Report on an announced inspection of

Her Majesty's Armed Forces Service Custody Facilities

by HM Chief Inspector of Prisons

24 February–6 March 2014

Glossary of terms

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Section 1. Introduction

Service Custody Facilities (SCF) were established in 2009 to replace the old system of army unit custody facilities (guard houses) and similar facilities in other Services that had been in place for many years. They were intended to professionalise the detention of Service personnel held for short periods in military custody (remand) or short sentences of military detention. Service personnel detained for longer periods are held in the Military Corrective Training Centre (MCTC) in Colchester. This was our first inspection of SCF and, like the MCTC, we inspect these establishments by invitation. In all other respects, our approach to this inspection was consistent with our inspections of all other types of custody.

We inspected 15 SCFs, three run by the Royal Navy (RN), five by the Army and seven by the Royal Air Force (RAF). They are spread across all four nations of the UK and some are very small and seldom used. In practice, they serve different functions. Many, like the facility at HMS Nelson in Portsmouth, seldom do more than hold intoxicated personnel for a few hours while they sober up and are staffed by RN Service police who are redeployed for other functions. A few, like the SCF at Ward Barracks, Bulford, Wiltshire, hold a wider range. With 'detainees under sentence' (DUS), serving a sentence of military detention for less than two weeks and detainees not under sentence (DNUS) awaiting further investigation or awaiting trial. Bulford SCF and Merville Barracks SCF in Colchester were staffed by dedicated and experienced detention personnel from the Military Provost Staff (MPS) and we were pleased that this professionalisation of the role was being extended to other Army SCFs.

We did not inspect the old system of unit custody facilities but we are in no doubt that the SCF represent a significant improvement. However, the process of modernisation needs to continue. Given the range of SCF that exist it was not surprising that we found significant inconsistency in how they operate – even in the same Service. Furthermore, some were so small and infrequently used that the personnel who were called into staff them when a detainee was held were unfamiliar with the procedures they were supposed to follow and the risks they had to manage. In our view, consideration needs to be given to further rationalisation of the SCF estate – consolidating on a smaller number of tri-Service facilities, all staffed by professional custody personnel in the same way as the MCTC, Bulford and Merville Barracks facilities. Some SCF had an agreement with the local police to hold military personnel, still in accordance with Service discipline regulations, in police cells and that seemed to be an appropriate option for the SCF in more remote locations which could be extended more widely.

In any event, in criminal matters it will be important to be clearer about the respective roles of the Service and civilian police and between the Service police and custody staff in SCF. There were joint protocols between the Services and civilian police in England in Wales but not in Scotland or in Northern Ireland and even where these protocols did exist, we found a lack of clarity about who would detain, hold and investigate an alleged offender. In the RN, the same personnel might be responsible for both investigative and custodial functions relating to the same alleged offender and this created a conflict of interest. In the RAF both functions were carried out by Service police but different staff dealt with different roles. In the Army, custody staff were separate from the Royal Military Police (RMP). However, RMP stations were not at the same location as SCF and when detainees were being questioned they would, in practice, be detained by the RMP in a separate location, occasionally for some hours. Our remit did not include the treatment and conditions of those held by the RMP which was an omission.

In those SCF that mainly held intoxicated personnel for short periods, the treatment and conditions of those held were generally acceptable. However, there were dangers in a tick-box and risk-averse approach. First, although detainees were checked regularly, the most important part of such a check – full rousing to ensure the detainee can wake and respond, was not done. Second, there was real danger that detainees who posed different risks, of self-harm for instance, or who had different needs, such as women and young people under the age of 18, were not well cared for.

Some Army staff, primarily those dedicated MPS personnel in Bulford SCF and Colchester SCF, had received training in dealing with detainees at risk of self-harm or with mental health problems but few others had. Little thought or provision had been made for what women in custody might need and although staff in those SCF most likely to hold young people under 18 knew that specific arrangements applied, they had little knowledge of those arrangements themselves.

The cells and the regime were bleak and spartan throughout and particularly for those held for longer periods – sometimes for a couple of weeks and in one exceptional case, for good compassionate reasons, much longer – the conditions needed improvement. Those held for longer periods did at least get good time out of their cells, a good range of activities and benefited from good, often very good, relationships with custody staff.

Recording practice was often confused which meant that important information might be missed. Information was recorded inconsistently and in different places. We could at least track down that detention was properly authorised but recording of and accountability for the use of force was very poor, although we were told it was rarely used. The transfer of information from an SCF to the MCTC or to the unit to which a detainee was returning also required improvement.

We were concerned that on a number of occasions detainees had been transferred in vehicles with their hands cuffed behind them which, was obviously dangerous. Complaints processes were seldom used, were not adequately confidential and there was little knowledge of the role of the Service Complaints Commissioner who we think might want to satisfy herself that the low number of complaints reflects the fact there are few concerns rather than an ineffective complaints process.

In all forms of custody it is the exceptions that prove the greatest risk to those held and consequently to the reputation of the detaining authority. The treatment and conditions of most detainees held in the SCF were an improvement on what went before. However, the process of professionalisation and standardisation needs to continue so that the Services can be confident that detainees whose risks and needs differ from the norm or who are among the few held for longer periods, can be managed safely and securely.

Nick Hardwick
HM Chief Inspector of Prisons — August 2014

Section 2. Background and key findings

2.1 Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody.

2.2 These statutory inspections 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 Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

2.3 In 2004, HM Inspectorate of Prisons, by invitation and under an agreed protocol, began regular independent inspections of the Military Corrective Training centre (MCTC). This is the UK Armed Forces single central custodial facility holding mainly Service personnel who have been sentenced to 14 days to two years detention. The MCTC is staffed by Service personnel. In 2013 this invitation was extended to include the inspection of Service Custody Facilities (SCF). SCF are short-term secure facilities for holding mainly Service men and women who have been detained on suspicion of, or have been sentenced to short terms of detention for, offending against Service discipline or criminal law. There are a number of Service Custody Facilities (SCF) across the UK. SCF are operated by all three Services and this is reflected in some of the operational, procedural and cultural differences between different SCF.

2.4 This report consists of three sections relating to SCF, one for each Service. All three inspections were the first full inspections of SCF, following a successful pilot inspection in March 2013. SCF inspections are not currently fully compliant with OPCAT because such inspections have no statutory basis but they meet these requirements in all other respects.

2.5 The inspections of SCF look beyond the implementation of the joint Service publications (JSPs) that relate to custody and the Service Custody and Service of Relevant Sentence rules (2009), the Services' statutory instruments. They look at outcomes for detainees, particularly addressing treatment and conditions, individual rights and health care. They are informed by HM Inspectorate of Prison's independent criteria, *Expectations for UK Armed Forces Service Custody Premises* (2014).

2.6 We visited all the SCF licensed for use at the time of the inspection. The extent of their use varied enormously.

Service	**Location**	**Number of cells**	**Throughput 1 March 2013 to 28 Feb 2014**
Royal Navy (RN)	HMS Neptune, Churchill Square, Helensburgh, Scotland; this facility was situated outside the Naval base	2 single	0
	HMS Nelson, Portsmouth	4 single	40
	HMS Drake, Plymouth	12 single, but only 9 licensed at the time of the inspection	42

Army	Aldergrove Barracks, County Antrim, Northern Ireland	3 single, 1 x 3 person	3
	Ward Barracks, Bulford, Salisbury, Wiltshire	6 single, 2 x 3-person dormitory	169
	Catterick Barracks, North Yorkshire	5 single, 8-person dormitory	76
	Dreghorn Barracks, Edinburgh	12 single	55
	Merville[1] Barracks, Colchester, Essex	11 single, 3-person dormitory	10
Royal Air Force (RAF)	RAF Boulmer, Alnwick, Northumbria	1 single	0
	RAF Brize Norton, Oxfordshire	3 single	29
	RAF Cosford, Shropshire	2 single	10
	RAF Halton, Aylesbury, Bucks	2 single	3
	RAF Honington, Bury St Edmunds, Suffolk	2 single	10
	RAF Valley, Anglesey	1 cell	2
	RAF Waddington, Lincoln	1 cell	3

2.7 Due to the low numbers of detainees held across all three Services, our ability to observe the experiences of and outcomes for detainees was limited. We tried to offset this by interviewing 18 detainees at the Military Corrective Training Centre (MCTC) at the start of the inspection, all of whom had been held in a UK SCF beforehand. We also met and interviewed four other detainees during the inspection, two at Bulford and two at Catterick.

2.8 The use of SCF differed across all three Services. The Royal Navy and Royal Air Force only held detainees not under sentence (DNUS) following arrest. These detentions were for very short periods, rarely more than 12 hours. Initial detention was authorised for 12 hours but could be extended incrementally for up to 48 hours by the Commanding Officer and thereafter up to 96 hours by a Judge Advocate. Detainees were transferred to the MCTC in Colchester to serve a sentence of detention once they had been either sentenced at a court martial or dealt with via a summary hearing (Commanding Officer award). The Army held DNUS following arrest but also for short sentences of detention of no more than 14 days. These personnel were known as detainees under sentence (DUS).

2.9 Overall, we found a lack of clarity about when an alleged offender would be detained and held in custody and investigated by civilian or Service police. There was a joint protocol in place between civilian police forces and the Service police which outlined the working arrangements between them. However the guidance was not clear and related to arrangements solely in England and Wales and associated territorial waters. It did not include Scotland or Northern Ireland, although there were SCF in both countries.

[1] Merville Barracks SCF was re-opened from December 2013 after a period of closure.

2.10 There were differences in the staffing arrangements in SCF across the Services. The arrest and detention of suspects and the subsequent investigation of offences and disciplinary matters in the RN and the RAF were the responsibility of the Service police. In the RN and the RAF, the SCF were within Service police buildings and SCF staff were Service police officers who also undertook custodial duties in the SCF. Custodial duties were very infrequent and only formed a small part of their overall police role and proved problematic in maintaining skills and knowledge of detention (see below). In the Army the SCF staff were purely custodians, separate from the Royal Military Police (RMP), with the sole responsibility of care of detainees in their custody. This structure had the benefit of providing regular, dedicated custodial staff. However, in the Army the arrest and investigations were generally the responsibility of the RMP. The RMP stations were not within the SCF and detainees were frequently removed from the SCF to these stations for interview and other processes. The remit of this inspection did not extend to the RMP stations and consequently we did not inspect the treatment and conditions of detainees while they were in the custody of the RMP.

2.11 We found that because of the very low numbers of detainees held in RN and RAF SCF, there was inevitable ‘de-skilling’ of trained custody staff. Some staff did not have sufficient training and experience to care for detainees safely. There were inconsistent practices relating to detention within and between both Services.

Treatment and conditions

2.12 The time it took for detainees to reach an SCF varied but could be lengthy. In some cases detainees were handcuffed in vehicles, and some RN and RAF staff told us that they handcuffed detainees behind their backs, which was unsafe during travel. Detainees and staff said that there were sufficient toilet breaks during long journeys. The escorting staff for detainees transferred to the MCTC varied depending on the Service – in some cases it was their own unit staff, in others there was at least one member of trained custody staff on the escort. There were misconceptions from some SCF staff about when a detainee could arrive at the MCTC, which meant that some detainees travelled long journeys overnight, which could have been avoided. There was no formal person escort record used when transferring detainees from the SCF. The purpose of such a document is to ensure that all staff transporting and receiving a detainee are provided with all necessary information about them, including any risks or vulnerabilities they may present. So not all information was shared with staff at the MCTC or, to a lesser extent, between SCFs.

2.13 Not all staff were aware of the need to treat women, young people or those with specific needs differently, and issues of safeguarding were not well understood, although were better at some of the Army SCF. In SCF more likely to hold those under 18, staff were aware that the Services had specific arrangements for the care of young people, although they had limited knowledge themselves. Most SCF were not set up to meet the needs of detainees with a physical disability. All SCF had access to a chaplain, and could provide specific religious artefacts if required.

