Report on an unannounced inspection visit to police custody suites in West Yorkshire

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by

HM Inspectorate of Prisons and

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Contents

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 United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention[1]. The inspections look at strategy, treatment and conditions, individual rights and health care.

This inspection of police custody suites in West Yorkshire was the first time we had gone back to a force we had previously inspected. We found significant improvement.

The force had excellent arrangements in place for the strategic management and leadership of its custody provision. Custody was managed on a day to day basis by divisions but there was strong proactive oversight by the force. This was enhanced by a programme of unannounced inspections by the headquarters custody services department and the operation of a well organised custody visitors scheme. The responsible assistant chief constable and police authority member had worked effectively together to address concerns we identified at our last inspection and initiate further improvements. There was a clear and very positive estates strategy. Overall, the strategic management of the custody provision in West Yorkshire was a model from which other forces might usefully learn.

Against this largely positive backdrop, we did identify some concerns which we hope the force will address. Some cells in the Leeds Bridewell were used for court detainees held by G4S. The same cells were routinely used by the police when the court was not operating. We had no remit to formally inspect the court cells and so could reach no definitive conclusion, but from observation they appeared in worse condition than the cells used solely for police detainees. It did not appear to us that ultimate responsibility for the court cells was clear and the force needed to ensure its own responsibilities were not affected by any shortcomings in the court custody arrangement or facilities.

In the police custody estate, generally good arrangements were not sufficiently tailored to any detainee who had special needs. For instance, we were troubled to encounter one 14-year-old, a frequent visitor to the Leeds Bridewell, who was processed as an adult and then held, protesting, in an observation cell a long way from the booking in desk. He was moved when he blocked the toilet and flooded the cell. Risk assessments as a whole were inconsistent in quality.

As in any force, police custody in West Yorkshire was too often the solution of last resort for individuals who would be better dealt with by other agencies. In particular, the force, as 'a place of safety', held a large number of people under section 136 of the Mental Health Act. This was not appropriate and arrangements to divert people with mental health problems from the criminal justice system were also underdeveloped. We hope the force will be successful in its efforts to work with the relevant health bodies to address this issue.

Despite these challenges, overall custody provision in West Yorkshire had improved. The physical condition of the custody suites had improved and they had been made safer. While some issues remain, the estates strategy should lead to further improvement. Staff treated

[1] Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

detainees professionally and respectfully. There was a positive approach to balancing the priorities of progressing investigations against the rights of detainees. Health care was generally good.

Police custody in West Yorkshire has much improved and in some areas provides a model to other forces. Its weaknesses often occur where it is reliant on others for the provision of services or joint responsibilities. We hope this report will help the force resolve these concerns.

Sir Denis O'Connor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

May 2011

2. Background and key findings

2.1 HM Inspectorates of Prisons and Constabulary have a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections 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* 2006 (SDHP) guide, and focus on outcomes for detainees. They are also informed by a set of *Expectations for Police Custody*[2] about the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice.

2.2 At the time of this unannounced inspection, West Yorkshire Police had 10 custody suites designated under PACE for the reception of detainees, operating 24 hours a day. These dealt with detainees arrested as a result of mainstream policing; we visited them all during the inspection. A further two custody suites were temporarily closed for refurbishment. At the time of the inspection, the force had a cell capacity of 227, although this was reduced when 20 cells at Leeds Central Charge Office (CCO) were used by the on-site magistrates' court. In the year to February 2011, 87,898 detainees had been held. In the same period, 744 detainees had been held for immigration matters.

2.3 The designated suites and cell capacity of each was as follows:

Custody suite	Number of cells
Weetwood, Leeds	10
Stainbeck, Leeds	34
Leeds CCO (Bridewell)	57
Ossett	4
Pontefract	10
Wakefield	15
Huddersfield	16
Bradford CCO	34
Keighley	33
Lawcroft House, Bradford	14
Dewsbury (closed for refurbishment)	17

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

Calderdale (closed for refurbishment)	21

2.4 Police custody cells in West Yorkshire had previously been inspected between 27–29 October 2008 and a report subsequently published. Comments in this report refer to all suites, unless specifically stated otherwise.

Strategic overview

2.5 There was strong strategic leadership of custody provision. An assistant chief constable (ACC) and the lead police authority (PA) member for custody had taken responsibility for responding to the recommendations made in the 2008 police custody inspection report. There was a clear, funded, ongoing estates strategy to enhance facilities and reduce the overall number of suites.

2.6 There was central oversight of custody but it was managed day to day in the policing divisions. Each suite had a custody manager, who reported to a chief inspector. Line management arrangements varied between suites. Staff working in custody were permanent and training arrangements were good. Staffing levels were adequate but there were delays in custody pre-booking-in processes and detention officers (DOs) did not move between the suites in response to fluctuations in demand.

2.7 The PA was appropriately challenging and involved in custody issues. There was a single independent custody visitors (ICV) scheme, which worked well.

2.8 The excellent themed visits programme was in abeyance during the estates refurbishment but was due to resume shortly. A range of local quality assurance arrangements were in place, although they were mainly ad hoc. There was a good central repository of 'learning the lessons' information available to staff, although some of this was not utilised effectively.

2.9 There was limited governance of use of force.

Treatment and conditions

2.10 Staff treated detainees respectfully and professionally. Awareness of a range of diversity issues was limited, including the needs of children in custody. Poor privacy was an issue in most suites, and in some inadequate management of the traffic in the custody area contributed to this.

2.11 The quality of the risk assessment carried out on arrival in custody was mixed. Risk management was appropriately cautious. A new care and management plan had recently been introduced. Some shift handovers were inadequate. Some staff said that they would consider doubling up detainees in cells if suites were full.

2.12 Physical conditions in custody suites varied greatly; most, but not all, were clean and free of graffiti. Cells used by the court service at Leeds CCO were particularly poor. Some cells contained ligature points, although far fewer than at the time of the previous inspection. Fire evacuation procedures were known and staff routinely explained the use of cell call bells.

