Inspecting policing in the public interest

Report on an unannounced inspection visit to police custody suites in

West Midlands

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

30 January–10 February 2017

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

Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Any enquiries regarding this publication should be sent to HM Inspectorate of Prisons at Victory House, 6th floor, 30–34 Kingsway, London, WC2B 6EX, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk, or
HM Inspectorate of Constabulary at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or haveyoursay@hmic.gsi.gov.uk

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/ or http://www.hmic.gov.uk

Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary

Contents

Section 1. Introduction

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

We previously inspected West Midlands in 2010, when, despite a number of issues that required attention, we found a reasonably positive picture concerning the provision of custody. Issues of most significance at the previous inspection concerned ligature points, use of force and risk assessments. It was disappointing that only one of those three areas, relating to risk assessments, had been addressed adequately.

During this inspection, we found a significantly different custody estate. A number of the older custody facilities had closed, which we welcomed. Two large, modern, purpose-built suites had opened, providing clean and bright environments.

A number of strengths were identified during the inspection. There was an appropriate governance structure and clear accountability for the safe delivery of custody. The force paid good attention to its Public Sector Equality Duty and we found the staff group to be engaged with detainees and focused on identifying and managing vulnerability and risk. It was commendable that custody was used rarely for the detention of people held under the Mental Health Act.

We did, however, identify several areas of concern. Some of these were similar to those we have found in other forces inspected recently. The first, and perhaps most concerning, was the substantial number of potential ligature points we identified. These presented a significant risk to detainees and the force.

The second principal issue concerned the lack of comprehensive performance information and related monitoring. This made it difficult for the force and others to assess how well custody services were performing. This was demonstrated most notably by the lack of governance and oversight of the use of force in custody. The force did not have adequate mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force in custody was always justified and proportionate.

As with other forces, the remaining concerns were closely linked to work with partner agencies. Too many children were detained overnight when alternative accommodation should have been provided by respective local authorities. This was despite good engagement with safeguarding children boards. It was clear that the provision of alternative accommodation for children detained overnight required even greater attention.

The health care contract was not being delivered effectively and we considered that this had a detrimental impact on the care afforded to detainees. Our concerns were shared by the force, which was trying to address the underperformance of the health care provider directly.

We found a number of instances in which aspects of the PACE codes of practice, particularly relating to the provision of individual and legal rights, were not complied with, which was concerning. Arrangements for securing appropriate adults for vulnerable detainees and for releasing detainees safely were not always good enough. Despite identifying these areas where improvement was required, throughout the inspection we found that detainees held in police custody were generally treated compassionately and with respect.

Overall, the findings from the inspection were mixed. Many of the existing strengths remained and there had been clear progress in some areas. However, it was disappointing that over a third of the recommendations made at the previous inspection had still not been achieved. Nevertheless, the force had a clear vision for custody and we were confident that if the strategic impetus was sustained, this would result in further improvement.

We noted that of the 21 recommendations made in our previous report after our inspection of 2010, five recommendations had been achieved, six had been partially achieved, nine had not been achieved and one was no longer relevant.

This report provides five recommendations to the force and highlights 35 areas for improvement.

Dru Sharpling CBE
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

March 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 (CRA) 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 168 records were 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 the average length of time in police detention.

2.5 This was our second inspection of West Midlands police custody, following up on our inspection of 18–27 October 2010. During the 2017 inspection, the designated suites and cell capacity were as follows:

---

[1] http://www.justiceinspectorates.gov.uk/hmiprisons/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 suites	Number of cells
Bournville	17
Coventry	25
Perry Barr	60
Oldbury	60
Solihull	9
Wolverhampton	19
Contingency suites	
Bloxwich (Walsall)	20
Stechford	16
Willenhall (Coventry)	20

Leadership, accountability and partnerships

2.6 Elements of leadership, accountability and partnerships were very good but there were some important gaps which required remedial attention.

2.7 The number of custody facilities had reduced since the previous inspection, with some older suites closing and two new modern, purpose-built suites being opened. There was an appropriate governance structure and clear accountability for the safe delivery of custody.

2.8 *Authorised Professional Practice – Detention and Custody* for detention and custody, as set by the College of Policing, was followed and underpinned by local protocols and practices, documented in a comprehensive guidance manual. However, not all processes and practices were compliant with written policy.

2.9 Thorough training was provided for custody staff and ensured that they remained operationally and occupationally competent. Resilience among the custody staff group was not always robust enough and often resulted in untrained staff providing cover, which was concerning.

2.10 The force considered that the health services provider was unable to deliver the contract owing to fundamental difficulties in recruiting and retaining suitable qualified staff. We agreed with this view, and considered that the lack of clinical leadership also contributed towards poor standards.

2.11 Mechanisms to collate data and monitor performance in custody were inadequate. Some data were available, including custody throughput, demographics and overall detention times, but this did not cover all key areas of activity.

2.12 Measures to assure the force itself, the Police and Crime Commissioner and the public that the use of force in relation to detention and custody was safe and proportionate were

inadequate. Data in relation to the use of force in custody could not be extracted, and the force was unable to provide us with cases for audit purposes.

2.13 A new force-wide initiative allowed detainees accused of shoplifting goods to be charged without being interviewed in certain circumstances However, there was no monitoring or evaluation of this practice. From our examination of a sample of cases, we were not confident that the initiative was always used appropriately.

2.14 It was concerning that a number of procedural issues, governed by the Police and Criminal Evidence Act 1984 (PACE), particularly codes of practice C and G, were not complied with.

2.15 Strategic attention to equality was good. The force was meeting its Public Sector Equality Duty and had agreed strategic equality objectives and local objectives specific to custody. Cultural competency training, including mental health, dementia, autism and cultural awareness, was delivered to staff.

2.16 Engagement with partners was generally positive. There were effective partnership arrangements to prevent individuals from being brought into custody as a place of safety under section 136 of the Mental Health Act 1983, except in exceptional circumstances.

2.17 There were safeguarding children boards in the seven local authorities serving the force. Regular meetings, chaired by each of the chief superintendent borough commanders, monitored performance. In spite of these arrangements, too many children were held in custody overnight when appropriate alternative accommodation should have been provided.

Pre-custody: first point of contact

2.18 Frontline staff demonstrated a good understanding of vulnerability, including mental health issues. Information was available from a number of sources but call centre staff did not always have direct access to them. Response officers felt that they generally received good information from the call centre and this was supplemented by access to the incident log through their mobile devices.

2.19 There was an appropriate focus on avoiding taking children into custody wherever possible. A range of alternative disposals, including voluntary attendance and community resolution, were often used.

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

2.20 Custody staff in all roles communicated both with and about detainees in an engaging, respectful and compassionate way.

2.21 The levels of privacy afforded to detainees during booking-in were often inadequate. This was mitigated slightly at the newer suites, where there was access to discrete booking-in areas for vulnerable detainees.

2.22 The risk assessment template used during booking-in specifically addressed detainees' diversity and vulnerability needs. Staff showed an impressive level of awareness when obtaining this information. However, this did not always translate to meeting diverse needs well enough in practice. The needs of female detainees, those with restricted mobility and foreign nationals who did not speak English were not always met adequately. Arrangements

for transgender detainees, those with care responsibilities and religious observance were generally good.

2.23 Risk assessments were completed well and were properly focused on managing risk and vulnerability. Records did not always reflect the required observations, and the determined frequency was not always adhered to (see below). However, when required, there was good use of higher levels of observations. Since the previous inspection, a death in custody had been investigated by the Independent Police Complaints Commission (IPCC). The progress made against the recommendations set, particularly concerning levels of observations, was inadequate.

2.24 Rousing practice was generally good and well documented, and most custody staff carried anti-ligature knives. The routine removal of cords and footwear, and the use of paper suits as replacement clothing were unnecessary and disproportionate to the risks posed.

2.25 Shift handover arrangements were not always good enough, particularly in the two newer suites.

2.26 Frontline officers were confident in providing the circumstances of and grounds for arrest on arrival in custody suites.

2.27 Aspects of the delivery of individual and legal rights were provided appropriately but we had some serious concerns, particularly around non-compliance with the PACE codes of practice (see above).

2.28 For a number of reasons, including the availability of investigating officers, appropriate adults (AAs) and interpreters, investigations were not always progressed in a timely manner. This resulted in some detainees being held in custody for longer than necessary.

2.29 Rights and entitlement leaflets were mostly up to date and were generally offered to detainees. Most suites lacked current copies of PACE code C.

2.30 Processes for the management and transportation of DNA were appropriate but we found a substantial number of elimination DNA samples and exhibits in refrigerators and freezers across all custody suites.

2.31 Access to a professional telephone interpreting service and hearing loops was adequate in most suites.

2.32 Initial pre-charge bail was managed well. However, timescales were not always met, leading to frequent and avoidable re-bails. Monitoring systems for pre-charge bail varied across suites and the process was hampered by the poor quality, or absence, of the investigation updates. The force was well prepared to implement the new bail legislation.

In the custody cell, safeguarding and health care

2.33 The physical conditions in the new suites, where most detainees were held, were good. Cells and communal areas there were clean and in good decorative order. However, the physical environments at some of the older suites, where a significant proportion of detainees were still held, were poor. Maintenance and cleaning arrangements were satisfactory. Cell call bells were in working order but their use was not always explained to detainees. There was little graffiti but we identified a substantial number of potential ligature points across the custody estate. Overall arrangements for fire evacuations were inadequate.

2.34 The governance and oversight of the use of force in custody were inadequate. Our analysis indicated that the force used was not always proportionate to the risk posed. Some practice was poor and some of the techniques used were deployed inappropriately. Handcuffs were not always removed quickly enough from compliant detainees. Managers did not review closed-circuit television (CCTV) footage of incidents in which force had been used, thereby missing opportunities to learn lessons and improve practice. The force was unable to provide any data concerning the number of strip-searches carried out in custody. Our analysis indicated that the level of strip-searching was higher than we usually encounter. In the records we examined, the rationale for strip-searches was often inappropriate.

2.35 There was an adequate range of microwave meals available. Detainees were able to receive food and drink regularly throughout the day. However, other aspects of detainee care were not good enough. Most detainees had little to occupy them during their, sometimes long, stays in custody. The selection of reading material available at most suites was poor, particularly for children and non-English-speaking detainees, and was not offered routinely. Little privacy was afforded to detainees taking a shower. Access both to showers and exercise was limited.

