Report on an unannounced inspection visit to police custody suites in

Lancashire

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

31 May–10 June 2016

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 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.

We last inspected Lancashire in 2011, when we reported positively on many aspects of the way custody suites were run, and we made a few recommendations to help the force address the concerns we identified. At this inspection we were very disappointed to discover that only 20% of these previous recommendations had been fully achieved, and most issues that we had highlighted had either drifted or got worse.

We had three particular areas of concern. The first was the way that force was used in the custody suites. There was no policy or proper oversight about the way force was carried out, and there were no data about the extent of its use, making it impossible to determine whether the work practice was sound or properly accountable. In a small number of the random sample of cases we viewed involving force, we identified concerns about the way force was used. In almost half of the other cases viewed, we found general concerns about the way detainees appeared to have been treated. These matters were referred back to the force for investigation.

Our second major concern related to respectful treatment. Despite a previous recommendation, CCTV coverage in cells was still not pixellated and, as a consequence, anyone standing in the control area had a clear view of detainees using the toilet. In one case we found a situation where a female detainee had her clothing removed in the presence of male staff, and in another, an individual had been left naked in a cell which could be seen on CCTV.

The other principal concern was about accountable practice and poor record keeping. Insufficient data were gathered and only limited monitoring was carried out. The force, therefore, was not able to identify patterns and trends and this made it difficult to 'learn lessons' or carry out necessary improvements. The standard of recording was unusually poor in most areas. The force was badly served by software that made it difficult to avoid using formulaic responses in, for example, assessments, but as well as this, most of the recording we saw lacked sufficient detail. A new IT system was, however, being introduced during our inspection, and it was anticipated that this would lead to considerable improvements.

Despite a move towards centralising custody services, the anticipated benefit of greater consistency in work practice across the force area had not yet emerged. At a strategic level, there had been some useful collaborative work by senior staff with partner agencies. However, in most cases there was a considerable gap between theory and practice in the application of policies within the force, notably with regard to safeguarding.

Despite the problems we identified, custody staff mostly behaved in a courteous and professional manner towards detainees. The physical environment in the custody suites was largely unchanged, and the older facilities remained inadequate.

The effective application of the Police and Criminal Evidence Act 1984 (PACE) was not always consistent, and children still remained in custody for too long. Although we were informed that there had been improvements in transferring children from police custody to suitable alternative accommodation, we were unable to assess this because no records were available.

Detainees told us that they were content with the health care provided in the suites, and we found that mental health support was particularly good. However, waits for Mental Health Act assessments

were often lengthy, and the lack of mental health beds meant that some unwell detainees remained in the unsuitable custodial environment for too long.

Our observations indicated that pre-release support for detainees varied considerably. This was yet another area in which it was difficult for us to reach a clear judgement because of weaknesses in the way records were kept.

Overall, this was a disappointing inspection. The force had failed to build on the progress we identified previously. With generally good treatment of detainees and mostly reasonable conditions, the fundamental building blocks remained intact. However, as we have indicated throughout this report, there was a clear need for the force to develop and improve the infrastructure supporting custody, so that outcomes for all detainees were always good enough.

We noted that of the 25 recommendations made in our previous report after our inspection of April 2011, five recommendations had been achieved, seven had been partially achieved and 13 had not been achieved.

This report provides three recommendations to the force and highlights 31 areas for improvement.

Dru Sharpling CBE
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

August 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 was conducted as part of the police custody inspection. The custody record analysis was carried out on a representative sample of the custody records, across all the suites in the Lancashire police area, opened in the week before the inspection was announced. Records analysed were chosen at random and a robust statistical formula provided by a government department statistician was used to calculate the sample size required to ensure that our records analysis reflected the throughput of the force's custody suites during that week.[2] The analysis focused on the legal rights and treatment and conditions of the detainee. A total sample of 144 records were analysed.

Custody suites	**Number of cells**
Blackburn	44
Blackpool	41
Burnley	28
Lancaster	24
Preston	32
Skelmersdale	14 – closed for refurbishment during the inspection

[1] http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/
[2] 95% confidence interval with a sampling error of 7%.

Leadership, accountability and partnerships

2.4 We were disappointed to discover that only 12% of recommendations made at the last inspection in 2011 had been fully achieved.

2.5 There was a clear governance structure in respect of custody in Lancashire constabulary and the force had a documented custody operating model. The assistant chief constable (ACC) had a clear focus on delivering appropriate custody services, but the vision stated was not fully realised and had not yet had a sufficiently positive impact on outcomes for detainees.

2.6 In an attempt to achieve efficiencies and to standardise work practices, custody services had been centralised 18 months previously. We found that inconsistencies continued to occur across the force area.

2.7 Throughput and demand for custody provision had been used to make best use of resources, and this was clearly defined in the custody operating model. However, some sergeants on custody duties had not met the specified training and accreditation. There was some evidence that issues picked up from the sampling of officers' work (see paragraph 2.14) were fed back in guidance to custody staff, although staff who were on custody duties infrequently did not always benefit from this input.

2.8 One objective of the custody operating model was to introduce standard operating procedures (SOPs) for consistent and effective custody across the constabulary. However, there were few local SOPs and it was unclear where staff would find guidance, other than in the College of Policing *Authorised Professional Practice* or in primary legislation.

2.9 Despite some improvements in quality assurance measures across the custody provision, there was still not sufficient focus on performance and there was little management information to assess strategically how the force was performing in critical areas. There was very limited data to monitor the outcomes for vulnerable people in custody, including bail times, children held in custody overnight, section 136 cases[3] or use of force, which was a concern. While there was a focus on trying to improve outcomes, there was currently no effective way of measuring this. A new IT system (Connect) was being introduced during the inspection, and staff were optimistic that this would enable the collation of data in a way that would meet the assurances we sought.

2.10 Senior staff in the force had held leading positions in some external strategic forums. The ACC chaired the Local Criminal Justice Board, where complex cases were raised and discussed, and the 'out of court disposal group', which promoted use of a range of interventions, including restorative justice panels. However, we were told that some local partners were preoccupied with delivering their own core activities, making it difficult for them to engage in collaborative work with the police.

2.11 There was some confusion about safeguarding procedures. The local safeguarding policy framework for children and vulnerable adults was not clear, we could find no specific guidance on how the force recognised and addressed safeguarding (other than by making referrals), and staff had no specific guidance on safeguarding matters. There was a lack of appropriate adult cover out of hours, which affected the number of children detained in

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[3] Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved mental health practitioner, and for the making of any necessary arrangements for treatment or care.

custody overnight. Despite this, the chief officer group had a clear strategic vision about the 'early action' approach to divert children and vulnerable adults from custody.

2.12 We were unable to find an equality and diversity action plan, and there were no systematic or effective measures to ensure that equality and diversity matters were dealt with properly.

2.13 There were effective mechanisms to discuss how to deal with section 136 detainees in custody, and there was a clear escalation process to raise concerns and highlight when and why people were detained in police custody under section 136. However, there were still too many instances where vulnerable adults were detained in custody for long periods.

2.14 The force had recently strengthened its approach to performance management by introducing sampling that involved custody sergeants reviewing each other's work – 165 custody records were sampled monthly and themes were fed back to staff for guidance. However, there were still many shortfalls in custody records that needed to be addressed. Entries were weak, frequently failed to describe individual circumstances, and were often formulaic, with little recording of justification for individual actions taken or decisions made.

2.15 Governance of the use of force was inadequate, with no preventive aspect, very limited accountability and few opportunities for learning lessons. The force was unable to identify or provide us with cases where force had been used in custody. Data on the use of force generally was inadequate, and it was not monitored at strategic or operational level. Deficiencies with data on the use of force in custody were a significant longstanding weakness, which the force had failed to address.

2.16 Independent custody visitors (ICVs) reported constructive and open relationships with custody staff.

Pre-custody: first point of contact

2.17 Frontline staff were well equipped to identify and assess the risks and vulnerabilities of detainees when called to incidents. Police officers and staff received regular face-to-face training, which helped enable them to make measured assessments about an individual's risks and needs.

2.18 The internal arrangements for sharing information about initial decisions were good. Customer service staff operated the IT systems confidently, and highlighted known risks and vulnerabilities effectively. This allowed them to prioritise their work and relay critical information to officers attending incidents. This included officer safety warnings and details about any risks or support needs concerning the relevant individual.

2.19 No partner agencies, such as NHS mental health, probation, or social services, were based in the customer call centre, and there was no shared access to external IT systems. This limited the scope of the background information used in assessments.

2.20 Frontline officers had mobile devices through which they could access some information about the detainee and police national computer (PNC) information.

2.21 It was a priority for frontline staff to avoid taking children into custody, and they actively explored a range of relevant alternatives to achieve this. However, children were not considered as vulnerable on the basis of their age alone, which was not consistent with good practice.

In the custody suite: booking in, individual needs and legal rights

2.22 Custody sergeants were able to provide examples where they had refused to give authority to detain, when there were insufficient grounds to do so. Suitable alternatives to custody used included restorative justice, fixed penalty notices and voluntary attendance. Voluntary attendees did not have to enter the custody suites to be dealt with, which was positive.

2.23 We found some evidence of cases not being progressed promptly, such as delays in access to appropriate adults, interpreters and staff in the custody process teams. We were told that there were also delays in decision making by the Crown Prosecution Service (CPS). All these factors resulted in detainees being held in custody for longer than necessary.

2.24 Custody staff told us that most immigration detainees were moved on to alternative accommodation within a short period, but sometimes this could still take over 24 hours.

2.25 Information on rights and entitlements were available to detainees in a range of languages, although not in Braille, and not all staff were aware of the availability of easy-read versions. We found some out-of-date PACE codes of practice in the suites. Custody staff were not sufficiently proactive in explaining the codes of practice.