2.13 Some elements of detainee care were by request only – for example, showers, toilet paper and outside exercise. Food provided was mainly adequate, although not for detainees held for longer periods.

Individual rights

2.14 There was a positive approach to balancing the priorities of progressing investigations with the rights of detainees, and a good focus on alternatives to custody. Custody was not used as a place of safety for children but secure local authority accommodation (PACE remand beds) was not available. PACE was adhered to and information was provided to detainees about their rights and entitlements during detention.

2.15 Detainees were not routinely asked if they had any dependency obligations, and pre-release risk assessments (PRRAs) were at best basic. A new system had recently been introduced to improve the quality of PRRAs.

2.16 A large number of detainees were held for immigration matters and the UK Border Agency (UKBA) sometimes took a long time to deal with them. There was no force-wide appropriate adult (AA) scheme, and arrangements were poor. Some court cut-off times were too early.

2.17 Arrangements for the taking and storage of DNA and forensics were good. Detainees were not told how to make a complaint, and when they requested to do so the procedures were not sufficiently clear.

Health care

2.18 Health care provision had improved. There was good strategic management of health and well-developed arrangements between the police and most providers. A good level of care was provided, although there were sometimes response delays.

2.19 Medical rooms and facilities throughout the force varied greatly. Defibrillators were not checked daily. The management of medications was good, and police took steps to ensure that prescribed medications were made available to detainees.

2.20 Substance use services were well developed and included support for alcohol-related issues. Symptomatic relief for substance users was available when needed.

2.21 There were no mental health diversion services operating and far too many people with mental health problems were held in police custody under section 136 of the Mental Health Act (1983).[3]

Main recommendations

2.22 West Yorkshire Police should ensure that ultimate responsibility for court detainees held by G4S and the condition of the cells shared between the force and G4S in the Leeds Bridewell is completely clean and detainees for whom the force has responsibility are not put at risk by weaknesses in the G4S arrangements.

[3] Under sections 135 and 136 of the Mental Health Act 1983 (the 1983 Act) a police officer may remove a person who is believed or appears to be suffering from a mental disorder to a place of safety. Section 44 of the 2007 Act amends these sections of the 1983 Act to allow a person to be taken from one place of safety to one or more other places of safety during the 72-hour maximum overall period during which they may be detained under either of these two sections. They may be taken between places of safety by a police officer, an approved social worker (until approved social workers are replaced in this role by approved mental health professionals in due course) or someone authorised by either of them.

2.23 There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities or religious needs, and custody staff should be trained to recognise these differing needs.

2.24 Risk assessments should be thorough and provide the opportunity for detainees to raise any relevant issues, and resulting care plans should reflect all the relevant information and be revised when circumstances change.

2.25 Police custody should only be used as a place of safety for Section 136 assessments in exceptional cases, and mental health diversion support should be more readily available.

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.

3.1 An ACC provided strong strategic leadership on custody issues and also sat on the Local Criminal Justice Board, which was chaired by the deputy chief constable. The force operated a devolved custody model, with provision being managed locally across eight divisions, with intrusive oversight and support from headquarters (HQ). A chief superintendent led the criminal justice department at HQ, within which a well-staffed custody services department, managed by a chief inspector, had responsibility for custody policy.

3.2 The force had a clear estates strategy, with the intention of moving from 13 main suites to nine by the end of July 2011. The force had made a large investment in upgrading the custody estate. At the time of the inspection, two of the suites (Calderdale and Dewsbury) were closed for refurbishment and two standby suites (Ossett and Lawcroft House) were being used in the interim. In the longer term, the force planned to build two purpose-built custody suites to replace Wakefield, Pontefract and Leeds CCO. It was anticipated that these new suites would be operational in 2014.

3.3 The force had been proactive in looking for alternatives to custody (for example, the use of community resolution) and, although the number of detainees going through custody was still high, custody throughput had dropped considerably over the preceding five years.

3.4 There was a proactive PA lead for custody. She was well engaged with the estates strategy and had oversight of the ongoing refurbishment programme. She had carried out several unannounced visits to custody suites with the ACC to check on conditions. There had been some excellent and detailed work to address the recommendations made after the previous custody inspection, and the ACC and PA had supported this process, with a clear strategic focus on continuous improvement.

3.5 Staffing levels in custody suites were good, comprising permanent custody sergeants and DOs, who looked after the ongoing care and welfare of detainees and who were trained to input detainees' details onto the NICHE custody computer system, overseen by the custody sergeant. We found a mixture of practices, with sometimes DOs and at other times the custody sergeant booking detainees into custody. Police constable (PC) gaolers were rarely used.

3.6 There were regular bottlenecks when booking detainees into custody, with officers and detainees often having to wait in holding areas. Arresting officers also reported dissatisfaction with these delays.

3.7 There was no flexibility to allow DOs to be moved between custody sites in response to demand. As a result, there was greater potential for police officers to be abstracted from frontline duties to act as gaolers.

3.8 Custody managers (who were inspectors) were in place in all the suites and, with the exception of Keighley, were full time in the role. Custody managers reported to a divisional chief inspector, who had custody responsibility. Line management of custody staff varied, with some being managed by the custody manager (for example, at Leeds CCO) and others by response team supervisors.

3.9 There was a PA lead for the active and well-supported ICV scheme, which was seen as an important independent oversight mechanism. The scheme was made up of just one panel, which was administered by the PA. ICVs regularly visited different custody suites across the force area, which they felt gave them a better overview of conditions. The PA held regular meetings for ICVs, with police (including the ACC) in attendance.

3.10 There was an excellent custody services-led thematic inspection programme, with unannounced visits to each custody suite annually. These included examination of working practices, identification of good practice, interviews with staff to check their knowledge of policies and procedures, and examination of physical conditions. They typically took place over a two-week period, which ensured that staff across all five shifts were interviewed. Following the visits, divisions were provided with a full report and, where appropriate, an action plan for which they were held to account by the ACC and PA. At the time of the inspection, these visits were in abeyance because of the custody refurbishment programme but were due to resume once this had been completed in summer 2011.

