

Report on an unannounced inspection visit to police custody suites in Essex

27 February – 10 March 2017

by HM Inspectorate of Prisons and
HM Inspectorate of Constabulary





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This inspection was carried out in partnership with the Care Quality Commission.

Glossary of terms

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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.

We last inspected Essex Police custody in January 2013, when we found that detainees were treated well, but that much of the estate needed refurbishment and staff shortages were affecting the treatment of detainees.

Since the last inspection, the custody estate had reduced and four suites had closed permanently. Conditions at the newer suites were good but the environment at some older suites remained poor. We identified several potential ligature points across the estate, which required attention.

The force was poorly served by its IT system. Custody sergeants found it bureaucratic and cumbersome to use, and managers found it difficult to search for data. The force did not comply with all procedures in relation to the Police and Criminal Evidence Act 1984 (PACE), in particular the application of codes C and G.

In an effort to improve the experience of detainees, the force had developed partnerships with key stakeholders. Despite this, too many vulnerable adults were still brought into custody as a place of safety, and too many children were held overnight when alternative accommodation should have been provided.

Staff continued to treat detainees well and were sensitive when dealing with vulnerable people or those from minority backgrounds.

Management of the use of force in custody was good. This was notable because Essex was the first force where we had not identified this as an area for concern under our new inspection methodology.

Overall, the standard of health care was adequate. In most cases, the force placed sufficient emphasis on ensuring that detainees were released safely.

The force impressed us as being very open to and prepared to learn from scrutiny. A recent peer review of custody provision by colleagues from two external forces had been thorough and exacting, producing relevant recommendations. The force had started to act on this comprehensive report. While our own findings showed some progress in most of the areas we examined, the internal work already being carried out reassured us that Essex police had a strong commitment to improve further the treatment and conditions for detainees held in its custody.

We noted that of the 35 recommendations made in our previous report after our inspection of 2013, 10 recommendations had been achieved, 13 had been partially achieved, 11 had not been achieved and one was no longer relevant.

This report provides three recommendations to the force and highlights 30 areas for improvement.

Dru Sharpling CBE
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons May 2017

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 College of Policing's *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 the police custody inspection. The custody record analysis was carried out on a representative sample of the custody records, across all of the suites in that area, opened in the week prior to the inspection being announced. Records analysed were chosen at random and a robust statistical formula provided by a government department statistician was used to calculate the sample size required to ensure that our records analysis reflected the throughput of the force's custody suites during that week.² The analysis focused on the legal rights and treatment and conditions of the detainee. Where comparisons between groups or with other forces are included in the report these differences are statistically significant.³ A total sample of 14 records were analysed.
- 2.4** A data collection template was completed by the force during the inspection and was based on police custody data for the 36 months prior to inspection. The template requested a range of information including data on the demographics of the custody population, the number of voluntary attendees and average length of time in police detention.

¹ <http://www.justiceinspectorates.gov.uk/hmiprison/about-our-inspections/inspection-criteria/>

² 95% confidence interval with a sampling error of 7%.

³ A statistically significant difference between the two samples is one that is unlikely to have arisen by chance alone, and can therefore be assumed to represent a real difference between the two populations. In order to appropriately adjust p-values in light of multiple testing, $p < 0.01$ was considered statistically significant for all comparisons undertaken. This means there is only a 1% likelihood that the difference is due to chance.

| Custody suites | Number of cells |
|---------------------------------|------------------------|
| Basildon | 20 |
| Chelmsford | 15 |
| Clacton | 12 |
| Colchester (closed temporarily) | 17 |
| Grays | 17 |
| Harlow | 14 |
| Southend | 30 |
| Stansted (closed temporarily) | 3 |

Leadership, accountability and partnerships

- 2.5** There were some strong aspects of leadership, accountability and partnerships but also several areas that needed further attention.
- 2.6** The custody estate had reduced since the last inspection, with four suites closing permanently. The new suites provided improved facilities, but conditions at some of the remaining older suites were still poor.
- 2.7** A clear governance structure provided accountability for the safe delivery of custody. However, we were not confident that the shift system was efficient or that there were sufficient sergeant and inspector staff. The force followed the College of Policing's *Authorised Professional Practice - Detention and Custody*, and this was underpinned by clear local policies. Training for custody staff was comprehensive. Regular contract monitoring meetings between the force and the health care provider, G4S, helped to ensure an early resolution of operational issues.
- 2.8** It was clear that inefficiencies associated with the force IT system (Athena) were having a detrimental impact on detainees in several areas.
- 2.9** The monitoring of custody performance was improving. Data were collated in key areas, including custody throughput and overall detention times. However, some of the data drawn from Athena were inaccurate, which made it difficult to assess performance.
- 2.10** Governance and oversight of the use of force in custody were effective. There were reliable mechanisms to assure the force, the Police and Crime Commissioner and the public that the use of force in detention and custody was safe and proportionate. The force was able to provide the data required for the Home Office annual data return as recommended by the National Police Chiefs Council.
- 2.11** The force did not comply with several procedural areas of PACE and codes C (covering the detention, treatment and questioning of persons by police officers) and G (the statutory power of arrest).

- 2.12** Although there were a number of arrangements to demonstrate how the force was meeting its obligations under the Equality Act 2010 and the public sector equality duty, it had no specific equality action plan for custody, and detainees were not routinely asked to define their ethnicity.
- 2.13** The force had developed partnerships with key stakeholders to improve the experience of detainees. Despite this, too many people detained under section 136 of the Mental Health Act⁴ were brought into custody as a place of safety, and too many children were held in custody overnight when alternative accommodation should have been provided.
- 2.14** The force was open to scrutiny and had invited a peer review of its custody provision as part of its internal improvement. Staff from two external forces had conducted a comprehensive review aligned to our own inspection standards and produced a comprehensive report with recommendations that the force was acting on.

Pre-custody: first point of contact

- 2.15** Call centre staff and frontline officers had a good understanding of detainee vulnerability. Call centre staff mostly provided officers with prompt and relevant information. Although not always successful, officers placed a strong emphasis on diverting children and vulnerable adults away from custody, and used a range of alternatives to achieve this.

In the custody suite: booking in, individual needs and legal rights

- 2.16** All custody staff showed a high level of awareness of vulnerability and diversity, and communicated with and about detainees in an engaging, respectful and compassionate way. Efforts to meet individual needs were generally good. However, detainee privacy was sometimes lacking.
- 2.17** There was sufficient attention to risk management in custody suites. Most detainees were admitted to the suites promptly. Risk assessments were thorough and focused on the identification of vulnerability and potential risk. Levels of observations were set appropriately and reviewed throughout the individual's detention.
- 2.18** Staff knowledge of procedures to rouse intoxicated detainees was good, and custody records included appropriate monitoring of those under the influence of drugs or alcohol. Custody staff were normally issued with anti-ligature knives but not all carried them in the suites. The almost routine use of anti-rip clothing to manage non-compliant detainees or those identified at risk of self-harm was not always effective at minimising risk.
- 2.19** Staff shift handover arrangements were sound.
- 2.20** The provision of individual and legal rights for detainees was mixed, and we had some concerns that elements of PACE were not complied with (see above). There were few copies of the current PACE code C in the suites, and they were not readily offered to

⁴ Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety - for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

detainees. However, easy-read rights and entitlements booklets were available. Some detainees were held in custody for longer than was necessary, for reasons that were avoidable.

- 2.21** There had been a sharp reduction in voluntary attendance (where suspects involved in minor offences attend a police station by appointment, avoiding the need for arrest and subsequent detention). Voluntary attendees were dealt with inside the custody suite, which was inappropriate and contrary to the ethos of this scheme as a diversion to custody.
- 2.22** The force had adequate access to professional telephone interpreting for non-English speakers, but this did not always take place with sufficient privacy.
- 2.23** The management of bail was inconsistent. The force had made reasonable preparations for the new bail arrangements under the Policing and Crime Act.
- 2.24** Arrangements for dealing with complaints were inconsistent and not always good enough.

In the custody cell, safeguarding and health care

- 2.25** Conditions in the custody estate varied from very good to poor. Unlike some of the older suites, the newer facilities were clean and free from graffiti. We found a range of potential ligature points that required remedial attention across the suites. The use of emergency cell call bells was not always explained to detainees. Maintenance and cleaning arrangements were reasonable. The arrangements for fire evacuation were generally adequate.
- 2.26** Management of the use of force in custody was good. Essex was the first force we inspected using our new standards where use of force was not identified as an area for concern. Staff generally dealt with challenging detainees very patiently. Most of the cases we reviewed showed that force was only used against detainees in custody as a last resort. However, in some cases force was used to remove clothing from detainees, which we considered a potentially aggravating factor that could escalate a situation. Handcuffs were not applied routinely, which was positive, but they were not always removed quickly enough from compliant detainees.
- 2.27** On the basis of the custody records we examined, we were not confident that all strip searches were warranted or properly justified.
- 2.28** Attention to detainee care was generally good. They had access to an adequate range of meals and drinks, and suitable supplies of alternative clothing. Showers and exercise were facilitated, and some detainees had access to reading materials to occupy them during their time in custody.
- 2.29** PACE reviews were mostly conducted with the detainee face to face, which was positive. Detainees were not always informed promptly about reviews that had taken place while they were asleep or reminded of their rights on waking.
- 2.30** Staff generally showed a good understanding of safeguarding and the need to protect vulnerable adults and children. Safeguarding referral forms were completed for all children entering custody, and referrals were made for vulnerable adults where appropriate. Custody sergeants focused on minimising the time children spent in custody, which was positive. Children generally received good care and treatment while in custody, and risks were properly assessed when they were leaving custody with good arrangements to ensure that children returned home safely. Arrangements for securing appropriate adults for both vulnerable adults and children were inconsistent.

