

Report on an unannounced inspection visit to police custody suites in Sussex

7 – 18 November 2016

by HM Inspectorate of Prisons and
HM Inspectorate of Constabulary





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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 last inspected Sussex Police in February 2011, when we reported mostly positively about the way that detainees were treated and the conditions in which they were held. Our two principal concerns related to the number of ligature points in cells and the use of police custody as a 'place of safety' under the Mental Health Act.

During the current inspection, we found that most detainees continued to be treated with respect and consideration, and that the condition of most cells was still adequate. Before this inspection, however, no progress had been made in relation to mitigating or eliminating the risks that we had previously identified in relation to potential ligature points. Soon after reporting our present concerns, the force quickly provided a helpful report about how they intended to address the outstanding problems.

We continued to find problems in relation to the inappropriate use of police custody as a place of safety. In spite of collaborative work between the force and partners to try to avoid this, the number of detainees held under section 136 of the Mental Health Act as a place of safety had increased in the most recent six-month period. Custody staff sometimes had no suitable alternative placements available and occasionally were placed in the unenviable position of holding vulnerable detainees beyond their lawful detention period, simply in order to keep them safe. There was an urgent need for these circumstances to be reviewed jointly with partner agencies.

As we often find in these inspections, the collation and extraction of data from force systems were inadequate, particularly in relation to the use of force; this led to an inability to monitor key areas of custody activity. Senior managers were aware of this, and there were plans to improve these weaknesses.

We also identified some procedural weaknesses in the way that the Police and Criminal Evidence Act 1984 (PACE) and the codes of practice were being applied. This mainly related to the overuse of remote reviews.

Initial risk assessments were consistently good, which is something we do not often find. Work in relation to diversity was particularly good and there were close links with relevant community-based organisations.

It was encouraging to find that the force had introduced a joint protocol with partners to avoid the overnight detention of children who had been charged and refused bail, and multi-agency training had taken place to support this approach. Additional effort was still required in order to obtain suitable alternative accommodation.

Overall, despite some mixed findings, this was still a relatively positive inspection. Importantly, most detainees held in police custody in Sussex continued to be treated decently.

We noted that of the 19 recommendations made in our previous report after our inspection of February 2011, eight recommendations had been achieved, two had been partially achieved and nine had not been achieved.

This report provides five recommendations to the force and highlights 29 areas for improvement.

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*¹ about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.
- 2.3** A documentary analysis of custody records was conducted as part of the police custody inspection. The custody record analysis was carried out on a representative sample of the custody records, across all 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.² 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.³ A total sample of 141 custody records was analysed.
- 2.4** A data collection template was completed by the force during the inspection and was based on police custody data for the 36 months prior to 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.
- 2.5** The designated custody suites and cell capacity of each was as follows:

¹ <http://www.justiceinspectorates.gov.uk/hmiprison/about-our-inspections/inspection-criteria/>

² 95% confidence interval with a sampling error of 7%.

³ 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 suite	Number of cells
Brighton	36
Chichester	19
Crawley	26
Eastbourne	21
Hastings	13
Worthing	19

Leadership, accountability and partnerships

- 2.6** There was a clear governance structure for custody. Overall responsibility was held at a sufficiently senior level, and the staffing and relevant meeting arrangements ensured that when risks were identified, they were managed effectively.
- 2.7** The force was committed to preventing the criminalisation of children, and the diversion of children away from custody was a priority. The force considered children to be vulnerable by virtue of age alone, and custody was regarded as a last resort.
- 2.8** Force policies were comprehensive and accessible to staff. They provided clear operational guidance and staff were generally knowledgeable about these instructions. The force invested appropriately in training for custody sergeants, although training opportunities for custody officers were more limited.
- 2.9** The force did not have sufficient understanding of service demand, in order to demonstrate that the level of resources ensured the safe delivery of custody and that the staff profile was appropriate for delivering the service in the most effective way. There were plans to try to address this by carrying out a demand analysis in the early part of 2017.
- 2.10** In some instances, the operational arrangements between the force and Tascor for the delivery of custody services were having an adverse impact on the treatment and outcomes for detainees, including some poor facilities and services.
- 2.11** Custody staff wore personal protective equipment routinely but the rationale and justification for this were not clear, given the overall positive culture within the force, together with the emphasis on de-escalation techniques.
- 2.12** The large number of potential ligature points across the custodial estate (see below) placed detainees and the force at significant risk. This was a serious area of concern, particularly as, before the inspection, there had been no plan to mitigate this. When we referred this matter back to the force, we received a helpful report about how they intended to address the outstanding problems.
- 2.13** The force had insufficient data available to monitor performance effectively in relation to key areas of activity in custody. This meant that it was unable properly to identify trends and inform organisational learning at a strategic level. The force was aware of this and had plans to improve the situation.
- 2.14** The force had implemented an internal inspection regime for custody. While a recent internal inspection highlighted a number of safety issues within suites, it failed to identify most of the ligature points that we found (see below).

- 2.15** The force did not have adequate mechanisms to demonstrate that the use of force in relation to detention and custody was safe and proportionate. Data in relation to use of force in custody were not easily extracted from the custody system and the force was unable to provide sufficient suitable cases for us to examine.
- 2.16** The force had a good relationship with its independent custody visitors (ICVs), who provided effective scrutiny, and the force welcomed and was receptive to their feedback. ICVs reported that conditions for detainees were broadly satisfactory and that the culture was generally respectful.
- 2.17** Equality was given a relatively high degree of priority, and the chief constable chaired the strategic equality and diversity board. There were named champions for each of the protected characteristics, and they were held to account by the deputy chief constable (DCC). The force had produced a 'fairness in custody' document, which described how staff should apply principles associated with equality in practice.
- 2.18** The force worked well with partners to improve the position in relation to dealing with detainees with mental ill health. In particular, the mental health nurses in the call centre and those working as part of the triage system provided valued support to help custody staff dealing with people with mental health problems. However, in spite of this, problems associated with the detention of persons held under section 136 of the Mental Health Act appeared to be increasing. Although the force had a clear strategic focus on protecting and diverting vulnerable people from custody, statutory partners did not always have sufficient capacity or capability to ensure that this priority led to improved outcomes for such detainees. As a result, an increasing number of people with mental health problems were being detained under section 136 and taken to custody as a place of safety (see paragraph 2.56).
- 2.19** The force sometimes detained people for a mental health assessment after their lawful detention had concluded. This action was considered on a case-by-case basis, and was authorised and monitored at senior officer level, ensuring that an escalation process was in place. Statutory partners were well sighted on these difficulties and worked closely with the force to try to address these concerns.

Pre-custody: first point of contact

- 2.20** Call centre staff and frontline officers had a good knowledge of why and when a person might be vulnerable, and how to tailor their approach to take account of this. Information on any warning makers and vulnerability was passed to response officers attending incidents, to help inform their decision making. However, this information was not always comprehensive, requiring officers to ask for further intelligence checks from either the call centre or the local police station.
- 2.21** Frontline staff and officers regarded all children as vulnerable. They were focused on avoiding taking children into custody wherever possible, by using a range of alternative disposals, including voluntary attendance, community resolution or returning the child home pending further investigations.

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

- 2.22** Overall, custody staff communicated with and about detainees in an engaging, respectful way.
- 2.23** We had several areas of concern relating to privacy within custody suites. Apart from in the most up-to-date suite, none of the toilet areas in cells were pixelated, which meant that detainees could be observed using the facilities. This was despite the fact this issue had been highlighted at the previous inspection.
- 2.24** Some suites had cramped facilities where the closed-circuit television (CCTV) monitors were visible to detainees. The booking-in desks at some of the newer suites were high, which prohibited good communication. Poor physical separation between desks and high noise levels during busy periods, when multiple detainees were being processed, all restricted the level of privacy that could be afforded.
- 2.25** Female detainees' needs were not being met adequately. They were not routinely asked whether they wished to speak to a female officer or if they wished to receive a feminine hygiene pack.
- 2.26** The arrangements for religious observance were inadequate. There were stocks of some religious items across the sites but not all of these were stored appropriately, and there was no guidance to staff about how they should be used.
- 2.27** Arrangements for detainees with mobility problems were mixed across the different sites, with not all offering adapted or step-free facilities. Wheelchairs and other support aids were available throughout, however, and we saw detainees with limited mobility being seated in the booking-in area.
- 2.28** Some newly appointed staff had received relevant specialist training on aspects of equality, but this was not widespread. In spite of this, staff generally showed a good knowledge of these issues, and we discovered some examples of good practice.
- 2.29** We saw some caring and compassionate engagement between custody staff and vulnerable detainees. Initial risk assessments were thorough and properly focused. Care plans set appropriate levels of observation and were reviewed dynamically. The frequency of set observations was adhered to. Rousing practice was good and well documented. Most custody staff carried anti-ligature knives, but not all staff attending cells carried them.
- 2.30** The routine removal of cords and footwear was a disproportionate and unsophisticated response to managing risk.
- 2.31** Handover arrangements focused appropriately on identified risks but they were not always attended by all relevant staff.
- 2.32** Although most custody officers were able to provide us with examples of instances when they had refused detention, some officers we observed were unable to provide reasonable grounds for arrest on arrival and were not challenged by custody sergeants. In some cases we observed, it was the custody sergeant, rather than the arresting officer, who volunteered the necessity test conditions that should apply.
- 2.33** In our custody record analysis (CRA), the average time for detention to be authorised was 10 minutes, which was significantly less than the force comparator figure. However, the time of arrival was not always recorded correctly.

- 2.34** Some custody sergeants were unaware of how to access rights and entitlements in foreign languages. The force had purchased a number of copies of the new pictorial version of the rights and entitlements in an easy-read format, but not all custody staff were aware of their availability.
- 2.35** Bail conditions and bail periods were generally set proportionally and appropriately. Efforts had been made recently to reduce the number of outstanding bails by allocating this task to named custody sergeants, and this appeared to be working well. However, we found no evidence of any senior management oversight of the bail management process.
- 2.36** There was no visible information on the complaints process in any of the custody suites. We received inconsistent responses from custody sergeants as to how they would deal with a complaint. However, they were all in agreement that if the complaint was one of assault, the inspector would be informed, and all injuries would be recorded and available evidence secured.

