Report on an unannounced inspection visit to police custody suites in

Northumbria

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

4–12 February 2014
Glossary of terms

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Section 1. Introduction

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

Northumbria covers a large geographical area with a number of custody suites. A new custody suite was due to be opened but the force maintained a good standard in the existing estate. The Police and Crime Commissioner (PCC) was involved in the training and development of an active Independent Custody Visitor (ICV) scheme.

We found custody recording systems to involve a mix of paper and computer records, allowing opportunities for human error and omission in recording both strategic and individual detainee information. The force did not have sufficient focus on learning from adverse incidents or robust quality assurance systems. There were three Independent Police Complaints Commission (IPCC) investigations ongoing during our inspection; none of them had concluded but the force had already been given some learning points. Sadly, a fourth referral had been made concerning a death following the release of a detainee from custody which highlighted the potential risks associated with such releases.

Individual detainee and officer interaction was respectful and sensitive, and in a few cases we saw exceptional individual attention, especially where it was obvious that something was wrong. In most cases risk assessments were often routine and mechanistic, with officers not using their skills to ascertain underlying or undisclosed issues. In some instances, we saw pre-release risk assessments being completed after the detainee had left custody.

We found that handovers could be subject to incorrect recording of risk information. In some instances, we found that notes had not been updated and the handover was conducted based on incorrect information.

We saw good evidence that police officers made efforts to keep children out of custody. However, when cases were more complex police staff did not pursue other options such as the local authority to provide alternative accommodation. We saw two children aged 12 and 13 being held in police cells overnight without any efforts made to provide alternative accommodation.

The force was in the process of developing a new health service specification; however, clinical governance had not improved since the previous inspection, and lacked performance monitoring, clinical audits and an appraisal system. Medical rooms varied in levels of clutter and cleanliness, although some were good.

The use of handwritten health care records meant that in some cases the writing was illegible, a point raised in a previous IPCC recommendation. Staff were also expected to administer medication prescribed by the healthcare practitioner and staff worried about the level of responsibility that this imposed upon them.

There were examples of good multi-agency working around help and support for detainees with a history of substance misuse for adults and young people alike. There was an increasing number of detainees reporting a history of mental health issues; the police force, with help from partner agencies, had provided an improved diversion scheme, helping to keep mentally ill people out of police cells.
We noted that, of the 25 recommendations made in our previous report after our inspection of 1–5 August 2011, four recommendations had been achieved, six had been partially achieved and 15 had not been achieved.

This report provides a number of recommendations to assist the force and the Police and Crime Commissioner to improve provision further. 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.

Thomas P Winsor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

July 2014
Section 2. Background and key findings

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

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

2.3 This was the second inspection of Northumbria Police Service. The first inspection took place in August 2011. The police service was in the process of making changes to its custody provision by opening a new custody suite, while closing existing buildings, but continued to maintain a good standard, which was positive, given the transition.

2.4 We examined the custody strategy, as well as treatment and conditions, individual rights and health care in the custody suites. For the 12 months up to January 2014, there had been 56,840 detainees held in custody suites across the force area.

2.5 The designated custody suites and cell capacity of each was as follows:

<table>
<thead>
<tr>
<th>Custody suite</th>
<th>Area command</th>
<th>Number of cells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle Etal Lane</td>
<td>Newcastle</td>
<td>28</td>
</tr>
<tr>
<td>Sunderland Gillbridge</td>
<td>Sunderland</td>
<td>20</td>
</tr>
<tr>
<td>Washington</td>
<td>Sunderland</td>
<td>14</td>
</tr>
<tr>
<td>Southwick (part-time resilience suite)</td>
<td>Sunderland</td>
<td>29</td>
</tr>
<tr>
<td>South Shields</td>
<td>South Tyneside</td>
<td>30</td>
</tr>
<tr>
<td>Gateshead</td>
<td>Gateshead</td>
<td>18</td>
</tr>
<tr>
<td>Whickham (part-time resilience suite)</td>
<td>Gateshead</td>
<td>10</td>
</tr>
<tr>
<td>Bedlington</td>
<td>Northumberland</td>
<td>20</td>
</tr>
</tbody>
</table>

\(^1\) [http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm](http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm)
Strategy

2.6 The force had no structured means of monitoring and evaluating a number of basic performance areas, owing to the limitations of the computer system, so there was no way of holding managers, staff and partner organisations to account for the delivery of safe detainee care. The current mix of computer- and paper-based records created opportunities for human error and omission.

2.7 There was insufficient focus from senior managers in directing or guiding force policies, quality assurance and learning from adverse incidents in matters of custody and detainee care and safety. The quality assurance process was inadequate and inconsistent, even though there was a template, and there was little oversight from the head of custody. There was no cross-referencing of custody records with CCTV recordings and no quality assurance of handovers. Some custody inspectors did not include person escort records (PERs) in the quality assurance process. There was no analysis to identify trends and areas for improvement.

2.8 All staff working in custody had undergone custody-specific training, and annual refresher courses were provided, although some staff regarded the computer-based e-learning as inadequate. Most staff had undergone attention-deficit hyperactivity disorder training, which was well received by the staff we spoke to, and training overall was well monitored.

2.9 The Police and Crime Commissioner (PCC) office was actively involved in the issue of custody and was developing an active and well-trained independent custody visitors (ICVs) scheme across the police area.

Treatment and conditions

2.10 Custody staff across all the suites were respectful and consideration was given to vulnerable detainees when issues were apparent; in more complex cases, there was a danger that these could be missed. We generally saw sergeants booking in and while physical space for privacy was limited during this process, sergeants did not consider alternatives for the privacy needs of detainees, sometimes in very sensitive circumstances.

2.11 Sergeants were consistent and clear that they would not detain children in custody unnecessarily; we saw evidence of this but we also found instances, in more complex cases, where they had been detained. It was unclear what efforts had been made to ensure that children in more complex cases were kept out of police cells.

<table>
<thead>
<tr>
<th>Custody Suite</th>
<th>Location</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hexham (part-time rural suite)</td>
<td>Northumberland</td>
<td>7</td>
</tr>
<tr>
<td>Alnwick (part-time rural suite)</td>
<td>Northumberland</td>
<td>8</td>
</tr>
<tr>
<td>Berwick (part-time rural suite)</td>
<td>Northumberland</td>
<td>7</td>
</tr>
<tr>
<td>Wallsend/Middle Engine Lane</td>
<td>North Tyneside</td>
<td>40</td>
</tr>
<tr>
<td>North Shields (part-time resilience suite)</td>
<td>North Tyneside</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>251</strong></td>
</tr>
</tbody>
</table>
2.12 The focus on diversity was poor overall. At most suites there were no adapted cells for detainees with disabilities. Women were not asked if they wanted to speak to a female officer or if they might be pregnant, and girls aged 16 or under were not allocated a named female officer.

2.13 Some sergeants appeared to take a formulaic approach to risk assessments, asking only basic questions, mainly following the computer system’s prompts, and the risk assessments we saw provided only a basic level of detail. Custody records showed little evidence of a dynamic, changing assessment or amendment of risk, except when detainees became less intoxicated and rousing checks were lifted.

2.14 Generally, the observations and checks in place for vulnerable or intoxicated detainees were appropriate, although in one suite a DO was monitoring six detainees on constant watch via closed-circuit television (CCTV) while also responding to other duties, which was unsafe. DOs understood what was expected of them when conducting rousing checks.

2.15 The quality of handovers was mixed and, apart from at Middle Engine Lane, there were separate handovers between DOs and sergeants. Most staff relied on the whiteboard for information about the detainee, which we found to contain errors, with no other means of safeguarding the integrity of the information. We also found that staff were issued with questionable advice about how to conduct handovers, expecting incoming sergeants to review the risk assessment for each detainee before the handover. Most custody sergeants chose not to comply with this instruction.

2.16 Pre-release risk assessments were generally weak, and in some cases sergeants completed them after detainees had left the suite.

2.17 The use of handcuffs seemed appropriate and proportionate, but use of force in the custody area was not recorded (other than in the custody log), monitored or analysed.

2.18 The general condition of the custody estate was good. Daily cleaning arrangements were reasonable and maintenance issues were responded to promptly, but at some suites the records of daily cell checks contained significant gaps.

Individual rights

2.19 There had been an increased use of alternatives to custody, such as voluntary attendance, but voluntary attendees were unnecessarily ‘booked-in’ at some of the custody suites. Investigations were progressed quickly, helping to minimise the time that detainees spent in police custody.

