HMICFRS

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

Report on an unannounced inspection visit to police custody suites in Cleveland Police

by HM Inspectorate of Constabulary and Fire & Rescue Services and HM Inspectorate of Prisons

10–21 May 2021

Contents

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Note: Data supplied by the force.

Force

Cleveland Police

Chief constable

Richard Lewis

Police and crime commissioner

Steve Turner

Geographical area

Middlesbrough, Stockton, Hartlepool and Redcar and Cleveland

Date of last police custody inspection

2014

Custody suites

Middlesbrough	50 cells
Redcar and Cleveland (contingency)	6 cells
Hartlepool (contingency replacing Redcar May 2021)	15 cells

Annual custody throughput

2020/21	15,877

Custody staffing

- 4 Police and Criminal Evidence Act 1984 inspectors
- 18 custody sergeants
- 40 detention officers (Mitie)

Health service provider

Mitie Care and Custody

Summary

This report describes our findings following an inspection of Cleveland Police custody facilities. The inspection was conducted jointly by HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and HM Inspectorate of Prisons (HMIP) in May 2021. It is part of our programme of inspections covering every police custody suite in England and Wales.

The inspection assessed the effectiveness of custody services and outcomes for detained people throughout the different stages of detention. It examined the force's approach to custody provision in relation to safe detention and the respectful treatment of detainees, with a particular focus on vulnerable people and children.

This was the first inspection of custody facilities since we paused our inspection activity at the start of the pandemic. To manage ongoing risks as the pandemic continues, we adapted our methodology to carry out some of our activities remotely and minimise our physical presence in the force and its custody suites. To achieve this, we gave the force more notice than usual of the inspection. Our case reviews and analysis, interviews and focus groups were carried out remotely. Our observations were carried out over the two-week period but with no more than two of our inspectors in the suite at any one time.

We also recognise that the force's operating policies and procedures continue to reflect the ongoing pandemic. Measures to minimise the spread of the COVID-19 virus, such as wearing face masks, are in use in the custody suites. The way that some custody services are provided is also affected – for example, managing risks to detainees. We highlight instances of these in the report.

We last inspected custody facilities in Cleveland Police in 2014. This inspection found that, of the 29 recommendations made during that previous inspection, 14 had been achieved, 6 had been partially achieved, 8 had not been achieved and 1 was no longer relevant.

To aid improvement, we have made 3 recommendations to the force (and the Police and Crime Commissioner) addressing main causes of concern and we have highlighted an additional 15 areas for improvement. These are set out in Section 6.

Leadership, accountability and partnerships

Cleveland Police has a governance structure that aims to ensure the respectful and safe delivery of custody, with strategic and operational meetings providing oversight and service management. The force has recently strengthened these arrangements by having a dedicated chief inspector for custody (previously this role included other responsibilities). The force now has a greater focus on improving outcomes for detainees.

This is important because several of our previous recommendations, and some made by the Independent Office for Police Conduct, have not been met. Significant concerns remain over the way that some custody services are run. The force has already made some changes, and there have been some additional resources for custody. This, along with the improved governance and focus, gives us more confidence that our concerns will now be addressed.

The force has adopted Authorised Professional Practice (APP) – Detention and Custody as set by the College of Policing, and also has some local policies and procedures. However, these are not always followed and inconsistent working practices across teams are leading to different outcomes for detainees. We have particular concerns about the management of risk, which is not always ensuring that detainees are kept safe.

There are some good arrangements to monitor the performance of Mitie Care and Custody which holds the contract to provide custody detention officers and health services. Most of these arrangements are about managing demand. But the force gathers and monitors little performance information outside the contract to show how well it achieves outcomes for detainees. Some of the information it collects is not accurate (detainees' ethnicity, for example) and cannot be relied on.

The quality of recording on detention logs is inconsistent. It was not always clear in the records we looked at what actions had been taken, and the rationale and justification for decisions. Quality assurance takes place, but this doesn't identify some of the concerns we had.

The force is meeting the requirements of the Police and Criminal Evidence Act 1984 (PACE) and its codes of practice well in some areas. But not all practices – for example, reviews of detention – meet these requirements.

The force cannot assure itself, the Police and Crime Commissioner and the public that the use of force in relation to detention and custody is always safe and proportionate. Despite a use of force scrutiny board meeting regularly, the governance and oversight of the use of force in custody is not good enough because the data used is not accurate. Quality assurance of incidents is limited and hindered by poor-quality CCTV footage and audio recordings. We had concerns over how force had been used in some cases we looked at, referring them back to Cleveland Police for review.

The force has good strategic oversight of equality, diversity and inclusion, and is committed to meeting the public sector equality duty. But there is little monitoring to ensure that outcomes for detainees are fair and equitable.

The force has a good strategic focus on diverting detainees away from custody when detention might not be appropriate, with effective partnership working to support this. This includes intervention programmes aimed at preventing re-offending. The force also works well with mental health services, achieving some good outcomes for people with mental ill health, and with local authorities to minimise the use of custody for children.

Pre-custody: first point of contact

Frontline officers responding to incidents have a good understanding of vulnerability, using this to help decide whether to arrest a person. Although the information they receive from the call handlers could be better, they generally have enough to help them make decisions. Children are only taken to custody as a last resort and the force uses alternatives when appropriate. Frontline officers feel well supported by mental health professionals working in the street triage scheme and the crisis team. This often means that the force avoids detaining people under section 136 of the Mental Health Act 1983 by finding better health-based solutions.

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

Detainees are generally treated with respect. However, there is little privacy for them when they are booked into custody and they are not offered the opportunity to speak to someone in private. There are notices explaining that CCTV operates in the suite but detainees are not always told this, or that they can use the toilets in private.

Custody officers understand the importance of identifying and meeting people's individual and diverse needs, but the way officers do this is inconsistent. The needs of women, transgender people and those with physical disabilities are, in the main, met. However, this is not always the case for detainees with religious or communication needs.

The force's approach to identifying risk is generally good, observation levels are usually set appropriately, and the visits made to detainees are usually carried out well and on time. But there are significant weaknesses with the ongoing management of risks to detainees. Some working practices do not follow APP guidance and mean that the force is not consistently ensuring detainees' safety.

The arrangements to constantly monitor detainees on CCTV (APP Level 3) are not satisfactory. Officers carrying out constant supervision on detainees from cell doors (APP Level 4) are not properly briefed about the risks. Cell call bells are hard to hear, not always answered promptly (or at all) and routinely switched off. Handovers between shifts are disjointed and not captured well enough on CCTV. All these practices potentially put detainees (and staff) at significant risk of harm.

Detention is appropriately authorised. Arresting officers provide good explanations about the circumstances of the arrest and the necessity to detain (PACE Code G). This allows custody officers to make informed decisions about whether to authorise detention.

Custody officers gave some good explanations to detainees about their three main rights. But the rights and entitlements leaflets and the PACE codes of practice are not routinely offered as required by PACE Code C.

Some detainees have to wait too long to be booked into custody and some spend longer than necessary in custody because of delays in their investigation. Reviews of detention are in person and usually on time. But the way they are carried out varies in quality and some are not thorough enough, with little attention paid to detainee care. Some aspects of these reviews do not meet the requirements of PACE Code C. But detainees wishing to make a complaint can generally do so easily.

Detainees released on bail or under investigation (RUI) are scrutinised but not always managed well enough, with some long waits before investigations are completed.

In the custody cell, safeguarding and health

Overall, conditions and cleanliness across the suites are reasonable. There is natural light in all cells and the temperature of the cells in Middlesbrough are individually controlled. There are potential ligature points (which could be used by a detainee to self-harm) in all three suites, mainly due to the design of toilets and fit of cell hatches. During the inspection, we provided the force with a comprehensive illustrative report detailing the physical conditions in custody suites.

Detainee care is poor, with little improvement since our last inspection. Some staff showed a caring approach to detainees. However, the range of food for detainees is limited. It is often only available at recognised mealtimes and has insufficient sustenance for detainees who spend a long time in custody. The provision of all other care such as showers, exercise or reading materials is extremely limited. Replacement clothing, although available, is not given out readily, leaving some detainees inappropriately dressed. Pillows are not provided routinely and there are often not enough blankets. Some detainees complained of being cold and others told us they were not happy with the level of care they had received.

Safeguarding responsibilities are well understood. Custody officers generally request appropriate adults (AAs) to support children and vulnerable adults as early as possible, although they did not always arrive promptly. Custody officers are also generally recognising when an AA is needed for an adult detainee because of their vulnerability, with good arrangements for AAs to be provided by MIND (a mental health charity) volunteers.

The force has some arrangements to care for children in custody, and we saw custody officers giving good explanations to children about what happens in custody and what they should expect. Girls are assigned a female officer to oversee their care needs. However, their care is mixed. Easy-read rights and entitlements leaflets are not always given out and reading or distraction activities to keep children occupied are rarely provided.

