Inspecting policing in the public interest

Report on an unannounced inspection visit to police custody suites in

South Yorkshire

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

28 April–2 May 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 South Yorkshire police custody suites, the first took place in 2010. In that inspection we were generally positive while drawing the service's attention to improvements required, notably the supervision of use of force, the management of medications and services for those with mental health concerns. This inspection identified a number of improvements that South Yorkshire police service has made to custody provision including a few instances of good practice, but there are also a number of inadequacies in service provision, in particular concerning risk assessments and a specific use of force technique.

There were clear lines of accountability in the leadership and management of custody supported by forums and structures in which custody issues were addressed. However, the process for the collection and analysis of custody data and management information required improvement, as did quality assurance arrangements and processes to ensure learning was applied. Strategically, there was clear evidence of South Yorkshire police service seeking to develop important partnerships with stakeholders in support of custody provision. It was also encouraging that South Yorkshire police service was developing plans to renew its custody suites by building new and larger facilities to replace the older suites it currently uses.

Most police forces have a computerised custody record system, but in South Yorkshire there was a mixed record keeping system including handwritten records. Many records we saw were in part illegible, something that has been commented on before and widely acknowledged. Such records undermine accountable and effective risk management and handover. Previously, an Independent Police Complaints Commission investigation made a recommendation on improving the quality of record keeping. We found no process to address this recommendation. Risk assessment and management in general was weak. Handovers and pre-release risks assessments were often formulaic, evidencing a mechanistic approach to risk management.

Police staff were polite and interactions between most detainees and staff that we observed were courteous. Detainees told us they were well looked after. Despite their age, custody facilities and cellular accommodation was clean and free from graffiti.

Appropriate adult services were available in most suites, except in Rotherham where there were delays outside normal office hours. There had been some excellent partnership work to secure local authority accommodation for young people in custody in Sheffield. Staff we spoke to were aware of the need to contact family or friends and appropriate adult services when young or vulnerable people were detained. All detainees were informed of their rights and entitlements during their time in custody.

Health care services were generally good. Consultations between detainees and staff were respectful and detainees we spoke to were satisfied with the service. The police service were developing after care service for people leaving custody, particularly for vulnerable people who needed further access to NHS schemes for alcohol and drug addiction. This was being developed and while a positive initiative, it was too early to assess any impact. There was also good practice in the street triage service, which allowed people in need of immediate health care to be diverted without the need to be taken in to police custody. This was most beneficial to people who were identified as having mental health concerns.

Of the 25 recommendations made in our previous report after our inspection in 2010, six recommendations had been achieved, seven had been partially achieved and 12 had not been achieved.

We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

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HM Chief Inspector of Constabulary

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December 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 South Yorkshire Police. The first took place in July 2010. The police service was in the early stages of opening a new custody suite and closing existing buildings; however, it continued to maintain a reasonable standard which was positive.

2.4 We examined the custody strategy as well as treatment and conditions, individual rights and health care in the custody suites. For the 12 months up to March 2014, 30,600 detainees had been held at custody suites across the police service area.

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

Custody suites	Cells
Barnsley	**24**
Charge Office Bridge Street (COBS) (Sheffield)	**26**
Doncaster	**38**
Ecclesfield (Sheffield)	**7**
Rotherham	**18**
Mossway (standby)	**11**

Strategy

2.6 The deputy chief constable (DCC) was responsible for providing overall leadership concerning custody; the operational management of custody was devolved to the head of custody. The police service's estate strategy involved plans to build a new 50-cell suite to replace some of the existing suites and staff had been included in ongoing consultations about these proposals. Staffing was adequate across all suites.

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

2.7 Custody issues were discussed at a number of meetings and minutes referred to some positive outcomes for detainees. The service had a process for collecting and evaluating data on detainee care; however there were notable omissions, for example, in relation to the number of detainees subject to strip-searching and incidents where officers used force.

2.8 Partnership arrangements with other organisations were good, with some exemplary work to secure local authority accommodation for young people in police custody in Sheffield. Efforts were being made to roll this out to the rest of the police service area where arrangements for children held in custody were less developed.

2.9 Staff received specific training before working in custody; they were positive about the mental health awareness and safeguarding training. A quality assurance process was in place, which included dip-sampling custody and other records; however it was ineffective – the template was basic and staff could not add comments on quality or lessons learnt.

2.10 A number of Independent Police Complaints Commission (IPCC) investigations had taken place, one of which was still continuing; it related to a death in custody. Lessons learned from investigations did not appear to be embedded in the quality assurance process.

2.11 The service had a process for recording near misses known as 'positive interventions'; however it did not define what a near miss was, which could have led to inconsistencies in reporting and identifying lessons learned. Lessons and improved practices, once they were identified, were appropriately accessible through the staff intranet.

2.12 South Yorkshire had a paper based custody record system unlike other forces which mostly had a computer based system. The illegibility of handwritten custody records was widely recognised throughout the force, including at senior management level, as a longstanding problem and representing a risk. We were told that the creation of fully electronic entries into the custody record had been under development but implementation was not until January 2015.

Treatment and conditions

2.13 Interactions between custody staff and detainees were polite and courteous and we saw some well managed interventions. Detainees told us they felt well looked after. However, there was a lack of privacy during the booking-in process and while in some suites there was some capacity for limited privacy, it was not used. Provision for diverse groups was poor and had not changed substantially since the last inspection. We identified a number of occasions when young people were held in custody overnight and it was not clear due to illegibility of records, if alternative accommodation had been sought.

2.14 We were concerned that every record we assessed contained some part that was illegible, compounding the already poor risk assessment framework. The risk assessment proforma used was too formulaic. We observed custody staff rushing through the questions, about health and self-harm without exploring concerns fully. The form was not designed to include information beyond a 'yes' or 'no' answer. We saw custody sergeants asking questions without explaining what they meant when it was apparent the detainee did not understand the question.

2.15 South Yorkshire Police used its own custody handling system, which meant that sometimes staff checked the police national computer (PNC) separately once detainees had been placed in the cell. This meant that custody sergeants were not always aware of other risks. It was difficult to determine from custody records whether or not observations were being

reviewed because there was no designated space for this information and handwriting was illegible. Our custody record analysis raised further concerns about risk assessments.

2.16 Handovers did not include the whole team and generally only involved sergeants. A written handover sheet was prepared and contained good quality relevant information about risks and case progression. Staff relied heavily on the written handover sheets rather than discussing detainees' risks and welfare with their colleagues. However at some suites, staff did not refer to the handover sheet or one was not prepared in time for the formal handover. No handover time was built into shift patterns.

2.17 Pre-release risk assessments were generally inadequate. The police service had a question to assess detainees' risk of self-harm or emotional distress, but we observed staff asking the question in what appeared to be a tokenistic way, without empathy or genuine inquiry. Some detainees were given a leaflet about support organisations but the information was poorly presented and was not handed out at all suites.

2.18 We were very concerned about the police service's use of protective helmets (which appeared to be boxing helmets) as a method of protecting the detainee against self-harm; it appeared to be used frequently alongside handcuffs and leg restraints. South Yorkshire Police claimed the restraint was used to prevent self-harm, although it was not a practice we had seen elsewhere. This method of restraint was, in our view, poorly supervised and subject to inadequate governance. We considered the practice to be potentially unsafe and certainly a degrading treatment. Strip-searches were mostly appropriately authorised and risk assessed.