2.20 Professional interpreting services were provided appropriately. The force adhered to the Children Act 1989 definition of a child, and contacted appropriate adults (AAs) on behalf of all children under 18. AA provision was generally good for children but less good for vulnerable adults. Local authority accommodation for children who were charged and refused bail was rarely available.

2.21 Rights and entitlements information was available but not routinely offered, and several different versions were in use across the custody suites, most of which were out of date.

2.22 Detainees were told of their rights on arrival in the custody suite. There were no facilities for them to speak to their legal representatives privately by telephone but interview rooms were available for detainees to use for private legal consultation. Solicitors were able to view the custody record. PACE reviews were thorough but many were not conducted on time.
In most cases, detainees were transported to court in a timely manner and courts accepted them up to 2–3pm on weekdays, with some flexibility on a day-to-day basis.

Custody staff told us that if detainees wanted to complain about their treatment in custody they would report this to the duty officer or custody manager. Any progression of the complaint depended on its severity. Some detainees were inappropriately advised to make their complaint after release from custody.

Health care

Clinical governance arrangements for primary medical services were poor. Interactions between clinical staff and detainees were respectful. None of the clinical rooms met expected standards of infection control, and some were cluttered and had damaged or worn fixtures. Custody staff received regular first-aid and resuscitation training and had easy access to emergency equipment, but first-aid kits were not standardised and most contained expired items.

Health provision was reasonable but custody staff said that there were often long delays in forensic medical examiners (FMEs) attending. The time that the FME was called was not recorded in most custody records, making performance monitoring impossible.

Most clinical records were reasonable but the handwriting on some was illegible. Detainees could continue to receive their prescribed medications while in custody.

Some aspects of medication management were good, including standardised stock lists and effective systems to dispose of unwanted medication. However, we found expired medication in some suites and stock levels were incorrect in one. Custody staff administered medications prescribed by an FME, against handwritten prescription charts; most DOs were worried about the high level of responsibility that this imposed on them.

There were effective arrangements for providing methadone and symptomatic relief for substance users. Turning Point provided a good level of support to all adult detainees with drug or alcohol issues; younger detainees with these issues were referred to local youth services.

Mental health diversion services had improved considerably and there was effective multi-professional working. Arrangements for arrests under section 136 of the Mental Health Act 1983 were effective, with few such detainees being taken to custody suites.

Main recommendations

Quality assurance sampling of custody records should be carried out to a consistent standard, including checking against closed-circuit television (CCTV) recordings, person escort records and staff handovers.

Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker, and for the making of any necessary arrangements for treatment or care.
2.32 The force should ensure that learning from adverse incidents has clear management ownership to ensure that there is effective monitoring of trends and areas for improvement, and is communicated to frontline staff.

2.33 The quality and consistency of initial risk assessments should be dynamic and ongoing, ensuring that correct information is considered at all times for the continued safety of detainees.

2.34 Pre-release risk assessments should be detailed, meaningful and the subject of discussion with the detainee before release.

2.35 There should be robust governance arrangements to monitor health service provision, including attendance times, training, supervision and accountability of individual practitioners in their clinical practice.
Section 3. Strategy

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

Strategic management

3.1 An assistant chief constable (ACC) provided strategic leadership on custody issues, with a centralised custody function delivered through a stand-alone custody department. There was a clear management structure, with the head of custody, who was a chief inspector, reporting directly to the ACC.

3.2 The force's long-term estates strategy was nearing completion, with a new police station, containing a 50-cell custody suite, due to open in autumn 2014, reducing the number of full-time suites from seven to five. Despite plans to close some of the suites, they had made efforts to keep the estate well maintained and in good condition.

3.3 The force had policies and procedures on custody but these had not been reviewed to ensure compliance with the guidance (Authorised Professional Practice – Detention and Custody), issued by the College of Policing, on detention and custody.

3.4 Staffing levels in custody suites during the inspection were adequate, although at busier times we found that custody staff were working at full capacity. Staffing comprised permanent custody sergeants and DOs employed by Northumbria Police. Sergeants from other duties and trained in custody were regularly used to cover for permanent custody sergeants. DOs were often moved between suites to cover for workload demands and absences. A number of DOs, known as 'key time workers', provided additional support during night shifts at weekends. The force maintained a number of trained PC gaolers but they were rarely used.

3.5 DOs were responsible for the care and welfare of detainees. They provided a good standard of care and were professional and positive in their role. There were five dedicated custody inspectors, who provided full-time force-wide cover for custody issues, including staff and PACE responsibilities.

3.6 The force's custody computer system could not provide the same level of functionality as more modern systems. As a result, custody records comprised a mix of computer-generated and handwritten forms, creating risks for human error and omission; for example, we saw the whiteboard alone being used to record an action, when it should have been recorded on both this and the custody record. In addition, the system provided minimal management information. The force had no structured means of monitoring and evaluating a number of basic performance areas (for example, detainee throughput, average detention times and the number of strip-searches), so there was no way of holding managers, staff and partner organisations to account for the delivery of safe detainee care. The force accepted that the computer system needed updating and were looking to identify a new one.

3.7 Custody matters were discussed at a weekly meeting between the head of custody and the ACC and at regular meetings between the head of custody and custody inspectors. The minutes showed that they were used mainly as a means of updating custody inspectors on issues. There was no custody user group meeting where practitioners could meet and discuss custody issues. Overall, there was insufficient strategic oversight of custody issues leading to risks for the organisation and detrimental outcomes for detainees.
Recommendation

3.8 **Staffing levels should be reviewed to ensure that there are sufficient custody staff on duty at all times to meet demand, and to ensure good and safe care of detainees.**

Housekeeping point

3.9 The force should review custody policies to ensure that they meet the standards outlined in the College of Policing’s ‘Authorised Professional Practice on Detention and Custody’.

Partnerships

3.10 There was a local criminal justice board (LCJB), chaired by the ACC lead for custody, which was attended by lead officers from other criminal justice agencies and the PCC. There was limited partnership working in respect of custody at a strategic level. For example, we were told that local authority accommodation for children who had been charged and refused bail was rarely available, leading to inappropriate detention of children in police cells.

3.11 There was an ICV coordinator in the PCC office. The ICV scheme consisted of seven panels with a regular schedule of visits. The PCC office was involved in the issue of custody and told us that they were keen to have active and well-trained ICVs across the police area. There was regular and consistent police representation at ICV meetings, and the deputy PCC was committed to improving the ICV scheme in Northumbria. We were told that ICVs were generally admitted to custody suites quickly and were challenging.

Recommendation

3.12 **The Police and Crime Commissioner or chief officer group should discuss with local authority partners at a strategic level how to address the lack of local authority accommodation for children and young people who have been refused bail at police stations.**

Learning and development

3.13 **All custody sergeants had undergone custody-specific training before taking on custody duties. The course was linked to the national custody officer learning programme (NCOLP) produced by the College of Policing. DOs underwent a four-week initial custody course adapted to their specific learning requirements and based on safer detention principles. This training included a placement in a custody suite.**

3.14 **The oversight and monitoring of training were good. Annual refresher training was available and records showed that most staff had undertaken it. It comprised a mixture of classroom- and computer-based training, although staff said that they preferred classroom training. We were told that the force was looking into alternatives to computer-based training. Recent refresher training had included a session on attention-deficit hyperactivity disorder, which had been classroom based, and staff we spoke to highlighted this as a good learning experience.**
3.15 There was an adverse incident reporting process, whereby custody sergeants completed an electronic form and sent it to the custody inspector. Senior managers had insufficient focus on directing or guiding force policies, and learning from adverse incidents in matters of custody and detainee care and safety. Adverse incident reports were put onto a database but there was little analysis or force-wide learning from these at a management level (see main recommendation 2.32).

3.16 There were three ongoing Independent Police Complaints Commission (IPCC) investigations, two of which referred to deaths in custody. The force was still waiting for the outcome and recommendations from these investigations, but had taken some action in response to the 'quick-time' learning points issued by the IPCC. Most custody staff knew of the IPCC 'learning the lessons' bulletins but were unsure where to find them and some could not recall reading any recently. During the inspection, the force was conducting a compliance review, as the result of an IPCC investigation.

