Report on an inspection visit to Border Force customs custody suites in England and Scotland

10 - 19 December 2012

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Glossary of terms

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1. Introduction

This report is the first in a programme of inspections of Border Force customs custody suites, which are carried out jointly by our two inspectorates and form a key part of the joint work programme of the criminal justice inspectorates. These inspections also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention. The inspections look at strategy, treatment and conditions, individual rights and health care. We appreciated the positive and helpful approach taken by Border Force managers and staff, for whom such an inspection was a new experience.

The network of custody suites, stretching across England and Scotland, had until recently been managed regionally with no national coordination. There had also been a lack of attention at national level to policy and practice in the suites, during a period of major structural changes as the customs and excise functions moved first into HM Revenue and Customs (HMRC), then to the UK Border Agency and, most recently, to Border Force, as well as attention to other priorities related to immigration. Following the creation of a national policy structure led by a Border Force director, in the six months before this inspection there were energetic attempts to improve the quality and consistency of delivery across all the sites.

Border Force refers to its custody facilities as either 'spine suites' or 'interview suites'. Spine suites consist of cells similar to those in a police custody suite, whereas interview suites are usually a couple of insecure rooms where suspects are detained for very short periods. Border Force generally use spine suites to detain people suspected of illegally importing controlled drugs or larger scale importation of other goods with a criminal intent of evading excise. The latter is often investigated by HMRC. The illegal importation of controlled drugs often involves the suspect ingesting them in sealed packages to avoid normal search procedures. Spine suites are equipped with specially adapted and supervised toilets where suspects can be detained until the body naturally excretes the packages, and the evidence is thus obtained. The ingestion of controlled drugs is, of course, inherently dangerous.

This report focuses mainly on the spine suites. There were very experienced staff in some of the busier spine suites, but in most cases staff with little or no training or recent experience were brought in on the rare occasions that other suites were opened. Staff interacted well with detainees, but procedures for the assessment and management of risk, and the provision of appropriate facilities for detainees, were undeveloped and inconsistent across the range of suites. Similarly, the physical environments varied in their suitability. The legal rights of detainees (under the Police and Criminal Evidence Act in England) were respected.

Health services presented the greatest organisational risk. They had developed to a varying extent across the regions, and were not governed by national standards or monitoring. A clinical review by the Chief Medical Officer in 2009 of the treatment of people suspected of concealing drugs was not made public until shortly after our inspection. At the time of our inspection several key areas needed attention as a priority.

This report provides a number of recommendations to assist Border Force to improve provision. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

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February 2013

2. Background and key findings

2.1 This report is the first in a regular cycle of inspections of customs custody carried out jointly by HM Inspectorates of Prisons and Constabulary, in association with HMIC Scotland and with the cooperation of HMIP Scotland. It covers all the custody suites operated by Border Force in England and Scotland (there are none in Wales). 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. The Inspectorates involved are among the bodies making up the NPM in the UK.

2.2 The inspections of customs custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice at strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Border Force Custody Suites*[1] about the appropriate treatment of detainees and conditions of detention, developed by HM Inspectorates of Prisons and Constabulary to assist best custodial practice.

2.3 Border Force operates 'spine suites', and 'interview suites'. There are nine custody facilities in England, five spine suites with cell facilities, and four interview suites. Interview suites do not have cells and although legally can be used for longer periods of detention they are, in practice, used for shorter-term detention of up to six hours. Scotland has one spine suite and three interview suites. The suites at Prestwick and Aberdeen were not inspected due to the low throughput. Most detainees in custody suites are suspected of concealing or having swallowed packages of illegal substances to frustrate customs controls.

2.4 The suites have a total average throughput of about 1,000 detainees per annum:

Spine suites	**Detention times**
Birmingham	When required
Colnbrook (Heathrow)	24/7
Dover	24/7
Gatwick	24/7
Manchester	24/7
Glasgow	When required
Interview suites	
Harwich	When required
Luton	When required
Stansted	When required
St Pancras	When required
Edinburgh	
Aberdeen	
Prestwick	

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

Strategy

2.5 An integrated national structure for the management and development of the custody estate had been introduced in spring 2012, led by a director; the suites had previously been under regional management. Since 2009 there had been a strong focus on developing other areas of business, and policies and procedures for the relatively small area of customs custody had not been considered. In 2012, an assistant director working with a new national team had made an energetic start on updating and bringing consistency to policy and practice in the widely dispersed network of custody suites. A set of policies was in preparation, derived from good practice guidance for police custody suites. Day-to-day running of the suites remained a regional responsibility.

2.6 The distribution of suites, particularly interview suites, had developed over time, and some interview suites were rarely used. Most staff working in the suites had been trained, but for many the training had been very short and a long time ago; there were plans to rectify this. Border Force staff did not have the authority to charge suspects, and detainees had to be taken to a police station to be charged. (Not Scotland, where suspects can be charged in the custody and interview suites.)

2.7 Work had started on generating systematic management information to inform planning, and on sharing information across teams, but this was at an early stage. Some useful operational instructions had recently been issued, but in a piecemeal manner.

2.8 Health and safety checks were well organised in the spine suites but less well in the interview suites. There was no coherent system for reporting incidents in custody, to ensure that learning was captured and trends analysed. Managers carried out random checks of custody records at some suites, but not others, and these checks were not sufficiently thorough. Handover of information about detainees from one shift to the next was inconsistent.

2.9 Border Force managers worked to varying degrees in partnership with other agencies across the regions. Health services were so diverse in type and quality that strategic attention to the provision of consistent, good quality care was a priority at national level. Independent custody visitors did not regularly attend any suite, but arrangements for external scrutiny were being explored for the spine suites.

Treatment and conditions

2.10 Vehicles used to transport detainees were reasonably clean; in some cases there was disproportionate use of handcuffs in transit. Staff in the spine suites were confident in managing and supporting adult detainees, and we observed good interactions with detainees, although it was not clear that all staff knew how to manage families and children safely. Facilities for women were available in most suites, but not always offered.

2.11 The newer spine suites had some adaptations for people with disabilities, but this did not apply to Dover (though they could receive wheelchair users) or Glasgow. Most suites contained prayer mats and other religious artefacts. In the airport suites, staff made good use of the airport retail facilities to buy, for example, foreign language newspapers or food items to meet specific diets.

2.12 A basic risk assessment was completed on paper for all detainees. In most cases, the Police National Computer (PNC) was checked for risk markers, although there was no uniform procedure to ensure that this was done. The frequency of observation of detainees in cells was

not recorded in all cases, and appeared too low in some. Some staff were not aware of the information contained in the person escort record form. However, in most suites detainees were allowed to keep certain items with them, and care plans were adjusted with changing circumstances.

2.13 CCTV equipment was used appropriately, although it was not working efficiently at Birmingham. Night observations were recorded consistently, but often in a brief, uninformative manner, and the quality of records declined when detainees were held for a long period. A standard handover sheet was used to pass information from one shift to the next. Practice and awareness in relation to ligature knives varied across the spine suites; not all staff carried them.

2.14 A pre-release risk assessment form had recently been introduced, but staff at Edinburgh and Glasgow were not aware of it. Staff at the English suites were able to give money for travel from petty cash where appropriate. Staff in England and Scotland gave examples of practical support given to people on release. Information about risk was not consistently passed to escort staff.

