Report on an unannounced inspection visit to police custody suites in

Cleveland

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

8–12 December 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.

In January 2014, the Home Secretary asked HM Inspectorate of Constabulary (HMIC) to undertake a thematic inspection in 2014–15 of the welfare of vulnerable people in police custody. HMIC and HM Inspectorate of Prisons decided to use the existing rolling programme of police custody inspections to facilitate the principal fieldwork. The inspection of police custody suites during the course of this fieldwork and the findings informed the final thematic report, which was published in 2015.

This was the second inspection of Cleveland police custody suites, the first being 9 –11 May 2011. Since then Redcar custody suite has closed and now just two full-time suites remain open. In terms of cell capacity, Middlesbrough custody suite remains one of the largest in the country.

Our inspection highlighted some progress - there was a good focus on safe detention through supporting and developing policies on dealing with adverse incidents and complaints; and quality checking of records, which ensured that procedures were followed consistently. However, improvements needed to be made in monitoring the use of force and shift handovers, which were often poorly managed, and inconsistent.

There was a concerted effort to develop partnership work with health services to reduce the number of people who suffered from mental ill health being kept in police cells under section 136 of the Mental Health Act. This had resulted in a significant improvement since the previous year; however, the number of people detained under section 136 was still unacceptably high. Other partnerships were less well developed, especially those relating to children. There was little monitoring of the numbers of children who needed alternative local authority accommodation and more needs to be done to ensure children are not kept in police cells overnight.

Staff interactions with detainees were generally polite, courteous and sometimes excellent. However, there were some inconsistencies; we saw children being booked in who were treated as adults in the way in which they were spoken to and dealt with. CCTV operators did not ensure that monitoring preserved detainees' dignity when they were using the toilet or being strip-searched.

Once booked in most detainees were placed on standard 30-minute checks which meant the process of risk assessment to help identify the most or least vulnerable detainees was irrelevant. Staff told us this ensured everyone was checked at the same time, which focused on making the process easier for staff rather than prioritising the welfare of detainees. Ongoing risk management was further undermined by poor shift handovers, especially at Middlesbrough custody suite which was disorganised. Pre-release risk assessments were inconsistent.

Custody sergeants told us they would refuse to detain people where appropriate, and Cleveland police could provide comprehensive data to support the reduced demand on custody through these measures. We saw good progress on investigations to ensure that those who were detained were released quickly. Staff told us that the late arrival of appropriate adults led to many delays. This meant children and vulnerable adults were held in detention for longer, especially outside office hours.

Leadership of health provision was good and the service was effective and well integrated. However, staff had limited understanding of reporting adverse incidents and safeguarding policies. The arrest referral team based in Middlesbrough, and available twenty four hours a day, screened detainees with

substance misuse problems. The team directed people to community services and organisations. This was an innovative service which allowed detainees to connect with community support networks as well as substance misuse services.

The NHS criminal liaison and diversion team had good access to other services to progress the welfare of people suffering from mental ill health.

Overall our inspection found that Cleveland police's senior management team was focused on ensuring detention was safe by establishing partnership arrangements with other organisations that provided detainees, especially those with mental ill health, with appropriate care. However, more could have been done in conjunction with local authorities to promote the welfare of children. Staff were courteous but further guidance should have been provided on preserving detainees' dignity in the course of CCTV monitoring. There was evidence of a reduction in the number of people passing through the custody suites. Patient care services, for people needing medical attention in custody suites were good.

We noted that of the 25 recommendations made in our previous report after our inspection of 2011, eight recommendations had been achieved, six had been partially achieved and 11 had not been achieved.

This report provides a small number of recommendations. We expect our findings to be considered and for an action plan to be provided in due course.

Sir Thomas P Winsor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

May 2015

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 Cleveland police custody suites, the first being in May 2011. Since then its Redcar custody suite had closed and there were now just two full-time designated suites in Middlesbrough (50 cells) and Hartlepool (25 cells). In terms of cell capacity, Middlesbrough custody suite was among the largest in the country.

Strategy

2.4 There was a clear management structure, which promoted the development of key policies and procedures to support safe detention. Custody was centrally managed and was part of the crime portfolio. The estate strategy had led to a reduction in the number of custody suites.

2.5 The assistant chief constable was in the process of reviewing internal meetings, which were to include a discussion of custody matters at a six-monthly strategic operations group. There were a number of custody management and user group meetings where custody issues such as 'successful intervention/adverse incidents'[2], complaints, quality control of records and emerging themes could be addressed.

2.6 Partnership arrangements were developing and were led at chief officer level to deliver better outcomes for detainees, for example, diversion services for those with mental ill health. However, use of police cells for people requiring specialist mental health facilities was still unacceptably high. Similarly, arrangements for monitoring and analysis of data for children in custody were also poor.

2.7 There was an active independent custody visitors (ICV) scheme, which the Police and Crime Commissioner's office oversaw. Recent recruitment initiatives had ensured ICVs were from a diverse range of backgrounds.

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

2 The term 'successful intervention' and/or 'adverse incident' means any incident which, if allowed to continue to its ultimate conclusion, would have resulted in the death, serious injury or harm to any person

2.8 A good training programme was in place for custody staff and quality assurance processes enabled the organisation to develop; however, further improvements could have been made through better monitoring of use of force and the quality checking of shift handovers.

Treatment and conditions

2.9 Staff were courteous, especially during the booking-in process; in some cases they were excellent and we spoke to many detainees who were mostly positive about the care they received from designated detention officers (DDOs). However, some staff did not always continue this approach with detainees after they were booked in.

2.10 Middlesbrough custody suite was busy, noisy and lacked privacy. The booking-in desks were very high, and as such inhibited easy and audible conversations between detainees and custody staff. The environment had the potential to deter detainees from divulging sensitive and pertinent information during risk assessments.

2.11 Detainees' diverse needs were not always recognised or catered for. Children were sometimes treated the same as adults and in some cases staff made little effort to change the way they communicated. Girls in detention were not always allocated a female officer as recognition of specific vulnerabilities. CCTV images of the toilet area were not obscured and operators did not always turn off the camera or switch to other images when detainees were using the toilet or being strip- searched.

2.12 Once booked in most detainees were placed on 30-minute observations. Staff told us this was because it was easier for officers to check everyone at the same time. This approach could have prevented officers from attending to those who genuinely required a higher level of observations. Many detainees were also observed on CCTV and we saw an officer 'observing' 10 cells on CCTV in addition to undertaking other duties; this meant it was unlikely that enough attention was being paid to the most vulnerable.

2.13 Shift handovers were poor. At Middlesbrough, handovers were disorganised and inconsistent, with many people coming and going. It was difficult for custody sergeants to ensure sufficient information had been passed onto ensure the most vulnerable detainees were held safely.

2.14 All detainees had a pre-release risk assessment (PRRA); overall the picture was mixed. The PRRAs we observed were not complex and required no aftercare. Our custody record analysis revealed that PRRAs often only described the initial risk assessment and provided a small amount of information on detainees' time in custody instead of focusing on pre-release planning. Worryingly other PRRAs did not record at all the erratic behaviour or self-harming actions of some detainees. An arrest referral team (ART) was co-located in Middlesbrough providing opportunities for greater links between the team and the PRRA process to provide aftercare support for some detainees.

2.15 When a detainee was transferred elsewhere, for example, to court or an immigration centre, police were required to complete a person escort record detailing the detainees' risks. Overall, those we read were completed well, contained significant and relevant information, such as police national computer warning markers (indicators showing that a person was known to the police), although a few required better information about risks.

2.16 We saw detainees in handcuffs when it was not always necessary; some officers told us that handcuffing was mandatory, when it was not. We saw three police officers transport a 13-year-old girl in handcuffs. This did not appear proportionate as she had already been thoroughly searched and held in custody for some time.

