Inspecting policing in the public interest

Report on an unannounced inspection visit to police custody suites in

Greater Manchester

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

5–14 January 2016

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

Glossary of terms

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Contents

Contents

Section 1. Introduction

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

This was the second inspection of Greater Manchester Police (GMP) custody suites, the first inspection having taken place in 2012. Since then, there have been various improvements and the force has responded well to lessons learnt and recommendations. We found good engagement with partners which had improved previously poor outcomes for detainees. However, much progress was reactive. Data management was poor and, although the force was expecting an upgrade to its computer systems, there were significant gaps in the effective use of management information which impeded plans and was a missed opportunity to proactively improve outcomes for detainees.

There was evidence of good partnership working with other organisations in mental health and with local authorities, but progress in providing accommodation for children in custody who had been charged but refused bail, was hindered by a lack of local authority accommodation resources. The Office of the Police and Crime Commissioner (OPCC) was actively involved in improving facilities for people needing mental health support, resulting in dedicated places of safety in three of the four health trust areas with which GMP worked.

The force did not record, monitor or analyse the use of force, and this presented a significant strategic and operational risk. It was concerning that there was no objective review of such incidents which would have provided opportunities for learning, supported a more preventative focus, as well as helping to ensure proper staff accountability.

Staff interaction with detainees was mostly good but inconsistent, although custody staff knew how to respond correctly to vulnerable detainees. The force had developed a risk assessment tool, which despite being complicated, sergeants were able to tailor and adapt appropriately and we saw some excellent interactions between staff and detainees when completing initial and pre-release risk assessments. However, we were disappointed and concerned that written records did not always reflect the standard and quality we observed. The force had also introduced a pre-release risk assessment jointly with health services staff, for detainees who required a heightened assessment. This was a good initiative but it sometimes prolonged stays in custody.

Sergeants were focused on progressing investigations but these were sometimes stalled because of investigative staff being unavailable. However, GMP were implementing a new process whereby arresting officers would be directly responsible for the progress of the investigation. It remains to be seen if this change improves outcomes and reduces the time detainees spend in custody.

Staff were aware of their responsibilities to contact an appropriate adult (AA) when dealing with vulnerable adults. There were two schemes covering the force area, and both were found to be accessible and good. We observed, however, that in most cases, the AA would be asked to arrive for the investigation interview, rather than earlier, which would enable additional support for vulnerable detainees through the custody process.

Health care overall was adequate. Manchester presents a complex picture owing to the number of local authorities and mental health trusts, the planned devolution of commissioning of health care, and the recent announcement cancelling the transfer of custody health care commissioning to NHS England.

Governance arrangements were improving but response times were not always met because of the exceptionally high demand. Some arrangements, such as the forensic medical examiner being the only person who could refer detainees for Mental Health Act assessments, despite other health services staff being available, compounded these demands and delays. Most suites did not have effective drug and alcohol services. Mental health provision in custody suites had improved considerably.

Overall, GMP had made some promising and significant improvements since the previous inspection. In our view, however, limited management and performance data, had hindered what could have been further progress. We saw some excellent staff interactions and useful risk assessment, but poor recording often undermined this.

We noted that, of the 31 recommendations made in our previous report, nine recommendations had been achieved, seven had been partially achieved, 13 had not been achieved and two were no longer relevant.

This report makes four recommendations to the force and highlights 14 areas for improvement.

Sir Thomas P Winsor
HM Chief Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

March 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 60 records were sampled.

2.5 This was the second inspection of Greater Manchester Police (GMP), following up on our first inspection on 5–9 March 2012. During this inspection, the designated suites and cell capacity were as follows:

Custody suite	**Number of cells**
North Manchester	30
Longsight	58
Cheadle Heath (Stockport)	36
Bury	24

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

Bolton	19
Ashton under Lyne (Tameside)	31
Swinton (Salford)	28
Pendleton (Salford)	27
Wigan	29

Strategy

2.6 There was a clear management structure up to assistant chief constable (ACC) level. A superintendent was in charge of criminal justice and custody, and the custody manager was a chief inspector.

2.7 All the suites had sufficient cell capacity and the force was planning to reduce the number of suites as part of its estate and modernisation programme. There were sufficient custody sergeants and detention officers (DOs) on duty to manage detainees' needs.

2.8 The force had poor access to data in relation to custody issues. It was actively engaged in an upgrade of computer systems to rectify this but much of the information that we expected to see could not be easily accessed or was not immediately available. Force staff were not able to provide data to evidence improvements or to support the effective management of custody operations. However, the force was working actively to improve the management and gathering of data.

2.9 Partnerships with local authorities and mental health trusts provided improved outcomes for some detainees.

2.10 The independent custody visitor (ICV) scheme was well embedded and supported by the force, which provided training for new volunteers.

2.11 Dip-sampling of custody cases had failed to identify some basic issues, such as the lack of information in detention logs. However, there was a good initiative to record and track all recommendations from the Independent Police Complaints Commission (IPCC) and other bodies.

Treatment and conditions

2.12 Custody staff had good individual interactions with detainees; they were able to address vulnerabilities and made efforts to ensure that children were not kept in custody if this could be avoided. However, when children were detained responses were inconsistent, and we observed variation in the support offered between the various custody suites.

2.13 Women were not always questioned thoroughly about potential vulnerabilities, for example they were not asked if they were pregnant or wanted to speak to a female officer. When dealing with sensitive cases, some sergeants cleared the suite to maintain confidentiality during the booking-in process but others did not.

2.14 There were limited facilities for detainees with disabilities but we were reassured that sergeants would respond appropriately. Custody staff and DOs generally knew how to deal with detainees presenting with diverse and individual needs.

2.15 An integrated custody information system (ICIS) had been introduced which contained the risk assessment and care plan. The risk assessment incorporated areas of learning from deaths following custody but the software was cumbersome and difficult to navigate, and we had some concerns about the lack of information recorded on it. The detention logs did not always reflect the very good staff–detainee interactions that we saw.

2.16 Many sergeants adapted the risk questionnaire appropriately and sensitively but this led to inconsistent practices. Most were properly focused on identifying and managing risks. Risk assessments were dynamic but the rationale for increases or reductions in observation levels was not always well recorded.

2.17 The content of handovers was generally appropriate and in some cases they were well conducted. Custody sergeants and DOs had staggered start times but some staff made efforts to overcome this issue.

2.18 There was poor recording of information in the pre-release risk assessments. However, those we observed directly demonstrated that the custody sergeants were properly focused on a safe release for detainees, and they showed a genuine concern for detainees in their care. Some pre-release risk assessments were conducted jointly with health services staff, to ensure a safe release from custody. Although this was a positive initiative, it could delay the release of such detainees.

2.19 The use of force in custody was not recorded effectively. There was no monitoring of individual incidents or trend data in relation to use of force, and learning from such incidents was not used sufficiently to provide guidance and training for staff. We could only review a very limited number of records or closed-circuit television (CCTV) recordings of use of force because the force was unable to provide them. This inadequate oversight we considered to present a strategic and operational risk. Evidence from custody staff and the few records we did see, caused us to question whether the application of force was always applied proportionately or appropriately.

2.20 The physical condition of the suites was very good at the newer facilities. The process of checking cells was not completed consistently and we were not confident that the force could identify safety concerns in cells.

