



Report on an unannounced inspection visit to police
custody suites in

Bedfordshire

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

7–11 April 2014

Glossary of terms

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Section 1. Introduction

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

This was the second inspection of Bedfordshire police custody suites, the first being in August 2010. The findings from our first inspection referred to the poor conditions of the custody estate and identified a number of risks concerning the cellular accommodation. We argued the need for investment in Bedfordshire's custody provision. At this inspection we were disappointed to find that both investment and improvement since our last visit was limited and that the estate had significantly deteriorated. We were told however that at a very recent meeting the executive had agreed a recommendation to build a new custody unit upon the Force Headquarters site at Kempston. The chief constable made a proactive decision to close Bedford custody suite during the inspection as a consequence of our findings.

We were also mindful of an ongoing Independent Police Complaints Commission investigation, which involved a man who died in Luton on 4 November 2013, while detained under section 136 of the Mental Health Act. The findings of this investigation have yet to be published.

The senior leadership of the force had changed in its entirety since the previous inspection. It was disappointing that it took over three years and a new senior leadership team to acknowledge the lack of strategic oversight. However, a new Head of Custody and Association of Chief Police Officers (ACPO) force lead had been appointed. A governance structure had been established, although at the time of the inspection this was in its infancy. There had been no structured process for collecting data and little quality assurance of the safe treatment of detainees; the governance structure was also developing this process at the time of inspection. Force policies were APP compliant, however learning from adverse incidents and other authoritative sources was not disseminated directly to staff, although it was made available on the force intranet. Staffing levels were barely adequate, with custody staff relying on non-custody staff to complete tasks.

Detention periods were kept to a minimum in accordance with the requirements of the Police and Criminal Evidence Act 1984 (PACE), and staff handovers reflected a focus on case progression to ensure minimum detention. We were told that there was no provision within the local authority area to accommodate children where a young person was charged but not bailed, so some children remained in custody which was disappointing. Appropriate adult services were generally reasonable, but deteriorated when emergency duty teams took over outside normal office hours. All staff reported difficult access to appropriate adult services for vulnerable adults, even during office hours. These delays led to detainees being held in custody longer than necessary.

Detainees across a range of religious and minority ethnic backgrounds told us that staff were respectful during their interactions. Staff were skilled and successful in de-escalating some very difficult and challenging situations and engaged detainees with sensitivity and empathy, exploring issues of health and self-harm. However, detainees leaving the custody suite were not sufficiently well advised on sources of help and assistance.

Rights and entitlements were explained to detainees, although lack of privacy in the small booking-in areas was a concern. We saw some good practice when a custody suite was cleared of non-essential staff when booking in an individual accused of a sensitive high profile offence.

Health care was improving. Although there had been significant improvements in relation to mental health provision, the use of custody for people with serious mental health issues was still unacceptably high. There was a good governance and accountability structure. We saw detainees being dealt with respectfully and clinical assessments were comprehensive. Health care practitioners were able to devise care plans for repeat detainees, and those who had alcohol and substance misuse issues had access to good support services. We also noted the good practice of engaging the Samaritans to provide a service to detainees with emotional distress.

We noted that, of the 26 recommendations made in our previous report after our inspection of 2–4 August 2010, seven recommendations had been achieved, four had been partially achieved and 15 had not been achieved.

This report provides a small number of recommendations to assist the force and the Police and Crime Commissioner to improve provision further. We expect our findings to be considered in the wider context of priorities and resourcing, and for the existing custody action plan to reflect any new recommendations and to be provided in due course.

Thomas P Winsor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

October 2014

Section 2. Background and key findings

- 2.1** This report is one in a series relating to inspections of police custody carried out jointly by HM Inspectorates of Prisons and Constabulary. These inspections form part of the joint work programme of the criminal justice inspectorates and contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorates of Prisons and Constabulary are two of several bodies making up the NPM in the UK.
- 2.2** The inspections of police custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the Association of Chief Police Officers (ACPO) *Authorised Professional Practice – Detention and Custody* at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*¹ about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.
- 2.3** This was the second inspection of Bedfordshire police, the first being in August 2010. The designated custody suites and cell capacity of each was as follows:

Custody suite	Number of cells
Luton	21
Dunstable	13
Bedford	15

Strategy

- 2.4** There had been little investment in the custody estate since the previous inspection. Although the force had a number of plans and options for custody arrangements, these were still some way off from being implemented.
- 2.5** A governance structure had been introduced very recently to address the previous lack of oversight and insufficient leadership. It was still too early to evidence outcomes. There were no structured processes for the collection, evaluation and monitoring of basic data relating to the treatment of those in custody. Staffing levels were barely adequate, with custody staff often having to rely on non-custody officers for the completion of some tasks.
- 2.6** There were links with partners at a strategic level, with the chief constable chairing the local criminal justice board and attending the Bedfordshire chief executives forum, and this had led to improved mental health provision. Further improvements in respect of accommodation

¹ <http://www.justiceinspectorates.gov.uk/hmiprison/>

for children and the provision of appropriate adults (AAs) needed to be addressed or resolved at these meetings.

- 2.7** Current quality assurance processes were poor. There was no audit of custody records or person escort record (PER) forms, and, although incidents in which a serious injury was averted were recorded, wider learning was not disseminated to staff. We could not determine how recommendations and learning from other organisations were embedded and monitored into the overall process. There were two ongoing Independent Police Complaints Commission investigations which had yet to report on outcomes or learning.
- 2.8** Staff received initial custody training but no refresher courses were provided. Some mental health- and autism-related awareness training was delivered.

Treatment and conditions

- 2.9** Detainees were treated with respect during the booking-in process. Custody staff asked questions about detainees' care and welfare needs. Female detainees were routinely asked if they would prefer to speak to a female member of staff. Provision for older detainees and those with disabilities was poor due to a lack of adapted cells. Children brought into custody were detained for a short period, accessing an AA was prioritised and alternatives to detention were considered as part of their care and welfare needs. We saw several detainees being given religious books and prayer mats.
- 2.10** Privacy for detainees was poor and holding rooms were inadequate at all the suites. We saw detainees and officers waiting in vehicles and corridors to be booked in, which was not safe. The booking-in area at both full-time suites was small and the general area was congested, sometimes with non-custody staff. At Bedford, staff were unable to switch off the closed-circuit television (CCTV) monitors while a strip-search was being conducted.
- 2.11** Risk assessments during the booking-in process were conducted sensitively and vulnerability or self-harm issues raised by detainees were explored with appropriate health care practitioners. These were undertaken with empathy and staff were engaged and approachable. However, the pre-release risk assessments were inadequate and the closed style of questioning did not offer or invite the detainee to disclose sensitive issues.
- 2.12** Levels of observation were appropriate and we saw a custody sergeant explaining to a police constable the protocols of conducting close proximity supervision. Handovers were conducted inconsistently as they did not always include all staff; however, the quality of information shared was generally good and focused on care planning and case progression.
- 2.13** The force did not collect or analyse use of force data related to custody. We saw few detainees arriving at the suites in handcuffs, and those who did had them removed promptly on arrival. Strip-searches were authorised, with a clear rationale given. We saw some good staff interventions in de-escalating potentially threatening situations.
- 2.14** The physical condition of the suites was poor. Bedford was especially degrading, unsafe because of ligature points and generally deemed not fit for purpose. As a result of our findings, the chief constable closed the suite during the inspection and relocated detainees from the Bedford custody suite to Dunstable. Dunstable was in much better condition and Luton was reasonably clean.
- 2.15** Detainee care was good and detainees told us that they were well looked after. They were offered mattresses, blankets and pillows but there was a lack of appropriate clothing, other

than 'scrubs' (similar to hospital theatre garments). The showers at the full-time suites were not sufficiently private, and few detainees used them. Meals were provided as required.