- 2.31** Health care provision was adequate, even though some response times by health care professionals (HCPs) fell outside the contracted requirement. Clinical records usually showed appropriate justification for clinical decision making. Some clinical rooms did not comply with infection control standards. Arrangements for emergency response were reasonable.
- 2.32** Health assessments were thorough, sensitively conducted and focused on risks. Custody staff had good access to medical advice by telephone. Detainees could be given their own prescribed medicines subject to verification, which was positive. Detainees in active withdrawal from alcohol or opiates received symptomatic relief subject to objective assessment.
- 2.33** Criminal justice liaison and diversion (CJLD)⁵ practitioners were provided in all suites and screened all detainees who met the criteria of the 'vulnerability model'. This included people with substance misuse needs, who were then signposted to specialist substance misuse services in the community. There was some useful collaboration between substance misuse providers and mental health services. The CJLD service was responsive, suitably focused and worked well to ensure detainees were appropriately cared for.
- 2.34** Custody was still used too often as a place of safety under the Mental Health Act, and there were regular and lengthy delays for Mental Health Act assessments.

Release and transfer from custody

- 2.35** There was a generally strong emphasis on making sure detainees were released safely, with good links with partner agencies and support organisations. Information about risk, vulnerability and safeguarding was shared regularly between custody staff and the CJLD team.
- 2.36** Arrangements to get detainees to court had improved since the previous inspection. We were told that in most cases detainees were accepted at local remand courts up to 2pm, with some additional flexibility each day. Most of the person escort records we saw were completed well, but confidential medical records were not always secured in sealed envelopes.

Areas of concern and recommendations

- 2.37** **Area of concern:** Performance information was not comprehensive or always accurate. This limited the force's ability to monitor and review its performance effectively.

Recommendation: The force should develop a comprehensive performance management framework for custody that ensures the accurate collection of data, particularly on ethnicity of detainees, and should use this to assess performance, identify trends and learning opportunities, and improve services.

- 2.38** **Area of concern:** The force did not comply with a number of procedures in relation to PACE, in particular the application of codes C and G.

Recommendation: The force should ensure that all custody processes comply with the Police and Criminal Evidence Act 1984.

⁵ The pan-Essex Criminal Justice Liaison and Diversion Scheme (CJLD) is an age-inclusive service operating within courts and police stations for people within the criminal justice setting who are experiencing any kind of vulnerability.

2.39 Area of concern: Too many people detained under section 136 of the Mental Health Act were being brought in to custody as a place of safety.

Recommendation: The force should, in collaboration with partners, undertake a review of the high numbers of vulnerable people detained in police custody as a place of safety, and take action to avoid the use of police custody as a place of safety for people with mental health problems.

Section 3. Leadership, accountability and partnerships

Expected outcomes:

There is a strategic focus on custody, including arrangements for diverting the most vulnerable from custody. There are arrangements to ensure custody-specific policies and procedures protect the wellbeing of detainees.

Leadership

- 3.1 There was a clear governance structure for custody with overall responsibility at assistant chief constable (ACC) level, supported by sufficient specialist staff trained to deliver custody functions. This structure provided clear accountability for the safe delivery of custody.
- 3.2 The force showed a strong commitment to diverting children and vulnerable adults away from custody. This focus was reflected in policies and procedures, and the practice of frontline officers and custody staff in seeking to find alternatives to custody for vulnerable adults and children – or, where this was not possible, to minimise their time in custody.
- 3.3 Since the previous inspection there had been a reduction in the custody estate, and four suites had been closed. The conditions across the remaining estate did not consistently support the safe delivery of custody; we found a wide range of potential ligature points in police cells and communal facilities that were a risk to detainees and the force. The force was aware of this problem and had a clear plan to address it. Although we carried out a site visit, Colchester custody suite was closed for remedial works throughout the inspection period, and there was a schedule of works at other suites.
- 3.4 Custody staff were generally professional, knowledgeable and trained. All custody sergeants had received prior comprehensive training and were tutored by experienced staff during an accreditation period. Officers were also expected to complete four days training a year to retain their accreditation. Force data showed that all custody sergeants had completed the mandatory personal safety and first aid training courses within the past 12 months, which included use of force. Although we were told that detention officers (DOs) received annual unarmed defence skills training, no data about their attendance were provided. The provision and effective monitoring of training is important to ensure that staff remain competent to perform their role.
- 3.5 The shift patterns were not ensuring sufficient experienced and qualified inspectors and custody sergeants were on duty at any given time, resulting in less qualified staff having to provide cover. The effectiveness of custody services was further compounded by problems in the force's custody IT system (Athena), which led to delays in the release of detainees from custody and in processing those returning on bail.
- 3.6 We were also concerned that some officers carrying out inspector roles, such as Police and Criminal Evidence Act (PACE) reviews, did not have the right qualification.
- 3.7 The force followed approved professional practice for the delivery of safer detention, supported by a range of policies across different areas. These policies were regularly reviewed and staff showed a good understanding of them.

- 3.8** The force had regular health care contract monitoring meetings with G4S, which helped the early resolution of operational issues. Health care practitioner (HCP) response times to custody suites varied across the county; in the year to January 2017, there had been an overall average response time of 90.5% within 60 minutes.

Area for improvement

- 3.9** **The force should identify any potential ligature points and eliminate or mitigate any risks they present.**

Accountability

- 3.10** The monitoring of custody performance had improved. However, some data drawn from Athena were inaccurate, and it was not clear how effective this information was in enabling the force to assess its delivery of custody services, identify trends and inform organisational learning. (See recommendation 2.37.)
- 3.11** The force had effective governance and oversight of the use of force in its custody suites. It also had good mechanisms to assure itself, the Police and Crime Commissioner (PCC) and the public that the use of force in detention and custody was safe and proportionate. The force was collating the mandatory data for the Home Office annual data return required from April 2017.
- 3.12** There were several procedural areas where PACE and codes C (for the detention, treatment and questioning of persons by police officers) and G (for the statutory power of arrest by police officers) had not been complied with (see also paragraph 5.17 and 5.18). (See recommendation 2.38.)
- 3.13** We were concerned that sealed envelopes were not used to hold medical information that accompanied the person escort record (PER) to court and prison; in one instance we saw, a psychiatric report with detailed medical information, a hospital discharge letter and copies of the Athena medical assessment record were attached with the PER, which was inappropriate. (See area for improvement 6.55.)
- 3.14** Although the force had some arrangements to demonstrate how it was meeting its obligations under the Equality Act 2010 and the public sector equality duty, it had no specific equality action plans relating to custody. Some ethnicity information was collected in records of use of force, but no other ethnicity data on custody were collected or monitored. Staff did not routinely ask detainees about their self-defined ethnicity and relied mostly on information provided by officers or data on the police national computer (PNC). Force data for the year to 31 January 2017 recorded 65% of the ethnicity of detainees in custody as 'not stated'. This made it difficult for the force to show that all detainees were treated fairly and equitably. (See recommendation 2.37.)
- 3.15** The force was open to effective scrutiny and had invited a peer review of its custody provision. Staff from two external forces had conducted a review aligned to HM Inspectorate of Constabulary (HMIC)/HM Inspectorate of Prisons (HMIP) formal inspection methodology and produced a comprehensive report, which the force had acted on. This was a very positive indication of its commitment to improving custody services.
- 3.16** The force also welcomed scrutiny through the independent custody visitor (ICV) scheme, and the ICV manager described a constructive working relationship. Issues raised by detainees tended to be relatively minor and could normally be resolved in the suite. We

were told that for a more complicated or serious matter, the force worked collaboratively with the ICV to resolve this.

Partnerships

- 3.17** The force engaged with health and local authority partners, in particular in relation to children and people with mental health problems, and was represented by senior or appropriate officers at various multiagency boards, such as the local safeguarding children boards. However, this work had not yet resulted in consistently good outcomes for detainees.
- 3.18** Too many people detained under section 136 of the Mental Health Act were brought into custody as a place of safety.⁶ Force data showed that 22% of all those detained under section 136 in the 12 months to December 2016 were brought into custody suites, even though there were four health-based places of safety across the county (see paragraph 6.75). This was a poor outcome for vulnerable detainees and a significant risk for the force. A joint protocol identified partners' expectations and intentions under section 136. The force had been collaborating with partners, including health, to develop a revised protocol and a contingency plan for 'exceptional' cases under new legislation that was due to come into force in April 2017.
- 3.19** Similarly, too many children remained in custody overnight, despite some positive joint working with local authorities and a jointly agreed protocol to support the transfer of children charged and refused bailed into alternative accommodation. Although the force was monitoring this position robustly, a shortage of appropriate local provision prevented the transfer of most children. (See paragraph 6.35.)