2.14 Risk assessments were carried out in all the SCF, but they were often poorly completed, not proportionate and did not inform subsequent actions. Whatever the risks identified, all detainees were considered high risk for their first 24 hours. This created some complacency in that custody staff might not be able to distinguish between detainees who were truly high risk and those who were just automatically classified as such. We found only one care plan prepared as a result of an assessment. Although observation books often gave a comprehensive account of a detainee’s time in custody, such information was not recorded in their individual file. Some Army personnel had received training in suicide and self-harm prevention and mental health, but other Services had not. Not all staff were clear about

rousing checks to check on intoxicated detainees overnight, and in some cases they were not carried out as staff wrongly believed that a detainee had to have eight hours' uninterrupted rest. Given that many detainees were under the influence of alcohol, staff should have been more risk aware.

2.15 The recording of use of force was different across most sites and within each Service. It was poor within the RAF SCF. Some assurance measures were in place in the Army and RN SCF, but monitoring to identify trends and improve practice was weak.

2.16 The quality of the pre-release risk assessment was poor, and not all detainees had one. We were not always assured that information about detainees' risks and needs was handed over to their units.

2.17 The cells in all the SCF were bleak, often with low bed plinths, no chair or table, and no toilet or running water (see photographs in Appendix II). They were particularly unsuitable for detainees held for longer periods, and were at odds with the care provided and risks posed. In all but one SCF cell, showers and toilets were clean, although they did not always provide sufficient privacy for female detainees. All SCF were checked regularly even when not used, although there was no requirement to run the water regularly to reduce the risk of bacteria build-up.

2.18 All SCF provided detainees with bedding, but none had the option of anti-ligature bedding. Arrangements for providing toiletries and women's sanitary products varied across all the SCF and they were not always readily available. Food was provided from the mess or galley, but meals were mostly only available at designated meal times, despite the fact that detainees could arrive at any time. Often there was nowhere for detainees to sit and eat their meals except the low bed plinths. Detainees who were taken to the mess for their meals told us that they felt humiliated as they were identifiable in their overalls and had to eat separately from other Service personnel.

2.19 In the RN and RAF SCF, detainees had limited access to fresh air, activities, reading material or radios. In the Army SCF, detainees were unlocked during the day and most could take part in activities on site. Visits were allowed in the Army SCF, which was good practice, although the facilities were poor. In the other SCF, staff told us that they would facilitate visits if they were thought to be in the detainee's best interest, although most had limited or no space for such visits.

Individual rights

2.20 In the RN there was a blurring of lines between arrest, custody and investigation, with a subsequent lack of clarity on roles and a conflict of interests. In the RAF there was clear separation of arresting officer and custody officer duties, but this resulted in some delays waiting for custody staff to be available. There was no such confusion in the Army SCF as they were purely custodians, separate from the RMP (see paragraph 2.10).

2.21 Detention was appropriately authorised in all the files we reviewed, but information was recorded in a variety of places, and not always in the same place even within the same Service. Some entries in the daily occurrence book were detailed and gave an excellent account of a detainee's stay, but such information was not replicated in their individual file.

2.22 Staff understanding of how a detainee might make a complaint varied across the Services, and arrangements were not sufficiently confidential. Even if they were aware of the Service Complaints Commissioner they did not understand the role sufficiently, so were unable to explain it to detainees in their care.

Health care

2.23 Detainees had good access to health professionals, except in a couple of cases where out-of-hours access to GPs was poor. Most SCF did not have clear local protocols for accessing emergency help quickly, and staff relied on local relationships. Both SCF and health staff demonstrated good knowledge to ensure detainees' health needs were met, but not all followed the Joint Service Publication (JSP) covering health issues. All SCF staff were highly trained in first aid management, but the first aid equipment was inadequate for predictable emergencies. Staff had some basic awareness of mental health and substance misuse issues but most had not received any formal regular training, which limited their ability to identify and support detainees. When a detainee had required clinical care, custody records did not contain sufficient entries on their health issues or any interactions with custody staff.

2.24 There were no protocols for medicine administration, although SCF staff described safe practices and medication administration was consistently recorded. Detainees were unable to access simple pain relief without a prescription, which created unnecessary delays.

Main recommendations

2.25 Concern: There were very low numbers of detainees held in some of the RN and most of the RAF SCF, yet each Service was required to maintain and staff a number of facilities. Staff in these SCF were not dedicated custodians, were used infrequently and inevitably became inexperienced and de-skilled.

Recommendation: A review of the current Service custody facilities should take place with a view to consolidating management of these facilities on behalf of all three Services with the Provost Marshal (Army) or, in the case of the smaller and more isolated units, agreeing protocols with local police forces for them to provide custody facilities for the Service concerned.

In the meantime, and for those SCF that remain:

2.26 Concern: Many detainees had offended against military discipline rather than criminal law. For those who had committed a criminal offence the criteria for determining whether they would be taken into Service custody, whether an alleged offence would be investigated and prosecuted by civilian or military authorities, and the processes for civil authorities informing the military of arrests and prosecution of Service personnel were unclear. Central guidance, through a joint protocol, was not clear and specific, which left room for local agreement, but we did not find any local written protocols. In any event, the guidance did not cover Northern Ireland or Scotland although there were SCF in both countries.

Recommendation: There should be clear and specific written national and local protocols to ensure a clear understanding between civil and Service police about which authority is responsible for the detention of alleged offenders, the investigation and prosecution of offences, and communication about involvement of Service personnel in the civilian criminal justice system.

2.27 Concern: Staff transporting and receiving detainees were not provided with any formal documentation providing them with the necessary information about the detainees, including any risks or vulnerabilities they may have presented.

Recommendation: Service custody facility staff should complete a person escort record whenever a detainee is transferred to another place of detention.

2.28 Concern: Risk assessments were carried out in all the SCF, but they were often poorly completed, not proportionate and did not inform subsequent actions. Whatever the risks identified, all detainees were considered high risk for their first 24 hours. This created some complacency in that custody staff might not distinguish between detainees who were truly high risk and those who were just automatically classified as such. We found only one care plan prepared as a result of an assessment.

Recommendation: Risk assessments should be proportionate to the risks identified and inform subsequent care of detainees.

2.29 Concern: Many detainees were under the influence of alcohol but not all staff were clear about rousing checks on intoxicated detainees overnight. In some cases they were not carried out as staff wrongly believed that a detainee had to have eight hours' uninterrupted rest.

Recommendation: All three Services should adopt the civilian police practice of rousing checks on detainees who are intoxicated, and record these on the custody record.

2.30 Concern: It was very difficult to get an overall picture of a detainee's treatment and respect for their rights during custody, Information about detainees, including authorisation of detention, was recorded in a variety of documents, not always located together and not always in the same place, even within the same Service.

Recommendation: Information relating to the detainee should be kept in one contemporaneous custody record.

Section 3. Royal Navy

Treatment and conditions

3.1 *Some escort transport for detainees was dirty and some detainees were handcuffed in unsafe conditions. Staff provided mainly good care for detainees but information from risk assessments did not result in a care plan, staff did not make regular rousing checks of detainees who were asleep and intoxicated, and they did not carry anti-ligature knives routinely. Information about detainees was held in too many different documents. Safeguarding protocols were not evident. Use of force was not effectively monitored. There were few formal pre-release risk assessments although detainees in need of support were given information about relevant agencies. The SCF were clean but cells were stark and inadequately furnished. Some detainees had their own clothing removed unnecessarily. Food could not always be provided when needed.*

Transfers and escorts

Expected outcomes:
Detainees transferring to and from Service custody premises are treated safely, decently and efficiently.

3.2 Detainees were transported to the SCF in Royal Navy police vans. Those at HMS Drake were clean, but those at HMS Neptune and HMS Nelson were dirty. The area in vehicles for carrying detainees was caged with a metal bench with no seat belts. We were told of detainees who had been handcuffed to both the front and rear in this caged area, which was unsafe. Handcuffs were removed on arrival at the SCF unless detainees' behaviour warranted otherwise.

3.3 A further van, used to transfer detainees for longer journeys from HMS Nelson in Portsmouth to the Military Corrective Training Centre (MCTC) at Colchester, was clean and had a compartment with upholstered seats and safety belts. We were told that detainees were generally transferred within a few hours of being sentenced and were not handcuffed. The van carried water and sandwiches on longer journeys, and staff assured us that detainees were given refreshments and regular toilet breaks, usually at police stations. Although transfers to the MCTC could take place throughout the day or night, staff at HMS Nelson said that they would keep detainees in custody overnight rather than travel then, which was appropriate. Staff did not complete formal person escort forms when transferring detainees to other places of detention (see main recommendation 2.27).

Recommendation

3.4 **Detainees should not be handcuffed with their hands behind their back during transfer.**

Housekeeping point

3.5 Vehicles used for transfer and escort should be clean.

Respect

Expected outcomes:
Detainees are treated with respect and their diverse needs are recognised and addressed during their time in custody.

3.6 No detainees were in custody at the time of the inspection, so we had no opportunity to observe interactions between staff and detainees. We were told that only one detainee was booked in at a time, so privacy was ensured, and each detainee had an initial risk assessment.

3.7 The SCF gave reasonably good attention to the potential needs of women detainees, although sanitary products were not always available. Women would be searched by a female officer, with such staff called in if required.

3.8 Although Service personnel were mostly physically able, retained injured personnel, including amputees, would require reasonable adjustments in the facilities if they were detained. None of the SCF had specific provision for detainees with disabilities. A national rehabilitative facility at HMS Drake provided support and treatment to injured personnel, and custody staff could seek help from its staff if they were concerned about individuals who were vulnerable or with disabilities. There was some recognition in HMS Nelson and HMS Drake of the specific needs of young detainees, and staff had access to the welfare services to support them. Staff at HMS Neptune were less sure about how to manage young people.

3.9 Some religious texts were available and these, and religious artefacts, could be provided by the base chaplain, who could also see detainees on request. However, HMS Drake staff said that they had been unable to obtain a Qur'an. Staff at Drake were not able to tell us how they would manage a detainee who was observing Ramadan.

Recommendations

3.10 Custodial facilities should be able to meet the needs of detainees with disabilities that affect their mobility or such detainees should not be held in an SCF.

3.11 All SCF should have access to significant religious texts and artefacts to meet the faith needs of detainees, and detainees should be able to observe their main faith services.

Safety

Expected outcomes:
Detainees feel and are safe throughout the duration of their detention. Detainees presenting any risks to themselves or others are assessed and managed by custody staff.

3.12 Custody staff in all the SCF were aware of the need to carry out risk assessments on all detainees, and used a standard pro forma checklist. Very few completed assessments that we reviewed contained much more than ticked answers to the questions. Detainees were asked about self-harm, drugs and alcohol misuse and other possible areas of vulnerability. Completed risk assessments did not always fully explain the issues that were raised and did not lead to individual care plans for the detainee (see main recommendation 2.28). All detainees, irrespective of the risks posed, were assessed as high risk and checked at least every 15 minutes for their first 24 hours, and this was excessive in some cases. Night lights were left on in cells to facilitate these checks, and were bright enough to disturb detainees' sleep. Reviews did not lead to a reduction in risk. All detainees were held singly in cells.

Information about a detainee, including information from risk assessments, and any resulting actions were contained in several different documents, not always kept together, which made it difficult to get an overall picture of the issues faced by the detainee, their needs and the care and timeliness of care provided (see main recommendation 2.30).

3.13 Most staff had received some training in suicide and self-harm prevention but none routinely carried anti-ligature knives when detainees were held. The knives were available in all SCF but sometimes at a distance from the cells, which could lead to delays in access.

3.14 Staff were aware of the need to take additional care when managing detainees under the influence of alcohol. However, only staff at HMS Drake told us they would undertake full rousing checks, which would include obtaining a response to questions or commands from the detainee. Checks at HMS Nelson usually took place through a closed cell door with no close physical check of the detainee (see main recommendation 2.29).

Housekeeping point

3.15 When detainees are held, all staff should carry appropriate ligature cutters.

Safeguarding

Expected outcomes:
Young detainees (under 18) are properly protected in a safe environment. All staff safeguard and promote their welfare. Detainees will only be subject to force which is proportionate, lawful and used as a last resort. Detainees are transferred or released safely and decently.

3.16 Staff had very little understanding of the concept of adults at risk, although they said they would contact the defence community mental health team if they had concerns. We were told that it was rare to detain naval personnel under the age of 18 and staff were aware of the need to provide additional support to detainees under 18. However, they did not know of any formal safeguarding protocols or referral systems for young detainees or adults at risk and had not received any formal training in safeguarding. Staff at HMS Nelson called on naval family Services to assist with detainees under 18, and also said that they could provide the services of appropriate adults for young people or adults at risk[2] through their legal Services division.

