Report on an unannounced follow-up inspection visit to police custody suites in Avon and Somerset

9–13 July 2012

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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1. Introduction

This report is part of a programme of 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 UK'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 visit to police custody suites in Avon and Somerset was a follow-up to a previous inspection in August 2010. On our return, we were pleased to find that the force had taken our previous recommendations seriously and we identified improvement in several areas, particularly in strategic management (which needed further strengthening) and in the provision of health services. There had been improvements to the custody estate, but some concerns remained, including several aspects of treatment and conditions in custody.

Strategic leadership for custody provision was provided by an assistant chief constable (ACC). Custody management and operational delivery was devolved to the six policing districts. However, arrangements were confusing and affected consistent standards of practice. This was being addressed through the programme managing the delivery of three new custody private finance initiative (PFI) builds by summer 2014, and the centralisation of the custody function.

Staff interactions with detainees were professional, although the assessment and management of risk during booking-in and pre-release would have benefited from more regular quality checking to ensure consistency. Staff development was needed to raise awareness of the specific needs of vulnerable detainees, and shift handover processes needed improvement. There was no effective process for monitoring use of force. Seventeen-year-olds were generally treated as juveniles, which was good practice. There had been improvements to the physical conditions of the suites but most were still in a rundown condition.

An appropriate balance was maintained between progressing cases and the rights of individuals, and staff generally displayed a respectful approach to detainees. Voluntary attendance was systematically encouraged. There was a lack of local authority beds for juveniles who had been refused bail, and several courts closed earlier than agreed, resulting in detainees being held until the following working day. Complaints were taken while the detainee remained in custody.

Health care monitoring arrangements were good, although response times for forensic medical examiners were often too long. Substance use services were good but there were often unacceptable delays in carrying out mental health assessments. The use of police cells as a place of safety under section 136 of the Mental Health Act 1983 had reduced but there was still inadequate provision of health-based places of safety, particularly for the Bristol and Avon area.

Overall, police custody provision in Avon and Somerset was adequate. There was clear strategic direction, and the force was at a critical point where there was a need to implement some key changes and engage staff in the process. This report provides a small number of recommendations to assist the force and the Police & 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.

Drusilla Sharpling
HM Inspector of Constabulary
September 2012

Nick Hardwick
HM Chief Inspector of Prisons

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 the 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 *Safer Detention and Handling of Persons in Police Custody* 2011 (SDHP) 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 Avon and Somerset police had 10 full-time designated custody suites with a total cell capacity of 119, and eight non-designated suites with a total cell capacity of 26. The inspection team visited all the custody suites. The force had held 44,069 detainees in the year to 31 March 2012, and 304 detainees for immigration matters in the same period.

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

Custody suite	Number of cells	Custody suite	Number of cells
Trinity Road, Bristol	29	Yeovil	13
Broadbury Road, Bristol	12	Taunton	9
Southmead Road, Bristol	10	Minehead	8
Staple Hill, Bristol	9	Bridgwater	8
Bath	9	Weston-super-Mare	12

2.5 In addition, there were eight non-designated suites but many of the cells were not in use: at The Mall (one holding room), Thornbury (no cells in use), Radstock (one), Frome (three), Wells (two), Burnham-on-Sea (none in use), Chard (one) and Nailsea (two).

[1] http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm

Strategy

2.6 The central Criminal Justice department was responsible for policy, procedure and strategy for custody but operational management was devolved to the six districts. The amount of time that the inspectors given responsibility for custody in each district could devote to custody management varied widely, as did the line management arrangements for custody sergeants. Staffing of the custody suites was generally adequate.

2.7 The non-designated suites presented a number of risks, through their physical condition and other factors (mitigated by the fact that only upgraded cells were in use), and their continued use was open to question. Plans were well advanced for the building of three new suites, to be opened in the spring/summer of 2014, although it was intended to upgrade and keep in use two of the existing designated suites in outlying locations (at Minehead and Yeovil). The prospective changes presented an opportunity to establish a consistent and corporate approach to custody across the force area, with the added value of crime investigation teams being co-located with the new custody suites.

2.8 There was a good structure of oversight meetings, with an assistant chief constable (ACC) taking an active lead, but no forum for practitioners at local level. Partnership arrangements were sound. The police authority had a lead member for custody who played an active role, and there was a strong independent custody visitor (ICV) scheme, with which the force engaged positively.

2.9 Quality assurance of custody records was effective but not sufficiently in-depth across the force. An on-the-job approach to training created some risks but there were plans to provide basic training for designated detention officers (DDOs) before they took up their duties. Staff said that they had had no recent refresher training, although this was planned. Staff had good awareness of information available on the force intranet, including a well-presented regular newsletter.

Treatment and conditions

2.10 In general, staff treated detainees courteously and considerately. All suites had a good level of privacy for booking-in interviews. There were good examples of care by individual sergeants and DDOs. Staff were reasonably aware of equality issues but provision for the specific needs of women and children was uneven. Not all detainees were asked about any dependency issues but, in the main, the needs of female detainees were properly met. There were some physical access problems, and there was limited provision for those with disabilities, but signing was available for those with impaired hearing and religious needs were well supported.

2.11 The standard of risk assessment was variable, although in most cases sergeants asked supplementary questions, explaining why the information was needed, and checked warning markers. Risk assessment and observation levels were appropriately adjusted in response to changing circumstances. There was mostly a good understanding and practice of the levels of observation but closed-circuit television (CCTV) images were not always clear enough. Safety issues were uppermost in the minds of sergeants considering detention but there was evidence that observations of detainees in cells were not always carried out on time. The quality of staff handovers was not consistent. We saw some good examples of practical care for the needs of those being discharged but in some records there was no evidence of vulnerabilities being addressed in preparation for release. Use of force was not monitored for any patterns or trends but there was relatively little use of handcuffs.

2.12 The physical environment of most suites was worn; the recent refurbishment had improved them and made them safer but a number of deficiencies remained. In general, there were daily checks of the facilities but in some cases they were superficial or intermittent. The number of ligature points had been considerably reduced but at least one ligature point remained in the majority of suites. Call bells were answered promptly in most suites but in two of them they did not sound at all. In several suites there was poor control of who accessed the cell areas.

2.13 The issuing of bedding and clothing was consistent in most respects but the provision of food and showers remained barely adequate and in some cases unsatisfactory. Exercise was available at most suites but several of the exercise yards were in poor condition.

Individual rights

2.14 Voluntary attendance (as an alternative to arrest and detention) was systematically encouraged. Most custody officers took the initiative in questioning whether custody was necessary or appropriate in particular cases. The neighbourhood justice panels, through which community volunteers use restorative justice to deal with anti-social behaviour and low-level crime, were well developed in this force area and also made a contribution. Detainees' rights were carefully explained. Suites were not used as a place of safety for children.

