Report on an unannounced inspection visit to police custody suites in

Surrey

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

12–16 January 2015

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 on the welfare of vulnerable people in police custody. It was decided by HMIC and HM Inspectorate of Prisons to use the existing rolling programme of police custody inspections to facilitate the principal fieldwork. The inspection of police custody suites in Surrey formed part of this fieldwork, and the findings informed the final thematic report, which was published in March 2015.

At the time of the inspection, there were three ongoing Independent Police Complaints Commission investigations, we could not however, report on any learning or recommendations arising from them. We noted one case determined as an Independent investigation, the highest level of seriousness afforded to any IPCC investigation, which involved restraint on someone who could be described as vulnerable.

There was a clear organisational structure to support the provision of safe detention for people held in police custody in Surrey. However, further work needed to be completed to ensure the adequate resourcing of custody suites. Engagement with partner agencies was evident and had led to reduced numbers of detainees in police cells under section 136 of the Mental Health Act. However, more progress needed to be made with health care partners to reduce this number further, and with the local authority to provide accommodation for children who have been refused police bail. There were high-quality checking processes used to inform organisational learning.

All custody staff, observed by the inspection team, were professional and courteous in their dealings with detainees, providing a good standard of care. Generally, attention was paid to the diverse needs of detainees, especially in the care of women. Custody staff produced good risk assessments, and care plans were routinely updated in response to changes in detainees' circumstances. However, shift handovers were inadequate. Oversight and governance of use of force, especially the use of restraints such as body cuffs, were also inadequate and there was no common understanding of the term 'use of force', which could lead to an under-reporting by police officers.

Designated detention officers were proficient in booking in detainees, and detention was authorised by custody sergeants, in line with legislation. Staff reported receiving an excellent service from Surrey Appropriate Adult Volunteer Scheme, which provided a prompt, 24-hour service. However, we were told, and saw, that police staff routinely fingerprinted, photographed and took DNA samples from children without the presence of an appropriate adult.

There were some delays in the transfer of immigration detainees, and of detainees to court. There were variations in the approach to taking complaints from detainees, depending on whether the complaint related to custody or elsewhere.

Detainees received effective health service provision. However, there was evidence that they were not always seen in a timely fashion, owing to problems with the recruitment of staff and the provision of absence cover. There was an improvement plan, which had enhanced staffing arrangements. Drug and alcohol services worked well, and mental health input within custody was effective.

We noted that, of the 26 recommendations made in our previous report after our inspection of 2010, 15 recommendations had been achieved, three had been partially achieved and eight had not been achieved. Overall, the inspection found that Surrey police were making progress in some areas but that there were others which required improvement. Immediate attention is required in the treatment of children, and oversight and accountability of use of force in the custody suite.

This report provides a number of recommendations to the force and the Police and Crime Commissioner. 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.

Sir Thomas P Winsor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

June 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 College of Policing Authorised Professional Practice 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 Surrey Police, the first being in February 2010. Since then, there had been a reduction in the custody estate from four full-time suites to three full-time suites and one stand-by suite. Reigate had closed and a new purpose-built custody suite had been built (Salfords). Woking was now a stand-by suite and there were 82 cells in total across all the suites. The designated custody suites and cell capacity of each was as follows:

Custody suite	Number of cells
Guildford	24
Staines	19
Salfords	24
Woking (stand-by suite)	15

Strategy

2.4 Surrey police had a centralised custody function with a clear senior management structure. The condition of the custody estate was good. Internal meetings appropriately focused on custody matters, discussion, review of performance and quality of service delivered. Data were used to monitor outcomes for detainees and improve custody provision.

2.5 Staffing levels had been reduced since the closure of Woking custody suite and were not always adequate to meet the demands of the throughput of detainees. Staffing comprised permanent custody sergeants and designated detention officers (DDOs). Additional support was provided by trained sergeants and police constables when needed. Custody sergeants

[1] http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/02/police-custody-expectations.pdf

had operational line management of DDOs, who undertook the booking-in of detainees in addition to looking after their care and welfare.

2.6 Further improvement was needed by Surrey police to reduce the number of individuals detained in police custody under section 136 of the Mental Health Act 1983 (MHA). [2] This was potentially impeded by a protocol with health services that declared that accident and emergency departments at hospitals in Surrey were 'exceptional places of safety' for persons in mental health crisis detained by police under this legislation.

2.7 Arrangements with the local authorities to provide safe accommodation for children in police custody were ineffective.

2.8 There was an active independent custody visitors (ICV) scheme, and regular, consistent police representation at ICV team meetings. Cross-panel visiting arrangements to share experience were a good initiative.

2.9 The quality assurance process was good, and included dip-sampling of custody records, cross-referencing to closed-circuit television (CCTV) and checking the person escort record (PER) form, but did not include oversight of the shift handover.

Treatment and conditions

2.10 Detainees were treated courteously by custody staff, who were responsive to the diverse needs of detainees. Staff had excellent interpersonal skills and detainees told us that they felt cared for.

2.11 More needed to be done to ensure privacy in booking-in areas, particularly for cases that were sensitive, and to facilitate detainees in disclosing any vulnerabilities that might affect their safe detention. Staff at Guildford were particularly attuned to ensuring detainee privacy during the booking-in process. The focus on diversity had generally improved, particularly the overall treatment of women and children. The newly introduced 'dignity' questions, specifically for female detainees, were a positive innovation.

2.12 The children we saw being booked in were treated appropriately and none was held overnight. Children were routinely referred to a health care professional (HCP), but none of the staff understood the purpose of this. The lack of access to local authority safe accommodation resulted in children being held overnight.

2.13 The provision for older detainees and those with disabilities had improved, with adaptations made to custody suites. Staff had a good understanding of religious diversity and an awareness of conducting searches which respected a detainee's culture, religion and gender, and of how to search transgender detainees appropriately.

2.14 The process for completing risk assessment varied across the suites; where DDOs completed them, there was little oversight, which created potential risk and inconsistency. Despite this inconsistency, risk assessments were completed to a high standard. Custody staff were flexible in their approach and asked supplementary and sensitive questions, depending on detainees' responses. Other than the fact that at all suites, cords were

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

routinely removed from detainees' clothing, regardless of risk. Otherwise, most risk assessments were individual and dynamic. Custody staff were clear about how to obtain a response from detainees who were subject to rousing checks.

2.15 Officers were fully briefed before undertaking close-proximity observations. There was a helpful guide to their responsibilities, especially with regard to maintaining attentiveness by not using mobile telephones and airwave radio sets.

2.16 The quality of shift handovers needed to be improved. The sharing of relevant information was largely undermined by not including all incoming and outgoing staff, and too many interruptions. Handovers were audio and visually recorded at Guildford and Salfords, but not at Staines.