In the custody cell, safeguarding and health care

- 2.37** A large number of potential ligature points were identified in all of the custody suites, despite having made a main recommendation to this effect in our previous inspection.
- 2.38** Nightly checks by custody assistants were conducted but the cells were only checked in relation to removing blankets and rubbish. During our cell checks, we found numerous sinks across the estate that had objects in them, suggesting that they were not routinely checked. There was little graffiti in any of the custody suites.
- 2.39** Fire evacuation drills were practised regularly at all the custody suites; however, the quality of recording of these was variable. At one suite, there were not sufficient sets of handcuffs available for evacuation purposes.
- 2.40** Throughout the inspection, we observed staff dealing with challenging detainees patiently and de-escalating some difficult situations well. Around half of the incidents that we reviewed involving the use of force had been managed well. We were not confident the staff response was always proportionate to the risk posed, however, and some techniques were deployed poorly. As a result of this, we identified a range of missed opportunities for learning.
- 2.41** We found examples of spit hoods being used en route to custody suites, and in some instances they remained in place for too long after the detainee arrived in custody. The use of Captor (incapacitant spray) in custody was frequent and of concern, and we considered its use against some self-harming detainees to be an inappropriate response to individuals in crisis. We were not assured there was sufficient governance for the use of either of these interventions. Handcuffs were used sparingly but were not always removed quickly enough from compliant detainees.
- 2.42** The range of food available for detainees was adequate. Although the provision of meals was prescribed within specific periods, staff used their discretion appropriately to provide additional food outside these times.
- 2.43** The availability of reading material at most suites was poor.
- 2.44** We observed some good examples of thorough Police and Criminal Evidence Act 1984 (PACE) reviews being carried out, particularly those conducted in person. However, there appeared to be an over-reliance on conducting reviews remotely by telephone, including those involving children. We also found examples of reviews taking place remotely without

detainees or sergeants being consulted. The reasons for this were not always documented on the custody record. We were not confident that detainees who were reviewed while asleep were always notified of this upon waking or reminded of their rights and entitlements; this was not in compliance with the PACE codes of practice.

- 2.45** Frontline and custody officers demonstrated a good understanding of safeguarding issues and were familiar with the safeguarding referral arrangements.
- 2.46** Risk assessments for children were completed appropriately. All children were placed on 30-minute observations as a minimum, and some good care was shown towards them.
- 2.47** In most instances, children and vulnerable adults, received a timely and effective service from appropriate adults (AAs). In the cases we examined and observed, there were some examples of delays in AAs attending, as a result of requests not being made by custody staff.
- 2.48** Custody sergeants tried to avoid criminalising children by referring those who admitted their offence to the youth offending teams, to determine the most appropriate community resolution. They also referred children to the police and court liaison and diversion (PCLD) service based in the custody suites, to provide support to prevent or minimise further offending behaviour.
- 2.49** There was a strong focus on avoiding detaining children overnight in custody. Custody sergeants used bail well and we found examples of children being released late at night or in the early hours of the morning into the care of family or care workers.
- 2.50** The force had introduced a joint protocol with partners to avoid children charged and refused bail from being detained overnight, and multi-agency training had taken place to support the approach. Close monitoring took place of all cases but, despite this, alternative accommodation was provided in only a few instances.
- 2.51** Mitie Care and Custody Health provided physical health care services. Clinical governance meetings and established monitoring arrangements provided effective oversight and management of practice. Monthly safety meetings with the police appropriately supported operational practice, but strategic oversight of health was underdeveloped. Emergency equipment was mostly appropriate and all health care professionals were adequately trained to use it.
- 2.52** Skilled practitioners offered appropriate support to detainees, with most contacts taking place within contracted time frames. The distance between suites and the current staffing profile led to some delays in detainees being seen, which could affect health outcomes.
- 2.53** Clinical environments were not fit for purpose; none of them met infection control standards. The use of CCTV within treatment facilities at two of the suites was inappropriate.
- 2.54** Support for detainees with drug and alcohol problems was variable. Some suites had no direct provision, while Eastbourne, Hastings and Brighton offered more effective support. Where available, services supported harm minimisation, signposting to a range of community services and, in some areas, needle exchange. Symptomatic relief was provided for those withdrawing from drugs or alcohol where clinically indicated. However, nicotine replacement was not accessible, which created some avoidable problems for custody staff.
- 2.55** Mental health services in the custody suites and street triage were provided by Sussex Partnership NHS Foundation Trust and we found the support offered to be good. Detainees received a timely and comprehensive assessment. Detainees needing ongoing support were diverted to appropriate services. Assessments for detention under the Mental Health Act

were generally undertaken in a timely fashion but there were delays in accessing a hospital bed, which could lead to detainees remaining in custody for too long.

- 2.56** There had been significant year-on-year reductions in the number of uses of the custody suites as a place of safety under section 136 of the Mental Health Act. In the previous six months, this trajectory had stalled and the number of such detentions had started to rise. The lack of capacity to meet demand, along with the limited access to beds, meant that officers were having to make difficult decisions about how to keep people safe, with the result that too many vulnerable people were still being brought into custody (see paragraph 2.18).

Release and transfer from custody

- 2.57** Pre-release risk assessments were not completed well consistently. The records were not always focused enough on managing risk or on securing a safe release for detainees. We saw some vulnerable detainees released with little or no assistance from the police. Recording of release arrangements on detention logs was mostly poor.
- 2.58** A wide range of support leaflets was available but they were not generally issued to detainees on release.
- 2.59** Custody staff told us that the local remand courts would not normally accept detainees after 2pm on weekdays, but there was sometimes a limited degree of flexibility. Staff at two suites said that detainees regularly remained in police custody for longer than necessary owing to the adjacent courts having limited cell capacity for holding detainees.

Areas of concern and recommendations

- 2.60** There were a substantial number of potential ligature points across the force custody estate, which presented significant risk to detainees and the force if left unattended. The force was largely unaware of these and, before the inspection, there had been no plans to address or mitigate the risks that these posed.

Recommendation: The force should address the safety issues involving potential ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed to ensure that custody is delivered safely. (Repeated recommendation 2.22)

- 2.61** Performance information in relation to custody was not comprehensive and there was limited monitoring across the different custody functions, making it difficult for the force and others to assess how well custody services were performing.

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

- 2.62** Governance and oversight of the use of force in custody was inadequate, with insufficient information to demonstrate that all uses of force were both justified and proportionate.

Recommendation: Measures should be put in place immediately that allow all uses of force to be scrutinised, to demonstrate that the application is justified and proportionate.

- 2.63** A number of procedures in relation to the provision of custody services were not compliant with code C of the codes of practice relating to the detention, treatment and questioning of persons by police officers.

Recommendation: All staff should comply with code C of the codes of practice, and reviews of detention for children should always be carried out in person. The most recent version of code C should be available in all custody suites.

- 2.64** The number of detainees held under section 136 of the Mental Health Act as a place of safety had increased in the previous months. In spite of work by the force with partners, the position was continuing to deteriorate. In addition, the force was unlawfully detaining vulnerable people, when no other alternative existed, in order to keep them safe.

Recommendation: The force should undertake an urgent review, in collaboration with partners, in relation to the reasons behind the increase in the numbers of vulnerable persons 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 such people.

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 (ACC) level, supported by a superintendent and a chief inspector, who was responsible for operational delivery. Four dedicated inspectors managed the custody environment from day to day, and there was a central pool of custody sergeants to carry out the custody functions. Detention supervisors and custody assistants were provided by Tascor. This structure provided clear accountability for the safe delivery of custody.
- 3.2 The force governance programme was focused on monitoring and managing risk. The DCC chaired an organisational reassurance board (ORB). The ACC held regular portfolio meetings with the custody superintendent, who in turn held senior management team meetings monthly. The chief inspector was responsible for both a force custody safety meeting, with partners including Tascor, and a custody inspectors meeting. This structure ensured that any risks identified were managed effectively.
- 3.3 The force followed Authorised Professional Practice for custody, as set by the College of Policing. This was underpinned by a number of local policies and operating procedures. These documents were accessible to staff and provided clear operational guidance. Staff were generally knowledgeable in relation to policies and procedures.
- 3.4 The force was committed to diverting vulnerable people away from custody, and frontline officers were proactive in considering alternative options. However, the capacity and capability of partners in providing appropriate facilities for people with mental health problems meant that too many vulnerable people were detained in police custody as a place of safety (see also paragraph 6.67 and area of concern 2.64).
- 3.5 The force was committed to preventing the criminalisation of children, and the diversion of children away from custody was a clear priority. The force considered children to be vulnerable by virtue of age alone and custody was considered as a last resort (see also paragraph 4.4).
- 3.6 The force's custody estate did not consistently support the safe delivery of custody. We found numerous potential ligature points in police cells, presenting a serious risk to detainees and to the force. The force was unaware of these and, before the inspection, had had no plans to mitigate the risks they posed, except the routine removal of clothing with cords and footwear (see also paragraph 6.1 and area of concern 2.60). Shortly after passing on our concerns about the potential ligature points, we received a helpful report about how the force intended to address the outstanding problems.
- 3.7 The force had insufficient understanding of service demand, so we were not confident that it could meet this effectively and efficiently in terms of both the number and mix of staff

deployed. There were plans to undertake a demand analysis early in 2017 to try to improve the situation.

- 3.8** The operational arrangements between the force and Tascor for the delivery of custody services sometimes had an adverse effect on detainees' treatment and outcomes. This included poor clinical facilities (see paragraph 6.49), onward transfer of DNA samples (see paragraph 5.36), non-clearance of rubbish from occupied cells and restrictions on the provision of food and blankets (see section on detainee care and Police and Criminal Evidence Act 1984 (PACE) reviews). It was unusual to see sergeants undertaking duties which were better suited to a detention officer (DO) role, such as searching detainees, listing and bagging property, and lodging detainees in the cells, as the custody assistants were not delegated to carry out these roles.
- 3.9** The force had improved its investment in training for custody sergeants, with an initial three-week course provided. However, there was little opportunity for new custody sergeants to improve their knowledge and skills by shadowing experienced staff because of the limited numbers available on shifts. Not all officers we spoke to had received refresher training and there was a reliance on training via e-learning packages. Overall, staff were negative about the quality of the training that they had received (see also paragraph 5.11).

Accountability

- 3.10** The monitoring of performance in relation to the custody function was limited, and in some areas inadequate. The force had insufficient data to monitor performance effectively in relation to key areas of activity in custody, to identify trends and to inform organisational learning at a strategic level. It was aware of this gap and had plans to produce a criminal justice data pack in order to improve this situation (see also paragraphs 5.29 and 6.43, and area of concern 2.61).
- 3.11** The force had inadequate mechanisms to assure itself, the Police and Crime Commissioner and the wider public that the use of force in relation to arrest, detention and custody was safe and proportionate. Data in relation to use of force in custody were not easily extracted from the force computer systems, so details of cases could not be provided for audit purposes. This presented a strategic risk to the force as it was unable to provide performance information and also meant that it could not identify trends or learning opportunities sufficiently (see also paragraph 6.6 and area of concern 2.62).
- 3.12** Custody staff wore personal protective equipment routinely but the rationale and justification for this were not clear, given the overall positive culture within the force, together with the emphasis on de-escalation techniques (see also paragraph 6.11).
- 3.13** The force had taken steps to ensure that it complied with the national reporting arrangements on use of force, effective from April 2017. It had moved to a national reporting form to meet the new requirement to provide mandated data sets to the Home Office as part of its annual data return. Unfortunately, these new forms were less detailed than the previous ones used, but those we viewed were, in most cases, well completed (see also paragraph 6.6).
- 3.14** We were concerned to find a number of procedural areas where PACE and code C (the code of practice for the detention, treatment and questioning of persons by police officers) were not complied with (see also section on detainee care and PACE reviews, and area of concern 2.63).