Custody officers told us they try to keep children in custody for as little time as possible, and there is some good oversight of this by the force and other agencies. Very few children are charged and refused bail with only three, in the year to 30 April, requiring a move to alternative accommodation arranged through the local authority.

The local authority has no such accommodation available so none of these children were moved.

There is good governance and oversight of the healthcare service, with the parties working together well to review activities and performance. Detainees routinely receive timely access to healthcare services, delivered by experienced and competent healthcare practitioners (HCPs). The treatment rooms are clean and comply with infection control and prevention standards, with enhanced measures to manage the risks posed by COVID-19. Detainees we spoke with who had seen an HCP were generally positive about the service they had received. This is a much-improved position since our last inspection.

There are effective arrangements for storing medicines, including detainees' personal medication. Ongoing treatment for detainees is appropriate and includes access to opiate substitution treatment. There is good support and signposting to community services for detainees with drug, alcohol or other dependencies. There is, however, no access to nicotine replacement products for smokers.

The criminal justice liaison and diversion (L&D) team offers good support to vulnerable detainees. It works with different agencies to provide wide-ranging services, including immediate crisis support and help in the community. The service is highly valued by custody officers and demand for it is high.

The mental health street triage scheme and the arrangements at the local mental health hospital work effectively to keep people with mental ill health out of custody. Nobody had been detained under section 136 of the Mental Health Act 1983 and taken to custody in the year immediately before our inspection. When detainees require a Mental Health Act assessment in custody, this is carried out with no undue delay and, if needed, the force arranges transfer to a hospital bed.

Release and transfer from custody

Detainees are released safely. Custody officers complete thorough pre-release risk assessments with particular attention to the safe release of children and vulnerable detainees. The L&D team and/or other agencies are involved, as needed, to offer and provide support.

The quality of electronic person escort records varies and they do not always include enough information. They are completed by detention officers with little or no oversight from custody officers, which is poor practice and contrary to APP guidance.

Detainees held overnight for court are efficiently processed and not held in police custody for longer than necessary. Those arrested on a warrant are booked in to police custody but accepted by the court until 2.00pm. The force works flexibly with the court with some detainees accepted much later in the afternoon.

Causes of concern and recommendations

Cause of concern: Detainee safety

We found that detainee safety is not always assured:

- Constant CCTV monitoring (authorised professional practice [APP] Level 3) of detainees is not satisfactory.
- Cell call bells are hard to hear, not always answered promptly (sometimes not at all) and routinely switched off.
- Officers carrying out constant watches on detainees from cell doors (APP Level 4) are not properly briefed about the risks.
- Handovers between shifts are disjointed and not captured well enough on CCTV.

All these practices are contrary to APP guidance and place detainees at significant risk of harm.

Recommendation

The force should take immediate action to mitigate the risk to detainees by ensuring that its risk management practices follow APP guidance and are carried out to the required standard.

Cause of concern: Use of force

The force's governance and oversight of the use of force are limited. Not all incidents involving the use of force in custody are recorded, making the data unreliable and preventing effective scrutiny. Quality assurance of incidents is hindered by poor-quality CCTV. Our review of incidents showed that some use of force appeared unnecessary and, in some cases, punitive.

Recommendation

The force should scrutinise the use of force in custody based on accurate data and robust quality assurance, including satisfactory CCTV viewing of incidents. It should use this to show that, when force is used in custody, it is fair and proportionate.

Cause of concern: Detainee care

Detainee care is poor with little improvement since our last inspection. Food and drink are not proactively offered or provided, and the food that is provided does not have sufficient sustenance, especially for those in custody for some time. Detainee access to other aspects of care, such as washing, showers, exercise and reading materials is very limited.

Recommendation

The force should significantly improve the care of detainees by ensuring that they are regularly offered drinks and food of sufficient variety and sustenance to meet their needs. Access to other aspects of care should be readily available to detainees.

Introduction

This report is one in a series of inspections of police custody carried out jointly by HM Inspectorate of Prisons and HM Inspectorate of Constabulary & Fire and Rescue Services. 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. HMIP and HMICFRS are two of several bodies making up the NPM in the UK.

Our inspections assess how well each police force is fulfilling its responsibilities for the safe detention and respectful treatment of those detained in police custody, and the outcomes achieved for detainees.

Our assessments are made against the criteria set out in the Expectations for Police Custody. These standards are underpinned by international human rights standards and are developed by the two inspectorates. We consult other expert bodies on them across the sector and they are regularly reviewed to achieve best custodial practice and drive improvement.

The expectations are grouped under five inspection areas:

- leadership, accountability and partnerships;
- pre-custody: first point of contact;
- in the custody suite: booking in, individual needs and legal rights;
- in the custody cell: safeguarding and health care; and
- release and transfer from custody.

The inspections also assess compliance with the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing's Authorised Professional Practice – Detention and Custody.

The methodology for carrying out the inspections is based on:

- a review of a force's strategies, policies and procedures;
- an analysis of force data;
- interviews with staff;
- observations in suites, including discussions with detainees; and
- an examination of case records.

We also conduct a documentary analysis of custody records based on a representative sample of the custody records across all the suites in the force area open in the week before the inspection was announced. For Cleveland Police we analysed a sample of 119 records. The methodology for our inspection is set out in full at Appendix I.

The joint HMICFRS/HMIP national rolling programme of unannounced police custody inspections, which began in 2008, ensures that custody facilities in all 43 forces in England and Wales are inspected regularly.

Section 1. 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

Cleveland Police has a governance structure for overseeing the respectful and safe running of custody that has recently been strengthened to improve the effectiveness of its scrutiny.

Under the direction of an assistant chief constable, there is a superintendent and a chief inspector with overall responsibility for day-to-day custody operations. Recent changes (December 2020) have led to the chief inspector being dedicated to the custody role (previously the postholder had a wider portfolio). This provides greater focus on custody services and is leading to changes in how custody services are run to improve outcomes for detainees.

For example, custody officers are given responsibility for a specific custody wing with dedicated detention officers to look after detainees. This provides greater accountability and consistency. However, other changes recently introduced, such as the approach to risk management, are not yet embedded, and there is some cultural resistance to change from some custody officers and staff that needs to be overcome to deliver the desired improvements.

The crime and investigation delivery group meets every two months to direct and manage custody services. Governance through these meetings is being strengthened as more areas of custody operations are added for scrutiny and more detailed reports presented. In future, areas such as the use of force and disproportionality will be included. Also, there are custody management meetings with the head of crime, Mitie Care and Custody managers and other interested parties to discuss custody matters.

However, until recently, there has not been enough focus on custody. Several of our previous recommendations have not been met and neither have recommendations to the force from the Independent Office for Police Conduct. The force has responded positively to this inspection's findings, implementing some changes straightaway. This gives us more confidence that improvements will now be made.

In general, the force has sufficient staff to deliver custody services – although it was not at full establishment at the time of inspection. There are four Police and Criminal Evidence Act 1984 (PACE) inspectors and an extra inspector for policy and development. A recent review of demand led to an increase in custody officers from 18 to 20. Detention officers and detention supervisors are provided under contract by Mitie. The contract specifies 4 detention officer managers and 36 detention officers. At the time of inspection, 16 custody officers and 32 detention officers were in their posts, although some posts were due to be filled. Gaps are filled by trained resilience staff whenever possible. Otherwise, overtime is used. This can include police officers conducting gaoler duties. But not all of these officers are experienced in custody and we were told that they had received little training.

Initial training is two weeks for custody officers and three weeks for detention officers. It covers the legal aspects of their role together with practical guidance on dealing with detainees including those who may be vulnerable. Training has also recently been provided to officers who are required to cover for custody officers when needed. There was a continuing professional development day for all custody staff in April 2021 (this had been delayed due to the pandemic). This will be held every year. There is a comprehensive and useful monthly custody newsletter that supports training and ongoing learning, often focusing on a particular subject to increase understanding.

However, police officers and detention officers are trained separately on the use of force using different training packages. The force needs to assure itself that this training is compatible.

There is a clear process for recording and reporting adverse incidents. Until recently, these were not reviewed quickly enough. But reviews of incidents are now better and we found that learning is effectively shared with staff. There has been one death since our last inspection in 2014, which was following release from police custody and occurred in 2019/20.

The force has adopted Authorised Professional Practice (APP) – Detention and Custody as set by the College of Policing. There are also local policies and procedures for staff to follow. However, not all practices we observed during the inspection follow these. Working practices are often inconsistent across teams, leading to different outcomes for detainees. We have particular concerns about the management of risk, which does not follow APP guidance and does not ensure that detainees are kept safe. This is a cause of concern.

The force is open to outside scrutiny, and responsive to addressing any concerns raised by independent custody visitors (ICVs). The pandemic has meant that physical visits to the suite by ICVs have not taken place in the past year. Instead, some custody records have been examined each week. Before this, ICVs gained access to the suite easily and any problems they raised were quickly dealt with by custody staff.

