged from good to some that raised concern because they missed important factors we had identified. Risk management processes were too formulaic, sometimes disproportionate and in other cases not sufficiently focussed on the identified risks. Staff sometimes applied 15-minute observations instead of more appropriate higher-level checks. We were very concerned about how the risks of some very vulnerable detainees were managed. Risk assessments were generally better in Warwickshire than in West Mercia.

2.21 We saw disproportionate use of anti-rip clothing. Staff told us they used such clothing for detainees considered to be violent or very intoxicated, who in some cases had their own clothes removed forcibly or unnecessarily. We were also told anti-rip clothing was used for people who were non-compliant, which appeared punitive rather than the protective approach for which it was intended. The practice and rationale for the use of anti-rip clothing was inadequately recorded.

2.22 Detention officers were generally aware of the need to conduct rousing checks on intoxicated detainees and get them to respond. In West Mercia, our custody record analysis showed such checks were not always recorded or undertaken, or both

2.23 Staff handovers between shifts also varied in quality. Most included good information, with handover sheets completed, and sergeants usually visited detainees after the handover, but this did not happen in all suites.

2.24 Pre-release risk assessments were very variable across the custody suites. In some cases the form was completed after the detainee had left custody, making the process redundant. Staff failed to acknowledge that some people might be as vulnerable, and in some cases more so, leaving the suite as arriving. There was a good information leaflet for detainees leaving the custody suites, but this was not given to them routinely. There were good referrals to other agencies.

2.25 There was inadequate oversight of use of force. We were concerned about the lack of full accountability for the use of emergency restraint belts in West Mercia, which in some instances seemed a disproportionate measure, and which was not adequately monitored. Data supplied by the force showed for West Mercia the belt had been used 64 times in the calendar year 2013, and 44 times up to October 2014. We reviewed three cases, including CCTV; two of the three cases were referred to the Professional Standards Department for further investigation. The type of force and restraint used was unsafe, without any governance, management check or risk assessment. Senior staff were often unaware of its use in the suites.

2.26 Protocols and practices for the removal of handcuffs varied between the custody suites. In West Mercia, handcuffs were only removed from some detainees when in view of the CCTV, which staff told us was to ensure evidence against any litigation. This meant detainees remained in handcuffs longer than necessary. In Warwickshire, handcuffing was more proportionate; few people arrived in handcuffs, and staff generally removed handcuffs on arrival in the custody suites.

2.27 Staff were not held sufficiently accountable for use of force in custody. Use of force forms were available but not always used appropriately. Forms were monitored but only for officer training, not the necessity for and proportionality of the use of force.

2.28 Some detainees in West Mercia were taken to cells by arresting officers who regularly forgot or did not know they should explain basic facilities, such as call bells. These facilities should be explained to first-time detainees in case of an emergency. In contrast, Warwickshire custody sergeants prompted arresting officers to give detainees an explanation and ask if the detainee needed anything.

2.29 Detainee care was generally satisfactory, although there was an observable 'request' culture in West Mercia – an assumption that detainees would ask if they needed anything, although they were not told what was available.

Individual rights

2.30 We observed sergeants checking the grounds for detention with arresting officers. Sergeants told us they had previously refused detention, mostly on the grounds of the arrested person's ill health. Voluntary attendance, where people agree to attend the police station for an interview rather than be detained in custody, was well used.

2.31 Detention periods were kept to a minimum, which was positive. Custody sergeants were well aware of their obligations to ensure cases were progressed promptly but the unavailability of appropriate adults sometimes caused delays.

2.32 There were several appropriate adult schemes available to support children and vulnerable adults in custody. In West Mercia, they mostly operated between 6am and 11pm and were not available overnight. In Warwickshire, the local authority emergency duty team provided appropriate adults. During office hours provision for children was fairly prompt but vulnerable adults experienced long delays. Outside office hours there were regular delays for children and adults.

2.33 For people who did not speak English there was telephone and face-to-face interpreting available through a registered provider website. However, several suites in West Mercia held business cards for interpreters in case of non-availability and there was no assurance that the interpreters obtained this way were registered and suitable. Staff were aware of how to access information on detainees' rights and entitlements in different languages, and an easy-

read format was available in some suites. Legal advisers told us of positive relationships with custody suite staff and good care for their clients.

2.34 Early court closure times were reported to be a problem, which caused unnecessary and prolonged detention. During our inspection we identified several cases where detainees were kept in custody solely due to court restrictions. Although there was a prisoner escort contractor, staff told us that sometimes police officers escorted detainees to court to ensure they got there before the cut-off time, rather than rely on the contractor.

2.35 Staff response to taking complaints from detainees varied, and we were not satisfied that all complaints would be taken from detainees while they were in custody. Every suite displayed a poster about how to make complaints and had a stock of leaflets.

Health care

2.36 Detainees had access to competent health care professionals from Primecare Forensic Medical Services (the contracted provider) to handle their physical and mental health and substance misuse needs. Detainees were asked if they wished to see a health care professional and could request to see one at any time. Detainees' medical care needs were treated appropriately, although Primecare response times varied and were poor at several custody suites because of staff shortages. In West Mercia, the health care professional contract response time of 60 minutes was not achievable, mostly due to the travelling time between custody suites.

2.37 The quality of health care was very good, although generally better in Warwickshire due to geographical and contractual arrangements. Liaison between health care practitioners and custody staff was courteous and sensitive.

2.38 There was evidence of very good working relationships between the police, NHS, Primecare, the local authorities and ambulance service. The sergeant and nurses had good operational links, which were replicated at a senior level.

2.39 Detainees were offered access to a drugs and alcohol arrest referral service, and referred to community drugs and alcohol teams as necessary. Substance misuse services were good. Detainees expressed their satisfaction with the health and substance misuse care provided.

2.40 There were several providers of mental health services to the custody suites in West Mercia. Only some custody suites had liaison and/or diversion schemes to identify and divert detainees with mental health problems into appropriate mental health services. Custody staff had received training in mental health awareness as part of their induction, and an electronic learning exercise from the National Centre for Applied Learning Technologies (NCALT). Staff had mixed views about the effectiveness of this type of learning.

2.41 Staff told us that the NHS crisis and community mental health teams in West Mercia were generally unreliable as it was often on answerphone and not available at night. Child and adolescent mental health services were provided by a separate NHS trust, which prevented direct referrals by adult mental health workers.

2.42 The response times from the approved mental health practitioners, in some cases within 90 minutes of arrival at a place of safety, was impressive.

Main recommendations

2.43 Warwickshire and West Mercia police should strengthen the current strategic and management oversight of custody provision to ensure there is a clear line management and accountability between senior officers and operational staff.

2.44 Quality assurance measures including reviews of custody records, complaints and use of force data should be collected and reviewed regularly by senior managers.