2.17 The pre-release risk assessments (PRRAs) that we saw lacked detail, although only concerned detainees who did not have significant concerns that needed to be addressed before release. In our custody record analysis (CRA), we found that PRRAs were completed for all detainees, but that they generally lacked detail and did not always mention how detainees would get home. There was a helpful leaflet available which contained the contact details of local and national support agencies.

2.18 There was a use of force policy and form; however, there was inadequate oversight of the use of force in custody suites. In most cases, we did not see detainees waiting in handcuffs. Custody staff had good de-escalation skills. There was widespread confusion among custody staff as to what constituted a 'use of force', which potentially could have resulted in an under-reporting of force used in custody. Body cuffs were available in all custody suites, and staff recalled occasions when they had been used. We found no governance or policy on their use, which was a significant concern. We were made aware of an investigation of a death in custody case in which restraint had been used; however, this had not concluded, so we could not comment on any recommendations arising from that incident.

2.19 We knew of several strip-searches, which had all been authorised appropriately. However, staff did not routinely switch off the CCTV monitors while searches were being carried out, to protect the dignity of detainees.

2.20 Custody suites were clean, safe and in good repair. Cell checks were undertaken regularly in all suites but maintenance records were not always completed.

2.21 Detainee care was good. Food and drink were provided as required. Showers were offered to those held overnight, especially if they were due to attend court.

Individual rights

2.22 In most cases, custody sergeants supervised DDOs booking in detainees and asked arresting officers for a full explanation of the circumstances of, and the reasons for, the arrest before authorising detention. In a few cases, however, we saw a sergeant accepting the circumstances as detailed by arresting officers on the custody arrival sheet, rather than first hand with the officers in the presence of the detainee.

2.23 Custody sergeants told us that operational officers did not always have a good understanding of the necessity criteria contained in PACE code G,[3] but that they themselves were confident enough to refuse detention when the circumstances did not merit arrest, and they provided us with details of such cases. There had been 2,632 voluntary attendees recorded in 2014 but data had not been collected prior to this.

2.24 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 quickly. We saw examples of timely progression of cases. Detainees were booked in promptly after arrival at the custody suites but there were sometimes delays due to the volume of demand. Data supplied by the force showed that the average waiting times were 17 minutes at Staines, 23 minutes at Salfords and 35 minutes at Guildford. These delays potentially prevented the early identification of risk.

2.25 During the inspection, we saw nine immigration detainees in the cells, eight of whom went on to be detained for over 24 hours. Staff were courteous and reassuring towards this group of detainees, none of whom could speak English, but were not proactive in offering showers and outside exercise.

2.26 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.[4] Surrey Appropriate Adult Volunteer Scheme (SAAVS) provided a prompt and effective service, which staff described as excellent and an important tool in progressing investigations in a timely manner. Despite this, we were told, and saw, that police staff routinely fingerprinted, photographed and took DNA samples from children without an AA being present.

2.27 A professional telephone interpreting service was available to assist in the booking-in process, and a good face-to-face interpreter service was available for interviews. DDOs were able to access rights and entitlements documents in foreign languages for non-English-speaking detainees.

2.28 All detainees, including immigration detainees, were offered free legal representation and could speak to legal advisers privately, on the telephone and in person. Detainees were told that they could inform someone of their arrest, and staff facilitated this.

2.29 PACE reviews were timely and thorough. We saw some, but not all, detainees being told that reviews had taken place while they were asleep, and they were reminded of their rights and entitlements.

2.30 The local magistrates' courts did not normally accept detainees after 3pm on weekdays and just after 9am on Saturdays, meaning detainees could spend a night in police custody. Detainees wishing to complain about a custody matter could make their complaint to a custody inspector.

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[3] PACE code G refers to the Police and Criminal Evidence Act 1984, Code G, which is the code of practice for the statutory power of arrest by police officers.

[4] 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.

Health care

2.31 Health care practitioners (HCPs) were based at each of the three suites, and each site had a medical room. Staffing levels occasionally dropped below contract levels, which led to some long delays in detainees being seen.

2.32 Medical and other health professionals' credentials were monitored and Tascor, the health care provider, provided induction and ongoing mandatory training, although supervision and professional development arrangements were not well developed. Opportunities for frontline clinicians and custody staff to meet were limited but working relationships between these groups were good. Tascor had an appropriate range of policies and procedures, which frontline staff were aware of and used.

2.33 The health services provided were effective and valued by detainees. Clinical assessment and treatment measures were appropriate, and detainees were treated with respect. Medicines management was generally acceptable. Daily checks were effective but weekly medication stock checks required improvement. Detainees could continue to receive valid prescribed medication in custody but opportunities for detainees to continue to receive prescribed methadone in custody were limited as this could only be authorised by the forensic medical examiner (FME), which could lead to delays in accessing treatment.

2.34 Substance misuse services were comprehensive, offering a single point of referral for detainees on arrest, delivering case-managed substance misuse interventions in courts and custody suites across Surrey and in the community as part of the local integrated management team. Governance arrangements for the service appeared robust and staff were well trained and supported.

2.35 Mental health provision in custody was good, with two practitioners generally covering three sites, seven days a week.

2.36 There appeared to be gaps in the provision of crisis and psychiatric liaison services at the local acute hospitals. There were delays in accessing mental health assessments and in obtaining a bed when need was identified, which meant that detainees requiring such interventions could spend too long in custody.

2.37 There was no evidence of police custody suites being used inappropriately to detain people under section 136 of the MHA. Only 45 out of 573 individuals subject to section 136 of the Act had been held in custody in 2014.

Main recommendations

2.38 The Police and Crime Commissioner and chief officer group should engage with their counterparts in the local authority, instigate an immediate review of the provision of local authority accommodation under section 38(6) PACE 1984 for children, and monitor performance data proactively to ensure that children are not unnecessarily detained in police cells.

2.39 Surrey Police should examine use of force data from custody for trends in accordance with the Association of Chief Police Officers' policy and College of Policing guidance, ensuring safe and appropriate outcomes for detainees.

2.40 Surrey Police should ensure that the fingerprinting, photographing and the taking of DNA samples in cases involving vulnerable adults and children should take place in the presence of an appropriate adult.

Section 3. Strategy

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

Strategic management

3.1 An assistant chief constable (ACC) provided strategic leadership on custody issues for Surrey and Sussex police forces, with a chief superintendent, head of criminal justice and custody. There was no further formal collaboration between Surrey and Sussex police forces on the provision of custodial services below this senior management level. Surrey police had its own centralised custody function, delivered through the criminal justice and custody portfolio business area, with a clear senior management structure.