- 3.15** Most copies of code C that we found in suites were out of date (code C, section 1.2) and therefore not compliant with PACE (see also paragraph 5.33 and area of concern 2.63). In addition, the CCTV signage at some suites was inadequate and some was inappropriate (see also paragraph 6.2).
- 3.16** The force had implemented an internal inspection regime for custody, with the first inspection conducted in August 2016. This was potentially a good means for the force to assure itself and others that custody services were being delivered effectively and safely, and to identify areas for improvement. However, while a recent internal inspection identified a number of safety issues within the suites, it failed to identify most of the ligature points we found (see also paragraph 6.1 and area of concern 2.60).
- 3.17** There was a good working relationship between the force and the ICVs, providing effective external scrutiny. The force clearly welcomed this and was receptive to feedback from them. The ICV manager had regular meetings with the custody chief inspector, to address any issues that volunteers had been unable to resolve locally, and also attended the six-weekly multidisciplinary custody safety meetings. ICVs told us that conditions for detainees were satisfactory and that the culture was generally respectful.
- 3.18** The force had taken steps to improve its approach to equality and diversity, and the chief constable had provided guidance through the strategic equality and diversity board, which he chaired twice yearly. There were named champions for each of the protected characteristics and they were held to account by the DCC for operational improvements. The force had produced a 'fairness in custody' document, which described how staff should apply principles associated with equality in practice and included a section on the public sector equality duty. However, apart from the generic inputs that staff received as part of their induction training, equality and diversity training tended to be ad hoc (see also paragraph 5.11).

Partnerships

- 3.19** The force was clearly committed to engaging with partners to improve the approach to vulnerable people and children entering custody. It was represented at the appropriate level in various partnership forums – for example, the mental health monitoring meetings. A number of joint procedures had been developed to help divert people with mental health problems away from custody, including the mental health triage patrol car. This scheme allowed a specially allocated officer and a mental health nurse to respond quickly to incidents where a mental health intervention was required (see also section on mental health). More recently, a mental health nurse had been introduced into the call centre on a pilot scheme, operating at the weekends to provide additional advice and support to the force (see also paragraph 4.3).
- 3.20** However, this commitment to joint working was not consistently resulting in better outcomes for detainees. There appeared to be an increasing number of problems associated with the detention of persons held under section 136 of the Mental Health Act. Statutory partners did not always have sufficient capacity or capability to ensure that the force's focus on protecting and diverting vulnerable people from custody led to improved outcomes for such detainees. As a result, an increasing number of people with mental health problems were being detained under section 136 and taken to custody as a place of safety (see also paragraph 6.67 and area of concern 2.64).
- 3.21** The force sometimes detained people for a mental health assessment after their lawful detention had concluded. This action was considered on a case-by-case basis, and was authorised and monitored at senior officer level, ensuring that an escalation process was in place. Although statutory partners understood these issues and worked closely with the

force to address them and obtain better outcomes for these detainees, it remained a serious area of concern (see also paragraph 6.67 and area of concern 2.64).

- 3.22** The force had also worked with partners to develop joint arrangements to provide accommodation for children who had been charged and refused bail, to avoid them being detained in custody overnight. However, in practice, due to a lack of capacity, alternative accommodation for children in these circumstances was rarely provided (see also paragraph 6.42).

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** Call centre staff and frontline officers had a good knowledge of why and when a person might be vulnerable and how to tailor their approach to take account of this. Staff were expected to identify vulnerability based on a range of factors, such as age, mental health, disability, or drug and alcohol use, and there was also recognition that the nature of the incident could make a person vulnerable. There had been training in vulnerabilities, including mental health (and autism, in particular), to better equip staff in their roles, although not all response officers had received this type of training.
- 4.2** In the control room, the call handlers used the risk assessment process well. They accessed information across a range of police systems on people and addresses, to identify any vulnerability or warning makers, made their risk assessment based on this and passed the information on to response officers to help their decision making at the incident. When needed, detailed intelligence could be obtained from a specialist unit that was available 24 hours a day. This information was not always comprehensive, requiring officers to seek further intelligence checks from either the call centre or the local police station, to help them to deal with the situation and decide what action to take. However, generally, officers had enough relevant information and used this in making their decisions.
- 4.3** Frontline officers were often called to deal with incidents involving people with mental health problems. They recognised that detention in custody was inappropriate for these individuals and sought to make alternative arrangements through the health service. Mental health practitioners in the triage patrol car offered valuable help, along with the recently introduced mental health nurse based in the control centre at the weekend (see also paragraph 6.65). However, despite officers' best efforts, they were often left with no choice but to take people with mental health problems into custody, to keep them or others safe from harm.
- 4.4** All children were regarded as vulnerable by virtue of their age, and frontline officers also recognised that they might have additional needs, such as being in care or regularly going missing. Officers proactively sought to avoid taking a child into custody, exploring a range of other options such as voluntary attendance, community resolutions or returning the child home pending further enquiries (see also paragraph 5.27). Response officers told us that they took fewer children into custody because of these efforts, and that they were aware that they would have to provide a robust justification to custody sergeants for any decision to arrest and detain a child.
- 4.5** Frontline officers were not always fully aware of some of the schemes that were available to divert people away from custody and reduce reoffending. They were familiar with the work of youth offending teams and knew that referrals could be made by the police and court liaison and diversion (PCLD) service in the custody suites (see also paragraph 6.64), but had more limited knowledge about the 'Think Family' scheme (part of the government's troubled families programme), other early intervention projects and the diversion scheme for women.

- 4.6** Arrangements for transporting people to custody from the point of arrest were generally adequate. Officers used their cars or police vans, depending on the circumstances. There were no specific guidelines or arrangements to cover transporting vulnerable people to custody, but officers risk assessed each case to determine the most appropriate form of transport.
- 4.7** The arrangements for transporting people with mental health problems to a health-based place of safety (HBPOS) were not fully effective. Long waits for ambulances, with an impact on both the welfare of the detainee and police officers' time, had resulted in response officers obtaining inspector authorisation to transport such detainees in their police vehicle, which was not satisfactory.
- 4.8** Frontline staff completed use of force forms for all incidents in which force was used, including compliant handcuffing. The decision to apply handcuffs was at the arresting officer's discretion, based on a risk assessment, but we were told that they were used often. De-escalation training to avoid the use of force was included in induction training but there was no additional training in this regard. There was no guidance on the use of handcuffs or force for vulnerable people or children. We observed a number of detainees brought into custody in handcuffs who were calm and compliant, and we were unclear why the handcuffs had not been removed earlier (see also paragraph 6.13).
- 4.9** There were no systematic arrangements for ensuring that arresting officers provided any additional information or concerns to the custody sergeants, to help them to care for the detainee while in custody; this relied on the arresting officer's discretion. However, we observed arresting officers and custody sergeants having discussions, without the detainee present, to identify concerns about them and/or further clarity about the circumstances of the incident.

Area for improvement

- 4.10** **The force should work more closely with the ambulance service to improve the arrangements to ensure that detainees with mental health problems are transported by ambulance to a place of safety in a timely manner.**

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 We mostly observed custody staff treating detainees in a patient, caring and dignified way, seeking to establish a positive rapport with each individual. However, occasionally, we also saw staff speaking both to and about detainees in a way that did not meet this standard.
- 5.2 Arrangements for identifying and meeting diverse needs were reasonable. Force custody policy required custody sergeants and detention supervisors to consider each individual's equality, diversity and vulnerability issues during their initial risk assessment. From our observations, as well as speaking to staff, the knowledge and understanding of these issues were generally good but their application was less so. Staff recognised the sensitivities and importance of meeting individual and diverse needs, including how to respond appropriately to detainees with cultural, religious or transgender needs. It was also positive that some detainees were asked to self-define their ethnicity, selecting from an available list of categories displayed, although this did not happen in all instances. Staff routinely asked detainees about their religious and dietary requirements. In our case audits, we came across one individual whose grounds for arrest had involved religious issues, who had been allowed to retain religious worship items, following a detailed consideration of his individual history, risks and diverse needs.
- 5.3 Detainees entering custody were not routinely asked if they had caring responsibilities. In addition, despite force custody policy specifically requiring it, custody staff did not routinely ask female detainees if they wished to speak to a female officer or offer them a feminine hygiene pack on arrival, with the expectation that the detainee would proactively request this.
- 5.4 Tampons were not available to female detainees (only sanitary towels); staff believed that this was because of long-standing safety concerns resulting from a non-custodial incident involving such items several years earlier. However, we felt that the current arrangements were a disproportionate response to the risks purportedly posed, and adversely affected the care and welfare of female detainees coming into custody.
- 5.5 The levels of privacy afforded to detainees in custody were generally inadequate. Aside from one newer block of cells in Crawley, toilets were not obscured on CCTV monitors in any of the suites, despite the fact that we had highlighted this issue in the previous inspection (see also paragraph 6.2).
- 5.6 The booking-in desks at the newer 'PFI' suites (Brighton, Chichester, Eastbourne and Worthing) were high, which could be intimidating for detainees. The addition of stencilled footprints to denote where detainees should stand, placed some distance away from the booking-in desk for the purposes of CCTV recording, created additional barriers to respectful, discreet communications between custody staff and detainees. We were satisfied,

by speaking to some staff, that efforts were made to mitigate this by asking detainees to step forward to increase the proximity and privacy of the conversation, and we saw this happen at Brighton, but not in all cases. Poor physical separation between front desks also raised concerns about sound levels and the privacy of disclosures during busy periods, when multiple detainees were being dealt with.

