Report on an unannounced inspection visit to police custody suites in

Hampshire

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

17–27 October 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 and which form a key part of the joint work programme of the criminal justice inspectorates. These inspections also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention. The inspections look at strategy, treatment and conditions, individual rights and health care.

We previously inspected Hampshire in 2012, when we found a well-managed custody estate with a culture in which detainees were treated respectfully. Physical conditions needed improvement and there were plans to build on new sites. The main area of weakness was health care, where there was a lack of general oversight, poor facilities and delays in detainees seeing health care professionals.

During this inspection, we found that the existing strengths remained. In some areas there had been improvements and where work still had to be carried out there had been advanced planning.

We did, however, identify several areas of concern. Most were similar to problems found in other forces recently, and two were linked to the performance of partner agencies, over which the force had limited control. The first, and most concerning, matter was the substantial number of potential ligature points we identified. These were a significant risk to detainees and the force. Although the force was largely unaware of this issue, when we raised it, it took it very seriously – immediately following the inspection, we were advised of the force's short- and long-term plans to eliminate or minimise the risk.

The second important area requiring attention was in the gathering of data. Performance information on custody was not comprehensive, and there was limited monitoring across the different custody functions, which made it difficult for the force and others to assess how well custody services performed. This was illustrated most clearly in the use of force, where the lack of effective oversight made it impossible for Hampshire to demonstrate that force was only ever used as a last resort.

The two further areas of concern were closely linked to work with partner agencies. The number of detainees held under section 136 of the Mental Health Act as a place of safety[1] had increased significantly in the previous six months. As a result, too many people with mental health problems were now brought to and/or staying in police custody. There was an urgent need to review this deteriorating situation to understand the reasons behind it and refocus action.

We were disappointed – but given our findings elsewhere, not surprised – to discover that most children charged and refused bail remained in custody overnight because the local authority did not provide alternative accommodation. Although there were jointly agreed procedures with partner agencies, these had not resulted in better outcomes for children detained in these circumstances. Once again, this was another area in which the force needed to reinvigorate its work with partners to achieve the necessary improvements.

It was encouraging to find that most of the recommendations we made at the previous inspection were either fully or partially achieved. This was particularly noteworthy in health care, where significant improvements had been achieved. The care provided by health care professionals was now consistently sound, and response times were shorter. In general, we were pleased to see that

[1] 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.

custody staff continued to deal with detainees consistently in a respectful, compassionate and constructive way. This reflected the very healthy underlying culture.

Cells were generally clean and free from graffiti and the physical conditions for most detainees were adequate. The force was upgrading its custody estate, with new facilities scheduled to open from spring 2017.

The quality of support for detainees immediately before and on release was extremely good, and once again reflected the high standard of professionalism shown by custody staff.

This was a positive inspection and, given the very constructive immediate response to our initial findings, we are confident that the force has the necessary drive and commitment to make the required improvements.

We noted that of the 27 recommendations made in our previous report after our inspection of November 2012, 11 recommendations had been achieved, 10 had been partially achieved, five had not been achieved and one was no longer relevant.

This report provides five recommendations to the force, and highlights 22 areas for improvement and one example of good practice.

Dru Sharpling CBE
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

January 2017

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*[2] 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 of the suites in that area, opened in the week prior to the inspection being 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.[3] The analysis focused on the legal rights and treatment and conditions of the detainee. Where comparisons between groups or with other forces are included in the report these differences are statistically significant.[4] A total sample of 128 custody records were analysed.

2.4 A data collection template was completed by the force during the inspection, based on police custody data for the 36 months before the inspection. The template requested a range of information, including data on the demographics of the custody population, the number of voluntary attendees, and average length of time in police detention.

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

[3] 95% confidence interval with a sampling error of 7%.

[4] A statistically significant difference between the two samples is one that is unlikely to have arisen by chance alone, and can therefore be assumed to represent a real difference between the two populations. In order to appropriately adjust p-values in light of multiple testing, $p<0.01$ was considered statistically significant for all comparisons undertaken. This means there is only a 1% likelihood that the difference is due to chance.

Custody suites	Number of cells
Aldershot	13 cells
Basingstoke	14 cells
Newport	11 cells
Portsmouth Central	29 cells
Southampton Central	36 cells
Fareham (reserve suite)	14 cells
Lyndhurst (reserve suite)	11 cells
Waterlooville (reserve suite)	12 cells

Leadership, accountability and partnerships

2.5 There was a clear governance structure for custody, and this provided a clear line of accountability for its safe delivery.

2.6 Since the previous inspection there had been significant reductions in the size of the custody estate and the number of detainees held. The force believed that this was due to a change in culture, resulting in a more focused approach to providing alternatives to arrest. The strong emphasis on diverting detainees was evident in practice, particularly for those who were vulnerable. However, the force did not have sufficient data to demonstrate that the reduction in numbers held was entirely due to diversion.

2.7 The force followed national guidance for custody, and this was underpinned by several very comprehensive local policies and operating procedures. These documents were accessible to staff and provided clear operational guidance.

2.8 There was a clear mission statement for custody, based on supporting investigations and caring for detainees, with the force giving priority to providing caring and effective custody arrangements. Our observations generally confirmed that these objectives were carried out effectively and, in the main, we found that custody staff operated in a respectful, courteous and caring manner.

2.9 The force had increased its investment in training and provided annual refresher training for custody staff. However, the uptake of training, although monitored, was not effectively governed.

2.10 There were plans for physical improvements to the custody estate. Meanwhile, the force was placing detainees and itself at significant risk due to the extensive number of ligature points that we found in most suites. This was a serious area of concern.

2.11 The force monitored performance and collated data on custody, including custody throughput and demographics, but this was not comprehensive for all key activities. At a strategic level, it was not clear how this work, along with the regular quality assurance, was used to identify trends and inform organisational learning.

2.12 The force had effective mechanisms to share learning about adverse incidents, and to identify and share good practice. The chief inspector produced an informative custody bulletin that provided useful guidance and professional reminders to staff.

2.13 The force had inadequate mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force during arrest, detention and custody was safe and proportionate. It was not easy to extract data on the use of force in custody from the IT system, and forms used by individual officers to justify their actions did not have sufficient data to correlate with custody records. Hampshire Police was not currently able to provide the datasets required for the Home Office annual data return, which it should have collated by 1 October 2016.

2.14 The force facilitated access to external scrutiny and was open to challenge. The force also had a healthy relationship with its independent custody visitors scheme, which provided effective scrutiny, and the force welcomed and was receptive to its feedback.

2.15 The force had made some improvements in its overall approach to equality and diversity work. Clear strategic objectives had been set and a centralised department coordinated this work. However, there was insufficient focus on equality and diversity in relation to custody, and equality and diversity training for custody staff was limited. There was no analysis of custodial processes by protected characteristics, which made it difficult to demonstrate that procedures in the custody suites were always carried out fairly.

2.16 There had been an increase in the detention of people under sections 135/136 of the Mental Health Act[5] over the previous six months. The force acknowledged that it faced challenges in dealing with vulnerable mental health detainees, and said that this was due to limits on resources and a lack of capability by some partners in fulfilling their statutory responsibilities. The reported fall-back position was to use hospital accident and emergency departments, which was not a sustainable response. Frontline staff said they were increasingly frustrated about this because they had to spend significant time waiting with mental health patients.

2.17 There was a comprehensive multiagency section 135/136 policy, and a Hampshire-wide crisis care concordat. However, the validity of the data produced was questionable, and there were no jointly agreed figures for section 136 cases. The difficulty reaching a clear understanding of this problem was compounded by the incomplete data supplied by the force.

2.18 There was a joint triage procedure between the force and Hampshire youth offending teams (YOTs) to determine the most appropriate measures for children. The force had also worked with partners to develop joint arrangements to accommodate children who were charged and refused bail, to avoid their detention in custody overnight. However, in practice, the shortage of provision meant this did not happen. Force data and our own findings indicated that significant numbers of children were held overnight. This needed to be addressed in collaboration with partner agencies.

[5] Section 135 of the Mental Health Act 1983 enables a police officer to remove someone from a private place, and section 136 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.

Pre-custody: first point of contact

2.19 Frontline officers showed a good understanding of vulnerability and how to recognise this in the individuals they dealt with. In general, they felt that they received good intelligence from the control room when attending incidents, and that they were provided with relevant information in advance.

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

2.20 Frontline officers were confident in using the necessity criteria to provide the circumstances of and grounds for arrest of detainees when they brought them into the custody suite. We were also encouraged that custody officers could provide us with examples of when they had challenged this and refused detention. Custody sergeants and frontline police officers had a good understanding of the alternatives to custody that were available.

2.21 The custody records we reviewed showed that there were sometimes lengthy delays between arrival and the authorisation of detention. Custody staff reported, and we observed, that investigations were not always conducted promptly, which lengthened detention for detainees unnecessarily.

2.22 Custody staff dealt with detainees in a respectful, compassionate and positive way. Evidence, consistently showed that they tried to provide support and meet detainees needs during their time in custody. Privacy at booking-in desks was generally good, with some suites providing split areas or separated desks.

2.23 Provision for detainees with diverse needs was reasonable. Female detainees were routinely offered the chance to speak with a female officer and offered sanitary packs. However, women and children were not routinely placed into specific cells or separated from other detainees at all suites.

2.24 The arrangements for detainees with disabilities were mixed. All suites had wheelchairs and hearing loops, although not all staff understood where to find the latter or how to operate them. There were very few adapted facilities in the older suites, with limited additional support for those with mobility issues. It was encouraging that detainee rights and entitlements information was available in Braille in all the suites, but disappointing that many staff were unaware of this.

2.25 Staff training in equality was limited with few opportunities to develop specialist knowledge of diversity and culture. Although this occasionally created difficulties, in most cases staff demonstrated a reasonable understanding of how to meet detainees' varied needs – for example, several staff showed a sound knowledge and were confident about how to deal with transgender detainees. Religious texts and artefacts were available in all suites and stored very carefully.

