Criminal Justice Joint Inspection

Report on an inspection visit to police custody suites in Cumbria Constabulary

8 – 12 June 2015

by HM Inspectorate of Prisons and HM Inspectorate of Constabulary

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Inspecting policing in the public interest

Report on an unannounced inspection visit to police custody suites in

Cumbria Constabulary

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We are grateful for the work of the Care Quality Commission on this inspection.

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

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

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Glossary of terms

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

Section 1. Introduction

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

This was the second inspection of Cumbria Constabulary; the first took place in September 2009. There had been some significant improvements since the previous inspection, particularly in the condition of the custody estate and some aspects of care for detainees, but other areas had deteriorated considerably.

At the time of the previous inspection, custody had been a devolved function, allowing areas to manage resources and policies locally. Custody was now a centralised function in the criminal justice portfolio, however, making it separate and distinct from territorial policing. This change was relatively new and needed to be embedded, and some custody staff did not understand their place in the new structure.

Cumbria Constabulary did not monitor or provide performance data on custody functions. Chief officers and senior staff were not sighted on the performance of basic custody processes. Data management was weak and was not used to drive planning or performance. There was, however, a concerted and focused effort to build key relationships with health providers. There was a regular custody forum, which included external organisations that had an interest in custody provision and improved outcomes for detainees.

Detainee care was generally reasonable, except when custody suites were busy. During these times, cell call bells were left too long before someone was able to respond. Risk assessments were mostly good and in some cases excellent. Levels of observations set for detainee care were appropriate and reviewed appropriately. Handovers between shifts were focused and relevant. We saw good team working between custody sergeants and detention officers, ensuring a safe environment for detainees.

Use of force was not monitored or analysed to determine trends or patterns, or to identify where it was used disproportionately. Spit helmets were provided to protect staff from being spat at, staff did not understand their use and we saw one being placed on a detainee even though it was intended to be worn by staff. We were not assured that all uses of force were proportionate, reasonable and lawful.

Individual rights were generally adhered to but there was poor provision of appropriate adult (AA) services to children and vulnerable adults. AAs were generally requested to arrive at the same time as the solicitor and interviewing officers. This practice suggested a misunderstanding of, and undermined, the purpose of AAs – to provide reassurance, respond to fears and anxieties, and be the 'trusted adult' outside the police service, throughout the custody experience.

Children were subject to further delays because The Appropriate Adult Service required a referral from children's services before an AA would attend, and children's social workers were sometimes not available to make the referral. When children were charged and could not be bailed, the local authorities generally did not provide alternative accommodation for them, and we were not assured that custody sergeants were always clear about which type of accommodation they should be requesting.

These combined processes resulted in delays and sometimes led to prolonged and unnecessary detention of children in custody.

Health care provision had recently changed to a new provider, with 24-hour embedded nursing cover in two locations and shared nursing provision in the other two. When the provision was shared, staff told us this sometimes resulted long delays in response times, but this could not be verified owing to the lack of data collected by the force. Individual interactions between health services staff and detainees were professional and clinically appropriate.

Services for people with mental health issues were less accessible. Although there were good partnerships in trying to resolve matters, detainees experienced long delays in receiving a mental health assessment in police custody. Too many mentally ill people were taken to police custody as a place of safety.

There had been improvements in the condition of the custody estate and the care of detainees since our last inspection. Nevertheless, new management arrangements were not yet embedded and arrangements to monitor and manage performance were weak. It was a particular concern that processes to protect and safeguard the most vulnerable detainees were not fully effective.

Sir Thomas P Winsor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

September 2015

Section 2. Background and key findings

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

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

2.3 A documentary analysis of custody records was conducted as part of our police custody inspection programme. The analysis provided case examples illustrating the level of care that detainees received, and the quality of risk assessments and care arrangements, including access to services such as health care and legal advice.

2.4 Records were randomly selected approximately four weeks before the inspection and the sample contained a minimum of five children (aged 17 years and under). The number of records sampled from each custody suite was proportional to throughput at those suites – that is, more records were sampled at suites with a higher throughput and fewer at those with a lower throughput. When this information was unavailable, proportional sampling was based on the number of cells in each suite. Owing to the small sample size, samples were not representative of the wider detention throughput. As part of this inspection, a total of 30 records were sampled.

2.5 This was the second inspection of Cumbria police, following up our inspection of September 2009. The designated custody suites and cell capacity of each were as follows:

Custody suites	**Cells**
Barrow	10
Carlisle	24
Kendal	10
Workington	16

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

Strategy

2.6 There was a clear management structure for custody, up to assistant chief constable (ACC) level. Since the previous inspection, Kendal custody suite had been rebuilt and the facility at Barrow was due to be replaced in autumn 2015. Custody was a centralised function within the criminal justice portfolio. This change in the structure had yet to be embedded, and many sergeants thought they were still part of territorial staffing.

2.7 There was a core group of sergeants designated to custody duties, but there was little provision for cover within the core group when it was required. Cover was provided by sergeants from territorial policing. We were not assured that there were sufficient custody sergeants and detention officers (DOs) to ensure the continued safety and welfare of detainees, especially in locations where there was only one sergeant and one DO.

2.8 The force did not monitor or provide oversight on basic custody functions to ensure that standards were consistent and effective. It also did not monitor booking-in times, the number of strip-searches or allocation of local authority alternative accommodation for children who had been charged and refused bail. Data on custody provision was weak and not used to drive performance and outcomes for detainees.

2.9 There was a concerted effort in building key partnerships in mental health provision for vulnerable people. There was also a custody forum, chaired by the custody manager, which regularly included external partners involved in custody.

2.10 The Police and Crime Commissioner was responsible for the provision of the independent custody visitor (ICV) scheme. This scheme was innovative and well organised, supported by the force and one of the best we had seen. Each custody centre was visited weekly.

2.11 There was an initial and refresher training programme for all custody staff, including sergeants used as cover for designated custody sergeants. The refresher training was relevant and well attended.

2.12 The dip-sampling process was adequate, with feedback delivered to staff, but too few records were sampled and they were not cross-referenced with closed-circuit television (CCTV) recordings or person escort records (PERs) to improve the process further.

2.13 The 'Custody Cares' section of the force intranet site identified learning opportunities, including reviews of adverse incidents and a briefing document on the trends of complaints. Learning was also disseminated from the Independent Police Complaints Commission (IPCC) 'learning the lessons' bulletin.

Treatment and conditions

2.14 Detainees were treated with respect, and staff were polite and generally addressed individual and diverse needs. There was impressive collaborative working between sergeants and DOs to ensure the welfare of detainees at all suites.

2.15 The children we saw were well cared for, with staff using mostly age-appropriate language, and there was a good understanding of their vulnerabilities, but some children were detained in custody too long.

2.16 Custody suites were well equipped with religious materials. There were adaptations for detainees with disabilities, including adapted toilets, lowered cell call bells and thick mattresses.

2.17 Risk assessments and management were good, and in some cases excellent, with custody staff noting detainees' demeanour as part of the assessment and taking account of other sources of information such as warning markers. Levels of observations were appropriate and complied with, and most staff demonstrated good understanding of risk factors. Risk management plans were reviewed regularly, based on ongoing assessments, but the automatic removal of corded clothing and footwear without assessment was disproportionate.

2.18 The use of anti-rip clothing was inconsistent, with some suites using this if detainees were uncooperative or inebriated and others reviewing past records to make a judgement on known risk factors.

2.19 The handovers we observed were good, with relevant content, and appropriately focused on risk and case progression; however, they did not include DOs who had a separate handover. Incoming sergeants visited and spoke to detainees.

2.20 Pre-release risk assessments were thorough, with detainees offered useful post-release referral advice and support from other agencies. Leaflets provided on release contained useful information, including local and national telephone numbers for a range of support organisations.