3.2 Since the previous inspection, the custody estate had reduced from four full-time suites to three full-time suites and one stand-by suite. The condition of the custody estate was good and included plans for improvements at the Staines and Guildford custody suites.

3.3 During the inspection, staffing levels in the custody suites were not always adequate. During the transition from four custody suites to three, the corresponding reduction in custody staffing had been excessive and currently there were insufficient staff to meet the demands of the increase in detainee throughput at some of the suites, particularly Guildford. The force had recognised this and, using the College of Policing custody profile tool, was planning to increase the number of custody staff.

3.4 Staffing comprised permanent custody sergeants and DDOs. There was a pool of custody-trained sergeants from other areas of work, to provide cover for custody sergeants. Similarly, a number of custody-trained police constables provided cover for DDOs, particularly during the shortfall of staff in the custody suites. However, these constables did not have the breadth of training of DDOs and therefore had a limited role within the custody suite environment. Custody sergeants had operational line management of DDOs, who undertook the booking-in of detainees in addition to looking after their care and welfare.

3.5 There were a number of internal meetings, where custody matters and performance, audits and the custody improvement plan were discussed and reviewed, and where the Police and Crime Commissioner held to account the ACC for performance and for the Surrey police custody improvement plan. This plan was comprehensive and developed through a self-assessment, HMI Prisons/HMI Constabulary inspection criteria, and published police custody inspection reports. Data were reviewed at these meetings to monitor detainee outcomes and improve custody provision. The ACC chaired a quarterly strategic custody oversight board, which covered issues such as mental health, leadership and organisational learning from reviews of performance information. Staff consultation meetings were led by the superintendent criminal justice and custody lead, attended by custody sergeants and DDOs, and provided the opportunity for staff to raise custody issues with management and receive updates on the ongoing custody review, which included the review of shift patterns.

Recommendation

3.6 Surrey Police should expedite the review of staffing levels in police custody to improve outcomes for detainees.

Good practice

3.7 The accreditation process for custody sergeants and DDOs as part of the initial training programme was a noteworthy investment in the training and development of custody staff.

Partnerships

3.8 There were a series of partnership meetings, attended by chief officers. The ACC attended the mental health crisis concordat partnership meeting and used this forum as an opportunity to develop mental health partnership working for police custody beyond the remit of provision under section 136 of the Mental Health Act 1983 (MHA). Although few of the people detained in the previous 12 months under section 136 MHA had been conveyed to police custody, which was commendable (see section on health care), more could have been done to reduce the numbers further. It was concerning that the current section 136 MHA protocol between Surrey police and health services declared that accident and emergency departments at hospitals in Surrey were 'exceptional places of safety' for persons in mental health crisis detained by the police.

3.9 The ACC had been working with the head of children's services for Surrey County Council to improve outcomes for children held in custody. A protocol for the provision of local authority accommodation for children in police custody who had been refused bail was being developed. Although the number of requests for such accommodation in the previous 12 months had been low (see section on individual rights), arrangements with the local authority to provide safe accommodation were ineffective (see main recommendation 2.38).

3.10 There were regular meetings with Tascor to monitor the contract for the provision of health services in custody.

3.11 There was an active independent custody visitors (ICV) scheme, with three panels providing a regular schedule of visits. We were told by a panel vice-chairperson that there were no current concerning trends and that ad hoc issues were dealt with effectively. There was regular and consistent police representation at ICV team meetings, and cross-panel visiting arrangements enabled ICVs to share experience and good practice.

Recommendation

3.12 The Police and Crime Commissioner and chief officer group should re-examine the current partnership protocols for section 136 of the Mental Health Act 1983, to ensure that police custody is used only in exceptional circumstances. They should engage with their counterparts in the health services to reduce further the number of persons detained under this legislation and held in police cells.

Good practice

3.13 *The cross-panel arrangements for independent custody visitors was a good initiative for sharing experience and good practice.*

Learning and development

3.14 All custody sergeants and DDOs had undertaken an initial custody-specific training course, followed by a comprehensive six-week accreditation process for custody sergeants and a six-month accreditation process for DDOs. There were five annual refresher training days for staff, two of which were allocated for mandatory training and the remainder for custody-specific refresher training, some of which was informed by the quality assurance processes.

3.15 There was a structured quality check process for dip-sampling custody records, referred to as 'non-conformance' checks. Custody inspectors and custody support sergeants were required to dip-sample 10% of custody records for their suite per month. This was overseen by the head of custody, and included cross-referencing to CCTV and checking person escort record (PER) forms, but did not include a review of shift handovers. Custody sergeants confirmed that they received feedback from this process.

3.16 There was a process for reporting successful interventions (where the intervention of staff averts a serious incident) in custody. Outcomes from the reporting process included recognising good practice, personal and organisational development and individual performance management. All successful interventions were reviewed at the force health and safety board.

3.17 We were made aware of an investigation of a death in custody case in which restraint had been used; however, the investigation had not concluded, so we could not comment on any recommendations arising from that incident.

3.18 The force intranet site included links to a range of policies and procedures for custody. The site also included links to the Independent Police Complaints Commission (IPCC) 'learning the lessons' document.

Housekeeping point

3.19 Surrey police should implement a quality assurance process for dip-sampling the quality of shift handovers.

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 respectful and demonstrated a good level of care and concern for detainees throughout the detention process. They had excellent interpersonal skills and we saw several excellent examples of verbal de-escalation techniques when staff were booking in detainees who appeared aggressive or distressed.

4.2 Detainees brought into custody who were considered vulnerable were permitted to remain in holding rooms in sight of the booking-in area and were appropriately reassured throughout their detention. We saw this on several occasions at Salfords and Guildford custody suites, and spoke to many detainees who were generally positive about the care they had received.

4.3 The layout of the booking-in areas differed in each suite. At Staines, this area lacked privacy, and conversations between custody staff and detainees being booked in could be easily overheard. At Guildford, which was a busy suite, staff were proactive in reducing the impact of the cramped environment by clearing the booking-in area for cases that were sensitive, but the booking-in desk remained too high. Custody staff at Salfords were not always sufficiently aware of the need to ensure privacy and the importance of this for detainees to disclose vulnerabilities that might affect their safe detention.

4.4 The focus on diversity had improved, and staff's attention to the individual needs of detainees was good. The newly introduced 'dignity' questions, specifically for female detainees, offered women the opportunity to speak to a female member of staff and access to a female health care professional, and they were made aware of the availability of hygiene products. We also saw custody staff ask detainees if anyone at home would be affected by their detention, such as dependants.