2.26 There had been reasonable attention to addressing issues raised following a self-inflicted death in custody two years earlier. Risk assessments conducted by both sergeants and detention officers were comprehensive and properly focused. The routine removal of cords from detainee clothing and footwear was a disproportionate and unsophisticated response to managing risk, and could be an aggravating factor. While we were pleased that anti-rip clothing was not used, it was inappropriate that detainees could be left naked for significant periods in order to reduce self-harm.

2.27 The quality of engagement between custody staff and vulnerable detainees was generally very good; it was caring, considered and sensitive. Care plans generally set appropriate levels of observation and were mostly adhered to. Rousing practice was generally good and well documented, and it was positive that all staff carried anti-ligature knives.

2.28 Staff shift handover arrangements were properly focused on identified risks, but meetings were not always attended by all relevant staff.

2.29 In the records we reviewed, bail conditions and bail periods were set proportionally. There were weekly processes across the force area to manage bail; however, we found no evidence of senior management oversight.

2.30 Although no information on the complaints process was displayed in any of the custody suites, custody staff and inspectors told us that if a detainee wished to make a complaint while in custody this would be facilitated, or an arrangement made for an interview at a later date.

In the custody cell, safeguarding and health care

2.31 The physical conditions that most detainees were held in were adequate overall. Cells were usually clean and there was an absence of graffiti. However, as already indicated, we were extremely disappointed to find such a large number of potential ligature points in the custody suites.

2.32 At two suites, cell toilets were not pixellated on CCTV monitors, which compromised detainee privacy. Detention officers (DOs) did not always explain to detainees how to use the cell call bells, and in some cases bells were muted, or not always responded to quickly enough.

2.33 Despite our previous recommendation, DOs and custody sergeants still did not complete all the daily and weekly cell checks they should have done across all the custody suites.

2.34 We observed some very good Police and Criminal Evidence Act (PACE) reviews carried out face-to-face with detainees. In our custody record analysis, several reviews were conducted early, and this was confirmed in the records we examined. PACE inspectors explained that they only did this when they were content there was going to be no change in circumstances, in order to assist the response and patrol (R&P) inspectors, who covered this task during the night. We saw very few detainees reminded that reviews had taken place while they were sleeping, even when this was identified as an outstanding task on office whiteboards.

2.35 There was a suitable selection of food and drinks for detainees at most suites, with reasonable provision to meet religious and cultural requirements. Food was normally provided whenever requested, including outside meal times.

2.36 There were generally adequate stocks of clothing in the suites, including footwear and underwear. There were also good supplies of toiletries and hygiene products. Reading material was available at all suites, including recent periodicals, but these were generally only in English and of limited range and supply.

2.37 As already indicated, oversight of the use of force was inadequate. Although we were advised that Taser had not been used in custody, we identified two incidents earlier in the year where detainees had been marked with a red dot by the Taser, to de-escalate the situation without discharging it. In one case we were not assured that there was sufficient governance.

Not all officers involved in incidents completed use of force forms consistently, and those that were completed did not contain enough usable information. Narrative entries in detention logs about the use of force were also inconsistent.

2.38 Throughout the inspection custody staff dealt with challenging detainees patiently. About half the use of force incidents we reviewed were managed well, but we also found several missed opportunities to learn lessons.

2.39 We were not assured that the use of force was always a proportionate response to the risk posed, and some techniques were deployed poorly (see paragraph 2.26). The use of spit hoods and limb restraints was common, and we were not assured there was sufficient governance of their use. Handcuffs were not always removed quickly enough from compliant detainees. Force data indicated that the number of strip searches was low, and they were properly justified and authorised.

2.40 Staff showed an understanding of safeguarding issues and were alert to them, but they had received no specific training in this area. Custody staff understood how the safeguarding referral processes worked, and were confident that the force's central safeguarding and specialist teams or multiagency teams would deal with concerns raised.

2.41 Risk assessments of children were completed appropriately and informed care plans, with all children placed on a minimum of 30-minute observations. Although children were not always located in separate designated cells, officers engaged with them actively and offered good care. Although girls were asked whether they would like to speak with a female officer, they were not allocated a single point of contact, as required under the legislation.

2.42 The appropriate adult (AA) service generally provided effective support. Custody staff regarded the service favourably, and there were no undue delays in AAs arriving after they had been called.

2.43 Custody sergeants tried to minimise the time that children spent in custody and aimed to avoid detaining them overnight, seeking to bail children where possible. However, records showed an average stay for children of almost 12 hours, some held in custody overnight pending investigation into their offence. Five children out of the 11 cases we reviewed were detained overnight before charge. Our more detailed case audits of children showed a similar picture.

2.44 Where a child was charged and had bail refused, alternative accommodation was requested from the local authority, but custody sergeants reported that this was rarely forthcoming, despite use of an escalation procedure.

2.45 Physical health services for detainees were provided by Mitie Care and Custody. Paper records were clinically appropriate but health care professionals (HCPs) could not access the police custody computer system, which was a risk in the prompt and accurate sharing of information.

2.46 Reported response times by HCPs were good overall, and especially in suites with a full-time HCP presence. There had been some recent notable gaps in forensic medical examiner (FME) cover, which were only partly offset by an on-call medical consultant. Senior HCPs were used to cover this gap, but it was still unclear if this provided all the clinical cover required. Care and assessment by HCPs was sound and thoughtful; records showed there were effective risk assessments and communication with custody staff. Arrangements for emergency responses were good in all suites, and all health staff were up to date in life support training.

2.47 Detainees were not routinely given the opportunity to see an HCP, but custody staff decisions to refer them to an HCP were risk based and included requests by detainees. Patient confidentiality was compromised in most suites because treatment doors were left open routinely, irrespective of risk assessment. Some medical rooms were in a poor and even unsafe condition. Infection control compliance was variable.

2.48 Detainees were allowed their own prescribed medicines, subject to verification. Police officers made efforts to obtain essential medicines from detainees' homes, and patient group directions (PGDs) enabled HCPs to provide a wide range of useful medicines. It was helpful that DOs could give detainees simple medicines based on the telephone authority of an FME, however they had not received specific training for this.

2.49 Drug and alcohol service provision varied across the custody suites. A substance misuse worker attended the Southampton and Portsmouth suites daily; there was less frequent or no regular attendance at other suites, with custody staff left to contact the agencies and/or provide contact information to detainees.

2.50 Detainees in active withdrawal from alcohol or opiates received symptomatic relief, subject to objective assessment, and those on prescribed opiate substitution could receive this subject to confirmation and risk assessment; these measures were appropriate. It was commendable that detainees had access to nicotine replacement lozenges, although different strengths were used at different suites.

2.51 Mental health services were very good in Southampton and Portsmouth, with a specialist practitioner based in the suites full time and access to an out-of-hours team. Custody staff welcomed this and we observed some excellent joint working. At Basingstoke, a specialist practitioner visited the suite daily and an out-of-hours crisis team was also available. The local crisis team also provided a call-out service at Newport, but there was no service at Aldershot.

2.52 Custody staff told us that there were delays in getting Mental Health Act assessments for detainees, who sometimes had prolonged detention due to delays in assessments and a lack of acute mental health beds; we found several cases that confirmed this, including some very lengthy delays.

2.53 Street triage on the Isle of Wight and telephone triage in the force control room were impressive projects providing early screening to help divert mentally ill detainees from custody. The control room nurse had no direct access to some health records, which was disappointing, although data collected by the nurse showed that the service was effective.

Release and transfer from custody

2.54 Pre-release risk arrangements were properly focused on securing a safe release for detainees. Recording on detention logs was mostly good but did not always reflect the actual care and attention given to detainees. It was positive that custody staff shared appropriate information with agencies involved with detainees before their release or shortly after. A range of support leaflets were available and issued to detainees on release.

2.55 Court cut-off times were too early and often caused extended stays for detainees in police cells, particularly at the weekend. Apart from a small number of cases, the quality of person escort records was generally very good and much better than we normally see.

Areas of concern and recommendations

2.56 The substantial number of potential ligature points identified in most suites were a significant risk to detainees and the force. The force was largely unaware of this, but following the inspection put in place short- and long-term plans to address the issues identified.

Recommendation: Hampshire Constabulary should address the safety issues arising from identified potential ligature points and work towards eliminating them. Pending such action, the risks should be mitigated to ensure that custody is delivered safely.

2.57 Performance information on custody was not comprehensive and there was limited monitoring across the different custody function, which made it difficult for the force and others to assess how well custody services performed.

Recommendation: The force should develop a comprehensive performance management framework for custody ensuring the accurate collection of data, and should use such data to assess performance, identify trends and learning points, and improve services.

2.58 All aspects of the use of force lacked governance and effective oversight. Not all staff had received recent training, and they did not always submit individual use of force forms following incidents. Force was sometimes used against detainees who had self-harmed at a low level and also to remove clothing with cords, which was disproportionate to the risk posed.

Recommendation: Hampshire Constabulary should maintain effective management oversight of use of force incidents and trends. Incidents involving force should be quality assured and cross-referenced with closed-circuit television. All staff involved in incidents should complete individual use of force forms. Staff should be adequately trained at least every 12 months. Force should only be used at the lowest level and be proportionate to the threat posed.

2.59 The number of detainees held under section 136 of the Mental Health Act as a place of safety had increased significantly in the previous six months. Too many people with mental health problems were now brought to and/or staying in police custody, with a lack of evidence of any other reason for their detention, and often because of insufficient appropriate spaces elsewhere.

Recommendation: The force should, in collaboration with partners, urgently review the reasons behind the increase in the number of vulnerable people detained in police custody as a place of safety, and take action to avoid the use of police custody as a place of safety for people with mental health problems.