2.17 We saw examples of good de-escalation skills being deployed; however use of force in custody was only recorded on the detainees' custody record and not on any monitoring form. This meant it was not possible to identify trends or monitor disproportionate and unreasonable use of force holding staff to account.

2.18 The condition of the suites was good but no audited daily checks of cells took place. Detainees said that call bells were seldom answered and staff concurred they would not always answer the call bell. This was unacceptable as the call bell was the only way detainees could contact staff in an emergency.

2.19 Most detainees received adequate care. All cells had mattresses but no pillows. Cells were adequately heated and there was a good supply of clean blankets. However they were rarely offered showers, outside exercise or reading materials. We were pleased to see staff offering extra meals to detainees who needed it, but concerned that staff told us this was discouraged.

Individual rights

2.20 Custody sergeants authorised detention and designated detention officers booked detainees in. Operational officers had a good understanding of PACE code G[3]. Staff told us they would refuse detention if circumstances merited it and could provide details of cases. The use of voluntary attendance[4] as an alternative to making an arrest was increasing. Voluntary attendees were brought before custody staff at the booking-in desk prior to being interviewed, which was unnecessary and contributed to overcrowding in the Middlesbrough suite.

2.21 Cases were mostly progressed promptly, ensuring that detainees did not remain in custody for a long time, but we did see some examples of handovers between arresting officers and investigation teams extending detention unnecessarily. Appropriate adult (AA) provision (which involves independent individuals providing support to young people and vulnerable adults in custody) was not available 24 hours a day and some long delays in the transfer of immigration detainees were reported.

2.22 Custody staff were aware of their responsibilities to contact an AA when dealing with children or vulnerable adults. They told us during office hours the service was efficient but AAs failed to attend or regularly arrived late outside office hours, unnecessarily prolonging detention for the most vulnerable.

2.23 Custody staff said they had not known the local authority provide appropriate secure accommodation for children who had been charged and could not be bailed. They also said they would go through the process of requesting accommodation in accordance with the requirements in PACE. However, during our inspection secure accommodation was made available for two girls charged with a serious offence.

2.24 Detainees were not always offered rights and entitlements information, and the documentation provided was out of date.

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[3] PACE code G refers to the code of practice for police officers' statutory power of arrest.

[4] Voluntary attendance is used usually, but not exclusively, or lesser offences, where suspects attend by appointment at a police station to be interviewed about alleged offences. This means arrest and subsequent detention in police custody can be avoided.

2.25 Information on PACE codes of practice was not routinely offered to detainees. PACE reviews were prompt but at Hartlepool the majority of reviews were conducted over the telephone. We knew of two detainees who had had their PACE reviews, but the PACE inspector had not seen either of them, which was unsatisfactory.

2.26 Detainees were transferred to court promptly.

2.27 Complaints would be taken while a detainee was in custody if the complaint was about a custody matter; otherwise, in most cases a detainee would be advised to make the complaint once released. All custody staff agreed however, that if the complaint centred on a detainee being assaulted, the detainee would be seen by a health care professional; any injuries sustained would be photographed and a complaint taken.

Health care

2.28 Cleveland police commissioned Tascor to provide physical health care services. Overall health services were effective, well integrated and well led. Arrangements for the strategic and operational management of health care practitioners were good, although staff had limited awareness of both adverse incident reporting and safeguarding policies. Complaints about health care were submitted through the police complaints system when they should have been submitted through the Tascor health care complaints system.

2.29 The quality of care, staffing levels and skill sets were appropriate. Resources were mostly concentrated on the Middlesbrough suite, which meant detainees from Hartlepool with continuing, and complex, health care needs were routinely sent there for treatment and observation. Clinical assessments and interventions were appropriate, although clinical records were handwritten and sometimes difficult to read.

2.30 We observed good professional interactions with detainees who could continue with prescribed medication in custody. Police made reasonable efforts to collect prescribed medication from home addresses.

2.31 Detainees with substance misuse problems were screened by the police service's arrest referral team and directed to community services. The team was available 24 hours a day at the Middlesbrough suite, offering a telephone advice service to the Hartlepool custody suite.

2.32 Twenty-seven per cent of detainees were identified as having a mental health issue as part of the custody risk assessment. The criminal liaison and diversion team provided community outreach support and worked closely with community mental health teams and GPs. There was access to a specialist learning disability practitioner from the NHS trust. Collaboration between the police and medical teams was good. A member of staff from the mental health charity MIND was also regularly on site to support detainees.

2.33 Data provided by the police service indicated a 50% reduction in cases where police cells were used as a place of safety for people with mental ill health under section 136 of the Mental Health Act. While this was a significant improvement, the number of people held – 132, under section 136, was still unacceptably high. However, the police-led street triage service had contributed to the reduction of people with mental ill health being held.

Main recommendations

2.34 Cleveland police should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers' policy and College of Policing guidance. (Repeated recommendation 4.24)

2.35 The Police and Crime Commissioner and Chief Officer Group should work with their counterparts in the local authority to instigate an immediate review for the provision of local authority accommodation under section 38(6) PACE 1984 to ensure that young people are not unnecessarily detained in police cells.

2.36 Cleveland police needs to improve the monitoring of detainees held under section 136 of the Mental Health Act to assess how well services are being delivered and hold other agencies to account to further reduce the number of people detained under this legislation and held in police custody.

2.37 Handovers should, where possible, include all team members, take place away from the booking-in area and be recorded. The shift handover should be more organised: a comprehensive briefing should take place and custody sergeants should take steps to assure themselves that this has been done.

2.38 Children and vulnerable adults should have prompt, timely and reasonable access to AAs.

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 assistant chief constable provided strategic leadership. There was a clear management structure in place in which the detective chief superintendent, head of crime, line-managed the chief inspector head of criminal justice and custody.

3.2 Since the previous police custody inspection in 2011, the estate strategy had led to the reduction in custody suites from three full-time suites to two full-time suites and one stand-by suite. The condition of the custody estate was good. There were some discussions about a 2020 estate strategy, but no immediate plans to change the existing custody provision.

3.3 Detainees were conveyed to the area custody facility where they were arrested. However, if it was assessed during the arrest process that detainees had a greater need or presented an increased risk, they would be taken to the Middlesbrough custody suite, which had a wider range of facilities (see section on treatment and conditions).

3.4 Staffing levels in custody suites during the inspection were adequate. Staffing comprised permanent custody sergeants. The provision of designated detention officers (DDOs) was outsourced to Tascor, which was contracted to run custody management services. Dedicated resource planners were responsible for ensuring rota absences for custody sergeants were covered by a process of re-rostering and moving staff between suites.

3.5 Custody sergeants line managed DDOs who booked detainees in and looked after their ongoing welfare. DDOs provided a good standard of care for detainees and all custody staff undertook their role professionally. The shift handover process was not well managed and was inconsistent across the custody suites, which meant that staff could potentially fail to receive information on the care of vulnerable detainees (see main recommendation 2.37).

3.6 Four custody inspectors each managed a custody shift. In addition, there was a custody management unit which consisted of an inspector, two sergeants and a constable. The unit provided a range of support functions, which included recording, monitoring and analysing custody data, maintaining and updating the custody intranet site and administrative support. The custody inspectors provided cover for the custody suites 24 hours a day, seven days a week. Custody inspectors spent the majority of their time at the Middlesbrough custody suite.

3.7 There was an internal meeting structure where custody matters and performance were discussed and reviewed; this included custody user groups meetings. The deputy chief constable chaired the risk management board, which reviewed the strategic risk register, national reports and HM Inspectorate of Constabulary (HMIC) and Independent Police Complaints Commission (IPCC) recommendations. The assistant chief constable had been in post for five months and was reviewing the strategic level meeting arrangements with a view to including custody matters at a six-monthly strategic operations group. The assistant chief constable met with the head of crime every Monday; the agenda for the meeting included 'successful intervention/adverse incidents' in custody. There was a monthly custody management meeting chaired by the chief inspector head of criminal justice and custody. The

agenda for this meeting included emerging issues from the custody record quality assurance process, as well as successful intervention/adverse incidents in custody and complaints. However, there was no forum for custody sergeants and DDOs to meet with police management, which meant there were few opportunities to raise issues and share good practice.