3.17 The quality assurance process was inadequate and inconsistent, even though there was a template, and there was little oversight from the head of custody. There was no cross-referencing of custody records with CCTV recordings and no quality assurance of handovers. Some custody inspectors did not include person escort records (PERs) in the quality assurance process (see main recommendation 2.31). There was no analysis to identify trends and areas for improvement. Some staff said that they had received feedback which varied from face-to-face meetings to emails, and there was no record of action(s) taken.
Section 4. Treatment and conditions

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

Respect

4.1 Custody staff across all the suites were respectful and demonstrated a good level of care and concern, particularly for detainees who openly displayed signs of distress and vulnerability; our concerns were more aimed at those people who did not disclose or demonstrate their vulnerabilities (see section on safety). At Bedlington, we saw the custody sergeant responding appropriately to a detainee who was upset at being detained. The registered mental health nurse was contacted and spent a considerable time with the detainee. The sergeant also allowed him to have frequent periods outside in the exercise yard to mitigate his distress at being confined to a cell. We saw DOs responding appropriately and, at times, considerately to detainees’ welfare needs.

4.2 Some DOs told us that they had recently received safeguarding training, and most were able to explain the steps they would take if a detainee made an allegation of abuse. We saw all detainees being asked if anyone at home would be affected by their detention and if there was anything further the custody sergeant should know in order to care for them in custody. At South Shields, the custody sergeant arranged to have a detainee’s children collected from school if she was not released in time to do this.

4.3 The booking-in area at most of the custody suites was small and the layout offered little privacy for detainees. The booking-in area at Middle Engine Lane was much better, with widely spaced booking-in points, separated by screens. Some custody sergeants seemed unaware or immune to the privacy needs of detainees in some sensitive circumstances. For example, at Gateshead a custody sergeant inappropriately asked a pregnant woman long, detailed questions about the pregnancy complications she had disclosed.

4.4 The Etal Lane booking-in area was noisy, making it difficult for staff and detainees to communicate clearly at times (see also section on physical conditions). Most of the custody suites contained whiteboards in the booking-in area; although these did not include detainees’ names, they contained some personal information about them, in full view of others (see also section on safety).

4.5 At Sunderland, the custody sergeant exercised little control over the suite. Arresting officers were allowed to talk to detainees in cells, go to detainees’ property lockers and make entries in detention logs unsupervised. Officers across all the custody suites often visited detainees in cells (see also section on safety).

4.6 The force’s focus on diversity was poor. Women coming into custody were not asked if they wanted to speak to a female officer or if they might be pregnant; although there were signs in a few of the custody suites (Etal Lane, Sunderland, Bedlington) alerting female detainees that they could ask to speak to a female member of staff, this was not sufficient. Girls aged 16 or under were not allocated a named female officer responsible for their care at any of the suites.
Section 4. Treatment and conditions

4.7 Only Middle Engine Lane had a designated cell for detainees with disabilities, with basic adaptations, including a lowered intercom/call bell button; there was also an adapted toilet at the suite. Staff at Middle Engine Lane located a portable hearing loop but were unable to operate it. None of the other suites had any adaptations or equipment for detainees with a physical disability or impairment.

4.8 There was little specific provision for children. Some custody sergeants told us that they would let a child wait with their AA in a consultation room rather than place them in a cell, and we saw this happen at Etal Lane. At all suites, custody staff consistently told us that they would not detain children in custody unnecessarily and would deal with them as soon as possible. We saw evidence of this but also found instances where children were inappropriately detained (see also section on individual rights).

4.9 We saw all detainees being asked if they had any religious or cultural needs but we were not convinced that detainees understood what was being asked. At Etal Lane, the custody sergeant clarified the question but only when a detainee appeared confused. Items for religious observance included prayer mats and a range of holy books at all suites; at some of the suites these were stored in a box but at others they were left among other items rather than being stored respectfully. There was no means of determining the direction of Mecca at any of the custody suites except Middle Engine Lane, where there was an arrow on the ceiling of each cell.

4.10 The toilet area was adequately pixilated on the CCTV monitors at all of the custody suites, except at Washington.

4.11 DOs told us that they would ask transgender detainees for their preference in relation to being searched by a male or female officer.

Recommendations

4.12 Booking-in areas should provide sufficient privacy to allow effective communication between staff and detainees. (Repeated recommendation 4.7)

4.13 Custody sergeants should ensure that non-custodial staff do not visit detainees in cells, make entries in detention logs or handle property unsupervised.

4.14 There should be a clearer focus on the specific needs of juvenile, female and disabled detainees; staff should be trained to deal effectively with these detainees. (Repeated recommendation 4.8)

Housekeeping points

4.15 A hearing loop should be available in all custody suites and staff should know how to use it.

4.16 Staff should ensure that detainees understand the question they are asked about their religious and cultural needs.

4.17 Items for religious observance should be stored respectfully and there should be a way to identify the direction of Mecca.

4.18 Toilet areas should be obscured on CCTV monitoring (Repeated recommendation 4.34)
Safety

4.19 We were concerned about the overall approach to risk assessment across the spectrum, from booking into custody, through the continued review and on to the pre-release risk assessment. The importance of understanding detainee vulnerabilities was highlighted during the inspection, when a person committed suicide post-release. It was not clear if anything could have been done to prevent this outcome; this will be determined by an inquiry.

4.20 Although there were a few notable and commendable exceptions, custody sergeants took a mainly formulaic approach to risk assessments, asking only basic questions following the prompts from the Northumbria Police Integrated Computer and Communications System (NPICCS) (see main recommendation 2.33). They did not explain to detainees that the questions were part of a risk assessment or ensure that they were well cared for. Staff did not attempt to establish a rapport with the detainee. Many sergeants were not sufficiently responsive to non-verbal cues, especially when detainees disclosed sensitive information.

4.21 In our custody record analysis, we were concerned to find that a health care assessment had not been requested for 14 detainees who were intoxicated on arrival at the custody suite. Several were described as being heavily intoxicated from alcohol and possibly drugs, and risk assessments had identified warning markers for mental health and self-harm issues. Furthermore, several were taking an array of medications and one had a cut to his neck which was not assessed (see main recommendation 2.33). None of the custody records showed whether it was a detainee’s first time in custody.

4.22 Custody staff had full access to the police national computer (PNC) and were able to cross-reference detainees’ details and use any relevant information in the risk assessment. The PNC was checked before the risk assessment was completed in every instance we observed.

4.23 Custody sergeants routinely removed shoes, jewellery and cords from all detainees, regardless of answers given to questions asked, again demonstrating a lack of engagement with the rationale of assessing true risk.

4.24 Observation levels were generally appropriate and the custody records we sampled indicated that the stated level of observation was adhered to. However, at the time of the inspection, the force was conducting a review of staff notes and CCTV footage to ensure that a true record was kept.

4.25 Most of the custody records we analysed showed little evidence of a dynamic, changing assessment or amendment of risk, except when detainees became less intoxicated and rousing checks were lifted.

4.26 We saw custody sergeants giving good briefings to DOs conducting close proximity observations. These DOs gave detainees their full attention, and those we spoke to knew the importance of obtaining a satisfactory response from intoxicated detainees who were subject to rousing checks. However, there was little information recorded on custody logs about detainees’ responses to rousing, particularly in entries made in the early hours of the morning.

4.27 All cells across the full-time custody suites were monitored by CCTV. Custody staff tended to use this as an additional means of observing detainees about whom they had concerns but who did not present a sufficiently high risk to be placed on level 3 (constant supervision) or level 4 (close proximity supervision) monitoring. Some of the CCTV monitors were located at the booking-in desk and therefore could not be used to conduct level 3 observations as there were too many distractions. This was not the case at Middle Engine Lane and South Shields custody suites, where the monitors were located in a discrete area. However, during
the inspection at Middle Engine Lane, a DO was monitoring six detainees on level 3 via CCTV while also completing PERs, answering telephones and cell intercoms, and activating access to the suite for visitors. This was clearly unsafe as the DO should have been concentrating on the CCTV monitor.

4.28 Custody staff were aware of when adverse incident forms should be used and we saw these being completed appropriately (see also section on strategy and main recommendation 2.32).

4.29 Custody staff had been issued with instructions about how to conduct the shift handover process but these contained questionable advice. Before handovers, custody sergeants were required to review the risk assessment for each detainee by visiting each cell and then verbally accepting responsibility for the detainee. Most custody sergeants told us that they did not comply with the requirement to visit each detainee before handover, as the approach was ineffective. We saw handovers in all suites and only at Middle Engine Lane did this include all the custody staff together. Elsewhere, the handover took place between sergeants, and DOs handed over separately. We were told by custody staff that the information that DOs exchanged with one another was different to that for custody sergeants.

