Report on an announced inspection of

Border Force customs custody suites in England and Scotland

by HM Inspectorate of Prisons

and

HM Inspectorate of Constabulary and Fire & Rescue Services

2–9 May 2017

Glossary of terms

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

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

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

Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

Contents

Section 1. Introduction

This report is the third in a programme of inspections of Border Force customs custody suites which are 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 Border Force custody suites in February 2015, when we found detainees were generally well cared for and that significant improvements had been made since our first inspection in 2012. Previously, our principal concerns related to the organisation's ability to maintain a suitably skilled and confident workforce, the proportionate use of force and weaknesses in ensuring women detainees were always treated with dignity.

At this inspection, we found that problems associated with deploying generic staff to deal with specialist functions involving high risk individuals remained problematic. We listened to ideas from staff about how this could be tackled but, in practice, not enough had been done to address the issue. Use of force was reportedly low and the small sample of cases we examined indicated that its use was proportionate. Formal structures of accountability, however, remained weak. We were pleased to see greater efforts were now being made to ensure women detainees were treated with dignity.

At a national level a loose management structure or framework was in place but Border Force regions tended to function as independent entities. One of our key findings was that there was a lack of clear communication and understanding between the central and regional tiers. This caused some confusion and led to inconsistent working practices. The problem was exacerbated by the lack of a central recording system and poor data recording locally, making it difficult for the organisation to monitor its performance accurately and identify where improvements were required.

Although the management of health care services had been improved, the impact on the ground was limited because of staff shortages.

Despite some weaknesses, we found that detainees held in Border Force customs custody suites continued to be well cared for and that elements of the service were good. The pace of improvement, however, and attention to our recommendations needs to be better if provision is to meet the best standards.

We noted that of the 26 recommendations made in our previous report after our inspection of February 2015, three recommendations had been achieved, nine had been partially achieved, 13 had not been achieved and one was no longer relevant.

Dru Sharpling CBE
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

June 2017

Section 2. Background and key findings

2.1 This report is the third relating to the inspection of Border Force customs custody carried out jointly by HM Inspectorate of Prisons (HMI Prisons) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS),[1] and in association with HM Inspectorate of Constabulary in Scotland (HMICS), who have jurisdiction in Scotland. 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 Inspectorate of Prisons, HM Inspectorate of Constabulary and Fire & Rescue Services and HM Inspectorate of Constabulary in Scotland are three of several bodies making up the NPM in the UK.

2.2 The inspections of Border Force custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing *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 Border Force Custody*[2] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 A documentary analysis of custody records was conducted as part of Border Force custody inspection. The custody record analysis was carried out on all custody records opened by Border Force in March 2017. A total of 39 records, across four suites (Gatwick, Colnbrook, Dover and Manchester), were included in this analysis. The analysis focused on the legal rights and treatment and conditions of detainees.

2.4 In addition, the five most recent custody records opened at suites that were not used in March 2017 (Birmingham, Harwich and Glasgow) were reviewed. This review also looked at the treatment and conditions of detainees.

2.5 A data collection template was completed by the force during the inspection and was based on Border Force 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 average time between arrest and arrival in custody and the average length of time in Border Force detention.

2.6 Border Force operates two types of suite: interview suites and 'spine' suites. Interview suites do not have cells, but can be used to detain someone usually for no longer than six hours. Spine suites are normal custody suites with cells. Scotland has one spine suite in Glasgow. Since the previous inspection in 2015, Border Force has had only one interview suite at Stansted airport, but it was closed during the inspection because it was being upgraded to a spine suite with two cells. Many people in customs custody suites are detained because they are suspected internal drug traffickers.[3]

---

1 This inspection was carried out before 19 July 2017, when HMIC also took on responsibility for fire & rescue service inspections and was renamed HM Inspectorate of Constabulary and Fire & Rescue Services. The methodology underpinning our inspection findings is unaffected by this change. References to HMICFRS in this report may relate to an event that happened before 19 July 2017 when HMICFRS was HMIC. Citations of documents which HMIC published before 19 July 2017 will still cite HMIC as the publisher.

2 http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm

3 A suspected internal drug trafficker is suspected of ingesting sealed packages of controlled drugs or secreting them in their body orifices to avoid their detection on entering or leaving the country.

2.7 Between 1 April 2016 and 31 March 2017, the suites had a total throughput of 557 detainees. The designated custody suites and cell capacity of each was as follows:

Suite	Detention times	Number of cells
Birmingham Airport	As required	2
Colnbrook (Heathrow Airport)	24/7	9
Dover Seaport	24/7	6
Gatwick Airport	24/7	6
Glasgow Airport	As required	2
Harwich Seaport	As required	2
Manchester Airport	24/7	6
Stansted Airport (closed for refurbishment)	As required	2 (on re-opening)

Strategy

2.8 The condition of and the facilities within the custody estate, varied across Border Force. There had been investment in some suites but there was no overarching estate strategy. A review of custody services was planned, but it was not clear whether it would address the custody estate.

2.9 Clear regional organisational structures were in place to deliver custody services as part of the wider Border Force framework. Officers we spoke to in the custody suites were clear about their direct roles and responsibilities towards detainees.

2.10 The regions were supported by a national team, which had strategic responsibility for ensuring the safe, respectful and consistent delivery of custody services. However, Border Force services remained operationally rather than strategically driven, with regions very much responsible for running their own areas of activity.

2.11 A range of meetings brought custody management together to share issues and lessons learned and develop consistent approaches. Despite this, the relationship between the regions and the national team seemed confused and not all regional staff were aware of the national team's role. Managers were aware of differences in working practices across the regions.

2.12 Many Border Force officers were multi-functional and covered both immigration and customs duties. Based on current throughput there were generally sufficient staffing resources to meet the demands of the service. Although carrying out custodial duties could be challenging, staff told us that there was little recognition of the uniqueness of these duties.

2.13 Custody policy was mainly based on College of Policing *Authorised Professional Practice* (APP) and most staff knew how to access policy documents. But in practice, APP policy and guidance were not being consistently followed and regional variations were evident.

2.14 We found the data supplied by the regions to the national team were flawed. There was little active monitoring of data and no evidence to show how performance information drove improvement. This was a serious weakness because it meant the organisation could not review its own performance.

2.15 The lack of a central recording system hindered the consistent delivery of custody and undermined the effectiveness of a number of custody processes. The paper custody record system was inefficient and made sharing and monitoring information cumbersome. We also found variations in the quality and detail of the custody records we examined.

2.16 Partnerships with the National Crime Agency, HM Revenue and Customs, police custody, courts and social care services linked up at an operational rather than strategic level. Staff said the local partnerships worked well. Apart from at Glasgow, independent custody visitors offered external scrutiny. A health contract had been introduced and arrangements were being reviewed to address concerns.

2.17 Staff regarded custody officer training as good. The initial training and subsequent refresher training, which were nationally coordinated, were supported by local arrangements, such as discussion sessions. However, there were insufficient data to assure us that all staff had received the training they required.

2.18 Keeping the skills and experience of officers up to date remained a significant challenge. Low throughput meant some custody officers gained little experience of dealing with detainees. Most of the staff we spoke to knew what was expected of them but, as we found during the previous inspection, some lacked confidence because of this lack of experience.

2.19 Managers had attempted to address the problem of keeping staff up to date and skilled, for example, by getting custody officers to spend time in police custody teams, using mentoring schemes or allowing for observing or shadowing. However, few of these ideas had been implemented.

2.20 A national quality assurance system was in place based on sampling custody records at different management levels. Despite this we found too many records with omissions in key areas and a lack of cross-referencing to CCTV footage.

2.21 Adverse and critical incidents were reported in line with procedures and individual cases could be discussed at meetings. However, there was no process for systematically learning lessons.

Treatment and conditions

2.22 Appropriately equipped vehicles were available for transporting detainees at most suites. Staff were generally respectful and responsive and had undertaken generic diversity training (see paragraph 4.3). They generally knew how to meet detainees' needs. However, detainees with disabilities or mobility issues were not sufficiently well catered for.

2.23 Staff generally had a good understanding of safeguarding issues. Detained children or those accompanying parents were treated well. The needs of women detainees were usually appropriately met and provision for religious worship was mostly adequate.

2.24 Custody officers we spoke to had a good awareness of vulnerability. We acknowledged efforts to upskill custody officers, particularly in the quieter suites. However, some custody officers still had not received refresher training and some lacked confidence and competence in the overall management of risk in the custody suite

2.25 We continued to find that clothing with cords and laces, as well as footwear were routinely removed. In the absence of an individual risk assessment, this remained disproportionate.