2.21 Detainee care was satisfactory and they were provided with various items to ensure basic comforts.

Individual rights

2.22 Custody sergeants booked in detainees and generally asked for the full circumstances of the arrest. Most sergeants were able to give examples of detention being refused when the circumstances did not merit it. However, in some cases custody sergeants failed to ask and officers did not give reasons for the arrest. Alternatives to arrest were available; it was positive that the use of voluntary attendance had significantly increased in the 12 months prior to the inspection.

2.23 The force was unable to provide data about the overall length of detention for all immigration detainees; however, custody staff told us that immigration detainees were generally moved on to appropriate alternative accommodation within a short period.

2.24 Detainees were not always dealt with in a timely manner. The appropriate adult (AA) schemes were generally good but AAs were only asked to attend for detainees' interview, rather than to support them during the initial booking-in and subsequent detention period.

2.25 Custody staff were clear about the differences between secure and safe accommodation when requesting this from the local authorities in relation to a child who had been charged and could not be bailed. Clear guidance detailing the process was displayed on the wall in several of the custody suites and staff demonstrated an impressive level of knowledge about the options for seeking alternative accommodation. However, despite making requests to local authorities, many of the children detained remained in custody overnight.

2.26 Custody staff were able to access a professional telephone interpreting service but only through a telephone loudspeaker, which undermined detainee privacy. There had been delays in the attendance of face-to-face interpreters for some of the languages required, resulting in some detainees remaining in custody for longer than necessary or having to be bailed to return at a later date.

2.27 Detainees received copies of their rights and entitlements and had access to legal advisers, although telephone calls had to be taken at the booking-in desk in some of the suites, undermining detainee privacy.

2.28 We were told that detainees were routinely refused appearance at courts owing to early closing times. They were sometimes held in custody overnight to wait for the next available court date.

Health care

2.29 Clinical governance arrangements were inadequate but the current provider, CRG Medical Ltd (CRG), was making improvements. NHS England and the force were working collaboratively to transfer commissioning of health services to NHS England from April 2016 but alternative models were being explored as this national initiative had been cancelled in December 2015 and because of the planned devolution arrangements for health and social care in Manchester.

2.30 The demand for health services was high. There were agreed response times and attendance was monitored rigorously. Consultations were routinely conducted with the door open, compromising detainee confidentiality. There were no privacy screens in consultation rooms and a DO was present during intimate examinations, which was inappropriate.

2.31 Custody suite first-aid kits were not standardised and many items were out of date. Stock medication was generally stored securely, with effective monitoring and management.

2.32 The clinical care provided was generally of a good standard. Clinical records were mostly good, and care plans were shared with custody staff. Support for detainees with substance misuse issues had declined and was inadequate. Most suites did not have effective drug and alcohol services.

2.33 Mental health provision in the custody suites had improved. However, some mental health liaison and diversion services were restricted to 4–5 hours daily, from Monday to Friday.

2.34 CRG registered mental health nurses were not able to refer detainees directly for a Mental Health Act assessment; instead, they had to refer to an forensic medical examiner (FME), who was the only person empowered to make such referrals, creating unnecessary delays

2.35 Twenty-five detainees had been detained in custody as a place of safety under section 136 of the Mental Health Act in 2015. Custody staff had a good understanding of mental health issues and had received formal training.

Areas of concern and recommendations

Area of concern

2.36 GMP had developed its approach to custody positively since the last inspection but the force still did not collect sufficient data, and more needed to be done to embed the improvements. Better data would potentially facilitate a more informed view of outcomes and allow the force to more effectively and proactively manage its custody provision, leading to yet more improvement.

Recommendation

Greater Manchester Police service should improve the collection and management of custody-related data to help them improve outcomes for detainees.

Area of concern

2.37 GMP did not record data on the use of force in custody effectively. There was insufficient managerial scrutiny of incidents of use of force in the custody environment. We were not assured that managers were always aware of incidents or that proper arrangements were in place to ensure accountability. The evidence we did see did not assure us that force was always applied in an approved or proportionate way. There was insufficient learning from incidents that required the application of force.

Recommendations

Greater Manchester Police service should introduce effective management systems for the scrutiny and oversight of use of force. There should be rigorous arrangements in place for staff to record their involvement in incidents; for the review of such incidents; for the collection of use of force data; and for the monitoring of trends.

Force should only be applied proportionately, and using only approved techniques and equipment.

Area of concern

2.38 A large proportion of adult and juvenile detainees entered custody with drug and alcohol issues but there was inadequate provision at most suites to support them into services effectively.

Recommendation

Adult and juvenile detainees should have timely access to substance misuse services in all suites.

Area of concern

2.39 The strategic approach to, and support for, detainees with mental health issues had improved but such detainees regularly experienced long delays and extended detention before their mental health needs were assessed and met. Opportunities to support detainees with lower-level mental health needs into relevant services were missed.

Recommendation

Detainees with mental health issues should receive prompt assessments and support in all suites.

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 There were nine custody facilities across the force and all had sufficient cell capacity. The force was planning to reduce the number of suites as part of its estate and modernisation programme. There were sufficient custody sergeants and DOs on duty to manage detainees' needs.

3.2 There was a clear management structure up to ACC level. A superintendent was in charge of criminal justice and custody. The custody manager was a chief inspector, and had additional responsibilities for some areas of business in criminal justice. An inspector was responsible for managing each custody facility. There was also an inspector working in the force headquarters who had responsibility for thematic issues such as dip-sampling and managing recommendations from the IPCC and other bodies.

3.3 There was no formal structure for meetings between the ACC and superintendent but there was regular contact and discussion to ensure that senior managers were aware of the issues affecting custody. The custody manager held regular meetings with the team of custody inspectors, and issues discussed included provision of staff, IPCC recommendations and the dip-sampling of custody records.

3.4 The force had poor access to data in relation to custody issues. It was actively engaged in an upgrade of computer systems to rectify this, but much of the information that we expected to see could not be easily accessed or was not immediately available, which was a cause for concern. The force also had difficulty providing data to evidence improvements to support the effective management of custody operations. For example, there was no data to show how many detainees had been strip-searched in custody. There was also no information to demonstrate how long all immigration detainees had been held in police custody before being transferred to immigration services (see area for concern 2.36).

3.5 Use of force was not monitored at a strategic level and there was no policy on its use. This presented a strategic and operational risk to the force, with no preventative aspect to governance, or accountability, and limited opportunities for learning (see area for concern 2.37 and section on use of force).

Partnerships

3.6 The force was a fully participating member of the mental health concordat.[2] Agreements were in place with the four mental health trusts covering the force area, to minimise the number of people brought into police custody facilities under section 136 of the Mental

[2] The mental health concordat is a national agreement between agencies involved in the care and support of people in crisis. It sets out how organisations will work together to ensure that people get the help they need when they are having a mental health crisis.

Health Act. The partnership work had resulted in dedicated places of safety across three of the four trust areas. Force data on the number of people brought to custody facilities under section 136 showed that this happened only occasionally (see section on mental health).

3.7 Greater Manchester Police had worked with the 10 local authorities to ensure that there was effective provision of accommodation for children who had been charged with a criminal offence and refused bail. However, although good efforts had been made, force data showed that there continued to be many children in custody overnight owing to a lack of local authority accommodation (see also paragraph 5.6).