- 5.7** None of the suites had a booking-in desk within a separate room, for dealing with particularly sensitive disclosures or vulnerable and high-profile detainees. To mitigate this, staff in several suites told us that they would consider taking the individual into another room, away from the booking-in desk, and use paper records, before signing and completing the electronic custody record back at the main desk. While this would not be ideal (and would be inappropriate if the alternative location did not contain audio or visual recording facilities), it showed that some staff were alert to, and considerate of, the negative impacts of the custody environment on detainees.
- 5.8** At Hastings, the booking-in area was cramped, with little space or privacy possible. We observed arriving detainees having to walk closely past others being booked in, as well as some being asked to move aside to allow others to pass. In the same suite, owing to the layout and limited space available, it was possible for detainees to observe monitors behind the front desk, including in-cell CCTV footage. Staff said that they were aware of the problem and would try to mitigate against this, but it presented a significant risk to the privacy and dignity of the detainees held there.
- 5.9** Provision for religious observance varied between the suites, and was mostly inadequate. Materials (texts, prayer aids) in some suites were particularly limited in range, and those that were available were not always stored appropriately. For Muslim detainees, no compasses were available to locate the direction of Mecca, and only one cell in each site had markings to indicate this direction. It was unclear what arrangements would be made for multiple detainees wishing to pray. There was no guidance immediately available to assist staff in managing religious observance needs. There was sufficient guidance for food suitability and halal provision but this did not extend to all other cultural restrictions, with staff relying on checking ingredients lists or asking detainees if meals were suitable (see also paragraph 6.15).
- 5.10** For detainees with disabilities or mobility issues, wheelchairs were available in all of the suites, although the one we found at Hastings had deflated tyres and was therefore not fit for use. Some sites also held additional support aids, such as Zimmer frames (Brighton) or crutches (Eastbourne), and we saw several such detainees being booked in at various sites being provided with seats to offer additional support. The availability of specifically adapted facilities was variable. All of the suites except Hastings had one adapted cell, suitable for visually or physically impaired detainees, containing a coloured 'band' wall marking (a broad blue line painted around the wall of the cell which makes it easier for visually impaired people to gauge the size of their cell, for example) and a low call bell for easier access when sitting or lying down (although the adapted cell at Crawley did not have a low call bell). However, it was unclear what would happen if the facility was required by more than one detainee simultaneously. None of the suites held extra-thickness mattresses offering additional support. While the PFI sites generally contained step-free showers and toilets, none of the facilities, with the exception of Crawley, had any support rails, and at Hastings there was no step-free access to showers or exercise yards.
- 5.11** The training of staff to support them in dealing with people with diverse needs and/or vulnerabilities was variable. Some custody sergeants said that they had had a wide range of relevant classroom-based training, including in equality and diversity, autism, female genital mutilation, transgender identity, mental health and vulnerabilities. However, this did not appear to have extended to custody assistants, or to other staff as part of their ongoing refresher training. Several sergeants we spoke to said that they had not received refresher training of any type in the previous year, and any that they had received had been several

years previously or not specific to custody. Some staff had received a range of useful and relevant awareness sessions, which had prepared them to cope with a range of situations and individual needs. The delivery of training was uneven and staff at all grades required suitable opportunities to learn and develop (see also paragraphs 3.9 and 3.18).

Areas for improvement

- 5.12 Female detainees should be automatically asked about access to female officers and offered (appropriate) hygiene products during booking in, as per current force policy. The force should also reconsider its ban on the provision of tampons.**
- 5.13 In-cell toilets should be obscured on all CCTV camera monitors.** (Repeated recommendation 4.36)
- 5.14 Booking-in areas should provide sufficient privacy to facilitate effective communication between staff and detainees.** (Repeated recommendation 4.9)
- 5.15 A full range of religious worship texts and materials should be available and stored appropriately in all custody suites, alongside guidance for staff.**
- 5.16 All custody sergeants, detention supervisors and custody assistants should receive the same training opportunities, specifically relating to better understanding of diverse needs, including mental health, vulnerabilities and protected characteristics.**

Risk assessments

- 5.17** Detainees were generally booked in promptly. In some suites, there was evidence that vulnerable or challenging detainees were prioritised for booking in. However, CCTV footage that we viewed indicated that one detainee in a spit hood had remained in a holding room for almost an hour before he was moved to the booking-in desk, which was unacceptable (see also paragraph 6.10).
- 5.18** Sergeants and detention supervisors were properly focused on identifying risks when completing standardised risk assessments. They generally responded well to individual need, and asked appropriate supplementary and probing questions to assist them in identifying risks. Initial risks were identified well, including for detainees in custody for the first time. We saw many examples where staff dealt with detainees patiently and compassionately. There was routine cross-referencing to police national computer warning markers and historical information held on local intelligence systems, to inform risk assessments further.
- 5.19** Care plans set observations at an appropriate level and were amended dynamically as required. There was good use of close proximity and constant watch, and appropriate adherence to observation levels. CCTV was available in all cells and was used appropriately to enhance observations, rather than replace physical checks. Staff were competent in rousing intoxicated detainees, and this was well documented. Most custody staff carried personal-issue anti-ligature knives, but we saw many other staff entering cell areas who were not carrying them, which presented a risk.
- 5.20** We saw anti-rip clothing used sparingly. The routine removal of clothing with cords and footwear was a disproportionate and unsophisticated response to managing risk (see also paragraph 6.21).

- 5.21** Principal sergeants took charge of ongoing information about detainees well. They led staff shift handovers, and those we observed were well conducted and focused appropriately on risk, detainee welfare and case progression, but they did not always include all relevant staff.

Areas for improvement

- 5.22** All staff attending detainees' cell should carry anti-ligature knives.
- 5.23** Detainees' clothing and footwear should be removed only on the basis of an individual risk assessment.
- 5.24** All custody staff should be involved collectively in the relevant shift handover.

Individual legal rights

- 5.25** Custody sergeants booked detainees into custody, as did detention supervisors acting under a sergeant's supervision. At most suites, arresting officers completed a form recording the detainee's details, brief details of the offence and the grounds for detention. The information recorded on the form was used to assist custody staff to create an initial custody record for the detainee. The custody sergeant 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 a number of officers who were not tested on their understanding of Police and Criminal Evidence Act 1984 (PACE) code G⁴ as custody sergeants volunteered the necessity criteria required to justify arrest rather than waiting for the officers to offer them.
- 5.26** Many custody sergeants were able to provide examples of instances when they had refused to authorise detention because there had been insufficient grounds to do so – for example, when a detainee had had clear health issues, which had resulted in the detainee being diverted to hospital instead. In our case audits, we found evidence of a custody sergeant refusing to authorise detention for a mentally vulnerable individual who had been detained under section 136 of the Mental Health Act; the sergeant had made swift arrangements for the individual's conveyance to a more appropriate health-based place of safety (see also section on mental health).
- 5.27** Alternatives to custody were available through community resolution⁵, fixed penalty notices⁶ and voluntary attendance⁷ (see also paragraph 4.4). Facilities for interviewing voluntary attendees outside custody were available at all police stations; however, custody staff told us that on a few occasions when these facilities had been busy, the custody suite interview rooms had been used. Data supplied by the force showed that the use of voluntary attendance had increased since 2014; there had been 2,716 voluntary attendees in the year ending 31 October 2014, 4,453 for the year ending 31 October 2015 and 3,658 in the year ending 31 October 2016.

⁴ PACE code G 1984 is the Code of Practice for the Statutory Power of Arrest by Police Officers.

⁵ 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.

⁶ Fixed penalty notices (FPNs) can be issued for a number of road traffic offences and disorder offences like shoplifting, possessing cannabis and being drunk and disorderly in public. If payment is received by the due date, the recipient does not get a criminal conviction.

⁷ Voluntary attendance is usually used for lesser offences, and involves suspects attending by appointment at a police station to be interviewed about these, avoiding the need for arrest and subsequent detention.

- 5.28** Most detainees were booked in promptly on arrival at the custody suites, but in the custody records we reviewed and from our observations we found delays of up to an hour between detainees arriving and their detention being authorised. In our focus group with response officers, they reported some long waits in holding rooms with detainees waiting to be booked in. In our custody record analysis (CRA), the overall average waiting time was 10 minutes, which was significantly less than the force comparator figure (from March to November 2016) of 24 minutes. Data supplied by the force showed that the average waiting time in the 12 months to the end of October 2016 was 18 minutes. However, we came across a number of instances where the time of arrival was recorded incorrectly on custody records. In at least three cases, we observed that detainees waited in a queue for up to 37 minutes but the booking-in time rather than the actual arrival time was recorded. In one case, we saw officers arrive at the custody suite vehicle bay and remain outside while their detainee had a cigarette before entering the building. His time of arrival was recorded from when he entered the custody suite holding room and not when he arrived at the premises. These gaps in the timeline had implications for the accuracy of custody records and for ensuring that detainees were issued with their rights and entitlements sufficiently quickly.
- 5.29** Custody staff reported a good relationship with Home Office Immigration Enforcement officers and told us that most immigration detainees were moved on within 24 hours. However, the force was unable to provide any data on the number of immigration detainees held or the average time that they remained in police custody following service of an IS91⁸ warrant of detention (see also paragraph 3.10 and area of concern 2.61).
- 5.30** During booking-in, custody sergeants and detention supervisors advised detainees of their three main rights,⁹ and in most cases detainees were routinely offered a written notice setting out their rights and entitlements (see also paragraph 5.45). These could be accessed in a number of foreign languages for non-English-speaking detainees but not all custody sergeants were aware of how to access these. Some of the custody suites held these notices printed off in folders but these were not always the current (2014) versions, and a link on the force website had also not been updated to provide access to the most recent versions.
- 5.31** The force had recently bought a number of colourful booklets containing the rights and entitlements information, with photographs and in an easy-read format. These were not available at Hastings, and in the other suites not all the custody staff were aware of their availability; of those who were, some did not know who these should be issued to (for example, detainees needing help with understanding or reading). An abbreviated version of the detainees' entitlements (not the rights) with pictures and a small amount of text was available in all the suites but at Brighton a detainee who intimated that he could not read or write was handed this, with no effort made to read its contents to him. The rights and entitlements were not available in Braille and, other than at Crawley, there were no hearing loops.
- 5.32** We saw detainees being told that they could inform someone of their arrest, which staff sometimes facilitated while the detainee was present.
- 5.33** During the booking-in process, detainees were told that they could read the PACE codes of practice but these were not always explained by custody staff. We found few copies of the up-to-date PACE code C available in the custody suites and we did not see these routinely being offered to detainees to read (see area of concern 2.63).

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 from the UK is imminent.

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

- 5.34** All detainees were offered free legal representation and told that if they declined, they could change their mind at any time. Detainees who declined this offer were asked why, and this was routinely noted on the custody record. Those wishing to speak to legal advisers could do so over the intercom in the privacy of their cell. There were sufficient consultation and interview rooms at all the suites, and legal advisers were provided with a printout of their client's custody record on request.
- 5.35** Detainees were not interviewed under the influence of alcohol or drugs. However, we saw a detainee returning from interview wearing a paper suit as his clothing had been removed because his trousers contained cords; this was not in compliance with the PACE codes of practice as a paper suit is not an adequate clothing replacement (see also paragraph 6.21, and area of concern 2.63).
- 5.36** There was a weekly collection, by Tascor staff, of DNA samples taken in custody, but we found a number of old DNA and blood samples in the refrigerators at Brighton and Crawley. We were told that these samples had not been collected as Tascor staff dealt only with samples that they had taken, and not those taken by police officers.