2.26 We observed custody staff generally treating detainees courteously. However, in a small number of cases, we reviewed CCTV footage which appeared to show detainees being treated with a lack of dignity and respect. We referred these cases back to the force for them to examine further.

2.27 The design of most suites made privacy difficult when detainees were booked in. There were sufficient consultation and interviews rooms in each custody suite. However, if telephone legal advice was required, calls had to be made from the booking-in area or at the booking-in desk, which lacked privacy. Custody staff were able to access telephone interpreting to assist non-English speaking detainees, although staff told us that detainees sometimes had to remain in custody for longer than necessary because interpreters were not available. There were no hearing loops in the custody suites other than at Lancaster.

2.28 Management of DNA samples was mainly effective with weekly collections; however, we found some inappropriate items stored in DNA freezers at three suites.

2.29 There was no information about the complaints process displayed in any of the custody suites. Complaints were generally not dealt with while the detainee remained in custody. The majority of custody staff told us that they would direct detainees who wished to make a complaint to go to the front counter on their release, while a few said they would advise the duty response or custody inspector, depending on the nature of the complaint.

In the custody cell, safeguarding and health care

2.30 There had been very little change in the physical conditions of the suites since our 2011 inspection and some of the weaknesses we identified then – such as inadequate cell checks, potential ligature points and poor quality recording of faults – continued to be problems.

2.31 The newer custody suites at Preston, Blackburn and Lancaster were clean and well maintained. However, the facility at Blackpool was dilapidated and conditions at Burnley were poor, with offensive graffiti in many of the cells. Detainees were not always able to shower privately. All suites had a fire evacuation policy, which staff understood, and there

had been drills recently. Despite our previous recommendation, detainees were still unable to use toilets in private because the in-cell toilets covered by CCTV had not been obscured; this was unacceptable. We were advised that a new CCTV system was now beginning to be installed. Although reading material was available in the custody suites, staff did not offer this to detainees.

2.32 Not all staff had received annual safety refresher training in the use of force, and custody sergeants and civilian detention officers (CDOs) received different training, potentially leading to inconsistencies in their approaches. When force was used it was not always recorded, and when it was documented it was generally insufficiently detailed. We requested documentation on 11 incidents involving use of force and received only two use of force forms.

2.33 There was excessive handcuffing of compliant detainees, including children. Too many individuals remained in handcuffs for long periods after they arrived in custody.

2.34 There was little recorded justification for the forcible removal of clothing, which seemed almost routine, even though this could potentially escalate conflict unnecessarily. Data collated by the force in the year to the end of April 2016 showed that black and minority ethnic detainees were overrepresented in strip searches. The rationale for strip searching was also not always clear, and we were not assured that it was always warranted.

2.35 Most custody suites had only a limited range of replacement clothing, and so some detainees were given ill-fitting clothing. In some suites we were told that paper suits were routinely as replacement clothing, and we observed this. We saw detainees in all the suites walking about in bare feet or socks, as replacement footwear was not routinely offered or issued. These practices were unacceptable.

2.36 The PACE reviews we observed were carried out to varying standards, from poor to very good. Some took place through the cell hatch, which was not appropriate. We saw no detainees informed that reviews had taken place while they were asleep.

2.37 There were no specific arrangements for detained children, other than they were put on 30-minute observations. Although staff did not receive any specific safeguarding or child protection training, those we spoke with understood safeguarding concerns and the importance of diverting vulnerable people away from custody or minimising the time spent there.

2.38 Children and vulnerable adults did not always have access to an appropriate adult promptly and records showed that average waits were long, with no support for children and vulnerable adults immediately on their admission to custody. Although suites held guidance for appropriate adults about their role, this was not routinely issued to them, and not all custody staff were aware of it. Fingerprinting and photographs were sometimes taken without an appropriate adult present, which breached PACE. Our review of cases showed that some children spent long periods in custody, and if they were detained overnight were sometimes placed in the cell for a period of 'rest' to be dealt with the following morning, which was unacceptable. Custody sergeants reported that responses to requests for suitable accommodation for children detained after they had been charged had improved, and that non-secure beds were available through foster carers and placements were normally found. However, we were unable to measure the reported improvements as data were not available.

2.39 The force was engaged in some effective health partnership working arrangements, including input by NHS England, and we were given generally positive feedback from police and custody staff. The standard of governance of health services was developing from a low base, but there was now evidence of efforts to improve standards.

2.40 Confidentiality in health consultations with detainees was often compromised by the presence of CDOs in the cell or within earshot, and the clinic room door was left open regularly, which was not an acceptable practice. We noted several examples of very poor quality clinical records from some practitioners, exacerbated by use of a cumbersome assessment template. Clinical rooms were generally clean but some had dusty areas, and the cleaning arrangements and infection control compliance were variable.

2.41 Health care referrals were generally dealt with appropriately. However, we noted a few cases where a detainee's request to see a health professional had not been met. Health care professionals and custody staff generally worked well together. Despite this, detainees we spoke to said they had been cared for well. The consultations we observed were generally of a good standard, but some were compromised by poor recording. We noted cases in the records where clinical care was inadequate, including a lack of clear care plans for custody staff. Health care professionals made appropriate referrals to other agencies.

2.42 Arrangements for detainees who needed prescribed medicines were reasonable. There was a range of patient group directions (authorising appropriate health care professionals to supply and administer prescription-only medicine), and we observed nurses using these properly. CDOs could give single doses prescribed by forensic medical examiners, which was appropriate.

2.43 Regular direct input to detainees who needed help with substance misuse in custody was mostly limited. The Criminal Justice Liaison Team (CJLT) mental health and vulnerability model was used, so that where mental health practitioners identified substance misuse as an issue, they referred this on to the local provider. Although a policy enabled detainees on confirmed prescriptions of methadone or buprenorphine to receive them in custody, in practice this rarely happened. Detainees had no access to nicotine replacement therapy.

2.44 Detainees received a good mental health service during the working day, coupled with provision for those with wider vulnerabilities. There was good identification of potential need, supported by effective joint working between all partners. Appropriate triage and risk assessment ensured detainees with mental health problems were generally well cared for while in custody. Overnight, too many detainees spent too long waiting to be seen by a mental health practitioner, which was sometimes simply due to waiting until the CJLT team was on duty. Waits for Mental Health Act assessments were often lengthy, and a regular lack of mental health beds meant some detainees spent too long in an inappropriate custody environment. The use of interim case management workers to support detainees with mental health needs post release was positive.

Release and transfer from custody

2.45 We were not assured that all detainees had a pre-release risk assessment before they left custody. Information on most of the pre-release risk assessment records we reviewed was poor, and several suggested that identified risk factors had not been addressed before release. Practice on pre-release work varied considerably. Although many of the arrangements we observed directly or on CCTV were reasonable, not all demonstrated that adequate attention had been taken to ensure a safe release. Sergeants had no access to travel warrants or petty cash to assist the most vulnerable detainees to get home safely. A range of support leaflets was available but not always actively offered to detainees on their release. The quality of person escort records was variable, and some had scant information about the risk posed to or by detainees. Most court cut-off times were reasonable, which helped ensure that detainees did not spend unnecessary time in custody.

Areas of concern and recommendations

2.46 There was insufficient gathering and monitoring of performance data in key areas that promote the safe and respectful detention of people in custody. The custody records also had insufficient detail to show justification for decision making for each individual.

Recommendation. The force should ensure that:

- **it strengthens its approach to performance management and that data (including custody throughput, demographics, adverse incidents, strip searching, length of detention for detainees with mental health issues, complaints) are routinely collated and analysed to identify trends, inform organisational learning and improve outcomes for detainees**
- **custody records show that decisions about detainee treatment are justified, and actions are appropriate to individual circumstances and risk assessments.**

2.47 Not all detainees were treated with respect and dignity, and their individual or diverse needs were not always met. Despite our previous recommendation, detainees using the in-cell toilet could still be viewed on CCTV, which was completely inappropriate.

Recommendation. Action should be taken immediately to obscure the toilet areas in cells with CCTV.

2.48 All aspects of the use of force lacked governance and effective oversight. The force did not record data on the use of force in custody effectively, use of force forms were not always submitted, and records of force in custody records were poor or absent. There was inadequate managerial scrutiny of use of force incidents, and no routine viewing of CCTV records to assure proportionality or for learning points. Training for staff was inadequate and unapproved equipment was used in the restraint of detainees. Handcuffs were used on compliant detainees for too long after their arrival in custody, and force was used often to replace detainees' clothes with anti-rip clothing.

Recommendation. Lancashire Police should improve its governance of use of force in custody, including ensuring that:

- **there is effective management oversight of use of force incidents and trends**
- **staff are adequately trained in appropriate techniques at least annually**
- **force is always used at the lowest level, is appropriate for the threat posed, and that only approved equipment is used**
- **all staff involved in incidents complete individual use of force forms**
- **handcuffs are removed from compliant detainees at the earliest opportunity after their arrival in custody.**

Section 3. Leadership, accountability and partnerships

Expected outcomes:
There is a strategic focus on custody, including arrangements for diverting the most vulnerable from custody. There are arrangements to ensure custody-specific policies and procedures protect the wellbeing of detainees.

Leadership

3.1 It was concerning that the force had failed to show sufficient improvements to custody services following its inspection in 2011, particularly in achieving recommendations in some key areas; only 12% of the recommendations from the previous inspection had been fully met.

3.2 As strategic lead officer, the assistant chief constable (ACC) provided a clear focus on 'early action' and objectives to divert people, specifically vulnerable adults and children, away from custody. This strategy was reflected operationally by a range of referral schemes to avoid criminalisation and reduce and minimise reoffending.

3.3 There were effective management arrangements for custody services. The ACC was supported by a chief inspector as head of custody services. Three inspectors provided custody management operational support of the six custody suites. The force had centralised its custody function in April 2014 to provide consistent and effective practices across the county. These arrangements were intended to provide a clear direction with a strong focus on identifying and improving areas of concern.

