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

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

11–22 October 2021

Contents

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Note: Data supplied by the force.

Force

Surrey

Chief constable

Gavin Stephens

Police and crime commissioner

Lisa Townsend

Geographical area

Guildford, Woking, Surrey Heath, Waverley, Spelthorne, Elmbridge, Runnymede, Tandridge, Reigate & Banstead, Mole Valley, Epsom & Ewell.

Date of last police custody inspection

2015

Custody suites

Guildford	24 cells
Staines	19 cells
Salfords	24 cells

Annual custody throughput

Rolling 12 months 4 October 2020–4 October 2021 – 10,670

Custody staffing

- 1 superintendent
- 1 chief inspector
- 3 inspectors
- 39 custody sergeants
- 3 support sergeants
- 1 dedicated training sergeant
- 76 detention officers
- 1 custody compliance officer
- 1 medical services advisor

Health service provider

Mountain Healthcare

Summary

This report describes our findings following an inspection of Surrey 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 October 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 children and vulnerable adults.

This inspection of custody facilities took place during the COVID-19 pandemic. We continue to adapt our methodology to manage risks during the pandemic. 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 we limited the number of our inspectors in the suite at any one time.

We last inspected custody facilities in Surrey Police in 2015. This inspection found that of the 23 recommendations made during that previous inspection, 19 have been fully or partially achieved.

To help the force improve, we have made 2 recommendations to it (and the police and crime commissioner) that address the main causes of concern, and we have highlighted 20 additional areas for improvement. These are set out in section 6.

Leadership, accountability and partnerships

Surrey Police has a clear governance structure. The arrangements to monitor the safe and respectful provision of custody services, and to support continuous improvement are generally good. The force is responsive to external feedback and custody services have improved since our last inspection.

The force provides its custody services across three suites in Guildford, Salfords and Staines. We found there were usually enough staff to provide custody services, but they were stretched at times. The force follows the College of Policing's Authorised Professional Practice (APP) well, with a few exceptions.

Performance is generally managed well. A range of information is monitored but some data is inaccurate, mainly about the use of force. Custody records contain a good level of detail and, despite a few gaps where some information is missing, we assessed the quality of the records as good overall.

The force isn't always following the legislation and guidance as set out in the Police and Criminal Evidence Act 1984 (PACE) and its codes of practice. Detainees aren't always given a written copy of their rights and entitlements. Some aspects of reviews of detention don't meet the requirements of Code C. There are also cases where reviews didn't take place, which is a breach of section 40 of PACE. This is a cause of concern.

There is little governance and oversight of the use of force and restraint in custody suites. Some of the information to allow scrutiny is inaccurate and there is little quality assurance of incidents. This makes it difficult for Surrey Police to show that when force is used, it is proportionate and justified. However, we reviewed incidents involving 20 detainees and found that, overall, cases are managed well.

The force is committed to diverting children and vulnerable adults away from custody. It works well with local authority and mental health partners to achieve this. There are schemes to prevent and minimise re-offending, some aimed specifically at children and women. Joint work with mental health services isn't yet resulting in enough help for frontline officers when they are dealing with people with mental ill health.

Pre-custody: first point of contact

Frontline officers have a good understanding of what makes a person vulnerable and take this into account when deciding whether to arrest. Children are only taken into custody after all other alternatives have been explored.

The support from mental health professionals to help frontline officers deal with people with mental ill health isn't good enough. This leads to officers detaining people under section 136 of the Mental Health Act 1983 because they can't get help in finding alternative solutions.

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

Custody officers and staff deal with detainees in a patient and respectful manner, and are confident in identifying individual and diverse needs. But privacy could be better for detainees disclosing sensitive information. Some detainees, for example those needing interpreters, don't always have their needs met well enough.

Custody officers identify and manage detainees' risks well. They carry out thorough risk assessments and set observation levels correctly. However, not all detainees who are under the influence of alcohol and/or drugs are put on checks to rouse them. Observation levels are reviewed regularly and checks are mostly carried out on time. Clothing with cords or items such as jewellery are only removed if the individual's risk makes this necessary. Some practices don't follow APP guidance. These include:

- how CCTV and physical supervision observations are carried out;
- having the same member of staff carry out the checks on detainees; and
- the recording of some information on custody records.

But overall, the approach to risk is good.

Custody officers generally authorise detention appropriately, although the necessity for arrest (code G) could be better explained in some cases. There are sometimes delays in booking detainees into custody and progressing investigations. This means some detainees spend longer than necessary in custody.

Detention officers give good explanations to detainees about their rights and entitlements. But they don't always give them a leaflet or notice explaining these as required by PACE code C 3.2 – although this started to happen more often during our inspection. Detainees also receive good explanations about PACE code C. A printed off version of the booklet is offered and provided if the detainee asks for this.

Detainees released under investigation receive a notice about the offences they may commit if they interfere with victims or witnesses while the investigation is in progress. Custody officers also explain this to them.

Detainees are made aware of how to complain about their treatment in custody.

In the custody cell, safeguarding and health

Conditions and cleanliness across the custody estate are good. The suites are well maintained and we didn't find any potential ligature points in any of the cells we checked.

Detainee care is good. Detainees told us they had been well cared for. Custody officers explain and offer the care provisions available. The range of food for detainees is good. Staff could be more proactive in offering some other provisions such as reading materials and distraction activities.

All the officers we spoke with during the inspection understood their safeguarding responsibilities for those they came into contact with. Children and vulnerable detainees generally receive support from appropriate adults (AAs) early on in their detention. Support is available at different stages of custody and is better than we normally see. However, we aren't assured that AAs are always called for vulnerable adults who may need one.

Children are only detained in custody when necessary. There is a good focus on keeping them there for as short a time as possible. They are generally cared for well, with boys as well as girls given a dedicated carer to support them. Few children are charged and refused bail. However, when this does happen, they aren't always transferred to local authority accommodation as they should be.

The health care practitioners working in custody are experienced and knowledgeable, and meet detainees' health needs promptly.

However, clinical governance over the health care service isn't good enough. As a result, the privacy and dignity of detainees receiving health care aren't protected. Consultations and intimate examinations take place in a way that doesn't maintain dignity and privacy. And confidential health information is shared inappropriately. This is an area of concern.

Detainees aren't able to access nicotine replacement products or continue with community-prescribed opiate substitution treatment while in custody, irrespective of the length of detention, which is poor. However, the Criminal Justice Liaison and Diversion team (L&D) provides reasonable support to detainees with addiction problems and directs them to further support in the community.

The L&D team also provides good support to detainees in custody with mental ill health. It helps detainees access valuable community services, although limited staffing levels affect how much it can help those with lower intensity needs. When detainees need a Mental Health Act assessment, these are usually arranged reasonably well but there can be delays out of hours. Sometimes detainees are further detained in custody under section 136 of the Mental Health Act 1983 so they can be taken to a health-based place of safety for an assessment.

Release and transfer from custody

Custody officers ensure that detainees are released safely and have the means to get home. Particular attention is paid to make sure children and vulnerable adults get home safely. Risk assessments are thorough and person escort records for those attending court, or recalled to prison, are mostly well completed. Information about further support is routinely given to detainees.

Detainees are generally collected promptly in the morning to attend court and can also attend later in the day, which minimises their time in custody.