2.15 A use of force form had recently been issued which focussed on informing training rather than supporting management oversight of the use of force. The form was on the intranet, although staff at Edinburgh and St Pancras could not find it. The use of handcuffs was proportionate, except in vehicles (see above).

2.16 The cells in several suites had no natural light; furnishings in interview suites were generally not suitable for detention but any risk was mitigated by the presence of at least one member of staff in the room at all times. The only spine suite in Scotland at Glasgow had cells with wooden walls and doors, which needed to be replaced. The newer suites were in good condition: Gatwick, Dover, Manchester and Colnbrook were clean and free of graffiti and most cells had natural light. The interview suites at Luton, Harwich and Stansted were not suitable for detention for any length of time.

2.17 Maintenance and repairs were carried out promptly in all suites, but there was inconsistency in the frequency and regularity of recorded health and safety checks. Cell call bells worked properly in all spine suites. Awareness of fire procedures, and evidence of fire drills, varied widely.

2.18 The bedding in all the spine suites was adequate. Toilets for most detainees took the form of 'specimen isolation units' (SIUs) which enabled staff to observe and detect excreted packages. While this was demeaning, it was necessary, and staff were conscious of the need to respect personal dignity, although the requirement for every detainee using the SIU to be naked was not related to individual risk. There was also an ordinary toilet in some spine suites.

2.19 Showers in spine suites were in good working order and were offered to detainees staying for longer periods. Detainees could shower in private if the risk assessment allowed, but otherwise staff observed detainees who were suspected of swallowing drugs. Spare clothing was not available in most suites, but staff had occasionally bought items in to the airport if a detainee had nothing to wear. However, we were informed that the majority of detainees did have spare clothing with them at the time of arrest. Not all suites had secure arrangements for storing detainees' property.

2.20 There was a reasonable supply of food and drink at all suites, supplemented as necessary from airport shops. There were reading materials in English at spine suites, with the best selection at Gatwick and Dover (including foreign languages); there was relatively little at

Manchester. Only Colnbrook had the facility for outside exercise, although detainees staying at Gatwick for several days were sometimes taken outside into a secure area.

Individual rights

2.21 We were informed that in Scotland the custody staff are not permitted to refuse detention, whereas elsewhere staff were aware that they could contest detention if there was justification for it, and some had done so. 'Compound penalties', financial fixed penalty tickets, were in use for smaller amounts of drugs in possession, and detention was only used when necessary. Records showed that staff actively progressed investigations and contacted solicitors promptly. Regular reviews of detention required in England were sometimes not carried out on time because the detainee had arrived from another location or a review had been conducted before, or after, a detainee's rest period. Reviews of detention were carried out by the on-call higher officer. We witnessed a good quality review. Courts were flexible over timing, to respond to requests for extension of detention. Copies of detainees' rights and entitlements were available in some suites.

2.22 Appropriate adult services for children and vulnerable adults worked well at the English suites but were not clear in the Scottish suites. There was access to interpreters, although occasionally with long delays. Telephone interpretation was available, but not all suites had double-handset telephones.

2.23 Detainees had access to legal advice. In Scotland, this was provided by the Scottish Legal Aid Board. At Gatwick a duty solicitor told us that staff were professional in their dealings with him. In some suites, custody records were made readily available to the detainee's solicitor. PACE Code of Practice C, the main custody document, was available to detainees in the suites.

2.24 Posters had recently been displayed in most suites, explaining how to make a complaint. However, the information on the posters was not consistent, and not all staff knew the procedure if a detainee wished to register a complaint. Complaint forms were available on the booking-in desk at Colnbrook. A system had recently been put in place for the central complaints office to pass information about complaints to senior custody managers.

Health care

2.25 There was no national oversight or organisation of health services which varied considerably. There had been some local liaison with commissioners of offender health services, or with a local police force. Clinical governance was not understood or implemented, and where contracts with providers existed, they were inadequate.

2.26 In records that we examined, detainees had to wait over an hour on average to see a health care professional, and sometimes much longer. At Dover, most consultations were by telephone. No detainee had seen a health care professional at an interview suite, although 10 had reported medical conditions and illnesses. Only five custody suites had a designated medical room, one of which was multi-purpose. First aid equipment was unsuitable and out of date. There were no defibrillators in suites.

2.27 Staff had received inadequate first aid training, and there was heavy reliance on paramedics or first aid staff from the airports, with no formal arrangements in place.

2.28 Clinical records were inconsistent. Management of medications was a concern at Colnbrook, and prescribing was a concern at Colnbrook and Dover. X-ray arrangements across suites were inconsistent.

2.29 No substance misuse services were available, and mental health services were poor, relying on contracted health professionals. Staff had very little awareness of substance misuse and mental health conditions.

Main recommendations

2.30 There should be national standards for the health care of detainees in the custody of Border Force, with local implementation arrangements.

2.31 Management and other relevant information should be used to develop an estates strategy, including a review of the appropriateness of current estate facilities.

3. Strategy

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

Strategic management

3.1 A director provided strategic leadership on custody which was devolved to regional areas. A recently appointed assistant director, supported by a central custody team, was responsible for policy and procedure on custody matters.

3.2 There were nine designated custody suites in England, consisting of five spine suites with cell facilities and four interview suites. There was one spine suite and three interview suites in Scotland; the suites at Prestwick and Aberdeen were not inspected due to low throughput.

3.3 There was no clear estates strategy. The current estate had been inherited from HM Revenue and Customs (HMRC), based on the need for custody spine suites throughout the UK. A review of facilities at the current sites was in progress. A new custody facility was due to open at Gatwick Airport in April 2013 when the existing facility would close. Border Force was considering the findings, as yet unpublished, of the Chief Medical Officer which could influence the estates strategy.

3.4 In most, but not all cases the suites were staffed by officers trained in custody work, as required by Border Force policy. Dedicated custody officers staffed Colnbrook, Gatwick and Dover spine suites; they told us that any gaps were filled by other officers, of whom most, but not all, had been trained for custody work. The less busy spine suites at Glasgow, Birmingham and Manchester and all interview suites were staffed on an ad hoc basis by officers drawn from the team fulfilling all Border Force tasks for the period of each shift. Some of these teams did not contain any staff trained in custody work, but still had to provide staff for custody work when required.

3.5 Serco were contracted to provide custody assistants at the Colnbrook spine suite; their primary responsibility was the care and welfare of detainees. Detainee visits remained the responsibility of the custody officer. At Gatwick, the dedicated custody officer was supported by another trained custody officer who undertook the custody assistant role, including visits. These officers were rotated every three months, which was good practice. Untrained staff undertook the custody assistant role in the other suites, however, their duties and responsibilities differed considerably from those of custody officers.

3.6 Custody resources were managed by area management structures. Some had higher officers dedicated to custody and in Scotland we were told that only senior officers could authorise the detention of suspected internal drug traffickers, unlike England. The use of the compound penalty disposal also varied between areas, with custody records generated in some areas but not others. Custody records were paper based and custody packs contained forms from agencies previously responsible for the customs custody service. The packs also varied between areas.

3.7 The director chaired a custody specific bimonthly strategic delivery group meeting attended by Grade 7 officers from each area. The assistant director chaired a monthly practitioner group

meeting attended by senior and higher officers from the areas and the training and professional standards department. Custody practitioners also attended this meeting.