2.15 Staff made efforts to ensure support for vulnerable people, both through family members and through the well-organised appropriate adult (AA) schemes (at Taunton and Bath). Seventeen-year-olds were generally treated in practice as juveniles, and in several suites staff said, and custody records showed, that an AA would be called for a 17-year-old. There was good access to and use of interpreting services at all suites. Interpretation in person was available and, with a few exceptions, waiting times were reasonable. Rights and entitlements documents were available in many languages at all suites. In general, the length of stay for immigration detainees appeared to be under 24 hours in most cases, and the local UK Border Agency dealt efficiently with cases.

2.16 Detention reviews by inspectors were carried out well, with concern for the detainee's welfare. PACE codes of practice were available in all suites, although not all were up to date. Solicitors were satisfied with the service they received from custody staff, and their access to custody records. Telephone calls to solicitors were offered but generally without sufficient privacy. Although, in principle, a 2.30pm cut-off time had been agreed with the courts across the area, this was not the case in practice, and several courts closed earlier, so that some detainees had to be held until the following working day. DNA samples were well managed in the designated suites. There was inconsistency in the handling of complaints across the suites, and several detainees were not aware of how to make a complaint.

Health care

2.17 The overall governance of health care had improved with the change to a new provider. There were clear policies and procedures in all the designated suites. Record keeping was largely satisfactory. There was access to the national strategy for police information systems (NSPIS) in all of the medical rooms and, in general, sufficient health information was recorded on police systems and shared with police staff.

2.18 Nursing and medical staff had all received, or were scheduled to undergo, intermediate life support training. Medical rooms were suitably equipped and most were reasonably clean. Arrangements for resuscitation kits had improved. Most custody staff had received basic life support training, including use of the automated defibrillator.

2.19 A range of patient group directions was in use, enabling nurses to administer commonly required medications. Management of stock medication was well organised and controlled, with a small number of discrepancies, but there was no audit trail for some detainees' own medications.

2.20 Detainees were referred to health care professionals appropriately and on request. Health assessments were generally conducted appropriately and respectfully. Custody staff received good and timely responses by nurses but often waited too long for the doctor to arrive. Detainees waited too long for mental health assessments, and thresholds for assessment appeared unduly restrictive.

2.21 People coming into custody with substance use withdrawal symptoms were assessed by the nurse or doctor and given appropriate symptom relief, while those coming in intoxicated or with alcohol problems were assessed and monitored.

2.22 Across the force area, approximately 683 people had been detained under section 136 of the Mental Health Act 1983[2] in 2011/12. There were delays of up to 12 hours in undertaking mental health assessments across the force area and difficulties in getting detainees into a place of safety. There was only one NHS section 136 suite available for the Avon area, serving a total population of approximately 1.1 million. The force was working with health commissioners and providers in the northern half of the force area to mitigate the position. In Somerset, with a smaller population, there were two section 136 suites for a population of approximately 525,000 but delays in assessments were similar. A number of staff said that they had not received mental health awareness training.

Main recommendations

2.23 The force should implement its decision to reorganise management structures to ensure the corporate and consistent care and welfare of detainees.

2.24 The risk assessment, care planning and observation level process should be monitored to ensure its consistency.

[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 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.

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 wellbeing of detainees.

Strategic management

3.1 An ACC provided strategic leadership on custody issues, and a Criminal Justice Department (CJD) was responsible for setting strategy, policy and procedure for custody. There was a chief superintendent, who was the head of the CJD, and a chief inspector, who was the head of custody within the CJD. Custody management and operational delivery were devolved to the six operational districts.

3.2 The force had a clear estates strategy, with plans to open three new PFI custody facilities by summer 2014. All other custody facilities would then close, with the exception of Yeovil and Minehead, which would be refurbished and retained to supplement the new suites. There was limited strategic oversight and management of the use of the eight non-designated suites, with issues around DNA management, ligatures and throughput. The police authority was engaged with the estates strategy, and an Accommodation Board had been established to oversee the PFI developments. There was a lead member for custody.

3.3 Staffing of the custody suites was generally adequate, although there was insufficient resilience in staffing – for example, cover for absences. It comprised permanent custody sergeants and police staff (DDOs) employed by Avon and Somerset Police. Cover for sergeants was provided by sergeants from the operational teams, and for DDOs was provided by DDOs from other areas or by sergeants or police constables (PCs) from operational teams. When PCs were used, their inability to operate the NSPIS custody system limited their effectiveness. Custody resources were managed under the operational district management structure. At Minehead, one shift was using an 'acting sergeant' to undertake custody duties, while another shift did not have a custody sergeant, so the custody suite was unable to operate during this time. DDOs looked after the ongoing care and welfare of detainees. There were no DDOs based at Minehead.

3.4 There were confusing arrangements with regard to operational custody management. In the Bristol district there were two dedicated custody managers; in the others, criminal justice inspectors spent varying proportions of their time on custody. Line management of custody sergeants varied between districts: in Bristol, all custody sergeants were managed by the custody inspectors, while in the other districts line management varied between the criminal justice inspectors and the shift inspectors. Custody sergeants line-managed DDOs. The force had recognised the lack of consistent corporate structures for the management of custody, and chief officers had recently agreed the centralisation of custody/criminal justice inspectors to the CJD. There were further plans to centralise all custody resources to the CJD, through Project Adapt, which was managing the transition to the new estate. The planned changes provided an opportunity for a consistent and corporate approach to custody provision, through clear force-wide operating practices and the establishment of crime investigation teams co-located with the new custody suites (see main recommendation 2.23).

3.5 There were sound strategic governance structures for custody. The ACC lead for custody held a biweekly meeting with the head of the CJD and chaired a quarterly meeting with the CJD

senior leadership team (SLT), where custody performance was reviewed. There was a CJD SLT weekly meeting, attended by the head of custody. The head of custody chaired a bimonthly heads of criminal justice meeting, which focused predominantly on custody delivery. Custody inspectors were generally visible in custody but there was no forum where custody practitioners, such as custody sergeants and DDOs, could discuss custody issues.

3.6 There was a process for recording adverse incidents in custody through the computer system. An adverse incident form was completed electronically by the custody sergeant and forwarded to the custody or criminal justice inspector for appropriate action. Adverse incidents were discussed at the bimonthly meeting of heads of criminal justice.

3.7 There was an effective quality assurance process for dip-sampling custody records, with each custody/criminal justice inspector required to review 20 custody records per month using a corporate template. This process was monitored by the CJD and was recorded and auditable. The CJD also determined themes for the dip-sampling of custody records, focusing, for example, on higher-risk detainees. However, the dip-sampling was not cross-referenced to the corresponding CCTV footage and person escort records (PERs). There was no quality assurance of shift handovers.

3.8 The force had comprehensive custody-related policies which were accessible to all staff on the force intranet. At the time of the inspection, several of these policies were undergoing review. The custody intranet site was the repository for the regular, comprehensive 'Custody Counts' newsletter, which included updates from the Professional Standards Department and the Independent Police Complaints Commission (IPCC) 'learning the lessons' document. Staff showed good awareness of the custody intranet site and often received emails containing information about adverse incidents.