Causes of concern and recommendations

Cause of concern: Meeting legal requirements and guidance

The force isn't always complying with section 40 of the Police and Criminal Evidence Act 1984 (PACE). Some reviews of detention are missed, which is a breach of section 40 of PACE. Some reviews of detention are carried out in a way that doesn't meet the requirements of code C of PACE for the detention, treatment and questioning of persons. Detainees aren't consistently provided with a written copy of their rights and entitlements.

Recommendation

The force should take immediate action to make sure that all custody procedures and practices comply with legislation and guidance.

Cause of concern: Maintaining privacy and dignity for detainees receiving health care in custody

Detainee privacy and their dignity isn't maintained when they are receiving health care services. Clinical governance over the health care service has failed to recognise these concerns. In particular:

- Patient consent forms state that information provided to medical practitioners by detainees is not confidential – this is inappropriate.
- Many patient assessments and interactions in clinical rooms take place with the door open and custody staff close by – this is inappropriate and breaches patient confidentiality.
- There are no screens or curtains in medical rooms to protect the dignity of detainees during the taking of intimate samples.
- One medical room has a spyhole in the door potentially allowing anyone in the custody area to look through.
- Medical information held on custody records is inappropriately shared with solicitors, independent custody visitors and AAs when they receive a printed copy of these.

Recommendation

The force and the health provider should take immediate action to ensure the privacy and dignity of detainees across all aspects of health care provision.

Introduction

This report is one in a series of inspections of police custody carried out jointly by HM Inspectorate of Constabulary & Fire and Rescue Services (HMICFRS) and HM Inspectorate of Prisons (HMIP). These inspections are 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).

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

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 fulfils its responsibilities when detaining people in police custody, and the outcomes for them. This includes how safely they are managed and how respectfully they are treated.

Our assessments are made against the criteria set out in our *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. This helps 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 and focus groups with staff;
- observations in suites, including discussions with detainees; and
- an examination of case records.

We also analyse a representative sample of custody records from all suites in the force area for the week before the inspection starts. For Surrey Police we analysed a sample of 121 records. The methodology for our inspection is set out in full at Appendix I.

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

Surrey Police has a clear governance structure to monitor the safe and respectful provision of custody services, and to support continuous improvement. An assistant chief constable has overall responsibility for the provision of custody services and is supported by a superintendent. A chief inspector is responsible for the day-to-day operation of the suites.

Monitoring and oversight arrangements are generally good. These include:

- The assistant chief constable (ACC) monitors custody performance through a monthly meeting with the superintendent for criminal justice and custody, and the local policing senior management team meeting.
- Joint monitoring with partner agencies, including the Surrey Criminal Justice partnership, the Safeguarding Adolescents Board and the Children and Young Persons Board chaired by the ACC for local policing focusses on outcomes for children and vulnerable adults.
- Monthly monitoring of the Health Care Contract (although the clinical governance of the health care service is a cause of concern).

The force has improved its custody services since our last inspection, with most of our recommendations fully or partially achieved. This suggests that the governance arrangements (with the exception of the use of force – see Accountability) work well in supporting continuous improvement.

Custody services are provided across three suites in Guildford, Salfords and Staines. The force is investing in its estate and carrying out extensive refurbishment work. The Guildford suite was closed until the second week of our inspection and Salfords was then due to close for refurbishment.

The force has 3 custody inspectors, 39 custody officers, 3 support sergeants and 76 detention officers to manage its custody services. We saw that there were generally enough staff on each shift during our visits. But there is little resilience to

cover unplanned absences such as staff sickness and we saw staff stretched at times. The force is aware of this problem and has recently recruited more staff. However only two custody suites were open during inspection and it is not clear whether there will be enough staff when all three locations are in use.

Staff training is good. There is a dedicated training sergeant for custody and a decommissioned suite in Woking is used to provide a realistic setting. Initial training is four weeks for custody officers and five weeks for detention officers. New officers shadow more experienced staff and complete a competency portfolio before they start their full duties.

Custody and detention officers attend regular training together for one day every eight weeks. These sessions have a particular focus on conflict management. The staff we spoke to were positive about the training they received.

The force has adopted the College of Policing's Authorised Professional Practice (APP) and also has its own local custody policies. These are generally followed with some exceptions relating to the management of risk.

In 2015 there was a death in custody at Guildford. The Independent Office for Police Conduct (IOPC) investigated this incident and made some learning recommendations to the force.

Accountability

Surrey Police generally monitors the performance of custody services well and was able to provide most of the information we asked for.

Operational and strategic custody meetings review service provision using a performance dashboard. This includes data such as the number of detainees entering custody and strip searches and information about children.

However, some of the data is inaccurate, in particular where force or restraint has been used in custody and detainee self-defined ethnicity.

The recording and reporting of adverse incidents in custody is good (an adverse incident means any incident which, if allowed to continue to its ultimate conclusion, could have resulted in death or serious injury to any person). Staff understand their responsibilities and all incidents are investigated and learning shared.

But staff don't always follow the legislation and guidance as set out in the Police and Criminal Evidence Act 1984 (PACE) and its codes of practice. Some reviews of detention didn't take place, which is a breach of section 40 of PACE. And some practices don't meet the requirements of code C. For example:

- The reasons for not carrying out reviews of detention face to face aren't always recorded (PACE code C, 15.14).
- If a review is made by telephone it is not clear why this is used instead of live link (Skype) as required by the code (PACE code C, 15.9B).
- Detainees aren't routinely given a written copy of their rights and entitlements (PACE code C, 3.2).

This is a cause of concern.

There is little governance and oversight of the use of force and restraint in custody suites. A use of force scrutiny board examines cases but few of the incidents reviewed are specific to custody. There is little quality assurance of incidents to show that when force is used, it is proportionate and justified. The information to support scrutiny isn't good enough:

- Not enough detail is recorded on detention logs to determine what force is used, by which officers, or why it is necessary.
- Not all staff complete the individual use of force forms in line with the National Police Chiefs' Council guidance.

We also found:

- two incidents that appeared to have been entered in error as no force had been used; and
- four cases where force had been used but hadn't been included in the force's data.

However, our CCTV review of incidents involving 20 detainees where force or restraint was used showed that overall cases are managed well. We referred eight cases to the force to review: seven cases for the force to learn from and one to evaluate in more detail.

The quality of recording on detention logs is generally good. Many entries are detailed, although important information is sometimes missing. For example, reasons aren't always recorded when a detainee has clothing with cords removed. And when detainees are held incommunicado (i.e. they aren't able to notify anyone that they are in custody) it isn't clear when this decision no longer applies and their nominated person is informed that they are being held in custody.

Records about rousing detainees who are under the influence of drugs or alcohol are detailed. And good attention is paid to recording who will be acting as the detainee's appropriate adult and when food and drink are offered.

We were told that custody officers routinely dip sampled to check records each month. However, this isn't consistently happening and it hasn't identified some of the gaps we found.

Surrey Police has a good understanding of the public sector equality duty. Staff told us they had received training in identifying and managing the diverse needs of detainees. The force monitors custody services to ensure outcomes are fair and to address any concerns identified. However, showing fair outcomes is difficult because the self-defined ethnicity for many detainees isn't known.

The force is open to external scrutiny, and the independent custody visitors (ICVs) have good access to the suites and visit each site weekly. Custody staff respond quickly to any problems raised and this is monitored by the chief inspector and the ICV scheme manager. There is a quarterly ICV steering group meeting, chaired by the police and crime commissioner (PCC) and attended by the chairs of the panels, the scheme manager and the force's representatives, where any concerns can be raised and discussed.