2.36 PACE reviews were not conducted consistently. Few were carried out by telephone but too many were completed early, with no apparent or stated justification for doing so, which was not always in the best interests of detainees. For detainees who had been reviewed while sleeping, we found no evidence that they had been informed of this, or reminded of their rights and entitlements, on waking. Some of the recording of reviews was poor and misleading.

2.37 Frontline and custody staff generally showed a good understanding of safeguarding concerns. There was effective assessment of risks for vulnerable adults and children, involving health professionals as necessary, to ensure that appropriate care and support were provided. In general, children were kept separate from adults. The discrete booking-in areas for children and sensitive cases in the newer suites were not always used. Children were placed on 30-minute visits as a minimum but we found examples where the required frequency was not adhered to.

2.38 Arrangements for securing AAs, both for children and vulnerable adults, were inadequate. Record keeping in relation to AAs was also poor.

2.39 We shared the force's concerns about the effectiveness of the health care contract. Health care practitioners (HCPs) were competent and appropriately skilled but detainees were not always seen within agreed timeframes. The nursing workforce was understaffed and clinical leadership of the physical health team was poor. There was limited evidence of clinical supervision and few opportunities for professional development for HCPs. Oversight of all aspects of health care was considered at monthly performance meetings, chaired by the police, but performance was not good enough in a number of areas.

2.40 Emergency resuscitation equipment in the suites did not meet essential standards, which put detainees at significant risk.

2.41 Access to health care for detainees took too long but the clinical interactions that took place were appropriate. The standard of clinical records was reasonable but dual recording could have had an impact on the continuity of care and resulted in clinical risks not being identified. Written records were not always stored confidentially.

2.42 Medication management arrangements were not always appropriate and there was evidence of some major stock discrepancies.

2.43 A number of community-based substance misuse teams operated within custody. Services collaborated effectively and offered good support to detainees with drug or alcohol problems.

2.44 Detainees were able to receive prescribed opiate substitution therapy in custody and clinical support was provided to detainees who experienced acute withdrawal symptoms. However, this was not responsive enough, which could have put detainees at risk.

2.45 Despite complex commissioning arrangements, we found effective partnership working and good and timely assessments and interventions offered to detainees. Assessments for detention under the Mental Health Act were generally timely.

2.46 Custody suites had only been used as a place of safety under section 136 of the Mental Health Act three times in the previous 12 months. Street triage and diversion to hospital and community services for people with mental ill-health ensured that vulnerable people were not inappropriately held in custody. These services were among the best we had seen.

Release and transfer from custody

2.47 There was no uniform approach to releasing detainees. The pre-release arrangements we observed generally paid attention to securing a safe release for detainees, although the recording of this was poor. Most custody records provided little reassurance that risks were routinely addressed, that detainees without money or means of transport were conveyed home safely or that detainees were provided with the support they needed on release.

2.48 Arrangements to transfer detainees to court after initial morning collections were confusing and did not appear to be efficient. We were given conflicting information at all suites about the reason for this, and we were not clear if the issue related to whether the courts would accept detainees or the way that GEOAmey transported them to court. The quality of person escort records varied and, inappropriately, were accompanied by confidential medical examination notes.

Areas of concern and recommendations

2.49 **Area of concern:** The health care practitioners we met were competent and skilled but fundamental difficulties in recruiting and retaining suitably qualified nurses had led to continuing shortages of frontline staff. These issues, when coupled with the nature of the contract, the absence of any effective clinical leadership and weak governance arrangements, had resulted in an overstretched physical health service which was struggling to meet demand and had generated poor standards in a number of clinical areas.

Recommendation: **The provider of the health care service should ensure that its staffing profile, leadership arrangements and approach to governance are adequate to deliver an effective and safe service, and the existing physical health care contract should be re-evaluated to ensure that it provides for the needs of detainees.**

2.50 **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 performed.

Recommendation: **The force should develop a comprehensive performance management framework for custody, ensuring that data are collected**

accurately, and use this to assess performance, identify trends and learning opportunities, and improve services.

2.51 **Area of concern:** The governance and oversight of the use of force in custody were inadequate, with insufficient information to demonstrate that any force used was both justified and proportionate.

Recommendation: **The force should introduce mechanisms to assure itself and others that all force used in the detention and custody of detainees is scrutinised robustly and that all such uses are justified and proportionate.**

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

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

2.53 **Area of concern:** There were a substantial number of ligature points across the force custody estate. These presented a significant risk to detainees and the force. The force was aware of some of these appeared to have no clear plan to address or mitigate the risks that they posed.

Recommendation: The force should take immediate action to remove or manage any ligature points, to ensure that it is delivering custody safely.

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 responsibility at assistant chief constable level, supported by sufficient specialist staff who were trained to deliver custody functions. This structure provided clear accountability for the safe delivery of custody. However, the force had experienced difficulties in maintaining sufficient custody officer assistants (COAs) as many went on to become police officers. These vacancies were regularly covered by frontline officers on overtime, who had not necessarily received training in all tasks, such as taking fingerprints and DNA samples (see also paragraph 5.23).

3.2 Since the previous inspection, there had been a reduction in the size of the custody estate, with some older suites closing and two new purpose-built suites being opened at Oldbury and Perry Barr, offering modern facilities. However, the custody estate did not consistently support the safe delivery of custody – for example, we found numerous ligature points (see paragraph 6.3 and area of concern 2.53); although the force was aware of some of these, there was no plan to mitigate the risk that they presented.

3.3 The force followed the *Authorised Professional Practice – Detention and Custody*, as set by the College of Policing. This was underpinned by some local protocols and practices documented in a comprehensive but long guidance manual. Staff were aware of the guidance and generally knowledgeable in relation to processes and procedures. However, not all processes and practices we observed were compliant with the written policy (see paragraphs 4.5, 5.7, 5.14, 5.42, 6.15, 6.18 and 7.2).

3.4 All custody staff received comprehensive training before undertaking duties. Ongoing training was provided at regular intervals and attendance was monitored. Data provided by the force showed that, in the previous 12 months, all necessary mandatory personal safety training had been completed. However, resilience among the custody staff group was not always robust enough and often resulted in untrained staff providing cover, which was concerning.

3.5 There were some serious difficulties with the contract for delivering health services in custody, resulting in detainees not receiving a consistently good service. The force considered that the health services provider was unable to deliver the contract owing to fundamental difficulties in recruiting and retaining suitable qualified staff. We agreed with this view, and considered that the lack of clinical leadership also contributed towards poor standards (see paragraph 6.51 and area of concern 2.49).

Accountability

3.6 While the force monitored performance and collated some data, including custody throughput, demographics and detention times, this was not comprehensive across all key areas of activity. For example, it was unable to provide data on the use of force (see

paragraph 6.8) or on strip-searches (see paragraph 6.12). Some data provided by the force for the inspection were inconsistent and it was not clear how it used performance data or regular quality assurance measures to assess how well it was delivering different aspects of the custody service, to identify trends and to inform organisational learning at a strategic level (see also paragraph 5.21 and area of concern 2.50).

3.7 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 the use of force in custody could not be extracted, and the force was unable to provide us with cases for audit purposes. This presented a strategic risk to the force and also meant that it could not identify trends or learning opportunities adequately (see paragraphs 4.6 and 6.9 and area of concern 2.50).

3.8 The force had introduced a pilot in March 2016, whereby detainees accused of shoplifting goods could be charged without being interviewed in certain circumstances, and had documented rationale and legal advice in respect of this. However, it was unable to provide any monitoring or evaluation of this practice, including details of the number of persons whose cases had been dealt with under this scheme, and had inadequate mechanisms to assure itself and criminal justice partners that all such instances had been appropriate and within the documented criteria. In a small sample we examined, we found examples of cases which should not have been included as part of the pilot. This meant that there was a risk that the potential vulnerability of the detainee had not been considered and/or that other, more serious offending had not been identified; in some cases, this could have constituted unlawful practice.

3.9 We found a number of procedural areas where PACE and codes C (code of practice for the detention, treatment and questioning of persons by police officers) and G (code of practice for the statutory power of arrest by police officers) were not complied with (see paragraphs 5.11, 5.19 and 6.24). In addition, most copies of code C that we found in suites were out of date (see also paragraph 5.28).

3.10 The force was meeting its Public Sector Equality Duty and had agreed comprehensive strategic equality objectives and local objectives specific to custody. There were force-wide champions for all strands covered by the Equality Act, and an equality impact assessment of the custody policy had been carried out. The force published annual data on its public website. Cultural competency training was provided for its staff, and custody was considered as a priority department for such training. In the previous 12 months, this had included training sessions in cultural awareness, mental health, dementia and autism. Staff comments in relation to this training were positive, and our observations showed staff to be respectful and understanding of individual needs (see also paragraph 5.2).

3.11 The force had a positive relationship with its independent custody visitors (ICVs), who provided effective scrutiny of custody service. The force welcomed this and was receptive to feedback.

Areas for improvement

3.12 The force should evaluate its procedures to assure itself and criminal justice partners that all instances where a detainee has been charged with shoplifting without interview are appropriate and compliant with its own documented scheme and lawful practice.

3.13 The force should ensure that all processes in relation to custody are compliant with codes C and G of the PACE codes of practice.

Partnerships

3.14 The force was committed to engaging with partners to improve their approach with regard to children. It was represented at the appropriate level in various partnership forums, including the seven local safeguarding children boards. Regular meetings, chaired by each of the chief superintendent borough commanders, monitored performance. There were monitoring and escalation procedures to enable the movement of children who had been charged and refused bail to alternative accommodation. However, in practice, a shortage of appropriate local provision prevented this from happening (see paragraph 6.47 and area of concern 2.52).

3.15 There were effective partnership arrangements to prevent individuals from being brought into custody as a place of safety under Section 136 of the Mental Health Act 1983,[4] except in exceptional circumstances. The force reported only three such instances in the 12 months to 31 December 2016 (see also paragraph 4.3). There were good arrangements to improve outcomes for people with mental health problems. A mental health triage car operated across the force area, providing advice and assistance to police officers and where possible offering alternatives to avoid these vulnerable individuals being taken into custody (see also paragraphs 4.3 and 6.74).