Recommendation

3.17 **Custodial staff should be fully trained in the needs of detainees under 18 and other detainees at risk, and how to make referrals to appropriate services.**

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[2] We define an adult at risk as a vulnerable person aged 18 years or over, 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'. *No secrets* definition (Department of Health 2000).

Use of force

3.18 Staff had been trained in the use of force and had regular refresher courses. Some told us of the need to prioritise de-escalation in cases where detainees were refractory. Handcuffs were only used where an assessment deemed it necessary, and they were removed at the earliest opportunity.

3.19 Use of force was recorded in officers' notebooks and reported on a specific form. We were not assured that there was any local scrutiny of use of force, and staff were not aware of any oversight of its use. Staff at HMS Nelson said that they would send use of force forms to the Service crime bureau, but in fact completed forms were copied to the Area Naval Provost Marshals and to the Defence School of Policing and Guarding to inform PST instructors.

Recommendation

3.20 Use of force in SCF should be subject to appropriate analysis and governance.

Release and transfer

3.21 We saw few completed pre-release risk assessments in the detainee records we examined. The ones that were completed lacked detail and were not useful in assisting the detainee on release.

3.22 Detainees released from HMS Nelson were often expected to make their own way back to their base or place of release. Travel warrants were provided at all SCF for those travelling long distances, and divisional officers could provide funds for those closer to their base, if required. At HMS Drake, detainees were released into the care of someone they knew, such as their unit officer.

3.23 Staff in all SCF signposted detainees to support agencies and some made referrals to divisional welfare staff. At HMS Nelson, staff ensured that commanding officers were aware of any of their staff held in detention and when they were released.

3.24 Not all SCF had a copy of the training and advice DVD about the MCTC or the means to show it to detainees expecting to go there. The DVD was also out of date (see paragraph 4.32).

Recommendation

3.25 All detainees should be fully assessed on their release, with appropriate referrals to support services where required.

Physical conditions

Expected outcomes:
Detainees are held in a safe, clean and decent environment, which is in a good state of repair and fit for purpose.

3.26 All the cells and communal areas were clean and well maintained. No cells had any furniture other than a bed plinth, some of which were low and not suitable for detainees to sit on comfortably. We found no obvious ligature points. Evacuation policies were in place and staff were aware of the procedures.

3.27 Cell call bells were tested daily and health and safety checks carried out regularly. Checks were recorded and use of the cell bell explained to detainees.

Recommendation

3.28 **Detainees should be provided with furniture in their cells, subject to a risk assessment.**

Detainee care

Expected outcomes:
Detainees are able to be clean and comfortable while in Service custody facilities. Detainees are offered sufficient food and drink. Detainees have regular access to facilities and activities that preserve and promote their mental and physical well-being.

3.29 All detainees were given mattresses, pillows and blankets or duvets. Access to toilets and showers was on request in all the SCF. Toilet and shower areas were clean and adequately screened, with toilet paper supplied. Checks when the facilities were not occupied did not include running the water regularly to reduce the risk of bacteria build-up. Not all SCF had supplies of sanitary products for women detainees. Custody staff said they would buy supplies if required but only during usual shop opening hours.

3.30 All detainees held in HMS Neptune and HMS Nelson had their clothing removed and were required to wear overalls. None of the SCF had supplies of underwear. Detainees at HMS Drake only had their clothing removed if it was needed for forensic examination. Paper overalls were sometimes provided if supplies of overalls had run out.

3.31 Food was provided from the galley at regular meal times but there were no formal arrangements for providing food outside these times. Some staff said they would provide food from elsewhere if a detainee was hungry, but most were unable to provide food outside regular meal times. Drinks, including water, were available throughout detention but only on request.

3.32 Detainee records showed that detainees spent much of their time sleeping. There was very little for detainees to do. A few newspapers, magazines and books were available on request, and radios were occasionally provided in some SCF.

3.33 Not all the outside exercise areas were sufficiently private – the one at HMS Neptune was overlooked by private houses and a school. At HMS Drake and HMS Nelson, detainees had to use the van dock to access fresh air, with the latter overlooked by offices. Detainees could generally smoke outside on request.

3.34 Detainees were given access to telephones on their initial reception and then daily. The initial call was free. Detainees were only able to receive visits in exceptional circumstances which was appropriate for most due to their short stays.

Housekeeping points

3.35 All SCF should stock women's sanitary products and routinely provide them to women detainees.

3.36 Detainee clothing should only be removed following risk assessment or for forensic reasons, and underwear should be available.

3.37 Food should be available for detainees 24 hours a day.

3.38 Detainees should have constant access to drinking water throughout their detention.

Individual rights

3.39 *Authorisation of detention was appropriate and rarely refused. The SCF ensured that detainees did not remain in custody for longer than necessary, and it was rare for detention to last longer than 12 hours. Detention records did not make clear that all legal rights had been facilitated. Detainees had good access to legal representatives. Staff knowledge of the complaints procedure was poor.*

Rights relating to detention

Expected outcomes:
Detention is appropriate, authorised and lasts no longer than is necessary.

3.40 The criteria for determining whether arrested Service personnel would be taken into Service custody, whether an alleged offence would be investigated and prosecuted by civilian or Service police, and the processes for civil authorities informing the Service of arrests and prosecution of Service personnel were vague. Central guidance, through a joint protocol, was not clear and specific, which left room for local agreement, but we did not find any local written protocols (see main recommendation 2.26).

3.41 Detention could only be authorised by the commanding officer or a delegated representative. The detention files we reviewed showed that appropriate authorisation was obtained in all cases. SCF staff were clear that they could not detain anyone until authorisation had been granted. Detention files recorded reasonable explanations for seeking authorisation. Staff we spoke to at all the custody facilities were not aware that custody had ever been refused, which they said was primarily because naval personnel were only arrested when absolutely necessary, after alternatives had been considered.

3.42 Royal Navy police were able to use section 69 of the Armed Forces Act 2006 ‘in anticipation of arrest’. This permitted them to take a member of the Navy away from potential conflict to prevent their involvement in a situation that might lead to their arrest. We were told that this was a useful piece of legislation that prevented individuals from being arrested.

3.43 There was a good emphasis on ensuring that detainees did not remain in custody longer than necessary. Detention was always initially authorised for 12 hours, and in the detention files we reviewed detainees did not remain in custody for any longer than this initial period. There was good use of direct orders to detainees to attend the SCF for later interview, and it was an arrestable offence if they failed to attend. This measure minimised the time that detainees spent in custody.

3.44 Royal Navy police officers had routine policing duties alongside their custodial roles. At HMS Neptune and HMS Drake we were told, and saw evidence in custody files, that the arresting officers sometimes had to undertake custody duties, and could potentially be the investigating officer. This was a clear conflict of interest and potentially compromised the integrity of the investigation.

3.45 All three SCF had a memorandum of understanding with the local police force to enable naval personnel to be held in local civilian police custody. At HMS Neptune this option was used to good effect and meant that the civilian police provided custodial Services for the very few alleged offenders who required detention, and the very limited SCF facilities and resources were not used.

Recommendation

3.46 **Custody staff should not investigate offences allegedly committed by detainees under their care.**

Rights relating to Joint Service Publications relevant to UK armed forces Service custody facilities

Expected outcomes:
All rights relating to relevant Service codes of practice are adhered to.

3.47 Although the custody records showed that detainees had been informed of their rights, information about whether their rights had been subsequently facilitated was difficult to locate in the detention files we reviewed. For example, at HMS Nelson, other than a notice given to the detainee immediately before interview, there was no record of whether the right to legal advice had been accepted or not or, if necessary, acted upon. At HMS Neptune, evidence that legal representation was requested was in the investigation paperwork rather than in the daily occurrence book. The recording was better at HMS Drake, where the daily occurrence book clearly recorded that detainees were informed of their rights as part of the booking-in process, and that the Ministry of Defence form (811A) 'Service police notice to suspect upon arrest or at interviews with the Service police', which outlined detainees' rights, had been given to them.

3.48 There was a duty solicitor scheme, and we were told that solicitors usually attended promptly, with no concerns about the scheme reported to us. There were private rooms, with a telephone, that detainees could use to consult their legal representative. There were no notices about detainees' right to free legal advice.

3.49 In most files we reviewed, detainees were asked to nominate a person they would like to be informed of their arrest. While the details of the nominated person was recorded in the occurrence book or register, it was not always clear whether the call had been made. One detention file stated that at 3am the detainee had requested his next of kin to be contacted, but he was released at 11.20am without being informed that this had been done, which was

poor practice. However, there were records that divisional officers had been informed of a detainee's arrest.

3.50 Detainees not under sentence (DNUS) were given a comprehensive booklet, *Your rights if you are accused of an offence under the Service justice system*. Codes of the Service custody and Services of relevant sentences rule 2009 were available in all the SCF, which would allow the detainee to read it or staff would photocopy the extracts they required. SCF staff were clear that if detainees were unable to comprehend the information given to them they would go through the documentation with them and ensure they understood their rights.

3.51 SCF staff told us that most detainees were brought into custody for alcohol-related offences, and that they contacted medical officers if they were concerned about their fitness to be detained. The detention records showed that detainees were given a rest period before they were interviewed, either because they were under the influence of alcohol or drugs or because of the late hour.

3.52 SCF staff could not recollect any recent requests for authorisation for an intimate search of a detainee, but they understood the level of authorisation required and the process for such a search.

3.53 There were no telephone interpreting services available for non-English speakers or appropriate equipment (double handsets), but all three bases said that they would contact the local police force and obtain an interpreter if required. Staff could not recall having to request such services.

3.54 SCF staff had no guidance on granting access to detainee records for legal representatives or detainees. Some told us that they would make these available on written request, and would copy paper files, registers and occurrence books.

Housekeeping points

3.55 Detainee records should clearly record that their rights have been explained, whether these have been accepted or not, and any subsequent facilitation of such rights.

3.56 Information about free legal advice should be displayed prominently in all SCF.

3.57 SCF staff should have sufficient knowledge about how to respond to the needs of young people detained.

3.58 Telephone interpreting services, and a double-handset telephone, should be available to interview and communicate with detainees who require them.

Rights relating to treatment

Expected outcomes:
Detainees know how to make a complaint and are able to do so.

3.59 Information about how a detainee could make a complaint was displayed in the SCF, but the notices were too small and would have to have been pointed out to the detainee. Some documentation given to detainees provided information about how to make a complaint, and in the records we reviewed detainees were asked as part of the release process if they had any complaints about their arrest or their detention. SCF staff said they had never known

any complaints being lodged which was not surprising as detainees were asked by the staff who detained them if they had any complaints.

3.60 We were not assured that there was a confidential complaints system in operation. We were told that complaints were taken by someone independent of the arrest. If the complaint was about a detainee's treatment, a senior manager investigated it. If appropriate, the matter was referred to the professional standards department (which dealt with complaints that potentially involved misconduct by a member of the Royal Navy and possible disciplinary action or advice). There were no standard complaint forms that detainees could complete. SCF staff were not aware of any timescales in dealing with complaints and so could not give a detainee any advice or guidance.

3.61 There was no information in the SCF or in the documentation for detainees about the Service Complaints Commissioner (SCC). Although staff were aware of the SCC, they had no relevant information to give to detainees.

Recommendation

3.62 **A confidential complaints system should be introduced and information about how to make a complaint, including the role of the Service Complaints Commissioner, should be given to all detainees and also be prominently displayed in the SCF.**

Health care

3.63 *Detainees had good access to required health care support, but there were insufficient local protocols to ensure their health needs were consistently met. Custody staff were well trained in first aid, but the available emergency response equipment was too limited.*

Expected outcomes:
The health needs of detainees are addressed during their time in custody.

3.64 Custody staff reported that the demand for health care professionals (HCPs) was low, but there was good access to health professionals as needed. They requested HCP involvement based on identified detainee need, such as medical history or injuries, and on detainee request. Requests for a same gender HCP were facilitated if possible.

3.65 Custody staff had not received mental capacity training, but said that they used a common sense approach. Custody staff had no training on mental health or substance misuse management, but contacted health staff for advice as required.