2.60 Most children charged and refused bail remained in custody overnight because alternative accommodation was not provided by the local authority. The jointly agreed procedures had not resulted in better outcomes for children detained in these circumstances.

Recommendation: The force should continue to engage actively with its local authority partners to find more effective ways of providing alternative accommodation for children charged and refused bail to avoid them remaining in custody overnight.

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 There was a clear governance structure for custody with overall strategic responsibility at assistant chief constable level, supported by a superintendent and a chief inspector responsible for operational delivery. Three dedicated inspectors were responsible for the day-to-day management of the custody environment, with an additional inspector as part of the central team. There was a sufficient central pool of custody sergeants and detention officers (DOs) to carry out the custody functions, and the structure provided clear accountability for the safe delivery of custody.

3.2 Since the previous inspection there had been a significant reduction in the size of the custody estate and the overall number of detainees held. The force said that this was due to a more focused approach to providing alternatives to arrest, and we observed a clear staff commitment to finding the most appropriate approach to support the individual. The active diversion of detainees, particularly those who were vulnerable, was very positive. However, the force had limited data to evidence that the reduction in numbers was entirely due to positive diversion.

3.3 The force followed the College of Policing's *Authorised Professional Practice – Detention and Custody*. This was underpinned by very comprehensive local policies and operating procedures. These documents were accessible to staff and provided clear operational guidance. Staff were aware of the local guidance and generally knowledgeable about policies and procedures.

3.4 There was a clear mission statement for custody based on supporting investigations and providing caring and effective custody arrangements. We observed that custody staff mainly operated in a respectful, courteous and caring manner. However, the custody estate did not consistently support the safe delivery of custody. With the exception of Southampton Central, we found many potential ligature points in the cells and some communal facilities (see paragraph 6.3), which presented a serious risk to detainees and to the force. The force was upgrading its custody estate, with a new suite at Basingstoke offering modern facilities scheduled to open in spring 2017 and plans to provide a further new suite. Despite this, it was unaware of the ligature points in its suites but, once brought to its attention, the force implemented both a short- and long-term plan on how they would mitigate these risks; this was a serious area of concern (see recommendation 2.56).

3.5 The force had improved its investment in training and provided annual refresher training for custody staff. However, the uptake of training, while monitored, was not effectively governed. Force data for the previous 12 months showed that 77.3% of custody staff had attended a refresher course, and 68% had attended and passed a first aid course. The force needed to ensure it had a formal mechanism to check which staff might have missed training and to remedy this so that all staff are fully trained for their role. Staff confirmed that they

lacked refresher training on equality and diversity issues (see paragraph 5.7). The force indicated that there were plans to address this.

Accountability

3.6 The monitoring of performance in the custody function was limited, and in some areas inadequate. Although the force monitored performance and collated some data, including custody throughput, demographics and detention times, this was not comprehensive across all key activities. Force data provided for the inspection were inconsistent. It was not clear how the force used this, along with regular quality assurance, to assess how well it delivered different aspects of the custody service, and to identify trends and inform organisational learning at strategic level (see recommendation 2.57).

3.7 The force had an adverse incident procedure and effective mechanisms to share learning on such incidents, and to identify and share good practice. The chief inspector produced a *Custody update* bulletin, which was informative and provided useful guidance and professional reminders to staff.

3.8 The force had inadequate mechanisms to assure itself, the Police and Crime Commissioner and the wider public that its use of force was safe and proportionate. Data on the use of force in custody could not be easily extracted from the force IT systems, and the forms used to justify individual actions did not contain sufficient data to correlate to custody records. The force's inability to provide performance information on the use of force, its frequency and whether it was justified was a strategic risk. It also meant that the force could not identify trends or learning opportunities accurately. (See recommendation 2.58.) The force was also not in a position to provide the datasets required for the Home Office annual data return, which it should have been collating by 1 October 2016.

3.9 The force had taken steps to improve its approach to equality and diversity. It had agreed strategic equality objectives, and a central equality and inclusion department led on force-wide equality issues, including training and the public sector equality duty. However, there was insufficient focus on equality and diversity in relation to custody. Positively, there had been an equality impact assessment of custody policies, and there was custody representation on the force-wide champion groups for disability and religion and belief, which had led to some changes. However, a previous equality and inclusion plan for custody was no longer being progressed, custody and frontline staff could not recall any training on equality issues, other than at induction, and there had been no analysis of custody processes by protected characteristics to assess whether there was any over- or under representation (for example, in the throughput of custody or the use of strip searches). This meant that the force was unable to identify any concerns or demonstrate to itself and the wider public that the custody service was delivered fairly.

3.10 The force also had a positive relationship with its independent custody visitors (ICVs) who provided effective scrutiny of custody services. The force welcomed this and was receptive to feedback. For example, the ICVs had informed the force that detainees were not being reminded that Police and Criminal Evidence Act (PACE) reviews had taken place when they were asleep, and the force had committed to address this.

Partnerships

3.11 The force was committed to engaging with partners to improve its approach to vulnerable people and children entering custody. It was represented at the appropriate level in various partnership forums, including the local safeguarding boards, and several joint procedures had

been developed. However, this commitment to joint working had not consistently led to better outcomes for detainees.

3.12 There was a comprehensive multiagency section 135/136 Mental Health Act (MHA) [6] policy, revised in March 2016 and in line with the act's code of practice. There was also a Hampshire-wide 'crisis care concordat' and local concordat meetings. A multiagency section 136 governance partnership group met quarterly to review the operation of the policy and individual cases and incidents, and associated training needs. There was evidence of some positive success with the Isle of Wight street triage scheme (see paragraph 6.67).

3.13 A network of local multiagency high intensity user groups included stakeholders from the police, ambulance services, mental health services, approved mental health professional providers and, occasionally, local GPs. These meetings aimed to take a planned systematic approach to managing a few frequent individual custody attendees and thus reduce the frequency of crises and custody attendance. However, despite these arrangements, the position had deteriorated in the previous six months as the number of people with mental health problems entering custody as a place of safety had increased. Since April 2016, the numbers of people taken into police custody on section 136 per month had varied between nine and 25. There were no jointly agreed data collection between partners for monitoring the number of people detained under section 136 or the subsequent outcomes (see also paragraph 3.6). This made it difficult for the force and its partners to understand and assess the true picture

3.14 The force acknowledged that it faced challenges in dealing with vulnerable mental health detainees due to a lack of resources and partners being unable to fulfil their statutory responsibilities because of funding issues. The reported fall-back position to avoid taking a person with mental health problems into custody was to use hospital accident and emergency departments, which was not an adequate response. Frontline officers said they were increasingly frustrated at spending significant time waiting with mental health patients/detainees both at A & E departments and on the street, which was a poor outcome for these vulnerable people (see also paragraphs 4.7 and 6.73 and recommendation 2.59.)

3.15 Partnership arrangements for supporting children and diverting them from custody and the criminal justice system were also mixed. There was a clear Hampshire joint triage procedure between the force and youth offending teams (YOTs) to determine the most appropriate measures for children charged with an offence. These arrangements sought, where possible, to avoid the criminalisation of children through the use of out-of-court disposals, such as restorative justice remedies.

3.16 The force had also worked with partners to develop joint arrangements for the accommodation of children who were charged and refused bail to avoid their detention in custody overnight. However, in practice a shortage of provision prevented this from happening. Force data and our own findings indicated that significant numbers of children were held overnight due to a lack of alternative accommodation (see paragraph 6.40 and recommendation 2.60).

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

Section 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 Force officers and staff were generally alert to, identified and made effective assessments of risk and vulnerability for both victims and suspects.

4.2 Hampshire Constabulary had a force enquiry centre (FEC) in Southampton, where staff responded to non-emergency calls, and a force control room (FCR) in Netley, which responded to emergency calls, although there was some overlap between the two at peak times. FEC staff were mostly call handlers while those at the FCR performed various roles as call handlers, controllers (dispatchers) and facilitators (assisting the controllers). FCR controllers were responsible for sending out the most appropriate response based on the 'threat, harm, opportunity and risk' (Thor) decision-making response. Staff had regular training opportunities, which for some included child sexual exploitation, safeguarding and mental health.

4.3 The force records management system contained information about vulnerability of people known to the police. This included warning markers, information about previous incidents and identified whether children were known to be at the address or if anyone was subject to public protection arrangements. Vulnerability markers were also highlighted and accessed on the force's command and control system. Staff checked on the police national computer (PNC) for further information relevant to the detainee and officer safety. All these systems were routinely searched by the controller responsible for dispatching officers to incidents. In addition, neighbourhood policing officers had access to a multi-agency information-sharing database (SafetyNet) that included information on action plans for vulnerable adults and children. However, we were told that this database was not available to the FCR, frontline officers or the central safeguarding team.

4.4 Frontline officers used the national decision-making model risk assessment framework when responding to incidents. Ongoing training of frontline officers was inconsistent and was predominantly via e-learning, which was poorly perceived by staff. Officers generally felt they received prompt and relevant information from the FCR. They also had access to further information on mobile devices, but they rarely had time to use this as they normally attended incidents on their own.

4.5 A mental health practitioner was based in the FCR five nights a week, alongside controllers (see paragraph 6.67). The combination of mental health expertise alongside the IT systems provided frontline officers with vital information, advice and guidance that helped them make informed decisions about the best response to detainees in need of mental health care (see good practice point 6.80). This support was well regarded by FCR staff and frontline officers.

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 schemes offered by the youth crime prevention outreach services and fire service (which offers courses to divert children involved in arson cases) to divert children from further

offending. Police officers and staff who had contact with children recognised them as vulnerable by virtue of their age.

4.7 Although the impact of custody on vulnerable people, including children, was a serious consideration for police officers, attempts to divert individuals from custody were sometimes hindered by a lack of relevant support services.