3.8 A procedure for dealing with serious incidents in custody was due to be implemented. This involved referral to the Border Force Command and Control Unit and advising the duty senior officer. There was no form to record the incident and no formal procedure to ensure effective follow up.

3.9 A quality assurance procedure for dip-sampling custody records operated inconsistently across suites and we saw evidence of outcomes being recorded and fed back to staff, although this was not always done. Different versions of the person escort record form were used across areas and there was no knowledge of the form in Scotland, which was a recent addition with the commencement of the Single Scottish Police Force in April 2013.

3.10 Border Force had reviewed the custody policy for Scotland which had been redrafted and communicated to staff. The policy for England was due to be reviewed in line with the Association of Chief Police Officers (ACPO) approved Safer Detention and Handling of Persons in police custody (SDHP) 2012 guidance; this needed to be done as a priority. A number of operating procedures had recently been issued through the interim operational instructions process, but had not yet been developed into a single document of standard operating procedures or linked to training and development of staff. The policies and operating procedures were not yet available on the newly developed custody-specific intranet site, and there was limited awareness of the Independent Police Complaints Commission Learning the Lessons documents.

Recommendation

3.11 The Border Force custody policy should be updated as a priority in line with the Association of Chief Police Officers' approved Safer Detention and Handling of Persons in police custody (SDHP) 2012 guidance for England and Wales and the ACPO Custody Manual of Guidance 2012 in Scotland.

Housekeeping points

3.12 Untrained staff should not be deployed in custody suites.

3.13 The feasibility of implementing an IT based custody system should be explored to achieve greater consistency in outcomes for detainees, effective monitoring of performance and provision of management information.

3.14 The procedure for the initial recording of serious incidents should be reviewed to ensure an audit trail of recording, actions, referral and learning.

3.15 Standard quality assurance procedures for custody suites should be embedded in all regions and fed back to staff for individual and organisational learning. Custody record dip-sampling, person escort record checking and monitoring of handovers should be cross referenced.

3.16 A custody-specific link should be placed on Border Force intranet pages.

Partnerships

3.17 Partnership arrangements varied across regions. The director had sought guidance from ACPO on developing custody procedures and had asked Offender Health to include Border Force in the programme for commissioning health services in police custody. The lack of strategic governance of health services was a concern and the appointment of a clinical director for health care was being considered. Border Force was represented on the ACPO National Custody Forum in England and Wales and on the ACPOS custody group in Scotland.

3.18 With the exception of Manchester, there was no independent custody visiting scheme. Opportunities were being explored for Dover, Colnbrook, Gatwick and Birmingham to link in to police force schemes. An earlier scheme at Glasgow was to be reinstated.

Recommendation

3.19 The strategic governance of health services in custody should be reviewed to ensure effective outcomes for detainees.

Learning and development

3.20 Most officers had undergone custody-specific training before undertaking custody duties, although staff identified occasions when untrained staff had performed the custody officer role (see section on strategic management). The existing training package was based on outdated policies and did not include the ACPO approved SDHP guidance. One week's training was provided in England and only one day in Scotland. Some staff who had received very little training and undertook the duties infrequently lacked experience and the opportunity to develop their skills. The training package was being revised to address these issues and there were plans to retrain all custody staff and to introduce a custody refresher training programme in early 2013. Additional health care training, including custody early warning signs, was also planned. By contrast, Serco custody assistants received six weeks' training before taking up their role, although this did not include training in restraint.

Recommendations

3.21 SDHP-based custody training should be implemented for all staff who undertake the custody officer and custody assistant roles.

3.22 Regular custody refresher training should be introduced.

4. Treatment and conditions

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

Respect

4.1 Cellular vehicles were used for the transport of detainees in England and we inspected vehicles at Manchester, Gatwick and St Pancras. They were clean and provided drinking water but did not have escape hatches. Staff had a clear view inside the compartments. The vans were equipped with a cassette toilet for the use of detainees who were passing packages of drugs through their digestive system. Privacy was less good in the cellular vehicle in use at St Pancras. If two detainees were in the vehicle and one needed to use the toilet, it would be in view of the other detainee.

4.2 In Scotland, detainees were transferred between suites, hospitals or police stations in estate cars, which were clean, safe and comfortable. Detainees were accompanied by the driver and a minimum of two escorting officers. Detainees sat behind the front passenger seat, wearing a seatbelt and handcuffed, which we were told was Border Force policy. Individual risk assessments were not taken into account and this practice was not justified or proportionate.

4.3 Staff we spoke to appeared confident in their role, although at most of the sites we inspected, we did not see them engaging with detainees. Many had worked in the custody suite for several years. They had not received formal refresher training in the previous five years. Two detainees whom we spoke to at Colnbrook and Gatwick said that staff were consistently responsive and helpful.

4.4 Most suites had booking-in desks of appropriate height to communicate with detainees. We did not observe detainees at the desks, but were told that they were booked in one at a time while other detainees waited in an interview room or holding area.

4.5 The custody staff we spoke to had a reasonable understanding of diversity and had received diversity training, albeit not recently. They ensured that female staff dealt with female detainees, including those with children, and, if there were no female staff on duty, Border Force staff from other areas of border controls were called on for support. However, they had not always received custody training and took on a restricted role. If a pregnant detainee arrived, staff consulted the forensic medical examiner to determine if she was fit to be detained.

4.6 Some custody staff had received safeguarding training, for example at Dover. We examined records of detainees brought into the custody suite with their children. At Manchester we were told that children remained with their parent/carer at all times and were placed in the consultation room while children's services were contacted to arrange a placement with an appropriate family member, or in care. At Dover one record indicated that the custody officer had gone to great lengths to get a seven-year-old removed from the custody suite to an appropriate carer by children's services. However, there were two further records which did not show any contact with children's services, and children, one as young as three accompanied by an older sibling, were left unsupervised in an unlocked cell while the parent was interviewed. A child welfare control sheet was opened for every child brought into the custody suite which recorded all the child's activities while in the suite and this was handed to

children's services. The custody suite, and particularly a cell, was not an appropriate place for children.

4.7 Custody staff were used to dealing with detainees of different ethnicity and culture, and interpretation services were used when necessary. We saw records of contact with embassies, high commissions or consulates if a foreign national detainee requested it or if it was a requirement. In our analysis of custody records in Scotland, the ethnicity of detainees was not recorded.

4.8 There were few specific adaptations for disabled or older people in the custody suites, although most bed plinths were a reasonable height and there were good quality firm mattresses. There were no adapted shower or toilet facilities. Some suites were easily accessible by wheelchair users – Gatwick and Colnbrook, for example, where ramps and lifts had been fitted, although cell call bell buttons were placed too high. Booking-in areas indicated the availability of hearing loops, although they were not always provided, for example at Edinburgh.

4.9 Religious observance artefacts and books were kept in all custody suites, including prayer mats and compasses, and detainees were informed of their availability. The artefacts were generally stored respectfully, and, if they were not, this was rectified during the inspection. The direction of Mecca was indicated in some suites, Gatwick and Colnbrook for example. Not all interview suites had religious observance artefacts and books.

4.10 There was some awareness of how to treat transgender detainees and staff told us that they asked the detainee how they wished to be searched and this was carried out in private. Staff did not routinely ask about obligations to dependants but enabled detainees to make telephone calls to make arrangements if it did not affect the investigation.