3.4 The force had adopted national policies and guidelines for safer detention from the College of Policing *Authorised Professional Practice – Detention and Custody*. A custody operating model outlined the operating procedures, governance arrangements and ancillary matters related to the centralised custody department. This model set out an intention to introduce standard operating procedures to provide local guidance for the effective provision of custody. However, these were not yet in place and there were insufficient local policies or procedures to provide clear guidance to staff for the delivery of custody services and to ensure compliance with national standards.

3.5 Resources and staffing for custody services had been reviewed and had led to a deployment model with staffing geared to meet demand at peak times. The centralisation of the custody department had reduced the number of custody staff. There were 60 dedicated custody sergeants under the custody chief inspector, with additional response sergeants as back-up. The force has 100 custody detention officers (CDOs) managed by G4S, with senior detention officers providing local management. Work was carried out under the direction of custody sergeants at each suite.

3.6 Custody sergeants received regular training, set out in the custody operating model, to maintain their professional accreditation. Custody-trained sergeants who did not hold a substantive custody post did not always work the required one shift per quarter in custody to maintain their operational competency. These sergeants did not always receive guidance about their work or the sharing of lessons learned.

3.7 Services provided by external partners were monitored. We were told that some of the local authority partners were struggling to deliver their core activities, which made it difficult for them to engage them in collaborative work. The ACC chaired both the Local Criminal Justice Board, where complex cases were raised and discussed, and an of 'out of court disposal group', which promoted a range of interventions, including restorative justice panels. This adequately monitored outcomes for detainees with needs for health care or support to divert them from custody.

3.8 Diverting children away from custody was a priority for the force. Child Action North West, commissioned by the office of the Police and Crime Commissioner, offered a youth triage scheme catering for 500 children a year. This aimed to avoid the criminalisation of children where possible, and was for lower-level offences. Cases were referred to the scheme through the youth offending team (YOT), but referrals were also made by frontline police officers for children on voluntary attendance. The scheme provided reparation projects, such as work on allotments or decorating, and in 2015-16 had helped 653 children, of who fewer than 5% reoffended.

3.9 Diverting people with mental health problems and avoiding the use of custody as a place of safety for people sectioned under section 136 of the Mental Health Act[4] was also a clear priority for the force. To help achieve this, there was a comprehensive multiagency strategy document and a current 'crisis concordat' action plan.

3.10 While the force recognised the importance of safeguarding children and vulnerable adults, there was a limited policy framework to guide this work. Referral arrangements were used but wider recognition of safeguarding issues was less clear. There had been some training on people trafficking and child sexual exploitation, and staff received more general safeguarding training. However, the force lacked clear policies and procedures to identify and act on safeguarding issues.

Area for improvement

3.11 The force should ensure that there are appropriate policies and procedures that cover the whole custody process, which are fully implemented and reviewed regularly. Policies and procedures should be accessible and understood by staff.

Accountability

3.12 The force did not have a sufficiently robust approach to performance management (see recommendation 2.46). Data on custody performance was basic and made it difficult to identify patterns or trends. However, a new IT system (Connect) was expected to address this weakness, and there had been significant efforts to create reports covering children and vulnerable adults detained in custody, use of force, intimate searches and other key custody areas. It was anticipated that these reports would enable the force to have a better understanding of the custody service and help identify areas for improvement.

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[4] Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved mental health practitioner, and for the making of any necessary arrangements for treatment or care.

3.13 Governance of the use of force in custody was inadequate. There was no policy on the use of force, and its use was not monitored at a strategic or operational level, which presented significant risks. (See also paragraphs 6.10-6.16 and recommendation 2.48.)

3.14 Quality assurance to demonstrate that custody services were delivered to required standards was not sufficiently robust. The force had recently introduced a sampling process where custody sergeants reviewed the work of their peers and provided feedback through a quality assurance template. A total of 165 records a month were sampled, and completed templates were reviewed by the custody inspectors. Where weaknesses were identified, guidance was provided to the central team through management emails. The force hoped that this approach, together with the Connect system, would strengthen performance management to ensure detainees were dealt with properly and that their welfare needs were met.

3.15 There was a focus on individual decision making and the force expected officers to use the national decision model (NDM) to identify and justify appropriate actions. However, we were concerned that custody records lacked sufficient narrative to account for decisions made or the rationale behind them, including the use of handcuffs and the removal of personal items. Custody officers were over-reliant on the options listed in the custody IT system, which offered a pro forma text, without additional written entries to justify the individual case. (See recommendation 2.46.)

3.16 There was a limited strategic approach to equality and diversity. There were no equality and diversity strategies or policies, and no evidence of monitoring of protected characteristics to ensure fair and equal treatment of detainees. Custody staff generally showed an understanding of how they would meet detainees' diverse needs and were able to give examples of this. However, without a strategic framework and robust monitoring it was not possible for the force to demonstrate if it met the public sector equality duty.

3.17 There were effective arrangements for the independent custody visitors (ICVs) to provide external scrutiny for the custody service. ICVs were part of the Police and Crime Commissioner's office and were volunteers who visited custody suites to look at conditions and speak with detainees about their treatment. The ICV coordinator reported a good relationship and dialogue with the force, sharing views on how custody was operating, and discussing any complaints or issues raised by detainees.

Partnerships

3.18 A range of partnership arrangements and schemes supported the diversion of vulnerable adults and children away from custody. The county-wide Avert Service successfully diverted women from the criminal justice system and aimed to reduce reoffending. The service worked well with staff in all custody suite to take referrals for women given conditional cautions or fixed penalties, and offered a range of services including counselling, anger management, self-esteem, educational courses, housing and debt advice, and mental health support. Outcomes were regularly monitored and since June 2015, 900 women had been through the scheme with a reported reoffending rate of just under 13%. There was also a scheme to support veterans and keep them out of custody. A scheme aimed at diverting male detainees aged 18-25 was being piloted in Preston with the intention of introducing it across the force area.

3.19 The force's chief officer team worked actively with health and other partners to improve the approach to dealing with people with mental health problems, specifically in relation to detentions under section 136, Mental Health Act 1983.[5] Although there were some current operational problems, we were told that the introduction of the mental health care triage service (with one car in each area, see paragraph 6.65) had made a significant positive impact on reducing the number of vulnerable adults held in custody. While it was clear that officers were committed to ensuring that police custody was not used as a place of safety for section 136, data were poor and we found some instances where people were detained in police custody under section 136 (see paragraph 6.67).

3.20 Dealing with detainees with mental health problems who had committed offences remained a significant challenge for the force. Although it was felt that more people with mental health problems were being diverted away from custody, there were no data to understand the picture, and staff said that people with mental health problems who were charged with offences continued to present issues they were not fully equipped to deal with. Detainees could spend significant time in custody waiting for transfer to an appropriate health facility, and we were not assured that the force monitored this effectively to inform partnership discussion on how to address these concerns. (See recommendation 2.46.)

3.21 There had been some effective joint working with partners for the provision of alternative accommodation for children to prevent them from remaining in custody overnight after they had been charged, and where bail was refused. Through Children's Social Care, the force could approach several providers for appropriate accommodation. Greater management focus on this issue had improved understanding of the need to secure alternative accommodation for children who had been remanded in custody. There was a monitoring and review process through the YOTs to raise any concerns when a child or young person had remained in custody overnight when alternative accommodation seemed to be more appropriate. We were told that examples of this were relatively rare, suggesting that the arrangements worked well, but given no data to corroborate this judgement.

3.22 Partnership arrangements for the provision of appropriate adults did not effectively support children in police custody. The appropriate adult service was provided by Child Action North West, commissioned through the Youth Offending Service for children, but was also available for vulnerable adults. The service was made up of 35 paid staff and available 365 days a year from 9am to midnight. Children and vulnerable adults did not always obtain appropriate adults promptly, which resulted in some spending longer in custody than necessary.

3.23 There were effective working arrangements between the force and health partners, including active engagement by NHS England. The force custody chief inspector chaired a bimonthly tactical custody leads meeting, which included representatives of Castle Rock Group (commissioned to provide physical health services), as well as quarterly contract meetings with the group; there was effective communication outside these meetings to identify and deal with problems swiftly.

3.24 The bimonthly multiagency operational group meeting brought together the wide range of health, local authority and other welfare- related partners. This fulfilled a wider strategic

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[5] 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.

function, alongside effective identification and action on mental health issues for detainees. Partners we spoke to described positive, responsive and honest working relationships.

Area for improvement

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

Section 4. Pre-custody: first point of contact

Expected outcomes:
Police officers and staff actively consider alternatives to custody and in particular are alert to, identify and effectively respond to vulnerabilities that may increase the risk of harm. They divert away from custody vulnerable people whose detention may not be appropriate.

Assessment at first point of contact

4.1 From the detainee's first point of contact with the police service, officers and staff were generally alert to, identified and made effective assessments of risk and vulnerability. However, these were not always specifically focused towards detainees and generally focused on alleged victims.

4.2 Lancashire Constabulary had one customer contact centre (CCC) within its headquarters. Customer contact advisers (CCAs) performed various roles and were multi-skilled as call handlers, dispatchers and facilitators. All had received training on vulnerability, mental health, child sexual exploitation and human trafficking but were unclear about the Mental Capacity Act (which provides a legal framework for making decisions on behalf of adults who lack the capacity to make decisions for themselves).

4.3 The force intelligence database (Sleuth) contained information about vulnerability. CCAs tended to associate vulnerability with victims of crime rather than detainees, and checks of Sleuth and the police national computer (PNC) generally also focused on officer rather than detainee safety. Vulnerability markers were highlighted on the force's command and control system (Storm) and could be further analysed on Sleuth, but again this was primarily focused on victims rather than detainees.