4.8 There was a recently introduced protocol for transporting mentally ill vulnerable individuals to hospitals to prevent them from harming themselves. Handcuffs were applied on a risk assessed basis with officers having discretion to remove these when they considered it appropriate to do so.

4.9 Staff received annual personal safety refresher training, in line with national guidelines and *Authorised Professional Practice*. However, individual officers did not always record use of force, outside or inside police custody, on a separate use of force form, as some believed it was appropriate for one shared form to be submitted (see paragraph 6.14 and recommendation 2.58).

Area for improvement

4.10 Access to the SafetyNet database should be extended to ensure that all relevant information is available to police officers and staff to inform their decision-making when dealing with vulnerable people, including children.

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 treated detainees in a very respectful, compassionate and positive way. The interactions that we observed were always positive and considerate of the individual's needs.

5.2 The privacy for detainees at booking-in areas varied significantly across the suites. The newer suite at Southampton Central offered adequate privacy with desks separated by thick partitions, and there was a separate booking-in desk in another room if sensitive disclosures were required. However, the other suites had either split booking-in desks in individual rooms or within the same area with some limited separation. Staff assured us that detainees would only be booked in one at a time (which we observed) or, where possible, the area would be 'closed' to facilitate processing a vulnerable detainee, which was a sensible approach given the constraints of the environment. Some booking-in desks, including those at Portsmouth Central, were at a raised level, which impeded communication between detainees and custody staff.

5.3 Arrangements for identifying and meeting diverse needs were reasonable. Force custody policy required custody staff to consider a wide range of diversity issues during detainees' initial risk assessment, and we observed that this practice was routine. Staff recognised the sensitivities and importance of meeting individual and diverse needs including, for example, how to respond appropriately to transgender detainees. Custody staff invited detainees to self-define their ethnicity rather than make assumptions about this, which was positive. Generally, detainees were asked about their dietary requirements or caring responsibilities when entering custody, which allowed individual needs to be managed appropriately. Women coming into custody were routinely offered sanitary packs and the opportunity to speak to a female officer.

5.4 Hearing loops were available in all custody suites to assist those with hearing impairments, but staff did not always know where to locate or how to use them. At Southampton Central, all cells were modified to offer assistance for visually impaired detainees (a blue band around cell walls) but this was not the case at the other suites.

5.5 All suites had wheelchairs for detainees with disabilities or mobility issues, with crutches also available at Southampton Central. Only Southampton Central offered adapted disabled-access toilet and shower facilities. Some suites, such as Portsmouth Central, had cell benches that were higher than the current Home Office design rules, but the majority elsewhere were placed much lower to the ground and were difficult to use for people with restricted mobility. There were no extra-thick mattresses at any of the suites to offset this, and staff had to provide supplementary mattresses instead, which was not as effective. Subject to risk assessment, detainees could also be allowed to use a chair in their cell for additional support, and we saw a detainee with mobility issues offered this facility. Some of the physical access

problems were compounded by the absence of low-level cell call bells for detainees to contact custody staff, except in one cell at Southampton Central.

5.6 Religious artefacts were available in all the suites and stored respectfully. Reading materials were available at all suites including some recent periodicals, but were limited in range with poor provision for children and non-English speakers. In our custody record analysis, only 11 of 128 detainees (9%) were offered access to reading materials, while none of the 11 children reviewed were offered any.

5.7 There was limited staff training in dealing with people with diverse needs. Although staff received some relevant input – such as on mental health – when they joined custody, this was not reinforced by refresher training on any equality and diversity issues. The force offered online advice and guidance covering a range of subjects through its intranet, but several staff told us that this was not sufficient to help with some of the issues they faced, such as communicating with intellectually impaired or mentally disordered detainees. They also said they relied heavily on their own experiences of working in custody, or actively sought learning through personal research or the limited availability of training opportunities (see also paragraph 3.5). This led to inconsistency in dealing with detainees' needs, and failed to provide staff with the support and knowledge they required to meet the challenges of working in custody.

Risk assessments

5.8 Detainees were not always booked in promptly (see paragraph 5.18). There was no evidence that detainees were triaged to identify vulnerable detainees quickly or prioritise them for booking in.

5.9 Custody staff focused appropriately on identifying risk, interacted well with detainees to complete standardised risk assessments, responded to individual need, and asked appropriate supplementary and probing questions. We saw many examples where staff dealt with detainees patiently and sensitively. Custody staff identified initial risks to detainees well, including those in custody for the first time. There was routine cross-referencing to police national computer warning markers and historic information held on local intelligence systems to inform risk assessments further.

5.10 Care plans generally set observations at an appropriate level, which were amended when required. Levels of observations were broadly adhered to. CCTV was not available in all cells but was used appropriately to enhance observations, rather than replace physical checks. Staff were competent in rousing intoxicated detainees, and where they did this, documented it well. All custody staff carried personal issue anti-ligature knives, which was positive. Overall there had been reasonable focus on addressing issues identified following a self-inflicted death in custody in 2014.

5.11 Anti-rip clothing was not used, which was positive, but it was unacceptable that detainees could be left naked for considerable periods as a strategy to manage self-harm. We saw CCTV footage where a man was left naked for two hours, and staff told us that this was not uncommon. The routine removal of clothing with cords and footwear was a disproportionate and unsophisticated response to managing risk, and was sometimes an aggravating factor (see paragraph 6.17).

5.12 The staff shift handovers we observed were well conducted in private and focused appropriately on risk, detainee welfare and case progression, but they did not always include all relevant staff.

Areas for improvement

5.13 Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment, and the dignity of the detainee should always be maintained.

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

Individual legal rights

5.15 Custody sergeants – and detention officers (DOs) at Southampton Central under a sergeant's supervision – booked detainees into custody. At most suites, arresting officers completed a form recording the detainee's details, brief details of the offence and the grounds for detention, but we found several versions of this form in use, which was inconsistent. Custody staff used the information recorded on the form to create an initial custody record for the detainee. The custody sergeant then asked the arresting officer, in the presence of the detainee, to provide a full explanation of the circumstances of and the reasons for arrest before authorising detention. We observed that frontline officers had a good understanding of Police and Criminal Evidence Act (PACE) code G, which sets out their statutory power of arrest, and the necessity criteria required to verify their reason for arresting individuals.

5.16 Sergeants told us that they were confident in refusing detention when the circumstances did not merit it, and they could provide us with examples. One evening we saw detention refused for a vulnerable 17-year-old girl who had health issues, which was appropriate; however, no custody record was created to record her detention in the custody suite (see paragraph 6.39).

5.17 Alternatives to custody were available through community resolutions, street bail and voluntary attendance. [7] Facilities for interviewing voluntary attendees outside custody were available at all police stations.

5.18 Most detainees were booked in promptly on arrival at the custody suites, but we saw some delays of up to 20 minutes before their detention was authorised. In our custody record analysis, the longest delay for a detainee waiting to be booked in was three hours 12 minutes while the overall average waiting time was 34 minutes, which was higher than the force comparator (from March to October 2016) of 22 minutes. Force data showed average waiting times from arrival in custody to authorisation of detention as 27 minutes for the year ending September 2016. Such delays were unacceptable, particularly when they involved vulnerable detainees (see paragraph 5.8).

5.19 Custody sergeants were aware of the need to minimise time in detention and to progress cases quickly. In addition to initial delays for detainees waiting to be booked in (see above), we were told that there were sometimes delays due to further factors, such as the non-availability of investigating officers or appropriate adults out of hours (see paragraph 6.37). Force data for the 12 months to September 2016 showed that the average time between

[7] Community resolution applies to the resolution of a less serious offence or antisocial behaviour incident involving an identified offender (both youth and adult), through informal agreement between the parties rather than progression through the criminal justice process. Street bail under section 4 of the Criminal Justice Act 2003 enables a police constable to release on bail a person arrested for an offence on condition that they attend at a police station at a later date. One of the benefits of street bail is that an officer can plan post-arrest investigative action and be ready to interview a suspect when bail is answered. Voluntary attendance is usually used for lesser offences, and involves suspects attending a police station by appointment to be interviewed, avoiding the need for arrest and subsequent detention.

time of arrival to release time (per visit if the DP is bailed) ranged from 62 minutes at Newport, Isle of Wight to 13 hours 49 minutes at Southampton Central.

5.20 Custody staff reported a good relationship with Home Office Immigration Enforcement officers, who were based in Portsmouth. Force data showed that 536 immigration detainees had been held in the year to 30 September 2016, up from 312 in the year to 30 September 2014, a 72% increase over a three-year period. Custody staff said that most immigration detainees were moved on within 24 to 30 hours. However, the force was unable to provide any data on the average time in custody for immigration detainees following service of an IS91 warrant of detention[8] (see also paragraph 3.6 and recommendation 2.57).

5.21 During booking in, custody sergeants and DOs advised detainees of their three main rights[9] and detainees were routinely offered a written notice setting out their rights and entitlements, although 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 the force had an abbreviated easy-read pictorial version of detainees' rights and entitlements, and none of these forms could be found at Aldershot. It was encouraging to see that the rights and entitlements form was available in Braille in all the full-time custody suites, although again most staff were unaware of this.

5.22 Although detainees were told during their booking in that they could read the PACE codes of practice. There were sufficient copies of the up-to-date PACE code C in the custody suites but we did not see these routinely offered to detainees.

5.23 All detainees were offered free legal representation and were told that if they declined, they could change their mind at any time and accept this offer. Detainees who declined the offer of free legal representation were asked why, and this was routinely noted on the custody record. Those wishing to speak to legal advisers could not always do so in private. At Southampton Central, telephone calls could be put through to cells through an intercom system, whereas at other suites such calls had to be taken at the booking-in desk or on cell corridors. There were sufficient consultation and interview rooms at all the suites, and legal advisers were given a printout of their client's custody record on request.