2.26 Processes and practices for determining observation levels varied across suites and were not compliant with APP guidance. There were no care plans and it was sometimes difficult to ascertain from records the level of observation set or when levels had been amended due to a change in circumstances. We were not confident that custody staff always implemented rousing as required. The quality of engagement recorded in custody records was inconsistent and did not always reflect what happened in practice.

2.27 Strategies for managing and minimising the risk of self-harm were reasonable but not all custody staff carried anti-ligature knives, which posed a potential risk. Custody officers understood how to manage and minimise the risks associated with the bodily concealment of drugs.

2.28 Handovers were normally well recorded but only took place between custody officers. The standardised person escort record (PER) was still not being used consistently and PERs were not always completed well enough.

2.29 Discussions with most custody staff showed they were focused on releasing detainees safely. However, records did not indicate that pre-release assessments were completed as they should have been.

2.30 Other than applying handcuffs, force was used infrequently.

2.31 Custody suites were generally well maintained and cleaned regularly. Potential ligature points were identified at a number of different sites. Fire evacuation testing was inconsistent, and most suites did not conduct regular drills or full smoke tests.

2.32 Custody staff we spoke with showed a clear focus on detainee care. Because of low throughput, the ratio of staff to detainee was often high, which enabled officers to provide a good standard of care. Detainees were well looked after and were provided with meals and offered suitable sanitary and laundry items.

2.33 However, a number of outstanding areas still needed addressing. At some suites, detainees had insufficient privacy when using the shower or toilet. There were few opportunities for detainees to exercise, and visits were not facilitated.

Individual rights

2.34 Custody officers rarely refused detention and were generally confident in authorising it. Their awareness of PACE code G relating to the need for an arrest was, however, extremely limited. Records too often contained limited explanations of the rationale and necessity for an arrest. Most detainees arrived at the custody suites shortly after arrest but delays sometimes occurred. Detainees were mostly booked in within a short period.

2.35 Most transfers were to police stations so detainees could be charged or appear in court. Changes to bail legislation meant some detainees who were being released under investigation had to be transferred to police stations to have their fingerprints, photograph and DNA taken.

2.36 Custody staff were generally confident in the use of telephone interpretation services but interpretation was mostly conducted through speakerphones, which did not provide

sufficient privacy. Hearing loops were generally available, but not all staff knew how to use them.

2.37 Detainees were routinely informed of their rights and all detainees could consult a legal representative, if they requested it. Reviews of detention were well managed and it was positive that they were usually completed face to face. Regulated timescales meant that detainees were generally presented before the first available court for Section 152 hearings (to seek an extension to detention). The use of video links across the estate was limited despite its availability at two suites.

Health care

2.38 Custody suites in England moved to a single health provider in February 2017. There were clear performance measures, which supported more effective governance and consistent service delivery across the suites. However, despite the issue being effectively managed, the predicted benefits had not been fully realised because the provider did not yet have all the necessary staffing and governance arrangements in place. The custody site in Scotland now had the same health provider as police custody suites. All suites had dedicated clean clinical rooms and the new facility in Glasgow was excellent. Telephone advice remained prompt, but attendance times in the English suites were very mixed, mainly due inadequate health staffing levels.

2.39 The demand for substance misuse support remained very low. Most custody staff said they had not received any substance misuse or ongoing mental health awareness training, however we were advised that the new health provider would provide training.

Areas of concern and recommendations

2.40 The strategic approach to custody services was limited and delivery was driven operationally by the regions rather than through a strong national approach to ensure effective and consistent outcomes for detainees.

Recommendation: Border Force should strengthen its strategic approach to the delivery of custody services to provide a strong overall framework that supports the regions, ensures consistent service delivery and outcomes for detainees, and drives service improvement.

2.41 Border Force has stated it follows the APP guidance for detention and custody as set by the College of Policing. Its practices did not reflect this in a number of areas and some staff demonstrated little knowledge of the content of the guidance.

Recommendation: Border Force should take immediate action to ensure all custody staff follow APP policy and guidance, and have arrangements in place to demonstrate compliance.

2.42 Performance management was limited and little proactive monitoring of the service and action took place as a result.

Recommendation: Border Force should ensure its data are accurate and performance is monitored effectively. The information should be used inform its work with the regions and to identify and act on areas requiring improvement.

2.43 Border Force had procured a single health provider for the seven English suites and had clear and appropriate performance monitoring mechanisms. However, at the time of the inspection the health provider did have not have adequate staffing or governance structures in place to ensure detainees received a consistent, safe and timely service.

Recommendation: The health provider in the English suites should ensure there are adequate staffing levels and governance systems in place to ensure all detainees receive a safe and timely service.

Section 3. Strategy

Expected outcomes:
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.

Strategic management

3.1 Overall, we found that the standard of custody suites and quality of the custody services delivered were similar to our inspection in 2015. There had been some improvements but only three of our previous recommendations had been achieved and nine partially achieved. Thirteen were still outstanding, and although Border Force had developed an improvement plan to address all our recommendations, progress had been limited.

3.2 The condition and facilities of the custody estate varied, but in general provided detainees with a good environment. There were seven designated custody suites in England and one in Scotland. Stansted was closed for refurbishment during the inspection, and improvements at other suites, such as replacement cell doors, had been made. Redevelopment proposals for Manchester were being discussed with airport authorities. However, there was no overarching estate strategy to determine which areas required investment and improvement.

3.3 A clear regional organisational structure was in place as part of the wider Border Force framework. Each area had regional assistant directors and several senior officers (SOs) and higher officers (HOs) were responsible for managing the service. The service was delivered through designated officers trained to perform the custody role. Officers we spoke to were clear about their roles and responsibilities towards detainees.

3.4 Arrangements for providing custody officers with support from other staff varied across suites with different roles performed. Integration was not always good, particularly where the support role was carried out by another agency. At Colnbrook, Border Force had a contract with private company Mitie to provide custody support assistants who seemed to take on fewer duties than those at some other suites, which risked providing detainees with inconsistent care.

3.5 The service lacked a strong strategic approach. The national team for custody and immigration detention consisted of a director, deputy director and an assistant director, who managed a small number of senior and higher officers. It had strategic responsibility for ensuring the safe and respectful delivery of custody, but we found that the service remained operationally rather than strategically driven. The team sought to achieve a more consistent approach by ensuring that policies and procedures were shared and that some functions were centrally managed. It also dealt with wider issues such as the introduction of the new healthcare contract. While the work of the national team had resulted in more consistent work practices being adopted, the regions still very much ran their own areas of activity (see main recommendation 2.40).

3.6 The relationship between the regions and the national team was confused and not all staff we spoke to understood the national team's role. Border Force managers were aware of the differences in working practices across the regions, and recognised that achieving an appropriate balance between national and regional requirements and delivering a consistent service was a challenge.

3.7 A range of meetings brought custody staff together to share issues and lessons learned and to develop a more consistent approach. They included the senior development, custody practitioner and custody trainers groups. They met quarterly and staff found them a positive way of addressing custody issues and improving the service. For example, a recent area for discussion had been the level of vetting that custody officers should have as a requirement for the role.

3.8 There were generally sufficient staffing resources to meet the demands of the service. Many officers in Border Force were multi-functional, covering immigration and customs duties. Custody services relied on officers volunteering for the role. Senior and higher officers dedicated to custody ensured the service was appropriately managed and a wider pool was available for them to draw on to cover Police and Criminal Evidence Act 1984 (PACE) reviews. Officers trained in custody could be called from their other duties to open and run suites when required. This took priority over other areas of work and ensured detainees received appropriate levels of care, although it potentially affected Border Force's other activities.

3.9 Ensuring sufficient officers were willing to carry out custody duties remained a challenge for Border Force. The service relied on volunteers from the multi-functional teams, but officers did not receive any additional reward or recognition for carrying out custody duties. In most suites, it also meant officers worked alongside each other performing either the custody officer or the assistant role, which carried significantly different levels of responsibility, but without being reflected in grading or remuneration. Staff told us this deterred some officers from volunteering.

3.10 All staff were vetted to security clearance level. Some Border Force staff were safeguarding specialists and had to be vetted through the Disclosure and Barring Service (DBS). A number of them were also trained in custody, which meant when they were on duty in the suites they had been appropriately vetted for dealing with vulnerable adults and children. Border Force was considering whether to extend DBS vetting to all staff working in custody. This would have provided additional assurances that all detainees were adequately safeguarded.