4.5 Each suite had allocated cells for children which were located close to the booking-in desks; they were identical to ordinary cells, except at Guildford, where they did not contain in-cell toilets, which was unsatisfactory. Children were appropriately placed on standard 30-minute observations, and we were pleased to see several being located in holding rooms with their Appropriate Adult (AA), rather than in cells. Holding rooms are usually nearer to the booking- in desk and less bleak, which was more appropriate for children. Staff had recently received safeguarding training.

4.6 Data supplied by the force showed that 43 children had been held overnight in the previous 12 months (see section on individual rights). They were routinely referred to an HCP, which was positive from a safe detention and child safeguarding perspective, although none of the staff were clear about the purpose of the referral (see recommendation 6.15). As a consequence, the custody staff we observed did not adequately explain the reason for the referral to the children they booked in, and HCPs did not explore any issues with the children, beyond the routine health questions. We observed three children being booked in, none of whom was held overnight; one was bailed to return a few days later, as he was low in mood and custody staff assessed that being further detained would exacerbate this.

4.7 The provision for older detainees and those with disabilities was reasonable. Salfords and Guildford had a designated cell for such detainees, with basic adaptations, including (at Salfords) a raised bench and lowered intercom/call bell button. Salfords also had an adapted toilet. Hearing loops were available at every suite.

4.8 Staff had a good understanding of religious diversity. Items for religious observance, including prayer mats and a range of holy books, were available and all were stored respectfully. Staff had a good awareness of conducting searches which respected a detainee's culture, religion and gender, and of how to search transgender detainees appropriately.

Recommendation

4.9 **Booking-in desks should be of an appropriate height and the reception area should allow adequate privacy for the interviewing of new arrivals.** (Repeated recommendation 4.27)

Safety

4.10 The process for completing risk assessments varied across the suites. At Guildford, they were well completed by the custody sergeant, who had good oversight and ownership of the assessment and subsequent care plan. At Salfords, they were mostly completed by DDOs, sometimes with little oversight by custody sergeants while they were being completed. We were told that this was not the way that the force expected the risk assessments to be completed and managers acknowledged that there were potential risks associated with custody sergeant not having direct input into their completion.

4.11 Despite this inconsistent practice, risk assessments were completed to a high standard. Custody staff were flexible in their approach to completing them, and asked supplementary and sensitive questions, depending on responses. Custody staff routinely undertook a check of the police national computer (PNC) and the local intelligence system to inform the risk assessment and overall care plan. HCPs helped custody staff to determine if detainees were fit to be detained and interviewed, and advised on how their physical and mental health care needs could be managed safely.

4.12 Our Custody Record Analysis (CRA) highlighted that a high level of detail was used in determining risk, including a detainee's mood and demeanour, and this was corroborated in our observations. The CRA also confirmed that risk assessments and care plans were updated throughout custody as new information became available to custody staff. DDOs understood the importance of, and techniques for, rousing intoxicated detainees to obtain a satisfactory response. Our CRA revealed that all detainees in our sample who were subject to rousing checks were assessed regularly, with the times, and often the conversations, recorded.

4.13 Custody staff routinely removed detainees' shoes and cords from their clothes, regardless of their level of risk or previous experience of self-harm, which was disproportionate. Anti-rip gowns were available across the suites. We saw one being issued to a detainee who had a recent history of self-harm, and threatened to harm himself in custody. This detainee was cared for appropriately, being referred to the HCP and placed on enhanced visits; the custody sergeant also liaised with the investigating officer to progress the case so that the detainee did not have to remain in custody too long.

4.14 We were satisfied that CCTV was not used excessively as an observation tool, or as an alternative to close-proximity observations. Staff were confident in using the range of observation levels, and we saw these changing as the custody sergeant reassessed the level of risk presented; the levels of observations set were appropriate. All staff carried anti-ligature knives.

4.15 In the close-proximity observations we observed, the police officers conducting them had been well briefed about the detainee and of their duties. Officers had been issued with a helpful guide to their responsibilities, especially with regard to maintaining attentiveness by not using mobile telephones and airwave radio sets. Although this was primarily aimed at observing detainees suspected of concealing drugs, it could be adapted to most circumstances in which close-proximity observations were deemed necessary.

4.16 The shift handover process was similar at all three suites but was not well managed. The quality of information passed between shifts was good but briefings did not include all incoming and outgoing staff, and at Staines they took place in an area which was not covered by audio- or visual recording equipment. In addition, some handover briefings were regularly interrupted by telephone calls or by other staff seeking advice.

4.17 Our CRA confirmed that PRRAs were completed for all detainees on release but they generally lacked detail, they tended to repeat the risks that had been identified during the original risk assessment and did not always mention how the detainee would get home. The PRRAs that we saw concerned detainees who did not have any significant risks that needed to be addressed before release. Travel warrants were available for issue to detainees on leaving custody. There was also a helpful leaflet available which contained the contact details of 35 local and national support agencies; we saw these being offered to every detainee on release.

Recommendations

4.18 All custody staff should be involved in the same shift handover and, wherever possible, this should be recorded.

4.19 Pre-release risk assessments should be detailed 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 required.

Good practice

4.20 *Surrey police had produced a helpful guide to assist officers undertaking close-proximity observations, which could be adapted to most circumstances in which this level of observation was deemed necessary.*

Use of force

4.21 Oversight of the use of force in custody suites was inadequate, although there was a use of force policy and form. The data supplied showed that there had been 352 recorded uses of force in custody from March to December 2014. This information was not analysed, so neither custody sergeants nor inspectors were fully aware of the types of force used or the proportionality of such actions in their custody suites (see main recommendation 2.39). We were told that uses of force in the custody suite were recorded in the custody record, and that a separate use of force form would only be submitted if the level of force used was

deemed to be serious enough to warrant it. Custody staff we spoke to were not confident about the circumstances in which a form should be submitted and there appeared to be widespread confusion among them as to what constituted a 'use of force', which potentially could have resulted in an under-reporting of force used in custody. The forms were only monitored for the annual officer safety refresher training.

4.22 All custody suites held body cuffs, used to restrain detainees who were violent or self-harming. Although we were told that staff had received training on the use of the body cuff, there was no policy or written guidance for their use and custody staff were unclear about the circumstances in which they could be used, although some gave examples of when they had used them. The lack of governance of their use was concerning. We were aware of an IPCC investigation involving the use of restraint, although the case had not concluded, so we were unable to comment on any recommendations arising from it (see also section on strategy).

4.23 We saw few detainees arriving in handcuffs, and operational officers we spoke to knew that handcuffing should be justified and proportionate. With the exception of two detainees we saw who were handcuffed in a holding area for 65 minutes and approximately 49 minutes, respectively, handcuffs were removed promptly from any detainees wearing them on arrival.

4.24 We saw evidence of several strip-searches being authorised appropriately. However, staff did not routinely switch off the CCTV monitors while searches were being carried out, to protect the dignity of detainees.