2.19 The condition of the custody suites had improved since the previous inspection; they had all been decorated in the previous two years, there was very little graffiti in the cells across the custody estate and they were mostly clean. Further improvements were still required and most cells had ligature points.

2.20 Each of the suites had reasonable cell cleaning arrangements. At Doncaster and Barnsley there were problems with the heating and ventilation system. We saw call bells receive a reasonably prompt response. There was no record of fire drills taking place at any of the custody suites, but staff told us they had fire safety training every year, which included evacuation drills.

2.21 All the suites had a good stock of blankets, replacement clothing and microwave meals catering for a range of diets. Detainees going to court had poor access to showers and in some suites there was a lack of privacy. Closed visits booths were available in all the custody suites. Only staff at Rotherham told us that they had been used in the previous 12 months for a vulnerable detainee. There was a reasonable stock of magazines and books at all the suites, but staff did not offer them to detainees.

Individual rights

2.22 Sergeants were observed checking the grounds for detention with arresting officers, and voluntary attendance, as an alternative to custody, appeared to have been well established across the police service area.

2.23 Staff described how a handover culture had built up across the South Yorkshire Police area. This meant that arresting officers did not take on the responsibility for finalising the cases of the detainees they had arrested, potentially increasing the time detainees spent in custody.

2.24 Staff said relations with immigration enforcement officers were good and that immigration detainees were now being held for shorter periods.

2.25 Staff we spoke to told us they knew to contact the family and friends of young or vulnerable detainees in the first instance. The appropriate adult schemes mostly provided a prompt service; however in Rotherham there were delays outside normal office hours. The rights and entitlements notice issued by staff was out of date and many details were not given in the older notices which were given in the newer ones.

2.26 Interpreting service posters at all suites informed non-English-speaking detainees that they could ask for an interpreter. The police service used a professional telephone interpretation service. Some staff mistakenly believed they no longer had to offer foreign nationals the opportunity to contact their high commission, embassy or consulate. PACE reviews were mixed: some were very thorough, while others were basic. They were mostly conducted face to face and telephone reviews were only carried out in exceptional circumstances.

2.27 All detainees were offered free legal representation and sufficient rooms were available for private consultations. Magistrates' courts would not accept detainees after 2pm on weekdays or after 9am on Saturdays. These early cut off times meant that some detainees remained in custody too long. When asked how detainees would make a complaint in custody we were given different accounts. Inspectors said complaints would be taken during custody or on release, or that an arrangement would be made to meet the detainees at a later date.

Health care

2.28 Clinical governance was generally satisfactory; however, the approach to clinical supervision was too informal.

2.29 The standard of rooms, cabinetry and furnishings was variable; in several cases it was very poor. None of the rooms were free of infection control problems or had clinical work surfaces for forensic purposes.

2.30 Systems for the storage and transportation of written clinical records were insufficiently developed. Medications management was good and stock levels were appropriate.

2.31 We observed consultations between detainees and health care professionals (HCPs); they were respectful and focused on the detainees' needs. Some HCPs left the door ajar for safety reasons, which compromised confidentiality. Detainees said they were satisfied with consultations and custody officers were generally happy with the service.

2.32 Clinical records we sampled were of a high standard and custody staff said printed care plans HCPs gave them were helpful.

2.33 In the previous six weeks, HCPs at the police service had begun liaising with aftercare services for people leaving custody, which might have helped detainees to access NHS services.

2.34 An appropriate range of substance and alcohol services were available and the service was available over extended hours in the busier custody suites. Schemes to divert detainees to mental health services varied between custody suites and provider mental health trusts. South Yorkshire Police's data on the use of police cells as a place of safety for people with mental health concerns was incomplete. However, despite this, it concluded that it was used to unacceptably high levels. An innovative street triage programme had been introduced in January 2014, which, anecdotally, was reducing the use of police custody for detainees and there were good joint working arrangements with Yorkshire Ambulance Service.

Main recommendations

2.35 Quality assurance processes should include monitoring trends, identifying areas for improvement, using learning from incidents and demonstrating how recommendations are implemented by frontline staff to ensure the safe treatment of detainees.

2.36 All detention logs and risk assessments should be legible to ensure the welfare and safe detention of people in police custody.

2.37 The use of head guards, with handcuffs and leg restraints to prevent self- harm should cease and alternative arrangements in keeping with best practice should be introduced to deal with extreme cases of self-harm.

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 The deputy chief constable (DCC) was responsible for providing strategic leadership on custody, which was operationally led by the head of custody who was a chief inspector rank.

3.2 A custody estates strategy outlined plans to replace custody suites in Sheffield and Rotherham with a new 50-cell suite and in addition build a new suite in Barnsley. Staff had been consulted on designs and were regularly updated on progress. Despite the plans, the service had nevertheless invested in redecorating the existing suites to improve them in the meantime.

3.3 We found that staffing levels in all suites were adequate; this included custody staff, permanent custody sergeants and detention officers (DOs), who were responsible for the care and welfare of detainees. The staffing model was self-sufficient and there was no need for extra staff to cover absences as permanent staff moved between suites to fill gaps.

3.4 A dedicated custody inspector, based at each of the five suites, was responsible for the day-to-day running of their respective suites and managed custody staff, as well as Police and Criminal Evidence Act 1984 (PACE) issues. Line management arrangements for custody staff were clear.

3.5 Custody was discussed at a number of governance meetings, including a monthly custody inspectors' meeting, chaired by the head of custody. The minutes of these meetings showed that they were active and well attended. Custody inspectors only held informal meetings with staff at a local level.

3.6 There was a structured process for the collection and evaluation of basic data relating to the treatment of those in custody. It involved monitoring detention times and the number of young people coming into custody; however, it was basic and there were gaps, for example, there were no strip-search or use of force data. This and other data sources would have provided a more comprehensive analysis of outcomes as they affected detainees.

3.7 Custody procedures were regularly reviewed and mostly complied with College of Policing Authorised Professional Practice guidance on detention and custody.

Recommendation

3.8 South Yorkshire Police Service should collate data on the number of strip-searches carried out and on the use of force.

Partnerships

3.9 There was an independent custody visitor (ICV) scheme, comprising five panels that were coordinated by the Police and Crime Commissioner's (PCC) office. This arrangement

generally worked well – the PCC coordinator reported a good relationship with ICVs and issues identified during visits were resolved promptly. However, we did find that ICVs were occasionally unable to visit detainees because custody staff were too busy. Police were regularly represented at ICV panel meetings.

3.10 There was some evidence of effective partnership working; an assistant chief constable chaired the local criminal justice board, which the head of corporate services attended as the police representative. There had been some exemplary partnership working to secure local authority accommodation for young people in police custody in Sheffield so that children were not held overnight. Efforts were being made to roll this out to the rest of the police service area. The police service was represented at local health and wellbeing boards. At an operational level, custody inspectors had links with partner organisations, such as immigration agencies, local authorities, escort contractor GeoAmey and health care provider Medacs.

Recommendation

3.11 ICV's access to detainees should be prompt and arrangements should be put in place to ensure this is expedited during busy periods.

Good practice

3.12 *Partnership working in Sheffield enabled the police service to access local authority accommodation for young people so that they did not need to be held in police custody overnight.*

Learning and development

3.13 All custody staff had undergone custody training before taking on custody duties. The custody sergeant's course was linked to the national custody officer learning programme (NCOLP), established by the College of Policing. Regular refresher training specific to the role was available for custody inspectors, custody sergeants and DOs. It covered areas such as mental health awareness and safeguarding, which staff valued.