Housekeeping point

3.8 The police service should implement a forum for custody sergeants and DDOs to meet formally with management.

Partnerships

3.9 The Police and Crime Commissioner (PCC) for Cleveland police chaired the local criminal justice board (LCJB), which was run jointly with neighbouring County Durham and which was attended by the assistant chief constable. There were regular meetings with Tascor to monitor the contract provision of DDOs and health services in custody. The chief constable and the assistant chief constable attended a mental health task group, which was working on the implementation of the national mental health crisis care concordat (a national agreement between local services and agencies on ensuring people in mental health crisis get the help they need). Individual cases under section 136 of the Mental Health Act 1983 were escalated to and discussed at this forum. The PCC held the police service to account at the performance and accountability scrutiny group, attended by the deputy chief constable, where independent custody visitor (ICV) data were reviewed along with custody data.

3.10 The number of people detained under section 136 of the Mental Health Act and taken to police cells in Cleveland had been reduced by 50% from the previous 12 months. However, while this was a significant improvement, police cells had been used on 134 occasions which was still unacceptably high. The police service could provide data on the number of times someone was taken to a police cell but not on the overall use of section 136 or on the number who had been taken directly to a place of safety run by a health provider (see also section on mental health and main recommendation 2.36).

3.11 According to data provided by the police service, over the last 12 months only 25 children had been refused bail while in police custody. Although this was encouragingly low, the effectiveness of the arrangements with the local authorities to provide secure and non-secure accommodation for those children was poor. In all of the 25 cases the child remained in police custody overnight, and the police service was not able to provide any data on how many occasions local authority accommodation had been requested for children who required non-secure accommodation (see main recommendation 2.35).

3.12 Cleveland police could provide comprehensive data on voluntary attendance, which had increased from 1,317 to 3,382 from the previous 12 months. Over the same period detainee throughput had dropped by over 4,000. This had reduced the demand on custody provision.

3.13 The PCC was responsible for the provision and coordination of the ICV scheme. The governance officer within the PCC's office coordinated the ICV team. It was active and operated a regular schedule of visits. The ICVs were admitted to custody suites promptly. Coordinators told us there were no concerning trends and ad hoc issues were dealt with effectively. Police were regularly represented at ICV team meetings and there was a good regime for induction training. Recruitment initiatives in 2014 had increased the diversity of ICVs. Six monthly reports were reviewed at the PCCs performance and accountability scrutiny group.

Learning and development

3.14 All custody sergeants and DDOs had undergone an initial custody-specific training course, followed by a period of mentoring, before undertaking custody duties. There was annual custody refresher training for custody sergeants and some of the content of the programme was informed by quality assurance processes, which was good. DDOs had separate development days provided by Tascor.

3.15 A structured quality assurance process for dip-sampling custody records was in place. The custody management unit provided 15 custody records to each of the four custody inspectors per month. They were randomly sampled, which meant inspectors reviewed custody records across all four shifts. Custody sergeants had been included in the process in 2014. The custody management unit oversaw the process and provided further quality assurance by checking returns marked 'no issues' to assess the quality of the dip-sampling. Written feedback was then provided to staff. The custody management unit also cross-referenced eight dip-sampled custody records with CCTV every month, overseen by the unit's inspector. This was an effective process, however it could have been improved by including completed person escort records, which were not checked and there was no process for quality assuring shift handovers. The custody management unit monitored trends and maintained an audit trail of communication to staff. This process also informed aspects of custody sergeants' refresher training. Although there was a process for recording use of force, it was not recorded, monitored or analysed (see section on treatment and conditions).

3.16 There was a reporting process for adverse incidents in custody. Incidents were identified in line with the College of Policing Authorised Professional Practice (APP) definition. The process was computer-based and used email to circulate information to staff and relevant departments. Ongoing monitoring and analysis of adverse incidents took place, however staff informed us that they found it difficult to update the IT form.

3.17 The police service's intranet site included links to a range of custody policies and procedures. The site also included links to the IPCC's *Learning the lessons* document, the APP and HMIC. Key information was circulated among staff but there was no custody-specific newsletter.

Housekeeping point

3.18 Cleveland police and Tascor should consider joint refresher training for custody sergeants and DDOs.

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 were polite and courteous and demonstrated a good level of care and concern, especially at the booking-in stage. We saw some excellent inter-personal skills from both custody staff and arresting officers who were booking in detainees who appeared distressed and vulnerable. We spoke to many detainees who were mostly positive about the care they received from designated detention officers (DDOs).

4.2 We did, however, have some concerns about the booking-in area itself and how it might affect both detainees' and staff's ability to explore undisclosed vulnerabilities. The custody desk at Middlesbrough was very high, restricting comfortable two-way conversations; and the layout of the booking-in area offered detainees little privacy. The suite quickly became very busy and noisy and at one point we observed 26 people in the booking-in area alone. These included other detainees, suspects attending voluntarily, solicitors, appropriate adults, arresting and investigating officers, as well as custody staff. At times it was congested, and, with some detainees displaying aggressive behaviour, could have made other detainees feel intimidated. We saw three detainees being booked in at a time. As a result we were not confident that all of them would readily have disclosed sensitive personal information to custody staff in that environment.

4.3 We saw a 13-year-old who had never been in custody before, clearly bewildered and afraid. Some custody staff did not always adapt their approach when dealing with younger people and did not explain terms such as 'duty solicitor' or 'appropriate adult'.

4.4 We did see one custody officer take appropriate action and temporarily close the booking-in area while he dealt with a 14-year-old, arrested for a serious offence. There were no specific cells for children but where possible, staff tried to keep women and children in a separate corridor from the rest of the detainee population. However, there was no conscious effort to ensure that girls under the age of 18 were allocated a female officer to care for them. Some DDOs told us that they had received some form of child safeguarding training, and most could explain the steps they would take if a detainee made an allegation of abuse. We rarely saw custody staff ask detainees if anyone at home would be affected by their detention, such as dependants.

4.5 We also saw health care professionals taking a proactive interest in detainees whom they believed were more vulnerable than others, for example those with substance misuse, mental health problems or physical disabilities.

4.6 Middlesbrough had two designated cells for detainees with disabilities that had basic adaptations, including a lowered intercom/call bell button. A wheelchair was also available and we saw it being used. However, we noted that a detainee who had severe mobility issues struggled to walk, and there were difficulties in accommodating them on an escort van for a court appearance, as staff had not notified the escort contractor that an adapted vehicle was required. Hearing loops were not available.

4.7 We saw an immigration detainee who had been detained for almost 24 hours and had only left his cell in that time to make a brief telephone call. He told us that he would have liked to have had some fresh air but did not know there were facilities for him to do so. Staff did not focus on detainees who were detained in cells for longer periods.

4.8 There were religious observance items, including prayer mats and a range of holy books, but they were not stored appropriately.

4.9 The cell toilet area was not obscured on CCTV monitors and although DDOs told us that they would change cameras on the monitors if they saw detainees using the toilet, this did not occur on several occasions, which undermined detainees' dignity.

4.10 Strip-searches were authorised and conducted in cells that were covered by CCTV. They were not always carried out in a way that preserved the dignity of the detainee. We saw a female officer viewing a CCTV monitor that showed a detainee being strip-searched; she intended to provide oversight in case he hurt himself, but it was not appropriate. DDOs told us that they would ask transgender detainees whether they preferred to be searched by a male or female officer.

