Inspecting policing in the public interest

Report on an unannounced inspection visit to police custody suites in

Staffordshire

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

3–12 April 2017

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

Glossary of terms

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Section 1. Introduction

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

We last inspected Staffordshire police custody in May 2012, when we reported positively about the conditions of detention. Changes in management had led to some improvements in the custody estate, but more work was needed to ensure that the quality of service provided was consistent. The other main area that required attention when we last inspected was the weak governance of health care.

During this inspection, we found that the majority of detainees continued to be treated with respect and the conditions that they were held in were adequate. The number of potential ligature points we identified in the custody suites was relatively low, and as soon as we highlighted the problems the force responded promptly and efficiently about how they intended to offset or eliminate many of the risks.

We also identified several areas of concern where we have made recommendations. First, and as we commonly find, performance information on custody was not comprehensive. Monitoring was limited, which made it difficult to assess how well custody services performed. In particular, governance of the use of force was poor, and there was not sufficient information to demonstrate that its use was always justified or proportionate. We also found some weaknesses in detention practice. CCTV monitoring of detainees on constant observations did not comply with professional guidance, and not all of the force's procedures and practices complied with the Police and Criminal Evidence Act 1984 (PACE). Some of our concerns were about functions outside the force's direct control. The arrangements for obtaining appropriate adults were unsatisfactory and sometimes led to long delays. Finally, although there had been some progress, health services still lacked effective clinical leadership, resulting in inadequate oversight and monitoring of the health provision.

During the inspection, we found the force to be open and transparent. The ethics transparency and audit panel, made up of members of the public, provided effective external scrutiny and reflected a desire by the police and partners to improve their joint response. This initiative was a model of good practice. Despite some mixed findings from this inspection, detainees in police custody in Staffordshire are likely to be held safely and treated decently. We are optimistic that the force has the capacity and commitment to make the changes required to provide further improvement.

We noted that of the 29 recommendations made in our previous report after our inspection of 28 May–1 June 2012, nine recommendations had been achieved, four had been partially achieved, 15 had not been achieved and one was no longer relevant.

This report provides six recommendations to the force and highlights 26 areas for improvement and one example of good practice.

Dru Sharpling CBE
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons May 2017

Section 2. Background and key findings

2.1 This report is one in a series relating to inspections of police custody carried out jointly by HM Inspectorates of Prisons and Constabulary. These inspections form part of the joint work programme of the criminal justice inspectorates and contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorates of Prisons and Constabulary are two of several bodies making up the NPM in the UK.

2.2 The inspections of police custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing's *Authorised Professional Practice - Detention and Custody* at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*[1] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 A documentary analysis of custody records was conducted as part of the police custody inspection. The custody record analysis was carried out on a representative sample of the custody records, across all of the suites in that area, opened in the week prior to the inspection being announced. Records analysed were chosen at random and a robust statistical formula provided by a government department statistician was used to calculate the sample size required to ensure that our records analysis reflected the throughput of the force's custody suites during that week.[2] The analysis focused on the legal rights and treatment and conditions of the detainee. Where comparisons between groups or with other forces are included in the report these differences are statistically significant.[3] A total sample of 128 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 average length of time in police detention.

2.5 This was our second inspection of Staffordshire police custody, following up on our inspection of 28 May–1 June 2012. During our 2017 inspection, the designated suites and cell capacity were as follows:

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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
Burton upon Trent	15 (closed for refurbishment during the inspection)
Northern area custody facility (NACF) (Stoke-on-Trent)	50
Watling Street (A5)	15
Contingency suites	
Tamworth	9 (open during the inspection while Burton upon Trent was closed)
Stafford	10

Leadership, accountability and partnerships

2.6 The governance structure provided clear accountability for the safe delivery of custody. The force had effective meetings to oversee external provision of custody services. It had adopted the College of Policing's *Authorised Professional Practice - Detention and Custody* as a minimum standard. This was complemented by a comprehensive procedures document, which provided local guidance.

2.7 Operational practice varied between suites, particularly between those in the north and south of the county. The force needed to assure itself that outcomes for detainees did not suffer as a consequence of inconsistency. The force provided comprehensive training for custody officers, which they had to complete before undertaking duties.

2.8 The collation and monitoring of performance data on custody were inadequate. The data available were not comprehensive across all key areas of activity. The force was also poorly served by its custody IT system, NSPIS (national strategy for police information systems), which inhibited its ability to derive effective data to monitor and improve performance.

2.9 The force collated data on the use of force. However, governance and oversight of such incidents were limited, and there were inadequate mechanisms to demonstrate that use of force in detention and custody was always safe and proportionate.

2.10 We found a number of procedural areas where PACE and code C (covering the detention, treatment and questioning of persons by police officers) had not been complied with.

2.11 The force was open to external scrutiny and had an ethics transparency and audit panel (ETAP) made up of members of the public, who tested the accuracy of crime recording, examined the response of police to incidents, and analysed the way they handled complaints about policing.

2.12 There was a strategic equality board chaired by an assistant chief constable (ACC), but there were no specific action plans or monitoring relating to custody. It was not clear how the force could demonstrate that it met the public sector equality duty (under the Equality Act 2010).

2.13 There was effective partnership working to address the issue of detainees with mental ill health who were bought into custody as a place of safety. The force was committed to diverting children, and in particular those who were first-time offenders, away from custody and the criminal justice system, and had a joint protocol with a range of partners to reduce the prosecution of looked-after children.

2.14 The force had failed to address weaknesses in the provision of appropriate adult services, leaving children and vulnerable adults without early support.

Pre-custody: first point of contact

2.15 Frontline officers had a good understanding of vulnerability and how this determined the action needed to be taken. Arresting officers generally received relevant information from the control room to inform their decision-making. There was also good access to multi-agency information about individuals.

2.16 Officers used a range of alternatives to avoid taking children into custody, such as voluntary attendance, community resolution[4] and referral to a pilot programme to divert children as an alternative to arrest and without the need to interview; it was too early to assess the effectiveness of this scheme. Avoiding overnight detention was a priority.

2.17 Dealing with people with mental health problems remained a challenge and took up significant police time. Triage cars were helping frontline officers avoid taking vulnerable adults into custody. Nevertheless, the lack of places of custody sometimes left no alternative but to take those detained under section 136 of the Mental Health Act to custody.[5]

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

2.18 We found some examples where there was poor attention to maintaining the dignity of detainees, including leaving some naked or in a partial state of undress, which was unacceptable. However, in most cases, custody staff treated detainees with care and compassion. Custody staff used the initial risk assessment effectively to identify detainees' diverse needs and make arrangements to meet them. Staff were sensitive to the needs of detainees from minority groups, and there were adequate facilities across the estate to meet the needs of detainees who had disabilities. The quality of engagement between custody staff and vulnerable detainees was generally very good.

2.19 Risk assessments of detainees by sergeants were mostly comprehensive, but the routine removal of cords from their clothes and their footwear were not an effective response to managing risk. Care plans generally set appropriate levels of observation, but reasons why observation levels were altered were not always clearly recorded. We had concerns about

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[4] 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. Community resolution applies to the resolution of a less serious offence or antisocial behaviour incident involving an identified offender through informal agreement between the parties rather than progression through the criminal justice process.

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

the way some CCTV monitoring of detainees on constant observations was carried out as we saw staff performing other tasks at the same time, which was distracting and contrary to guidance. Staff shift handover arrangements focused on identified risks, but they were not attended collectively by all relevant staff.

2.20 Custody officers gave us several appropriate examples of when they had refused detention. Although we saw detention being correctly authorised, we also observed a few instances when officers had not been asked by custody officers to explain their reasons for arrest, as required under the PACE code G (covering the statutory power of arrest) necessity test. We were pleased to see the active use of voluntary attendance as an alternative to custody.

2.21 While our custody record analysis showed an average waiting time of 13 minutes between arrival and detention being authorised, there were some inaccuracies in recording time of arrival. We observed significant delays for detainees waiting to be booked in, in some cases over three hours. There were also delays in the progress of some cases while appropriate adults (AAs) were being sought, which sometimes resulted in detainees being held in custody for longer than necessary.

2.22 The custody cases we examined covered detainees arrested before the new legislation on the pre-charge bail process, which came into effect on the day our inspection commenced. We assessed these cases against the previous framework. Contrary to force policy, the recording of bail rationale was limited, and in our case audits, initial bail was not always authorised at the correct level, although re-bails were. Bail periods were generally set appropriately, with consideration of likely timescales for relevant enquiries.

2.23 Management of bail was not sufficiently robust. The number of unanswered bails had increased, and custody records were not always updated with information on crime enquiries or crime reference numbers. Custody and crime IT systems did not link in, which created additional work for already busy custody sergeants.