3.8 The ICV scheme operated by the Office of the Police and Crime Commissioner was well supported by the force. Access to custody facilities was generally prompt. A review of the forms submitted by visitors demonstrated that the police were quick to respond to the issues raised. The force provided staff to help with scenario-based training for new visitors.

Learning and development

3.9 Custody sergeants undertook an initial training programme which included scenario-based learning, with the support of the Crown Prosecution Service and other legal professionals. There was appropriate training for DOs. Custody staff attended two refresher training days per year. They also had access to training in relation to the safeguarding of children and other vulnerable people.

3.10 At least 28 custody cases were dip-sampled for each custody suite each month but this had failed to identify some basic issues, such as the lack of information in detention logs. The force published a regular custody bulletin, which included information on learning from adverse incidents as well as proposals resulting from IPCC recommendations.

3.11 A custody policy was available to all staff, accessible through the force intranet, and covered areas of detention such as risk assessment, complaints and access to AA services.

3.12 As the use of force in custody was not recorded, the force was not able effectively to learn lessons and adapt training as a result of such incidents. The professional standards branch provided the custody branch with regular updates on the number and nature of complaints submitted, for each custody facility.

3.13 There had been some positive improvements to working practices as a result of responding to various recommendations from external organisations. For example, in response to an IPCC recommendation, DOs now had training in, and access to, force local intelligence systems. Another positive outcome was that the force made robust enquiries of the local authorities each time a child was charged with an offence. However, often these enquiries still resulted in children being kept in custody due to the lack of available local authority accommodation (see paragraphs 3.7 and 5.6).

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 The custody staff we observed dealt with detainees in a constructive and professional way. They were polite, courteous, and showed an interest and concern for the needs of detainees. At North Manchester and Bury, the booking-in areas were well designed, to enable interviews to be conducted privately. There were also discrete rooms at both of these suites, adjacent to the main booking-in desk, which were useful when staff dealt with high-profile or sensitive cases. At the other suites, it was difficult to maintain confidentiality during the booking-in process at busy times, although we saw some sergeants making efforts to book in sensitive cases individually, by clearing the booking-in area. Staff also pointed out, and we observed, that noise levels were problematic when detainees banged on their cell doors. This intimidated and disturbed some detainees and made the booking-in process more difficult.

4.2 In most cases, staff demonstrated an understanding about detainees' vulnerability but in a few cases individual care was inadequate. It was clear that sergeants were aware of the need to avoid children being held in custody. When children were detained, staff generally worked hard to ensure that this was for the shortest time possible. We saw variable approaches to supporting children in custody. In several instances, children were prioritised over other cases, and some were allowed to sit outside of their cell with their parent, carer or someone from the AA scheme. In other cases, children were not treated as vulnerable by virtue of their age and they were offered no other specific support or care. They were not provided with anything constructive to do to occupy their time in custody and some complained of being bored. Not all custody staff were aware that girls under 18 should be routinely allocated a female member of staff to be responsible for their care.

4.3 Custody staff did not always meet the individual needs of women in custody. Although staff spoke to them sensitively and with respect, they were not always given the opportunity to speak to a female member of staff, and were not routinely offered access to sanitary products or asked if they were pregnant, despite the latter being one of the booking-in questions. However, there was good support available for women following release from detention (see section on safety).

4.4 Detainees were generally asked if they had dependants. We saw examples of carers being prioritised to ensure that they could resume their caring responsibilities at the earliest opportunity, although this was not consistent across all the suites.

4.5 A stock of religious books and items reflecting the main faiths were held at all sites but detainees were rarely asked if they wanted to use them – again, despite this being one of the booking-in questions.

4.6 Although there were adapted toilet and shower facilities at most sites, they were used rarely. There were cells with different height benches at North Manchester and Bury custody suites, designed to accommodate detainees with wheelchairs or mobility issues. There were no specific adaptations to cells at the other sites to make them suitable for

detainees with disabilities. A member of staff who had been trained in British Sign Language worked at one suite but not all locations had hearing loops and, in those that did, staff did not know how to use them. Little information was available in Braille or in an easy-read format.

4.7 Although few custody staff had previously dealt with transgender detainees, they were all aware of the importance of engaging with such detainees and ascertaining how they identified their gender, particularly when making arrangements for searching them.

Safety

4.8 An integrated custody information system (ICIS) had been introduced which contained the risk assessment and care plan that custody sergeants completed for each detainee. The risk assessment appropriately incorporated areas of learning from cases of deaths following custody but the software was cumbersome and difficult to navigate. The risk assessment included lists of intrusive health-related questions – for example, asking if detainees were HIV positive or had scabies or fleas. Furthermore, these questions were often asked in the presence of a number of people in the booking-in area. Completed records we examined in our custody record analysis (CRA) and throughout the inspection often reflected insufficient recording of qualitative information.

4.9 The practice of undertaking risk assessments was generally much better than records suggested. We observed sergeants generally completing risk assessments which were properly focused on identifying and managing risks but the detention logs did not always reflect the good interactions we saw. Some sergeants were highly skilled in eliciting relevant information from detainees which they then used to inform the care plan. Many sergeants did not ask all of the questions on the risk assessment, and instead, tailored them appropriately and sensitively. We also observed inconsistencies in practices across the suites. It was good that arresting officers were always asked if they had any supplementary information about the detainee, for inclusion in the risk assessment. We were assured that sergeants took account of other sources of information during the risk assessment process, such as warning markers on the police national computer (PNC) and local intelligence systems.

4.10 Observation levels were generally set appropriately and there was a good awareness of the range of observation levels; however, in some cases there was poor recording of their frequency. Seven of the nine custody suites had a number of cells covered by CCTV. Staff repeatedly expressed concern about all cells not being monitored by CCTV as they considered it to add a further level of safeguarding for detainees with identified risks in custody. Risk assessments were dynamic but the rationale for increases or reductions in observation levels was not always well recorded. In our CRA, we came across a detainee who had gone from 60-minute observations to constant supervision following a shift handover, without an explanation for this change. Custody staff had good awareness of rousing practice but it was often poorly recorded. We were assured that observation levels were generally adhered to but the detail recorded in the detention log following checks was often limited.

4.11 Deaths following release from police custody had led to the force taking action to change some practices, based on lessons learned. Particular efforts were made to identify and reduce the risk of suicide or self-harm. Appropriately, anti-rip clothing was used only for detainees identified as being at risk of suicide or self-harm. However, clothing with cords and laces was removed routinely, even when the detainee had been identified as low risk, which was disproportionate. Custody staff and detainees told us, and our observations, showed, that this practice was sometimes unnecessarily aggravating, and it had led to an

escalation of detainee aggression which had sometimes resulted in force being used against the detainee to remove their corded clothing and/or laces.

4.12 Custody staff generally carried personal-issue anti-ligature knives. In some suites, these knives were also attached to sets of keys. There was poor control of keys in some suites, where we observed non-custody staff accessing keys to unlock detainees, when there were sufficient DOs to do this. This was particularly concerning in suites where anti-ligature knives were not attached to keys, which meant that these staff could not respond appropriately if a detainee had attached a ligature (see also section on physical conditions).