3.14 A quality assurance process was in place; each month, custody sergeants and custody inspectors, overseen by the head of custody, dip-sampled a number of custody records and person escort record forms (PER). The process, however, was ineffective – the template used for dip-sampling required 'yes' or 'no' answers about the activities undertaken and there was no space for an evaluation of the quality of records, which limited what lessons could be learned. The dip-sampling process did not refer to CCTV recordings or shift handovers (see main recommendation, paragraph 2.35).

3.15 The process meant custody inspectors provided staff with feedback, but they did not do it consistently. The system was not robust enough to identify individuals who repeatedly made mistakes. The quality assurance process was fundamentally compromised by poor hand-written custody records; the service had widely recognised the illegibility of handwritten custody records as a longstanding problem that represented a risk. We were told the creation of fully electronic entries into the custody record had been under development but implementation was not until January 2015. In the interim nothing had been done to address any of the problems associated with illegible handwriting (see paragraph 2.36).

3.16 A number of Independent Police Complaints Commission (IPCC) investigations relating to custody had taken place; at the time of our inspection, a continuing investigation into a death in Ecclesfield police custody was underway. Lessons learned from these investigations did not

appear to have been embedded in the quality assurance process, such as risk management and handover practices.

3.17 A process for recording 'near misses' known as 'positive interventions', overseen by the head of custody, was in place. Information and lessons learned were collated onto a database, which all staff could access via the police service's intranet. Lessons learned were discussed at monthly inspectors' meetings and disseminated to staff, through, for example, training days. However, there was no service-wide definition of a positive intervention, which might have created inconsistencies when incidents were reported. The head of custody distributed copies of the IPCC national bulletin *Learning the Lessons* to staff, but the information was not held centrally, which meant staff could not access it easily.

Recommendation

3.18 The police service should ensure that a positive intervention is clearly defined, so that staff can report and learn from these incidents, to ensure the continued safety of detainees.

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 Interactions between custody staff and detainees were mostly respectful and we observed some well managed interventions. For example, at Doncaster a detainee was brought in having been sprayed with an incapacitant (pepper spray) during his arrest. The custody sergeant observed that the detainee was agitated and in some discomfort and instructed the officers to take the detainee to the exercise yard so he could have some fresh air. The custody sergeant conducted the booking-in process in the exercise yard. The detainee calmed down and cooperated. The custody sergeant was aware of the detainee's discomfort and his risk to others and acted appropriately and considerately.

4.2 Custody staff told us that they felt the safeguarding and mental health awareness training they received helped them in their work (see section on strategy, paragraph 3.13). We saw all detainees being asked if they were primary carers. Detainees we spoke to told us that they were well looked after by staff, although we observed that they had to ask for reading material or if they wanted exercise rather than routinely being informed that these were available.

4.3 All the booking-in areas at the five custody suites lacked privacy and there had been no changes to the configuration since the previous inspection. We observed detainees at all suites except Ecclesfield being booked in alongside other detainees. Charge Office Bridge Street (COBS) and Doncaster had a discrete booking-in desk but we did not observe them being used. Staff at COBS told us that it was rarely used for booking in potentially vulnerable detainees. In addition, each cell at COBS had a small circular window through which the cell toilet could be viewed; the windows had no covers, so anyone in the corridor could see detainees using the toilet, which was inappropriate.

4.4 The processing rooms at Rotherham, where detention officers took detainees' photographs and finger prints, lacked privacy. We observed detainees being booked in while others, who were being processed directly opposite, could observe them and hear what was being said. The situation was similar at Ecclesfield.

4.5 Diversity provision had not changed significantly since the last inspection; women were not asked any specific questions about their individual needs, such as if they would like to speak to a female officer or if they might be pregnant, or told about the availability of hygiene products. The local computerised custody handling system prompted staff to ask questions about detainees' religious and dietary needs, but we did not observe any being asked about their religious needs. All suites had a good stock of religious books and prayer mats and the direction of Mecca was indicated on cell ceilings. Not all religious books were respectfully stored and detainees were not told that holy books were available. Muslim detainees with whom we spoke at COBS did not know prayer facilities were available.

4.6 Girls under the age of 16 were not allocated a female officer who was responsible for their care. Other than detention rooms, which were similar to ordinary cells, there was no specific provision for young people. We spoke with two 15-year-olds detained at COBS – staff had placed them in a detention room without asking them if they wanted anything to do.

In our custody record analysis of 30 custody records, there were five young people in the sample, two of which were held for approximately 22 hours and 25 hours, with no clear indication if alternative local authority accommodation had been explored (see section on individual rights).

4.7 At Rotherham custody suite we observed two 14-year-olds being brought into custody to prevent a breach of the peace. The custody sergeants and arresting officer treated them well, explained what was happening and made sure they understood what was being said to them, but placed them in detention rooms before they were taken home. It was not clear if this happened regularly and if so, whether an alternative to bringing young people into custody was available. We were aware of the rollout of the good practice in Sheffield of providing alternatives to custody for children, but this had not yet, developed in Rotherham.

4.8 The provision for disabled or older detainees was poor. There were no adapted facilities other than a toilet with grab rails at COBS and no hearing loops. Doncaster had a wheelchair and two pairs of crutches, which we were told detainees with limited mobility could use and, subject to a risk assessment, keep in their cell. Detention officers knew the importance of offering transgender detainees a choice about whether they were searched by a male or female officer.

Recommendations

4.9 **Booking-in desks should allow detainees and staff to communicate effectively and in private.** (Repeated recommendation 4.19)

4.10 **Custody staff should have a clearer focus on the needs of all detainees, particularly women, young people, those with disabilities and detainees who wish to practise their religion in custody.**

Housekeeping points

4.11 Windows overlooking the cell toilet area should be obscured or fitted with a cover.

4.12 Girls under 16 should be allocated a named female officer who is responsible for their care while in custody.

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

Safety

4.14 Overall risk assessment processes across the custody suites were poor. The illegibility of the records contributed to, and compounded the issue. In our analysis of custody records, all records contained some part of it that was illegible and, at best, staff would have had to guess what the risks were based on gathering other information throughout the record. This posed substantial risks to detainees and staff who confirmed that at times they could not read the custody records.

4.15 All detainees were risk assessed, but the risk assessment proforma that custody staff completed was too formulaic. We observed custody staff rushing through the questions about health and self-harm without exploring concerns fully. Staff relied too much on detainees disclosing risks themselves and at times detainees had very little opportunity to consider the questions or ask for clarification. The questions were poorly constructed,

contained inappropriate terms and resulted in detainees responding 'yes' or 'no' as the form was not designed to enable them to provide much supplementary information. For example, detainees were asked if they were suffering from 'mental problems' if they were a 'drug addict, substance abuser or alcoholic' or if they had 'suffered post-traumatic stress disorder'. On two separate occasions at two different custody suites we observed detainees asking what post-traumatic stress disorder was and being told that if they did not know what it was, it was unlikely they had it. It was apparent that some detainees did not understand the question, yet few custody sergeants took the time to explain it.

4.16 Custody staff now had access to the police national computer (PNC). South Yorkshire Police had a bespoke computerised custody handling system. Custody staff had to check the PNC separately by navigating between screens and logging onto the PNC. Detention officers generally checked for warning markers on the police national computer (PNC), while the custody sergeant booked detainees in, but many took a long time logging in to the PNC to obtain the information. Several custody officers told us that they would book people into custody, complete a risk assessment and place them in a cell before checking the PNC because it was so cumbersome; our observations confirmed this. This meant that any other risk indicators that were identified on the PNC were not taken into consideration when the risk assessment was being conducted, which presented risks.