3.11 Border Force's custody policy was largely based on the College of Policing *Authorised Professional Practice* (APP). The national team was responsible for keeping policies updated or developing any specific Border Force policies and ensuring staff were aware of them. For example, staff in the regions had been issued with interim guidance on new bail requirements introduced from April as part of the Policing and Crime Act 2017,[4] and understood the impact they would have on their work. Most staff we met knew how to access policy documents or kept their own copies.

3.12 However, although Border Force told us they followed APP policy and guidance, we were concerned that, in practice, they failed to do so in several areas. We found inconsistencies when risk observation levels were set, some local arrangements did not ensure handover procedures involved all staff and the justification for strip-searches was not always recorded on the custody record – all of which contravened APP guidance (see paragraph 4.17). We found that some staff demonstrated little knowledge of the content of APP guidance (see main recommendation 2.41).

3.13 In addition, Glasgow did not benefit from the work of the national team as much as the other regions. This was particularly the case where legislative and policy matters were concerned. Senior staff in Glasgow needed to carry out a significant amount of extra work to ensure that Border Force policies and procedures were amended to reflect the legal framework in Scotland and were applied appropriately.

---

[4] Not applicable in Scotland.

3.14 The lack of a central recording system hindered the consistent delivery of custody and the effectiveness of a number of custody processes. The paper custody record system was inefficient and made sharing and monitoring information cumbersome. We also found variations in the quality and detail of the custody records we examined.

3.15 Performance management arrangements were not robust. The regions submitted performance information to the national team on a quarterly basis across several areas, including throughput figures and details on use of force. However, the central team did not monitor the performance information provided, regions received little feedback and there was no evidence that it was being used to assess performance or identify where improvements were needed.

3.16 We also had concerns about the accuracy of the performance information collected. The throughput figures provided by Border Force had some detainees recorded twice, for example when they moved from one suite to another, because a new record was opened. Figures for the number of complaints also appeared incorrect and the PACE performance report recorded that a child had been held in custody when the detainee was an 18-year-old (see main recommendation 2.42).

Areas for improvement

3.17 **Border Force should extend DBS vetting to all custody officers to strengthen the approach to safeguarding.**

3.18 **An efficient and effective method of recording should be introduced.**

Partnerships

3.19 Staff said partnership arrangements worked well across the regions. Partnerships with the National Crime Agency, HM Revenue and Customs, police custody, courts and local authority social care services, as well as NHS England were mainly operational. Limited partnership working took place at a strategic level.

3.20 A new health contract had been implemented and the arrangements were being reviewed to address concerns that had arisen (see paragraph 6.1).

3.21 Apart from Glasgow, all the regions had introduced independent custody visitors (ICVs) to provide external scrutiny of custody facilities and detainee care. Whenever there were detainees in the custody suites, ICVs were contacted and asked if they wanted to visit and speak with the detainee. In addition, ICVs visited suites unannounced. Their scrutiny enabled Border Force to obtain feedback on its services.

Area for improvement

3.22 **ICVs should be available to provide scrutiny at the Glasgow suite.**

Learning and development

3.23 Staff thought custody officer training was good. The initial five-day induction training and subsequent half-day refresher training were coordinated nationally for all staff. In the regions, they were supported by local arrangements such as discussion sessions. The custody early

warning score training (to assess the well-being of detainees suspected of carrying drugs internally) was also viewed positively (see paragraph 6.9) and staff benefited from wider Border Force training covering, for example, safeguarding and modern day slavery. Training was delivered through a mixture of classroom and e-learning sessions, although in some areas there was an over-reliance on the latter.

3.24 Most staff told us they had received regular custody training. However, several officers at Glasgow were not up to date with their training, mainly because it had not been adapted to meet Scottish law requirements. Annual refresher training was mandatory for officers who only infrequently undertook the custody officer role and officers at busier suites had to take it at least every two years. Staff could opt to undertake the training more regularly, or repeat the full initial induction course if they or their managers thought it necessary. There seemed to be little or no central monitoring to ensure staff complied with training requirements.

3.25 Despite the training arrangements, keeping the skills and experience of custody officers up to date remained a significant challenge. Low throughput meant some custody officers gained little experience of dealing with detainees, and we met some who had not booked in detainees even though they had been trained and were available to perform the role for some time. Most of the staff we spoke to knew what was expected of them but some lacked confidence because they were inexperienced (see paragraph 4.2). This was similar to what we found at our previous inspection. Arrangements had been developed to address the problem. They included custody officers spending time in police custody teams, mentoring schemes and observing or shadowing more experienced staff with a mix of teams. However, few of these arrangements had been implemented.

3.26 A consistent approach to quality assurance had been introduced across all regions. It was based on sampling custody records at different management levels. Managers signed off their completed checks. We were told that any issues would be raised with the officers concerned, or at one of the national meetings.

3.27 In practice, we were not confident that the implementation of the quality assurance process was sufficiently robust. Several records we examined lacked detail and omitted some key information, which we would have expected the quality assurance system to address. No routine cross-referencing to CCTV footage took place despite it having been previously recommended and detailed in Border Force's action plan.

3.28 Adverse incidents were reported in line with procedures, and since the last inspection Border Force had introduced a national reporting form for critical incidents. Staff told us incidents could be discussed at the various national meetings. However, there was no systematic process for learning lessons from them and staff relied on the Independent Police Complaints Commission *Learning the Lessons* bulletins for information about national concerns.

Areas for improvement

3.29 Arrangements to ensure the skills and knowledge of custody staff are kept up to date should be implemented.

3.30 Border Force should strengthen its approach to quality assurance and introduce a systematic approach to learning lessons from adverse and critical incidents.

Section 4. Treatment and conditions

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

Respect

4.1 Arrangements for transporting detainees varied: either purpose-built cellular vans or standard vehicles were used. At Harwich, standard vehicles were used because the cellular vehicle had been awaiting repair for several months. The vans we saw were clean and sufficiently equipped, carrying first aid kits and water as a minimum. We were informed that detainees who were transported in standard vehicles would be handcuffed subject to an individual risk assessment and accompanied by a driver and a minimum of two officers.

4.2 During the inspection, we saw only two detainees in custody at Gatwick and Colnbrook. The interactions we observed were generally respectful and responsive. Custody staff we spoke to were not always confident about carrying out their role. How confident they were depended on their experience; some had not worked in the custody environment for a considerable time (see paragraph 3.25).

4.3 Staff had all undertaken some generic diversity training, although it did not relate specifically to their custody role or include mental health, and was often delivered online (see paragraph 2.22). We found staff did not always know how to manage or search transgender detainees appropriately.

4.4 We were informed that detainees at all suites were booked in one at a time while others were in an interview room or holding area, ensuring privacy. Booking-in desks were of an appropriate height. At Gatwick, we were told that a detainee in a wheelchair was booked into custody using an alternative interview room (with a standard height desk) to facilitate respectful communication, which was good.

4.5 As part of the booking-in process, detainees were routinely asked about their individual needs, including religious worship and dietary requirements and caring responsibilities. Women would also be offered the opportunity to speak to female officers, either those already on duty in custody or from other teams based nearby on site. We were assured that a female officer would automatically be allocated to girls throughout their detention in line with policy and legislation.[5]

4.6 Most of the staff we spoke with showed a good understanding of safeguarding children concerns. Most had received Keeping Children Safe training and were aware of their responsibilities, including the need to contact the local authority children's social care service to ensure arrangements were in place to keep a child safe. Some Border Force staff had received additional safeguarding training and, if on duty, could be asked to provide specialist safeguarding advice and support to custody officers (see paragraph 3.10).

4.7 From our review of records and speaking to staff, we were confident that detained children or accompanying parents were treated well. Staff knew that children should not be held behind closed doors in cells (even when arrested) and used interview rooms or other designated facilities to provide a more comfortable, less intimidating environment. Additional

[5] As per section 31, Children and Young Persons Act 1933.

staff could be called on to ensure the child's physical and emotional needs were met and to provide one-to-one support. Most suites had a good supply of toys, games, books, baby products (including changing or feeding products) or could source them easily. Local authorities were automatically notified about a child's detention, although staff said their response and level of assistance varied significantly.

4.8 We were, however, not confident that individual child welfare control sheets,[6] required to maintain records of each detained child's management in custody, were used sufficiently. We found evidence that they were not being completed, that insufficient detail was being recorded and that some staff were unaware of them.

4.9 Custody staff knew how to meet the needs of people with disabilities. Other than at Manchester thick mattresses were available at the suites, and at airport suites wheelchairs could be borrowed for detainees with mobility issues. We were told how alternative arrangements were made for one detainee, who was unable to use the specialist toilet facilities.