3.11 There was a centrally managed process for recording near-miss incidents in custody, with reports being collated and analysed by custody services. Where appropriate, custody services ensured that the NICHE custody computer system and Police National Computer (PNC) data were correct and entered the information about the incident onto a database, along with actions taken. When there was information for dissemination, this was done through the custody bulletins and training days.

3.12 All custody sergeants and DOs had received role-specific custody training, and regular refresher training thereafter. The force had recently introduced a four-day training course for PC gaolers. First-aid training was delivered to custody staff and refreshed annually. All staff working in custody also received regular refresher training in personal safety.

3.13 The force had comprehensive custody procedures, with policies easily accessible to all staff via the force computer system. Custody services maintained an excellent central repository on their intranet webpage, containing custody-related information, including policies, guidance and Independent Police Complaints Commission (IPCC) 'learning the lessons' bulletins. The website was accessible, easy to navigate and regularly updated. Custody staff knew where to access information and used the site regularly. However, the site was not being used optimally (see paragraph 5.5). Regular custody bulletins were produced by custody services, highlighting relevant issues. This information was also delivered during custody training days.

3.14 We found little evidence that custody inspectors carried out regular and formal quality assurance checks, such as the dip-sampling of custody records or closed-circuit television (CCTV) recordings. The approach to dip-sampling was inconsistent and in places ad hoc. Custody services had provided divisions with guidance for this but it was not being followed.

3.15 The central recording of use of force had been discontinued just before the inspection. However, there had been little governance of the use of force, even when it was being recorded, with no management information about the type of force being used, by whom or where.

3.16 Ultimate responsibility for the safety of court detainees held by G4S in the Leeds Bridewell lacked sufficient clarity. The condition of these cells, which were also used by the force, was worse than those used solely by the force and responsibility for addressing this was also unclear.

Recommendation

3.17 West Yorkshire police should collate the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance.

Housekeeping point

3.18 Custody record dip-sampling should be carried out consistently across the force.

Good practice

3.19 *The unannounced thematic custody inspections provided an excellent quality assurance process, identifying good practice and raising standards.*

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 With the exception of those attending at the custody suite by appointment, most detainees we observed arriving were transported to the custody suite by police car, with some brought under escort by G4S. The cars and vans that we inspected were clean.

4.2 All custody suite staff we observed were respectful in their approach to detainees, and the use of first names was the norm. DOs had built up a rapport with some detainees who had been in custody for several hours or on previous occasions. However, most custody staff appeared to use a 'one size fits all' approach to booking in detainees, failing to recognise adequately the particular needs of some individuals and groups.

4.3 None of the suites had an area suitable for booking in detainees with disabilities. There was a film using sign language available on the West Yorkshire Police intranet, to assist deaf detainees with the booking-in process. No suites had any cells adapted for detainees with disabilities, and there were no hearing loops or information available in Braille although we were told that during the week of the inspection these had been provided in all the custody suites. We were shown one cell with a door wide enough to accommodate a wheelchair but the interior of the cell was the same as that of the other cells. Staff told us that retention of a wheelchair or walking aid in-cell was subject to risk assessment. At Stainbeck and Bradford CCO there were toilets adapted for detainees with disabilities.

4.4 There was some provision for faith needs, such as prayer mats, the Qur'an and the Bible, but these were rarely issued. Records at Huddersfield indicated that they had been issued only five times in the previous four months. There was no indication of the direction of Mecca in any cells we examined, except at Bradford CCO, where it was shown by an arrow on the ceiling. At Keighley, a compass was available for this purpose.

4.5 Staff told us that, although they received no specific training about safeguarding children, they were mindful of its importance, referring, when necessary, to the police divisional safeguarding team. Other than understanding the significance of AAs, we could find few examples demonstrating staff awareness of the particular needs of children. We observed the booking in of a 15-year-old boy, during which the custody officer simplified the language used, to ensure that he understood the process. However, at Leeds CCO, we saw a 14-year-old boy detained and processed in the same manner as an adult, and most staff we asked told us that this would be the approach normally adopted. Although all custody suites had juvenile detention rooms located near the custody desk, juveniles at Leeds CCO, Stainbeck, Weetwood and Bradford CCO could be held in cells which were some distance away from the booking-in area.

4.6 The suites at Leeds CCO, Wakefield and Keighley each had cells designated for females but such detainees were not routinely offered the opportunity to speak to a female member of staff when they were booked in.

4.7 The booking-in areas at most suites were busy, crowded and sometimes chaotic. At Leeds CCO and Weetwood, the two booking-in desks afforded little privacy for people to disclose personal information. At Huddersfield, although staff attempted to manage the congestion in the booking-in area by processing detainees one at a time using a queuing system in the holding area, it remained excessively noisy. At Lawcroft House, the suite felt chaotic when it became busy, with the custody sergeant attempting to cover a wide range of tasks, including responding to cell call bells and taking telephone calls. The booking-in area at Keighley offered more space and more privacy, and similar to Stainbeck and Bradford CCO, there was an additional private booking-in cubicle which could be used for detainees who needed an enhanced level of privacy. The other suites did not offer this facility. Staff told us that they were usually told in advance of the imminent arrival in custody of anyone who was especially disruptive, so that they could clear the booking-in area in preparation for his or her arrival.

Recommendation

4.8 Booking-in areas should provide sufficient privacy to facilitate effective communication between staff and detainees.

Good practice

4.9 *The private booking-in cubicle at Keighley offered detainees an enhanced level of privacy.*

Safety

4.10 All detainees being booked in were subject to a risk assessment by custody staff, using prompts from the NICHE computer system. The quality of risk assessments we observed was mixed and some showed that staff had made few attempts to solicit further information when concerns were raised. Assessments were often hurried, especially at busy times. By contrast, at Wakefield and Bradford CCO, we saw detainees being encouraged by staff to provide full information. However, staff made use of previous risk assessments and on one occasion we observed a custody officer using previous records to appropriately challenge a detainee's responses.