Area for improvement

The force should ensure that all custody staff consistently follow the College of Policing's Authorised Professional Practice – Detention and Custody and its own guidance, so that detainees receive the appropriate treatment and care.

Accountability

Custody performance is managed at the monthly contract and performance meetings between the chief inspector, the custody inspector, the contract manager from the Office of the Police and Crime Commissioner and relevant Mitie staff. This focuses on the care in detention and health services provided by Mitie. Performance is assessed against agreed performance indicators such as waiting times for detainees and waits for different medical services. Other information is considered, such as custody throughput (the number of detainees entering custody over time). Some of this performance information is presented to the crime and investigation delivery board as part of the chief inspector's highlight report.

Much of the performance monitoring for the Mitie contract is geared towards contractual performance and understanding demand. The force monitors little information outside the contract to help assess outcomes for detainees – for example, appropriate adult requests and arrival times. Some of the data it collects is unreliable – mainly in the use of force in custody and the type of restraint used. These limitations make it difficult for the force to monitor performance effectively in some areas of its custody services.

The quality of recording on detention logs is inconsistent and not always clear in showing what actions have been taken and when. This includes the rationale and justification for any decisions. There is an over-reliance on standardised 'drop-down' menu texts, often with little description on the custody record of additional contextual information. Some important information is not captured well enough and sometimes not recorded at all. We saw little recording on provision of care and there was sometimes little information recorded about reviews of detention.

Custody inspectors and Mitie detention managers conduct dip-sampling to quality assure custody records. However, these do not seem to have identified the concerns and shortcomings in the records that we reviewed.

There is some good attention paid to meeting the requirements of the Police and Criminal Evidence Act 1984 (PACE) and its codes of practice. The requirement to demonstrate the necessity to arrest (Code G) is generally met well. But some practices do not meet the requirements of Code C, mainly information about individual rights and reviews of detention.

The force cannot assure itself, the Police and Crime Commissioner and the public that the use of force in relation to detention and custody is always safe and proportionate. Despite a use of force scrutiny board meeting regularly, the governance and oversight of the use of force in custody are not good enough because the data used is not always accurate.

Not all incidents of use of force in custody are recorded on the custody record and not all officers and staff involved in incidents are submitting use of force forms as required. This means that the data is not comprehensive, reliable or accurate. Reviews of incidents by inspectors are hindered by poor-quality CCTV footage and audio recording is limited. We had concerns over how force had been used in several of the cases we looked at, referring them back to the force for review. This is a cause of concern.

The force is committed to meeting the public sector equality duty and there is a good strategic oversight of equality, diversity and inclusion. An equality impact assessment has recently been carried out for custody to assess how services affect those with individual or diverse needs. But the data on ethnicity is not accurate and there is little monitoring to ensure that outcomes for detainees are fair and equitable.

Areas for improvement

- The force should strengthen its approach to performance management by improving the quality of its data and monitoring a wider range of information to show the outcomes achieved for detainees.
- The force should improve the quality of its custody records by ensuring that all necessary information is fully recorded, including the rationale and justification for any decisions made. Quality assurance should be strengthened to assess the standard of recording.
- The force should ensure that all custody procedures comply with legislation and guidance.

Strategic partnerships to divert people from custody

The force has a good strategic focus on diversion from custody with effective partnership working supporting this. The Cleveland Divert scheme (run by the Cleveland Rehabilitation Company) receives referrals from custody and seeks to divert low-level and first-time offenders into programmes aimed at preventing re-offending. It includes a specific pathway for women: 'A way out'. There is also good work with the Youth Offending Service for children with interventions to prevent them from entering the criminal justice system.

The force works well with other agencies to keep children out of custody whenever possible or to minimise any time they spend there. Protocols on how to deal with children have been agreed and there is good joint monitoring of children with the force's partners. However, when children need to transfer from custody to other accommodation because they have been charged and refused bail, they are not moved. The local authorities do not have the capacity or resources to provide this.

The force works well with mental health agencies to improve outcomes for detainees with mental ill health. Mental health service support is available to officers dealing with people on the street, often avoiding detention under section 136 of the Mental Health Act 1983. There are also effective arrangements for assessing and supporting detainees with mental ill health in custody.

Section 2. 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

Frontline officers responding to incidents have a good understanding of vulnerability. They recognise that some people may be vulnerable because they are unable to care for themselves due to (for example) mental ill health. Or they might become vulnerable because of a situation they face, such as domestic abuse. All children are regarded as vulnerable because of their age, but some have additional vulnerabilities due to their circumstances.

The force uses the College of Policing's definition of vulnerability. But officers apply their own judgments depending on the circumstances when dealing with individuals at the scene of an incident. Their understanding has been helped by regular training events regarding vulnerability, including work with agencies to broaden understanding.

Frontline officers reported that they do not always receive accurate, timely or enough information from the force's call handlers to help them respond to incidents. They can get information themselves from their handheld devices or laptops. But it is not always practical to do this while attending an incident, especially if they are the only officer at the scene. There is a vulnerability helpdesk in the call centre to help officers deal with incidents involving domestic abuse, and this provides any available information about the people involved. Officers value this service.

It is clear that officers take account of a person's vulnerability when deciding whether to arrest. When they decide that taking a person to custody is not the best action, they consider alternatives.

Frontline officers told us that they only take children to custody as a last resort – particularly if this would mean an overnight detention. Instead, they consider alternatives such as:

- interviews at home recorded on body-worn cameras;
- voluntary attendance interviews;

- referring children to the Youth Offending Service for interventions or restorative justice options; and
- practical solutions such as taking a child to another family member or requesting support from local authority or health partners.

We were given some good examples of where these arrangements had worked well and kept children out of custody. But officers also told us that they sometimes felt let down by other agencies that, we were told, sometimes advised parents to contact the police about a child's behaviour. Officers felt this was not always appropriate because sometimes there was little they could do and the behaviour was not something that a child would be arrested for.

When responding to incidents involving people with mental ill health, officers said they felt well supported by mental health services. There is a mental health triage scheme based in the force call centre and working noon to midnight. The scheme has mental health professionals who can access information, provide advice and attend incidents if needed. When the scheme is not available, officers contact the mental health crisis team based at the local mental health hospital for advice. Frontline officers valued both these services and the help given when they are considering detaining a person under section 136. This often resulted in the person being diverted to a more suitable alternative or service rather than being detained.

When a person is detained under section 136, they are taken to the mental health suite – custody is not used as a place of safety. Officers reported good working arrangements with the mental health suite. Detained people are risk assessed and, unless officers are requested to stay because the detainee is violent or presents risks to others, they can leave the detainee and return to their duties.

When a person is arrested and taken to custody but it is suspected that there may be mental health concerns, they are referred to the criminal justice liaison and diversion (L&D) team in custody. If needed, a Mental Health Act assessment is carried out. Frontline officers said these arrangements also worked well.

Frontline officers are aware of the force's priority to divert people away from custody, and they spoke positively about the Cleveland Divert scheme as a means of doing this and preventing re-offending.

Detainees are usually taken to custody in police vans. The officers we spoke with had never had to deal with a detainee in a wheelchair. But they suggested that, if the situation arose, they would arrange an adapted taxi or put the wheelchair in the police van.

Area for improvement

The force should ensure that frontline officers have access to good-quality and timely information to help them respond to incidents and make decisions.

Section 3. 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

Detainees are generally treated with respect. Most interactions between detainees and custody staff are polite and professional.

There is insufficient privacy for detainees to disclose sensitive or confidential information. The booking-in area at Middlesbrough is frequently congested and noisy. There is a separate booking-in area but this is currently set aside for any detainees suspected of having COVID-19. This means that, for the moment, children and those who are vulnerable, including by virtue of their alleged offence, are routinely booked in alongside others.

The design of the Middlesbrough suite does not lend itself to ensuring privacy for detainees. Although the custody desks at Middlesbrough are lower than at the last inspection, the desks remain too high at the resilience facility in Redcar. This hinders holding conversations easily. There are few arrangements to mitigate this and detainees are not asked if they wish to speak to a member of staff in private as required by the Police and Criminal Evidence Act 1984 (PACE) Code C, paragraph 3.5.

Notices advising that CCTV operates throughout the custody suite, including in cells, are clearly displayed. Most toilets are obscured from view on CCTV monitors. But the pixilation that hides them on the CCTV screens has slipped on some so that they are no longer hidden from view. Detainees are not consistently advised during booking in, or on being taken to a cell, that cells are covered by CCTV; nor are they assured privacy when using the toilet.

Areas for improvement

The force should improve its approach to detainee dignity and privacy by:

- ensuring that there is sufficient privacy for conversations with detainees;
- asking all detainees if they wish to speak to a member of staff in private; and
- advising detainees that they are being monitored on CCTV but can use the toilet in private.