Recommendations

4.11 When it is deemed necessary to keep accompanying children with their parents who have been arrested, they should not be left unsupervised and should be held in locations other than in cells with their parents.

4.12 Custody suites should be accessible to detainees with disabilities.

4.13 The safety implications of the lack of escape hatches in cellular vehicles should be established and, if necessary, vehicles should be adapted to allow a means of egress in the event of fire or collision.

Housekeeping points

4.14 Toilets in cellular vehicles should be screened from the view of detainees.

4.15 The ethnicity of detainees should be recorded on all custody records (Scotland).

4.16 Each suite should be equipped with a hearing loop.

4.17 Interview suites should be equipped with religious observance artefacts and books.

4.18 Staff should be made aware of the contents of Annex L, PACE Code C in respect of searching transgender detainees.

4.19 All detainees should be asked about their obligations to dependants and given the opportunity to make arrangements.

Safety

4.20 Custody staff said they were usually notified when a detainee was being brought to the suite which enabled them to ask for information about the detainee and any risk issues before they arrived. Police National Computer (PNC) checks were undertaken before the risk assessment was completed. Our analysis of custody records indicated that the PNC had been checked in 66 of the 75 completed risk assessments. These checks had to be telephoned to the National Coordination Unit (NCU) and staff said that some custody staff preferred to do the checks themselves or ask the detaining/arresting[2] officers to do so.

4.21 A standard risk assessment pro forma was used at all suites. Custody officers had been trained in risk assessment and talked of the importance of spotting non-verbal communication, making visual assessments, and asking about mental and physical health. Staff appeared sympathetic to the anxiety that detainees felt following arrest and told us that they explained to detainees why personal questions about their health were necessary.

4.22 Risk management was inconsistent: for example, at Colnbrook a detainee had been allowed to keep his jewellery despite a history of self-harm, whereas in other suites custody staff automatically removed detainees` shoes, jewellery and clothes with cords. At interview suites, all detainees were subject to constant observation by an officer outside the room while detainees were waiting for interview. Risk assessments did not indicate whether it was the detainee's first time in custody.

4.23 In our analysis, all but one custody record included a standard risk assessment form which was clear and logical and included prompts about potential vulnerability and when the detainee had last eaten and slept. Observation levels were based on the risk of a detainee having smuggled or concealed packages rather than a full range of risk factors.

4.24 Our custody record analysis indicated several failures at Gatwick and Colnbrook to record or review information about potentially serious health conditions. The risk assessment of a detainee at Gatwick identified that he was taking medication, but not that he had diabetes and high blood pressure. A health care professional was called after the detainee had been in custody for five hours and medication was prescribed. Not all the risk assessments and care plans that we examined appeared to be dynamic, but staff said that they amended risk assessments if there was a change in circumstances during detention.

4.25 Staff told us that very few detainees arrived under the influence of alcohol or drugs and a recent notice had outlined the procedure for rousing detainees who were intoxicated.

4.26 Each custody spine suite had cells with CCTV and detainees located in these cells were told that they were being monitored. Custody staff sat in the monitoring room to observe detainees and undertook cell visits. The CCTV system at Birmingham was not fully operational and technical problems had remained unresolved for several months.

4.27 There was no use of rip-proof or safety clothing for exceptional circumstances for detainees at risk of self-harm. Staff did not carry ligature knives and a knife was usually kept on a set of cell

[2] In England and Wales, the taking of a person`s liberty is defined as being 'arrested`; in Scotland the term is `detained`.

keys or behind the booking-in desk. Not all custody staff were familiar with the `learning the lessons` information that was emailed to them.

4.28 Newly trained custody staff at Edinburgh and Glasgow knew that a person escort record was to be introduced, but did not know when it should be completed. We were told that staff briefed those taking over from them on the next shift, although there was no evidence of written handover notes being recorded.

4.29 A comprehensive pre-release risk assessment (PRRA) form had recently been introduced by Border Force, though not all staff were aware of it. This form focused on current risk factors and their potential impact on the detainee's release. Many detainees were released from other establishments, such as police stations, and there was an assumption that the police PRRA form would be used in these cases.

4.30 Border Force staff rarely provided information leaflets and it was unclear how they supported vulnerable detainees, other than assisting them to get home: not all sites had access to petty cash for this purpose. However, in one case Border Force had arranged and paid for hotel accommodation for a vulnerable detainee released late at night, and at Glasgow staff had used social services to house a foreign national in a local hostel. Vulnerable detainees at Glasgow were given a comprehensive leaflet with a list of support agencies when they left the custody suite, but this was only available in English.

Recommendations

4.31 Care plans for detainees at risk of self-harm should include information from risk assessments to ensure effective management of potential risk factors.

4.32 All custody staff should carry anti-ligature knives while on duty in the custody area.

4.33 Pre-release risk assessments should be thorough and based on an ongoing assessment of detainees' needs while in custody. The custody record should reflect the position on release and any action that needs to be taken.

4.34 Risk management should be proportionate to the individual risk assessment of the detainee.

Housekeeping points

4.35 The result of the PNC check should be entered clearly on the custody record.

4.36 All risk assessments and care plans should specify if it is a detainee's first time in custody and the level of observation required.

4.37 The CCTV system at Birmingham should be fully operational.

4.38 Strip/safety clothing should be made available for exceptional circumstances.

4.39 A leaflet containing information about support organisations should be given to vulnerable detainees on release.

Use of force

4.40 None of the custody records that we examined indicated that detainees had been strip-searched and detainees could have been strip-searched before arriving at the suite. Strip-searches in the custody suites were undertaken in a private area, usually a room or a cell that did not have CCTV coverage.

4.41 We received varying accounts from staff about the regularity of personal safety training (PST). Some had completed PST level 2 training every two years instead of annually; others had received PST annually, but many said they had not been trained to level 3 and could not therefore apply handcuffs. PST level 3 training was to take place in May and July 2013. Custody staff described the de-escalation techniques they used and said that the use of force was rare.

4.42 The use of handcuffs varied across suites and staff needed guidance on their use. In some suites if any detainee had to be taken anywhere in a vehicle, for example between terminals, they were handcuffed, with two or three escorts, which was disproportionate unless justified by individual risk assessment. The only exception was a detainee with a medical condition that prevented the use of handcuffs. In other areas, handcuffs were used infrequently. In our analysis of custody records, risk assessments showed that 25 detainees had arrived in handcuffs.

4.43 A use of force form had recently been introduced at some sites, but not all staff knew where it was kept or how to complete it. The policy stated that the form should be completed within 24 hours of an incident and emailed to the National Arrest Team coordinator. The forms focused on providing information to plan staff training, rather than monitoring the treatment of detainees and facilitating management oversight of the use of force. Some staff we spoke to did not know when force should be used or that it was good practice to ask detainees if they wanted to see a health care practitioner after use of force.

Recommendations

4.44 Custody staff should have appropriate, up-to-date personal safety training to work in a custody environment.

4.45 Detainees should only be handcuffed when it is necessary, justified and proportionate.

Housekeeping points

4.46 The use of strip-searching should be noted on the custody record.

4.47 Staff should be told how and when to complete a use of force form, and data from the forms should be analysed to identify and address trends.