4.11 Some written care plans lacked important information and were not always updated as detainees' circumstances or risk assessments changed.

4.12 The arrangements for managing detainees with an identified risk were proportionate. CCTV covered all communal areas and some cells. It was not misused as a substitute for personal checks and interaction with detainees. Recordings were kept for three months. At some suites, such as Weetwood and Lawcroft House, the monitoring screens were visible from the booking-in desk but not monitored regularly.

4.13 Staff had received training on suicide and self-harm prevention. Monitoring of those at risk of self-harm involved four levels of observations, which had been introduced recently. Not all staff were familiar with the new requirements but appeared to understand how to manage detainees who were at risk. Staff we spoke to knew how to check detainees and use proper rousing to elicit responses. However, at Wakefield we observed one DO failing to gain a response from an intoxicated detainee. Not all staff we spoke to had looked at the 'learning the lessons` reports that were readily accessible on the intranet. All custody staff carried anti-ligature knives.

4.14 Staff handovers at most suites were well conducted and addressed to both custody sergeants and DOs, but at Leeds CCO and Wakefield they were less satisfactory. At Leeds CCO, the handover was thorough but took place only between custody sergeants. A written proforma was in use there but at a handover we observed, one detainee's personal details had been mistakenly copied and pasted into another's record, and officers failed to notice this. At Wakefield, a handover took place in the presence of police officers waiting to interview detainees. The officers chatted among themselves throughout the process. As well as signalling a lack of respect for the handover process, this may have prevented staff from hearing important personal information about detainees.

4.15 We observed no sharing of cells and staff told us that this had not happened for several months. At some suites, custody sergeants told us that they would double-up cells. Cells were not equipped for more than one person for an extended period and one of the detainees in a shared cell would have to sleep on a mattress on the floor. We were told that mattresses were available for this purpose. Custody sergeants told us about the risk assessment they would carry out before authorising a cell share. The practice of placing two or more persons in a cell is deemed acceptable under certain conditions and restrictions and is not a common event.

Recommendation

4.16 Handovers should be comprehensive, and attended by detention officers and police custody staff, with the area in which the handover takes place cleared of other personnel.

Use of force

4.17 All custody staff had been trained in approved use of force techniques, received regular refresher training and saw use of force as a last resort. They carried handcuffs and some also had leg restraints but we were told that the latter were rarely used. Staff assured us that incapacitant sprays would not be used in custody suites. There is a policy on the use of Tasers in custody, although no member of staff could recall the use, or threat of use, of a Taser. We saw staff at Keighley encouraging a disruptive detainee to return to his cell rather than using force, and most custody sergeants we spoke to were able to give examples of when they had successfully calmed down a detainee.

4.18 We were assured that all detainees subject to use of force would be examined by a qualified health care professional as soon as possible.

4.19 Not all detainees arrived in custody were wearing handcuffs and, of those who did, they were usually removed on arrival. This was not the case at Leeds CCO, where it was policy for all detainees to be handcuffed before entering the holding area – even when they were compliant and when they were brought to the police station without handcuffs.

Recommendation

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

Physical conditions

4.21 An extensive programme of custody suite refurbishment was in progress during the inspection, resulting in temporary closure of suites and the short-term use of some previously closed suites. We visited all operational custody suites to examine the physical conditions. The force had clearly been proactive in maintaining their custody suites and eliminating ligature points in cells, although we identified minor ligature points in some cells. The quality and condition of cells were variable.

4.22 Daily cleaning of communal areas and cells took place and staff were positive about the 24-hour callout service for deep cleaning. If the cleaner was not available, staff would mop floors to keep cells in use. There were 20 cells at Leeds CCO used by G4S to hold court detainees. These contained considerably more graffiti than those used solely for police custody. The Pontefract, Stainbeck, Bradford CCO, Keighley and Lawcroft House suites were in a good condition, light and clean but the Huddersfield and Weetwood suites were shabby and dull, with several cells containing a large amount of graffiti, and some with stains on the walls and ceilings, which appeared to be the result of food, drink or bodily waste being thrown about and not cleaned up. The Huddersfield and Weetwood suites were due to be closed, the former for refurbishment and the latter permanently, within a few weeks of the inspection. Ossett had just four cells and was being used temporarily while Dewsbury was closed. The cell area there was clean and the cells free of graffiti but the whole area was cramped and dull. It was apparently intended only for detainees being held briefly but we found two detainees there who had already been in custody for 12 hours and were likely to remain there longer. Cell temperatures were generally good but some cells were cold in Leeds CCO, Bradford CCO and Weetwood. At Leeds CCO, we spoke to a detainee who was shivering with cold and had not been offered a blanket.

4.23 Staff in custody suites were expected to carry out daily checks to identify health and safety or maintenance issues. We found that, although checks were being done, there were inconsistencies between custody suites and staff did not see them as a high priority. The quality of the recording of the checks was inadequate. For example, Huddersfield had a daily health and safety cell check system but although records showed that checks were done daily, there was no information about what was checked and it was not clear how remedial work was noted or actioned. No such record was available at Ossett or Pontefract, although these suites had a health and safety cell check policy.

4.24 There was a strict no-smoking policy in all the custody suites and nicotine replacement was not available. There were fire evacuation plans, along with records of fire alarm test and drills. Staff received regular training in fire and evacuation procedures and knew what to do in the event of a fire. Procedures to follow were accessible in all the suites, as were plastic flexi-cuffs for use in an evacuation. Practice evacuations were not frequent but had taken place at some suites.

4.25 All cells were equipped with call bells and some incorporated an intercom. Staff explained their use to detainees and we saw call bells responded to reasonably promptly. At Lawcroft House, staff struggled to see the dimly illuminated display on the cell call bell panel, which could have put vulnerable detainees at risk.

Recommendations

4.26 West Yorkshire police should address the safety issues around ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed.

4.27 Health and safety walk-through arrangements should be thorough and applied consistently at all custody suites. Records of these checks should be maintained.