Recommendations

4.25 Staff should be fully briefed about when use of force forms should be used.

4.26 Mechanical restraints such as body cuffs should be used only in exceptional circumstances when there are no other means of keeping detainees and staff safe. Staff should be sufficiently trained to use such equipment and its use should be monitored.

4.27 Closed-circuit television monitors should be switched off when detainees are being strip-searched.

Physical conditions

4.28 The physical conditions of the custody suites had greatly improved and were good. Regular, programmed deep-cleaning of each suite was undertaken, which necessitated the temporary closure of each suite to enable a thorough clean to take place. The daily cleaning arrangements across the estate were effective, with all unoccupied cells being cleaned every morning; records were kept of this and of maintenance checks. We found minimal graffiti in the cells.

4.29 When maintenance issues were identified, a record was made of when and to whom it was reported, but the date when maintenance was undertaken was not always recorded, so it was unclear how promptly these issues were resolved.

4.30 DDOs escorted detainees to the cells and explained what was available in them, such as the call bell. All cells were monitored by CCTV, and we heard DDOs telling detainees that the toilet area was obscured on the monitors. Most call bell activations were responded to

through intercom enquiries by the DDO, and when necessary a cell visit would be made. We saw call bell activations responded to promptly. All call bells were tested daily.

4.31 Staff at each suite were aware of their duties in the event of a fire, and a fire evacuation policy was displayed. Fire evacuation training was usually undertaken during the temporary 'deep clean' closure of the suites, and records were produced to show this.

Housekeeping point

4.32 Records of maintenance should be kept up to date.

Detainee care

4.33 There had been some improvement in detainee care since the last inspection. Mattresses and pillows were available in all cells and were routinely sanitised between uses. All occupied cells were heated adequately and all detainees were given a clean blanket shortly after being placed in a cell.

4.34 Alternative clothing, such as T-shirts, jogging bottoms and underwear, was available for detainees whose own clothing had been taken from them for evidential purposes or otherwise soiled. Plimsolls were also available but we saw some detainees walking around the suites in their socks. There was an ample supply of toiletries and feminine hygiene packs. Despite being assured that razor kits are provided in each suite, we did not see razors being made available for those wishing to shave before attending court.

4.35 There were showers at each suite, and all offered sufficient privacy. Staff told us that they routinely offered showers to those detained overnight, especially if the detainee was due to attend court; this was supported by the custody records we saw and our CRA. Toilet paper was supplied in every cell. Many cells had in-cell hand-washing facilities.

4.36 There was a good stock of microwave meals, catering for a range of dietary needs, including halal and vegetarian. They were of low calorific value but staff told us that they would give more than one meal if they thought that the detainee needed it. There was also a selection of breakfast cereals and cereal bars. Drinks were offered at mealtimes and at regular intervals. In our CRA, 24 out of 30 detainees had been offered at least one meal while in custody; many of these had been taken outside normal mealtimes and at the request of the detainee. The remainder had been held for less than seven hours, although one record showed no evidence of a meal being offered, despite the detainee being in custody for almost 21 hours.

4.37 All three suites had exercise yards that detainees could use without supervision, subject to a risk assessment, and all the yards were monitored by CCTV. The yard at Salfords was not in the open air. We saw only a few detainees in an exercise yard during the inspection, and just three detainees in our CRA sample had been offered outside exercise.

4.38 Each suite had a few old newspapers and magazines and a small supply of books available which staff had brought in for detainees, but none of these was in languages other than English and there was nothing for younger detainees. During the inspection, some detainees had newspapers or magazines in their cells, and reading materials were occasionally offered by DDOs; however, staff generally only provided them on request, even though it was not obvious that any were available. In our CRA sample, only four detainees had received any reading material, and they had been detained for periods between nine and 55 hours.

4.39 We were told that social visits rarely, if ever, took place, even for detainees who had been detained for long periods – for example, those held over the weekend or immigration detainees waiting for transfer.

Recommendations

4.40 **Detainees, particularly those held for more than 24 hours, should be offered outdoor exercise.** (Repeated recommendation 4.33)

4.41 **Detainees remaining in custody for more than 24 hours should be allowed visits.** (Repeated recommendation 4.34)

Housekeeping points

4.42 Subject to a risk assessment, razors should be made available to detainees who wish to shave before attending court.

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

Section 5. Individual rights

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

Rights relating to detention

5.1 On arrival with a detainee at a custody suite, arresting officers completed a custody arrival sheet, which summarised the full circumstances of the arrest, offence details and grounds for detention. DDOs used the information recorded on the form to create a custody record for the detainee while booking them in. In most cases, custody sergeants supervised the process and asked arresting officers, in the presence of detainees, to provide a full explanation of the circumstances of, and the reasons for, the arrest before authorising detention. In a few cases, however, we saw a sergeant accepting the circumstances as described by arresting officers on the custody arrival sheet, rather than first hand with the officers in the presence of the detainee, which lacked transparency and openness.

5.2 Custody sergeants told us that operational officers did not always have a good understanding of the necessity criteria contained in PACE code G, but that they themselves were confident enough to refuse detention when the circumstances did not merit arrest, and they provided us with details of such cases. Alternatives to custody were available in the form of voluntary attendance.[5] Data supplied by the force confirmed that there had been 2,632 voluntary attendees between 1 January and 31 December 2014 but data prior to these dates had not been collected.

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 quickly. We saw examples of timely progression of cases but staff told us, and we witnessed, that investigations for many detainees were not progressed by arresting officers but passed on to another department for completion. Our CRA showed that the average detention time in custody was 13 hours 13 minutes, with only eight detainees being held for less than six hours. This was at odds with the data supplied by the force, which showed the average detention time across the three full-time custody suites for the previous 12 months as just over 12 hours.

5.4 We generally saw detainees being booked in promptly after arrival at the custody suites but also witnessed delays of between 65 and 83 minutes at Guildford, mainly as a result of the volume of demand. According to data supplied by the force, the average waiting times from the time of arrival, which was date-stamped on custody arrival sheets, to custody records being opened was 17 minutes at Staines, 23 minutes at Salfords and 35 minutes at Guildford. These delays potentially prevented the early identification of risk.

5.5 Custody staff reported a good relationship with Home Office Immigration Enforcement officers. During the inspection, we saw nine immigration detainees in the cells, eight of whom went on to be detained for over 24 hours. Staff were courteous and reassuring towards this group of detainees, none of whom could speak English, and some of whom

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

appeared to be afraid; however, staff were not proactive in offering them showers and outside exercise until we prompted them to do so. Staff told us that immigration detainees were sometimes detained for two to three days. According to data supplied by the force, 631 immigration detainees had been held in the previous 12 months, with an average time spent in custody of 20 hours 29 minutes, which was too long.