Physical conditions

4.48 Most custody suites were clean and bright and staff took pride in their surroundings. There was no graffiti in most cells and, where there was, it was minimal. Few cells had toilets or hand-washing facilities. Most cells had natural light.

4.49 Cells were clean and most had individual temperature control, although a detainee at Colnbrook told us that he was very cold. Contract cleaners attended the suite every day and custody staff cleaned up minor spillages in their absence.

4.50 The suite at Glasgow contained four cells and two interview rooms. The cells had wooden walls and doors, fixed chairs and a bed plinth and no natural light. False ceilings consisting of tiles with air vents provided several ligature points. Staff recognised that the cells were not safe and local instructions ensured that a detainee was never left unattended. Border Force was in negotiation with the British Airports Authority to improve security. There were several cells at Manchester with loose screws securing ventilation grilles, providing ligature points.

4.51 Interview suites had no cells and presented a problem for detainee accommodation, although their detention was for shorter periods. Most of the interview rooms at St Pancras were clean but there were no facilities for detainees to lie down. One interview room had been designated for the use of families. It contained a cot and bean bags for children to sit on, but it was bleak and would have benefited from a rug on the hard grey floor.

4.52 With the exception of Glasgow and Edinburgh, custody staff undertook systematic cell checks, either daily or immediately before the site opened to receive a detainee. These were recorded but it was unclear if the checks were subject to management scrutiny. .

4.53 We were told that faults were repaired in reasonable time, for example during the inspection a faulty light in the medical room in Dover was expected to be dealt with within 24 hours. We were told that the use of cell call bells was always explained to detainees.

4.54 Most suites had had a fire evacuation exercise in the previous 12 months, although a few staff were unsure of the procedure.

Recommendations

4.55 Glasgow spine suite should be refurbished to the required standard to hold detainees safely.

4.56 All sites should receive daily and weekly checks for safety and any necessary repairs, which should be recorded systematically and regularly checked.

Housekeeping points

4.57 Every interview suite should have an area in which a detainee can lie down.

4.58 All cells and interview rooms should be adequately heated.

4.59 The interview room at St Pancras designated for families with children should be clean and suitably equipped for its purpose.

Detainee care

4.60 All cells had a mattress and detainees were given a clean blanket and pillow, which were in good condition. Cells with toilets all had toilet paper.

4.61 All detainees using the specimen isolation units had to lower their one-piece paper suits to sit down, so that they were effectively naked, although staff kept the door from the corridor to the toilet closed while it was in use to maintain detainees' privacy. Detainees were often transported in paper suits with ordinary clothes on top.

4.62 Showers and wash basins off the main corridors were clean and in working order. At Glasgow the shower cubicle had a waist-high glass screen so that detainees suspected of swallowing drugs could be supervised while taking a shower; with lower-risk detainees, the door was closed.

4.63 Our analysis of custody records in spine suites showed that 15 detainees had taken a shower while in custody. All but one detainee held for more than 12 hours had been offered a shower, and two detainees who had been held for more than 72 hours had had four and six showers.

4.64 All spine suites offered shower kits, with toothbrushes and paste, razors, cotton towels and hygiene products for women. Staff at Edinburgh said that they did not routinely offer hygiene products to females, although they were available.

4.65 There was little replacement clothing except for paper suits and blue overalls, and in a few suites footwear, such as slippers, and replacement underwear. Most detainees had clothes in their luggage, but, if a detainee did not have suitable items, staff went out to buy clothes. Most sites had facilities for storing detainees' property securely.

4.66 Kitchen areas were clean with microwave ovens to prepare `ready` meals. If microwave meals were not available, staff bought a range of good quality meals from local shops or canteens, often in the terminal complex. Detainees were given a choice of meal and there were funds to buy meals to meet particular diets. Detainees were asked when they last ate and a meal was provided accordingly. A range of hot and cold drinks were available. One detainee we spoke to said the food was tasty and there was plenty of choice.

4.67 Our analysis of records showed that 41 detainees had been offered at least one meal while in custody. Ten detainees who had not been offered a meal had been in custody for an average of two hours. The longest period in custody with no meal offered was 6 hours 12 minutes.

4.68 Colnbrook was the only suite with an exercise yard, but custody staff elsewhere occasionally gave detainees the opportunity to walk around the vehicle dock area supervised by a member of staff and on CCTV. Detainees could be detained for several days and the lack of outdoor exercise was a concern.

4.69 Most custody suites had a range of reading material, such as magazines, books and newspapers; some in foreign languages had been bought from terminal shops to meet the language needs of specific detainees, for example at Glasgow and Gatwick. There were few easy-read books or material appropriate for young people, although some suites had a few children`s books and toys. Staff generally waited for detainees to ask for something to read rather than offer it. In our sample, eight detainees in spine suites had been provided with reading materials. Interview suites did not provide reading material. Detainees were rarely permitted to have visits.

Recommendation

4.70 There should be facilities for outdoor exercise.

Housekeeping points

4.71 Detainees should not have to remove all their clothing at once when using the SIU, unless individual risk assessment justifies this.

4.72 Female detainees should routinely be offered hygiene packs.

4.73 Replacement underwear for men and women should be available at all suites.

4.74 A range of reading material should be available and routinely offered, including books and magazines in easy-read format and suitable for young people.

4.75 Visits should be allowed in exceptional circumstances for vulnerable detainees or those held for long periods.

5. Individual rights

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

Rights relating to detention

5.1 Custody officers clarified the reasons for detention with arresting or detaining officers to confirm that they were appropriate. Only one member of staff whom we spoke to had refused to accept a detention, although, anecdotally, staff at Gatwick knew of colleagues who had refused to accept detentions on the grounds of insufficient evidence. If detention was refused, arresting officers could appeal to the duty senior officer. In Scotland, custody officers did not authorise detention, which was the responsibility of the higher officer.

5.2 Our analysis of custody records showed that detention had been authorised in all but one case. No reason had been given but the detainee had only been held for 45 minutes and staff had known that he would be released quickly.

5.3 Alternatives to custody used at most suites were known as 'compound penalties'. These were formalised under Section 152(a) of the Customs and Excise Management Act (CEMA) 1979, which allowed a detainee to pay a penalty out of court, as an alternative to criminal prosecution for an alleged customs offence of a less serious nature. The payment of a compound penalty did not constitute a criminal conviction, but detainees were warned that, if they were convicted of any offence in respect of a drug specified in Schedule 2 of the Misuse of Drugs Act 1971 within the next five years, details of the compound penalty could be disclosed to the court.

5.4 Detainees were taken promptly to custody suites/interview rooms after arrest, although detainees arrested at Coquelles in France could experience significant delays in reaching the Dover custody suite depending on the time of arrest, the availability of transport and the next channel tunnel crossing. One record showed that the detainee had been arrested at 12.38am and arrived at Dover at 5.21am.

5.5 Spine suite records showed that 69% (35) of detainees had spent less than 12 hours in the custody suites. All detainees who had spent more than 72 hours in the suites had been held while waiting for packages to pass through their system which could take four to five days. In such circumstances, custody staff secured a Section 152 remand under the Criminal Justice Act 1988 (not Scotland) to hold the detainee for an extended period. Special courts were convened if a remand was sought outside working hours which could necessitate the detainee travelling to the court, with associated risks.