2.21 Use of force monitoring and trend analysis, accountability and governance in custody suites were areas of weakness. Force data showed a relatively high number of strip-searches, and also the use of spit helmets without any guidance for staff. We saw a spit helmet used on a detainee, although we were later told that these were for use by staff only. Information and data provided on uses of force did not assure us that they were all proportionate, reasonable and lawful.

2.22 The physical conditions of the suites varied according to the age of the buildings, but the cleanliness and general maintenance was good. Cells checks were not effective in finding ligature points across the suites, and we found several during the inspection.

2.23 Overall detainee care was good, although at busy times there were obvious gaps. Cell call bells were not answered promptly, and requests for drinks and exercise were not always met immediately, which undermined the otherwise good care offered by individual staff.

Individual rights

2.24 Custody sergeants booked in detainees and authorised detention appropriately, in line with legislation, and were confident in refusing detention when circumstances did not merit it. Voluntary attendance as an alternative to custody was well used.

2.25 Figures supplied by the force showed that 26 immigration detainees had been held in 2014/15 and their average length of detention had been 27 hours 37 minutes, which had increased considerably from the previous year. We were told that a Home Office immigration officer was based at Police Headquarters, but few staff were aware of this. Custody staff reported occasional difficulties in obtaining interpreters, resulting in detainees remaining in custody longer than necessary and sometimes having to be bailed to return, leaving some doubt if the detainee understood what was required of them.

2.26 We were not assured that custody staff understood the different requirements for safe and secure accommodation for children who were charged and could not be bailed. Our findings suggested that most requested only local authority secure accommodation, when safe accommodation might have been applicable and more frequently available.

2.27 Staff reported receiving a good service from youth offending service (YOS) staff and The Appropriate Adult Scheme (TAAS), when acting as appropriate adults (AAs). Despite being a breach of PACE, it was accepted practice that custody staff would photograph and take fingerprints and DNA samples from vulnerable adults without an AA being present.

2.28 We were concerned that the attendance of AAs was normally arranged for a time when interviews with detainees were due to be progressed, rather than having them attend as soon as practicable to support the child or vulnerable adult throughout the custody process. Another concern was that TAAS would not arrange for an AA to be present in custody for children unless they had received a direct referral from children's services. This caused delays and required children to spend more time than necessary in custody.

2.29 Up-to-date rights and entitlements leaflets were available and offered to detainees, but few staff were aware of the availability of an easy-read pictorial version, for detainees needing help with understanding or reading, through the Home Office website link. All detainees were offered free legal representation.

2.30 The PACE reviews we observed were mainly conducted face-to-face and were thorough and timely.

2.31 Local magistrates' courts had early closure times, which resulted in detainees having unnecessarily long stays in police custody. Staff told us that there was some flexibility on a daily basis.

2.32 Detainees wishing to make a complaint were mostly advised to submit it after they left the custody suite. The force policy did not make it clear that complaints should be noted while a detainee was in custody, where possible. There was no visible information in any of the custody suites informing people how to make a complaint.

Health care

2.33 Staff were competent and compassionate. All the treatment rooms were clean and met infection control standards, with the exception of a minor issue at Workington.

2.34 There was a range of partnership meetings, which covered strategic and operational issues, but monitoring mechanisms had not been established. The quality of health care provision was good, and this was confirmed by custody staff and detainees.

2.35 There was 24-hour embedded nursing cover in Carlisle and Workington, with a health care practitioner (HCP) shared between Barrow and Kendal. There was only one forensic medical examiner (FME) on call for the whole area. Staff told us that this sometimes caused delays in attending to medical needs, but there was no data available to verify this. One FME told us that he was regularly on duty for several consecutive days but the burden was mitigated by a low demand for their services.

2.36 Interactions between detainees and health services staff were professional and clinically appropriate, and records were of a good quality. Custody staff spoke positively about the embedded nursing services, where they were provided. In areas where HCP staff travelled to or between suites, there were sometimes long delays in attendance.

2.37 Medication management arrangements were robust and had improved. Checks were in place with the call centre to record stock balances for the use of controlled drugs. Detainees were not able to receive prescribed opiate substitution therapy in custody.

2.38 The community-based substance misuse team offered a good support service to detainees with drug or alcohol problems. There had been some occasional gaps when staff had failed to attend, which could have affected outcomes for detainees.

2.39 There was evidence of good partnership working between the police and mental health services. However, there were long delays in expediting assessments for detention under the Mental Health Act, resulting in vulnerable detainees remaining in custody for too long. This delay was compounded if the request was made out of hours; after 9pm, there was only one approved mental health professional on duty for Cumbria.

2.40 There had been an overall increase in the use of section 136 of the Mental Health Act (1983) in Cumbria over the previous three years but the use of a custody suite as a place of safety had decreased. In 2014/15, there had been 53 incidents of police cells being used as a place of safety, which was still unacceptably high.

Main recommendations

2.41 Cumbria Constabulary should collect and analyse information, including quality assurance data, to ensure a robust assessment of standards in custody, providing safe and timely outcomes for detainees.

2.42 Cumbria Constabulary should ensure routine recording and monitoring of use of force data from custody, examine it for trends, and ensure accountability in accordance with the Association of Chief Police Officers' policy and College of Policing guidance.

2.43 The Police and Crime Commissioner and Chief Officer Group should engage with their counterparts in the local authority, instigate an immediate review of the provision of local authority accommodation for children under section 38(6) PACE 1984, and monitor performance data to ensure that children are not detained unnecessarily in police cells.

2.44 Appropriate adults should be available 24 hours a day and be requested to attend as soon as possible to ensure the welfare and safety of vulnerable adults and children in custody.

2.45 Police custody should not be used as a place of safety for section 136 of the Mental Health Act 1983 assessments.

Section 3. Strategy

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

Strategic management

3.1 There were four designated custody facilities (see paragraph 2.5) and also small, non-designated facilities at Appleby-in-Westmorland and Penrith, which were used infrequently for short periods when local events, such as Appleby Fair, were operating. Since the previous inspection, the Kendal custody suite had been rebuilt, increasing its cell capacity, and the custody suite at Barrow was due to be replaced in autumn 2015.

3.2 An ACC provided the strategic lead for custody. Custody was a recently centralised function and formed part of the criminal justice portfolio. The criminal justice department was led by a chief inspector, who was also the force custody manager. There were four custody inspectors, who reported to the custody manager, including a lead inspector for policy matters. The custody manager had a number of additional responsibilities within his portfolio, which meant that only around 40% of his time was spent on managing custody business.

3.3 There was a core group of designated custody sergeants who were part of the criminal justice department. Most of the time, particularly in Barrow and Kendal, there was only one sergeant on duty, which did not allow for breaks in the working day or for sickness or other short-notice absences. Several sergeants working within territorial policing were also trained to be custody sergeants. Many of the designated custody sergeants were not aware that they were part of the criminal justice department and no longer territorial policing staff. Most sergeants we spoke to said that they felt confident in questioning the grounds for detention if the circumstances did not merit it (see section on individual rights).

3.4 DOs were also available at all custody suites but we saw several working on their own in busy custody suites, leading to delays in answering cell call bells and attending to detainee needs (see section on detainee care). The force had also trained a number of territorial policing constables to act as DOs, and we saw several working in the custody suites during the inspection, suggesting greater numbers of DOs were needed to adequately meet demand.

3.5 There was no quality assurance process to monitor the basic aspects of custody delivery. Chief officers and senior managers were unsighted on the basic elements of performance owing to the general lack of monitoring of issues such as booking-in times, allocation of local authority alternative accommodation for children who had been charged and refused bail, and the number of strip-searches undertaken. Information was not analysed regularly and trends were not acted on. Data on custody provision was weak and not used to drive improvements on performance and outcomes for detainees (see main recommendation 2.41).

Recommendations

3.6 Cumbria Constabulary should ensure that the management structure and roles for custody are communicated effectively and understood by staff.