5.24 There was an effective weekly system for collecting DNA samples taken in custody, but some custody staff were confused about the circumstances for disposal of these samples, which could be misleading for detainees.

Communication

5.25 A professional telephone interpreting service was available to assist the booking in of non-English speakers. Most staff used double-handset telephones to access this, which provided privacy, but these were not available at Portsmouth Central or in medical rooms (see paragraph 6.49). Staff told us that a face-to-face interpreter service was available for interviews, but there were sometimes delays, depending on the language requested, and so some detainees remained in custody for longer than necessary.

5.26 Most suites did not display posters in foreign languages informing detainees of their right to free legal advice, and those available were in a poor condition.

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[8] An IS91 warrant of detention is served on an immigration detainee when there is no reasonable alternative action, for example, if there is a likelihood that they may abscond or that their removal for the UK is imminent.

[9] To have someone informed of their arrest, to consult a solicitor and access free independent legal advice, and to consult the PACE codes of practice.

Area for improvement

5.27 Double-handset telephones should be provided at Portsmouth Central and in medical rooms to facilitate telephone interpreting.

Access to swift justice

5.28 In the records we reviewed, initial bail conditions and bail periods were set proportionally, but a clear rationale was not always recorded for decisions such as releasing on unconditional bail. The administration of bail cases varied across the force. There were dedicated bail sergeants, supported by a DO, at Southampton Central and Portsmouth Central, whereas at Basingstoke and Aldershot, a sergeant administered bail cases for both custody suites from a back office, and at Newport this task was covered by custody sergeants. These sergeants collectively were responsible for the oversight of all bail cases due to return to custody in the following one to two weeks, and this worked efficiently.

5.29 In several cases we reviewed, it was not always clear that there was active supervision of investigations where a suspect was on pre-charge bail, and no way of determining if enquiries had taken place swiftly. Sergeants confirmed that written authorisation was required from an appropriate supervisor for bail to be continued, but there was no uniform means of recording this continued authority. Other than the sergeants, no individual in the force was responsible for the oversight of bail management, and there were no data to monitor the number of people currently on bail or who failed to return.

Complaints

5.30 No information on the complaints process was displayed in any of the custody suites. Although it was contained in the full version of the rights and entitlements notice offered to all detainees, as indicated above, this was seldom accepted. Custody staff told us that if a detainee wished to make a complaint while in custody this would be facilitated, provided they were in a fit state (for example, not under the influence of alcohol). We saw an inspector noting a complaint from a detainee at Southampton Central, and found additional evidence of this in one of the custody records we reviewed, which was a significant improvement since our previous inspection.

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 The custody estate in Hampshire had reduced significantly since the 2012 inspection from nine full-time designated suites and two reserve suites to five full-time designated suites and three reserve suites. Some of the problems we identified then – such as inaudibility of cell call bells at Portsmouth Central and inadequate cell checks – remained.

6.2 New doors had been installed in several suites but not at Aldershot and Basingstoke, which were scheduled to close in 2017 following the completion of a new police investigation centre at another site in Basingstoke.

6.3 Cleanliness across the custody estate was adequate and there was very little evidence of graffiti. We identified numerous potential ligature points in cells and communal areas in most custody suites (see paragraph 3.4 and recommendation 2.56). Exercise yards were in a fair condition.

6.4 CCTV coverage in cells varied from three or four cells in the smaller suites to 11 cells at Portsmouth Central, and every cell at Southampton Central. There were no signs at Aldershot to advise detainees that CCTV was in operation in the cell corridors and in some cells. In-cell toilets were clearly visible on CCTV monitors at Basingstoke and in one cell at Fareham, which was undignified and inappropriate.

6.5 The cell call bells we tested were functioning, although detention officers (DOs) did not always explain to detainees how to use them. At Newport, we found the call bells had been muted but this was rectified when we informed the inspector. At Portsmouth Central, we saw several delays in responses to call bells, as part of the system was still unable to produce an audible signal and staff had to rely on viewing an illuminated panel – despite our previous recommendation for the panel to be repaired or replaced. At Southampton Central, staff could speak to detainees in cells through an intercom at the booking-in desks.

6.6 While the newest suite, Southampton Central, was in a good condition, there was poor natural light in two cells that backed on to medical examination rooms, despite modifications to address this.

6.7 Portsmouth Central had the poorest environment for detainees – the suite was very cramped, the walls were grimy and there was only one shower for 29 cells. The two holding rooms were dirty, and detainees had to walk behind two booking-in desks into a narrow corridor to access the cells, which was potentially unsafe. During the inspection, the suite was overheated and there was no air conditioning. Eleven cells had no toilets and detainees had to use one of two communal toilets, but one was sited at the end of a corridor with a very small privacy wall and the other, which was recessed into a corridor wall space, had no

screening whatsoever; this was unacceptable. These toilets remained unchanged from our previous inspection.

6.8 Despite the requirement for daily and weekly checks of the physical environment, the records at some suites still showed significant gaps in these, as at our previous inspection, and the forms used were not consistent across the force. We were told, and found evidence, that where problems with cleanliness, hygiene or broken equipment were identified, action was taken to resolve this, depending on the nature of the defect and the cost.

6.9 All custody suites displayed fire evacuation plans, which most staff were aware of. However, some staff who had recently transferred to Portsmouth Central had not been briefed on this subject. We were unable to find evidence of when fire evacuation drills had last taken place in any suite, but staff assured us that there was a weekly test of the fire alarm system. There were sufficient sets of handcuffs in the custody suites to evacuate the cells safely if required.

Areas for improvement

6.10 Notices that CCTV cameras are in use should be clear and prominently displayed throughout the custody suite, and toilets should not be visible on CCTV monitors.

6.11 The cell call bell system at Portsmouth Central should be repaired or replaced. (Repeated recommendation 4.43)

6.12 The communal toilets on cell corridors at Portsmouth Central should be screened immediately.

6.13 There should be consistent daily and weekly maintenance cell checks, including systematic identification and reporting of ligature points, and these should be recorded promptly, regularly and be subject to quality assurance.

Safety: use of force

6.14 Oversight and governance of the use of force were poor (see paragraph 3.8 and recommendation 2.58), and the force struggled to identify cases for us to review. Accountability for individual staff use of force against detainees was inadequate. Not all staff involved in incidents submitted use of force forms (see paragraph 4.9). Forms provided no details about the detainee involved, and little meaningful information about the necessity for using force. Narrative entries in detention logs were also sporadic and varied in quality. We were not assured that the constabulary always reviewed use of force in custody to ensure proportionality or to assist with individual and organisational learning.

6.15 Data provided were difficult to disaggregate but we estimated that around 30% of custody staff had not completed officer/personal safety training in the last 12 months, which was unacceptable.

6.16 CCTV footage was only kept routinely for 30 days and therefore we were unable to review incidents earlier than that. Through our custody record analysis, case audits and observations we were able to identify 16 cases in the previous month that we cross-referenced against CCTV. Throughout the inspection and during our review of CCTV footage we saw custody staff de-escalating some potentially challenging situations well. Despite this, we were not assured that all use of force was as a last resort.

6.17 Around 50% of the cases we reviewed were handled well overall, but there were some learning points in about two-thirds of the incidents. Force was sometimes heavy handed, uncoordinated and involved poor techniques, including prolonged prone restraint. In two cases, force was used to manage low-level, non-life threatening self-harm, which was an inappropriate response, as was the routine removal of clothing with cords (see paragraph 5.11 and area for improvement 5.13).

6.18 Spit hoods and limb restraints were used frequently. We reviewed three cases where spit hoods were used, and saw a further incident during the inspection. Limb restraints were also applied in four cases we reviewed. We were not assured there was either sufficient governance of their use or that they remained in place for the shortest time possible.

6.19 Custody sergeants carried batons, handcuffs and CS canisters on their utility belts. We were told that CS spray had been used in custody at least once in the previous 12 months but were unable to corroborate this. Although we were advised that Taser had not been used in custody, we found two incidents in the previous year where detainees had been marked with a red dot by the Taser, to de-escalate the situation without discharging it. We were able to review one case, which was well managed and demonstrated a proportionate response. The second case, found in the detention log, appeared to have been carried out without a plan or oversight, and had taken place because a Taser-trained officer was on duty when a man detained under section 136 of the Mental Health Act became aggressive in the suite.

6.20 Not all detainees arrived in custody in handcuffs, which was positive. However, most of those who did remained in handcuffs for long periods when they were compliant, which was disproportionate in the controlled custody environment.

6.21 In the previous 12 months, 612 detainees (3%) had been subject to a strip search in custody, which was relatively low. Few strip searches were authorised during the inspection, and we were assured that all were for proper reasons. However, we were concerned to see male staff present during part of the removal of clothing from a female detainee.

Area for improvement

6.22 Clothing should only be removed from detainees in the presence of staff of the same gender.

Detainee care and PACE reviews

6.23 Microwave meals, fresh sandwiches and other food of reasonable quality – including halal, vegetarian and vegan options – were available at all the full-time designated suites, except Newport. Food preparation areas were clean and well stocked, although not all suites contained guidance to staff on food suitable for various diets. We observed staff showing consideration to detainees' dietary requirements. Staff said meals would be provided to detainees on request outside of meal times or in multiple quantities, wherever possible – and we observed a detainee at Portsmouth Central provided with hot and cold food for breakfast en route to court. In our custody record analysis, 84% of detainees were offered a meal, including all nine held for longer than 24 hours. Staff provided drinking water, if not available in cells, and often proactively.

6.24 Some force-wide decisions had affected detainees' rights in custody. Pillows were not allowed in cells, following their use in incidents where detainees had attempted to attack staff. This was a disproportionate response.

6.25 Stocks of replacement clothes, shoes and blankets were generally available at all suites, although there were some clothing shortages at Southampton Central. Anti-rip or paper suits were not used as a replacement for clothing, which was positive.