4.4 CCAs had access to the custody management system (C3PO), which had details of vulnerability from risk assessments of those previously detained. However, this was not routinely searched. Partner agencies, such as social services, mental health and ambulance services, were not based in the CCC. There was no shared access to external IT systems, which limited the scope of background information available for use in assessments.

4.5 Frontline officers were well informed when responding to incidents. The control room generally provided prompt and relevant information, and officers had access to further information on mobile devices. This included any warning markers, and information about vulnerability and previous incidents, and was used to inform decision making on how to deal with the alleged offender.

4.6 It was a priority for frontline staff to avoid taking children into custody and they actively explored alternatives, such as voluntary attendance, community resolutions, and referrals to the youth triage scheme and the early intervention team in the force. Police officers and staff who had contact with children did not recognise them as vulnerable on the basis of their age only. Officers were aware of various diversion schemes that they could refer to. In particular, the youth triage scheme, which aimed to reduce reoffending by diverting children away from custody, and the early action team, which offered a wide assessment and support service for children and their families to keep them out of the criminal justice system.

4.7 Although all police officers and staff should be trained in the safe use of restraint techniques, not all staff had received annual officer refresher safety training in line with national guidelines and *Authorised Professional Practice*. The comprehensive transportation policy

provided clear guidance on the safe transportation of people to custody suites to prevent harm. Specific guidance stated that officers should use the national decision-making model to assess the need for the use of handcuffs. However, we saw little evidence of specific recording in custody records giving a rationale for the use of handcuffs, which were used routinely (see paragraph 6.15).

Section 5. In the custody suite: booking in, individual needs and legal rights

Expected outcomes:
Detainees receive respectful treatment in the custody suite and their individual needs are reflected in their care plan and risk assessment. Detainees are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the earliest opportunity.

Respect

5.1 Custody staff generally treated detainees courteously, and we observed some positive professional staff interactions with them. Staff showed an understanding of how to respond to and meet detainees' diverse needs. This included, for example, how they would deal with transgender detainees and interact with those with learning difficulties. However, understanding of diverse needs did not always translate into practice.

5.2 We found a small number of some very concerning cases of a lack of regard for detainees' dignity. For example, a distressed female detainee was brought into custody in her underwear and not offered anything to cover herself with for a significant time, a male detainee was verbally insulted by a sergeant and left naked in his cell with no replacement clothing, and male officers were involved in the forcible removal of clothing from a female detainee who was left naked in her cell for almost three hours. In addition, detainees in cells with CCTV could still be observed when using the toilet, which showed a continued lack of respect for their dignity, and it was unacceptable that to date there had been insufficient action to address this. We were advised that a new CCTV system was now beginning to be installed. (See recommendation 2.47).

5.3 The booking-in areas at the custody suites did not offer sufficient privacy, which could deter detainees from disclosing any individual vulnerabilities or specific needs. We were told there were no Disability Discrimination Act-compliant custody suites in the Lancashire force. There were no cells in any custody suite adapted to meet the needs of people with disabilities or mobility issues, and no accessible showers or toilets.

5.4 Although we observed some instances where detainees had their individual needs met, this was not always the case and depended largely on the detainee's request. Detainees were not routinely asked if they had caring responsibilities, although this had been addressed with the implementation of the new risk assessment on Connect, which we only saw in use at the end of our inspection. Women were not asked whether they required any sanitary items, and could not be guaranteed care by a female member of staff while in detention.

5.5 Children were not deemed vulnerable just because of their age. There were no special arrangements for children, other than placing them on 30-minute observations. Sergeants were generally not aware of the requirement for female children to be allocated a female officer to be responsible for their welfare needs. Children were not kept separate from adult detainees in line with good practice, although the design of one custody suite meant they were placed on a separate wing. There was limited reading material for children and this was rarely offered. Although custody staff told us they would interact positively with children while in custody, we did not see evidence of this during the inspection.

5.6 Religious books and items were available at the request of detainees, but they did not cover all the main faiths and in some suites were not stored respectfully.

5.7 Training to support staff to deal with detainees with specific or diverse needs was not comprehensive. All staff had received induction training but ongoing training was not consistent. Training was offered in mental health, learning disabilities and other vulnerabilities, but not all custody staff had the opportunity to attend the sessions. There had been no specific training on equality and diversity. The lack of a coordinated approach to training meant that not all staff could identify, understand and meet the individual and diverse needs of detainees consistently.

Area for improvement

5.8 Staff should be trained to recognise and provide for the individual needs of detainees, particularly children, women and detainees with disabilities.

Risk assessments

5.9 Detainees were generally booked in promptly, although we saw cases where waits were up to 55 minutes, which was inappropriate, particularly when they were generally held in handcuffs (see paragraph 6.15). In some of these cases the detainees were held in vehicles outside the custody suites with no management oversight of the queue during delays. In our custody record analysis, the average waiting time was 12 minutes and the longest was 75 minutes, which was unacceptable. The force was unable to supply any data on average waiting times (see paragraph 3.12 and recommendation 2.46).

5.10 Custody sergeants generally interacted well with detainees to complete the risk assessments, which were generally thorough and appropriately focused. Custody sergeants paid particular attention to detainees' mental and physical health needs, and asked probing supplementary questions to enhance the assessment. We observed custody staff dealing patiently and sensitively with some detainees who were intoxicated and/or vulnerable. Despite a lack of and inconsistent training on vulnerability and diverse needs, we observed that custody sergeants generally identified detainee risks and vulnerabilities well initially, including those in custody for the first time, with appropriate cross-referencing to police national computer warning markers and information held on the force 'protecting vulnerable people' (PVP) database.

5.11 Although risk assessments were generally dynamic, this was not always reflected in care plans for the management of risk. We reviewed detention logs and some CCTV footage and found that levels of observations were sometimes set too low for the apparent risks posed, and that observation levels were not always adhered to. The rationale for reduction in levels of observations was not always recorded.

5.12 Anti-rip clothing was often used routinely when risk assessments were not completed because detainees were uncooperative or unable to cooperate because of intoxication. In some cases, anti-rip clothing was used when there was a risk of suicide or self-harm, when higher levels of observation would have been more appropriate and given the detainee greater dignity and better care. Most detainees remained in this clothing when their heightened risk levels had reduced, which was inappropriate. This clothing was sometimes used with no rationale recorded in the custody record, and on some occasions we saw it used as replacement clothing, which was inappropriate (see also paragraph 6.21 and recommendations 2.46 and 2.48).

5.13 The routine removal of clothing with cords and footwear was disproportionate, particularly where detainees were assessed as low risk. This practice could, on occasion, be inflammatory, potentially leading to unnecessary use of force.

5.14 The majority of detention officers and custody sergeants did not carry anti-ligature knives, but in some custody suites these knives were attached to the cell keys. We sometimes saw staff visiting cells who were not carrying anti-ligature knives, which compromised detainee safety and was poor practice.

5.15 As at our previous inspection, staff shift handovers did not include all staff, and we saw sergeants and CDOs handing over separately to their incoming peers rather than as one team. Nevertheless, the handovers we observed were well conducted in private and focused on risk, detainee welfare and case progression. At least one custody sergeant and CDO visited all detainees following the handover to engage with and check the individuals.

Areas for improvement

5.16 Detainees should be booked in promptly on arrival at the custody suites.

5.17 Removal of detainees' clothing and footwear should be subject to individual risk assessment.

5.18 The force should investigate the use of anti-rip clothing and associated uses of force. Anti-rip clothing should only be used in exceptional circumstances and as a last resort to protect the detainee from harm, with a recorded rationale based on a risk assessment. The detainee's own clothes should be returned to them as soon as possible.

5.19 All custody staff should carry anti-ligature knives in the custody suites at all times.

5.20 All custody staff should be involved collectively in the relevant shift handover.

Individual legal rights

5.21 Custody sergeants were responsible for booking detainees into custody and asked arresting officers to provide a full explanation of the circumstances of, and the reasons for, arrest before authorising detention. Sergeants were confident in refusing detention and could provide us with examples when they had done so. We observed detention being refused for a female detainee arrested for a minor offence who had significant health needs, which was appropriate.

5.22 Alternatives to custody were available in the form of voluntary attendance,[6] restorative justice[7] and fixed penalty notices. Facilities for interviewing voluntary attendees outside custody were available at all custody suites.

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

[7] A process whereby some lesser criminal cases can be resolved at the time of the offence through an agreement between the offender and victim.

5.23 Custody sergeants were aware of the need to keep time in detention to a minimum and were clear on their obligation to progress cases quickly. We were told that delays could sometimes occur due to factors such as low staffing levels in the custody process teams (responsible for interviewing detainees in custody), who only worked dayshifts, or while waiting for Crown Prosecution Service (CPS) decisions. During our inspection we saw one detainee (at Blackpool) who was held in custody overnight for eight hours 15 minutes while the CPS made a charging decision; the detainee was charged and bailed to court within 25 minutes of receipt of the charging decision.

5.24 We were also told that detainees could be held in custody for longer than necessary waiting for the arrival of an appropriate adult (see paragraph 6.33) or an interpreter (see paragraph 5.30). We met a 14-year-old boy at Preston who had been brought into custody at 9.40pm, but no appropriate adult was available and he was held in custody until the following morning when an appropriate adult from the approved scheme arrived at 10am. He was still in custody at 1.15pm waiting for a decision on his case. The force was unable to supply any data on the average length of detention for detainees (see paragraph 3.12 and recommendation 2.46), but in our custody record analysis the average length of detention was 11hrs 55mins, with 68 detainees (47%) held in custody overnight, which suggested a substantial amount were lengthy.

5.25 Custody staff reported a good relationship with Home Office Immigration Enforcement officers, two of who were based at Blackburn police station. We were told that in most cases immigration detainees who were to be transferred to immigration removal centres (IRCs) were usually moved on within 12 to 24 hours, although there were sometimes longer delays. Data supplied by the force confirmed that 121 immigration detainees had been held in the year to 30 April 2016, but the force was unable to supply any data on the average detention time for immigration detainees.