Good practice

- 3.20** *The force had developed contingency planning with partners to prepare for the new legislation and further restrictions on the police to take people into custody under section 136 of the Mental Health Act.*

⁶ Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety - for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

Section 4. Pre-custody: first point of contact

Expected outcomes:

Police officers and staff actively consider alternatives to custody and in particular are alert to, identify and effectively respond to vulnerabilities that may increase the risk of harm. They divert away from custody vulnerable people whose detention may not be appropriate.

Assessment at first point of contact

- 4.1** Frontline staff had a good understanding of vulnerability and used this to assess detainee risk and deal with incidents appropriately. Training for staff and force guidance supported this approach, and included use of a helpful vulnerability pocket guide. All children were regarded as vulnerable by virtue of their age, and staff were knowledgeable about other vulnerable factors for detainees, such as mental ill health or alcohol dependency, as well as any individual circumstances.
- 4.2** Call handlers accessed a range of information to help prioritise incidents and for response officers to decide what action to take. Additional information was available from the force's intelligence unit, which operated 24 hours a day. Officers could also access information directly from their handheld mobile devices, where they could view the ongoing incident log. Information from partner agencies was more limited and there were none based in the control centre, which could have provided, for example, quicker access to an individual's mental health information.
- 4.3** At busy periods, there was not always sufficient time for call handlers to gather comprehensive information, and additional information supplied by the intelligence unit was not always provided in a readily clear format for officers on their way to or at the scene of the incident. As a result, officers did not always have all the relevant information required to make further enquiries before deciding whether to arrest a suspect(s) or explore other alternatives to deal with the incident.
- 4.4** Frontline officers were focused on avoiding taking children and vulnerable adults into custody. In the case of children, arrest was seen as the last resort and officers sought alternatives, such as community resolution.⁷ Officers also referred children directly to the youth offending team (YOT) triage scheme, which engaged with children to avoid their contact with the criminal justice system and to reduce reoffending. The children in our case audits and those we observed in custody had committed serious offences or had a history of offending, with little alternative to arrest.
- 4.5** In the case of vulnerable adults, frontline officers also considered alternatives to arrest, such as interview at the scene or voluntary attendance⁸ (although the latter still involved attendance at the custody suite). They also made referrals to drug and alcohol support services or local support schemes.
- 4.6** Officers had a good understanding of the Mental Capacity Act 2005 and told us they felt confident in applying this when deciding whether or not to arrest. In our case audits and

⁷ Community resolution applies to the resolution of a less serious offence or antisocial behaviour incident involving an identified offender (both youth and adult), through informal agreement between the parties rather than progression through the criminal justice process.

⁸ Suspects involved in minor offences attend a police station by appointment to be interviewed about these, avoiding the need for arrest and subsequent detention.

discussions with staff, it was clear that officers spent considerable time attempting to take people detained under section 136 of the Mental Health Act⁹ to health-based places of safety and not custody. However, despite the efforts of frontline officers, too many people with mental health problems were taken into custody as a place of safety because of the lack of alternative provision (see paragraph 6.75). Two mental health triage cars staffed by trained officers and mental health professionals were reported to be making a significant impact on diverting people away from custody (see paragraph 6.74). However, dealing with people who presented a risk to themselves or others remained a significant challenge for frontline staff and took up much of their time.

- 4.7** The transport of detainees from arrest to the custody suite was based on risk and expediency. In general, police officers used their own vehicles as the quickest option but arranged a police van if detainee risk necessitated this. There were no specific arrangements for detainees with physical disabilities or mobility issues. Although people detained under section 136 should be transported by ambulance to a place of safety, officers told us that they often decided to use their vehicles due to long waiting times.
- 4.8** Decisions on use of force on detainees were based on the risks posed and kept under review, with officers deciding whether to remove any restraints when they were no longer needed. Frontline officers were required to complete use of force forms in all cases, including compliant handcuffing, and they were aware that custody staff would check this to ensure compliance.
- 4.9** We observed good interactions between frontline officers and custody staff in the suites. Frontline officers were aware that they would be expected to justify the reasons for arrest. They took responsibility for providing additional information to custody staff about any risks posed if these were not identified during the booking-in process, and to ensure that the care needs of detainees were recognised.

Area for improvement

- 4.10 The force and health partners should ensure that the transport used for people detained under section 136 of the Mental Health Act supports their mental health needs.**

⁹ Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety - for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

Section 5. In the custody suite: booking in, individual needs and legal rights

Expected outcomes:

Detainees receive respectful treatment in the custody suite and their individual needs are reflected in their care plan and risk assessment. Detainees are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the earliest opportunity.

Respect

- 5.1 Custody staff treated detainees in a respectful and compassionate way, and the interactions that we observed were positive and considerate.
- 5.2 The privacy of the booking-in process varied between suites. Basildon and Chelmsford had sectioned-off areas but these were not sufficiently private and detainees could clearly hear conversations from the adjacent section. Older suites, such as Harlow and Clacton, had no partitions and little or no privacy. Custody staff were aware of this and where practical, and in the case of children in particular, tried to avoid booking in detainees side by side at the same time.
- 5.3 Foreign detainees were treated appropriately and offered access to their consulate. For non-English speakers, a professional telephone interpreting service was used to good effect. Provision of reading materials for non-English speakers was poor.
- 5.4 Arrangements for identifying and meeting diverse needs were reasonable. Detention officers (DOs) had received training on diversity, including the needs of transgender detainees. Generally, detainees were asked about their dietary requirements or caring responsibilities, which allowed individual needs to be managed appropriately. In order to meet their needs, women coming into custody were assigned a female officer where possible.
- 5.5 There were suitable arrangements at some suites to meet the needs of people with physical or mobility difficulties. Facilities at Chelmsford and Southend complied with the Disability Discrimination Act and provided accessible toilets and showers, and specially adapted cells with extra thick mattresses were available. Basildon and Grays were wheelchair-accessible, and Chelmsford had a wheelchair for detainee use and a wheelchair ramp into the suite. All cells at Southend and Chelmsford were modified to offer assistance for visually impaired detainees (with a blue band around cell walls,) but this was not the case at the other suites. Hearing loops were available for detainees with hearing impairments but were not often used, although staff knew where they were stored.
- 5.6 Religious artefacts were available and stored respectfully.

Risk assessments

- 5.7 Most detainees did not have to wait outside the suites in vehicles for long periods and were admitted promptly.
- 5.8 The majority of detainees were booked in quickly by custody sergeants or DOs, and oversight by sergeants was generally adequate. Custody staff identified detainees' initial risks

effectively, and treated them respectfully during completion of the comprehensive risk assessment. In particular, we observed staff taking sufficient time to consider the needs of vulnerable detainees fully. Staff used the risk assessment template effectively to guide and prompt supplementary questions to obtain more detailed information from detainees. Warning markers from the police national computer (PNC) and historical information on the custody record system were routinely cross-referenced to inform risk assessments further.

- 5.9** Staff had a clear focus on detainee welfare and safety. Detainee observation levels were set appropriately in consultation with the custody sergeant, and staff demonstrated confidence in adjusting the levels when necessary to support detainees throughout their time in detention. In most custody suites during busy periods we saw some examples of observations of detainees carried out later than scheduled. Despite this, staff across the suites prioritised interaction with detainees and regularly visited cells.
- 5.10** Staff were aware of the importance of monitoring and rousing detainees, particularly those under the influence of drugs or alcohol. Although all staff had been issued with anti-ligature knives, an improvement since the last inspection, not all of them carried the knives routinely when working in the suites.
- 5.11** Anti-rip clothing for detainees at risk of self-harm was issued too often and usually without an individual risk assessment. The justification for its use was inconsistent, and in some suites staff told us that they routinely issued anti-rip clothing to any detainee with a history of self-harm, which was disproportionate. In contrast, we saw examples where staff did not issue anti-rip clothing to detainees with a history of self-harm following completion of a dynamic risk assessment. The routine use of anti-rip clothing to manage non-compliant detainees or those with a history of self-harm was demeaning and not an effective way of reducing the level of risk.
- 5.12** The quality of staff shift handovers was reasonable and they usually involved all relevant staff. They focused properly on detainee welfare and case progression, but they did not always take place in private. Sergeants attempted to ensure that booking-in areas were quiet and free of detainees and non-custody staff during handovers, but confidential information about cases was not always discussed in private. At the start of a new shift, sergeants did not routinely visit all detainees in their care. During busy periods, sergeants did not always have sufficient oversight of the handovers taking place between staff responsible for the supervision of detainees on a constant watch.