Meeting diverse and individual needs

Custody staff are properly focused on, and generally have a reasonable understanding of, the importance of identifying and meeting diverse needs. However, many feel that they have received little training to help them and we are not assured that diverse needs are always identified or met. Custody records rarely reflect any information on diverse needs.

Detainees are not routinely asked to give their ethnicity during booking in. Custody staff generally complete the ethnicity field on the force's computer system (Niche) without reference to the detainee, which undermines the integrity of the data (see above, 'Leadership').

The arrangements to meet the needs of women have improved since our last inspection. All women are advised that they have been assigned a female member of custody staff should they wish to discuss anything with someone of the same gender. There are sufficient female custody staff but those allocated this responsibility do not always visit the women in their care to introduce themselves or explain their purpose, including after shift changes. Women are generally held on the custody wing (C wing) designated for children, women and those who are vulnerable but they may be put in other wings if cells on C wing are occupied. A good range of menstrual care products are stocked but are not readily available or proactively offered. Only C wing has an appropriate disposal unit.

Many custody staff have direct experience of working with transgender detainees and were able to describe well how they meet their needs.

Provision for detainees with physical disabilities is mostly adequate. Middlesbrough custody suite is accessible throughout and detainees can use an adapted toilet and shower if needed. The benches in these cells are too low but this is generally mitigated by a thick mattress to raise the height. A wheelchair is available and two cells are suitable for wheelchair users. Detainees are not permitted to have their wheelchair or walking aids in the cell with them. This can create problems when they move about the cell or use the toilet.

All cells have coloured band markings on the walls to assist detainees with sight impairments. A hearing loop is available but not all staff are aware of this.

Staff awareness of neurodiversity is limited. Autism awareness featured in a recent continuing professional development workshop but very few custody staff are

confident in identifying needs or providing individual care for detainees with neurodiverse conditions.

Detainees are not asked if they have any religious needs and we are not assured that these needs are either identified or met. Custody facilities have stocks of religious articles and texts for the main faiths, but staff don't always know where they are. Some are in a poor condition and, on occasion, not stored respectfully. All cells, except those at Redcar, have a Qibla marking showing the direction of prayer for people following Islam.

The arrangements for detainees who speak limited or no English are inconsistent. Professional telephone interpreting services are available but, when used, the loudspeaker function (used because dual handsets were removed as a COVID-19 control measure) allows poor privacy. This service is not used consistently for important custody processes such as booking in or reviews of detention. Some staff communicate to detainees by gesticulating rather than using the interpreting services available to them, and this is an ineffective way of communicating. However, foreign national detainees' home nation embassies, High Commissions or consulates are advised of a detainee's arrest, when required or requested.

Rights and entitlements leaflets are available in a range of different languages, in Braille and easy-read format. But not all custody staff are aware of this and the latter are not issued consistently. Not all custody staff we spoke to were aware of the requirements of PACE Code C, Annex M, on translated documents (see below, 'Individual legal rights').

Areas for improvement

The force should ensure that the individual and diverse needs of all detainees are met. In particular, they should do this by:

- offering female detainees easy access to menstrual care products;
- appropriately identifying any detainee's religious needs and meeting these respectfully;
- providing interpretation services consistently for all detainees who need this help; and
- allowing detainees with disabilities to keep equipment, such as a wheelchair or walking aids, in their cell based on an individual risk assessment.

Risk assessments

The approach to identifying risk is generally good but there are significant weaknesses with its ongoing management. Some working practices mean that the force is not ensuring the safety of detainees. This is a cause of concern that we expect the force to immediately address.

Some detainees are booked in promptly but, during busy periods, some are made to wait too long in vehicles or in the holding room before their detention is authorised

(see individual rights). There is no management of queues to triage risks or to prioritise children or vulnerable detainees for booking in.

During booking in, custody officers and detention officers focus appropriately on identifying risks and vulnerability factors. Custody staff interact positively with detainees to complete the risk assessment template and ask relevant supplementary and probing questions when required. There is routine cross-referencing to the police national computer warning markers to help identify additional risk factors. However, the risk assessment questions, and ancillary COVID-19-specific questions, are sometimes rushed and asked inconsistently. Arresting and escorting officers are rarely asked whether they have any relevant information to inform the risk assessments further.

In most cases, initial care plans reflect observations set at a level that is commensurate with risks. But Authorised Professional Practice (APP) guidance is not always followed. Custody records show that some detainees had the wrong observation level recorded. For example, a detainee under the influence was recorded as needing Level 1 30-minute rousals (when it should have been Level 2, which requires the detainee to be both visited and roused every 30 minutes), and a detainee with self-harm concerns was recorded as needing Level 1, 30 minutes, with CCTV monitoring (which should be Level 3, requiring the detainee to be constantly monitored on CCTV). This may be a recording problem with the force's computer system but it is potentially confusing. In general, observation levels are reviewed regularly but there is not always sufficient justification recorded on custody records when they are changed.

When the assessment indicates a heightened level of risk, detainees are observed more closely at either Level 3 (constant observation via CCTV) or at Level 4 (physical supervision in close proximity). The detention officers responsible for Level 3 CCTV monitoring do not work within APP guidance. They regularly monitor more than four detainees at the same time. On one occasion, we saw a detention officer monitoring 11 detainees simultaneously, including 8 on Level 3. This is unsafe practice.

In addition, the detention officers control access to the suite and monitor the cell call bell system, which distracts them from their task of monitoring detainees. Other than a refreshment break, they remain in post for the whole of their shift. These practices are contrary to APP guidance and are not ensuring detainee safety. They are included in our cause of concern.

Not all custody officers adequately brief staff conducting Level 4 close proximity supervision. Officers frequently receive no briefing other than from their departing colleague(s). They can also remain in this post for long periods without any breaks. These practices do not follow APP guidance and remain largely unchanged since our last inspection. This is included in our cause of concern.

Checks on detainees are consistently carried out by the same member of staff. This is positive and means that the force can readily identify changes in a detainee's behaviour or condition. When rousing for detainees under the influence of alcohol and/or drugs is required, staff conduct these checks thoroughly in accordance with Annex H of PACE Code C, although the details of the checks are not always adequately recorded in the custody record. The frequency of checks conducted on detainees is mostly adhered to but some are late.

Clothing with cords and footwear continue to be routinely removed without an individualised risk assessment, which does not follow APP guidance. The rationale for their removal is not routinely recorded. Anti-rip (harm reduction) clothing is used infrequently but the rationale and justification for its use is not always fully recorded on the detainee's custody record.

It is positive that all custody staff carry anti-ligature knives (these are for cutting ligatures) but these are often used to cut cords from detainees' clothing. Staff do not recognise that this practice can reduce the effectiveness of the knives if required in an emergency.

Cell call bells are barely audible in the back office and there is no visual indicator on the custody wings to show when they have been activated. They are routinely switched off and rarely responded to. Detainees told us that staff are slow to respond, if at all, when cell call bells are activated. This practice poses potential risks to detainees who require assistance and is the same as in our last inspection. It is included in our cause of concern.

Although custody keys are freely available and frequently swapped between custody staff, there is generally good control by custody staff and access by non-custody staff is appropriately limited.

There is no collective handover between all the incoming and outgoing custody staff to ensure that all relevant information is passed on to those taking over responsibility for detainees. We raised this in our last inspection. Custody officers and detention officers with responsibility for different wings hand over separately to their incoming peers and these handovers are not always conducted in an area covered by CCTV. This is included in our cause of concern. Healthcare practitioners (HCPs) are generally on duty but are not involved with the handovers, which is a missed opportunity and does not follow APP guidance.

The content of individual handovers is sufficiently focused on detainee risk and welfare. At the start of a new shift, the custody officer and detention officer for each wing visit the detainees in their care. While staff engage with detainees on some visits, some staff have little, if any, meaningful interaction with detainees.

Area for improvement

Detainees' clothing, including cords and footwear, should only be removed based on an individual risk assessment and the rationale for doing so should be fully recorded on the custody record.

Individual legal rights

The way in which detainees receive their individual rights in custody is inconsistent and requires improvement in some areas.

Some detainees wait a long time to be booked into custody. Information provided by the force showed that, in the year to 30 April 2021, detainees waited an average of 25 minutes. However, our observations and review of custody records showed that,

while some detainees were presented to the custody desk with little or no wait, others waited a lot longer – on occasions for an hour or more. It was not always clear why. Frontline officers also reported some long waits and said this often depended on the shift on duty.

Detention is appropriately authorised. Arresting officers provide good circumstances of arrest and of the necessity to detain (PACE Code G). This allows custody officers to make informed decisions on whether to authorise detention. They refuse detention when necessary and we saw examples of this happening appropriately.

Detention officers can also book detainees into custody. When this takes place, they are properly supervised by the custody officers. However, the practice involved is unclear and inconsistent. Sometimes the detention officer is only recording the details and writing up the custody record while the custody officer books the detainee into custody. This is duplication of effort and not making best use of available staff.