5.6 Border Force did not have the legal power to charge or bail detainees, who had to be taken to a police station for this purpose. This seemed unnecessary. (This is not applicable to Scotland as there is no bail process there; however, this is currently under review.)

5.7 An appropriate adult was present for any detainee aged 17 and under and for any vulnerable adult. In our sample of records, no detainees under the age of 17 had been held. Some staff said they would use the detainee's family or friends in the first instance to act as an appropriate adult, while others indicated they would not do this in case the family member or friend was involved in the alleged offence. Appropriate adults were supplied by private contractors, volunteers or local social services.

5.8 There was no formal appropriate adult scheme at Birmingham, where Solihull Social Services were used and we were informed that, on occasion, a member of airport staff (as at Glasgow and Gatwick) was used. Gatwick staff were able to contact the Appropriate Adult Service (TAAS) but in the first instance they used West Sussex Social Services who had a social worker at one of the terminals during the working week to cover immigration cases. At Manchester, the Greater Manchester Police Authority provided trained volunteer appropriate adults between 8.30am and 4.30pm for juveniles and vulnerable adults, after which the Salford emergency duty team was used. Dover relied solely on Kent County Council children's services for appropriate adults for juveniles and vulnerable adults. At St Pancras, staff called on one of the two station chaplains to act as an appropriate adult and said that there was never any delay or difficulty in securing their attendance.

5.9 Suites in Scotland had recently been supplied with details of the Scottish Appropriate Adult Network, but none of the staff we spoke to had had occasion to use it.

5.10 All custody officers had received safeguarding training and understood the procedures; juveniles and vulnerable adults were not often detained.

5.11 Staff provided all detainees being booked in with a leaflet summarising their rights and entitlements, which could be downloaded and printed in their own language for a non-English speaking detainee. There were 27 foreign nationals in the records that we sampled. Six of these detainees had been given information about their rights but it was unclear whether the remaining detainees had been given this information. Detainees had been asked if they required their high commission, embassy or consulate to be notified and 14 detainees had accepted this offer. The rights and entitlements information was not available in a pictorial, easy-read format or in Braille and we were told that information was given verbally if detainees could not read.

5.12 Access to telephone interpretation services was good and a number of services had been used during the booking-in process. At Dover two different telephone interpretation services were used depending on whether it was an HM Revenue and Customs or Border Force case. Edinburgh, Glasgow and Birmingham did not have two-handset telephones, while Gatwick used a second telephone to facilitate a three-way conversation.

5.13 Staff told us that an effective face-to-face interpreter service was available for interviews, but there were occasional delays. In our record sample, 15 detainees had needed an interpreter. The average waiting time for an interpreter was 87 minutes. One interpreter had taken four hours to attend at Gatwick, which had delayed custody procedures.

Recommendations

5.14 Court-video links should be available in all custody spine suites to reduce the incidence of detainees suspected of ingesting drugs being conveyed to courts.

5.15 Border Force should have the power to charge and bail suspects.

5.16 Appropriate adults should be available out of hours to support juveniles aged 17 and under and vulnerable adults in custody.

Housekeeping points

5.17 Foreign nationals should be provided with a copy of their rights and entitlements in their native language and this should be noted on the custody record.

5.18 Two-handset telephones should be provided in all suites to facilitate telephone interpretation services.

Rights relating to PACE

5.19 In Scotland, legal advice was provided by the Scottish Legal Aid Board and in England by the Defence Solicitors Call Centre, who were contactable 24 hours a day. Posters were displayed at some sites in a range of languages advising detainees of their right to free legal advice. We spoke to one duty solicitor who felt that custody staff adhered to PACE. With the exception of Colnbrook, staff in England photocopied custody records on request for solicitors; in Scotland solicitors had to apply to the Procurator Fiscal for a copy.

5.20 Our analysis of custody records showed that all detainees were offered legal advice; 38 detainees had accepted the offer and 11 had declined, with no reason given on the custody record. Some suites had mobile handsets which detainees could use to speak to their legal representative in private. Solicitors had been contacted for the 38 detainees and they attended at a time agreed with staff. Notices in the Edinburgh and Glasgow suites explained that a copy of CCTV footage could be requested up to 28 days after the period of detention.

5.21 Two detainees at Glasgow had not had legal representation despite requesting it. One detainee declined an alternative when staff were unable to contact his solicitor and, in the second case, the duty solicitor refused to attend until the detainee had been certified by a doctor as fit to be interviewed as the detainee had potentially swallowed drugs. Staff had pointed out to the solicitor that the detainee was being denied his legal rights and the solicitor agreed to attend if the detainee consented to an x-ray before receiving legal advice. There was no record of the solicitor attending before the detainee was released into immigration detention.

5.22 Detainees were told during booking in that they could inform someone of their arrest. Our analysis of spine suite records indicated that 32 detainees had wished to do this and in 24 cases there was evidence that staff had tried to contact the nominated person. In Birmingham and Glasgow it was unclear why the person had not been contacted, whereas in Manchester and Gatwick, it was recorded that the person had not answered the telephone. Police had seized the phones of four detainees, on which their contacts were stored, and staff had been unable to respond to their request to contact someone.

5.23 Detainees were allowed to make a telephone call during their time in custody and we observed one detainee at Gatwick calling his mother to tell her of his detention. Records showed that 21 detainees had made a telephone call while in custody. We saw evidence of investigating officers securing authorisation for the detainee to be held incommunicado and this was noted in the custody record and explained to the detainee.

5.24 Copies of the PACE codes of practice (not applicable in Scotland) were available in all suites, albeit only Code C in some. Detainees were told during the booking-in process that they could read these codes.

5.25 We were told at all sites that it was very unusual for detainees to arrive under the influence of alcohol or drugs. If this happened, staff contacted the forensic medical examiner to confirm that the detainee was fit to be detained and sought advice on levels of observation and when the detainee would be fit to interview.

5.26 We observed one PACE Review[3] which was conducted thoroughly; we were told that telephone reviews were rare. Higher officers, who conducted the six- and nine-hour reviews, and senior officers, who conducted the 24-hour review, were clear about the purpose of the review and the importance of progressing the case and giving the detainee the opportunity to exercise any rights that he had previously declined. The timing of first reviews differed between suites, for example at Colnbrook five reviews had taken place early, one by as much as three hours, and one had been late by four hours. At Dover six reviews had taken place early, one by four hours. Early or late reviews were usually caused by the detainee arriving from another location or to accommodate the detainee's rest period.

5.27 All detainees held for more than six hours received a review (see footnote).

Housekeeping points

5.28 Legal advice posters should be displayed at all suites.

5.29 Custody staff should provide a copy of the custody record to the detainee and/or solicitor on request.

5.30 If detainees decline the offer of legal advice, they should be invited to give their reasons which should be noted in the custody record.

5.31 If custody staff fail to contact the detainee's nominated person, custody records should indicate that attempts have been made and an offer has been made to the detainee to nominate another person.

5.32 Reviews should be undertaken on time where possible, subject to operational requirements.

Rights relating to treatment

5.33 Most staff we spoke to were unclear how to deal with a detainee who wished to make a complaint. Some recent posters were displayed at some sites, advising detainees to write to or email a UK Border Agency address which we confirmed was accurate. At Birmingham, a notice advised detainees to write to or email a Border Force address in Dover, but the email was returned as undeliverable when we tried to use the address. 'How to complain' booklets with a complaints registration form were available in some suites, but staff did not always know where they were kept.

