Report on an unannounced inspection visit to police custody suites in

Wiltshire

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

7–11 December 2015

This inspection was carried out in partnership with the Care Quality Commission.

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.

There was a clear management structure up to assistant chief constable, who had strategic lead on custody matters. There were good staffing levels to support custody operations, including an innovative use of bank staff, used to provide cover at short notice. It was notable that they had made significant progress on reducing the numbers of mentally ill people detained in police custody as a place of safety. However, there had been relatively poor progress on the issue of finding accommodation for children in custody who had been charged but refused bail. Similarly, the issue of detainees being held in police custody for a prolonged period, owing to a lack of court availability, had not been progressed at a senior level. The force demonstrated good levels of consultation and engagement with staff on identifying training priorities.

The treatment and conditions of detainees was generally considerate. Staff had good awareness of vulnerabilities and diversity. Children were treated as a vulnerable group and we saw staff responding appropriately to children in their care. We were impressed that the force had provided some suitable space for children, and appropriate adults, to wait while custody processes were ongoing.

Risk assessments, handovers and pre-release risk assessments were all suitably focused, with appropriate questioning. Care plans recorded the rationale for assessing, reducing or increasing risks and observation intervals.

Our findings on the use of force within the custody suite were disappointing: force was not recorded, was sometimes disproportionate to the threat encountered, and in some cases involved the use of leg restraints for people who were self-harming, which was inappropriate. We saw more use of Tasers than we expect to see, especially in a controlled custody environment, and there was no force policy on their use in custody suites. Moreover, Tasers were used not by custody staff but by response officers who were in the custody suite at the time. Our expectation is that Taser should only be used in exceptional circumstances and that use is proportionate to the threat posed. We were not confident that there was sufficient oversight of use of force.

Despite efforts to keep detention to a minimum, external factors, such as Crown Prosecution Service decisions, the attendance of appropriate adults (especially during the night) and delays in courts, increased the amount of time spent in custody. Detainees had access to private legal consultations and solicitors reported good relationships with custody staff. PACE reviews were thorough and timely, giving the detainee the opportunity to discuss any concerns.

At the time of the inspection, the health care contract was inadequate but a new, more robust contract was due to start in January 2016. There were not enough health services staff, which sometimes led to long and unacceptable delays. However, most detainees we spoke to were satisfied with the level of health care received. Substance misuse services had deteriorated; there was no daily or regular access to substance misuse workers.

Mental health services had improved and staff were positive about the mental health and liaison and diversion service, which assisted detainees in getting referrals and support from other specialist agencies. By contrast, the time taken to complete a mental health assessment for those in custody was poor, with extensive waits. Data supplied by the force showed a decrease in the use of police custody as a place of safety for people at risk of harming themselves or others. There had been good efforts to divert vulnerable people but the data collated also showed that police custody continued

to be used, on average, three times a month, which was still unacceptably high. The force had started a street project, with an embedded mental health practitioner in the communications centre, providing advice to officers on the street. The initial experience suggested a useful service enhancement to reduce the use of police cells as a place of safety.

Overall, the force had made notable progress in most areas of inspection. Individual interactions between staff and detainees were good, with considerable attention paid to vulnerable groups. Senior management needed to ensure support from statutory partners, local authorities and courts, in particular, in providing good outcomes for detainees. Recording and monitoring use of force was poor and required immediate attention; substance and alcohol misuse support was inadequate; and while there was an encouraging and improving picture in mental health, this needed to be sustained.

We noted that, of the 37 recommendations made in our previous report after our inspection of September 2009, 21 recommendations had been achieved, nine had been partially achieved, six had not been achieved and one was no longer relevant.

This report provides recommendations to the force and the Police and Crime Commissioner to improve provision further. 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

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

April 2016

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's *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 A documentary analysis of custody records is conducted as part of all police custody inspections. The analysis provides case examples illustrating the level of care that detainees receive, the quality of risk assessments and care arrangements, and access to services such as health care and legal advice.

2.4 Records are randomly selected from approximately four weeks before the inspection and the sample contains a minimum of five young people (aged 17 years and under). The number of records sampled from each custody suite is proportional to throughput at those suites – that is, more records are sampled at suites with a higher throughput and fewer from suites with a lower throughput. When this information is unavailable, proportional sampling is based on the number of cells in each suite. Due to the small sample size, samples are not representative of the wider detention throughput. As part of this inspection, a total of 30 records were sampled.

2.5 This was the second inspection of Wiltshire police, following up on our inspection of September 2009. The designated custody suites and cell capacity of each were as follows:

Custody suites	Number of cells
Swindon	40
Melksham	20

1 http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/

Strategy

2.6 There was a clear management structure up to the assistant chief constable (ACC), who had strategic lead on custody matters. The force custody manager was an inspector, who allocated most of his time to custody duties..

2.7 There was good capacity at sergeant rank, with high levels of support for the frontline custody sergeants. There were good staffing levels to support custody operations, including an innovative approach using a bank of staff, to provide cover at short notice.

2.8 The force had restructured without the rank of chief inspector or chief superintendent. There was an adequate internal meeting structure but external meetings with key strategic providers had ceased and were not active at the time of the inspection.

2.9 There was confusion among staff about force policy in respect of recording use of force.

2.10 The ACC was a member of a number of partnerships across the county. Significant progress had been made in reducing the number of people brought into custody under section 136 of the Mental Health Act. However, the provision of accommodation for children who had been charged but refused police bail, and access to courts for detainees were not on the strategic partnership agenda.

2.11 The independent custody visitor (ICV) scheme was well supported by the force, representatives of which attended their quarterly meetings, and ICVs made regular visits to police custody units.

2.12 There was a comprehensive training programme for new custody staff and regular consultation with staff on the content of other training days, leading to positive staff engagement and attendance. Sergeants and detention officers (DOs) underwent training together.

2.13 The process of dip-sampling was positive and we saw evidence of feedback and improvements in standards over time. However, only 25 custody records were sampled per month, which was too few, and restricted opportunities for meaningful organisational learning. There was some cross-referencing against closed-circuit television (CCTV) footage.

2.14 There were opportunities to learn lessons in custody, with regular circulation of Independent Police Complaints Commission (IPCC) documents and other emails from managers, including a summary of dip-samples.

Treatment and conditions

2.15 Custody staff engaged appropriately and courteously with detainees. There was good awareness of vulnerabilities and diversity, and the individual needs of detainees were generally met. Children were treated as a vulnerable group and attention was given to ensuring that they were offered appropriate support and care. We saw good care of a particularly vulnerable child.