The force uses alternatives to custody such as:

- restorative justice (the collective resolution between victim and offender as to how to deal with the consequences of an offence);
- conditional cautions (whereby the offender admits the offence and accepts the conditions being imposed: if the offender fails to comply with the conditions, they can be prosecuted); and
- voluntary attendance (whereby suspects involved in minor offences attend a police station by appointment to be interviewed about these, avoiding the need for arrest and subsequent detention).

Information supplied by the force showed that, in the previous year, 2,472 people attended voluntarily for interview, including 300 children. Voluntary interviews take place outside of custody preventing unnecessary exposure to the custody environment.

The number of immigration detainees has reduced significantly over the past three years. In the year to 30 April 2021, 79 entered custody, compared with 328 two years earlier. They spent an average of 26 hours and 31 minutes in custody from arrival to departure.

Detainees should be kept in custody for the minimum time necessary. However, we found that some detainees were held in custody for longer than necessary because of delays in progressing their case. This included delays in assigning an investigating officer to the case. Because of this, some detainees waited too long before being interviewed. We saw two detainees who were not interviewed but released with no further action after about 16 hours in custody.

We observed custody officers generally giving good explanations to detainees about their three main rights and entitlements. These are: 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. But detainees were not consistently offered or given the information leaflet about their rights and entitlements. This does not meet the requirements of PACE Code C, paragraph 3.2. Nor were the detainees proactively offered the PACE codes of practice to read, and the codes held in the custody suite

were not the latest version. During our inspection, the force ordered the latest versions of the PACE Code C books.

Posters advising detainees of their right to free legal advice in different languages were put up during our inspection, but only one side was displayed at each booking desk so only half of the available languages could be seen.

There are sufficient interview/consultation rooms for detainees to consult their legal representatives in private. Those wishing to speak to their legal representatives on the telephone can do so privately, in a separate area of the custody suite – although they can be overheard. Legal representatives can view a summary printout of the front sheet of their client's custody record on request.

Not all the custody officers we spoke to were aware of the requirements of Annex M and how to access translated documents and records for non-English speaking detainees or those who have difficulty understanding English. We noticed that, during our second week of inspection, the awareness of Annex M had increased among custody officers and staff.

There are copies of the easy-read version of the rights and entitlements leaflet. We did not see one always being given when it was needed – for example, when a detainee disclosed dyslexia. Again, this improved during our inspection, which shows that the force responds quickly to concerns when raised.

DNA is regularly collected from the suite. However, we found that the freezer was not locked, which could affect the integrity of the samples. Once we told the force, this was rectified immediately.

Area for improvement

The force should ensure that detainees have their cases dealt with promptly and effectively so that they do not spend longer than necessary in custody.

Reviews of detention

Overall, the approach to PACE reviews of detention was inconsistent and some aspects of them did not always meet the requirements of PACE Code C.

Reviews of detention are carried out in person and generally on time. Detainees are treated courteously. But we saw several reviews taking place using the cell hatch, making it difficult for detainees and reviewing inspectors to clearly hear each other, particularly when the cell corridors were noisy.

The reviews we observed, and our examination of custody records, showed that some are comprehensive and conducted well while others are not thorough enough.

Detainees are not always clearly advised that their further detention is being authorised, nor asked if they have any representations to make. This does not meet the requirements of PACE Code C, paragraph 15.3. Neither are detainees always reminded at the earliest opportunity when a review has taken place overnight while they were sleeping. This does not meet the requirements of PACE Code C, paragraph

15.7. We found little attention paid to detainee care during reviews of detention. Detainees are not routinely asked about any welfare needs, whether they are receiving enough food and drink, or whether they require any other care provisions.

Recording of reviews of detention was inconsistent and sometimes poor, making it difficult to assess whether they had been conducted properly and in the interests of the detainee.

Area for improvement

Reviews of detention should be carried out to a consistent standard and in the interests of the detainee.

Access to swift justice

The arrangements to ensure that detainees can access swift justice are not working well enough. Our analysis of custody records showed that 40 percent of cases were concluded during a detainee's first period in custody. This means that many are either bailed or released under investigation (RUI) pending further enquiries. They then wait too long for their cases to be completed.

The force collects and monitors performance information for bail and RUI. This shows that both are increasing – at 7 May 2021, there were 510 suspects on bail and 2,273 RUI. Nearly a sixth of RUI cases are between six and twelve months old and some are more than a year old.

There are arrangements to manage investigations within agreed timescales, with sergeants and inspectors monitoring these cases at regular intervals. However, these timescales are not kept to and many cases have not been reviewed as required. Some cases are delayed – for example, because of waits for digital forensics. Frontline officers and supervisors told us that they did not always have time to complete outstanding investigations because of competing demands on their time.

A notice outlining the possible offences suspects may commit if they interfere with the course of justice while the investigation is ongoing is given to detainees when they are RUI. This also includes how they will be notified should further action be taken, like prosecution.

Complaints

Information telling detainees how to make a complaint is provided in the leaflet 'What to expect while you are in custody'. We did not see this always being given out and sometimes it was inserted into the rights and entitlements leaflet so detainees might not be aware of it.

We found that promotion of how to complain was limited, but the force had ordered posters that were put up in the custody suite during our inspection.

If detainees wish to complain, their complaint is taken while they are still in custody. This is positive because it offers the opportunity for the detainee to have their complaint dealt with quickly.

Section 4. 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 healthcare practitioners (HCPs) who meet their physical health, mental health and substance use needs in a timely way.

The physical environment is safe

Since our 2014 inspection, the custody suite at Hartlepool has closed, leaving the force with one full-time designated suite in Middlesbrough (50 cells) and a resilience suite at Redcar (6 cells). The force plans to re-open the Hartlepool suite (15 cells) as a resilience suite. Our visits to all three facilities highlighted potential ligature points, mainly due to the design of toilets and fit of cell hatches. During the inspection, the force was provided with a comprehensive illustrative report detailing these and general conditions.

Overall, conditions and cleanliness across the suites are reasonable, but there is some ingrained dirt on bench surfaces at Middlesbrough. There is natural light in all cells and little evidence of graffiti. The temperature of the cells in Middlesbrough is individually controlled in the custody suite and can be boosted or reduced on request. Specialist cleaners attend promptly to deep-clean any biological hazards in cells.

There is no formal daily safety and maintenance check of the physical environment, including cells and communal areas, as required by Authorised Professional Practice (APP) guidance. A weekly check is conducted, but records suggest that there are delays in reporting identified faults. We were told that repairs are completed quickly but did not see any evidence to support this.

CCTV covers most of the suite and all cells. However, coverage is sometimes limited by poor camera angles and a lack of audio in many detainee-facing areas, including cells.

Custody staff's awareness of emergency evacuation procedures is generally good. Fire evacuation drills are carried out regularly at Middlesbrough. But, from the records, it is not always clear who is involved. There are sufficient sets of handcuffs available to evacuate the cells safely if required.

Area for improvement

CCTV should be of good enough quality and cover all areas of the custody suite so that it properly supports custody processes, the safety of all those in the suite and allows effective oversight of custody operations.

Safety: use of force

Information on the use of force in custody is not always accurate. It is not always captured, either through the submission of a use of force form or by recording the details on the custody record. This means that the force does not know accurately how often force is being used in its custody suite.

We reviewed some custody records that indicated force had been used against the detainee. But when we checked the CCTV coverage of the incident, it was clear that not all the officers using force had submitted a form (as required by the National Police Chiefs' Council guidance) and not all instances of force had been recorded. Often the custody records contained little rationale for force being used. This made it difficult to assess whether the force used had been appropriate and proportionate.

We reviewed CCTV recordings of 14 cases. Some of these showed officers displaying patience and reassurance to de-escalate situations and minimise the need to use any force. But, in others where force was used, the necessity for it was questionable, with little attempt to de-escalate the incident. We found some poor techniques being used. In some cases, the force used appeared to be punitive. We referred seven cases back to the force for it to review and learn from.

There is limited quality assurance of use of force incidents in custody. The reviews conducted by the custody management team only include incidents that the force knows about. There are no mechanisms to identify incidents that take place in custody but are not captured on the custody record.

Quality assurance is further hindered because the CCTV system in the Middlesbrough custody suite is of poor quality. Camera angles result in gaps in coverage and audio recordings are only available at the booking-in desks. Those reviewing cases do not include officers who are likely to be better able to identify poor techniques and potential disproportionate use of force.

Most police officers are up to date with their personal safety training. However, due to the pandemic, most of the detention officers have not had face-to-face training in the past 12 months. Training for detention officers is planned for September 2021 to remedy this.

We observed that many compliant detainees had cuffs removed quickly on arrival in custody. There is no specific policy on the removal of handcuffs. Arresting officers told us they can decide when to remove them based on their own risk assessment. However, the time that handcuffs are removed is not recorded, which would enable the force to show that it is not holding detainees in handcuffs for longer than necessary.