5.34 Custody staff said that they rectified simple complaints immediately, such as cold cells or not having anything to eat, and reviewing officers confirmed that they asked detainees during reviews if they had any complaints to make.

[3] PACE legislation is not applicable in Scotland and while an SO is responsible for reviewing cases, there is no formal timetable in which this should take place other than at three hours and after 24 hours when application must be made to a Sheriff to grant a warrant for continued detention in custody.

Recommendation

5.35 The complaints procedure should be simplified and staff should be aware of it; detainees should be given the opportunity to make a complaint while in custody.

6. Health care

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

Governance

6.1 There was no national oversight or management of health services. The provision of health services had been arranged locally: some contracts had expired; others had no performance measures; and in some cases local police health service staff had been used with no formal arrangements in place.

6.2 Border Force staff in different suites talked of a 'national contract' to start in 2013. In reality, discussions with Offender Health in England had only recently started. Contact had been made with commissioners of offender health services in Sussex and with City of London and Greater Manchester Police, but these were not national or strategic initiatives.

6.3 Clinical governance was not understood by Border Force staff. At Gatwick, Harwich, Luton and Stansted, health services were provided by an external contractor and clinical governance, including the management, training and supervision of staff, was in place. However, the contract at Gatwick did not include response times or penalty clauses and staff at these four sites did not know how the contracts operated. At Birmingham the contract with a local provider had lapsed, and the manager had taken the decision to close the suite. At Dover and Colnbrook local GPs ran their own surgeries while on call for Border Force, and at Manchester two retired GPs provided cover.

6.4 Some suites had a clinical examination room of reasonable standard, although the room at Manchester was also used to search detainees, which could compromise infection control.

6.5 There was limited first aid equipment, some of which was out of date. There was not suitable equipment to deal with accidents or injuries, nor for resuscitation. On the whole, staff relied on airport paramedics, although no formal arrangements were in place. Staff first aid training was basic and some staff that had been trained did not have a good awareness of basic life support, while at the time when we visited Dover, none of the staff on duty was first aid trained.

Recommendations

6.6 All health service contracts should include performance measures and robust monitoring arrangements.

6.7 All Border Force staff should receive adequate first aid training to meet the needs of detainees, and appropriate resuscitation and first aid equipment should be available.

Patient care

6.8 Not all staff offered detainees the opportunity to see a health professional and detainees were not always able to see a professional of their own gender. Our analysis of custody records at interview suites showed that seven detainees had reported medical conditions and illnesses, a health professional had been contacted in only three cases, and none of the detainees saw a

professional while detained in the interview suites. Spine suite records showed that 21 detainees had been unwell or injured and a health professional had been requested in only 10 cases. Relatively long waits were common and the average wait was 1 hour 20 minutes and the longest was 3 hours 9 minutes. Waiting times were not always recorded. A range of illnesses and injuries had been reported, which were referred to in assessments, together with whether the detainee required and could take medication. In Manchester, a detainee who had reported a brain aneurysm was immediately put in touch with a doctor and placed on constant observation. Three detainees had arrived at Glasgow with conditions ranging from high blood pressure to diabetes and asbestosis. A health professional had not been requested for any of the detainees, although two of them remained in the suite for between five and seven hours. The records did not make further reference to these medical conditions during the detainees' time at Glasgow.

6.9 Clinical information was noted in the custody record, but it was not always clear if it had been entered by health staff or Border Force staff after a telephone consultation. Some of the clinical information was confidential and should not have formed part of the custody record. There was no evidence of patient consent being sought for the sharing of information.

6.10 Medicines management was of particular concern. There was variation in the stocks held, and in some suites there were no safe systems for the storage, handling, administration and disposal of medications. In most suites, Border Force staff were expected to administer medications without any formal training. In Scotland, no medications were held in the suites, and staff did not know what to do if a detainee required medication. At Birmingham, the doctor left medications in small bags for staff to administer when required, while at Gatwick a very small stock of over-the-counter medications was held in a locked box and recorded in a loose leaf book. Staff at Gatwick, Manchester, Harwich and Stansted said that, if a detainee required medications, they obtained a private prescription from the doctor which could be fulfilled at a nearby pharmacy. At St Pancras staff told us that they never administered medications.

6.11 The practices at Dover and Colnbrook were of greatest concern. At Dover a small stock of medications was kept in a secure cupboard, with a record of the number of Dihydrocodeine and Diazepam tablets. There was a clear policy for the destruction of unused medications, although we found that some medications dispensed for a named patient had been used as stock. There was evidence of a doctor instructing Border Force staff over the telephone to give a detainee his 'blood pressure' tablet, when the doctor had not seen the patient or the medication. This instruction was entered in the custody record by the staff but was not followed up by a prescription. Staff told us, and records confirmed, that this was common practice.

6.12 At Colnbrook medications were stored in a locked cupboard and the doctor had given staff a private prescription to restock the cupboard on the day before our inspection. About a third of the medications were out of date, a named patient's medications were being used as stock and there was no register of the number of scheduled drugs held.

6.13 There was also evidence that detainees who had swallowed drug packages and were being held at the suite until the packages had been passed, had been given large doses of codeine medications, which were contra indicated when there was a risk of blockage of the small bowel and were known to cause constipation. One detainee had been given 360mg of codeine in a 24-hour period, when the recommended dose was no more than 240mg. Medications were not prescribed in accordance with best practice and we brought this to the attention of managers and the doctor during the inspection.

6.14 Some detainees required body scans and abdominal x-rays to provide evidence that they had packages of illegal drugs inside them. In most cases, the correct procedure was followed to

obtain a detainee's consent and to request the x-ray. At Gatwick, x-rays were taken to the local private hospital which was also undertaking a pilot project of detainees undergoing a CT scan to detect liquid in swallowed packages. At Dover, the detainee was taken to the local hospital for the x-ray and, if packages were seen by the radiographer, the detainee was admitted to an inpatient bed. Detainees with a positive x-ray elsewhere were transported to the nearest spine suite.

Recommendations

6.15 Detainees should be able to see a health professional at any time and should be treated appropriately.

6.16 Detainees who are seen by a health professional should have a clinical record which includes an assessment and care plan conforming to professional guidance from regulatory bodies and in line with Caldicott guidance[4].

6.17 All medications should be stored securely according to relevant legislation. There should be safe pharmaceutical stock management and safe prescribing, and medications should only be administered by staff competent to do so.

Substance misuse

6.18 No substance misuse services were available at any of the suites and staff did not see the need for them. One member of staff said he would tell a detainee who declared alcohol or drug addiction to see their GP, but he did not see it as his responsibility to do any more. At Birmingham a leaflet was given to detainees on release which gave details of support agencies, including the local drug and alcohol action team and Alcoholics Anonymous.

Recommendation

6.19 A substance misuse service should be provided for detainees.

Mental health

6.20 Mental health services were poor and there was no access to mental health liaison or diversion schemes. Border Force staff relied on the contracted health professionals, who, in some cases, gave vague responses to us on how they would manage a detainee who displayed signs of mental illness.