3.66 Custody staff reported that all medications brought in by detainees was checked by a HCP and administration instructions written as required. All medications were stored in locked cupboards, although not all the storage facilities were sufficiently secure. Custody staff supervised and recorded all medication administration, but there was no medication protocol to ensure consistent safe practice.

3.67 Not all the SCF had clear easily accessible protocols to identify and respond to medical emergencies, although staff described the appropriate action to take. All staff were first aid trained and all SCF had basic first aid supplies, but the equipment was inadequate for

predictable emergencies related to intoxication or major self-harm. All staff said that first aid supplies were checked regularly, although these checks were not always recorded.

3.68 Staff said that they would request health professionals to attend after the use of force or mechanical restraints if injury was evident or on detainee request, but they had never been asked to attend and injuries had never occurred. They did not routinely attend as specified in joint Service protocol (JSP) 837. Staff said that they would refer any need for intimate searches of detainees to Service health staff, but we were not assured that they could provide this service.

Recommendations

3.69 There should be a complete range of evidence-based protocols, agreed with key stakeholders, covering all aspects of detainees' health needs, including medical emergencies, medications administration, referral to health services and intimate searches. All medication should be securely stored in lockable wall-mounted drug cupboards.

3.70 Detention staff should receive training to identify and safely manage detainee health issues, including mental health awareness, substance misuse awareness and mental capacity.

3.71 First-aid kits should contain sufficient in-date equipment to manage predictable incidents, such as serious self-harm or choking, and have regular recorded checks, and all staff should be trained in its use.

Section 4. Army

Treatment and conditions

4.1 Facilities were used to detain people both under sentence and during investigation, usually for no more than 14 days. All staff had been trained in basic custody management but further training, such as in mental health, was inconsistent. Detainees sometimes travelled long distances overnight unnecessarily. Custody recording was inconsistent and failed to provide a constant record between different sites. Provision for young people was mixed. Physical conditions were clean and well maintained but unnecessarily austere. Pre-release risk assessment was inconsistent. The remit of the inspection did not include the treatment of detainees once they were in the custody of the Royal Military Police (RMP).

Transfers and escorts

Expected outcomes:

Detainees transferring to and from Service custody premises are treated safely, decently and efficiently.

4.2 Transfers to and from SCF were generally made by the detainee's own unit staff. The escort complement was usually a driver and two escorting staff, of whom at least one would be of the same sex as the detainee. Ordinary saloon cars were used to transport detainees and although handcuffs were carried they were rarely used.

4.3 Some journeys were very long – for example, it took more than eight hours to travel from Dreghorn in Scotland to the Military Corrective Training Centre (MCTC) in Colchester. This particular journey usually took place overnight, which was unnecessary, but escorting staff were under the misapprehension that MCTC staff would only receive detainees during the early morning when, in fact, they would have received detainees at any time. Toilet stops were scheduled and were normally at motorway service stations, although there could be stops at other Army bases en-route if required.

4.4 Escorts from Aldergrove in Northern Ireland were flown to Stansted Airport (again usually not handcuffed) and then by road for the short journey to MCTC. Other journeys were significantly shorter and usually took place during the working day.

4.5 A full copy of the detainee's assessment record (DAR) was provided to the escort for delivery at MCTC, but there was little recorded evidence of information sharing with escort staff (see main recommendation 2.27) and no continuous record of custody beyond the use of a form known as a 'live body receipt', which gave basic information about the detainee and their detention (see main recommendation 2.30). Detainees were informed of their transfer as soon as transfer notices were received and were allowed a free telephone call to inform families.

4.6 In addition to transfers from places of arrest to hearings and to the MCTC, members of the RMP also escorted detainees from the SCF to RMP stations. We were told that this was primarily for investigative interviews, but that the RMP often released detainees from custody without the need for them to return to the SCF. SCF staff were unaware of the treatment of and conditions for detainees once they had left the SCF, and few had ever

visited the local RMP station. As our remit during the pilot SCF inspection in March 2013 and this first full inspection did not include RMP stations, we did not inspect the treatment and conditions of detainees while they were in the custody of the RMP.

Recommendations

4.7 Detainees should not be escorted overnight to the Military Corrective Training Centre.

4.8 Custody procedures should provide assurance about the treatment and conditions of detainees while detained in RMP facilities.

Respect

Expected outcomes:

Detainees are treated with respect and their diverse needs are recognised and addressed during their time in custody.

4.9 There were very few detainees in custody during our inspection but almost all who we spoke to at the MCTC reported good and respectful treatment. SCF staff were able to demonstrate a good knowledge of those who had been in their care.

4.10 The initial interviews and subsequent risk assessment of detainee arrivals at an SCF were held in sufficient privacy – usually in designated interview rooms or in offices next to the custody staff office. Searching was proportionate and always conducted by custody staff of the same sex.

4.11 Although Service personnel were mostly physically able, retained injured personnel, including amputees, would require reasonable adjustments in the facilities if they were detained. There was no awareness by any SCF of the potential needs of detainees with disabilities or temporary debilitating injuries. The only suitable adaptation at any of the sites was a disabled toilet at Bulford.

4.12 All sites had access to the base chaplaincy and contact varied from 'on request' to a daily visit by the chaplain to see those in custody and also the custodians. Access to chaplains of minority faiths depended on the religious make up of the barracks. All SCF held a range of religious artefacts, although, with the exception of Bulford, there had been little consideration of the practicalities required for some observance – such as indicating the direction of Mecca for Muslim detainees or how to arrange food during Ramadan and other religious festivals. As with other daytime activities, detainees could usually attend religious services under the supervision of their own units. Where this was not possible for security reasons, the chaplain would visit the unit.

4.13 It was very unusual for women to be held in custody and arrangements were subsequently underdeveloped, although separate accommodation had been allocated at Merville Barracks SCF. We were told that as there were few (or no) female custody staff, female RMPs or NCOs from the detainee's unit would be seconded to the custody team for a woman detainee. Not all the sites held any sanitary packs for women, and we were told that these would be bought locally or brought over from the detainee's possessions in her barracks. With the exception of Merville, the showers and toilets had little privacy and would need very careful arrangements for any woman who was detained.

Recommendation

4.14 Custodial facilities should be able to meet the needs of women detainees. Detainees with disabilities that affect their mobility should not be held in SCF unless provision can be made to meet their needs.

Safety

Expected outcomes:

Detainees feel and are safe throughout the duration of their detention. Detainees presenting any risks to themselves or others are assessed and managed by custody staff.

4.15 All SCF staff had undergone initial custody training and subsequent annual refresher sessions. Two of the four staff at Dreghorn had undergone mental health awareness training with Health Scotland, which they said had improved their knowledge and skills. As elsewhere, there was a large reliance on the barracks mental health team in the event of any concerns.

4.16 Initial risk assessment processes were thorough and conducted in private. The DAR took around an hour to complete and provided a good range of information for custody staff, although we saw no specific care planning for those in custody. Whatever the result of the risk assessment, all detainees were considered to be high risk for at least 24 hours. There was the real potential for this to lead to complacency among staff in that they might not be able to distinguish between detainees who were truly high risk and those who were not, but had been classified as such. As the detainees were considered high risk, they were also subject to additional observations throughout night and held in very stark conditions during lock-up periods. This was incongruous with the remainder of their time in custody when they could take part in normal activities (see paragraph 4.44), and could have raised their anxiety levels (see main recommendation 2.28).

4.17 When a detainee was received from the RMP, a check had already been made with the police national computer or the Redcap-Coppers database. These databases identified any relevant warning markers to aid the risk assessment. However, if a detainee was received from elsewhere, there would have been no such check and SCF staff had to take steps to obtain this information, as no SCF had direct access to these databases. Staff knowledge of these databases and the procedure to obtain information was often vague – for example, staff at Bulford SCF informed us that this information could be obtained within a couple of hours, while staff elsewhere were unsure and said it could be 'a day or two'.

4.18 Anti-ligature knives were issued to custody staff whenever a detainee was received into custody. In general, detainees only remained in their cells between 8pm and 6am, when they received a high level of observation (usually every 15 minutes), and in some cases, cell lights remained on all night, which led to discontent for many of the detainees we spoke to. There was limited awareness among some custody staff of the risk of self-harm, and at one site, only the senior non-commissioned officer had received any in-depth awareness and harm management training. The SCF self-harm monitoring form was not universally available, and not all staff knew of its existence.

4.19 We did, however, learn of some good levels of care for detainees at risk of self-harm at Bulford SCF. In one case which involved a particularly at-risk detainee, we saw appropriate risk assessments had been completed with the involvement of the mental health team and good quality care plans were in place. Staff had a good knowledge of the detainee and a longer- term detainee had been asked to keep an eye on him. This was part of his overall care plan and was a common sense approach to ensure his continued safety.

4.20 Not all sites held detainees who were under the influence of drink or drugs, with alternative options including location in the health care unit, constant observation in barracks or being held by civilian police. Where those 'under the influence' were detained, observation checks were made at least every 15 minutes, although these were not always civilian police type 'rousing checks', such as checking responses to commands etc (see main recommendation 2.29). We were informed that this often meant ensuring that the detainee's head faced the door to aid observation. The detainee was then allowed an eight-hour 'rest' period before interview. Bulford SCF had two open-door areas, known locally as 'drunk tanks', sited directly opposite the booking-in desk, and with low benches, where heavily intoxicated detainees could be monitored. However, we were informed that these areas were seldom used.

4.21 There were multiple-bed cells at some sites and cell sharing risk assessments were available if required. However, to reduce opportunities for bullying, all sites operated a policy of a three-person minimum for cell sharing, but no staff could recall any multiple-bed cells ever being used, due to the low number of detainees.

4.22 Except for Catterick SCF and Bulford SCF (which had detailed custody records for detainees), detainee issues were mostly recorded in the daily occurrence book, which, unlike a custody record, failed to provide any record of care or issues to subsequent facilities following transfer. There was some recording in individual files, but no common process for ensuring continuity of recording between sites (see main recommendation 2.30).

4.23 We did not observe any handover processes between escort and SCF staff or between shifts, so it was not possible to ascertain the quality of information passed. All sites had a handover sheet which, in the main, just stated that a handover had taken place between shifts.

Recommendations

4.24 **All SCF staff should have knowledge of and better access to relevant computer databases to retrieve and, where necessary, upload information that could affect the current and future safety of detainees and staff.**

4.25 **All custody staff should be regularly trained in the management of self-harm.**

Safeguarding

Expected outcomes:

Young detainees (under 18) are properly protected in a safe environment. All staff safeguard and promote their welfare. Detainees will only be subject to force which is proportionate, lawful and used as a last resort. Detainees are transferred or released safely and decently.

4.26 Not all SCF were licensed to hold detainees under the age of 18, who had to be transferred immediately to the MCTC or to Catterick SCF if this occurred. There was a disparity in understanding of the issues and custody requirements of under-18s. Catterick SCF was the most likely to hold under-18s and staff there, and those at Merville SCF and Bulford SCF, had some reasonable understanding of the potential issues. Safeguarding protocols were in place

although they had not needed to be used. There was no understanding of or policies for the protection of adults at risk.[3]

Recommendation

4.27 Safeguarding policies and procedures for under-18s and adults at risk should be available and standardised across all sites.

Use of force

4.28 There had been no recent uses of force recorded at any of the sites, and it was clear that force was very rarely required. Handcuffs were available but not used in the SCF, and if RMP officers had handcuffed detainees they were removed on entry to the SCF.

4.29 All custody staff had undergone basic use of force and personal protection training. Any use of force would be recorded in the detainee's custody file and an incident report submitted to the Provost Marshal (Army). However, Catterick SCF used a comprehensive set of forms modelled on Prison Service processes and submitted a monthly report to the PM (A).

Recommendation

4.30 Use of force recording and reporting should be standardised across sites, monitored to identify issues and fed into improving protective safety training.

Release and transfer

4.31 All sites had information available that referred detainees to external agencies such as The National Debt line, Alcoholics Anonymous and the Samaritans but pre-release procedures and process varied across the sites. We were unable to find any reference to assessment at Dreghorn, Aldergrove and Merville SCFs but at Bulford and Catterick SCFs there was a comprehensive assessment that covered key elements of post-custody support and assurance of safety with detainees released into the care of unit or escort staff. We were informed that detainees were always released from the SCF into the care of unit staff, never alone.