Most strip searches are appropriate, and the rationale properly recorded. We observed one case where poor technique was used, and a lack of dignity shown – we referred this back to the force for review. However, these searches take place where there is CCTV coverage that cannot be switched off. This allows staff other than those carrying out the search to observe them on the CCTV screen. This does not ensure that detainee dignity is protected.

The force is unable to provide accurate information on how many strip searches take place. However, our analysis of custody records showed that Cleveland Police has a higher percentage of strip searches than other police forces we have inspected since March 2016. The force is planning to improve its strip search data so that it can improve its understanding in this area.

Area for improvement

The force should improve the information it holds about strip searching so that it can identify how often these occur and whether these powers are being used appropriately and proportionally.

Detainee care

Detainee care is poor, with little improvement since our last inspection. It is a cause of concern. Although some staff showed a caring attitude to detainees, most of the detainees we spoke to were dissatisfied with one or more aspects of their care or treatment in custody. We also noted that several of the formal complaints made to the force in the six months before our inspection related to unsatisfactory treatment.

The stock of meals meets the needs of most common dietary requirements. However, the range of food offered or provided to detainees is often limited. Cereal bars are usually the only breakfast option, while at other mealtimes detainees are generally only offered or given two or three choices from the much wider range of available microwaveable meals. Food and drinks are generally only offered or provided at recognised mealtimes, although a few staff will offer them more often or on request. The food was insufficient sustenance for detainees who spend a long time in custody. Sinks in cells do not dispense drinking water. But there's no sign explaining this at Middlesbrough and detainees may not be told, which is potentially unsafe.

The provision of all other aspects associated with detainee care is extremely limited. Our examination of custody records and observations in the suite showed that detainees are not proactively offered or provided with outside exercise, showers or reading materials. The offer and/or provision of washing facilities, toilet paper and distraction activities are also severely lacking. This is particularly poor for detainees who remain in custody overnight or for longer periods, or who are remanded for court. This does not meet APP guidance.

There are stocks of towels, some limited toiletries and a few books (mostly in English) but these are given out infrequently. Showers are available on each wing, but they allow insufficient privacy. Detainees are rarely provided with toiletries to wash with or clean their teeth in the cell. Replacement clothing, including underwear, is available but also not given out readily. As a result, some detainees are poorly or

inappropriately dressed. For example, a detainee remanded for court attended in his pyjamas and slippers, which is unacceptable. All detainees are required to remove their footwear on entering their cell. This isn't based on an individual risk assessment, which is contrary to APP. But they can put footwear back on when moving about the custody suite.

Cells are generally equipped with thick mattresses, although some are damaged. Pillows are available in the storeroom but not routinely provided and rarely on request. We were not given any satisfactory explanation for this. There are often not enough blankets and many detainees complained of being cold. Although heating can be adjusted in individual cells, this is not always sufficient to keep detainees warm and comfortable.

Safeguarding

Frontline and custody officers have a good awareness of the importance of safeguarding children and vulnerable adults, and their responsibilities in relation to this. Frontline officers are primarily responsible for making safeguarding referrals into relevant arrangements. If safeguarding concerns come to light while a person is in custody, the custody officer is expected to make or arrange the appropriate referrals.

Custody officers use safeguarding information to help them care for detainees during custody, to release them safely and to make sure they get home, and for children to be put in the care of a responsible adult. But there is little recording on custody records to show that referrals have been made or what the concerns are.

Children and vulnerable adults are referred to the liaison and diversion (L&D) team. The team members provide advice and help if detainees are willing to engage with them. The L&D team, or the HCP when the team is not on duty, put in their own safeguarding referrals. They alert other agencies that the individual is in custody and to any support that may be needed.

In general, custody officers try to secure appropriate adults (AAs) for children and vulnerable adults to help them understand their rights and entitlements in custody as early as possible. The custody management team expects that a request is made within one hour of a detainee arriving at custody. Family or carers are sought in the first instance. If possible, frontline officers try to make these arrangements as part of the arrest to minimise any delays. If family or carers cannot attend, or their involvement in any incident means that this is not appropriate, the Youth Offending Service attends for children, or the Social Services Emergency Duty Team (EDT) out of hours. AAs for adults are provided by volunteers from MIND – a national mental health charity.

The length of time children wait before receiving support from an AA varies, regardless of whether the AA is a family member or from one of the agencies. Some receive support from very early on in their detention, but others wait much longer. It is difficult to get an AA from EDT for a child brought in at night if a family member or carer can't attend, and EDT do not have enough staff to send one. We found one case where, despite the force trying to get an AA for one girl, none could attend because it was late at night. She was RUI to avoid her remaining in custody until the following morning.

In some cases, we noted that an AA from MIND acted as an AA for a child. This does not happen often because AAs from MIND should only be used for vulnerable adults, unless it is out of hours and EDT agrees. However, some custody officers told us they would never use a MIND AA for children because it is not allowed – even if one was already in the suite. We were also told that, on occasion, when an AA cannot attend in person, they speak with the child by telephone to help them understand their rights and entitlements. Although this is better than nothing, it is not good practice, and it is not always clear if the rights are explained again when the AA attends in person.

The AA service provided by MIND for vulnerable adults is highly valued by custody officers. We were told that AAs arrive promptly and are often already in the suite to help detainees as they use an office there. The AA coordinator can be reached during the night, if needed, and AAs will attend during the early hours of the morning. There are regular meetings between the force and the MIND service where performance information is discussed including how many detainees have received support and the average waiting time. This shows that detainees are receiving prompt and effective support.

We looked at cases involving vulnerable adults and observed some while we were in the custody suite. In most cases custody staff identified when an AA was needed. Sometimes there were delays in deciding this, while the HCP or L&D team was asked for their views, or if information did not come to light until later in the detention. There were some cases where, in our view, an AA should have been considered. But, mostly, vulnerable adults are receiving the support they are entitled to. Despite the MIND volunteers attending promptly once called, we did find that some vulnerable adults waited some time before they received support.

We examined the custody records that should show when AAs were requested. This information was inconsistent and often missing. This made it difficult to assess when and why any delays were occurring. We found that often the first entry about an AA was when they arrived in the suite or were present at an interview, with no entry to show when they had been called. Neither was it clear whether the AA was a family member, carer or from an agency. The force knows it needs to improve its recording but is hindered by its Niche computer system. This only allows ‘free text’ entries, rather than mandatory entries that could then be extracted and monitored.

The force discusses AA support for children as part of its regular meetings with partners. This allows information from the force and agencies about AAs to be shared on a case-by-case basis. This helps identify any concerns and where improvements could be made, but better information is needed to support these discussions.

The force has developed guidance to give to AAs. However, we did not see this given out in the suites and, when we asked to see the guidance, it could not be readily found.

The force has guidance on how children in custody should be treated. This includes, for example, putting them in a cell in the children, women and vulnerable person wing, providing easy-read rights and entitlements leaflets and other care, including distraction activities such as foam footballs. Our observations in the suites and review of custody records suggests that the guidance is not consistently followed.

We saw some good attention by custody officers when booking children into custody, with some clear explanations given on their rights and entitlements and what happens in custody. All were put in the cell wing used for children. They were referred to the L&D team, or the HCP in the team's absence, and any child where force had been used was seen by the HCP. However, we did not see the easy-read rights and entitlements leaflets routinely given out. There was little to suggest that reading or other distraction materials had been offered or provided, and it was not always clear whether the children had received regular food and drink.

The force has a separate booking-in area and desk for children, vulnerable detainees and sensitive cases. This minimises the effect that a busy custody environment may have on children. However, while this is being used for detainees suspected of having COVID-19, children are more exposed to the main custody environment and the force needs to take action to mitigate this.

In most cases we looked at, girls were assigned a female officer to oversee their welfare needs in line with legal requirements. It was not always clear from the custody record whether they had visited or spoken with the girls.

The force keeps children out of custody whenever possible, with custody officers refusing detention if they assess that the incident can be dealt with in another way. In most of the cases we looked at, arrest was necessary and detention was appropriately authorised.

Custody officers told us that they try to keep children in custody for as little time as possible. Some children were dealt with quickly, but we found some whose case had not been progressed as quickly as it could have been. Information provided by the force shows that children spent an average of just under 13 hours in custody in the year up to 30 April 2021.

There is some good monitoring of children in custody by the force and other agencies. Regular meetings take place to review children held in custody overnight (any time between 10.00pm and 6.00am), those held for 12 hours or more, and those charged and refused bail. Cases are examined to see if they have been dealt with appropriately and if they could have been dealt with more quickly.

In early 2021, the force and other agencies came together to discuss children who had been arrested multiple times. The aim was to identify themes and where improvements could be made. This reflects the clear priority shared by interested parties to work together to achieve better outcomes for children.