Recommendations

3.9 Avon and Somerset Police should review its continued use of its eight non-designated police custody facilities to ensure they provide a consistently safe and decent environment for detainees.

3.10 The force should include cross-referencing of custody record dip-sampling, person escort record checking and monitoring of handovers as part of its quality assurance regime.

Housekeeping points

3.11 The force should review the use of acting sergeants as custody sergeants and the use of police constables as gaolers.

3.12 The force should introduce a forum where custody practitioners and managers can discuss custody issues, to enable them to contribute to the change process.

Partnerships

3.13 Partnership arrangements were satisfactory, with active engagement with relevant criminal justice partners at the strategic level. The chief constable chaired the Local Criminal Justice Board (LCJB), which the ACC lead for custody also attended. The ACC lead for custody also chaired the community safety subgroup to the LCJB.

3.14 There was a police authority coordinator for the ICV scheme. The scheme was active and comprised nine panels, administered by the police authority. ICVs said that they were generally admitted to custody suites quickly. There were quarterly meetings for panel coordinators, with good, consistent police attendance.

Learning and development

3.15 All custody sergeants had undergone custody-specific training before undertaking custody duties and received twice-yearly training in first aid and personal protection equipment (PPE). DDOs received first-aid training and PPE training before working in custody, with twice-annual refresher training, but only received custody-specific initial training if there were sufficient numbers to run a course. DDOs who did not receive this training were supervised in the custody suite until they had completed a competency-related National Vocational Qualification accredited workbook to evidence their learning and development. However, we were told that, from September 2012, the Corporate Learning and Development Department would deliver initial DDO training on a one-to-one basis if required.

3.16 The force described a programme of training, but we were told by staff that they had not had refresher training on custody work, and there were examples of staff with many years of service in custody who had received no formal refresher training. This was a risk, particularly when cover for custody sergeants was provided by operational team sergeants who had limited experience in the custody role. The lack of refresher training reduced opportunities for learning from adverse incidents, complaints and quality assurance checking. We were told that the force had developed a custody refresher training programme for delivery from September 2012 by the Corporate Learning and Development Department.

Recommendations

3.17 The force should implement its plans to provide structured custody training for DDOs before their deployment in custody.

3.18 The force should implement its plans to introduce regular custody refresher training.

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 We inspected two GEOAmey cellular vehicles, one of which was dirty. Staff told us that they had insufficient storage space for detainees' property. Escort staff on one of the vehicles told us that they never used the partition designed to separate male and female detainees because it was difficult to open and close when the vehicle was in motion, whereas staff on the other vehicle had no such issue.

4.2 We observed staff treating detainees politely and considerately, addressing them by their first names when appropriate. Booking-in areas were small, which restricted the number of people present, thus affording a good level of privacy. Toilet areas in most cells were screened. This meant that in cells equipped with CCTV cameras, detainees could not be observed using the toilet. This was not the case at Trinity Road, where the toilet area could be clearly observed on the CCTV monitor.

4.3 Staff demonstrated a reasonable awareness of diversity but there was little additional provision for minority groups. Staff at all suites told us that women detainees would be offered the opportunity to speak to a female member of staff, and our custody record analysis confirmed that this was standard practice; however, we spoke to a female detainee at Trinity Road who had not been so informed. Not all staff were aware that there should be a named female officer responsible for the care of female juveniles in custody. At Southmead Road we observed a 15-year-old girl attend the custody suite with her mother. The custody sergeant took time to explain the process to both of them and the juvenile was well cared for.

4.4 Custody sergeants had a good awareness of safeguarding issues that could impact on juveniles or vulnerable adults and had a list of agencies to which they could refer such individuals if they identified any concerns. Most juvenile detainees were placed in cells or detention rooms situated close to the booking-in area. Most detainees were asked during the booking-in process about issues relating to any dependants but the question was not always clearly or simply put.

4.5 Most suites did not have suitably adapted cells for detainees with disabilities, for some of whom cell call bells were too high. There was a wheelchair available for the use of detainees at Bridgwater, and at Trinity Road there was an adapted toilet and shower but this was being used as a storeroom and staff told us that it was seldom, if ever, used. None of the suites had a hearing loop, even though at Staple Hill a 'hearing loop available' sign was prominently displayed. At many suites there was information displayed about the availability of local police personnel trained as signers.

4.6 All suites had a box containing items for religious observance, although at some suites it was not easily located and not always stored respectfully. A wide range of holy books was available, including the Bible, Qur'an, Torah and, at some, Sikh and Hindu holy books. Not all suites had access to a compass with which to determine the direction of Mecca.

4.7 There was uneven understanding of the needs of transgender detainees but at Bridgwater and Taunton, custody staff rightly told us that they would offer a transgender detainee the choice of being searched by a male or female officer.

Recommendations

4.8 The force should work with partner agencies to ensure that cellular vehicles are clean and have sufficient space for detainees' property, with women and men kept separate.

4.9 The closed-circuit television system should effectively obscure the toilet area in cells in Trinity Road.

4.10 Staff should be trained to recognise and provide for the individual needs of detainees, particularly those who are vulnerable, juveniles and women.

4.11 There should be appropriate cells that meet the needs of older detainees and those with mobility difficulties.

Housekeeping points

4.12 A hearing loop should be available in the booking-in area and all custody staff should be made aware of how to operate it.

4.13 Each suite should have a range of items necessary for religious observance, which should be stored respectfully.

Safety

4.14 Risk assessments stated the risks identified clearly but were sometimes mechanistic, involving simply reading questions from the NSPIS online template. Although some custody sergeants asked supplementary questions about health and emotions, especially when there were indications of self-harm, others made little attempt to explore potential risks. Markers for self-harm were flagged on the Police National Computer at the start of the booking-in process. Although most custody sergeants told us that they always explained the reasons for asking personal questions about mental health and self-harm, we observed several instances when detainees were not given such explanations.

4.15 Initial risk assessments set appropriate levels of observations but our custody record analysis found that observations were often around 10–15 minutes late. We saw observations reviewed appropriately as circumstances changed. For example, we saw the observation level of one intoxicated detainee, who had initially been placed on 30-minute observations with rousing, being reduced as he became more sober. However, for one vulnerable female detainee, observations were not recorded as being undertaken at the specified intervals.

4.16 It was not always clear how level 4 (close proximity) observations were managed. Some custody sergeants told us that it would require two police officers sitting with the detainee, which in some of the more rural areas might be difficult to achieve. However, others told us that close proximity could be provided by one officer drawn from a response team. Staff told us that the prompt supply of an officer to undertake close proximity observations varied considerably; in rural areas it was described as good, whereas in Bristol (Trinity Road) it was

described as `*always a battle*` (see main recommendation 2.24). We were shown a useful briefing sheet for police officers conducting close proximity observations.