2.16 Custody suites lacked sufficient privacy for booking-in procedures but custody sergeants managed the process as well as possible to ensure that more sensitive cases were dealt with appropriately. Religious materials were provided for those who requested them.

2.17 Facilities for those with disabilities were adequate and staff made reasonable adjustments wherever possible.

2.18 Staff understood the specific vulnerabilities of transgender detainees, including how to conduct a search with staff of the appropriate gender.

2.19 The computer-based risk assessment was comprehensive, properly focused and enhanced by supplementary questions. Care plans generally identified all risks and the set levels of observations were appropriate. Risk assessments were generally dynamic and care plans recorded the rationale for reducing or increasing the frequency of observations, which were adhered to, including rousing intoxicated detainees.

2.20 Handovers were generally well conducted and properly focused on risk and case progression but they were not attended by all staff, as sergeants and DOs had separate handovers. Incoming custody sergeants generally visited detainees following the handover.

2.21 The pre-release risk assessments we observed were very good, and sighted appropriately on the initial risk assessment and on delivering a safe release for detainees, including ensuring that they had an appropriate means of getting home.

2.22 All of the custody staff we spoke to had undergone control and restraint training within the previous 12 months and acknowledged that force should only be used as a last resort. However, not all staff submitted use of force forms if they were involved in an incident in which force was deployed. We saw few detainees handcuffed on arrival to custody; for the few who were, they were generally removed quickly after arrival. Staff generally negotiated well with detainees to try to de-escalate situations.

2.23 We encountered officers removing their Tasers and pointing them at the detainee, sometimes where there was a red dot on the detainee in custody, more than we would expect to see in a controlled environment. Our expectation is that Taser should only be used in exceptional circumstances and that use is proportionate to the threat posed. We were concerned that their use had been disproportionate to the level of threat posed in some situations. Tasers were often deployed by response officers in the block, rather than custody staff. There was no policy or governance on their use. Proper recording of all types of use[2] is essential for assurance purposes.

2.24 From the records we examined and staff we spoke to, we found that leg restraints were used more than we would expect, and we were not assured that this was a proportionate action in all cases. In one case, we observed some potentially injurious practice and found that too many staff were sometimes involved unnecessarily in incidents. Strip-searching was authorised properly and used sparingly.

2.25 The cleanliness and general maintenance of the custody suites was very good. There was a clear process for cleaning and checking cells. We identified some potential ligature points in cells at both custody suites that staff had not been aware of.

2.26 Mattresses and pillows were provided in each cell and were cleaned between uses. The provision of blankets and clothing, including underwear, was adequate.

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[2] Taser is one of a number of tactical options available to police officers when dealing with incidences of potential harm to victims, the public, officers and the subject. The way Taser is used is categorised into seven escalating actions, from drawing the device (removing from the holster), aiming at an individual, arcing (sparking as a deterrent without aiming), red dot (aiming and partially activating so that a laser dot is placed on the individual but not firing), through to drive-stun, angled drive-stun and firing. More information is available from *College of Policing Authorised Professional Practice on armed policing – legal framework and Taser* at www.app.college.police.uk/app-content/armed-policing/conducted-energy-devices-taser

2.27 Showers were not sufficiently private but were offered frequently and there was good use of exercise yards. A range of books was available for detainees, including some in foreign languages and some suitable for children.

Individual rights

2.28 Operational officers had a good understanding of PACE code G and were able to provide thorough reasons for the necessity of arrest.

2.29 Voluntary attendance was well used and individuals were mainly diverted from custody suites, except on a few occasions when the interview was conducted in the custody suite interview facilities.

2.30 Custody staff were aware of the need to keep detention to a minimum. However, during the inspection, external factors, such as long waits for Crown Prosecution Service decisions, the attendance of appropriate adults (AAs) and delays experienced in video-enabled courts, increased the time spent in custody.

2.31 The force provided data to show that 226 immigration detainees had been brought into custody in the year to November 2015 and that they were generally not held for long periods.

2.32 Custody staff routinely requested alternative accommodation for children, particularly those charged and not bailed. At the time of the inspection, one child was placed with a family friend, following successful liaison between the force and the local authority. However, force data for the period July to November 2015, showed that despite force requests, there was a lack of local authority accommodation provision for children charged and not bailed (see also paragraph 5.8).

2.33 Family members or friends were contacted in the first instance to act as AAs for children and vulnerable adults. If they were not available, AAs were provided for children by the youth offending team, which offered a good service. During the night, custody staff relied on the emergency duty team (EDT) but this provision was less reliable. In these instances, staff told us that they would bail the detainee, if possible. AAs were able to remain with vulnerable detainees, particularly children, in interview rooms and designated areas.

2.34 Detainees were able to have private telephone consultations with solicitors in all the custody suites. There were sufficient consultation and interview rooms to meet demand, and solicitors we spoke to reported good relationships with custody staff.

2.35 The PACE reviews we observed were conducted face-to-face and were thorough. Inspectors checked on the treatment of the detainees, giving them the opportunity to discuss their concerns.

2.36 Staff told us that there was some flexibility on a daily basis to get detainees to the remand court up to 3pm at Swindon and 2pm at Chippenham. There were examples of detainees remaining in custody longer than necessary because courts were not able to deal with cases on the appointed day via the virtual court at Melksham.

2.37 Information about the IPCC and the complaints process was included in the rights and entitlements documentation offered to detainees. All custody sergeants told us that if a detainee wished to make a complaint, they would inform the duty inspector.

Health care

2.38 The contract failed to hold the provider accountable for the service but a new, more robust one was due to start on 11 January 2016.

2.39 In the previous four months, access to health care professionals (HCPs) had sometimes been compromised by a lack of staff on shifts. HCPs were appropriately trained but there was inadequate clinical supervision, although there were plans to address this.

2.40 Clinical consultations took place with the clinical room door closed, with good attention to the patient's privacy and dignity. Health care rooms were not compliant with relevant infection control standards, and surfaces were not suitable for forensic sampling.

2.41 Detainees we spoke to expressed satisfaction with their clinical care. Custody staff tried to retrieve medications from detainees' homes, where appropriate, and these were checked by health services staff before administration. In our custody record analysis (CRA), the average response time by a HCP was two hours 24 minutes, which was unacceptably higher than the target of 60 minutes.