3.7 There should be sufficient staff in custody suites at all times to ensure the safety and well-being of detainees.

Partnerships

3.8 There were three tiers to the force's approach to partnership work pertaining to custody. The ACC was a member of the strategic mental health partnership group, a Cumbria-wide partnership; the custody manager was engaged at a tactical level with the criminal justice and mental health steering group and there was a custody forum, managed by the force.

3.9 The criminal justice and mental health steering group was allocated work by the mental health partnership group and reported back on its results. This steering group was working towards providing a review of the provision of out-of-custody facilities for people detained under section 136 of the Mental Health Act (1983) (see section on mental health).

3.10 The custody forum was managed by the force and chaired by the chief inspector, and met monthly. External partners from Unity, Cumbria Partnership NHS Foundation Trust and the ICV scheme (see below), all of whom had an interest in custody matters, were invited to attend bimonthly. The minutes showed that the meetings were focused on detainee outcomes, but lacked some meaningful management data (see main recommendation 2.41).

3.11 The provision of local authority accommodation for children who had been charged and detained was inadequate but this had not been managed or challenged effectively by the force through its partnership structures. This was mainly because of weak data collection (see above), which meant that there was a lack of evidence to provide challenge and a case for change (see section on rights relating to detention).

3.12 The ICV scheme operated across the force area and was innovative and well organised. The rota was managed so that custody visitors routinely changed partners for each of the weekly visits to the custody suites. As part of the induction programme for new visitors, they observed a custody team during a night shift to give them a better understanding of police processes. The scheme was administered by the Police and Crime Commissioner's office, which reviewed each visitor's service every three years. Visitors could volunteer for a maximum of nine years. The force supported the scheme by providing input into ICV training courses and attending their annual conferences. Overall, the scheme one of the best we have seen.

Learning and development

3.13 All custody sergeants had received a three-week initial custody training course. This training included policy and procedure, information technology skills and enhanced first-aid training. The territorial policing sergeants who were required to support the designated custody sergeants were trained to the same level, although some performed the role infrequently and risked being deskilled between deployments. Training for DOs was suitable for their role and a number of territorial policing constables were also trained to the same level.

3.14 There were no training days built into the shift pattern for custody staff but there was an annual one-day refresher course. The content of this refresher day was current and relevant, and records showed a good level of attendance. Staff also attended regular personal safety and other generic training courses.

3.15 Custody inspectors dip-sampled 11 custody records (approximately 5%) per month, which was insufficient. Relevant areas such as pre-release risk assessments were considered but

there was no cross-referencing with CCTV recordings or PERs to improve the process further. Individual feedback was provided to the custody sergeant or DO, and trends were highlighted to staff by email or through the custody section on the force website.

3.16 Custody inspectors completed a quarterly review of adverse incidents to check that correct procedures had been followed and to identify learning points. Individual feedback was provided to staff involved in the incident and was also disseminated more widely through the 'Custody Cares' section of the force intranet site. The Professional Standards Department provided a quarterly briefing document on the trends of complaints in custody, and the IPCC 'learning the lessons' bulletin was also available through the force intranet. Some staff we spoke to were not aware that all of these documents were available.

Recommendations

3.17 The proportion of custody records that are dip-sampled should be increased and the sample should be cross-referenced with person escort records and closed-circuit television recordings.

3.18 Territorial policing sergeants who do not work regularly in custody should receive refresher training.

Housekeeping point

3.19 Staff awareness of the custody intranet site should be improved.

Section 4. Treatment and conditions

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

Respect

4.1 Custody staff were respectful and considerate during their interactions with detainees and this was confirmed by detainees we spoke to. We saw impressive collaborative working between custody sergeants and DOs at all suites to ensure that detainees were cared for. This care was compromised when the suites were busy, however, and only one sergeant and one DO were on duty at most times (see section on detainee care).

4.2 Detainees' diverse needs were not always explored sufficiently; for example, staff did not always ask detainees if they had obligations as carers, or religious or dietary needs. Women were offered the opportunity to speak to a female member of staff and there were designated questions in the risk assessments for them. In one case we observed, there was good use of street bail[2] for a female detainee who needed to take care of her child; she was bailed to return to the custody suite at a later time, when her child was being looked after. This was proportionate and showed good judgement by staff.

4.3 Custody staff told us that they would make every attempt not to hold a child in custody for longer than necessary. We found that children were detained for too long, however, owing to problems with finding alternative accommodation. In our analysis of 30 custody records, five of the detainees had been children, three of whom had been detained for approximately four hours or less and the other two for 14 hours and 40 hours, respectively – the latter because staff had been unable to find secure accommodation for the child (see section on rights relating to detention). We saw good care being provided to some vulnerable detainees. The children we saw in the suites were reasonably well looked after, with staff using mostly age-appropriate language, and all were placed on at least 30-minute observation; however, girls were not routinely allocated a female officer responsible for their care.

4.4 Custody suites were well equipped with religious books and prayer mats, and the direction of Mecca was indicated on cell ceilings. Access for those with disabilities was good in most suites, with adapted toilets, lowered cell call bells and thick mattresses. The lowered booking-in desks at Kendal and Carlisle were available as discrete booking-in spaces for vulnerable detainees and those with disabilities. DOs understood the importance of offering transgender detainees a choice about being searched by a male or female officer.

Recommendations

4.5 Custody staff should ask all detainees if they have any obligations as carers or are being cared for by others, and whether they need help to address these requirements.

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[2] Street bail under Section 4 of the Criminal Justice Act 2003 enables a person arrested for an offence to be released on bail by a police constable on condition that they attend the police station at a later date. One of the benefits of street bail is that an officer can plan post-arrest investigative action and be ready to interview a suspect when bail is answered.

4.6 Girls under 18 should be allocated a named female officer who is responsible for their care while in custody.

Safety

4.7 Risk assessments were good, and in some cases excellent. They were completed thoroughly, with custody staff paying particular attention to detainees' mental and physical health and asking probing supplementary questions to enhance the assessment; however, there was a lack of consistency about the management of risk. Some sergeants automatically removed corded clothing and footwear without assessment, which was disproportionate, whereas others used the risk assessment appropriately to determine how to manage a detainee's risk. As an example of the latter, we saw a detainee who had no warning markers, had fully engaged with the risk assessment and presented no issues of concern being permitted to wear his shoes and belt in the cell.

4.8 We were assured that staff took account of other sources of information during the risk assessment process, such as warning markers on the police national computer and local intelligence systems. We were satisfied that the level of observations was appropriately set during the inspection and this was confirmed by our custody record analysis (CRA). Risk management plans were reviewed regularly, based on ongoing assessments, and changed appropriately. Levels of observations were complied with and we saw some sergeants asking DOs to check on the mood and demeanour of some detainees when there were some initial concerns. DOs were aware of the importance of rousing detainees who were intoxicated.

4.9 Anti-rip clothing was used, with detailed recording of the reasons for the removal of clothing. In some suites, we were told that detainees were automatically placed in anti-rip clothing if they were uncooperative or inebriated, which was disproportionate. Our CRA highlighted further inconsistencies in practice. For example, two of the records showed that a risk assessment could not be completed for the detainees, and there was evidence of custody sergeants appropriately looking at previous custody records to look for information they could use to inform them of any potential risks that the detainees might pose to themselves or others, but this practice was not universal.

4.10 We observed a close-proximity supervision of a woman detained under section 136 of the Mental Health Act 1983 (see section on mental health). The officer conducting the supervision had been well briefed by the sergeant, engaged well with the detainee and updated the sergeant about the detainee's demeanour. The care of this particular detainee was well managed.

4.11 DOs and custody sergeants did not carry personal-issue anti-ligature knives; these were attached to the cells keys, with spares located behind the custody desk. Sometimes staff would answer a call bell or undertake a visit, but see the detainee through the hatch and not enter the cell.

4.12 The shift handovers we saw were conducted well; the content was relevant and appropriately focused on risk and case progression. They were not conducted with the whole team, however, with DOs having a separate handover. Sergeants visited and also spoke to detainees after the handover.