4.32 Most of the detainees we interviewed at the MCTC said that they had watched the training and advice DVD about the MCTC at the SCF before transfer there. Most said that it was helpful but outdated, and did not explain all the appropriate aspects of the MCTC (such as the procedures for DNUS awaiting the result of an investigation). We were told that detainees were permitted to inform their relatives or friends of their impending transfer.

4.33 SCF staff could complete a temporary release form if a detainee was escorted by the RMP elsewhere, but we were told that once the detainee was in RMP custody, the RMP usually released them, but we were unable to ascertain the process for this (see paragraph 4.6).

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[3] We define an adult at risk as a vulnerable person aged 18 years or over, 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'. *No secrets* definition (Department of Health 2000).

Recommendation

4.34 **All detainees should be fully assessed on their release, with appropriate referrals to support services where required**.

Housekeeping point

4.35 The training and advice DVD about the MCTC should contain all the relevant information for detainees.

Good practice

4.36 *Detainees were always released from the SCF into the care of unit staff.*

Physical conditions

Expected outcomes:
Detainees are held in a safe, clean and decent environment, which is in a good state of repair and fit for purpose.

4.37 All SCF were certified appropriately by the Provost Marshal (Army). The cells were checked regularly, including the call bells. All the detainees we spoke to said that the call bells had been explained to them, but none had needed to use them.

4.38 The cells in all the SCF were unsuitable for detainees held for more than 24 hours. The cells were clean but very bare and equipped to cater for a high risk of self-harm, rather than on the basis of individual risk assessment. There was no seating or other furniture, and only a plinth for a bed, a mattress, pillow and minimal bedding. There was no in-cell sanitation or drinking water, with access these having to be requested from custody staff. Detainees could not have any possessions in their cell, and had no control over the lighting – a night light was kept on all night to aid staff observations. At Aldergrove SCF the cells were cold, even with the heating on, but elsewhere they were appropriately heated.

Recommendation

4.39 **Detainees should be provided with furniture in their cells, subject to a risk assessment.**

Housekeeping point

4.40 Detainees should have constant access to drinking water.

Detainee care

Expected outcomes:
Detainees are able to be clean and comfortable while in Service custody facilities. Detainees are offered sufficient food and drink. Detainees have regular access to facilities and activities that preserve and promote their mental and physical well-being.

4.41 Basic clothing was available at most sites, and it was expected that a detainee's parent unit would provide uniforms and possessions. All showers and toilets were clean, and those we tested provided hot water, but checks when the facilities were not occupied did not include running the water regularly to reduce the risk of bacteria build-up.

4.42 Meals were usually taken in the junior ranks mess hall, with detainees escorted by custody staff. They were inevitability identifiable as detainees due to their escort, and more often than not by their overalls. Some detainees said this was embarrassing or humiliating.

4.43 At some sites, frozen meals were held in case detainees arrived late, but at others the arresting or escort staff were responsible for ensuring that meals were provided on time before the detainee's arrival.

4.44 Where possible, detainees took part in normal unit-based activities during the day, which made the return to solitary and bleak cells (see photograph in Appendix II) all the more incongruous (see paragraph 4.16). At Bulford and Catterick SCFs a range of activity programmes were available, including lessons and gym sessions. At Aldergrove SCF a programme of activities was displayed on SCF walls, but on investigation these were aspirational and unlikely to take place.

4.45 All sites had exercise yards but in practice they were used as smoking areas due to the relatively free access to activities during the day. Both legal and domestic visits were facilitated in the SCF and usually held in briefing or interview rooms. In Bulford SCF a family visit was held in the communal association room with the agreement of the other detainees. While the facilitation of the visit was good practice the environment was unsatisfactory. All detainees received a free telephone call on arrival, with a free weekly 10-minute call for those remaining longer than 24 hours.

4.46 Most sites had a rest area with television, some games consoles and a small library of books and DVDs. Newspapers were also available at some sites, and detainees had access to on-site shops to purchase goods.

Housekeeping point

4.47 Detainees should be able to take their meals in conditions that are respectful.

Individual rights

4.48 *Detention and custody was appropriately authorised by commanding officers (or their delegate), except in one case where we found no authorisation in the detention file. All detainees were issued with a copy of the relevant rights booklet on arrival at the SCF. The relevant Service rules and right to free legal advice were not always prominently displayed or the rules available for personal issue. The consistency of information recorded in the detention register, detention files and daily occurrence book varied, with the need to constantly cross-refer information and the potential for inaccuracy. Complaints processes were displayed but staff were unclear about complaints to the Service Complaints Commissioner or the monitoring role of the Headquarters Provost Marshal (Army) (HQ PM (A)).*

Rights relating to Joint Service Publications relevant to UK Armed Forces Service custody facilities

Expected outcomes:

Detainees are informed of and understand the reasons for their detention or sentence. All rights relating to relevant Service codes of practice are adhered to.

4.49 The criteria for determining whether arrested Service personnel would be taken into Service custody, whether an alleged offence would be investigated by civilian or Service police, and the processes for civil authorities informing the Service of arrests and prosecution of Service personnel were unclear. Central guidance, through a joint protocol, was not clear and specific, which left room for local agreement, but we did not find any local written protocols (see main recommendation 2.26).

4.50 We were told that not all arrested personnel were taken to an SCF. Where detainees were arrested by the RMP, the appropriate grounds for custody were, in the first instance, established by the RMP arresting police officer, and such detainees were often initially taken to an RMP station. We were informed that SCF were only used if it was necessary to detain a person for a longer time. Authorisation was then sought from the soldier's Commanding Officer (CO) (or their delegate), who could authorise custody for up to 48 hours from the time of arrest, with reviews after 12 and 36 hours. We did not inspect the process of custody of arrested persons outside the SCF. However, most of the detainees to whom we spoke, and the cases in the files that we looked at, were not arrested by the RMP and were brought directly to an SCF by a parent unit, often directly from barracks or courts martial. In such instances, if there was no authority from the courts martial, CO or judge advocate, SCF sought the relevant authority immediately.

4.51 SCF staff said that it was their role to ensure that the paperwork accompanying detainees was correct and fully completed. In the files we examined at all SCF, detention and custody was authorised appropriately by COs or their delegates, with the exception of one case at Dreghorn SCF, where there was no authorisation in the detention file for a detainee not under sentence (DNUS). SCF staff said they would make contact with the RMP arresting officer or relevant unit to obtain continued authorisation to detain an individual.

4.52 The SCF could be used to detain detainees under sentence (DUS) for up to 14 days. Any sentence longer than that meant an immediate transfer to the MCTC, and any DNUS would normally not be permitted to remain at an SCF for more than eight days. However, we saw a detainee who had been DNUS for almost three weeks on the authority of a Judge

Advocate and agreed by a senior officer in HQ Provost Marshal (Army) (PM(A)). This was to facilitate contact with his family, which displayed some compassion and flexibility.

4.53 All the detainees we spoke to at Bulford and Catterick SCFs confirmed they had received a copy of *Your rights if you are accused of an offence under the Service justice system* booklet on arrival at the SCF. Elsewhere, the daily occurrence book (DOB) or detention files recorded that these had been offered and accepted. However, in Aldergrove SCF, the booklet available for issue was an old version and out of date. Staff told us that if a detainee had difficulty in reading or understanding the booklet, they would read it to them and explain its content.

4.54 Where the RMP had made the arrest, the arresting RMP officer was responsible for asking detainees if they wanted legal advice, although staff at all SCF said they would remind detainees of their entitlement to this right. In three of the SCF, posters, in English, were displayed advising detainees of their right to free legal advice, including the contact telephone number for the Armed Forces Criminal Legal Aid Authority (AFCLAA). However, Dreghorn SCF displayed no details about the right to free legal advice or the AFCLAA, and staff directed detainees to contact a single firm of solicitors if they sought legal advice. Aldergrove SCF had alternative arrangements with security cleared solicitors which was appropriate in the circumstances. The detainees we spoke to at Bulford and Catterick SCFs said they had been told of their right to contact a solicitor, which they had declined or had already accessed one.

4.55 The SCF varied in the way they recorded whether detainees had been reminded of and accepted or declined their right to free legal advice. Most recorded that such rights had been offered, but there was seldom a record of whether it had been accepted and, if it had, whether contact had been made. There was inconsistency both within the SCF as well as across them in how and where information was recorded – in detention registers, detention files and the DOB – which resulted in the need for staff to constantly cross-refer information, heightening the potential for incorrect recording (see main recommendation 2.30).

4.56 Staff at all sites told us visits from legal representatives were facilitated, which we evidenced through our documentation check, but again there was variance in where these visits were recorded – some were recorded solely in the DOB whereas others were recorded in both the DOB and the individual's detention register. Legal visits were held in appropriate private facilities, but not all SCF had facilities to allow private telephone consultations.

4.57 Our checks of detention files and DOBs showed that detainees were offered a telephone call to inform someone of their arrest and subsequent custody, but it was not always clear that the call had been made. Detainees we spoke to at the MCTC and in the SCF confirmed they had been offered a telephone call. Staff told us they would inform the parent or guardian if a young person under 18 was detained in an SCF.

4.58 Copies of part 3 of the Service Custody and Service of Relevant Service Rules 2009 (SCSRSR) were displayed and issued to DUS at most sites, although at Dreghorn SCF they were only held in a file and had to be read at the booking-in desk. There were no copies of the SCSRSR in Aldergrove SCF, although staff said they could access them in their office and photocopy them for detainees.

4.59 Staff told us they routinely ensured that detainees were granted an eight-hours' continuous break from interviewing in any 24-hour period, which was confirmed in our checks of the DOB and detention files.

4.60 Staff were not aware of any detainees or their legal representatives who had requested a copy of their custody record on release or within 12 months. Most staff were unclear about whether this would only cover documentation in a detainee's detention file or if it would also include information recorded in the DOB and detention register. No guidance on this had been issued.

4.61 Staff told us no interpreting services were available in the SCF for non-English speakers, although they would contact the detainee's unit or the RMP arresting officer to facilitate this if required.

Recommendation

4.62 **All SCF should prominently display part 3 of the Service custody and Service of relevant Sentences rules 2009 and have copies of it readily available for personal issue to detainees under sentence.**

Housekeeping points

4.63 Documentation relating to authorisation of custody, and delegation where relevant, should be filed and retained in the detention files for DNUS.

4.64 All SCF should have current up-to-dates copies of the rights relating to detention booklet.

4.65 Information about free legal advice should be displayed prominently in all SCF.

4.66 Detainee records should clearly record that their rights have been explained, whether these have been accepted or not, and any subsequent facilitation of such rights.

4.67 Detainees should be able to consult their legal adviser by telephone in private.

4.68 SCF staff should receive clear guidance on granting access to records to detainees and their legal representatives.

4.69 Telephone interpreting services should be available to interview and communicate with detainees who require them.

Rights relating to treatment

Expected outcomes:
Detainees know how to make a complaint and are able to do so.

4.70 All SCF displayed details of a local complaints process. Some displayed SCF 'concern' forms on a notice board, while others (such as Aldergrove SCF) issued writing paper to detainees to write out their complaints. At Merville SCF, any written complaints had to be handed to an SCF staff member, who forwarded them to their CO for investigation. Elsewhere, detainees could post complaints into a secure wall-mounted box. The process of checking and emptying these boxes varied from daily, weekly or monthly, and was done by the duty field officer in the presence of the officer in charge of the SCF. However, we were told that in some SCF the keys for the complaint boxes were held in the facility or the staff office and were accessible to staff; this was unacceptable and compromised confidentiality. None of the staff at any of the sites were aware that any formal complaints had been made.

4.71 Details of the Service Complaints Commissioner (SCC) were displayed in all the SCF, and some also displayed SCC complaint forms. Despite this, staff were unaware of the route and investigation process for such complaints. Although the detainees we spoke to at Bulford and Catterick SCFs were aware of the SCC, they did not fully understand the process or the extent of the complaints that could be directed to the commissioner. However, they were satisfied that there was a complaints system that they could use if required.