Individual rights

- 2.16** Custody sergeants questioned and refused detention where appropriate and were aware of alternatives to custody, such as restorative justice and voluntary attendance.² All staff were aware of the need to keep detention periods to a minimum, and custody sergeants were clear about their obligations to ensure that cases proceeded quickly. However, there were some notable exceptions to this practice due to the demand placed on the prisoner handling units.
- 2.17** Staff reported reasonably good access for AAs for young people during office hours as this was provided by the youth offending teams; however, outside these hours, the service provided by the emergency duty team was poor. We were told that the AA service for vulnerable adults was poor, even during office hours. Staff considered alternatives, such as bail, if accessing AAs caused unnecessary delays in detention.
- 2.18** Most custody staff said that they had never known secure accommodation to be made available for children and young people, and had stopped requesting this facility. They told us that they had never requested non-secure accommodation and could not think of a case where this might have been appropriate.
- 2.19** During booking-in, custody staff advised detainees of their rights, and offered them copies of PACE codes, although in some suites these were out of date. Solicitors were routinely given the front copy of the custody record, and face-to-face reviews were conducted by inspectors. We saw staff asking detainees why they had declined legal representation or advice.
- 2.20** Court cut-off times were too early, which could have contributed to unnecessary detention. Complaints were taken only after the detainee's release from custody.

Health care

- 2.21** There was a good governance structure and target response times were met in 94% of cases. The contract with G4S had an escalation clause that enabled the police to register concerns over the performance of health care professionals, including doctors.
- 2.22** Medicines management was good, with effective assurance processes. Infection control auditing took place weekly but many fixtures and fittings were not compliant with minimum standards. There were no clinical work surfaces suitable for forensic sampling.
- 2.23** Health care professionals treated detainees respectfully and sensitively, and clinical assessments were comprehensive. Health care practitioners shared relevant information with custody staff using the national strategy for police information systems (NSPIS), and care plans were kept for repeat detainees. Services for detainees with alcohol and substance misuse problems, coordinated by the Westminster Drugs Project, were also good.

² Usually for lesser offences, where suspects attend by appointment at a police station to be interviewed about alleged offences. This avoids the need for an arrest and subsequent detention in police custody.

- 2.24** Custody staff complained of delays in getting assessments under the Mental Health Act 1983; response times were not in line with the agreed protocol. The use of custody for people with serious mental health issues had reduced but was still unacceptably high.

Main recommendations

- 2.25** Quality assurance processes, leading to improved outcomes for detainees, should include sampling of custody records, checking against closed-circuit television (CCTV) recordings, person escort records and staff handovers.
- 2.26** The police custody estate should be clean, safe and free of ligature points, and staff should be trained to identify these issues or manage and mitigate the presenting risks.
- 2.27** There should be sufficient staff in custody at all times to ensure the safety and well-being of detainees. (Repeated recommendation 2.13)
- 2.28** The police force should ensure that learning from adverse incidents has clear ownership and is overseen at a strategic level to ensure that there is effective collation, monitoring of trends and identifying areas for improvement. There should be an effective process for communicating this learning to frontline staff.
- 2.29** The force should facilitate the provision of appropriate adults for vulnerable people in custody.
- 2.30** The force should facilitate the provision of PACE beds for children in custody to prevent them from being held in police custody overnight.

Section 3. Strategy

Expected outcomes:

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

Strategic management

- 3.1 An assistant chief constable (ACC) was responsible for leading on custody issues, with a centralised custody function delivered through a criminal justice and custody department, led by a detective chief inspector. Although a governance structure was in place, this was in its infancy and it was apparent that, historically, there had been insufficient strategic oversight and direction in respect of custody.
- 3.2 There had been significant underinvestment in the two main custody suites at Bedford and Luton, which had seen little improvement since the previous inspection. The poor condition of the estate, especially Bedford custody suite, which was unsafe, posed a significant risk to the force. During the inspection, the force made an operational decision to close the suite at Bedford and reopen the suite at Dunstable.
- 3.3 There were plans to build a new custody suite on the police headquarters site, although planning permission and finances were in place, this was still in the planning rather than developmental stage. The force anticipated that this facility could be operational within 18–24 months. In the longer term, the force was exploring collaboration opportunities with neighbouring forces.
- 3.4 Staffing levels in both suites were barely adequate, with custody staff often having to rely on arresting/processing officers for some tasks, such as escorting detainees to, and placing them in, cells. Custody staff included permanent custody sergeants and detention officers (DOs), employed by Bedfordshire Police. Sergeants from other duties, who were trained in custody, were regularly used to cover for permanent custody sergeants. We were told that trained police constable gaolers were occasionally used (see main recommendation 2.27).
- 3.5 There were two custody inspectors, who had day-to-day responsibility for the management of the force's custody suites and line management of custody staff, as well as Police and Criminal Evidence Act (PACE) issues. Line management arrangements for permanent custody staff were clear. However, the custody inspector at Bedford was expected to carry out a large number of duties to cover response policing, taking them away from their core role of managing custody issues.
- 3.6 There was no embedded process for the collection, evaluation and monitoring of basic data relating to the safe treatment of those in custody (such as the number of strip-searches, detention times and waiting times on arrival into custody), which would assist in holding staff, or partners, to account for the delivery of service.
- 3.7 There were force procedures on custody, which were regularly reviewed and complied with the College of Policing's Authorised Professional Practice on detention and custody. These procedures were updated, when appropriate, following national learning – for example, from the Independent Police Complaints Commission (IPCC) 'learning the lessons' bulletins. However, staff told us that they had no awareness of these, and derived no learning from them (see main recommendation 2.28).

Recommendation

- 3.8 There should be robust arrangements to collect, evaluate and monitor data relating to the treatment of those in custody to improve outcomes and safety for detainees.**

Partnerships

- 3.9** There was one independent custody visitor (ICV) scheme for the force, coordinated by the Police and Crime Commissioner's (PCC) office. This arrangement generally worked well; the ICVs and the PCC coordinator reported a good relationship, and issues identified during visits were resolved promptly. ICVs commented on the increased professionalism of custody staff over recent years and there was regular police representation at ICV panel meetings.
- 3.10** There were good partnership arrangements at a strategic level, with the chief constable chairing the local criminal justice board and attending the Bedfordshire chief executives forum, which had been important in driving forward improvements in respect of mental health provision; however, there was still room for improvement. The opportunity that these strategic structures provided needed to be translated into improving other areas of detainee care. For example, we were told that local authority accommodation for young people who had been charged and refused bail was rarely available, as a result of which staff never asked for it (see also section on rights relating to detention and main recommendation 2.30). This issue should be addressed at a strategic level.

Learning and development

- 3.11** All custody sergeants had undergone custody-specific training before taking on custody duties. The course was linked to the national custody officer learning programme (NCOLP), produced by the College of Policing. DOs had a four-week initial custody course linked to the NCOLP, adapted to their specific learning requirements and based on safer detention principles.
- 3.12** There was no annual refresher training, specific to role, available for custody sergeants and DOs but the force had plans to introduce this from September 2014. Most officers, including custody staff, had been trained in mental health awareness, and training in autism awareness was being rolled out. Staff were up to date on first-aid and self-defence skills.
- 3.13** No quality assurance checks of custody records or PER forms took place, which meant there was a significant gap in the audit and assurance process (see main recommendation 2.25).
- 3.14** Incidents in which a serious injury was averted by the action of staff were recorded. Custody staff completed a computer-based near-miss form, which was sent to custody inspectors and the professional standards department. Immediate issues were identified and actioned, but we found no evidence to suggest that wider learning from these incidents had been captured, monitored and disseminated (see main recommendation 2.28). We were aware of the ongoing Independent Police Complaints Commission investigations into a life-changing event and a death in custody, which were ongoing and not yet published.