4.17 Detainees did not have care plans detailing how they would be looked after. There was no designated field on custody records in which to record the frequency of observations. Some custody sergeants only recorded them in the detention log, where it was hard to find. We saw a detainee who was depressed and who had attempted to stab himself placed on 60-minute checks. When our inspector queried this, the custody sergeant said the detainee was actually subject to more frequent checks, but we found this was not outlined in the custody record or recorded on the custody suite 'whiteboard' - a quick reference recording system for identifying detainees held, such as cell numbers, checks required and medical needs.

4.18 In the custody records we reviewed we noted different observation frequency levels; sometimes these were appropriate, at other times they were not, there was no rationale. It was unclear from the records of four detainees in the sample, how often they were observed because it was not recorded.

4.19 We saw detainees being taken off the rousing checks procedure as they became more lucid; however, it was difficult to determine whether or not this had happened purely from custody records because there was no designated space for the information and handwriting was illegible. Observation levels were adhered to and custody staff were aware of the importance of carrying out rousing checks correctly; however, responses to rousing were often not recorded.

4.20 Our custody record analysis raised further concerns about risk assessment and care planning. The forms did not state if detainees needed to see a health care professional (HCP), whether or not it was their first time in custody or if they were a young person.

4.21 Doncaster custody suite was the only suite that that had a small number of cells covered by CCTV, four in total. These were used appropriately for the most vulnerable detainees. Some detention officers carried anti-ligature knives, although custody sergeants did not, and at Rotherham anti-ligature knives were attached to cell keys. At one custody suite we observed a custody sergeant using an anti-ligature knife to cut plastic handcuffs. We would expect custody staff to carry anti-ligature knives but they should not be used for other purposes.

4.22 The handovers we observed at all custody suites were generally poor. Some custody sergeants used a handover sheet they had prepared during the shift. They contained relevant good quality information about potential risks, including health and self-harm, as well as about what stage the investigation process was at. But at some suites, staff did not refer to

the handover sheet or one was not prepared in time for the formal handover. The poor quality of handovers was significantly compounded by the fact that, as at the last inspection, no time was built in to the shifts to undertake the process in an organised and coherent way. We observed handovers conducted from sergeant to sergeant. Custody staff came on their shift at different times, which meant only some of them received the formal handover, while others relied on custody records or what they were told by their colleagues.

4.23 At COBS, details of potential risks were not explained comprehensively to incoming sergeants and the frequency of checks on detainees was unclear. More worrying was the practice of separating the detention log from other parts of the custody record, so that incoming staff sometimes could not immediately identify a detainee's risks or how often they needed to be checked. It was disappointing to find that after handover, some of the sergeants did not check on the welfare of detainees or personally introduce themselves.

4.24 Pre-release risk assessment (PRRA) planning was largely unsatisfactory, and too often consisted only of detainees being asked to sign a form stating that they would not harm themselves on release. In some cases, we observed staff asking detainees about their state of mind on release in a tokenistic way, rather than as if it were a genuine inquiry into the detainee's welfare. We saw a much better PRRA at Barnsley, where the custody sergeant went to considerable trouble to arrange support before a vulnerable detainee was released, and at Rotherham where a 14-year-old was involved, but these examples were exceptional.

4.25 There was a two-page leaflet listing support organisations. The information was poorly presented and incomplete leaflets were handed out at Barnsley and COBS. Our custody record analysis found that PRRAs concerning young people were particularly unsatisfactory, given their potential vulnerability. Out of the 30 records we analysed, five PRRAs were not completed or signed by detainees and an additional four were not completed but were signed. This represented almost a third of records sampled, posing a potential risk of adverse outcomes.

Recommendations

4.26 The quality and consistency of initial risk assessments should be improved to ensure detainees' safety. A comprehensive risk assessment should in all instances be completed, and the management of risk should be consistent with the outcome of the risk assessment.

4.27 All custody staff should be involved in the same shift handover, which should be recorded.

4.28 PRRAs should be detailed, meaningful and based on an ongoing assessment of detainees' needs while in custody; the custody record should reflect the needs of the detainee on release and any action that needs to be taken. All detainees should on release be offered accurate, up-to-date information about organisations that can provide them with support.

4.29 Anti-ligature knives, which should only be used in an emergency and should be issued to all staff who undertake cell visits.

Housekeeping point

4.30 The custody record should describe the detainee's response when they are subject to rousing checks.

Use of force

4.31 We were very concerned to find that each suite kept a protective helmet (which appeared to be a sports boxing helmet), which, we were told, was used on detainees who were non-compliant and at risk of self-harm, along with leg straps and handcuffs. We reviewed six months of use of force information and identified that the helmet alongside leg and arm straps had been used on several occasions for detainees who were vulnerable and at risk of self-harm. Use of the helmet did not require authorisation from a senior officer. A custody sergeant told us: 'If it makes our lives easier, I wouldn't hesitate to use them.' Another sergeant told us that they were not aware of any detainees for whom the use of the helmet would not be appropriate, including pregnant women and young people. These comments, as well as examples that custody staff across the suites provided of having used the helmet, illustrated the limited accountability with which custody sergeants could resort to such extreme and potentially degrading and unsafe methods (see main recommendation, paragraph 2.37).

4.32 We saw few detainees being brought in wearing handcuffs; they were removed at the booking-in desk. We observed two strip-searches being authorised on the basis of warning makers (indicators showing that a person has previously had a problem) indicating that they had secreted items while in police custody. Both detainees were strip-searched in private by two officers of the same gender and controlled drugs were found on both detainees. In our custody record analysis we found one case in which authorisation for a strip-search had been recorded on paper; however, not all the handwriting could be read and authorisation for the search had not been recorded electronically, therefore, it was difficult to ascertain if the appropriate authority was given.

4.33 There was a use of force form, but custody sergeants gave us inconsistent accounts of how it should be used and who would complete it. Copies of completed forms were not held at the suites. We were told that collated use of force data was used only for personal safety training.

Recommendation

4.34 Strip-searching should be correctly documented, authorised and recorded as a positive or negative search.

Physical conditions

4.35 The condition of the custody suites had improved since the previous inspection, but significant improvements were still needed. The suites had all been painted in the past two years, which meant there was very little graffiti in the cells across the custody estate. However, the suites still looked tired and the floor paint was peeling at Barnsley and at COBS, making them difficult to keep clean. However, Moss Way custody suite (which was only used for short periods for detainees who were having their images captured for identification purposes) was clean and in good condition, while Doncaster was in the best state of repair.

4.36 Except at Moss Way, most of the cells had ligature points, for example, on several cell wash basins; drainage holes were larger than 2mm and were therefore also potential ligature points.

4.37 Each of the suites had reasonable cell cleaning arrangements and unoccupied cells were cleaned each morning. Detention officers told us that they were expected to clean up any general spillages and ensure that the cells were clean throughout the day. The daily cell checks sheet was basic and was not sufficient for any record of the condition of each individual cell to be made. We observed some custody sergeants and detention officers checking lights and call bells but failing to complete a comprehensive check of cells or identify ligature points. It was also unclear what happened to reported faults. We were concerned about delays in getting defects repaired at COBS. Records of daily maintenance checks were incomplete. Records of independent custody visitors' checks showed that they had been concerned about delays in maintenance being carried out, particularly the repair of a lift that had meant the exercise yard was out of use for four months. It was not clear whether or not an infestation of silverfish at COBS had been eradicated.