4.30 The quality of the handovers was mixed. At a handover we observed at Bedlington, insufficient risk management information was communicated to the incoming sergeant, whereas one we observed at Etal Lane contained information that was relevant to detainees’ risk assessments and concise. We noted that, across most of the suites, DOs and custody sergeants alike referred to the whiteboard during the handover process. We found evidence of human error and omission there, including incorrect and missing information, and there appeared to be no additional safeguards to prevent incorrect information being passed on. Incoming custody sergeants at all suites spoke to each detainee following the handover.

4.31 Pre-release risk assessments (PRRA) were generally weak. Although staff said that they arranged help on release for vulnerable detainees, custody sergeants did not normally ask detainees about any concerns they might have at the point of release. At Sunderland, we saw an 18-year-old woman, who had been arrested for driving while three times over the legal alcohol limit, released without a PRRA being conducted or any attempt at encouraging her to address her drinking problem. In some cases, sergeants completed the PRRA after the detainee had left the suite. There appeared to be a disproportionate focus on arranging transport for detainees to get home, rather than on risk factors. This was despite the NPICCS requiring the custody sergeant to consider a detainee’s emotional and mental health before release and to record the ‘control measures’ that had been put in place to minimise any potential risks. In our custody record analysis, 53 of 60 detainees had been released to home, and a PRRA had been completed in all these cases. However, these were generally lacking in detail and, for three detainees who had self-harmed while in custody, this had not been identified in the PRRA. One of the records referred to a 17-year-old who had been seen tying jeans around his neck. He did not receive a health care assessment and it was not clear whether his parent had been informed when released into their care. None of this information had been recorded on the pre release risk assessment (see main recommendation 2.34).

4.32 There were no leaflets containing details of support agencies, other than one produced by Turning Point (a health and social care provider), except at Gateshead, where a list existed but was not given out.
Recommendations

4.33 All custody staff should carry suitable anti-ligature knives while carrying out their duties in the custody suite.

4.34 All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded.

4.35 Detainees should be offered information about relevant support organisations at the point of release.

Housekeeping point

4.36 Custody staff conducting constant supervision via CCTV should not be engaged in other tasks.

Use of force

4.37 The use of handcuffs was appropriate and proportionate. Not all detainees arrived at the suites in handcuffs and those who did had them removed promptly on arrival. The reasons for using handcuffs were recorded on custody records; from our observations, they were used mainly to transport detainees safely.

4.38 All staff exercised good de-escalation skills and all custody staff received annual personal safety training. We saw many examples of good de-escalation used with intoxicated detainees at Middle Engine Lane. At Etal Lane, we saw force being used to remove the shoes and jewellery of an intoxicated detainee and apply handcuffs to escort her to the cell. The handcuffs were quickly removed once she was located in the cell and the detainee calmed down. The custody sergeant did not consider this as a use of force and little information about this incident was noted in the custody record. Use of force in the custody area was not recorded (other than in the custody log), monitored or analysed, making it difficult to identify trends for learning and training.

4.39 The force was unable to provide data on strip-searching across the custody suites but during the inspection few detainees were strip-searched and those we knew of appeared proportionate. In our custody record analysis, six detainees in our sample (10%) had undergone strip-searches, all of which had been authorised. There were no designated searching rooms, which meant that strip-searches were carried out in cells monitored by CCTV; at most suites, sergeants were aware of this and ensured that the cell was obscured on the CCTV monitor, except on one occasion at Gateshead.

Recommendation

4.40 Northumbria Police Service should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers policy and College of Policing guidance. (Repeated recommendation 4.22)

Physical conditions

4.41 The general condition of the custody estate was good, with only a few suites requiring a deep-clean. At Sunderland, many cells had an unacceptable amount of detritus on the
ceilings, and the air vent in a detention room was blocked with an accumulation of dust. There was a foul smell, thought to be from the drains, pervading parts of the suite. At Bedlington and Etal Lane, the cell floors and communal areas had a build-up of dirt, and the ventilation at Etal Lane was poor, although custody staff tried to improve the situation by opening the door to the exercise yard when it was safe to do so. The Etal Lane custody suite lacked natural light and had low ceilings, raising the overall levels of noise in the booking-in area (see also section on respect).

4.42 There were small amounts of graffiti across the estate. Most of the cells had been redecorated in the previous 12 months, so some of the issues regarding offensive and excessive graffiti in cells found at the previous inspection had been addressed. At Middle Engine Lane, there was rubbish lying around in the van dock, including discarded vinyl gloves, and some of the cells were too cold.

4.43 During the inspection, detainees held at Gateshead had to be transferred to Southwick. However, we were concerned that Southwick custody suite, being a part-time resilience suite, was not ready to be opened at short notice. Custody staff, having transferred to the new site, had to request for medication to be brought over, and did not know which FME was on call. In addition, three detainees had to move cells as theirs were too cold and no one knew how to turn off the air conditioning. Overall, preparation and planning for use of this suite were poor.

4.44 Daily cleaning arrangements across the estate were reasonable, with all cells cleaned, when not occupied, each morning. Cells that required cleaning were appropriately placed out of use, reported and responded to promptly. Several suites had cells containing ligature points. The records of daily cell checks showed that at some suites there had been significant gaps, of several days, when no cell checks had been recorded. There was no consistent approach to the daily cell checks; for example, cells at Etal Lane and Middle Engine Lane were not checked when occupied, but they were at Sunderland.

4.45 At most suites, DOs checked the cell call bells to ensure that they were in working order. However, at Sunderland and Gateshead they were not tested as part of the daily cell checks, and at Middle Engine Lane a random sample were selected for testing each day. The cell call bell was not sufficiently audible at Bedlington, although staff responded to the flashing lights. Staff across all the custody suites responded quickly when the bells were activated.

4.46 When maintenance issues were identified, a record was made of whom it was reported to and when, but the action taken was not always recorded so it was unclear how quickly these issues were resolved. Quarterly checks were conducted by the custody inspector and the estate manager to provide oversight and managerial action when necessary.

4.47 Across the custody suites, it was common for arresting officers to place detainees in the cell and have unsupervised access to them (see recommendation 4.13). However, this practice was associated with risks, as these officers did not have training in dealing with detainees in custody and did not carry anti-ligature knives, and there were no safeguards for detainees or officers against potential allegations. At Gateshead, we saw a woman with mental health problems, who had not been in custody before, placed in a cell without an explanation of the call bell. At South Shields, arresting officers did not explain how to access drinking water in the cells. At Bedlington, when a DO escorted a detainee to the cell he explained everything that was in the cell, including the fact that the cell was monitored by CCTV.

4.48 Staff at each suite thought that there had been practice evacuations but there were no records of them taking place.
Recommendations

4.49 All cells should be clean, well maintained, and properly heated and ventilated.

4.50 Emergency practice evacuations should take place regularly, and be recorded.

Housekeeping points

4.51 Part-time resilience suites should be ready for use at short notice and staff should be familiar with the equipment there.

4.52 Recorded cell checks should take place daily and include the testing of call bells, and the correct use of cell call bells should be explained to all detainees.

Detainee care

4.53 Mattresses were available in each of cells but were not routinely sanitised between uses. There was only a small supply of pillows at each of the custody suites. At South Shields and Etal Lane, pillows were left in some of the cells but at other suites, such as Washington, they were kept in a storage cupboard and we were told that detainees could request one; however, they would have no way of knowing this. We saw detainees making makeshift pillows using blankets or the mattress. There was a good supply of blankets and replacement clothing. At Middle Engine Lane, where the cells were cold (see section on physical conditions), we saw a woman wearing insufficient clothing put into a cell at midnight without being given a blanket.

4.54 Detainees who did not want the cords cut from their clothing were routinely given a tracksuit to wear. They were required to leave their shoes outside the cells. Plimsolls were available but we saw detainees walking around some custody suites in their socks or barefoot. There was an ample supply of toiletries and female hygiene packs, but these were not offered routinely. Razors were not available at all the custody suites for those wishing to shave before attending court. There was no stock of paper suits or safety clothing.