6.26 There were showers in all the suites and most offered reasonable privacy, although the shower at Fareham was compromised by its location at the end of a corridor where it could be seen by any passer-by. 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 a detainee at Portsmouth Central due to go to court request a shower, which was not facilitated. Similarly, in our custody record analysis we found that only five detainees (4%) were offered a shower, dropping to 3% for those detained more than 24 hours. None of the 11 children identified in the analysis were offered a shower.

6.27 Most of the cells contained toilets and usually toilet paper. Not all cells had hand washing facilities but detainees could use those on cell corridors on request, subject to staff availability.

6.28 All the custody suites had at least one outside exercise area for detainees. Staff told us they would facilitate their use wherever possible, including on hourly rotation during periods of high demand, such as in hot weather. We observed one detainee who requested and was allowed to use an exercise yard. However, in our custody record analysis only nine detainees were offered outside exercise. It was unclear why there was inconsistency in the facilitation of exercise as staff did not always need to supervise or monitor it.

6.29 Only Southampton Central had a dedicated visits room for children and vulnerable adults in detention. We did not observe or find evidence in our case audits of any visits that were facilitated.

6.30 Reviews of detainees were undertaken by dedicated PACE inspectors, custody inspectors or in their absence, particularly during the night, by response and patrol (R&P) inspectors. We observed some very good face-to-face reviews, which were timely, appropriate and fully recorded on detention logs. In the 78 cases in our custody record analysis where reviews were required, it was not clear in four cases why no review was conducted, and in 18 of these cases reviews were conducted early (24%). PACE and custody inspectors told us that they were likely to conduct a review early if they judged there was going to be no change in circumstances, and so assist the R&P inspector. We saw very few detainees informed that reviews had taken place while they were asleep, even when this was identified as an outstanding task on office white boards. Custody sergeants confirmed that the information that reviews had taken place was not always exchanged during staff shift handovers or flagged on the Niche custody computer system and, therefore, could be overlooked.

Areas for improvement

6.31 Reviews of detention should always be conducted in accordance with the Police and Criminal Evidence Act 1984 code C.

6.32 Unless there are good reasons not to, detainees should be supplied with pillows in their cells.

Safeguarding

6.33 Custody staff were alert to safeguarding issues and showed a good understanding of them. Although safeguarding referrals were generally the responsibility of arresting or investigating officers, custody staff knew the referral processes and were confident that the force's central safeguarding and specialist teams, or the multiagency teams, would deal with any concerns raised. Staff were able to access information about vulnerable people and children from a range of sources, and worked well with health colleagues to share information and decide appropriate actions. We saw some good examples of safeguarding arrangements for vulnerable detainees.

6.34 There was a force policy on dealing with vulnerable detainees, and some of the custody policies and procedures included aspects of safeguarding. However, there was no overarching safeguarding policy and most staff had not received any specific training in identifying and addressing safeguarding concerns, relying instead on their own experience and that of colleagues, which meant an inconsistent approach (see paragraphs 3.5 and 5.7).

6.35 Good care was shown to children, with recognition of their particular risks and needs. All children were placed on 30-minute observations as a minimum. The case audits we examined showed active engagement with children, offering assurance as well as meeting their needs, and regular offers of food and drink. Most children brought into custody were known to other agencies, who were advised and involved in any safeguarding arrangements needed. Not all the suites were able to keep children in cells away from adult detainees, but custody staff recognised the importance of keeping children separate and took practical steps where possible to achieve this. However, although girls were offered the opportunity to speak with a female member of staff they were not allocated a female officer as a single point of contact, as required by legislation and in line with good practice.

6.36 Vulnerable adults and children generally received an effective appropriate adult (AA) service. Custody staff initially sought to contact family members, carers or guardians to act as appropriate adults, and written guidance in this role was available. Where this was not possible, they contacted the AA scheme, though the youth offending teams (YOTs) in the case of children. The scheme complied with national standards and was available from 8am to 11pm, although an AA could be available outside these hours if arranged in advance. AAs were based in the Southampton Central suite from 10am to 8pm, providing a quick response when needed, and there were plans to extend this approach to other suites. Custody staff in all the suites regarded the service positively and said there were no undue delays in AA arrivals. However, not all vulnerable adults or children received early support from an AA.

6.37 Outside of Southampton Central, AAs were called to arrive in time for the detainee interview. It could, therefore, be some time, and involve an overnight stay for some vulnerable adult or child detainees, before an AA could explain their rights to them. The cases we examined showed wide-ranging time differences between the rights being read to a detainee when they were booked into custody and their rights being re-read in the presence of an AA. These times ranged from five minutes in one case in Southampton Central, where the service was embedded, to 15 hours in another case. In a few cases related to vulnerable adults, we were not completely assured that an AA was called when the detainee required this assistance (see paragraph 5.19).

6.38 Record keeping for use of AAs was inconsistent. The custody records did not always show when a request was made, and therefore the time between request and arrival, nor whether the AA was a family member or from the AA scheme. This made it difficult to assess how well the service was performing, any differences between the use of the AA scheme and family members or guardians, and how this affected the time that detainees remained in custody.

6.39 Custody sergeants had a strong focus on seeking to minimise the time spent by children in custody and to avoid detaining children overnight. They made efforts to contact parents, or appropriate agencies for children in care, to explore options and bail children as quickly as possible. In one case we observed, detention was refused for a girl arrested on a minor public order offence and she was returned to her mother's care (see paragraph 5.16). Most children who were bailed were referred to YOTs to determine the most appropriate sanction, with the emphasis on using out-of-court disposals where possible to avoid the criminalisation of children. However, despite these efforts, some children spent a long time in custody. Our custody record analysis showed that children stayed an average of 11 hours and 43 minutes in custody, and five of the 11 cases we reviewed were detained overnight before charge pending investigation into their offence. Our more detailed case audits of children showed a similar picture. Force data showed that 1,749 children had been detained in custody in the year to September 2016, but the force did not routinely monitor performance information on children, which would have helped inform any approach to avoid and minimise the time children spent in custody (see paragraph 3.6 and recommendation 2.57).

6.40 The arrangements to provide alternative accommodation for children charged and refused bail did not work well. A procedure had been agreed with the local authorities who have a statutory responsibility for providing alternative accommodation in these circumstances. Custody sergeants followed the procedure and escalated cases when necessary, and the position was closely monitored. However, force information showed that 43 requests had been made in the previous 12 months but accommodation was offered in only three cases. This meant that most children remained in a police cell overnight pending their court appearance (see paragraph 3.16 and recommendation 2.60).

Areas for improvement

6.41 Girls under 18 in custody should be allocated a named female member of staff as their single point of contact to attend to their welfare needs.

6.42 The force should ensure that all vulnerable adults and children receive support from an appropriate adult during the early stages of their custody.

6.43 The force should assess whether it is taking all actions needed to avoid the detention of children overnight before charge, and explore alternatives to avoid this.

Health care

Governance

6.44 Strategic oversight of health provision had improved since our last visit. In February 2016, the force had commissioned Mitie Care and Custody to provide physical health services for detainees. A new comprehensive health needs assessment had been published in July 2016.

6.45 Arrangements for contract monitoring were sound with regular meetings between the force and Care and Custody. Reported response times were good and had improved, with responses within 60 minutes rising from a low point of 91% in July 2016 to an average of 96% in September 2016, against the target of 95%. Identification and action on risks, including delays of more than 75 minutes, was reasonable, and longer delays had reduced since the closure of some custody suites.

6.46 There had been some notable gaps in forensic medical examiner (FME) cover. Senior health care professionals (HCPs) were used to cover these gaps and provide a leadership role, coupled with telephone access to an on-call medical consultant. The lack of FME cover conflicted with the force expectation for a direct assessment by a doctor of any detainee in custody subjected to Taser deployment, and posed a potential risk for the practice of telephone authorisation for DOs to give prescription-only medicines.

6.47 There were regular clinical governance meetings but attendance was poor. Reporting of clinical incidents was increasing but there were limited opportunities for shared learning. A separate health complaints system included a helpful leaflet for detainees but had not been widely advertised; there had been one health complaint by a detainee in the previous year.

6.48 Training arrangements for HCPs were better than we usually see and all were up to date with intermediate life support and safeguarding training. HCPs were alert to their responsibility regarding safeguarding and had made referrals within the last year. Arrangements for management supervision were in transition, and there was no formal clinical supervision.

6.49 Most medical rooms had been refurbished since our last visit. The room at Basingstoke was extremely small and unsuitable for examinations or consultations. There was no telephone in several suites and none had dual handsets to use with professional interpreters for non-English speaking detainees. At Basingstoke, the HCP said they would use the telephone at the custody desk for telephone interpreting (see paragraph 5.25 and area for improvement 5.27). Cleaning arrangements through contacted cleaners were generally reasonable, but some rooms had dust on high surfaces. Infection control audits had been completed for all suites and showed variable compliance.

6.50 Arrangements for forensic sampling were good, with dedicated crime scene investigators responsible for managing kits and samples.

6.51 Arrangements for emergency response were generally sound. There were a few inconsistencies in emergency kits and plans to streamline them across the suites. At Newport, the hand-assisted ventilation bag (Ambubag) and suction apparatus were stored in a separate bag from the rest of the emergency kit.

Patient care

6.52 Assessment of individual detainee health needs was sound and thorough, and we observed polite and clinically appropriate health staff engagement with detainees. Clinical records were suitably detailed and indicated effective risk-based assessments. However, treatment room doors were routinely left open during consultations, irrespective of assessment of detainee risk, which comprised patient confidentiality.

6.53 In our custody record analysis, 39% of detainees required referral to an HCP and an HCP attended in all but two cases. The mean response time was 35 minutes. Detainees were referred to an HCP based on risk assessment and/or requests by detainees. The mean rate of detainees seen by an HCP during September 2016 was 45% across the suites. The lowest rates were at Aldershot and Newport, where there was no 24-hour HCP presence.