4.72 As an additional part of the SCF complaints process, the officer, warrant officer or duty officer should visit detainees at least once every 24 hours and ask them if they want to record any complaints, and note the actions taken as a result. Although we found that these visits generally took place, there were some gaps at weekends. For example, at Merville SCF, two DNUS were not visited on a Saturday or Sunday, and at Dreghorn SCF one DUS did not receive a visit on a Saturday or Sunday, while another DUS did not receive a visit on a different Sunday.

4.73 Staff were not aware of any monitoring of complaints, however they were received, although details of any recorded would be included in the SCF monthly return and forwarded to HQ PM (A), where they would be logged on a database for collation and analysis.

Recommendation

4.74 **A confidential complaints system should be introduced and information about how to make a complaint, including the role of the Service Complaints Commissioner, should be given to all detainees and also be prominently displayed in the SCF.**

Housekeeping points

4.75 SCF concern forms should be readily available in all the SCF.

4.76 Detainees should be visited by an officer, warrant officer or duty officer at least once every 24 hours to check their treatment, record any complaints and note the actions taken as a result.

Health care

4.77 *Detainees had good access to required health care support, but there were insufficient local protocols to ensure their health needs were consistently met. Custody staff were well trained in first aid, but the available emergency response equipment was too limited.*

Expected outcomes:
The health needs of detainees are addressed during their time in custody.

4.78 Custody staff arranged for input from a health care professional (HCP) based on identified detainee need, such as injuries or health history, and on detainee request. Joint Service publication (JSP) 837 specified several situations when automatic assessment by an HCP was indicated, including clearing detainees to work, which staff told us had never arisen. The demand for HCP involvement was low, but custody staff reported there was always good access. Requests for a same gender HCP were facilitated if possible.

4.79 Custody staff had not received mental capacity training, but said they used a common sense approach. Custody staff described, and we observed, some excellent individual care, but staff entries in the custody file and daily occurrence book did not consistently demonstrate this. Some custody staff at Dreghorn SCF had attended mental health awareness training, which they reported had improved the care they provided. Most custody staff had no training on mental health or substance misuse management, but contacted health staff for advice as required.

4.80 Custody staff supervised and recorded all medications administration. All medications were stored in locked cupboards, although not all storage facilities were sufficiently secure. Not all sites had a medications protocol to ensure consistent safe practice, but custody staff described safe practices to store and administer medications learned in their custody training. Some custody staff we spoke to were anxious about medication administration and said they would request a HCP to attend to administer it.

4.81 Not all SCF had clear, easily accessible protocols to identify and respond to medical emergencies, although staff described the appropriate action to take. All staff were first aid trained and all SCF had basic first aid supplies, but the equipment was inadequate for predictable emergencies related to intoxication or major self-harm. Staff said that first aid supplies were checked regularly, although recorded checks were not completed in every SCF and we found some out-of-date items.

4.82 Staff said they would request assessment by an HCP after the use of force or mechanical restraints if there was injury evident or on detainee request, but not routinely as specified in JSP 837. They said they would refer any need for intimate searches to the health staff on site, although the health staff we spoke to said they would not provide this service.

Recommendations

4.83 **There should be a complete range of evidence-based protocols, agreed with key stakeholders, covering all aspects of detainees' health needs, including medical emergencies, medications administration, referral to health services and intimate searches.**

4.84 **All medications should be securely stored in lockable wall-mounted drug cupboards.**

4.85 **Detention staff should receive training to identify and safely manage detainee health issues, including mental health awareness, substance misuse awareness and mental capacity.**

4.86 **First-aid kits should contain sufficient in-date equipment to manage predictable incidents, such as serious self-harm or choking, and have regular recorded checks, and all staff should be trained in its use.**

Section 5. Royal Air Force

Treatment and conditions

5.1 *The policy and use of handcuffs during escorts to SCF were mixed, and the use of force was poorly recorded. Risk assessments did not always fully record or analyse risk. The records satisfied us that the care of detainees was generally adequate, but staff did not make regular rousing checks of detainees who were asleep and intoxicated. Physical conditions in the SCF were mainly good, except for RAF Honington. Cells, showers and toilets were clean, but detainees had to request toilet paper at all sites. Most detainees had bedding, and a suitable choice of food. There was little pre-release risk assessment.*

Transfers and escorts

Expected outcomes:
Detainees transferring to and from Service custody premises are treated safely, decently and efficiently.

5.2 Vehicles used to transport detainees varied. For example, at RAF Halton, a standard police estate car was used while in RAF Waddington and RAF Honington a similar car had been modified with a partition separating the detainee from the driver. This made the conditions in the vehicle very cramped and uncomfortable (see photograph in Appendix II).

5.3 Handcuffing during transport varied. At RAF Halton, an assessment could lead to no use of restraints, while at RAF Waddington all detainees were handcuffed during transport and those assessed as highest risk had cuffs applied to hands behind their back. Seating in transport vehicles could not accommodate such 'back cuffing' so detainees had to sit sideways, which was unnecessarily uncomfortable and potentially unsafe.

Recommendation

5.4 **Detainees should not be handcuffed with their hands behind their back during transfer.**

Respect

Expected outcomes:
Detainees are treated with respect and their diverse needs are recognised and addressed during their time in custody.

5.5 All RAF SCF had arrangements for the private interviewing of detainees. Searching was mainly limited to a pat-down search, but if the risk assessment indicated a need for a strip search, this took place in private.

5.6 There were no routine facilities to meet the needs of women detainees, but women police officers could be called on to conduct searches and provide supervision. Such staff were not always custody trained but could be briefed by custody staff. No sanitary packs for women

were available in the SCF and had to be provided from the detainee's staff quarters or bought locally. There was no spare women's clothing for women detainees.

5.7 Custody facilities had not been modified to meet the needs of detainees with disabilities. Although Service personnel were mostly physically able, retained injured personnel, including amputees, would require reasonable adjustments in the facilities if they were detained.

5.8 Each custodial facility had access to Christian chaplains at all times. Chaplaincies had contacts with other faith groups and could make provision for detainees of other faiths. The case file records we reviewed showed that the chaplain often visited at a detainee's request.

Recommendation

5.9 **Custodial facilities should be able to meet the needs of women detainees. Detainees with disabilities that affect their mobility should not be held in SCF unless provision can be made to meet their needs.**

Safety

Expected outcomes:

Detainees feel and are safe throughout the duration of their detention. Detainees presenting any risks to themselves or others are assessed and managed by custody staff.

5.10 A standard risk assessment based on a checklist was used across all SCF, but all detainees were treated as high risk for the first 24 hours of detention irrespective of the risks identified. Risk information was obtained from the detainee as well as the police national computer and the Services police Redcap-Coppers database. These databases identified any relevant warning markers to aid the risk assessment, but staff told us that they relied heavily on self-disclosure. They also said that any change in circumstances prompted a review of the risk assessment. In practice, very few detainees were held in the SCF for more than 24 hours and so the risk assessment rarely changed from high risk.

5.11 The risk assessments that we examined did not fully record or analyse risk, and we were not satisfied that all risks of detainee self-harm would be identified (see main recommendation 2.28). We were also concerned about the attitude of a few staff who saw risk assessments as an administrative burden, rather than an informative process to care for detainees.

5.12 Staff had not been fully trained in suicide prevention and there was no programme of refresher training. The practice on rousing detainees who were intoxicated varied, and put at risk those who were not fully roused (see main recommendation 2.29). In most facilities, staff had anti-ligature knives that they carried at all times a detainee was held, but at RAF Boulmer an unsuitable tool was used as a ligature cutter (see photograph in Appendix II).

5.13 Detailed information about detainees and their time in custody was recorded in more than one location – for example, in the daily occurrence book and in the custody folder. This meant that information could be duplicated or difficult to find (see main recommendation 2.30 and paragraph 5.44). Nevertheless, the detention files we reviewed recorded that detainees were visited at least every 15 minutes and any concerns or interactions were documented. The recording of information at RAF Honington and RAF Halton was detailed and especially thorough.

Recommendation

5.14 Custody staff should be specifically trained in suicide prevention and there should be a programme of refresher training.

Housekeeping point

5.15 When detainees are held, all staff should carry the appropriate ligature cutters.

Safeguarding

Expected outcomes:
Young detainees (under 18) are properly protected in a safe environment. All staff safeguard and promote their welfare. Detainees will only be subject to force which is proportionate, lawful and used as a last resort. Detainees are transferred or released safely and decently.

5.16 Custodial staff had limited understanding of or training in the specific needs of young people. They were aware that interviews would require the presence of an appropriate adult and most would rely on senior personnel from the young person's unit or the chaplaincy but at RAF Halton, which had an initial training unit, welfare personnel dedicated to each young person were available at all times.

5.17 Staff had little understanding of adults at risk, and there were no arrangements for the referral of adults at risk[4] to local safeguarding processes.

Recommendation

5.18 Custodial staff should be fully trained in the needs of detainees under 18 and other detainees at risk, and how to make referrals to appropriate services.

Use of force

5.19 There was poor governance and oversight of the use of force by custodial staff. Staff told us that their personal safety training (PST) emphasised the use of de-escalation and we found some evidence in case files where it had been used appropriately. Apart from PST there was no specific training in the appropriate and safe use of force on detainees. Recording of the use of force was inconsistent and we found a clear example of use of force at RAF Brize Norton that had not been recorded. In this example, the SCF occurrence book recorded that a female detainee was brought into the custody suite intoxicated and failing to comply with instructions. There was insufficient information in the occurrence log but it stated that she was located in a cell by four officers. After further enquiries the SCF staff confirmed that

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[4] We define an adult at risk as a vulnerable person aged 18 years or over, 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'. *No secrets* definition (Department of Health 2000).

she was restrained by four officers and placed in the cell. There was no separate record of the force used and the information in the occurrence book was poor.

5.20 As with escorts and transfers (see paragraph 5.3), we were informed of varied practice in the policy of handcuffing, with some officers handcuffing everyone on arrest and others taking a more risk-based approach.

Recommendations

5.21 Use of force in SCF should be recorded and subject to appropriate governance.

5.22 Detainees should only be handcuffed if this is safe, necessary, proportionate and justified.

Release and transfer

5.23 SCF staff told us that they usually briefed the detainee's supervisor about the circumstances of their arrest, and any concerns for their welfare. Before release, detainees were risk-assessed at RAF Halton but not at the other facilities. We were not assured that this assessment was sufficiently thorough with appropriate and effective action to manage identified risks to a detainee's safety. A generic leaflet with contact numbers for support services was given to released detainees, but we did not find evidence of appropriate referrals where vulnerabilities had been identified.

Recommendation

5.24 All detainees should be fully assessed on their release, with appropriate referrals to support services where required.

Physical conditions

Expected outcomes:
Detainees are held in a safe, clean and decent environment, which is in a good state of repair and fit for purpose.

5.25 Except for RAF Honington, where conditions were poor and showers dirty (see photographs in Appendix II), cells in the SCF were clean and free of ligature points but lacked any furnishing other than a bed platform. With the exception of RAF Valley, they did not have integral toilet or washing facilities. Apart from RAF Halton (which had high bed plinths), beds were on low plinths making them unsuitable as seating, especially for less physically able detainees. All cells had working call bells and there were regular cell condition checks. Secure emergency evacuation procedures were in place.

Recommendation

5.26 Detainees should be provided with furniture in their cells, subject to a risk assessment.

Detainee care

Expected outcomes:
Detainees are able to be clean and comfortable while in Service custody facilities. Detainees are offered sufficient food and drink. Detainees have regular access to facilities and activities that preserve and promote their mental and physical well-being.

5.27 Bedding provided for detainees was not tear-proof, and in RAF Halton there were no pillows. Showers and toilets were available but toilet paper was not freely provided at all facilities. The shower facilities for women detainees were not sufficiently private in all SCF inspected. Checks when the facilities were not occupied did not include running the water regularly to reduce the risk of bacteria build-up.

5.28 Detainees at all facilities were given a set of overalls and trainers but no underwear. Not all SCF offered a full range of sizes. However, overalls were not issued routinely but mainly if a detainee's clothing was required for evidence purposes. The detention records showed that SCF staff made efforts to collect clothing from the detainee's accommodation where it was practicable.

5.29 There was no food on site in the SCF. Meals were provided from the base messes, so were not available at all times, and in RAF Waddington only cold food was available. Drinks, including water, were available during detention but only on request.