4.38 There were problems with the heating and ventilation system at Doncaster and Barnsley. Staff told us that cells were cold in winter and unbearably hot in summer. Staff at Barnsley told us that on warm days they had to move detainees from cell to cell to vacate those that were on the sunny side of the suite.

4.39 The kitchen at COBS was unhygienic; an air grille above the food preparation area was covered with filthy fluff. Microwave ovens at Barnsley needed cleaning.

4.40 Not all detainees said that they had had the use of the cell call bell explained to them, but at Rotherham and Doncaster custody sergeants informed arresting officers that they should point out the call bell to detainees, which we saw being done. In some of the cells across the custody suite, call bell buttons were helpfully labelled 'press for assistance'. We saw call bells receive a reasonably prompt response.

4.41 There was no record of fire drills taking place at any of the custody suites, but staff told us they had fire safety training every year, which included evacuation drills. There was an adequate stock of handcuffs for evacuation purposes.

Recommendations

4.42 Cells should be well maintained, properly heated and ventilated.

4.43 There should be clear detailed records of daily cell checks with a means of recording defects, including any ligature points that have been repaired.

Housekeeping point

4.44 Regular emergency evacuation drills should take place at each suite and be recorded.

Detainee care

4.45 All suites had a good stock of blankets, although they were too thin; however, we saw staff give detainees who said they were cold several of them. The mattresses were also very thin, and some were old and worn, and they were not routinely sanitised after use. At Ecclesfield, mattresses and pillows were removed from cells when they were not being used.

4.46 A good range of replacement clothing was available at all suites, including underwear and plimsolls, as were packs of soap, toothbrushes, razors and other items. There was no anti-rip clothing, but we were shown anti-rip blankets at Doncaster. A small quantity of toilet paper was available in each cell.

4.47 Shower facilitates varied. Doncaster had only two showers for 38 cells. The showers were clean and private and located in an enclosed room. Custody staff told us that they could only allow one detainee to shower at a time and there was a notice on the door stating that staff should stand outside the door and talk to detainees to ensure they were not harming themselves as there were ligature points in the shower block. The lack of showers posed a problem for staff and on one day during the inspection we were told that six detainees had requested a shower; two detainees had to be 'put off' showering as it would have taken too long. Two shower cubicles at COBS did not provide detainees with anywhere private where they could dry off and get dressed. Staff told us they often did not have time to offer showers. Privacy in showers was much better at Barnsley, where we found that detainees going to court were offered a shower.

4.48 All the custody suites had a good stock of microwave meals catering for a range of diets, including halal, vegetarian and gluten-free. Cereal bars and porridge were available for breakfast. The microwave meals provided only 150 to 300 calories each, but staff told us detainees could have more than one if they wanted to and we observed this happening. Staff told us that families could bring in sealed packs of sandwiches, crisps and other food for detainees. Water and hot drinks were freely available. However, staff at COBS were not aware that detainees were still waiting for their breakfast at 10.40am. One detainee we spoke to said 'I didn't ask for any breakfast because staff seem very busy and I didn't want to be seen as a nuisance'; this was not acceptable. In addition, our custody record analysis found that six detainees held for between six and 12 hours were not, according to the custody record, offered a meal.

4.49 Closed visits booths were available in all the custody suites. Only at Rotherham were we told that they had been used in the previous 12 months for a vulnerable detainee. All suites had exercise yards but they contained graffiti, which raised concerns about the level of supervision detainees were under when they were in the exercise yards. The yard at Ecclesfield had no natural light and air vents near the ceiling were small, which was not adequate. There was a reasonable stock of magazines and books at all the suites, but staff did not offer them to detainees. At Barnsley there were three books in Urdu, but staff did not know what they were about. No detainees in our custody record analysis appeared to have been offered exercise and only one had been offered reading material.

Recommendations

4.50 A stock of thick mattresses should be available.

4.51 All detainees held overnight and those who require one should be offered a shower, which they should be able to take in private. (Repeated recommendation 4.26)

4.52 All detainees who require food should be offered good quality meals that have sufficient calorific content at regular intervals.

4.53 Detainees should be offered outside exercise if they are held for long periods or overnight.

Housekeeping points

4.54 Suitable blankets should be offered to all detainees routinely.

4.55 Mattresses and pillows should always be sanitised after each use.

4.56 All detainees should be offered suitable reading material.

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, an arrest before authorising detention. Sergeants told us that they felt comfortable refusing detention when the circumstances did not merit arrest, and all could provide details of such cases.

5.2 In addition, alternatives to custody, such as voluntary attendance, were available and many custody staff said they were increasingly using this often. Data provided by the police service supported this: 2,171 people were dealt with through voluntary attendance in the first four months of 2014, while the number of detainees had, on average, declined slightly over the previous 12 months.

5.3 All custody 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. Although we saw detainees being booked in promptly on their arrival, there were some exceptions at Charge Office Bridge Street (COBS), where queues could build up and where a detainee's subsequent detention was not always handled efficiently. Staff told us, and we witnessed, a 'handover culture', in which arresting officers did not make progress on investigations in many cases, but passed them on to the following shift or another department for completion. At Ecclesfield, we saw three young people who had been arrested in the early evening and held for just over 22 hours. During this time, their cases were dealt with by uniformed officers, the Criminal Investigation Department and the Robbery Squad before they were released on bail pending further enquiry. Our custody record analysis also showed that 53% of detainees had been held overnight, while just 30% were held for less than six hours; the average time spent in custody was 12 hours 17 minutes. This was at odds with figures provided by the police service, which recorded an average detention time of around nine hours.

5.4 Custody staff reported a good relationship with Home Office immigration enforcement officers and said that immigration detainees, who were to be transferred to immigration removal centres, rarely remained in the custody suites for longer than 24 hours, but on occasion they could stay for up to 48 hours. Figures supplied by the service, revealed that during 2013–14, the average detention time for detainees held for immigration offences was just under 23 hours.

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

5.6 Custody staff understood they had a responsibility to contact an appropriate adult (AA) when dealing with vulnerable adults or young people under the age of 18. Family or friends were contacted in the first instance, but despite the police service having a comprehensive guide to assist AAs in carrying out this role, custody staff did not routinely hand it out (although we did observe one being given to a social worker at Rotherham). When family or friends were not available, the police used AAs from two schemes, which, in the majority of cases, provided a prompt and efficient service. One scheme covered the Sheffield, Doncaster

and Barnsley areas and provided a 24-hour, seven-day-a-week service for both vulnerable adults and young people; in Rotherham, the scheme provided the same cover for vulnerable adults only. Custody staff said that the provision for young people in Rotherham during office hours, which the youth offending team provided, was good, but that outside these hours, the service offered by the local authority emergency duty team was generally poor. In our custody record analysis we could not determine when AAs had been contacted because it was not routinely documented in custody records, demonstrating poor record keeping. Overall the provision of AAs had improved since our previous inspection.

5.7 Custody staff in Doncaster, Rotherham and Barnsley said they had never known local authorities to have made secure accommodation available for a young person who had been charged but could not be bailed. However, the police service still requested this facility when it was required. In the absence of available accommodation, staff completed a juvenile detention certificate recording the reasons why a young person had to be held in custody overnight. In our custody record analysis, two young people were held overnight, but in neither record did it state that alternative accommodation had been sought. However, entries in the custody records were often illegible and therefore it was impossible to evidence if alternative accommodation had been sought or not.