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

5.7 Of the 43 children held overnight in the previous 12 months (see also section on treatment and conditions), safe accommodation had been requested but not made available for 27; in the remaining cases, 10 children had been taken directly to court, one had been returned to the secure children's home where they resided, and no information had been recorded in the final five cases (see main recommendation 2.38).

5.8 Custody staff were not always aware of their responsibilities in relation to AAs when dealing with vulnerable adults or children. At Salfords, we saw police staff taking fingerprints, photographs and a DNA sample from a 17-year-old youth without an AA being present, which was a breach of PACE. Custody staff at all the suites told us that this was common practice, particularly if the individual had been in custody previously (see main recommendation 2.40).

5.9 Family or friends were contacted in the first instance to act as an AA, and all custody sergeants were aware of the availability of a guidance document to assist AAs when carrying out this role. In the absence of family members, AAs were available, both for vulnerable adults and children through Surrey Appropriate Adult Volunteer Scheme (SAAVS), which provided a prompt and effective service with a pool of 80 volunteers to call on. Custody staff described the service provided by SAAVS as excellent and an important tool in progressing investigations in a timely manner.

5.10 In our CRA sample, there were six (20%) children aged between 15 and 17. All of these children had had an AA present while being re-read their rights and during interview.

5.11 A professional telephone interpreting service was available to assist in the booking-in process. However, this was through the use of loudspeaker telephones, which lacked privacy and, when the suites were busy, resulted in staff and detainees having to raise their voices in an attempt to be heard. Staff told us that there was a good face-to-face interpreter service for interviews.

5.12 During booking-in, DDOs advised detainees of their three main rights (the right to have someone informed of their arrest, the right to consult a solicitor and access free independent legal advice, and the right to consult the PACE codes of practice), and all detainees were offered a written notice setting out these rights and their entitlements while in custody. DDOs were able to access these documents in foreign languages for non-English-speaking detainees but most custody staff were not aware that there was an easy-read pictorial version available on the Home Office website.

Recommendation

5.13 The custody sergeant should in all cases ask the arresting officer, in the presence of the detainee, to explain the reasons for the arrest before authorising detention.

Housekeeping points

5.14 Suitable telephone equipment should be provided in all suites to facilitate private telephone interpreting.

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

Rights relating to PACE

5.16 We saw detainees being told that they could read the PACE codes of practice during the booking-in process, but these were not routinely shown or explained by custody staff. There were sufficient copies of the up-to-date PACE code C available at all suites; however, it took staff at Staines some time to find these. The Criminal Defence Service posters informing detainees of their right to free legal advice in 24 languages were not displayed in either Staines or Guildford, but at Salford four posters were on display.

5.17 All detainees, including immigration detainees, were offered free legal representation, and those wishing to speak to legal advisers on the telephone were able to do so in private in a consultation room. There were sufficient consultation and interview rooms where detainees could speak privately, in person, with their legal advisers. We saw legal advisers being given a 'sanitised' version of their client's custody record without having to request this facility. In our CRA, all detainees had been offered legal advice and 15 (50%) had accepted this offer. Records showed that solicitors were contacted shortly after being requested. The legal advisers we spoke to reported good relationships with custody staff.

5.18 We saw detainees being told that they could inform someone of their arrest, and staff facilitating this.

5.19 PACE reviews of detainees were undertaken by dedicated custody and operational inspectors across the force area. The face-to-face reviews we observed were timely and thorough. In our CRA, of the 20 detainees who had required a PACE review, 13 had been conducted on time, four had been early and two had been late; one review had not taken place as the detainee had been in the process of being bailed when the review was due. In the case of the two late reviews, entries were recorded with an explanation noting that there would be delays – for example, because the inspector was engaged in operational commitments. We saw some, but not all, detainees being told that reviews had taken place while they were asleep, and being reminded of their rights and entitlements.

5.20 There was an effective system for collecting DNA samples taken in custody. At Staines and Guildford, samples were immediately placed in a freezer; however, at Salfords samples taken were kept at room temperature for several hours before being transported onwards for processing.

5.21 Custody staff at all suites told us that the local magistrates' courts would not normally accept detainees after 3pm on weekdays and just after 9am on Saturdays, which was too early. We saw Guildford Magistrates' Court refuse to accept two detainees at 3.15pm, despite the request being made by telephone at 12.50pm, immediately followed up by an email to the court. PERs were completed for all detainees travelling to court, and most that we examined were of a good standard; however, entries relating to warning markers from the PNC were not always dated, so it was not clear how current the identified risks were. A prisoner escort contractor was available for both morning and afternoon courts; however, most staff said that they would not normally contact them for an afternoon court, choosing to take

detainees in police vehicles, to ensure that they did not remain in police custody longer than necessary.

Recommendation

5.22 Senior police managers should work with HM Courts and Tribunals Service to ensure that early closure times do not result in unnecessarily long stays in police custody.

Housekeeping points

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

5.24 The force should ensure that DNA samples taken at Salfords are handled and stored appropriately.

Rights relating to treatment

5.25 At Guildford and Staines, but not at Salfords, there were notices displayed advising detainees to ask to speak to the duty inspector if they had any complaints. No IPCC leaflets were available in any of the custody suites. Custody staff and inspectors told us that if a detainee wished to make a complaint about their time in custody, they would be spoken to while in custody by the custody inspector in an attempt to resolve the issue. For all other complaints, we were told that a record would be noted on the custody detention log and the detainee advised to make their complaint once they had left custody, either by attending at a police station front counter or reporting it online via the force or IPCC websites. The one exception, which all custody staff agreed on, was if the complaint was about an alleged assault on a detainee, in which case the detainee would be seen by an HCP, any injuries sustained would be photographed and the duty inspector would be advised.

Recommendation

5.26 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 Tascor provided the physical health services, commissioned by Surrey Police. HCPs were based at each of the three suites. Two registered practitioners (nurses or paramedics) were expected to cover the Salfords and Guilford suites, and a FME was based on site at Staines 24 hours a day. However, due to vacancies and other absence, staffing levels occasionally dropped below contract levels, which led to some long delays in detainees being seen, which could impact on health outcomes. In October 2014, the service had appointed new medical and operational leads, who were implementing an improvement plan for staffing as a priority.

6.2 Medical and other health professionals' credentials were monitored and Tascor provided induction and ongoing mandatory training; this had recently been enhanced, although supervision and professional development arrangements were not well developed. The police monitored health care performance through monthly contract monitoring meetings. Clinical governance arrangements had been revamped by the new leadership team but were underdeveloped. Opportunities for frontline clinicians and custody staff to meet were limited but we saw good working relationships between these groups.