3.16 There were some diversion opportunities aimed at preventing and minimising reoffending. The force had recently reviewed its diversion pathways and identified improvements needed, such as ensuring that opportunities were available to non-English-speaking detainees. There was a scheme, supported by the Police and Crime Commissioner, to help young people who have offended or who are at risk of offending into training and work. There were also a number of local schemes which custody sergeants could consider referring to as part of any disposal for a detainee – for example, an anger management course.

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

Section 4. Pre-custody: first point of contact

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

Assessment at first point of contact

4.1 Frontline staff demonstrated a good understanding of vulnerability and the difference this could make in responding to calls, both in the call centre and at incidents. Call centre staff accessed information from a number of sources to relay to response officers attending the scene. There were no partner agencies based in the control room, so call centre staff had to obtain any necessary multi-agency information from the intelligence unit and/or specialist protection teams. Response officers told us that that they generally received sufficient information from the call centre to assist them in making their arrest decisions, and were able to supplement this by accessing the incident log through their mobile devices.

4.2 Frontline staff had received training on identifying vulnerabilities and assessing risk – for example, on mental health and child sexual exploitation – and had found this useful. Response officers also had prompt cards to assist in the assessment of a person's vulnerability, although most of those we spoke to felt well informed and no longer needed to rely on the cards.

4.3 Response officers had a good understanding of mental health issues, including the Mental Capacity Act 2005. They felt well supported by the mental health triage cars in dealing with incidents involving people with mental health problems, which helped to avoid taking them into custody (see also paragraph 6.74). They took people detained under section 136 of the Mental Health Act 1983 directly to health-based places of safety and avoided custody (see paragraph 3.15). However, officers told us that dealing with individuals with mental health problems was becoming increasingly challenging. For such individuals who were not detained under section 136, officers told us that they often had no choice but to take them into custody because they had committed an offence, or were under the influence of drugs or alcohol and would not be accepted at a hospital or other health care facilities. This resulted in people with mental health problems being detained in custody and subsequently requiring a mental health assessment to determine the next course of action.

4.4 Response officers recognised the importance of diverting vulnerable people and children away from custody and avoiding their criminalisation. They were able to make referrals to a number of diversion schemes, such as the Prince's Trust, aimed at preventing or minimising reoffending. They were also clear about their responsibilities to refer any safeguarding concerns for children or vulnerable adults through the safeguarding portal, so that it could be dealt with by the appropriate agency. In particular, officers were focused on avoiding taking children into custody, and used a range of alternatives such as arranging a voluntary interview at a later date or community resolutions (see also paragraph 5.21). When children were the subject of a planned arrest, officers timed this for the morning, so that they could be dealt with as quickly as possible and avoid any overnight detentions.

4.5 There were satisfactory arrangements for transporting people to custody from the point of arrest. Officers used their cars or police vans, depending on the detainee, risk and circumstances. For people with mobility issues, a taxi was used. It was force policy to transport people in a mental health crisis by ambulance, rather than in police cars. However,

because of delays in ambulances arriving, response officers, following a risk assessment, sometimes transported the detainee in a police vehicle in order to get help for the detainee as quickly as possible.

4.6 Response officers routinely handcuffed detainees, including vulnerable people and children, while transporting them to custody, rather than carrying out individual assessments of the risks posed. The application of handcuffs and any other force used was captured on the detention log, and response officers also recorded this in their statement. However, due to the lack of monitoring of use of force, the force had no way of knowing or demonstrating whether uses of handcuffs were justified and appropriate (see paragraphs 3.7 and 6.11, and area of concern 2.51).

4.7 Frontline officers rang custody suites in advance of bringing in detainees, which in some cases gave custody sergeants the opportunity to challenge whether the arrest was necessary at an early stage. Response officers were expected to provide robust justification for arrest and were aware that custody sergeants would refuse detention if this was not presented. Response officers took responsibility for providing any relevant information about the detainee at the booking-in stage, as well as responding to the formal questions asked by custody staff as part of this process. We observed some good information exchanges and clear justifications being provided for the need to arrest and detain, although this information was not always given directly to the custody sergeant (see also paragraph 5.19).

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

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

Respect

5.1 Custody staff in all roles communicated both with and about detainees in an engaging, respectful and compassionate way, establishing a positive rapport with each individual. Most of the interactions that we observed, during both booking-in and regular welfare checks, indicated that custody staff were mindful of detainees' welfare, although this was less evident during PACE reviews.

5.2 Arrangements for identifying vulnerability and diverse needs were good. Custody sergeants and detention escort officers (DEOs) used a comprehensive risk assessment process when booking people into custody, asking them specific questions about their particular needs, including those relating to religious worship, dietary requirements, female-specific welfare issues, mobility, care responsibilities and vulnerabilities. This systematic process ensured that all such issues were highlighted, so that they could inform the management of these individuals during their detention (see also paragraph 5.11), and resulted in some good outcomes for detainees. For example, at Perry Barr we saw two different women being provided with opportunities to organise care arrangements for their children. Staff knowledge and awareness of these issues were also generally good, some of which had been underpinned by specific training (such as guidance on dealing with autistic and transgender individuals) (see also paragraph 3.10).

5.3 While female detainees' needs were generally identified, and their particular vulnerabilities recognised, the quality of the provision to address these was mixed. Female officers were not available on every shift, so it was not always possible for female detainees to speak to one. Although freely available and usually offered automatically, the selection of feminine hygiene products available was poor.

5.4 The levels of privacy afforded to detainees during booking-in were often inadequate. Although cell toilets were obscured on all CCTV monitors, at Solihull the screens displaying footage from the cells was clearly visible to anyone standing near the booking-in desk, including other detainees. Showers in many of the suites, including the new facilities at Perry Barr and Oldbury, offered little privacy from accompanying staff (see also paragraph 6.19).

5.5 Booking-in areas at the older suites, particularly Coventry and Bournville, were extremely cramped and offered little possibility for discreet communications, so would have been unlikely to encourage sensitive disclosures by detainees to custody staff. These problems were compounded by the lack of a separate booking-in desk at these suites. Although the new suites offered more physical space and separation, the poor acoustics of these buildings made it difficult for staff and detainees to hear each other during particularly busy periods. There was access to discrete booking-in areas for vulnerable detainees at the newer suites.

5.6 Although staff were not always familiar with their location, the resources available allowing detainees to observe their religion, including texts and prayer aids, were good. Sufficient supplies were held and items were stored respectfully, with accompanying guidance available to assist staff. Markings to denote the direction of prayer for Muslim detainees were also common throughout the custody estate.

5.7 For detainees with disabilities or mobility issues, arrangements were mixed. Two of the three suites designated as Disability Discrimination Act compliant (Bloxwich and Willenhall) were being used as a contingency resource only. The other (Oldbury) did not have a wheelchair, thicker support mattresses or raised cell benches for those with restricted movement (see also paragraph 6.1). The remaining suites were unsuitable for detainees requiring mobility support. Force custody policy required arresting officers to identify any such detainee needs when contacting the force control room, so that these individuals could be allocated to an appropriate facility. However, the confusion about the application of this policy in regard to the suitability of the various suites would have hindered this process. The needs of foreign national detainees who did not speak English were not always met adequately.

Areas for improvement

5.8 **Booking-in desks should allow effective and private communication between detainees and staff.** (Repeated recommendation 4.9)

5.9 **Female detainees should have access to female staff at all times, and the selection of feminine hygiene provisions should be improved.**

5.10 **Force policy and arrangements for the management of detainees requiring physical and mobility support should be improved.**

Risk assessments

5.11 Detainees rarely had to wait outside in vehicles, and most were booked in quickly. Custody sergeants and DEOs booked detainees into custody, and there was generally insufficient oversight of this process by sergeants. Custody staff interacted well with detainees when completing risk assessments. In addition to going through the comprehensive risk assessment template, staff asked supplementary questions to elicit helpful information from detainees (see also paragraph 5.2).

5.12 Custody staff identified detainees' initial risks effectively. Police national computer warning markers and historical information on the custody record system were routinely cross-referenced to inform risk assessments further. However, the subsequent recording of care plans, particularly the required frequency of observations, was often poor. In 15 of 47 records we reviewed, we were unsure of the required levels of observation and in 30 records we found evidence of the required frequency not always being adhered to (see also paragraph 6.35). However, when required, there was good use of higher levels of observation. Since the previous inspection, there had been a death in custody which had been investigated by the IPCC. Progress against some of the recommendations made, particularly concerning levels of observation, was inadequate.

5.13 Notwithstanding the death in custody, staff were clearly focused on keeping detainees safe. They showed good attention to individual care for vulnerable people and we saw appropriate dynamic and responsive risk assessment when risk levels changed. They responded proactively when rousing sleeping/intoxicated detainees, and this was well documented.

Designated staff made good use of CCTV monitoring, which enhanced physical checks, and we observed staff responding quickly to incidents viewed on CCTV.

5.14 However, some practices were unnecessary and disproportionate to the risks posed. Footwear and clothing with cords were removed routinely, including for detainees assessed as low risk. This was contrary to the force policy, which indicated that this decision should be made after conducting a risk assessment and that the removal of clothing should be justified and recorded. The use of paper suits to replace detainees' clothing was not routine but they were sometimes used to offset the risk of self-harm, which we considered to be demeaning and ineffective, and also contrary to force policy.

5.15 The quality of shift handovers varied across custody suites but generally did not include all staff. At the older suites, the content of handovers was properly focused on detainees' case progression and welfare. At the two new suites, most sergeants had little personal contact with detainees and often handed over only the information logged on the custody record system, the quality of which we also had concerns about. In one custody record, a sergeant noted that he had received no handover and had 'self-briefed' about the detainee, which was inadequate.

Areas for improvement

5.16 Levels of observations should be recorded clearly on the custody record system and the required frequency of observation should always be adhered to.

5.17 Detainees' clothing and footwear should be removed only on the basis of an individual risk assessment, and more effective alternatives to using paper suits should be used, to minimise the risk of self-harm.