2.42 Detainees at both custody suites did not have daily or regular access to substance misuse workers; the service was inadequate and had deteriorated since the previous inspection.

2.43 Mental health services were good. Mental health practitioners had access to detainees' electronic records and checked if detainees were known to mental health services before they undertook assessments. Staff spoke positively about the mental health liaison and diversion service and the court assessment referral service, which offered improved access to specialist advice and services.

2.44 There was general dissatisfaction with the responsiveness of mental health services to requests for Mental Health Act assessments, which sometimes led to extensive waits.

2.45 The use of police custody as a place of safety for those detained under section 136 was actively discouraged and monitored. Police custody had been used for this purpose three times a month, on average, in the year to November 2015, which was still too high.

2.46 In September 2015, the police and Avon and Wiltshire Partnership Trust (AWP) had started a street project, with an embedded mental health practitioner (MHP) in the communications room and the potential to work alongside officers in the street. The initial experience suggested a useful service enhancement to reduce the use of police cells as a place of safety.

Areas of concern and recommendations

Area of concern

2.47 The force was not sufficiently effective within its strategic partnerships to ensure good outcomes for detainees. Particular areas of concern included: the lack of local authority accommodation provision for children who had been charged and refused bail, resulting in children being detained in police custody unnecessarily; and poor engagement with the court service, whereby early cut-off times often led to detainees spending too long in police custody.

Recommendation

Wiltshire police should work with local authorities to improve the accommodation provision for children who are charged and refused bail, and with HM Courts and Tribunals Service to ensure that early court closure times do not result in unnecessarily long stays for detainees in police custody.

Area of concern

2.48 All aspects of use of force were lacking oversight and governance. Use of force was not discussed at a senior level. We found some use of Tasers and leg restraints on particularly vulnerable detainees and were not assured that their use was proportionate to the threat posed. Use of force forms were not submitted by each member of staff involved in the deployment of force, to account for their involvement in each incident.

Recommendation

Where force is necessary, all staff should ensure all use of force is proportionate and lawful. It should account for all uses of force to ensure accountability, safe techniques, commensurate with the threat posed. All uses of force should be recorded, subject to monitoring, oversight and learning to improve the safety and welfare of detainees. Tasers should only be used in exceptional circumstances, with a custody policy on Taser use in the custody block.

Area of concern

2.49 A large proportion of detainees who entered custody had substance misuse issues. The service for detainees with substance misuse had deteriorated considerably since the previous inspection. Drug and alcohol workers visited custody suites infrequently and there were often long delays in following up detainees who wished to be referred to services.

Recommendation

Wiltshire Police and partner agencies should urgently assess the need for substance misuse services in police custody and commission appropriately responsive services.

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 ACC provided the strategic lead on custody issues. A superintendent had responsibility for custody and three other departments. The force custody manager was an inspector, who devoted most of his time to custody duties.

3.2 Custody staffing levels were high, with a total of 20 sergeants working within the department. One sergeant deputised and supported the custody manager. There were five teams at both Swindon and Melksham, with a dedicated custody sergeant for each team. The other sergeants ensured that 24-hour cover was provided. Each sergeant had a thematic responsibility for leading an area of business within the department, including dip-sampling, training and mental health policy development.

3.3 DOs were allocated to shifts and there was good resilience provided by a bank system of staff who could be called upon at short notice to provide cover.

3.4 In 2014/15, the throughput of detainees had totalled 14,616. The two custody suites had sufficient cell capacity and support facilities, such as consultation rooms, to manage the number of detainees held.

3.5 The custody manager met his team regularly and also had a fortnightly meeting with the superintendent. The force had restructured, reducing the number of ranks, and operated without chief superintendents or chief inspectors. As a result, although there was no formal meeting structure, the superintendent had direct access to the ACC. Meetings with key stakeholders – such as the health care provider, courts and mental health services – had ceased and were not active at the time of the inspection.

3.6 The force collected a good level of management data to inform its decision making and performance management process. They did not, however, discuss the use of force in custody at a senior manager level and there was some confusion among staff over the recording of the use of force. Officers did not know if they were each to complete a form or if one form would be required regardless of the numbers of officers involved (see section on use of force, and area of concern 2.48).

Partnerships

3.7 The ACC was a member of a number of key partnerships across Wiltshire. Significant progress had been made in reducing the number of people brought into custody under section 136 of the Mental Health Act, although the figures remained too high (see paragraph 6.21).

3.8 Wiltshire and Swindon local authority areas had signed up to a protocol shortly before the inspection, acknowledging their responsibility for looking after children who had been charged but refused bail by the police. However, strategically, not enough was being done to ensure compliance.

3.9 There was no partnership engagement with HM Courts and Tribunals Service to ensure that detainees were bought to courts as soon as possible. This resulted in some detainees remaining at police stations for longer that necessary (see paragraph 5.18).

3.10 The ICV scheme was well supported by the force. Quarterly meetings were held between the force, the Independent Custody Visiting Association coordinator from the Police and Crime Commissioners Office, and the independent visitors. Each of the custody suites received regular visits, and visitors felt confident in their ability to challenge the force if they found shortcomings.

Learning and development

3.11 There was a comprehensive initial and ongoing training programme for all custody staff. The initial training lasted three weeks and included a module on policy, procedure and practice, including the management of strip-searches, drugs awareness, vulnerability and risk assessment; one week on computer systems and a further week on personal safety training. Sergeants completed a further 200 hours of shadowing in a custody block before they took up a primary position in custody, which ensured that they were properly prepared for the role.

3.12 The shift pattern allowed for each member of staff to attend five training days per year, two of which comprised mandatory training on officer safety and first aid. One of the sergeants within custody took the lead for training and there was regular consultation with staff over the content of the training days. This led to positive engagement within the training programme and high levels of attendance. Sergeants and DOs attended training together in their working teams.

3.13 One of the sergeants was responsible for conducting dip-samples. Only 25 custody records were dip-sampled per month, which was too few to draw representative and meaningful conclusions, and restricted opportunities for organisational learning. It was, however, positive to see that some of the dip-sampled records were cross-referenced against the CCTV footage. Dip-sampling focused, among other things, on the correct completion of processes such as risk assessment and the timeliness of contacting AAs. When shortfalls were identified, these were recorded as 'errors', and the number identified over the previous year had reduced considerably. There was appropriate feedback to custody staff as a result of the dip-sampling and we saw evidence of improvements in standards over time. When there were common themes to be learned from a monthly dip sample, these were emailed to all staff in custody.