2.24 The force had been preparing for the new bail legislation since January 2017. All staff had been given access to an online training package and guidance documents. Face-to-face training had been primarily directed towards custody sergeants and supervisors. While custody sergeants were aware of the new arrangements, frontline officers were not clear about their responsibilities.

2.25 There were inconsistencies in the complaints process. Detainees were not always able to make a complaint while in custody, which was not good enough.

In the custody cell, safeguarding and health care

2.26 The standard of the custody estate in Staffordshire was generally good: cells and communal areas were clean and well maintained, with a notable lack of graffiti. Although we found a number of potential ligature points that required attention, this area was generally scrutinised effectively.

2.27 Emergency cell call bells were in good working order and their use was usually explained to detainees. Arrangements for fire evacuation were generally good.

2.28 Staff mostly dealt with challenging detainees patiently and generally only deployed force that was proportionate to the risk or threat posed. Most staff were up to date with officer safety training, but this only happened every two years for custody staff. Given the emphasis on de-escalation in the suites, the inconsistencies in the equipment carried by sergeants ran counter to this and could have been a provoking factor. Around half the use of force cases

we cross-referenced against CCTV were managed well, but the remainder raised some learning points. One case raised serious concerns, and we immediately referred this back for review. The force used individual use of force forms, which was better than we normally find, but not all officers completed them. Handcuffs were not applied routinely, which was positive, but they were not always removed quickly enough from compliant detainees. The number of strip searches was comparatively low, and the cases we examined were warranted and properly justified.

2.29 The suites generally provided an adequate range of meals that met most cultural and dietary needs. Meals and drinks were offered to detainees on their arrival into custody, and not just standard meal times. We found little evidence that detainees were offered outside exercise or showers.

2.30 While PACE allowed for telephone reviews of detention, in our case audits we found that this had taken place on two occasions with children; this was contrary to the relevant guidance. PACE also enabled reviews to be brought forward to allow a detainee an uninterrupted period of rest. In our custody record analysis, almost half of the reviews were conducted too early. We were also concerned that reviews of detainees while they were asleep were not always carried out appropriately.

2.31 Frontline officers and custody staff generally showed a good awareness of safeguarding. Referrals were made to multiagency teams for children and vulnerable adults, and custody sergeants were focused on the safe release of detainees. However, not all staff had received safeguarding training.

2.32 Children and vulnerable adults did not always receive prompt support from AAs. Record keeping was poor and there was no monitoring of how long detainees waited. We found delays both in requesting AAs and in the time they took to arrive. Although some AAs arrived promptly after being called, there were several cases where detainees spent longer in custody because of delays, including detainees being held overnight. In some cases, no AA arrived. Vulnerable adults were routinely fingerprinted without an AA present, which was a breach of PACE.

2.33 Detention of children was regarded as a last resort, especially at night, and our case audits showed good use of bail and returning children home for interview the following day. Case records and discussions with staff showed that children who were detained in custody were generally well cared for, and held in dedicated cells or wings. Girls were allocated a female officer.

2.34 The force and partner agencies closely monitored children detained overnight to ensure that all actions had been taken to avoid this – however this excluded children detained between 11pm and 7am so was not a complete picture, and potentially misleading. Force figures showed that in the year to March 2017, 35 children were charged, refused bail and held in custody overnight. Custody sergeants followed the procedure for requesting alternative accommodation from the local authority but reported that this had never been provided - although some officers were confused about the difference between secure and non-secure accommodation. We were told that there was currently very limited suitable alternative accommodation in the county, which, was a poor outcome for those children.

2.35 Staffordshire Police managed the health contract with Primecare effectively with good support from NHS England. Most custody staff reported that health provision and partnership working with health care professionals had improved since our last inspection and were good, but response times, particularly in the south of the county, were regularly too long.

2.36 Many Primecare clinical governance systems were inadequate, mainly due to staffing shortages. A new provider was due to start in September 2017, and we were concerned that the transitional period posed a significant risk to the force and outcomes for detainees.

2.37 Individual patient care was generally good, but detainee confidentiality could be compromised, for example, by clinic room doors routinely left open. Detainees had satisfactory access to medication, including methadone, although nicotine replacement therapy was not provided, which could exacerbate detainee anxiety. Detainees had appropriate access to symptomatic relief for drug and alcohol withdrawal in custody, but these medications were not sent with detainees to court, which presented risks to their health. The northern area custody facility (NACF) continued to have very good substance misuse support services, but detainees in the southern suites were disadvantaged by not having access to visiting services.

2.38 The NACF had impressive mental health liaison and diversion services, and the Watling Street suite had a limited service that provided valuable support for detainees and informed effective risk management. However, detainees held in Burton upon Trent still had no access to a similar service.

2.39 There were some delays in assessments under the Mental Health Act. Effective partnership working and a clear strategic approach, including the county-wide community triage service, had helped to reduce significantly the number of people detained in police custody under section 136. However, the number remained too high.

Release and transfer from custody

2.40 Despite poor recording, our observations should evidence of good attention to releasing detainees safely. Officers often conveyed detainees home, particularly the most vulnerable, which was positive. The quality of person escort records was mostly good, but the inclusion of confidential medical information was inappropriate.

2.41 Detainees in the NACF sometimes benefited from an afternoon court, but other suites, particularly in the south of the county, reported difficulties in booking some detainees into court in the afternoon, which could potentially prolong detention unnecessarily.

Areas of concern and recommendations

2.42 Performance information on custody was not comprehensive, and limited monitoring made it difficult for the force and others to assess how well custody services performed.

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

2.43 The force used some procedures and practices that did not comply with the Police and Criminal Evidence Act 1984 (PACE) or the Act's code C (covering the detention, treatment and questioning of persons by police officers).

Recommendation: The force should ensure that all processes in custody comply with code C of the Police and Criminal Evidence Act 1984 (PACE).

2.44 CCTV monitoring of detainees on constant observations did not comply with the College of Policing *Authorised Professional Practice* guidance, and required improvement to identify, offset and address risk.

Recommendation: Constant observation of detainees through CCTV should be in accordance with College of Policing *Authorised Professional Practice* guidance.

2.45 Governance and oversight of the use of force in custody were limited, with insufficient information to demonstrate its use was justified or proportionate.

Recommendation: Staffordshire police should immediately introduce the robust scrutiny of all force used in the detention and custody of detainees to assure itself and others that all use of force is justified and proportionate.

2.46 The arrangements for obtaining appropriate adults were unsatisfactory and sometimes led to long delays. Some vulnerable adults had their fingerprints taken without an appropriate adult present, which breached PACE.

Recommendation: Children and vulnerable adults should consistently receive early support from appropriate adults. The force should fully comply with PACE requirements when taking fingerprints, and should improve record keeping and monitor the effectiveness of the AA service.

2.47 The health service provider, Primecare, lacked effective clinical leadership and had weak governance, which resulted in inadequate oversight and monitoring of the health provision.

Recommendation: There should be robust clinical leadership and governance of health care provision to ensure adequate oversight and lead service improvement.

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 governance structure for custody under the overall responsibility of an assistant chief constable (ACC), which was supported by sufficient specialist staff trained to deliver custody functions. This provided clear accountability for the safe delivery of custody. The external provision of custody services was overseen by appropriate meetings, chaired by the ACC, which showed effective scrutiny in a range of areas, including mental health issues and the health care contract.

3.2 Dedicated custody sergeants were supported by a pool of appropriately trained local policing team sergeants. There was a strong reliance on the latter to maintain staffing levels in the suites; although operationally competent, there was little evidence that this was the most effective way to deliver the custody service.

3.3 The force followed the College of Policing *Authorised Professional Practice* for custody. This was underpinned by some local protocols and practices set out in a comprehensive document. Staff were aware of the guidance and generally knowledgeable about the processes and procedures. However, some operational practice varied between suites, particularly those in the south and north of the county. This meant that detainees could be dealt with differently in different suites. There was little evidence that the force recognised the potential impact of this or whether it affected outcomes for detainees.

3.4 Initial training for custody staff was good. The force provided comprehensive training for custody officers before they started their duties. Newly trained sergeants were tutored by experienced staff during a consolidation period. Local policing sergeants received the same level of training and had to complete at least six custody shifts a year to retain their professional competence. Civilian detention officers (CDOs) also had comprehensive initial training from an external provider.

3.5 Custody sergeants and lead detention officers also received five additional training days annually. These covered a range of subjects and included vulnerabilities, such as autism and human trafficking. CDOs were not included in this training, although lead detention officers were expected to pass on the information to them. The resulting differentials in CDOs' knowledge could affect consistency of care for detainees.