Recommendations

4.11 **Booking-in areas should provide sufficient privacy to allow effective communication between staff and detainees.** (Repeated recommendation 4.8)

4.12 **There should be a clearer focus on the specific needs of children, female and disabled detainees; staff should be trained to deal effectively with them.**

4.13 **Girls aged 18 or under should be allocated a female officer responsible for their care.**

4.14 **Toilet areas should be obscured on CCTV monitors and detainees should be informed of this.** (Repeated recommendation 4.37)

4.15 **Strip-searches should not be observed on CCTV.**

Housekeeping points

4.16 A hearing loop should be available in all custody suites.

4.17 Items for religious observance should be stored respectfully.

Safety

4.18 Despite the layout and construction of the suite (see paragraph 4.2) we saw some good risk assessments, with staff often asking questions beyond the prompts offered on the computer system. At Middlesbrough, we also noted that custody staff were supported by the health care professional who, when not otherwise engaged, was in the booking-in area observing and assessing detainees as they arrived. Staff told us that they would take an additional interest in detainees who had not been in police detention before, but our custody record analysis (CRA) revealed that this was not explicitly recorded on the custody system. It was therefore difficult to confirm how this information was passed on to other people on incoming shifts.

4.19 We saw staff checking the police national computer (PNC) for information about detainees so they could use any relevant details for the risk assessment. Staff also checked a local intelligence database.

4.20 DDOs routinely removed detainees' shoes, jewellery and cords from trousers, regardless of the answers they gave to any questions asked about risks or self-harm. We were told that spectacles would be removed routinely but we saw several detainees in cells wearing them, it was unclear if in those cases there was a specific risk assessment which concluded detainees could keep their spectacles or an inconsistency in approach. Staff also routinely removed shoelaces, which were then placed in a shoe locker; those who later attended court could not replace their shoe laces and we saw several detainees in shoes without laces being led in handcuffs to escort vehicles; in some cases they were shuffling because the shoes were loose on their feet.

4.21 After booking in, only DDOs escorted detainees to cells. It was good to see them explaining everything that was in the cell, such as the call bell, and mentioning the fact that the cell was monitored by CCTV. We only saw four detainees placed on 60-minute observation levels. We were told that the default position was 30 minutes even if the risk assessment did not warrant it. Staff told us that it was easier for DDOs to check all detainees at once, every 30 minutes. Our CRA supported this – all detainees in the sample were subject to the 30-minute observation level. We believed this obscured detainees' real risks, and had the potential to distract officers from attending to those who genuinely required a higher level of observations. During busy times DDOs continuously checked on detainees in their cells, mainly through the door hatch and mostly by looking briefly, without much further interaction. They then confirmed their visit in writing on the custody record.

4.22 Many detainees were placed on observations via CCTV, which custody staff used as an additional means of watching detainees about whom they were concerned but who did not present a sufficiently high risk to be placed on close proximity supervision. During the previous inspection we raised the issue of the excessive use of CCTV and were concerned it might have been used as an alternative to the highest level of observations – close proximity. While we saw less evidence of this on this inspection, the number of detainees an operator observed on CCTV was too high. At one point we saw one DDO observing 10 detainees on CCTV using three monitors. This operator had other duties, including monitoring and arranging a response to cell call bells, answering telephone calls, monitoring other cameras and operating electronic security doors. Staff did not make any assessment of when there were too many detainees to observe and we were not satisfied that the number of CCTV observations a DDO was expected to undertake was adequate for people presenting an enhanced risk. We did not believe that such observations were meaningful or safe.

4.23 DDOs understood the importance of and techniques for rousing intoxicated detainees to obtain a satisfactory response and we saw several good examples of this. In our CRA, staff generally recorded when they roused detainees, but details were often very basic, noting that the detainee had been roused and responded but failing to record their response.

4.24 All custody staff carried anti-ligature knives and additional cutters were located behind the custody desk.

4.25 DDOs checked all cells after they had been occupied to ensure no unauthorised items had been left behind, but no recorded daily checks of cells were made. However, a process was in place for every cell to be checked for maintenance and faults on a three-weekly basis.

4.26 The quality of shift handovers was poor. We observed three handovers during the course of the inspection. At Middlesbrough, this consisted of many one-to-one conversations between incoming and outgoing DDOs. Custody sergeants briefed each other. The process was

disorganised, and it was very difficult for custody sergeants to be assured that relevant information about detainees had been passed on between shifts.

4.27 Middlesbrough was the larger suite where a complete team briefing would have been impracticable due to the number of staff involved. However, at Hartlepool, a much smaller suite, where this could easily have been achieved, DDOs and custody sergeants were also briefed separately. Incoming custody sergeants did not always visit detainees after the briefings (see main recommendation 2.37).

4.28 Pre-release risk assessments (PRRAs) were mixed overall, both in our observations and our analysis of custody records. Some reflected that detainee aftercare had been considered, while others were clearly deficient. PRRAs observed during our inspection were not particularly complex, required little aftercare and mainly checked on how a detainee was going to get home without focusing on other risk factors. However, in one instance we did see a custody sergeant helpfully arrange for a detainee who had threatened self-harm to be released earlier to ensure their safety, otherwise would have had to spend several hours in custody. This demonstrated pre-planning and showed that detainees' needs had been considered.

4.29 Our CRA revealed that PRRAs were completed for all detainees on release but they generally lacked detail, usually describing risks that were identified during the risk assessment rather than how these risks might impact on them following custody. For example a detainee who had an ulcer, suffered from depression and was a methadone user did have these potential risks identified as well as a note saying that he had seen a nurse. However, in this instance, there was no reference to how the detainee would get home. A detainee who had self-harmed while intoxicated had PNC warning markers (indicators showing that a person has previously had a particular problem) for setting his cell on fire; as a result he was restrained and strip-searched. He was later seen tying a ligature around his neck and trying to slash his wrists. The detainee, who continued to display erratic behaviour, was observed throughout his time in custody. We were concerned that the PRRA failed to reflect his actions in the suite or any follow-up actions required for his welfare after release.

4.30 There was also a helpful, albeit limited, leaflet available with contact details of several support agencies. However, we were told only certain categories of detainee, such as domestic abuse and sex offence suspects, received them.

4.31 Middlesbrough had an arrest referral team embedded within the suite, which offered detainees advice and assistance in addressing some of the possible reasons for their arrest. For example, the team had links with alcohol and drug dependency programmes, housing agencies, a gambling support group and Jobcentre Plus. However, it had only been operating for a few months and it was too early to gauge its success. There was no tracking system to determine if people referred to other services benefited or changed their behaviour. Nevertheless, there was potential to connect this service with the PRRA to ensure detainees were released safely or action was taken to address their emotional and physical wellbeing (see section on health care, substance misuse).

4.32 When a detainee was transferred elsewhere, for example, to court or an immigration centre, police were required to complete a person escort record (PER) detailing the detainees' risks. Overall, those we read showed that they were completed well and contained significant and relevant information, such as PNC warning markers. However, some forms fell short, for example one PER for a foreign national who could not speak any English, failed to identify that communication was an issue or what his first language was, and did not confirm if an interpreter had been booked for court. Another simply indicated that the detainee had 'self-harm' as a warning marker but did not indicate what the individual had done or when he had done it. Medication sheets were also included so that staff receiving the detainee could see what an individual had been administered while in police custody.

Recommendations

4.33 There should not be a default 30-minute observation level of detainees; observation levels should reflect the level of risk identified during the initial risk assessment and/or subsequent dynamic risk assessment.

4.34 There should be sufficient monitors and staff available so that detainees are safely supervised via CCTV; where possible staff carrying out these observations should not be engaged in other tasks.

4.35 Pre-release risk planning should take into account risks arising during custody as well as any consequences of release, and detainees should be offered information about relevant support organisations at the point of release.