3.14 IPCC bulletins were circulated and there were regular updates from managers, both in meetings and through email communication, including a summary of dip-samples. The force policy and procedure for custody matters was held on the force intranet and was easily accessible.

Area for improvement

3.15 **Dip-sampling of custody records should be increased to around 10% of the throughput of custody, to allow for a representative and meaningful sample and to facilitate organisational learning.**

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 We saw appropriate and courteous engagement between custody staff and detainees. Booking-in desks were too high and offered insufficient privacy but custody sergeants tried to mitigate this by booking in detainees individually if there were sensitive aspects to their case.

4.2 Overall, we were impressed by the attention and thought given to identifying and addressing the individual needs of detainees. The booking-in process was comprehensive. Staff always asked detainees if they had dependants and we saw examples where they either prioritised such cases or assisted the detainee to make appropriate arrangements to ensure that they could resume their caring responsibilities. Women were routinely asked if they wanted to speak to a female member of staff and whether they required sanitary products.

4.3 Custody staff dealt with children very well, and used age-appropriate language with them. Children were treated as a vulnerable group in their own right, and the risk assessment and booking-in process had questions tailored to their specific needs. Staff told us that they would try to deal with them promptly. In our CRA, children accounted for five of the 30 sampled records. Their average length of stay had been just over 14 hours but this was skewed by one child who had remained in custody for 33 hours over a weekend before he was taken to court. Three of the children had stayed in police custody overnight (see also paragraph 5.3). Where possible, children were not located in cells, and AAs were able to sit with children outside of cells. The waiting room at Melksham was particularly good as it was furnished with comfortable chairs. We reviewed the record of a 13-year-old boy who had been treated exceptionally well by custody staff, who had recognised that he was vulnerable. An AA could not be found and custody staff had placed the boy in a waiting room with the arresting officer, deeming it unsuitable for him to be placed in a cell because of his age. The police had liaised with social services until a family friend was identified who was willing to look after him until the next day, when an AA could be secured to progress the case; this had resulted in the boy not having to remain in custody any longer than necessary (see also section on rights relating to detention).

4.4 Detainees were routinely asked if they had any religious needs. Religious materials for the main faiths were stored sensitively and were readily accessible.

4.5 There were accessible toilets and hearing loops for detainees with disabilities at both custody suites. There were also thicker mattresses to raise the height of the low plinths, and access to detainee rights and entitlements in Braille. Wheelchairs were readily available at Swindon and Melksham. We were assured from our conversations with staff that they would try to meet the individual needs of detainees with disabilities, including allowing them to keep their wheelchair and any mobility aids, where necessary.

4.6 Custody staff understood the importance of respecting the requests of transgender detainees, particularly about the gender of the person who searched them.

Safety

4.7 Custody staff used the electronic risk assessment on the computer system. Risk assessments were comprehensive, properly focused and enhanced by supplementary questions. Custody staff were responsive in asking detainees to clarify their circumstances. We saw custody staff dealing patiently and sensitively with some detainees who were intoxicated and/or vulnerable. Custody sergeants were responsible for setting levels of observations and for developing the care plan. Our CRA and observations during the inspection assured us that risk assessments were of a good standard and generally recorded relevant information in sufficient depth.

4.8 Risk assessments were dynamic. Initial levels of observation were appropriate to the risks identified, and there was a good rationale in custody records for any reduction or increase in these levels. Observations were recorded at the required frequency. Staff were fully aware of how to rouse detainees when the level of observation required it, and did this well, engaging in varying degrees of contact and communication.

4.9 Anti-rip clothing was used sparingly, when detainees were believed to be at risk of suicide or had actively self-harmed. However, the routine removal of corded clothing and footwear with laces was disproportionate in the absence of an individualised risk assessment, particularly when detainees had been assessed as low risk.

4.10 Custody staff exerted appropriate control over cell keys and all carried anti-ligature knives. However, non-custody staff undertaking constant observations and review inspectors did not carry anti-ligature knives, which compromised detainee safety.

4.11 The handovers we observed were generally well conducted and focused on risk, detainee welfare and case progression. However, they did not include all staff and we saw sergeants and DOs handing over separately to their incoming counterparts, rather than as one team. It was good that incoming custody sergeants generally visited all detainees following the handover, to engage with and check them.

4.12 Pre-release risk assessments were conducted on all detainees being released from custody. The quality of those we observed was good; they involved the detainee, revisited the initial risk assessment and were properly focused on achieving a safe release, including ensuring that the detainee had an appropriate means of getting home. Our CRA further supported our view and reflected some good individualised pre-release care for some detainees. DOs had access to a car and sometimes drove detainees home, and sergeants could access rail warrants and petty cash, if required, to assist detainees in getting home. All detainees who left custody were provided with two support leaflets and were directed to specific agencies if issues had been highlighted on the initial risk assessment.

Areas for improvement

4.13 All staff who unlock detainees or who undertake constant supervision should have ready access to an anti-ligature knife.

4.14 All custody staff should be involved in the same shift handover.

Use of force

4.15 Use of force was not discussed at a senior manager level (see also paragraph 3.6) and there was a lack of strategic oversight and accountability, and no policy on its use. There was a database detailing use of force incidents. However, only one person was usually responsible for submitting the use of force form on behalf of all staff involved in the deployment of force and therefore not everyone was accountable for the part they played in the incident. All staff we spoke to said that they had undertaken officer safety/personal protection training within the previous 12 months and told us that they would only use force as a last resort. We saw staff negotiating well with detainees in challenging situations to try to de-escalate them.

4.16 From our conversations with staff and records we looked at, we were concerned about the use of equipment that should only be used in extreme circumstances. We were told that Tasers had been drawn on six occasions and detainees 'red dotted' (that is, aiming the Taser or placing the laser sight red dot onto a subject) twice in the previous two years. This was unusual in custody, particularly considering the controlled environment and that there were generally sufficient staff to de-escalate situations using other techniques. From the custody records, use of force forms and CCTV footage, we were not assured that the use of Tasers (see paragraph 2.23 and footnote 2) had always been proportionate to the threat posed. At least two of the situations had been spontaneous and involved detainees who were actively self-harming. The use of force form submitted for the only incident for which we were able to see CCTV footage did not reflect what we actually observed. We noted it was response officers who used Tasers in the custody blocks. Custody officers did not carry Tasers.