Areas for improvement

- The force should robustly quality assure custody records to identify and act on any concerns.
- The force should improve its monitoring of the use of force so that it can show that when it is used in custody suites it is proportionate and justified. This should be based on comprehensive and accurate information.

Strategic partnerships to divert people from custody

Surrey Police has a clear strategic priority to divert children and vulnerable adults away from custody, and staff are aware of this. There are clear diversion pathways to prevent reoffending.

The force works with partners and other bodies to divert people away from the criminal justice system (CJS). The Checkpoint scheme offers a range of activities and support to help prevent reoffending, including a specific pathway for women. The Women's Justice Intervention scheme also provides support through a programme provided by police officers and women support officers. An evaluation of the scheme has shown a range of benefits for those who have taken part.

Work with children's social services and the youth offending service is good, using restorative options to help prevent children from entering the CJS. The Engage programme, funded by the PCC, also makes early contact with children at risk of offending to help divert them away from the CJS.

The force has good working relationships with the local authority children's services. But there is no secure accommodation for children who are charged and remanded, and the local authority isn't always able to provide appropriate alternative accommodation.

The force works well with mental health services to try and divert people with mental ill health away from custody. People who are regularly taken into custody are given support by the Surrey High Intensity Partnership Programme, which aims to prevent or reduce offending behaviour. However, this joint work with mental health services isn't yet resulting in enough help for frontline officers on the street.

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 have a good understanding of what makes a person vulnerable. Surrey Police has a definition for vulnerability and provides training. Officers think the training is good but much of it is by e-learning and they feel classroom-based sessions are a better way to learn. Staff groups representing different interests and needs also share knowledge and offer advice.

Officers are confident in assessing and taking account of any vulnerabilities when deciding whether to arrest. They make decisions to reflect the circumstances of the incident they are attending. Officers told us they consider factors such as mental ill health, disabilities and neurodiverse conditions. All children are regarded as vulnerable.

Frontline officers are given information by force call handlers (who take calls from the public) to help them respond to incidents. This information needs to be improved. Officers told us the quality varied depending on how busy the call handlers were and sometimes details weren't provided quickly enough.

They can also get information from their mobile devices, although this is more difficult when only one officer is attending an incident.

Officers told us that the information held about individuals on the force computer system is good and often includes details held by partner organisations. Officers said they usually have enough information to determine whether finding an alternative to arrest is appropriate.

Children are only arrested as a last resort. Instead of arrest, and where appropriate, frontline officers consider:

- taking the child to another family member if a situation needs calming down or to safeguard them;
- talking to the child with their parents about the incident;

- arranging for the child to be interviewed at a later time outside custody; and
- speaking with social services and the youth offending team to find ways of dealing with incidents that avoid taking a child to custody and entering the criminal justice system.

Sometimes the nature of the offence leaves no choice other than to arrest the child. In the cases we examined, all the children taken into custody had committed serious offences that meant arrest was necessary.

The importance the force places on keeping children out of custody is shown through a scheme jointly agreed with Surrey County Council during the COVID-19 pandemic. This provides respite accommodation for children as an alternative to arrest in domestic incidents where the child cannot safely remain in the home. The force hopes to continue with the scheme after the pandemic.

Frontline officers responding to incidents involving people in mental health crisis aren't given enough support from mental health professionals. Officers told us that when they call the health service's mental health team there isn't always someone available to give help and advice, particularly outside normal working hours. This leaves officers to decide whether to detain a person under section 136 of the Mental Health Act 1983 without the expertise of a mental health professional or the information they hold about the individual. Officers feel this leads to detaining more people than necessary because they can't fully explore alternatives.

Safe Haven drop-in centres, run by voluntary and charitable organisations, provide some help. The centres support people suffering with mental ill health but not in crisis. They don't cover all of Surrey but, when they are open, they offer a place officers can take people.

When officers detain people under section 136, they call an ambulance to take the person to hospital. There are sometimes long waits so, with an inspector's authorisation, they take the person in a police vehicle.

Officers reported long waits with the person pending their Mental Health Act assessment at hospital or a place of safety – sometimes a whole shift. They said they tried to get family members to come and wait with the person but this wasn't always possible. Officers then stay to prevent the person from leaving. We were given examples of waits of many hours, including a 15-year-old girl taken to hospital A&E in the afternoon and still there the following day.

Frontline officers don't take people detained under section 136 to custody as a place of safety (they are only allowed by law to do this in exceptional circumstances).

However, where a person has committed an offence, they are arrested and taken to custody. If there are signs of mental ill health, the health care professionals in custody determine whether a Mental Health Act assessment is needed and arrange for this to be carried out in custody. Frontline officers reported that they sometimes attend custody to further detain the person under s136 and take them to a health-based place of safety for an assessment. It is not clear why this is necessary, but they said this is happening more and more.

Detainees are taken to custody in a police van or, if there are two officers, police car. Officers use a police van to transport detainees with mobility difficulties and take a wheelchair in the van if necessary.

Area for improvement

The force should work with mental health services to make sure frontline officers have enough support to make appropriate decisions when dealing with people with mental ill health.

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

Staff are patient and positive, and treat detainees as individuals. Custody staff take extra time to explain processes and give reassurance, particularly to those in custody for the first time. Detainees told us they appreciated the care and respect shown to them.

The booking-in areas of the three custody suites are similar. Desks are spaced apart in a row, with solid partitions dividing them.

The layout gives some visual privacy, but the suites are often busy and noisy. Staff and detainees have to raise their voices, and conversations can be overheard. There are no private booking-in desks where detainees could discuss confidential information. Detainees are usually asked if they would like to talk in private but this is towards the end of the booking-in process. We didn't see a custody officer take a detainee for a private conversation at this point. But we did see officers going to the cell to speak to a detainee if they felt there was any cause for concern.

Detainees are told that all cells are covered by CCTV but that the toilets aren't visible. When a strip search happens, the cell should be taken off CCTV monitors. Staff are clear that when strip searches are carried out, the CCTV monitor for the cell should be taken off.

Two cells in Guildford have mattresses on the floor instead of benches. These are used for detainees under the influence of alcohol and/or drugs. This isn't respectful and the low benches in other cells are suitable for people who pose these risks. We also saw a detainee returned to one of these cells after he had sobered up and been interviewed, and was no longer at risk.

The showers in Staines don't provide enough privacy. They have low stable doors fitted that don't meet in the middle.

Areas for improvement

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

- having arrangements to allow private or sensitive information to be disclosed in a confidential environment;
- making sure that detainees can shower with privacy in all custody suites; and
- using appropriate cell arrangements when detaining those under the influence of alcohol and/or drugs.

Meeting diverse and individual needs

Custody staff are confident about meeting the diverse needs of detainees, although there are some gaps in practice.

Women are, with some exceptions, given appropriate and consistent support. Women and men are kept separate as far as possible. Women are always given a female officer who they can speak to. However, not all officers introduce themselves or ask about any needs the woman may have.

There are enough menstrual care products available but custody staff must take used products away. This is not satisfactory.

There is a good standard of individual care. For example, independent custody visitors told us about staff buying a breast pump for a detainee. Work is also being done to improve perinatal care.

Staff give appropriate support and supervision to people whatever their gender profile. Training on this has also recently been provided. Custody staff described many times when they had met transgender and non-binary people. They emphasised that the person must be treated as an individual.

Interpretation services don't always meet detainee needs. There were times when a detainee clearly didn't understand English well but interpretation wasn't used.