5.18 Arrangements for shift handovers should be improved.

Individual legal rights

5.19 Custody sergeants did not always ask the arresting officer, in the presence of the detainee, for a full explanation of the circumstances and reasons for arrest before authorising detention when this information was initially provided to a DEO. However, when asked, frontline officers had a good understanding of PACE code G[5] and the necessity criteria to justify arrest (see also paragraph 4.7).

5.20 Sergeants told us that they were confident in refusing detention when the circumstances did not merit it, and they were able to provide details of such cases – such as when a detainee had had clear health issues, resulting in the arresting officers and detainee being diverted to hospital instead.

5.21 Alternatives to custody were available through community resolution, [6] voluntary attendance[7] and street bail,[8] the latter being used to a much lesser degree (see also

---

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

6 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.

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.

paragraph 4.4). Facilities for interviewing voluntary attendees outside of custody were available at all police stations but we could not establish how effective this was as a diversion from custody as the force was unable to provide any reliable data on its usage (see also paragraph 3.6).

5.22 Most detainees were booked in promptly on arrival at the custody suites but in some of the cases we audited, we found delays of up to 48 minutes between detainees arriving and their detention being authorised. In our CRA, the longest delay for a detainee waiting to be booked in involved a 13-year-old girl, who waited two hours 36 minutes, and the overall average waiting time was 25 minutes. During a night visit to Perry Barr, we observed the longest waiting time to be 28 minutes. Such delays were unacceptable, particularly when they involved vulnerable detainees, as these individuals mostly remained in handcuffs until brought to the booking-in desk (see also paragraphs 4.6 and 6.11).

5.23 Custody sergeants were aware of the need to keep the time in detention to a minimum and to progress cases quickly. We were told, and observed, that investigations were not always progressed in a timely manner because of a number of factors, such as the non-availability of investigating officers. On one day during the inspection at Perry Barr, at noon we checked if all detainees had been allocated an investigating officer, and found that four detainees who had been held from between 5.10pm and 9.30pm on the previous day were still waiting for allocation, which was poor. Delays were also experienced owing to the non-availability of AAs (see also paragraph 6.38) and interpreters. At Wolverhampton, we saw two female detainees, one of whom was only 17 years of age, who had been held in custody overnight, waiting for the attendance of a Romanian interpreter, which lengthened their stay in detention by an additional 12 hours (see also paragraph 5.34). We were also told that there could sometimes be delays in releasing detainees due to there being insufficient staff on duty who were trained to take fingerprints and DNA samples (see also paragraph 3.1). In our CRA, the average total time held in custody across the force was 15 hours five minutes, which was significantly higher than the force comparator figure (forces inspected between March and December 2016) of 12 hours 26 minutes.

5.24 We also found detainees remaining in custody for longer than necessary because GEOAmey, the local prisoner escort and custody service contractor, did not always attend promptly to pick up detainees who had been recalled to prison.[9] In two custody records we examined, the detainees had been recalled to prison and had remained in police custody for just over 27 hours and 34 hours, respectively. Custody staff told us that it was routine for such a detainee to be transferred to prison on the day after they had been arrested, and they were usually left until the end of the court working day before being picked up.

5.25 Home Office Immigration Enforcement staff were based full time at Oldbury and Perry Barr custody suites, which had resulted in a streamlining of processes when dealing with immigration detainees at these suites. These staff operated between 8am and 4pm, from Monday to Friday, with cover provided at weekends from a local immigration office. Custody and Immigration Enforcement staff alike reported good working relationships and considered the joint working to be a positive initiative. We were told that, in most cases, immigration detainees who were to be transferred to immigration removal centres were moved on within 24 hours, although longer delays could be experienced. In the custody records we

---

[8] Street bail under Section 4 of the Criminal Justice Act 2003 enables a person arrested for an offence to be released on bail by a police constable on condition that they attend at a police station at a later date. One of the benefits of street bail is that an officer can plan post-arrest investigative action and be ready to interview a suspect when bail is answered.

[9] Prisoners who are sentenced to more than 12 months in prison may be released early on licence with conditions that they must adhere to. This means the individual is still serving a prison sentence but can live in the community instead of prison. If they breach any of the conditions of their licence, they can be recalled to prison to serve either a short period in prison or the remainder of their sentence.

reviewed, we identified two immigration detainees who had been held for just over 26 hours and 43 hours, respectively, following service of an IS91 warrant of detention.[10] Data supplied by the force showed that 909 immigration detainees had been held in the year to 31 December 2016, which was a 16% increase compared with the year to 31 December 2014. The data provided also showed that the average length of detention in police custody for immigration detainees following service of an IS91 warrant for the year to 31 December 2016 had been 19 hours 31 minutes. These overall detention times had improved since the previous inspection but were still too long.

5.26 During booking-in, custody sergeants and DEOs advised detainees of their three main rights[11] and detainees were routinely offered a written notice setting out their rights and entitlements; however, at Wolverhampton and Coventry these were considerably out of date (see also paragraph 5.42). Custody staff were able to access these notices in foreign languages for non-English-speaking detainees but few staff were aware that an easy-read pictorial version for detainees needing help with understanding or reading was also available. The rights and entitlements leaflet was not available in Braille.

5.27 We saw detainees being told that they could inform someone of their arrest, which staff sometimes facilitated while the detainee was present.

5.28 Detainees were told during the booking-in process that they could read the PACE codes of practice but these were not always explained by custody staff. We found only two copies of the up-to-date PACE code C across the entire custody estate; although each suite had a few out-of-date copies available, we did not see these routinely being offered to detainees to read.

5.29 All detainees were offered free legal representation and were told that if they declined, they could change their mind at any time. Detainees who declined the offer of free legal representation were asked why, and this was noted on the custody record. Those wishing to speak to legal advisers on the telephone could not do so in private as such calls had to be taken either at the booking-in desk or on cell corridors. There were sufficient consultation and interview rooms at all the suites, and legal advisers were given a printout of the front sheet of their client's custody record on request.

5.30 There was an effective daily system for collecting DNA samples taken in custody but we found many old DNA, blood and evidential samples in refrigerators and freezers in all of the custody suites, with the exception of Coventry. Some attempts had been made to clear these backlogs but without success. Custody staff were not clear about the circumstances under which DNA samples would be disposed of, which could have been misleading for detainees.

[10] An IS91 warrant of detention is served on an immigration detainee when there is no reasonable alternative course of action, e.g. if there is a likelihood they may abscond; their removal from the UK is imminent, etc.

[11] 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.

Areas for improvement

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

5.32 West Midlands Police should monitor the length of time that detainees, including prisoners recalled on licence and immigration detainees, are kept in detention, to ensure that there are no unnecessary delays in progressing their cases or in transferring them to prison or immigration removal centres where applicable.

5.33 Old DNA, blood and evidential samples in the refrigerators and freezers in custody suites should be removed and only current samples stored.

Communication

5.34 A professional telephone interpreting service was available to assist the booking-in of non-English-speaking detainees but it was not always clear from the custody records we reviewed if this service was used. Double-handset telephones were available at Wolverhampton and Solihull, which provided privacy, but not at Perry Barr, Oldbury and Coventry, where loudspeaker telephones were used, which lacked privacy and were sometimes difficult to use because of the noise levels in the suite. Staff told us that a face-to-face interpreting service was available for interviews but there were sometimes delays, depending on the language requested, resulting in some detainees remaining in custody for longer than necessary (see also paragraph 5.23).

5.35 A few custody sergeants were aware of the availability of documents – such as authorisation of detention, and charge details – in a range of languages.[12] Of those who were aware, some failed to find the location of these documents. There were no posters informing detainees of their right to free legal advice in languages other than English in any of the suites.

5.36 We found hearing loops at most sites and were advised that portable systems had been introduced into all of the custody suites a number of years earlier. However, many remained in the packaging as they had not been required. There was a recognition by managers that staff may not be aware of their existence and it was agreed that this would be addressed.

Area for improvement

5.37 Double-handset telephones should be available in all custody suites, to facilitate telephone interpreting.

Access to swift justice

5.38 Initial pre-charge bail was managed well, with consideration given to the personal circumstances of the detainee and the length of time available to complete enquiries. Our case audits showed some good recording of decisions, the rationale for bail being granted and the reasons for the conditions set. We observed custody sergeants deciding on bail periods and bail conditions, in discussion with the investigating officer and the detainee, and providing clear explanations to the detainee. In the case of children and vulnerable adults,

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

particular care was shown to ensure that they understood the meaning of the bail conditions and the consequences if they were breached.

5.39 However, the timescales set for bail were not always met, resulting in the need for detainees to be re-bailed. Our case audits and discussions with custody staff led us to conclude that these re-bails could have been avoided in many cases. Delays in investigations and the time it took for the Crown Prosecution Service to provide charging advice were sometimes unacceptably long, requiring bail periods to be extended, often several times. This led to some detainees waiting many months – and, in one case we examined, over a year – for their case to be resolved. The number of re-bails also had an impact on the setting of bail dates for new detainees. Some were on bail for longer than needed because an increase in the number of re-bails reduced the number of available appointments.

5.40 The arrangements for managing and monitoring bail varied across the suites. At Oldbury and Perry Barr, there were sergeants specifically allocated to fulfil this role but at the remaining suites it was absorbed into the sergeants' existing duties; this meant that at the latter suites, custody sergeants were not always able to review the records of detainees scheduled to answer bail as actively as the dedicated sergeants. However, across all suites, the effectiveness of these arrangements was hindered by the poor quality, and often the absence, of the investigation updates and the documentation of these on the custody records. This sometimes resulted in appointment slots remaining booked for a detainee answering bail who was no longer required to attend. In addition, we were told that bail was rarely extended without a personal visit to the custody suite, which blocked bail appointments that could have been used for other cases. This limited custody sergeants' ability to manage bail effectively and ensure that the bail appointments were used efficiently, so as to minimise delays for detainees.

5.41 As a result of involvement in the College of Policing pilot scheme for managing bail, the force was well prepared to implement the new bail legislation to be introduced from April 2017. Custody sergeants showed a good awareness of the new scheme and the force had started implementing an action plan to prepare the wider workforce for it, including training, briefings and guidance documents.