4.55 There were showers at each suite, although at Etal Lane some of the detention room showers were not used as they did not offer sufficient privacy. At Sunderland, one of the shower areas had a cracked basin and in another, grouting was missing, creating health hazards. Records of independent custody visits showed several occasions when ICVs had complained about detainees not being offered showers, and staff had told them that they did not have time to offer them. Our custody record analysis showed that two detainees at Middle Engine Lane had been sent to court after being detained for a long time without being offered a shower. We saw showers being offered at Middle Engine Lane and South Shields for detainees who were going to court the next day. At Etal lane, detainees who had declined the offer of a shower were permitted to wash their faces and brush their teeth before going to court. There was an ample supply of cotton towels at the suites. Toilet paper was provided in most of the cells.

4.56 There were good stocks of microwave meals at all suites, offering options for a range of dietary needs, including halal, vegetarian and gluten free. The meals were of low calorific value but staff told us that they would provide more than one meal, on reasonable request. However, in our custody record analysis we found instances where detainees had been held for substantial periods without any record that they had been offered a meal. Some custody sergeants allowed relatives to bring in food in factory-sealed containers.
At all suites, there were exercise yards that detainees could use without supervision, subject to risk assessment, and all the yards were monitored by CCTV. We saw detainees in the exercise yard at some of the custody suites but in our sample of custody records, only three detainees (5%) had received outside exercise, one of whom had been held for 19 hours; however, none of the other detainees who had been held in custody for long periods had been offered outside exercise.

There were a few newspapers and magazines at each suite, and at Middle Engine Lane some staff brought in free newspapers to give to detainees. There was a small supply of books at some suites, which staff had brought in, but none of these was in languages other than English. At Middle Engine Lane, we saw three non-English-speaking immigration detainees who had been in custody for 48 hours with nothing to read or occupy their time. Social visits were rarely facilitated, even though there were visits rooms at some suites.

Recommendations

Pillows and blankets should be provided to all detainees, subject to risk assessment.

The shower area at Sunderland custody suite should be repaired and safe for detainees to use.

All detainees held overnight, or who require one, should be offered a shower and should be able to use one in reasonable privacy. (Repeated recommendation 4.33)

Detainees, particularly those held for more than 24 hours, should be offered exercise.

Housekeeping points

Mattresses should be wiped down between uses.

Female detainees should routinely be offered hygiene packs.

A stock of disposable razors should be maintained so that, subject to risk assessment, detainees who wish to shave before attending court can do so.

A range of reading materials should be available and routinely offered, including books and magazines suitable for children and for those whose first language is not English.
Section 5. Individual rights

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

Rights relating to detention

5.1 Due to the sequencing of the computer booking-in process, custody sergeants did not check the reasons for detention with arresting officers, to ensure that there were appropriate grounds, until late into the process. This approach differed from almost all other police forces we have inspected. Sergeants offered few examples of when they had refused detention. Several custody sergeants told us that they had seen an increase in the number of officers seeking advice before making a potential arrest, but we did not see this.

5.2 The use of alternatives to custody, such as voluntary attendance, had increased. Northumbria Police had begun recording the use of voluntary attendance in 2012/13, when the figure had been 2,763, and in the 12 months to January 2014 this had risen to 4,094. Police officers at Gateshead were able to process voluntary attendees themselves at a nearby part-time resilience custody facility (Wickham), but elsewhere we saw voluntary attendees being ‘booked-in’ by custody staff. This led to some delays in processing people but also was inappropriate as it treated people attending voluntarily to be interviewed under caution in the same way as an arrested person. We were told that at more rural police stations, the absence of a custody-trained sergeant meant that voluntary attendees had to be taken to another custody suite, staffed by appropriately trained officers, which meant travelling some distance. This appeared to be unnecessary, given that most police stations had interview facilities.

5.3 Custody sergeants were clear about their obligations to ensure that cases proceeded quickly and we saw most detainees’ cases being progressed promptly, minimising their time in police custody. In our custody record analysis, the average length of detention was 10 hours 36 minutes, and 17 (28%) of the detainees in our sample had been held for less than six hours.

5.4 The number of immigration detainees in custody suites held on immigration-related offences had remained reasonably constant over the previous four years (350–380 each year). Custody staff reported a good relationship with Home Office Immigration Enforcement staff; however, they said that immigration detainees regularly remained in police custody for longer than 24 hours before being released or transferred to an immigration removal centre. We saw one Chinese detainee in custody at Gateshead who had been served a notice of detention (IS91 form) by immigration enforcement officers. He was held for just under 39 hours in police custody before the decision was taken to release him, pending further enquiry. At Middle Engine Lane, where most immigration detainees had been held in the 12 months to January 2014, we saw data showing that in December 2013, five immigration detainees, who had been served with notices of detention, had been held in police custody for between 35 and 62 hours. Similarly, in January 2014, three such immigration detainees had been held for between 26 and 41 hours.

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3 Usually for lesser offences, where suspects attend by appointment at a police station to be interviewed about alleged offences. This avoids the need for an arrest and subsequent detention in police custody.
5.5 There was a useful language identification poster in some suites to help to determine a detainee's language. A professional telephone interpreting service was available to assist in the booking-in process. All suites, with the exception of Southwick and Bedlington, had double-handset telephones available for this purpose. Staff said that a good face-to-face interpreter service was available for interviews. Some suites had posters displaying the British Sign Language alphabet and some useful words and phrases.

5.6 Staff assured us that the custody suites were never used as a place of safety for children under Section 46 of the Children Act 1989.

5.7 Custody staff were clear on their responsibilities to contact an AA when dealing with vulnerable adults or children under 18 years of age. Family or friends were usually contacted in the first instance to act as an AA, and the force had an informative leaflet clarifying the role and responsibilities of an AA, although during the inspection this was not always issued as required. When it was not possible to contact a relative or friend, the police used schemes operated by five local authorities across the Northumbria area. Custody staff said that the AA provision for children during office hours was quick and effective as these services were mainly covered by the youth offending teams (YOTs), except in Sunderland, where a 24/7 service was available, run by The Appropriate Adult Service (TAAS). Outside of office hours, the AA service (except in Sunderland) was provided by the emergency duty teams, and their response times were said to be variable across the different local authorities in the force area.

5.8 Staff in some areas said that it was difficult to access AAs to provide assistance for vulnerable adults as social services maintained that they had no legislative responsibility to attend in such cases. We were told about several recent cases involving vulnerable adults, where the detainees had been bailed to appear before police at a future date as no AA could be accessed to assist them at the time. In our custody record analysis, we were unable to determine the time taken for an AA to attend the custody suite as no records had been kept of contact or arrival times.

5.9 At Middle Engine Lane, we saw two boys, one aged 12 and the other 13, being kept in custody overnight after being arrested at 8.50pm on the previous evening. The mother of the 13-year-old had refused to attend and social services staff had declined to attend as the interview had been due to start after the service had terminated for the evening. As a consequence, both children had remained in custody overnight. The detention logs for these children did not record any consideration being given to bailing them overnight or any attempt made to secure alternative overnight accommodation for them. Staff across all the custody suites said that they would request secure accommodation from the local authorities in all cases where a child had been charged and could not be bailed, but most said that they were unaware of this facility being provided.

5.10 Only at Washington, Etal Lane and Bedlington were detainees routinely offered a detailed leaflet summarising their rights and entitlements while in custody. Across the custody suites, we found several versions of the rights and entitlements in stock, some dating as far back as 2004; none of the suites had a copy of the current 2013 version. Not all staff knew how to access these documents in foreign languages and none was aware that an easy-read format was also available on the Home Office website.
Recommendations

5.11 Custody staff should check the grounds for detention at the start of the booking-in process.

5.12 Northumbria Police should liaise with Home Office Immigration Enforcement to ensure that immigration detainees are held in police custody suites for the shortest possible time.

5.13 Appropriate adults should be available at all times for children and vulnerable adults.

5.14 Northumbria Police should engage with the local authorities to ensure the provision of safe beds for children who cannot be bailed, to prevent them from being held in police custody overnight.

Housekeeping points

5.15 Voluntary attendees should not be ‘booked-in’ at custody suites by custody staff.

5.16 Double-handset telephones should be available in all custody suites.

5.17 Contact and attendance times for appropriate adults should be clearly recorded on custody records for monitoring purposes.

5.18 All detainees should be given an up-to-date written notice of their rights and entitlements, and custody staff should be able to access the intranet to provide these in a range of languages and formats.