Recommendation

6.21 There should be a liaison or diversion scheme for detainees with mental health conditions.

[4] The use and confidentiality of personal health information

7. Summary of recommendations

Main recommendations

7.1 There should be national standards for the health care of detainees in the custody of Border Force, with local implementation arrangements. (2.30)

7.2 Management and other relevant information should be used to develop an estates strategy, including a review of the appropriateness of current estate facilities. (2.31)

Recommendations

Strategy

7.3 The Border Force custody policy should be updated as a priority in line with the Association of Chief Police Officers approved Safer Detention and Handling of Persons in police custody (SDHP) 2012 guidance for England and Wales and corresponding guidance in Scotland. (3.11)

7.4 The strategic governance of health services in custody should be reviewed to ensure effective outcomes for detainees. (3.19)

7.5 SDHP-based custody training should be implemented for all staff who undertake the custody officer and custody assistant roles. (3.21)

7.6 Regular custody refresher training should be introduced. (3.22)

Treatment and conditions

7.7 When it is deemed necessary to keep accompanying children with their parents who have been arrested, they should not be left unsupervised and should be held in locations other than in cells with their parents. (4.11)

7.8 Custody suites should be accessible to detainees with disabilities. (4.12)

7.9 The safety implications of the lack of escape hatches in cellular vehicles should be established and, if necessary, vehicles should be adapted to allow a means of egress in the event of fire or collision. (4.13)

7.10 Care plans for detainees at risk of self-harm should include information from risk assessments to ensure effective management of potential risk factors. (4.31)

7.11 All custody staff should carry anti-ligature knives while on duty in the custody area. (4.32)

7.12 Pre-release risk assessments should be thorough and based on an ongoing assessment of detainees' needs while in custody. The custody record should reflect the position on release and any action that needs to be taken. (4.33)

7.13 Risk management should be proportionate to the individual risk assessment of the detainee. (4.34)

7.14 Custody staff should have appropriate, up-to-date personal safety training to work in a custody environment. (4.44)

7.15 Detainees should only be handcuffed when it is necessary, justified and proportionate. (4.45)

7.16 Glasgow spine suite should be refurbished to the required standard to hold detainees safely. (4.55)

7.17 All sites should receive daily and weekly checks for safety and any necessary repairs, recorded systematically and regularly checked. (4.56)

7.18 There should be facilities for outdoor exercise. (4.70)

Individual rights

7.19 Court-video links should be available in all custody spine suites to reduce the incidence of detainees suspected of ingesting drugs being conveyed to courts. (5.14)

7.20 Border Force should have the power to charge and bail suspects. (5.15)

7.21 Appropriate adults should be available out of hours to support juveniles aged 17 and under and vulnerable adults in custody. (5.16)

7.22 The complaints procedure should be simplified and staff should be aware of it; detainees should be given the opportunity to make a complaint while in custody. (5.35)

Health care

7.23 All health service contracts should include performance measures and robust monitoring arrangements. (6.6)

7.24 All Border Force staff should receive adequate first aid training to meet the needs of detainees, and appropriate resuscitation and first aid equipment should be available. (6.7)

7.25 Detainees should be able to see a health professional at any time and should be treated appropriately. (6.15)

7.26 Detainees who are seen by a health professional should have a clinical record which includes an assessment and care plan conforming to professional guidance from regulatory bodies and in line with Caldicott guidance. (6.16)

7.27 All medications should be stored securely according to relevant legislation. There should be safe pharmaceutical stock management and safe prescribing, and medications should only be administered by staff competent to do so. (6.17)

7.28 A substance misuse service should be provided for detainees. (6.19)

7.29 There should be a liaison or diversion scheme for detainees with mental health conditions. (6.21)

Housekeeping points

Strategy

7.30 Untrained staff should not be deployed in custody suites. (3.12)

7.31 The feasibility of implementing an IT based custody system should be explored to achieve greater consistency in outcomes for detainees, effective monitoring of performance and provision of management information. (3.13)

7.32 The procedure for the initial recording of serious incidents should be reviewed to ensure an audit trail of recording, actions, referral and learning. (3.14)

7.33 Standard quality assurance procedures for custody suites should be embedded in all regions and fed back to staff for individual and organisational learning. Custody record dip-sampling, person escort record checking and monitoring of handovers should be cross referenced. (3.15)

7.34 A custody-specific link should be placed on Border Force intranet pages. (3.16)

Treatment and conditions

7.35 Toilets in cellular vehicles should be screened from the view of detainees. (4.14)

7.36 The ethnicity of detainees should be recorded on all custody records (Scotland). (4.15)

7.37 Each suite should be equipped with a hearing loop. (4.16)

7.38 Interview suites should be equipped with religious observance artefacts and books. (4.17)

7.39 Staff should be made aware of the contents of Annex L, PACE Code C in respect of searching transgender detainees. (4.18)

7.40 The result of the PNC check should be entered clearly on the custody record. (4.35)

7.41 All risk assessments and care plans should specify if it is a detainee's first time in custody and the level of observation required. (4.36)

7.42 The CCTV system at Birmingham should be fully operational. (4.37)

7.43 Strip/safety clothing should be made available for exceptional circumstances. (4.38)

7.44 A leaflet containing information about support organisations should be given to vulnerable detainees on release. (4.39)

7.45 The use of strip-searching should be noted on the custody record. (4.46)

7.46 Staff should be told how and when to complete a use of force form, and data from the forms should be analysed to identify and address trends. (4.47)

7.47 Every interview suite should have an area in which a detainee can lie down. (4.57)

7.48 All cells and interview rooms should be adequately heated. (4.58)

7.49 The interview room at St Pancras designated for families with children should be clean and suitably equipped for its purpose. (4.59)

7.50 Detainees should not have to remove all their clothing at once when using the SIU, unless individual risk assessment justifies this. (4.71)

7.51 Female detainees should routinely be offered hygiene packs. (4.72)

7.52 Replacement underwear for men and women should be available at all suites. (4.73)

7.53 A range of reading material should be available and routinely offered, including books and magazines in easy-read format and suitable for young people. (4.74)

7.54 Visits should be allowed in exceptional circumstances for vulnerable detainees or those held for long periods. (4.75)

Individual rights

7.55 Foreign nationals should be provided with a copy of their rights and entitlements in their native language and this should be noted on the custody record. (5.17)

7.56 Two-handset telephones should be provided in all suites to facilitate telephone interpretation services. (5.18)

7.57 Legal advice posters should be displayed at all suites. (5.28)

7.58 Custody staff should provide a copy of the custody record to the detainee and/or solicitor on request. (5.29)

7.59 If detainees decline the offer of legal advice, they should be invited to give their reasons which should be noted in the custody record. (5.30)

7.60 If custody staff fail to contact the detainee's nominated person, custody records should indicate that attempts have been made and an offer has been made to the detainee to nominate another person. (5.31)

7.61 Reviews should be undertaken on time where possible, subject to operational requirements. (5.32)

Appendix I: Inspection team

Martin Kettle	HMIP team leader
Peter Dunn	HMIP inspector
Vinnett Pearcy	HMIP inspector
Gary Boughen	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Paul Tarbuck	HMIP health services inspector
Elizabeth Tysoe	HMIP health services inspector
Rachel Murray	HMIP researcher
Helen Ranns	HMIP researcher
Joe Simmonds	HMIP researcher