Accountability

3.6 The collation and monitoring of performance data on custody were limited, and in some areas inadequate. Although some data were collected, this was not comprehensive across all key areas of activity. The force's custody IT system (NSPIS, national strategy for police information systems) was also weak in the collation of performance reports. It was not clear how the force used performance data together with regular quality assurance to assess how

well it was delivering different aspects of custody, and to identify trends and inform learning at strategic level. (See recommendation 2.42.)

3.7 Governance and oversight of the use of force were limited. The force recorded incidents of use in custody suites, and could provide the data required for the Home Office annual data return, as recommended by the National Police Chiefs Council. However, it did not have adequate mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force in detention and custody was always safe and proportionate. (See recommendation 2.45.)

3.8 The force did not always comply with Police and Criminal Evidence Act 1984 (PACE) and its code C (code of practice for the detention, treatment and questioning of persons by police officers), which was a significant concern. (See recommendation 2.43.) We report examples of this (see paragraphs 5.19 and 6.25).

3.9 The force had an effective process to record adverse incidents and staff were aware of their responsibilities. The force identified learning from adverse incidents and near misses, and used this effectively to inform training.

3.10 The force had an ethics transparency and audit panel (ETAP), made up of members of the public, who tested the accuracy of crime recording, examined the response of police to incidents, and analysed the handling of complaints about policing. This panel had reviewed a case where a detainee with mental health issues was bought into custody as a place of safety, and provided comprehensive recommendations to improve services, which was good practice.

3.11 The force also worked positively with its independent custody visitor (ICV) scheme and welcomed external scrutiny. ICV members and custody staff described their working relationships as positive. Matters brought to the attention of ICV volunteers tended to be low level and were generally resolved on site

3.12 The force had a strategic equality board chaired by an ACC, but there were no specific custody-related action plans or monitoring. It was not clear how the force could demonstrate that it met the public sector equality duty (under the Equality Act 2010), and the staff we spoke with had little knowledge or understanding of their responsibilities under this.

Good practice

3.13 *The ethics transparency and audit panel provided effective external scrutiny, and indicated a desire by the police and partners to improve their joint response, particularly in dealing with people with mental ill health.*

Partnerships

3.14 The force was involved in effective partnership working to address issues where detainees with mental ill-health needs were brought into custody as a place of safety. The force vulnerability coordinator received a weekly report on such cases. There was effective liaison with respective police and external managers, the assistant directors of NHS trusts and the clinical commissioning groups to identify improvements. However, the West Midlands Ambulance Trust did not engage effectively (see paragraph 6.71). All cases were reviewed and those that involved detention beyond 24 hours were discussed at a formal meeting of professionals. An 'urgent care crisis group' was overseeing changes to mental health

legislation due as part of the Policing and Crime Act 2017. There were clear actions to ensure that the force and partners could respond and implement the new guidance.

3.15 The force worked strategically to divert children away from custody and the criminal justice system. However, it had not yet addressed the weaknesses identified in our last inspection on the provision of effective appropriate adult services, leaving children and vulnerable adults without early support. (See recommendation 2.46) Despite some good joint working, there had also been limited progress in ensuring that local authority partners provided alternative accommodation for children charged and refused bail.

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 officers had a good understanding of vulnerability. Children were regarded as vulnerable by virtue of their age, which was positive. Officers had been trained in a range of topics to help them deal with vulnerable people.

4.2 Call handlers in the control room prioritised calls if vulnerabilities were identified. Information was accessed from a range of sources, including other partner agencies and a 24-hour intelligence unit. Information was passed on to police officers attending the incident to help inform their decision making. Although the quality of this information varied depending on how busy the control room was, frontline police officers said that it was generally good, and they could access further information directly from the incident log on their handheld devices. Officers could also obtain information from social services or health services through a single access point, as well as a shared database.

4.3 Frontline officers avoided taking vulnerable people and children into custody. They made appropriate use of alternatives to custody, including voluntary interviews, interviews at the scene, community resolutions and restorative justice.[6] They also referred individuals to support agencies, such as drug services or anger management courses.

4.4 Custody was regarded as a last resort for children and they were only arrested when officers could robustly justify this and other alternatives were not appropriate. To minimise arrests of looked-after children, the force worked with care home staff so that they could take other actions to resolve the situation before calling the police. In some of the force area, officers could make referrals to a youth offending scheme pilot programme that offered early intervention to divert children away from custody and avoid their contact with the criminal justice system. This scheme had not yet been formally evaluated, but staff indicated that it was showing some success.

4.5 Dealing with people with mental health problems remained a challenge for frontline officers and took up a significant amount of their time. Triage cars with mental health professionals were valuable in providing information and advice to officers. They also dealt with people at incidents, often finding alternative solutions to arrest. Officers had an understanding of the Mental Capacity Act 2005,[7] and felt well supported by mental health professionals and ambulance crews when they needed to make decisions relating to this. However, the lack of

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[6] 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. 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. Restorative justice provides the opportunity for individuals to consider the consequences of their offending for all parties and to offer an apology or reparation.

[7] 'Mental capacity' refers to an individual's ability to understand and make a decision when needed.

places of safety sometimes left officers with no alternative but to take a person to custody when they have been detained under section 136 of the Mental Health Act. [8]

4.6 Frontline officers determined the most suitable transport to custody for detainees based on risk. There were no arrangements for wheelchair users and officers were expected to arrange an appropriate option, such as a taxi. Although it was force policy that ambulances were always used to transport people detained under section 136, because there were still some long waits for these, officers often resorted to using their own vehicles, which, although not ideal, provided a reasonable outcome for detainees (See paragraph 3.14 and paragraph 6.71).

Area for improvement

4.7 The force and health partners should ensure that appropriate transport is available and used to support timely transfer of people detained under section 136 of the Mental Health Act.

[8] 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 5. In the custody suite: booking in, individual needs and legal rights

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

Respect

5.1 We observed custody staff treating detainees with care and compassion, and they often did everything they could to meet detainee needs, sometimes in challenging circumstances. However, in our case audits and review of CCTV footage we found some instances where this standard of treatment was not met, such as leaving detainees naked in cells (see paragraphs 5.13 and 6.13).

5.2 The privacy of booking-in desks continued to vary considerably. In some suites, privacy was very limited and conversations, including sensitive information, were clearly overheard. The largest suite, the northern area custody facility (NACF), had high partitions between desks that offered some privacy, but at other suites the desks were not partitioned. The NACF also had a separate booking-in area but this was not always used; for example, we saw a child being booked in alongside adults.

5.3 Staff generally understood the importance of meeting detainees' diverse needs. Custody staff used the initial risk assessment effectively to identify and help meet specific needs, such as dietary or religious requirements. Detainees were routinely asked if they had any caring responsibilities for others. All women were asked if they would like to see a female member of staff, whether they were pregnant and were offered a range of sanitary items.

5.4 The custody suites had a range of facilities to meet the needs of detainees with disabilities although this was not consistent in all suites. All suites could offer wheelchairs and thick mattresses. All suites, except Stafford, had toilet and washing facilities to cater for detainees with disabilities but most did not have adapted showers. Each custody suite had a hearing loop, although some staff were still not sure how to operate them.

5.5 We saw good care of a detainee who used a wheelchair. He was given a thick mattress for comfort and allowed his wheelchair in his cell. Custody staff overcame a number of difficulties and made special arrangements to ensure that he was presented to court that day.

5.6 A range of religious books and items were available and were stored respectfully.

Area for improvement

5.7 **Booking-in areas should provide sufficient privacy**. (Repeated recommendation 4.12)

Risk assessments

5.8 Detainees were not always booked in promptly (see paragraph 5.22). There was no evidence of triage to identify vulnerable detainees quickly or prioritise them for booking in, or to show that there were ongoing risk assessments when there were delays in booking in.

5.9 Custody sergeants were properly focused on identifying risks when completing standardised risk assessments, interacted well with detainees, responded to individual need, and asked appropriate supplementary and probing questions. Arresting/escorting officers were asked if they had any information relevant to the risk assessment, and we saw many examples where staff dealt with detainees patiently and sensitively. Custody sergeants identified initial risks for detainees well, including those in custody for the first time. There was routine cross-referencing to previous custody records on the NSPIS (national strategy for police information systems) custody computer system and police national computer (PNC) warning markers to inform risk assessments further.

5.10 Care plans generally set appropriate observation levels, although in the custody records we saw there was not always a clear rationale why observation levels were subsequently amended. Levels of observations were broadly adhered to, and staff were competent in rousing intoxicated detainees and documenting this well. Police officers on close proximity observations interacted well with detainees. However, we were concerned by some poor monitoring of cameras for detainees on constant supervision. At the NACF, we saw two staff observing up to 10 detainees between them while also answering cell call bells and the telephone, which was contrary to the College of Policing *Authorised Professional Practice* guidelines. In two cases where we reviewed CCTV footage, we saw lengthy delays before it was identified that detainees on constant supervision were self-harming, which was concerning. (See recommendation 2.44).