Recommendation

- 3.15 Custody-specific refresher training should be delivered regularly to ensure staff respond appropriately to the welfare and safety of detainees in their care.**

Section 4. Treatment and conditions

Expected outcomes:

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

Respect

- 4.1 Custody staff across all the suites treated detainees with respect and considered their needs during the booking-in process. We saw several vulnerable detainees being booked in at Luton; the custody sergeants took care in explaining the process, reassured the detainees that they would be visited regularly and located them in the detention room closest to the booking-in desk. DOs told us that they had received some training in the safeguarding of vulnerable groups. We saw all detainees being asked if they were primary carers. Detainees told us that they felt well looked after.
- 4.2 Custody staff asked questions about detainees' care and welfare, and informed them of their rights and access to specific provision, such as reading material and exercise. Detainees we spoke to, from a range of religious and minority ethnic backgrounds, told us that they had been treated with respect.
- 4.3 The booking-in area at both full-time suites was small and the general area was sometimes congested with non-custody staff. Privacy for detainees was poor; when it was busy, they were booked in two at a time and were unable to discuss any concerns without being overheard by other detainees and non-custody staff. We saw some detainees actively listening to what was being disclosed by other detainees being booked in next to them. Furthermore, custody staff at both full-time suites used professional telephone interpreting services over the speaker, within hearing distance of everyone in the custody suite (see also section on rights relating to detention). However, at both suites we also saw some good practice, with custody sergeants clearing the booking-in area when a detainee was brought in regarding a sensitive alleged offence, which demonstrated some awareness of the need for privacy in such circumstances. At Dunstable, privacy was better as detainees were booked in singly.
- 4.4 Holding rooms were inadequate at all the suites. At Luton, detainees and officers were permitted to wait in one of the three consultation rooms, depending on availability. However, at Dunstable and Luton we saw officers waiting with detainees in vehicles out in the yard to book them in, and at Bedford detainees had to wait in the corridors; neither of these options was suitable or safe. Data provided by the force recorded that the average waiting time in 2013/14 across the three suites was just over 19 minutes, which was a long time to be waiting in these environments.
- 4.5 The force's focus on diversity was mixed and had not changed significantly since the previous inspection. Women coming into the custody suite were asked if they wished to speak to a female officer about any welfare issues and if they might be pregnant, and were told about the availability of hygiene products. However, girls aged 16 or under were not allocated a named female officer responsible for their care at any of the suites. In our custody record analysis, we found several examples where women had been cared for appropriately and health and welfare issues correctly responded to.
- 4.6 Data provided by the force indicated that the number of children detained had reduced year on year since 2011. The few children we saw being brought into the custody suite were

detained for only a few hours. Alternatives to their detention were discussed and accessing an AA was prioritised. This was mainly confirmed by our analysis of 30 custody records, although we came across one case of a 15-year-old who had been arrested for a serious offence and held overnight, with no clear indication if alternative local authority accommodation had been explored (see section on individual rights).

- 4.7** Children and young people were held in detention rooms, rather than cells, when they were available; these were similar to ordinary cells in configuration but were located closer to the custody desk and did not contain in-cell sanitation, which was poor. The standard level of observations for children and young people was every 30 minutes due to their vulnerability.
- 4.8** The provision for older detainees and those with disabilities was poor. There were no adapted facilities or thick mattresses to make some of the low bed plinths more accessible and comfortable. However, at Luton we saw two older male detainees given chairs to sit on in the cells (following a risk assessment of their needs) as they found it difficult to sit on the low benches. There were no hearing loops available at any of the suites to assist people with impaired or poor hearing.
- 4.9** All suites had a good supply of items for religious observance, including prayer mats and religious texts, and they were all appropriately stored. However, there was no means of determining the direction of Mecca in the cells or cell corridors. At Dunstable, we saw several detainees being given a copy of the Qur'an and a prayer mat to use in the cell. At Luton, we saw a detainee being permitted to wash before praying, and the DO informed the detainee of the availability of religious equipment. Staff had a good awareness of conducting searches while respecting a detainee's culture, religion and gender. They understood how to search transgender detainees appropriately.

Recommendations

- 4.10 Booking-in areas should provide sufficient privacy to allow effective communication between staff and detainees.** (Repeated recommendation 4.7)
- 4.11 All holding rooms should be suitable for their purpose.**
- 4.12 Some cells should be adapted for use by detainees with physical disabilities.** (Repeated recommendation 4.6)

Housekeeping points

- 4.13** Girls aged 16 or under should be allocated a female officer responsible for their care.
- 4.14** A hearing loop should be available in all custody suites and staff should know how to use it.
- 4.15** There should be a means for indicating the direction of Mecca.

Safety

- 4.16** Risk assessments were well conducted and any vulnerabilities or self-harm issues raised by detainees were explored. Warning markers, police national computer checks and information from previous custody records were well used as part of the risk assessment process. Health care professionals and mental health workers were also used effectively to assist. There was good justification for the level of observations that detainees were placed

on and these were adhered to, and amended as appropriate. Our custody record analysis supported our observations; all detainees with a history of self-harm, mental health issues or in custody for the first time had been placed on 30-minute observations.

- 4.17** Custody sergeants routinely removed detainees' shoes and cords from their clothing regardless of their risk or past experience of self-harm. At Dunstable, this was carried out prior to completing risk assessment, suggesting a mechanistic approach to risk management.
- 4.18** DOs we spoke to understood the importance of obtaining a satisfactory response from intoxicated detainees who were subject to rousing checks. Rousing was generally recorded where necessary.
- 4.19** At Bedford, there was a laminated sheet instructing staff how to undertake constant supervision/close proximity watches. This was not available at Luton but we saw the custody sergeant giving a thorough briefing to a police constable carrying out such a duty. However, we subsequently had to inform the police inspector that this officer was not focusing on supervising or interacting with the detainee but using his mobile telephone. Significant interactions between detainees and the observer were not recorded in a separate log or on the custody record.
- 4.20** All the cells across the full-time custody suites and six of the 13 cells at Dunstable were monitored by CCTV, the latter being used for vulnerable detainees. Custody staff appropriately used CCTV as an additional means of observing detainees about whom they had concerns but who did not present a sufficiently high risk to be placed on constant supervision or close proximity supervision. At Luton, three of the camera monitors in the main booking-in area failed to identify which cell they related to, which could have caused a delay in responding to a self-harm incident.
- 4.21** All staff carried anti-ligature knives and there were spare knives behind the custody desk, but at Bedford these were used to cut some of the cords in detainees' clothing, which could have compromised the effectiveness of the blade.
- 4.22** Handovers were conducted inconsistently, and at Bedford they did not always include all staff. The quality of the information shared was generally good at all suites, focusing primarily on care planning and case progression. However, incoming staff did not introduce themselves to detainees, which would have enhanced the handover process.
- 4.23** In the pre-release risk assessments (PRRAs) we observed, the questions asked were closed, not offering or inviting a dialogue. However, we saw a very good PRRA at Bedford, where the detainee was given advice about her alcohol use, given a support leaflet, and asked how she felt and if she had any concerns she wished to discuss. Our custody record analysis showed that PRRAs were completed routinely but highlighted a general lack of detail in them, with only 'yes' or 'no' responses recorded, except for a few records in which the detainee's intended mode of transport had been noted.
- 4.24** Travel warrants were available at the custody suites but custody staff had to ask an inspector for permission to issue them, which could potentially have led to unnecessary delays. The support leaflets available were helpful and always offered to detainees, but were available only in English.