2.45 The Police and Crime Commissioner and chief officer group for both forces should engage with their counterparts in the local authority areas and immediately review provision of local authority accommodation for young people under section 38(6) PACE 1984 to ensure that children are not detained unnecessarily in police cells.

2.46 Risk assessment and management should be improved with risk management reflecting the risks identified initially through speaking to the detainee and relevant records, and should be reviewed throughout the detainee's time in custody. Risk assessment processes should reflect a consistent approach across custody operations.

2.47 Use of force data should be collated in line with national guidance. Extreme measures such as the use of anti-rip clothing and emergency restraint belts, should be used only in exceptional circumstances when there were no other means of keeping detainees and staff safe and each incident should be reviewed by a senior officer.

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 Warwickshire and West Mercia police forces had formed a strategic alliance in 2013, and an assistant chief constable (ACC) provided strategic leadership on police custody provision across both organisations. This was a positive development. A centralised custody function was managed through the joint operations support department but was due to move to the criminal justice department from November 2014. The chief inspector head of custody had management responsibility for custody provision across both forces.

3.2 The estate consisted of seven full-time custody suites, two in Warwickshire and five in West Mercia, which provided adequate capacity, although the suites at Kidderminster and Worcester were ageing. There were no immediate or medium-term custody estate plans.

3.3 Detainees were generally conveyed to the area custody facility where they were arrested. We were told that custody sergeants could decline further detainees when their custody suite had reached capacity, based on the risks they were managing in the suites and this would be communicated to the force duty inspector. We did not observe this implemented during the inspection.

3.4 Staffing comprised permanent custody sergeants who had operational management of detention officers (DOs), provided through a contract with Tascor. DOs looked after the care and welfare of detainees, but demands on staffing meant that some aspects of detainee care were devolved to arresting officers. When they were able to, DOs provided a satisfactory standard of care for detainees, and all custody staff acted professionally.

3.5 On one occasion in Warwickshire we saw only one detention officer on duty in each suite. This meant that arresting officers undertook some DO duties. This affected detainee care (see paragraph 4.18) as sometimes detainees did not have trained staff to deal with their specific needs.

3.6 There were no dedicated custody inspectors at any of the seven custody suites to provide direct management and oversight. Inspectors covered custody as part of their general duties. We spoke to three inspectors who told us they would spend between 20% and 30% of their time dealing with custody issues, which limited any meaningful oversight.

3.7 Some custody sergeants were unclear about who they reported to and whether they were a specific custody or local station resource. As a result, there was a lack of accountability to senior staff. In one case we identified an issue that should have been raised from custody staff, but when we checked with the head of custody the information had not reached him because it was relayed to the local area management team. This lack of oversight, accountability and clarity was a significant risk to the custody operations (see main recommendation 2.43).

3.8 Custody matters were discussed and reviewed through an internal meeting structure. The head of custody held a monthly custody management meeting with the relief inspectors (see above), but due to other demands, they were not always able to attend. There were also

separate monthly and quarterly meetings between the head of custody and Primecare to review health care provision. Monthly performance data were available and discussed at these meetings. However, there was no qualitative data – such as analysis of quality assurance of custody records, complaints and use of force – to reassure managers and chief officers of the standards of custody provision in Warwickshire and West Mercia police (see main recommendation 2.43).

Recommendation

3.9 Warwickshire and West Mercia police should ensure that staffing levels are adequate to ensure good and consistent detainee care.

Partnerships

3.10 There were several external strategic groups and meetings focusing on criminal justice matters, and the relevant chief officers chaired and attended these as appropriate. It was clear that both forces faced challenges and constraints in dealing with the number of different local authorities and geographical partnerships, which affected custody. There was senior officer representation at the Local Safeguarding Children (LSCB) and Safeguarding Adults (LSAB) Boards and at strategic multi agency public protection arrangements (MAPPA) meetings.

3.11 Data supplied by the force indicated that the police had requested local authority secure accommodation (under section 38(6) PACE 1984) for children who had been refused bail 39 times in the previous 12 months, but accommodation had been provided on only three occasions. This meant 36 children were held in custody overnight. We were told that the LSCB was reviewing the lack of local authority accommodation for children who had been remanded in police custody, although it was unclear whether this was across all the local authorities covered by the two forces. It was also not clear if there were attributable and tangible outcomes across the partnerships, especially in relation to children and accommodation (see main recommendation 2.45).

3.12 The Police and Crime Commissioners (PCCs) were responsible for the provision and coordination of the Independent Custody Visitors (ICV) scheme, and the two offices coordinated five panels of ICVs. The scheme was active, providing a regular schedule of visits. The ICVs were generally admitted to custody suites quickly and were appropriately challenging in holding the force to account for custody provision. The coordinator told us there were no current concerning trends, and ad hoc issues were dealt with effectively. There was regular and consistent police representation at ICV panel meetings, and a good regime for induction and refresher training. ICVs were due to take part in the quarterly health and safety inspections of the suites, which was a good initiative.

Learning and development

3.13 All custody sergeants had completed an initial three-week custody-specific training before commencing custody duties. This was supplemented by a period of shadowing and completion of a competency-based portfolio. DOs completed four-and-a-half-week initial training. Both courses were cross-referenced to the national custody officers learning programme objectives. Custody sergeants received annual custody-specific refresher training, but there was no similar provision for DOs.

3.14 Under a new quality assurance process, custody sergeants conducted 10 peer reviews of custody records a month for custody sergeants at other custody suites but there was no inspector involvement to provide management and oversight. Custody sergeants told us that they had not received any feedback on their performance so far. The custody alliance could not evidence any audit of organisational learning from such processes, which should also have included cross-referencing to CCTV footage, person escort records (PERs) and sampling of staff shift handovers.

3.15 There was no specific adverse incident process; the health and safety near-miss process was used instead to identify such incidents in custody. This did not comply with the Association of Chief Police Officers (ACPO) and College of Policing authorised professional practice, the standard operating protocol. However, there was a review process, email circulation of relevant incidents to custody staff and a link to the custody trainer.

3.16 A range of custody policies and procedures were available on the forces' intranet. The site included a link to the Independent Police Complaints Commission (IPCC) website, which included the IPCC 'Learning the Lessons' document. However, the custody support inspector was not able to update the custody portal on the intranet, as this was outside the custody department's control. This had led to a gap in provision of up-to-date information for staff. The custody department had created a separate drive to fill this gap, which was not a satisfactory situation. There was no custody newsletter, which could have been effective in providing information on learning and development in custody provision.

Recommendations

3.17 Warwickshire and West Mercia police, in conjunction with Tascor, should implement a programme of custody refresher training for detention officers.

3.18 Warwickshire and West Mercia police should implement a process for handling adverse incidents in line with the Association of Chief Police Officers and College of Policing authorised professional practice.