5.26 During booking in, custody sergeants advised detainees of their three main rights[8] and, in most cases, detainees were routinely offered a written notice setting out their rights and entitlements, but these were seldom accepted. Custody staff could access these notices in foreign languages for non-English speaking detainees but very few staff were aware that an easy-read pictorial version for detainees needing help with understanding or reading was also available. Rights and entitlements were not available in Braille. Posters in a range of languages informing detainees of their right to free legal advice were displayed in the suites, apart from Lancaster and Blackburn. Detainees were told they could inform someone of their arrest, and we observed staff facilitating this in the detainee's presence.

5.27 Detainees were told during the booking in that they could read the Police and Criminal Evidence Act 1984 (PACE) codes of practice, but these were not always explained by custody staff. There were large numbers of out-of-date copies of PACE code C, but insufficient copies of the up-to-date version at all suites, and these were offered infrequently to detainees.

5.28 All detainees were offered free legal representation and were told that if they declined they could change their mind at any time and accept the offer. Detainees who declined the offer of free legal representation were asked why, and in most cases this was routinely noted on the custody record. Those wishing to speak to legal advisers could not always do so in private, as telephone calls had to be taken at the booking-in desk or elsewhere in the booking-in area. There were sufficient consultation and interview rooms at all the suites, and

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[8] 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.

we saw legal advisers routinely given their client's custody record front sheet or being allowed to view the detention log on request.

5.29 There was an effective system for collecting DNA samples taken in custody but we found some inappropriate items in the DNA freezer at Preston, which the force quickly disposed when it was informed. Custody staff were able to relay the circumstances when DNA would be disposed of.

Communication

5.30 A professional telephone interpreting service was available to assist the booking in of non-English speakers, with dual telephone handsets available in all the suites. However, we saw that staff did not always use the dual handsets, preferring to pass a single telephone handset to and from the detainee. Whatever the means, staff said there were difficulties in using telephone interpreting when the suites were busy and noisy. Although a face-to-face interpreter service was available for interviews, there had been delays in getting interpreters for some languages, resulting in some detainees remaining in custody longer than necessary or having to be bailed to return at a later date (see paragraph 5.24). For example, at 11pm one evening at Preston we were told that a Romanian interpreter was required for a detainee but the nearest one was over three hours away. As a result, it was arranged for the interpreter to attend at 10am the following day, with the detainee 'bedding down' for the night. This detainee was unsuitable for bail as he was also wanted on warrant for other matters.

5.31 Hearing loops were not available in any of the suites apart from Lancaster.

Complaints

5.32 There was no information displayed on the complaints process in any custody suite. Although this information was in the rights and entitlements notice offered to all detainees, as indicated above, this was seldom accepted. Most custody staff told us they would direct detainees who wished to make a complaint to attend the police station front desk on release, while a few said that they would notify the duty response or custody inspector and it would be their decision whether to note the complaint from the detainee while they were still in custody or make an arrangement to see them after release.

Area for improvement

5.33 The force should ensure that detainees are able to make a complaint while they are still in custody.

Section 6. In the custody cell, safeguarding and health care

Expected outcomes:
Detainees are held in a safe and clean environment in which their safety is protected at all points during custody. Officers understand the obligations and duties arising from safeguarding (protection of children and adults at risk). Detainees have access to competent health care practitioners who meet their physical health, mental health and substance use needs in a timely way.

Physical environment is safe

6.1 There had been very little change in the physical conditions since the 2011 inspection and some of the frailties we identified then – such as inadequate cell checks, abundant graffiti, poor quality recording of faults and lack of responsibility for how faults are recorded – remained as problems.

6.2 Five of the six designated custody suites were operational; Skelmersdale was closed for refurbishment, which included the upgrading of cell doors. The newer custody suites at Preston, Blackburn and Lancaster were generally clean and well maintained.

6.3 Blackpool custody suite was the oldest suite. Notwithstanding £21 million investment, the interior was showing its age and looked dilapidated. The low ceilings and dark floors created a dark and oppressive environment. There was peeling paint on some of the walls and floors, and the cells did not meet current safety standards. Scraps of paper were used to cover the viewing panel in the cell doors to give detainees some privacy, including from other detainees, which contributed to the unkempt environment. Open drains on corridors were full of stagnant water. Ten prefabricated cells had been added to the custody suite structure; these were clean and more comfortable and safer for detainees.

6.4 Burnley was a poor environment to hold detainees and it was apparent that custody staff had become inured to the poor conditions. Even though some cells were inappropriate to hold detainees, custody staff did not recognise this or report some of the obvious issues. Many cells were filled with graffiti, much offensive, on the backs of doors and walls. There was ingrained dirt on cell floors, and some floor areas around the toilets were heavily stained and damaged. Burnley custody suite needed a deep clean and graffiti removal.

6.5 As previously, custody detention officers (CDOs) were expected to complete daily health and safety check, including checking cells for ligature points, that the defibrillator was present and working, the cleanliness of work space and that all equipment was in working order. The cell check forms used were not consistent across the force and did not always help staff to report effectively defects, ligature points or the cleanliness of individual cells. Records we reviewed showed that cells were not checked regularly at Blackburn and Blackpool and not thoroughly at any of the suites, except Lancaster. At Blackburn we identified holes that had been punctured into the cell walls, which had not been recorded as defects by custody staff. At Burnley, one cell deemed ready to be occupied by a detainee had blood stains on the walls and floor, and another cell had the remnants of a meal splashed on the wall. None of these problems had been identified by custody staff during the checks.

6.6 We identified potential ligature points at some custody suites and reported these to the force. Ligature points that we had identified on cell door hatches at Blackpool at the last

inspection had not been dealt with, and there was no evidence that the risk posed was offset when detainees at risk of suicide or self-harm were located in those cells.

6.7 The use of cell equipment, such as the emergency call bell and intercom, was not always explained to detainees. Cell bells were not always answered promptly and the practice of 'muting' them, particularly at Blackpool, was unacceptable.

6.8 All suites had a fire evacuation policy, which custody staff understood. We were given comprehensive records about fire evacuations that had had taken place.

Area for improvement

6.9 Staff should conduct and record daily cell checks, including identification of ligature points. Cells at Burnley should be deep cleaned, and graffiti should be removed across the custody estate to improve the overall environment.

Safety: use of force

6.10 Oversight and governance of the use of force were inadequate. Not all staff involved in incidents where force was used completed the relevant electronic use-of-force forms. Of the 11 incidents we requested documentation for, we received only two use of force forms and were not assured they were for incidents related to custody. The forms we saw gave no details about the detainee or the necessity for using force against them. There was also scant information, if any, in detention logs to justify the use or type of force. (See recommendation 2.48.)

6.11 Data provided showed that 14% of staff were out of date with their safety/personal protection training, but the figures for custody staff were not separated out. Although most staff we spoke to said that they had taken this training within the previous 12 months, it was unacceptable that some staff had not. CDOs employed by G4S received different training to that for directly employed police staff, and we were given some instances where the training seemed inconsistent – for example, some sergeants told us they were not trained in removing detainees' clothing while under restraint, while CDOs were. This created the potential for confusion in carrying out some working practices. (See recommendation 2.48.)

6.12 The force could not identify cases where force had been used. However, we managed to identify and review 20 custody records where force was used against detainees, and we were able to cross-reference these with CCTV footage in 16 cases. Some incidents took place in cells where there was no CCTV coverage. CCTV footage was routinely kept for 90 days and was backed up on a system that allowed us to review cases going back further. Only a minority of incidents that we reviewed were handled well. In eight of the cases we examined we had some sort of concern about the way force was deployed and we referred these cases back to the force for them to investigate. We were not assured that force was always proportionate to the risks/threats posed and had concerns about the techniques deployed on a number of occasions.

6.13 In nine of the cases we reviewed, force was used to remove the detainees' clothes to replace it with anti-rip clothing (see paragraphs 5.12 and 5.13 and area for improvement 5.18). There was often insufficient justification for the removal of clothing. We were concerned that the almost routine use of anti-rip clothing in the absence of an individual detainee risk assessment was potentially an aggravating factor that escalated situations unnecessarily.

6.14 Although we did not see them in use, we were told consistently by staff, particularly at Blackpool and Preston, that head guards (similar to helmets used in contact sports) were applied to detainees, along with handcuffs, to prevent self-harm. Such equipment is used rarely in other forces and is not a Home Office-approved technique. It is a potentially unsafe response to the management of detainees in crisis.

6.15 Most detainees we observed arrived in custody in handcuffs, and many compliant detainees remained in handcuffs for long periods unnecessarily. This was disproportionate to the threat posed in the controlled custody environment. It was commendable that Tasers had not been used in custody in the previous two years, and we were assured that they would only be used in exceptional circumstances.

6.16 In the 12 months to the end of April 2016, there had been 2,827 strip searches, covering 9% of all detainees, which was high. Proportionately more black and minority ethnic detainees were strip searched than white detainees, and we could find no reasonable explanation for this. From the records we reviewed, we were not always assured that there had been a reasonable rationale for strip searches. Most took place in rooms without CCTV. However, we did observe some examples where clothing was removed in cells with CCTV and where the dignity of the detainee was not maintained: there were no efforts to cover the CCTV monitors in the custody suite, which could be viewed by any passing staff.

Area for improvement

6.17 The force should monitor the number of strip searches to ensure they are carried out with suitable justification. Strip searches should always be conducted appropriately and with consideration to the detainee's dignity.

Detainee care and PACE reviews

6.18 Microwave meals, porridge and breakfast bars were available, and food and drink were provided at mealtimes and on request. Food preparation areas were clean and well equipped. In our custody record analysis, 69% of the detainees had been offered a meal, including all (10) held for over 24 hours.