5.11 There had been a death in custody since the last inspection. We were advised by the force that the coroner did not issue a Regulation 28 notice as he deemed the force had taken all necessary steps to address the learning points identified.

5.12 Most custody staff carried anti-ligature knives, but we saw other staff entering cell areas without carrying them, which presented a risk.

5.13 The routine removal of detainees' clothing with cords and footwear was a disproportionate response to managing risk (see paragraph 6.20). Although anti-rip clothing was used sparingly, which was positive, when used in isolation it was not always effective in minimising the risk of self-harm. Two cases that we reviewed on CCTV showed detainees left naked for significant periods as a strategy to reduce the potential for self-harm, which was inappropriate.

5.14 The staff shift handovers we observed were well conducted. They took place in private and focused appropriately on risk, detainee welfare and case progression, but they did not always include all relevant staff. Not all sergeants visited the detainees on completion of the handover.

Areas for improvement

5.15 There should be ongoing risk assessment of all detainees whose booking in is delayed.

5.16 All staff attending detainees' cells should carry anti-ligature knives.

5.17 Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment, and detainees should never be left naked in a cell as a strategy to reduce self-harm.

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

Individual legal rights

5.19 Custody sergeants booked detainees into custody and asked the arresting officer, in the presence of the detainee, to provide a full explanation of the circumstances of and the reasons for the arrest before authorising detention. In a few cases, however, we observed that officers were not tested on their understanding of the Police and Criminal Evidence Act 1984 (PACE) code G (covering the statutory power of arrest), as custody sergeants did not ask for or they volunteered the necessity criteria required to justify arrest, rather than waiting for the officers to offer them. In one case we reviewed on CCTV footage, no necessity was provided and the custody sergeant did not advise the detainee why they had been detained or why their detention had been authorised; this was not compliant with PACE code C (covering the detention, treatment and questioning of persons by police officers). (See recommendation 2.43)

5.20 Sergeants told us they rarely had to refuse detention but they were confident to do so when the circumstances did not merit it. They were able to provide us with examples, such as when a detainee had an injury or obvious health concern that resulted in the diversion of arresting officers and detainee to hospital.

5.21 Alternatives to custody were available through community resolutions and voluntary attendance.[9] There were facilities for interviewing voluntary attendees outside of custody at all police stations. Force data showed that the use of voluntary attendance had increased by 36% since 2014; there had been 4,240 voluntary attendees in the year ending 31 March 2015, 4,967 in 2016 and 5,787 in 2017, which was positive.

5.22 Most detainees we saw were booked in promptly on arrival at the custody suites, and force data showed that the average waiting time to be booked in was 13 minutes in the year ending 31 March 2017. However, we found several instances where the time of arrival was recorded incorrectly on custody records. In one case that we observed, a detainee waited up to 59 minutes, but the booking-in time rather than the actual arrival time was recorded. Such gaps affected the accuracy of custody records. In addition, at NACF we saw delays of between one hour and three hours 12 minutes for up to eight detainees waiting to be booked in. In our focus groups, frontline officers said they regularly experienced delays of between one and two hours waiting to have their detainees booked into custody. Such

[9] 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. 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.

delays were unacceptable, particularly when they involved vulnerable and compliant detainees who could remain in handcuffs throughout this period (see paragraph 6.15).

5.23 Custody sergeants were aware of the need to keep time in detention to a minimum and to progress cases quickly. We observed some custody sergeants actively liaising with investigating officers to ensure cases were prioritised, particularly when these involved vulnerable detainees. We were told, and observed, that investigations were mostly progressed promptly but that delays were possible because of the non-availability of appropriate adults. We observed this at Tamworth where two vulnerable detainees were held for at least an additional eight hours waiting for appropriate adults (see also paragraph 6.31 and recommendation 2.46).

5.24 Custody staff reported a good relationship with Home Office Immigration Enforcement officers and said that most immigration detainees were moved on within 24 hours, although there were sometimes longer delays. Force data showed that 223 immigration detainees had been held in the year to 31 March 2017, but there were no data on the average time these detainees remained in police custody following service of an IS91 warrant of detention.[10]

5.25 Custody sergeants advised detainees during booking in of their three main rights,[11] and detainees were routinely offered a written notice setting out their rights and entitlements, although these were seldom accepted. These notices were available online in several foreign languages for non-English speaking detainees, but the force website had not been updated to provide access to the current version.

5.26 We saw detainees being told they could inform someone of their arrest. Staff facilitated this on most occasions, and also allowed the detainee to speak to their named representative while still at the booking-in desks.

5.27 The rights and entitlements information was available in an easy-read format in all the suites, but the version at NACF was not the most recent one. The rights and entitlements notice was available in Braille in all the suites, which was positive, but many staff were unaware of or unable to find these.

5.28 All detainees were told during booking in that they could read the PACE codes of practice. We found a limited number of copies of PACE code C in the suites, but these had not been updated to the current version.

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

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

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[10] Served on an immigration detainee when there is no reasonable alternative action, for example, if there is a likelihood that they may abscond or that their removal from the UK is imminent.

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

Areas for improvement

5.31 Custody sergeants should ensure that the detainee's time of arrival is accurately recorded on custody records.

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

Communication

5.33 A professional telephone interpreting service was available to assist the booking-in of non-English speakers. There were double-handset telephones for this n all the suites, which provided privacy and was an improvement since our previous inspection. Staff told us that a face-to-face interpreter service was available for interviews, but there were sometimes delays depending on the language requested.

5.34 The majority of custody sergeants were not aware of the availability of translated documents – such as authorisation of detention, charge details, etc – in a range of languages on the force website.[12] Some of the few who were aware of these documents could not locate them. Posters in foreign languages informing detainees of their right to free legal advice were displayed in all the custody suites.

Access to swift justice

5.35 Our inspection began on the day the Policing and Crime Act 2017 came into effect, changing the pre-charge bail process. The custody cases we examined related to the arrest of detainees under the previous legislation, and we assessed those cases against the previous framework. We also reviewed the force's new processes to address the changes to the pre-charge bail rules.

5.36 Force policy stated that detailed rationale for police bail should be recorded on the custody record, but in our case audits we found this was limited and lacking detail. In addition, initial bail was not always authorised at the correct level, although authorisation for re-bails were. Bail periods were generally set appropriately with consideration of likely timescales for relevant enquiries, such as forensic analysis.

5.37 Management of bail was not sufficiently robust. The number of unanswered bails had increased. Custody records were not always updated with crime enquiries or crime reference numbers to find further information. This meant that when individuals were due to answer bail custody sergeants had to contact investigating officers to establish the status of investigations, rather than readily access this information on the IT system. Custody and crime IT systems did not link in, which created additional work for custody sergeants.

5.38 The force had been preparing for the new bail legislation since January 2017, and all staff had been given access to an online training package and guidance documents. Face-to-face training had been primarily directed to custody sergeants, cadre inspectors (duty inspectors responsible for several tasks) and supervisors, who had good awareness and understanding of the new scheme. However, frontline officers were not clear about their new responsibilities, for example, how the investigation would be managed when a suspect was 'released under investigation' where the grounds for bail were not met. However, the force

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

had recognised the importance of robustly monitoring the new system and was developing performance management through the daily management meeting.

Complaints

5.39 Only the Watling Street suite displayed information on the complaints process, although it was contained in the rights and entitlements notices routinely offered to most detainees. This information was also included in the support leaflet issued to some detainees on release (although not at NACF). Most custody staff told us they would direct detainees who wished to make a complaint to attend the police station front desk on release or to write, telephone or email the force performance and standards unit or contact the Independent Police Complaints Commission (IPCC). However, at NACF we saw a complaint of excessive force from one detainee being noted. A few staff told us they would make the cadre inspector aware of a detainee wishing to make a complaint. In two custody records we audited, detainees expressed concern over handcuff injuries but neither record mentioned the option of a formal complaint. As at the previous inspection, we did not find evidence that a detainee would be able to make a complaint while they were still in custody.

Area for improvement

5.40 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 At the time of the inspection, the Burton upon Trent suite was closed for refurbishment and Tamworth was being used as a contingency suite. Physical conditions across the custody estate were generally good, apart from at Tamworth. Cells and communal areas, including showers and exercise yards, were clean and maintained well, and there was a commendable lack of graffiti. All the suites had designated separate accommodation for men, women and children, which was appropriate. With the exception of Tamworth, some cells in each suite were monitored by CCTV.