Areas for improvement

- 5.13** **Observations of detainees should be carried out on time as determined by the custody sergeant.**
- 5.14** **All custody staff should carry anti-ligature knives.**
- 5.15** **Anti-rip clothing should not be issued routinely to all detainees with a self-harm marker but be based on individual and dynamic risk assessments.**
- 5.16** **Staff shift handovers should be carried out in private.**

Individual legal rights

- 5.17** Custody sergeants and DOs booked detainees into custody. We did not always see custody sergeants checking with the arresting officer, in the presence of the detainee, for a full

explanation of the circumstances of and reasons for the arrest before authorising detention when this information was initially provided to a DO. Not all sergeants attempted to confirm whether the detainee had understood the full reason for their arrest before continuing with their booking in; this did not comply with the Police and Criminal Evidence Act (PACE) code C (see recommendation 2.38). However, most frontline officers had a good understanding of PACE code G (covering the statutory power of arrest by police officers) and the necessity criteria required to justify arrest.

- 5.18** We saw three detainees at Southend who were de-arrested after they were brought into the custody suite holding room in handcuffs. They were released without being presented to the custody sergeant or any custody records being formally opened, which also did not comply with PACE code C (see recommendation 2.38).
- 5.19** Sergeants told us they rarely had to refuse detention but they were confident about doing this when necessary. They provided us with details of cases such as when a detainee had an injury, which resulted in the diversion of arresting officers and the detainee to hospital instead.
- 5.20** Alternatives to custody were available through community resolution, street bail and voluntary attendance.¹⁰ The management of voluntary attendees was protracted as these interviews could only take place using recording facilities in the custody suites. Voluntary attendees had to be booked in by custody staff on Athena (the custody computer system) and a risk assessment completed before the interview could take place. There were sometimes unnecessary delays while the attendee waited to be booked in alongside detainees, which was contrary to the aim of diverting individuals from custody. Force data showed that the use of voluntary attendance had dropped by 56% over the last three years from 7,301 attendees in the year to 31 January 2015 to 3,206 in the year ending 31 January 2017.
- 5.21** Most detainees were booked in promptly on arrival at the custody suites, but in the custody records we reviewed and from our observations we found delays of up to 74 minutes between detainees arriving and the authorisation of their detention. In our custody record analysis, the longest delay for a detainee waiting to be booked in was four hours 22 minutes while the average waiting time was 26 minutes. These delays were unacceptable, particularly when they involved vulnerable and compliant detainees who could remain in handcuffs throughout this period (see paragraph 6.12).
- 5.22** Custody sergeants were aware of the need to keep the time in detention to a minimum and to progress cases quickly. We were told, and observed, that investigations were not always progressed promptly due to factors such as the non-availability of investigating officers, appropriate adults (see paragraph 6.27), solicitors and interpreters (see paragraph 5.32), which lengthened detainees' stay in police custody. At Grays, we observed a detainee who returned on bail and was interviewed immediately, but then had to be held in custody in a cell for an additional 50 minutes as there was a problem with his case file being transferred over on Athena. The force was unable to provide us with any data on average detention times, but in our custody record analysis the average time between arrival and charge was 11 hours 23 minutes, which was much higher we usually find.

¹⁰ Community resolution applies to the resolution of a less serious offence or antisocial behaviour incident involving an identified offender (both youth and adult), through informal agreement between the parties rather than progression through the criminal justice process. Street bail, under section 4 of the Criminal Justice Act 2003, enables a person arrested to be released on bail by a police constable on condition that they attend at a police station at a later date - one benefit of this is that an officer can plan post-arrest investigative action and be ready to interview a suspect when bail is answered. Voluntary attendance is usually used for lesser offences, and involves suspects attending by appointment at a police station to be interviewed about these, avoiding the need for arrest and subsequent detention.

- 5.23** Custody staff described having a good relationship with Home Office Immigration Enforcement officers and said that most immigration detainees were moved on within 24 hours, but there were sometimes longer delays. Force data showed that 633 immigration detainees had been held in the year ending 31 January 2017, but there were no data on the average time that detainees remained in police custody following service of an IS91 warrant of detention.¹¹
- 5.24** During booking in, custody sergeants and detention officers advised detainees of their three main rights¹² and detainees were routinely offered a written notice setting out their rights and entitlements. Custody staff could access these notices in foreign languages for non-English speakers, and were aware of an easy-read pictorial version for detainees needing help with understanding or reading. Rights and entitlements were not available in Braille apart from a copy we found at Grays. Although detainees were told that they could read the PACE codes of practice, these were not always fully explained or routinely offered. We found only a limited number of copies of PACE code C (covering the detention, treatment and questioning of persons by police officers) in the suites, apart from Grays, which held a large stock. The one copy we found at Clacton was out of date.
- 5.25** We saw detainees being told that they could inform someone of their arrest, which staff facilitated, and the detainee was sometimes allowed to speak to their named representative while still at the booking-in desk.
- 5.26** All detainees were offered free legal representation and told that if they declined, they could change their mind at any time and accept this offer. Detainees who declined free legal representation were asked why, and in most cases this was noted on the custody record. Those who wished to speak to legal advisers on the telephone could do so in private. There were sufficient consultation and interview rooms at all the suites, and legal advisers were routinely given a printout of their client's custody record front sheet.
- 5.27** There was an effective system for collecting DNA samples taken in custody, but not all custody staff were clear about the circumstances for their disposal.

Areas for improvement

- 5.28** **Voluntary attendees should not be booked into custody in the custody suite environment.**
- 5.29** **Detainees should be booked in promptly on arrival at the custody suites.**
- 5.30** **Essex Police should monitor the time that detainees are kept in detention to ensure that there are no unnecessary delays in progressing their case.**

Communication

- 5.31** A professional telephone interpreting service was available to assist the booking in of non-English speakers. Ordinary speaker telephones were still used at all the suites. This made it difficult to maintain privacy, particularly when the suites were busy and noisy. Double

¹¹ An IS91 warrant of detention is served on an immigration detainee when there is no reasonable alternative action, for example, if there is a likelihood that they may abscond or that their removal from the UK is imminent.

¹² The rights to have someone informed of their arrest, to consult a solicitor and access free independent legal advice, and to consult the PACE codes of practice.

handsets, which were designed to resolve this problem, were available at Grays but were not used.

- 5.32** Staff told us that a face-to-face interpreting service was available for interviews, but there were sometimes delays; we saw one interview with a Romanian detainee at Grays held up for over three hours due to the non-availability of an interpreter. At Clacton, we saw staff making efforts to secure the attendance of a Japanese interpreter, without success. As the detainee could not be released without interview, the telephone interpreting service was used as no other option was available (see paragraph 5.3).
- 5.33** The majority of custody sergeants were not aware of the translated documents available,¹³ and several sergeants who were aware of these failed to locate them. We saw one detainee who was served with a translated notice advising him that his detention had been reviewed and continued to allow him to be interviewed. There were no posters in any suite informing detainees in a range of languages of their right to free legal advice.
- 5.34** Custody staff in all the suites could identify the location of portable hearing loops.

Area for improvement

- 5.35 All suites should have two-way telephone handsets to facilitate telephone interpreting.** (Repeated recommendation 5.14)

Access to swift justice

- 5.36** The management of bail was inconsistent and some responsibilities were confused. In our custody record analysis and observations, we found good examples of custody officer use of bail, including considered reasons for the length of bail and whether conditions should be used, and links to investigations. But we also found poor examples without rationale, and arbitrary decisions on the length of bail. Investigating officers were frequently unavailable to deal with people returning to answer bail, and they often did not record cancellation of bail and amendments appropriately, leading to confusion among custody staff and unnecessary work. For example, some appointment slots remained booked for people no longer required to attend to answer bail.
- 5.37** Custody officers received most bail applications by email from supervisors of investigating officers; others were conducted face to face in the custody suite by the investigating officer or occasionally their supervisor. The quality of information varied and it was frequently not recorded in detention logs, despite evidence that many bail applications were considered carefully by custody officers before they made decisions.
- 5.38** Custody officers regularly set the length of bail according to their experience of timescales for further investigation requirements, including forensic examination. However, the timescales were not always met and so detainees were often re-bailed. We observed some detainees answering unconditional bail for the sole purpose of being charged, whereas 'postal requisition' (reporting for summons) should have been used.
- 5.39** The number of detention officers was doubled between 10am and 2pm every day to respond to demand, although we observed only a few people answering bail during these times. The force could have made greater use of the extra resource available during this period.

¹³ PACE code C annex M details the documents considered essential for written translation.

- 5.40** The force had made reasonable provision to prepare for the new system for bail after arrest but before charge (which came into force in April 2017 under the Policing and Crime Act 2017). However, current bail timescales for forensic examination and analysis of digital devices were much longer than stipulated in force guidance (see paragraph 5.38), which could jeopardise management of the limits imposed by the Act. While weekly data on the length of bail were available for management, action to reduce timescales was not effective.
- 5.41** Essex Police together with Kent Police had created and tested a bail management application in readiness for the changes to bail due in April 2017. The concept of this application was good, and with robust management it should support the force in managing bail within the Act's stricter timescales and levels of approval of bail.