6.3 Tascor had an appropriate range of policies and procedures, which frontline staff were aware of and used. However, the health care complaints procedure was not well advertised and detainees were not aware of it.

6.4 Each site had a medical room, and the Salfords medical suite was very modern. Cleaning schedules were established and all rooms were clean, including those at Woking, which only operated as a part-time facility. Clinical environments were generally of an appropriate standard but no room had a clinical work surface suitable for forensic sampling.

6.5 All custody staff had undertaken resuscitation training, including the use of automated external defibrillators, and staff we spoke to expressed confidence in their skills. Arrangements to check essential emergency equipment were appropriate and the kit could be moved easily in the event of an emergency. Other medical apparatus was held separately in the booking-in area; at Salfords, this was not checked routinely and we found some out-of-date items. Additional equipment was kept in treatment rooms for use only by HCPs; HCPs we spoke to provided different interpretations of the purpose of this kit and how it was managed.

Recommendations

6.6 Workforce plans should be appropriate to fulfil contract requirements, including robust arrangements to cover short-term absences with appropriately skilled staff.

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

Patient care

6.8 Our CRA showed that the average waiting time to see an HCP was 12 minutes over the contract standard (100 minutes), although 97% of detainees in our sample had been seen within this timeframe, with the shortest wait being eight minutes and the longest over five hours. In our CRA sample, all detainees had been offered the opportunity to see an HCP, and referrals by the police had been based on an appropriate initial risk assessment; in total, 60% of detainees had been seen. Children were routinely referred to an HCP, but HCPs were often unclear about the purpose of this contact (see section on treatment and conditions).

6.9 Overall, we found that the health services provided were good, and were valued by the detainees we spoke to. The clinical assessment and treatment measures we observed were appropriate. Detainees were treated with respect and the interactions we saw were professional.

6.10 Clinical records were handwritten and generally of an appropriate standard, although some of the records we scrutinised were illegible. HCPs appropriately shared information with police directly in the custody record. The management of clinical records was problematic. At Guilford, we saw a large bundle of patient records which, although securely held, had been waiting for a long time to be archived, and at Woking we found detainee clinical records, dating from when the suite had last been in operation, left in an unsecured cabinet in the treatment room.

6.11 Medicines management was generally appropriate. Daily checks were effective but we found that weekly medication stock checks were not always completed within the required timescale and noted that a number of small errors had not been reconciled.

6.12 A range of patient group directions were in use, enabling HCPs to administer any necessary medicines.

6.13 Detainees could continue to receive valid prescribed medication in custody. Symptomatic relief was provided for those withdrawing from drugs or alcohol when clinically indicated. However, the opportunities for detainees to continue to receive prescribed methadone in custody were limited as this could only be authorised by the FME, which could lead to delays in accessing treatment.

Recommendations

6.14 The expectation of health care professionals (HCPs) to see all young people in custody should be clarified and any amended instructions communicated to HCPs and custody staff.

6.15 Records should be fully legible, auditable and held in line with the Data Protection Act and Caldicott guidelines.

6.16 Medicine stock monitoring arrangements should be regularly verified and audited by the HCP team leader.

Substance misuse

6.17 Substance misuse services were provided by Crime Reduction Initiatives (CRI). The service was comprehensive, offering a single point of referral for detainees on arrest, delivering case-

managed substance misuse interventions in courts and custody suites across Surrey and in the community as part of the local integrated management team. Referrals were received via custody staff or through other health professionals. CRI staff were available at the custody suites five days a week and also approached detainees directly to offer confidential services. Young people were seen by the service if requested, and signposted or directly referred into age-appropriate services. CRI services facilitated needle exchange as appropriate. The team also provided alcohol treatment services in the community, including treatment orders imposed by the courts.

6.18 Governance arrangements for the service appeared robust and staff were well trained and supported. Services appropriately sought consent from detainees to share information; however, CRI staff did not have access to the police computer system to receive referrals, but instead had to rely on direct signposting by the duty sergeant or through a secure email address.

Recommendation

6.19 HCPs should be trained and supported to facilitate opiate substitution therapy.

Mental health

6.20 Surrey and Borders Partnership NHS Foundation Trust provided a criminal justice mental health liaison and diversion service at the suites. There was an effective force-wide focus on mental health issues and strategic partnerships between the police, the mental health provider and other stakeholders.

6.21 Mental health provision in custody was good, with two practitioners generally covering three sites, seven days a week. However, there was no out-of-hours service, although additional funding had been received to provide a continuous presence on all three sites every day, from 7am to 7pm. The team supported detainees with mental health needs, and could trigger MHA assessments and make recommendations about the need for admission to hospital.

6.22 There appeared to be gaps in the provision of crisis and psychiatric liaison services at the local acute hospitals. In addition, we were told about delays in accessing mental health assessments and in obtaining a bed when need was identified, which meant that detainees could spend more time in custody when they should have been moved to specialist care.

6.23 Data supplied by the force recorded that in 2014, 45 out of 573 individuals (less than 8%) subject to section 136 of the Act had been held in custody. While this was good progress more could be done to reduce the numbers.

Recommendation

6.24 The local Mental Health Trust should work with police to ensure that Mental Health Act assessments in custody are timely and that, where necessary, transfers to hospital are expedited.

Section 7. Summary of recommendations and housekeeping points

Main recommendations

7.1 The Police and Crime Commissioner and chief officer group should engage with their counterparts in the local authority, instigate an immediate review of the provision of local authority accommodation under section 38(6) PACE 1984 for children, and monitor performance data proactively to ensure that children are not unnecessarily detained in police cells. (2.38)

7.2 Surrey Police should examine use of force data from custody for trends in accordance with the Association of Chief Police Officers' policy and College of Policing guidance ensuring safe and appropriate outcomes for detainees. (2.39)

7.3 Surrey Police should ensure that the fingerprinting, photographing and the taking of DNA samples in cases involving vulnerable adults and children should take place in the presence of an appropriate adult. (2.40)

Recommendations

Strategy

7.4 Surrey Police should expedite the review of staffing levels in police custody to improve outcomes for detainees. (3.6)

7.5 The Police and Crime Commissioner and chief officer group should re-examine the current partnership protocols for section 136 of the Mental Health Act 1983, to ensure that police custody is used only in exceptional circumstances. They should engage with their counterparts in the health services to reduce further the number of persons detained under this legislation and held in police cells. (3.12)

Treatment and conditions

7.6 Booking-in desks should be of an appropriate height and the reception area should allow adequate privacy for the interviewing of new arrivals. (4.9, repeated recommendation 4.27)

7.7 All custody staff should be involved in the same shift handover and, wherever possible, this should be recorded. (4.18)