4.28 Cells should be clean, free of graffiti and properly heated and ventilated, and the particular issues with cells at Leeds CCO being used by the court should be addressed.

Housekeeping point

4.29 The display on the cell call bell panels should be adequately illuminated.

Personal comfort and hygiene

4.30 All cells contained a mattress but they were not always wiped down between uses. They were in reasonable condition and adequate stocks were held. There were no pillows, although a supply had been ordered. Blankets were plentiful and laundered between uses but were not provided routinely to detainees at all the suites.

4.31 With the exception of Pontefract, there was a good supply of hygiene packs for women. Female DOs said that they would inform women that these were available but male officers did not always appear to do so.

4.32 All cells, except the juvenile detention rooms, had toilets but in most suites no washbasins. CCTV coverage of the toilet area was obscured by pixellation. At most suites, toilet paper was provided only on request.

4.33 It appeared that showers were rarely used. At Ossett and Pontefract, they were used as storage areas and, when tested, were cold. Two detainees, who had been in custody for almost 48 hours, told us that they had not been offered a shower. In our custody record analysis, only two out of 30 detainees had had a shower. Sinks were available in corridors for detainees to wash or clean their teeth. We saw detainees ask to use them and this was facilitated. Clean towels were available. In Huddersfield, we were told that showers were offered more regularly and we found them to work efficiently and deliver hot water. At Keighley, the showers were clean but the screening was unsatisfactory, providing little privacy.

4.34 All suites had a good selection of alternative clothing, such as track suits, T-shirts, underwear, slippers and plimsolls. Paper suits were also available but we were told that these were seldom used, although we saw one detainee on constant watch in Huddersfield wearing one. Staff told us that they normally accepted clothing brought in by family members.

Recommendation

4.35 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private.

Housekeeping points

4.36 Mattresses should routinely be wiped down after use.

4.37 All detainees should be offered a pillow.

4.38 All detainees should be routinely provided with blankets.

4.39 All female detainees should be offered a hygiene pack on arrival.

4.40 Subject to risk assessment, toilet paper should be provided in each cell.

Catering

4.41 There was a good stock of a range of microwave meals, including halal and vegetarian options. These were issued at recognised mealtimes and when requested. However, their calorific content was low and most detainees told us that they disliked them. Staff said that they could not accommodate individual requests for alternative meals. We observed food being withheld at lunchtime from a detainee who had earlier thrown a hot drink at a DO. The detainee could have been provided with a cold snack. At Wakefield and Keighley, family and friends were able to hand in sandwiches that had been purchased in sealed containers but this rarely happened.

4.42 Custody records we looked at showed that 24 detainees (80% of cases) had been offered at least one meal while in custody. Six detainees had not been offered a meal while in custody, even though one of them had been in custody for more than six hours.

4.43 Water and hot drinks were provided on request. DOs had had basic food hygiene training. Probes were used to test the temperature of microwave meals but records were not kept at all suites.

Recommendation

4.44 Food offered to detainees should be of sufficient quality and calorific content to sustain them for the duration of their stay.

Housekeeping point

4.45 The serving temperature of microwave meals should be recorded in each instance.

Activities

4.46 Exercise was rarely, if ever, offered. At Pontefract, there was no such facility, as the exercise area had recently been built over to provide the new holding area. At Huddersfield, there was a large exercise yard but it was considered unsafe and could be used only if the detainee was constantly supervised; we were told that staff rarely had the time to supervise exercise. Detainees we met at Pontefract who had been in custody for 48 hours had not had access to the open air.

4.47 All suites had a minimal supply of books and magazines. There was nothing available in foreign languages or suitable for teenagers. Most detainees told us that they had not been offered anything to read. Visits to detainees from family members were not encouraged because of the lack of facilities.

Recommendation

4.48 Detainees held for long periods should be offered outside exercise.

Housekeeping points

4.49 The stock of reading materials should be improved, to cater for the specific needs of detainees who are young, non-English speakers or who have limited literacy.

4.50 Visits should be allowed, where appropriate, particularly for juveniles and those detained for long periods.

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 checked that detention was appropriate before authorising it. They were aware of initiatives to promote alternatives to custody and believed that these provisions were being used by patrol officers. West Yorkshire Police had recently started using a form of restorative justice known as 'community resolution' and staff were encouraged to use this wherever possible. In addition, the use of voluntary attendance at police stations was also encouraged. A large number of detainees were held for immigration matters. There were good relationships with UKBA and custody staff usually knew when an operation might result in an influx of foreign national detainees. We were told that some immigration detainees waited several days to be collected. The average time in custody for immigration detainees was just over 25 hours, although records showed that at least one person had been detained at Huddersfield for four days.

5.2 There was no evidence that suites were used as a formal place of safety for children and young people under section 46 of the Children Act 1989.[4] Staff said that it was impossible to obtain PACE remand beds for juveniles, resulting in some juveniles being kept in custody overnight.

5.3 A telephone interpreting service was available and used during booking in and risk assessment. Other than at Keighley, a telephone handset had to be passed between custody staff and the detainee, which was cumbersome. All detainees were offered a leaflet outlining their rights and entitlements in English and other languages. Custody sergeants told us that when interpreters attended for interviews, they asked them to go through the detainee's rights again. We saw examples of interpreters attending on request. There were no notices displayed in languages other than English in any of the custody suites, except at Keighley. We observed a poorly managed booking in of a foreign national woman at Lawcroft House. She appeared to speak English sufficiently well to understand the process but the DO, custody sergeant and the UKBA officer who had arrested her all fired questions at her simultaneously. She became tearful and appeared confused and distressed by this.

5.4 Detainees were told that they could inform someone of their whereabouts. The staff we observed did not enquire about possible dependency obligations. When we queried this, they told us that they believed female detainees would volunteer information about dependants. One custody sergeant expected arresting officers to have dealt with any caring or dependency obligations before bringing the detainee into the custody suite. Detainees' concerns about this issue were not recognised as risk factors that could affect their behaviour or well-being while in custody.

[4] 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 there.