Areas for improvement

- 5.37** **Custody sergeants should ensure that the detainee's correct time of arrival is accurately recorded on custody records.**
- 5.38** **Hearing loops and the rights and entitlements information in Braille should be available in custody suites.** (Repeated recommendation 4.11)

Communication

- 5.39** A professional telephone interpreting service was available to assist the booking-in of non-English speakers. Double-handset telephones were available in all the suites to access this service, which provided a good level of privacy at the booking-in desks. Staff told us that a face-to-face interpreter service was available for interviews but that there were sometimes delays, depending on the language requested and also because of interpreters cancelling; this resulted in some detainees remaining in custody for longer than necessary or having to be bailed, where practicable. At Crawley, we saw a non-English-speaking individual answering bail who was charged without an interpreter being present as the latter had cancelled on the previous day and there had been difficulties in arranging for another to be present. This procedure was carried out with the full consent of the detainee, who spoke good English, and his solicitor. At Chichester, staff used interpreters' business cards to identify contact telephone numbers; this did not provide sufficient assurance that the individuals concerned were suitably qualified or had had the necessary continuing vetting clearances and registration.
- 5.40** Few custody sergeants were aware that documents – such as authorisation of detention and charge details, among others – translated into a range of languages were available on a computer shared drive;¹⁰ of those who were aware, several were unable to locate them. Multilingual posters informing detainees of their right to free legal advice were not available in all the suites; where these were displayed, they mainly comprised a single poster relating

¹⁰ PACE Code C Annex M details the documents considered essential for the creation and provision of written translations.

to the languages from A to P (Arabic to Polish) and none for those from P to V (Portuguese to Vietnamese).

Access to swift justice

- 5.41** In the records we reviewed, initial bail conditions and bail periods were generally set proportionally and appropriately. In our case audits, one case involved a detainee with a serious medical condition who was bailed in the late evening, to return for interview the following afternoon, when an appropriate adult (AA) would be available in the suite to assist with the booking-in and interview process. The individual was re-bailed for a second time, for a suitable period, to allow for forensic enquiries; this resulted in him being held in custody for less than six hours, which was appropriate.
- 5.42** There was little active management of bail, other than to check on a daily basis who was attending to answer bail, but efforts had recently been made to reduce the number of outstanding bails by allocating this task to named custody sergeants in each of the custody suites, and this appeared to be working well. All custody sergeants were aware of the minimum bail periods that should be allocated for completing investigations and of the need for an appropriate supervisor to provide written authorisation of any bail or subsequent re-bail decisions.
- 5.43** In most of the cases we reviewed, investigations were progressed promptly and there was active supervision of ongoing investigations when a suspect was on pre-charge bail. In one case, however, involving a 16-year-old boy with significant health issues, there was insufficient investigative priority by the detective allocated to the enquiry, and this was also criticized by his supervisor for the lack of progress. The offence involved was serious and, despite the level of care shown to the vulnerable child while in custody, he was bailed three times and still awaited an outcome, which was inappropriate in the circumstances.
- 5.44** There was no individual in the force with overall responsibility for overseeing the bail management process, but we were told that a sergeant had been tasked with implementing new bail management procedures by 1 April 2017, in line with proposed new legislation.¹¹

Complaints

- 5.45** No information on the complaints process was displayed in any of the custody suites; however, it was contained in the rights and entitlements notices offered to most detainees (see also paragraph 5.30). Custody staff gave us a variety of responses concerning how they would deal with a detainee who wished to make a complaint. Some staff said that their response would depend on whether the complaint related to a custody matter or another issue; others said that they would notify the custody inspector or operational inspector; and others still said that they would tell the detainee to attend at their local police station on release or to report their complaint online, either to the force or to the Independent Police Complaints Commission.
- 5.46** In the records we reviewed, we found one case where a detainee wished to make a complaint about poor treatment while in custody. It was recorded in the detention log that the detainee was advised to make his complaint in writing on release, and thereafter forward it to a named custody inspector. The only complaint procedure that all custody staff agreed

¹¹ The Policing and Crime Bill is currently under consideration by the House of Lords. This proposes a number of changes to the management of pre-charge bail including conditions in relation to time limits on bail.

on was in the case of an alleged assault on a detainee, where the custody inspector or operational inspector would be notified, the detainee would be seen by a health care practitioner and all available evidence would be secured.

Area for improvement

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

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

Expected outcomes:

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

Physical environment is safe

- 6.1** Cleanliness across the custody estate was good, with the exception of Hastings and Worthing, where some of the cell walls were grubby. Hastings had the poorest environment; it was an old suite, with a cramped booking-in area, and there was no toilet for detainees, other than the in-cell toilet facilities (see also paragraph 5.8). There was little graffiti across the custody estate but, despite having made a main recommendation to this effect in our previous inspection report, we identified a large number of potential ligature points in the cells and shower areas of all the custody suites, which we reported to the force (see area of concern 2.60). We also found several potential ligature points in exercise yards across the custody estate; the force was aware of these and had instructed that no detainee was to be left unattended when using these facilities, which allowed them to be used safely (see also paragraph 6.22).
- 6.2** There were working call bells and intercoms in all cells, the use of which was explained to detainees before they were placed there. All cells were fitted with CCTV cameras but there was no signage in the cells to indicate this and not all detainees were advised of this fact. One male detainee, held overnight in custody for the first time, told us that he had not gone to the toilet as the CCTV camera had not been explained to him and he was concerned that someone was constantly watching him (see also paragraph 5.5 and recommendation 5.13). This was remedied by allowing him access to a toilet elsewhere in the cell block.
- 6.3** Daily checks of the physical environment were required to be conducted by custody assistants. However, at Eastbourne and Hastings we were told that this was not carried out in line with a set checklist as staff knew what was expected of them; this meant that we could not establish when or how regularly these were conducted there. Elsewhere, the custody assistants carried out a nightly check on various areas of the custody suites and equipment, and this was recorded and filed for audit purposes. However, they told us that they were required only to remove blankets and rubbish from unoccupied cells, and not to check for potential ligature points (see area of concern 2.60). During our cell checks, we found numerous sinks across the custody estate with objects secreted in them, suggesting that they were not routinely checked. Custody sergeants told us that they carried out a daily check of the custody suite but this was not conducted against any checklist, so there was no way of establishing if these checks were conducted consistently.
- 6.4** All custody suites had fire evacuation plans displayed, which staff were aware of, and fire evacuation drills took place regularly. However, the level of recording of these drills was variable. Fire alarm systems were tested weekly and, with the exception of Crawley, there were sufficient sets of handcuffs in the custody suites to evacuate the cells safely if required.

Area for improvement

- 6.5** There should be thorough daily and weekly maintenance checks, and these should be conducted consistently. The recording and quality assurance of cell checks should be improved.

Safety: use of force

- 6.6** Oversight and governance of the use of force were inadequate (see area of concern 2.62). The force struggled to identify cases for us to review. Accountability for individual staff use of force against detainees was generally good. Documentation before October 2016 provided a good level of detail about the incident and the necessity for using force, but thereafter they focused on quantitative data, which we considered to be a retrograde change (see also paragraph 3.11). Narrative entries in detention logs were sporadic and varied in quality. We were not confident that use of force in custody was always reviewed, to ensure proportionality and to assist with individual and organisational learning.
- 6.7** We were not provided with any data about the number of staff who had completed officer/personal safety training in the previous year and could not be assured that all staff had completed annual training, as required by Authorised Professional Practice.
- 6.8** All CCTV footage was kept routinely for only 30 days but some systems allowed access outside of these timescales. Through our custody record analysis (CRA), case audits and observations, we identified and reviewed in depth (including cross-referencing against CCTV) 27 cases involving the use of force that had occurred over the previous month or so. Throughout the inspection and during our review of CCTV footage, we saw custody staff de-escalating some potentially challenging situations well, but we were not confident that force was always used as a last resort.
- 6.9** Around 50% of the cases we reviewed had been handled well overall. There were learning points in about half of the incidents. The force used had sometimes been heavy handed, uncoordinated and involved the use of poor techniques, including prolonged prone restraint. In four cases, force had been used to manage low-level, non-life-threatening self-harm, which we considered to be an insensitive and unsophisticated response to individuals in crisis.
- 6.10** Staff told us that spit hoods were used frequently, mainly en route to custody suites. We reviewed three cases in which they had been used, and were not confident that there had been sufficient governance of their use or that they had remained in place for the shortest time possible. We saw one spit hood remain in place for over an hour and a half and were not satisfied that its application for such a prolonged period was appropriate. Limb restraints had been applied in two of the cases we reviewed but seemed to have been removed at the earliest opportunity.
- 6.11** Custody sergeants carried batons, handcuffs and Captor (incapacitant spray) canisters on their utility belts. From discussions with sergeants, it appeared that Captor was used often in custody. We reviewed four cases in which Captor had been used. In two of these, the spray had been used to prevent self-harm, which we considered to be a disproportionate and inappropriate response to detainees in crisis.
- 6.12** We discovered an incident in the previous six months in which a detainee had been 'red dotted' with a Taser (that is, aiming the Taser or placing the laser sight red dot onto a subject). There was good justification for this in the detention log and use of force form but CCTV footage showed that the detainee, who had been detained under section 2 of the Mental Health Act, had been lying on his bench and been given no warning when officers

entered his cell and used this technique, which appeared disproportionate to the risk posed at that time.

- 6.13** Not all detainees arrived in custody in handcuffs, which was positive. However, for the small number who did, too many remained in them for long periods even though they were compliant, which was disproportionate in the controlled custody environment (see also paragraph 4.8).
- 6.14** In the 12 months to the end of October 2016, 1,980 detainees (7%) had been subject to a strip-search in custody, which was a relatively small proportion. Strip-searches authorised during the inspection were all for appropriate reasons, and justification was generally well recorded. There was a good emphasis on ensuring that children were strip-searched only when absolutely necessary. Proper attention was given to ensuring that detainees' dignity was maintained at these times.

Detainee care and PACE reviews

- 6.15** The range of microwave meals available was limited but generally adequate, and met a range of dietary needs, including vegetarian, vegan and gluten intolerances. All detainees were asked during booking in if they had any special dietary requirements. If existing provisions were not suitable, alternative arrangements were made, including staff buying appropriate replacements as required or making arrangements with the detainee's friends or family to supply these. Food preparation areas were sufficiently clean, although at Crawley only one refrigerator was available for use both for staff and for any detainee needs (such as food or insulin storage), which was inappropriate. There was limited guidance on meal suitability for special diets, with different versions found across the suites; there was a focus on halal and vegan suitability but no guidance for other needs (such as gluten-free, nut-free and kosher), which could have led to an inconsistent approach. However, staff generally said that they would in the first instance check the ingredients themselves or discuss food suitability with the individual concerned (see also paragraph 5.9).
- 6.16** There was drinking water in most cells, which detainees could use after receiving a paper cup from staff on arrival. For detainees in Hastings and Crawley, water was available only on request from staff. Other drinks, such as orange squash and hot drinks, were available across the estate.
- 6.17** From our observations, case audits and speaking to staff, we found that food and drinks were offered to detainees regularly, including during booking in and on arrival in their cell. Signs were displayed at all booking-in desks, advertising the standard mealtimes, although staff assured us that these would not be strictly adhered to in cases where detainees required food at other times, and our observations confirmed this. In our CRA, 115 of the 141 detainees reviewed (82%) had been offered a meal, including all nine who had been held for over 24 hours. However, custody assistants did not regularly remove rubbish such as empty meal cartons from cells while these remained occupied, only doing this once a cell was finally vacated.
- 6.18** Owing to the contractual arrangements between Tascor and the force, each meal had to be accounted for, and the provision of additional or supplementary meals required the authority of custody sergeants. While we were satisfied that custody sergeants would consider detainees' welfare over any such restrictions, it was of concern that less experienced staff might not have felt sufficiently empowered to challenge this policy (see also paragraph 3.8).
- 6.19** Mattresses and pillows were available and cleaned after each use. Used stocks of blankets and replacement clothing were cleaned twice every week. We were concerned to find staff

notices in some suites 'permitting' detainees to receive a maximum of one to two blankets each; however, we were satisfied that, in practice, this policy would not be strictly followed when the individual circumstances deemed it inappropriate. Mattresses were of a poor quality, offering little support or comfort, and there were no extra-thick mattresses available in any of the suites for detainees with limited mobility. The temperatures in the suites were generally pleasant but they were not measured at night.