4.13 The pre-release risk assessments we saw were good, and custody staff appropriately assessed how the detainee presented on first arrival and at the point of release. Transport was offered to those who needed it and fares were provided in exceptional circumstances. Detainees with substance misuse issues were asked if they were receiving support and whether they wanted to see a drug and alcohol worker. Leaflets containing useful

information, including local and national telephone numbers for a range of support organisations, were given to detainees, with the offer of making referrals on their behalf, with their consent. There was also a more detailed pre-release process for detainees who were bailed or charged with sex offences.

Recommendations

4.14 Restrictions on detainees' footwear and clothing should be subject to individual risk assessment.

4.15 Anti-rip clothing should only be used in exceptional circumstances and as a last resort to protect the detainee from harm, with a recorded rationale, based on a risk assessment.

4.16 All staff undertaking cell visits and answering cell bells should be issued with keys and anti-ligature knives.

4.17 All custody staff should be involved in the same shift handover, which should be recorded.

Use of force

4.18 Oversight and governance of the use of force were inadequate. We were not assured that use of force was monitored, that officers were held accountable or that managers were aware of its use in the custody suites (see main recommendation 2.42). A use of force form was generally completed by the custody sergeant after each incident.

4.19 Spit helmets were available at each of the custody suites but there was no policy or guidance for their use, which created a great deal of confusion among custody staff. Some staff thought that they were for their use, to protect themselves if a detainee was spitting at them, and others thought that they were for detainees' use. It was later clarified by the custody manager that they were for staff use, so its use on a detainee in one case we reviewed had been inappropriate. This detainee had been placed in a spit helmet for 11 minutes. Information and performance data provided on uses of force did not assure us that all such uses were reasonable, proportionate and lawful.

4.20 Force data showed a number of strip-searches were being recorded and we were aware that the placing of a detainee in anti-rip clothing was recorded as strip-search. In our CRA, a strip-search had been conducted in five out of the 30 cases, all of which had been authorised appropriately, although the gender of the searching officers had not been recorded.

4.21 Few detainees arrived handcuffed, and those who did had them removed soon after arrival.

Recommendations

4.22 There should be training and guidance on the use of spit helmets.

4.23 Strip-searches should be recorded accurately in the custody record, including the authorising officer, gender of searching staff and subsequent outcomes.

Physical conditions

4.24 The physical conditions of the custody suites varied according to the age of the buildings. The cleanliness and general maintenance of the suites was good, with the exception of Barrow, although a new suite was being built there and would be available for use in autumn 2015. Cells were mostly clean and well maintained, with few signs of graffiti, and were checked between uses. DOs cleaned them during the day if required. There was a clear process for cleaning and checking cells and for reporting maintenance issues. The records we reviewed showed that reported maintenance problems were generally responded to and resolved within 48 hours.

4.25 Daily, weekly and monthly checks were conducted at each of the custody suites but were not effective at finding ligature points across the suites. During the inspection, we found several ligature points, including gaps in cell hatches and around door frames, across some of the custody suites.

4.26 CCTV operated in all custody suites and there were signs to inform detainees but these were not displayed prominently at Workington, however when we reported this to the force this was rectified. All toilet areas were pixilated on the CCTV monitor.

4.27 After booking in, in most cases detainees were escorted to their cell by a DO, who explained in-cell equipment, such as the cell call bell, hand-washing facility and toilet flush. When DOs were busy, this task was sometimes handed to arresting officers, who were not as thorough in providing an explanation (see recommendation 3.7). With the exception of Barrow and Kendal, responses to cell call bells were generally prompt. Although all call bells were responded to eventually at the latter suites, the shortage of staff there resulted in delays (see section on detainee care).

4.28 Each suite had a fire evacuation policy, and fire evacuation plans were clearly displayed in the suites. None of the staff could recollect undertaking fire evacuation exercises, however, and there were no records of any such exercises taking place.

Recommendations

4.29 There should be clear, detailed records of daily cell checks, with a means of recording defects, including any ligature points that have been identified.

4.30 Responses to cell call bells should always be prompt.

4.31 Regular emergency evacuation drills should take place at each suite and be recorded.

Detainee care

4.32 Overall detainee care was good. In our CRA, most detainees in the sample had been offered at least one meal while in custody, and five detainees in the sample had received outside exercise. The duties of DOs were compromised when it was busy at Kendal and Barrow, where there was only one DO and one sergeant on duty most of the time. Sergeants were generally flexible, particularly at these suites, and conducted some DO tasks such as cell visits, answering cell call bells and providing refreshments when they could (see also section on strategy and recommendation 3.7).

4.33 Mattresses and pillows were provided but were not always cleaned between uses. Clean blankets were offered routinely at all suites. At Barrow, custody staff also offered jumpers because some cells were cold. There were sufficient stocks of replacement clothing, including underwear, but replacement footwear was not always provided, even though most detainees had their footwear removed. Detainees were routinely given toilet paper.

4.34 Microwave meals and cereal bars were available, and food and drink were provided at mealtimes and on request. Food preparation areas were generally clean and well equipped.

4.35 All the custody suites had reading material, mainly brought in by staff. There was insufficient stock for children and there was nothing available in languages other than English. All the suites had rooms to facilitate visits, and these had been used to support some vulnerable detainees.

4.36 Custody suites had exercise yards that were well used. Staff tried to facilitate detainees' requests for time outside but during busier times this was not always possible.

4.37 Showers were available at all suites. At Workington, the shower facilities in the men's corridor were dirty, in a poor decorative state, with paint peeling off the wall and floors, and had an unpleasant smell. In our CRA, five of the six detainees held overnight had been offered showers, and two had accepted. Not all women were routinely offered sanitary products.

Recommendations

4.38 Replacement footwear should be provided for all detainees if their own footwear is removed or stored outside their cell.

4.39 All suites should hold a stock of reading material suitable for children and in a range of languages.

4.40 The showers on the men's corridor at Workington should be clean and hygienic.

4.41 Women detainees should be offered sanitary products.

Section 5. Individual rights

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

Rights relating to detention

5.1 Custody sergeants asked arresting officers to provide a full explanation of the circumstances of, and the reasons for, arrest before authorising detention. Sergeants told us that they were confident in refusing detention when the circumstances did not merit it, and they were able to provide us with details of such cases. Custody staff told us, and we observed, that voluntary attendance[3] was sometimes used as an alternative to custody. Data supplied by the force confirmed that the use of voluntary attendance was increasing, with 3,907 voluntary attendees recorded for the 12 months from 1 April 2014 to 31 March 2015, compared with 3,069 for the preceding 12 months. Street bail as an alternative to custody was also available to officers, and we saw this being put to good use when dealing with a female detainee who had childcare commitments (see section on respect).

5.2 All custody staff were aware of the need to keep detention periods to a minimum and custody sergeants were clear about their obligations to ensure that cases progressed quickly. Data supplied by the force showed that the average length of detention was 10 hours 25 minutes, and this was similar to the average figure in our CRA, in which 13 out of 30 detainees in the sample had been held for less than six hours.

5.3 We saw detainees being booked in promptly after arrival at the custody suites. According to data supplied by the force, the average waiting time from arrival at the suites to authorisation of detention was 10 minutes 17 seconds.

5.4 Custody staff reported a good relationship with Home Office immigration enforcement officers, but few were aware that an immigration officer was based at Police Headquarters. We were told that few immigration detainees were held and that those who were to be transferred to immigration removal centres were usually moved on within 24–48 hours, which was similar to the situation at the time of the previous inspection. Data supplied by the force confirmed that only 26 immigration detainees had been held between 1 April 2014 and 31 March 2015, which was similar to the number held in the preceding 12 months. The overall average time spent in custody by immigration detainees, however, had increased from 17 hours 25 minutes in 2013/14 to 27 hours 35 minutes in 2014/15, which was poor.