3.19 Warwickshire and West Mercia police should develop a custody intranet portal that ensures the timely distribution of information to staff.

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 generally treated detainees politely, and this was confirmed by detainees. Custody sergeants and detention officers were courteous in dealing with detainees, but the lack of privacy in booking-in areas, and high desks in some suites in West Mercia, impeded effective communication and potentially inhibited disclosure of information needed for a full risk assessment. Privacy was further compromised by the use of speaker telephones instead of a two-handset device when booking in non-English speaking detainees via the telephone interpreting service (see paragraph 5.9). This had been a recommendation in our previous inspection of West Mercia police.

4.2 The booking-in desks in Warwickshire were at a better height, but custody sergeants were not sufficiently mindful of ensuring privacy when booking in detainees for sensitive matters while there were other detainees in the area. Simple things, such as speaking in a quiet voice or leaning towards the detainee when asking for sensitive information, could have made a difference. We observed this across all custody suites.

4.3 Detainees were mostly booked in promptly after arrival at the custody suites but we saw significant delays of up to 45 minutes at Worcester and 84 minutes at Kidderminster due, in part, to the number of detainees. Waiting times of over an hour were too long. At Worcester, detainees waited in the holding room to be processed because one of the three booking-in computers was faulty. None of the five custody sergeants on duty were willing to use another terminal to clear the congestion, because it was not within range of a microphone that recorded the booking-in process – the effect on detainees was not considered and prevented early identification of risk. Data supplied by the forces showed that the average wait from time of arrival in custody to authorisation of detention ranged extensively from 10 minutes at Shrewsbury up to 78 minutes at Leamington – the latter was unacceptable as it prevented the early identification of risk.

4.4 Custody staff were generally aware of protected characteristics (the grounds upon which discrimination is unlawful) and a range of vulnerabilities. It was, therefore, unsatisfactory that some custody sergeants made inappropriate decisions about detainees' ethnic origin instead of asking them to self-declare the information. At Kidderminster, the custody sergeant asked a detainee of possible Asian appearance, 'what do you look like?' and when he answered 'Asian' disagreed with him, telling him that he looked southern European. However, we generally saw good police-detainee interactions, and in one case a young man who had reacted angrily when arrested in Worcester told us he felt arresting officers had given him the 'space' he needed to express his frustration. He said it had enabled him to calm down, and also felt that custody staff had looked after him well.

4.5 Women were asked if they had dependants, but not all custody sergeants asked this of male detainees. At Kidderminster, when a male detainee told the custody sergeant he was worried about his mother who was ill and dependent on him, the implications were not explored. There was little specific provision for children or women. Women were asked questions about their health and if they wanted to speak to a female member of staff.

4.6 Despite the best efforts of custody staff 39 children had been detained without bail over the last 12 months and of them 36 had been held overnight. Girls under 16 were not routinely allocated a female officer responsible for their care. At Worcester, children were normally placed in a corridor furthest from the booking-in desk on the grounds it would be quieter, but where their needs might be overlooked by staff and we were concerned by the lack of attention to individual needs in some cases. For example, we saw two children detained for over 24 hours at Worcester who were given little attention and nothing to help them occupy the time. In contrast, better care and support was offered to a 14-year-old girl at Leamington Spa. Custody staff were aware of her needs and vulnerabilities, used age-appropriate language, took time to listen to her concerns, and gave advice about the proceedings both to her and her appropriate adult. They also provided support leaflets on her release and allowed the child to remain in a consultation room for a time with the appropriate adult.

4.7 All suites had provision for religious observance, including a stock of religious books, prayer mats, and a means of determining the direction of Mecca. In our analysis of 60 custody records (which covered West Mercia only), we found that a detainee at Worcester was regularly allowed to use a room without a toilet in which to pray, and that a detainee at Telford was permitted a shower before he prayed. This demonstrated good care.

4.8 All suites had level access, but not all had a toilet adapted for detainees with disabilities. Detainees could not reach call bells when they were seated on the bed plinths. At Nuneaton, Leamington Spa and Shrewsbury all the bed plinths were low. Staff at Shrewsbury acknowledged they struggled to accommodate people with limited mobility, despite having some thicker mattresses that increased the height of the bed. A high step into the exercise yard at Telford would be difficult for a wheelchair user. Most, suites except Worcester and Nuneaton, had a hearing loop.

4.9 Staff knew how to search transgender detainees respectfully.

Recommendations

4.10 Booking-in desks should be of an appropriate height to facilitate effective and private communication between staff and detainees.

4.11 There should be accessible facilities for detainees with disabilities, such as access to call bells.

Safety

4.12 We saw staff undertake risk assessment that ranged from very good to some that raised some concerns. Custody sergeants sometimes asked useful supplementary questions when assessing detainee risk, and were empathetic in doing so, but levels of observation and risk management plans were not always sufficiently focused on risks that had been identified initially. Our custody record analysis confirmed that other sources of information, such as warning markers on the police national computer (PNC), were taken into account during risk assessment, and that risk management was dynamic, with care plans regularly reviewed. However, we also found some instances where important risk information known to custody staff was not included in the risk assessment and care plan, and levels of observation and risk management plans were not always sufficiently focused on the risks identified.

4.13 At most suites, all detainees were started unnecessarily on 30-minute observations, unless they were high risk and required more frequent checks. Our custody record analysis noted that in most cases 30-minute observations were standard.

4.14 Throughout our inspection we found a lack of consistency between the risk assessment and the subsequent care given to some detainees. We were concerned about one case in particular, involving a 14-year-old boy, where the initial risk assessment showed that he was at an increased risk of harming himself and very vulnerable. He had very recently self-harmed through cutting and attempted hanging, but was placed on 15-minute, rather than constant, observation and went on to self-harm in his cell within the first 15 minutes. We saw other cases where detainees were placed on 15-minute observations rather than constant supervision with little rationale for this decision. In our judgement, 15-minute observations were used inappropriately and instead of an increased level of observations for some detainees[3] (see main recommendation 2.46).

4.15 Risk management in West Mercia, in particular, was inconsistent, risk averse and sometimes disproportionate. Too many detainees had their clothing removed and were placed in anti-rip clothing, which was potentially demeaning and should be used only as a last resort. Detainees were not allowed to keep their underwear, and the anti-rip clothing did not always provide dignity for detainees. At several West Mercia suites, we were told that all detainees who would not comply with risk assessment would have their clothing removed – forcibly if necessary – and be placed in anti-rip clothing, which was disproportionate. The use of anti-rip clothing for non-compliance appeared punitive rather than its intent, which is protection against harm. The practice and rationale for the use of anti-rip clothing was inadequately recorded. Furthermore, spectacles and cords from items of clothing were still removed routinely. The removal of clothing and other items was done in the absence of any robust risk assessment to justify this (see main recommendation 2.47)

4.16 In Warwickshire, a very good written briefing was available to officers conducting close proximity observations but we did not see it used in West Mercia. All detention officers (DOs) and some custody sergeants carried anti-ligature knives. At several suites we saw them used inappropriately for cutting cords and opening parcels, which made them blunt and therefore potentially not usable in an emergency.