Telephone interpretation is often limited to booking in and not used for other important processes such as reviews of detention and release. Conversations usually happen by speakerphone, which means others can hear what is said. Detainees are also sometimes held longer because the contractor isn't able to supply an interpreter promptly.

Information about rights and entitlements is available in many languages, and most staff know how to access other translated documents.

There is some support for people with a disability. There is a wheelchair at each suite and, subject to a risk assessment, detainees can keep their walking aids. Thicker mattresses are also available to increase the height of benches for people with mobility issues.

Guildford and Staines both have low desks accessible to wheelchair users. There is an accessible cell in Guildford that has two call bells but these are at the standard

height and the bench is much lower than expected by Home Office design guidance. Salfords is the only suite with adapted toilets.

All cells in Salfords and Staines, and one cell in Guildford, have coloured bands on the walls to help people with visual impairment. Information in Braille isn't provided but staff said that they would read rights and entitlements aloud for anyone with visual impairment.

We were told that hearing loops are available but staff in Salfords and Staines weren't aware of them. The force provides a British Sign Language (BSL) interpreter for people with hearing impairments.

A cell with a large glass panel in the door is used for people who might benefit from this, for example those suffering with claustrophobia, at Salfords and Guildford.

Staff have recently had training about neurodiverse conditions. They described good support given to detainees but this wasn't always obvious in the cases we reviewed.

Detainees are usually asked if they need any religious materials during booking in. Each suite has plenty of faith resources for Muslim and Christian detainees, including copies of the Qur'an, prayer mats and bibles. They are respectfully stored. There currently aren't enough texts and items provided for other faith groups, although the force told us it was arranging for a wider selection.

Areas for improvement

The force should strengthen its approach to meeting the individual and diverse needs of detainees by making sure that:

- all suites have suitable provision for detainees with disabilities;
- telephone interpretation is readily available, takes place through two-way handsets and is used at all points during detention when information needs to be given or requested;
- the female member of staff acting as the nominated contact for women detainees makes early contact with them and carries out the role effectively;
- satisfactory disposal arrangements are used for menstrual care products; and
- there are enough religious texts and items for all faiths to allow all detainees to observe their religion.

Risk assessments

The identification and management of risk is generally good, and better than we normally see. Detainees are usually booked in promptly but when it is busy there can be a long wait in holding rooms or vehicles before their detention is authorised (see Individual legal rights). Queues aren't managed well. Staff don't assess risks or prioritise booking in children or vulnerable adults.

Arresting and escorting officers complete a detainee risk form when they arrive at the suite. Custody officers use this as part of their formal risk assessment. During booking

in they focus on identifying risks, vulnerability and welfare concerns. They ask relevant supplementary and probing questions, and routinely cross-reference to the police national computer (PNC) warning markers to help identify additional risk factors.

Observations are generally set at a level commensurate with presenting risks. But not all detainees under the influence of alcohol and/or drugs are monitored at a level that means they need to be roused. This is required by level 2 in APP and presents a significant risk. Detention officers do rouse those on level 2 in the right way and record this accurately. However, the observation levels of some of the detainees monitored at level 2 are reduced too quickly.

Officers review observation levels regularly and usually record enough information on custody records to show when and why the levels have been changed.

Most detainees are checked at the required frequency. But officers don't record the times accurately in detention logs, rounding up or down to 15 or 45 minutes past the hour regardless of the actual time of the check. Different officers also complete the checks, which means changes in a detainee's behaviour or condition might not be picked up. These practices don't follow APP guidance.

Most custody officers don't routinely remove clothing with cords or other items, such as jewellery, unless an individual risk assessment deems it necessary. However, when items are removed the reasons aren't recorded well enough.

Anti-rip clothing is available but isn't often used. Instead, custody officers increase observation levels to mitigate risk. This is more appropriate.

Some detainees may need higher levels of observation through either constant observation via CCTV (level 3 in APP) or physical supervision in close proximity (level 4 in APP). Custody officers should fully brief the responsible officer(s) when this is needed. But we found the quality of the briefings wasn't consistent and some officers only ever receive handover information from those they take over from. Guidance sheets are available but aren't always used and some information is out of date. Custody records rarely include details of the briefing or the identity of officers involved.

Officers conducting these duties often stay in post for long periods without a break and aren't always properly focused on their duties. For example, we saw officers using their handheld devices. These practices don't follow APP guidance.

Handovers between shifts are recorded on CCTV and have improved since our last inspection. All custody staff, except health care professionals, are routinely involved and the content has enough focus on risk and welfare. Custody officers visit detainees in their care after handover, but they don't always engage with them.

Custody staff carry anti-ligature knives and maintain control of cell keys. Cell call bells are audible and there is usually a prompt response.

Areas for improvement

The force should improve its approach to risk by making sure that:

- custody officers triage queues for booking in;
- observation levels for detainees under the influence of alcohol and/or drugs are always set appropriately and remain in place long enough;
- the same staff member conducts detainee checks and the timing is recorded accurately;
- reasons are always recorded when a detainee's clothing is removed following an individual risk assessment;
- level 3 constant observation and level 4 close proximity watches are conducted and recorded in line with APP guidance; and
- custody officers always engage with detainees in their care following the handover.

Individual legal rights

Some detainees are waiting too long to be booked into custody when they arrive at the suite. The average wait time is 12 minutes, according to force data for the previous year. But we found longer wait times, sometimes over an hour, in the cases we examined. Frontline officers told us that they could wait with their detainees for a long time, especially during custody shift changes. Reasons for delays aren't routinely recorded.

Custody officers generally authorise detention appropriately. Arresting officers explain reasons for the arrest well, but there are times when they don't explain the need to detain (PACE code G, the necessity test) in enough detail. And custody officers don't always ask further questions to help decide whether to authorise the detention.

The force uses voluntary attendance interviews well to deal with investigations and keep people away from custody, particularly for children and vulnerable adults. Over 25 percent of potential detainees are diverted away from custody. There are enough rooms in the reception areas of all suites so that voluntary attendees only have to enter the custody area if biometrics are needed.

Detainees should be kept in custody for the minimum time necessary. But we found some cases weren't progressed quickly enough and detainees spent longer than needed in custody. Some delays are caused by solicitors and interpreters not being available, and in Staines there are sometimes waits for the consultation rooms. But it is not clear why other cases aren't dealt with more quickly. Custody officers also told us it could be difficult to keep in contact and get updates from investigating officers. This can be a particular problem at Salfords, where the custody suite is located on an industrial estate and the investigating officers are based elsewhere.

We saw some immigration detainees during our visits. Officers told us that immigration detainees aren't held in custody for long. But information provided by the force shows they spend an average of 18 hours and 26 minutes in custody. The data doesn't

show how long detainees wait after they are served with their immigration papers (IS91) – at which point they should be transferred by immigration services to an immigration facility.

Detention officers explain the three main rights and entitlements to detainees clearly. 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 aren't always given the leaflets or notices setting out their rights and entitlements. This is required by PACE Code C paragraph 3.2. Instead officers show the detainee a laminated version of their rights and entitlements but don't hand this to them. The force addressed this quickly when we brought it to its attention and told detention officers to issue the notice as required. We saw this happening as our inspection continued, although some detention officers were still forgetting to do it.

Officers explain PACE Code C to detainees. They offer the detainee a printed off version of the booklet so that it is always up to date.

All suites have posters advertising the right to free legal advice in different languages. However, these aren't always in places where detainees can easily see them.