4.17 From the records we examined and staff we spoke to, we found that leg restraints were used, and we were not assured that they were always used before all other techniques had been exhausted. In the CCTV footage of one incident, leg restraints were called for before it was evident that the vulnerable female detainee was going to be non-compliant. Other concerns included: the high number of staff who were involved in some incidents, which at times appeared unnecessary and was not always helpful to the safe resolution of situations; a lack of control over some incidents, particularly when non-custody staff were involved; and some poor execution of techniques, including one case where a detainee had been carried and the technique used could have injured him (see area of concern 2.48).

4.18 We saw few detainees handcuffed on arrival to custody; for the few who were, they were generally removed quickly after arrival.

4.19 In the 12 months to the end of November 2015, there had been 361 strip-searches, which appeared high. However, from records we were able to review, we were assured that there had been a reasonable rationale for these, and that they had been properly authorised.

Physical conditions

4.20 The environment and overall physical conditions in both custody suites were good. Communal and cell areas were clean, with little evidence of graffiti, and general maintenance was mostly reasonable. Sergeants conducted daily cell checks and reported any faults or defects, which were generally responded to quickly, particularly at Swindon, which operated a private finance initiative contract. Cells were cleaned each day and checked between uses.

4.21 There were daily, weekly and monthly checks at each suite. Although they were focused on checking for ligature points, we identified potential ligature points in each custody suite.

4.22 CCTV operated in all custody suites, and signs advised detainees of this. All cells were monitored by CCTV, with toilet areas pixellated to ensure privacy, and this was explained to detainees during the booking-in process.

4.23 Custody staff escorted detainees to cells after the booking-in process, explained the use of the cell call bell and tested it to ensure that it was working. Responses to cell call bells were prompt.

4.24 Each suite had a fire evacuation policy and fire evacuation plans were displayed. Records of fire drills were maintained.

Area for improvement

4.25 **The force should take action to identify potential ligature points and mitigate any risks posed to detainees.**

Detainee care

4.26 Detainee care was very good overall. In our analysis of 30 custody records, six had been offered a period of exercise, four had been offered washing facilities and six had been provided with or offered reading materials. Mattresses and pillows were provided in each cell and were cleaned between uses, and clean blankets were offered routinely. There were sufficient stocks of replacement clothing, including underwear. Toilet paper was not always placed into cells routinely. Women detainees were routinely offered sanitary items.

4.27 Showers were available at all suites but were not private enough. They were offered frequently to detainees, particularly those who had remained in custody overnight or were required to attend court.

4.28 Food preparation and storage areas were clean. Hot, fresh meals were provided from the canteen at Swindon for breakfast and lunch, and a range of microwaveable meals, drinks and toast was offered at regular mealtimes and sometimes provided at other times on request, depending on the individual circumstances of the detainee.

4.29 Custody suites had a range of reading materials for detainees, including for children and in foreign languages, but there was nothing in easy-read format. These were promoted well and offered routinely. Both suites had designated visits facilities and allowed visits on a case-by-case basis.

4.30 All suites had outside exercise areas and we saw evidence that they were well used.

Section 5. Individual rights

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

Rights relating to detention

5.1 Custody sergeants and DOs under supervision booked detainees in but custody sergeants took full responsibility for asking arresting officers to provide an explanation of the circumstances of, and the reasons for, the arrest before authorising detention. Operational officers had a good understanding of PACE code G[3] and were able to provide thorough reasons for the necessity of arrest. Sergeants were only able cite examples of when they had refused to authorise detention when the circumstances had not merited it.

5.2 Alternatives to custody were available in the form of voluntary attendance[4] and fixed penalty notices. Voluntary attendance was well used and individuals were mainly diverted from custody suites, except on a few occasions when the interview was conducted in the custody suite interview facilities; however, appropriately, on those occasions attendees were not subjected to any of the custody booking-in processes.

5.3 All custody staff were aware of the need to keep detention to a minimum. However, during the inspection there were external factors which resulted in detainees remaining in custody for long periods. For example, we saw two 17-year-olds waiting over four hours for a charging decision to be made by the Crown Prosecution Service. Furthermore, the AA service for children and vulnerable adults was less reliable at night, and the video-enabled court which operated at Melksham could result in detainees waiting in custody all day for their court hearing (see paragraph 5.18). Custody sergeants kept themselves informed of how the investigation was being progressed, in an effort to minimise detainees' time in custody. Data supplied by the force showed that in the 12 months to November 2015, the average length of detention was just under eight hours at Swindon and just over seven hours at Melksham.

5.4 Custody staff reported a good relationship with Home Office immigration enforcement officers. Data supplied by the force showed that 226 immigration detainees had been held at the two suites in the year to November 2015. The average length of detention for immigration detainees in the same period had been just under 12 hours at Swindon and just over nine hours at Melksham, which was reasonable.

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

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

[4] Voluntary attendance is usually used for lesser offences, and involves suspects attending 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.

[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.

5.6 Custody staff told us that they had never known local authorities to provide suitable accommodation when a child had been charged and could not be bailed. Force data showed that 10 children had been charged and had bail refused between July and November 2015. For all of these, requests had been made to the local authority to provide suitable accommodation but no accommodation had been found. In one such case we reviewed, involving a 15-year-old boy, the emergency duty team (EDT) had explored the possibility of transferring him to foster care or secure accommodation but neither had been available. This had resulted in the child remaining in custody over the weekend. This had been mitigated to some extent by the social worker making welfare visits to the child while he remained in custody, and providing him with food, reading material and time out of his cell.

5.7 Custody staff were aware of their responsibilities to contact an AA when dealing with vulnerable adults and children under the age of 18. Family or friends were contacted in the first instance, and all custody staff we spoke to were aware of the guidance documents to assist AAs when they supported detainees. These documents were readily available in all the custody suites and we saw them issued to several AAs during the inspection.

5.8 In the absence of family members, AAs were available through the local authorities. AAs for children were provided by the youth offending team. Custody staff said, and records we reviewed confirmed, that they received a good service from this team, which operated until 10pm on weekdays. Similarly, the contracted AA service, provided by the County Community Project, primarily for vulnerable adults, was a good service, operating from 9am to 10pm, seven days a week. Outside these times, the service for both groups was provided by the EDT, which was not always able to provide an AA to the custody suite. Custody staff told us that, where possible, they would bail a detainee waiting for an AA if one was not readily available. However, this was not always possible and led to detainees being held in custody for longer than necessary. We saw custody staff making it possible for AAs to stay with vulnerable detainees, particularly children, in interview rooms and designated waiting areas (see also paragraph 4.3).