4.13 The shift patterns did not allow for a handover period but sergeants arrived earlier than their start time. Custody sergeants and DOs had staggered start times, which meant that whole-team handovers sometimes took place some time after DOs had started their shift, and at some suites handovers were not conducted with the whole team. However, some staff made good efforts to overcome the issues of staggered start times, and most handovers were well conducted, relevant and focused on detainee welfare, risk and case progression. The handovers were particularly well conducted at Ashton, North Manchester and Swinton. Sergeants visited and spoke to all detainees following the handover.

4.14 A pre-prelease risk assessment was completed for all detainees released from custody. However, our CRA and observations reflected some poor recording of information concerning release arrangements. In our CRA, the pre-release assessment addressed risk in only 13 of the 21 cases for which risks were recorded. In the cases of children, six out of 10 had no record of where they were being released to. In the record we saw of a 17-year-old girl, who had previously been sectioned under the Mental Health Act, her current mental health issues and suicide and self-harm risks were noted but these were not mentioned in the pre-release risk assessment. However, in practice, we observed some very good pre-release risk assessments. Sergeants were properly focused on securing a safe release for the detainees in their care. They generally ensured that detainees had a means of getting home; when this could not be arranged through family or friends, they had access to bus tickets and petty cash, and could also arrange for police officers to drive vulnerable detainees home.

4.15 The recent deaths following a period in custody had resulted in the requirement for sergeants to request an enhanced pre-release risk assessment by a health care professional (HCP) when a high risk of suicide or self-harm or other vulnerability had been identified. Although this was a positive initiative, it could delay the release of such detainees; in one custody record we reviewed, the detainee's release had been delayed by 10 hours. A 'safeguarding' pilot at Wigan had begun in early January 2016 and was aimed at trying to identify as early as possible any risks for suicide or self-harm that needed to be addressed to secure a detainee's safe release from police custody. This was a positive initiative but at the time of the inspection it was too early to evaluate its effectiveness.

4.16 Learning from a death following custody, concerning a detainee who had been charged with a sexual offence, had led to welfare interviews which were designed to support individuals in a potentially vulnerable position. This was a good initiative for those who received it.

4.17 All custody suites held information about helpful triage services for women and support services for veterans who had experienced custody, and we observed referrals for these services being made.

Areas for improvement

4.18 Records should reflect all risks identified in the risk assessment and hold sufficient relevant detail to make accurate decisions about detainee safety and welfare while in custody.

4.19 All staff who unlock detainees should be able to respond to ligature threats and should have immediate access to an anti-ligature knife.

Use of force

4.20 Oversight and governance of the use of force were inadequate. We were not confident that police officers and custody staff were held accountable or that managers were aware of its use in the custody suites. We were initially told that each use of force would be recorded on an adverse incident form; however, staff we spoke to said that they would not record uses of force on any specific form, other than the detention log – but even this was not always the case, and in most instances there was little detail. There was no monitoring of trends in relation to the use of force, and staff were unable to tell us how often it was used, or under what circumstances (see also area of concern 2.37). 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 use force only as a last resort. We saw staff negotiating well with detainees in challenging situations to try to de-escalate them.

4.21 Custody staff did not carry personal protective equipment such as batons, incapacitant spray or Tasers, which was appropriate. We were told that such equipment would generally only be deployed when response officers carrying it were present in the custody suites. The force told us that a Taser 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) three times since February 2015. This was unusual in custody, particularly considering the controlled environment and that there were generally sufficient staff to de-escalate situations using other techniques. CCTV footage was retained for only 90 days, so we were unable to review any footage relating to the Taser incidents to assess their proportionality.

4.22 The force did not retain sufficient records or CCTV footage involving the use of force. Force was not recorded so incidents were difficult to identify and we were only able to review records and/or CCTV footage relating to nine occurrences. We had concerns in varying degrees in eight of the cases; we were not assured that force was always used as a last resort, or was always proportionate to the risks posed. Restraints sometimes remained in place for too long once the detainee was calm and sometimes unapproved equipment was used. In four cases, force was used to remove clothing where there was a perceived risk of self-harm. In these cases there was too little negotiation and communication with the detainees. We believed the action to remove the clothing, cords or laces led to an escalation in aggression and, subsequently, use of force (see paragraph 4.11). In one case, a detainee had attempted to bite and spit at staff and a sergeant had used a blanket to cover the detainee's face. This was not an approved technique and carried risks in restricting the detainee's breathing. Some staff said they did not feel able to effectively deal with detainees who behaved in this way and, sometimes, resorted to unapproved techniques to manage it (see area of concern 2.37). We also observed some custody staff responding to a difficult situation where a detainee threatened staff and covered himself in his own excrement. They dealt with the situation using good communication and de-escalation skills.

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

4.24 Data on the number of strip-searches were not collected. However, the records we reviewed, and our observations, assured us that there had been a reasonable rationale for these, and that they had been properly authorised.

Physical conditions

4.25 The overall cleanliness of custody cells had improved and those in the newer suites were generally of a high standard. All custody suites had cleaning contracts, with dedicated staff available daily to clean cells and other areas within the suites. If cells were vacated and subsequently required when cleaning staff were not on duty, they were usually cleaned by custody staff, although at a fairly basic level. Showers were generally clean and well maintained but had saloon doors that afforded insufficient privacy.

4.26 CCTV operated in all custody suites. Cells that were covered by CCTV contained information to notify detainees about it. Few of the suites we visited had clear and consistently recorded processes for checking cells daily. A weekly form was completed by sergeants but this did not address the adequacy of cells and was not always completed consistently. We found (and reported immediately) ligature points in a number of cells and were not assured that staff were properly sighted on them or that they took action to mitigate risks.

4.27 After booking in, detainees were generally escorted to their cell by a DO or one of the custody sergeants. Although there were sufficient DOs, we also saw arresting officers locating detainees in cells. Cell equipment such as the emergency call bell and intercom were not routinely explained to all detainees and this was even less likely when arresting officers escorted detainees to the cells.

4.28 Cell call bells were generally answered promptly, and in most suites cell calls were channelled through the intercom to a nominated DO. However, in some suites the responses were barely audible. At Wigan, calls went through to the custody front desk and there were sometimes delays in responses. The acoustics were also poor, which meant that staff often had to go to the cell to respond, which sometimes disrupted the booking-in process.

4.29 Each suite had a fire evacuation policy and staff were aware of it, but they told us that fire drills were undertaken infrequently. In spite of our requests, we were not told of when fire drills had taken place.

Area for improvement

4.30 All suites should have a consistent and recorded system of daily cell checks, including identification of ligature points.

Detainee care

4.31 Overall detainee care was satisfactory. Detainees were provided with mattresses and clean blankets routinely but pillows were not available at any of the custody suites, and it was not clear why this was the case. Extra blankets were folded and used as makeshift pillows by detainees in cells. Mattresses were not always cleaned between uses. Sufficient stores of

clean blankets and replacement clothing were available across the suites. Paper suits were no longer routinely used as replacement clothing. Toilet areas in cells covered by CCTV were pixellated to afford some privacy. Toilet paper was available only on request, which was unsatisfactory. In our CRA, no detainees had been offered a shower or access to washing facilities (including those held overnight and taken to court).