5.5 A toolkit for undertaking pre-release risk assessments (PRRAs) was available on the intranet but it was not widely used. The PRRAs completed by staff were superficial, confined to asking detainees if they were going to self-harm on release, and then telling them that there were agencies that could help them.

Recommendations

5.6 West Yorkshire Police should engage with the local authority to ensure the provision of secure beds for juveniles who have been charged but cannot be bailed to appear in court.

5.7 Two-handset telephones should be installed, so that interpreting by telephone can be conducted efficiently and privately.

5.8 PRRAs should be meaningful, with enquiries made about the detainee's risk to self and to others. When concerns are highlighted, full information should be given about sources of help.

Rights relating to PACE

5.9 PACE was adhered to well. Reviews of detention were timely and appropriate, involving face-to-face contact with the detainee, mostly on a one-to-one basis, although some were undertaken when the detainee was asleep. Although all custody suites had an up-to-date copy of the PACE codes of practice available, and all detainees were told of their right to read it, it was not shown to detainees in all suites.

5.10 Some staff told us that there was a 'lift and dump' culture. It was claimed that arresting officers were under pressure to return to operational duties quickly and were encouraged to hand over the processing of all cases to specialist units. Some custody staff expressed concerns that this had led to detainees being held in custody for longer than necessary.

5.11 Our custody record analysis showed that legal rights were given on arrival and at reviews of detention. However, it was not recorded whether three foreign national detainees had been told their rights. Detainees were offered legal advice through the duty solicitor scheme and someone was informed of their arrest. Detainees were not interviewed while intoxicated. A medical opinion was sought if there was any doubt, and also on whether an appropriate adult (AA) was required.

5.12 Juveniles were not interviewed unless accompanied by an AA. There was no force-wide AA scheme and provision varied across the force. Youth offending teams (YOTs) provided an AA service to detainees under the age of 17 between 7am and 5pm, delivered by YOT staff or trained volunteers when a family member was not available. Services were provided by the emergency social services duty (EDT) team in the evening but it was difficult to obtain an AA after 10pm. The position with regard to vulnerable adults was even more problematic, with no reliable service, and generally there were difficulties out of hours. An assessment of the suitability of the AA, including a PNC check, was supposed to be completed but was often left until just before the interview. The length of time that a detainee spent in custody could be extended while an AA was found. The force adhered to the PACE definition of a child (as a

person under 18) instead of the Children Act definition, which meant those aged 17 were not provided with an AA unless they were otherwise deemed to be vulnerable. [5.]

5.13 Court cut-off times varied between suites, with the earliest being 11.30am during weekdays and 9.30am on a Saturday, resulting in longer stays in custody than would otherwise be necessary. During the inspection, one detainee was charged at 1.15pm but the court refused to hear the case that day. This would have meant at least a further 19 hours in police custody, and the detainee was on constant watch. We brought this to the attention of the custody sergeant, who made further representations to the court, which reversed its initial decision. It was sometime difficult to get transport to court at short notice and custody staff often resorted to taking detainees in their vehicles.

5.14 Defence solicitors reported good relationships with custody staff and the interactions we saw were professional. They were given copies of custody records, and the detainee could apply in writing for a copy of the record after release.

5.15 The force had clear policies on the management of DNA and forensic samples in custody. We found no issues in respect of samples, with custody freezers being well managed and an effective process for the transport of the samples to HQ.

Recommendations

5.16 West Yorkshire Police should work with relevant partner agencies to ensure appropriate adults are available 24 hours a day to support vulnerable adults and juveniles in custody.

5.17 West Yorkshire police should work with senior court managers to minimise delays in holding detainees who are to be produced at court.

Housekeeping point

5.18 Detainees should be given written information about individual rights in their preferred language and they should be shown a copy of the PACE codes of practice.

Rights relating to treatment

5.19 There was a general expectation from the force that complaints from detainees would be taken once they had been released from custody. Information about how to make a complaint was not provided to detainees and was not displayed in the custody suites. We met a detainee at Weetwood who wished to complain about an alleged physical assault by the arresting officer. He was advised to make the complaint at the front desk on release. Staff at some suites said that any detainee who wanted to complain during their detention would be seen by the duty inspector. We could not ascertain how detainees who were going to court would be able to complain. The force collected data on complaints and analysed patterns and trends. These data were collated, along with issues raised by ICVs, and informed an inspection regime managed by custody services.

[5] Although this met the current requirements of PACE, in all other UK law and international treaty obligations, 17-year-olds are treated as juveniles. The UK government has committed to bringing PACE into line as soon as a legislative slot is available.

Recommendation

5.20 Detainees should routinely be told how to make a complaint, in line with the Independent Police Complaints Commission statutory guidance,[6] and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody.

[6] IPCC statutory guidance (2010)

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.

Clinical governance

6.1 General health care provision had improved since the previous inspection. Serco provided 24-hour health care cover to the force. Their staff included health care professionals, such as doctors (forensic medical examiners (FMEs), GPs and psychiatrists) and registered nurses. Mental health services were provided by four mental health trusts across the region. Drug services were provided by a number of substance use agencies, depending on their location in the force area. There were no information-sharing protocols between the police and health providers.

6.2 Serco held bimonthly meetings with the police to discuss clinical governance issues. We observed a good level of respect and understanding between health care staff, drug workers and detainees. Chaperones were available where necessary and female detainees could request a female doctor, although it was not always possible to provide this, as most doctors were male. Interpreting services were used when required.

6.3 A chief inspector had responsibility for health services and provided robust strategic oversight of service delivery. The contract was monitored regularly and data collection challenged appropriately. Regular minuted meetings between the police and the health provider took place, and there was frequent telephone contact. The relationship between the police and Serco was said to be good, and this was supported by frontline staff, who said that health care support had improved, as had their confidence in the service.