5.5 A professional telephone interpreting service was available to assist when dealing with foreign national detainees through the use of loudspeaker telephones. At Carlisle, during an interpreting session, we saw that the use of speaker telephones lacked privacy and that they had poor sound quality. Staff told us that depending on the language required the face-to-face interpreter service was regularly unavailable for interviews resulting in detainees remaining in custody longer than necessary. Detainees sometimes had to be bailed to return because of the delays in getting a face-to-face interpreter, leaving some doubt as to whether the

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

detainee understood the process as to why they were being bailed and that they had to return for the appointment.

5.6 In our CRA there was one foreign national detainee who had been held at Workington. He had arrived in custody in the early hours of the morning and a Vietnamese interpreter was arranged for 11am. The interpreter failed to attend for the interview and the interpreter service was contacted, they said no one would be able to attend until the following day. As a result, based on the evidence available, a decision was made to take no further action against the detainee and he was released from custody. Custody staff conducted his release process through an online translation service (Google Translate). It was good that the matter was resolved promptly.

5.7 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.[4]

5.8 Custody staff told us that they had never known the local authorities to provide accommodation when children had been charged and could not be bailed. Data supplied by the force showed that there had been 51 such children between 1 May 2014 and 30 April 2015 (see main recommendation 2.43). We were not assured that staff understood the different requirements for safe and secure accommodation[5] as most told us that they would only request secure accommodation, when safe accommodation – such as a foster carer or extended family – might have been applicable and more frequently available.

5.9 In our CRA, there was evidence of one child, aged 16 years, being detained overnight. He had been held for over 40 hours before being transferred to court. He had been charged six hours into his detention and bail was refused. There was evidence of custody staff contacting children's services to obtain suitable alternative accommodation, but none had been available (see main recommendation 2.43). There was also evidence of a 14-year-old boy who had been held in custody at Kendal for over eight hours after being charged while social services tried to find him accommodation. They had finally been able to provide some, but the type of accommodation was not recorded in the custody log.

5.10 During the inspection, a 16-year-old boy was held overnight at Barrow pending his appearance at court. He was unable to return home as he had offended at that location. A check of his custody record revealed that family members contacted had refused to provide accommodation and that out-of-hours social services had been contacted. The record simply stated that no secure accommodation was available, but it was unclear if safe accommodation had been requested, as the circumstances and actions implied that this type of accommodation would have been appropriate in these circumstances.

5.11 Custody staff were not always aware of their responsibilities in relation to AAs when dealing with vulnerable adults. At Workington and Carlisle, we saw vulnerable adults held in custody who had been fingerprinted, photographed and had a DNA sample taken without an AA being present, which was inappropriate and a breach of PACE. Custody staff at all the suites told us that this was common practice for vulnerable adults, but that they always ensured that an AA was present before carrying out such procedures for a child under the age of 18 years.

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[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] Under PACE Code C Note 16D the availability of secure accommodation is only a factor in relation to a juvenile aged 12 or over when other local authority accommodation would not be adequate to protect the public from serious harm from them.

5.12 Family or friends were contacted in the first instance to act as an AA, but none of the custody staff we spoke to were aware of the Home Office guidance document to assist AAs when carrying out this role. In the absence of family members, AAs for children were available from Monday to Friday, between 8am and 5pm, through the local YOS, and between 5pm and midnight and over the weekend via children's services, which tasked TAAS to attend. TAAS was also responsible for a daily service for vulnerable adults between 8am and midnight. Staff reported receiving a good service from both providers, and this had improved since the previous inspection; however, it was poor that neither operated on a 24-hour basis, which could lead to detainees being held in custody for longer than necessary (see main recommendation 2.43).

5.13 We were concerned that the role of AAs was being misunderstood or misapplied, as they were not requested to attend early enough – that is, as soon as vulnerability was identified. Custody staff told us, and we observed, that they were normally requested to attend only when interviews with detainees were due to be progressed, rather than having them attend as soon as practicable to support the child or vulnerable adult throughout the custody experience. At Barrow, we saw a 12-year-old boy who had been held in custody overnight, after being arrested at 10.50pm on the previous night. His AA from YOS and his solicitor were not requested to attend until noon on the day after arrest, when the investigating officer was ready to interview the child (see main recommendation 2.44). The child's rights and entitlements were re-read in the presence of the AA.

5.14 Further delays arose because TAAS would not arrange for an AA to be present in custody for children unless they had received a direct referral from children's services, In one case, custody staff had been unable to contact children's services and TAAS had refused to arrange an AA until they received a direct referral from them. It had taken five hours and three minutes for an AA to attend for this child. This process was failing vulnerable children (see main recommendation 2.44).

5.15 In our CRA, a detainee reporting mental health problems had been seen by a health care professional, who noted his vacant mood and considered that he required an AA. The AA had arrived 32 minutes after being contacted and it appeared that a strip-search had been delayed until their arrival, which was appropriate.

Recommendation

5.16 Cumbria Constabulary should ensure that fingerprinting, photographing and the taking of DNA samples in cases involving vulnerable adults take place in the presence of an appropriate adult (AA).

Housekeeping points

5.17 Cumbria Constabulary should monitor and record details of all occasions when the interpreting service is unable to provide either a telephone or face-to-face interpreter.

5.18 Custody staff should be provided with a written guidance document to assist family or friends acting as AAs, and this should be issued routinely where relevant.

Rights relating to PACE

5.19 During booking-in, custody sergeants advised detainees of their three main rights (the right to have someone informed of their arrest, the right to consult a solicitor and access free

independent legal advice, and the right to consult the PACE codes of practice), and all detainees were offered an up-to-date written notice setting out their rights and entitlements while in custody. Custody sergeants were able to access these documents in foreign languages for non-English-speaking detainees but few staff were aware that an easy-read pictorial version of detainees' rights and entitlements, for detainees needing help with understanding or reading, was available from the Home Office through the same website link.

5.20 We saw detainees being told that they could read the PACE codes of practice during the booking-in process, but these were not routinely explained by custody staff. There were sufficient copies of the up-to-date PACE code C available at all suites but we did not see these being offered or given to any detainees to read. The Criminal Defence Service (CDS) posters informing detainees of their right to free legal advice in 24 languages were available in only two suites; in the others, these were displayed in only a limited number of languages.

5.21 All detainees were offered free legal representation; however, if a detainee declined, staff did not always ask them, or record any reason, why they did not wish to use this service. Detainees were not always told that they could change their mind at any time and accept the offer of free legal representation. Those wishing to speak to legal advisers were able to do so in the privacy of their cells, through the use of portable handset telephones. We saw legal advisers being given copies of the front sheet of their client's custody records, and at Carlisle they were also provided with a copy of the detention log. In our CRA, all detainees had been offered legal advice and 10 had accepted this offer. Logs demonstrated that solicitors had been contacted promptly after being requested. We were told that voluntary attendees attending at police stations were routinely issued with a notice about access to free legal advice.

5.22 We saw detainees being told that they could inform someone of their arrest, which staff facilitated. In our CRA, 11 detainees had asked for someone to be so informed, and in all but one case it was clear that the chosen person had been contacted.

5.23 Reviews of detainees' cases were undertaken by dedicated custody and operational inspectors across the force area. We observed some taking place, mainly face-to-face but a few over the telephone, and these were all timely and appropriate. In our CRA, 17 detainees had required a PACE review, 16 of which had been conducted on time and one had taken place 30 minutes early. Some, but not all, detainees had been told that reviews had taken place while they were asleep and been reminded of their rights and entitlements. In our CRA, 11 reviews had taken place while the detainee was asleep and it was recorded in seven instances that the detainee had been informed of this and that they had been reminded of their rights and entitlements when awake.

5.24 The management of refrigerators and freezers in the custody suites was inadequate. We found some old blood samples, volunteer DNA samples and forensic samples there. In one suite, the freezer drawers were filled to capacity, leaving little room for fresh samples to be stored.