4.32 All custody suites had exercise yards but they were used infrequently and staff did not offer access to them routinely. In our CRA, only four detainees had been offered exercise.

4.33 All suites had limited stocks of reading materials but few had any in foreign languages or anything suitable for children. Reading materials were generally provided only on request, which required detainees to have prior knowledge of their availability. In our CRA, only two detainees had been offered reading materials.

4.34 There was a wide range of microwavable meals available in all suites, including vegan, vegetarian and halal options. Food was served at set mealtimes and detainees' requests outside of these times were accommodated. In our CRA, 41 detainees had been offered food. Kitchens were generally clean and adequately equipped. Hot drinks, juice and water were offered regularly throughout detainees' time in custody.

Area for improvement

4.35 Exercise, showers, toilet paper and reading materials should be offered routinely to detainees.

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 were responsible for booking detainees into custody and we observed them asking arresting officers to provide a full explanation of the circumstances of the arrest. In some cases however, custody sergeants failed to ask for, and the officers did not provide, any reason(s) for the arrest under PACE code G.[3] This caused us to question whether the requirements of PACE code G were being monitored or complied with fully. However, most sergeants were able to provide examples of when they had refused to authorise detention when the circumstances did not merit it, and they provided us with details of these cases.

5.2 Alternatives to custody were available in the form of voluntary attendance,[4] fixed penalty notices and restorative justice.[5] Facilities for interviewing voluntary attendees outside custody were available at all the police stations in the force area. It was positive that the use of voluntary attendance had significantly increased in the 12 months prior to the inspection. Figures supplied by the force showed that there was a 94% increase in the use of voluntary attendance, with 2,226 uses in 2014 and 4,322 in 2015 (see also section on strategy and area of concern 2.36).

5.3 Custody sergeants were clear about their obligations to ensure that cases were progressed quickly but told us that delays sometimes occurred because of the non-availability of investigative staff and HCPs (see also section on health care). They said that delays were also experienced when detainees were lodged at a suite in a different area from where they were arrested, resulting in officers having to travel from elsewhere for interview purposes. We saw two 17-year-old boys at Ashton custody suite who were arrested at 8.45pm and were still in custody at 3pm the following day, waiting for interview, while decisions were made as to who would be dealing with their case. Conversely, we saw one detainee at Longsight who was interviewed and bailed for further enquiries by the arresting officer within four hours of their arrival in custody. Data supplied by the force showed that in the 12 months to 31 December 2015, the average length of detention was 15 hours. In our CRA the average length of detention was 12 hours 27 minutes, with 22 of the 60 detainees being held for less than six hours, which was acceptable.

5.4 Custody staff reported a good relationship with Home Office immigration enforcement officers, a number of whom were based at force headquarters at Central Park. In the absence of any relevant data from the force, we were told that large numbers of immigration detainees were regularly held and that those who were to be transferred to

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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] Restorative justice is a process whereby some lesser criminal cases can be resolved at the time of the offence through an agreement between the offender and victim.

immigration removal centres (IRCs) or elsewhere were usually moved on within a short period; however, delays of up to 48 hours had been experienced. At North Manchester, we saw one immigration detainee being moved to an IRC just over three hours after his warrant of detention had been served on him, which was very good. Data supplied by the force confirmed that 876 immigration detainees had been held in 2015. However, they could supply data only for those who had been arrested initially for a PACE offence, so were unable to tell us the overall average length of detention for all immigration detainees held.

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.[6]

5.6 Custody staff we spoke to were clear about the differences between secure and safe accommodation when requesting this from the local authorities in relation to a child who had been charged and could not be bailed, and demonstrated an impressive level of knowledge about the available options. Clear guidance detailing the process was displayed on the wall in several of the custody suites. Staff told us about many instances when safe accommodation had been obtained; however, few could recall ever having obtained secure accommodation for a child. Force data showed that 4,586 children had been arrested during 2015. Of 157 cases where children had been charged and refused bail between January and October 2015, 125 requests had been made to the local authorities for accommodation. Safe accommodation had been provided in 34 cases. The force had made 37 requests for secure accommodation, and this had been provided for only two children, which meant that 121 children had remained in custody overnight. There was severely limited availability of local authority accommodation across the force area. Despite this limitation, we saw some significant improvements in the force's efforts in attempting to provide alternative accommodation for children in custody. However, too many children continued to be held in custody.

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. However, we observed that, in most cases, AAs were only asked to attend for the detainee's interview when their rights were re-read, rather than to support them during the initial booking-in and subsequent detention period. Family or friends were contacted to act as an AA in the first instance but not all custody sergeants were aware of the availability of a guidance document helping individuals to understand their role and responsibilities when acting as an AA.

5.8 In several suites, the Police and Crime Commissioners' Appropriate Adult (PCCAA) scheme was available on a 24/7 basis and could be accessed via the local authorities. However, not all custody staff in these areas were aware that the service was available 24 hours a day. In Wigan, Bolton, Longsight and North Manchester, a contracted service provided cover between 9am and midnight, and was available later for serious cases if necessary. Overall, we found the AA schemes to be good.

5.9 In our CRA, there were 10 children in the sample, aged between 15 and 17. One of these, a 17-year-old, had been held at Bolton and spent two hours 45 minutes in custody; although it was noted that their father had been contacted, there was no record of an AA arriving, or of their rights being repeated. The child had not been interviewed while in custody and there was no information on the pre-release risk assessment about where

[6] 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.

they were going on leaving custody or who they were leaving with. All the other children in the sample had had an AA present for the re-reading of their rights and entitlements and, where relevant, for interview. Although it was not always recorded when the AA had been contacted, there had been some long waits for their attendance. In one case at Cheadle Heath, a child had had to wait 17 hours five minutes for an AA to arrive; this delay appeared to have been due to a wait for a decision on whether a Mental Health Act assessment was required and also to delays in the attendance of the support worker who was to act as an AA. In another case at Wigan, a child had spent 14 hours 36 minutes in custody before receiving the support of an AA, with nothing in the record to explain the reasons for the delay or to identify who was acting as the child's AA.

5.10 A professional telephone interpreting service was available to assist the booking-in process but this was used via loudspeaker telephones, which undermined detainee privacy and was difficult to hear when the suites were busy. Staff told us that a face-to-face interpreter service was available for interviews but some delays had been experienced for some of the languages required, resulting in some detainees remaining in custody for longer than necessary or having to be bailed to return at a later date.

Areas for improvement

5.11 Children charged and refused bail should be provided with alternative safe and secure accommodation. The force should work with local authorities to increase the accommodation provision for children in custody.

5.12 Detainees should have access to appropriate adults (AAs) from the point of booking into custody. The force should ensure that AAs are requested to attend as soon as possible, to ensure the welfare and safety of vulnerable adults and children in custody.

Rights relating to PACE

5.13 During the booking-in process, custody sergeants advised detainees of their rights. However, not all detainees were advised of their right to consult the PACE codes of practice. When detainees were advised of this right, the codes of practice were not routinely explained or offered by custody sergeants. We found between one and three copies of the codes of practice in each of the custody suites, which was insufficient for the numbers of detainees held. At Longsight, there was a copy of the codes of practice available in Braille.