Rights relating to PACE

5.19 During booking-in, custody staff told detainees of the right to have someone informed of their arrest, the right to consult a solicitor and obtain free independent legal advice, and the right to consult the PACE codes of practice but they did not routinely show or explain the latter. All of the custody suites had a limited number of copies of PACE code C available but at some suites we saw out-of-date copies being handed out. The Criminal Defence Service poster informing detainees of their right to free legal advice was not routinely displayed in the custody suites.

5.20 All detainees were offered legal representation but, at all suites, detainees wishing to telephone legal advisers had to use a telephone located at or near the custody desk, which lacked privacy. However, there were sufficient consultation and interview rooms where detainees could speak in private with their legal advisers. We saw legal advisers routinely being offered custody records for inspection without having to request them. In our custody record analysis, all detainees had routinely been offered legal advice and 31 (52%) had accepted this offer, and in all cases solicitors had been contacted promptly. We saw custody sergeants asking detainees why they had declined legal advice.

5.21 In most of the records we reviewed, when detainees had opted to have someone told about their detention the nominated person had been informed. We saw staff contacting nominated people routinely during the booking-in process.
Section 5. Individual rights

5.22 PACE reviews of detainees in custody were undertaken by dedicated custody and operational inspectors across the force area. The primary responsibility for these reviews lay with the custody inspector but, as they covered such a large geographical area, operational inspectors undertook some reviews to ensure that they were conducted on time. We saw some good face-to-face reviews by inspectors, and detainees being told that reviews had taken place while they were asleep, and reminded of their rights and entitlements.

5.23 In our custody record analysis, of the 32 records we inspected, 13 reviews had been conducted on time, nine had been conducted early and 10 had been late. Most of the reviews had taken place face-to-face.

5.24 There was an effective system for collecting DNA samples taken in custody but few DOs knew the force’s retention and disposal policy.

5.25 Staff told us that delays could be experienced in transporting detainees to Newcastle Magistrates’ Court owing to limited cell capacity at the court. On one morning during the inspection, the court was able to accept only four male detainees, with two female detainees remaining in police custody (at Middle Engine Lane) until 3pm, when they were transferred to court. However, in most cases detainees were transported to court in a timely manner, with courts accepting detainees up to 2–3pm on weekdays, with some flexibility on a day-to-day basis. There were only two Saturday courts available in the force area, and their cut-off time was 9.30am.

5.26 Berwick Magistrates’ Court had sessions on Tuesdays and Thursdays only. Any overnight police detainees held at Berwick outside these days were taken to Bedlington Magistrates’ Court. On a day that Berwick Magistrates’ Court was sitting, we saw a detainee being taken from Bedlington police station to this court, a distance of approximately 55 miles and at least an hour’s drive, in a secure escort vehicle, even though Bedlington Magistrates’ Court was located directly opposite this police station.

Recommendations

5.27 Detainees should be able to have a telephone consultation with their legal adviser in private.

5.28 Senior police managers should engage with HM Courts and Tribunal Service to ensure that detainees are not held in police custody for longer than necessary because of limited cell capacity at the courts, and that detainees are taken to the nearest available court.

Housekeeping points

5.29 Detainees should be offered an up-to-date copy of PACE codes of practice.

5.30 Posters, in a range of languages, detailing detainees’ right to free legal advice should be prominently displayed in all custody suites.

5.31 PACE reviews should be carried out on time.
Rights relating to treatment

5.32 Custody staff said that if a detainee wished to make a complaint, they would either inform the custody inspector or duty inspector or, if the complaint was of a less serious nature, they would tell them to attend at the front desk of the police station on release. Our custody record analysis included the case of a 15-year-old detainee who said that he had been ‘kicked in the van on the way to the station’. He had been held in custody for over 22 hours but no request had been made for him to be examined by an FME. There was no evidence in the custody record that this child had been given any information about making a complaint. There was no consideration of how to take complaints from detainees who were taken directly to court from police custody.

Recommendation

5.33 Detainees should be able to make a complaint about their care and treatment before they leave custody.
Section 6. Health care

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

Governance

6.1 FMEs provided primary medical services. Clinical governance processes for primary medical services had not improved since the previous inspection and were poor. There was no contract or performance monitoring, limited training, no clinical audits and no appraisal system (see main recommendation 2.35). Partnership working between NHS England (NHSE) and Northumbria Police had started in preparation for NHS commissioning in 2016 but this had not yet impacted on service delivery. A health needs assessment from 2012 recommended an alternative service model and we were told that a new service specification was being developed. Governance of mental health and substance misuse services was effective.

6.2 There was 24-hour FME cover – one each for the three northern and three southern suites and one for Gateshead on 12-hour shifts. However, some FMEs regularly did shifts of 24 hours in the busier suites and up to 72 hours in Gateshead, which raised concerns about their fitness to practice.

6.3 We saw respectful interactions between clinical staff and detainees. There was good access to telephone interpreting services if required. There was only one female FME and female officers said that they acted as chaperones if required, but this was not advertised. Clinical consultations generally occurred in private unless a risk assessment indicated otherwise; however, privacy screens were not available in every clinical room.

6.4 The police regularly checked that FMEs were correctly registered with the General Medical Council but there were no systems to check that mandatory training and annual appraisals were completed (see main recommendation 2.35). FMEs we spoke to said that there were limited training opportunities but there were regular FME peer support meetings.

6.5 All part-time custody suites had clinical rooms but had no FME cover, so detainees with medical needs at such suites were transferred to a full-time suite. All full-time suites had clinical rooms dedicated to health services. These varied considerably in size, tidiness and cleanliness, from dirty and cluttered at Gateshead (including an open specimen pot of urine on the sink) to Middle Engine Lane, which had two large tidy clinical rooms. The previous inspection and a 2012 infection control audit had identified that the cleaning standards and management of clinical waste were inadequate in all rooms and that some had additional issues, including inappropriate hand-washing facilities. There had been no improvement and all, except Middle Engine Lane, needed deep-cleaning.

6.6 There was no agreed stock list for clinical rooms and most contained expired and excessive stock. Apart from at Middle Engine Lane, most fixtures and fittings were excessively worn or damaged. At Etal Road, the top of the examination couch was detached from the frame, which presented a significant risk of falls if used. Examination lights were not available in all clinical rooms and the examination light at Sunderland was lying on the floor.
6.7 There was no health promotion literature in the clinical rooms and there were out-of-date pharmacology reference materials in most suites. In several rooms, the emergency alarm was not accessible from the doctor’s chair.

6.8 Custody staff in all suites received regular first-aid and resuscitation training and had easy access to automatic external defibrillators and suction, but there was no oxygen available. The contents of first-aid kits varied across the suites and, despite daily recorded checks, most were either over- or under-stocked and contained some expired items.

Recommendations

6.9 There should be robust infection control procedures for all clinical rooms, which should be regularly cleaned and capable of being used for taking forensic samples, and custody staff should have access to a full range of appropriate and standardised first-aid and resuscitation equipment that is checked regularly. (Repeated recommendation 6.10)

6.10 All clinical rooms, including fixtures and fittings, should be fit for purpose and meet current environmental guidelines.

Housekeeping points

6.11 Detainees should be able to see a female health professional on request or be aware that they can request a female chaperone.

6.12 Clinical rooms should have a standardised stock list and there should be regular checks of expiry dates.

6.13 Relevant patient information leaflets should be accessible in all clinical rooms.

6.14 Out-of-date clinical and pharmacological reference materials should be replaced by up-to-date materials.

Patient care

6.15 Detainees were referred to the FME based on assessed need or detainee request. Our custody record analysis identified two instances where a referral to the FME had been indicated but did not appear to have been considered.

6.16 Custody staff told us that the health service provision was reasonable but detainees sometimes waited several hours to be seen, either because of high demand at other suites or because the FME was running a community GP clinic. In the records we examined, FME response times varied from five minutes to eight hours; however, the callout time was not documented in most records, precluding effective monitoring. An ambulance was called for emergencies and we were told that response times were good.
6.17 FMEs used Northumbria Police ‘Detainee Medical Care’ paper pro-formas to record consultations; one copy went into the custody record, one went into the PER and one was retained by the FME. There was no agreed protocol for the storage and destruction of FME clinical records and we were not assured that they were stored in accordance with Caldicott requirements. We found the FME copy of several clinical records from January 2014 in a cupboard in one clinical room.

6.18 Most clinical records we examined were reasonable but some were very brief and the handwriting on some was illegible. This had been raised in previous recommendations from the IPCC. We observed some excellent discussion of risk and management between custody sergeants and FMEs but it was not recorded in the custody record, so this information would not have been available to other staff.