Custody staff are aware of the requirements of annex M (translation of documents and records) and can easily print off copies when needed. An easy-read version for rights and entitlements is also available but isn't always given to children and vulnerable adults.

There are enough interview and consultation rooms for detainees to consult their legal representatives in private at Salfords and Guildford. There are only two consultation rooms at Staines, which can cause delays. Detainees can also speak to their legal representative on the telephone in private. Legal representatives are given a summary printout of the front sheet of their client's custody record on request.

Foreign nationals brought into custody are routinely asked whether they want their embassy, high commission or consulate to be contacted. Custody officers know how to do this and we saw cases where this was done proactively.

The storage of DNA samples in freezers is in line with current guidance. However, samples aren't held securely enough at Salfords and Staines to ensure sample integrity.

Area for improvement

Detainees should be booked in and have their cases dealt with promptly and effectively so that they don't spend longer than necessary in custody.

Reviews of detention

Reviews of detention aren't always carried out in the best interests of the detainee. The force doesn't always follow PACE code C and in some cases is in breach of section 40 of PACE. This is a cause of concern.

Our examination of case records found that some reviews hadn't been carried out. This is a breach of section 40 of PACE and results in detainees being kept in detention without a review to authorise that this is still necessary.

Many reviews of detention are conducted either late or early with little, or an unsatisfactory, explanation recorded on the custody record. Inspectors fit their reviews in around their other operational commitments rather than doing what is best for the detainee.

Few reviews are carried out face to face. We examined the case records for 68 detainees where reviews were carried out and just over a third of these were carried out in person.

Inspectors carry out many reviews by telephone and by live link (Skype). The reasons aren't always recorded when the telephone is used instead of attending in person. This doesn't meet the requirements of PACE code C paragraph 15.14. It is also not clear why live link hasn't been used. PACE code C paragraph 15.9B states that telephone reviews aren't permitted if live link is available and practical to use.

When reviews are carried out and the detainee is asleep, they are usually told that their continued detention has been authorised, reminded of their rights and entitlements and given an opportunity to make representations (PACE code C paragraph 15.7). This is then endorsed on the custody record.

The way in which reviews are carried out with the detainee is good. Detainees were treated with respect, reminded of their rights and entitlements, and their welfare was discussed in the reviews we saw.

Access to swift justice

The access to swift justice for detainees needs to be better. Many detainees are waiting too long for their cases to be completed.

Our custody record analysis showed 49 percent of cases were finalised during the first period of detention. Detainees were bailed or released under investigation in the remaining cases.

The force has governance processes to monitor suspects who are bailed or released under investigation, but many cases take too long. Frontline supervisors are initially responsible for the management and review of investigations of suspects. There is a compliance and audit process, but this doesn't give the force a full understanding of how these cases are dealt with. Data provided by the force shows 21 percent of cases where detainees have been released under investigation are over 12 months old. However, the reasons for delays aren't clear.

Detainees are given notices when they are released under investigation. These outline the possible offences they may commit if they interfere with victims or witnesses while the investigation is ongoing. Custody officers also explain this to detainees.

Complaints

Information is available to detainees about how to complain about their treatment while in custody. Posters in the custody suites also explain this.

Custody staff understand the complaints process and are clear about how to take a complaint from a detainee. Each custody suite has a PACE inspector who is responsible for dealing with complaints.

The force monitors complaints, but we found none of the seven that related to health care had been shared with the health care provider.

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 who meet their physical health, mental health and substance use needs in a timely way.

Physical environment is safe

Surrey Police has three full-time designated suites at Guildford, Salfords and Staines. Guilford was closed for some time as part of a refurbishment programme and re-opened during the second week of our inspection. Salfords was then due to close for its refurbishment.

Overall, conditions and cleanliness across the custody estate are good. The suites are well maintained and benefit from an annual closure programme, which allows additional works and redecoration to take place. No potential ligature points were found in any of the cells we checked. We gave the force a comprehensive illustrative report detailing the general conditions we found across the estate during the inspection.

Facilities vary across the suites. For example, cells at Staines don't have handwashing basins or intercoms. Some cells at Guildford have no natural light and two cells have no benches.

A good quality CCTV system is installed in each suite, including in all cells. Notices that CCTV is in operation are prominently displayed in all suites. However, these aren't always where detainees can see them and there are none in cells at Salfords.

Suites should have maintenance checks twice a day but this doesn't always happen. We were told that repairs are completed quickly.

Most custody staff are aware of emergency evacuation procedures and there are enough handcuffs to evacuate cells if needed. But few staff have taken part in a physical evacuation to make sure the procedures work in practice. Drills had taken place at Salfords in the previous six months and didn't identify any custody-related learning points.

Area for improvement

The force should adhere to legal requirements for fire regulations, particularly around emergency evacuations.

Safety: use of force

Custody staff take part in regular personal safety training and all the staff we spoke to were up to date as required.

Data about the use of force in custody isn't accurate. There isn't enough information on detention logs and staff involved in restraining detainees don't always submit individual use of force forms as required. This makes it difficult to know how often and what type of force is used.

There is little quality assurance of use of force incidents in custody. Few incidents are reviewed or cases watched on CCTV footage. This means Surrey Police can't show that restraint is only used when necessary and proportionate and that it is carried out in the right way.

We reviewed CCTV relating to 20 detainees who had force used against them in custody (some involved multiple occurrences). On the whole, the incidents were managed well and in many there was good control and clear direction. In most, the force used was necessary and proportionate to the risk or threat posed.

Good communication and negotiation calmed down some challenging situations well. This often resulted in only low-level force such as guiding holds being used and very few incidents concluded with full cell exit procedures.

However, we did find some poor techniques and practice that weren't always the most appropriate way of dealing with the incident. We referred these cases to the force for review and to learn from.

Some detainees were placed on higher levels of observation but still had their clothing forcibly removed. There was little detail recorded to explain why this was needed. In our view it wasn't necessary because the risks were being appropriately managed through the observations, and the use of force could have been avoided. However, officers maintained detainees' dignity well when clothing was removed by force.

We saw many detainees arrive without handcuffs and those who did usually had them removed quickly if they were compliant. However, the time handcuffs are removed isn't recorded.

We found few strip searches during the inspection. We reviewed three cases on CCTV, and found the verbal rationale for and the conduct of strip searches was appropriate but the written authorisation and justification wasn't always good enough.

Areas for improvement

The force should improve its approach to the use of force on detainees by:

- always using restraint techniques that are appropriate to the circumstances of the incident; and
- quality assuring enough cases, including review of CCTV footage where possible, to make sure that the force used on detainees is necessary and proportionate.

Detainee care

Detainee care is good. Detainees told us that custody staff cared for them well, especially in building a relationship with them, calming any anxieties and providing basic necessities such as food and drink.

The custody officer at every booking in told the detainee that exercise, a shower and reading material were available on request. It is good that these are routinely offered although we found that they could be more actively provided.

Hot drinks and a good range of food, which meet a variety of dietary and cultural requirements, are offered throughout the day. The range of food and drink offered in custody has been recently increased. This includes more vegan and gluten-free options as well as plant-based milk. Staff use petty cash to buy food for those with special diets when necessary. Items for children such as pizza, apple juice and soft drinks have also been introduced. The provision was better than we normally see. The food preparation areas are fit for purpose and clean.

There is drinking water in the cells at Guildford and Salfords although this isn't signed as such. There is no water supply in the cells at Staines, but two drinking fountains have been installed in the cell corridors to make it easier for staff to provide water.