4.10 However, not all the suites could cater for people with disabilities. Harwich had limited facilities for people with mobility issues. Manchester did not comply with the Disability Discrimination Act and any detainee needing a wheelchair or unable to manage stairs was transported to police custody facilities. None of the cells had cell benches from which call bells could easily be reached. The accessibility of showers and toilets also varied, for example, we found facilities, such as showers and drug toilets, that only had step access.

4.11 A good supply of religious texts and aids was available at most suites, including prayer mats, compasses and, in some cells, an arrow indicating the direction of Mecca. However, texts were not always stored appropriately and copies of the Torah were not available in some suites.

Areas for improvement

4.12 Border Force should ensure custody officers complete a child welfare control sheet for any child entering a custody suite.

4.13 Detainees with disabilities should be appropriately catered for at all suites.

Safety

4.14 Custody staff were informed when a detainee was being brought in to custody, which allowed staff to be deployed and for the suite to be prepared. We were informed that arresting officers asked for a basic police national computer check, supplemented by a more in-depth check requested by custody officers. Custody officers were generally able to identify any existing warning markers (indicators showing a person has previously had a problem or is at risk) to be considered during the risk assessment process.

4.15 With some exceptions, a post-arrest and transfer risk assessment[7] containing basic information was completed by arresting officers prior to a detainee's arrival in custody. A further, more comprehensive risk assessment was completed for all detainees booked in to custody. The lack of a computerised system often resulted in numerous loose-leaf additions

[6] Child welfare control sheets are designed to be completed for every child held in custody and they should contain a risk assessment and details of all interactions with the child.

[7] In Scotland, this refers to the post detention and transfer risk assessment form.

to the custody record, making it difficult to find where relevant information had been recorded and a risk of the information becoming detached or mislaid (see paragraph 3.27).

4.16 Custody throughput was low and we did not see any detainees being booked in during the inspection. We acknowledged that efforts had been made to upskill custody officers, particularly in the quieter suites. We were, however, concerned that refresher training was not always regular enough or sufficient to maintain an adequate level of professional skills. From conversations with custody officers we found some lacked confidence and competence in the overall management of risks in the custody suite. They did, however, have a generally good awareness of potential vulnerabilities, which was positive (see paragraph 3.25).

4.17 Few strip-searches took place as they were generally conducted by arresting officers before arrival. Strip-searches were not justified well enough in custody records (see paragraph 3.12)

4.18 Border Force's policy on the removal of personal property was confusing. We were told that clothing with cords, footwear, belts and sometimes other personal property, including spectacles, continued to be routinely removed. This remained disproportionate in the absence of an individual risk assessment.

4.19 Processes for determining observation levels varied across suites, none of which were compliant with College of Policing *Authorised Professional Practice* (APP) guidance. Custody records did not contain individual care plans and it was sometimes difficult to determine what level of observation had been set or if it had been amended following a change in circumstances. In our custody record analysis, we found some cases in which no observation levels were set and others where adherence to set levels was not recorded.

4.20 Detainees could be monitored on CCTV if the custody officer thought it appropriate. CCTV monitors were observed by additional staff but there was some confusion about how many detainees could be observed by one member of staff at any one time. Recording of these observations varied across suites.

4.21 Despite notices in each suite describing what was required when rousing a detainee, we were not confident that custody officers were all aware of what this practice involved. Entries in custody records varied and did not always reflect what happened in practice. Some were detailed and reflected very good interactions with detainees, while others only contained scant information.

4.22 Not all staff in custody carried anti-ligature knives, posing a potential risk to detainees. Custody keys were not always controlled well enough, notably at Gatwick, where we saw a cell key left in a cell door while a detainee was secured.

4.23 Strategies for managing and minimising the risks of self-harm seemed reasonable from what custody officers described. They appeared confident and knew how to manage and minimise the risks associated with the bodily concealment of drugs, including sending detainees for X-rays and scans as soon as possible, carrying out custody early warning score assessments (see paragraph 6.9) and raising levels of observations in the custody suite.

4.24 Handovers generally only took place between custody officers and did not involve other staff who had been involved in the detainees' care. We found some evidence of formal handover sheets, which reflected a proper focus on detainee welfare.

4.25 Staff did not always use the national standardised person escort record (PER), and local versions were still evident in some suites. PERs[8] we reviewed did not always contain all relevant risk information.

4.26 The template for formally assessing a detainee's risks prior to their release was not always completed. Custody records did not always assure us that staff did enough to ensure detainees were released safely. However, when we spoke to custody officers they knew about the risks post-release and appeared focused on trying to ensure detainees were released safely. They made telephone calls to make arrangements for their release. Most custody officers gave examples of where they had used petty cash funds to, for example, secure hotels prior to a return flight, buy food and arrange transport home for detainees.

4.27 Generic support leaflets were available in all suites except Glasgow but only in English. The leaflet at Gatwick was incomplete. Discussions with custody officers failed to confirm that the support leaflets were routinely handed out prior to release.

Areas for improvement

4.28 Clothing with cords, footwear and other personal possessions should only be removed subject to an individual risk assessment.

4.29 Standardised levels of observation in line with APP guidance should be implemented, clearly recorded, reviewed when circumstances change and adhered to.

4.30 The content of custody records should be improved; they should include a full account of rousing and other interactions between staff and detainees.

4.31 All staff in custody should carry anti-ligature knives.

4.32 Handovers should include all incoming and outgoing staff. (Repeated recommendation 4.22)

4.33 The standardised PER should be thoroughly completed for all detainees and kept with the detainee custody record.

4.34 Pre-release risk assessments should be thorough and based on an ongoing assessment of detainees' needs while in custody. The custody record should reflect the position on release and any action that needs to be taken. (Repeated recommendation 4.20)

Use of force

4.35 Data demonstrated that not all custody staff were up to date with personal safety training, particularly at Glasgow, presenting a significant risk. Staff and a personal safety trainer told us there was good emphasis on de-escalation during training (see paragraph 3.24).

4.36 There was no guidance on the personal protective equipment that custody staff had to wear and the equipment being worn was not consistent throughout the inspection. Many staff carried batons, which was disproportionate in a controlled custody environment. Leg

[8] Person escort records provide a standard format agreed with and used by all relevant agencies and contain information about a detainee's risk.

restraints were available, but no staff could recall either leg restraints or a baton being used in custody, which was good.

4.37 All staff we spoke to knew what constituted use of force against a detainee. All were also aware that they had to complete an individual use of force form whenever any force, including compliant handcuffing, was used. We were told that in the 12 months before the inspection, handcuffs had been applied 461 times, but we were not sure in how many instances they had been applied in custody.

4.38 During the inspection, we saw handcuffs applied to two detainees who were going to be transported. They would have had them on while they travelled to their next location. We were not, however, provided with correlating use of force forms for one of the detainees. This was a concern and we were not confident that use of force forms were submitted for all incidents.

4.39 Although handcuffs prior to custody continued to be almost routinely applied, we were told they were removed promptly on arrival in custody. Discussions with custody staff did not reassure us that they used their discretion or carried out an individual assessment before handcuffs were applied when detainees were to be transported, even when they were compliant.

4.40 Data suggested that use of force in custody was infrequent. Only two incidents involving force, other than handcuffs, were recorded since April 2016. We reviewed custody records and use of force forms associated with these incidents and found that it was properly justified and appeared necessary and proportionate. We were, however, unable to cross reference either of the incidents against CCTV footage. We were told that detainees did not see a health care professional routinely after force was used, but one would be called if the detainee asked to see one or if an injury was noticeable.

4.41 There was no governance or oversight of the use of force in custody. Border Force managers did not cross reference incidents against CCTV to assure themselves that the force used was necessary and proportionate.

Areas for improvement

4.42 Personal protective equipment should be standardised for staff in all custody suites and should be proportionate to the controlled custody environment.

4.43 Border Force should ensure that detainees are handcuffed only when it is necessary, justified and proportionate, using a risk assessment, in all suites. (Repeated recommendation 2.37))

4.44 Individual use of force forms should be submitted following every use of force against detainees, including compliant handcuffing.

Physical conditions

4.45 Glasgow was the only suite to have been fully refurbished since our last inspection; Stansted was closed for refurbishment during our inspection. However, most other suites had been updated relatively recently and were generally all in good condition, with no graffiti anywhere in the custody estate. Each suite had a good cleaning regime and cleaners were available on request and routinely, attending on most days, even at suites that held few detainees, which was good. Twice yearly deep cleans also took place at most suites.