4.17 DOs were aware of the importance of rousing detainees who were intoxicated, but our custody record analysis raised questions about whether rousing checks were specified for all detainees who required them. The analysis could not determine whether it was poor recording or poor assessment. However, we mostly observed appropriate rousing checks. In Warwickshire, a woman who had been found driving while four times over the legal alcohol limit was made subject to rousing checks appropriately. We saw officers taking considerable trouble when caring for detainees with drug addictions, including collecting their methadone or ensuring that interviews could take place promptly so that they could be bailed in time to collect it themselves.

4.18 The Warwickshire suites had only one detention officer on duty, which affected detainee care and carried significant risks. We saw some detainee care devolved to arresting officers when the detention officer was busy. The diligence required of detention officers, (processing detainees, answering call bells, conducting cell visits promptly and thoroughly)

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[3] Level 1 is usually a minimum of 60-minute checks, level 2, a minimum of 30-minute checks, level 3, constant observation CCTV and level 4, close proximity observation.

was compromised when there was only one on duty, with the custody sergeant engaged in booking-in detainees.

4.19 Staff shift handovers varied in quality and consistency. Custody sergeants involved DOs in their own handovers, despite shift handovers only coinciding at 7am. The information shared during the handover was relevant and sufficiently detailed, but not all custody sergeants cleared the area so that it could take place in private. Although there was a useful handover sheet for custody sergeants, this was not used by all shifts. Similarly, not all sergeants visited detainees and spoke to them after receiving a handover.

4.20 Pre-release risk assessments were very mixed across the custody suites. Although most custody sergeants tried to ensure that detainees leaving the suite had appropriate arrangements to get home or to a place of safety, many pre-release assessments were mechanistic and very limited. They did not always address issues of risk previously identified. Most concerning was that some assessments was completed after the detainee had left the custody suite, making the process redundant.

4.21 In our analysis of 60 custody records, pre-release risk assessments were completed for all detainees on release, but generally lacked detail and frequently simply stated 'no issues identified'. The assessments rarely demonstrated any steps to ensure a person's safe return home when they left custody late at night (see also main recommendation 2.46). Although we saw some good assessments in West Mercia involving referral to other agencies, there was generally insufficient understanding that some people might be as vulnerable, and in some cases more so, leaving the suite as arriving. At Worcester, a very frail and unwell drug-using woman needed considerable health care attention while in custody, but was released without an assessment of what would happen to her next. The pre-release risk planning we observed in Warwickshire was better, including a full discussion with a drug-using detainee about what she would do when she got home and if she was willing to keep in contact with local drug services, and excellent care and referrals made for a 14-year-old girl.

4.22 Every suite had excellent leaflets with details of local support agencies, including helplines for sex offenders and domestic violence perpetrators, and we saw these handed out, but not routinely.

Recommendations

4.23 Anti-rip clothing should only be used to protect the detainee from harm, and based on an appropriate rationale and risk assessment.

4.24 Intoxicated detainees should be roused regularly, and rousing should be clearly recorded in the custody record and log.

Use of force

4.25 Oversight of the use of force in custody suites was inadequate, and there was no use of force policy. Neither custody sergeants nor inspectors were fully aware of the numbers, types of force or proportionality of such actions in their custody suites. A use of force form was available but staff were not required to complete it each time force was used, which meant that they were not adequately accountable for the use of force in custody. The forms were only monitored for the annual officer safety refresher training.

4.26 The documentation we were able to read lacked any detailed narrative about the incident, which made it difficult to assess proportionality or whether de-escalation techniques were

used before force was applied. We were concerned about the lack of full accountability for the use of emergency restraint belts in West Mercia which was much greater than we see elsewhere. We raised two of the three uses that we reviewed on CCTV with senior officers, who referred them to the Professional Standards Department for further investigation. In one case, the detainee was restrained and placed in an emergency restraint belt twice during his detention; while this might have been appropriate, we were concerned by the lengthy periods he spent lying face down while this equipment was applied, which had health implications and was potentially dangerous. Custody staff were also unclear about the circumstances when emergency restraint belts could be used, and how. We were told that the emergency restraint belt had been used 66 times in the previous year and at the time of the inspection had been used 44 times in the current year. The incidents and frequency of use caused concern (see main recommendation 2.47).

4.27 Protocols and practices for the removal of handcuffs in the custody suites varied. In West Mercia, the removal of handcuffs from some detainees was delayed until they were in view of the CCTV – staff told us this was to ensure evidence against future litigation. Use of handcuffing on arrest was mostly proportionate, but with some notable exceptions. At Kidderminster, a male detainee arrived handcuffed to the rear and remained so for almost 40 minutes in the holding room. He was compliant and there appeared to be no reason to continue use of handcuffs in a secure environment. When we asked why restraint was necessary, we were told there would have been warning markers concerning risk of violence or escape, but when we checked the PNC, no such markers were recorded. In Warwickshire, few detainees were handcuffed on arrival. Staff had the discretion to remove the handcuffs at any stage, without approval by custody sergeants.

4.28 We saw few instances of strip searching; such cases were authorised appropriately and CCTV monitors were switched off to protect the dignity of detainees, which was positive.

Recommendation

4.29 Detainees should only be handcuffed when a risk assessment indicates this is necessary for the safety of staff, the public or the detainee.

Physical conditions

4.30 The condition of the custody suites at Warwickshire had changed significantly since the last inspection. The suites at Nuneaton and Leamington Spa were both maintained by Serco. The Leamington Spa suite had been refurbished and was in a good state of repair, but conditions in Nuneaton had deteriorated. Most suites, except for Worcester and Nuneaton, were clean and had little graffiti; Worcester required deep cleaning and painting.

4.31 The night lights in the cells at Worcester and Telford were far too bright – some detainees asked for them to switched off. At some suites, such as Kidderminster, the bed plinths were too narrow, and staff told us some detainees preferred to sleep on the floor. Nuneaton had no cells with natural light, and at Telford, the cells felt cold and Independent Custody Visitors (ICV) records noted the cells were cold in winter and too hot in summer.

4.32 All suites had suitable showers, although the one at Telford was very badly sited near the booking-in desk with minimal privacy. There were no washbasins in the cells. CCTV images of cell toilets were obscured appropriately but not all detainees were told about this.