Complaints

5.42 No information on the complaints process was displayed in any of the custody suites; however, it was contained in the current version of the rights and entitlements notice routinely offered to detainees (but not available at Wolverhampton and Coventry) (see paragraph 5.26). Custody staff told us that if a detainee wished to make a complaint, they would notify the PACE inspector or duty inspector and it would be their decision whether to deal with the matter or leave it until the detainee was released. Some inspectors told us that if they were available they would note a complaint while the detainee was in custody, and we saw this taking place. However, we saw an inspector telling a detainee that their complaint could not be dealt with while they were in custody; this was contrary to force policy, which stated that complaints should be noted at the earliest practicable time.

Area for improvement

5.43 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 The physical conditions across the custody estate varied considerably. At the newer suites (Oldbury and Perry Barr), where more than half of all detainees were held, cells and communal areas were clean and maintained to a high standard. However, the conditions at the four older suites (Bournville, Coventry, Solihull and Wolverhampton), where a significant proportion of detainees were still held, were shabby and worn, with some of the cells having limited natural light. The corridors in the Coventry suite were dark and narrow. The floors in some of the cells at Solihull were stained and dirty. At Wolverhampton, the communal sink in the men's cell block was dirty. With the exception of Perry Barr and Oldbury, where men and women were held on the same corridors, all of the suites had designated accommodation for men, women and children, so they could be held in separate blocks. In Perry Barr and Oldbury, all cells had low benches and in each of the older suites, a small number of cells contained low benches, for use by detainees who were intoxicated (see also paragraph 5.7). In all of the suites, there were some cells monitored by CCTV.

6.2 The maintenance and cleaning of the suites were managed reasonably well. There was an efficient force-wide electronic system, 'SharePoint', through which damage to cells or facilities could be reported; most repairs were carried out without delay, and custody staff were positive about this process. Daily fabric checks were conducted by COAs, although at one site we observed that cells checks were not carried out. Weekly suite checks were conducted by custody sergeants, and monthly facility and health and safety checks by inspectors. We saw evidence of the regular checks recorded on the 'SharePoint' system. In-cell biohazards were removed promptly by an external contractor, which employed a trained team of cleaners.

6.3 There was little graffiti present in the suites. In the older suites, warnings were displayed in cells to inform detainees that they would be charged if they caused damage to cells or equipment. We identified several potential ligature points in cells and communal areas in each of the custody suites (see also area of concern 2.53). Exercise yards were in a reasonable condition but some were too small and had limited natural light.

6.4 The cell call bells we tested were functioning; however, we observed a 14-year-old detainee at Coventry and a 17-year-old at Oldbury being placed in cells without an explanation from staff about how to use the call bell. We saw some delays in responses to call bells when suites were busy. With the exception of Stechford, staff could speak to detainees in cells through an intercom at the booking-in desk.

6.5 There was evidence of regular fire drills taking place at each suite. Despite this, too many custody staff had limited knowledge about the emergency evacuation procedures. At Perry Barr, Oldbury and Coventry, staff were vague about the location of emergency evacuation packs and uncertain about where or how to evacuate detainees. At Oldbury and Perry Barr,

there were not enough handcuffs available in the emergency packs to evacuate all detainees safely from the suites at full capacity. The detail and quality of the written debriefs following a drill or evacuation were poor.

Areas for improvement

6.6 The cell call bell system should be explained to all detainees before they are located in their cell.

6.7 Staff should be aware of the emergency evacuation procedures in each suite and be able to locate the emergency evacuation pack, which should contain sufficient sets of handcuffs to evacuate all detainees safely.

Safety: use of force

6.8 The governance and oversight of the use of force in custody were inadequate. There was no collation or analysis of data concerning the use of force, and the force could not identify any cases for us to audit (see also section on accountability and area of concern 2.51). Data provided by the force showed that all custody staff were in date with their safety/personal protection training.

6.9 Through our CRA, observations and conversations with staff, we were able to identify 12 cases of the use of force, which we reviewed in depth and cross-referenced against CCTV. Individual use of force forms were not used and detention logs generally contained little or no information about the incident to justify why force had been used. We found learning points in three-quarters of the cases and referred one case back to the force for review. Managers did not review CCTV footage to satisfy themselves that the force used was always proportionate to the risks posed or to identify learning points.

6.10 Our analysis indicated that the force used was not always proportionate to the threat posed. Concerns from the CCTV footage included: poor use of techniques, some of which were potentially injurious to the detainee; prolonged prone restraint and pressure placed on the back of detainees in the prone position; unnecessarily large numbers of staff involved in restraint; and a detainee remaining in handcuffs while locked in a cell on his own.

6.11 Most detainees arrived in custody wearing handcuffs, mostly for compliant transportation. We saw many examples where handcuffs remained in place on compliant detainees for too long. This was disproportionate to the threat posed in the controlled custody environment (see also paragraphs 4.6 and 5.22).

6.12 The force was unable to provide any data concerning the number of strip-searches carried out in custody (see also paragraph 3.6 and area of concern 2.50). Strip-searching had taken place in 19% of the cases in our CRA, against a comparator of only 8% in the custody records for forces we inspected between March and December 2016. We saw a number of strip-searches authorised during the inspection and did not always consider that there was sufficient rationale to justify this. The records we examined also did not always indicate specific grounds for the strip-search. We were concerned that a 14-year-old girl had been strip-searched without the presence of an AA, and in another case a detainee had been asked to squat during their search, contrary to force policy (see also paragraph 3.3).

Area for improvement

6.13 Strip-searching should only be conducted when there are sufficient grounds, and the rationale for this should be clearly recorded on the detainee's custody record.

Detainee care and PACE reviews

6.14 A limited but generally adequate range of microwave meals was available, meeting various dietary needs, including vegetarian, vegan, halal and gluten intolerance requirements, although the vegetarian selections at Perry Barr and Wolverhampton were poor. Water, tea, coffee and hot chocolate were available. Breakfast consisted of cereal bars or a microwave breakfast, although there was no hot breakfast option for vegetarians.

6.15 All detainees were asked about their dietary requirements on arrival into custody. Pictorial guidance on meal suitability for each diet was available throughout, and staff regularly used this both for English- and non-English-speaking detainees, in order to communicate quickly and efficiently. Staff in all suites confirmed that force policy, which allowed them to authorise food items to be brought in by detainees' friends and family where appropriate, was rarely followed.

6.16 From our observations, case audits and speaking to staff, we were confident that detainees were able to receive food and drink regularly throughout the day. Staff often asked detainees if they wanted something to eat, including outside of 'standard' mealtimes, and confirmed that they would be happy to facilitate this and/or multiple requests when they were sure that it was in the person's best interests to do so. Offers of food and drink, and whether or not they were accepted, were also regularly recorded on custody logs. In our CRA, 129 (77%) of the 168 detainees reviewed had been offered a meal, including all 20 who had been held for over 24 hours.

6.17 Mattresses and pillows were readily available but at some suites (for example, Coventry) they were not disinfected between uses. Good stocks of blankets and replacement clothing were available at all suites, and we saw staff regularly and proactively offering blankets to detainees. Temperatures in the suites were generally comfortable, with the exception of Coventry, where staff confirmed that some cells were prone to excessively high or low temperatures due to their location and the poor air-conditioning system.

6.18 Other than at Coventry, where stocks were low, sweatshirts, T-shirts, jogging bottoms and plimsolls were readily available as replacement clothing for detainees whose clothing had been seized for evidential purposes or had been soiled. Staff told us that they would allow friends and family to bring in clothes for detainees, particularly those staying in custody over the weekend. However, force policy governing detainees' retention of personal clothing and the provision of replacement items was both contradictory and confusing; it stated in one place that custody staff should risk assess detainees before considering if there was a need to remove items such as belts and corded clothing for safety reasons, and elsewhere that such items should be confiscated automatically. There was also inconsistent practice regarding the removal of shoes, with some staff stating that they would let detainees keep shoes without laces, but others saying that they would not. Although plimsolls were available at all sites, we rarely saw these being used, with detainees moving around the suites in their socks.

6.19 Cotton towels were available at all suites, along with hygiene products including razors, shaving cream, shower/shaving gel, toothbrushes, toothpaste and combs. However, arrangements for detainees to take a shower were limited, and in some places poor (see also paragraph 5.4). We identified some concerns about the shower facilities provided, and the

privacy they afforded, at Perry Barr and Oldbury, despite being new. Those at Perry Barr were in particularly poor condition, with three of the five available showers out of use because of poor water drainage. At Oldbury, the shower for detainees with disabilities was unavailable due to a faulty door. The arrangements at Coventry were also poor, with only one shower available; this was located beyond a 'swing door' entrance, with a small changing area immediately beyond it with no further cover provided, compromising privacy.

6.20 Staff at all suites told us that they would offer detainees a shower whenever possible, particularly those detained overnight who were attending court the following morning, but some also acknowledged that it was not always operationally convenient to do so, and they relied on detainees requesting this rather than offering it proactively. A few detainees took showers during the inspection. In our CRA, only 8% of the detainees in the records reviewed had been offered a shower, including only 25% of those held for over 24 hours. It was unclear whether this could be attributed to the staff's failure to provide the facility, accurately record when they had or both.

6.21 All custody suites had at least one outside exercise area, and staff said that exercise would be facilitated with an accompanying member of staff present. The yards were mostly private and out of sight from nearby buildings, except at Wolverhampton and Stechford, where the adjacent police station and staff car park overlooked the yards. One of the two exercise areas at Perry Barr was in a poor condition, with standing water and moss covering the ground, while staff at Coventry said that the yard often flooded. In our CRA, only four out of 168 detainees (2%) in the records we reviewed had been offered the opportunity to exercise, including one of 20 detainees held for more than 24 hours, and none of the nine children reviewed.

6.22 The stock of reading materials for detainees at Perry Barr was reasonable, and at Wolverhampton a little less so, but at the other suites was poor. Overall, there was little provision for children or in languages other than English, with stocks at Coventry particularly poor in variety and condition. Staff told us, and we observed, that they offered these items to detainees regularly, primarily during routine welfare checks, although we found little evidence of such provision in the custody records reviewed during our case audits. Similarly, in our CRA, we found that only16 (10%) detainees had been offered something to read, including five (25%) of those held for over 24 hours. None of the nine children included in our analysis had been offered anything to read.

6.23 Perry Barr and Oldbury had bespoke visits facilities, although these were of limited size and not suitable for use by those with mobility issues. The other custody suites had no such provision. Staff told us that they rarely facilitated visits, with only one member of staff being able to provide an example of when this had been allowed.