5.9 In our CRA, there were five children in the sample, aged between 12 and 17. All had had an AA present while being informed of their rights and entitlements during interview. Although it was not always recorded when the AA had been contacted, there was only one long wait – of just under 12 hours– for an AA to attend. In this case, the child entered custody late at night and the family member who was acting as AA said that they would attend in the morning. The CRA showed that detention processes such as fingerprinting had been delayed until the arrival of the AA.

5.10 A professional telephone interpreting service was available to assist the booking-in process but this was used via a loudspeaker telephone, which lacked privacy. Staff told us that a face-to-face interpreter service was also available for interviews.

Areas for improvement

5.11 The force should ensure effective provision of appropriate adults for vulnerable adults and children at all times.

5.12 There should be suitable telephone equipment in all suites that should be used to facilitate private telephone interpreting.

Rights relating to PACE

5.13 During booking-in, custody sergeants advised detainees of their three main rights[6] and all detainees were offered a written notice setting out their rights and entitlements while in custody. Custody staff could source these notices in foreign languages for non-English-speaking detainees, and both suites had printed copies of the easy-read pictorial format version, but did not routinely offer these to children. There were sufficient copies of the up-to-date PACE code C at all suites. All detainees were offered free legal representation, and posters informing detainees of this right were available at both suites.

5.14 Detainees who wished to speak to legal advisers could do so privately, in person or by telephone; those who declined these services were routinely reminded that they could change their mind. There were sufficient consultation and interview rooms to meet demand. We saw legal advisers being given copies of their client's custody record without having to ask for them. The legal advisers we spoke to reported good relationships with the police. In our CRA, all detainees had been offered legal advice, and 19 had accepted.

5.15 We saw detainees being told that they could inform someone of their arrest, and staff facilitated this. In our CRA, 12 detainees had requested that someone be informed of their arrest, and in 11 cases it was clear that this had happened. For the remaining detainee, staff had attempted to contact their chosen person but had not been able to reach them.

5.16 PACE inspectors carried out reviews of detainees. Those we observed, which took place face-to-face, were timely and thorough, and inspectors checked on detainees' overall treatment, giving them the opportunity to discuss their concerns. In our CRA, of the 23 detainees who required an initial review, custody records showed that 12 reviews had been conducted face-to-face with the detainee. Ten reviews had taken place while the detainee was asleep and in seven of these instances it was recorded that they had been informed of this or reminded of their rights and entitlements on awakening. Only one review had been conducted over the telephone.

5.17 There was an effective system for collecting DNA samples taken in custody.

5.18 A video-enabled court operated from Melksham custody suite twice a week. During the inspection, we were made aware of a detainee who was due to have his case heard via the video-enabled court. However, the court did not have enough time to hear his case on the appointed day, and he remained in custody until the next day, when he was transported to the local court. We were told that this was a regular occurrence and that detainees could remain in custody longer than necessary while waiting for their court hearing to start, or to be collected by the escort contractor for transportation to prison. There were no cases suitable for the video-enabled court during the inspection, so we could not confirm this. Custody staff at Swindon told us that they could sometimes get detainees to court as late as 3pm because of their close proximity to Swindon Magistrates' Court; by contrast, we were told that when remand cases were heard at Chippenham Magistrates' Court, detainees would not normally be accepted after 2pm, which was too early (see also paragraph 3.9 and area for concern 2.47).

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[6] 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.

Rights relating to treatment

5.19 Information about the complaints process was displayed only at Swindon custody suite but details about this and the IPCC were included in the rights and entitlements notice offered to detainees. Custody staff told us, and inspectors confirmed, that if a detainee wished to make a complaint, they would tell the duty inspector, who would see the detainee in the custody suite, provided that this did not hinder the investigation.

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 Detainees we spoke to expressed satisfaction with their health care arrangements. AWP commissioned the physical health service, which was provided by G4S. The current contract was ineffective, failing to hold the provider accountable for the service, but a new, more robust one had been agreed and was due to start on 11 January 2016. Partnership working between police and providers was good, with focused and well-attended partnership meetings.

6.2 A mix of health care professionals (HCPs) – doctors and nurses – provided 24-hour cover. There were problems in recruiting clinical staff, and this impeded service delivery and development. For example, in the previous four months, up to 15% of nurses' shifts had not been covered, leading to reduced access for detainees. HCPs were appropriately trained but systematic clinical supervision was not available to them; the service manager had plans to address this deficit in clinical assurance.

6.3 A member of custody staff referred detainees to an HCP following a risk assessment or during their stay in custody. There was an expected response time of 60 minutes, which was achieved on over 80% of occasions. Generally, most custody staff were satisfied with this performance. However, our CRA indicated an average response time of two hours 24 minutes. Under the new contract, nurses were to be embedded in both custody suites, which would reduce waiting times in most cases.

6.4 There had been no complaints or serious incident reports in the previous year.

6.5 Clinical consultations took place with the clinical room door closed, with good attention to the patient's privacy and dignity. Professional interpretation was used appropriately for detainees with limited knowledge of English.

6.6 Health care rooms were not compliant with relevant infection control standards, and surfaces were not suitable for forensic sampling. We saw the police and G4S working closely to address these issues. The clinical room at Melksham was dirty and dusty, although we noticed an improvement after we highlighted this. Custody staff had annual first-aid training and easy access to automated external defibrillators and oxygen. First-aid kits were standardised, and items of kit were checked regularly. We found that some stock medical supplies were out of date. Ambulance response times for emergencies were reported to be good.

Areas for improvement

6.7 **There should be sufficient health care professionals to provide health services to detainees at the time required, and staff should have access to clinical supervision, receipt of which should be documented.**

6.8 Clinical rooms should be refurbished to optimal standards, including meeting infection control standards and being suitable for the taking of forensic samples. The rooms should be subject to regular cleaning, the standard of which should be audited.

Patient care

6.9 About 450 detainees were referred to HCPs per month, as a result of risk assessment or detainee request. We observed respectful interactions between HCPs and detainees, and between HCPs and custody staff.