4.33 Each suite had reasonable cell cleaning arrangements and unoccupied cells were cleaned each morning. Detention officers told us that they were expected to clean up any general spillages

and ensure that the cells were clean throughout the day. The daily cell check sheets were completed regularly and thoroughly, and signed off by the custody sergeant.

4.34 In West Mercia many detainees who were placed in their cell by the arresting officer were not told how to use the call bell, including a detained child who had never been in custody before. In contrast, custody sergeants in the Warwickshire suites prompted arresting officers to provide detainees with an explanation and ask if they needed anything. Responses to cell call bells were prompt in all suites.

4.35 All suites kept records of fire evacuations, including a very clear fire evacuation policy with which staff were familiar.

Recommendations

4.36 Cells in all suites should be appropriately lit, heated and ventilated, and have natural light, and there should be a regular programme of deep cleaning.

4.37 Bed plinths should be wide enough to accommodate detainees, with some that are accessible to detainees with limited mobility.

Detainee care

4.38 Detainee care was generally satisfactory, with some exceptions. Mattresses and pillows were provided and routinely cleaned between cell occupancy. There were good stocks of replacement clothing and paper underwear, and even socks at some suites. Our custody record analysis showed examples of detainees allowed a shower before going to court.

4.39 Food consisted of cereal bars and microwave meals. Food preparation areas were mostly clean and well equipped, except at Telford where the small microwave oven was not suitable, and at Nuneaton, where the microwave needed cleaning. We saw staff giving detainees cereal bars if they did not want a microwave meal. At Worcester, we heard a detainee being reviewed ask the inspector for a meal, but he had to wait an hour for food. Elsewhere, meals were available at all times on reasonable request.

4.40 All suites had reading materials, including some in foreign languages at most but not all suites. Telford and Worcester had a good range, including some books in Polish and Urdu, and magazines appropriate for young people. However, we generally saw few books and magazines given out and staff told us there was little demand. All suites had visits facilities although access to visits varied from occasionally at Telford to never at Shrewsbury. Worcester had an excellent leaflet explaining the facilities available in detention, but this was not given out to detainees. A larger version of the leaflet was displayed as a poster in the booking-in areas at Nuneaton and Leamington Spa.

4.41 All custody suites, except Shrewsbury, had an exercise yard. We saw very few detainees using exercise yards, and some we spoke to were unaware that they were available. Custody staff also told us that they did not routinely inform detainees there was an exercise yard they could use or offer this to them.

4.42 Women's sanitary packs were available at all suites but were not actively offered to every female detainee. At Leamington Spa, six immigration detainees who had been travelling for two days were not able to have showers as there was only one DO on duty. In all suites, toilet paper was available on request only. In West Mercia, detainees were expected to ask

for things but were not told what was available, so some would not know what they could request.

Recommendations

4.43 Every suite should have an exercise yard accessible to detainees held for long periods.

4.44 All detainees held overnight, or who require one, should be offered a shower that provides sufficient privacy.

4.45 Toilet paper should be routinely provided in each cell, subject to individual risk assessment.

Housekeeping point

4.46 Reading materials should be routinely offered to detainees.

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 sergeants asked arresting officers to provide a full explanation of the circumstances and reasons for the arrest before authorising detention. Sergeants told us that they were confident in refusing detention where the circumstances did not merit arrest, mostly when health concerns were identified, and all could provide details of such cases. We observed a detention being refused at Worcester, which was appropriate.

5.2 Custody staff also told us that they believed that voluntary attendance[4] was well used, and this was confirmed by data supplied by the forces, which showed that approximately 25% of people were dealt with as voluntary attendees. Detainee throughput had also been reduced by a quarter over the past three years.

5.3 All custody staff were well aware of the need to keep detention periods to a minimum and custody sergeants were clear about their obligations to ensure that cases progressed quickly. This was confirmed by our custody record analysis, in which 43% of detainees in West Mercia were held for less than six hours. Arresting officers were responsible for case progression and we saw examples of investigations being progressed promptly. This led to minimum periods of detention for detainees.

5.4 Custody staff reported a good relationship with Home Office immigration enforcement officers and said that immigration detainees transferring to immigration removal centres were usually moved on in between 24 and 48 hours, which was an improvement on the situation at the previous inspections. We saw four immigration detainees at Leamington who were moved within 24 hours. Data supplied by the forces showed the average time in police detention for immigration detainees was 19 hours 25 minutes in Warwickshire and 26 hours eight minutes in West Mercia.

5.5 Staff assured us that the custody suites were never used as a place of safety for children under section 46 of the Children Act 1989 (which empowers a police officer who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm to remove them to suitable accommodation and keep them there).

5.6 Our inspection found thirty-six children were held overnight. Custody staff told us that they had never known local authorities to provide secure accommodation for a child had been charged and could not be bailed, although some recalled that non-secure accommodation had been provided in a few cases. Custody staff said they would only keep a child in police custody overnight in exceptional circumstances. However data supplied by the forces for the previous 12 months showed that in Warwickshire only eight children had been charged and

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[4] Usually for lesser offences, where suspects attend by appointment at a police station to be interviewed about alleged offences. This avoids the need for an arrest and subsequent detention in police custody.

had bail refused, and 37 in West Mercia. In 39 of the 45 cases the local authorities were requested to provide alternative accommodation, with arrangements made available for only three children – this was poor and resulted in 36 children being detained inappropriately in custody overnight. Our custody record analysis showed one 15-year-old boy who was charged and held overnight in custody due to a history of serious and violent offending and possible witness intimidation. The custody log recorded many attempts by officers to obtain alternative accommodation through the local authority and social services without success. A second case concerned a 17-year-old girl who was bailed overnight to an alternative address (with her father) rather than being kept in custody, which was appropriate; she returned to the custody suite the following morning. Custody staff understood their responsibility to contact an appropriate adult (AA) when dealing with vulnerable adults or children under 18. Family or friends were contacted in the first instance to act as an AA, but not all custody sergeants were aware of the availability of a guidance document to assist AAs when carrying out this role, and this document was not always issued when applicable.

5.7 Custody staff in both areas reported that provision of AAs had improved since the previous inspections but that there were still gaps in coverage, particularly during the night. In West Mercia, there were several AA schemes that operated between 6am and 11pm and no service overnight. Exceptionally, Hereford had a 24-hour scheme operated by approved social workers.

5.8 In Warwickshire, in the absence of family members, AAs were available through the social services emergency duty team (EDT), who identified staff from suitable services (such as the youth offending service, community mental health team, learning difficulties team). Custody staff told us the service was efficient during office hours for children but there were regular delays for vulnerable adults. Outside office hours, there were lengthy delays in AA attendance for both vulnerable adults and children. Our custody record analysis included 12 children aged between 14 and 17 who all had an AA present while they were told their rights or during interview, if required.