7.8 Pre-release risk assessments should be detailed 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 and any action required. (4.19)

7.9 Staff should be fully briefed about when use of force forms should be used. (4.25)

7.10 Mechanical restraints such as body cuffs should be used only in exceptional circumstances when there are no other means of keeping detainees and staff safe. Staff should be sufficiently trained to use such equipment and its use should be monitored. (4.26)

7.11 Closed-circuit television monitors should be switched off when detainees are being strip-searched. (4.27)

7.12 Detainees, particularly those held for more than 24 hours, should be offered outdoor exercise. (4.40, repeated recommendation 4.33)

7.13 Detainees remaining in custody for more than 24 hours should be allowed visits. (4.41, repeated recommendation 4.34)

Individual rights

7.14 The custody sergeant should in all cases ask the arresting officer, in the presence of the detainee, to explain the reasons for the arrest before authorising detention. (5.13)

7.15 Senior police managers should work with HM Courts and Tribunals Service to ensure that early closure times do not result in unnecessarily long stays in police custody. (5.22)

7.16 Detainees should be able to make a complaint while they are still in custody. (5.26)

Health care

7.17 Workforce plans should be appropriate to fulfil contract requirements, including robust arrangements to cover short-term absences with appropriately skilled staff. (6.6)

7.18 Detainees should be able to complain about health services through a well-advertised and confidential health care complaints system. (6.7)

7.19 The expectation of health care professionals (HCPs) to see all young people in custody should be clarified and any amended instructions communicated to HCPs and custody staff. (6.14)

7.20 Records should be fully legible, auditable and held in line with the Data Protection Act and Caldicott guidelines. (6.15)

7.21 Medicine stock monitoring arrangements should be regularly verified and audited by the HCP team leader. (6.16)

7.22 HCPs should be trained and supported to facilitate opiate substitution therapy. (6.19)

7.23 The local Mental Health Trust should work with police to ensure that Mental Health Act assessments in custody are timely and that, where necessary, transfers to hospital are expedited. (6.24)

Housekeeping points

Strategy

7.24 Surrey police should implement a quality assurance process for dip-sampling the quality of shift handovers. (3.19)

Treatment and conditions

7.25 Records of maintenance should be kept up to date. (4.32)

7.26 Subject to a risk assessment, razors should be made available to detainees who wish to shave before attending court. (4.42)

7.27 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. (4.43)

Individual rights

7.28 Suitable telephone equipment should be provided in all suites to facilitate private telephone interpreting. (5.14)

7.29 Staff should be made aware of the availability of the easy-read pictorial version of the rights and entitlements information. (5.15)

7.30 Posters detailing detainees' right to free legal advice, in a range of languages, should be prominently displayed in all custody suites. (5.23)

7.31 The force should ensure that DNA samples taken at Salfords are handled and stored appropriately. (5.24)

Good practice

Strategy

7.32 The accreditation process for custody sergeants and DDOs as part of the initial training programme was a noteworthy investment in the training and development of custody staff. (3.7)

7.33 The cross-panel arrangements for independent custody visitors was a good initiative for sharing experience and good practice. (3.13)

Treatment and conditions

7.34 Surrey police had produced a helpful guide to assist officers undertaking close-proximity observations, which could be adapted to most circumstances in which this level of observation was deemed necessary. (4.20)

Section 8. Appendices

Appendix I: Inspection team

Paul Davies	Team leader
Gary Boughen	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Heather Hurford	HMIC inspector
Patricia Nixon	HMIC inspector
Vijay Singh	HMIC inspector
Stephen Eley	HMIP health services lead inspector
Jan Fookes-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.

Recommendations

Surrey Police should review its current staffing model for custody. (3.13)
Not achieved

The use of force should be monitored locally and at a force-wide level. (3.14)
Not achieved

Treatment and conditions

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

Main recommendations

Risk assessments should take into account all the relevant information available to staff, including safety markers from the local intelligence system and PNC. (2.24)
Achieved

All cells should be fit for purpose and free of ligature points and custody staff should be trained to identify potential ligature points. (2.25)
Not achieved

Recommendations

Booking-in desks should be an appropriate height and the reception area should allow adequate privacy for the interviewing of new arrivals. (4.27)
Not achieved (recommendation repeated, 4.9)

Subject to individual needs assessment, nicotine replacement aids should be available to detainees. (4.28)
Not achieved

The daily, weekly and monthly health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate and the results reviewed by managers. Staff should be provided with appropriate training to allow them to carry out these checks. (4.29)
Achieved

All graffiti should be regularly removed. (4.30)
Achieved

Blankets and toilet paper should be provided routinely. (4.31)
Achieved

Women detainees should routinely be offered hygiene packs. (4.32)
Achieved

Where exercise yards are available, detainees held overnight or for long periods of time should be offered outdoor exercise. (4.33)
Partially achieved (recommendation repeated, 4.40)

Detainees remaining in custody for more than 24 hours should be allowed visits. (4.34)
Not achieved (recommendation repeated, 4.41)

Individual rights

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

Main recommendation

How the force takes, stores, tracks and deals with DNA should be urgently reviewed and the review should be owned by a senior responsible officer. (2.26)
Partially achieved

Recommendations

Custody staff should ensure that detainee dependency obligations are routinely identified and, where possible, addressed. (5.12)
Achieved

Detainees requiring immigration advice should be referred to the Legal Services Commission's immigration advice line. (5.13)
Achieved

Detainees aged 17 years should be provided with an appropriate adult. (5.14)
Achieved

Staff should be made aware of the correct process for handling complaints and these should be taken while the detainee is still in custody. (5.15)
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

Surrey police should have clear contractual arrangements, including relevant management information, with all health providers and there should be strategic oversight and robust management and performance monitoring of all health provider contracts. (2.27)
Achieved

Recommendations

Female detainees should be able to see a female health professional on request. (6.22)
Partially achieved

FMEs should be contracted solely to FME duties when working for Surrey police force and their hours of work should be such as not to compromise their clinical judgment. (6.23)
Achieved

There should be cover for absence and out of hours for both the forensic mental health team and substance use workers to meet the needs of detainees. (6.24)
Achieved

All detainees should be asked on arrival if they want to see a health professional. (6.25)
Achieved

Substance use services should be provided for juvenile detainees and those with alcohol issues. (6.26)
Partially achieved

Out-of-hours drug service provision should be clarified. (6.27)
Not achieved

Drugs workers should offer clean needles and relevant equipment to injecting drug users who are being released into the community. (6.28)
Achieved

Arrangements for the admission of detainees to S136 mental health suites should be reviewed so that all staff are aware of the policy and work to meet the needs of detainees expeditiously. (6.29)
Achieved