Area for improvement

- 5.42 The force should take account of the management of bail in any review of resources or shift patterns.**

Complaints

- 5.43** Notices detailing the complaints process were displayed at or near the booking-in desks in all the custody suites, except at Southend. Custody staff told us that if a detainee wished to make a complaint while in custody they would notify the custody or duty inspector. Inspectors provided varying accounts on the circumstances when they would note a complaint from a detainee while they were in police custody and, as at our previous inspection, some still said that they would advise the detainee to report to the station front desk once they left custody. We observed an inspector attempt to note a complaint from a detainee while in custody, but the detainee then declined to proceed. None of the suites, other than Grays, had Independent Police Complaints Commission complaints forms available for detainees.

Area for improvement

- 5.44 Detainees should be able to make a complaint about their care and treatment before they leave custody. (Repeated recommendation 5.28)**

Section 6. In the custody cell, safeguarding and health care

Expected outcomes:

Detainees are held in a safe and clean environment in which their safety is protected at all points during custody. Officers understand the obligations and duties arising from safeguarding (protection of children and adults at risk). Detainees have access to competent health care practitioners who meet their physical health, mental health and substance use needs in a timely way.

Physical environment is safe

- 6.1** The physical conditions across the custody estate varied considerably. At the newer suites (Basildon, Chelmsford, Grays, Southend), cells and communal areas were very clean and maintained to a high standard. However, the conditions at the older suites (Clacton, Colchester, Harlow and Stansted) were poor, with some of the cells in Harlow having limited natural light. Some cell walls in Harlow were stained and the floors were worn. There was very little graffiti in the newer suites, but the cells at Harlow had etched-in graffiti. We identified several potential ligature points in cells and communal areas in every custody suite, as well as ligature points in the exercise yard at Harlow, which should not be used by detainees without supervision. (See area for improvement 3.9.) With the exception of Harlow and Stansted (which did not have an exercise yard), most exercise yards were in a reasonable condition, but some were too small and had limited natural light.
- 6.2** None of the suites had separate accommodation for women but all had specific cells for children. All the cells in the newer suites had low benches – which were suitable for older people, those with mobility problems and intoxicated detainees – and there were a few cells with low benches in the older suites. All the suites had some cells monitored by CCTV.
- 6.3** At the time of the inspection, Colchester and Stansted suites had been closed to carry out remedial repairs, including the risks presented by potential ligature points.
- 6.4** Each suite had a daily cleaning programme, and we observed cell cleaning being carried out by the contract cleaners. There was no record of any deep cleaning in the previous six months. Biohazards were removed by an external organisation. Civilian detention officers (DOs) cleared cells after occupancy and carried out daily fabric checks to identify any damage; custody sergeants made and recorded weekly checks. Inspectors carried out a more detailed monthly check of the suites, which included health and safety checks. Most repairs were dealt with promptly.
- 6.5** Cell call bells were working in most suites and we observed call bell checks during the morning fabric checks. In Chelmsford, we observed cells taken out of use if the call cell bell was not working. In Basildon and Clacton, some detainees were not given an explanation of how to use the cell call bell before they were locked up, which was of concern as the bells were activated through a discreet sensory panel. We saw some delays in responses to call bells when suites were busy.
- 6.6** Custody staff were able to locate the emergency evacuation packs in all suites, but the packs did not have sufficient handcuffs to evacuate all detainees from the suites safely when they were at full capacity. There were monthly fire drill tests and evacuation reports in each suite, and staff were knowledgeable about how and where to evacuate detainees in the event of an emergency.

Areas for improvement

- 6.7 The cell call bell system should be explained to all detainees before they are located in cells.**
- 6.8 There should be sufficient handcuffs in the emergency evacuation packs to evacuate all detainees safely.**

Safety: use of force

- 6.9** Governance and oversight of the use of force in custody were good, and better than we usually see. Data on the use of force were collated. Custody staff were in date with their safety and personal protection training.
- 6.10** The force identified use of force cases for us to audit, which was positive. In our case audits, custody records analysis and observations, we identified 14 cases in the previous month where force had been used in custody. We reviewed these cases in depth and cross-referenced them against CCTV records. Although the force issued individual use of force forms, these had been submitted by only around half of officers in the required cases; this was better than we normally see but required further attention. Most detention logs contained sufficient information about the incident to justify why force had been used.
- 6.11** Our analysis indicated that force was generally used as a last resort and was mostly proportionate to the threat posed. Staff were very patient with detainees in challenging situations and generally paid good attention to maintaining their dignity. Unusually, we were able to pass one case back to the force to share as an example of good practice. We found learning points in about 40% of the cases and referred another case back to the force for review; the force was already sighted on these cases. We identified some concerns in the CCTV footage, including the use of force to remove clothing from detainees – which potentially escalated conflicts unnecessarily (see paragraph 5.11), as well as some staff using inappropriate language and poor techniques.
- 6.12** Detainees did not arrive routinely in custody wearing handcuffs, which was positive. However, handcuffs sometimes continued to be used for compliant detainees for too long, which was disproportionate to the threat posed in the controlled custody environment.
- 6.13** Our custody record analysis showed that 27% of detainees were being strip searched, which was relatively high. This figure included all searches under section 54 of PACE where any item of clothing was removed or replaced. The force's own data showed that only 9% of detainees were strip searched, which was more in line with comparative findings elsewhere. Despite this lower figure, based on what we found in our case audits, CCTV reviews, observations and conversations with members of staff, we were still not confident that all strip searches were warranted or sufficiently justified.

Areas for improvement

- 6.14 Each member of staff involved in using force against a detainee should submit an individual use of force form.**
- 6.15 Detainees should only be strip searched when there are sufficient grounds to do so, and the justification for this should be clearly recorded on their custody record.**

Detainee care and PACE reviews

- 6.16** Detainee care was generally good. Microwave meals and other food of reasonable quality, including halal and vegetarian options, were available at all the suites. Food preparation areas were clean and well stocked, and staff showed consideration in meeting detainees' dietary requirements. Detainees were regularly offered drinks and meals, including when they returned from interview. In our custody record analysis, 77% of all detainees were offered a meal, and 92% of those held for longer than 24 hours.
- 6.17** Reading materials were available at all the suites, including some recent periodicals, but were limited in range, especially for children. In our custody record analysis, only 14% of all detainees were offered reading materials, and only 17% of those held over 24 hours.
- 6.18** Stocks of replacement clothes, shoes and blankets were generally available at all suites, although not always in all sizes. Suitable clothing and blankets were also available for those considered to be at risk of self-harm.
- 6.19** Most showers in the suites provided reasonable privacy. Detainees were being offered showers, particularly before they were transferred to court. Our custody record analysis showed that 32% of all detainees were offered a shower and 75% of those held over 24 hours.
- 6.20** Most of the cells contained toilets and usually toilet paper. Not all cells had handwashing facilities but detainees could use those on cell corridors on request, subject to staff availability.
- 6.21** All the custody suites, except Stansted, had at least one area where detainees could exercise. However, at some suites, such as Grays the area was small with little more space than a cell. Staff told us they would facilitate their use wherever possible. Our custody record analysis showed that 21% of detainees held under 24 hours were offered outside exercise and 42% of those held over 24 hours.
- 6.22** Inspectors carried out reviews of detainees. We observed some very good face-to-face reviews, which were timely, appropriate and fully recorded on detention logs. Our custody record analysis showed that most reviews were carried out in person with very few by telephone – although a high proportion of these (46 out of 96 first reviews) took place while the detainee was asleep. We saw very few detainees informed that reviews had taken place while they were asleep, even when this was identified as an outstanding task on electronic white boards. This was not compliant with PACE code C (covering the detention, treatment and questioning of persons by police officers). (See recommendation 2.38.)
- 6.23** Most PACE reviews were carried out on time, although a number were carried out early and only a few were late. In our case audits and checks of detention log entries we generally found that reasons for an early or late review were clearly explained. Our custody record analysis showed that 60 first reviews were on time, 29 were early and seven were late.
- 6.24** We had concerns over the rank, and therefore the authority, of the officer carrying out the review. Our case audits showed many instances of acting inspectors, rather than temporary inspectors, conducting PACE reviews.¹⁴ (See recommendation 2.38.)

¹⁴ See section 1.9 code C, section 15.2 code C and section 107 PACE.