5.9 A professional telephone interpreting service was available to assist the booking in of non-English speakers, and we saw it used on several occasions, as well as posters in all suites informing detainees that they could ask staff to use it. Warwickshire staff used loudspeaker telephones during the interpreting, which lacked privacy and was noisy when we observed two immigration detainees booked in at the same using the telephone service. West Mercia staff used two single telephones connected to the same telephone line. While this was more private, staff said it was difficult for detainees and staff to hear three-way conversations. Staff in all suites told us that face-to-face interpreters were also available for interviews, and at several suites in West Mercia we found a large number of business cards for interpreters who were also used. This informal use of interpreters outside the contracted interpreting service did not provide assurance that the individuals were suitably qualified or had the necessary vetting clearances.

5.10 During booking in, custody staff advised detainees of their rights (to have someone informed of their arrest, to consult a solicitor for free independent legal advice, and to consult the PACE codes of practice), and offered them a written notice setting out these rights and entitlements while in custody. However, our custody analysis found three detainees who were not advised of their rights – two because they were unfit due to their level of intoxication and the third because he was waiting for a breathalyser test and therefore not read his rights. None of these cases recorded that the detainees were subsequently informed of their rights while in custody, which was unsatisfactory practice.

5.11 Custody staff were aware of the availability of an easy-read pictorial version of the rights and entitlements material, as well as how to access these documents in foreign languages for non-English speaking detainees. The eight foreign nationals in our custody record sample were all told their specific rights as foreign nationals. Two requested that their embassy be

informed of their detention, but in one case the embassy was informed after they had been released from custody.

Recommendations

5.12 Warwickshire and West Mercia police should monitor the average waiting times for detainees from their time of arrival in custody to authorisation of detention to ensure that detainees are booked in promptly on arrival.

5.13 Appropriate adults (AAs) should be available at all times for vulnerable adults and children, and custody staff should ensure that family or friends acting as AAs are given a relevant written guide to assist them.

5.14 All detainees should be advised of their rights and entitlements at the earliest opportunity, and this should be recorded in the custody log.

5.15 All suites should have suitable telephone equipment to facilitate telephone interpreting in privacy.

Rights relating to PACE

5.16 Detainees were told during their booking in that they could read the PACE codes of practice, but custody staff did not routinely show or explain them to detainees. There were insufficient copies of the up-to-date PACE code C in some custody suites and several out-of-date copies. The Criminal Defence Service poster informing detainees of their right to free legal advice in 24 languages was routinely displayed in all the custody suites, and several suites also had a similar leaflet for non-English speaking detainees.

5.17 All detainees (with the exception of the three noted in paragraph 5.11) were offered free legal representation, and detainees wishing to speak to legal advisers on the telephone could do so in the privacy of their cells. There were sufficient consultation and interview rooms. We saw legal advisers routinely offered custody records for inspection without having to request them. Legal advisers told us they had good relations with custody staff and felt their clients were well looked after while in police custody.

5.18 We observed detainees being told that they could inform someone of their arrest, which staff facilitated, but this was not always recorded in the custody records we analysed.

5.19 Dedicated custody and operational inspectors undertook reviews of detainees across the force areas. The standard of face-to-face PACE reviews by inspectors was inadequate as they failed to ask detainees if they wished to make any representations. Most detainees, but not all, were informed if reviews had taken place while they were asleep, and they were reminded of their rights and entitlements. Of the 32 detainees in our custody record analysis who required a PACE review, 25 were on time, six were early and one was late.

5.20 There was an effective system for collecting DNA samples taken in custody.

5.21 Custody staff at all suites told us that the local magistrates' courts would not normally accept detainees after 2pm on weekdays and after 9am on Saturday, which was too early. Some courts had sometimes refused to accept detainees as early as 11.30am and noon, although most courts were close to the custody suites. During the inspection we saw several cases where detainees were kept in custody unnecessarily due to court restrictions. At Telford, we found that a non-English speaking Polish man had been detained unnecessarily in police

custody for two nights because the local court did not fulfil a request promptly enough for him to be dealt with earlier. At Worcester, we saw a detainee who was conveyed to Redditch Magistrates' Court at 1.30pm, but the court failed to deal with him that day and he was transferred to Kidderminster, where he was booked in at 7.51pm to appear at Kidderminster Magistrates' Court the following morning. We had found such unacceptable delays at our previous inspections.

5.22 A prisoner escort contractor was available for both morning and afternoon courts, but staff said they did not always contact them for an afternoon court, taking detainees in police vehicles instead to ensure they did not remain in custody for longer than necessary. At Telford, custody staff had considered the individual needs of a wheelchair user by making every effort to look after him in the custody suite and transferring him to Shrewsbury Magistrates' Court at the earliest opportunity in a police vehicle, as the escort contractor was unable to supply a suitable vehicle.

Recommendations

5.23 Detainees should be asked during reviews if they want to make any representations.

5.24 Senior police managers should work with HM Courts and Tribunals Service to ensure that early court closure times do not result in unnecessarily long detentions in police custody.

Housekeeping point

5.25 There should be sufficient copies of up-to-date PACE codes of practice in all custody suites, and custody staff should routinely show and explain them to detainees.

Rights relating to treatment

5.26 Custody staff gave us a mixed response when we asked how they would handle complaints from detainees, and we were not satisfied that all complaints would be taken while people were in custody. Some said they would notify the duty inspector immediately, while others said they would advise detainees to make a complaint at the police station front counter on their release or report it online through the Independent Police Complaints Commission (IPCC) website. Some staff told us that inspectors would refuse to take complaints while the detainee was in custody but would arrange to meet them on their release, which could potentially deter and reduce the number of complaints made. All custody staff agreed that if a complaint alleged an assault on a detainee they would be seen by a health care professional and any injuries sustained photographed. All the custody suites displayed notices on how to make a complaint, and some had a stock of IPCC leaflets. Data on complaints in custody were not routinely circulated to custody staff.

Recommendation

5.27 Detainees should be able to make a complaint while they are still in custody.

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 Primecare Forensic Medical Services provided the medical service to the custody suites in both West Mercia and Warwickshire. Health care professionals (HCPs) – nurses and forensic medical examiners (FMEs) – were available to the police 24 hours a day. Temporary shortages in nurse staffing meant cover was occasionally thin and availability varied between the custody suites, resulting in some delays. More nurses had been recruited.

6.2 Governance arrangements, including scrutiny of HCPs' professional credentials, induction and mandatory training, were good. There was clinical supervision through peer review and reflective practice based on audit of case notes.

6.3 Police management of the contract was tight, with monthly performance data available electronically. There had been 945 HCP calls for assistance in West Mercia in September 2014, resulting in 922 visits to custody suites, of which 65% were by FMEs. We observed very positive working relationships between custody staff and HCPs. In our custody record analysis (which covered West Mercia only), 42% of detainees had been seen by a HCP who gave the police good details about medical issues that could have affected detention.