There are enough facilities for personal hygiene with good handwash facilities, except in the cells at Staines. Toilet paper is placed in each cell routinely. The shower rooms are in good condition and hygiene packs are available for both women and men. Showers are mainly used by detainees held overnight before attending court. We saw few other detainees use the showers, although this is offered at booking in.

The small exercise areas at Salford and Staines are fully enclosed. The area at Guildford has a partial roof. Detainees are offered, and use, these exercise rooms reasonably regularly. Staff see this as a good resource to support detainees who become restless or to help relieve anxieties. However, these exercise areas don't allow detainees access to outdoor or external exercise as required by PACE code C paragraph 8.7 or in line with APP guidance.

Detainees complained that some of the cells on the outside walls at Staines were cold. Cells at Salfords also feel cold and staff aren't able to adjust the heating.

Mattresses and pillows are in good condition and present in all cells. All suites have a good supply of blankets, which are routinely offered to detainees. There is enough

stock of clothes and footwear. However, some detainees aren't given replacements and many walk around the suites without shoes on.

There is a good selection of books, some in languages other than English, at each suite. Nearly all detainees are offered these at booking in and staff also often make a further offer at the cell door. However, in practice, few detainees are given reading materials.

Each suite also has a box of distraction activity materials that includes items such as a jigsaw puzzle, Rubik's Cube, foam ball and coloured pencils. The force continues to improve the range of resources available. Staff also sometimes add to them and we were told they might print a crossword from the internet. These items aren't provided routinely but are usually given to detainees when they are upset or clearly unsettled.

Family visits aren't normally allowed. However, custody officers at Guildford said that they had allowed visits in the legal visits area when there was good cause.

Area for improvement

The force should improve its care for detainees by:

- making sure that cells are kept at a comfortable temperature;
- providing signs in cells that water is drinkable;
- proactively providing the care facilities on offer; and
- providing a consistent range of distraction activity materials to suit a range of preferences, abilities and needs.

Safeguarding

Officers, both in and outside custody, demonstrated a clear awareness of their safeguarding responsibilities for those they come into contact with. They also have a good understanding of the importance of making safeguarding referrals. These are routinely made to the force's specialist team or children's social services so that any concerns can be addressed.

Safeguarding arrangements are further strengthened by the work of the Criminal Justice Liaison & Diversion service (CJLDS) and the healthcare practitioners based in custody. They assess all children, women and other vulnerable adults on referral, and make their own safeguarding referrals for children as needed. We found good recording on custody records to show when these assessments and referrals had taken place, and who to.

Arresting or custody officers usually arrange an appropriate adult (AA) early in a person's detention. The Surrey Appropriate Adult Volunteer Scheme (SAAVS) is used when friends or family members are unable to perform this role. The scheme is for both children and vulnerable adults, and is available 24 hours a day. It is generally a prompt and effective service. AAs will attend custody early when possible so that they are present when the detainee receives their rights and entitlements. This includes

during the night. This isn't something we often see. Although we found a few long waits, AAs usually arrived quickly.

AAs are present throughout the different stages of custody processes. This includes for photographs and taking DNA and other samples – this is an improvement since our last inspection.

There is good recording about AAs in custody records. The time that AAs are contacted and when they arrive is often recorded. This shows how long each detainee waits. This is better than we often see.

However, this information isn't routinely monitored or used to show how well the service meets detainees' needs. SAAVS provide some performance data such as the number of instances it attends. But the force doesn't monitor other information such as when an AA arrives (regardless of whether it is a family member or an AA from SAAVS). The data also isn't used to identify where the service could be improved.

The force told us that it felt custody officers are good at identifying whether an adult detainee is vulnerable and needs the support of an AA. But we didn't always see evidence of this happening. We identified some occasions where vulnerable adults, particularly those in potential mental ill-health crisis, weren't identified as needing the support of an AA. In some cases, an AA wasn't arranged even when the health care assessment suggested this was needed.

Children are only arrested and detained when necessary and after consideration of alternatives to custody. Arresting officers give clear reasons why a child has been brought in. We found no examples where custody wasn't appropriate for the few children we saw coming into custody and in our examination of cases.

There is good scrutiny over children coming into custody. Custody officers promptly notify the custody or duty inspector of any child entering custody. The inspector reviews the case, assesses the need for the child's detention and makes sure that the investigation is progressing as quickly as possible.

This results in a good focus on keeping children in custody for as short a time as possible. Investigations are started quickly and carried out late at night if needed. The child is bailed or released under investigation if this can't be done quickly, especially if this avoids overnight detention. We saw this happening in some of our case reviews. We also observed this during our time in suites – for example, a 17-year-old boy was interviewed and then released under investigation to avoid keeping him in custody while awaiting the results of various investigative enquiries.

Children detained in custody are generally well looked after. Distraction materials such as playing cards, puzzles, colouring books and foam footballs are available at each of the suites. These are available following a risk assessment, although they aren't routinely provided (see Detainee care). Easy-to-read rights and entitlements leaflets are also available in the suites, but again these aren't always provided (see Individual legal rights).

Designated cells for children are available. These are closer to the custody front desk and further away from some of the other cells in the suite. However, there is no natural light, toilet or handwashing facility in these cells at the recently refurbished

suite in Guildford. We saw these cells used during our observations. But in one case the benefit to the child was reduced because a disruptive adult detainee was placed in the cell next door.

Both girls and boys are assigned a member of staff of the same gender to act as their nominated carer and support them while in custody. (This is a legal requirement for girls under the Children and Young Persons Act 1933 but not for boys.) This shows a good focus on care. We found good quality entries recorded on custody records showing that nominated staff had introduced themselves and spoken with the child they were responsible for.

Few children are charged and refused bail. But when this does happen, they aren't always transferred to local authority accommodation as they should be. A joint accommodation protocol agreed with Surrey County Council sets out the legal requirements and the escalation procedures. The latter are followed when the local authority can't provide alternative accommodation.

However, more needs to be done to achieve better outcomes for detained children. In the year to 30 September 2021:

- three requests for secure accommodation were made but not met; and
- five requests for appropriate (non-secure) accommodation were made, with only two met.

When children were kept in police custody the force tried to secure alternative accommodation. However, we were told there is no secure accommodation available within the force area and that the availability of appropriate accommodation had reduced because of the COVID-19 pandemic.

The force holds various internal meetings where children (including those detained) are discussed, as well as meetings with children's social services. But there is little quality assurance to review individual cases to better monitor outcomes and identify how improvements could be made.

Areas for improvement

- The force should make sure that all vulnerable adults receive support from an AA when this is required.
- The force should continue to work with its local authority partners to improve the provision of alternative accommodation for children who are charged and refused bail.

Governance of health care

Physical health care services are provided by Mountain Healthcare Limited (MHL). Substance misuse and mental health support are provided by Surrey and Borders Partnership NHS Foundation Trust (SABP).

The force monitors the contract and holds monthly performance meetings. There is generally a sound oversight of physical health care. But there are weaknesses in

some aspects of clinical governance that haven't been identified by either MHL or the force (see Patient care).

Health care professionals (HCPs) including doctors, nurses and paramedics are usually available in each suite 24 hours a day. The force monitors response times monthly. Practitioners are stretched but staffing levels meet demand, partly because there are only two suites currently in use.

There are policies to report and manage incidents, and a confidential health complaints system is advertised in all custody suites. However, the force doesn't routinely share complaints about health care with either the police health lead or the health provider. This means the health care provider can't respond to the detainee's concerns, which may not then be addressed.