4.46 Ligature points were found in all custody suite cells or in shower and toilet areas. Some of the risks they presented would have been offset if staff had monitored detainees closely. However, Border Force needed to ensure that all ligature points were routinely identified and measures put in place to mitigate the risk they posed.

4.47 Staff at all the custody suites routinely conducted health and safety checks of the cells. They were conducted by custody staff except in Glasgow, where non-custody trained freight staff did this on occasion, and records were generally completed consistently. Checks included identifying any graffiti, damage and cleanliness concerns, as well as ensuring call bells were working. However, the checklist differed across the suites; only some specifically required staff to look for ligature points. Higher and senior officers conducted regular additional weekly, monthly and quarterly oversight checks.

4.48 Due to the small number of detainees in custody during our visit, we could not observe what information staff gave them when they were taken to their cell. However, we were told that staff would explain the use of the call bell to them once they were in their cell. Custody records we examined demonstrated that staff frequently checked the facilities before allowing a detainee into a cell.

4.49 Arrangements for repairing and maintaining each custody suite varied and different contractors were in place. Staff told us that the service maintenance providers offered was mixed; they were mainly concerned about the length of time some faults took to be repaired.

4.50 Staff we spoke to were confident about what to do in the event of a fire and evacuation arrangements were usually clearly displayed in the suite. However, most suites did not conduct regular evacuation drills or testing to determine how quickly smoke could spread through the suite.

4.51 Suites or cells often had either limited natural light or none at all. For example, cells in the Harwich custody suite offered no natural lighting. Suites were generally ventilated and heated reasonably well. However, Dover had problems with inconsistent temperatures, which we were informed was a long running problem.

Area for improvement

4.52 Emergency evacuation drills should be carried out and recorded regularly.

Detainee care

4.53 The custody staff we spoke to focused well on detainee care. They said they would determine what detainees' requirements were and try to meet them where possible. Staff had access to a cash float, which they used to buy items detainees needed that were not held in stock.

4.54 The ratio of staff to detainees was often high because of the low throughput, which meant a good standard of care could be offered. Mattresses and pillows were wiped down after use and blankets, linens and towels laundered. We found sheets and pillow cases in some suites, which made bedding more comfortable.

4.55 Border Force had made little progress when it came to addressing our previous concerns about the lack of dignity for those who were suspected internal drug traffickers when they used the specialist toilet facilities. They continued to wear a one-piece paper suit which left

their upper body naked when it was lowered. This was a particular concern for women. Border Force had introduced an additional paper vest, which it was piloting at Colnbrook, Gatwick and Manchester, but it had not been used at the time of the inspection. Some staff gave women their underwear, but there was no consistent approach or evidence to suggest that other options had been considered for use more widely.

4.56 The custody suites were generally sufficiently well equipped to care for detainees. A range of meals and drinks was available and staff told us they offered them to detainees regularly throughout their stay. Their religious or dietary needs could be met. In suites at the airports, staff told us they would also obtain meals from the outlets on site. Our custody record analysis of detainees entering the suites during March 2017 showed 87% of detainees were offered food.

4.57 Most custody suites did not keep stocks of alternative clothing, other than paper suits. Most detainees had access to their own clothes and staff allowed them to change into them if necessary. When other clothing was required, custody staff said they would buy items from retail outlets nearby. A good supply of underwear was available in most suites but could also be bought if necessary.

4.58 Supplies of reading material, including books for children, and toys were available at all suites, although there was no reading material at Harwich. Material in other languages was limited but could be obtained if required. However, it did not seem to be offered routinely – in our custody record analysis only 23% of detainees were offered reading material.

4.59 We were told that detainees could normally have a shower on request and would be offered one if they had been held for some time. Privacy in the shower rooms varied across the suites. Some shower rooms had doors, which could be closed for detainees assessed as low risk but would otherwise be left open. Other shower rooms had screens or shower curtains which offered limited privacy.

4.60 Opportunities for outside exercise were limited and dedicated exercise yards were only available at Harwich and Colnbrook. However, detainees at Dover and Gatwick were able to exercise in areas usually used for other purposes. Our custody record analysis showed that only 10% of detainees were offered exercise.

4.61 Visits were not normally allowed, although staff told us, they would consider them on a case-by-case basis, especially for a child. Security arrangements at the sites were a barrier, however. Staff were not aware of any policy on visits and the position remained similar to our previous inspection.

Areas for improvement

4.62 Border Force should have arrangements to maintain the dignity of detainees using the specialist toilet facilities.

4.63 Border Force should improve detainee care in relation to the arrangements for outside exercise and the opportunities for visits in some circumstances.

Section 5. Individual rights

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

Rights relating to detention

5.1 Custody officers booked detainees into custody on their arrival at the suites. Staff we spoke to said they rarely ever refused detention as they were aware that in most cases a higher officer would have considered whether detention was appropriate before a detainee was transported to a custody suite. They were aware, however, that they could refuse detention if there were insufficient grounds. We did not see any detainees being booked in during our inspection.

5.2 Custody officers we spoke to had little or no awareness of Police and Criminal Evidence Act 1984 (PACE) Code G,[9] which was disappointing because it affected what a detainee should have been told about their arrest, depending on whether they had been detained under customs and immigration legislation or under PACE. Custody records we examined recorded limited information about the rationale or necessity for an arrest.

5.3 Alternatives to custody were available through compound penalties,[10] which were available for less serious offences, for example possession of small amounts of drugs for personal use other than heroin or cocaine. Voluntary attendance[11] was available, however, it was inappropriate that a voluntary attendee was brought into the Gatwick custody suite to be interviewed because it was contrary to the ethos of the process, which involved diverting individuals away from the custody environment.

5.4 Most detainees arrived at the custody suites shortly after their arrest, however, we were told that some transfers took too long, but there were usually mitigating circumstances. For example, if a detainee had to attend hospital in the first instance for an X-ray or CT scan to check if drugs were concealed internally. In our custody record analysis, the shortest transfer time was 24 minutes and the longest four hours and 59 minutes.

5.5 We were informed that most detainees were booked in promptly on arrival. In our custody record analysis, the overall average waiting time was 22 minutes. However, we found some delays of 55 minutes and one hour and 17 minutes, because other detainees were being booked in at the same time. We could not confirm if the detainees would have remained in handcuffs while they waited to be booked in (see paragraph 4.39).

5.6 When a suspected internal drug trafficker ingested drugs into their body to conceal them, it could take several days for the packages to pass through their digestive system. In these circumstances, custody staff secured a section 152 remand under the Criminal Justice Act 1988[12] to hold the detainee for an extended period (see paragraph 5.31). In our custody record analysis, one detainee was appropriately held for just under five days and at

---

9 PACE Code G is the code of practice for the statutory power of arrest by police officers – not applicable in Scotland.
10 Under section 152(a) of the Customs and Excise Management Act (CEMA) 1979, compound penalties allow a detainee to pay a penalty out of court, as an alternative to criminal prosecution for an alleged customs offence of a less serious nature.
11 Voluntary attendance is usually used for lesser offences, and involves suspects attending by appointment a customs office or police station to be interviewed about them, avoiding the need for arrest and subsequent detention.
12 Applicable legislation in Scotland is section 26 Criminal Law (Consolidation) (Scotland) Act 1995.

Colnbrook we saw a woman who was similarly held for almost six days until she passed the drugs she had attempted to conceal.

5.7 Custody officers we spoke to were aware of the need to keep the length of time in detention to a minimum and to progress cases quickly. We were told that investigations were not always progressed promptly owing to several factors, such as the lack of availability of solicitors and interpreters (see paragraph 5.13). We were also told there could be delays while waiting on Crown Prosecution Service (CPS) advice. Border Force data showed the average overall time detainees spent in custody across the estate was just over 12 hours in the 12 months to March 2017.

5.8 Custody officers could release detainees if there had been no further action in their case or if further investigations were to be carried out. Border Force did not have the legal power to charge or bail detainees or take fingerprints, photographs or DNA samples. This had to be done by the police or delegated staff at a local police station. While this meant detainees would be dealt with by trained and experienced staff, it also meant they could remain in custody for a longer period of time.[13]

5.9 Custody officers we spoke to knew they were responsible for contacting appropriate adults (AAs) (individuals who provide support to young people and vulnerable adults in custody) for children under 18 and vulnerable adults.[14] Some custody staff told us they would contact a detainee's family member or friends in the first instance, but at Colnbrook staff said they could not do so because of the security surrounding access to the custody suite. Other than at Colnbrook, guidance leaflets advising AAs what their role involved were available in the suites, but not all staff we spoke to knew about them. It was only available in English.