- 6.20** All suites had clean showers, which were mostly private, with the exception of one at Worthing. Conversely, those at Hastings were potentially too obscured, increasing the existing self-harm risks present in those facilities (see also paragraph 6.1). Custody staff at all suites told us that detainees were always offered a shower early each morning (between 5am and 6am) if they were due in court that day, and our observations confirmed this. Arrangements outside of these times were dependent on how busy the suite was and each individual's circumstances, but they were always prompted by a request from the detainee rather than being offered proactively by staff. However, at Worthing we saw a man who had been in custody for less than two hours being allowed to shower before interview owing to his personal circumstances, which indicated that staff were willing to facilitate this when appropriate to do so. Cloth rather than paper towels were available at all suites, along with hygiene products including razors, shaving cream, shower/shaving gel, toothbrushes, toothpaste and combs.
- 6.21** Sweatshirts, T-shirts and jogging bottoms were readily available as replacement clothing for detainees whose clothing had been seized for evidential purposes or had been soiled. We saw replacement clothing issued to detainees who had cords in their trousers as these were removed routinely to mitigate self-harm risks. However, in Hastings, Brighton and Worthing we also found paper suits; although staff said that these were used 'infrequently', when alternatives were not available, during the inspection a detainee in Hastings was interviewed wearing one (see also paragraph 5.35). Shoes were removed routinely from detainees, although some sergeants said that they would exercise discretion if they did not have shoelaces. Good stocks of plimsolls were available in all the suites but were not always offered to detainees routinely. At Brighton, we saw some detainees walking around the suite in their socks.
- 6.22** All custody suites had at least one outside exercise area, which was private and out of sight of nearby buildings, but these were not used often. In our case audits, we came across the case of a female detainee with mental health concerns held at Worthing who had been allowed to use the facility twice during her approximate 10-hour detention. By contrast, of the 141 detainees reviewed as part of our CRA, only four (3%) had been offered outside exercise while detained, and only one out of the nine detainees held for over 24 hours had been offered this. Staff in all suites told us that exercise would be provided whenever possible but would generally be dependent on how busy the suite was and the availability of staff to facilitate this; detainees were not allowed to use exercise yards unaccompanied (see also paragraph 6.1).
- 6.23** In general, stocks of reading materials at all of the suites were poor, with extremely limited ranges of books and magazines available and no specific material for children. However, limited stocks of foreign language materials were available in some suites, including Polish materials in Worthing. We saw several detainees offered reading materials during their detention. In our CRA, 21 detainees (15%) had been offered access to reading materials, with only three out of the nine detainees held for over 24 hours offered this. From our observations, the offer of reading materials was not routine but would depend on the individual member of staff involved.
- 6.24** All suites, except Hastings, had designated visits facilities. These were limited in size and not suitable for use by those with mobility issues. Responses from staff about whether detainees would be allowed to use these facilities varied; some newer staff had no recollection of their

use, and others stated that they would facilitate this only when the person had been detained for over 24 hours (such as over the weekend) and when staffing levels permitted. We did not observe any examples of visits taking place. Arrangements for friends and family to bring in items of food or clothing were inconsistent, with some staff stating that this would not be permitted, but others (such as at Hastings) saying that this would be allowed, but with restrictions (for example, including sealed food only).

- 6.25** The force did not comply consistently with the Police and Criminal Evidence Act 1984 (PACE) codes of practice when carrying out reviews of detention for detainees (see area of concern 2.63). During the day, PACE reviews of detainees were undertaken by the four custody inspectors across the force, one or two of whom were usually on shift. When they were unavailable or outside of these times, responsibility was transferred to duty (divisional) inspectors. We observed some face-to-face PACE reviews with detainees that were timely, appropriate and fully recorded on detention logs, with good detail. We also found positive examples of reviews which had been conducted remotely, where full consideration had been given to the individual's circumstances, including an appropriate rationale for the decision not to attend to see the detainee in person and consideration of the individual's care and welfare, including provision of food, exercise, reading material and showers.
- 6.26** However, there appeared to be a general culture of reviews taking place over the telephone, rather than in person. We were told that this was because it was impractical for inspectors 'covering' all suites across the force to attend in person, given the geographical spread of locations. This included reviews of children, as we found in our case audit reviews, which is inappropriate and contrary to PACE codes of practice guidance. We also found other breaches of this guidance, such as: inspector reviews conducted without due consultation with the relevant custody sergeant or detainee fully to identify and consider the individual circumstances, even when the reviewing officer had been in the same building as the detainee; failure to document the reasons for conducting reviews remotely; and failure to remind detainees for whom a 'sleeping review' had been conducted of outcomes and their rights, entitlements and opportunity to make representations (see area of concern 2.63).
- 6.27** In our CRA, of 90 cases (64%) which had required an initial PACE review, 13 had taken place face to face, 13 while the detainee was asleep and the remaining 64 over the telephone. Of these 64 cases, only 12 records indicated that the detainee had been spoken to over the telephone. Of 19 cases where the detainee had required a second review, 16 had been conducted over the telephone, and only one of these had involved a telephone conversation with the detainee. For two of the four children whose cases were reviewed in our analysis and required a PACE review, these had been conducted by telephone. These findings were consistent with evidence we identified during the inspection which indicated that detention was generally not reviewed appropriately (see area of concern 2.63 and paragraph 6.34).

Areas for improvement

- 6.28** **Guidance on the dietary and cultural suitability of the food provided should be consistent and available in all suites.**
- 6.29** **Cell mattresses should be of adequate quality to support all detainees, including additional support versions for those with restricted mobility.**
- 6.30** **Appropriately diverse selections (age, gender, language, type) of reading materials should be available in all suites.**

Safeguarding

- 6.31** The force had an appropriate focus on safeguarding vulnerable adults and children. There had been no specific training on safeguarding for officers but there was a force-wide, detailed safeguarding vulnerable adults policy, and the principles of safeguarding children were reflected in several other policies and procedures. All staff had a clear understanding of when and how to raise safeguarding concerns. Frontline and investigating officers were expected to complete the multi-agency referral form to alert specialist police teams and partner agencies of all children and vulnerable adults brought into custody. Our case audits showed examples of this happening in some, but not all, cases.
- 6.32** Risk assessments for vulnerable adults and children were carried out well and informed the level of observation needed to ensure that they were safeguarded adequately. Force policy set out that all children were to be placed on 30-minute observations as a minimum. Our observations and case audits showed that cell visits were consistently carried out on time, to meet the observation levels set. In addition, to provide additional assurance for children, there was a requirement that the cell door was opened, rather than just dropping the hatch, on every third visit.
- 6.33** Children in custody were shown a good level of care. Girls were assigned a female member of staff to care for their needs, which was good practice and in line with legislative requirements. In one case that we examined, a mother had been allowed to remain with her child in the cell, with the door open, and we observed another case where a child had been removed from his cell and taken to a visits room, where he had stayed with his care worker pending his release from custody.
- 6.34** However, although custody sergeants were aware of the potentially adverse impact of the custody environment on children, the design of the suites did not make it possible always to keep children separate from adult detainees, either when being booked in or in the cells. We were also concerned about the large number of reviews of detention for all detainees that were carried out remotely (see section on detainee care and area of concern 2.63 and paragraph 6.27).
- 6.35** In general, vulnerable adults and children received a good service from appropriate adults (AAs). Family members, carers or guardians were sought for this role in the first instance but when this was not possible, AAs from other sources were easily available. AAs for children were provided through the youth offending teams, and for vulnerable adults through a contracted provider (TAAS). AAs usually attended for the reading of the rights and entitlements to detainees, returning as necessary for the other stages of the detention process. Once requested, AAs usually arrived promptly. In Crawley and Brighton, the force was piloting an embedded AA service for vulnerable adults, with an AA based in the suites from 8am until 8pm, which was offering a flexible and quick response.
- 6.36** The AA service was available 24 hours a day, in line with good practice. Custody sergeants said that they would consider the circumstances of the case before calling an AA during the night, but had this option available to them. Our case audits showed examples of AAs attending late at night and in the early hours of the morning to ensure that the detainee had support from early on in their detention.
- 6.37** Custody sergeants and frontline officers had a good understanding of the role of an AA and that they were required for all children and, in line with force policy, for all adults who were vulnerable because of mental health problems. Although written guidance for AAs was available for custody sergeants to give to those who were unfamiliar with the role, our observations showed that this was not routinely issued, although good verbal guidance was given in some cases.