5.14 Detainees were routinely offered a written notice setting out their rights and entitlements, although the version offered in most custody suites was out of date. Custody staff were able to access these notices in foreign languages for non-English-speaking detainees but not all staff were aware that an easy-read pictorial version was also available. Posters informing detainees of their right to free legal advice, in a range of languages, were available in all the suites.

5.15 All detainees were offered free legal representation, and if they declined they were told that they could change their mind at any time. Those wishing to speak to legal advisers were not always able to do so in private as telephone calls had to be taken at the booking-in desk in some of the suites. There were sufficient consultation and interview rooms at all of the suites and we saw legal advisers routinely being given their client's custody record front sheet or a copy of their detention log on request. In our CRA, all detainees had been

offered access to free legal advice and 38 had accepted this offer. Logs demonstrated that solicitors were contacted promptly after being requested.

5.16 We saw detainees being told that they could inform someone of their arrest, which staff facilitated; in most cases, this was done in the detainee's presence, so they were able to speak to their nominated person on the telephone. In our CRA, 25 detainees had asked for someone to be informed of their arrest and it was clear that efforts had been made in all cases to contact the person; if they had not been available; multiple attempts had been made to contact them.

5.17 Reviews of detainees' cases were undertaken by dedicated custody and operational duty inspectors across the force area. Across the custody suites, we observed some good face-to-face reviews taking place, which were timely and appropriate. In our CRA, 20 of the 34 detainees had had a face-to-face review. Eleven reviews had taken place while the detainee was asleep and there was no evidence in any of the detention logs that they had been informed of this or reminded of their rights and entitlements on awakening.

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

5.19 Custody staff at all the suites told us that the local remand courts would not normally accept detainees after 1.30pm on weekdays and after 9.30am on Saturdays, which was too early. We were told that there could be a limited amount of flexibility on a daily basis, depending on how busy the courts were, but this could have resulted in detainees being held in custody for longer than necessary. We saw two detainees at Bury being refused acceptance by Bury and Rochdale Magistrates' Court at 1.50pm, resulting in them being held in custody overnight.

Area for improvement

5.20 Detainees should receive timely access to courts, ensuring that the period spent in custody is kept to a minimum. The force should work with HM Courts and Tribunals Service to ensure that early court refusals do not result in unnecessarily long stays for detainees in police custody.

Rights relating to treatment

5.21 We found that complaints were not always handled while the detainee was in custody, which contravened force policy. In one custody record we reviewed, it was noted that the detainee wished to make a complaint about not receiving a shower but he had been transferred to court without his complaint being submitted or any information being provided to him on how to complain. We also reviewed CCTV footage of a case involving a 15-year-old boy who had stated that he wanted to make a complaint about being assaulted on arrest. The custody sergeant had told the detainee, incorrectly, to make his complaint after he was released, and had not informed the custody or duty inspector. No visible information about the complaints process was displayed in any of the custody suites.

Area for improvement

5.22 Detainees should be able to make a complaint in custody about their treatment.

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 CRG Medical Ltd (CRG) had taken over primary health care services in January 2015. Criminal justice mental health workers from two mental health trusts provided embedded mental health services in five suites and several substance misuse services had input into the suites. Partnership working between providers and with custody staff was mostly good.

6.2 Commissioning health service provision in Manchester was complex owing to high levels of social deprivation and health need served by multiple local authorities, mental health trusts, acute trusts and clinical commissioning groups, which was further complicated by the planned devolution arrangements for health and social care in Manchester. A 2015 health needs assessment informed service development. NHS England and the force were working collaboratively to transfer the commissioning of health services to NHS England from April 2016 but alternative models were being explored as this national initiative had been cancelled in December 2015.

6.3 CRG was contracted to provide 41,000 HCP attendances per annum, although the demand exceeded this. The proportion of all detainees who required an HCP had increased from 38% to 44% between the 2012 and 2015 health needs assessments. Five nurses/paramedics and one FME covered the nine suites 24 hours a day. A second FME was on duty from 10am to 10pm daily and an additional nurse was embedded at Bury from 4pm to 2am on six days a week, to address high demand. Requests for HCP and FME attendance went through a call centre, which then allocated clinicians to meet agreed response times and clinical need. Response times were rigorously monitored. The average HCP response time had been 59 minutes for the year to November 2015, which was good. However, some excessively long response times, of up to 10 hours, due to multiple factors, including very high demand, travelling between suites and an over-reliance on FMEs for some interventions (including mental health assessments), meant that CRG consistently failed to meet overall response targets.

6.4 Clinical governance was inadequate but had improved since the appointment of new clinical governance and contract managers. Most appraisals were out of date, there was no formal supervision, and training did not adequately address all areas, such as safeguarding and mental capacity. The new managers were addressing these deficits by introducing such measures as an enhanced training plan, monthly clinical governance newsletters, audits and team meetings. Clinical leads received appraisal and Nursing and Midwifery Council revalidation training during the inspection and were to be released from clinical responsibilities one day a week from February 2016 to improve clinical leadership. A lead FME completed six-monthly audits of FMEs' clinical records. Registration status was monitored and induction processes were satisfactory. HCPs had easy access to relevant current policies and procedures.

6.5 CRG and the force had dedicated, well-advertised health care complaints procedures. We were told that no health-related complaints had been received in the previous six months. Professional telephone interpreting was used for detainees with limited knowledge of English.

6.6 Health consultations were routinely conducted with the door open, without any individual risk assessments; this compromised detainee confidentiality, particularly at North Manchester, where the clinical room was near the booking-in desk. Intimate examinations were conducted with the door closed and a DO present, but none of the rooms had privacy screening. Information on detainees' right to request an HCP of the same gender was displayed in most clinical rooms.

6.7 Clinical rooms were superficially clean, except at Pendleton, where the room was dirty. However, they did not meet the required infection control standards as a result of non-compliant fixtures and fittings, excess clutter, and cleaning that was not to NHS standards, so they were unsuitable for forensic testing. Clinical rooms were used to store forensic kits and were accessible to custody staff, which further compromised infection control standards. Refrigerator temperatures in clinical rooms were not monitored; although we were told that these were for forensic samples only, we found named-patient insulin for released detainees stored in the refrigerator at Longsight. Clinical stock was not standardised across the suites and we found some expired items. Equipment was not maintained adequately but new, standardised check lists and maintenance processes were being implemented.

6.8 Custody staff had annual first-aid training and easy access to automatic external defibrillators. However, custody suite first-aid kits were not standardised, there were no check lists, and we found expired items and inadequate stock in most suites, in spite of weekly checks. HCPs had access to emergency bags, including oxygen, but we found expired items and missing or insufficient equipment, in spite of daily recorded checks. There were plans to introduce enhanced standardised emergency bags. Ambulance response times for emergencies were reported to be good.

Areas for improvement

6.9 Detainees should consistently be seen by a health care professional within agreed response times.

6.10 Detainees should be treated by appropriately trained health services staff, who receive regular, recorded access to clinical and managerial supervision and performance appraisals. Clinical leads should have dedicated time to complete regular audits and provide clinical leadership.

6.11 Health consultations should always take place in private, unless an individual recorded risk assessment indicates that this is not appropriate, and privacy screens should be available in all clinical rooms.