Housekeeping point

4.36 Subject to a risk assessment, shoe laces should be returned to detainees when they leave the suite for court.

Use of force

4.37 Most detainees who arrived in handcuffs had them removed promptly on arrival, however, despite this observation, we also saw situations when handcuffs were used inappropriately. Several operational officers told us they thought handcuffing detainees was a mandatory requirement of the Cleveland police, when it was not.

4.38 We saw a 13-year-old girl arrive at Middlesbrough in handcuffs after being transported from Hartlepool custody suite where she had been detained for some time. This child was compliant and had been escorted by three male officers and transported in the back of a secure van. The risks posed by her appeared very low and consequently we could not understand why officers felt they needed to use handcuffs.

4.39 All custody staff had good de-escalation skills and we saw some examples of de-escalation carried out on intoxicated detainees. All custody staff received annual personal safety training.

4.40 Custody staff told us that use of force in the custody area was not recorded (other than in the custody record), monitored or analysed to ensure good training, including trends and patterns, accountability and challenge to any disproportionate use of force. We saw one difficult detainee who was promptly taken to a cell in handcuffs and searched on a mattress in line with approved techniques. We were told this was classed as 'use of force' and the arresting officer rather than custody staff member was responsible for completing a record of this on a use of force monitoring form. We were unable to verify whether this particular incident was recorded anywhere other than on the custody record.

Recommendation

4.41 Detainees should only be handcuffed if it is necessary, justified and proportionate.

Physical conditions

4.42 The general condition of the custody estate was good. The amount of graffiti was minimal. Cleaning arrangements across the estate were good – all cells were cleaned each morning when they were not occupied, but not at weekends. Cells that required cleaning were appropriately placed out of use and reported. No records of daily cell cleaning or maintenance checks were evident.

4.43 All cells had call bells but they were not tested every day to ensure that they were working. There was no activation light outside the cell. Hartlepool had an intercom facility, which received a prompt response. At Middlesbrough, however, only the CCTV operator in the back office of the custody bridge received a notification that the bell had been pressed. We received different explanations as to what would happen next. Some DDOs told us that subject to viewing the CCTV they would make a judgement on whether to ask a colleague to attend the cell (which meant they had to leave the CCTV monitoring area) or ignore it as a colleague would most probably be visiting within 30 minutes anyway. One DDO said: 'We tell them the call bell is for emergencies only but mostly it's used to ask for toilet paper or they want to know how long they are going to be here'. As it was not apparent to inspectors when a call bell had been activated it was difficult to determine from observations alone how promptly, if at all, cell bells received a response. However, many detainees who had pressed the call bell told us that they rarely, if ever, got a response. This was unacceptable; the call bell facility was the only way detainees could contact staff in an emergency.

4.44 Maintenance logs clarified that reported faults had been addressed but it was not clear how long this took.

4.45 Staff at each suite were aware of their duties in case of a fire, and a fire evacuation policy was displayed. Some staff said they could recall evacuation drills taking place in the past but no records could be produced.

Recommendation

4.46 Call bells should be tested every day and receive a prompt response.

Housekeeping points

4.47 Recorded cell checks should take place daily.

4.48 Emergency evacuations practices should take place regularly, and be recorded.

Detainee care

4.49 Mattresses were available in all cells but were not routinely sanitised between uses. No pillows were available and we saw detainees making makeshift pillows using blankets or the mattress. The cells' temperature could be controlled individually and we found all occupied cells were adequately heated. A good supply of clean blankets was available; they were handed out at night or on request.

4.50 Detainees who did not want the cords cut from their clothing were routinely given a tracksuit to wear. They had to leave their shoes outside the cells. Plimsolls were available. There was an ample supply of toiletries and feminine hygiene packs, and the latter were offered routinely. Razors were not available for those wishing to shave before attending

court. A stock of paper suits was available, but no safety clothing. Replacement underwear was also available.

4.51 There were showers at each suite, although some did not offer sufficient privacy and one at Hartlepool did not work. None showed signs of recent use. Staff told us that they did not routinely offer showers as they were often too busy, but would facilitate one if requested. However, we spoke to detainees who did not know a shower was available. Our CRA showed that only one detainee in the sample had had a shower, and he had been in custody for almost 42 hours. A further six had been detained overnight before court, two for over 24 hours; none had been offered a shower.

4.52 Toilets could not be used privately (see paragraph 4.9) and toilet paper was only provided on request, which was unsatisfactory.

4.53 A good stock of microwave meals catered for detainees with a range of dietary needs. Staff told us that they would occasionally give detainees more than one meal if they thought that they needed it. While we were pleased to see that this took place we were concerned when some staff told us that this was not the norm, and supervisory staff discouraged it. We were concerned that breakfast consisted of one cereal bar and a drink, which was insufficient. One custody record revealed that a young person had asked for an additional meal, and was told that he had had his breakfast and that an officer would be coming round shortly with lunchtime meals.

4.54 Both suites had exercise yards that detainees could use without supervision, subject to a risk assessment, and all the yards were monitored by CCTV. We only saw one detainee in the exercise yard during the inspection; she had been taken outside by a health care professional. Many DDOs stated that they would facilitate time outside if detainees requested this, but in our view, some did not know this opportunity was available. One detainee was given just five minutes outside in an almost 36-hour period of detention, and only then because we brought the matter to staff's attention. No detainees in our CRA sample received outside exercise.

4.55 There were a few old newspapers and magazines at each suite and a small supply of books which staff had brought in, but none of these were in languages other than English and there was nothing for younger detainees. We saw that some detainees had newspapers in their cells, but they were not offered to detainees and staff waited for them to request a newspaper, even though it was not clear why they would know they could ask for one. There was only one instance in the CRA sample of a detainee receiving any reading material.

4.56 Both suites had good closed visits rooms, but we were told that social visits rarely took place.

Recommendations

4.57 **Pillows should be provided to all detainees, subject to risk assessment.** (Repeated recommendation 4.36)

4.58 **All detainees held overnight, or who require one, should be offered a shower and should be able to use one in reasonable privacy.** (Repeated recommendation 4.38)

4.59 **Food provided should be sufficient to sustain detainees for the duration of their stay or their court appearance.**

4.60 **Detainees, particularly those held for more than 24 hours, should be offered outdoor exercise.** (Repeated recommendation 4.48)

Housekeeping points

4.61 Mattresses should be sanitised between uses.

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

4.63 The shower facilities in Hartlepool should be accessible and in good working order.

4.64 Subject to individual risk assessment, a stock of toilet paper should be made available in every cell.

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

4.66 Social visits should be facilitated for those detained for longer periods.

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 Detention officers booked detainees in but custody sergeants supervised and asked arresting officers to provide a full explanation of the circumstances of, and the reasons for, the arrest before authorising detention. Sergeants told us that they rarely had to refuse detention as officers were aware of the necessity to meet criteria contained in PACE code G. Some custody sergeants told us they had occasionally refused to authorise detention when the circumstances did not merit it, mostly when health concerns were identified, and they provided us with details of these cases.

5.2 Data supplied by the police service confirmed the increased use of voluntary attendance: 3382 voluntary attendees were recorded for the 12 months from 1 December 2013 to 30 November 2014, compared with 1317 voluntary attendees for the preceding 12 months. Interviewing officers were responsible for creating voluntary attendance records but custody staff had to transfer the records to allocated recording machines in the custody suite interview rooms, which led to delays. It seemed unnecessary for voluntary attendees to be brought to the booking-in areas before being interviewed. This frequently added to the often crowded and oppressive environment of the Middlesbrough suite (see section on treatment and conditions, paragraph 4.2). We saw children being brought into the custody area at busy times simply to have an interview room allocated.

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 progressed promptly. We saw examples of cases being progressed swiftly, but we also saw some detainees being held in custody for longer than necessary when investigations were not progressed by arresting officers but were passed on to prisoner handling teams or other departments for completion. Our custody record analysis (CRA) showed that the average detention time in custody was 11 hours 41 minutes, with 40% of detainees being held for less than six hours. This varied from data supplied by the police service, which showed the average detention time across the two full-time custody suites for the previous 12 months was nine hours 57 minutes.