Safeguarding

- 6.25** There was generally good understanding of safeguarding and the need to protect vulnerable adults and children, with sufficient attention to identifying risks and meeting individual needs. Custody staff checked that referrals had been made for all children entering custody.
- 6.26** The force's 'protecting vulnerable people' policy and associated procedure set out the approach to safeguarding, including working with partners, and that all officers and staff had responsibility for safeguarding. Procedures for children set out how they should be cared for in custody and the requirement to make safeguarding referrals. This policy was supported by comprehensive public protection training, and some staff had received training in vulnerabilities and safeguarding.
- 6.27** The appropriate adult (AA) service did not always provide early enough support for children and vulnerable detainees. Custody staff mainly requested AAs early so that the detainee's rights and entitlements could be read in their presence, and ensured that AAs unfamiliar with the role received verbal and written guidance. However, waiting times for AAs varied significantly. In our custody record analysis, detainees requiring an AA waited an average of four hours and 37 minutes for one after they arrived in custody – ranging from 35 minutes to 13 hours 11 minutes. Our case audits and observations showed similar variation in waiting times.
- 6.28** Delays in AA arrival were not always documented in the custody records that we audited, and the information was not recorded in a way that allowed for easy monitoring of how long children and vulnerable adults waited and whether AAs were a family or scheme member. This made it difficult for the force to demonstrate the effectiveness of its arrangements for securing AAs as early as possible.
- 6.29** In the first instance, custody staff sought out parents, other family members, guardians or other carers as AAs. Where this was not possible they relied on the local authority AA service, but arrangements varied between the local authorities, which used either volunteers or their own staff. This led to different levels of service with, for example, some AAs only attending for the interview stage onwards, rather than for the reading of the detainee's rights and entitlements.
- 6.30** There was little overnight provision by local authority social care emergency teams, and the volunteer scheme only operated from 7am until 11pm. However, there were cases when AAs stayed in suites beyond these hours if it meant a detainee, and a child in particular, could be dealt with and released from custody quickly.
- 6.31** The force had been working actively with its local authority partners to try to ensure more consistent AA provision across the force area and to have access to the service around the clock if needed.
- 6.32** Force data showed that for the year to 26 February 2017, 2,632 children had been brought into custody (9% of total detainees). Although we were told that fewer children were now entering custody, in line with the priority to avoid their custody and entry into the criminal justice system, the force did not monitor this and so could not demonstrate any progress.
- 6.33** Our case audits and observations indicated that children were looked after well in custody. Staff used checklists to ensure that all the necessary actions for child detainees were taken – for example, that girls had been allocated a female member of staff. All children were seen by a health care practitioner, risk assessments were thorough and appropriate observation levels were generally set. The requirement for staff to visit children at least every 30 minutes was largely met. Children were allocated to juvenile detention rooms, where these were

available, and kept separately from adults where possible. Children were regularly offered food and drink, and reading materials were sometimes provided, although documentation on the custody record was not always adequate to demonstrate this. When children left custody, officers paid particular attention to ensuring they were returned home safely.

- 6.34** Custody sergeants actively sought to minimise the time children spent in custody and avoid overnight detention. In our case audits and observations, we saw some good use of bail and other disposals to achieve this. Two inspectors had dedicated responsibility to review all cases of children brought into custody to ensure that their detention, care and disposal were appropriate. Custody sergeants were required to send a separate justification form to custody inspectors for all children detained after 10pm and before 8am to provide the reasons for the detention. Despite this, some children remained in custody for long periods. Force performance information showed that children had spent an average of just over seven hours in custody in January 2017. Our custody record analysis showed a higher average of 10 hours 38 minutes, ranging from two to 26 hours. In one case that we observed, a child spent several hours in custody before an investigation team was allocated to deal with the case.
- 6.35** Children who were charged and refused bail often remained in custody overnight rather than be transferred to alternative accommodation, as required to be provided by the local authority. Before June 2016, no children had been moved to other accommodation, but a protocol for the transfer of children had been agreed then with local authority partners. However, alternative accommodation was limited to one bed for the whole of the force area. Between 6 June 2016 and 26 February 2017, force data showed that of 73 requests for appropriate accommodation for children charged and refused bail, only 17 children were moved; no children requiring secure accommodation were moved. Because of the lack of alternative overnight accommodation, in one case it was decided to release the child back to their care home to ensure court attendance the following day, but two other children arrested at the weekend had to remain in custody for over 40 hours.
- 6.36** Senior officers reviewed all cases where accommodation was not provided at their daily meetings, and raised them with local authority partners if needed. Joint meetings with partners had started to monitor implementation of the protocol, and performance information was also presented to the public protection board.

Areas for improvement

- 6.37 Children and vulnerable adults should always receive early and effective support from appropriate adults.**
- 6.38 Record keeping on the use of appropriate adults should assess waiting times accurately and identify areas that require improvement.**
- 6.39 The force should continue to engage actively with its local authority partners to ensure that children charged and refused bail are transferred to alternative accommodation to avoid their custody overnight.**

Governance of health care

- 6.40** There was good strategic oversight of health services. The force had commissioned health services from G4S since April 2015, and there were regular contract monitoring meetings and a constructive working relationship. The deputy custody commander had initiated a regular monthly meeting with the G4S clinical lead to resolve more immediate operational issues quickly.

- 6.41** The average reported health care professional (HCP) response within 60 minutes was 90.5% in the year to January 2017, which was lower than we usually see. In some instances, it was particularly low, such as 82% at Colchester in February 2016. The force relied on G4S for response time data, and its own system did not easily enable useful data collection.
- 6.42** Custody staff in all the suites were generally confident in the health service, but there had been instances of long waits of up to five hours for an HCP in the current year, and occasional delays in response to calls to the G4S control centre; we tested the control centre reaction and received a response within a couple of minutes. There was appropriate escalation of issues about delays and discussion between the force and health partners.
- 6.43** Five HCPs were deployed across the six suites through any 12-hour shift period, with one designated forensic medical examiner (FME) on call for the Essex area. While this did not provide for one HCP based in every custody suite, we found overall consistency and continuity of cover during our visit.
- 6.44** Paper clinical records were clear and suitably detailed with appropriate justification for clinical decision making; there was secure storage of records. Almost all HCPs could now record directly on to the medical assessment form in the police detainee IT system, which enabled detainees to be cared for safely. We saw examples of medical information attached to person escort records (PERs) for transfer to court and prison that was not appropriately secured in sealed envelopes; police and custody staff appeared to do this regularly with no indication that health staff were aware of this breach of medical confidentiality.
- 6.45** There were regular staff meetings, including clinical governance issues and actions, although the last meeting in December 2016 had been very poorly attended. There was a reliable system for reporting clinical incidents – 63 had been logged in the year to 31 January 2017, with consistency of numbers and types across the suites, and a system for investigation and follow-up. There was no health complaints system advertised to detainees.
- 6.46** Most paper policies held in the suites were out of date, and some electronic versions were overdue for review. HCPs told us they were given a personal copy of relevant policies at their induction, and updates were emailed. Copies of patient group directions (PGDs), authorising appropriate health care professionals to supply and administer prescription-only medicine, were out of date at Clacton, and there was no up-to-date list of all HCPs authorised to use PGDs or copies of their signatures.
- 6.47** Training compliance was good and all HCPs were up to date in intermediate life support and safeguarding, in addition to other relevant training. Most training was online and some HCPs said that the system was difficult to use. Custody staff told us they had received basic life support training, and this was supported by 100% compliance in the force figures. Custody staff had received some mental health awareness training and there were plans to provide a regular session on health-related matters.
- 6.48** There were clear lines of management accountability and regular management supervision and performance appraisal. HCPs said they felt well supported. Clinical supervision was being developed and HCPs relied on informal peer support.
- 6.49** Arrangements for emergency response were reasonable overall. There were several different emergency bags in some medical rooms and some variance in equipment in some HCP bags. All suites had at least one oxygen cylinder, but in one suite the single cylinder was almost empty. Hand-suction equipment was scheduled to be replaced. Automated external defibrillators (AEDs) were stored in the medical rooms and all were working, with spare batteries and in-date contact pads. Although almost all these rooms were accessible to custody staff, the wall mounting of AEDs by the custody desk would be a better option. Regular checks on the equipment were not always completed and/or recorded.

- 6.50** Forensic sampling was conducted in the medical rooms. Sample kits were stored in wall and floor cupboards, and we saw some kits in boxes on the floor at Basildon and Clacton, where we also found some out-of-date kits. At Basildon, a fridge contained some forensic samples dating back to September 2016 with no attached paperwork and poor labelling.
- 6.51** Most of the medical rooms still had basins with domestic taps, rather than medically complaint washbasins, and floors that did not comply with national infection control standards. There was unnecessary clutter in some suites, including boxes of forensic sampling kits. Some chairs were not wipeable, not all examination couches were height adjustable and there were no paper towel rolls. All rooms were cleaned daily and, with the exception of Harlow, appeared clean; there were no cleaning schedules displayed.
- 6.52** Clinical sharps disposal containers were not dated or signed, and most were not fixed to the walls. At Basildon, there were several old needle exchange containers, and several suites had old wall-mounted needle disposal containers that were no longer used. Medical rooms were mostly unlocked, which risked clinical equipment being compromised, and we saw the room at Chelmsford used inappropriately by custody staff as a changing room.
- 6.53** There were speaker telephones in all the medical rooms and HCPs told us they regularly used professional interpreting services for detainees who did not speak English.