4.17 CCTV images were not always clear and at Trinity Road light glare made the image on the monitor appear misty.

4.18 Staff were aware of the need to obtain a response when undertaking rousing checks for detainees under the influence of drugs or alcohol, and in many suites a magnetic 'R' sign was placed on the relevant cell door as an additional reminder. Anti-ligature knives were carried with cell keys and a knife capable of cutting thick ligatures was kept in the booking-in area in most suites.

4.19 Most staff handover briefings were poor. With the exception of Bath, they were not undertaken in the presence of the full team. Each DDO individually briefed their incoming colleague, as did the custody sergeant. We saw one handover briefing which clearly did not communicate information about the self-harm history of a detainee

4.20 The NSPIS custody record system incorporated a pre-release risk assessment prompt, to which custody sergeants had to respond. At Bridgwater we observed pre-release planning for a detainee arrested for alleged domestic violence; in this case, the custody sergeant offered helpful advice about future contact with the detainee's partner. However, at Staple Hill we saw a potentially vulnerable woman who had been arrested for the first time being released with no obvious pre-release risk planning. Custody sergeants were conversant with local arrangements for passing information about vulnerable detainees to social services, and some gave examples of when they had referred detainees to the emergency duty team, crisis team or a GP. Leaflets giving details of support organisations were available in only some of the suites.

4.21 In our custody record analysis, 11 detainees had had obvious vulnerabilities but in three of these records (37%) there was no evidence that this had been addressed. One involved a 15-year-old boy released at 9.45pm on a Saturday with no AA involvement and no information about where he was going.

Recommendations

4.22 Closed-circuit television should provide sufficiently clear images at all custody suites.

4.23 Shift handovers should involve all staff on duty and, wherever possible, should be recorded.

4.24 Pre-release risk assessments should be of consistent quality and should be subject to dip-sampling.

Housekeeping point

4.25 Detainees being released should be offered a leaflet about support agencies.

Use of force

4.26 The use of handcuffing was proportionate and we observed few detainees arriving at suites in handcuffs. Custody staff recorded the use of force on custody records but the data were not

collated; one inspector told us that this was because it was '*too bureaucratic*' and '*time consuming*' to do so. There was a lack of clarity about the criteria for the use of leg straps and other restraints; some told us that they would leave detainees in cells in leg straps, whereas others said that they would never do so.

4.27 All staff had been trained in approved safety techniques and received refresher training at least annually. The force collected data on strip-searching, which was showing a steady increase year on year. In 2011/12 the force had recorded 1,204 strip-searches, compared with 990 two years earlier. The force was of the view that this figure was unreliable and was likely to be higher, as strip-searching was not singularly recorded on NSPIS but collated by custody officers completing a separate form, and this was not always done.

Recommendation

4.28 Avon and Somerset Constabulary should collate use of force data in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance.

Physical conditions

4.29 The recent redecoration and modifications of most suites had improved the environments and made them safer, and there was minimal graffiti; however, this had been a temporary measure pending the new builds due in 2014, and a number of deficiencies remained. Many of the suites still appeared worn and run down. The Minehead suite was dirty, and the sinks at which detainees washed were cracked, dirty and contained rubbish. At Taunton, toilet bases showed much ingrained dirt. At Bridgwater, Taunton and Trinity Road some cell CCTV cameras had been pelted with detritus that had not been cleaned off. At Broadbury Road some cell tiles appeared not to have been wiped down for some time and there was a build up of dirt in some cell corners.

4.30 In most suites we found several ligature points, and Yeovil and Bridgwater suites contained the older-type T-bar cell handles, which presented an additional risk if door hatches were left open or were closed incorrectly.

4.31 We were told that DDOs carried out daily cell checks, which included testing the cell call bells and toilet flush and checking if any prohibited items had been left in the cell. When we reviewed the daily cell check sheets, we found gaps and mistakes in these records at Staple Hill and Bridgwater. Not all suites had evidence that these records had been scrutinised by a manager.

4.32 Call bells had been fitted in all cells, although we saw detainees being placed in cells without staff explaining their use. We observed some call bells being muted and ignored at Bridgwater and Staple Hill, although most were answered promptly. At Taunton and Yeovil the call bells did not sound; we were told at Yeovil that there was a long-standing fault with the audible alarms and at Taunton staff said that they muted the call bells to prevent the buzzing in the corridors disturbing other detainees.

4.33 In several suites we saw poor management of cell keys, which were frequently given out to non-custody staff or were seen lying on desks. We regularly saw non-custody staff, including police officers and drug workers, gaining access to detainees for interviews and to relocate them back to their cells, out of sight of and without the knowledge of the custody staff.

4.34 Only at Southmead Road and Yeovil could staff recall undertaking a fire drill or an inspection. However, all suites had an evacuation policy which staff understood, and adequate stocks of handcuffs were held for evacuation processes.

Recommendations

4.35 A programme of regular deep cleaning should be established, and broken, inappropriate or insanitary equipment should be replaced.

4.36 Cell call bells should not be permanently muted and should be responded to promptly.

4.37 Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them, and custody staff should be aware of who is in the custody suite.

Housekeeping point

4.38 Daily cell checks should be undertaken and accurately recorded.

Detainee care

4.39 All cells contained a mattress, which DDOs wiped with antibacterial wipes after each use. There were no pillows. There were ample supplies of clean blankets but these were given mostly on request. In some suites toilet paper was provided in the cells only on request, whereas in others a small supply was available in most cells. Many cells did not have hand-washing facilities. Hygiene packs for female detainees were available but not routinely offered.

4.40 There were showers in all suites. Some were well screened and afforded good privacy but others – for example, at Staple Hill – were not. Our custody record analysis found that no detainees had showered in custody. Two detainees had gone to court without a shower and one person had been held for 32 hours without being offered one. There were good stocks of cotton towels, toothpaste, razors and soap.

4.41 There were adequate stocks of replacement clothing, in a range of sizes, including tracksuit tops and bottoms, T shirts and plimsolls/slippers. However, replacement underwear was available in only one suite. Paper suits were rarely used. Anti-rip clothing was available at all suites. We were told that family and friends could bring in clothing for immigration detainees and detainees who were held over the weekend and required appropriate clothing for court.

4.42 A force policy, inappropriately entitled '*Feeding detainees: guidance to staff*', had recently been issued, encouraging the restriction of meals normally to recognised times and to those whose detention was likely to stretch over several hours. Most staff described using their discretion about the timing of meals and quantities of food provided to detainees. However, at Bath we observed a detainee being refused a meal when he arrived in custody as he was unlikely to be detained for more than three hours. In our custody record analysis, only 11 detainees in our sample (37%) had been offered at least one meal while in custody. Of the 19 (63%) who had not been offered a meal, six had been held for between five and 10 hours. One detainee had been in custody for 15 hours without being offered a meal.