6.10 For each detainee they treated, HCPs completed a G4S electronic health assessment and gave the custody staff a written assessment/care plan (form 450) and verbal report. Form 450 was scanned into the computer system as an attachment. Not all custody records referenced form 450, so not all of them indicated the outcome of medical advice. Clinical records were stored and retrieved correctly, protecting clinical confidentiality. The clinical records we examined were appropriate and we were impressed to see two care plans, securely stored, for repeat patients. At the time of the inspection, a new initiative was being implemented to enable HCPs to access directly the national single clinical record held by detainees' GPs to inform care; elsewhere, this has benefitted continuity of care.

6.11 Standardised stock medication was reasonably well organised, checked regularly, in date and stored securely in appropriate drug cupboards, although we could not find records of stock orders and receipts. There were patient group directions (PGDs; to enable nurses to supply and administer prescription-only medicine) pertaining to each stock item, although the PGDs were out of date and we could not find the antibiotic stock. We were told that new PGDs had been signed but not yet distributed. Sedatives and painkillers were checked daily by HCPs, and records showed that the counts were correct. Daily totals were communicated to G4S by telephone, in an attempt to check the stock levels of these potentially divertible medications. Verbal reporting of stock levels was suboptimal as it relied on self-reporting.

6.12 In our CRA, nine out of 30 detainees had been taking prescribed medications. Custody staff tried to retrieve medications from detainees' homes, where appropriate, and these were checked by health services staff before administration. Custody staff had access to over-the-counter remedies, including nicotine replacement therapy, and inhalers to give to detainees for self-administration on HCP advice. Detainees on methadone prescriptions for opiate addiction could continue on this. Symptomatic relief for drug and alcohol withdrawal was prescribed.

6.13 HCPs administered medication when they were on site; when they knew they would not be available at the appropriate times for administration, they placed a dose in a bag, with details of the drug and administration times, alongside an electronic prescription on the computer system. Custody staff then supervised the detainee taking the medication, usually with another staff member witnessing the process. Custody staff we spoke to understood their responsibilities and the local policy.

Substance misuse

6.14 Custody staff told us that a large proportion of detainees had substance misuse issues. In our CRA, 19 out of 30 detainees had consumed an intoxicant before arrival in custody and 40% indicated that they had a problem.

6.15 Support for those with substance misuse issues was inadequate. There had been a reduction in the visibility and availability of substance misuse workers in custody suites since the previous inspection. At Swindon, the Crime Reduction Initiative (CRI) provided a visiting service once a week, and the service of an alcohol worker at weekends. At Melksham, staff told us that they rarely saw a drug worker; the worker (from Turning Point) told us that she tried to visit once a week but this was not sufficiently regular. Drug workers could sometimes be reached by telephone but this rarely resulted in visits. Beyond that, police took details of detainees wishing to be referred, and the substance misuse workers took these details when visiting. This meant that referrals could take nearly a week to reach the substance misuse services, which was unacceptable as the detainees had left custody by then (see area of concern 2.49).

6.16 Both CRI and Turning Point provided services for those with alcohol problems and supported the police in providing needle exchange and harm minimisation equipment. Children with substance misuse issues were referred, or signposted, to local age-appropriate services by custody staff.

Mental health

6.17 Custody staff told us that a large proportion of detainees had mental health problems. In our CRA, six out of 30 detainees in our sample had arrived in custody with a history of mental health problems.

6.18 AWP provided the mental health liaison and diversion service and the court assessment referral service to both custody suites; the police spoke positively about these services. There was effective joint working between the police and local mental health services at local and strategic levels.

6.19 There was access to mental health workers from 8am to 8pm daily. Detainees were referred by custody staff, based on the risk assessment or observations, or could self-refer. Mental health practitioners had access to Trust electronic clinical records and checked if detainees were known to mental health services before they undertook assessments. Out-of-hours support was available from crisis teams but was rarely required.

6.20 Custody staff were not satisfied with the responsiveness of mental health services to referrals for Mental Health Act assessments. Problems cited included getting approved mental health professionals (AMHPs) to attend custody suites, difficulties for AMHPs in obtaining the services of section 12-approved doctors[7] and long waits for mental health beds.

6.21 The use of police custody as a place of safety for those detained under section 136[8] was actively discouraged and monitored. Police custody had been used for this purpose three times a month, on average, in the year to November 2015. Although this figure was relatively low, it was still too high. In September 2015, the police and AWP had started a street project, with an embedded mental health practitioner in the communications room and the potential to work alongside officers in the street. The initial experience demonstrated that

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[7] A section 12-approved doctor is a medically qualified doctor who has been recognised under section 12 (2) of the Mental Health Act 1983. They have specific expertise in mental disorder and have additionally received training in the application of the Act.

[8] Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety - for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

street officers had taken advice on mental health issues on over 90 occasions per week, which suggested a useful service enhancement. It was hoped that street triage could assist in driving down the use of police custody for detainees under section 136.

6.22 Custody staff we spoke to had a good understanding of mental health issues, and revised training was being arranged for 2016.

Area for improvement

6.23 NHS commissioners should ensure that patients requiring Mental Health Act assessments are seen quickly and that transfers to mental health facilities are effected promptly.

Section 7. Summary of areas of concern, recommendations and areas for improvement

Areas of concern and recommendations

7.1 **Area of concern:** The force was not sufficiently effective within its strategic partnerships to ensure good outcomes for detainees. Particular areas of concern included: the lack of local authority accommodation provision for children who had been charged and refused bail, resulting in children being detained in police custody unnecessarily; and poor engagement with the court service, whereby early cut-off times often led to detainees spending too long in police custody.

Recommendation: Wiltshire police should work with local authorities to improve the accommodation provision for children who are charged and refused bail, and with HM Courts and Tribunals Service to ensure that early court closure times do not result in unnecessarily long stays for detainees in police custody. (2.47)

7.2 **Area of concern:** All aspects of use of force were lacking oversight and governance. Use of force was not discussed at a senior level. We found some use of Tasers and leg restraints on particularly vulnerable detainees and were not assured that their use was proportionate to the threat posed. Use of force forms were not submitted by each member of staff involved in the deployment of force, to account for their involvement in each incident.

Recommendation: Where force is necessary, all staff should ensure all use of force is proportionate and lawful. It should account for all uses of force to ensure accountability, safe techniques, commensurate with the threat posed. All uses of force should be recorded, subject to monitoring, oversight and learning to improve the safety and welfare of detainees. Tasers should only be used in exceptional circumstances, with a custody policy on Taser use in the custody block. (2.48)

7.3 **Area of concern:** A large proportion of detainees who entered custody had substance misuse issues. The service for detainees with substance misuse had deteriorated considerably since the previous inspection. Drug and alcohol workers visited custody suites infrequently and there were often long delays in following up detainees who wished to be referred to services.