6.2 The maintenance and cleaning of the suites were managed well. Daily cleaning and routine maintenance were carried out by a contractor, Kier. There was an efficient system to report damage to cells or facilities; most repairs were carried out without delay, and custody staff were generally positive about this process. In-cell biohazards were removed promptly by an external contractor.

6.3 Sergeants completed regular fabric checks that were properly focused on the identification of potential ligature points, and we saw cells out of action due to potential ligature points, which was positive. Notices in some custody suites also alerted staff to higher risk areas that required closer supervision when used by detainees, such as the communal toilet at Tamworth. Despite this focus, we identified several potential ligature points in cells and communal areas in each custody suites, which sergeants and inspectors were not sighted on We provided the force with a detailed, illustrative report at the end of the inspection and it responded reasonably positively to address and/or mitigate some of the identified potential ligature points.

6.4 The cell call bells we tested were functioning and were routinely explained to detainees. Responses to call bells were generally quick. With the exception of Tamworth, staff could speak to detainees in cells through an intercom at the booking-in desk.

6.5 Custody staff had good knowledge about emergency evacuation procedures. Emergency evacuation boxes were readily available and included sufficient sets of handcuffs to evacuate all detainees when suites were at full capacity. We were provided with only one report for a full fire evacuation in the last year, which was at Burton upon Trent. The detail and quality of the written debrief following that evacuation was good.

6.6 Custody staff had ready access to manual suction and automated external defibrillators, and received annual first aid training that included use of these items. The northern area custody facility (NACF) had regularly checked, standardised in-date first aid kits on each wing. However, the first aid kits in the main booking-in areas in all the suites contained expired items, lacked a clear contents list and were not standardised. Oxygen was still not available

in any suite, which was a risk for detainees. Ambulance response times for emergencies were reported to be good.

Areas for improvement

6.7 The force should take remedial action to remove or manage any potential ligature points.

6.8 Custody staff in all suites should have access to adequate stocks of in-date first aid and emergency equipment, including oxygen.

Safety: use of force

6.9 Although data on the use of force in custody were collected, its governance and oversight were inadequate. Force data showed that more than 98% of custody staff were in date with their safety/personal protection training. However, some custody sergeants only received refresher training every two years rather than the annual training we expect. We were not given data for civilian detention officers (CDOs), but all those we asked were in date and received equivalent safety training annually.

6.10 Custody staff generally dealt patiently and sensitively with some challenging detainees. They only resorted to using force as a last resort and following negotiations with detainees, and paid good attention to maintaining the dignity of detainees. However, managers did not consistently review CCTV footage to check that the force used was always proportionate to the risks or to identify learning points.

6.11 The force custody policy placed strong emphasis on de-escalating situations in the controlled custody environment. However, there was no guidance on the equipment that custody sergeants were expected to wear and we found inconsistencies in all suites: some wore irritant/incapacitant spray (PAVA), batons, handcuffs and limb restraints, while others carried none of these. The latter ran counter to the force policy focusing on de-escalation and could be an escalating factor.

6.12 Data on the use of force since October 2016 was easily disaggregated to see when force had been used in custody, which was positive. Through our case audits and custody record analysis we identified 12 cases, which we reviewed in depth, including cross-referencing them against CCTV where possible. Individual use of force forms were used by the force, which was positive and better than we sometimes see. However, they had only been completed by around half the officers directly involved with incidents involving force in custody. Detention logs generally contained reasonable information about the incident to justify why force had been used, but we found some accounts that did not always reflect what we viewed on CCTV (see recommendation 2.45).

6.13 Half the incidents we reviewed were managed well overall. We found at least learning points in the remainder. We had serious concerns in one case, which we referred back to the force for review and action as appropriate. Concerns from the CCTV footage included: proportionality of the force for the risk posed; poor use of techniques, some of which were potentially injurious to the detainee; proportionality of the deployment of PAVA; and the removal of clothing, particularly for self-harming detainees (see paragraph 5.13).

6.14 Positively, we found no use of Taser in the previous six months. However, there was some use of spit hoods in custody suites, and we had concerns about the proportionality and governance of their use in the custody environment.

6.15 Detainees did not arrive in custody routinely wearing handcuffs, which was positive, but we saw some examples where handcuffs remained in place on compliant detainees for too long - in one case for 100 minutes. This was disproportionate to the threat posed in the controlled custody environment.

6.16 Force data showed that 6% of detainees had been strip searched in custody in the previous 12 months, which was comparatively low. We saw few strip searches authorised during the inspection. The rationale to justify these was sufficient, and the records we examined indicated the specific grounds and justification for the strip search, which was appropriate.

Detainee care and PACE reviews

6.17 Detainees were offered food and drinks on arrival into custody and throughout the day and night. The range of microwave meals was limited but generally adequate, and met a range of dietary needs – including halal, vegetarian and vegan options. Cereal bars, biscuits and, at Watling Street, porridge were also available. If the provisions were not suitable, alternative arrangements were made. Food preparation areas were clean and well stocked, although not all suites contained guidance to staff of food suitable for various diets. In our custody record analysis, 81% of detainees had been offered a meal, including all eight detainees held for over 24 hours.

6.18 Mattresses were provided and were wiped down between use. There were good stocks of clean blankets, which were routinely offered to detainees at night and on request. Pillows had been removed from all custody suites following an incident of self-harm in a South Wales suite, which was not proportionate. A small amount of toilet paper was routinely available in the cells, and the view of the toilet area was obscured on CCTV images of the cells. At Tamworth, the cells had no handwashing facilities but those in the cell corridor shower area could be used on request and subject to staff availability.

6.19 Showers were clean but not sufficiently private. Custody staff said they were not always able to offer showers but would attempt to facilitate any request, provided sufficient staff were available, and there were cotton towels and toiletries in all suites. In our custody record analysis, 14 detainees (11%) had been offered a shower, three of whom had been held for over 24 hours. At NACF, only 3% of detainees had been offered a shower. During our inspection, we saw very few detainees having a shower or a wash, and the use of shower facilities had not improved since our previous inspection.

6.20 T-shirts, jogging bottoms, sweatshirts and underwear were available in all the suites as replacement clothing for detainees whose clothes had been seized for evidential purposes, contained cords (see paragraph 5.13) or were soiled. Our custody record analysis, however, recorded one case where a detainee was left in his cell in his underwear as no replacement clothing was available; this was inappropriate. All shoes were routinely removed from detainees before they entered their cells, and most were offered plimsolls or foam slippers. Custody staff indicated that they would accept replacement clothing for detainees from family and friends.

6.21 All the custody suites had at least one outside exercise area for detainees, which staff told us they would facilitate whenever possible. We observed one detainee who requested and was allowed to use an exercise yard but he was locked in without any staff supervision or monitoring on CCTV, which had an element of risk as the area contained potential ligature points (see paragraph 6.3). However, in our custody record analysis only four detainees (3%) were offered outside exercise, and only one of those detained for more than 24 hours. None of the eight children identified in the analysis were offered exercise.

6.22 There was a small range of reading materials but these were generally provided only on request. There was limited material for children or in foreign languages or easy-read format but the stock at NACF was slightly more varied. In our custody record analysis, only 13 detainees (10%) had access to reading materials. Only NACF had a designated visits room but staff in all the suites told us they did not facilitate visits.

6.23 The force did not comply consistently with the Police and Criminal Evidence Act 1984 (PACE) codes of practice when carrying out reviews of detention for detainees (see recommendation 2.43). Detainees were reviewed by dedicated cadre inspectors (duty inspectors responsible for several tasks), who were also responsible for covering several other duties, including the management of all ongoing operational incidents. We observed some very thorough face-to-face reviews, which were timely, appropriate and fully recorded on detention logs. These reviews did not concentrate solely on legal processes but also considered the individual's care and welfare, which was positive. However, we also saw a number of reviews conducted with compliant detainees through cell hatches, which was inappropriate.

6.24 In the 70 cases in our custody record analysis where reviews were required, 32 were conducted early, with the shortest time between authorisation of detention and review being two hours and 56 minutes; we were not satisfied that such timescales were always appropriate. Cadre inspectors told us that they were likely to conduct a review early if they judged there was no change in circumstances and to assist the dayshift inspector, who had other priorities when they initially came on duty. In our custody record analysis, 38 reviews also took place while the detainee was sleeping but this was not always appropriate. For example, in one case a detainee was recorded as being asleep at 10.58 am and was not disturbed for a review, even though he had been given a cup of tea just eight minutes beforehand. We saw very few detainees informed that reviews had taken place while they were asleep, which we also found in the case audits. Custody sergeants confirmed that the information that reviews had happened while the detainee was sleeping was not always exchanged during staff shift handovers or flagged on the NSPIS custody computer system and, therefore, could be overlooked.