Recommendations

- 4.25 Detainees' shoes and cords should not be routinely removed.**

- 4.26 All custody staff should be involved in the same shift handover and incoming staff should introduce themselves to detainees.**
- 4.27 Pre-release risk assessment questions should encourage a discussion with detainees.**
- 4.28 Information about support agencies should be available in languages in addition to English.**
- 4.29 The CCTV monitors should clearly identify which cells are being displayed.**

Housekeeping points

- 4.30** Custody staff conducting constant supervision via closed-circuit television (CCTV) should not be engaged in other tasks, and significant events and interactions should be recorded.
- 4.31** Anti-ligature knives should not be used to cut cords from clothing.

Use of force

- 4.32** Not all detainees arrived at the suites in handcuffs and those who did had them removed promptly on arrival. The reasons for using handcuffs were recorded on custody records; from our observations, they were used mainly to transport detainees safely.
- 4.33** All staff exercised good de-escalation skills and all custody staff received annual personal safety training. We saw one detainee at Luton being verbally abusive and physically threatening to custody staff and refusing all instructions. Custody staff and officers talked to him calmly, escorted him to his cell without any force being used and started a close proximity supervision as he was threatening to hit his head against the wall. Staff talked to him during the constant supervision and the detainee calmed down. This situation was well handled by all staff involved.
- 4.34** We were told that use of force forms existed and staff confirmed knowledge of them, but they did not know what happened to the forms once they had been completed. In the previous year, approximately 2,880 of these forms had been completed but it was unclear if this included force used in custody, and there was no monitoring or analysis of data.
- 4.35** We saw strip-searching being authorised, with a clear rationale given. There were no designated searching rooms and at Bedford staff were unable to switch off the CCTV cameras while a strip-search was being conducted, so it could be viewed by staff behind the custody desk. At Luton, not all staff knew how to switch the cameras off but strip-searches there took place in the small consultation rooms, which did not contain CCTV cameras.

Recommendations

- 4.36 Bedfordshire Police Service should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers policy and College of Policing guidance.**
- 4.37 Detainees should not be observed being strip-searched.**

Physical conditions

- 4.38** There had been no improvement in the condition of the custody estate since the previous inspection. Bedford custody suite, in particular, was in a poor state; the environment in which detainees were held there was degrading, unsafe and not fit for purpose. The cells and communal areas were dirty. The floors in some of the cells and corridors were cracking, with the paint on the concrete peeled off. The cells contained multiple ligature points (see main recommendation 2.26): they all had grilles with holes in excess of 2 mm, contrary to Home Office design guidance; cell doors had T-bar handles on both the cell hatches and the cell door; and the toilet fittings had exposed brackets. The shower unit in the designated female block was dirty and there was a gaping joint in the unit which was unsafe. There was graffiti throughout the suite and on the walls in the exercise yard, which also had floor drains with gaps in excess of 2 mm, presenting further ligature points. As a result of these findings, the chief constable closed this custody suite during the inspection and relocated detainees from the Bedford custody suite to Dunstable.
- 4.39** The suite at Luton was reasonably clean but the cells and the communal areas were in need of urgent deep-cleaning. The custody suite was worn and in a poor state of decoration, particularly in regard to the benches and the cell doors, where attempts made to remove graffiti had resulted in large patches of paint and varnish being removed. Despite this action being taken, there was still graffiti in the cells. All the cell doors at this suite opened inwards, which was contrary to Home Office design guidance (see main recommendation 2.26).
- 4.40** The stand-by suite at Dunstable was in a much better condition; it was clean, with good natural light and minimal graffiti. There were concerns about ligature points in this custody suite, as the cells contained an air vent with holes, the light fittings had gaps in excess of 2 mm and the toilet flush buttons protruded. The two detention rooms and the interview rooms were very cold but staff told us that this could have been because they had not been used for some time.
- 4.41** Each of the suites had reasonable cleaning arrangements and unoccupied cells were cleaned each morning. DOs told us that they were expected to clean up any general spillages and ensure that the cells were clean; however, during the inspection we saw them simply removing litter and checking that the cells were clear of any items. The frequency of cell checks varied at the two full-time suites; at Luton, they conducted a cell check during every shift (three times a day) but at Bedford, as there was potentially only one DO on a shift, checks were sometimes conducted only once a day. The cell check we observed at Luton was conducted well, although it was clear that staff were not sufficiently well trained to identify ligature points. When we reviewed the electronic records of daily cell checks, it was difficult to establish whether they had been completed consistently each day as they were stored among unrelated information. Although some of the issues raised by the checks had been reported to the health and safety representative and estate management, there was little evidence that this had resulted in any significant improvements.
- 4.42** Across the custody suites, it was common for arresting officers to place detainees in the cells, with the custody sergeant clearly explaining what was available in the cells, including the fact that the toilet area was obscured on the CCTV monitor. We saw non-custody staff accessing cell keys and going to speak to detainees, although this happened to a lesser degree at Bedford. This practice was associated with risks, as these officers did not have training in dealing with detainees in custody and did not carry anti-ligature knives, and there were no safeguards for detainees or officers against potential allegations.
- 4.43** Staff at each suite thought that there had been practice evacuations but there were no records of them taking place. All detainees were asked if they would require any assistance

in leaving the building in the event of a fire, which was a good way of identifying if detainees had any undisclosed disabilities or mobility issues.

Recommendations

- 4.44** The shower areas in the custody suites should be clean, repaired and safe for detainees to use.
- 4.45** Custody sergeants should ensure that non-custodial staff do not visit detainees in cells unsupervised.
- 4.46** Emergency practice evacuations should take place regularly, and be recorded.

Housekeeping points

- 4.47** Records of cell checks should be accessible so they can be reviewed to ensure that any reported repairs are monitored and completed.
- 4.48** Staff should be trained to identify ligature points.

Detainee care

- 4.49** Mattresses and pillows were available in each of cells but were not routinely sanitised between uses. There was a good supply of blankets and we saw custody staff at all suites offering them to detainees.
- 4.50** Detainees whose clothing was removed for evidential or hygiene reasons, or if they did not want the cords cut out of their clothing, were given clinical theatre garments ('scrubs') to wear, which was unsuitable. They could not be transferred to court in this clothing or released in it. Custody staff told us that they would ask detainees' friends and family to bring in clothing for them, but if this was not possible they had a small amount of petty cash that they could use to purchase clothing for detainees. At Luton, there was a small supply of tracksuits but this was unlikely to be sufficient.
- 4.51** Detainees' footwear had to be left outside their cells. Foam slippers were available but were of poor quality. There was a stock of plimsolls at all the custody suites but they were rarely given to detainees, and at Bedford larger sizes of plimsolls were not available at the time of the inspection. We saw several detainees walking around the Bedford custody suite in their socks, one of whom was placed in the exercise yard, with no thought to giving him replacement footwear until we pointed this out.
- 4.52** There was an ample supply of toiletries and feminine hygiene packs. Razors were not available at all the custody suites for those wishing to shave before attending court. There was a stock of paper suits and anti-rip clothing but we did not see either in use during the inspection. At Luton, the cupboard containing the anti-rip clothing was inappropriately labelled 'suicide suits', and this could be seen by detainees moving around in the cell block. Paper underwear was available only to female detainees, on request.
- 4.53** At Luton, the showers were not sufficiently private if they were used while other detainees were being escorted along the corridor. At Bedford, the shower cubicle for women was inappropriately monitored by CCTV. In our custody record sample, all detainees had been made aware of their right to access washing facilities while in custody but it did not appear

that any of them had used these facilities. There was an ample supply of cotton towels at the suites. Toilet paper was provided in most of the cells.