5.25 Custody staff at all suites told us that the local magistrates' courts would not normally accept detainees after 2pm to 3pm on weekdays and after 9am on Saturdays, which was too early, potentially prolonging detention unnecessarily. Staff told us that there was some flexibility on a day-to-day basis. We were told that some courts had occasionally refused to accept detainees as early as 11am on weekdays, which was similar to the situation at the time of the previous inspection, resulting in detainees having to be held in police custody overnight. During the inspection, we saw Barrow Magistrates' Court accept a detainee at 2pm and Carlisle Magistrates' Court accept a detainee at 2.40pm.

Recommendations

5.26 Cumbria Constabulary should review its policy and procedure with regard to managing the refrigerators and freezers in the custody suites, to ensure the timely submission of samples.

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

Housekeeping points

5.28 Staff should be made aware of the availability of the easy-read pictorial version of the rights and entitlements information.

5.29 PACE codes of practice should be routinely explained and offered by custody staff.

5.30 The reasons why detainees decline the offer of legal advice should be recorded in the custody record.

Rights relating to treatment

5.31 There was no visible information displayed in the custody suites about the complaints process. Although details of this were included in the rights and entitlements notice, most detainees we observed declined to accept this document. Most custody staff told us that if a detainee wished to make a complaint, they would be advised to attend at the police station front desk after release. The force guidance on dealing with complaints did not make it clear that complaints should be noted while a detainee is in custody, where possible. Some custody staff indicated that if detainees wished to complain while remanded in custody pending appearance at court, they would advise the inspector covering PACE reviews about this; it would then be the inspector's decision as to whether or not they logged the complaint from the detainee while they were still in custody. We saw a detainee at Barrow ask custody staff for a complaint form; no form could be found and the detainee was advised to attend at the police station front desk and ask to speak to the duty inspector. We were told that the Professional Standards Department conducted a trend analysis in relation to complaints but not all custody staff were aware of this.

Recommendation

5.32 Cumbria Constabulary should review its guidance on complaints, to ensure that detainees are able to make a complaint while they are still in custody, and staff should be made aware of this.

Section 6. Health care

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

Governance

6.1 Cumbria Constabulary had contracted G4S Forensic & Medical Services (UK) Ltd to provide health care practitioners (HCPs) and forensic medical examiner (FME) services since April 2015. Mental health services were provided by Cumbria Partnership NHS Foundation Trust, and drug and alcohol recovery services by Unity, Greater Manchester West NHS Foundation Trust.

6.2 There was a range of well-established partnership meetings, which covered strategic and operational issues and were attended by all providers. G4S had started to collect and record some data but there were no regular audits, and monitoring mechanisms were not fully established, which meant that there were no data available to monitor service delivery effectively. We were told that a quarterly data report, including response times, was due to be presented to the police at the end of June 2015. The service was engaging with NHS England to prepare for the transfer of commissioning in April 2016.

6.3 Twenty-four-hour embedded nursing cover was provided in Carlisle and Workington, with an HCP shared between Kendal and Barrow who worked 12-hour shifts. There was only one FME on call for the whole area at any one time, and staff told us that this sometimes caused a delay in response times, although there were no data available to verify this. They worked 24-hour shifts and were employed by G4S through an agency (Sensible Staffing). One FME told us that he was regularly on duty for several consecutive days, which could raise concerns about fitness to practice when tired. We were told that the low demand for FME services mitigated the impact of these shifts; this was overseen by the G4S manager, who arranged for an additional locum or relief doctor to attend when necessary.

6.4 Health services staff told us that they felt supported by the new provider but that for several months before the contract change there had been a lack of clinical and managerial supervision. Mandatory training dates had been passed to G4S and training was being scheduled to ensure that staff remained up to date with this. Opportunities for professional development had recently been instigated by G4S.

6.5 Medical and nursing professional credentials and revalidation were monitored and G4S had provided an induction. Staff had received some corporate policies but the range of clinical policies was limited, although this was being addressed. Most staff knew how to report an incident but there was no feedback about local trends, to drive service improvement. It was not clear how a detainee could make a health-related complaint.

6.6 Health services staff were competent and compassionate, and interventions were generally completed in private. Telephone interpreting services were available when required.

6.7 All the treatment rooms were clean and met infection control standards, although the recently refurbished room at Workington needed some minor attention to the wall behind the sink, where tiles had been removed, but this was being addressed. Clinical work surfaces were suitable for forensic sampling.

6.8 Custody staff received annual enhanced first-aid training that included basic life support, and had access to an automated external defibrillator and oxygen. These were in date, although there was no clear audit trail to verify that the emergency equipment was routinely checked and maintained.

Recommendations

6.9 A comprehensive range of data, including response times, should be collected and monitored to ensure effective service delivery and robust contract management.

6.10 Support for front-line HCP staff should be enhanced to include regular managerial and clinical supervision, and they should have access to evidence-based clinical policies and procedures.

6.11 Clinical governance processes should be embedded to ensure safe practice, including agreed protocols for checking resuscitation kits, infection control and record-keeping audits, and incident analysis and feedback.

Housekeeping point

6.12 Detainees should be able to complain about health services through a well-advertised and confidential health care complaints system.

Patient care

6.13 The interactions we observed were professional and clinically appropriate. Contemporaneous handwritten clinical assessment records were legible and those we assessed were of a good quality. Appropriate entries were also placed on an electronic proforma on the custody record, to ensure safety and maintain confidentiality.

6.14 Custody staff were complimentary about the embedded nursing services, where they were provided, and they valued individual HCPs' clinical interventions. We were told, however, that, because of the travel time of an hour between Barrow and Kendal, and depending on the workload at each location, HCPs were sometimes delayed in attending at these suites. Our CRA cited two examples when it had taken over two hours for the HCP to arrive, with one detainee released without seeing them, although the opportunity to wait had been offered but declined. Custody staff recorded response times on individual custody records but no collated data was available to monitor trends effectively (see recommendation 6.9).

6.15 Clinical records were stored securely and complied with Caldicott and Data Protection Act requirements. They were retained in the suites for a month and then collected and stored by G4S. Consent to share information was sought and recorded routinely, and detainees we spoke to were content with the health interventions they had received.

6.16 Medication management arrangements were generally satisfactory and had improved since the previous inspection. Checks were in place with the call centre to record stock balances for the use of controlled drugs, and these were checked daily or when the HCP visited the suite. Stock levels were well managed, medication counts were correct and cupboards were well organised. Medication was in date and disposed of appropriately. Drug refrigerator temperatures were not consistently recorded and there was no refrigerator in the treatment

room at Barrow for heat-sensitive medication. The keys for the medicine cupboard at Kendal were stored in the main key safe, which could be accessed by non-medical staff.

6.17 An appropriate range of patient group directions (enabling nurses to supply and administer prescription-only medicine) were in each medical room and were signed and in date, so that nurses could provide specified medications without referring to a doctor, ensuring that detainees had timely access to required medicines.

6.18 Detainees could continue to receive validated prescribed medication in custody, although this did not include opiate substitution therapy. The police made reasonable attempts to collect prescribed medications from detainees' home addresses. There was a comprehensive assessment tool for opiate and alcohol withdrawal, and symptomatic relief was given by the HCPs. Nicotine replacement therapy was available.

Recommendation

6.19 Detainees who are prescribed opiate substitution medication in the community should be supported to continue this in custody if clinically appropriate.

Housekeeping points

6.20 A refrigerator should be available in each treatment room, with minimum and maximum temperatures recorded daily and remedial action taken if these are outside of range, to ensure the correct storage of heat-sensitive medication.

6.21 Keys to access medicine cabinets should be available only to health services staff.

Substance misuse

6.22 The community-based drug and alcohol recovery service (Unity) offered good support to adult detainees with drug or alcohol problems. There had been occasional gaps when staff had not attended, which could have affected outcomes for detainees. Referrals were made by custody staff out of hours and at weekends, and the Unity information leaflet was given as part of the pre-release risk assessment.