6.54 There was effective information sharing and positive working relationships between HCPs and custody staff. Detainee consent to information sharing was sought routinely and most commonly recorded as verbal consent. There were safe and compliant storage arrangements for paper records. However, HCPs had no access to the police custody computer system (Niche), and the consequent duplication and transcribing of clinical information by DOs on

to that system posed a risk; we found one example of an almost illegible record. Plans to enable access by HCPs had not yet been implemented.

6.55 Detainees could receive their own prescribed medicines, subject to verification by an HCP. HCPs could administer a range of medicines from a suitable range of patient group directions (authorising them to supply and administer prescription-only medicine). In addition, DOs could give detainees paracetamol and ibuprofen for pain relief, salbutamol inhaler (for asthma) and glyceryl/trinitrate spray (for angina pain), subject to telephone authorisation by an FME. Although this allowed detainees to have early access to essential medicines, there was no direct assessment by an HCP and this practice was not governed by any force policy or protocol. DOs had not received training in medicines administration.

6.56 There was appropriate objective assessment, monitoring and symptomatic treatment for detainees undergoing alcohol and drug withdrawal. Prescribed methadone could be collected and given based on a risk assessment.

6.57 Detainees' own medicines, including any controlled drugs, were stored with their property, but some property stores were not locked securely. Storage, access and stock control of stock medicines available to HCPs, including controlled drugs, was sound. Medicines issued by DOs were stored in separate locked cabinets with records of individual doses given but no running balance; at Newport, these medicines were stored in two separate places.

Areas for improvement

6.58 Health care professional (HCP) consultations with detainees should preserve patient confidentiality, except where an individual risk assessment indicates otherwise.

6.59 All HCPs, including mental health practitioners, should have access to the police custody computer system (Niche) to enable direct and accurate recording of detainees' health needs.

6.60 Detention officers should receive training in the issue of prescribed medicines and simple pain relief to ensure they are aware of their effects and implications.

Substance misuse

6.61 There was good drug and alcohol misuse service provision to the two larger custody suites: at Southampton Central, workers from Southampton Drug and Alcohol Recovery service attended daily and identified need; and Recovery Hub staff visited the Portsmouth Central suite. Substance misuse workers also signposted detainees from outside the custody area to their local services. Detainees at Portsmouth Central could also be directed to the local Portsmouth user-led group (PUSH). Portsmouth Central also had a separate alcohol service provided by Solent NHS Trust, which enabled the police to give a conditional caution or fixed penalty; however, this service was about to cease.

6.62 Drug and alcohol workers from the Society of St James visited the Basingstoke and Aldershot custody suites on three weekday mornings. At Newport, there had been regular attendance during the week by the local Island Recovery Service (IRIS), but this had ceased due to security vetting issues. Custody staff across all the suites knew how to refer detainees and signpost them to services, and all the custody staff and workers we spoke to described positive working relationships and active referrals from custody staff.

6.63 There were good arrangements for needle exchange, with packs available on release at Southampton Central and Portsmouth Central suites. Suites also had reasonable arrangements to signpost detained people to local needle exchange points.

6.64 Detainees could have nicotine replacement lozenges, provided by the force and given by DOs; however, we found two different strengths available in one suite. This led to difficulties ensuring DOs always adopted the same approach.

Mental health

6.65 Southern Health NHS Trust provided health services for Southampton Central, Basingstoke and Aldershot custody suites, Solent NHS Trust for Portsmouth Central and the Isle of Wight NHS trust for Newport.

6.66 There were four designated health-based places of safety (HBPOS) on the mainland for people detained on section 135 or 136 of the Mental Health Act [10] and a further one in Newport.

6.67 Two mental health triage schemes operated to divert people with mental ill health from custody and potentially into hospital. The Serenity project on the Isle of Wight provided daily street triage between 5pm and 1am, and a telephone triage scheme using a single mental health practitioner operated from the force central control room on five evenings a week between 6pm and 2am; the mental health practitioner could not access all the health record systems. Both schemes were highly valued by the force and operational staff, and the data indicated that the service had some effect on the proportion of people successfully diverted from custody (see paragraph 4.5).

6.68 The Hampshire Liaison and Diversion Scheme (HLDS), a collaboration between the Solent and Southern trusts funded by NHS England, was a comprehensive pilot scheme that had operated at Southampton Central and Portsmouth Central suites since April 2015. The service was available for 12 hours a day, seven days a week. A mental health practitioner was based in the Southampton Central suite between 9am and 9pm daily. Because the Southampton team was based in the custody suite, staff could access and enter information into both the police custody computer system (Niche) and their own health electronic record system. The Portsmouth team was not based in the suite full time, due to space constraints, and had no direct access to the police custody records (see area for improvement 6.59).

6.69 The criteria for HLDS referrals were based on a vulnerability model that enabled practitioners to support and signpost detainees of any age with both mental ill health and learning disability, alongside homelessness, housing and benefit issues, and domestic abuse. There was also community support by social workers and support workers following release. While the HLDS practitioners had no formal role in Mental Health Act assessments, they provided advice to custody staff and liaised with approved mental health practitioners (AMHPs) and FMEs, if indicated.

6.70 The HLDS service had been involved with approximately 250 detainees a month in recent months, of whom 50-60 % had needed a full mental health assessment. Evaluation by NHS England was positive, and senior police described the scheme as 'of immense benefit'. We

[10] Section 135 of the Mental Health Act 1983 enables a police officer to remove someone from a private place, and section 136 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.

observed some excellent collaborative working between mental health practitioners and custody staff, and both groups were overwhelmingly positive about the joint working arrangements.

6.71 At Basingstoke, a mental health practitioner visited the suite daily and there was access to the local crisis team outside those times. There were plans to extend the HLDS to Basingstoke in 2017. There was no service to the Aldershot custody suite, and at Newport the local crisis team provided a callout service.

6.72 Despite the lack of data (see paragraph 3.13), the number of people detained under section 136 appeared to have steadily decreased across Hampshire until April 2016, since when it had been higher. It was not always clear whether these detainees were later transferred to a HBPOS for assessment, except at Newport where no one had been held in custody under section 136 since 2013.

6.73 We were told that the police had recently started to take section136 detainees to hospital emergency departments when an HBPOS was not available, which was not appropriate or sustainable.

6.74 Custody staff told us of some lengthy delays in getting Mental Health Act assessments completed and, as a consequence, some prolonged detentions. These delays seemed due to the lack of AMPHs and approved doctors, compounded by insufficient acute and intensive care mental health beds locally and often nationally. We found several cases that confirmed this, including some particularly lengthy delays of up to 48 hours. In addition, a recent change in the AMPH service had ended the previous cross-local authorities' agreement and AMHPs now only assessed detainees in suites in their own local authority area, regardless of the home address of the detainee.

6.75 There was guidance to escalate the issue if a detainee with identified mental health problems continued to be held in custody when there was no other reason for detention. We noted recent examples of escalation to silver command in the force and to NHS director level in the trusts due to failure to transfer a detainee to a mental health bed or section 136 space appropriately and within a suitable timescale. There had been examples of potentially unlawful detention.

Areas for improvement

6.76 All mental health practitioners, including triage nurses, should have access to all the relevant health systems.

6.77 Multiagency shared information and datasets should be improved to enable identification of the reasons for the number of section 136 detainees held in custody inappropriately.

6.78 People detained under Mental Health Act section 136 should not be held in police custody as a place of safety, other than in exceptional circumstances.

6.79 Detainees who require a Mental Health Act assessment and/or transfer to mental health facilities should be assessed and transferred promptly.

Good practice

6.80 *The use of mental health triage nurses in both the force control room and alongside the street policing team on the Isle of Wight were positive interventions to prevent people presenting with mental ill health being taken to custody inappropriately; there were early indications of their effectiveness.*

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, case audits and observations assured us that all detainees had a pre-release risk assessment completed. Many of the records were good and included good information that showed that identified risks had been addressed or mitigated before release. In a minority of cases recording was poor and did not reflect staff care of and attention to detainees, and we were unable to determine how some detainees got home.

7.2 All the pre-release risk assessments we saw showed good attention to securing a safe release for the detainees. We observed that initial risk assessments and care plans were always checked to ensure that all identified risks had been addressed or managed to provide a safe release. Sergeants ensured that detainees had the means of getting home safely, and issued travel warrants and petty cash to pay for transport if detainees had no money. Police officers were sometimes relied on to provide transport home, particularly for the more vulnerable detainees who had no other means of getting home safely.

7.3 Detainees were generally given a generic support leaflet with useful telephone numbers on their release. Some sergeants spent extra time explaining relevant support agencies that could benefit them and provided additional material if required, including mentoring scheme services. Sergeants were aware of the specific offences and circumstances that made detainees more at risk on release. Officers carried out a comprehensive pre-release risk assessment for detainees alleged to have committed or been charged with a sex offence, and this was reinforced by custody sergeants before release.

Courts

7.4 The force did not use court video links, and detainees charged with offences were expected to appear at the nearest remand court. The Portsmouth Central and Basingstoke suites were next to a magistrates' court. The court at Basingstoke could be accessed without leaving the building, and here we observed two detainees moving to court who were allowed to take food and reading materials with them.

7.5 Custody staff at all the suites told us that local magistrates' courts usually accepted detainees until approximately 2pm on weekdays, depending on how busy they were, and could extend this to 3pm on rare occasions. Staff cited very limited court availability on Saturdays, which was usually served by a single early morning van transfer.

7.6 There was evidence that the early court cut-off times resulted in some detainees being held in custody for longer than necessary. At Portsmouth Central we were told it was unlikely that anybody coming into custody after 9am would be accepted into court that day. In a recent case, a young man came into custody at approximately 2.30am on a Saturday morning and although the custody sergeant liaised with the court clerk he was told it would not be possible for the court to accept the detainee, who had to remain in custody over the

weekend. Such outcomes were unacceptable for detainees, and we saw little demonstrable improvement since our recommendations in 2012.