- 4.54** There were good stocks of microwave meals at all suites, catering for a range of dietary needs, including halal, vegetarian and gluten free. These were of low calorific value but staff told us that they would provide more than one meal, on reasonable request. Detainees were offered cereal for breakfast. Although DOs said that they tried to adhere to mealtimes, we saw meals being requested and provided throughout the day.
- 4.55** At all suites, there was an exercise yard that detainees could use without supervision, subject to a risk assessment. All the yards were covered by CCTV but the screens were not monitored while detainees were in the yard alone. We saw detainees in the exercise yard at some of the custody suites but in our custody record analysis only six detainees in our sample (20%) had received outside exercise.
- 4.56** There was a reasonable supply of reading material at Luton and Bedford, some in foreign languages, but there was nothing suitable for young people. We saw many detainees with reading material in their cells. At Dunstable, detainees were given the opportunity to collect a magazine or book on the way to being placed in the cells, although the magazines were torn and old and the book stock was limited, and there were none in languages other than English. Social visits were not facilitated.

Recommendations

- 4.57 Replacement clothing that maintains detainees' dignity should be provided.**
(Repeated recommendation 4.29)
- 4.58 All detainees held overnight and those who require one should be offered a shower and should be able to take it with an appropriate degree of privacy.**
(Repeated recommendation 4.28)
- 4.59 Detainees, particularly those held for more than 24 hours, should be offered exercise.**

Housekeeping points

- 4.60** Mattresses should be wiped down between uses.
- 4.61** Replacement plimsolls should be given to detainees whose shoes have been removed.
- 4.62** A stock of disposable razors should be maintained so that, subject to risk assessment, detainees who wish to shave before attending court can do so.
- 4.63** A range of reading materials should be available and routinely offered, including books and magazines suitable for young people and for those whose first language is not English.

Section 5. Individual rights

Expected outcomes:

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

Rights relating to detention

- 5.1** Custody sergeants asked arresting officers to provide a full explanation of the circumstances of, and reasons for, the arrest before authorising detention. Sergeants told us that they were confident in refusing detention when the circumstances did not merit arrest and were able to provide us with historical details of such cases. We saw a number of custody sergeants appropriately refusing to accept detainees on the basis of the information available. Alternatives to custody were available, such as restorative justice and voluntary attendance. Although staff believed that voluntary attendance was being used increasingly, figures supplied by the force showed that its use had remained static since 2011/12. Sergeants told us that they had seen an increase in the number of officers seeking advice before making an arrest, and we saw this taking place on a number of occasions.
- 5.2** All staff were aware of the need to keep detention periods to a minimum, and custody sergeants were clear about their obligations to ensure that cases proceeded quickly. In our custody record analysis, the average length of detention had been 11 hours and 30 minutes, which was comparable to the figure supplied by the force. We saw some delays in cases being progressed due to the volume of demand placed on prisoner handling units and the fact that they only operated between 8am and 2am; for example, at Luton a detainee who had been arrested at 2.45am was not interviewed until 2.35pm as initially there had been no staff free to be allocated his case. He was not released from custody until 9pm that evening.
- 5.3** Custody staff reported a good relationship with Home Office Immigration Enforcement staff. They said that immigration detainees who were to be transferred to immigration removal centres rarely remained in the custody suites for longer than 24 hours, although could occasionally stay for up to 72 hours. From figures supplied by the force, during 2013/14 263 immigration detainees had been held for transfer to alternative accommodation, with an average detention time of only 21 hours, which was an improvement from the time of the previous inspection.
- 5.4** Staff assured us the custody suites were never used as a place of safety for children under section 46 of the Children Act 1989.
- 5.5** Custody staff were clear on their responsibilities to contact an AA when dealing with vulnerable adults or children under 18 years of age. Family or friends were contacted in the first instance to act as an AA, but when this was not possible the police used a scheme operated by the local authorities' social services departments to cover the role. Custody staff said that the AA provision for young persons during office hours was reasonably good as these services were mainly covered by the youth offending teams (YOTs) but that outside these hours the service provided by the emergency duty teams (EDTs) was poor. All staff we spoke to said that it was difficult to access AAs for vulnerable adults, even during office hours, especially if the detainee was not known to the social services mental health team, community team or the vulnerable adult team, and delays were often experienced when no one would accept responsibility for supplying an AA. In addition, there had been delays in accessing an AA when the detainee was lodged at a police station other than where they were resident (for example, residents of Luton being detained at Bedford custody suite) as a

result of the social services teams negotiating over whose responsibility it was to attend (see main recommendation 2.29).

- 5.6** We saw a number of delays in accessing AAs, which led to detainees being held in custody for longer than necessary. In one case at Luton, we saw a vulnerable female detainee who had been arrested at 11pm. She was under the influence of alcohol and was allowed to sober up before being seen by a health care practitioner (HCP), who said that she needed an AA. Family members were unable to attend and staff attempted to secure the services of an AA throughout the following day, without success, until the woman's father eventually attended at 5pm. She was bailed at 8.30pm and instructed to return to the custody suite at a later date (see main recommendation 2.29).
- 5.7** Staff told us that because of the lack of availability of AAs, they often had to bail detainees to be dealt with at a later time. At Luton, we saw a 20-year-old vulnerable adult with a range of issues being bailed at 9.30pm, as social services were unable to provide an AA. He was bailed to return to the custody suite at 10.30am the next day; however, when staff contacted social services early the next morning to establish a time of arrival for the AA, they were told that no message had been passed on from the EDT to indicate that they were required. Despite the confusion, the AA attended the custody suite at 11.30am.
- 5.8** Our custody record analysis highlighted issues about accessing local authority accommodation for children and young people (see main recommendation 2.30). One case concerned the detention of a child of 15, who was a resident of a care home. Staff at the care home had been contacted at 6.41pm (half an hour after the child's arrival at the custody suite) to act as an AA; however, no one had been available to attend that evening and the EDT had been contacted. No AA had attended that evening and the child had been kept in custody owing to '[the] lateness and seriousness of [the] offence'. There was no record in the detention log of any attempt made to request alternative accommodation, secure or non-secure, from the local authority. From the detention log it was evident that an AA had not attended until around 1pm the following day, but an exact time was not recorded (see main recommendation 2.29).
- 5.9** Most custody staff said that they had never known secure accommodation to be made available by local authorities in cases where a young person had been charged and could not be bailed, and therefore they had stopped even requesting this facility. They said that, instead, they simply completed a juvenile detention certificate and attached it to the custody record; however, this meant that social services were not provided with an opportunity to source alternative accommodation and would therefore be unaware of the scale of this issue. Figures supplied by the force showed that 60 children under the age of 17 had been remanded in custody following charge during 2013/14. However, they were unable to identify how many requests had been made for local authority accommodation during that period, or if any of these requests had resulted in children being moved to either secure or non-secure accommodation. Staff we spoke to told us that they had never requested non-secure accommodation and could not think of a case where this might have been appropriate.
- 5.10** At all suites, a professional telephone interpreting service was available to assist in the booking-in process, and most staff said that a good service was provided. They told us of some delays in the provision of the service, depending on the language involved. We witnessed one case at Luton where a custody sergeant had to remain on hold on the telephone for 40 minutes before being put through to a Romanian interpreter. The booking-in process for the detainee concerned took approximately 90 minutes to complete because of this delay and the subsequent poor standard of the service received. At all suites, loudspeaker telephones were used to access the interpreting services, which lacked privacy and, when the suites were busy, resulted in staff and detainees having to raise their voices in

an attempt to be heard. Staff said that a good face-to-face interpreter service was available for interviews.