Recommendation: Wiltshire Police and partner agencies should urgently assess the need for substance misuse services in police custody and commission appropriately responsive services. (2.49)

Areas for improvement

Strategy

7.4 Dip-sampling of custody records should be increased to around 10% of the throughput of custody, to allow for a representative and meaningful sample and to facilitate organisational learning. (3.15)

Treatment and conditions

7.5 All staff who unlock detainees or who undertake constant supervision should have ready access to an anti-ligature knife. (4.13)

7.6 All custody staff should be involved in the same shift handover. (4.14)

7.7 The force should take action to identify potential ligature points and mitigate any risks posed to detainees. (4.25)

Individual rights

7.8 The force should ensure effective provision of appropriate adults for vulnerable adults and children at all times. (5.11)

7.9 There should be suitable telephone equipment in all suites that should be used to facilitate private telephone interpreting. (5.12)

Health care

7.10 There should be sufficient health care professionals to provide health services to detainees at the time required, and staff should have access to clinical supervision, receipt of which should be documented. (6.7)

7.11 Clinical rooms should be refurbished to optimal standards, including meeting infection control standards and being suitable for the taking of forensic samples. The rooms should be subject to regular cleaning, the standard of which should be audited. (6.8)

7.12 NHS commissioners should ensure that patients requiring Mental Health Act assessments are seen quickly and that transfers to mental health facilities are effected promptly. (6.23)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	Team Leader
Vinnett Pearcy	HMIP inspector
Kellie Reeve	HMIP inspector
Clive Burgess	HMIC lead staff officer
Anthony Davies	HMIC staff officer
Denise Hotham	HMIC staff officer
Paul Tarbuck	HMIP health services inspector
Andrea Crosby-Josephs	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

The force and police authority should develop a long-term plan to improve and upgrade the facilities and infrastructure at the Salisbury custody suite. (3.18)
Partially achieved

The current role and duties of the custody site managers should be reviewed. (3.19)
Achieved

The workforce modernisation programme should be reviewed to ensure that staffing arrangements are suitable for custody suites and minimise risks to detainees and staff. (3.20)
Achieved

A chief officer at strategic level should address the lack of engagement with health partners. (3.21)
Partially achieved

The membership of the strategic custody group should be expanded to include representatives of external partners. (3.22)
Achieved

Use of force should be monitored centrally to enable managers to identify patterns and monitor trends, and to assure that it has been deployed appropriately and proportionately. (3.23)
Partially 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.

Recommendations

Booking-in desks should be of an appropriate height, and the reception area should allow adequate privacy for new arrivals. (4.37)
Not achieved

All cells should be fit for purpose and free of ligature points, which custody staff should be trained to identify. (4.38)
Not achieved

There should be clear policies to meet the needs of female detainees and those with disabilities or mobility issues while they are in custody. (4.39)
Achieved

There should be cells adapted for use by detainees with disabilities. (4.40)
Not achieved

Regular health and safety, maintenance and cleanliness checks should be formalised across the custody estate, and should be fully recorded and monitored by custody site managers and the headquarters justice department to ensure that there is appropriate action on identified issues. (4.41)
Achieved

Quality assurance sampling checks should be recorded and monitored by headquarters justice department to ensure these are completed on time, and that identified issues are addressed and learning points are disseminated. (4.42)
Partially achieved

Cells, mattresses and pillows should be cleaned between use and kept clean, free of graffiti and functional for use. (4.43)
Achieved

Detainees held overnight and those who are dirty should be offered a shower. (4.44)
Achieved

Shower areas should allow sufficient privacy, particularly for female detainees. (4.45)
Not achieved

Toilet paper should be provided routinely in all suites. (4.46)
Partially achieved

Views of in-cell toilets covered by closed-circuit television should be obscured. (4.47)
Achieved

Tracksuits, underwear and plimsolls should be provided when clothing is removed from detainees, unless there is a specific need for an alternative. (4.48)
Achieved

Detainees held for longer periods should be offered outdoor exercise. (4.49)
Achieved

Individual rights

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

Recommendations

The force should liaise with the UK Border Agency to ensure that immigration detainees are held for the shortest possible time. (5.26)
Achieved

Custody staff should identify and, where possible, address any dependency issues for detainees. (5.27)
Achieved

Appropriate adults should be available 24 hours a day to support juveniles and vulnerable adults in custody. (5.28)
Not achieved

Detainees aged 17 years should be provided with an appropriate adult. (5.29)
Achieved

There should be an urgent review of the processes used to take, store, track and submit all DNA and forensic samples taken from detainees, volunteers and victims. This should identify gaps in policies, training, storage facilities and destruction audit trails, with a senior officer responsible for delivery of an action plan to address these. (5.30)
Achieved

Information about how to make a complaint should be given to all detainees during the booking-in process in a format they understand, and clearly displayed in the custody suites. (5.31)
Achieved

Detainees should able to make a formal complaint about their treatment during arrest or detention while they are still in custody, and all such complaints should be investigated promptly and fully. (5.32)
Achieved

The number and nature of complaints with a racial element should be monitored and any trends identified acted on. (5.33)
Not achieved

Health care

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

Recommendations

Women detainees should be able to see a woman doctor on request and be informed of this possibility. (6.39)
Achieved

The contract monitoring of health services should ensure that robust clinical governance arrangements are in place. (6.40)
Partially achieved

Healthcare staff should have the appropriate knowledge and skills to meet all the physical and mental health needs of detainees. (6.41)
Achieved

There should be clear infection control procedures, including cleaning schedules that should be adhered to, and monitored. (6.42)
Partially achieved

There should be safe pharmaceutical management and use of medications. All medications should be stored safely and securely, and disposed of safely if not consumed. (6.43)
Partially achieved

All resuscitation equipment should be checked at least weekly, and there should be documentary evidence that these are completed. (6.44)
Achieved

Secondary dispensing by nurses should cease. (6.45)
No longer relevant

Detainees should be able to continue prescribed medication for any clinical condition, and to receive medications to provide relief for drug and alcohol withdrawal symptoms if needed. (6.46)
Achieved

Services for detainees with substance use issues should be provided consistently across the county, including access to clean needles. (6.47)
Partially achieved

Services for detainees with mental health needs should be provided consistently across the county. (6.48)
Achieved