5.30 There were no reading and writing materials for the use of detainees, but staff told us that they could be obtained on request. A good example in one detention record showed that a detainee had been allowed to keep his Kindle, so that he was sufficiently occupied for the more than 24 hours that he was held.

5.31 Detainees were allowed limited time in the open air while in detention. Exercise areas were fully enclosed, provided limited space and most were marked by graffiti. The exercise yard at RAF Honington was barely more than a cage and in view of the road.

5.32 Detainees had access to telephones in some facilities but in RAF Cosford and RAF Brize Norton this was limited to a call during admission. Although visitors were admitted, custody facilities did not have suitable rooms for visits. At RAF Honington, visits took place in the cell and at other facilities spare offices were used.

Recommendations

5.33 **Detainees should be provided with full sets of safe bedding.**

5.34 **When visits are authorised a suitable room should be made available.**

Housekeeping points

5.35 Toilet paper should be freely available to detainees.

5.36 Detainees whose clothing is removed should be given a full set of adequate clothing in a suitable size.

5.37 Reading and writing materials for detainees should be available on site.

5.38 Food should be available for detainees 24 hours a day.

5.39 Detainees should have access to drinking water throughout their detention.

Individual rights

5.40 *Authorisation of detention was given by senior ranks and was rarely refused. There was an emphasis on ensuring that detainees did not remain in custody longer than necessary, and it was rare for detention to last longer than 12 hours. The role of the arrest and release officers was effective. Detainees had good access to legal representatives, but there was insufficient information on how to make a complaint.*

Rights relating to detention

Expected outcomes:

Detention is appropriate, authorised and lasts no longer than is necessary.

5.41 The criteria for determining whether arrested Service personnel would be taken into Service custody, whether an alleged offence would be investigated and prosecuted by civilian or Service police, and the processes for civil authorities informing the Service of arrests and prosecution of Service personnel were unclear. Central guidance, through a joint protocol, was not clear and specific, which left room for local agreement, but we did not find any local written protocols (see main recommendation 2.26).

5.42 All custody staff knew the process for seeking authorisation to detain. The arrangements were clear, and a commanding officer or their designated representative was available on the base 24 hours a day. Detention was appropriately authorised in all the detention files we reviewed, although in two files at RAF Valley this was not documented and we had to confirm, from previous rotas, that the officers who authorised detention were delegated to do so. There was a clear separation of arresting officer and custody officer duties, but this resulted in some delays waiting for custody staff to be available. For example, at RAF Halton a detainee was arrested at 1.40am and not booked in until 3.25am when the custody staff arrived at the SCF.

5.43 Detention files recorded reasonable explanations for seeking authorisation. Staff we spoke to at nearly all the RAF bases were not aware of custody ever being refused (except at RAF Cosford where a commanding officer refused to authorise the detention of an individual as he believed this was not necessary or proportionate). The RAF police could use section 69 of the Armed Forces Act 2006 'in anticipation of arrest'. This permitted them to take air force personnel back to their accommodation or away from potential conflict to prevent them from becoming involved in a situation that might lead to their arrest. We were told that this was a useful piece of legislation that prevented individuals from being arrested. There was a good emphasis on ensuring that detainees did not remain in the SCF for longer than necessary. Detention was initially authorised for 12 hours, but in one file at RAF Brize Norton, the initial detention period requested was three hours as the arresting officers assessed that they did not require any longer. Similarly at RAF Cosford and RAF Valley the initial detention period requested in most of the files we reviewed was only six hours, which was positive. Detainees rarely remained in custody for longer than the initial authorised detention period although this could be extended incrementally up to 48 hours by the Commanding Officer and up to 96 hours by a Judge Advocate. Where further detention was necessary, investigating officers provided sufficient and appropriate information for the duty commander to decide whether this was necessary.

Rights relating to Joint Service Publications relevant to UK Armed Forces Service custody facilities

Expected outcomes:
All rights relating to relevant Service codes of practice are adhered to.

5.44 Detainees were informed of their rights as part of the booking-in process. The Ministry of Defence form (811A) 'Service police notice to suspect upon arrest or at interviews with the Service police' also clearly outlined detainees' rights and should have been given to all detainees, but the form was included in some of the detention files we looked at, suggesting that it may not have been issued to the detainee. Information was recorded in a variety of places (detention files, daily occurrence book, daily register) and it was sometimes difficult to establish when or if detainees' rights had been met (see main recommendation 2.30). However, at RAF Honington and RAF Halton information was clearly recorded in the daily occurrence book detailing whether someone had been informed of the detainee's whereabouts, whether they had been informed of their right to free legal advice and whether they were offered the Service Police Codes of Practice (SPCoP) to consult.

5.45 A duty solicitor scheme was available at all the SCF but only some had notices about free legal advice. Detention records highlighted that detainees were offered legal representation during the booking-in process, and some records showed that detainees were reminded about this right during their detention. Custody staff had no concerns about the availability of solicitors or the timeliness of their arrival.

5.46 RAF Brize Norton had a private room, with a telephone, that detainees could use to consult their legal representative, and a private interview/consultation room within the SCF. There were no such dedicated consultation/interview rooms at the other SCF, where custody staff had to make other arrangements. For example, at RAF Cosford and RAF Valley we were told that legal visits took place in the booking-in area, which had a table and two seats, or in the interview room if it was free. Staff said that they would retreat into the corridor but would check that the solicitor was safe as there was no panic alarm. This arrangement was not suitable for legal consultations.

5.47 In the majority of files we reviewed, detainees were asked to nominate a person to be informed of their arrest. However, although these details were recorded in the occurrence book or register, it was not always clear whether the call had been made. The importance of such calls was highlighted in one detention file at RAF Honington, where the father of a detainee was able to provide important information to custody staff about some recent difficulties for the detainee, which assisted custody staff care.

5.48 SCF staff were clear that they would always notify the detainee's work manager or next in command about their arrest, and this was evident in many of the files we reviewed. Some SCF staff told us that they would contact the welfare services if the detainee did not have friends or relatives and did not want a unit representative contacted. At the few SCF that could potentially hold detainees under 18, staff were not sufficiently clear about their responsibility in notifying the detainee's parent or guardian. Staff at RAF Valley and RAF Cosford told us that they would notify the parent or guardian, but staff at RAF Halton were not clear about the process for dealing with anyone under 18, which was a concern as the base had a large training unit with under-18s.

5.49 Detainees not under sentence were given the comprehensive booklet, *Your rights if you are accused of an offence under the Service justice system*. Although this had been updated in October 2013, some SCF still used the old version. Copies of the Service custody and Services of relevant sentences rule 2009 were available in all of the SCF except RAF Valley.

Only RAF Cosford permitted detainees to take the document into the cell to read. Staff elsewhere believed that the large document could potentially be used by detainees to harm themselves, and said that they would allow the detainee to read it in the booking-in area or photocopy the extracts they required. However, staff could not recollect ever having to do this and we were not convinced that access to the document would be adequately facilitated. Custody staff also had little awareness that some detainees might struggle to comprehend the material they were given to read.

5.50 There was no independent appropriate adult Service for under-18s. Bases with training units for under-18s said they would contact the training coordinator or seek another representative from the same unit. SCF staff told us that family members could act as an appropriate adult but only if they could get to the base promptly and not delay the young person's interview. It was less clear what staff would do if a detainee wanted an independent person to support them. There were no under-18s in the detention files we reviewed but there were some adults at risk. In one case, a detainee's social worker was contacted at his request and he was subsequently referred to the defence community mental health team on the base, assessed as 'unfit to be detained' and released into the care of a social worker.

5.51 SCF staff told us that most detainees were brought into the facility for alcohol-related offences, and that they contacted medical officers if they were concerned about their level of intoxication; this was evident in the detention files we reviewed. Staff were clear that anyone who was too intoxicated would not be accepted into the SCF and would be told to go to the hospital. In the detention files we reviewed, we saw that detainees were given a rest period before they were interviewed, either because they were under the influence of alcohol or drugs or because of the late hour.

5.52 SCF staff had no recent experience of seeking authorisation for an intimate search but knew the authorisation and conduct processes.

5.53 There were no telephone interpreting Services for non-English speakers or equipment (double handsets) or a clear process to access interpreting Services. Some SCF staff told us that they could potentially use foreign language speaking Service personnel to assist with interpreting information. Most SCF had reasonable relationships with the civilian police force in their areas and said they could liaise with them if they required interpreters to attend.

5.54 Staff had no guidance on granting access to detainee records to legal representatives or detainees. Some said that they would make these available on written request and would copy paper files, registers and occurrence books.

Housekeeping points

5.55 Information about free legal advice should be displayed prominently in all the SCF.

5.56 All detainees should be given the updated rights booklet.

5.57 The detention log should clearly record when a telephone call has been made to inform someone of a detainee's arrest.

5.58 SCF staff should be aware of voluntary agencies that could provide support to detainees.

5.59 All SCF should have a copy of the Service custody and Services of relevant sentences rule 2009 in an appropriate form for all detainees to read.

5.60 Telephone interpreting Services should be available to interview and communicate with detainees who require them.

5.61 SCF staff should receive clear guidance on granting access to records to detainees and their legal representatives.

Rights relating to treatment

Expected outcomes:
Detainees know how to make a complaint and are able to do so.

5.62 Some SCF displayed notices on how detainees could make a complaint through a station warrant officer or orderly officer, but these were in the booking-in area and would have to be brought to the detainee's attention. Some documentation given to detainees provided information about how to make a complaint, and in the records we reviewed detainees were asked as part of the release process if they had any complaints about their arrest or their detention. SCF staff did not know of any complaints made, except at RAF Brize Norton where a detainee's complaint about their arrest was taken and passed to the orderly officer, and subsequently to the professional standards department.

5.63 There was no consistent approach to taking a complaint from a detainee. Staff at RAF Valley said they would notify the SCF warrant officer to deal with the complaint. Staff at other SCF told us they would take the complaint or provide writing material for the detainee to make the complaint and then pass it to the orderly officer. There was no standard complaint form for detainees and SCF staff were not aware of any timescales in dealing with complaints and so were not able to give detainees any advice or guidance.

5.64 The SCF had no information about the Service Complaints Commissioner (SCC). Some staff had insufficient awareness and understanding of the SCC, and relied on the fact that all RAF personnel should know how to make a complaint.

Recommendation

5.65 A confidential complaints system should be introduced and information about how to make a complaint, including the role of the Service Complaints Commissioner, should be given to all detainees and also be prominently displayed in the SCF.

Health care

5.66 *Most detainees had good access to required health care support, but there were insufficient local protocols to ensure detainee's health needs were consistently met. Custody staff were well trained in first aid, but the available emergency response equipment was too limited.*

Expected outcomes:
The health needs of detainees are addressed during their time in custody.

5.67 Custody staff arranged for input from a health care professional (HCP) based on identified need, such as injuries or health history, and on detainee request. Joint Service protocol (JSP)

837 specified situations when routine assessment by a HCP was indicated, such as intoxication, but this did not occur. The demand for HCP involvement was low, but custody staff reported easy access, except at RAF Boulmer where the lack of an out-of-hours GP service was unacceptable. Requests for a same gender HCP were facilitated if possible.

5.68 Custody staff had not received mental capacity training, but said that they used a common sense approach. Custody staff described some good individual care they had provided that considered underlying risk factors, but this was not adequately recorded. Custody staff had no training on mental health or substance misuse management, but contacted the health team for advice as required.

5.69 There were appropriate staff entries about medications in the records we examined, although most custody staff said they had never had a detainee who required medication. There was no medications administration protocol to ensure consistent safe practice, but custody staff described safe practices on storing and administering medications learned in their custody training. Some custody staff we spoke to were anxious about medication administration and said they would request a HCP to attend to administer it.

5.70 There were comprehensive protocols on the service intranet to help custody staff identify and manage common health emergencies, such as asthma and cardiac conditions, but they were not easily accessible in all the SCF and not all staff were aware of them. All staff were first aid trained and clearly understood the appropriate action to take in a medical emergency, although most had never cared for a detainee with health complaints. All SCF had basic first aid supplies, but the equipment was inadequate for predictable emergencies related to intoxication or major self-harm, and there was a lack of recorded checks.