6.23 Unity workers were scheduled to visit three out of the four custody suites twice on weekdays, in the morning and afternoon, to screen all detainees and respond to need identified by custody staff and the HCP. The service at Kendal was referral based and the manager told us that they received approximately one referral a week.

6.24 Unity offered an initial assessment in the community to identify an individualised recovery plan, which could include harm minimisation services, clinical help to detoxify, psychosocial options, and links to local recovery groups and family support. Social circumstances, including safeguarding considerations when children were involved, were also considered. There were no needle exchange schemes in the custody suites but services were available locally for each suite. Children were signposted to appropriate services or referred directly into age-appropriate services.

Housekeeping point

6.25 Substance use staff should be available at the agreed times, to ensure that detainees receive the appropriate level of intervention.

Mental health

6.26 There was evidence of good partnership working between the police and mental health services. A multi-agency criminal justice and mental health steering group met quarterly and had established a protocol for mentally disordered offenders, a joint operational protocol for interagency assistance and a section 136 protocol (see below), all of which required updating. All custody staff had received training in mental health awareness as part of their induction but none had received refresher training.

6.27 In our CRA, seven detainees had entered custody with mental health problems and a further six with current or previous self-harm or suicide issues. There was no dedicated mental health liaison and diversion service. However, following their assessment of the detainee's fitness to detain, the HCP could contact the access and liaison integrated service, part of community mental health services, to request a mental health assessment if necessary. HCPs did not receive Mental Capacity Act training, which would have given them additional support in making this assessment.

6.28 In all of the custody suites, HCPs and custody officers alike reported long delays in accessing mental health assessments for adults and children, particularly out of hours, resulting in detainees being held in custody when they needed specialist assessment and, potentially, inpatient mental health care. After 9pm, there was only one approved mental health professional for Cumbria, which meant that assessments were prioritised according to risk, and travel time could affect the response times.

6.29 Useful data collected by Cumbria Partnership NHS Foundation Trust indicated that there had been an increase in the use of section 136 of the Mental Health Act (1983)[6] in Cumbria over the previous three years, with a total of 198 in 2012/13 and 230 in 2014/15, but the use of a custody suite as a place of safety had decreased from 70 in 2012/13 to 53 in 2014/15, although this was still too high (see main recommendation 2.45). There were four hospital-based places of safety, although we were told that not all were available because of staffing issues.

6.30 All key stakeholders were sighted on the overuse of police custody suites as a place of safety under section 136 in Cumbria. An action plan identified areas for improvement, which included a review of the provision of places of safety, outside of police cells, under the Crisis Care Concordat (a national agreement between services and agencies involved in the care and support of people in crisis).

[6] Section 136 of the Mental Health Act 1983 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.

Recommendations

6.31 Mental Health Act assessments should be expedited to ensure that detainees do not remain in custody for too long.

6.32 Mental health awareness training should be regular and enable all custody staff to identify and manage the care of detainees appropriately and safely.

6.33 The joint mental health protocols should be updated to reflect current practice.

6.34 Health care professionals should be given Mental Capacity Act training and mental health updates.

Section 7. Summary of recommendations and housekeeping points

Main recommendations

7.1 Cumbria Constabulary should collect and analyse information, including quality assurance data, to ensure a robust assessment of standards in custody, providing safe and timely outcomes for detainees. (2.41)

7.2 Cumbria Constabulary should ensure routine recording and monitoring of use of force data from custody, examine it for trends, and ensure accountability in accordance with the Association of Chief Police Officers' policy and College of Policing guidance. (2.42)

7.3 The Police and Crime Commissioner and Chief Officer Group should engage with their counterparts in the local authority, instigate an immediate review of the provision of local authority accommodation for children under section 38(6) PACE 1984, and monitor performance data to ensure that children are not detained unnecessarily in police cells. (2.43)

7.4 Appropriate adults should be available 24 hours a day and be requested to attend as soon as possible to ensure the welfare and safety of vulnerable adults and children in custody. (2.44)

7.5 Police custody should not be used as a place of safety for section 136 of the Mental Health Act 1983 assessments. (2.45)

Recommendations

Strategy

7.6 Cumbria Constabulary should ensure that the management structure and roles for custody are communicated effectively and understood by staff. (3.6)

7.7 There should be sufficient staff in custody suites at all times to ensure the safety and well-being of detainees. (3.7)

7.8 The proportion of custody records that are dip-sampled should be increased and the sample should be cross-referenced with person escort records and closed-circuit television recordings. (3.17)

7.9 Territorial policing sergeants who do not work regularly in custody should receive refresher training. (3.18)

Treatment and conditions

7.10 Custody staff should ask all detainees if they have any obligations as carers or are being cared for by others, and whether they need help to address these requirements. (4.5)

7.11 Girls under 18 should be allocated a named female officer who is responsible for their care while in custody. (4.6)

7.12 Restrictions on detainees' footwear and clothing should be subject to individual risk assessment. (4.14)

7.13 Anti-rip clothing should only be used in exceptional circumstances and as a last resort to protect the detainee from harm, with a recorded rationale, based on a risk assessment. (4.15)

7.14 All staff undertaking cell visits and answering cell bells should be issued with keys and anti-ligature knives. (4.16)

7.15 All custody staff should be involved in the same shift handover, which should be recorded. (4.17)

7.16 There should be training and guidance on the use of spit helmets. (4.22)

7.17 Strip-searches should be recorded accurately in the custody record, including the authorising officer, gender of searching staff and subsequent outcomes. (4.23)

7.18 There should be clear, detailed records of daily cell checks, with a means of recording defects, including any ligature points that have been identified. (4.29)

7.19 Responses to cell call bells should always be prompt. (4.30)

7.20 Regular emergency evacuation drills should take place at each suite and be recorded. (4.31)

7.21 Replacement footwear should be provided for all detainees if their own footwear is removed or stored outside their cell. (4.38)

7.22 All suites should hold a stock of reading material suitable for children and in a range of languages. (4.39)

7.23 The showers on the men's corridor at Workington should be clean and hygienic. (4.40)

7.24 Women detainees should be offered sanitary products. (4.41)

Individual rights

7.25 Cumbria Constabulary should ensure that fingerprinting, photographing and the taking of DNA samples in cases involving vulnerable adults take place in the presence of an appropriate adult (AA). (5.16)

7.26 Cumbria Constabulary should review its policy and procedure with regard to managing the refrigerators and freezers in the custody suites, to ensure the timely submission of samples. (5.26)

7.27 Senior police managers should work with HM Courts and Tribunals Service to ensure that early court closure times do not result in unnecessarily long stays in police custody. (5.27)

7.28 Cumbria Constabulary should review its guidance on complaints, to ensure that detainees are able to make a complaint while they are still in custody, and staff should be made aware of this. (5.32)

Health care

7.29 A comprehensive range of data, including response times, should be collected and monitored to ensure effective service delivery and robust contract management. (6.9)

7.30 Support for front-line HCP staff should be enhanced to include regular managerial and clinical supervision, and they should have access to evidence-based clinical policies and procedures. (6.10)

7.31 Clinical governance processes should be embedded to ensure safe practice, including agreed protocols for checking resuscitation kits, infection control and record-keeping audits, and incident analysis and feedback. (6.11)

7.32 Detainees who are prescribed opiate substitution medication in the community should be supported to continue this in custody if clinically appropriate. (6.19)

7.33 Mental Health Act assessments should be expedited to ensure that detainees do not remain in custody for too long. (6.31)

7.34 Mental health awareness training should be regular and enable all custody staff to identify and manage the care of detainees appropriately and safely. (6.32)

7.35 The joint mental health protocols should be updated to reflect current practice. (6.33)

7.36 Health care professionals should be given Mental Capacity Act training and mental health updates. (6.34)

Housekeeping points

Strategy

7.37 Staff awareness of the custody intranet site should be improved. (3.19)

Individual rights

7.38 Cumbria Constabulary should monitor and record details of all occasions when the interpreting service is unable to provide either a telephone or face-to-face interpreter. (5.17)