6.4 Each suite had a medical room that had been audited for fitness for purpose in July 2014, and an action plan for improvement was being implemented. The rooms at Hereford, Leamington Spa, Nuneaton and Telford were modern, but those in the other suites were tired and dated. The work surfaces in some rooms were difficult to decontaminate for forensic sampling, some rooms did not have natural light, and the Worcester room had no examination lamp. The door to the toilet at Hereford, which was accessible from the custody suite and medical room, had a spy hole, which would be unethical to use. Medical rooms were locked when not used, reducing the likelihood of contamination.

6.5 Cleaning schedules were displayed and rooms were usually clean, although Worcester had ingrained dirt that required a deep clean. Some detention officers were unsure where to find biohazard cleaning materials and some biohazard kits were out of date. Some fixtures and fittings did not fully comply with minimum infection control standards. For example, some tap fittings were of the wrong type and some consulting rooms, such as at Worcester, did not have a hand washbasin. Primecare had an action plan to address deficits.

6.6 Each custody suite had an emergency bag of essential medical equipment and an automated external defibrillator (AED) sited at the custody desk, which were regularly checked. There was no oxygen and some of the suction units were inefficient. Drugs for emergency use were accessible. All custody staff underwent resuscitation training, including use of the AEDs.

6.7 The management of clinical records complied with statutory requirements, and the lead nurse sampled records to ensure consistency of quality. Written clinical records were duplicated on the electronic clinical record. Some features of the electronic system required improvement, including access to previous records (which was not always possible) and sources of evidence-based practices.

6.8 The storage of medicines in clinical rooms and behind the booking-in desks, stock management, and disposal of discarded medications was very good, with clear audit trails. HCPs made daily and weekly checks. There were appropriate patient group directions (authorising appropriate HCPs to supply and administer prescription-only medicine) for individual practitioners. Detention officers used pre-printed envelopes containing prescribed medications to assist detainees with self-administration of tablets, although these sometimes meant that tablets were spilled on the floor, which would have been less likely with clear bottles or plastic containers.

Recommendation

6.9 Clinical rooms and practices should comply with relevant standards of infection control, and contemporary standards for preventing contamination and forensic sampling.

Housekeeping points

6.10 The medical rooms should have regular deep cleaning and all should contain examination lamps.

6.11 The spy hole in the communicating door between the medical room and toilet at Hereford should be removed immediately.

6.12 The electronic clinical record should be capable of retrospective searches and enable reference to contemporary sources of evidence-based practice.

6.13 Clear containers, rather than envelopes, should be used for medicines administration.

Patient care

6.14 The health needs assessment for West Mercia in November 2013 indicated that 43% of detainees required medical care or forensic assessment. It also stated that the HCP contract response time of 60 minutes was not achievable due to the travelling time between custody suites in West Mercia – such as 71 minutes between Hereford and Telford and 70 minutes between Shrewsbury and Worcester. The police allowed for the extended travel times in managing the contract.

6.15 In our custody record analysis, the average waiting time was one hour 43 minutes (ranging from six minutes to nine hours and 40 minutes). Custody sergeants monitored response times informally and were generally satisfied with the service, although they were more critical at Hereford and Shrewsbury.

6.16 Although one 75-year-old detainee whose detention had been authorised at 5.47pm had several health concerns, custody staff did not contact the HCP until 7.07pm and the HCP did not see the detainee until 8.28pm, when they advised that he was not fit to detain. The detainee was still held for approximately a further two hours before his eventual release with a caution. These delays were unacceptable for someone of his age and health.

6.17 Detainees were asked if they wished to see a health care professional and could request to see one at any time. HCPs treated detainees courteously and sensitively. We observed them explaining health assessments and information clearly to detainees and checking their understanding, in line with best practice for informed consent. There had been no

complaints about health care in 2014. Detainees we spoke with expressed satisfaction following consultations, and custody officers were generally content with HCP contacts.

6.18 There was a systematic approach to medical assessment and limited evidence-based guidance materials on site. Clinical records, which were of a high standard, were handwritten then typed on to computers. HCPs made entries directly onto NSPIS (the police records management system) and then checked if custody staff required explanation, which enabled good continuity of care and there was a formal mechanism to deal with conflicts or related issues through reports to contract monitoring meetings.

6.19 In our custody record analysis, 15% of detainees who arrived in custody were on medication. This was continued, subject to authentication, and the police made reasonable attempts to collect prescribed medications from detainees' homes.

Substance misuse

6.20 In our custody record analysis, 13% of detainees had entered custody with alcohol or drug dependencies and 22% were intoxicated. Due to the geographical extent of the custody suites, several local providers offered drug intervention programme or arrest referral workers. These staff regularly visited or provided a telephone service to custody suites and detainees between 7am and 5pm.

6.21 Opiate substitution therapy was available in police custody, as was symptomatic relief for drug and alcohol withdrawal, which was also available to take to court. This was very good detainee care. Nicotine replacement therapy was available and appreciated by detainees.

6.22 Test on arrest for offences related to class A drugs was in place. Custody staff referred on detainees who were substance misusers needing treatment, or where treatment was a condition of caution or bail, to appropriate services, which were available at all suites. Arrest referral workers offered prompt support for adults with drug and alcohol issues, and access to substance misuse treatment and harm minimisation services; they also followed up out-of-hours referrals. Detainees under 18 were signposted to specialist children's services. Detainees and custody staff thought highly of the substance misuse services.

Good practice

6.23 *The provision of alcohol withdrawal symptomatic relief in court custody ensured that treatment commenced in police custody was continued; and the risk to detainees of more serious complications of withdrawal were minimised.*

Mental health

6.24 There were several providers of mental health services to the custody suites in West Mercia and Warwickshire. Only detainees in the custody suites at Leamington Spa, Nuneaton and Telford had access to mental health criminal justice workers.

6.25 In our custody record analysis, 25% of detainees said they had entered custody with mental health problems and 15% with current or previous self-harm or suicide issues. Custody staff had received training in mental health awareness as part of their induction and had access to National Centre for Applied Learning Technologies (NCALT)[5] training thereafter. There were mixed views on the effectiveness of the NCALT in learning. Custody staff indicated their wish to be better briefed to help detainees. There were good links at operational level between sergeants, inspectors and nurses working in the custody suites. This good practice was replicated at a strategic level with the custody manager and managers of mental health, local authorities and ambulance services.

6.26 Crisis and community mental health teams were available in West Mercia but staff told us these services were unreliable as there was no guarantee of a prompt response from them. They said that the telephone advice service offered by the crisis team was often on answerphone and not available during the night. Child and adolescent mental health services were provided by a separate NHS trust, which prevented direct referral by adult mental health workers.