5.10 Several volunteer and contracted schemes could supply AAs if a family member or friend was unavailable. Custody staff told us they seldom used them and did not know how effective or reliable they were. In our custody record analysis only one detainee required an AA, who attended just over two hours after being contacted.

5.11 At Manchester, Colnbrook and Gatwick we were informed that if a detainee had difficulties reading or writing, informal arrangements were in place to supply an 'independent adult' to help detainees during the booking-in process with documentation. In our custody record analysis, we found evidence that one had been used in two cases. In one case, we could not identify the individual that had attended, but in the other case at Colnbrook, the record stated that a custody support assistant had been used for the role, which did not satisfy us they were truly independent.

5.12 Most custody staff we spoke to were confident about accessing and using professional telephone interpretation services. The post-arrest and transfer risk assessment form was faxed in most cases to the custody officer before the arrival of a detainee and it identified in advance if an interpreter was required for the booking-in process. Telephone interviews with professional interpreters were conducted at booking-in desks on speaker phones, which failed to provide adequate privacy. During the booking-in process, detainees were required to share confidential information about their health, including details of any prescribed medication or medical conditions, which should have been conducted in private. However, custody staff told us only one detainee would be booked in at the custody suite at a time. At some locations speaker phones were also used for confidential health consultations with health professionals (see paragraph 6.3).

---

[13] Suspected internal drug traffickers who had not yet excreted packages would initially be taken to a police station to be charged but then returned to Border Force custody for their continued care and subsequent transfer to court.

[14] In Scotland AAs were required for detainees under the age of 16 or under 18 and subject to a compulsory supervision order.

5.13 Custody staff informed us that the face-to-face service provided by interpreters was mostly good, but delays could be experienced. In our custody record analysis, the average time for an interpreter to arrive after being called was two hours and 24 minutes, but the longest time was just over 13 hours. One custody record we reviewed at Harwich demonstrated that a custody officer had made eight calls before he found a Polish interpreter who could attend the suite, which prolonged the detainee's stay in custody. (See also paragraph 5.7.) Not all custody staff we spoke to were aware that an international telephone line was available in the suite to allow foreign national detainees to make a call home.

5.14 Information for detainees was not available in a range of formats in all suites. Rights and entitlements notices (see paragraph 5.24) were not available in some suites in an easy read format for detainees needing help reading. Braille and audio formats were not available in any of the suites. Additional information, including the custody early warning score form (see paragraph 6.9), and CCTV notifications advising detainees of the need to be monitored, were only printed in English. This was unacceptable, particularly when our custody record analysis showed 69% of detainees to have been foreign nationals.

5.15 Hearing loops were available in most suites, but staff were not always aware of where they were and were not confident about how to use them.

Areas for improvement

5.16 Custody officers should be aware of PACE arrest powers and of what a person subject to these powers must be told on arrest.

5.17 Custody officers should ensure that the circumstances and reasons for a detainees' arrest are fully and clearly documented on the custody record.

5.18 Voluntary attendees should not be interviewed in the custody suite.

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

5.20 Border Force should monitor the length of time that detainees are kept in detention to ensure there are no unnecessary delays.

5.21 All suites should have double handset phones to facilitate telephone interpreting in private.

5.22 Information for detainees should be available in a range of formats to meet their individual needs.

5.23 All custody suites should have access to hearing loops and staff should know where they are and be trained to use them.

Detainee rights

5.24 We were told that during the booking-in process, custody officers advised detainees of their three main rights.[15] They were offered a written notice setting them out. In Scotland detainees received a letter of rights, which outlined similar rights and entitlements. The notices were available in a number of foreign languages, which staff could access easily. At

[15] The right to have someone informed of their arrest, the right to consult a solicitor and access free legal advice, and the right to consult the PACE codes of practice. PACE codes of practice are not applicable in Scotland.

one suite, the foreign language versions had been pre-printed and stored in a file but were out of date. When we pointed this out, they were immediately updated. We found evidence in custody records of notices being issued to detainees in foreign languages.

5.25 Legal advice in Scotland was provided by the Scottish Legal Aid Board and in England by the Defence Solicitors Call Centre, both of which could be contacted 24 hours a day. Posters in 15 languages were displayed in all custody suites advising detainees of their entitlement to consult a solicitor. Detainees could mostly speak to their legal representatives in private in rooms or by phone. However, at some suites we were told calls to a legal adviser had to be taken at the booking-in desk and at Glasgow we found the interview room was not sufficiently sound-proofed to be private.

5.26 Custody staff told us that legal representatives received a copy of their client's custody record, but at some suites only a copy of the front sheet of the record was copied, while others copied the full document.[16] Only Birmingham, Gatwick and Dover had the most recent version of the PACE Code C[17] document and only out-of-date versions were available elsewhere.

5.27 Our analysis of custody records showed that all detainees were offered legal advice, 85% of whom accepted the offer. The shortest time between arrival and a solicitor being called was 17 minutes, while the longest was 28 hours and 50 minutes.

5.28 Higher officers undertook PACE reviews after a detainee had been held for six hours and then again after nine hours. Senior officers carried out PACE reviews if an extension was required when the 24-hour detention period was approaching. Custody records we examined showed that some reviews were very thorough, focusing on legal requirements, but also emphasising detainees' welfare.

5.29 PACE legislation is not applicable in Scotland. In Scotland, we were told that a senior officer was responsible for reviewing cases no later than after 12 hours of detention and then again no later than 24 hours after detention, at which time an application had to be made to the sheriff to grant a warrant for continued detention.

5.30 In our custody record analysis, 34 out of 39 detainees required an initial PACE review while in detention; 28 of the reviews were conducted face to face and three while the detainee was in hospital. In one case, it was not clear how the review was conducted, one review was carried out while the detainee was asleep and it was not clear if the detainee was reminded of the review when they woke up. In the final case, the review took place over the telephone, but no justification was recorded for doing so. We also found reviews were on occasion conducted early. However, this was to allow detainees to rest and had been documented in custody records.

5.31 Detainees held under section 152 of the Criminal Justice Act 1988 for an extended period (see paragraph 5.6) were presented at court promptly and usually at the first available hearing. From the small number of cases we analysed, custody records showed extensions were reasonable and proportionate.

5.32 Video links to court allow suspected internal drug trafficker to be remanded in continued custody without having to travel, reducing the risk of the suspected package bursting inside them while being transported and having a severe impact on their health. Video-link facilities were only available in two suites at Colnbrook and Dover. The facility was not used

[16] In Scotland, a request for a copy of the custody record by a detainee or solicitor on release must be directed to the procurator fiscal who deals with all disclosure requests.
[17] Not applicable in Scotland.

frequently at Dover but the Colnbrook video link had been used 34 times in the 12 months preceding the inspection at Uxbridge Magistrates' Court. We were told that some detainees who appeared in court via the video link at Colnbrook wore paper suits, which was inappropriate.[18]

Areas for improvement

5.33 **Custody facilities should ensure conversations between legal representatives and detainees are conducted in private and cannot be overheard.** (Repeated recommendation 5.30)

5.34 **Up-to-date copies of PACE Code C documents should be available in all relevant custody suites.**

5.35 **Video links should be made available and used in all custody suites to reduce the incidence of suspected internal drug trafficking detainees needing to be conveyed to court for section 152 Criminal Justice Act 1988 remand applications.** (Repeated recommendation 5.31)

5.36 **Detainees should not appear in court via video link wearing a paper suit.**

Rights relating to treatment

5.37 Systems advising detainees how to complain were inconsistent across the suites. As at the last inspection, posters explaining how detainees could make a complaint were not displayed where detainees could see them in all the suites or were not printed in a range of languages. A stock of complaint forms was stored at the booking-in desks and was easily accessible to staff in most suites, but the forms were only available in English. Complaints could only be received in English and Welsh, which did not help foreign nationals. The forms were generic and did not include issues specifically related to being held in custody. Custody staff told us they did not offer the forms to detainees routinely and they were mostly only issued on request.

5.38 Custody staff said very few detainees made complaints about custody. Custody records indicated that higher or senior officers asked most detainees during reviews if they had any issues about their time in custody and custody staff asked them again just before they left the suite. We were told that if a detainee had a concern about their treatment, staff would try to resolve it immediately. Data supplied by the force showed a small number of complaints had been made in the previous year at Colnbrook. However, corresponding custody records did not always make it clear if a complaint had been received or if any steps had been taken to deal with the matters raised (see paragraph 3.28).