6.19 Custody staff tried to retrieve medication from detainees’ homes where appropriate, and it was checked by an FME before it was administered. Detainees on opiate substitution medication were supported to access their medication. Symptomatic relief for drug and alcohol withdrawal, including nicotine replacement therapy, was prescribed. FMEs did not have an agreed formulary (a list of medications used to inform prescribing), which meant that there could have been variations in prescribing practices.

6.20 There was standardised stock medication and a robust process to dispose of unwanted medication safely in each suite. Stock was stored in locked drug cupboards, and recorded stock checks were carried out regularly by two custody staff. However, we found expired medication at four suites and the stock count was wrong in one suite. Asthma inhalers were reused for multiple detainees; although some suites used a disposable attachment for each detainee, this practice was unacceptable.

6.21 Custody staff administered medications prescribed by an FME. Two custody staff dispensed medication from stock boxes against handwritten prescription charts and one of them then administered it to the detainee. We observed several instances of careful drug administration by DOs; however, most of those we spoke to were worried about the high level of responsibility that this imposed on them. They also said, and we observed, that the handwriting on some prescriptions was very difficult to read.

Recommendations

6.22 All clinical records should be stored in accordance with the Data Protection Act and Caldicott principles to ensure confidentiality of personal health information. (Repeated recommendation 6.20)

6.23 There should be robust governance of medication management, including an agreed prescribing formulary, stock checks which include expiry dates as well as quantities, and oversight by a pharmacist.

6.24 Medication should only be administered by appropriately trained staff against legible prescriptions.

4 Caldicott guidelines are the general principles that health and social care organisations should use when reviewing their use of client information.
Housekeeping points

6.25 The time that a forensic medical examiner is called should be clearly recorded in the custody record to ensure that response times can be monitored.

6.26 All clinical records should be legible and accurately reflect both the consultation and the management plan to ensure that custody staff are able to provide appropriate levels of care.

6.27 Asthma inhalers should only be used for individual detainees.

Substance misuse

6.28 A large proportion of detainees presented with a substance misuse history. Our custody record analysis indicated that 45% of detainees had come into custody under the influence of drugs or alcohol. Custody staff at Middle Engine Lane said that recent alcohol awareness training by Turning Point had been useful.

6.29 Substance misuse workers from Turning Point provided a good level of support to all adult detainees with drug or alcohol issues. The ‘drug testing on arrest and access’ scheme in the force had recently ended. There were effective local multi-agency working arrangements, and substance misuse workers made appropriate, prompt community referrals, with detainee consent. Detainees under the age of 18 with these issues were referred by the YOT to local youth services. Detainees were signposted to local needle exchange programmes if required.

Mental health

6.30 A large and increasing number of detainees had current or previous mental illness. In our custody record analysis, 25% of detainees had reported a history of mental health problems. Mental health diversion services had improved considerably and custody staff we spoke to were positive about the service.

6.31 Five custody suites had a dedicated registered mental health nurse (RMN), who visited daily (from Monday to Friday) and discussed concerns with custody staff before visiting every detainee to offer support. RMNs checked if detainees were known to mental health services and shared relevant risk information with custody staff. They liaised effectively with relevant services, including probation services, prisons and community mental health services, as required. Although two suites did not have an on-site nurse, the RMNs based at the local magistrates’ courts checked if detainees were known to mental health services, and were available if needed. Both suites were due to move to new premises later in 2014, and would then have a dedicated RMN. There was also a pilot community-based diversion service in the south of the force area. Out-of-hours support was available from the emergency response team.

6.32 Detainees who required an assessment under section 136 of the Mental Health Act 1983 were referred to the emergency response team and we saw two detainees receive timely referral, assessment and transfer to community mental health facilities, although custody staff reported occasional long delays.
6.33 Children were referred to specialist services through the YOT team. The mental health service at Sunderland was to become a 24-hour facility from April 2014, for detainees of all ages. Training by YOT workers was planned for all of the suite-based nurses in preparation for future ‘ageless’ mental health services across all the suites.

6.34 Northumbria had five designated NHS section 136 suites and those we visited provided a positive environment. Although the number of section 136 arrests in the previous year had almost doubled from the year before, the proportion of such detainees being taken into custody had reduced from 46% to 14%. There were effective local and strategic meetings for the police to discuss strategic issues with Northumberland, Tyne and Wear NHS Foundation Trust, underpinned by an appropriate range of joint operational policies.

6.35 All custody staff received mental health awareness training during their induction and an online training package was available.
Section 7. Summary of recommendations and housekeeping points

Main recommendations

7.1 Quality assurance sampling of custody records should be carried out to a consistent standard, including checking against closed-circuit television (CCTV) recordings, person escort records and staff handovers. (2.31)

7.2 The force should ensure that learning from adverse incidents has clear management ownership to ensure that there is effective monitoring of trends and areas for improvement, and is communicated to frontline staff. (2.32)

7.3 The quality and consistency of initial risk assessments should be dynamic and ongoing, ensuring that correct information is considered at all times for the continued safety of detainees. (2.33)

7.4 Pre-release risk assessments should be detailed, meaningful and the subject of discussion with the detainee before release. (2.34)

7.5 There should be robust governance arrangements to monitor health service provision, including attendance times, training, supervision and accountability of individual practitioners in their clinical practice. (2.35)

Recommendations

Strategy

7.6 Staffing levels should be reviewed to ensure that there are sufficient custody staff on duty at all times to meet demand, and to ensure good and safe care of detainees. (3.8)

7.7 The Police and Crime Commissioner or chief officer group should discuss with local authority partners at a strategic level how to address the lack of local authority accommodation for children and young people who have been refused bail at police stations. (3.12)

Treatment and conditions

7.8 Booking-in areas should provide sufficient privacy to allow effective communication between staff and detainees. (4.12, repeated recommendation 4.7)

7.9 Custody sergeants should ensure that non-custodial staff do not visit detainees in cells, make entries in detention logs or handle property unsupervised. (4.13)

7.10 There should be a clearer focus on the specific needs of juvenile, female and disabled detainees; staff should be trained to deal effectively with these detainees. (4.14, repeated recommendation 4.8)
Section 7. Summary of recommendations and housekeeping points

7.11 All custody staff should carry suitable anti-ligature knives while carrying out their duties in the custody suite. (4.33)

7.12 All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded. (4.34)

7.13 Detainees should be offered information about relevant support organisations at the point of release. (4.35)

7.14 Northumbria Police Service should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers policy and College of Policing guidance. (4.40, repeated recommendation 4.22)

7.15 All cells should be clean, well maintained, and properly heated and ventilated. (4.49)

7.16 Emergency practice evacuations should take place regularly, and be recorded. (4.50)

7.17 Pillows and blankets should be provided to all detainees, subject to risk assessment. (4.59)

7.18 The shower area at Sunderland custody suite should be repaired and safe for detainees to use. (4.60)

7.19 All detainees held overnight, or who require one, should be offered a shower and should be able to use one in reasonable privacy. (4.61, repeated recommendation 4.33)

7.20 Detainees, particularly those held for more than 24 hours, should be offered exercise. (4.62)

Individual rights

7.21 Custody staff should check the grounds for detention at the start of the booking-in process. (5.11)

7.22 Northumbria Police should liaise with Home Office Immigration Enforcement to ensure that immigration detainees are held in police custody suites for the shortest possible time. (5.12)

7.23 Appropriate adults should be available at all times for children and vulnerable adults. (5.13)

7.24 Northumbria Police should engage with the local authorities to ensure the provision of safe beds for children who cannot be bailed, to prevent them from being held in police custody overnight. (5.14)

7.25 Detainees should be able to have a telephone consultation with their legal adviser in private. (5.27)

7.26 Senior police managers should engage with HM Courts and Tribunal Service to ensure that detainees are not held in police custody for longer than necessary because of limited cell capacity at the courts, and that detainees are taken to the nearest available court. (5.28)

7.27 Detainees should be able to make a complaint about their care and treatment before they leave custody. (5.33)
Health care

7.28  There should be robust infection control procedures for all clinical rooms, which should be regularly cleaned and capable of being used for taking forensic samples, and custody staff should have access to a full range of appropriate and standardised first-aid and resuscitation equipment that is checked regularly. (6.9, repeated recommendation 6.10)

7.29  All clinical rooms, including fixtures and fittings, should be fit for purpose and meet current environmental guidelines. (6.10)