5.4 We saw detainees being booked in promptly after arrival at the custody suites. The average waiting time from time of arrival in the holding room to entry into the custody suite according to data supplied by the police service was only 10 minutes in both of the two full-time custody suites.

5.5 Custody staff reported a good relationship with Home Office immigration enforcement officers and we were advised that an immigration officer had been seconded to the Middlesbrough custody suite in 2014. Custody staff told us that immigration detainees who were to be transferred to immigration removal centres were usually moved on within 24 to 48 hours; however on some occasions they remained in the custody suites for up to three or four days. Custody staff told us that in 2014, a woman immigration detainee had been held at Middlesbrough for almost four days before being moved on to more suitable accommodation, which was too long. In our CRA one immigration detainee was held for almost 45 hours before being transferred to alternative accommodation. Data supplied by

Cleveland police confirmed that 152 immigration detainees had been held in the previous12 months and that the average time they spent in police detention was 22 hours and 33 minutes.

5.6 Staff assured us that the custody suites were never used as a place of safety for children under section 46 of the Children Act 1989[5].

5.7 Custody staff told us they had not known local authorities provide secure accommodation where a child had been charged and could not be bailed. However, during our inspection the local authority obtained secure accommodation in a neighbouring area for two girls who were charged with a serious offence. Custody staff told us they would only keep a child in police custody overnight in exceptional circumstances. Data supplied by Cleveland police showed that 25 children had been charged and had bail refused in the previous 12 months (see section on strategy, paragraph 3.11).

5.8 Some staff recalled that non-secure accommodation had been made available on a limited number of occasions in the past. In our CRA, the local authority was asked in one case to find alternative accommodation for a 17-year-old boy who was unable to return home. The boy was kept in police custody overnight as the social services emergency duty team (EDT) could only provide accommodation the following morning.

5.9 Custody staff were aware of their responsibilities to contact an appropriate adult (AA) when dealing with vulnerable adults or children under the age of 18. Family or friends were contacted in the first instance, but none of the custody staff we spoke to were aware of the Home Office guidance document to assist AAs when carrying out this role.

5.10 In the absence of family members, AAs were available through the EDT. Custody staff told us that during office hours the service was efficient; however outside office hours AAs often either failed to attend or regularly arrived late. This meant vulnerable detainees were held in custody for longer than necessary or were bailed to return to the custody suite at a later date. This was similar to what we found during the last inspection.

5.11 In our CRA, there were six (20%) children in the sample aged between 14 and 17. All had an AA present while being re-read their rights and during later interviews. In one case involving a 16-year-old boy, however, it appeared that the EDT acted as an AA over the telephone rather than in person when his rights were re-read; he was subsequently charged and remanded for court without an AA having been present. Two of these detainees entered the custody suite at night; the EDT could not provide an AA until the following morning, resulting in both being held in custody for longer than necessary (see main recommendation 2.38).

5.12 During the booking-in process, designated detention officers advised detainees of their three main rights (the right to have someone informed of their arrest, the right to consult a solicitor and have access to free independent legal advice and the right to consult the PACE codes of practice); however, not all detainees were offered a written notice setting out these rights and their entitlements while in custody. The rights and entitlements documentation that was available was out of date. We saw two detainees being booked in at Hartlepool who indicated that they could not read or write but staff made no effort to read out the contents of the documentation to them. Not all custody staff could access these documents in foreign languages for non-English-speaking detainees, which were held on their computers,

[5] Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child to suitable accommodation and keep him/her there.

and those held on paper at Middlesbrough were out of date. Most custody staff did not know that there was an easy-read pictorial format version of detainees' rights and entitlements on the Home Office website.

5.13 A professional telephone interpreting service was available to assist in the booking-in process. Custody staff told us that a good face-to-face interpreter service was available for interviews.

Recommendation

5.14 Up-to-date information about detainees' rights and entitlements should always be offered to all detainees and be available in a range of formats to meet specific needs. If a detainee cannot read or write, the rights and entitlements documentation should be read to them.

Housekeeping points

5.15 Custody staff should be provided with a written guidance document to assist family or friends acting as AAs, which should be routinely issued where relevant.

5.16 Staff should be made aware of the availability of the easy-read pictorial format version of the rights and entitlements information.

Rights relating to PACE

5.17 We saw detainees being told they could read the PACE codes of practice during the booking-in process, but custody staff did not routinely show detainees the information or explain it to them. There were insufficient copies of the up-to-date PACE code C available at Middlesbrough (five copies for 50 cells). The Criminal Defence Service (CDS) poster informing detainees of their right to free legal advice in 24 languages was not displayed in either suite but at Hartlepool similar CDS leaflets were available for non-English-speaking detainees.

5.18 All detainees were offered free legal representation and those wishing to speak to legal advisers on the telephone could do so in privacy in rooms with wall-mounted telephones. There were sufficient consultation and interview rooms where detainees could speak in private with their legal advisers. We saw legal advisers being given the opportunity to view custody record summaries on computer screens without having to request this facility. In our CRA all detainees were offered legal advice, 10 of whom (33%) accepted the offer. Legal advisers we spoke to said relations with custody staff were good.

5.19 We observed detainees being told that they could inform someone of their arrest, which staff facilitated.

5.20 Reviews of detainees' cases at both full-time custody suites were undertaken by dedicated PACE inspectors based at Middlesbrough. At Middlesbrough the reviews took place face-to-face but custody staff at Hartlepool advised us that the majority of reviews there were conducted over the telephone. We observed two detainees at Hartlepool having reviews conducted over the telephone mid-morning without the PACE inspector seeing either detainee. They were neither asleep nor being interviewed. The custody sergeant was asked to inform both detainees that a review had taken place and that the authority had been given to extend their time in detention. Our CRA corroborated our observations. This was

unsatisfactory and PACE inspectors should speak to detainees unless they are in an interview or asleep.

5.21 There was an effective system for collecting DNA samples taken in custody. However, at Hartlepool, samples were kept at room temperature for several hours before being transported for processing.

5.22 Custody staff at Middlesbrough told us that Teesside Magistrates' Court accepted all detainees without advance notice up to 2pm daily and then through negotiation up to as late as 4.15pm, which we observed taking place. This was good when compared to other places. Custody staff at Hartlepool advised us that Hartlepool Magistrates' Court, which acted as a remand court Monday to Thursday, would normally accept detainees up to 2.30pm and sometimes as late as 4pm. We were told that on occasion, detainees for Hartlepool Magistrates' Court had been transferred to Teesside Magistrates' Court for them to appear on the same day as their arrest. This minimised the time detainees had to be held in police custody. The average time in police detention for those who had bail refused was 24 hours and 17 minutes over the previous 12 months.

Recommendation

5.23 Reviews in custody should be undertaken in person and if circumstances require a telephone review the PACE inspector should speak to detainees unless they are asleep or in an interview.

Housekeeping points

5.24 There should be sufficient copies of the up-to-date PACE codes of practice in all custody suites; custody staff should routinely show and explain the codes to detainees.

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

5.26 The police service should ensure that the way that DNA samples are handled and stored does not unnecessarily jeopardise their integrity.

Rights relating to treatment

5.27 There was no visible information regarding the complaints process and no Independent Police Complaints Commission (IPCC) leaflets were available in either custody suite. Custody staff and PACE inspectors told us that if a detainee wished to make a complaint regarding a custody matter, a PACE inspector would speak to them while in custody to resolve the issue. For all other complaints, we were told a record would be made on the custody detention log and the detainee advised to make their complaint once they had left custody either by attending the police station front counter or by reporting it online via the police service or IPCC website. All custody staff agreed, however, that if the complaint centred on a detainee being assaulted, they would be seen by a health care professional and any injuries sustained would be photographed and a complaint taken.