6.24 PACE review arrangements varied considerably across the force. At Oldbury and Perry Barr, a dedicated PACE inspector, with responsibility for undertaking reviews and managing issues relating to detainees' management, remained on-site at all times. However, at the other custody suites, reviews were conducted by duty 'response' inspectors based off-site, who held multiple portfolios of operational responsibility. We were told that the latter inspectors monitored the detention times of detainees and tried to conduct reviews in person rather than over the telephone. This was supported by the findings of our CRA; of 110 records (66%) in which a PACE review had been required, 41 had taken place while the detainee was asleep and 64 had occurred in person,[13] with no evidence of telephone reviews taking place. Only one of 59 detainees requiring a second PACE review had been reviewed by telephone. However, some custody staff said that duty inspectors often conducted detainee reviews all

[13] Of the remaining five, two were in an interview, two were at hospital and one was 'unfit' to receive a review.

together at the start of their shift, irrespective of whether the review was due at that time or whether the person was asleep.[14]

6.25 During the inspection, we observed some good face-to-face PACE reviews that were timely, appropriate and conducted with due care and consideration of the detainee's welfare needs. However, we also observed some that were more basic, with more focus given to completing the process than addressing the individual's concerns or needs. We also found examples in the custody records we audited of reviews taking place up to several hours early, with no apparent or stated justification for doing so, which was not always in the best interests of detainees. We also identified an error with the custody recording system, with many reviews labelled as taking place 'in person' with the detainee, when the free text described them as being asleep at the time. For detainees who had been reviewed while sleeping, we found no evidence that they had been informed of this, reminded of their rights and entitlements, or given an opportunity to make representations on waking.

6.26 In our CRA, the timeliness of completion of reviews was mixed, with 15 of 110 first reviews and 15 of 59 second reviews being completed early. For four of the six children whose cases were reviewed in our analysis and required a PACE review, this had been carried out while they were asleep; for the remaining two this had been carried out face to face.

Areas for improvement

6.27 Cell mattresses and pillows should be routinely disinfected between uses.

6.28 Force policy on the confiscation of detainees' personal clothing should be reviewed, to ensure that it is consistent.

6.29 Appropriately diverse selections (age, gender, language, type) of reading materials should be available in all suites.

6.30 All detainees, particularly those held for longer periods, should be offered exercise and showers routinely, and able to shower with a reasonable level of privacy.

6.31 Detainees held for longer periods should be offered the opportunity for family visits.

Safeguarding

6.32 Custody staff had a strong focus on protecting detainees from harm. We observed some good and reassuring interactions between custody staff and detainees. Staff used appropriate language with children and vulnerable adults, providing clear explanations of the custody process and checking that these had been understood.

6.33 Safeguarding guidance was included in the custody operating manual. Although specific training on safeguarding had not been delivered consistently to all staff, frontline and custody staff generally showed a good understanding of safeguarding issues and the resulting needs of detainees. From our observations and discussions with staff, we were confident that such

[14] Section 15C of PACE code of practice (code C) permits reviews to be conducted early if the person is likely to be asleep when their review was originally due if it means this can be done in person.

concerns would be identified and raised with arresting or investigating officers, so that referrals would be made and appropriate actions taken.

6.34 There was effective assessment of risks for vulnerable adults and children, which involved health services professionals as necessary, to ensure that appropriate care and support were provided. Children were placed on 30-minute cell visits as a minimum, and when there were particular concerns they were constantly observed by staff either on CCTV or in person, as appropriate. Girls were allocated a female member of staff to look after their needs. This provided a good level of care for them, and we saw a particularly good example of a 14-year-old girl with mental health problems being well cared for through frequent interactions and being dealt with as quickly as possible.

6.35 However, our case audits and observations showed that these 30-minute visits were not always carried out at the required times. In addition, in some custody records the required visit frequency had not been clearly stated. This could have left some detainees at risk and the force unable to demonstrate that it was consistently protecting detainees from harm, in line with its policies (see also paragraph 5.12).

6.36 Custody staff generally tried to keep children away from adult detainees while in custody. Most children were placed in juvenile cells, with the two newer suites having a dedicated wing for children. We observed a clearly distressed 15-year-old boy being allowed to sit in a glass-fronted holding room with his AA, rather than being placed in a cell.

6.37 In the new suites, some use was also made of the separate booking-in areas for children and particularly sensitive cases. However, even though these facilities were available, we observed a number of children being booked in at the main desks, sometimes alongside adult detainees whose behaviour and language was challenging and inappropriate for children to observe and hear.

6.38 The arrangements for securing AAs, both for children and vulnerable adults, were not fully effective. Parents, other family members or existing care home or social workers were relied on to attend as AAs. Although arresting officers assisted by trying to identify a suitable person to act as an AA at the time of arrest, which could speed up the process, it was often some time before an AA arrived at the suite. They were usually asked to attend for the time of interview, which could be several hours after the detainee's arrival at the suite – or the next day for detainees brought in late at night. This meant that detainees did not benefit from independent support early on in their detention.

6.39 When AAs could not be arranged in this way for children, a request was made to children's social services to provide a member of staff to attend under their statutory duty. Although custody staff told us that these requests were usually met promptly, the service was not available on a 24-hour basis and custody staff told us that they would be unlikely to make a request after 9pm. There were also particular difficulties if the child had come from another local authority area or had been placed in a care home from outside the area, as it was then unclear as to which local authority was responsible for providing the AA, leading to unnecessary delays.

6.40 There was no statutory duty for social services to provide an AA for vulnerable adults. In these cases, custody staff or investigating officers resorted to ringing round a list of volunteers held at each of the suites. Attendance was dependent on the goodwill of volunteers and, although some were willing to attend late at night or in the early hours of the morning, custody sergeants were reluctant to take advantage of this, and said that they would only request this on an exceptional basis. As a result, vulnerable detainees could have a long wait before receiving support from an AA to ensure that they understood their rights and entitlements and what would happen at key stages of the custody process.

6.41 In our CRA, the average wait for an AA was 11 hours 35 minutes. Our case audits suggested a similar picture. There were some examples where no AA had arrived to support the detainee.

6.42 Record keeping in relation to AAs was poor, with request and arrival times not always recorded. In addition, the records did not always make clear the relationship between the AA and the detainee, and at what time the rights and entitlements had been re-read in the presence of an AA – or even whether this had been done at all. This was unsatisfactory as the force had no means of assuring itself and others that children and vulnerable detainees were receiving timely and effective support, or to identify where improvements were needed. The evidence from our case audits, observations and discussions with staff showed that some detainees were being let down by not receiving a timely service.

6.43 During our observations in the suites, we saw little evidence of family members/friends acting as AAs being advised about the role they were expected to perform. Custody sergeants sometimes gave a verbal explanation of the role but written advice and information was not always issued in line with good practice.

6.44 The force had recognised some of the difficulties in securing AAs, and responsibility for providing the volunteer scheme had been transferred to the Office of the Police and Crime Commissioner. One of the challenges faced was that most of the volunteers on the current scheme were also ICVs. Although the two roles of AA and ICV were kept separate in terms of attendance at the suites, there was the potential for a conflict of interest that needed to be addressed. At the Coventry suite, students from the local university acted as volunteers for the AA scheme, and although there were some limitations regarding availability, this was a good initiative.

6.45 Custody sergeants had a good focus on minimising the length of time that children spent in custody and avoiding overnight detention. They sought to deal with children quickly and used bail, where appropriate, to achieve this. However, some delays occurred as investigations were not always conducted as quickly as possible and/or there were sometimes difficulties in obtaining an AA. Our CRA showed that, in the cases we reviewed, children had spent an average of just under 10 hours in custody, with a number detained overnight.

6.46 Between 1 January and 31 December 2016, 5,336 children had been detained in custody, accounting for 9% of the total number of detainees. A significant proportion of these would have been detained overnight. The force monitored the number of children charged and refused bail but not the number detained pending the investigation, which limited their ability to understand and identify ways of minimizing the length of time that children spent in custody, and whether overnight detention could be avoided (see area of concern 2.52).

6.47 The force had improved its approach to obtaining alternative accommodation for children charged and refused bail, to avoid them spending the night in custody. Custody sergeants requested this accommodation from children's social care services, and logged the details accordingly. If no accommodation was offered, the case was escalated to an inspector, to make a further request and log the outcome. This information was monitored by the force and reports were made to the local safeguarding children's boards (see also paragraph 3.14). However, despite this strengthened approach, the improvement had been limited. Of the 384 children charged and refused bail in the year to 31 December 2016, alternative accommodation had been requested in 239 cases but provided for only 22 children. It was not clear how many secure beds had been requested but custody sergeants told us that there were no secure beds available locally, so even if a bed were to be offered, the geographical distance for transporting the child made it impracticable to take up. As a result, most children were detained overnight.

6.48 Children from care homes detained because of violent behaviour at the home could spend long periods in custody before they could be returned safely or found alternative accommodation. We saw a boy brought into custody in the early hours of the morning who, because of his behaviour, was unable to return to his care home. He was bailed for a youth offending team assessment the following day but, despite ongoing liaison between the custody sergeant, the care home manager and the social worker, no alternative accommodation was found before he left custody. He was released to the care of the investigating officer, after spending a total of 15 hours in custody, to await his new accommodation details.

Areas for improvement

6.49 The arrangements for securing appropriate adults (AAs) should be improved, to ensure that children and vulnerable adults consistently receive early and effective support while in custody.

6.50 Record keeping in relation to AAs should be improved, in order to assess waiting times accurately and identify other areas that require improvement.

Governance of health care

6.51 Nestor Primecare Services Limited, known as 'Primecare Secure', delivered all physical health care services through a shared contract between West Midlands and Staffordshire forces. The force expressed concerns about the effectiveness of this contract, and we shared these. The nursing workforce was significantly understaffed, with the team carrying 8.5 vacancies out of 31 whole-time-equivalent posts. We found that shifts were not always covered and detainees not always seen within agreed contractual timescales, which could have had an impact on health outcomes. The nursing team had no effective operational or clinical leadership (see also paragraph 3.5 and area of concern 2.49). In addition, there was limited managerial and clinical supervision, with many staff left to 'self-manage', including, for example, covering duty rotas. Policies and procedures were held on the computer system, which was not always available to visiting agency staff.