6.4 Serco employed 22 FMEs, either full or part time, from varying clinical backgrounds, including four who were Mental Health Act section 12 approved. The 22 nursing staff were all employed and worked varying shifts over the 24-hour period. Access to professional training was supported, as well as specialist courses such as forensic sampling and court writing. We were told that clinical supervision was available. Nurses' backgrounds were varied and included intensive care and health studies degrees. Serco staff participated in an induction course and were able to access various courses related to their practice.

6.5 The standard of the health care rooms across the force was variable and there was no evidence that an infection control audit had ever been carried out. While the clinical room at Bradford CCO was clean, tidy and well maintained, some clinical rooms (for example, at Weetwood, Ossett and Leeds CCO) were in a poor condition. We could not confirm that infection control measures were in place for all rooms or that they were cleaned regularly. In some cases, clinical rooms doubled as staff rooms. At Leeds CCO, the examination couch did not have any paper roll and there were storage boxes on the floors. It appeared that, in most suites, no one had ownership of the clinical rooms. Many of them were used as store rooms for all types of equipment. At Stainbeck, the health care room opened onto the main booking-in area, reducing the amount of privacy. We saw one female detainee become visibly distressed as a result.

6.6 Medications were provided for detainees but were not held in clinical rooms. Nurses and doctors carried a small stock of agreed medications, which were replenished from their base when necessary. Senior Serco clinical staff conducted monthly audits on all medication boxes, and the Serco pharmacy provider carried out monthly checks on the boxes. Nurses carried patient group directions and associated medicines in a lockable metal case, which they handed over at the end of each shift. Prescribed medicines unused by detainees were placed in a locked metal container belonging to Serco; this was emptied fortnightly by the Serco operations manager.

6.7 Custody staff told us that they would administer prescribed medication to detainees only if the medicines had been verified by a doctor and placed in named patient packets. Nine detainees that we surveyed said that they were on medication; four of them had been seen by a health care professional but there was no mention of the medication in their care plans.

6.8 At Huddersfield, Lawcroft House and Keighley, we found small amounts of medicines held in locked cabinets in the booking-in area. Staff were unsure where the medicines originated from and Serco assured us that they were not theirs. Officers collected detainees' own medication from their homes if necessary but would not administer it without the permission of the FME. All injectable medications (for example, anti-diabetic agents) were administered by the FME.

6.9 Each custody suite had a defibrillator. It was usually located behind the custody desk but in Weetwood was locked in the FME room. Although custody staff were supposed to check the equipment daily and record the checks, this did not happen in most suites, and in some cases the equipment had not been checked for several days. Most custody staff had been trained to use the defibrillator, and training was repeated annually.

Recommendations

6.10 There should be information-sharing protocols with all appropriate agencies, to ensure that relevant health and social care information is shared efficiently.

6.11 Serco and the police should establish responsibility for the ownership of clinical rooms and ensure that rooms are clean, refurbished where necessary, properly equipped and maintained, and meet infection control guidelines. Unnecessary items should be removed from all clinical rooms.

6.12 Defibrillators should be conveniently located and checked daily. These checks should be recorded.

Housekeeping point

6.13 Only medicines provided by Serco should be held in custody suites. All other medicines should be removed.

Patient care

6.14 Detainees were asked if they had any health care needs during the booking-in process. If so, they were referred to the on-call health care professional. They could also request to see a health care professional. Custody staff told us that if they requested a doctor, a nurse would often respond. A small minority of custody staff felt unhappy with this response. The contract stipulated that Serco would respond on site within 60 minutes. Custody staff said that response

times had improved but there were still incidents where the health care professional did not respond within the contracted time.

6.15 In our custody record analysis, 23% of detainees were seen by a health care professional and the average wait to be seen was three hours and 15 minutes. Apart from the case of one detainee, who had had to wait six hours because he had consumed alcohol, the longest wait recorded was five hours and 25 minutes.

6.16 Health care professionals used medical assessment forms and doctors also kept their own clinical records separately. Detainees' legal representatives were able to obtain a copy of their clinical records, with the detainee's consent. Clinical records were held securely in doctors' own residences. Nurses completed their clinical records and stored them in lockable plastic boxes, not attached to the fabric of the building, in individual suites. The notes were returned to Serco HQ monthly. Any contact with a health care professional was also documented on a West Yorkshire Police medical and/or medication sheet, which was kept in the custody record.

Housekeeping point

6.17 Clinical records held in custody suites should be held in secure, fixed conditions.

Substance use

6.18 Several drug and alcohol services provided support to the force. The availability of on-site drug workers depended on the locality of the suite. Not all drug workers were based in custody suites, although all suites were either visited or contacted by a drug worker every weekday. Not all drug workers carried out a 'sweep' of custody areas when they were on duty. For example, one provider had two drug workers providing cover from 7am until 8pm every day, including weekends; one was based in Wakefield custody suite in the morning and the other in Pontefract in the afternoon. In other suites, attendance times varied considerably. Custody staff all said that they knew how to contact drug workers and that they felt supported by them. Most drug workers had some form of liaison with local prison counselling, assessment, referral, advice and throughcare (CARAT) services and were able to provide throughcare for detainees. Most drug workers either provided on-site support to alcohol users or signposted them to community services. Registered methadone users were able to continue their medication following assessment by an FME, who verified their prescription. Methadone could only be administered by an FME. Symptomatic relief for drug users was available.

6.19 Needle exchange and condom provision was available at some suites. When needle exchange was not available, detainees were signposted to community needle exchange services.

Mental health

6.20 The management of detainees with mental health problems did not appear to have improved since the previous inspection. Custody staff were concerned at their perceived lack of mental health support in relation to detainees held under section 136 of the Mental Health Act (1983). In the year to February 2011, 673 such detainees had been held, for an average time of over nine hours.

6.21 There were five section 136 suites in the force area, some of which excluded detainees who had been found to have consumed alcohol or be under the influence of drugs, or who were considered violent. There was also anecdotal evidence that detainees taken to some section

136 suites were breathalysed before assessment and that if a trace of alcohol was detected they had to be returned to custody.