4.43 In many suites, the provision of a hot `all day breakfast` had been replaced with the offer of a cereal bar. At other times, ambient microwave meals were provided, although these appeared to be of poor quality and low calorific value. Vegetarian and halal options were available. All

food was in date, and hygienically stored and handled. Tea, coffee and water were freely available and detainees told us that they had been offered drinks regularly. At most suites, food preparation areas were clean and tidy, although at Yeovil the inside of the microwave oven was dirty.

4.44 Exercise was available at most suites but no detainees in our custody record analysis had been offered it. Most exercise yards contained obvious ligature points and could only be used if the detainee was supervised. At Taunton the yard was slippery and full of weeds and the yard at Weston-super-Mare was dismal, dank and dirty.

4.45 Most suites had a reasonable selection of books and magazines, although little in languages other than English and nothing in easy-read formats. However, reading materials were rarely offered. Some detainees we spoke to said that they would welcome something to read but did not know that this was available.

4.46 No suite had provisions for visits, although we were told that at some suites visits could be arranged for immigration detainees.

Recommendations

4.47 Blankets and pillows should be routinely provided to all detainees.

4.48 All detainees held overnight, or who require one, should be offered a shower.

4.49 Detainees held for long periods should be offered outside exercise and the exercise yards should be fit for purpose.

4.50 Visits should be facilitated for detainees held for long periods, particularly if they are vulnerable.

Housekeeping points

4.51 Toilet paper should be routinely provided in each cell.

4.52 Hygiene packs should be routinely offered to female detainees.

4.53 Replacement underwear should be available at all suites.

4.54 Meals should be offered to all detainees at regular mealtimes and at other times according to individual need.

4.55 Reading materials suitable for a range of detainees, including young people, those whose first language is not English and those with limited literacy skills, should be made available.

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 We observed custody sergeants checking the circumstances of detainees' offence and arrest to determine if detention was necessary. Most custody sergeants could recall few occasions when they had refused to detain. However, at Broadbury Road we observed an officer consulting the custody sergeant about detaining a woman who was alleged to have committed an offence two months earlier. The sergeant directed the officer to conduct a voluntary interview instead. At all suites sergeants perceived that the use of alternatives to custody, such as street bail and voluntary interviews, had increased. We were also told that restorative justice approaches, such as Neighbourhood Justice Panels, were becoming popular in diverting low-level offenders away from custody.

5.2 Most solicitors we spoke to said that their clients were generally dealt with quickly but could recall cases where they felt they had been detained for too long. Custody sergeants were clear about their obligations to ensure that cases proceeded quickly and told us that officers were expected to interview and process detainees during the night wherever possible. Custody sergeants at Weston-super-Mare, Broadbury Road and Bridgwater suites told us that when there were delays (for example, owing to lack of availability of AAs or interpreters), they sought to bail the detainee, depending on the offence, rather than keep them in custody.

5.3 Staff told us that the length of time that immigration detainees were kept at police stations had reduced over the previous 12 months, and appeared to be under 24 hours in most cases, but that they were still held for longer periods at weekends. However, they said that they generally received a good service from the UK Border Agency. A total of 304 immigration detainees had been held in custody in 2011/12, approximately 30% fewer than in 2009/10, although the first quarter of 2012 had shown an increase.

5.4 During booking-in, staff gave all detainees a leaflet summarising their rights and entitlements, and this was available in around 40 different languages; there were no easy-read formats available. At all suites a professional telephone interpreting service could be used at the booking-in desks but it was operated through speaker phones, which compromised privacy. Custody staff said that there was a good face-to-face interpreter service available to facilitate investigative interviews, although there were sometimes delays in obtaining interpreters in person and on the telephone, depending on the language required and/or distances they were travelling.

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.[3] They said that they contacted social services to confirm the availability of PACE beds for juveniles held overnight who were refused bail, although none were aware that any such beds had ever been available in the county.

[3] Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child to suitable accommodation and keep him/her

5.6 Relatives or family friends were usually contacted initially to act as an AA. When this was not possible, an AA scheme was contacted. PACE requires an AA to be provided for young people under the age of 17 and it is rare for police forces to make an exception to this. However, in the case of Avon and Somerset Constabulary, we were told that the force required juveniles aged 17 to be represented with an AA usually, but not exclusively, if it was their first time in custody or they appeared to be vulnerable. Custody sergeants at many custody suites said that they would always consider an AA for a 17-year-old. In our custody record analysis, two 17-year-olds in the sample had been provided with an AA.

5.7 The Somerset districts were covered by a volunteer scheme, run through the Somerset youth offending team (YOT) and overseen by a coordinator. Approximately 35 trained volunteers were available to provide AAs for juveniles from 8.30am until midnight, seven days a week. After midnight, the emergency duty team was contacted.

5.8 Custody staff in the Somerset custody suites were positive about the service that was provided. Recently, the scheme had started providing AAs for vulnerable adults. Elsewhere, the `*People First*` scheme provided AAs for vulnerable adults during office hours, and the YOT provided an AA service for juveniles, with out-of-hours cover by the emergency duty team for both juveniles and vulnerable adults. Custody staff were positive about the AA service for juveniles but had experienced difficulties in accessing AAs from the *People First* scheme.

5.9 In our custody record analysis, there were four young people under the age of 17, all of whom had spent less than three and a half hours in custody. AAs had been provided for three of them but there was no record of an AA being provided for a 15-year-old.

Recommendations

5.10 Information about detainees' rights and entitlements should always be available in a range of formats that meet specific needs.

5.11 There should be two-handset telephones in all suites to facilitate telephone interpreting.

5.12 Avon and Somerset Constabulary should work with the local authority to ensure the provision of beds for juveniles who have been charged but refused bail to appear in court.

Good practice

5.13 *The force required juveniles aged 17 to be represented by an AA, especially if it was their first time in custody or they appeared to be vulnerable.*

Rights relating to PACE

5.14 All detainees had their right to free legal representation clearly explained to them. Those we observed who declined the services of a solicitor were asked the reasons why, which were recorded in the custody record, and they were reminded that they could change their mind later if they wished. The duty solicitor scheme was advertised in a multi-language poster displayed in all custody suites. In our custody record analysis, 10 detainees (33%) had accepted the offer of free legal representation. However, of the 20 detainees who had declined this offer, the reason for this was recorded in only five cases. The reasons for declining were

typically because the detainee did not believe they needed a solicitor or that it would extend their stay in custody.

5.15 Detainees were told that they could inform someone of their arrest, and that they could consult the PACE codes of practice; these were readily available, and we observed two detainees being given a copy to take to their cells. Some of these codes of practice were out of date.

5.16 All custody suites had consultation and interview rooms. Solicitors we spoke to were satisfied with the service they received from custody staff, and their access to custody records. Telephone calls to solicitors were offered but generally could not take place with sufficient privacy as the telephones were located in communal corridors or at the booking-in desk, and DDOs had to supervise the detainees when making the call.