5.8 In Sheffield we were told that negotiations between the police and social services, had led to accommodation for young people with a number of foster families, this was an exemplary initiative. Staff at both COBS and Ecclesfield told us of occasions when young people had been accommodated elsewhere, which meant they did not need to be held in police custody overnight. Efforts were being made to extend the scheme across the police service area; figures supplied by the service showed that 56 young people had been remanded in custody overnight after being charged during 2013–14.

5.9 Interpreting service posters at all suites informed non-English speaking detainees that they could ask staff for interpretation. A professional telephone interpretation service was available to assist in the booking-in process, and we saw this used to good effect. All suites had at least one double-handset telephone available for this purpose. Staff said that a good face-to-face interpreter service was available for interviews.

5.10 During the booking-in process, custody staff advised detainees of their three main rights (the right to have someone informed of their arrest; the right to consult with a solicitor and the right to consult the Police and Criminal Evidence Act 1984 (PACE) codes of practice). They were also informed that free independent legal advice was available. However the written notice offered to detainees setting out these rights and entitlements was out of date. The notice did not contain any information regarding detention under the Mental Health Act, the independent custody visitors scheme, making a complaint (see section on rights relating to treatment) or breath tests, all of which were contained in the latest version of the notice agreed by the Home Office, Legal Aid Agency and Law Society. Custody staff were aware that a similar version could be downloaded from the custody intranet and printed for non-English-speaking detainees in their own language. However, with the exception of staff using one terminal at Ecclesfield, when they attempted to do this, the process was blocked and they could not access the notice.

5.11 In our custody record analysis there were two foreign nationals (7%). Neither of them was informed of their foreign national rights. One was identified as 'struggling with English' and for that reason was unable to acknowledge that he had received foreign national rights information. He was interviewed but did not appear to have an interpreter. Some staff at Doncaster mistakenly believed that due to changes in PACE, they no longer had to offer foreign national detainees the right to have their high commission, embassy or consulate contacted on their behalf.

5.12 None of the staff knew that an easy-read version of the rights and entitlements leaflet was available on the Home Office website.

Recommendations

5.13 Information about detainees' rights and entitlements should always be available and accessible in a range of formats to meet specific needs.

5.14 South Yorkshire police should ensure that there are no unnecessary delays in progressing detainees' cases because 'handover folders' are created and passed on.

Housekeeping points

5.15 Custody staff should ensure that family or friends acting as appropriate adults are issued with the relevant guide (form PACE 11) to assist them in carrying out this role.

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

5.17 Detainees should be offered an up-to-date version of the rights and entitlements notice.

Rights relating to PACE

5.18 We observed detainees being told they could read the PACE codes of practice during the booking-in process, but custody staff did not routinely show or explain them to detainees. All the suites had up-to-date copies of PACE code C (which outlines requirements for the detention, treatment and questioning of suspects in police custody), with the exception of Ecclesfield. However we observed that staff at some of the suites continued to hand out copies of the code that were out of date. The Criminal Defence Service poster informing detainees of their right to free legal advice in 24 foreign languages was only displayed at Barnsley and COBS. Doncaster had two copies of one poster in 12 languages, but none were available at either Ecclesfield or Rotherham.

5.19 All detainees were offered free legal representation. There were sufficient consultation and interview rooms where detainees could speak with their legal advisers in private. Detainees at Doncaster and COBS could not consult their legal advisers in private on the telephone because they were next to the booking-in desks. We observed legal advisers routinely being offered a front copy of their detainees' custody record (which summarises the details of the alleged offence, the circumstances of the arrest and other information) and being allowed to read the full paper copy of the record, without having to request this.

5.20 In our custody record analysis, only eight (27%) detainees wished to have someone informed of their detention. It was clear from the detention logs that the nominated person was informed in every case. We observed such contact routinely taking place during the booking-in process.

5.21 Custody and operational inspectors across the police service area conducted reviews of detainees in custody. The standard of face-to-face PACE reviews that inspectors carried out with detainees in their cells varied – some were extremely thorough, providing the detainee with a lot of information, while others were too basic, offering detainees only minimal information about the progress of their case. In our custody record analysis, all reviews were

conducted face-to-face with the detainee and hardly any took place over the telephone or while detainees were asleep. Throughout our inspection, we observed only one review that took place over the telephone because the circumstances were exceptional.

5.22 An effective system was in place to ensure that DNA samples taken in custody were collected regularly.

5.23 Custody staff advised us that local magistrates' courts would not accept detainees after 2pm weekdays or 9am on a Saturday, although there was some limited flexibility each day. These early cut-off times meant detainees remained in custody too long. In one case at Barnsley we observed a court refusing to accept a detainee arrested on a warrant at 1.30pm, which led to an unnecessarily long stay in custody.

Recommendation

5.24 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

5.25 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.

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

5.27 The force should ensure that the way that DNA samples are handled and stored does not unnecessarily jeopardise the integrity of these samples.

Rights relating to treatment

5.28 Custody staff had a mixed response to how they would handle a complaint, as at our previous inspection. Some said they would notify either the custody or duty inspector immediately, while others said they would advise detainees to make a complaint at the police station counter on their release or report it through the police service website. Inspectors said they would take a complaint from a detainee while they were either in custody or on release or an arrangement would be made to meet with them at a later date. We observed one detainee who, during a PACE review, informed the custody inspector that he wished to make a complaint. This was about to be noted when the detainee was released, but no further action was taken following Crown Prosecution Service advice. He refused to remain in custody for his complaint to be noted but he was provided with contact details for the local custody inspector. All staff agreed that if a complaint centred on being assaulted, the detainee would be seen by a health care professional and any injuries sustained would be photographed. Detainees were not told how to make a complaint and no information about the complaints procedure was displayed in the custody suites.

Recommendation

5.29 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 South Yorkshire police commissioned medical services with NHS England, which was involved in the provision of care and had an obligation to take over health services in the future. The service provider was Medacs. At the time of our visit the service was out to tender. Health care professionals (HCPs) – two registered nurses and one doctor – were available 24 hours a day; a third nurse was available during periods of peak demand. Medacs scrutinised professional credentials and provided induction and mandatory training. HCPs received clinical supervision, but it did not take place on a regular basis and was not documented despite a proforma being available.

6.2 A chief inspector was responsible for monitoring service delivery and arrangements for strategic and operational contract management were good. Medacs supplied performance data, which the police verified. There had been, on average 1200 calls to Medacs a month in 2013–14 resulting in around 1100 attendances per month. We observed positive working relationships between custody staff and HCPs.

6.3 Each custody suite had a medical room. Some rooms had a toilet and natural lighting. All had examination lamps. A cleaning schedule was displayed and rooms were cleaned regularly, although several were grubby in places. Cleaning was inadequate as several wall cupboards were very dusty. Infection control auditing took place every week, but many fixtures and fittings did not comply with minimum standards. For example, some tap fittings were of the wrong type and others were heavily tarnished; few examination couches were free of rips or holes. At Ecclesfield, the tiles on the floor were cracked; at Rotherham walls were stippled and the floor carpeted. Most cabinets, such as at Sheffield, was of a domestic standard. The medical room at Barnsley was particularly poor. None of the rooms had clinical work surfaces suitable for forensic sampling and deep cleaning was not scheduled regularly in forensic sampling areas.

6.4 Each custody suite had an emergency bag of essential medical equipment, an automated external defibrillator (AED) and oxygen, usually at the custody desk. Drugs for emergency use were securely stored but accessible. The equipment was checked regularly. All custody staff underwent resuscitation training, including in the use of the AED.