- 5.11** During booking-in, custody staff advised detainees of their three main rights (the right to have someone informed of their arrest, the right to consult a solicitor and access free independent legal advice, and the right to consult the PACE codes of practice), and all detainees were offered a written notice setting out these rights and their entitlements while in custody. All staff were aware of how to access these documents in foreign languages for non-English-speaking detainees, and we saw these routinely being retrieved and offered. We also saw detainees being given their foreign national rights. Not all staff were aware of the availability of an easy-read version of the rights and entitlements, which was available on the Home Office website. Copies of the rights and entitlements were available in Braille at Bedford and Luton, but not all staff were aware that these were held.

Recommendations

- 5.12** Police officers should be encouraged to make more use of alternatives to custody processes where appropriate, such as voluntary attendance at the police station.
- 5.13** Bedfordshire police should ensure that there are no unnecessary delays in progressing detainees' cases due to the lack of availability of staff from the prisoner handling units.
- 5.14** Double handset telephones should be provided in all suites to facilitate telephone interpreting.

Housekeeping points

- 5.15** Contact and attendance times for appropriate adults should be clearly recorded on custody records for monitoring purposes.
- 5.16** Bedfordshire police should provide a private and timely access to interpreter services for detainees to avoid unnecessary delays in custody.

Rights relating to PACE

- 5.17** We saw detainees being told that they could read the PACE codes of practice during the booking-in process, but these were not routinely shown or explained by custody staff. Only Bedford and Luton had up-to-date copies of PACE code C available; however, at all the suites we saw staff handing out out-of-date copies of the code. The Criminal Defence Service poster, informing detainees of their right to free legal advice in a number of foreign languages, was not routinely displayed in the custody suites.
- 5.18** All detainees were offered legal representation. There were sufficient consultation and interview rooms, where detainees could speak in private with their legal advisers. We saw legal advisers routinely being offered the front sheet of their detainees' custody records without having to request this facility.
- 5.19** All the records we reviewed indicated that solicitors were contacted shortly after they were requested. We saw custody sergeants asking detainees why they had declined legal advice and also telling them that they could change their mind at any time. It was clear from the

detention logs that the person nominated by the detainee to be told about their detention was notified in every case. We saw this contact routinely taking place during the booking-in process.

- 5.20** Reviews of detainees in custody were undertaken by custody and operational inspectors across the force area. We saw inspectors conducting good face-to-face reviews with detainees in their cells, including one that was carried out for a non-English-speaking detainee in their own language. We also saw detainees being told about reviews that had taken place while they were asleep, and reminded about their rights and entitlements. In our custody record analysis, of the 22 detainees who had required a PACE review while in detention, six had been conducted on time, eight had been early and eight had been late; none had been more than an hour early and none more than 90 minutes late. The remaining eight reviews had taken place while the detainee was asleep and in all instances they had later been informed of this and reminded of their rights and entitlements.
- 5.21** At Luton, we saw the mother of a vulnerable adult detainee asking staff questions about the taking of DNA, and the investigating officer and custody sergeant were thorough in their explanation of the force DNA retention policy. There was an effective system for collecting DNA samples taken in custody.
- 5.22** We were told that the area remand court (Luton Magistrates' Court) would not accept detainees after 2pm on weekdays or 11am on Saturdays, with very limited flexibility each day. These early timings could potentially have contributed to detainees remaining in custody too long.

Recommendation

- 5.23 Senior police managers should engage with HM Courts and Tribunal Service to ensure that detainees are not held in police custody for longer than necessary.**

Housekeeping points

- 5.24** Up-to-date copies of the PACE codes of practice should be made available at all custody suites and old versions should be withdrawn from use.
- 5.25** Posters detailing detainees' right to free legal advice, in a range of languages, should be prominently displayed in all custody suites.

Rights relating to treatment

- 5.26** The notice of rights and entitlements, offered to all detainees when they were booked in, detailed the process for making a complaint. Detainees we spoke to who had accepted the notice were aware of how to make a complaint. Custody staff gave us mixed responses when asked how they would handle a complaint; some said that they would notify either the custody or duty inspector immediately, while others said that they would advise detainees to make a complaint at the police station front counter on their release or go online and report it via the force website. These latter practices had the potential to reduce the number of complaints made as detainees would be less likely to make a complaint in their own time than during custody. There was no consideration of how to take complaints from detainees who were taken directly to court, rather than being released from custody.

Recommendation

- 5.27 Detainees should be able to make a complaint about their care and treatment before they leave custody.**

Section 6. Health care

Expected outcomes:

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

Governance

- 6.1** At the time of the inspection, NHS England had become responsible for commissioning police health services and G4S Forensic Medical Services (G4S) was contracted to provide first-line health care. HCPs, comprising nurses and forensic medical examiners, provided the service. A revised protocol for information sharing had been agreed between the police, health services and other agencies. Detainees could see an HCP of their gender, but this could mean that waiting times were prolonged.
- 6.2** A chief inspector was responsible for monitoring service delivery. A new, minuted health and social care group was to develop a strategic focus on health care issues, and G4S had a clinical governance group. The police were reliant on performance data supplied by G4S and had yet to develop verification systems. There had been, on average, 495 medical requests a month in 2013/14. Working relationships between custody staff and HCPs were positive.
- 6.3** G4S scrutinised professional credentials. New staff underwent a robust induction and ongoing training arrangements were set at the appropriate level. All HCPs undertook mandatory training and received clinical supervision. The contract with G4S had an escalation clause that enabled the police formally to register concerns over the performance of HCPs, including doctors.
- 6.4** Each site had a dedicated clinical room with an attached toilet. The rooms had natural lighting but no examination lamps. A cleaning schedule was displayed and rooms were cleaned daily but the rooms were worn and grubby in places. Infection control auditing took place weekly but most fixtures and fittings did not fully comply with minimum standards. Some tap fittings were of the wrong type and some were heavily tarnished. No room had clinical work surfaces suitable for forensic sampling. The medical room at Bedford was particularly poor, with several problems, including open shelving and limited space. Isolated items of stock were out of date but were quickly removed when we pointed this out. We saw HCPs paying attention to privacy and dignity when seeing patients.
- 6.5** The storage of medicines, disposal of unused medications and stock management were good, with registers of usage and audit trails. Weekly checks were undertaken by G4S. Drug reference books were in date, with one exception, and this was quickly removed when we pointed it out.
- 6.6** Nurses and custody staff accepted telephone prescriptions for medicines from doctors and said that the conversations were recorded, saved as computer files and kept for the same length of time as written clinical records. Custody staff had not received training in the administration of medicines or their side effects.
- 6.7** There was a written policy and information on the use of patient group directions (which enable nurses to supply and administer prescription-only medicine) in each medical room but there was no copy of the required signatures, and the policy was not the latest version. These deficits were rectified immediately. Contrary to professional guidance for nurses, custody staff administered medicines on behalf of HCPs.