7.39 Custody staff should be provided with a written guidance document to assist family or friends acting as AAs, and this should be issued routinely where relevant. (5.18)

7.40 Staff should be made aware of the availability of the easy-read pictorial version of the rights and entitlements information. (5.28)

7.41 PACE codes of practice should be routinely explained and offered by custody staff. (5.29)

7.42 The reasons why detainees decline the offer of legal advice should be recorded in the custody record. (5.30)

Health care

7.43 Detainees should be able to complain about health services through a well-advertised and confidential health care complaints system. (6.12)

7.44 A refrigerator should be available in each treatment room, with minimum and maximum temperatures recorded daily and remedial action taken if these are outside of range, to ensure the correct storage of heat-sensitive medication. (6.20)

7.45 Keys to access medicine cabinets should be available only to health services staff. (6.21)

7.46 Substance use staff should be available at the agreed times, to ensure that detainees receive the appropriate level of intervention. (6.25)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	HMIP team leader
Fionnuala Gordon	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Clive Burgess	HMIC lead staff officer
Anthony Davies	HMIC staff officer
Maureen Jamieson	HMIP health services inspector
Kathleen Byrne	Care Quality Commission inspector
Joe Simmonds	HMIP researcher

Appendix II: Progress on recommendations from the last report

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

Strategy

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

Recommendations

The current staffing model in custody suites should be reviewed to ensure sufficient staff are on duty to provide an appropriate level of care to detainees. (3.19)
Partially achieved

The time detention officers are taken away from work ensuring the welfare and safety of detainees should be assessed and monitored to ensure these core duties can be effectively carried out. (3.20)
Partially achieved

Custody staff should be released to attend off-the-job refresher training. (3.21)
Achieved

The dissemination of good practice and lessons learned should be improved to ensure that all staff are fully briefed and up to date with current practices and knowledge. (3.22)
Achieved

Use of force should be monitored centrally to enable managers to identify patterns and monitor trends. (3.23)
Not achieved

There should be a clear policy for staff outlining when the use of Tasers or incapacitant sprays is justifiable and proportionate within a custodial environment. (3.24)
Achieved

Treatment and conditions

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

Recommendations

Refresher training should be offered that incorporates the specific needs of female detainees, detainees with disabilities and those with differing religious needs. (4.28)
Partially achieved

Operational staff should receive child protection awareness training. (4.29)
Not achieved

All female detainees should be offered a hygiene pack on arrival in custody. (4.30)
Partially achieved

There should be clear policies to meet the needs of detainees with disabilities or mobility issues while in custody. (4.31)
Not achieved

Booking-in desks should be of an appropriate height and the reception area should allow adequate privacy for new arrivals. (4.32)
Partially achieved

Closed-circuit television monitors should be visible only to staff. (4.33)
Achieved

All cells should be fit for purpose and free of ligature points, and custody staff should be trained to identify potential ligature points. (4.34)
Not achieved

All staff should carry anti-ligature knives. (4.35)
Not achieved

Regular fire evacuation drills and smoke detector tests should be conducted. (4.36)
Not achieved

The daily, weekly and monthly health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate. They should be fully recorded and monitored by custody site managers to ensure identified issues are progressed and actioned accordingly. (4.37)
Achieved

All custody staff should receive refresher self-harm and suicide training. (4.38)
Partially achieved

Handcuffs should be removed as soon after arrival in custody as is practical, subject to risk assessment. (4.39)
Achieved

Views of in-cell toilets covered by closed-circuit television should be obscured. (4.40)
Achieved

Detainees held overnight and those who are dirty should be offered a shower and shower areas should allow sufficient privacy, particularly to female detainees. (4.41)
Partially achieved

Detainees held overnight or for over eight hours should be offered outdoor exercise. (4.42)
Partially achieved

A change of underwear should be provided for all detainees when appropriate. (4.43)
Achieved

On an individual needs assessed basis, nicotine replacement should be made available to smokers. (4.44)
Achieved

Pillows should be provided routinely to all detainees. (4.45)
Achieved

The calorific content of microwave meals should be improved. Meals should be offered on arrival and then when requested at meal times. (4.46)
Achieved

Individual rights

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

Recommendations

Children detained under section 46 of the Children Act should not be held in police cells. (5.18)
Achieved

Unless there is a clear reason not to do so, detainees should be offered a free five-minute telephone call when they arrive in custody. (5.19)
No longer relevant

Managers should liaise with the UK Border Agency to ensure that immigration detainees are held in police custody for the shortest possible time. (5.20)
Partially achieved

A professional telephone interpreting service should be used as necessary when detainees are examined by healthcare professionals. (5.21)
Achieved

Custody staff should ensure that any detainee dependency issues are identified and, where possible, addressed. (5.22)
Partially achieved

Formal pre-release risk management planning for vulnerable detainees should be implemented consistently and any actions taken recorded on NSPIS. (5.23)
Achieved

Up-to-date PACE codes of practice should be readily available at Workington. (5.24)
Achieved

Appropriate adults should be available 24 hours a day to support juveniles and vulnerable adults in custody. (5.25)
Partially achieved

Detainees aged 17 years should be provided with an appropriate adult. (5.26)
Achieved

The court service and the responsible assistant chief constable should work together to minimise delays in holding detainees who are to be produced at court, including the early introduction of video links. (5.27)
Partially achieved

The force should review and put in place a standard operating procedure and follow up mechanism that identifies and ensures that exhibits or forensic samples in fridges or freezers but not entered in log books are not overlooked. (5.28)
Partially achieved

Information about how to make a complaint should be given to all detainees during the booking in process in a format they understand and clearly displayed in the custody suites. (5.29)
Partially achieved

All staff in custody suites should be fully aware of the force policies for taking and dealing with complaints. (5.30)
Partially achieved

Health care

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

Recommendations

There should be an urgent review of the provision of health services to ensure that the physical, mental and substance use needs of detainees are met in good time by competent healthcare professionals. (6.21)
Achieved

The contract for health service provision should be robustly managed by the constabulary and performance data challenged when appropriate. (6.22)
Not achieved

Nursing staff should ensure that they adhere to their Nursing and Midwifery Code and remember that they are personally accountable for actions and omissions in their practice and should always be able to justify their actions. (6.23)
Achieved

Female detainees should be told that they can see a female doctor on request. (6.24)
Not achieved

There should be clear infection control procedures, including cleaning schedules that should be adhered to and monitored. (6.25)
Achieved

There should be safe pharmaceutical management and use. All medications should be stored safely and securely and disposed of safely if not consumed. (6.26)
Achieved

Resuscitation equipment should be available and ready for use in every custody suite and all staff trained in its use. (6.27)
Achieved

Healthcare professionals should attend in person within the agreed response times when detainees request to see them or custody staff assess that their services are required. (6.28)
Partially achieved

Health professionals should not provide prescriptions for medications over the telephone for non-health professionals to administer. (6.29)
Achieved

Detainees should be able to continue with prescribed medications for any clinical condition and to receive medications to provide relief for drug and alcohol withdrawal symptoms if needed. (6.30)
Partially achieved

All clinical records should be stored in line with Caldicott guidelines, the Data Protection Act and other relevant legislation. (6.31)
Achieved

Access to services for detainees with substance use issues should be consistent across the county and adequate services for juveniles should be provided. (6.32)
Partially achieved

Injecting drug users who are released into the community should be offered clean needles by drugs workers. (6.33)
Achieved

There should be a liaison officer and/or diversion scheme that enables detainees with mental health problems to be identified and diverted into appropriate mental health services or referred on to prison health services. (6.34)
Partially achieved

HM Inspectorate of Prisons and HM Inspectorate of Constabulary are members of the UK's National Preventive Mechanism, a group of organisations which independently monitor all places of detention to meet the requirements of international human rights law.