Very few children are charged and refused bail. In the year to 30 April 2021, this happened to five children. Two were taken to court shortly after they had been charged but the remaining three were detained in custody overnight. Custody officers asked the local authority for secure accommodation for two of them and appropriate (non-secure) for the third. No accommodation was provided, which was a poor outcome for these children.

Local authorities have a statutory duty to provide accommodation in these circumstances but are rarely able to do so. Cases where requests for accommodation are made are scrutinised at joint meetings. The force follows the concordat on children in custody, with a jointly agreed protocol on how this is implemented. This includes

escalation processes to senior officers in the force and the local authority when requests are not met. At the time of inspection, the force was exploring with the local authority whether funding could be obtained to try and provide a non-secure bed space for children to move to pending their court appearance.

The force completes juvenile detention certificates to explain to the court why a child has been kept in custody after charge. We were told that these are also completed for children held for breach of bail or on a warrant to provide additional oversight that their detention was justified.

Areas for improvement

There should be good and consistent care for children in custody by:

- giving easy-read rights and entitlements leaflets to all children;
- providing reading or other distraction materials to keep children occupied; and
- keeping delays to a minimum in an appropriate adult attending to provide support.

Governance of health care

The force has worked closely with NHS England to develop the healthcare specification for custody with Mitie Care and Custody Ltd to provide medical and health services as part of these arrangements. There are close working relationships between the parties, regular reviews on activity and agreed performance measures. The quality of data and level of scrutiny are good and demonstrate providers being held to account. Healthcare reports, our custody record analysis and observations all indicate that detainees routinely receive timely access to healthcare services.

A robust system of integrated clinical governance drives improvement. There is a full range of clinical policies, a separate complaints process, an incident-reporting system and regular audits of clinical activity. There is strong emphasis on learning and staff's professional development. From speaking with, and observing HCPs, it is evident that they feel well supported and have good access to supervision and specialist medical support when required. HCPs are confident, competent and all have a wide range of experience.

Control measures introduced in the custody suite due to the pandemic mean that most initial health consultations take place in cells, which can limit confidentiality. However, if a risk assessment shows no COVID-19 risks, vulnerable detainees are taken to the treatment rooms for private consultations. This seems a sensible approach.

The two treatment rooms are clean, uncluttered and comply with infection control and prevention standards. Enhanced COVID-19 measures include an additional screen and routine use of personal protective equipment. Medical equipment, including resuscitation equipment, is all suitable for the demands of detainee care. HCPs are all trained to Immediate Life Support standards and training records indicate that staff are all up to date with mandatory training requirements.

Patient care

Generally, two HCPs are on duty to cover the suite, and custody staff clearly value their input as an accessible and skilled resource enabling prompt support for detainees. Referrals are appropriate and response is based on need. Clinical consultations reflect good engagement and appropriate support taking place. Detainees who have used health services are generally positive about the service they received.

The HCP appropriately seeks consent from detainees about sharing information and records all contacts with detainees on an electronic clinical record (SystmOne). This also provides access to information held on the NHS system, enabling more effective detainee care. A sample of records showed that entries are clear and concise, and these are subject to ongoing audit.

The force has good arrangements to store detainees' personal medication and to hold medicine stock on-site. Safe key management and stock check arrangements are effective. Ongoing treatment arrangements are used appropriately, including facilitating access to opiate substitution treatment. However, there is no access to nicotine replacement products for smokers. This could be physiologically and psychologically distressing, particularly during long periods of detention.

The service has developed an appropriate range of patient group directions (authorising HCPs to supply and administer prescription-only medicine), which include provision to enable symptomatic relief for withdrawal from alcohol and drugs. Staff are trained in the use of patient group directions and records indicate that they are being used well.

On occasions, some HCPs are less confident in completing some of the out-of-hours duties normally done by the L&D team – for example, reviews of children brought into custody, or liaising with the emergency duty team and mental health crisis teams. Mitie managers and local clinical leads are taking steps to respond to this concern by providing extra training and establishing enhanced contacts with the respective agencies.

HCPs are not directly making use of person escort records (PERs) to capture any important clinical risks or treatment milestones that may leave a detainee who is transferred to court or prison more vulnerable if their condition were to deteriorate. HCPs rely on custody staff to include any relevant health messages detailed in the custody record on the respective PER form. (see the area for improvement under pre-release risk assessment).

Area for improvement

Nicotine replacement products should be available to detainees who smoke on an individually assessed basis.

Substance misuse

Although there is no dedicated stand-alone substance misuse service or any specialist drug and alcohol workers operating in the custody suite, the 'all vulnerabilities mental health model' is designed and used to support detainees with drug, alcohol or other dependencies. The Mitie HCPs offer good clinical support and signpost detainees to a number of community services.

Also, the 'navigators' employed by Spectrum Health provide bespoke face-to-face support including facilitating links to other agencies after release. Support time and recovery workers (STRs) actively accompany detainees post-release to appointments and help them access community support. This includes providing advice on accessing harm minimisation support after release.

Mental health

Police staff have access to regular training on mental health and understand it as it relates to custody. Improvements have clearly been made in many areas of practice since our last inspection. The force now ensures that people with mental health needs and other vulnerabilities are appropriately diverted from custody.

The criminal justice L&D team operates within custody seven days a week from 6.30am to 8.00pm. Specialist mental health practitioners from Tees Esk and Wear Valleys NHS Foundation Trust work with a number of agencies, including Spectrum Health and Humankind, providing support to detainees. A good range of additional support is also available including health navigators, staff with speech and language therapy skills, and STR workers. It allows immediate crisis support from specialist practitioners and access to a range of other pathways for detainees with vulnerabilities. This includes help with benefits, housing and support for drug and alcohol problems after release. The L&D team also engages with voluntary attendees outside custody.

The L&D team's contribution is valued by custody staff and their time is much in demand, sometimes leading to the services being stretched. There are no regularised arrangements to provide cover if staff are absent. Data on detainees who have been seen in custody, or on why a detainee has not been assessed, is not routinely gathered. This could be used to show how well the L&D team is able to meet demand.

Partnership arrangements are good, and the parties meet regularly to review service provision and deal with any concerns. Street triage arrangements and robust section 136 facilities at the local hospital are clearly working well, and contribute to custody facilities not being used as a place of safety. The specialist mental practitioner providing support in the control room is valued – although they have been temporarily withdrawn due to the pandemic.

The force has good arrangements to ensure that detainees receive timely Mental Health Act assessments and are subsequently transferred to a health-based place of safety without undue delay. Out-of-hours arrangements to access approved mental health professionals and then to arrange Mental Health Act assessments for detainees and their subsequent transfer to a mental health facility, if needed, are reasonable. These are needed relatively infrequently. We were told that services can be less

responsive in the absence of the L&D team. Information to show response times is not captured and monitored well enough to better understand demand and identify any potential constraints.

Section 5. Release and transfer from custody

Expected outcomes

Pre-release risk assessments (PRRAs) reflect all risks identified during a 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

The force has improved its focus on ensuring that detainees are released safely. Custody officers engage well with detainees to complete PRRAs. They generally make appropriate use of initial risk assessments and care plans to ensure that all identified risks have been addressed or mitigated before release. Particular attention is given to managing the safe release of children and vulnerable detainees. When necessary, relevant agencies, such as the liaison and diversion (L&D) team, are involved to support the release of the detainee. However, some custody records lack sufficient detail and don't reflect the practice we saw during our observations. For example, release arrangements are not always thoroughly recorded and do not always show how a detainee will get home safely after release.

The force provides bus tickets and petty cash as required to assist detainees without the means to get home safely. When these options are not suitable, police officers sometimes take detainees home, particularly if they are children or vulnerable. But this depends on their availability.

Custody officers are aware of the enhanced safeguarding arrangements for those arrested under suspicion of committing serious sexual offences. They report a good exchange of information with investigating officers in charge of these cases and use this when completing the PRRAs.

Generic information about support agencies is available and routinely given to all detainees on release, but it is only available in English. Many detainees leaving custody are also provided with support leaflets by the L&D team.

Detention officers complete electronic person escort records. These vary in quality. They do not always include sufficiently detailed information, including about medical issues. For detainees attending court or recalled to prison, custody officers do not supervise or take any part in their transfer to the prisoner escort and custody services staff. The lack of appropriate custody officer scrutiny is contrary to Authorised Professional Practice guidance.

Area for improvement

Custody officers should oversee the release of all detainees, including those being transferred to court or prison. They should ensure that the person escort records are fully completed, including appropriate health information.

Courts

Detainees who are required and ready to appear in court after being held overnight are efficiently processed and not held in police custody for longer than necessary.

Those arrested on warrant during the day are not accepted directly at the local remand court so must be booked into police custody. However, detainees are accepted by the court until 2.00pm with no requirement for advance notification. There is some further flexibility with the court regularly accepting detainees later, sometimes until about 4.30pm. This is positive and generally means that detainees are not held in police custody for longer than necessary.