5.17 The inspector PACE reviews we observed were well conducted, with detainees being told why they were still in detention. Our custody record analysis confirmed that these reviews were held in line with PACE requirements but in our sample of records, over a third of reviews were late. In such circumstances the reason for this was always recorded. When reviews had been conducted while the detainee was asleep, there was usually evidence that the detainee had been informed of the review on waking. Detainees were not interviewed while under the influence of drugs or alcohol. DNA samples were well managed in the designated suites.

5.18 We were told that there was a 2.30pm court cut-off time across the force area. In practice, this was not the case, and court cut-off times varied widely. We were told that in North Somerset, the cut-off time could be as early as noon. Staff told us that they would try to get detainees to court before the court cut-off times, even if it meant using police transport. However, because of the early cut-off times, detainees were frequently detained overnight for a court hearing on the following morning. There was no video link available.

Recommendation

5.19 Avon and Somerset Constabulary should work with HM Court and Tribunal Service to ensure that early court cut-off times do not result in unnecessarily long detentions in custody.

Rights relating to treatment

5.20 When detainees arrived in custody they were not routinely told how to make a complaint about their treatment, and this information was not included in the rights and entitlements documentation they received. At a few suites (for example, at Minehead and Bridgwater) there was a notice on the wall advising detainees how to submit a complaint to external organisations, such as the IPCC or Citizen Advice. At Broadbury Road there was a notice which informed detainees that they could make a complaint to the duty inspector. Inspectors at several suites told us that detainees were asked during reviews if they wished to make representations about their detention and that this was intended to act as an opportunity for detainees to raise complaints. Detainees we interviewed said that this had not been made clear to them. Custody sergeants said that they dealt directly with low-level complaints informally and with some immediacy where possible, but at Trinity Road. we observed a custody sergeant ignoring a detainee's request to make a complaint. However, complaints alleging assault were treated seriously and early evidence was gathered. IPCC leaflets were available behind some custody desks.

Recommendation

5.21 Detainees should be able to make a complaint about their care and treatment, and be able to do this before they leave custody; data about complaints should be monitored to identify and act upon any trends.

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 Health services had been provided by Reliance since 1 September 2011. Mental health services were provided by Avon and Wiltshire Partnership Trust (AWP) in the north of the force area and Somerset Partnership NHS Trust (SPT) in the south. Court assessment and referral services (CARS) were provided by both trusts. Substance use services were provided by AWP through the Criminal Justice Intervention Team (CJIT) in the Bristol and Avon area, Turning Point in the Bath and Somerset areas and Addaction in Weston-super-Mare. The contract with Reliance was monitored by the force monthly, largely through the achievement of response times and complaints.

6.2 Forensic nurse practitioners (FNPs) were employed by Reliance, with some bank and agency cover. Forensic medical examiners (FMEs) were directly employed by Reliance, with some cover provided by agency locums (Go Locum). FMEs also covered the sexual assault and rape crisis suite and provided other forensic medical services to the force. There was a clinical supervision policy. Permanent FMEs received annual appraisals but it was not clear how they accessed clinical supervision. FNPs had annual appraisals and some accessed clinical supervision from external senior colleagues. Arrangements for individual management supervision for health care staff were variable and there was no regular formal contact with line managers.

6.3 Staffing rosters provided for three FNPs working 12-hour shifts during the day and two FNPs during the evening/night; we were told that there were plans to provide a fourth FNP for the Somerset suites during the day to reduce response times. Pool cars were centralised at Staple Hill and Bridgwater, which sometimes resulted in delays at the start of shifts while nurses collected vehicles. FMEs worked similar shifts to the FNPs. One FME covered the force area, with two at weekends; there were plans to replace this second FME with an FNP.

6.4 Overall governance had improved. There was a bimonthly local clinical governance meeting, which was accessible by all Reliance staff and reviewed local issues, including clinical and serious untoward incidents and complaints; the second half of this meeting was used for training and development issues. Not all staff took the opportunity to attend these meetings. All FNPs and FMEs had received, or were scheduled to undergo, intermediate life support training.

6.5 A total of 40 clinical incidents had been logged between September 2011 and June 2012, the majority of which were related to variances in medication stocks.

6.6 Reliance held a comprehensive range of largely up-to-date policies. The infection control policy contained a reference to an outdated Department of Health code of practice on infection control (2003 code, now superseded by the 2008 version).

6.7 Reliance made monthly checks on the professional registration status of all the permanent nursing and medical staff. New staff attended a four-day forensic medicine course and FNPs were given a number of shifts shadowing, followed by some sessions of observed practice.

6.8 Treatment rooms in the designated suites were generally clean and tidy. Broadbury Road was in a poor state, with a dirty hand basin and worn floor; at Weston-super-Mare there were no elbow taps on the basin; and at Bath the sharps bin was bloodstained. Staff toilets were sited within the treatment rooms in all suites and some were still in active use by custody staff. The treatment room at Weston-super-Mare was next to the custody desk, with an adjoining door compromising confidentiality both to health care consultations and custody business. At Southmead there was a noisy extractor fan in the treatment room.

6.9 Infection control audits had been conducted on all the suites in April 2012, and actions that required shared interventions had been notified to the force. Some force actions were still outstanding.

6.10 Resuscitation kits and automated defibrillators were now sited in the custody suites, with the exception of Bath, where they remained in the treatment room. Kits were checked and recorded daily through a shared system between custody and nursing staff. There were some gaps in checks and a few missing or out-of-date items in some kits. At Trinity Road, replacement suction tubing had been ordered in November 2011 and had not been replaced, although the checklist showed it as present. Most custody staff had received training in basic life support and use of the defibrillator.

Recommendations

6.11 Appropriate clinical supervision arrangements should be made for all health care staff to ensure that practitioners working in isolation reflect on and enhance their clinical practice.

6.12 There should be a clearly agreed protocol and related audits for the checking and restocking of resuscitation kits, with clear timescales and responsibilities identified.

Housekeeping point

6.13 All health care policies and protocols should be kept up to date.

Patient care

6.14 Detainees were asked whether they wanted to see a health care professional but were not always asked whether they preferred to see someone of their own gender, and the chaperoning arrangements were not clear. There was provision for telephone interpretation, and some health information was available but not in languages other than English.

6.15 The performance monitoring data indicated that the response times for FNPs were good but for FMEs were poor, and could sometimes be up to six hours, particularly at night. We noted a case where the doctor had refused to attend a suite an hour and a quarter before his shift ended and observed one occasion when an FME did not wait to provide a verbal handover to the custody sergeant before leaving the suite. There was a low formal complaint rate (0.5%/68) from the force regarding poor response times from health care staff but many custody staff cited long delays in response times by FMEs.