6.25 Only four reviews in our custody record analysis took place over the telephone, although in our case audits we found there had been telephone reviews with two vulnerable detainees - a 16-year-old and a 14-year-old - which was contrary to the guidance in PACE code C (see recommendation 2.43).

Areas for improvement

6.26 All detainees held overnight, or who require one, should be offered a shower, and all custody suites should facilitate exercise periods for detainees.

6.27 All suites should hold and offer a range of reading materials, including books and magazines suitable for young people and non-English speakers. (Repeated recommendation 4.52)

6.28 Detainees held for long periods, particularly those who are vulnerable, should be allowed visits.

Safeguarding

6.29 Custody staff showed a generally good awareness of safeguarding issues. Referrals were made to multiagency teams for children and vulnerable adults, and custody sergeants focused on their safety while in custody and their safe release. However, not all staff had yet had safeguarding training, and there was limited guidance in the force's custody procedures to ensure that concerns were appropriately and consistently addressed.

6.30 Arrangements for securing the attendance of appropriate adults (AAs) were unsatisfactory. There were some long delays before AAs arrived, for both children and vulnerable adults. When it was not possible to use family members or care home workers, custody sergeants called AAs from the youth offending service for children during the day or social services out of working hours. While custody sergeants said that the daytime service generally worked well, this was not the case out of hours and there was no provision after 10.30pm. This position was similar for AAs for vulnerable adults sourced through social services in the north of the force area, and from a list of volunteers in the south.

6.31 Our custody record analysis showed an average wait of seven hours and 50 minutes between a detainee arriving in custody and an AA attending. This ranged from one hour 29 minutes to 17 hours nine minutes. A significant proportion of this time was due to delays in making the requests. There was poor record keeping of when AAs were called and their relationship to the detainee. As the force did not monitor the service, it was difficult to assess how well it met the needs of children and vulnerable adults, and to identify where improvements were needed. (See recommendation 2.46.)

6.32 Our case audits and observations showed that while AAs arrived promptly after being called in several cases, significant delays led to some detainees spending longer than necessary in custody, and sometimes overnight. There were particular problems for looked-after children in care homes when care worker involvement in the specific incident meant they were unable to act as AAs. This was further compounded if the child had been placed by a local authority outside of the force area, with custody sergeants required to make considerable efforts before the relevant local authority took responsibility for supporting the child.

6.33 We were not assured that AAs were always requested for vulnerable adults. We also found that vulnerable adults were fingerprinted without an AA present, and some custody sergeants we spoke to were not aware that this was a breach of PACE. (See recommendation 2.43.)

6.34 Custody sergeants told us they issued guidance to individuals acting as AAs and would also give verbal advice to ensure they understood their role and responsibilities.

6.35 Our case records and discussions with staff showed that children detained in custody were generally well cared for. Risks were well assessed, and appropriate observation levels set and adhered to. Children were placed in cells designated for them, where possible, and girls were allocated a female member of staff to care for their needs.

6.36 There was a strong focus on diverting children away from custody and the detention of children was regarded as a last resort, especially at night. Custody sergeants expected arresting officers to fully justify the arrest. Most of the children in our case audits had committed serious offences with outcomes mainly police bail or court. Force information showed that 1,197 children had been brought into custody in the year to 31 March 2017 – 6% of total custody throughput (and a lower percentage than we have found elsewhere).

6.37 Custody sergeants told us they sought to progress cases involving children as quickly as possible. Our custody record analysis and case audits showed good use of bail and returning

children home for interview the following day to avoid detaining them longer than necessary. In our custody record analysis, children spent an average of eight hours 27 minutes in custody, ranging from 32 minutes to 20 hours seven minutes.

6.38 The monitoring of performance data on children in custody was not comprehensive but covered some key elements. The force monitored the number of children arrested and the number held overnight for court as part of its custody performance pack, with further oversight at the vulnerability and mental health group chaired by the assistant chief constable. The performance information showed some reductions in both categories.

6.39 There was also joint monitoring of children detained overnight by the force, local authorities, health and the youth offending teams, which looked at whether the detention was appropriate and if it could have been avoided. This information was also monitored by the local safeguarding children's board, which was positive and offered oversight of individual cases. The information showed that for the six months to January 2017, 58 children were detained overnight. However, children arrested between 11pm and 7am were excluded from the information, which meant that not all children detained overnight were subject to the same scrutiny and that the overall number recorded was not accurately captured.

6.40 Force information showed that in the year to 31 March 2017, 35 children (3%) were charged and refused bail. In these circumstances, there was a statutory duty on local authorities to provide alternative accommodation to avoid children remaining in a police cell overnight. Custody sergeants told us they followed the procedure for requesting alternative accommodation but, although the force had not collated information on how many requests were made or were met, staff said that children were never moved to alternative accommodation as this was very limited; this was a poor outcome for these children. The force was developing its joint work with partners to agree the provision of local authority accommodation for children charged and refused bail. However, some custody sergeants were confused about the difference between the use of secure and non-secure accommodation when needed.

Area for improvement

6.41 The force should continue to work with its local authority partners to ensure that children charged and refused bail are transferred to alternative accommodation to avoid their custody overnight. Custody sergeants should be clear on the type of accommodation they request.

Governance of health care

6.42 Primecare (part of the Allied Healthcare Group) delivered all physical health services through a shared contract between Staffordshire and West Midlands police forces. The contract required that a health care professional (HCP) attend 90% of calls within either 30 or 90 minutes (depending on call type). Primecare regularly did not meet the targets, primarily due to staffing shortages and the shared contract arrangements with West Midlands. A nurse was usually based in the busiest suite, NACF, which improved the response times. Burton upon Trent and Watling Street both shared nurses with the West Midlands force, which affected response times. For example, in the 14 months to January 2017, an average of only 83% of calls at Burton upon Trent and 78% at Watling Street met the target times. In our custody record analysis, the average waiting time to see an HCP was one hour 37 minutes.

6.43 The force monitored the health contract effectively and there were improvement plans to address identified deficits. Partnership working between the force, Primecare and NHS England was good. The service had recently been re-tendered with a new provider (Mitie) due to commence from 1 September 2017 on a Staffordshire-only contract. We were concerned that the transitional period until the providers changed and as the new provider bedded in posed a significant potential risk to the force and outcomes for detainees.

6.44 There was a significant shortage of nursing leaders. One operational lead nurse covered two staff roles across four police areas (West Midlands, Staffordshire, Warwickshire and West Mercia), and there were no clinical leads in Staffordshire or West Midlands. Consequently, many governance systems were inadequate, with no regular managerial supervision, out-of-date appraisals and no regular clinical audits to improve the service. (See recommendation 2.47.)

6.45 Not all Primecare staff adhered to the clinical supervision policy. Mental health and substance misuse professionals had regular clinical supervision and managerial support. Primecare policies and standard operating procedures were available in some clinical areas but were out of date. Current versions were available electronically but not always accessible due to unreliable IT provision (Adastra).

6.46 At the time of inspection, Primecare had a backlog of 110 complaints from the force waiting for a response. Most related to poor response times and some dated back 13 months. Recruitment and retention issues resulted in gaps in rota cover, although the effect was partly offset by regular staff working overtime and forensic medical examiners (FMEs) covering nurse calls.

6.47 Although the 2013 health needs analysis was out of date, a wide range of contract monitoring data had informed the recent re-tendering and the monthly contract review meetings. The monitoring of HCPs' registration status was appropriate. Voluntary joint FME and nurse training events were offered regularly, but timing and distance to travel meant poor attendance by some staff. All staff were up to date with intermediate life support training. Face-to-face refreshers were only required every three years, which was insufficient to maintain skills, although yearly online updates were provided.

6.48 Professional interpreting services were used appropriately for non-English speaking detainees, although we saw no translated health care material. There was no health care specific complaints process. We were told that one complaint had been received from a patient in the previous year via the police. There had been no robust analysis of complaints from the force or detainees to inform service development.

6.49 None of the clinical rooms complied with infection control standards, mainly due to non-compliant fixtures and fittings and inadequate cleaning. The clinical room at Tamworth was particularly poor. Only Watling Street had a published cleaning schedule.

6.50 Stocks of medical equipment were low, particularly in the NACF, and systems for replacement were inadequate. Nurses told us about shortages of equipment and some carried their own. There was no evidence of regular calibration. The suites at Burton upon Trent and NACF had appropriate separate forensic sampling rooms, but in the other suites the clinical rooms were used and were not satisfactory; however, all received specialist cleaning before forensic sampling which was positive.