6.5 Management of written medical records was unacceptable. HCPs told us of a variety of means of storing written medical records, some of which involved taking them home, and we observed two ring binders containing almost a year of medical records on the floor of the toilet attached to the medical room at Doncaster. When this was brought to the attention of Medacs, the records were moved to a desk drawer in the medical room. The drawer could not be locked and the medical room door was open. Locks had been ordered but had not yet arrived.

6.6 The storage of medicines, stock management and disposal of discarded medications had improved and were good, with clear audit trails. Daily and weekly checks were undertaken by Medacs HCPs. Drug reference books were up to date, except at Doncaster, which Medacs dealt with immediately.

6.7 There was a written policy and information on the use of patient group directions (PGDs), (which enable nurses to supply and administer prescription-only medicine) in each medical room. Nurses administered medicines supplied by them under PGDs, which frequently meant revisiting patients for that purpose. Custody staff could administer paracetamol following telephone prescribing by a doctor; the calls were recorded.

Recommendations

6.8 Clinical rooms should comply with relevant standards of infection control and contemporary standards for forensic sampling.

6.9 The management of medical records should be in accord with the Data Protection Act and conform to Caldicott principles on the use and confidentiality of personal health information.

Housekeeping point

6.10 The receipt of regular clinical supervision by HCPs should be documented.

Patient care

6.11 For most of 2013–14 the 90% target for HCP attendance at custody suites within 60 minutes had not been achieved, although the situation had improved since January (91%). Attendance times were inconsistent between custody suites – detainees at Doncaster were seen promptly compared to those at Barnsley or Ecclesfield. In our custody record analysis, the average attendance time was 58 minutes, which was good.

6.12 Detainees were treated respectfully and sensitively, although some HCPs left the door ajar for safety reasons, which compromised confidentiality. Detainees were satisfied with consultations and custody officers were generally happy with their contact with HCPs.

6.13 There was a comprehensive approach to medical assessment, and evidence-based guidance materials were available on site. Clinical records were of a high standard. HCPs gave custody staff printed care plans for detainees, which they found useful.

6.14 In our custody record analysis, 13% of detainees who arrived in custody were on medication. Subject to authentication, medicines could be continued. The police made reasonable attempts to collect prescribed medication from detainees' home addresses. Detainees could occasionally continue with some types of opiate substitution therapy while in police custody, otherwise symptomatic relief was available.

6.15 Since April 2014, HCPs at South Yorkshire Police liaised formally with aftercare services for people leaving custody, on a trial basis.

Housekeeping point

6.16 During medical consultations the door to the medical room should be closed unless an individual risk assessment indicates otherwise.

Good practice

6.17 *Medacs' liaison with aftercare services for people leaving custody, albeit on a trial basis, had the potential to ensure access to NHS services was available to detainees who might otherwise not have had it.*

Substance misuse

6.18 In our custody record analysis, 37% of detainees entered custody under the influence of drugs or alcohol. Drug workers based in each suite provided those with drug or alcohol problems with prompt support. Custody staff referred detainees whose attendance at appointments was a condition of bail. Additionally, drug workers offered all detainees services such as assessment, harm minimisation advice and referral to other support services, such as opiate substitution prescribing, specialist alcohol workers, housing and benefits support. At Barnsley, detainees with an alcohol-related charge received a follow-up alcohol intervention before their court dates. Drug workers followed up out-of-hours referrals.

6.19 Some suites provided clean injecting equipment, but all drug workers informed detainees about local syringe exchange services if required. Detainees under the age of 18 were directed or referred to specialist young people's services if necessary.

Mental health

6.20 In our custody record analysis, 13% of detainees had entered custody with mental health problems and 20% with current or previous self-harm or suicide issues. All custody staff had received training in mental health awareness in the previous year, which they said they benefited from. Custody staff said that most detainees had emotional, mental health or substance misuse-related problems. The police had good strategic and operational partnerships with three mental health service providers.

6.21 Mental health liaison and diversion schemes for detainees varied between suites and depending on which NHS trust was involved. Telephone assistance or visits from mental health professionals were available from 7am through to 5pm. Custody staff told us that the access team at Doncaster was particularly responsive, and the mental health nurse at Sheffield Magistrates' Court was considered to be very helpful, although his availability was limited. None of the suites had a mental health professional based there permanently or available after 5pm. All had telephone numbers for local crisis or access teams, but the police said that responses were not always helpful.

6.22 Detainees requiring formal assessment under the Mental Health Act 1983 were seen by emergency duty teams (EDT). Custody officers said that EDT responses had improved, although they often took several hours to attend the suites because of the lack of available approved mental health professionals. This was regarded as less of a problem in Doncaster, which had an EDT dedicated to child welfare who shared the workload.

6.23 South Yorkshire Police's data on the use of section 136 under the Mental Health Act 1983 was incomplete. It concluded that it was used over 500 times a year in 2013–14 (381 times in Doncaster and Rotherham alone) and that police custody was used as a place of safety on 194 occasions in that period, which was unacceptable. In Sheffield, police custody was believed to have been used on 40%–50% of occasions, which was too high. There was an up-to-date protocol for the use of section 136 between South Yorkshire Police and Rotherham, Doncaster and South Humber NHS Trust. The respective protocols operating between the

police service and Sheffield Health and Social Care Trust (for Sheffield custody suites) and South West Yorkshire NHS Trust (for Barnsley) were substantially out of date.

6.24 Other than at Barnsley, street triage had been introduced in January 2014. Formal evaluation had not taken place, but we were told that, anecdotally, individuals had been sent to NHS services rather than been subject to section 136. Good joint working arrangements took place with Yorkshire Ambulance Service.

Recommendation

6.25 **Detainees subject to section 136 of the Mental Health Act 1983 should not enter police custody unless there are exceptional circumstances.** (Repeated recommendation 6.28)

Good practice

6.26 *The introduction of street triage potentially allowed people with mental health who cooperated to be sent to mental health services before being arrested or subject to section 136.*

Section 7. Summary of recommendations and housekeeping points

Main recommendations

7.1 Quality assurance processes should include monitoring trends, identifying areas for improvement, using learning from incidents and demonstrating how recommendations are implemented by frontline staff to ensure the safe treatment of detainees. (2.35)

7.2 All detention logs and risk assessments should be legible to ensure the welfare and safe detention of people in police custody. (2.36)

7.3 The use of head guards, with handcuffs and leg restraints to prevent self- harm should cease and alternative arrangements in keeping with best practice should be introduced to deal with extreme cases of self-harm. (2.37)

Recommendations

Strategy

7.4 South Yorkshire Police Service should collate data on the number of strip-searches carried out and on the use of force. (3.8)

7.5 ICV's access to detainees should be prompt and arrangements should be put in place to ensure this is expedited during busy periods. (3.11)

7.6 The police service should ensure that a positive intervention is clearly defined, so that staff can report and learn from these incidents, to ensure the continued safety of detainees. (3.18)

Treatment and conditions

7.7 Booking-in desks should allow detainees and staff to communicate effectively and in private. (4.9, repeated recommendation 4.19)

7.8 Custody staff should have a clearer focus on the needs of all detainees, particularly women, young people, those with disabilities and detainees who wish to practise their religion in custody. (4.10)

7.9 The quality and consistency of initial risk assessments should be improved to ensure detainees' safety. A comprehensive risk assessment should in all instances be completed, and the management of risk should be consistent with the outcome of the risk assessment. (4.26)