6.19 Mattresses were provided but were not always cleaned between use. Pillows were available at Blackburn, Blackpool and Burnley, but they had been withdrawn from cells with sinks in them at Preston and Lancaster. This had followed a recent self-harm attempt in another force where a pillow had been used in a sink to form a potential ligature point. Although the sinks in these suites were a different design from the one where the incident had occurred, the force had replicated the ligature point. The response to remove all pillows was however disproportionate to the risk posed to most detainees. Stocks of blankets were clean but were not always offered to detainees, particularly during the day. Most cells had toilets but toilet paper was only available on request from the detainee. Toilet areas in cells covered by CCTV continued to lack any privacy (see paragraph 5.2 and recommendation 2.47). Hand washing facilities were not always available in the cells, but detainees could use those on cell corridors on request, subject to staff availability.

6.20 Showers were available in all the suites, but those at Blackburn and Preston lacked privacy and at Blackpool they required deep cleaning. Custody staff said they were not always able to offer showers but would do so if a detainee requested it and there were sufficient staff on duty. We saw one detainee at Burnley who arrived into custody in a filthy condition. He was allowed to shower and change into replacement clothing, which had been brought from his home, before he was placed in his cell. In our custody record analysis, only three detainees

were offered a shower, one of whom had been held for over 24 hours. Cotton towels, toiletries and women's sanitary items were available at all suites, but the latter were stored unhygienically at Preston.

6.21 All the custody suites had shortages of replacement clothing – which should be readily available for detainees whose clothes have has been seized for evidential purposes or otherwise soiled. We saw several detainees wearing clothes that were too large for them, and some were also offered anti-rip clothing when no other clothes were available (see paragraph 5.12). A 14-year-old boy we spoke with at Preston was wearing anti-rip shorts as his own clothing contained cords, which was inappropriate (see paragraph 5.13). In some suites we were told that paper suits were issued routinely if no suitable clothing was available. We saw a 15-year-old boy held at Blackburn being given a paper suit to wear as his own shorts had cords. He was later taken into interview (with his mother acting as his appropriate adult), still wearing the paper suit, which was a breach of PACE (code C, section 8.5), as a paper suit is not 'adequate clothing'. These degrading and unacceptable practices were similar to what we found in our previous inspection, and our recommendations about this had not been implemented.

6.22 As at our previous inspection, footwear was routinely removed from detainees, even if it did not contain shoelaces. Although plimsolls and foam slippers were available in all the suites, these were not offered to detainees routinely. We saw many detainees in all the suites walking about in their bare feet or in socks. We saw only one detainee who was given plimsolls, and that was as he left the custody suite to appear at court as he had no other footwear. As with the clothing issue (see above), these practices were degrading and inappropriate.

6.23 All the custody suites had at least one outside exercise area where detainees could access some fresh air. We did not see any of these areas in use, and in our custody record analysis only five detainees were offered outside exercise, which included two of the detainees held for over 24 hours. As at our previous inspection, we were told that it was not always possible to facilitate exercise because of lack of staff to supervise them.

6.24 Custody suites had a limited range of reading materials, mostly books donated by staff, but these were generally only provided on request. There was no material for children, in foreign languages or easy-read format. In our custody record analysis, only nine detainees were offered reading materials while detained, including four held for over 24 hours. Not all suites had designated visits facilities but where they did, staff told us they would allow visits in exceptional circumstances, and if staffing levels allowed.

6.25 Detainees' cases were reviewed by custody inspectors or, in their absence, by duty response inspectors. We observed some very good face-to-face reviews, which were timely and appropriate. However, others took place through the cell hatch and not all inspectors asked detainees if they had any representations to make. In the records we reviewed, inspectors gave little justification for their rationale to keep a detainee in custody – the text was formulaic, with no information about the enquiries that were being progressed or outstanding. In our custody record analysis, of the 84 detainees who required an initial review, 18 cases recorded that the detainee was 'incapable of understanding', but it was unclear what this referred to. We saw no detainees being told that reviews had taken place while they were asleep, and inspectors confirmed this action was not something they endorsed in the custody record. Custody sergeants indicated that the information that there had been a review while the detainee was asleep was not exchanged at shift handovers or flagged on the custody computer system (C3PO), and therefore was overlooked.

Areas for improvement

6.26 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (Repeated recommendation 4.37)

6.27 Sufficient and suitable alternative clothing should always be available in all the custody suites, and replacement footwear should be provided for all detainees whose own footwear is removed.

6.28 All custody suites should facilitate exercise in the open air for detainees. No change.

6.29 All suites should have a stock of reading material in a range of languages, easy-read format and suitable for children.

6.30 Reviews of detention should take place in accordance with the Police and Criminal Evidence Act 1984, code C.

Safeguarding

6.31 The force did not have any specific policies on the safeguarding and protection of vulnerable adults and children, although some elements were covered in policies and guidance on dealing with different types of crime. There was no specific training for staff on safeguarding, or child protection.

6.32 Despite the lack of a policy framework, custody staff showed an understanding of safeguarding concerns, and routinely checked the police information systems to see if there was any information about vulnerable individuals that could affect how they were treated in custody. Custody staff were familiar with the referral processes to specialist police teams responsible for protecting vulnerable people, although in practice we observed that it was arresting officers who were responsible for making these referrals. Custody staff and frontline police officers also recognised the importance of diverting vulnerable people away from custody or minimising the time spent there, especially children and those with mental health problems.

6.33 Children and vulnerable adults did not always have an appropriate adult (AA) with them at key stages of the custody process, and some spent considerable time in custody before speaking with an AA. Our custody record analysis showed the average wait for an AA was eight hours and four minutes, with the longest wait 19 hours and two minutes. Where possible, a parent or relative was called to act as an AA but, in the absence of these, an AA was secured though the independent service provider, Child Action North West. This service covered children and, increasingly, vulnerable adults, as the local authority's own team was unable to meet the demand. Custody sergeants reported a good working relationship with the service, with AAs arriving at the time requested. However, under the service contract, the AA was not required to attend until the child or vulnerable adult was scheduled for interview. This meant that vulnerable people did not have early support when they arrived in custody or were told about their individual rights, and that fingerprints and photographs were sometimes taken without an AA present, which is a breach of PACE.

6.34 In addition, the service was not available after midnight, unless there were exceptional circumstances. As a result, vulnerable adults and children, who were brought into custody late at night spent the night in the cells, with an AA arranged to attend the following morning.

6.35 There was guidance for AAs to explain their expected role, which was particularly important for family members. However, not all custody staff were aware of this guidance and it was not routinely given to AAs.

6.36 Our case reviews showed that some children spent long periods in custody, with an average time of five hours and 54 minutes - the longest time was 13 hours and 19 minutes. Of the 11 children randomly sampled in our case reviews, four had been held overnight. We were not assured from this analysis, other case records and our observations that detaining children overnight was justified in all cases and that other alternatives had been actively sought to avoid this. It was a particular concern that many of these children were already in the care of the local authority but custody sergeants were unable to return them to their care home, or to other local authority accommodation.

6.37 Information provided by the force showed that in 2015-16, 12% of children (342) detained in custody were charged and had bail refused. In these cases, alternative accommodation should have been provided to avoid the child being detained in custody overnight. The force could not provide data on the number of requests for alternative accommodation or how many children were subsequently transferred to this. (See recommendation 2.46.) However, the force had worked to ensure that children were not detained in custody when bail was refused. There was now greater clarity about whether it should request secure or non-secure accommodation, and there were arrangements with local children's social care services to provide non-secure accommodation, often through foster placements. Custody sergeants reported that alternative accommodation was generally found when requested, which was positive, but we were given no data to corroborate this. There was no secure accommodation available across the force area for children who presented high risks, but custody sergeants told us that they rarely needed to request such accommodation.

Areas for improvement

6.38 There should be a policy framework and training on safeguarding vulnerable adults and children to equip custody staff to be effective in identifying and taking the necessary actions to deal with such detainees.

6.39 Appropriate adults should be available to support vulnerable adults and children throughout the custody process, and the force should comply with PACE in taking fingerprints and photographs only when an appropriate adult is present.

6.40 The force should assure itself that alternatives to avoid detaining children in custody overnight before any charge are actively explored so that detention is the last resort.

Governance

6.41 There was an up-to-date health needs assessment covering all the force area. The police commissioned Castle Rock Group (CRG) to provide physical health services for detainees. Detainees had access to a reasonable health service, and those we spoke to said they had received good care.

6.42 Data for the six months to the end of May 2016 showed that an average of 92% of calls to health care professionals (HCPs) met the target response time. Contract monitoring was effective and close partnership working meant that problems were escalated promptly.

6.43 There were effective systems for logging adverse incidents, with increased reporting in recent months; learning from events was being developed. There had been no complaints logged for the duration of the contract, which had been in place for approximately a year, and no robust system to enable detainees to complain - some suites displayed posters but otherwise there was little evidence of information to detainees about how to complain about health services.

6.44 Rostered HCP cover for the five operational suites included three nurses/paramedics and one forensic medical examiner (FME) for each 24-hour period. At the time of our visit, there were seven HCP vacancies and difficulties with recruitment, which had resulted in lower cover for some shifts. There was only one FME registered to undertake a mental health assessment under the Mental Health Act.

6.45 The registration details of HCPs, including FMEs, were monitored and there was now reasonable provision of induction and continuing essential training, including monitoring of compliance with training requirements. HCPs told us that they did not get clinical supervision, but this was being developed. Arrangements to ensure regular management supervision, including appraisals, were being strengthened.

6.46 One HCP covered Blackburn and Burnley, Preston and Lancaster and one HCP was usually designated to cover Blackpool, although this was historic rather than based on need. The FME provided medical cover, including face-to-face visits and telephone advice to HCPs and custody staff. Detainees were not always able to choose the gender of the HCP, and this was partly offset by providing a chaperone of the chosen gender.