7.7 Hampshire Constabulary was one of two police forces in the UK currently trialling a new person escort record (PER) document. This was used by custody staff and receiving agencies (such as escorts) to record important information about each detainee's risks for onward transfer to any other establishment, such as courts, prisons, hospitals or another police force. Although some staff considered the new format to be repetitive, there was greater scope for them to record the risks and current presentation of the detainee. The PERs we examined were generally very good, containing dated and comprehensive information on the individual's risk markers (including health, self-harm, violence or drugs).

Area for improvement

7.8 **Hampshire Constabulary should engage with HM Courts & Tribunals Service to ensure that early cut-off times do not result in unnecessarily long stays in custody.** (Repeated recommendation 5.18)

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

Areas of concern and recommendations

8.1 The substantial number of potential ligature points identified in most suites were a significant risk to detainees and the force. The force was largely unaware of these issues, but following the inspection put in place short- and long-term plans to address the issues identified.

Recommendation: Hampshire Constabulary should address the safety issues arising from identified potential ligature points and work towards eliminating them. Pending such action, the risks should be mitigated to ensure that custody is delivered safely. (2.56)

8.2 Performance information on custody was not comprehensive and there was limited monitoring across the different custody function, which made it difficult for the force and others to assess how well custody services performed.

Recommendation: The force should develop a comprehensive performance management framework for custody ensuring the accurate collection of data, and should use such data to assess performance, identify trends and learning points, and improve services. (2.57)

8.3 All aspects of the use of force lacked governance and effective oversight. Not all staff had received recent training, and they did not always submit individual use of force forms following incidents. Force was sometimes used against detainees who had self-harmed at a low level and also to remove clothing with cords, which was disproportionate to the risk posed.

Recommendation: Hampshire Constabulary should maintain effective management oversight of use of force incidents and trends. Incidents involving force should be quality assured and cross-referenced with closed-circuit television. All staff involved in incidents should complete individual use of force forms. Staff should be adequately trained at least every 12 months. Force should only be used at the lowest level and be proportionate to the threat posed. (2.58)

8.4 The number of detainees held under section 136 of the Mental Health Act as a place of safety had increased significantly in the previous six months. Too many people with mental health problems were now brought to and/or staying in police custody, with a lack of evidence of any other reason for their detention, and often because of insufficient appropriate spaces elsewhere.

Recommendation: The force should, in collaboration with partners, urgently review the reasons behind the increase in the number of vulnerable people detained in police custody as a place of safety, and take action to avoid the use of police custody as a place of safety for people with mental health problems. (2.59)

8.5 Most children charged and refused bail remained in custody overnight because alternative accommodation was not provided by the local authority. The jointly agreed procedures had not resulted in better outcomes for children detained in these circumstances.

Recommendation: The force should continue to engage actively with its local authority partners to find more effective ways of providing alternative accommodation for children charged and refused bail to avoid them remaining in custody overnight. (2.60)

Areas for improvement

Pre-custody: first point of contact

8.6 Access to the SafetyNet database should be extended to ensure that all relevant information is available to police officers and staff to inform their decision- making when dealing with vulnerable people, including children. (4.10)

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

8.7 Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment, and the dignity of the detainee should always be maintained. (5.13)

8.8 All custody staff should be involved collectively in the relevant shift handover. (5.14)

8.9 Double-handset telephones should be provided at Portsmouth Central and in medical rooms to facilitate telephone interpreting. (5.27)

In the custody cell, safeguarding and health care

8.10 Notices that CCTV cameras are in use should be clear and prominently displayed throughout the custody suite, and toilets should not be visible on CCTV monitors. (6.10)

8.11 The cell call bell system at Portsmouth Central should be repaired or replaced. (6.11, repeated recommendation 4.43)

8.12 The communal toilets on cell corridors at Portsmouth Central should be screened immediately. (6.12)

8.13 There should be consistent daily and weekly maintenance cell checks, including systematic identification and reporting of ligature points, and these should be recorded promptly, regularly and be subject to quality assurance. (6.13)

8.14 Clothing should only be removed from detainees in the presence of staff of the same gender. (6.22)

8.15 Reviews of detention should always be conducted in accordance with the Police and Criminal Evidence Act 1984 code C. (6.31)

8.16 Unless there are good reasons not to, detainees should be supplied with pillows in their cells. (6.32)

8.17 Girls under 18 in custody should be allocated a named female member of staff as their single point of contact to attend to their welfare needs. (6.41)

8.18 The force should ensure that all vulnerable adults and children receive support from an appropriate adult during the early stages of their custody. (6.42)

8.19 The force should assess whether it is taking all actions needed to avoid the detention of children overnight before charge, and explore alternatives to avoid this. (6.43)

8.20 Health care professional (HCP) consultations with detainees should preserve patient confidentiality, except where an individual risk assessment indicates otherwise. (6.58)

8.21 All HCPs, including mental health practitioners, should have access to the police custody computer system (Niche) to enable direct and accurate recording of detainees' health needs. (6.59)

8.22 Detention officers should receive training in the issue of prescribed medicines and simple pain relief to ensure they are aware of their effects and implications. (6.60)

8.23 All mental health practitioners, including triage nurses, should have access to all the relevant health systems. (6.76)

8.24 Multiagency shared information and datasets should be improved to enable identification of the reasons for the number of Mental Health Act section 136 detainees held in custody inappropriately. (6.77)

8.25 People detained under section 136 should not be held in police custody as a place of safety, other than in exceptional circumstances. (6.78)

8.26 Detainees who require a Mental Health Act assessment and/or transfer to mental health facilities should be assessed and transferred promptly. (6.79)

Release and transfer from custody

8.27 Hampshire Constabulary should engage with HM Courts & Tribunals Service to ensure that early cut-off times do not result in unnecessarily long stays in custody. (7.8, repeated recommendation 5.18)

Good practice

8.28 The use of mental health triage nurses in both the force control room and alongside the street policing team on the Isle of Wight were positive interventions to prevent people presenting with mental ill health being taken to custody inappropriately; there were early indications of their effectiveness. (6.80)

Section 9. Appendices

Appendix I: Inspection team

Ian MacFadyen	HMI Prisons team leader
Kellie Reeve	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary inspection lead
Anthony Davies	HMI Constabulary inspection officer
Patricia Nixon	HMI Constabulary inspection officer
Majella Pearce	HMI Prisons health services inspector
Nicola Rabjohns	HMI Prisons health services inspector
Sue Simmons	Care Quality Commission inspector
Alissa Redmond	HMI Prisons researcher
Laura Green	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

The force should review its strategic governance arrangements of health care provision in custody and work with health care partners to ensure effective outcomes for detainees. (2.37)
Achieved

Recommendation

Police constable gaolers should receive custody-specific training. (3.10)
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 recommendation

Intoxicated detainees should be roused, and this clearly recorded in the custody record. (2.38)
Achieved

Recommendations

At Winchester, sergeants should have a clear view of those whom they are booking-in. (4.11)
No longer relevant

A hearing loop should be available at each suite and all custody staff should know how to use it. (4.12)
Partially achieved

Care plans should include information from the risk assessment process, to ensure adequate management of potential risk factors. (4.29)
Achieved

Handovers should be comprehensive and attended by all custody staff, with the area in which the handover takes place cleared of other staff and detainees. (4.30)
Partially achieved

Pre-release risk assessments should be detailed, meaningful and based on an ongoing assessment of detainees' needs while in custody, and the custody record should reflect the position on release and any action that needs to be taken. (4.31)
Achieved

Hampshire Police should collect and analyse data about use of force in accordance with the Association of Chief Police Officer's policy and National Policing Improvement Agency guidance. (4.35)
Not achieved

There should be thorough daily and weekly maintenance checks at all custody suites, including systematic identification and reporting of ligature points. (4.42)
Partially achieved

The cell call bell system at Portsmouth Central should be repaired or replaced. (4.43)
Not achieved (Recommendation repeated as area for improvement 6.11)

Pillows should be provided to all detainees. (4.56)
Not achieved

All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.57)
Partially achieved

Detainees held for long periods should be offered outside exercise. (4.58)
Partially achieved

Individual rights

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

National issue

Appropriate adults should be available at all times to support without undue delay detained juveniles aged 17, provided that informed consent has been given. (2.40)
Achieved

Recommendations

Hampshire Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but cannot be bailed. (5.9)
Partially achieved

Hampshire Police should engage with HM Courts and Tribunals Service to ensure that early cut-off times do not result in unnecessarily long stays in custody. (5.18)
Not achieved (Recommendation repeated as area for improvement 7.8)

Detainees should be able to make a complaint about their care and treatment, and be able to do this before they leave custody. (5.26)
Achieved

Health care

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

Main recommendation

Police custody should not be used as a place of safety for section 136 assessments. (2.39)
Not achieved

Recommendations

The force should monitor the contract with G4SFMS to ensure that detainees receive the appropriate level of care. (6.5)
Achieved

All clinical rooms should be fit for purpose and meet infection control guidelines. (6.6)
Partially achieved

Detainees should be able to see a health care professional within the timeframe specified in the G4S Forensic Medical Services contract. (6.16)
Achieved

All medications should be administered safely and in accordance with relevant laws and guidance from professional bodies. (6.17)
Partially achieved

Detainees should be able to receive appropriate medication for their condition. (6.18)
Achieved

There should be a consistent and comprehensive service for all drug and alcohol users in custody. (6.27)
Achieved

Needle exchange services should be available in custody. (6.28)
Partially achieved

There should be a consistent and comprehensive liaison and diversion scheme across the force area which enables detainees with mental health problems to be identified and diverted into appropriate mental health services. (6.37)
Partially achieved