- 6.38** Record keeping for AAs was inconsistent. The times of requests for an AA and their subsequent arrival at the suite were not always captured accurately, making it difficult to assess how long detainees waited before receiving support. Our observations and case audits also showed some examples of requests not being made for vulnerable adults, and of requests made late into the detention process (see area of concern 2.61).
- 6.39** Custody sergeants were focused on avoiding the criminalisation of children. They were prepared to refuse detention unless this could be justified robustly by arresting officers. They referred children who admitted their offence to the youth offending teams, to determine the most appropriate course of action, such as a conditional caution or an appropriate community resolution. They also referred children to the police and court liaison and diversion (PCLD) service based in the custody suites, to provide support to prevent or minimise further offending behaviour.
- 6.40** It was a clear priority for custody sergeants to minimise the length of time that children were detained in custody, and particularly to avoid overnight detention, and they actively sought to achieve this. They engaged with parents and partner agencies to process children and made effective use of bail to release children as early as possible. Our case audits and observations showed examples of children being released late at night or in the early hours of the morning into the care of family or care workers, avoiding overnight detention. In one case, a child had been processed through custody without the need to enter a cell.
- 6.41** The force had been proactive in developing arrangements to avoid the overnight detention of children who had been charged and refused bail. In these cases, the local authority has a statutory duty to provide alternative accommodation. The force had signed up to the children's concordat, introduced a joint protocol with partners and arranged multi-agency training. All cases in which a child was detained overnight rather than being moved to alternative accommodation were monitored closely, on a weekly basis, and custody sergeants were expected to justify robustly their decision to detain a child in these circumstances. Custody sergeants had a good understanding of these arrangements and followed the agreed procedures. This included alerting the youth offending teams about the possible need for alternative accommodation early on in the detention period, so that they could plan accordingly, rather than waiting for a formal request. However, custody sergeants told us that the number of children charged and refused bail was reducing. Some said that they had not needed to use the new procedures under the joint protocol because they had not had any children falling into this category.
- 6.42** Despite the arrangements and the close monitoring of these cases, there had been little improvement in securing alternative accommodation for children charged and refused bail. In the 12 months to the end of October 2016, 38 children had been charged and refused bail. Requests for accommodation had been made for 33 of these children but provided for only three. No secure accommodation had been provided.
- 6.43** The force lacked data and performance information to assess the overall position in relation to children entering custody. In the 12 months to the end of October 2016, 2,316 children had been brought into custody, representing 9% of the custody throughput. The force had started to assess the total number of children remaining in police custody overnight; this mostly involved children who had not been charged but for whom enquiries were ongoing, or for whom there were concerns for their welfare. Although our CRA looked at only a small number of children, they showed that they spent an average of just over nine hours in custody, with several detained overnight (see area of concern 2.61).

Area for improvement

- 6.44 The force should continue to work with partners to ensure that children charged and refused bail do not remain in custody overnight but are transferred to alternative accommodation.**

Governance of health care

- 6.45** Mitie, Care and Custody Health, had provided physical health care services since April 2016 through a subcontract with Tascor, which held the main PFI contract. The service provided 24-hour support, seven days a week, with access to a forensic medical examiner on call. The monitoring of medical and allied health professionals' registration status and credentials was appropriate. Training and supervision arrangements were also effective, and there were good opportunities to maintain and develop professional competencies. Clinical governance meetings were established; these considered service improvement, audit outcomes and professional learning.
- 6.46** Operational oversight of health care was considered at regular safety meetings with the police, but arrangements for the strategic review of detainee care were disjointed because of the arm's-length nature of performance management, which focused on quantitative rather than qualitative detainee outcomes. There was no overarching health care partnership board, although robust multi-agency meetings with external partners took place to review areas such as mental health provision.
- 6.47** There was a wide range of appropriate policies, although some had been authored by Tascor and were being updated as part of the transitional arrangements. Staff we spoke to knew how to report adverse incidents and any safeguarding concerns. A leaflet explained how to make a complaint about health care, and we saw examples of how complaints had been dealt with appropriately.
- 6.48** All health care professionals (HCPs) had received intermediate life support training and custody staff underwent resuscitation training, which included the use of automated external defibrillators. We found small discrepancies with some out-of-date minor stock, but arrangements for the checking of emergency equipment were generally adequate.
- 6.49** Each site had identified treatment rooms. Cleaning schedules were in place but many of these rooms were cluttered, showed signs of wear and tear, and appeared poorly maintained, with an absence of simple amenities from paper towel dispensers to examination tables. The Hastings treatment room had a particularly poor environment, with tap fittings, flooring and access to soap dispensers not complying with infection control standards. The facilities to undertake forensic sampling at Chichester and Worthing were inadequate and not forensically clean, with the environments also being used to search detainees. CCTV was used in these areas during medical examinations, which was unacceptable.

Areas for improvement

- 6.50 There should be systematic and strategic oversight of all health care provision to determine and monitor outcomes for detainees.**
- 6.51 A formal review of treatment rooms and clinical facilities should be undertaken and acted on, to ensure that environments where detainee care and forensic examination occur are fit for purpose.**

6.52 The use of closed-circuit television in health care areas should cease.**Patient care**

- 6.53** Operational leadership was good and HCPs were skilled and experienced. There were generally four HCPs covering the region: one covering Chichester and Worthing, one covering Eastbourne and Hastings, one located at Brighton and one at Crawley. Access and response times were scrutinised as part of the contract monitoring arrangements. Requests were graded according to clinical need and criminal justice requirements. In our CRA, the average waiting time to see an HCP was one hour nine minutes. We were told that there were some delays in meeting performance targets due to the distance between custody suites and the availability of HCPs, and that this had attracted penalties; however, 95% of all health requests were delivered within the contract parameters, which we judged to be proportionate, although further analysis was needed to provide assurance that detainee need was being met.
- 6.54** Clinical assessment and interventions were appropriate. Health records were handwritten and generally of a reasonable standard, with relevant contacts and risk information shared with police through the custody record. Detainees were not routinely seen in private, with treatment room doors kept ajar or detainees accompanied by a chaperone.
- 6.55** Detainees could continue with prescribed medication in custody, including opiate substitution treatment. Symptomatic relief was provided for those withdrawing from drugs or alcohol where clinically indicated. However, nicotine replacement was not accessible, which created some avoidable problems for custody staff.
- 6.56** Medicine storage and administration complied with standards, and medication stocks were checked regularly and appropriately by HCPs. A number of patient group directions (which enable HCPs to supply and administer prescription-only medicine) were in place. Following a telephone consultation with an HCP, custody staff could supply detainees with over-the-counter medicines, such as simple pain relief.

Areas for improvement

- 6.57** **Waiting times to see a health care professional should be subject to further ongoing analysis, to ensure that graded response times are proportionate in qualitative and quantitative terms.**
- 6.58** **Detainees should be seen in private unless a risk assessment indicates that this is inappropriate.**
- 6.59** **Nicotine replacement support should accessible for detainees who smoke.**

Substance misuse

- 6.60** Substance misuse support was provided in Hastings and Eastbourne by Change Grow Live (CGL) and in Brighton by Pavilions. In Worthing, Chichester and Crawley there was no direct provision, with custody staff and the PCLD signposting detainees to community support. The service provided by CGL and Pavilions was similar in nature. Both teams attended their respective suites for half a day, five days a week, offering a single point of referral for detainees, which included supporting arrest diversion schemes. The teams provided support in local courts and custody suites across East Sussex and Brighton as part

of existing local community networks. Referrals were received through cell sweeps, via custody staff or through other health professionals. There was no out-of-hours access to substance misuse services. Young people were seen by the service if requested and signposted, or directly referred into age-appropriate services. CGL services facilitated needle exchange as appropriate.

- 6.61** Staff were motivated and received appropriate training and support, and the respective teams were valued by other custody staff. However, we judged that support for detainees would benefit from having a more regular and integrated level of input. The absence of identified provision in Worthing, Chichester and Crawley meant that detainees in these areas received limited local support.

Areas for improvement

- 6.62** **Contact activity and support for detainees should be monitored as part of robust health performance management arrangements.**
- 6.63** **Detainees with alcohol or drug problems should be supported through a comprehensive and integrated level of service within all custody suites.**

Mental health

- 6.64** Sussex Partnership NHS Foundation Trust provided liaison and diversion services to six police custody suites across Sussex through the PCLD. The PCLD was made up of a team of mental health practitioners and custody support workers. The team worked across all police custody suites and within the courts at Hastings, Crawley and Brighton as part of an NHS England pilot project. The PCLD team was embedded in two of six police custody suites (Crawley and Brighton), and assigned staff from the team worked between either Eastbourne and Hastings, or Worthing and Chichester. The service operated seven days a week, between 8am and 8pm, and police officers, custody staff, other HCPs and detainees could make referrals. The service liaised with community mental health teams when a detainee was already known to the service, and a specialist children's mental health practitioner was part of the team. In addition to delivering core support, the service had adopted a health and well-being focus. As a result, all detainees considered as 'vulnerable' were generally referred. This included, for example, individuals with substance misuse problems, vulnerable women and people who were homeless. Detainees were actively supported and signposted to a number of other agencies when appropriate. The PCLD also provided support and liaison between custody staff and approved mental health professionals when a request for a formal Mental Health Act assessment was made. All custody staff we spoke to were positive about the service that the team provided.
- 6.65** The force had employed a mental health nurse to work in the control room, to provide specialist support to frontline operational staff, which we judged to be a positive initiative. Street triage was in operation in four areas of Sussex. It had started as a pilot scheme in October 2013 in Eastbourne and had gradually been commissioned across the county. It consisted of mental health professionals working alongside police officers to provide support and advice to police officers responding to vulnerable people, including children. A team manager for the street triage staff told us that the scheme had reduced the incidence of people being taken into police custody, and the number of people needing to be taken to a health-based place of safety, as nursing staff were able to assess risks and offer less restrictive options.

- 6.66** The force had a mental health lead and there was close joint working between the police and local mental health services at local and strategic levels, which included the trust and the local authority. This was done through the quarterly Mental Health Act review committee and through monthly section 136 liaison meetings, which reviewed all incidents of the use of section 136,¹² both in police custody suites and health-based places of safety.
- 6.67** Since the previous inspection, there had been significant year-on-year reductions in the number of uses of the custody suites as a place of safety under section 136 of the Mental Health Act. In the previous six months, this trajectory had stalled and the number of such detentions had started to rise – and had already surpassed the total of 119 such detainees reported in 2015/16. We were told that arresting officers experienced difficulty in accessing health-based places of safety because of a number of variables, including Trust staff not being available to supervise the suite, with the result that too many vulnerable people were still being brought into custody. Similarly, although we found that access to Mental Health Act assessments was generally timely, detainees regularly had to wait for a bed to be found across the Sussex area, and this often involved reviewing other hospitalised patients and arranging transfers to alternative services in order to facilitate a hospital bed. This had a significant impact on the time that detainees spent in custody (see area of concern 2.64).

Area for improvement

- 6.68 Detainees with mental health issues should receive prompt assessments, and agreed transfers to hospital facilities should be expedited in a timely manner.**

¹² Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved Mental Health Practitioner, and for the making of any necessary arrangements for treatment or care.

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 (CRA), case audits and observations did not assure us that all detainees were involved in, or subject to, a pre-release risk assessment. Most of the records were poor and included inadequate information to demonstrate that identified risks had been addressed or mitigated before release. In most cases, we were unable to discern how detainees, including the most vulnerable, had got home.
- 7.2** Only around half of the pre-release risk assessments we observed showed good attention to securing a safe release for the detainees. Initial risk assessments and care plans were not always checked to ensure that all identified risks had been addressed or managed before release. Sergeants were not always focused on ensuring that detainees had the means to get home safely and we saw a few extremely vulnerable detainees being released with insufficient assistance from the police. Travel warrants were available if detainees had no money but these were used sparingly. Police officers were sometimes relied on to provide transport home and we saw them being utilised in a few cases.
- 7.3** A wide range of generic support leaflets was available but these were rarely given to detainees on their release. Sergeants were generally aware of the specific offences and circumstances that made detainees more at risk on release but did not always take extra time with them to ascertain risks or mitigate them where possible.
- 7.4** However, good use was made of the police and court liaison and diversion (PCLD) staff, who saw and assessed numerous detainees during their stay in custody and also before release. These staff had good access to external support services and could make appointments and referrals – for example, to housing and substance misuse agencies. As a result of confidentiality rules, they could not always communicate their activity with custody sergeants. Although they undertook some positive and supportive work with detainees, we were not assured that this was consistent; overall, therefore, we considered that there was insufficient attention to ensuring that all detainees, particularly the most vulnerable, were released safely.