6.27 In Herefordshire and Worcestershire, the police referred consenting individuals to the Samaritans for support. While there were no data on referrals available, this was a promising scheme for detainees.

6.28 Detainees requiring formal assessment under the Mental Health Act were seen by emergency duty teams; custody officers said that responses were prompt.

6.29 In West Mercia, we were initially shown two sets of conflicting data on the use of section 136 of the Mental Health Act.[6] Following clarification we were satisfied that in the six months ending 30 September 2014, 184 people were detained under section 136 of the Mental Health Act, only one of whom entered police custody; 150 had received ambulance triage and 180 were seen by an approved mental health professional within 90 minutes of arrival at a place of safety, which was a high standard of service.

Recommendations

6.30 There should be an analysis of the need for mental health practitioners to be available to detainees in police custody in West Mercia.

6.31 The police and health care professionals should have access to telephone advice from the mental health services.

Good practice

6.32 *Nearly all of those detained under section 136 of the Mental Health Act were taken to an NHS place of safety in accord with national policy, the use of section 136 was treated as a medical emergency, and the multiagency approach was exemplary.*

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[5] NCALT is a collaboration between the College of Policing and the Metropolitan Police Service.
[6] Section 136 enables a police officer to remove someone from a public place and take them to a place of safety – for example, 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 7. Summary of recommendations and housekeeping points

Main recommendations

7.1 Warwickshire and West Mercia police should strengthen the current strategic and management oversight of custody provision and ensure that there is sufficient direction, control and accountability. (2.43)

7.2 Quality assurance measures including reviews of custody records, complaints and use of force data should be collected and reviewed regularly by senior managers. (2.44)

7.3 The Police and Crime Commissioner and chief officer group for both forces should engage with their counterparts in the local authority areas and immediately review provision of local authority accommodation for young people under section 38(6) PACE 1984 to ensure that children are not detained unnecessarily in police cells. (2.45)

7.4 Risk assessment and management should be improved with risk management reflecting the risks identified initially through speaking to the detainee and relevant records, and should be reviewed throughout the detainee's time in custody. Risk assessment processes should reflect a consistent approach across custody operations. (2.46)

7.5 Use of force data should be collated in line with national guidance. Extreme measures such as the use of anti-rip clothing and emergency restraint belts, should be used only in exceptional circumstances when there were no other means of keeping detainees and staff safe and each incident should be reviewed by a senior officer. (2.47)

Recommendations

Strategy

7.6 Warwickshire and West Mercia police should ensure that staffing levels are adequate to ensure good and consistent detainee care. (3.9)

7.7 Warwickshire and West Mercia police, in conjunction with Tascor, should implement a programme of custody refresher training for detention officers. (3.17)

7.8 Warwickshire and West Mercia police should implement a process for handling adverse incidents in line with the Association of Chief Police Officers and College of Policing authorised professional practice. (3.18)

7.9 Warwickshire and West Mercia police should develop a custody intranet portal that ensures the timely distribution of information to staff. (3.19)

Treatment and conditions

7.10 Booking-in desks should be of an appropriate height to facilitate effective and private communication between staff and detainees. (4.10)

7.11 There should be accessible facilities for detainees with disabilities, such as access to call bells. (4.11)

7.12 Anti-rip clothing should only be used to protect the detainee from harm, and based on an appropriate rationale and risk assessment. (4.23)

7.13 Intoxicated detainees should be roused regularly, and rousing should be clearly recorded in the custody record and log. (4.24)

7.14 Detainees should only be handcuffed when a risk assessment indicates this is necessary for the safety of staff, the public or the detainee. (4.29)

7.15 Cells in all suites should be appropriately lit, heated and ventilated, and have natural light, and there should be a regular programme of deep cleaning. (4.36)

7.16 Bed plinths should be wide enough to accommodate detainees, with some that are accessible to detainees with limited mobility. (4.37)

7.17 Every suite should have an exercise yard accessible to detainees held for long periods. (4.43)

7.18 All detainees held overnight, or who require one, should be offered a shower that provides sufficient privacy. (4.44)

7.19 Toilet paper should be routinely provided in each cell, subject to individual risk assessment. (4.45)

Individual rights

7.20 Warwickshire and West Mercia police should monitor the average waiting times for detainees from their time of arrival in custody to authorisation of detention to ensure that detainees are booked in promptly on arrival. (5.12)

7.21 Appropriate adults (AAs) should be available at all times for vulnerable adults and children, and custody staff should ensure that family or friends acting as AAs are given a relevant written guide to assist them. (5.13)

7.22 All detainees should be advised of their rights and entitlements at the earliest opportunity, and this should be recorded in the custody log. (5.14)

7.23 All suites should have suitable telephone equipment to facilitate telephone interpreting in privacy. (5.15)

7.24 Detainees should be asked during reviews if they want to make any representations. (5.23)

7.25 Senior police managers should work with HM Courts and Tribunals Service to ensure that early court closure times do not result in unnecessarily long detentions in police custody. (5.24)

7.26 Detainees should be able to make a complaint while they are still in custody. (5.27)

Health care

7.27 Clinical rooms and practices should comply with relevant standards of infection control, and contemporary standards for preventing contamination and forensic sampling. (6.9)

7.28 There should be an analysis of the need for mental health practitioners to be available to detainees in police custody in West Mercia. (6.30)

7.29 The police and health care professionals should have access to telephone advice from the mental health services. (6.31)

Housekeeping points

Treatment and conditions

7.30 Reading materials should be routinely offered to detainees. (4.46)

Individual rights

7.31 There should be sufficient copies of up-to-date PACE codes of practice in all custody suites, and custody staff should routinely show and explain them to detainees. (5.25)

Health care

7.32 The medical rooms should have regular deep cleaning and all should contain examination lamps. (6.10)

7.33 The spy hole in the communicating door between the medical room and toilet at Hereford should be removed immediately (6.11)

7.34 The electronic clinical record should be capable of retrospective searches and enable reference to contemporary sources of evidence-based practice. (6.12)

7.35 Clear containers, rather than envelopes, should be used for medicines administration. (6.13)

Good practice

7.36 The provision of alcohol withdrawal symptomatic relief in court custody ensured that treatment commenced in police custody was continued; and the risk to detainees of more serious complications of withdrawal were minimised. (6.23)

7.37 Nearly all of those detained under section 136 of the Mental Health Act were taken to an NHS place of safety in accord with national policy, the use of section 136 was treated as a medical emergency, and the multiagency approach was exemplary. (6.32)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	HMIP team leader
Peter Dunn	HMIP inspector
Kellie Reeve	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC lead staff officer
Paul Tarbuck	HMIP health services inspector