- 6.8** Each custody suite had an emergency bag of essential medical equipment and an automated external defibrillator (AED) stored at the custody desk. The equipment was checked regularly. All custody staff underwent resuscitation training, including the use of an AED.

Recommendations

- 6.9** **Clinical rooms should comply with relevant standards of infection control and contemporary standards for forensic sampling.**
- 6.10** **Nurses should ensure that they are in compliance with their professional standards of medicines management when using patient group directions to administer medicines.**

Housekeeping points

- 6.11** The police should verify contract performance data supplied by G4S.
- 6.12** Examination lamps should be available for clinical examinations.

Patient care

- 6.13** Custody officers sought medical assistance for 37% of detainees. HCPs were on call 24 hours a day and they achieved the target response times in 94% of cases. Our custody record analysis revealed an average response time of 48 minutes, the longest wait being one hour and 38 minutes, which was much better than at the time of the previous inspection.
- 6.14** HCPs treated detainees respectfully and sensitively. There was a comprehensive approach to medical assessment, and evidence-based guidance materials were available on site. Clinical records were good and stored securely. HCPs made entries on NSPIS to guide custody staff, who found this beneficial. Care plans were kept for several detainees with complex needs who regularly frequented the custody suites at Luton and Dunstable. The results of clinical examinations were shared with detainees or their legal representatives on request.
- 6.15** In our custody record analysis, eight detainees (27%) had arrived in custody with their own medicines and, subject to authentication, medicines had been continued. Custody officers made reasonable attempts to collect prescribed medications from detainees' home addresses. G4S policy was to provide for the continuance of some types of opiate substitution therapy during police custody, although, in practice, this did not occur.

Recommendation

- 6.16** **Detainees should be able to continue with prescribed medications for any clinical condition, including opiate substitution therapy.**

Good practice

- 6.17** *Care plans were prepared for detainees who frequently visited the custody suites, demonstrating continuity of patient-centred care in a challenging setting.*

Substance misuse

- 6.18** Our custody record analysis indicated that 30% of detainees entered custody intoxicated. Westminster Drug Project drug intervention programme (DIP) workers were based in Bedford and Luton custody suites on weekdays and saw all detainees before they went to court. They assessed all detainees who tested positive for drugs on arrest for trigger offences; if requested by custody officers, they returned to the custody suite to see detainees in the afternoons. Out of hours, custody staff made an appointment for the detainee to see a DIP worker on the next working day, and attendance for appointments was a condition of bail for some detainees.
- 6.19** DIP workers acted as gatekeepers to opportunities for throughcare for detainees with alcohol and substance misuse problems. Young people were referred to the relevant specialist services for this age group. Custody staff told us that they valued the services of DIP workers and the training they provided. There was good liaison between substance misuse and mental health workers.
- 6.20** Detainees requiring substance misuse or alcohol withdrawal therapy were prescribed substitutes such as dihydrocodeine and diazepam, and the police provided nicotine replacement lozenges if required. Clean needles and syringes were available to intravenous drug users on release.

Mental health

- 6.21** In our custody record analysis, 13% of detainees in our sample had entered custody with mental health problems, one of whom had a learning disability. Custody staff told us that many detainees had mental health- and substance misuse-related problems.
- 6.22** Mental health services had improved, with more extensive hours; revised protocols with an assertive approach; multi-agency training for all custody staff in 2013/14 and additional training in autism awareness; and custody staff being prepared as mental health champions to ensure a focus on support. At Bedford, the Samaritans offered a service to detainees with emotional distress; this service was about to be extended to Luton and, although Bedford was closed during the inspection, this was still considered to be a good service and a good practice initiative.
- 6.23** The South Essex Partnership NHS Trust (SEPT) criminal justice liaison team (CJIT) had extended their hours in the custody suites from 7am to 7pm, from Monday to Saturday. They saw all detainees with mental health problems before courts opened and were available during the day. Outside office hours, custody officers offered such detainees mental health appointments on the next working day. CJIT had access to SEPT mental health records in custody and we saw effective coordination of multi-agency support for detainees. However, CJIT workers did not have access to NSPIS, which would have improved the efficiency of communication.
- 6.24** Detainees requiring formal assessment under the Mental Health Act 1983 were seen by the local EDT. The revised protocol stipulated that the assessment should occur within four hours of referral but custody officers said that EDT responses, although improved, commonly took six hours.

- 6.25** In 2013, approximately eight persons had entered police custody under section 136 of the Mental Health Act³ compared with around 18 per month in 2011. Although this represented a considerable improvement, it remained unacceptably high.

Recommendation

- 6.26** **Detainees under section 136 of the Mental Health Act 1983 should not enter police custody unless there are exceptional circumstances.**

Housekeeping point

- 6.27** Criminal justice liaison team staff should place advice and instructions for custody staff directly onto the national strategy for police information systems.

Good practice

- 6.28** *The Samaritans service offered face-to-face and telephone support to detainees in emotional distress.*

³ Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker, and for the making of any necessary arrangements for treatment or care.

Section 7. Summary of recommendations and housekeeping points

Main recommendations

- 7.1** Quality assurance processes, leading to improved outcomes for detainees, should include sampling of custody records, checking against closed-circuit television (CCTV) recordings, person escort records and staff handovers. (2.25)
- 7.2** The police custody estate should be clean, safe and free of ligature points, and staff should be trained to identify these issues or manage and mitigate the presenting risks. (2.26)
- 7.3** There should be sufficient staff in custody at all times to ensure the safety and well-being of detainees. (2.27)
- 7.4** The police force should ensure that learning from adverse incidents has clear ownership and is overseen at a strategic level to ensure that there is effective collation, monitoring of trends and identifying areas for improvement. There should be an effective process for communicating this learning to frontline staff. (2.28)
- 7.5** The force should facilitate the provision of appropriate adults for vulnerable people in custody. (2.29)
- 7.6** The force should facilitate the provision of PACE beds for children in custody to prevent them from being held in police custody overnight. (2.30)

Recommendations

Strategy

- 7.7** There should be robust arrangements to collect, evaluate and monitor data relating to the treatment of those in custody to improve outcomes and safety for detainees. (3.8)
- 7.8** Custody-specific refresher training should be delivered regularly to ensure staff respond appropriately to the welfare and safety of detainees in their care (3.15)

Treatment and conditions

- 7.9** Booking-in areas should provide sufficient privacy to allow effective communication between staff and detainees. (4.10)
- 7.10** All holding rooms should be suitable for their purpose (4.11).
- 7.11** Some cells should be adapted for use by detainees with physical disabilities. (4.12)
- 7.12** Detainees' shoes and cords should not be routinely removed. (4.25)

- 7.13** All custody staff should be involved in the same shift handover and incoming staff should introduce themselves to detainees. (4.26)
- 7.14** Pre-release risk assessment questions should encourage a discussion with detainees. (4.27)
- 7.15** Information about support agencies should be available in languages in addition to English. (4.28)
- 7.16** The CCTV monitors should clearly identify which cells are being displayed. (4.29)
- 7.17** Bedfordshire Police Service should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers policy and College of Policing guidance. (4.36)
- 7.18** Detainees should not be observed being strip-searched. (4.37)
- 7.19** The shower areas in the custody suites should be clean, repaired and safe for detainees to use. (4.44)
- 7.20** Custody sergeants should ensure that non-custodial staff do not visit detainees in cells unsupervised. (4.45)
- 7.21** Emergency practice evacuations should take place regularly, and be recorded. (4.46)
- 7.22** Replacement clothing that maintains detainees' dignity should be provided. (4.57)
- 7.23** All detainees held overnight and those who require one should be offered a shower and should be able to take it with an appropriate degree of privacy. (4.58)
- 7.24** Detainees, particularly those held for more than 24 hours, should be offered exercise. (4.59)