6.12 Clinical rooms should consistently meet current infection control standards and be suitable for forensic testing.

6.13 Each suite should have sufficient stocks of in-date emergency equipment that is checked regularly against an agreed stock list and meets the identified needs of detainees and staff in that suite.

Patient care

6.14 Custody sergeants referred detainees to HCPs based on need or detainee request, and HCPs reviewed all detainees who returned from hospital. We observed good interactions between HCPs and detainees. HCPs completed electronic clinical notes and gave a care

plan to custody staff. The clinical records we examined were mostly good and were generally stored and shared correctly, although we found 40 clinical records in an unlocked drawer in the clinical room at Bolton; this was addressed by clinical managers during the inspection. Custody staff were frustrated by delays in the provision of health care for detainees but said that the care given and communication by HCPs were good. Detainees we spoke to were positive about the health care they had received.

6.15 Standardised stock medication was well organised, checked regularly and stored securely, and use was recorded centrally, although we found one expired medication in Cheadle Heath. Stock balance discrepancies were managed as clinical incidents. CRG drug cupboard keys were accessible only by HCPs. Records were kept of discarded drugs but the reason for disposal was not recorded and the disposal bins used had large apertures, which made diversion possible. HCPs checked the stock of opiate and alcohol withdrawal medications daily and balances were correct during the inspection. Most clinical suites contained out-of-date pharmaceutical reference books.

6.16 Custody staff tried to retrieve medications from detainees' homes, where appropriate, and this was checked by health services staff and prescribed before administration by DOs. DOs we spoke to said that they had not been trained for this role. We were concerned that untrained staff reading prescriptions and administering medicines from multiple boxes of medication carried a significant risk of drug errors. Custody staff generally stored detainees' medication securely, although at Pendleton, Longsight and North Manchester some medications were kept with the detention record, which created a risk of it being misplaced.

6.17 At Cheadle Heath, unlabelled asthma inhalers were given by custody staff to detainees to use, without authorisation from CRG, and they were reused by multiple detainees; this practice was unsafe and unsanitary.

6.18 Only pregnant women on methadone prescriptions for opiate addiction could continue their prescription in custody, which was too limited. Symptomatic relief for drug and alcohol withdrawal was prescribed, although this was not sent with the detainee to court, which could have led to serious health consequences for those withdrawing from alcohol. FMEs left medication in envelopes for DOs to administer; however, other HCPs, such as nurses and paramedics, had to administer the symptomatic relief that they prescribed. This meant that they had to return to the custody suite to review the detainee and administer the medication, which sometimes delayed drug administration if the detainee remained in custody for prolonged periods.

6.19 Nicotine replacement therapy was not available, which could have exacerbated the distress of prolonged detention for those who smoked.

Area for improvement

6.20 **Medication should be stored securely and administered safely by trained staff at the correct time, and medication that is due to be taken while a detainee is at court should be sent with them, with clear administration instructions.**

Substance misuse

6.21 Support for detainees with substance misuse issues had declined since the previous inspection and was inadequate. Custody staff reported, and we observed, that a large proportion of detainees presented with substance misuse issues. In November 2015, 493

out of 3,124 (16%) calls received by CRG had related to substance misuse issues. At each suite, detainees arrested for 'trigger' offences who tested positive for category A substances such as heroin received a mandatory appointment with a drug service.

6.22 Most suites did not have effective drug and alcohol services. Substance misuse workers attended North Manchester, Wigan and Bury suites daily and offered support to all adult detainees but this service was not available at the other suites, so the opportunity to support detainees into services was missed. Custody sergeants offered referrals to services but they were rarely accepted. There was no dedicated provision for children with substance misuse issues (see area of concern 2.38).

Mental health

6.23 Mental health provision in the custody suites had improved but still did not meet the needs of detainees. A large number of detainees presented with current or previous mental illness, often with concurrent substance misuse issues. In November 2015, 430 out of 3,214 (14%) requests for HCP attendance had been related to mental health issues, and a further 135 (5%) had been specifically for joint exit risk assessments (see paragraph 4.15).

6.24 Mental health services were embedded in five of the nine suites (Wigan, North Manchester, Longsight, Bolton and Swinton). These services typically were based in the suites for 4–5 hours daily, from Monday to Friday, and included aftercare in the community if required, which was excellent. Custody staff in these suites were positive about the services provided. However, the limited hours of operation meant that some detainees who could have benefitted were missed. In addition, with the exception of those at Wigan, these workers could not refer detainees directly for a Mental Health Act assessment and had to call an FME to repeat the assessment and refer, which unnecessarily extended detention for some detainees.

6.25 FMEs and CRG registered mental health nurses (RMNs) completed mental health assessments in the four suites that had no onsite mental health services, and at the other five suites completed them out-of-hours, although waiting times could be excessive. In addition, CRG RMNs could not refer detainees directly for a Mental Health Act assessment; instead, they had to refer to an FME, who was the only person empowered to make such referrals, creating unnecessary delays. Custody staff and beat officers had access to 24-hour telephone advice from mental health practitioners, which was helpful. There was effective joint working between the police and local mental health services at local and strategic levels, including panels post-custody to agree on how best to support identified offenders with mental health issues.

6.26 Four mental health trusts provided adult mental health services across Manchester and another trust provided children's mental health services. The complexity of these arrangements sometimes created challenges in obtaining prompt assessments, particularly when detainees were located in a custody suite outside their home area. We were told that access to Mental Health Act assessments was generally timely following FME assessment, although there were occasional delays in accessing beds in mental health facilities. We observed an instance where a detainee with complex mental health issues was in custody for a total of 76 hours 40 minutes, including almost 51 hours between the referral for a Mental Health Act assessment and transfer to a mental health bed, which was too long.

6.27 Children with possible mental health issues were assessed by CRG FMEs before referral to specialist children's services, if required.

6.28 The force actively discouraged the use of police custody as a place of safety for those detained under section 136 of the Mental Health Act 1983.[7] A pilot street triage scheme assisted this policy in Oldham. The force told us that 25 people had been detained in police custody under section 136 in 2015. Custody and trust mental health staff said that detainees were rarely detained in police custody under section 136. Trust mental health staff said that joint working with street officers was good and that section 136 protocols were generally followed.

6.29 Custody staff we spoke to demonstrated a satisfactory understanding of mental health issues and had received formal training from mental health staff.

[7] 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.

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

Areas of concern and recommendations

7.1 **Area of concern:** GMP did not have ready access to custody data that would allow it to improve outcomes for detainees.

Recommendation: Greater Manchester Police service should improve the collection and management of custody-related data to help them improve outcomes for detainees. (2.36)

7.2 **Area of concern:** GMP did not record data on the use of force in custody effectively. There was no managerial scrutiny of incidents of use of force in the custody environment. We considered that the force needed to do more to ensure learning and to train staff in techniques to deal with confrontational situations more effectively.

Recommendation: Greater Manchester Police service should introduce effective management systems for the scrutiny and oversight of use of force. There should be rigorous arrangements in place for staff to record their involvement in incidents; for the review of such incidents; for the collection of use of force data; and for the monitoring of trends.