7.30  All clinical records should be stored in accordance with the Data Protection Act and Caldicott principles to ensure confidentiality of personal health information. (6.22, repeated recommendation 6.20)

7.31  There should be robust governance of medication management, including an agreed prescribing formulary, stock checks which include expiry dates as well as quantities, and oversight by a pharmacist. (6.23)

7.32  Medication should only be administered by appropriately trained staff against legible prescriptions. (6.24)

Housekeeping points

Strategy

7.33  The force should review custody policies to ensure that they meet the standards outlined in the College of Policing’s ‘Authorised Professional Practice on Detention and Custody’. (3.9)

Treatment and conditions

7.34  A hearing loop should be available in all custody suites and staff should know how to use it. (4.15)

7.35  Staff should ensure that detainees understand the question they are asked about their religious and cultural needs. (4.16)

7.36  Items for religious observance should be stored respectfully and there should be a way to identify the direction of Mecca. (4.17)

7.37  Toilet areas should be obscured on CCTV monitoring (4.18, repeated recommendation 4.34)

7.38  Custody staff conducting constant supervision via CCTV should not be engaged in other tasks. (4.36)

7.39  Part-time resilience suites should be ready for use at short notice and staff should be familiar with the equipment there. (4.51)

7.40  Recorded cell checks should take place daily and include the testing of call bells, and the correct use of cell call bells should be explained to all detainees. (4.52)

7.41  Mattresses should be wiped down between uses. (4.63)
7.42 Female detainees should routinely be offered hygiene packs. (4.64)

7.43 A stock of disposable razors should be maintained so that, subject to risk assessment, detainees who wish to shave before attending court can do so. (4.65)

7.44 A range of reading materials should be available and routinely offered, including books and magazines suitable for children and for those whose first language is not English. (4.66)

**Individual rights**

7.45 Voluntary attendees should not be ‘booked-in’ at custody suites by custody staff. (5.15)

7.46 Double-handset telephones should be available in all custody suites. (5.16)

7.47 Contact and attendance times for appropriate adults should be clearly recorded on custody records for monitoring purposes. (5.17)

7.48 All detainees should be given an up-to-date written notice of their rights and entitlements, and custody staff should be able to access the intranet to provide these in a range of languages and formats. (5.18)

7.49 Detainees should be offered an up-to-date copy of PACE codes of practice. (5.29)

7.50 Posters, in a range of languages, detailing detainees’ right to free legal advice should be prominently displayed in all custody suites. (5.30)

7.51 PACE reviews should be carried out on time. (5.31)

**Health care**

7.52 Detainees should be able to see a female health professional on request or be aware that they can request a female chaperone. (6.11)

7.53 Clinical rooms should have a standardised stock list and there should be regular checks of expiry dates. (6.12)

7.54 Relevant patient information leaflets should be accessible in all clinical rooms. (6.13)

7.55 Out-of-date clinical and pharmacological reference materials should be replaced by up-to-date materials. (6.14)

7.56 The time that a forensic medical examiner is called should be clearly recorded in the custody record to ensure that response times can be monitored. (6.25)

7.57 All clinical records should be legible and accurately reflect both the consultation and the management plan to ensure that custody staff are able to provide appropriate levels of care. (6.26)

7.58 Asthma inhalers should only be used for individual detainees. (6.27)
## Section 8. Appendices

### Appendix I: Inspection team

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
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<tbody>
<tr>
<td>Maneer Afsar</td>
<td>HMIP team leader</td>
</tr>
<tr>
<td>Gary Boughen</td>
<td>HMIP inspector</td>
</tr>
<tr>
<td>Fiona Shearlaw</td>
<td>HMIP inspector</td>
</tr>
<tr>
<td>Peter Dunn</td>
<td>HMIP inspector</td>
</tr>
<tr>
<td>Vinnett Pearcy</td>
<td>HMIP inspector</td>
</tr>
<tr>
<td>Mark Ewan</td>
<td>HMIC lead staff officer</td>
</tr>
<tr>
<td>Paul Davies</td>
<td>HMIC staff officer</td>
</tr>
<tr>
<td>Majella Pearce</td>
<td>HMIP health services inspector</td>
</tr>
<tr>
<td>Elizabeth Wands-Murray</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Laura Nettleingham</td>
<td>HMIP researcher</td>
</tr>
<tr>
<td>Joe Simmonds</td>
<td>HMIP researcher</td>
</tr>
</tbody>
</table>
Appendix II: Progress on recommendations from the last report

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

Strategy

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

Recommendations
The day-to-day management arrangements in custody should be sufficient to provide the required oversight of staff, clarity around roles and responsibilities and adequate quality assurance of outcomes for detainees. (3.14)
Not achieved

Treatment and conditions

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

Main recommendations
A comprehensive risk assessment should in all instances be completed on arrival in custody and this should be reflected in the level of observations undertaken. (2.19)
Not achieved

Detainees should be handcuffed only when a risk assessment indicates that this is necessary. (2.20)
Achieved

Cells and corridors should be clean, free from graffiti and properly ventilated. (2.21)
Partially achieved

Recommendations
Booking-in areas should provide enough privacy to allow effective communication between staff and detainees. (4.7)
Not achieved (recommendation repeated, 4.12)

There should be a clearer focus on the specific needs of juvenile, female and disabled detainees; staff should be trained to deal effectively with these detainees. (4.8)
Not achieved (recommendation repeated, 4.14)

Anti-ligature knives should be carried. (4.16)
Partially achieved
Custody sergeants and detention officers should attend the same handover briefings wherever possible. (4.17)  
**Not achieved**

Northumbria Police should collate the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.22)  
**Not achieved** (recommendation repeated, 4.42)

Rigorous health and safety walk-through arrangements should be applied consistently at all custody suites and should include the identification of ligature points. Records should be kept of these and remedial action taken, especially in relation to deep cleaning. (4.27)  
**Not achieved**

All detainees held overnight, or who require one, should be offered a shower and should be able to use one in reasonable privacy. (4.33)  
**Not achieved** (recommendation repeated, 4.63)

Toilet areas should be obscured on closed-circuit television monitoring. (4.34)  
**Partially achieved** (recommendation repeated as a housekeeping point, 4.18)

Food should routinely be offered at meal times and provided at other times on request and should be of sufficient quality and calorific content to sustain detainees for the duration of their stay. (4.40)  
**Achieved**

Detainees, particularly those held for more than 24 hours, should be offered exercise and the exercise yards should be made fit for purpose. (4.45)  
**Partially achieved**

**Individual rights**

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

**Recommendations**
Northumbria Police should further develop and promote alternative to custody approaches and custody officers should ensure that the ‘necessity test’ for arrest is meaningfully undertaken. (5.8)  
**Partially achieved**

Custody staff should ensure that detainee dependency obligations are routinely identified and, where possible, addressed. (5.9)  
**Achieved**

Northumbria police should liaise at a senior level with UKBA to ensure there are no undue delays in transporting immigration detainees to placements identified in the Immigration Custody Estate. (5.10)  
**Not achieved**

Pre-release risk assessments should be detailed and meaningful, based on an ongoing assessment of detainees needs while in custody, and leaflets giving details of local support services should be provided for detainees. (5.11)  
**Not achieved**

Appropriate adults should be provided to 17-year-olds and vulnerable adults. (5.21)  
**Partially achieved**
Northumbria Police should engage with the local authority to ensure the provision of secure beds for juveniles who have been charged but cannot be bailed to appear in court. (5.22)
Not achieved

Detainees should routinely be told how to make a complaint in line with the Independent Police Complaints Commission statutory guidance and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody. (5.25)
Not achieved

Health care

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

Main recommendations
There should be mental health diversion schemes that enable detainees with mental health problems to be identified and diverted expeditiously into appropriate services. (2.22)
Achieved

Recommendations
Clinical governance arrangements should be improved, including clear lines of accountability for checking the training, clinical supervision and appraisal of all forensic medical examiners. (6.9)
Not achieved

There should be robust infection control procedures for all clinical rooms, which should be regularly cleaned and capable of being used for taking forensic samples, and custody staff should have access to a full range of appropriate and standardised first-aid and resuscitation equipment that is checked regularly. (6.10)
Not achieved (recommendation repeated, 6.9)

All clinical records should be stored in accordance with the Data Protection Act and Caldicott principles to ensure confidentiality of personal health information. (6.20)
Not achieved (recommendation repeated, 6.22)