Individual rights

- 7.25** Police officers should be encouraged to make more use of alternatives to custody processes where appropriate, such as voluntary attendance at the police station. (5.12)
- 7.26** Bedfordshire police should ensure that there are no unnecessary delays in progressing detainees' cases due to the lack of availability of staff from the prisoner handling units. (5.13)
- 7.27** Double handset telephones should be provided in all suites to facilitate telephone interpreting. (5.14)
- 7.28** Senior police managers should engage with HM Courts and Tribunal Service to ensure that detainees are not held in police custody for longer than necessary. (5.23)
- 7.29** Detainees should be able to make a complaint about their care and treatment before they leave custody. (5.27)

Health care

- 7.30** Clinical rooms should comply with relevant standards of infection control and contemporary standards for forensic sampling. (6.9)

- 7.31** Nurses should ensure that they are in compliance with their professional standards of medicines management when using patient group directions to administer medicines. (6.10)
- 7.32** Detainees should be able to continue with prescribed medications for any clinical condition, including opiate substitution therapy. (6.16)
- 7.33** Detainees under section 136 of the Mental Health Act 1983 should not enter police custody unless there are exceptional circumstances. (6.26)

Housekeeping points

Treatment and conditions

- 7.34** Girls aged 16 or under should be allocated a female officer responsible for their care. (4.13)
- 7.35** A hearing loop should be available in all custody suites and staff should know how to use it. (4.14)
- 7.36** There should be a means for indicating the direction of Mecca. (4.15)
- 7.37** Custody staff conducting constant supervision via closed-circuit television (CCTV) should not be engaged in other tasks, and significant events and interactions should be recorded. (4.30)
- 7.38** Anti-ligature knives should not be used to cut cords from clothing. (4.31)
- 7.39** Records of cell checks should be accessible so they can be reviewed to ensure that any reported repairs are monitored and completed. (4.47)
- 7.40** Staff should be trained to identify ligature points. (4.48)
- 7.41** Mattresses should be wiped down between uses. (4.60)
- 7.42** Replacement plimsolls should be given to detainees whose shoes have been removed. (4.61)
- 7.43** A stock of disposable razors should be maintained so that, subject to risk assessment, detainees who wish to shave before attending court can do so. (4.62)
- 7.44** A range of reading materials should be available and routinely offered, including books and magazines suitable for young people and for those whose first language is not English. (4.63)

Individual rights

- 7.45** Contact and attendance times for appropriate adults should be clearly recorded on custody records for monitoring purposes. (5.15)
- 7.46** Bedfordshire police should provide a private and timely access to interpreter services for detainees to avoid unnecessary delays in custody. (5.16)
- 7.47** Up-to-date copies of the PACE codes of practice should be made available at all custody suites and old versions should be withdrawn from use. (5.24)

- 7.48** Posters detailing detainees' right to free legal advice, in a range of languages, should be prominently displayed in all custody suites. (5.25)

Health care

- 7.49** The police should verify contract performance data supplied by G4S. (6.11)
- 7.50** Examination lamps should be available for clinical examinations. (6.12)
- 7.51** Criminal justice liaison team staff should place advice and instructions for custody staff directly onto the national strategy for police information systems. (6.27)

Good practice

Health care

- 7.52** Care plans were prepared for detainees who frequently visited the custody suites, demonstrating continuity of patient-centred care in a challenging setting. (6.17)
- 7.53** The Samaritans service offered face-to-face and telephone support to detainees in emotional distress. (6.28)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	HMIP team leader
Gary Boughen	HMIP inspector
Fiona Shearlaw	HMIP inspector
Vinnett Percy	HMIP inspector
Mark Ewan	HMIC lead staff officer
Paul Davies	HMIC staff officer
Jan Fookes-Bale	CQC Inspector
Paul Tarbuck	HMIP health services inspector
Alissa Redmond	HMIP researcher

Appendix II: Progress on recommendations from the last report

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

Strategy

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

Main recommendations

There should be sufficient staff in custody at all times to ensure the safety and well-being of detainees. (2.13)

Not achieved (recommendation repeated, 2.27)

Recommendations

Only trained staff should be allowed to work in the custody environment. (3.10)

Achieved

The force should collate the use of force and monitor for trends, for example by ethnicity, location and officer involved. (3.11)

Not achieved

Treatment and conditions

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

Main recommendations

Cells and other detainee areas should be clean and free of ligature points, which staff should be trained to identify. Where current resources do not allow ligature points to be removed, a strategy should be put in place to manage the new risks identified. (2.14)

Not achieved

Recommendations

Some cells should be adapted for use by detainees with physical disabilities. (4.6)

Not achieved (recommendation repeated, 4.12)

Booking in areas should allow effective and private communication between detainees and staff. (4.7)

Not achieved (recommendation repeated, 4.10)

An overlap period should be built into all shifts to facilitate an effective handover between staff. (4.14)

Achieved

Health and safety checks should be formalised and consistent across all suites and staff given sufficient training to carry them out effectively. (4.23)

Not achieved

All staff should be familiar with fire prevention procedures and practice evacuations should be carried out. (4.24)

Partially achieved

All detainees held overnight and those who require one should be offered a shower and should be able to take it with an appropriate degree of privacy. (4.28)

Not achieved (recommendation repeated, 4.58)

Replacement clothing that maintains detainees' dignity should be provided. (4.29)

Not achieved (recommendation repeated, 4.57)

Food provided should be of sufficient quality and calorific content to sustain detainees for the duration of their stay. (4.34)

Not achieved

Individual rights

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

Main recommendations

Appropriate adults should be readily available to support vulnerable adults and juveniles aged 17 years. (2.15)

Not achieved

Recommendations

There should be no undue delays in transporting immigration detainees to placements in the immigration custody estate. (5.7)

Not achieved

Pre-release plans should be produced for all vulnerable detainees in line with the force policy. (5.8)

Partially achieved

Detainees should be told how to make a complaint and should be able to do this before they leave custody. (5.18)

Not achieved

Health care

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

Recommendations

There should be clear infection control procedures, including cleaning schedules that are adhered to and monitored. (6.11)

Achieved

The system for storing, checking and administering dihydrocodeine, diazepam and paracetamol should be subject to clinical audit. (6.12)

Achieved

The use of patient group directions should be formalised, consistently applied across all suites and monitored. (6.13)

Achieved

Responsibility for the management of, and determining the need for, first aid stock items in the clinical rooms should be clarified. (6.14)

Achieved

Health care professionals should not instruct non-health care professionals to administer prescribed medicines. (6.15)

Not achieved

Detainees should be able to continue with prescribed medications for any clinical condition, including opiate substitution therapy. (6.23)

Partially achieved

The commissioning of mental health services should be formalised to ensure the needs of all detainees with mental health issues are met. (6.30)

Partially achieved

There should be out-of-hours cover for mental health workers to meet the needs of detainees. (6.31)

Not achieved

Custody staff should have appropriate training to recognise and take appropriate action when a detainee may have mental health problems and work effectively with health staff to ensure a detainee's care. (6.32)

Achieved

Section 136 detainees should be held in police cells only as a last resort. (6.33)

Not achieved