Recommendation

5.28 Detainees should be able to make a complaint while they are still in 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 Cleveland police commissioned Tascor to provide physical health care services. Medical and operational leadership of the service was good and health care professionals (HCPs) from a wide variety of backgrounds had an appropriate range of skills. An HCP was based at Middlesbrough round the clock, seven days a week and a forensic medical examiner (FME) was always on call. The monitoring of medical and allied health professionals' registration status and credentials was thorough. Training and supervision arrangements were also effective and opportunities to maintain and develop professional competencies were good. We found that the service was sensitive to detainees' needs, appropriately delivered and appreciated by those we spoke to.

6.2 In December 2013, the police and NHS England commissioned a comprehensive health needs assessment in preparation for the transfer of commissioning responsibilities. The assessment had considered needs and identified future service requirements. A health care partnership board and a local operational clinical governance meeting considered service improvements, audits and lessons learned. Other multi-agency custody group meetings were established and routine meetings with external partners took place.

6.3 There was a wide range of policies; however most had not been adequately adapted to the environment. Health staff we spoke to were not fully aware of how to apply them. For example, staff did not know how to report adverse incidents and some health care practitioners were not completely familiar with the reporting standards contained within safeguarding policies. In addition, most complaints about health services went through the police complaints system, which was not sufficiently confidential, rather than through the Tascor health complaints system.

6.4 All custody staff underwent resuscitation training, including in the use of automated external defibrillators (AEDs) but the arrangements to check emergency equipment were inadequate. We found out-of-date pads for the AED on both sites and at Hartlepool the emergency equipment bag contained out-of-date products and no clear contents list. At Hartlepool confidential records were left in an unlocked cupboard, medicine keys were not secured and medicines and sharps were disposed of in the same waste container.

6.5 Each site had appropriate, clean treatment rooms. Some fixtures and fittings, including tap fittings and soap dispensers, did not comply with infection control standards. Medicine cabinets also failed to comply with standards. Daily and weekly medication stock checks were undertaken by HCPs at Middlesbrough but at Hartlepool checks were irregular and we found discrepancies in stock, and the disposal of discarded medications was inconsistent.

6.6 A range of patient group directions (PGDs) were in place, enabling HCPs to supply and administer prescription-only medicine. Over-the-counter remedies such as paracetamol and ibuprofen were not included and at Hartlepool custody staff gave detainees these preparations following telephone consultation with an HCP, which could have led to delays in providing appropriate pain relief.

Recommendations

6.7 Health staff should understand and use a full range of local policies including safeguarding, adverse incident management and complaints.

6.8 Detainees should be able to complain about health services through a well-advertised and confidential health complaints system.

6.9 The police service should introduce systematic processes to check medical emergency equipment and medicine stock that are regularly verified and audited by the nurse team leader.

6.10 Medicine keys in use in both suites should be appropriately secured when not in use and medicine storage cabinets should comply with national pharmaceutical standards.

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

6.12 PGDs, incorporating over-the-counter preparations, should be developed for use by HCPs and protocols covering treatment advice offered over the phone to custody staff should be devised and implemented.

Patient care

6.13 Access and response times appeared appropriate and were scrutinised as part of the contract monitoring arrangements. In our custody record analysis, the shortest waiting time to see an HCP was four minutes and the longest just over an hour, which was proportionate. Middlesbrough had an embedded health professional and response times were short. Detainees with complex health needs were diverted to Middlesbrough and either the FME or nurse would attend Hartlepool as required.

6.14 There was a systematic approach to clinical assessment and interventions were clinically appropriate. Clinical records were handwritten and generally of a reasonable standard, although a small number of scripts were difficult to read due to the handwriting. Relevant information was shared with police through the custody record.

6.15 Detainees were treated with respect and we observed good professional interactions. All detainees were seen privately unless risk processes indicated otherwise.

6.16 Detainees could continue with prescribed medication in custody, including opiate substitution treatment, and police made reasonable attempts to collect prescribed medications from detainees' home addresses. Symptomatic relief was provided for detainees withdrawing from drugs or alcohol where clinically indicated.

Recommendation

6.17 Consideration should be given to the introduction of an electronic health records system to ensure clinical records are legible and auditable.

Substance misuse

6.18 No direct provider of substance misuse treatment services was available, although clinical support for acute detoxification was offered. The arrest referral team (ART) was employed directly by Cleveland police to focus on trigger offences testing (for example, those that are linked to drug problems), carry out screening and to direct or refer detainees to relevant services.

6.19 The services offered by the ART, however, went beyond directing detainees to substance misuse services and included links to food banks, accommodation agencies and other organisations. The team also organised visits from specialist substance misuse treatment providers to work directly with detainees. It was available 24 hours a day, seven days a week, at the Middlesbrough site but only offered telephone support to the custody suite in Hartlepool. The ART was an innovative scheme, although it was relatively new and too early to gauge its success (see section on treatment and conditions, safety, paragraph 4.31).

Mental health

6.20 Twenty-seven per cent of detainees had a mental health issue, which had been identified as part of the custody risk assessment. Esk, Tees and Wear NHS Trust provided mental health services. The criminal liaison and diversion team based at Middlesbrough had a rich skills mix, including a child and adolescent mental health practitioner. It was well integrated with the police, the physical health care team and community-based services.

6.21 The criminal liaison and diversion team provided direct community outreach support as well as work in court settings. It liaised closely with community mental health teams and GPs and could directly prompt emergency duty team referrals and arrange voluntary admission to hospital. The team also had access to a specialist learning disability practitioner from the trust if required. The FME was available to undertake mental health assessments and collaboration between the team and medical staff was good. A worker from mental health charity MIND was regularly on site to support detainees by acting in an appropriate adult role when requested.

6.22 Detainees at Hartlepool could access the trust's mental health criminal liaison and diversion services from Monday to Friday; custody staff could access the Middlesbrough-based arrest referral team by phone for advice at weekends. In addition custody staff received training in mental health awareness as part of their mandatory training. The team used the NHS trust reporting systems but could also make entries in custody records.

6.23 Police cells had been used on 134 occasions for those detained under section 136 of the Mental Health Act in the previous 12 months, which was half the number compared with the previous year, but still unacceptably high. The police-led mental health street triage service had significantly reduced the number being held (see also section on strategy, partnerships as well as main recommendation 2.36).

Section 7. Summary of recommendations and housekeeping points

Main recommendations

7.1 Cleveland police 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. (2.34, repeated recommendation 4.24)

7.2 The Police and Crime Commissioner and Chief Officer Group should work with their counterparts in the local authority to instigate an immediate review for the provision of local authority accommodation under section 38(6) PACE 1984 to ensure that young people are not unnecessarily detained in police cells. (2.35)

7.3 Cleveland police needs to improve the monitoring of detainees held under section 136 of the Mental Health Act to assess how well services are being delivered and hold other agencies to account to further reduce the number of people detained under this legislation and held in police custody. (2.36)

7.4 Handovers should, where possible, include all team members, take place away from the booking-in area and be recorded. The shift handover should be more organised: a comprehensive briefing should take place and custody sergeants should take steps to assure themselves that this has been done. (2.37)

7.5 Children and vulnerable adults should have prompt, timely and reasonable access to AAs (2.38)

Recommendations

Treatment and conditions

7.6 Booking-in areas should provide sufficient privacy to allow effective communication between staff and detainees. (4.11, repeated recommendation 4.8)

7.7 There should be a clearer focus on the specific needs of children, female and disabled detainees; staff should be trained to deal effectively with them. (4.12)

7.8 Girls aged 18 or under should be allocated a female officer responsible for their care. (4.13)

7.9 Toilet areas should be obscured on CCTV monitors and detainees should be informed of this. (4.14, repeated recommendation 4.37)