5.71 Custody staff said that they would refer any need for intimate searches to the health staff on site, although the health staff we spoke said they would have to seek advice as they were not trained to provide this Service. Custody staff also said they would ask a HCP to attend after the use of force or mechanical restraints on a detainee if injury was evident, or on detainee request, but not routinely as specified in JSP 837.

Recommendations

5.72 There should be a complete range of evidence-based protocols, agreed with key stakeholders, covering all aspects of detainees' health needs, including medical emergencies, medications administration, referral to health services and intimate searches.

5.73 RAF Boulmer should have access to a GP service out-of-hours.

5.74 Detention staff should receive training to identify and safely manage detainee health issues, including mental health awareness, substance misuse awareness and mental capacity.

5.75 First-aid kits should contain sufficient in-date equipment to manage predictable incidents, such as serious self-harm or choking, and have regular recorded checks, and all staff should be trained in its use.

Housekeeping point

5.76 Custody staff should have easy access to and fully understand the available emergency protocols.

Section 6. Summary of recommendations and housekeeping points

The reference numbers at the end recommendation refers to the paragraph location in the report.

Main recommendations

To the Ministry of Defence

6.1 A review of the current Service custody facilities should take place with a view to consolidating management of these facilities on behalf of all three Services with the Provost Marshal (Army) or, in the case of the smaller and more isolated units, agreeing protocols with local police forces for them to provide custody facilities for the Service concerned. (2.25)

6.2 There should be clear and specific written national and local protocols to ensure a clear understanding between civil and Service police about which authority is responsible for the detention of alleged offenders, the investigation and prosecution of offences, and communication about involvement of Service personnel in the civilian criminal justice system. (2.26)

6.3 Service custody facility staff should complete a person escort record whenever a detainee is transferred to another place of detention. (2.27)

6.4 Risk assessments should be proportionate to the risks identified and inform subsequent care of detainees. (2.28)

6.5 All three Services should adopt the civilian police practice of rousing checks on detainees who are intoxicated, and record these on the custody record. (2.29)

6.6 Information relating to the detainee should be kept in one contemporaneous custody record. (2.30)

Royal Navy

Recommendations

Transfers and escorts

6.7 Detainees should not be handcuffed with their hands behind their back during transfer. (3.4)

Respect

6.8 Custodial facilities should be able to meet the needs of detainees with disabilities that affect their mobility or such detainees should not be held in an SCF. (3.10)

6.9 All SCF should have access to significant religious texts and artefacts to meet the faith needs of detainees, and detainees should be able to observe their main faith services. (3.11)

Safeguarding

6.10 Custodial staff should be fully trained in the needs of detainees under 18 and other detainees at risk, and how to make referrals to appropriate services. (3.17)

6.11 Use of force in SCF should be subject to appropriate analysis and governance. (3.20)

6.12 All detainees should be fully assessed on their release, with appropriate referrals to support services where required. (3.25)

Physical conditions

6.13 Detainees should be provided with furniture in their cells, subject to a risk assessment. (3.28)

Individual rights

6.14 Custody staff should not investigate offences allegedly committed by detainees under their care. (3.46)

Rights relating to treatment

6.15 A confidential complaints system should be introduced and information about how to make a complaint, including the role of the Service Complaints Commissioner, should be given to all detainees and also be prominently displayed in the SCF. (3.62)

Health care

6.16 There should be a complete range of evidence-based protocols, agreed with key stakeholders, covering all aspects of detainees' health needs, including medical emergencies, medications administration, referral to health services and intimate searches. All medication should be securely stored in lockable wall-mounted drug cupboards. (3.69)

6.17 Detention staff should receive training to identify and safely manage detainee health issues, including mental health awareness, substance misuse awareness and mental capacity. (3.70)

6.18 First-aid kits should contain sufficient in-date equipment to manage predictable incidents, such as serious self-harm or choking, and have regular recorded checks, and all staff should be trained in its use. (3.71)

Housekeeping points

Transfers and escorts

6.19 Vehicles used for transfer and escort should be clean. (3.5)

Safety

6.20 When detainees are held, all staff should carry appropriate ligature cutters. (3.15)

Detainee care

6.21 All SCF should stock women's sanitary products and routinely provide them to women detainees. (3.35)

6.22 Detainee clothing should only be removed following risk assessment or for forensic reasons, and underwear should be available. (3.36)

6.23 Food should be available for detainees 24 hours a day. (3.37)

6.24 Detainees should have constant access to drinking water throughout their detention. (3.38)

Rights relating to Joint Service Publications

6.25 Detainee records should clearly record that their rights have been explained, whether these have been accepted or not, and any subsequent facilitation of such rights. (3.55)

6.26 Information about free legal advice should be displayed prominently in all SCF. (3.56)

6.27 SCF staff should have sufficient knowledge about how to respond to the needs of young people detained. (3.57)

6.28 Telephone interpreting services, and a double-handset telephone, should be available to interview and communicate with detainees who require them. (3.58)

Army

Recommendations

Transfers and escorts

6.29 Detainees should not be escorted overnight to the Military Corrective Training Centre. (4.7)

6.30 Custody procedures should provide assurance about the treatment and conditions of detainees while detained in RMP facilities. (4.8)

Respect

6.31 Custodial facilities should be able to meet the needs of women detainees. Detainees with disabilities that affect their mobility should not be held in SCF unless provision can be made to meet their needs. (4.14)

Safety

6.32 All SCF staff should have knowledge of and better access to relevant computer databases to retrieve and, where necessary, upload information that could affect the current and future safety of detainees and staff. (4.24)

6.33 All custody staff should be regularly trained in the management of self-harm. (4.25)

Safeguarding

6.34 Safeguarding policies and procedures for under-18s and adults at risk should be available and standardised across all sites. (4.27)

6.35 Use of force recording and reporting should be standardised across sites, monitored to identify issues and fed into improving protective safety training. (4.30)

6.36 All detainees should be fully assessed on their release, with appropriate referrals to support services where required. (4.34)

Physical conditions

6.37 Detainees should be provided with furniture in their cells, subject to a risk assessment. (4.39)

Rights relating to Joint Service Publications

6.38 All SCF should prominently display part 3 of the Service custody and Service of relevant Sentences rules 2009 and have copies of it readily available for personal issue to detainees under sentence. (4.62)

Rights relating to treatment

6.39 A confidential complaints system should be introduced and information about how to make a complaint, including the role of the Service Complaints Commissioner, should be given to all detainees and also be prominently displayed in the SCF. (4.74)

Health care

6.40 There should be a complete range of evidence-based protocols, agreed with key stakeholders, covering all aspects of detainees' health needs, including medical emergencies, medications administration, referral to health services and intimate searches. (4.83)

6.41 All medications should be securely stored in lockable wall-mounted drug cupboards. (4.84)

6.42 Detention staff should receive training to identify and safely manage detainee health issues, including mental health awareness, substance misuse awareness and mental capacity. (4.85)

6.43 First-aid kits should contain sufficient in-date equipment to manage predictable incidents, such as serious self-harm or choking, and have regular recorded checks, and all staff should be trained in its use. (4.86)

Housekeeping points

Safeguarding

6.44 The training and advice DVD about the MCTC should contain all the relevant information for detainees. (4.35)

Physical conditions

6.45 Detainees should have constant access to drinking water. (4.40)

Detainee care

6.46 Detainees should be able to take their meals in conditions that are respectful. (4.47)

Rights relating to Joint Service Publications

6.47 Documentation relating to authorisation of custody, and delegation where relevant, should be filed and retained in the detention files for DNUs. (4.63)

6.48 All SCF should have current up-to-dates copies of the rights relating to detention booklet. (4.64)

6.49 Information about free legal advice should be displayed prominently in all the SCF. (4.65)

6.50 Detainee records should clearly record that their rights have been explained, whether these have been accepted or not, and any subsequent facilitation of such rights. (4.66)

6.51 Detainees should be able to consult their legal adviser by telephone in private. (4.67)

6.52 SCF staff should receive clear guidance on granting access to records to detainees and their legal representatives. (4.68)

6.53 Telephone interpreting services should be available to interview and communicate with detainees who require them. (4.69)

Rights relating to treatment

6.54 SCF concern forms should be readily available in all the SCF. (4.75)

6.55 Detainees should be visited by an officer, warrant officer or duty officer at least once every 24 hours to record any complaints and note the actions taken as a result. (4.76)

Good practice

6.56 Detainees were always released from the SCF into the care of unit staff. (4.36)

Royal Air Force

Recommendations

Transfers and escorts

6.57 Detainees should not be handcuffed with their hands behind their back during transfer. (5.4)

Respect

6.58 Custodial facilities should be able to meet the needs of women detainees. Detainees with disabilities that affect their mobility should not be held in SCF unless provision can be made to meet their needs. (5.9)

Safety

6.59 Custody staff should be specifically trained in suicide prevention and there should be a programme of refresher training. (5.14)

Safeguarding

6.60 Custodial staff should be fully trained in the needs of detainees under 18 and other detainees at risk, and how to make referrals to appropriate services. (5.18)

6.61 Use of force in SCF should be recorded and subject to appropriate governance. (5.21)

6.62 Detainees should only be handcuffed if this is safe, necessary, proportionate and justified. (5.22)

6.63 All detainees should be fully assessed on their release, with appropriate referrals to support services where required. (5.24)

Physical conditions

6.64 Detainees should be provided with furniture in their cells, subject to a risk assessment. (5.26)

Detainee care

6.65 Detainees should be provided with full sets of safe bedding. (5.33)

6.66 When visits are authorised a suitable room should be made available. (5.34)

Rights relating to treatment

6.67 A confidential complaints system should be introduced and information about how to make a complaint, including the role of the Service Complaints Commissioner, should be given to all detainees and also be prominently displayed in the SCF. (5.65)

Health care

6.68 There should be a complete range of evidence-based protocols, agreed with key stakeholders, covering all aspects of detainees' health needs, including medical emergencies, medications administration, referral to health services and intimate searches. (5.72)

6.69 RAF Boulmer should have access to a GP service out-of-hours. (5.73)

6.70 Detention staff should receive training to identify and safely manage detainee health issues, including mental health awareness, substance misuse awareness and mental capacity. (5.74)

6.71 First-aid kits should contain sufficient in-date equipment to manage predictable incidents, such as serious self-harm or choking, and have regular recorded checks, and all staff should be trained in its use. (5.75)

Housekeeping points

Safety

6.72 When detainees are held, all staff should carry the appropriate ligature cutters. (5.15)

Detainee care

6.73 Toilet paper should be freely available to detainees. (5.35)

6.74 Detainees whose clothing is removed should be given a full set of adequate clothing in a suitable size. (5.36)

6.75 Reading and writing materials for detainees should be available on site. (5.37)

6.76 Food should be available for detainees 24 hours a day. (5.38)

6.77 Detainees should have access to drinking water throughout their detention. (5.39)

Rights relating to Joint Service Publications

6.78 Information about free legal advice should be displayed prominently in all the SCF. (5.55)

6.79 All detainees should be given the updated rights booklet. (5.56)

6.80 The detention log should clearly record when a telephone call has been made to inform someone of a detainee's arrest. (5.57)

6.81 SCF staff should be aware of voluntary agencies that could provide support to detainees. (5.58)

6.82 All SCF should have a copy of the Service custody and Services of relevant sentences rule 2009 in an appropriate form for all detainees to read. (5.59)

6.83 Telephone interpreting services should be available to interview and communicate with detainees who require them. (5.60)

6.84 SCF staff should receive clear guidance on granting access to records to detainees and their legal representatives. (5.61)

Health care

6.85 Custody staff should have easy access to and fully understand the available emergency protocols. (5.76)

Section 7. Appendices

Appendix I: Inspection team

Nick Hardwick	Chief Inspector
Elizabeth Tysoe	Team leader and head of health inspection
Alison Perry	Team leader
Gary Boughen	Inspector
Karen Dillon	Inspector
Sandra Fieldhouse	Inspector
Vinnett Pearcy	Inspector
Andrew Rooke	Inspector
Paul Rowlands	Inspector
Fiona Shearlaw	Inspector
Michael Bowen	Health services inspector
Majella Pearce	Health services inspector

Appendix II: Photographs

RAF Boulmer Cell

RAF Honington Cell

RAF Honington – vehicle for transporting detainees

RAF Boulmer – anti ligature tool

RAF Honington - shower

RAF Honington – exercise yard