Mandatory training compliance is good. It is policy to provide regular supervision to staff, but HCPs didn't always feel able to access support. The induction processes for the HCPs aren't competency based and the four shadow shifts may not give staff the experience they need. This leaves some staff lacking in confidence, particularly in providing the out-of-hours mental health service and vulnerability assessments.

Clinical rooms in all suites generally meet infection prevention standards although some work needed to be completed following the recent refurbishment. In Guildford the detainee sits directly behind the practitioner during consultations. This compromises staff safety. Providers have adequate access to PPE.

Many patient assessments and interactions in clinical rooms take place with the door open and custody staff close by. This practice is inappropriate and breaches patient confidentiality. It contributes to our cause of concern.

A new emergency bag containing life-saving equipment is available in all suites. The bags contain a defibrillator and the contents meet the national standards. The bags aren't securely sealed to make sure they haven't been tampered with, but they are checked by detention officers every day. All custody staff complete basic life support training and are unable to work shifts if they don't keep this up to date.

Areas for improvement

- Induction processes for all HCPs should be competency based and ensure all relevant skills and practices, particularly those which are new to the HCP, are observed and tested by an experienced member of the clinical team.
- Complaints relating to health care received by the police should be shared with the health provider so they can respond appropriately to the concerns raised.

Patient care

The HCPs we met are experienced and knowledgeable practitioners who meet detainees' health needs promptly. All custody staff we spoke to value the support and contribution made by HCPs.

The clinical records we sampled were of good quality and accurately reflected the care given. All HCPs have access to police custody records to document important risks and interventions, which is good.

However, privacy and dignity for detainees receiving health care in custody isn't maintained. And this is significantly compromised in some areas:

- The detainee's health information held on the custody record can be seen by solicitors and independent custody visitors when they are given a copy of the record – this is a breach of patient confidentiality.
- Patient consent is obtained before each contact with detainees but the consent forms state that no information the detainee shares is confidential – this is inappropriate.
- Intimate samples are taken in clinical rooms with the door closed. But an officer is present and no screen or curtains are used to protect the detainee's privacy and dignity while the samples are taken. This is very poor. HCPs are unable to offer blankets, sheets or a gown for detainees during these procedures because of infection control.
- There is a spy hole in the clinical room door in the Guildford suite, allowing anyone in the custody area to look through.

The clinical governance arrangements haven't identified these serious issues. They are a cause of concern.

Medicines management is generally safe and appropriate for detainee care. Detainees can receive prescription medicines if confirmed and authorised by a health care professional. However, HCPs don't have easy access to the NHS Spine to confirm medication and this can cause delays in authorising treatments.

Detainees aren't able to access nicotine replacement products while in custody. MHL policy also doesn't allow detainees to continue community-prescribed opiate substitution treatment, irrespective of the length of detention. This is poor. However, detainees are provided with relief for their symptoms if they experience withdrawal.

A range of patient group directions (authorising HCPs to prescribe and administer prescription-only medicines) are signed and up to date. An appropriate range of stock medicines is held securely in each suite. And regular checks on stock balances, including controlled drugs, are recorded.

Areas for improvement

- Detainees should be able to access community prescribed opiate substitution treatment while in custody.
- Detainees who smoke should be able to access nicotine-replacement products while in custody.

Substance misuse

No dedicated specialist drug and alcohol workers visit the custody suites. However, overall support in this area is reasonable.

Liaison and diversion (L&D) practitioners from SAPB are available to help detainees with addiction problems. The demand for L&D services is high and not everyone identified as needing this support receives face-to-face contact. However, practitioners usually carry out a vulnerability assessment and direct individuals to community services including Catalyst, a not-for-profit organisation commissioned by SAPB.

Detainees who engage with this service can access general housing and benefits support. The dedicated I-access team also provides specialist addiction support in the community. Naloxone (used to counter the effects of an opioid overdose) is available on site as part of the emergency drugs stock held by the HCPs. But there is no access to clean needle exchange or supply in the suites. L&D practitioners can arrange face-to-face contact with services after release who can provide this support if necessary.

Mental health

The SABP L&D team provide a service to support detainees who are vulnerable. There is a good relationship with the force and there are clear accountability arrangements overseen by NHS commissioners. Mental health training for frontline officers and custody staff is extensive and involves service users sharing their experiences of criminal justice services.

There are two tiers of practitioners in the L&D team: registered professionals and support staff who work as vulnerability practitioners.

Demand for these services in custody continues to increase. The L&D staff we met are skilled and confident but vacancies in both roles was creating problems with service delivery. The L&D team are currently operating from only two suites at present, which allows them to better manage the demand to support detainees. This will be more difficult once all three suites are open.

Detainees who present with significant risk and require specialist assessment and support do receive it. However, the service is stretched and not everyone requiring face-to-face assessment receives it before release.

Detainees with more generic vulnerabilities and lower-intensity needs are usually identified and most receive support. But this often depends on whether acute demand is draining resources. This is unfortunate, as feedback from recipients of this type of support shows they find it valuable.

The L&D team help individuals to access a range of community services, including police-led programmes such as the Surrey High Intensity Partnership Programme (SHIPP). SHIPP supports vulnerable people who regularly come into contact with criminal justice services and helps make sure they receive the more intensive and productive support they need to prevent or reduce their offending.

Most custody staff value the contribution from the L&D team, but there are some frustrations about being able to access help from practitioners.

Approved mental health professionals (AMHPs) and the emergency duty team (EDT) respond reasonably well to carry out Mental Health Act assessments in custody for detainees. Ambulance transport is also generally reasonable. The information we were given on Mental Health Act assessments suggested that delays are due to the lack of beds to take detainees to after their assessment. Out-of-hours support varies and sometimes section 136 detentions are made in custody to allow transfer from custody to a hospital place of safety. Custody itself isn't used as place of safety under section 136.

There is significant community demand for mental health beds. Police officers can be required to stay at A&E departments for long periods while arrangements are made to transfer the detainee to designated mental health facilities.

Area for improvement

Vulnerable detainees should consistently receive an assessment of their needs by the L&D team so that support can be provided when concerns are identified.

Section 5. Release and transfer from custody

Expected outcomes

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

Pre-release risk assessment

The focus on the safe release of detainees is good. This has improved since our last inspection.

Custody officers engage well with detainees to complete pre-release risk assessments. They use initial risk assessments and care plans appropriately to make sure any risks identified are addressed or reduced before release. Relevant agencies such as the Criminal Justice Liaison & Diversion Service (CJLDS) are involved when necessary. However, some custody records don't have enough detail – for example, how a detainee is getting home after release – and don't show everything that has happened to support the safe release.

Detainees who don't have the means to get home safely can access train tickets and accounts with local taxi firms. Police officers often take children and vulnerable adults home when it is not possible to release them into the care of a responsible adult.

Custody officers are aware of the enhanced safeguarding arrangements for people arrested under suspicion of committing serious sexual offences. They told us there is a good exchange of information from investigating officers and they use this when completing the pre-release risk assessment.

Generic information about local and national support organisations is supplied by the L&D team and is routinely given to detainees on release. However, it is only available in English.

Detention officers complete digital person escort records (dPERs) and book transport for detainees attending court or who have been recalled to prison. These are mostly well completed but not all custody officers check the content before signing them off.

Area for improvement

Custody officers should check that dPERs are fully completed before signing off.