Area for improvement

- 7.5 Attention to pre-release arrangements should be improved. Custody sergeants should ensure that all identified risks are mitigated before release and that this is documented accurately.**

Courts

- 7.6** Custody staff told us that the local remand courts would not normally accept detainees after 2pm on weekdays, which was too early. We were told of a number of occasions when

detainees had been refused even earlier in the day; however, at Worthing, we saw a detainee being escorted from the custody suite at 2pm to attend at Crawley Magistrates' Court, where he would not arrive until at least 3pm.

- 7.7** Staff at Crawley and Hastings told us that detainees regularly remained in police custody for longer than necessary. This was because they were not picked up to be taken to court until the end of the day as the adjacent courts had limited cell capacity for holding detainees. We were told of a recent instance on a Monday at Crawley, when the first of four detainees who had been held over the weekend was not taken to the remand court until 4pm. This situation was made worse as these four detainees were all subsequently remanded and returned to the police custody suite as they had been 'locked out' of prison that evening owing to a shortage of spaces; this had denied them access to the entitlements they would have received in prison – for example, contact with a family member.
- 7.8** The person escort records (PERs) we checked were of variable quality. Some were completed to a high standard, while others contained limited information, which was not always dated. For example, one PER we checked at Crawley indicated that the detainee had tied an item around their neck in an attempt to self-harm while in custody but it did not specify the date or time of day when this had taken place. Some custody assistants told us that they had been instructed to include only details from the police national computer on a detainee's PER; this presented significant risks for detainees, escorting and receiving staff. One PER we checked at Hastings failed to identify that a detainee was suffering from depression and anxiety, as disclosed in the initial risk assessment. Another, at Brighton, omitted the fact that a detainee was dependent on heroin/cocaine, which, again, had been disclosed in the initial risk assessment.

Areas for improvement

- 7.9** **Sussex Police should engage with HM Courts and Tribunals Service to ensure that detainees are not held in police custody for longer than necessary.**
- 7.10** **Person escort records should clearly record all known risks for the detainee.**

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

Areas of concern and recommendations

8.1 Area of concern: There were a substantial number of potential ligature points across the force custody estate which presented significant risk to detainees and the force if left unattended. The force was largely unaware of these and, before the inspection, there had been no plans to address or mitigate the risks that these posed.

Recommendation: The force should address the safety issues involving potential ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed to ensure that custody is delivered safely. (2.60, repeated recommendation 2.22)

8.2 Area of concern: Performance information in relation to custody was not comprehensive and there was limited monitoring across the different custody functions, making it difficult for the force and others to assess how well custody services were performing.

Recommendation: The force should develop a comprehensive performance management framework for custody, ensuring the accurate collection of data, and use this to assess performance, identify trends and learning opportunities, and improve services. (2.61)

8.3 Area of concern: Governance and oversight of the use of force in custody was inadequate, with insufficient information to demonstrate that all uses of force were both justified and proportionate.

Recommendation: Measures should be put in place immediately that allow all uses of force to be scrutinised, to demonstrate that the application is justified and proportionate. (2.62)

8.4 Area of concern: A number of procedures in relation to the provision of custody services were not compliant with code C of the codes of practice relating to the detention, treatment and questioning of persons by police officers.

Recommendation: All staff should comply with code C of the codes of practice, and reviews of detention for children should always be carried out in person. The most recent version of code C should be available in all custody suites. (2.63)

8.5 Area of concern: The number of detainees held under section 136 of the Mental Health Act as a place of safety had increased in the previous months. In spite of work by the force with partners, the position was continuing to deteriorate. In addition, the force was unlawfully detaining vulnerable people, when no other alternative existed, in order to keep them safe.

Recommendation: The force should undertake an urgent review, in collaboration with partners, in relation to the reasons behind the increase in the numbers of vulnerable persons 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 such people. (2.64)

Areas for improvement

Pre-custody: first point of contact

- 8.6** The force should work more closely with the ambulance service to improve the arrangements to ensure that detainees with mental health problems are transported by ambulance to a place of safety in a timely manner. (4.10)

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

- 8.7** Female detainees should be automatically asked about access to female officers and offered (appropriate) hygiene products during booking in, as per current force policy. The force should also reconsider its ban on the provision of tampons. (5.12)
- 8.8** In-cell toilets should be obscured on all CCTV camera monitors. (5.13, repeated recommendation 4.36)
- 8.9** Booking-in areas should provide sufficient privacy to facilitate effective communication between staff and detainees. (5.14, repeated recommendation 4.9)
- 8.10** A full range of religious worship texts and materials should be available and stored appropriately in all custody suites, alongside guidance for staff. (5.15)
- 8.11** All custody sergeants, detention supervisors and custody assistants should receive the same training opportunities, specifically relating to better understanding of diverse needs, including mental health, vulnerabilities and protected characteristics. (5.16)
- 8.12** All staff attending detainees' cell should carry anti-ligature knives. (5.22)
- 8.13** Detainees' clothing and footwear should be removed only on the basis of an individual risk assessment. (5.23)
- 8.14** All custody staff should be involved collectively in the relevant shift handover. (5.24)
- 8.15** Custody sergeants should ensure that the detainee's correct time of arrival is accurately recorded on custody records. (5.37)
- 8.16** Hearing loops and the rights and entitlements information in Braille should be available in custody suites. (5.38, repeated recommendation 4.11)
- 8.17** The force should ensure that detainees are able to make a complaint while they are still in custody. (5.47)

In the custody cell, safeguarding and health care

- 8.18** There should be thorough daily and weekly maintenance checks, and these should be conducted consistently. The recording and quality assurance of cell checks should be improved. (6.5)
- 8.19** Guidance on the dietary and cultural suitability of the food provided should be consistent and available in all suites. (6.28)

- 8.20** Cell mattresses should be of adequate quality to support all detainees, including additional support versions for those with restricted mobility. (6.29)
- 8.21** Appropriately diverse selections (age, gender, language, type) of reading materials should be available in all suites. (6.30)
- 8.22** The force should continue to work with partners to ensure that children charged and refused bail do not remain in custody overnight but are transferred to alternative accommodation. (6.44)
- 8.23** There should be systematic and strategic oversight of all health care provision to determine and monitor outcomes for detainees. (6.50)
- 8.24** A formal review of treatment rooms and clinical facilities should be undertaken and acted on, to ensure that environments where detainee care and forensic examination occur are fit for purpose. (6.51)
- 8.25** The use of closed-circuit television in health care areas should cease. (6.52)
- 8.26** Waiting times to see a health care professional should be subject to further ongoing analysis, to ensure that graded response times are proportionate in qualitative and quantitative terms. (6.57)
- 8.27** Detainees should be seen in private unless a risk assessment indicates that this is inappropriate. (6.58)
- 8.28** Nicotine replacement support should be accessible for detainees who smoke. (6.59)
- 8.29** Contact activity and support for detainees should be monitored as part of robust health performance management arrangements. (6.62)
- 8.30** Detainees with alcohol or drug problems should be supported through a comprehensive and integrated level of service within all custody suites. (6.63)
- 8.31** Detainees with mental health issues should receive prompt assessments, and agreed transfers to hospital facilities should be expedited in a timely manner. (6.68)

Release and transfer from custody

- 8.32** Attention to pre-release arrangements should be improved. Custody sergeants should ensure that all identified risks are mitigated before release and that this is documented accurately. (7.5)
- 8.33** Sussex Police should engage with HM Courts and Tribunals Service to ensure that detainees are not held in police custody for longer than necessary. (7.9)
- 8.34** Person escort records should clearly record all known risks for the detainee. (7.10)

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
Stephen Eley	HMI Prisons health services inspector
Kathleen Byrne	Care Quality Commission inspector
Helen Ranns	HMI Prisons researcher
Joe Simmonds	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.

Recommendation

Quality assurance processes should be improved, with centre inspectors making regular dip sampling of custody records and CCTV recordings. (3.12)

Not achieved

Treatment and conditions

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

Main recommendation

The force should address the safety issues involving ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed. (2.22)

Not achieved (Recommendation repeated, 2.60)

Recommendations

Booking-in areas should provide sufficient privacy to facilitate effective communication between staff and detainees. (4.9)

Not achieved (Recommendation repeated, 5.14).

Female detainees should only be searched by staff of the same gender. (4.10)

Achieved

Hearing loops and information in Braille should be available in custody suites. (4.11)

Not achieved (Recommendation repeated, 5.38)

All safety information should be recorded on the police national computer, and decisions about the management of risk should be proportionate. (4.21)

Achieved

Detainees should only be handcuffed when a risk assessment indicates it is necessary for the safety of staff, the public or the detainee. (4.25)

Not achieved

The toilet area in cells should be obscured on closed circuit television screens. (4.36)

Not achieved (Recommendation repeated, 5.13)

All detainees held overnight, or who require one, should be offered a shower. (4.37)

Achieved

Individual rights

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

Recommendations

Senior police officers should engage with the local authority to ensure the provision of place of safety beds for juveniles. (5.14)

Partially achieved

Appropriate adults should be available out of hours and also to support juveniles aged 17. (5.15)

Achieved

Sussex Police should liaise with court managers to ensure that early court cut-off times do not result in unnecessarily long stays in custody. (5.16)

Not achieved

Detainees should routinely be told how to make a complaint in line with the Independent Police Complaints Commission statutory guidance. (5.18)

Partially achieved

Health care

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

Main recommendation

Police custody should only be used as a place of safety for Mental Health Act Section 136 assessments in extreme cases. (2.23)

Not achieved

Recommendations

The practice of secondary dispensing by health care professionals should cease. (6.6.)

Achieved

All detainees should be able to continue to receive prescribed medications, and symptomatic relief for substance use withdrawal. (6.15)

Achieved

Clinical staff should use a documented assessment tool for the assessment of withdrawal symptoms. (6.16)

Achieved

All contemporaneous clinical records should conform to guidance from professional bodies and include evidence that consent has been sought. (6.17)

Achieved

There should be comprehensive data kept to monitor the provision and performance of services to problem substance users in custody. (6.23)

Not achieved

HM Inspectorate of Prisons and HM Inspectorate of Constabulary are members of the UK's National Preventive Mechanism, a group of organisations which independently monitor all places of detention to meet the requirements of international human rights law.