Force should only be applied proportionately, and using only approved techniques and equipment. (2.37)

7.3 **Area of concern:** A large proportion of adult and juvenile detainees entered custody with drug and alcohol issues but there was inadequate provision at most suites to support detainees into services effectively.

Recommendation: Adult and juvenile detainees should have timely access to substance misuse services in all suites. (2.38)

7.4 **Area of concern:** The strategic approach to, and support for, detainees with mental health issues had improved but detainees with mental health issues regularly experienced long delays and extended detention before their mental health needs were assessed and met. Opportunities to support detainees with lower-level mental health needs into relevant services were missed.

Recommendation: Detainees with mental health issues should receive prompt assessments and support in all suites. (2.39)

Areas for improvement

Treatment and conditions

7.5 Records should reflect all risks identified in the risk assessment and hold sufficient detail to make accurate decisions about detainee safety and welfare while in custody. (4.18)

7.6 All staff who unlock detainees should be able to respond to ligature threats and should have immediate access to an anti-ligature knife. (4.19)

7.7 All suites should have a consistent and recorded system of daily cell checks, including identification of ligature points. (4.30)

7.8 Exercise, showers, toilet paper and reading materials should be offered routinely to detainees. (4.35)

Individual rights

7.9 Children charged and refused bail should be provided with alternative safe and secure accommodation. The force should work with local authorities to increase the accommodation provision for children in custody. (5.11)

7.10 Detainees should have access to appropriate adults (AAs) from the point of booking into custody. The force should ensure that AAs are requested to attend as soon as possible, to ensure the welfare and safety of vulnerable adults and children in custody. (5.12)

7.11 Detainees should receive timely access to courts, ensuring that the period spent in custody is kept to a minimum. The force should work with HM Courts and Tribunals Service to ensure that early court refusals do not result in unnecessarily long stays for detainees in police custody. (5.20)

7.12 Detainees should be able to make a complaint in custody about their treatment. (5.22)

Health care

7.13 Detainees should consistently be seen by a health care professional within agreed response times. (6.9)

7.14 Detainees should be treated by appropriately trained health services staff, who receive regular, recorded access to clinical and managerial supervision and performance appraisals. Clinical leads should have dedicated time to complete regular audits and provide clinical leadership. (6.10)

7.15 Health consultations should always take place in private, unless an individual recorded risk assessment indicates that this is not appropriate, and privacy screens should be available in all clinical rooms. (6.11)

7.16 Clinical rooms should consistently meet current infection control standards and be suitable for forensic testing. (6.12)

7.17 Each suite should have sufficient stocks of in-date emergency equipment that is checked regularly against an agreed stock list and meets the identified needs of detainees and staff in that suite. (6.13)

7.18 Medication should be stored securely and administered safely by trained staff at the correct time, and medication that is due to be taken while a detainee is at court should be sent with them, with clear administration instructions. (6.20)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	Team leader
Fiona Shearlaw	HMIP inspector
Vinnett Pearcy	HMIP inspector
Kellie Reeve	HMIP inspector
Ian MacFadyen	HMIP inspector
Fionnuala Gordon	HMIP inspector
Keith McInnis	HMIP inspector
Clive Burgess	HMIC lead staff officer
Anthony Davies	HMIC staff officer
Denise Hotham	HMIC staff officer
Majella Pearce	HMIP health services inspector
Kathleen Byrne	Care Quality Commission inspector
Tanveer Akhtar	Care Quality Commission inspector
Joe Simmonds	HMIP researcher
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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 should introduce a forum where custody practitioners and managers can discuss custody issues so that they are able to inform and be part of the change process. (3.13)
Not achieved

The force should ensure that all managers with responsibility for custody understand and carry out the required quality assurance of custody records, including person escort records. (3.14)
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.

Main recommendations

Risk assessment procedures, including initial and pre-release assessments, should be consistent and provide an effective system for carrying out detailed risk assessment and care planning. (2.19)
Achieved

Handovers should be comprehensive and should involve both CDOs and police custody staff. (2.20)
Partially achieved

There should be a programme of regular deep cleans in place at all suites and graffiti should be removed promptly. (2.21)
Achieved

The NHS should provide appropriate support to police custody to ensure that detainees with mental health problems are promptly diverted to appropriate mental health services. (2.22)
Partially achieved

National issue

Appropriate adults should be available for juveniles aged 17. (2.23)
No longer relevant

Recommendations

Booking-in areas should be sufficiently private so that staff and detainees are able to communicate effectively, and custody sergeants should exercise greater control over personnel present in the booking-in areas to this end. (4.8)
Not achieved

There should be clear policies and procedures in place to meet the specific needs of detainees particularly those of women, juveniles and detainees with disabilities. (4.9)
Not achieved

Staff should inform detainees that arrangements may be made to enable them to observe any reasonable religious practice while in custody, and items should be stored respectfully. (4.10)
Not achieved

Custody sergeants should ask detainees during the booking-in process if they have any concerns about dependants. (4.11)
Achieved

Staff should receive up to date awareness training on child protection and safeguarding in respect of juveniles and vulnerable adults. (4.12)
Achieved

Staff should be briefed on the requirements of the four levels of observation in use so that observations are applied consistently. (4.24)
Achieved

Greater Manchester Police Service should collate use of force data in accordance with the Association of Chief Police Officers' policy and National Policing Improvement Agency guidance. (4.30)
Not achieved

Cell heating at Chadderton should be adequate. (4.37)
No longer relevant

The correct use of call bells should be explained to all detainees, the system at Bury should function correctly and they should be responded to promptly. (4.38)
Partially achieved

Cells should be free from ligature points, and safety checks should be regular and thorough at all custody suites. (4.39)
Not achieved

Custody staff should carry out, or be present at any visit to a cell. (4.40)
Not achieved

Showers should be offered to all detainees held overnight and to those who require one. (4.49)
Not achieved

Replacement clothes rather than paper suits should be given to detainees to wear when their clothes are removed. (4.50)
Achieved

Detainees held for long periods should be offered outside exercise. (4.51)
Not achieved

Individual rights

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

Recommendations

Greater Manchester Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but who cannot be bailed. (5.10)
Partially achieved

Senior police officers should engage with HM Court Service to ensure that the early court cut-off times do not result in unnecessarily long stays in custody. (5.21)
Not achieved

Detainees should be told routinely how to make a complaint in line with the Independent Police Complaints Commission statutory guidance and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody. (5.24)
Partially 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

HCPs should be offered regular clinical supervision, receipt of which should be recorded. (6.10)
Not achieved

There should be robust infection control procedures for all medical rooms, which should be cleaned regularly. It should be possible to take forensic samples in the rooms. A daily record of scheduled cleaning should be kept. (6.11)
Not achieved

Equipment within medical rooms should be rationalised and standardised and the ownership of stock within the medical rooms should be clarified, and effectively managed. (6.12)
Not achieved

Detainee clinical records should not be routinely shared with third parties except by express permission of the detainee and the HCP. (6.25)
Achieved

Clinically indicated medication should be available to patients for whom they are prescribed and should only be administered to detainees following prescription by an HCP. (6.26)
Achieved

Discarded medicines should be disposed of securely and should not expose custody staff to unnecessary risk. (6.27)
Partially achieved

Police custody should be used as a place of safety for the purposes of section 136 on an exceptional basis only. (6.44)
Achieved