Courts

Detainees remanded for court are generally collected promptly in the morning. Those arrested on warrant during the day aren't accepted directly at Guildford Magistrates' Court and are booked into police custody. Staff report the court has some flexibility and often accepts detainees later in the afternoon, which minimises their time in custody.

However, there are occasions when the transfer is delayed due to lack of available transport. This sometimes results in the cancellation of planned transfers and extended stays in police custody. This is a poor outcome for those affected. These delays are out of the control of Surrey Police, but the force is working with Her Majesty's Courts and Tribunals Service (HMCTS) and the contracted escort provider to improve the situation.

Area for improvement

Surrey Police should continue to engage with HMCTS and Prisoner Escort & Custody Services to ensure that detainees are not held in police custody for longer than necessary.

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

Causes of concern and recommendations

Cause of concern: Meeting legal requirements and guidance

The force isn't always complying with section 40 of the Police and Criminal Evidence Act 1984 (PACE). Some reviews of detention are missed, which is a breach of section 40 of PACE. Some reviews of detention are carried out in a way that doesn't meet the requirements of code C of PACE for the detention, treatment and questioning of persons. Detainees aren't consistently provided with a written copy of their rights and entitlements.

Recommendation

The force should take immediate action to make sure that all custody procedures and practices comply with legislation and guidance.

Cause of concern: Maintaining privacy and dignity for detainees receiving health care in custody

Detainee privacy and their dignity isn't maintained when they are receiving health care services. Clinical governance over the health care service has failed to recognise these concerns. In particular:

- Patient consent forms state that information provided to medical practitioners by detainees is not confidential – this is inappropriate.
- Many patient assessments and interactions in clinical rooms take place with the door open and custody staff close by – this is inappropriate and breaches patient confidentiality.
- There are no screens or curtains in medical rooms to protect the dignity of detainees during the taking of intimate samples.
- One medical room has a spyhole in the door potentially allowing anyone in the custody area to look through.
- Medical information held on custody records is inappropriately shared with solicitors, independent custody visitors and AAs when they receive a printed copy of these.

Recommendation

The force and the health provider should take immediate action to ensure the privacy and dignity of detainees across all aspects of health care provision.

Areas for improvement

Leadership, accountability and partnerships

- The force should robustly quality assure custody records to identify and act on any concerns.
- The force should improve its monitoring of the use of force so that it can show that when it is used in custody suites it is proportionate and justified. This should be based on comprehensive and accurate information.

First point of contact

The force should work with mental health services to make sure frontline officers have enough support to make appropriate decisions when dealing with people with mental ill health.

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

- The force should improve its approach to detainee dignity and privacy by:
    - having arrangements to allow private or sensitive information to be disclosed in a confidential environment;
    - making sure that detainees can shower with privacy in all custody suites; and
    - using appropriate cell arrangements when detaining those under the influence of alcohol and/or drugs.
- The force should strengthen its approach to meeting the individual and diverse needs of detainees by making sure that:
    - all suites have suitable provision for detainees with disabilities;
    - telephone interpretation is readily available, takes place through two-way handsets and is used at all points during detention when information needs to be given or requested;
    - the female member of staff acting as the nominated contact for women detainees makes early contact with them and carries out the role effectively;
    - satisfactory disposal arrangements are used for menstrual care products; and
    - there are enough religious texts and items for all faiths to allow all detainees to observe their religion.
- The force should improve its approach to risk by making sure that:
    - custody officers triage queues for booking in;
    - observation levels for detainees under the influence of alcohol and/or drugs are always set appropriately and remain in place long enough;
    - the same staff member conducts detainee checks and the timing is recorded accurately;
    - reasons are always recorded when a detainee's clothing is removed following an individual risk assessment;
    - level 3 constant observation and level 4 close proximity watches are conducted and recorded in line with APP guidance; and
    - custody officers always engage with detainees in their care following the handover.
- Detainees should be booked in and have their cases dealt with promptly and effectively so that they don't spend longer than necessary in custody.

In the custody cell, safeguarding and health care

- The force should adhere to legal requirements for fire regulations, particularly around emergency evacuations.
- The force should improve its approach to the use of force on detainees by:
    - always using restraint techniques that are appropriate to the circumstances of the incident; and
    - quality assuring enough cases, including review of CCTV footage where possible, to make sure that the force used on detainees is necessary and proportionate.
- The force should improve its care for detainees by:
    - making sure that cells are kept at a comfortable temperature;
    - providing signs in cells that water is drinkable;
    - proactively providing the care facilities on offer; and
    - providing a consistent range of distraction activity materials to suit a range of preferences, abilities and needs.
- The force should make sure that all vulnerable adults receive support from an AA when this is required.
- The force should continue to work with its local authority partners to improve the provision of alternative accommodation for children who are charged and refused bail.
- Induction processes for all HCPs should be competency based and ensure all relevant skills and practices, particularly those which are new to the HCP, are observed and tested by an experienced member of the clinical team.
- Complaints relating to health care received by the police should be shared with the health provider so they can respond appropriately to the concerns raised.
- Detainees should be able to access community prescribed opiate substitution treatment while in custody.
- Detainees who smoke should be able to access nicotine-replacement products while in custody.
- Vulnerable detainees should consistently receive an assessment of their needs by the L&D team so that support can be provided when concerns are identified.

Release and transfer from custody

- Custody officers should check that dPERs are fully completed before signing off.
- Surrey Police should continue to engage with HMCTS and Prisoner Escort & Custody Services to ensure that detainees are not held in police custody for longer than necessary.

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. Our inspections are unannounced, and we visit the force over two weeks. 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 various 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;
- 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 background information and to help assess how well the force performs against some main areas of activity.

A documentary analysis of custody records is carried out on a representative sample of all records opened in the week preceding the inspection in all the suites in the force area. Records analysed are chosen at random. A government statistical formula with a 95 percent confidence interval and a sampling error of 7 percent is used to calculate the sample size. This makes sure that our records analysis reflects the throughput of the force's custody suites in that week. The analysis focuses on the legal rights and treatment and conditions of the detainee. Only statistically significant comparisons between groups or with other forces are included in the report.

A statistically significant difference between 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 adjust p-values for multiple testing, $p<0.01$ was considered statistically significant for all comparisons. This means there is only a 1 percent likelihood that the difference is due to chance.

Case audits

We audit around 40 case records in detail (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 examining 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 get support from appropriate adults when they need it, and whether detainees are released safely. We also assess whether force used against a detainee is proportionate and justified, and is properly recorded.

Observations in custody suites

Inspectors spend a significant amount of their time during the inspection in custody suites assessing their physical conditions, observing operational practices, and assessing how detainees are 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 examine 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 concerns at the earliest opportunity. Then we publish our report 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 about 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
- Anthony Davies: HMI Constabulary and Fire & Rescue Services inspection officer
- Patricia Nixon: HMI Constabulary and Fire & Rescue Services inspection officer
- Ramzan Mohayuddin: HMI Constabulary and Fire & Rescue Services inspection officer
- Sutinderjit Mahil: HMI Constabulary and Fire & Rescue Services inspection officer
- Andy Reed: HMI Constabulary and Fire & Rescue Services inspection officer
- Kellie Reeve: HMI Prisons team leader
- Fiona Shearlaw: HMI Prisons inspector
- Martin Kettle: HMI Prisons inspector
- Steve Ely: HMI Prisons Health and Social Care inspector
- Dayni Johnson: CQC inspector
- Johanne White: CQC inspector
- Joe Simmonds: HMI Prisons researcher
- Becky Duffield: HMI Prisons researcher

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