6.52 We saw limited evidence of clinical governance arrangements to promote improvement or professional learning. Primecare Secure did not have an independent complaints system, although detainees dissatisfied with their care or treatment could raise a complaint through the police complaints system. During the inspection, we came across two significant health care complaints that had been raised by the police, which were only escalated when we raised these with Primecare Secure.

6.53 Oversight of all aspects of health care was considered at monthly performance meetings, chaired by the police, and the strategic development of detainee care had seen services improve in areas such as substance misuse and mental health provision.

6.54 All health care practitioners (HCPs) had undergone intermediate life support training and custody staff underwent resuscitation training, which included the use of automated external defibrillators (AEDs). Although all custody areas had AEDs, the emergency equipment was inadequate; there was no oxygen or standardisation of kit, and no routine checking of this equipment.

6.55 Although consent was sought for any sharing of clinical information, clinical details were routinely shared with the police through the supply of an 'MK 62' form. In addition, we were

told that the police often copied this information into the police log, so it potentially became available to third parties.

6.56 Each suite had an identified treatment room. The rooms at Wolverhampton, Coventry and Solihull did not meet infection control standards. The rooms at Wolverhampton and Coventry were cluttered, showed signs of wear and tear, and appeared poorly maintained. The Coventry room was particularly grubby, with dust, congealed dirt and an overfilled sharps box. None of the suites offered discrete facilities for forensic sampling, even the newer suites at Perry Barr and Oldbury, where the treatment rooms were generally good. The treatment areas in the latter suites had a discrete section for nurses and another for doctors.

Areas for improvement

6.57 The service should ensure that staffing is sufficient to meet the needs of detainees.

6.58 Clinical governance processes should be fully integrated into the work of the provider, to include provision of a confidential complaint system.

6.59 Custody staff and health care professionals should have access to emergency equipment which is of an agreed professional standard and is regularly maintained and checked.

6.60 Clinical information relating to detainees should not be appended to police record systems, and the physical health care provider should ensure that only health contacts and any pertinent risk information are noted in the custody record.

6.61 There should be robust infection control procedures for all the clinical rooms, which should be clean and capable of being used for the taking of forensic samples. (Repeated recommendation 6.9)

Patient care

6.62 Doctors and nurses offered good face-to-face support to detainees. Staffing arrangements included one nurse embedded at the Perry Barr and Oldbury suites, with two nurses on site in both of these areas from Thursday evening to Monday morning. According to the contract, nurses were expected to initiate most contacts, covering around 80% of all interventions. However, in reality the situation was more complicated, with staff redeployed to mitigate emergent risk. In addition, a 'roaming nurse', located at Wolverhampton, also had responsibility for the Watling custody suite and sometimes the Burton-on-Trent suite, both of which were located in Staffordshire. Another roaming nurse provided cover to the Coventry and Solihull suites, and under the contractual arrangements also covered suites in Warwickshire.

6.63 Requests to see detainees were graded according to clinical need and criminal justice requirements. In our CRA, the average waiting time to see an HCP was one hour 52 minutes, with the expectation that calls would be responded to within one hour 30 minutes. Police and frontline clinical staff described nurse input as stretched and we were told that there were some delays in meeting performance targets due to nurses having to cover areas outside of the West Midlands area.

6.64 The quality of the health records we scrutinised were of a reasonable standard. A combination of electronic and handwritten records was used, which did not facilitate continuity of care and could result in clinical risks not being identified. We were told, and witnessed, that handwritten records were removed from suites, which did not comply with information governance standards. We also found handwritten records which were not stored confidentially.

6.65 Detainees could continue with prescribed medication in custody, including opiate substitution treatment. Symptomatic relief was provided for detainees withdrawing from drugs or alcohol when clinically indicated. However, this was not responsive enough, which could put detainees at risk. Nicotine replacement therapy was not available.

6.66 Medicines management was a serious concern. At Wolverhampton and Coventry, routine stock checks were inconsistent, with some major stock discrepancies (missing medicines). At Solihull, medication records indicated that stock discrepancies were also an issue there. These issues had not been escalated to managers, and there had been no investigations. Medicines management at Perry Barr and Oldbury was appropriate.

Areas for improvement

6.67 Adequate local managerial support should be provided for health care frontline staff.

6.68 Record keeping and record storage should comply with information governance standards and ensure effective continuity of care.

6.69 Medicines management arrangements should ensure that the stock is secure and fully accounted for, with any discrepancies being fully investigated.

Substance misuse

6.70 A number of community-based substance misuse services provided support to custody suites across the West Midlands. Reach out Recovery provided in-reach services to Perry Barr and Bournville, Monday to Friday, from 8am to 7pm; out of hours, custody staff could refer detainees to the service. Integrated Recovery in Service (IRIS) provided a six-day service at Oldbury. Recovery near You provided services at the Wolverhampton suite. Solihull Integrated Addiction Services (SIAS) provided in-reach services to the Solihull suite, and The Recovery Partnership provided in-reach services to the Coventry suite.

6.71 These services were similar in nature, with substance misuse workers visiting most suites from Monday to Friday, and some services offering weekend cover. Input included support to arrest diversion schemes, liaising with local courts and facilitating access to support in the community, including harm minimisation advice. Young people were not ordinarily seen but were referred into age-appropriate services. Staff we met were motivated and competent. The respective teams had access to good training and were valued by detainees and custody staff alike, and we judged the provision for detainees with drug or alcohol problems to be reasonably good overall.

Mental health

6.72 Birmingham and Solihull Mental Health NHS Foundation Trust provided liaison and diversion services to the Perry Barr, Solihull and Bournville custody suites, with an embedded team located at the Perry Barr suite. The service operated from 8am to 8pm on Monday to Friday, and from 8am to 4pm at weekends. The Black Country Partnership NHS Foundation Trust, in partnership with Dudley and Walsall Mental Health Partnership NHS Trust, provided embedded liaison and diversion services to the Wolverhampton and Oldbury suites between 8am and 8pm, seven days a week. Coventry and Warwickshire Partnership Trust provided liaison services to the Coventry suite.

6.73 Providers worked closely together, with teams operating on broadly similar lines. Teams were staffed predominantly by mental health nurses and each service liaised with community mental health teams when a detainee was already known to the service. All detainees considered as vulnerable were seen by the teams, including those who were homeless. Detainees were actively supported and signposted to a number of other agencies when appropriate, and some areas offered direct community follow-up. Teams 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 extremely positive about the services that the teams provided, and we considered the support offered to detainees to be very good and timely.

6.74 Street triage schemes and diversion to hospital and community services were a valued resource in diverting detainees with mental ill-health away from custody. The teams comprised police officers, mental health nurses and paramedics, and they were able to assess risks and offer less restrictive support options. This had reduced the number of people taken into police custody, and the number requiring a health-based place of safety or hospital bed; in the previous 12 months, there had been only three uses of custody suites as a place of safety under section 136 of the Mental Health Act (see also paragraph 4.3). These services were among the best we had seen.

6.75 The force had a mental health lead and there were robust joint working arrangements between the police and mental health services at local and strategic levels involving each trust and relevant local authority, which ensured that detainee outcomes were monitored effectively.

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 In our case audits and in the records we reviewed, the recording of pre-release risk assessments was mostly poor and inconsistent; the records generally contained little indication that risks were routinely addressed and it was often unclear how detainees were getting home. In one custody record we reviewed, a detainee was bailed and released at 3.22am but had had no pre-release risk assessment completed, so it was unclear how they would get home at that time of the morning.

7.2 However, our observations provided assurance that, in most cases, the working practice was actually better than reflected in the records. In contrast to the situation with initial risk assessments (see paragraph 5.12), custody sergeants did not take a uniform approach to pre-release assessments, even though the custody computer system offered a drop-down menu to facilitate these; we were told that this menu would only be used in exceptional cases. Individual custody sergeants had adapted their own 'script' of questions to consider, and simply added free-text entries to cover the pre-release process, which led to an inconsistency in the amount of detail recorded. The force custody policy stipulated that vulnerable detainees should be transported home by officers or by a dedicated taxi firm (with which the force had a written agreement and whose drivers had been vetted), and we found some evidence of this taking place in the custody records we reviewed. However, we observed that not all sergeants checked that detainees had the means to get home, with the assumption being that they would ask for assistance if they needed it. We saw a female detainee who disclosed that she had no funds being released wearing a T-shirt and sweatshirt in damp weather as the custody sergeant considered her fit enough to walk several miles home with a fellow detainee, who had been released just before her.

7.3 A support leaflet with useful telephone numbers was available but was rarely given to detainees on their release. Sergeants were aware of the specific offences and circumstances that made detainees more at risk on release. It was the responsibility of investigating officers dealing with detainees involved in sexual offence cases to provide initial support details, and this was reinforced by custody sergeants before release.

Area for improvement

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

Courts

7.5 At Perry Barr and Oldbury, GEOAmey, the local prisoner escort and custody service contractor, had introduced measures whereby some of their staff started work early at these suites, to streamline the processes when dealing with large numbers of detainees attending

court. This involved checking the person escort records (PERs) and sorting the corresponding detainees' property in advance of the detainees being received and transferred onto waiting vehicles. We saw this working well at both sites but there was little supervision of the process at Perry Barr.

7.6 Staff appeared to be confused about the time that local remand courts would normally stop accepting detainees each day. Some told us that a detainee would not be accepted any later than 1pm but others said that there was some flexibility on a daily basis, and that they would always contact the court to see if a detainee could be accepted. Some sergeants told us that the lack of GEOAmey transport was a delaying factor in getting detainees to court as they had been instructed not to use police vehicles for this purpose.

7.7 We saw one woman at Oldbury who was not transferred to court in the morning as there was no space left on the escort vehicle. GEOAmey staff said that they would send another vehicle to pick her up but at 1pm they told the custody sergeant that this vehicle had broken down. At 3pm, the custody sergeant contacted staff at Dudley Magistrates' Court, who indicated that they would still accept the detainee, provided that she could be delivered by 3.45pm. A short time later, GEOAmey called back to say that the court would not accept the detainee that day, and as a result she remained in custody until the following day. At Perry Barr, we saw a female who arrived at 11.55am being booked into Dudley Magistrates' Court by noon but the court indicated that they and Walsall Magistrates' Court were full. Custody staff were advised to call again in 30 minutes to check availability, and the arresting officers indicated that would transport the detainee to court, to make sure that she got there that day. However, when they telephoned the court again, they were told that there was no space, and the woman was held in custody until the following day.