Areas for improvement

- 6.54** **Health care professionals should see detainees promptly, and within a timescale that supports their health and well-being and does not unnecessarily hinder custody processes.**
- 6.55** **Confidential detainee medical records should be sealed in envelopes and clearly marked to be 'opened only by health professionals'.**
- 6.56** **Detainees should be able to make complaints about health care, and this should be advertised in the medical rooms.**
- 6.57** **The automated external defibrillators should be located where they are readily accessible in the custody suites.**
- 6.58** **All health care professionals should receive regular clinical supervision.**
- 6.59** **Forensic sample kits should be stored in cupboards and routinely checked to ensure they are in date.**
- 6.60** **All medical rooms should meet appropriate standards for conducting clinical activities.**

Patient care

- 6.61** There was effective identification and handover of detainee health-related risk information by custody staff between shifts and HCPs were requested appropriately, including where the detainee asked to see an HCP. We observed good quality health assessments, which were sensitively conducted and focused on risk. HCPs and criminal justice liaison and diversion

(CJLD)¹⁵ practitioners were encouraged to conduct joint assessments where appropriate. We saw a very good example of a joint assessment at Basildon that also resulted in a safeguarding referral; the approach supported effective and safe clinical care.

- 6.62** Custody staff had good access to telephone advice from an FME. One inspector reported three instances where he believed that the FME was too quick to refer people to hospital accident and emergency; the examples of hospital referral we saw in clinical records appeared clinically appropriate.
- 6.63** HCPs routinely notified custody staff of key health risks for detainees and also recorded this, alongside medication needs and care plans, on the police detainee information system.
- 6.64** Detainees could receive their own prescribed medicines subject to suitable verification. Police made efforts to obtain essential medicines from detainees' own homes, and PGDs enabled HCPs to provide a suitable range of medicines from stock. DOs could give detainees a limited range of prescription-only and over-the-counter medicines, including nicotine replacement lozenges, based on the telephone authority of an FME, but there was no follow-up faxed or written prescription to confirm the prescription.
- 6.65** Detainees experiencing withdrawal from alcohol or opiates received symptomatic relief, subject to objective assessment by an HCP. We were told that some FMEs prescribed and administered methadone subject to verification of previous community prescribing. Custody staff told us that they would collect methadone if required.
- 6.66** Storage of medicines by HCPs was good with robust stock control and monitoring. The small stock of medicines used by the DOs was managed safely. Detainees' own prescribed medicines were stored with their property.

Areas for improvement

- 6.67 Prescription-only medicines authorised by forensic medical examiners by telephone should be followed up by a written or signed prescription.**
- 6.68 Clinically indicated opiate substitution should be available to all detainees in line with national guidelines.** (Repeated recommendation 6.23)

Substance misuse

- 6.69** There was no longer a dedicated substance misuse service. Under the 'vulnerability' model (see paragraph 6.71), detainees with drug and alcohol problems alongside other relevant issues, such as mental ill health, learning disabilities, housing or financial problems, were screened and signposted into appropriate specialist community services. These could include a CJLD worker at a first appointment. The main community substance misuse provider was closely aligned with the mental health service, which resulted in some helpful collaboration to meet detainees' needs on release from custody. There were plans to extend the service for detainees through alcohol and drug testing on arrest schemes due to start on 1 April 2017.

¹⁵ The pan-Essex Criminal Justice Liaison and Diversion Scheme (CJLD) is an age-inclusive service operating within courts and police stations for people within the criminal justice setting who are experiencing any kind of vulnerability.

Mental health

- 6.70** NHS England had commissioned the North Essex Partnership Trust and the South Essex Partnership Trust to provide a CJLD service, with a practitioner in three suites every day between 7am and 10pm, and cover in the other three suites on weekdays between 8am and 4pm. The cover was due to be streamlined and extended from 1 April 2017.
- 6.71** Since 2014, a vulnerability model provided a single gateway for detainees into other community services. The approach covered vulnerability from mental ill-health, learning difficulty and substance misuse, as well as the needs of women and children, and was to be extended to ex-services veterans from 1 April 2017. The service was responsive and suitably focused, and worked well to ensure appropriate care for detainees while in custody. There were regular joint assessments between CJLD practitioners and HCPs (see paragraph 6.61), and custody staff were positive about the service and its impact on care for detainees.
- 6.72** Custody staff reported regular and sometimes lengthy delays in access to an approved mental health worker (AMPH) to organise assessment under the Mental Health Act; there were early indications that the new centralised AMPH hub at Basildon Hospital had improved this during normal working hours. Out of hours, referrals were handled by the local authority emergency duty team, with evidence of lengthy delays in initiating assessments.
- 6.73** In the previous year, there had been several cases where, following a decision to transfer a detainee to hospital, they were held in custody inappropriately due to lack of a suitable mental health beds. In late December 2016, one young person was held in custody for approximately 39 hours due to a delay in assessment and then finding a suitable bed. While this was an exceptional case, which occurred over the Christmas period, delays of several hours, including overnight, were not unusual.
- 6.74** A street triage service to divert people from custody operated from two police cars, one in the north and one in the south of the force area, every day between 6pm and 2 am. The hours covered were due to be extended from May 2017.
- 6.75** In the nine months to 31 December 2016, 569 people had been detained under section 136 of the Mental Health Act,¹⁶ and approximately 22% (124) were taken into police custody, which was higher than we usually see. The data on the number of people detained under section 136 and then discharged were not detailed enough to indicate the proportion detained who did not have a mental health problem. The force together with health partners was reviewing the training of officers in the use of the Act and mental health awareness. At the time of our visit, although there were four health-based places of safety (HBPOS) across Essex, including one for young people – which was more than we often see – a high number of people detained under section 136 ended up in police custody. This was for a variety of reasons, including the exclusion criteria applied by health services for admission to an HBPOS, some HBPOS closures, and police being too ready to assess detainee risk as a mental health need and to use custody when other options were not available.

¹⁶ 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 Mental Health Practitioner, and for the making of any necessary arrangements for treatment or care.

Area for improvement

6.76 Detainees should have prompt access to Mental Health Act assessment while in custody.

Section 7. Release and transfer from custody

Expected outcomes:

Pre-release risk assessments reflect all risks identified during the detainee's stay in custody. Detainees are offered and provided with advice, information and onward referral to other agencies as necessary to support their safety and wellbeing on release. Detainees appear promptly at court in person or by video.

Pre-release risk assessment

- 7.1** In our case audits and in the records we reviewed, the recording of pre-release risk assessments (PRRA) was mostly adequate. PRRAs were completed by custody sergeants and contained evidence that risks were addressed before release.
- 7.2** Although most detainees were released safely, in our case audits and during the inspection too many PRRAs were completed after the detainee had left the custody suite. We observed staff experiencing technical problems with the Athena computer system, which delayed their access to the pre-release risk template. To speed up the release process, custody sergeants asked detainees a range of questions and updated the system once they had been released. This resulted in inconsistencies and reduced the quality of PRRAs across the force.
- 7.3** Custody staff worked closely with the criminal justice liaison and diversion team who visited each suite daily. The team took referrals directly from custody staff and signposted detainees to appropriate support services in the community. The team was well integrated into the custody teams and was due to expand its service from April 2017 to include weekend and evening working.
- 7.4** A support leaflet with useful information was given to most detainees on their release. The leaflet contained contact details for a wide range of local and national support services, but it was only available in English.
- 7.5** In line with the force policy, vulnerable detainees were routinely offered a lift home or had arrangements made to assist with travel from the custody suite. We saw examples where custody staff facilitated telephone calls to enable detainees to arrange a lift from the custody suite after release. There was a sufficient supply of rail travel warrants in all suites.
- 7.6** The person escort records (PERs) we sampled were mostly completed well, but in some cases detailed risk information had not been provided. Some warning markers were identified but the dates of specific incidents not included. Confidential medical records were not always sealed in envelopes, which was unacceptable and disrespectful (see area for improvement 6.55), and a large number of PERs held unnecessary paperwork, such as copies of risk assessments, which was inappropriate.

Area for improvement

- 7.7** **Pre-release risk assessments should be carried out consistently.**

Courts

- 7.8** Custody staff at all the suites told us that the local remand courts normally accepted detainees until 2pm on weekdays but only to 9am on Saturdays. We were told of occasions when detainees had been accepted as late as 4pm and there was generally some flexibility each day, depending on how busy the courts were. We found no evidence that court acceptance times meant that detainees were held in custody for longer than necessary, which was an improvement since our previous inspection.

Section 8. Summary of areas of concern, recommendations, areas for improvement and good practice

Areas of concern and recommendations

- 8.1 Area of concern:** Performance information was not comprehensive or always accurate. This limited the force's ability to monitor and review its performance effectively.

Recommendation: The force should develop a comprehensive performance management framework for custody that ensures the accurate collection of data, particularly on ethnicity of detainees, and should use this to assess performance, identify trends and learning opportunities, and improve services. (2.37)

- 8.2 Area of concern:** The force did not comply with a number of procedures in relation to PACE, in particular the application of codes C and G.

Recommendation: The force should ensure that all custody processes comply with the Police and Criminal Evidence Act 1984. (2.38)

- 8.3 Area of concern:** Too many people detained under section 136 of the Mental Health Act were being brought in to custody as a place of safety. (2.39)

Recommendation: The force should, in collaboration with partners, undertake a review of the high numbers of vulnerable people detained in police custody as a place of safety, and take action to avoid the use of police custody as a place of safety for people with mental health problems.