[18] Section 8.5 Code C of the Police and Criminal Evidence Act (1984) states 'If it is necessary to remove a detainee's clothes for the purposes of investigation, for hygiene, health reasons or cleaning, replacement clothing of a reasonable standard of comfort and cleanliness shall be provided. A detainee may not be interviewed unless adequate clothing has been offered'. The same principle should be applied to detainees appearing before a court via video-link as a paper suit is not considered to be adequate replacement clothing for these purposes.

Section 6. Health care

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

Governance

6.1 Joint working between Border Force and NHS England was effective and there had been an up-to-date health needs assessment. CRG Medical provided health services for the English suites since 6 February 2017. The new contract included clear response times, performance targets and reporting structures, with financial penalties if response times were not met. However, the intended governance and service delivery benefits of having a single provider had not been realised mainly because of significant health staffing shortages. Additionally, the health provider's governance systems were still developing, for example while CRG policies were available in each suite, most were overdue a review and were not tailored to Border Force provision (see main recommendation 2.43). Border Force was managing the concerns robustly and the health provider was addressing deficits. Despite these problems, custody staff at most sites were generally positive about the health provider.

6.2 Custody and Offender Medical Services (COMS) provided health services at the Glasgow suite since 2015; from April 2016, the service became part of the wider Greater Glasgow and Clyde police custody contract. There were no agreed response times, although we were told calls were prioritised according to clinical need. Health professionals had been requested three times since April 2016, all for telephone advice, which had been prompt. Custody staff were positive about the health provider.

6.3 Most of the English suites had a notice in the clinical room stating that detainees could request a health professional of their own gender, although it was only in English and was not on display in Glasgow. An examination of clinical records indicated that access to face-to-face interpretation for clinical consultations was generally good, however the lack of telephones in the clinical room meant it was hard to provide confidential telephone interpretation (see paragraph 5.12). Custody staff said detainees could generally see a health professional in private, based on an individual risk assessment.

6.4 Detainees could complain directly to CRG about the health provision; however, the complaints procedure was not well advertised in all suites and all the posters were only in English. No information was available in the Glasgow suite to advise detainees how they could make a complaint about health services.

6.5 All custody suites now had a small clean clinical room, including an excellent new facility in Glasgow. No forensic testing was completed at any suite. Most suites had some fixtures and fittings that did not meet national infection control standards. However planned alterations in Colnbrook and the replacement of fabric chairs in most clinical rooms would make them adequate. Sharps bins did not routinely have dates or signatures detailing the first time they were used and those that did, had vastly exceeded the six-month expected period of use.

6.6 Custody staff had access to excellent emergency equipment (see paragraph 6.9), plus standardised well-stocked and checked first aid kits, including burns dressings and eyewash, although those in Colnbrook contained some recently expired items. CRG had installed emergency equipment for health staff in each suite, but checking processes were not robust and we found some expired medicines and equipment that was not working.

Area for improvement

6.7 Detainees should have easy access to information about health services in an appropriate range of languages. Information should include details about the complaints procedure and the availability of same gender health professionals.

Patient care

6.8 Dover, Colnbrook and Gatwick had the highest detainee throughput rate and the greatest demand for health professionals. Clinical records and staff reports confirmed detainees were promptly referred to a health professional based on their clinical need or if the detainee requested input. Border Force data showed that 43% of detainees had been referred to a health care provider in the 12 months up to March 2017. Our custody record analysis indicated around 40% of all detainees were referred to a health professional, most for telephone advice. Most requested visits related to a detainee's fitness to be detained, interviewed or charged. Telephone advice was available promptly through a well-advertised single contact for each provider; however staffing shortages had caused some excessive delays in health care visits in some English suites. Custody staff said ambulances generally attended promptly in emergencies.

6.9 Detainees suspected of carrying drugs internally received timely scans or X-rays at local facilities. The custody early warning score (CEWS) process for assessing the well-being of detainees suspected of carrying drugs internally was excellent. Medical emergency response kits linked to the CEWS process remained comprehensive and well checked. In most suites, all custody staff were up to date with CEWS training, however, in Glasgow and Stansted only 36% and 56% of staff respectively were up to date.

6.10 Health professionals did not directly record information on the custody record, but did provide a care plan. Care plans were mostly satisfactory, although not all full assessments adequately outlined the detainee's presentation (demeanour) or the rationale for prescribing and some handwriting remained hard to read. CRG was developing more robust information governance processes in the English suites, including getting health professionals to send suites a written care plan by fax or email following telephone advice, which was good.

6.11 Custody staff received guidance on medicine administration during their training and the processes staff described sounded safe. Glasgow held no medication on site due to low throughput, but supplies were obtained as required on the authorisation of a health professional.

6.12 Most English suites held stocks of over-the-counter remedies, such as paracetamol and antacids, which custody staff could issue after speaking to a doctor, although as on the last inspection only Dover routinely sought written confirmation for their records. Additional medicines were procured from local suppliers. CRG held a supply of more potent standardised medication in most suites, which only visiting health professionals could access. However, custody staff at Dover still effectively managed a large variety of medication, as agreed with their previous health provider. CRG systems to ensure that medication had not expired and was correct were still underdeveloped and we found some expired items. We saw evidence of prescription medicines being authorised by a health professional without having seen the patient. CRG advised us that shared medication protocols were being developed.

6.13 Detainees could only smoke in Harwich. Nicotine replacement treatment (NRT) was not available in Birmingham or Manchester but was regularly issued in Dover. All suites offering NRT liaised with the health provider before it was given to detainees.

Areas for improvement

6.14 Clinical assessments should meet all pertinent professional standards for recording and storage and be subject to regular audits.

6.15 Medicines management processes should ensure safe and secure stock management, and detainees should only receive prescribed medication following a face-to-face assessment by a health professional.

6.16 NRT should be offered to all detainees who smoke within an agreed protocol which is regularly reviewed. (Repeated recommendation 6.20)

Substance misuse and mental health

6.17 Custody staff reported no direct demand for substance misuse services and had not completed any related training. Custody staff said local support information would be obtained for individuals before release if required. The Border Force support leaflet, issued on release, included national contact numbers for mental health and substance misuse support (see paragraph 4.27).

6.18 Custody staff said they would request a face-to-face health assessment for detainees with significant mental health issues. They received brief mental health awareness training during their induction, but no ongoing training and those we spoke to demonstrated a variable level of mental health awareness. The new CRG contract included developing pathways with relevant community services and the provision of mental health awareness training for custody staff. Some custody staff in Scotland had received mental health awareness training and we were advised wider courses were planned, although no details were available.

Area for improvement

6.19 Custody staff should receive regular mental health awareness training, which should cover how cultural variations can influence how mental health issues may present themselves in a patient.

Section 7. Summary of areas of concern, recommendations and areas for improvement

Areas of concern and recommendations

7.1 **Area of concern:** The strategic approach to custody services was limited and delivery was driven operationally by the regions rather than through a strong national approach to ensure effective and consistent outcomes for detainees.

Recommendation: Border Force should strengthen its strategic approach to the delivery of custody services to provide a strong overall framework that supports the regions, ensures consistent service delivery and outcomes for detainees, and drives service improvement. (2.40)

7.2 **Area of concern:** Border Force has stated it follows the APP guidance for detention and custody as set by the College of Policing. Its practices did not reflect this in a number of areas and some staff demonstrated little knowledge of the content of the guidance.

Recommendation: Border Force should take immediate action to ensure all custody staff follow APP policy and guidance, and have arrangements in place to demonstrate compliance. (2.41)

7.3 **Area of concern:** Performance management was limited and little proactive monitoring of the service and action took place as a result.

Recommendation: Border Force should ensure its data are accurate and performance is monitored effectively. The information should be used inform its work with the regions and to identify and act on areas requiring improvement. (2.42)

7.4 **Area of concern:** Border Force had procured a single health provider for the seven English suites and had clear and appropriate performance monitoring mechanisms. However, at the time of the inspection the health provider did have not have adequate staffing or governance structures in place to ensure detainees received a consistent, safe and timely service.