7.10 All custody staff should be involved in the same shift handover, which should be recorded. (4.27)

7.11 PRRAs should be detailed, meaningful and based on an ongoing assessment of detainees' needs while in custody; the custody record should reflect the needs of the detainee on release and any action that needs to be taken. All detainees should on release be offered

accurate, up-to-date information about organisations that can provide them with support. (4.28)

7.12 Anti-ligature knives, which should only be used in an emergency, should be issued to all staff who undertake cell visits. (4.29)

7.13 Strip-searching should be correctly documented, authorised and recorded as a positive or negative search. (4.34)

7.14 Cells should be well maintained, properly heated and ventilated. (4.42)

7.15 There should be clear detailed records of daily cell checks with a means of recording defects, including any ligature points that have been repaired. (4.43)

7.16 A stock of thick mattresses should be available. (4.50)

7.17 All detainees held overnight and those who require one should be offered a shower, which they should be able to take in private. (4.51, repeated recommendation 4.26)

7.18 All detainees who require food should be offered good quality meals that have sufficient calorific content at regular intervals. (4.52)

7.19 Detainees should be offered outside exercise if they are held for long periods or overnight. (4.53)

Individual rights

7.20 Information about detainees' rights and entitlements should always be available and accessible in a range of formats to meet specific needs. (5.13)

7.21 South Yorkshire police should ensure that there are no unnecessary delays in progressing detainees' cases because 'handover folders' are created and passed on. (5.14)

7.22 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. (5.24)

7.23 Detainees should be able to make a complaint about their care and treatment before they leave custody. (5.29)

Health care

7.24 Clinical rooms should comply with relevant standards of infection control and contemporary standards for forensic sampling. (6.8)

7.25 The management of medical records should be in accord with the Data Protection Act and conform to Caldicott principles on the use and confidentiality of personal health information. (6.9)

7.26 Detainees subject to section 136 of the Mental Health Act 1983 should not enter police custody unless there are exceptional circumstances. (6.25, repeated recommendation 6.28)

Housekeeping points

Treatment and conditions

7.27 Windows overlooking the cell toilet area should be obscured or fitted with a cover. (4.11)

7.28 Girls under 16 should be allocated a named female officer who is responsible for their care while in custody. (4.12)

7.29 A hearing loop should be available in all custody suites and staff should know how to use it. (4.13)

7.30 The custody record should describe the detainee's response when they are subject to rousing checks. (4.30)

7.31 Regular emergency evacuation drills should take place at each suite and be recorded. (4.44)

7.32 Suitable blankets should be offered to all detainees routinely. (4.54)

7.33 Mattresses and pillows should always be sanitised after each use. (4.55)

7.34 All detainees should be offered suitable reading material. (4.56)

Individual rights

7.35 Custody staff should ensure that family or friends acting as appropriate adults are issued with the relevant guide (form PACE 11) to assist them in carrying out this role. (5.15)

7.36 Contact and attendance times for appropriate adults should be clearly recorded on custody records for monitoring purposes. (5.16)

7.37 Detainees should be offered an up-to-date version of the rights and entitlements notice. (5.17)

7.38 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)

7.39 Posters detailing detainees' right to free legal advice in a range of languages should be prominently displayed in all custody suites. (5.26)

7.40 The force should ensure that the way that DNA samples are handled and stored does not unnecessarily jeopardise the integrity of these samples. (5.27)

Health care

7.41 The receipt of regular clinical supervision by HCPs should be documented. (6.10)

7.42 During medical consultations the door to the medical room should be closed unless an individual risk assessment indicates otherwise. (6.16)

Good practice

7.43 Partnership working in Sheffield enabled the police service to access local authority accommodation for young people so that they did not need to be held in police custody overnight. (3.12)

7.44 Medacs' liaison with aftercare services for people leaving custody, albeit on a trial basis, had the potential to ensure access to NHS services was available to detainees who might otherwise not have had it. (6.17)

7.45 The introduction of street triage potentially allowed people with mental health who cooperated to be sent to mental health services before being arrested or subject to section 136. (6.26)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	HMIP team leader
Peter Dunn	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Mark Ewan	HMIC lead staff officer
Heather Hurford	HMIC staff officer
Paul Tarbuck	HMIP health services inspector
Alissa Redmond	HMIP research officer

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 recommendation

The force should collate the use of force and monitor the use of force locally and at force-wide level, for example by ethnicity, location and officer involved. (2.20)
Not achieved

Recommendations

The force should review its custody facilities and its strategic plan to ensure it develops the custody estate to enhance the wellbeing of detainees. (3.14)
Partially achieved

The force should address the shortcomings of extracting management information from the custody handling system. (3.15)
Partially achieved

There should be direct access to the police national computer from custody suites. (3.16)
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 should be safe and staff should be trained to identify potential ligature points and other health and safety issues. (2.21)
Not achieved

All cells and detainee areas should be clean, adequately heated and free of graffiti. (2.22)
Partially achieved

Recommendations

Booking-in desks should allow effective and private communication between detainees and staff. (4.19)
Not achieved (recommendation repeated, 4.9)

There should be clear policies and procedures to meet the specific needs of women and children. (4.20)
Not achieved

Some cells should be adapted for use by detainees with physical disabilities. (4.21)
Not achieved

Risk assessments should take into account all the relevant information available to staff, who should actively engage with detainees when booking them into custody. (4.22)
Not achieved

An overlap period should be built into all shifts to facilitate an effective handover between staff. (4.23)
Not achieved

Governance arrangements and management oversight of all interventions dealing with violent detainees should be put in place and details issued to all staff. (4.24)
Not achieved

The processes for carrying out health and safety, maintenance and cleanliness checks should be formalised across the custody estate and the results reviewed by managers. Staff should be given appropriate training to allow them to carry out these checks. (4.25)
Partially achieved

All detainees held overnight and those who require one should be offered a shower, which they should be able to take with an appropriate degree of privacy. (4.26)
Not achieved (recommendation repeated, 4.51)

Food should be of sufficient quality and calorific content to sustain detainees for the duration of their stay. (4.27)
Partially achieved

Detainees held for over 24 hours should be offered outdoor exercise in exercise yards that should be clean, well maintained and fit for use. (4.28)
Not achieved

Individual rights

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

Recommendations

Custody staff should ensure that detainee dependency obligations are routinely identified and where possible, addressed. (5.11)
Achieved

Appropriate adults should be available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (5.12)
Achieved

Detainees should be told how to make a complaint and facilitated to do so before they leave custody, in line with IPCC guidance. (5.13)
Not achieved

Health care

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

Main recommendations

All medications should be stored safely, securely and in accordance with current legislation. Discrepancies in stocks of controlled drugs should be thoroughly investigated and reported to the relevant accountable officer at the primary care trust. (2.23)
Achieved

Recommendations

Health care staff should receive ongoing training, supervision and support to maintain their professional registration and development so that they have the necessary competencies and skills to meet detainees' needs. (6.24)
Partially achieved

All clinical rooms should be fit for purpose, subject to infection control measures and free of clutter. (6.25)
Partially achieved

Detainees with any ongoing prescribed medications should continue to receive them while in custody. (6.26)
Achieved

Detainees requiring relief from the symptoms of drug or alcohol withdrawal should be provided with the relevant medications. (6.27)
Achieved

Police custody should be used as a place of safety for section 136 assessments only in extreme cases. (6.28)
Not achieved (recommendation repeated, 6.25)