Areas for improvement

6.51 Health care professionals should see detainees within agreed response times.

6.52 Detainees should be able to complain about health care services through a well-advertised and confidential health care complaints system. Complaints should be routinely analysed for trends and learning points to inform service improvement.

6.53 All clinical rooms should comply with relevant standards of cleaning and infection prevention and control, including regular internal and external audits. All custody suites should have suitable forensic sampling facilities.

Patient care

6.54 Custody staff requested medical input through a call centre that then booked the appropriate HCP. While most custody staff reported good working relationships with frontline clinical staff and an improved service since our last inspection, many complained about some excessive response times for an HCP to attend.

6.55 Consent was sought from all detainees before medical assessment. As the electronic medical records system (Adastra) only worked infrequently or was inaccessible in some suites, health staff made handwritten records, which were not always transposed on to the health care IT system. The HCP usually added less detailed but relevant information to the electronic custody record (NSPIS) but not all FMEs had access to this, which resulted in incomplete NSPIS records. All handwritten records were sealed in an envelope at the end of the shift, but we found records in an unlocked drawer and cupboard in two suites. The records we reviewed were reasonable, and information relayed to the police was appropriate.

6.56 In two suites health staff reported, and we observed, that detainees were generally seen in private following individual risk assessments. However, at NACF the room was next to the booking-in desk and the clinic room door was routinely left open with a CDO standing outside, which compromised privacy and confidentiality.

6.57 Medicines management had improved since our last inspection. Standardised and appropriate stock medicines were securely stored in each suite, and drug cupboard keys were only accessible to the HCP. However, we found some accounting errors and irregular checking of stock and fridge temperatures. Custody staff attempted to retrieve detainees' prescribed medication from their homes where possible. Nurses used an appropriate range of patient group directions (authorising them to supply and administer prescription-only medicine), and there were effective systems to ensure medication was continued during the detainee's custody, with both HCPs and CDOs administering medication appropriately.

6.58 Symptomatic relief was available for people withdrawing from alcohol or drugs, but detainees were not prescribed medication to take to court, which could have put them at risk. Community prescriptions of methadone could be continued in custody where clinically appropriate. Nicotine replacement therapy was not available, which could have exacerbated anxiety for detainees who smoked.

Areas for improvement

6.59 All health care professionals, including mental health and substance misuse workers, should be consistent in making relevant entries on the detainee's custody record. All clinical records should be made and stored in line with national and professional standards.

6.60 Detainees who are due to have medication while they are at court should have this sent with them, with clear administration instructions.

6.61 Nicotine replacement therapy should be available for detainees who require it.

Substance misuse

6.62 In NACF, Lifeline provided substance misuse support, including drug testing on arrest, seven days a week, with good links with both Primecare and mental health services. In addition to taking referrals from custody sergeants, workers did regular tours of the suite to facilitate self-referrals. Children were referred to the dedicated young person team at Lifeline and seen by specialist workers.

6.63 There were no visiting drug and alcohol support services in Burton upon Trent and Watling Street, which meant poorer outcomes for detainees at these suites. Some detainees gave permission for the police to make referrals to appropriate community services.

6.64 On release, detainees were given an advice sheet with details of local drug and alcohol services, which enabled self-referral. Sterile injecting equipment was not provided at any suite.

Area for improvement

6.65 Detainees with alcohol or drug problems should be supported through a comprehensive and integrated service in all custody suites.

Mental health

6.66 Two mental health trusts covered Staffordshire police force – NACF was within the North Staffordshire Combined Healthcare NHS Trust area, and Burton upon Trent and Watling were in South Staffordshire and Shropshire Healthcare NHS Foundation Trust. We saw evidence of good strategic working between the force and the mental health services, particularly in the north of the county.

6.67 Custody sergeants received regular mental health awareness training as part of their ongoing training programme. CDOs in all suites said they had had no regular mental health training since their induction.

6.68 As at our last inspection, there was significant inequity of provision and access to mental health care between the suites. NACF had impressive embedded adult mental health liaison and diversion services. The team of six community psychiatric nurses (CPNs) and a support worker was well integrated into the suite, and provided effective risk management and timely support for detainees with mental health problems between 9am and 5pm daily. Detainees at Watling Street had access to a team of two CPNs on weekdays between 9am and 5pm. Both services also provided input into local courts. Custody sergeants could refer directly to both

services, and were positive about them. CPNs from the liaison and diversion teams did not make entries into the police IT system, with a reliance on verbal information sharing with custody sergeants. Detainees in Burton upon Trent had no access to mental health liaison and diversion services, which was inequitable.

6.69 It took too long for detainees to receive a mental health assessment at all times in Burton upon Trent, and out of hours in Watling Street and NACF. Custody sergeants made a referral to Primecare, and an HCP assessed the detainee and referred them to an FME who could refer directly to the relevant mental health service. Children were referred to age-appropriate specialist services as required. Between August 2016 and February 2017, there had been 65 referrals for mental health assessment under the Mental Health Act. While 69% were seen within the target of three hours, almost a fifth (17%) experienced delays, mainly due to waits for beds and transport.

6.70 The number of people detained in custody under section 136 of the Mental Health Act[13] had reduced significantly from 168 in 2012 to 31 in 2016, but was still too many. However, in the first quarter of 2017 there had only been three cases. There was one section 136 bed available in the north of the county and two in the south. Both trusts shared access to each other's facilities, which was positive, although this did not meet the demand. At three sites throughout the county, CPNs, supported by a police officer, provided telephone and face-to-face community mental health triage services daily between mid-afternoon and 2am-3am. Custody staff were very positive about this service, which they felt had made a significant impact on reducing the number of detainees held in custody under section 136.

6.71 The force had robust monitoring and oversight of section 136 activity, and there was good strategic working between the force, local authorities and NHS trusts to support the care and treatment of detainees under section 136. However, the West Midlands Ambulance Trust did not engage effectively: they had not attended crisis concordat meetings and had not been involved in policy development concerning the attendance of ambulances, which had the potential to have a detrimental outcome for detainees. (See paragraph 3.14 and 4.6.)

Area for improvement

6.72 All detainees with mental health needs should have prompt access to specialist mental health services, and those who need an assessment under the Mental Health Act should receive this without delay.

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

Section 7. Release and transfer from custody

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

Pre-release risk assessment

7.1 In our case audits and custody record analysis, the recording of pre-release risk assessments was mostly poor; records generally contained little indication that risks were routinely addressed and it was often unclear how detainees were getting home. However, our observations indicated that the working practice was better than what was recorded.

7.2 Custody sergeants were properly focused on ensuring a safe release for detainees, and were aware of the specific offences and circumstances that made detainees more at risk on release. Detainees involved in sexual offence cases received additional support from investigating officers and custody sergeants before release. All detainees were asked about their means to get home. Officers took many detainees home, particularly if they were vulnerable, which was positive.

7.3 The force had a support leaflet with useful telephone numbers but this was not routinely given to all detainees on their release. Two versions of the leaflet were in circulation and contained inconsistent information.

7.4 The quality of information in the person escort records (PERs) we examined was generally good. However, many PERs also had additional unnecessary documents, such as risk assessments and confidential medical notes, which was inappropriate.

Areas for improvement

7.5 Records of arrangements to ensure that detainees are released safely should be more detailed and indicate that risks have been addressed.

7.6 Unnecessary documentation should not be added to person escort records, and any medical examination notes that need to accompany the detainee should be placed in a sealed envelope marked 'confidential'.

Courts

7.7 Since the last inspection, the force had engaged with Her Majesty's Courts & Tribunals Service (HMCTS) to address the issue of detainees not being presented to the first available court. The force did not collate data on how frequently detainees remained in custody for longer than necessary due to the lack of court availability. Staff from HMCTS and GEOAmey (the escort contractors) reported that detainees were refused by the courts infrequently and generally only as a result of a lack of available court slots and/or space in court cells.

7.8 At NACF, detainees were sometimes collected for court appearances during the afternoon, which was positive. Some custody staff, particularly in suites in the south of the county, still

suggested that court cut-off times were generally too early in the day, although we found no evidence of this potential for unnecessarily prolonged detention in police custody.

Area for improvement

7.9 The force should monitor detention times to check that they are not prolonged unnecessarily by delays in court appearances.

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

Areas of concern and recommendations

8.1 **Area of concern:** Performance information on custody was not comprehensive, and limited monitoring made it difficult for the force and others to assess how well custody services performed.

Recommendation: The force should develop a comprehensive performance management framework for custody that ensures the accurate collection of data, and use this to assess performance, identify trends and learning opportunities, and improve services. (2.42)

8.2 **Area of concern:** The force used some procedures and practices that did not comply with the Police and Criminal Evidence Act 1984 (PACE) or the Act's code C (covering the detention, treatment and questioning of persons by police officers).