7.10 Strip-searches should not be observed on CCTV. (4.15)

7.11 There should not be a default 30-minute observation level of detainees; observation levels should reflect the level of risk identified during the initial risk assessment and/or subsequent dynamic risk assessment. (4.33)

7.12 There should be sufficient monitors and staff available so that detainees are safely supervised via CCTV; where possible staff carrying out these observations should not be engaged in other tasks. (4.34)

7.13 Pre-release risk planning should take into account risks arising during custody as well as any consequences of release, and detainees should be offered information about relevant support organisations at the point of release (4.35)

7.14 Detainees should only be handcuffed if it is necessary, justified and proportionate. (4.41)

7.15 Call bells should be tested every day and receive a prompt response. (4.46)

7.16 Pillows should be provided to all detainees, subject to risk assessment. (4.57, repeated recommendation 4.36)

7.17 All detainees held overnight, or who require one, should be offered a shower and should be able to use one in reasonable privacy. (4.58, repeated recommendation 4.38)

7.18 Food provided should be sufficient to sustain detainees for the duration of their stay or their court appearance. (4.59)

7.19 Detainees, particularly those held for more than 24 hours, should be offered outdoor exercise. (4.60, repeated recommendation 4.48)

Individual rights

7.20 Up-to-date information about detainees' rights and entitlements should always be offered to all detainees and be available in a range of formats to meet specific needs. If a detainee cannot read or write, the rights and entitlements documentation should be read to them. (5.14)

7.21 Reviews in custody should be undertaken in person and if circumstances require a telephone review the PACE inspector should speak to detainees unless they are asleep or in an interview. (5.23)

7.22 Detainees should be able to make a complaint while they are still in custody. (5.28)

Health care

7.23 Health staff should understand and use a full range of local policies including safeguarding, adverse incident management and complaints. (6.7)

7.24 Detainees should be able to complain about health services through a well-advertised and confidential health complaints system. (6.8)

7.25 The police service should introduce systematic processes to check medical emergency equipment and medicine stock that are regularly verified and audited by the nurse team leader. (6.9)

7.26 Medicine keys in use in both suites should be appropriately secured when not in use and medicine storage cabinets should comply with national pharmaceutical standards. (6.10)

7.27 Clinical rooms should comply with relevant standards of infection control and contemporary standards for preventing contamination and forensic sampling. (6.11)

7.28 PGDs, incorporating over-the-counter preparations, should be developed for use by HCPs and protocols covering treatment advice offered over the phone to custody staff should be devised and implemented. (6.12)

7.29 Consideration should be given to the introduction of an electronic health records system to ensure clinical records are legible and auditable. (6.17)

Housekeeping points

Strategy

7.30 The police service should implement a forum for custody sergeants and DDOs to meet formally with management. (3.8)

7.31 Cleveland police and Tascor should consider joint refresher training for custody sergeants and DDOs. (3.18)

Treatment and conditions

7.32 A hearing loop should be available in all custody suites. (4.16)

7.33 Items for religious observance should be stored respectfully. (4.17)

7.34 Subject to a risk assessment, shoe laces should be returned to detainees when they leave the suite for court. (4.36)

7.35 Recorded cell checks should take place daily. (4.47)

7.36 Emergency evacuations practices should take place regularly, and be recorded. (4.48).

7.37 Mattresses should be sanitised down between uses. (4.61)

7.38 A stock of disposable razors should be maintained so that, subject to a risk assessment, detainees who wish to shave before attending court can do so. (4.62)

7.39 The shower facilities in Hartlepool should be accessible and in good working order. (4.63)

7.40 Subject to individual risk assessment, a stock of toilet paper should be made available in every cell. (4.64)

7.41 A range of reading materials should be available and routinely offered, including books and magazines suitable for children and for those whose first language is not English. (4.65)

7.42 Social visits should be facilitated for those detained for longer periods. (4.66)

Individual rights

7.43 Custody staff should be provided with a written guidance document to assist family or friends acting as AAs, which should be routinely issued where relevant. (5.15)

7.44 Staff should be made aware of the availability of the easy-read pictorial format version of the rights and entitlements information. (5.16)

7.45 There should be sufficient copies of the up-to-date PACE codes of practice in all custody suites; custody staff should routinely show and explain the codes to detainees. (5.24)

7.46 Posters detailing detainees' rights to free legal advice in a range of languages should be prominently displayed in all custody suites. (5.25)

7.47 The police service should ensure that the way that DNA samples are handled and stored does not unnecessarily jeopardise their integrity. (5.26)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	HMIP team leader
Gary Boughen	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC staff officer
Stephen Eley	HMIP health services inspector
Jan Fooks-Bale	Care Quality Commission inspector
Joe Simmonds	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.

Recommendation

Cleveland police should undertake regular dip-sampling of custody records, focusing on the management of risk of harm and on the quality of detainee care. (3.8)
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

Staff should ensure that detainee risk assessments reflect all available information and regular management checks on risk assessments and detention records should be undertaken. (2.20)
Partially achieved

Closed-circuit television (CCTV) should not be used when it is deemed necessary for constant observation of a detainee to take place. (2.21)
Achieved

Recommendations

Arrangements in booking-in areas should allow for private communication between detainees and staff. (4.8)
Not achieved (recommendation repeated, 4.11)

Staff should be trained to recognise and provide for the individual needs of detainees, particularly those who are deemed to be vulnerable for some reason. (4.9)
Partially achieved

The process for placing new risk markers on the Police National Computer should be more robust. (4.17)
Achieved

All staff should carry anti-ligature knives. (4.18)
Achieved

Handover arrangements should allow for comprehensive briefing for staff to take place, and should include both custody sergeant and detention officers. (4.19)
Not achieved

Cleveland police should monitor the use of force at each custody suite by ethnicity, age, location and officers involved, in line with Association of Chief Police Officers (ACPO) guidance. (4.24)
Not achieved (recommendation repeated, 2.34)

A systematic programme of health and safety walk-throughs should be established and staff appropriately trained to carry them out, and the results should be reviewed by custody managers. (4.30)
Achieved

Regular fire practice evacuations should be conducted. (4.31)
Not achieved

Pillows should be provided, and every detainee should be offered a blanket. (4.36)
Partially achieved (recommendation repeated, 4.57)

Toilet areas should be obscured on closed-circuit television monitors and detainees should be informed of this. (4.37)
Not achieved (recommendation repeated, 4.14)

All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.38)
Not achieved (recommendation repeated, 4.58)

Food provided should be of sufficient quality and calorific content to sustain detainees for the duration of their stay or their court appearance. It should be offered to all detainees at mealtimes, and always be recorded in the custody log. (4.43)
Not achieved

Detainees held for long periods should be offered outside exercise. (4.48)
Not achieved (recommendation repeated, 4.60)

Individual rights

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

Recommendations

Subject to risk assessment, all detainees should be offered the opportunity to make a telephone call and enabled to do so. (5.7)
Achieved

Senior police officers should engage with the UK Border Agency to ensure that the time spent in police custody by immigration detainees is minimised. (5.8)
Partially achieved

Pre-release risk assessments should be completed, and detainees who disclose problems on release should be offered information about sources of help. (5.9)
Partially achieved

Appropriate adults should be available to support without undue delay juveniles and vulnerable adults in custody, including out of hours. (5.17)
Not achieved

Detainees should be routinely informed about how they can make a complaint about their care and treatment and be able to do this before they leave custody. (5.19)
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 recommendation

The Mental Health Trust should improve access to section 136 suites to minimise the extent to which people with mental health problems are held in police custody. (2.22)
Partially achieved

Recommendations

Controlled drugs specified in Schedule 2 to the Misuse of Drugs Regulations 2001 should be recorded in the controlled drug register. (6.9)
Achieved

Custody staff should have access to a full range of appropriate first-aid and resuscitation equipment that is checked and recorded regularly. (6.10)
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 care staff to ensure a detainee's care. (6.24)
Achieved