6.16 We observed FNPs treating detainees politely and respectfully, and some good assessments, with appropriate follow-through actions recorded, although a few were mechanistic. The FME

records we reviewed showed some variation, with some thorough assessments recorded but also some poor-quality records evidencing inadequate assessments.

6.17 Medicines management was generally satisfactory. Diazepam, co-codamol and dihydrocodeine tablets were checked daily or when a nurse visited the suite. We noted a few examples of small variances in stock checks but there had been action to address these.

6.18 There was a range of patient group directions to enable nurses to administer commonly used prescribed medications. Patients' own medications were given to detainees by custody staff after assessment by the FNP, and stock medicines were administered by FNPs using the patient group directions. Controlled drugs were always administered by the FME; the recent change to PACE, enabling nurses to give controlled drugs, had not been implemented at the time of the inspection.

6.19 The health care medicine cabinets were secured using combination digital locks to which only the FMEs and FNPs had access. Several of the custody cabinets for detainees' own medications contained several medications, some dating back a year, with no audit trail. We observed a detainee arrive at Trinity Road with a single buprenorphine (controlled drug) tablet in a blister strip, which was not administered as it was out of its labelled packaging; it was not clear how this was subsequently dealt with by custody staff.

6.20 Refrigerator temperature checks had not been recorded consistently, and room temperatures were often outside the acceptable range for the storage of medication.

6.21 Record keeping was largely compliant with professional guidelines; however, we noted missing dosages on a few records, as well as illegible entries and signatures from medical and nursing staff alike, and a few particularly poor records in which whole fields had been left blank. Monthly sampling audits were conducted by the lead nurse. A brief summary of key issues, including medication, was recorded on NSPIS in addition to a verbal handover to custody staff.

6.22 Clinical records were stored securely in locked filing cabinets, with access only by health care staff, in compliance with Caldicott and Data Protection Act requirements.[4] They were retained in the suite for a month and then stored at the Reliance base. Consent to share information with other staff, including custody staff, was sought and recorded but the mechanism was perfunctory and it was not clear whether detainees fully understood what they were consenting to.

Recommendations

6.23 Response times by forensic practitioners should be reviewed to ensure that detainees receive suitably prompt treatment and do not spend unnecessary time in police custody.

6.24 All health care professionals should record accurately and legibly in the clinical records and on the national strategy for police information systems (NSPIS) in compliance with General Medical Council and Nursing and Midwifery Council standards and codes of conduct.

[4] The Caldicott review (1997) stipulated certain principles and working practices that health care providers should adopt to improve the quality of, and protect the confidentiality of, service users' information.

Housekeeping points

6.25 Health information should be available in a range of languages.

6.26 Forensic medical examiners should always provide a verbal handover to the custody sergeant before leaving the suite.

6.27 Refrigerator temperatures should be checked and recorded regularly and the ambient room temperature maintained at recommended levels for the storage of medication.

Substance use

6.28 Detainees in the Bristol area (Trinity Road, Southmead and Broadbury Road) were served by the integrated CJIT, which provided a regular substance use service; this was also a drug intervention programme (DIP) area (that is, testing was linked to trigger offences).The '*Impact*' programme (part of the DIP process) used a 'traffic light' approach to ensure that detainees across the criminal justice pathway were managed according to the level of risk generated by their substance use status and offence history. There was also an alcohol referral service. Staple Hill was covered by the CJIT but was not a DIP intensive area. Rapid access prescription services were provided to the Bristol suites to enable detainees to receive substitute prescribing. Workers carried out a cell sweep first thing in the morning and regularly reviewed new arrivals on NSPIS during the day, with worker coverage between 7am and 10pm; the DIP operated between 9am and 4.30pm. There was a needle exchange service. Juveniles were referred to the young people's services.

6.29 Turning Point provided services in Somerset, and Addaction for the Weston-super-Mare suite. Turning Point workers carried out morning cell sweeps between Monday and Saturday, before detainees were taken to court. There were needle exchange services at Bridgwater, Taunton and Yeovil.

6.30 At Yeovil there was a specialist alcohol worker as part of a local pilot scheme, with voluntary alcohol testing to inform advice and support for detainees.

6.31 There were plans for DDOs to drug test for trigger offences in Bridgwater, Taunton and Yeovil.

Mental health

6.32 Detainees with indications of mental health problems were assessed firstly by the FNP, then the FME; if appropriate, the detainee was then referred to the local intensive teams or the local authority emergency duty team. This three-stage assessment process often resulted in long delays in custody. FNPs told us that FMEs did not always accept their call to attend detainees, checking with custody staff before accepting the need to come out. There were plans to enable FNPs to make direct referrals to the intensive and emergency duty teams but this had not yet been implemented. Custody staff told us that they had not received training in mental health awareness, although we were told that e-learning material was available.

6.33 When there was a need for assessment out of hours, there were additional delays while waiting for the emergency duty team to respond and getting an approved mental health worker. The clinical records and our observations showed regular delays of up to 12 hours in getting a mental health assessment, especially overnight. We were told of occasions when there was confusion as to which intensive team had responsibility for attending the custody

suite. Only one of the permanent FMEs was an approved section 12 (Mental Health Act) doctor, which could mean a further delay if an assessment under the Mental Health Act 1983 was required.

6.34 There were plans for a trial of mental health nurses to be sited during working hours in three custody suites (Trinity Road, Yeovil and Bath) from Autumn 2012, as part of a nationally funded pilot scheme on dual diagnosis (mental health and substance use).

6.35 In 2011/12, approximately 683 people had been detained under section 136 of the Mental Health Act 1983 across the force area, with a median of 56 per month. Figures supplied by the force suggested a possible trend of more such detainees being taken to a section 136 suite and fewer to a police station, which would be encouraging. However, clinical records showed that four detainees had been brought into police custody under section136 in the week before the inspection, and during the inspection at least three detainees were brought into police custody under section 136, pending a mental health assessment; the number of detainees taken into police custody, rather than a place of safety, thus still appeared to be high.

6.36 In Somerset, there were section 136 suites at Yeovil (Rowan Ward) and Taunton (Rydon Ward) for a population of approximately 350,000. There was an agreed protocol between the force and Somerset Partnership Trust; this was a live document reflecting ongoing changes for each organisation. Both suites had strict admission criteria, excluding detainees with any indication of alcohol consumption and/or violence and aggression. Yeovil operated a policy of alcohol testing before admission.

6.37 In Avon, one section 136 suite at Callington Road Hospital (AWP) served a population of approximately 1.2 million; the space was often full, which meant that people detained under section 136 were regularly brought into police custody. There was an agreed protocol between the force and AWP for admission to the suite, with some discretion regarding judgement as to violence and alcohol status. There were plans for a multi-stakeholder meeting in September, bringing together NHS commissioners, NHS providers, Reliance, the local authority providers and the police force.