Recommendation: The force should ensure that all processes in custody comply with code C of the Police and Criminal Evidence Act 1984 (PACE). (2.43)

8.3 **Area of concern:** CCTV monitoring of detainees on constant observations did not comply with the College of Policing Authorised Professional Practice guidance, and required improvement to identify, offset and address risk.

Recommendation: Constant observation of detainees through CCTV should be in accordance with College of Policing Authorised Professional Practice guidance. (2.44)

8.4 **Area of concern:** Governance and oversight of the use of force in custody were limited, with insufficient information to demonstrate its use was justified or proportionate.

Recommendation: Staffordshire police should immediately introduce the robust scrutiny of all force used in the detention and custody of detainees to assure itself and others that all use of force is justified and proportionate. (2.45)

8.5 **Area of concern:** The arrangements for obtaining appropriate adults were unsatisfactory and sometimes led to long delays. Some vulnerable adults had their fingerprints taken without an appropriate adult present, which breached PACE.

Recommendation: Children and vulnerable adults should consistently receive early support from appropriate adults. The force should fully comply with PACE requirements when taking fingerprints, and should improve record keeping and monitor the effectiveness of the AA service. (2.46)

8.6 **Area of concern:** The health service provider, Primecare, lacked effective clinical leadership and had weak governance, which resulted in inadequate oversight and monitoring of the health provision.

Recommendation: There should be robust clinical leadership and governance of health care provision to ensure adequate oversight and lead service improvement. (2.47)

Areas for improvement

Pre-custody: first point of contact

8.7 The force and health partners should ensure that appropriate transport is available and used to support timely transfer of people detained under section 136 of the Mental Health Act. (4.7)

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

8.8 Booking-in areas should provide sufficient privacy. (5.7, repeated recommendation 4.12)

8.9 There should be ongoing risk assessment of all detainees whose booking in is delayed. (5.15)

8.10 All staff attending detainees' cells should carry anti-ligature knives. (5.16)

8.11 Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment, and detainees should never be left naked in a cell as a strategy to reduce self-harm. (5.17)

8.12 All custody staff should be involved collectively in the relevant shift handover. (5.18)

8.13 Custody sergeants should ensure that the detainee's time of arrival is accurately recorded on custody records. (5.31)

8.14 Detainees should be booked in promptly on arrival at the custody suites. (5.32)

8.15 The force should ensure that detainees are able to make a complaint while they are still in custody. (5.40)

In the custody cell, safeguarding and health care

8.16 The force should take remedial action to remove or manage any potential ligature points. (6.7)

8.17 Custody staff in all suites should have access to adequate stocks of in-date first aid and emergency equipment, including oxygen. (6.8)

8.18 All detainees held overnight, or who require one, should be offered a shower, and all custody suites should facilitate exercise periods for detainees. (6.26)

8.19 All suites should hold and offer a range of reading materials, including books and magazines suitable for young people and non-English speakers. (6.27, repeated recommendation 4.52)

8.20 Detainees held for long periods, particularly those who are vulnerable, should be allowed visits. (6.28)

8.21 The force should continue to work with its local authority partners to ensure that children charged and refused bail are transferred to alternative accommodation to avoid their custody overnight. Custody sergeants should be clear on the type of accommodation they request. (6.41)

8.22 Health care professionals should see detainees within agreed response times. (6.51)

8.23 Detainees should be able to complain about health care services through a well-advertised and confidential health care complaints system. Complaints should be routinely analysed for trends and learning points to inform service improvement. (6.52)

8.24 All clinical rooms should comply with relevant standards of cleaning and infection prevention and control, including regular internal and external audits. All custody suites should have suitable forensic sampling facilities. (6.53)

8.25 All health care professionals, including mental health and substance misuse workers, should be consistent in making relevant entries on the detainee's custody record. All clinical records should be made and stored in line with national and professional standards. (6.59)

8.26 Detainees who are due to have medication while they are at court should have this sent with them, with clear administration instructions. (6.60)

8.27 Nicotine replacement therapy should be available for detainees who require it. (6.61)

8.28 Detainees with alcohol or drug problems should be supported through a comprehensive and integrated service in all custody suites. (6.65)

8.29 All detainees with mental health needs should have prompt access to specialist mental health services, and those who need an assessment under the Mental Health Act should receive this without delay. (6.72)

Release and transfer from custody

8.30 Records of arrangements to ensure that detainees are released safely should be more detailed and indicate that risks have been addressed. (7.5)

8.31 Unnecessary documentation should not be added to person escort records, and any medical examination notes that need to accompany the detainee should be placed in a sealed envelope marked 'confidential'. (7.6)

8.32 The force should monitor detention times to check that they are not prolonged unnecessarily by delays in court appearances. (7.9)

Example of good practice

8.33 The ethics transparency and audit panel provided effective external scrutiny, and indicated a desire by the police and partners to improve their joint response, particularly in dealing with people with mental ill health. (3.13)

Section 9. Appendices

Appendix I: Inspection team

Ian Macfadyen	HMI Prisons team leader
Kellie Reeve	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary inspection lead
Viv Cuthill	HMI Constabulary inspection officer
Anthony Davies	HMI Constabulary inspection officer
Patricia Nixon	HMI Constabulary inspection officer
Majella Pearce	HMI Prisons health services inspector
Dr Elizabeth Walsh	HMI Prisons health services inspector
Anna Fenton	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 recommendation

Staffordshire Police should ensure clear lines of accountability, and systematic monitoring and control at inspector level and above. (2.19)
Not achieved

Recommendations

The format of the 'team room' computer page should be made more accessible, and staff should be given the necessary training to use it effectively. (3.16)
No longer relevant

All staff working in custody should receive regular refresher training, with effective management oversight of this process. (3.17)
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 areas should provide sufficient privacy. (4.12)
Not achieved (repeated as area for improvement 5.7)

Managers should ensure that the reasonable requirements of detained children, women and people with disabilities are met. (4.13)
Achieved

There should be hearing loops in the booking-in areas, and all custody staff should know how to operate them. (4.14)
Not achieved

Staff should be given up-to-date guidance on the treatment of transgender detainees. (4.15)
Achieved

Custody records should be sampled to ensure that where observations are not undertaken at the required intervals, action is taken to improve practice. (4.24)
Achieved

Suicide prevention kits should include anti-ligature shears and be readily accessible. (4.25)
Achieved

All custody staff should be involved in the same shift handover and, where possible, this should take place away from the booking-in area and be recorded. (4.26)
Not achieved

Detainees should only remain handcuffed while they are booked in when a risk assessment indicates this is necessary for the safety of staff, the public or the detainee. (4.33)
Not achieved

The fire alarm system at Burton should be made reliable or replaced. (4.39)
Achieved

All detainees held overnight, or who require one, should be offered a shower. (4.50)
Not achieved

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

All suites should hold and offer a range of reading materials, including books and magazines suitable for young people and non-English speakers. (4.52)
Partially achieved (repeated as area for improvement 6.27)

Visits should be facilitated for vulnerable young people or detainees held for long periods. (4.53)
Not achieved

Individual rights

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

National issue

Appropriate adults should be available to support without undue delay juveniles aged 17 and under in custody, including out of hours. (2.21)
Not achieved

Recommendations

Staffordshire police should work with the local authority to ensure the provision of appropriate overnight accommodation for juveniles who have been charged but cannot be bailed to appear in court. (5.8)
Not achieved

Information about detainees' rights and entitlements should always be available in a range of formats that meet specific needs. (5.9)
Achieved

There should be two-handset telephones in all suites to facilitate telephone interpreting. (5.10)
Achieved

Staffordshire Police should work with HM Court and Tribunal Service to ensure that early court cut-off times do not result in unnecessarily long detentions in custody. (5.17)
Achieved

Detainees should be able to make a complaint before they leave custody, and data on complaints should be monitored. (5.23)
Partially achieved

Health care

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

Main recommendation

The new health care arrangements should ensure sound clinical governance, prompt attendance by health care professionals, and secure handling of records and medicines. (2.20)
Not achieved

Recommendations

Clinical governance arrangements for health professionals, including the management, training and accountability of staff, should be robustly implemented and monitored. (6.6)
Not achieved

All clinical rooms should be fit for purpose and meet infection control guidelines. (6.7)
Not achieved

All clinical records should be stored in line with the Data Protection Act and Caldicott guidelines on the use and confidentiality of personal health information. (6.17)
Not achieved

All medications should be stored safely and securely at all times. (6.18)
Achieved

All detainees should have equal access to mental health services across the force area. (6.29)
Not achieved

Police custody should not be used as a place of safety for those arrested under section 136 of the Mental Health Act 1983. (6.30)
Partially achieved