6.47 The consultations we observed in clinical rooms took place with closed doors, while those in cells were with a CDO in the cell or within earshot. Some HCPs told us that the police expected them to leave clinical room doors open routinely. Most clinical rooms were near to custody desks or suite activity, but the one at Blackpool was in a poor and potentially unsafe location. Clinical rooms were generally reasonable and appropriately equipped with adjustable couches and paper rolls, but most lacked privacy screens. The clinical room at Blackpool was very cramped and the medicine cabinet was an ordinary kitchen cupboard. Rooms were visibly clean but most had some dusty high areas.

6.48 There was poor compliance with infection control requirements; some rooms lacked the correct basin/sink taps to minimise infection risks, had no separate hand washing basin, and plugs were used. We found coffee cups on the sink surface in one suite, and milk was stored in a medicines fridge. Sharps bins were usually on the floor and some were not dated; we noted one small sharps bin in a filing cabinet drawer. We did not see hand washing guidance in all the suites. An infection control audit was planned.

6.49 All clinical rooms held an emergency response policy but copies had missing pages. Automated defibrillators were kept behind custody desks or the main custody office; CDOs checked batteries and pads daily. Some custody first aid kits lacked key items, such as burns dressings, or contained out-of-date items, and there was a lack of standardisation. First aid checklists were not always visible, and the frequency of checks varied across the suites, with some gaps noted. At Preston, a telephone waiting repair was stored on top of the defibrillator and all three spare pads were out of date. Oxygen cylinders were stored in clinical rooms and checked daily. New resuscitation bags for HCP use had been recently introduced but they remained in sealed plastic bags and were incomplete, risking confusion. Most HCPs were up to date in intermediate life support training, and CDOs received annual basic life support and use of defibrillator training. Custody sergeants were given refresher training as part of their regular training, but some had not received resuscitation skills training in the last three years.

6.50 Multiagency working was effective, and custody staff and health professionals told us that working relationships were generally positive. We saw no evidence of protocols for the sharing of clinical information.

Areas for improvement

6.51 Detainees should be given clear information on how to make a complaint about health services.

6.52 All health care professionals should have regular clinical and management supervision and appraisals.

6.53 Patient confidentiality should be preserved, except where individual risk assessment indicates this cannot happen.

6.54 Clinical areas and practice should comply with NHS-equivalent standards for infection control.

6.55 Emergency resuscitation arrangements, including all staff training and equipment, should ensure a prompt and appropriate response in a medical emergency.

Patient care

6.56 In our custody record analysis, 47% of detainees had seen a HCP while in custody. We observed thorough and thoughtful clinical assessments, and detainees we spoke to were generally positive about the care they received.

6.57 Detainees could ask to see an HCP or were referred by custody staff. Custody staff could call a central CRG call centre, and they told us initial call response times were short. We observed and were told there was effective liaison between custody staff and HCPs regarding detainees.

6.58 Some electronic HCP clinical records lacked sufficient detail and proper rationale for decisions. Care plans on the police custody record were not always clear and meaningful in order to inform detainee care. Verbal handover by HCPs to custody staff was reasonable. The clinical template used was cumbersome and did not support good quality documentation, and CRG was changing it. There was limited use of paper records for body mapping and forensic sampling, and these were stored according to Caldicott guidance on the use and confidentiality of personal health information; however, we noted a chaotic collection of old paper records in a locked filing cabinet at Preston. We were assured there were plans to collate and store these records centrally.

6.59 Detainees' verbal consent to health care was usually recorded, and we observed HCPs confirming consent with detainees. The records we reviewed showed a few examples where a detainee had requested an HCP but had been released before being seen or where it was not clear why an HCP had not seen the detainee. While we accept that this might sometimes be appropriate, custody and clinical records did not clearly show the reasons. We observed some active HCP liaison with other agencies, such as GP, mental health and substance misuse services, to ensure appropriate care was provided.

6.60 Detainees' own medicines were stored and verified appropriately before use. Police made efforts to obtain essential medicines from detainees' homes, and patient group directions

(authorising appropriate health care professionals to supply and administer prescription-only medicine) enabled HCPs to provide a wide range of useful medicines. CDOs could give up to three single doses of medicines prescribed by an FME and using a printed storage envelope. However, while this supported continuity of care, and CDOs were aware of their responsibility, they had not received training and there was still potential for error. Medicine stock management arrangements were sound, and additional checks had been recently introduced.

Areas for improvement

6.61 Clinical records and the custody detention record should provide clear and meaningful information to inform the care of detainees in custody, and comply with national and professional standards.

6.62 Civilian detention officers should receive training in issuing prescribed medicines to ensure safe practice.

Substance misuse

6.63 The drug and alcohol service provision to the custody suites had reduced significantly since our last visit, and there was very little regular direct contact of these services with detainees. Detainees in active withdrawal from alcohol or opiates could receive symptomatic relief. A policy supported administration of opiate substitutes, including methadone and buprenorphine, but it had rarely been used and the reasons were unclear. Custody staff at Preston could make referrals to Discover (Greater Manchester West Mental Health NHS Foundation Trust) supported by fortnightly attendance at the suite by a worker. At Blackburn and Burnley, staff from Inspire (integrated substance misuse service) attended weekly to pick up referrals, and at Lancaster they worked closely with the criminal justice liaison team (CJLT) to identify potential referrals. CRG health professionals and custody staff could identify detainee needs and make referrals, but it was not clear whether detainees always received the support or onward referral they required. Detainees had no access to nicotine replacement therapy for their well-being while in custody.

Area for improvement

6.64 Detainees with substance misuse needs should be consistently identified and referred to appropriate agencies to meet their ongoing needs.

Mental health

6.65 Lancashire Care NHS Foundation Trust provided mental health services through designated CJLTs. The model was impressive and encompassed all vulnerabilities, including learning disabilities and substance misuse. A mental health triage car operated in each division between 2pm and midnight. Although there were some staffing difficulties that affected the scheme, it was generally leading to a reduction in the number of detainees with mental health problems brought into custody. CJLT teams provided an excellent and responsive service to all the suites between 8am and 4pm seven days a week, and we observed some good liaison work with custody staff to ensure detainee needs were met.

6.66 During service hours, the response to referrals was good and supported by a screening system that enabled prompt identification of detainees already in contact with mental health

services. The interim case management model provided a good service to vulnerable detainees after their release. Out of hours, some detainees waited too long to see a mental health practitioner and there was evidence that this could have been avoided in some cases by early referral to the local crisis team for advice, or the emergency duty team where consideration for a Mental Health Act assessment was likely.

6.67 Access to suitable mental health beds was often very difficult and had resulted in some detainees waiting far too long and inappropriately in custody. The trust told us that between 1 January 2016 and 9 June 2016 there had been 24 reported breaches of PACE due to delays. An escalation pathway agreed between the force and the trust sought to ensure early resolution of delays, alongside logging as an adverse incident. In the previous year, there were no reported detentions under section 136 of the Mental Health Act.[9] However, our case audit revealed several instances and this, along with weaknesses in the data, meant we could not be confident of the precise numbers or the legitimacy for detaining people under section 136 in police custody.

6.68 Custody sergeants had received mental health awareness training as part of their custody training, and we were advised that CDOs had received some specific training during their initial training courses.

Areas for improvement

6.69 There should be prompt access to mental health beds to ensure detainees with mental health needs are cared for in a suitable therapeutic environment.

6.70 Data on section 136 of the Mental Health Act should clearly demonstrate the numbers of and reasons for such people who are brought into custody.

[9] Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved mental health practitioner, and to make any necessary arrangements for treatment or care.

Section 7. Release and transfer from custody

Expected outcomes:
Pre-release risk assessments reflect all risks identified during the detainee's stay in custody. Detainees are offered and provided with advice, information and onward referral to other agencies as necessary to support their safety and wellbeing on release. Detainees appear promptly at court in person or by video.

Pre-release risk assessment

7.1 Our custody record analysis and case audits did not assure us that all detainees had a pre-release risk assessment. Recording was mostly poor, with little information, and we could not be assured that all identified risks had been addressed. We were often unsure how detainees, particularly the most vulnerable, were getting home.

7.2 The practice we observed varied greatly. Most of the pre-release risk assessments we observed showed reasonable attention to securing a safe release for the detainees, but some were notably poor and did not pay sufficient attention to ensuring detainees were released safely. For example, we observed a case on CCTV footage where a woman was released at 1.30am with insufficient consideration of how she was going to get home safely. Initial risk assessments and care plans were not always checked to ensure all identified risks had been addressed or managed to ensure a safe release. Some suites did not have ready access to public transport. Sergeants did not always ensure that detainees had the means of getting home, and they had limited access to travel warrants or petty cash to pay for detainees' fares, which they advised us they accessed infrequently. It was positive that police officers sometimes arranged transport.

7.3 A support leaflet with useful telephone numbers was available but was not always given to detainees on their release. Most sergeants were aware of the specific offences and circumstances that made detainees more at risk on release, and there were some leaflets about additional support to women and veterans on release. We saw some consented referrals to the Samaritans when a risk of suicide or self-harm had been identified

Area for improvement

7.4 All pre-release risk assessments for detainees should take account of all identified risks, and manage and offset these to ensure a safe release.

Courts

7.5 Custody staff at all the suites told us that the local remand courts would normally accept detainees until approximately 3pm on weekdays but only to 10am on Saturdays, which was too early. We were told that there was generally some flexibility each day, depending on how busy the courts were. We found no evidence that court cut-off times resulted in detainees being held in custody for longer than necessary.

7.6 The quality of the person escort records (PERs) we examined varied. Most contained scant information and only a minority were completed to a good enough standard. For example, we saw a woman at Blackpool who was withdrawing from heroin and this was not mentioned on her PER.