Recommendations

6.38 There should be a clearly agreed pathway and process for health referrals and assessment, starting with arrival in police custody, identifying the roles and responsibilities of custody staff and health care staff.

6.39 Delays in mental health assessments should be reviewed in both Avon and Somerset and action taken to reduce the long delays for detainees waiting for assessment and decisions.

6.40 Current provision of section 136 suites and criteria for admission should be reviewed to reflect the new guidance agreed between the Association of Chief Police Officers and the Department of Health, population density and geography, to prevent people with mental health problems being detained inappropriately in police custody.

7. Summary of recommendations

Main recommendations

7.1 The force should implement its decision to reorganise management structures to ensure the corporate and consistent care and welfare of detainees. (2.23)

7.2 The risk assessment, care planning and observation level process should be monitored to ensure its consistency. (2.24)

Recommendations

Strategy

7.3 Avon and Somerset Police should review its continued use of its eight non-designated police custody facilities to ensure they provide a consistently safe and decent environment for detainees. (3.9)

7.4 The force should include cross-referencing of custody record dip-sampling, person escort record checking and monitoring of handovers as part of its quality assurance regime. (3.10)

7.5 The force should implement its plans to provide structured custody training for DDOs before their deployment in custody. (3.17)

7.6 The force should implement its plans to introduce regular custody refresher training. (3.18)

Treatment and conditions

7.7 The force should work with partner agencies to ensure that cellular vehicles are clean and have sufficient space for detainees' property, with women and men kept separate. (4.8)

7.8 The closed-circuit television system should effectively obscure the toilet area in cells in Trinity Road. (4.9)

7.9 Staff should be trained to recognise and provide for the individual needs of detainees, particularly those who are vulnerable, juveniles and women. (4.10)

7.10 There should be appropriate cells that meet the needs of older detainees and those with mobility difficulties. (4.11)

7.11 Closed-circuit television should provide sufficiently clear images at all custody suites. (4.22)

7.12 Shift handovers should involve all staff on duty and, wherever possible, should be recorded. (4.23)

7.13 Pre-release risk assessments should be of consistent quality and should be subject to dip-sampling. (4.24)

7.14 Avon and Somerset Constabulary should collate use of force data in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.28)

7.15 A programme of regular deep cleaning should be established, and broken, inappropriate or insanitary equipment should be replaced. (4.35)

7.16 Cell call bells should not be permanently muted and should be responded to promptly. (4.36)

7.17 Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them, and custody staff should be aware of who is in the custody suite. (4.37)

7.18 Blankets and pillows should be routinely provided to all detainees. (4.47)

7.19 All detainees held overnight, or who require one, should be offered a shower. (4.48)

7.20 Detainees held for long periods should be offered outside exercise and the exercise yards should be fit for purpose. (4.49)

7.21 Visits should be facilitated for detainees held for long periods, particularly if they are vulnerable. (4.50)

Individual rights

7.22 Information about detainees' rights and entitlements should always be available in a range of formats that meet specific needs. (5.10)

7.23 There should be two-handset telephones in all suites to facilitate telephone interpreting. (5.11)

7.24 Avon and Somerset Constabulary should work with the local authority to ensure the provision of beds for juveniles who have been charged but refused bail to appear in court. (5.12)

7.25 Avon and Somerset Constabulary should work with HM Court and Tribunal Service to ensure that early court cut-off times do not result in unnecessarily long detentions in custody. (5.19)

7.26 Detainees should be able to make a complaint about their care and treatment, and be able to do this before they leave custody; data about complaints should be monitored to identify and act upon any trends. (5.21)

Health care

7.27 Appropriate clinical supervision arrangements should be made for all health care staff to ensure that practitioners working in isolation reflect on and enhance their clinical practice. (6.11)

7.28 There should be a clearly agreed protocol and related audits for the checking and restocking of resuscitation kits, with clear timescales and responsibilities identified. (6.12)

7.29 Response times by forensic practitioners should be reviewed to ensure that detainees receive suitably prompt treatment and do not spend unnecessary time in police custody. (6.23)

7.30 All health care professionals should record accurately and legibly in the clinical records and on the national strategy for police information systems (NSPIS) in compliance with General Medical Council and Nursing and Midwifery Council standards and codes of conduct. (6.24)

7.31 There should be a clearly agreed pathway and process for health referrals and assessment, starting with arrival in police custody, identifying the roles and responsibilities of custody staff and health care staff. (6.38)

7.32 Delays in mental health assessments should be reviewed in both Avon and Somerset and action taken to reduce the long delays for detainees waiting for assessment and decisions. (6.39)

7.33 Current provision of section 136 suites and criteria for admission should be reviewed to reflect the new guidance agreed between the Association of Chief Police Officers and the Department of Health, population density and geography, to prevent people with mental health problems being detained inappropriately in police custody. (6.40)

Housekeeping points

Strategy

7.34 The force should review the use of acting sergeants as custody sergeants and the use of police constables as gaolers. (3.11)

7.35 The force should introduce a forum where custody practitioners and managers can discuss custody issues, to enable them to contribute to the change process. (3.12)

Treatment and conditions

7.36 A hearing loop should be available in the booking-in area and all custody staff should be made aware of how to operate it. (4.12)

7.37 Each suite should have a range of items necessary for religious observance, which should be stored respectfully. (4.13)

7.38 Detainees being released should be offered a leaflet about support agencies. (4.25)

7.39 Daily cell checks should be undertaken and accurately recorded. (4.38)

7.40 Toilet paper should be routinely provided in each cell. (4.51)

7.41 Hygiene packs should be routinely offered to female detainees. (4.52)

7.42 Replacement underwear should be available at all suites. (4.53)

7.43 Meals should be offered to all detainees at regular mealtimes and at other times according to individual need. (4.54)

7.44 Reading materials suitable for a range of detainees, including young people, those whose first language is not English and those with limited literacy skills, should be made available. (4.55)

Health care

7.45 All health care policies and protocols should be kept up to date. (6.13)

7.46 Health information should be available in a range of languages. (6.25)

7.47 Forensic medical examiners should always provide a verbal handover to the custody sergeant before leaving the suite. (6.26)

7.48 Refrigerator temperatures should be checked and recorded regularly and the ambient room temperature maintained at recommended levels for the storage of medication. (6.27)

Good practice

Individual rights

7.49 The force required juveniles aged 17 to be represented by an AA, especially if it was their first time in custody or they appeared to be vulnerable. (5.13)

Appendix I: Inspection team

Martin Kettle	HMIP team leader
Gary Boughen	HMIP inspector
Gordon Riach	HMIP inspector
Vinnett Pearcy	HMIP inspector
Peter Dunn	HMIP inspector
Ian Thomson	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Paul Eveleigh	HMIC inspector
Martine Moore	HMIC inspector
Rob Bowles	HMIC inspector
Nicola Rabjohns	HMIP health care inspector
Andy Brand	CQC inspector
Alice Reid	HMIP researcher