Areas for improvement

Leadership, accountability and partnerships

- 8.4** The force should identify any potential ligature points and eliminate or mitigate any risks they present. (3.9)

Pre-custody: first point of contact

- 8.5** The force and health partners should ensure that the transport used for people detained under section 136 of the Mental Health Act supports their mental health needs. (4.10)

In the custody suite: booking in, individual needs and legal rights

- 8.6** Observations of detainees should be carried out on time as determined by the custody sergeant. (5.13)
- 8.7** All custody staff should carry anti-ligature knives. (5.14)

- 8.8** Anti-rip clothing should not be issued routinely to all detainees with a self-harm marker but be based on individual and dynamic risk assessments. (5.15)
- 8.9** Staff shift handovers should be carried out in private. (5.16)
- 8.10** Voluntary attendees should not be booked into custody in the custody suite environment. (5.28)
- 8.11** Detainees should be booked in promptly on arrival at the custody suites. (5.29)
- 8.12** Essex Police should monitor the time that detainees are kept in detention to ensure that there are no unnecessary delays in progressing their case. (5.30)
- 8.13** All suites should have two-way telephone handsets to facilitate telephone interpreting. (5.35, repeated recommendation 5.14)
- 8.14** The force should take account of the management of bail in any review of resources or shift patterns. (5.42)
- 8.15** Detainees should be able to make a complaint about their care and treatment before they leave custody. (5.44, repeated recommendation 5.28)

In the custody cell, safeguarding and health care

- 8.16** The cell call bell system should be explained to all detainees before they are located in cells. (6.7)
- 8.17** There should be sufficient handcuffs in the emergency evacuation packs to evacuate all detainees safely. (6.8)
- 8.18** Each member of staff involved in using force against a detainee should submit an individual use of force form. (6.14)
- 8.19** Detainees should only be strip searched when there are sufficient grounds to do so, and the justification for this should be clearly recorded on their custody record. (6.15)
- 8.20** Children and vulnerable adults should always receive early and effective support from appropriate adults. (6.37)
- 8.21** Record keeping on the use of appropriate adults should assess waiting times accurately and identify areas that require improvement. (6.38)
- 8.22** The force should continue to engage actively with its local authority partners to ensure that children charged and refused bail are transferred to alternative accommodation to avoid their custody overnight. (6.39)
- 8.23** Health care professionals should see detainees promptly, and within a timescale that supports their health and well-being and does not unnecessarily hinder custody processes. (6.54)
- 8.24** Confidential detainee medical records should be sealed in envelopes and clearly marked to be 'opened only by health professionals'. (6.55)

- 8.25** Detainees should be able to make complaints about health care, and this should be advertised in the medical rooms. (6.56)
- 8.26** The automated external defibrillators should be located where they are readily accessible in the custody suites. (6.57)
- 8.27** All health care professionals should receive regular clinical supervision. (6.58)
- 8.28** Forensic sample kits should be stored in cupboards and routinely checked to ensure they are in date. (6.59)
- 8.29** All medical rooms should meet appropriate standards for conducting clinical activities. (6.60)
- 8.30** Prescription-only medicines authorised by forensic medical examiners by telephone should be followed up by a written or signed prescription. (6.67)
- 8.31** Clinically indicated opiate substitution should be available to all detainees in line with national guidelines. (6.68, repeated recommendation 6.23)
- 8.32** Detainees should have prompt access to Mental Health Act assessment while in custody. (6.76)

Release and transfer from custody

- 8.33** Pre-release risk assessments should be carried out consistently. (7.7)

Example of good practice

- 8.34** The force had developed contingency planning with partners to prepare for the new legislation and further restrictions on the police to take people into custody under section 136 of the Mental Health Act. (3.20)

Section 9. Appendices

Appendix I: Inspection team

| | |
|------------------|---------------------------------------|
| Ian MacFadyen | HMI Prisons team leader |
| Fionnuala Gordon | HMI Prisons inspector |
| Kellie Reeve | HMI Prisons inspector |
| Fiona Shearlaw | HMI Prisons inspector |
| Norma Collicott | HMI Constabulary inspection lead |
| Simon Burton | HMI Constabulary inspection officer |
| Anthony Davis | HMI Constabulary inspection officer |
| Adrian Gough | HMI Constabulary inspection officer |
| Patricia Nixon | HMI Constabulary inspection officer |
| Nicola Rabjohns | HMI Prisons health services inspector |
| Paul Tarbuck | HMI Prisons health services inspector |
| Anna Fenton | HMI Prisons researcher |
| Joe Simmonds | HMI Prisons researcher |
| Helen Ranns | HMI Prisons 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 force should review operating procedures for the custody suites, to include clear and consistent guidance on roles and standards relating to the treatment and conditions of detainees in particular to ensure that inspectors are undertaking the full range of duties relating to custody and fulfilling their obligations in providing care for detainees. (3.15)

Not achieved

The sampling of custody records should include cross-referencing checks to CCTV, and the quality assurance process should cover shift handovers. (3.16)

Partially 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.

Main recommendations

The force should ensure that the custody staff and suites provide for a respectful and suitable environment for detainees. (2.43)

Partially achieved

Sufficient officers should be deployed in custody to provide safe and decent management of detainees at all times (2.44)

Not achieved

Recommendations

Booking-in areas should provide sufficient privacy to facilitate effective communication between staff and detainees, and there should be clear policies and procedures to meet the specific needs of females, children and young people and those with disabilities. (4.13)

Not achieved

The role of detention officers should be clarified to ensure that detainees receive a level of care which ensures they are looked after and kept safe. (4.14)

Achieved

Adult and child safeguarding training should be given to and understood by all custody staff. (4.15)

Partially achieved

All custody staff should carry anti-ligature knives in the custody suite. (4.35)

Not achieved

Risk assessments and subsequent observation levels should be monitored to ensure they are appropriate. (4.36)

Achieved

Staff handovers should be comprehensive, recorded and attended by all custody staff, and take place in an area cleared of other staff and detainees. (4.37)

Partially achieved

Pre-release risk assessment of detainees should take into account all known risk factors, and staff should take action appropriately to mitigate the risks. (4.38)

Partially achieved

Handcuffs should be removed from detainees as soon after arrival in the custody suite as the evidenced level of risk permits. (4.43)

Not achieved

Essex police should monitor the use of force at each custody suite by ethnicity, age, location and officers involved, identifying trends and taking appropriate action in line with the Association of Chief Police Officers (ACPO) guidance. (4.44)

Not achieved

There should be thorough daily and weekly maintenance checks to ensure cell and other detainee areas are in a good state of repair, clean, free of graffiti and have a source of natural light. (4.52)

Partially achieved

All visits to cells should be made by, or accompanied by, a member of custody staff. (4.53)

Achieved

The correct use of call bells should be explained to all detainees, and all call bells should activate an audible alert. (4.54)

Partially achieved

All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.65)

Achieved

Food offered to detainees should be of adequate quality and calorific content to sustain them for the duration of their stay. (4.66)

Achieved

Detainees held for long periods should be offered outside exercise. (4.67)

Achieved

Detainees should not walk around the custody suite semi-clothed and barefoot. (4.68)

Partially achieved

Individual rights

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

National issue

Appropriate adults should be available out of hours, given informed consent when necessary to support children and young people aged 17 and under and vulnerable adults in custody (2.46)

Partially achieved

Recommendations

Police should engage with the local authority to ensure the provision of safe beds for children and young people who have been charged but cannot be bailed to appear in court. (5.13)

Partially achieved

All suites should have two-way telephone handsets to facilitate telephone interpreting. (5.14)

Not achieved (repeated as area for improvement 5.35)

The force should evaluate the impact of the PACE G code of practice training relating to voluntary attendance over the next 12 months. (5.15)

Partially achieved

Senior police managers should engage with HM Court Service to ensure that early court cut-off times and the restricted hearings for remanded detainees do not result in unnecessarily long stays in custody. (5.23)

Achieved

Detainees should be able to make a complaint about their care and treatment before they leave custody. (5.28)

Not achieved (repeated as area for improvement 5.44)

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.

Main recommendation

Police custody suites should not be used routinely as places of safety for detainees under section 136 Mental Health Act (2.45)

Not achieved

Recommendations

Medical rooms should only be used for medical examination, be locked when not in use and comply with contemporary standards of infection control. (6.10)

Not achieved

Any audio-visual recording devices sited in medical rooms should have isolating switches under the control of health care professionals and visual warnings of use. (6.11)

Achieved

Scheduled drugs should be stored in compliance with contemporary regulations and all medicine storage safes should be locked when not in use. (6.12)

Achieved

Patient group directions should meet legal requirements. (6.13)

Partially achieved

Custody officers should not administer prescription-only medications without a signed medical prescription. (6.14)

Not achieved

Secondary dispensing of medicines should cease. (6.15)

No longer relevant

Suction units should be assembled and ready for use in case of emergency. (6.16)

Achieved

Clinically indicated opiate substitutes should be available to detainees in line with national guidelines. (6.23)

Partially achieved (repeated as area for improvement 6.68)

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.