A video link facility is available in the custody suite. This is currently only used if a detainee is suspected or confirmed to have COVID-19. Hearing the case virtually manages and minimises the risk of infection transmission by avoiding any unnecessary travel.

Section 6. Summary of causes of concern, recommendations and areas for improvement

Causes of concern and recommendations

Cause of concern: Detainee safety

We found that detainee safety is not always assured:

- Constant CCTV monitoring (authorised professional practice [APP] Level 3) of detainees is not satisfactory.
- Cell call bells are hard to hear, not always answered promptly (sometimes not at all) and routinely switched off.
- Officers carrying out constant watches on detainees from cell doors (APP Level 4) are not properly briefed about the risks.
- Handovers between shifts are disjointed and not captured well enough on CCTV.

All these practices are contrary to APP guidance and place detainees at significant risk of harm.

Recommendation

The force should take immediate action to mitigate the risk to detainees by ensuring that its risk management practices follow APP guidance and are carried out to the required standard.

Cause of concern: Use of force

The force's governance and oversight of the use of force are limited. Not all incidents involving the use of force in custody are recorded, making the data unreliable and preventing effective scrutiny. Quality assurance of incidents is hindered by poor-quality CCTV. Our review of incidents showed that some use of force appeared unnecessary and, in some cases, punitive.

Recommendation

The force should scrutinise the use of force in custody based on accurate data and robust quality assurance, including satisfactory CCTV viewing of incidents. It should use this to show that, when force is used in custody, it is fair and proportionate.

Cause of concern: Detainee care

Detainee care is poor with little improvement since our last inspection. Food and drink are not proactively offered or provided, and the food that is provided does not have sufficient sustenance, especially for those in custody for some time. Detainee access to other aspects of care, such as washing, showers, exercise and reading materials is very limited.

Recommendation

The force should significantly improve the care of detainees by ensuring that they are regularly offered drinks and food of sufficient variety and sustenance to meet their needs. Access to other aspects of care should be readily available to detainees.

Areas for improvement

Leadership, accountability and partnerships

- The force should ensure that all custody staff consistently follow the College of Policing's Authorised Professional Practice – Detention and Custody and its own guidance, so that detainees receive the appropriate treatment and care.
- The force should strengthen its approach to performance management by improving the quality of its data and monitoring a wider range of information to show the outcomes achieved for detainees.
- The force should improve the quality of its custody records by ensuring that all necessary information is fully recorded, including the rationale and justification for any decisions made. Quality assurance should be strengthened to assess the standard of recording.
- The force should ensure that all custody procedures comply with legislation and guidance.

First point of contact

The force should ensure that frontline officers have access to good-quality and timely information to help them respond to incidents and make decisions.

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

- The force should improve its approach to detainee dignity and privacy by:
    - ensuring that there is sufficient privacy for conversations with detainees;
    - asking all detainees if they wish to speak to a member of staff in private; and
    - advising detainees that they are being monitored on CCTV but can use the toilet in private.
- The force should ensure that the individual and diverse needs of all detainees are met. In particular, they should do this by:
    - offering female detainees easy access to menstrual care products;
    - appropriately identifying any detainee's religious needs and meeting these respectfully;
    - providing interpretation services consistently for all detainees who need this help; and
    - allowing detainees with disabilities to keep equipment, such as a wheelchair or walking aids, in their cell based on an individual risk assessment.
- Detainees' clothing, including cords and footwear, should only be removed based on an individual risk assessment and the rationale for doing so should be fully recorded on the custody record.
- The force should ensure that detainees have their cases dealt with promptly and effectively so that they do not spend longer than necessary in custody.
- Reviews of detention should be carried out to a consistent standard and in the interests of the detainee.

In the custody cell, safeguarding and health care

- CCTV should be of good enough quality and cover all areas of the custody suite so that it properly supports custody processes, the safety of all those in the suite and allows effective oversight of custody operations.
- The force should improve the information it holds about strip searching so that it can identify how often these occur and whether these powers are being used appropriately and proportionally.
- There should be good and consistent care for children in custody by:
    - giving easy-read rights and entitlements leaflets to all children;
    - providing reading or other distraction materials to keep children occupied; and
    - keeping delays to a minimum in an appropriate adult attending to provide support.
- Nicotine replacement products should be available to detainees who smoke on an individually assessed basis.

Release and transfer from custody

Custody officers should oversee the release of all detainees, including those being transferred to court or prison. They should ensure that the person escort records are fully completed, including appropriate health information.

Section 7. Appendices

Appendix I: Methodology

Police custody inspections focus on the experience of, and outcomes for, detainees from their first point of contact with the police and through their time in custody to their release. During the pandemic our inspections are announced about two weeks in advance to manage the risks presented by COVID-19. We visit the force over a two-week period to observe how detainees are treated but carry out our other activities remotely, as far as possible. Our methodology includes the following elements, which inform our assessments against the criteria set out in our *Expectations for Police Custody*.

Document review

Forces are asked to provide a number of important documents for us to review. These include:

- the custody policy and/or any supporting policies, such as the use of force;
- health provision policies;
- joint protocols with local authorities;
- staff training information, including officer safety training;
- minutes of any strategic and operational meetings for custody;
- partnership meeting minutes;
- equality action plans;
- complaints relating to custody in the six months before the inspection; and
- performance management information.

We also request important documents, including performance data, from commissioners and providers of health services in the custody suites and providers of in-reach health services in custody suites, such as crisis mental health and substance misuse services.

Data review

Forces are asked to complete a data collection template, based on police custody data for the previous 36 months. The template requests a range of information, including:

- custody population and throughput;
- demographic information;
- the number of voluntary attendees;
- the average time in detention;
- children; and
- detainees with mental ill health.

This information is analysed and used to provide contextual information and help assess how well the force performs against some main areas of activity.

Custody record analysis

A documentary analysis of custody records is carried out on a representative sample of the custody records opened in the week preceding the inspection across all the suites in the force area. Records analysed are chosen at random. And a robust statistical formula provided by a government department statistician is used to calculate the sample size required to ensure that our records analysis reflects the throughput of the force's custody suites during that week. This has a 95 percent confidence interval with a sampling error of 7 percent. The analysis focuses 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.

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

Case audits

We carry out in-depth audits of approximately 40 case records (the number may increase depending on the size and throughput of the force inspected). We do this to assess how well the force manages vulnerable detainees and specific elements of the custody process. These include looking at records for children, vulnerable people, individuals with mental ill health, and where force has been used on a detainee.

The audits examine a range of factors to assess how well detainees are treated and cared for in custody. For example, the quality of the risk assessments, whether observation levels are met, the quality and timeliness of Police and Criminal Evidence Act (PACE) reviews, if children and vulnerable adults receive timely support from appropriate adults and whether detainees are released safely. Where force is used against a detainee, we assess whether it is properly recorded and if it is proportionate and justified.

Observations in custody suites

Inspectors spend a significant amount of their time during the inspection in custody suites assessing detainees' physical condition, and observing operational practices and how detainees are dealt with and treated. We speak directly to operational custody officers and staff, and to detainees to hear their experience first-hand. We also speak with other non-custody police officers, solicitors, health professionals and other visitors to custody to get their views on how custody services operate. We look at custody records and other relevant documents held in the custody suite to assess the way in which detainees are dealt with, and whether policies and procedures are followed.

Interviews with staff

During the inspection we carry out interviews with officers from the force. These include:

- chief officers responsible for custody;
- custody inspectors; and
- officers with lead responsibility for areas such as mental health or equality and diversity.

We speak to people involved in commissioning and running health, substance misuse and mental health services in the suites and in relevant community services, such as local Mental Health Act section 136 suites. We also speak with the co-ordinator for the Independent Custody Visitor scheme for the force.

Focus groups

During the inspection we hold focus groups with frontline response officers, and response sergeants. The information gathered informs our assessment of how well the force diverts vulnerable people and children from custody at the first point of contact.

Feedback to force

The inspection team provides an initial outline assessment to the force at the end of the inspection, to give it the opportunity to understand and address any issues at the earliest opportunity. Following this, a report is published within four months giving our detailed findings and recommendations for improvement. The force is expected to develop an action plan in response to our findings, and we make a further visit approximately one year after our inspection to assess progress against our recommendations.

Appendix II: Inspection team

Norma Collicott: HMI Constabulary and Fire & Rescue Services inspection lead

Patricia Nixon: HMI Constabulary and Fire & Rescue Services inspection officer

Vijay Singh: HMI Constabulary and Fire & Rescue Services inspection officer

Viv Cutbill: HMI Constabulary and Fire & Rescue Services inspection officer

Kellie Reeve: HMI Prisons team leader

Fiona Shearlaw: HMI Prisons inspector

Steve Eley: HMI Prisons health and social care inspector

Mathew Tedstone: Care Quality Commission inspector

Joe Simmonds: HMI Prisons researcher

Helen Ranns: HMI Prisons researcher

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