6.22 A senior police officer was working with relevant health partners, including the Ambulance Trust, NHS primary care trusts/foundation trusts, local authorities and the police service to agree and implement a new joint agency protocol for the implementation of section 136 of the Mental Health Act. We were told that this was well advanced and would address the difficulties currently facing the police. Serco also employed, as an FME, a senior psychiatrist who was working with its mental health partners in an effort to progress mental health services to detainees.

6.23 There was no evidence of diversion facilities for the mentally ill.

6.24 Most custody staff had undergone some mental health awareness training in their initial training but only Bradford CCO staff had recently received mental health awareness input from the local mental health trust.

Recommendation

6.25 Mental health awareness training should be part of all custody staff annual training, to ensure they are appropriately equipped to support detainees with mental health needs.

7. Summary of recommendations

Main recommendations

7.1 West Yorkshire Police should ensure that ultimate responsibility for court detainees held by G4S and the condition of the cells shared between the force and G4S in the Leeds Bridewell is completely clean and detainees for whom the force has responsibility are not put at risk by weaknesses in the G4S arrangements. (2.22)

7.2 There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities or religious needs, and custody staff should be trained to recognise these differing needs. (2.23)

7.3 Risk assessments should be thorough and provide the opportunity for detainees to raise any relevant issues, and resulting care plans should reflect all the relevant information and be revised when circumstances change. (2.24)

7.4 Police custody should only be used as a place of safety for Section 136 assessments in exceptional cases, and mental health diversion support should be more readily available. (2.25)

Recommendations

Strategy

7.5 West Yorkshire police should collate the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (3.17)

Treatment and conditions

7.6 Booking-in areas should provide sufficient privacy to facilitate effective communication between staff and detainees. (4.8)

7.7 Handovers should be comprehensive, and attended by detention officers and police custody staff, with the area in which the handover takes place cleared of other personnel. (4.16)

7.8 Detainees should be handcuffed only when a risk assessment indicates that it is necessary for the safety of staff, the public or the detainee. (4.20)

7.9 West Yorkshire police should address the safety issues around ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed. (4.26)

7.10 Health and safety walk-through arrangements should be thorough and applied consistently at all custody suites. Records of these checks should be maintained. (4.27)

7.11 Cells should be clean, free of graffiti and properly heated and ventilated, and the particular issues with cells at Leeds CCO being used by the court should be addressed. (4.28)

7.12 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.35)

7.13 Food offered to detainees should be of sufficient quality and calorific content to sustain them for the duration of their stay. (4.44)

Individual rights

7.14 West Yorkshire Police should engage with the local authority to ensure the provision of secure beds for juveniles who have been charged but cannot be bailed to appear in court. (5.6)

7.15 Two-handset telephones should be installed, so that interpreting by telephone can be conducted efficiently and privately. (5.7)

7.16 PRRAs should be meaningful, with enquiries made about the detainee's risk to self and to others. When concerns are highlighted, full information should be given about sources of help. (5.8)

7.17 West Yorkshire Police should work with relevant partner agencies to ensure appropriate adults are available 24 hours a day to support vulnerable adults and juveniles in custody. (5.16)

7.18 West Yorkshire Police should work with senior court managers to minimise delays in holding detainees who are to be produced at court. (5.17)

7.19 Detainees should routinely be told how to make a complaint, in line with the Independent Police Complaints Commission statutory guidance, and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody. (5.20)

Health care

7.20 There should be information-sharing protocols with all appropriate agencies, to ensure that relevant health and social care information is shared efficiently. (6.10)

7.21 Serco and the police should establish responsibility for the ownership of clinical rooms and ensure that rooms are clean, refurbished where necessary, properly equipped and maintained, and meet infection control guidelines. Unnecessary items should be removed from all clinical rooms. (6.11)

7.22 Defibrillators should be conveniently located and checked daily. These checks should be recorded. (6.12)

7.23 Mental health awareness training should be part of all custody staff annual training, to ensure they are appropriately equipped to support detainees with mental health needs. (6.25)

Housekeeping points

Strategy

7.24 Custody record dip-sampling should be carried out consistently across the force. (3.18)

Treatment and conditions

7.25 The display on the cell call bell panels should be adequately illuminated. (4.29)

7.26 Mattresses should routinely be wiped down after use. (4.36)

7.27 All detainees should be offered a pillow. (4.37)

7.28 All detainees should be routinely provided with blankets. (4.38)

7.29 All female detainees should be offered a hygiene pack on arrival. (4.39)

7.30 Subject to risk assessment, toilet paper should be provided in each cell. (4.40)

7.31 The serving temperature of microwave meals should be recorded in each instance. (4.45)

7.32 The stock of reading materials should be improved, to cater for the specific needs of detainees who are young, non-English speakers or who have limited literacy. (4.49)

7.33 Visits should be allowed, where appropriate, particularly for juveniles and those detained for long periods. (4.50)

Individual rights

7.34 Detainees should be given written information about individual rights in their preferred language and they should be shown a copy of the PACE codes of practice. (5.18)

Health care

7.35 Only medicines provided by Serco should be held in custody suites. All other medicines should be removed. (6.13)

7.36 Clinical records held in custody suites should be held in secure, fixed conditions. (6.17)

Good practice

Strategy

7.37 The unannounced thematic custody inspections provided an excellent quality assurance process, identifying good practice and raising standards. (3.19)

Treatment and conditions

7.38 The private booking-in cubicle at Keighley offered detainees an enhanced level of privacy. (4.9)

Appendix I: Inspection team

Nick Hardwick	Chief Inspector of Prisons
Sean Sullivan	HMIP team leader
Gary Boughen	HMIP inspector
Peter Dunn	HMIP inspector
Sandra Fieldhouse	HMIP inspector
Karen Dillon	HMIP inspector
Angela Johnson	HMIP inspector
Mark Ewan	HMIC inspector
David Thompson	HMIC inspector
Julia Walsh	HMIC inspector
Bridget McEvilly	HMIP health care inspector
Steve Quinn	CQC inspector
Michael Skidmore	HMIP researcher
Helen Wark	HMIP researcher