7.8 The quality of the PERs we examined varied. Most were completed to a good standard but a minority contained too little information. Some lacked basic information, such as failing to identify that two female detainees were pregnant (even though one was heavily so), that a detainee had a broken leg and was using crutches, or that another had two fingers missing. These failures could have had implications for the safe transportation of the detainees to court. In other PERs, there was a lack of specific dates and details of previous self-harm, violence or drug use. A large number of PERs were accompanied by extraneous paperwork stapled inside them, such as copies of risk assessments and confidential medical examination notes, which was inappropriate.

Areas for improvement

7.9 The processes for holding detainees pending appearance at court should be improved, to ensure that they do not remain in police custody for longer than necessary.

7.10 The practice of adding extraneous paperwork to person escort records should cease. If there is a need for medical examination notes to accompany the detainee, these should be placed in a sealed envelope marked 'confidential'.

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

Areas of concern and recommendations

8.1 **Area of concern:** The health care practitioners we met were competent and skilled but fundamental difficulties in recruiting and retaining suitably qualified nurses had led to continuing shortages of frontline staff. These issues, when coupled with the nature of the contract, the absence of any effective clinical leadership and weak governance arrangements, had resulted in an overstretched physical health service which was struggling to meet demand and had generated poor standards in a number of clinical areas.

Recommendation: The provider of the health care service should ensure that its staffing profile, leadership arrangements and approach to governance are adequate to deliver an effective and safe service, and the existing physical health care contract should be re-evaluated to ensure that it provides for the needs of detainees. (2.49)

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 performed.

Recommendation: The force should develop a comprehensive performance management framework for custody, ensuring that data are collected accurately, and use this to assess performance, identify trends and learning opportunities, and improve services. (2.50)

8.3 **Area of concern:** The governance and oversight of the use of force in custody were inadequate, with insufficient information to demonstrate that any force was used was both justified and proportionate.

Recommendation: The force should introduce mechanisms to assure itself and others that all force used in the detention and custody of detainees is scrutinised robustly and that all such uses are justified and proportionate. (2.51)

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

Recommendation: The force should continue to engage actively with its local authority partners to find ways of providing alternative accommodation for children charged and refused bail, to avoid them remaining in custody overnight. (2.52)

8.5 **Area of concern:** There were a substantial number of ligature points across the force custody estate. These presented significant risk to detainees and the force. The force was aware of some of these appeared to have no clear plan to address or mitigate the risks that these posed.

Recommendation: The force should take immediate action to remove or manage any ligature points, to ensure that it is delivering custody safely. (2.53)

Areas for improvement

Leadership, accountability and partnerships

8.6 The force should evaluate its procedures to assure itself and criminal justice partners that all instances where a detainee has been charged with shoplifting without interview are appropriate and compliant with its own documented scheme and lawful practice. (3.12)

8.7 The force should ensure that all processes in relation to custody are compliant with codes C and G of the PACE codes of practice. (3.13)

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

8.8 Booking-in desks should allow effective and private communication between detainees and staff. (5.8, repeated recommendation 4.9)

8.9 Female detainees should have access to female staff at all times, and the selection of feminine hygiene provisions should be improved. (5.9)

8.10 Force policy and arrangements for the management of detainees requiring physical and mobility support should be improved. (5.10)

8.11 Levels of observations should be recorded clearly on the custody record system and the required frequency of observation should always be adhered to. (5.16)

8.12 Detainees' clothing and footwear should be removed only on the basis of an individual risk assessment, and more effective alternatives to using paper suits should be used, to minimise the risk of self-harm. (5.17)

8.13 Arrangements for shift handovers should be improved. (5.18)

8.14 Detainees should be booked in promptly on arrival at the custody suites. (5.31)

8.15 West Midlands Police should monitor the length of time that detainees, including prisoners recalled on licence and immigration detainees, are kept in detention, to ensure that there are no unnecessary delays in progressing their cases or in transferring them to prison or immigration removal centres where applicable. (5.32)

8.16 Old DNA, blood and evidential samples in the refrigerators and freezers in custody suites should be removed and only current samples stored. (5.33)

8.17 Double-handset telephones should be available in all custody suites, to facilitate telephone interpreting. (5.37)

8.18 The force should ensure that detainees are able to make a complaint while they are still in custody. (5.43)

In the custody cell, safeguarding and health care

8.19 The cell call bell system should be explained to all detainees before they are located in their cell. (6.6)

8.20 Staff should be aware of the emergency evacuation procedures in each suite and be able to locate the emergency evacuation pack, which should contain sufficient sets of handcuffs to evacuate all detainees safely. (6.7)

8.21 Strip-searching should only be conducted when there are sufficient grounds, and the rationale for this should be clearly recorded on the detainee's custody record. (6.13)

8.22 Cell mattresses and pillows should be routinely disinfected between uses. (6.27)

8.23 Force policy on the confiscation of detainees' personal clothing should be reviewed, to ensure that it is consistent. (6.28)

8.24 Appropriately diverse selections (age, gender, language, type) of reading materials should be available in all suites. (6.29)

8.25 All detainees, particularly those held for longer periods, should be offered exercise and showers routinely, and able to shower with a reasonable level of privacy. (6.30)

8.26 Detainees held for longer periods should be offered the opportunity for family visits. (6.31)

8.27 The arrangements for securing appropriate adults (AAs) should be improved, to ensure that children and vulnerable adults consistently receive early and effective support while in custody. (6.49)

8.28 Record keeping in relation to AAs should be improved, in order to assess waiting times accurately and identify other areas that require improvement. (6.50)

8.29 The service should ensure that staffing is sufficient to meet the needs of detainees. (6.57)

8.30 Clinical governance processes should be fully integrated into the work of the provider, to include provision of a confidential complaint system. (6.58)

8.31 Custody staff and health care professionals should have access to emergency equipment which is of an agreed professional standard and is regularly maintained and checked. (6.59)

8.32 Clinical information relating to detainees should not be appended to police record systems, and the physical health care provider should ensure that only health contacts and any pertinent risk information are noted in the custody record. (6.60)

8.33 There should be robust infection control procedures for all the clinical rooms, which should be clean and capable of being used for the taking of forensic samples. (6.61, repeated recommendation 6.9)

8.34 Adequate local managerial support should be provided for health care frontline staff. (6.67)

8.35 Record keeping and record storage should comply with information governance standards and ensure effective continuity of care. (6.68)

8.36 Medicines management arrangements should ensure that the stock is secure and fully accounted for, with any discrepancies being fully investigated. (6.69)

Release and transfer from custody

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

8.38 The processes for holding detainees pending appearance at court should be improved, to ensure that they do not remain in police custody for longer than necessary. (7.9)

8.39 The practice of adding extraneous paperwork to person escort records should cease. If there is a need for medical examination notes to accompany the detainee, these should be placed in a sealed envelope marked 'confidential'. (7.10)

Section 9. Appendices

Appendix I: Inspection team

Ian MacFadyen	HMI Prisons team leader
Fionnuala Gordon	HMI Prisons inspector
Kellie Reeve	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary inspection lead
Peter Currie	HMI Constabulary inspection officer
Viv Cuthill	HMI Constabulary inspection officer
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
Laura Green	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.

Main recommendations

The safety issues concerning ligature points should be addressed as a matter of urgency and, where resources do not allow them to be dealt with immediately, the risks should be carefully managed. The concerns about the Steelhouse Lane custody suite should be prioritised. (2.28)
Not achieved

A use of force form should be submitted in every appropriate instance and the force should monitor the use of force locally by ethnicity, age, location and officers involved. (2.29)
Not achieved

Initial risk assessments should be comprehensive and uniform in format. (2.30)
Achieved

Recommendations

The UK Border Agency should ensure that immigration detainees are held in police custody suites for the shortest possible time. (5.5)
Partially achieved

Treatment and conditions

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

Recommendations

Booking-in desks should allow effective and private communication between detainees and staff. (4.9)
Not achieved (recommendation repeated, 5.8)

There should be clear policies and procedures to meet the specific needs of female and juvenile detainees. (4.10)
Partially achieved

Some cells should be adapted for use by detainees with physical disabilities. (4.11)
Partially achieved

Care planning for detainees at risk of self-harm should be developed. (4.22)
Partially achieved

A schedule of fire evacuation tests should be implemented. (4.31)
Achieved

All detainees held overnight, or who require one, should be offered a shower, which they should be able to take with a reasonable level of privacy. (4.37)
Not achieved

Detainees held for longer periods should be offered outside exercise. (4.46)
Not achieved

Individual rights

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

Recommendations

Custody staff should ensure that detainees' dependency issues are identified and, where possible, addressed. (5.6)
Achieved

Comprehensive risk assessments and, if appropriate, care plans should be completed before release for all vulnerable detainees. (5.7)
Not achieved

Appropriate adults should be readily available to support vulnerable adults in custody, including out of hour. (5.16)
Not achieved

All evidential samples taken from suspected drunk drivers should be submitted for analysis in a timely fashion. (5.17)
Achieved

The force should instigate discussions with the court service to extend court cut-off times. (5.18)
Partially achieved

Detainees should be told how to make a complaint and should be facilitated to do so before they leave custody. (5.22)
Partially achieved

Health care

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

Recommendations

There should be robust infection control procedures for all the clinical rooms, which should be clean and capable of being used for the taking of forensic samples. (6.9)
Not achieved (recommendation repeated, 6.61)

Custody staff should have access to a full range of appropriate first-aid and resuscitation equipment. (6.10)
Not achieved

The detainee assessment at point of arrest (DAPA) scheme at Wolverhampton custody suite should be resurrected and the model adapted across the force, to ensure that detainees with mental health problems are identified and diverted to appropriate services as soon as possible. (6.38)
No longer relevant

Police custody should only be used as a place of safety for section 136 assessments in exceptional cases. (6.39)
Achieved