Recommendation: The health provider in the English suites should ensure there are adequate staffing levels and governance systems in place to ensure all detainees receive a safe and timely service. (2.43)

Areas for improvement

Strategy

7.5 Border Force should extend DBS vetting to all custody officers to strengthen the approach to safeguarding. (3.17)

7.6 An efficient and effective method of recording should be introduced. (3.18)

7.7 ICVs should be available to provide scrutiny at the Glasgow suite. (3.22)

7.8 Arrangements to ensure the skills and knowledge of custody staff are kept up to date should be implemented. (3.29)

7.9 Border Force should strengthen its approach to quality assurance and introduce a systematic approach to learning lessons from adverse and critical incidents. (3.30)

Treatment and conditions

7.10 Border Force should ensure custody officers complete a child welfare control sheet for any child entering a custody suite. (4.12)

7.11 Detainees with disabilities should be appropriately catered for at all suites. (4.13)

7.12 Clothing with cords, footwear and other personal possessions should only be removed subject to an individual risk assessment. (4.28)

7.13 Standardised levels of observation in line with APP guidance should be implemented, clearly recorded, reviewed when circumstances change and adhered to. (4.29)

7.14 The content of custody records should be improved; they should include a full account of rousing and other interactions between staff and detainees. (4.30)

7.15 All staff in custody should carry anti-ligature knives. (4.31)

7.16 Handovers should include all incoming and outgoing staff. (4.32, repeated recommendation 4.22)

7.17 The standardised PER should be thoroughly completed for all detainees and kept with the detainee custody record. (4.33)

7.18 Pre-release risk assessments should be thorough and based on an ongoing assessment of detainees' needs while in custody. The custody record should reflect the position on release and any action that needs to be taken. (4.34, repeated recommendation 4.20)

7.19 Personal protective equipment should be standardised for staff in all custody suites and should be proportionate to the controlled custody environment. (4.42)

7.20 Border Force should ensure that detainees are handcuffed only when it is necessary, justified and proportionate, using a risk assessment, in all suites. (4.43, repeated recommendation 2.37)

7.21 Individual use of force forms should be submitted following every use of force against detainees, including compliant handcuffing. (4.44)

7.22 Emergency evacuation drills should be carried out and recorded regularly. (4.52)

7.23 Border Force should have arrangements to maintain the dignity of detainees using the specialist toilet facilities. (4.62)

7.24 Border Force should improve detainee care in relation to the arrangements for outside exercise and the opportunities for visits in some circumstances. (4.63)

Individual rights

7.25 Custody officers should be aware of PACE arrest powers and of what a person subject to these powers must be told on arrest. (5.16)

7.26 Custody officers should ensure that the circumstances and reasons for a detainees' arrest are fully and clearly documented on the custody record. (5.17)

7.27 Voluntary attendees should not be interviewed in the custody suite. (5.18)

7.28 Detainees should be booked in promptly on arrival at custody suites. (5.19)

7.29 Border Force should monitor the length of time that detainees are kept in detention to ensure there are no unnecessary delays. (5.20)

7.30 All suites should have double handset phones to facilitate telephone interpreting in private. (5.21)

7.31 Information for detainees should be available in a range of formats to meet their individual needs. (5.22)

7.32 All custody suites should have access to hearing loops and staff should know where they are and be trained to use them. (5.23)

7.33 Custody facilities should ensure conversations between legal representatives and detainees are conducted in private and cannot be overheard. (5.33, repeated recommendation 5.30)

7.34 Up-to-date copies of PACE Code C documents should be available in all relevant custody suites. (5.34)

7.35 Video links should be made available and used in all custody suites to reduce the incidence of suspected internal drug trafficking detainees needing to be conveyed to court for section 152 Criminal Justice Act 1988 remand applications. (5.35, repeated recommendation 5.31)

7.36 Detainees should not appear in court via video link wearing a paper suit. (5.36)

Health care

7.37 Detainees should have easy access to information about health services in an appropriate range of languages. Information should include details about the complaints procedure and the availability of same gender health professionals. (6.7)

7.38 Clinical assessments should meet all pertinent professional standards for recording and storage and be subject to regular audits. (6.14)

7.39 Medicines management processes should ensure safe and secure stock management, and detainees should only receive prescribed medication following a face-to-face assessment by a health professional. (6.15)

7.40 NRT should be offered to all detainees who smoke within an agreed protocol which is regularly reviewed. (6.16, repeated recommendation 6.20)

7.41 Custody staff should receive regular mental health awareness training, which should cover how cultural variations can influence how mental health issues may present themselves in a patient. (6.19)

Section 8. Appendices

Appendix I: Inspection team

Ian MacFadyen	HMI Prisons team leader
Fionnuala Gordon	HMI Prisons inspector
Kellie Reeve	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMICFRS lead inspector
Anthony Davies	HMICFRS inspection officer
Patricia Nixon	HMICFRS inspection officer
Laura Paton	HMI Constabulary in Scotland lead inspector (in attendance at Glasgow Airport)
Majella Pearce	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

Border Force should ensure that staff are skilled, competent and confident in their ability to ensure the continued welfare and safe custody of all detainees in their care. (2.36)
Partially achieved

Recommendations

Custody refresher training should be delivered at least annually and should be informed by quality assurance, critical incidents, use of force and complaints procedure. (3.15)
Partially achieved

The procedure for the dip sampling of custody records should be reviewed to improve the quality of completion and to develop an audit trail of feedback to individuals and wider organisational learning. This quality assurance should be cross referred to CCTV recordings and the person escort record (PER). (3.16)
Not achieved

The national PER form should be used for all transfers of detainees, to ensure that risk information is consistently passed to other agencies. Policy on the use of the form should be clarified and communicated to staff. (3.17)
Not achieved

A form should be introduced for the recording of critical incidents to ensure all details are recorded at the earliest opportunity, and at the location of the incident. (3.18)
Achieved

Treatment and conditions

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

Main recommendations

Border Force should ensure that detainees are handcuffed only when it is necessary, justified and proportionate, using a risk assessment, in all suites. (2.37)
Not achieved (recommendation repeated, 4.43)

Border Force should ensure the dignity of all detainees, especially women during close proximity observation. Border Force should provide an alternative to the one-piece suit for detainees. (2.38)
Not achieved

Recommendations

The safety implications of the lack of escape hatches in cellular vehicles should be established and, if necessary, vehicles should be adapted to allow a means of egress in the event of fire or collision. (4.11)
No longer relevant

Custody suites should be fully accessible to detainees with disabilities. (4.12)
Not achieved

Pre-release risk assessments should be thorough and based on an ongoing assessment of detainees' needs while in custody. The custody record should reflect the position on release and any action that needs to be taken. (4.20)
Partially achieved (recommendation repeated, 4.34)

Person escort record should be kept with the detainee custody record. (4.21)
Not achieved

Handovers should include all incoming and outgoing staff. (4.22)
Not achieved (recommendation repeated, 4.32)

Replacement clothing should be available at all suites. (4.43)
Achieved

There should be facilities for outdoor exercise. (4.44)
Not achieved

A range of reading material should be available and routinely offered, including books and magazines in easy-read format and suitable for young people. (4.45)
Partially achieved

Visits should be allowed in exceptional circumstances for vulnerable detainees or those held for long periods. (4.46)
Not achieved

Individual rights

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

Recommendations

Steps should be taken to ensure that detainees are not held in custody for longer than necessary. (5.16)
Partially achieved

Custody staff should be provided with a written guidance document to assist family or friends acting as appropriate adults (AAs), which should be routinely issued where relevant. (5.17)
Partially achieved

Custody facilities should ensure conversations between legal representatives and detainees are conducted in private and cannot be overheard. (5.30)
Not achieved (recommendation repeated, 5.33)

Video-enabled court links should be made available in all custody suites to reduce the incidence of suspected internal drug trafficking detainees needing to be conveyed to court for Section 152 Criminal Justice Act 1988 remand applications. (5.31)
Not achieved (recommendation repeated, 5.35)

Health care

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

Recommendations

All health services should be based on a regular health needs assessment and meet national clinical governance arrangements. Service contracts should include appropriate performance measures, penalties and robust monitoring arrangements. (6.7)
Achieved

All suites should have a dedicated medical room that meets NHS infection control standards. (6.8)
Partially achieved

Detainees who are seen by a health professional should have a clinical record which includes an assessment and care plan conforming to professional guidance from regulatory bodies and in line with Caldicott guidance on the use and confidentiality of personal health information. (6.18)
Partially achieved

There should be safe pharmaceutical stock management and safe prescribing, and medications should only be administered by staff competent to do so. (6.19)
Partially achieved

Nicotine replacement therapy should be offered to all detainees who smoke within an agreed protocol which is regularly reviewed. (6.20)
Not achieved (recommendation repeated, 6.16)

Custody staff should have access to regular training and standardised protocols based on current national guidance to identify and manage drug and alcohol withdrawals promptly. (6.23)
Not achieved