Area for improvement

7.7 Person escort records should contain all known information concerning risks posed to or by the detainee.

Section 8. Summary of areas of concern, recommendations and areas for improvement

Areas of concern and recommendations

8.1 There was insufficient gathering and monitoring of performance data in key areas that promote the safe and respectful detention of people in custody. The custody records also had insufficient detail to show justification for decision making for each individual.

Recommendation. The force should ensure that:

- it strengthens its approach to performance management and that data (including custody throughput, demographics, adverse incidents, strip searching, length of detention for detainees with mental health issues, complaints) are routinely collated and analysed to identify trends, inform organisational learning and improve outcomes for detainees
- custody records show that decisions about detainee treatment are justified, and actions are appropriate to individual circumstances and risk assessments. (2.46)

8.2 Not all detainees were treated with respect and dignity, and their individual or diverse needs were not always met. Despite our previous recommendation, detainees using the in-cell toilet could still be viewed on CCTV, which was completely inappropriate.

Recommendation. Action should be taken immediately to obscure the toilet areas in cells with CCTV. (2.47)

8.3 All aspects of the use of force lacked governance and effective oversight. The force did not record data on the use of force in custody effectively, use of force forms were not always submitted, and records of force in custody records were poor or absent. There was inadequate managerial scrutiny of use of force incidents, and no routine viewing of CCTV records to assure proportionality or for learning points. Training for staff was inadequate and unapproved equipment was used in the restraint of detainees. Handcuffs were used on compliant detainees for too long after their arrival in custody, and force was used often to replace detainees' clothes with anti-rip clothing.

Recommendation. Lancashire Police should improve its governance of use of force in custody, including ensuring that:

- there is effective management oversight of use of force incidents and trends
- staff are adequately trained in appropriate techniques at least annually
- force is always used at the lowest level, is appropriate for the threat posed, and that only approved equipment is used
- all staff involved in incidents complete individual use of force forms
- handcuffs are removed from compliant detainees at the earliest opportunity after their arrival in custody. (2.48)

Areas for improvement

Leadership, accountability and partnerships

8.4 The force should ensure that there are appropriate policies and procedures that cover the whole custody process, which are fully implemented and reviewed regularly. Policies and procedures should be accessible and understood by staff. (3.11)

8.5 Lancashire Police should engage with their counterparts in the local authority to instigate an immediate review of the provision of local authority accommodation for children under section 38(6) PACE 1984, and monitor performance data to ensure that children are not detained unnecessarily in police cells. (3.25)

In the custody suite: booking in, individual needs and legal rights

8.6 Staff should be trained to recognise and provide for the individual needs of detainees, particularly children, women and detainees with disabilities. (5.8)

8.7 Detainees should be booked in promptly on arrival at the custody suites. (5.16)

8.8 Removal of detainees' clothing and footwear should be subject to individual risk assessment. (5.17)

8.9 The force should investigate the use of anti-rip clothing and associated uses of force. Anti-rip clothing should only be used in exceptional circumstances and as a last resort to protect the detainee from harm, with a recorded rationale based on a risk assessment. The detainee's own clothes should be returned to them as soon as possible. (5.18)

8.10 All custody staff should carry anti-ligature knives in the custody suites at all times. (5.19)

8.11 All custody staff should be involved collectively in the relevant shift handover. (5.20)

8.12 The force should ensure that detainees are able to make a complaint while they are still in custody. (5.33)

In the custody cell, safeguarding and health care

8.13 Staff should conduct and record daily cell checks, including identification of ligature points. Cells at Burnley should be deep cleaned, and graffiti should be removed across the custody estate to improve the overall environment. (6.9)

8.14 The force should monitor the number of strip searches to ensure they are carried out with suitable justification. Strip searches should always be conducted appropriately and with consideration to the detainee's dignity. (6.17)

8.15 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (6.26, repeated recommendation 4.37)

8.16 Sufficient and suitable alternative clothing should always be available in all the custody suites, and replacement footwear should be provided for all detainees whose own footwear is removed. (6.27)

8.17 All custody suites should facilitate exercise in the open air for detainees. (6.28)

8.18 All suites should have a stock of reading material in a range of languages, easy-read format and suitable for children. (6.29)

8.19 Reviews of detention should take place in accordance with the Police and Criminal Evidence Act 1984, Code C. (6.30)

8.20 There should be a policy framework and training on safeguarding vulnerable adults and children to equip custody staff to be effective in identifying and taking the necessary actions to deal with such detainees. (6.38)

8.21 Appropriate adults should be available to support vulnerable adults and children throughout the custody process, and the force should comply with PACE in taking fingerprints and photographs only when an appropriate adult is present. (6.39)

8.22 The force should assure itself that alternatives to avoid detaining children in custody overnight before any charge are actively explored so that detention is the last resort. (6.40)

8.23 Detainees should be given clear information on how to make a complaint about health services. (6.51)

8.24 All health care professionals should have regular clinical and management supervision and appraisals. (6.52)

8.25 Patient confidentiality should be preserved, except where individual risk assessment indicates this cannot happen. (6.53)

8.26 Clinical areas and practice should comply with NHS-equivalent standards for infection control. (6.54)

8.27 Emergency resuscitation arrangements, including all staff training and equipment, should ensure a prompt and appropriate response in a medical emergency. (6.55)

8.28 Clinical records and the custody detention record should provide clear and meaningful information to inform the care of detainees in custody, and comply with national and professional standards. (6.61)

8.29 Civilian detention officers should receive training in issuing prescribed medicines to ensure safe practice. (6.62)

8.30 Detainees with substance misuse needs should be consistently identified and referred to appropriate agencies to meet their ongoing needs. (6.64)

8.31 There should be prompt access to mental health beds to ensure detainees with mental health needs are cared for in a suitable therapeutic environment. (6.69)

8.32 Data on section 136 of the Mental Health Act should clearly demonstrate the numbers of and reasons for such people who are brought into custody. (6.70)

Release and transfer from custody

8.33 All pre-release risk assessments for detainees should take account of all identified risks, and manage and offset these to ensure a safe release. (7.4)

8.34 Person escort records should contain all known information concerning risks posed to or by the detainee. (7.7)

Section 9. Appendices

Appendix I: Inspection team

Ian MacFadyen	HMI Prisons team leader
Vinnett Pearcy	HMI Prisons inspector
Kellie Reeve	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary inspection lead
Anthony Davies	HMI Constabulary inspection officer
Huw Morrisey	HMI Constabulary inspection officer
Anthony Joslin	HMI Constabulary inspection officer
Vijay Singh	HMI Constabulary inspection officer
Patricia Nixon	HMI Constabulary inspection officer
Majella Pearce	HMI Prisons health services inspector
Nicola Rabjohns	HMI Prisons health services inspector
Kathleen Byrne	Care Quality Commission inspector
Joe Simmonds	HMI Prisons researcher
Michelle Bellham	HMI Prisons 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.

Main recommendation

Custody detention officers should engage more fully with detainees. They should routinely ask them about any concerns they may have about their detention and take time to explain why unwelcome or intrusive procedures are necessary. (2.21)
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

There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities, and custody staff should be trained to recognise these differing needs. (2.22)
Not achieved

The risk assessment process should be revised, to enable more effective and dynamic care plans to be drawn up, and staff should be trained in its use. (2.23)
Achieved

A programme of regular cell deep cleaning should be implemented and maintained and graffiti removed as soon as is possible. (2.24)
Partially achieved

Recommendations

Custody officers should manage the number of people in the booking-in areas to provide sufficient privacy to facilitate effective communication between staff and detainees. (4.7)
Not achieved

Handovers should include custody detention officers and police custody staff on duty. (4.13)
Not achieved

Detainees should be handcuffed only when a risk assessment indicates that it is necessary for the safety of staff, the public or the detainee. (4.19)
Not achieved

Lancashire Constabulary should collate the use of force and examine it for trends in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.20)
Not achieved

Lancashire Constabulary should address the safety issues around ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed. (4.26)
Not achieved

Staff should be familiar with the fire evacuation procedures, which should be regularly practised. (4.27)
Achieved

All detainees should be routinely provided with a pillow, blanket and appropriate replacement clothing (e.g. a track suit) and footwear. (4.35)
Not achieved

Toilet areas should be obscured on closed-circuit television monitors and detainees should be informed of this. (4.36)
Not achieved

All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.37)
Partially achieved (recommendation repeated, 6.26)

Food should be of sufficient quality and calorific content to sustain detainees for the duration of their stay. (4.46)
Achieved

Detainees held for long periods should be offered outside exercise. (4.52)
Not achieved

Individual rights

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

Recommendations

Senior police officers should engage with the UK Border Agency to ensure that the time spent in police custody by immigration detainees is minimised. (5.10)
Achieved

Custody staff should ensure that any dependency obligations of detainees while in custody are identified and, where possible, addressed. (5.11)
Not achieved

Custody officers should ensure that any vulnerabilities they have identified in detainees are recorded, and where possible mitigated before they are released. (5.12)
Partially achieved

Appropriate adults should be available to support without undue delay juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (5.23)
Partially achieved

Detainees should be routinely informed about how they can make a complaint about their care and treatment and be able to do this before they leave custody. (5.27)
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

There should be robust infection control procedures for all the clinical rooms, which should be clean and be capable of being used for the taking of forensic samples. (6.9)
Not achieved

If it is clinically indicated methadone should be available to detainees, in line with national guidelines. (6.10)
Partially achieved

Custody staff should have access to a full range of appropriate first-aid and resuscitation equipment that is checked regularly, and records should be kept confirming this. (6.11)
Partially achieved

All clinical records should be compliant with professional standards and stored in accordance with the Data Protection Act and Caldicott principles, to ensure confidentiality of personal health information. (6.23)
Not achieved

Custody staff should have appropriate training to recognise and take appropriate action when a detainee may have mental health problems, and should work effectively with health services staff. (6.31)
Achieved